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PROCEEDINGS AND DEBATES OF THE 111th CONGRESS, FIRST SESSION

SENATE—Wednesday, December 16, 2009

The Senate met at 10 a.m. and was called to order by the Honorable TOM UDALL, a Senator from the State of New Mexico.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.
Our Father God, we thank You for this day, for eyes to see and for hearts to feel the wonders of Your world. Today, fill our Senators with a fresh faith and a triumphant confidence in Your final victory over the hearts of humanity. May our lawmakers face these sometimes baffling days with the glad assurance that no weapon that has been formed can prevail against Your eternal purposes.

Lord, help them to relinquish any negative thoughts to You and receive a fresh infusion of Your hope. Burn away the barriers to unity so that Your will can be done on Earth even as it is done in Heaven.

We pray in Your sovereign Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable TOM UDALL led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 16, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable TOM UDALL, a Senator from the State of New Mexico, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. UDALL of New Mexico thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

SCHEDULE

Mr. REID. Mr. President, following leader remarks, the Senate will resume consideration of the health care reform legislation. The first hour will be equally divided and controlled between the two leaders or their designees. The majority will control the first 30 minutes and the Republicans will control the next 30 minutes. We expect a vote in relation to the Hutchison motion to commit today, and the Sanders amendment. It is my understanding Senator SANDERS will offer his amendment at around 11 o'clock today. They will both be pending. Senators will be notified as to when any votes are scheduled.

HEALTH CARE REFORM

Mr. REID. Mr. President, we continue making progress toward making it possible for every American to afford to live a healthy life. Senators continue to work together toward that goal because even though we may have differences of opinion on the details, we all share the strong belief in the differences we can make for the American people as it relates to their being healthy.

We all know our current system is beyond broken, and we know the citi-

zens of this country demand that we fix it. We know this because they tell us—in letters, in phone calls, and visits we have at home, and we have not been going home very much, but certainly when we are able to get there. Those who oppose making health insurance more affordable and making health insurance companies more accountable would like you to believe that is not the case. But that is only propaganda by the insurance industry.

They want you to think the American people are happy when these greedy insurance companies deny health care to the sick and take away their coverage at the exact moment they need it the most.

They would like you to believe the American people do not mind hearing a multibillion-dollar company tell them: I am sorry you have diabetes. I am sorry you have a heart condition. But, also, it hurts my bottom line, so you are on your own.

These insurance companies and health care deliverers want you to believe that women gladly pay more than they should for the screenings they have to catch breast cancer, that men gladly pay more than they should to have the test to catch prostate cancer, and that seniors gladly pay much more than they should to get their prescription drugs.

Those who are trying to slow the Senate—and really the country—and stop reform want you to believe the American people do not mind paying hidden taxes to cover the uninsured, they do not mind the waste and fraud rampant in the health care system, and they do not mind losing their health insurance if they lose their job. But, simply, that is not true. That is not the case.

The people we represent—whether it is New Mexico, Montana; we have two from New Mexico, we have one from Michigan, one from Kentucky, Oklahoma—it does not matter what State you represent; there are stories.

Listen to what Mike Tracy, who lives in north Las Vegas, NV, said. His 26-year-old son has been an insulin-dependent diabetic since he was a baby. The insurance Mike's son gets through

● This "bullet" symbol identifies statements or insertions which are not spoken by a member of the Senate on the floor.

work will not cover his treatments, and the Tracys cannot afford to buy more coverage on their own.

But this family's troubles are about more than just money. Since they could not afford to treat their son's diabetes, it developed into something called Addison's disease—a disease that President Kennedy had. If you have money, you can treat the disease. If you do not, it is a very bad disease, likely could be fatal.

This is what Mike wrote me this past Friday.

I don't know what to pray for first: that I will die before my son will so I don't have to bear the burden, or that I outlive him so I can provide support to his family when he is gone.

This should not be a choice for any American, and when given the chance to help people such as Mike, our choice should be easy.

Here is another example: Ellen O'Rourke wrote to me last Tuesday about her friends, the Hidalgos, who live in Incline Village, NV, a town on the shores of Lake Tahoe. The Hidalgos' 2-year-old daughter Lexie Mae has a cancer of the eye that could cost her vision or her life.

Lexie Mae's parents do not have health insurance and are counting on friends to help pay for their daughter's mounting medical bills. They are also counting on us to lower the cost of health care so they can afford their own. They work hard. They want health insurance. They cannot get it.

Another letter I got last week was from Elizabeth Parsons. She teaches music at an elementary school in Reno and volunteers after school at a dance and drama theater in town. She is 60 years old and wanted to retire at the end of this school year. But as she wrote me last Thursday.

Unfortunately that plan has been postponed indefinitely for one reason only:

"one reason"—

I can't afford to retire because of the skyrocketing increases in [my] health insurance.

Ms. Parsons has done a lot for her community. Now her country's leaders should do something for her: We should make sure her decision about whether to retire doesn't hinge on how expensive it is to keep her insurance.

A man named Walt Cousineau from Elko wrote me last Monday to tell me about his wife. She had a heart attack three Decembers ago. Health insurance companies are using that as an excuse to charge \$2,000 a month for coverage, \$25,000 a year. They call it a pre-existing condition, a prior heart attack. She is not old enough yet for Medicare, but Walt is. He is 68. He had to go back to work so she could be put on his health insurance. Now Walt is asking us to go to work for him and asking us to make sure no one's health history can make staying healthy in the future more expensive.

Ken Hansen is from Mesquite, a town on the Arizona-Nevada border. He has chronic health problems and parts of his feet have been amputated. Ken can't go to a doctor because he makes too much to qualify for Medicaid and too little to afford private insurance. I wish to share with the Senate exactly what Ken wrote me:

I am very frustrated because my only hope is that I die very soon because I can't afford to stay alive.

Those are his words—not my words—that his only hope is that he die. How can we look the other way? How can we possibly do nothing? This isn't about balance sheets or graphs or charts; it is not about contracts or fine print; it is not about politics or partisanship. This is about life and death in America.

Each story is more heartbreaking than the last. Each of these Nevadans has more than enough on his or her mind. Yet each of these citizens took time out of his or her day to beg their leaders to do something.

Mike Tracy, the father of the young man with diabetes and Addison's disease, ended his letter to me just a few days ago with this plea. Here is what he said:

Democrats need health care. Republicans need health care. Independents need health care. All Americans need health care. Get it done.

We can't let them down. We just can't let them down.

Those trying to kill this reform have made it clear they will do anything to stop us. They can recite recycled talking points until their hearts' content, but that is it. But as long as Mike Tracy's son might die from a disease we know how to treat, we can't let these obstacles stand in our way. As long as Lexie Mae's parents have to borrow from their friends to take their daughter to the doctor, we can't take no for an answer. As long as Elizabeth Parsons can't afford to retire, Walt Cousineau can't afford to stay retired, and Ken Hansen says he can't afford to stay alive, we can't stop fighting for them.

ESTATE TAX REFORM

Mr. REID. Mr. President, on a final point, for some time now we Democrats have been trying to reform the estate tax to avoid the train wreck that is coming next month.

Because of the legislation passed by the Republicans in 2001, the estate tax is repealed for 2010—gone, nothing. But because of the gimmick they used to pass this legislation, the estate tax returns in 2011, and it does so at the levels that were in effect in 2001.

This chicanery has created a nightmare for families trying to plan their affairs.

We have proposed a responsible path forward toward curing the estate tax problem. We proposed to extend the

current tax parameters so that in 2010 couples would be able to pass down up to \$7 million completely tax free. An estate tax at that level exempts all but the wealthiest two-tenths of 1 percent of estates from paying any estate tax.

The other side has rejected this reasonable approach. Instead, they want to keep the Bush tax law in place for 2010 as originally designed.

The irony in the Republicans' position is, it hurts the very families—small business men, women, and family farmers—whom they claim they are trying to help.

The surprise facing family farms and family-owned small businesses in 2010 is that repeal of the estate tax will actually increase their tax liabilities. These are families who would never pay the estate tax because they don't have assets totaling more than \$7 million for a couple.

So why do they face a tax increase? It has to do with a provision in the Tax Code called stepped-up basis. What does this mean? The assets of family-owned businesses are often in the form of unrealized capital gains, the appreciation of the family business over time. Right now, until the end of this year, December 31, these capital gains are forgiven when a person dies—no capital gains at death and for these families with less than \$7 million there is no estate tax under current law. Therefore, for these families, death is not a taxable event.

The capital gains tax is forgiven because the heirs to the property receive a step up in its basis for measuring tax liability when they ultimately sell the property.

The law my Republican colleagues insist go into place next month repeals stepped-up basis.

The bargain my Republican colleagues are advancing is simple. If you are rich, celebrate. If you are not, you should be afraid. If you are very wealthy, you get a huge windfall from repeal of the estate tax. If you are modestly successful—say you have a shoe store, a service station, a small farm, or whatever small business—but not to the point where you are facing an estate tax liability, your heirs will, nonetheless, face a tax increase because of the repeal of the estate tax.

For the wealthiest families in this country, they say don't worry about that. The estate tax is gone. For many more small businesses, Republicans say that is too bad. All these years, as Republicans were using family farms and small businesses as props in their zeal to repeal the estate tax, their real goal was protecting the wealthiest of the wealthy. The unfortunate aspect of that campaign is that repeal of the estate tax, even for just 1 year, will come at the expense of family-owned farms and small businesses.

We asked, last night, and it will be asked again by the chairman of the Finance Committee, the senior Senator

from Montana, Mr. BAUCUS, to extend the estate taxes that now exist, giving a couple an exemption of up to \$7 million for 2 months while we work things out on that and a number of other issues, but that has been rejected by my friends on the other side of the aisle.

I repeat: If the estate tax lapses for a period at the beginning of 2010, this will be a boon for the wealthy, a huge drain on the U.S. Treasury and, more importantly, let me also note that tens of thousands of middle-class families could suffer. If the estate tax lapses, even for a short period, these families will be subject to capital gains when they sell their inherited or bequeathed property, a process that will be enormously complicated for families who have no estate tax or planning issues today. Although this could be retroactively eliminated, in the meantime the uncertainty and planning around this would affect a large number of families who ordinarily don't have to think about the estate tax.

RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The Republican leader is recognized.

ORDER OF BUSINESS

Mr. MCCONNELL. Mr. President, I would ask my colleague, the majority leader, was it his intention to propound a unanimous consent request on this issue?

Mr. REID. I say to my friend, the chairman of the Finance Committee will do that.

Mr. MCCONNELL. All right. I will go ahead and make my opening remarks. I don't know when the chairman of the Finance Committee wanted to make this request. Did he want to make a speech in connection with it as well?

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, let me say to my friend from Kentucky, I will not make a lengthy speech, but I am more than prepared to wait until you give your comments, and when you conclude, I will make my request.

Mr. MCCONNELL. I would say to my friend from Montana, it would be helpful if you could go ahead and do the unanimous consent agreement, if you want to speak to the issue later.

Mr. BAUCUS. Well, other Senators wish to speak as well.

HEALTH CARE REFORM

Mr. MCCONNELL. Mr. President, reclaiming my leader time, the longer the debate over health care goes on, the clearer it becomes that the problem the Democrats are having isn't

with some of the provisions we keep hearing about on the news; their problem is the fundamental opposition of the American people to the core components of the bill—the core of the bill.

Americans oppose the Democratic plan because they know the final product is a colossal legislative mistake. Not only does this bill fail to achieve its primary goal of lowering the cost of health care, it makes matters worse by driving up premiums, raising taxes, and wrecking Medicare for seniors.

The bill is fundamentally flawed, and the American people know it can't be fixed. That is why they are asking us to stop and start over with the kind of commonsense, step-by-step reforms that will address the cost problems.

Fortunately, a growing number of Democrats are beginning to listen to the voices of the American people. We have, just today, a Washington Post poll indicating, once again, the polls are unanimous that the American people are overwhelmingly opposed to this bill, and seniors in particular, by a very wide margin, do not favor this bill.

So our friends on the other side of the aisle face a choice. They can either side with those who are making a call to history or they can side with their constituents who say a vote on this bill would be a historic mistake.

That is what is unfolding behind the scenes: As a handful of Democratic leaders press ahead in a blind rush of frantic dealmaking to find 60 votes by Christmas, a handful of other Democrats are wondering which side they want to be standing on when the dust settles—with those who are pushing them to support a bill they don't like or with the American people who are imploring them not to do it.

This is an important moment in the life of our Nation. This is one of those moments when the free decisions of a handful of elected leaders are the only difference between America going down one road or another. History will be made either way. History will be made either way. But in this case, as in many others from our history, Americans want history to show that a determined few took their side and triumphed over a powerful majority—a majority who clearly misread its mandate.

GUANTANAMO BAY

Mr. MCCONNELL. Mr. President, early yesterday, the administration announced what can only be viewed as the latest in a string of seriously misguided decisions related to the closing of the secure facility at Guantanamo Bay. It plans to move dozens of terrorist detainees from Guantanamo Bay Cuba to a prison in northern Illinois.

The explanation we used to get for moving detainees onto American soil was that Guantanamo's existence is a

potent recruiting tool for terrorists. But even if you grant that, it is hard to see how simply changing Guantanamo's mailing address would eliminate the problem. Does anyone believe Al-Jazeera will ignore the fact that enemy combatants are being held on American soil? It is naive to think our European critics, the American left, or al-Qaida will be pacified by creating an internment camp in northern Illinois, a sort of "Gitmo North" instead of "Gitmo South."

As I said, this is just the latest in a series of misguided decisions. First, there was the decision to close Guantanamo by an arbitrary date without a plan for doing so. Americans expect their Government to protect them. That is why Americans overwhelmingly rejected the idea of closing Guantanamo.

Then there was the decision to bring the self-avowed mastermind of the 9/11 attack, Khalid Shaikh Mohammed, and his fellow 9/11 plotters into New York City for trial. We learned just this week, the administration plans to give other terrorists the benefits of a civilian trial in the United States.

Now there is this: According to the reports we have seen, the administration intends to bring as many as 100—100—foreign terrorist fighters from Guantanamo Bay to America, a plan that would make our Nation less safe, not more so. What is worse, the defenders of the proposal don't even seem to get the implications.

Rather than even attempt to reassure people about safety, politicians in Illinois are trumpeting this decision—get this now—as a jobs program, a jobs program. That is how out of touch they are. Democratic politicians are so eager to spin the failure of the \$1 trillion stimulus, they are now talking about national security in the language of saved and created jobs.

The advocates of closing Guantanamo without a plan can't seem to make up their minds as to why it is a good idea. First, we were told we had to bring them here because Guantanamo is a dangerous symbol—the whole symbolism over safety argument. Now, with unemployment in double digits, it is being sold—incredibly—as a jobs project, some kind of shovel-ready plan.

But leaving aside the absurdity of marketing this as a jobs program, let's get to the core issue. The core issue is this: Moving some of the worst terrorists on Earth to U.S. soil on its face is more dangerous than leaving them where they are. Nobody could argue with that. Make no mistake, this decision, if implemented, will increase the threat to security at home. Let's count the ways in which it increases the threats of security in the United States.

There will now be another terrorist target in the heartland of America—an

obvious one at that, right near the Mississippi River.

The FBI Director has already stated his concerns about the radicalization of other prisoners that could happen by moving terrorists here.

There is also the danger of detainees communicating with terrorists on the outside, as has happened in the past—a danger that would undoubtedly increase with the additional legal rights detainees will enjoy once they are moved into the United States.

Then there is the danger that the detainees could sue their way to freedom—yes, that the detainees could sue their way to freedom. Before the first detainee has even set foot in the United States, their lawyers stand ready to challenge in court the administration's decision to incarcerate detainees indefinitely in the United States. By purposefully moving detainees here, the administration is making it easier for detainees and their lawyers to succeed in doing so.

The Supreme Court has repeatedly held that foreign nationals have more rights if they are present on U.S. soil than if they are not. We have already seen the application of this principle. We have seen a Federal judge order detainees released into the United States—only to be reversed because the detainees at the time didn't enjoy the advantage of being present in the United States—an advantage the Obama administration intends to confer on them.

Then there is the case of the so-called shoe bomber, Richard Reid, who narrowly failed in his effort to blow up a passenger jet in midair. Americans might recall that Reid ended up in a supermax facility in Colorado. They might not recall what happened next. Not satisfied with his conditions of confinement, Reid sued the government. He said he wanted to be placed in less restrictive conditions where he could watch TV, order periodicals through the mail, and learn Arabic. He got his wish. The Obama administration acceded to Reid's demands. He has been placed in the general prison population, a less restrictive environment where he can speak to the media and where his visitors and mail will no longer be regularly monitored by the FBI. Is this how we should treat people who attempt to blow up commercial airliners? We will no longer have the FBI routinely monitor their mail? This is an outrage, an absolute outrage. Unfortunately, it is not an isolated case.

Just a few years ago, this same supermax allowed terrorist inmates to communicate with terrorist networks abroad. At the time, our Democratic colleagues criticized these security lapses harshly. The senior Senator from New York said Federal prison officials were "incompetent when it comes to detecting possible terrorist activity in Federal prisons." He noted

"past evidence of terrorists communicating with live terror cells from inside prison walls." That was the senior Senator from New York.

Our Democratic colleagues now raise concerns about similar potential lapses at the proposed "Gitmo North."

This decision is ill-advised on multiple levels. It is also prohibited by law. Fortunately, if and when the Obama administration submits its plan for closing Guantanamo, Congress will have an opportunity to revisit the prohibition in current law that bars the transfer into the United States of Guantanamo detainees for the purposes of indefinite detention. That is against the law. At that point, we will decide whether this prohibition ought to be removed and whether millions of dollars ought to be appropriated to make this ill-advised decision a reality.

In short, Congress will have a chance to vote on whether we should treat the national security needs of the country as just another local jobs project. I suspect the American people will be no more supportive of this idea than they were of the administration's plan to close Guantanamo by an arbitrary date. Security can't take a backseat to symbolism, and it certainly should not take a backseat to some parochial jobs program.

I yield the floor.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER (Mr. BEGICH). Under the previous order, leadership time is reserved.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The PRESIDING OFFICER. Under the previous order, the Senate will resume consideration of H.R. 3590, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid amendment No. 2786, in the nature of a substitute.

Hutchison motion to commit the bill to the Committee on Finance, with instructions.

The PRESIDING OFFICER. Under the previous order, the first hour will be equally divided and controlled between the two leaders or their designees, with the minority controlling the first half and the majority controlling the second half.

The Senator from Montana is recognized.

Mr. BAUCUS. Under current law, the estate tax disappears next year—in 16 days—but snaps back to a 55-percent rate the year after. I believe that is not

sound policy. The estate tax should not be zero in 1 year and then be snapped up to a very high rate in the subsequent year. As the Chair knows, current law has the rate slowly declining and the exemption slowly increasing. The individual exemption now is \$3.5 million. If Congress takes no action, then beginning on January 1 of next year, that could be zero. The estate tax could be zero.

But another consequence that will occur too is that all heirs of the estate will find that the property they receive will be subject to a carryover basis. Currently, today, property received by heirs is subject to a step-up basis. They get the new basis and the value of the estate as of the date of the decedent's death. If this law expires, there would be no estate tax paid next year on any estate, but also the heirs will no longer have a step-up basis on the assets they receive.

There are several problems with letting the current law expire next year. One is the yo-yo effect. It is an outrage if Congress allows estate taxes to change so much, particularly near the end, that is, a lower rate this year with an expiration to a zero rate next year, and also changing a step-up to a carryover basis, and the following year up at a much higher rate.

The second problem, frankly, is I do think there should be an estate tax on the highest value estates. I think that is good policy.

Third, people don't talk much about this, but I think we should focus on it. If current law expires, every heir will be subject, as I said, to a carryover basis in determining his or her taxes when that taxpayer, the heir, at a later date sells the property and has to pay capital gains. What are the problems with that? First of all, massive record-keeping confusion—massive.

Soon, I am going to propose an extension in the current law. If that is not passed and if we do not extend the estate tax law, all taxpayers, all heirs, will be subject to massive confusion in trying to determine the value of the underlying assets when they later try to sell. The value of the step-up basis to the heir obviously is a lower capital gains tax, but there is also certainty. People pretty much know the value at the death of the decedent.

I cannot emphasize strongly enough how much confusion there will be on January 1, if my consent is not agreed to. There will be such confusion because of the heirs receiving property subject to a carryover basis, not a step-up basis, let alone the capital gains tax they will have to pay when they sell that capital asset at a subsequent date. Currently, when the heir receives that capital asset, because it is a step-up basis, there is much less capital gain paid, presumably, by that heir who sells the asset.

Here it is mid-December. The only responsible thing to do to prevent the yo-

yo effect—how in the world can people look at planning in their estates if the law goes up and down and changes all the time? It has kind of leveled off, as I said, at the 2009 rates and people have a pretty good idea what those are. Some in this body would like to see the rate go lower and exemptions go higher. Some in this body would like to see other changes. We kind of leveled off at 2009 estate tax laws, where the rates are set and the exemptions are set. Most people in the country are anticipating Congress will eventually pass that.

It would be irresponsible to further the yo-yo effect by allowing current law to expire and create all this massive confusion, this chaos that will apply to heirs of the estates on January 1 because of this change in capital assets from step-up to a carryover basis, among other things.

UNANIMOUS CONSENT REQUEST—H.R. 4154

Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of H.R. 4154, which was just received from the House and is at the desk; that the Baucus substitute be considered and agreed to, the bill, as amended, be read the third time and passed, the motion to reconsider be laid upon the table; that any statements relating to the measure be printed in the RECORD without any further action or debate.

The PRESIDING OFFICER. Is there objection?

Mr. MCCONNELL. Mr. President, reserving the right to object, there is nothing more outrageous to the American people than the thought that they will have to visit both the IRS and the undertaker on the same day.

Surveys indicate that Americans, even after informed that estate tax may not apply to them, object to it in principle.

I am going to ask that the chairman of the Finance Committee modify his request in the following way:

That there be an amendment considered that reflects a permanent, portable, and unified \$5 million exemption that is indexed for inflation, and a 35-percent top rate; and further, that the amendment be agreed to, the bill then be read the third time and passed, with the motion to reconsider laid upon the table.

Before the Chair rules, I want to acknowledge my good friend Senator KYL, the Republican whip, who has been our leader on this side of the issue. He has crafted a proposal, along with the leader on this on the other side, Senator LINCOLN of Arkansas, that is consistent with the consent agreement and with the modification I am now asking the chairman of the Finance Committee to make. This approach would provide certainty and clarity to all taxpayers, especially small businesses and farmers; whereas the UC propounded by the chairman

would only create additional confusion, with three different rates coming into effect in the course of a 12-month period.

Summing it up, I ask that my friend from Montana modify the agreement in the way I described.

Mr. BAUCUS. Mr. President, I don't think this is the way to do business here; that is, to enact estate tax law here on the floor of the Senate without any notice, and also because there are so many considerations Senators on both sides want to look at. It would be improper. I object.

Mr. MCCONNELL. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. BAUCUS. Mr. President, I yield 5 minutes to the Senator from New Mexico.

The PRESIDING OFFICER. The Senator from New Mexico is recognized.

Mr. BINGAMAN. Mr. President, let me speak in support of what Senator BAUCUS, the Senator from Montana, attempted to do just now—to get a short-term extension of current law with regard to the estate tax, so we would have a \$3.5 million exemption from the estate tax into next year for a short period, while we actually settle on what type of permanent change in estate tax law is appropriate.

As the Senator from Montana pointed out, the circumstance we find ourselves in right now, given the current state of the law, is untenable and irresponsible. What the current status is that if a person dies in the next 16 days, if their estate exceeds \$3.5 million, they will be subject to an estate tax, and a couple whose estate—when the second member of the estate dies and their estate would exceed \$7 million, they would be subject to an estate tax.

After the next 16 days, beginning on January 1 of next year, we have no estate tax under the law as it now exists. But at the end of next year—or the beginning of 2011—the estate tax comes back at a 55-percent rate.

That is not a reasonable set of circumstances for the American public to have to face. Not only is it a 55-percent rate that comes back on January 1, 2011, the exemption—the amount that is exempt from the estate tax—is reduced to \$1 million. That is, obviously, adverse to many families in this country.

What has happened on the Senate floor is that the Senator from Montana has said let's do a short-term extension of the current estate tax provisions for a few months and get a resolution of what should be done on a permanent basis. The Republican leader has said: No; here is a permanent solution. Take this permanent solution or we object.

That is not a responsible way for this body to proceed, in my opinion. I do think this issue that both Senator REID and Senator BAUCUS have spoken about

of this problem with a stepped-up basis going away for inherited assets is a very real problem. It is arcane, I understand that. It sounds like accounting speak. But it is a very real problem for American families when they inherit property in the future to have to take the value for purposes of paying capital gains tax. If that property is ever sold, they will have to go back and try to determine what was the basis that their parent or the person from whom they inherited the property had in that property. It is a bookkeeping nightmare and will create great confusion for American families.

Clearly, the right course is for us to do a short-term extension of the current estate tax provisions and then get agreement between the two parties as to what a long-term solution could be in the next couple of months.

That course, evidently, is being blocked. The request was made yesterday, I understand, by Senator PRYOR to have a short-term extension. The Republican leaders objected to that request. The same objection has been raised to the request by Senator BAUCUS today.

I do think this is an unfortunate circumstance. It is a great disappointment to me to see us doing business in this fashion. I know there are many who think there should be no estate tax. I do not agree with that perspective. The estate tax in my State—I went back and got the IRS figures. There were 80 individuals in the year 2008 who wound up having to pay some estate tax, whose estates had to pay some estate tax in the State of New Mexico. It does not apply to most individuals.

I do believe it is appropriate that there be an estate tax for large estates. I do believe we should have a consistent policy, and it should not be something that is here today, gone tomorrow, and back again in a much worse form at the beginning of January 2011. That is the course we are on today. I think it is very unfortunate.

Again, I strongly support what the Senator from Montana was trying to accomplish with his unanimous consent request.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that Senator KYL be permitted to speak for up to 5 minutes and that following his remarks, the hour of controlled time on the health care legislation begin.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Arizona.

Mr. KYL. Mr. President, the argument that the chairman of the Finance Committee made reminds me of a story told in law school of the fellow accused of murdering his parents. He pled for mercy on the court since he was an orphan.

I asked the chairman of the committee numerous times this year to address this problem, and the response always was: We are too busy. We are too busy with health care was the usual response. Now we find ourselves at the end of the year, and it is odd that the chairman argues that we have a big emergency on our hands and we have to act.

It is not as if we have not known this issue was out there. Nor, as Senator BINGAMAN just suggested, has it been a big mystery that the rate on the estate tax was going to go to zero next year. That is the 2001 law. We have known that for years.

Frankly, people have applauded the fact there is not going to be an estate tax next year. The only problem is if the people on the other side of the aisle intend to repeal that law so we do have an estate tax. I know that is their intention. They are creating the confusion because the law has been known about for 10 years that we are going to have a zero rate. Now all of a sudden they say we cannot let that happen. We are going to have to change it next year. Since we think we may be able to do that, we should extend what we have right now and not let the zero rate take hold.

I suspect the great dilemma that is being posed is one most folks would love to have as a problem. The dilemma being proposed is that if the rate goes to zero and the heirs of the property decide to sell the property at some point, they will have to pay a capital gains tax. That is just fine. That is what most people would like to do.

Since this income is taxed twice—it is taxed once when you make the income, then it is taxed again if you have any of that left over when you die—that is unfair. What we have always argued is that the estate tax, therefore, should go away and just leave the existing Tax Code where it is, which says: If somebody inherits property and later sells that property, sure, they should pay a capital gains tax on it. I would think most people would think that is a pretty good deal.

The capital gains tax is 15 percent; whereas the estate tax under the proposals of my friend from Montana would go to 45 percent. As between paying 45 percent and 15 percent, I think it is pretty clear what most small business folks and farmers would like to do.

Of course, the original basis of the property is the basis for paying the tax. Again, if you put that question to small business folks or farmers, they would tell you they would rather pay the capital gains tax than they would an estate tax of 45 percent.

Mr. President, I ask unanimous consent to have printed in the RECORD at the conclusion of my remarks an editorial from the Wall Street Journal

from December 11 called, "The Tax That Won't Die, Death Blow, Night of the Living Death Tax, Estates of Pain."

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. KYL. Mr. President, among the things pointed out in this editorial, they say:

We've long argued that the economically optimal and fairest death tax rate is zero. The tax is applied to income that was already taxed when it was earned, so it is a double tax on savings and capital. The correct way to tax a gain in the value of assets bequeathed to an heir is with a capital gains tax of 15 percent when the assets are sold, rather than at the time of the funeral of the original owner.

I think that says it all. I hope the problem my friends are so concerned about—first of all, they recognize a problem they themselves manufactured by not getting around to doing anything about this until the eleventh hour. Second, it is a problem that does not have to exist if they will leave the existing law alone and let the rate go to zero, which is what everybody wants it to be.

Sure enough, if your heirs sell property after that, they will have to pay capital gains. Ask them what they would rather do—pay a 15-percent rate or a 45-percent rate. I think the answer to that is pretty clear.

EXHIBIT 1

[From the Wall Street Journal, Dec. 11, 2009]

THE TAX THAT WON'T DIE

Well, the moment of truth has arrived, and House Democrats recently voted 234-199 to cancel the 2010 repeal and hold the rate permanently at 45% with a \$3.5 million exemption. Senate Majority Leader Harry Reid now wants to do the same. But to suspend the Senate's health-care debate and turn to the estate tax, he needs 60 votes. All Republicans and some Democrats are saying no. Blanche Lincoln of Arkansas and Jon Kyl of Arizona will accept no more than a 35% permanent rate with a \$5 million exemption.

We've long argued that the economically optimal and fairest death tax rate is zero. The tax is applied to income that was already taxed when it was earned, so it is a double tax on savings and capital. The correct way to tax a gain in the value of assets bequeathed to an heir is with a capital gains tax of 15% when the assets are sold, rather than at the time of the funeral of the original owner.

Study after study, including one co-authored years ago by White House economist Larry Summers, finds that a powerful motivation for entrepreneurs to grow their businesses is to pass that legacy to their children. The left disparages this as building "family dynasties," but most Americans think that it is immoral for the government to confiscate the fruits of a life's effort merely because of the fact of death.

Democrats also say their rate would apply only to the richest 2% of estates. But a new study by economists Antony Davies and Pavel Yakovel of Duquesne University finds that the estate tax "impacts small firms disproportionately versus large firms" by encouraging well-capitalized companies to gobble up smaller ones at the owner's death. The

study shows the result is to "promote the concentration of wealth by preventing small businesses from being passed on to heirs."

Republicans and willing Democrats shouldn't give up on eliminating the death tax. The Kyl-Lincoln amendment to create a permanent 35% rate is far better than the confiscatory House bill. But the best strategic outcome now is to let the death tax expire in January as scheduled under current law, and return to this debate next year when the tax rate is zero. Then let liberal Democrats explain to voters on the eve of elections that they must restore one of the most despised of all taxes.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, clearly, the right public policy is to achieve continuity with respect to the estate tax. If we do not get the estate tax extended, even for a very short period of time, say, 3 months, we would clearly work to do this retroactively so when the law is changed, however it is changed, or if it is extended next year, it will have retroactive application.

The uncertainty for tens of thousands of middle-class families needs to stop. That is why retroactive application of anything that passes next year makes sense.

Right now, 99.7 percent of estates do not have to worry about the estate tax. If we do not extend current law, many heirs are going to have to worry about capital gains. There is the potential for high-income households to take advantage of the temporary reductions in the rates for gift taxes and temporary elimination of GST to do massive estate planning—potentially benefiting those households by billions of dollars at the expense of U.S. taxpayers. Beyond this, what Congress is doing is a huge benefit for lawyers and accountants who do all the estate planning.

The right thing to do is to extend current law for a brief period of time to get our act together to decide what estate laws should be. That is the right thing to do. I am very disappointed that the other side of the aisle does not let us do the right thing—at least extend current law for a while until we know what the estate tax law should be.

Mr. COBURN addressed the Chair.

The PRESIDING OFFICER. The Senator from Montana has the floor.

Mr. BAUCUS. Mr. President, for the benefit of Senators, we are now back on the health care bill. Let me lay out today's program.

It has been nearly 4 weeks since the majority leader moved to proceed to the health care reform bill. This is the 16th day that the Senate has considered the bill.

The Senate has considered 23 amendments or motions and conducted 18 rollcall votes.

Today the Senate will debate the motion to commit regarding taxes offered last night by the Senator from Texas, Mrs. HUTCHISON. Under the previous order, later this morning, we expect

that the Senator from Vermont, Mr. SANDERS, will offer his amendment No. 2837 on a national single-payer system.

This morning, the first hour of debate will be equally divided and controlled between the two leaders or their designees. The majority will control the first half hour and the Republicans will control the second half hour.

We expect the Senate to conduct votes today in relation to the Hutchison motion and the Sanders amendment.

Also, today, the House of Representatives is scheduled to act on the Department of Defense Appropriations Act which also contains a number of vital year-end measures. We look forward to receiving that measure in the Senate as well.

I yield 10 minutes to the Senator from Ohio and then 15 minutes to the Senator from Delaware.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. BROWN. Mr. President, I thank Senator BAUCUS for yielding, and I thank Senator KAUFMAN also for him yielding.

Less than 5 percent of cancer patients enroll in clinical trials. Only 6 percent of people who suffer from severe chronic illnesses participate. These low participation rates mean it is harder to conduct a timely trial. In fact, delays in patient recruitment for clinical trials account for an average of almost 5 months lost per trial. Nearly 80 percent of trials run over schedule by more than a month. Only 6 percent are completed on time.

Clinical trial delays lead to treatment development delays, whether it is the next breakthrough drug or some other lifesaving therapy. Without clinical trials, medical innovation would come to a halt.

Unfortunately, one major reason more patients do not enroll in clinical trials is that their insurance company coverage discourages it.

Insurers today take advantage of lax regulations that allow them to deem all care for a person in a clinical trial as "experimental"—even routine services they would get if they were not in the trial, such as x rays, blood tests, and doctor visits.

This draconian policy predictably scares many patients away from potentially lifesaving trials. Patients simply cannot afford to pay out of pocket for all of their own care. Understand, they do not expect the insurance company to pay for the trial itself. No one is suggesting that. No one thinks that. But insurers should not be allowed to use a patient's participation in a clinical trial as an excuse to deny them coverage for standard care.

To address this problem, Senator HUTCHISON of Texas and I have filed amendment No. 2871. This amendment would require all insurance companies

to simply live up to the promises they have made to their premium-paying policyholders. It means covering the cost of routine care for clinical trial participants.

More than 30 States have already enacted a similar clinical trials policy for their State-regulated insurance plans. Medicare has already enacted a similar clinical trials policy for its beneficiaries. The VA and DOD have already enacted similar clinical trials policies for their members. Even some insurance companies are already doing the right thing in covering the routine costs associated with clinical trials.

But because many are not and because there is no standard criterion by which appeals can be adjudicated, countless patients who would otherwise enroll in clinical trials do not.

Take, for example, Sheryl Freeman from Dayton, OH. Sheryl and her husband Craig visited my office in Washington in 2007. Sheryl was a retired teacher suffering from multiple myeloma. Thankfully, she had health insurance through her husband's employer. Yet when Sheryl tried to enroll in a promising clinical trial at James Cancer Hospital at Ohio State, her insurance company balked, refusing to cover the routine care costs.

Understand this: She had insurance, she had good insurance—she thought she had good insurance. She enrolled in a clinical trial paid for by the people doing the clinical trials—the hospital, the drug company, whomever. But the insurance company pulled back and said: We are not going to cover routine care for her anymore since she is in a clinical trial, something she was entitled to with or without the clinical trial. Regardless of whether or not Sheryl enrolled in a clinical trial, she still needed to visit her oncologist in Dayton once a week for standard cancer monitoring, including scans and blood tests. But her insurance company would stop covering these services if she enrolled in the clinical trial.

Sheryl wanted to enroll in a clinical trial because she hoped it would save her life. She hoped it would give her more time with her loved ones. She hoped it would help future patients diagnosed with the same type of cancer, but she was not willing to force her family into bankruptcy. So instead of devoting her energy toward combating cancer, Sheryl spent the last months of her life haggling with the insurance company. By the time her insurance company relented, it was too late. Sheryl died December 7, 2007.

Sheryl's husband Craig, with whom I have spoken a couple of times and met with, wrote the following about the ordeal:

No patient should have to fight insurance when battling a disease such as cancer.

How many times have we heard that in this Chamber? Tragically, Sheryl's experience is not an isolated case.

In Ohio—my State—one cancer hospital has reported that over one-third of patients who tried to enroll in a clinical trial over a 6-month period were automatically denied access by their insurance company. Again, I understand how that happens. You have decent insurance, you think. Then you decide to enroll in a clinical trial that your doctor suggests. The insurance company then quits covering you for the things it used to cover you for—the routine care you need as a patient.

Take Gene Bayman. I met and talked to Gene—a courageous man who loved his family. His family was so fond of him, as you could see, when I saw him in Columbus with his family. He was diagnosed in February 2007 with multiple myeloma. Gene's doctor recommended a combination of standard treatment and clinical drugs, but Gene's insurance company threatened to stop paying for the routine care otherwise covered under the policy if he enrolled in the clinical trial.

If that is not rationing, Mr. President, I don't know what is.

Gene died in June of this year, never having the chance to participate in the cutting-edge research that might have saved his life. Gene wrote, before he died:

I don't want my health options limited by insurance companies concerned with the bottom line rather than the medical research my doctor prescribes.

Mark Runion, also from Ohio, faced the same barrier. Mark was being treated for multiple myeloma with standard care—a stem cell transplant and chemotherapy. His doctor recommended he enroll in a clinical trial to try out a new drug that might help him recover quickly. The insurance company refused to comply, telling Mark if he were to enroll in the clinical trial they wouldn't pay for any of his cancer care. Another terrible lost opportunity. The clinical trial would have helped us learn more about which drugs we should administer to patients after stem cell transplants. In other words, while this most directly, most tragically, most painfully affected Mark Runion and his family, it also affects all of us who have loved ones or who might ourselves come down with this disease. The clinical trial that Mark wanted to enroll in would have given him an opportunity and would have given all of us more scientific knowledge and information that would have been helpful.

Instead, the insurance company took a shortsighted view and denied Mark the recommended care. Mark writes:

I personally would rather make my medical decisions with my doctor—the expert in my care—rather than my insurer.

These stories should have ended differently. Sheryl, Gene, and Mark all paid premiums to health insurance for years. But when they got sick and were

referred to a clinical trial, the insurance company refused to pay for the benefits guaranteed under its policy.

Health insurance reform should be about making sure insurance companies can't renege on their commitments. It is about ensuring that insurance companies can't write sham policies that allow for rescissions and riders and exceptions and bring about more horror stories than we all care to recount. It is about closing loopholes that health insurance companies are great at taking advantage of, and as some say, staying one step ahead of the sheriff.

This amendment is consistent with those goals. It would help advance important research in the most serious diseases. This is a public health issue for all of us.

In closing, if we are ever going to find a cure for cancer and diabetes and cardiovascular disease and Alzheimer's and ALS and the hundreds of other diseases killing millions of Americans each year, we need to encourage in every way possible participation in clinical trials and not put up barriers against participation.

This amendment is endorsed by the Lance Armstrong Foundation, the American Academy of Pediatrics, the Susan G. Komen for the Cure Advocacy Alliance, the American Cancer Society, the Alzheimer's Foundation of America, and dozens of other national organizations.

Along with Senator HUTCHISON, this bipartisan amendment is also sponsored by Senators FRANKEN, WHITEHOUSE, SANDERS, SPECTER, and CARDIN. Please join us in supporting amendment No. 2871.

I yield the floor.

The PRESIDING OFFICER (Mr. KIRK). The Senator from Delaware is recognized.

Mr. KAUFMAN. Mr. President, I ask unanimous consent to speak as in morning business for up to 15 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

FINANCIAL MARKETS AND JOB LOSS

Mr. KAUFMAN. Mr. President, my colleagues have heard me speak in recent weeks about the troubling trends in our financial markets—the growing use of dark pools and high-frequency trading, increasing market fragmentation and looming regulatory gaps at the Securities and Exchange Commission. Today, I want to talk about an economic threat that encompasses these developments and why I think they are negatively affecting the long-term health of our economy.

After suffering through the most severe recession in decades, we are now in the midst of the most fragile of recoveries. It is evident to all that we are in a jobs crisis. We need a laser-like focus on innovation policies that encourage industry to create jobs. But this challenge comes not just from the

financial crisis and the recession that followed, the American economy has slowed in its efforts to create jobs for the past decade.

According to the Bureau of Labor Statistics, the United States had 108.5 million private, nongovernmental jobs as of September of this year. But while our population has grown 9 percent in the last 9 years, the number of jobs now available is essentially the same as June of 1999.

Let me repeat that: The number of jobs now available is essentially the same as June of 1999—over 10 years ago.

Many of the jobs this economy did create in the past decade were in the financial, housing, and consumer-led retail sectors. Two of those—financial and housing—were bubbles that have now burst. Without these sectors playing a key role in providing new jobs, many Americans are asking: Where will the future job creation most likely occur?

In the past, job creation would often come from the raft of small, newly financed, often innovative companies that raised their capital with the help of Wall Street underwriters. Thousands of times I have heard in the last months that the recovery is going to come because of small businesses, and many of those raise their capital with the help of Wall Street underwriters.

Now I am deeply concerned there is a choke point in our efforts to return to economic vibrancy, a choke point that can be found on Wall Street. Our capital markets, which have long been the envy of the world, are no longer performing one of their most essential functions; that is, the constant and reliable channeling of capital through the public sale of company stock, known as initial public offerings—or IPOs—which small companies use to innovate and, most importantly, to create jobs.

Look at this chart. There is an IPO crisis in this country. Indeed, according to a report released last month by the accounting firm Grant Thornton, the IPO market in the United States has practically disappeared. That, in turn, according to a second Grant Thornton study, has had a ripple effect on the U.S. stock markets, with the number of stock listings since 1991 dropping 22 percent in absolute terms and 53 percent when factoring in inflation-adjusted GDP growth.

New companies have been shed from the NASDAQ, New York, and American Stock Exchanges faster than being created, from almost 7,000 publicly listed companies in 1991 and nearly 8,900 in 1997, during the dot-com bubble, to 5,400 listed in 2008, a turn of events Grant Thornton has dubbed the "Great Depression of Listings."

The United States is practically the only market in the world where this phenomenon is occurring. The major stock exchanges—as you can see from

this chart—in Hong Kong, London, Milan, Tokyo, Toronto, Sydney, and Frankfurt, have all grown from their 1997 levels, Grant Thornton reports. Just look at this chart. This is what is going to take us out of the recession. Look at where we are—the United States—in relation to Hong Kong, Tokyo, Australia, and the other markets.

The effects of the IPO crisis have rippled throughout the U.S. economy. Because 92 percent of job growth occurs after a company goes public, job creation may have been stunted by these developments. In fact, according to the Grant Thornton study, if the IPO market was working properly today, we would have as many as 10 million to 20 million additional high-quality jobs for middle-class Americans. Even if that estimate is off by a factor of 10, this failure of Wall Street to provide capital to small companies may be costing our economy millions of jobs.

Mr. President, most every large company begins as a small company. That is axiomatic. The IPO market has been hit hardest at the smallest end of the market. The medium IPO in the first 6 months of 2009 was \$135 million. Let me say that again—\$135 million. Twenty years ago, IPOs at \$10 million were routine, and routinely succeeded.

Take a look at this chart and look at these companies. Venture capitalists play a critical role in long-term investment, in growing our economy and creating jobs. Indeed, when you look at these 17 venture-backed companies that raised a total of \$367 million in capital and today provide 470,000 U.S. jobs, they are among our economy's biggest success stories.

Look at this list. Think of where we would be today if these companies were not able to get IPS: Adobe, Computer Associates, Intel, Oracle, Yahoo. These are all the companies where growth came from. Right now, in our present market, they cannot go public the way they went public originally.

What has happened? A host of well-intentioned changes—some technological, some regulatory—with many unintended consequences have created this situation. Online brokerage firms, with their \$25 trades, first appeared in 1996, hastening the decline of traditional full-service brokerage firms who charge \$250 a trade. There was an advantage to those hefty fees, however. They helped maintain an underwriting apparatus that encouraged small businesses to go public and supported a substantial research base that attracted both institutional and retail clients.

The rich ecosystem of investment firms, including the Four Horsemen—Robertson Stephens, Alex Brown & Sons, Hambrecht & Quist, and Montgomery Securities—that helped their institutional buy-side clients take part in IPOs and marketed follow-on offerings, no longer exists today.

Structural changes in the U.S. capital markets dealt the final coup de grace. There were new order handling rules—decimalization, which shrank spreads significantly and made it increasingly difficult for traditional retail brokers to remain profitable; Regulation ATS and NMS, which vastly expanded the electronic marketplace.

Finally, there has been an explosive growth in high-frequency trading, which takes advantage of the market's now highly automated format to send more than 1,000 trades a second ricocheting from computer to computer.

The result, as *The Economist* magazine wrote last week, is that high-frequency traders who have come to dominate stock markets within their computer-driven strategies pay less attention to small firms, preferring to jump in and out of larger, more liquid shares.

The economist quoted:

Institutional investors wary of being stuck in an illiquid of the market are increasingly following them.

This is a situation that stands as a veritable wall against a sustained economic recovery.

One of the very vital tasks before Congress is to help unemployed Americans by crafting innovation policies that will rebuild our economy, catalyze growth, and create high-quality jobs for struggling Americans. That is our No. 1 job in the Congress right now. I think if you asked every 1 of the 100 Senators, they would say that is the case.

We must identify the causes of last year's debacle and apply them to our current economic challenges in order to help the millions of struggling Americans and to avert a future disaster. The fact that Wall Street has resumed its risky and—as we know all too well—potentially disastrous behavior is simply inexcusable.

In order to reverse this ominous trend and help companies raise capital to innovate, create jobs, and grow, we must restore the financial sector's historical role as a facilitator of long-term growth and not the source of one bubble after another.

The question, finally, is this: How can we create a market structure that works for a \$25 million initial public offering, both in the offering and the secondary aftermarket? If we can answer that question, this country will be back in business.

Mr. President, I yield the floor, and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. KAUFMAN. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. KAUFMAN. Mr. President, I ask to speak in morning business for up to 5 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

IN PRAISE OF WILLIAM PHILLIPS

Mr. KAUFMAN. I rise once again to recognize one of America's great federal employees.

Last week, in Stockholm and Oslo, the 2009 Nobel laureates accepted their prizes. I am particularly proud that 11 of this year's 13 prizes were won by Americans. This is a reminder of our Nation's global leadership in science, medicine, economics, and peace-making.

My honoree today holds the distinction of having been the first Federal employee to win a Nobel Prize in physics for work performed while serving the public.

Our Federal workforce is composed of citizens who are both highly educated and incredibly motivated.

Dr. William Phillips is the perfect example. A native Pennsylvanian, William learned the importance of public service and hard work from a young age. His mother, an immigrant from Italy, and his father, a descendent of American revolutionaries, were the first in their families to attend college. They both pursued careers as social workers in Pennsylvania's coal-mining region. William, along with his brother and sister, grew up in a home where reading and education were emphasized.

As a boy, William fell in love with science, and he tinkered with model rockets and chemical compounds in the basement of his family's home. While attending Juniata College in the 1960s, William delved into physics research. He spent a semester at Argonne National Laboratory and, after graduation, pursued his doctorate at M.I.T.

During his time at M.I.T., the field of laser-cooling was just heating up, and William wrote his thesis on the collisions of atoms using this new technology.

In 1978, William began working at what is today the National Institute for Standards and Technology—or "NIST"—at the Department of Commerce. At NIST, he pursued further research into laser-cooling, and his discoveries have helped open up a new field of atomic research and expand our knowledge of physics. His findings have found important application in precision time-keeping, which is important for both private industry and for national security.

In 1997, William received the Nobel Prize for Physics along with two other scientists. One of his fellow-laureates that year was Dr. Steven Chu, who now serves as Secretary of Energy.

After winning his Nobel Prize, William made a commitment to using his fame to promote both science education and public service. He regularly speaks to student groups, and he serves as a mentor to graduate students in his field.

William won the prestigious Arthur S. Flemming Award for Public Service in 1987, and he was honored by the Partnership for Public Service with its 2006 Service to America Medal for Career Achievement.

He and his wife, Jane, live in Gaithersburg, MD, and are active in their community and church. Today, after a 3-decade Federal career, William continues to work at NIST as the leader of its Laser-Cooling and Trapping Group.

I hope my colleagues will join me in honoring Dr. William Phillips and all those who work at the National Institute of Standards and Technology for their dedicated service and important contribution to our national life. They keep us at the forefront of science and human discovery. They do us all proud.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. MCCAIN. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MCCAIN. Mr. President, before my colleagues begin, I think it is important for us to point out where we are here on December 16, 2009. We are now almost a year into the discussion and debate about "reforming health care in America" and we still do not know what is in the bill. We still do not know the specifics of what we are considering here.

I have had the honor of serving here for a long period of time, but I have never seen a process like this. I have never seen a situation where a major piece of legislation is not before the body and is somehow being negotiated and renegotiated amongst the other side. Meanwhile, according to the Washington Post this morning, a newspaper I always have the utmost trust and confidence in—I wish to say the title is "Public cooling to health-care reform as debate drags on, poll finds."

As the Senate struggles to meet a self-imposed, year-end deadline to complete work on legislation to overhaul the nation's health-care system, a new Washington Post-ABC News poll finds the public generally fearful that a revamped system would bring higher costs while worsening the quality of their care.

A remarkable commentary about where we are in this legislation. One of the interesting things is this poll goes back to April, where in April, 57 percent of the American people approved and 29 disapproved of the President's handling of health care. Today it is 53 disapprove and 44 approve, which means the American people, the more they find out about this, the less they like it and the more concerned they are. According to this poll again:

Medicare is the Government health insurance program for people 65 and older. Do you

think health-care reform would strengthen the Medicare program, weaken Medicare or have no effect on it?

American people have figured it out. Amongst seniors, those who are in Medicare, 12 percent say it would strengthen, 22 percent no effect, and 57 percent of seniors in America believe—and they are correct—that this proposal would weaken Medicare, the benefit they paid into and that they have earned.

Let me say it again: I plead with my colleagues on the other side of the aisle and the majority leader. Let's stop this. The American people do not approve of it. Let's sit down and work together; let's have real negotiations; let's even have the C-SPAN cameras in, as the President promised October a year ago. This present legislation spends too much, taxes too much, and reduces benefits for American citizens as far as overall health care is concerned, including Medicare, as the American people have figured out.

I welcome my colleagues here. I see Dr. COBURN is here. Let me restate: It is time to say stop. It is time to start listening to the American people. It is time to start being straightforward with the American people because the American people need to know what we are doing and they do not. The distinguished Senator from Illinois, last Friday when I asked him what is in the bill, said none of us know what is in the bill.

I ask my friend from Oklahoma, isn't what is happening—we have a proposal, we send it to CBO, CBO sends back numbers they do not like so they try to fix it, send it back to CBO, they send it back again. That is why only one Senator, the majority leader, knows what is going on.

Mrs. HUTCHISON. Mr. President, parliamentary inquiry.

Mr. MCCAIN. What is the parliamentary situation, I ask the President?

Mrs. HUTCHISON. Mr. President, I was under the impression there would be a 30-minute allocation for colloquy for our side. I am not sure when we start that process.

The PRESIDING OFFICER. The Republican side has 25 minutes 15 seconds.

Mrs. HUTCHISON. How many?

The PRESIDING OFFICER. There is 25 minutes 15 seconds.

Mr. MCCAIN. Mr. President, I thank the Chair. I think I have made my point here. I wish to yield. I ask unanimous consent to have a colloquy with the Senator from South Dakota, the Senator from Texas, the Senator from Oklahoma, and the Senator from Wyoming.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. COBURN. If I might respond to the question of the Senator, one of the things our President has promised is transparency. We are going to see at

sometime in the next week or 10 days another bill—whatever the deal is. It would seem to me that 72 hours with a complete CBO score, much like was asked by 12 Members on their side, before we have to take up or make any maneuvers on that, would be something everybody could agree to since nobody knows, except HARRY REID and the CBO, what is in this bill now. At a later time, after we finish this colloquy, I will be making that unanimous consent request.

Mrs. HUTCHISON. I thank the Senator from Oklahoma. I think it is very important that before we start talking about passing a bill or having a cloture on a bill—I think the Senator from Oklahoma is making the main point. I think the Senator from Oklahoma was making a very good point that I was hoping to work with him on and that is: Where are we now? The Republicans have put forward reform alternatives for our health care system that are not a government takeover and are not going to be \$½ trillion in taxes and are not going to be \$½ trillion in Medicare cuts.

The Republican proposals would do what health care reform should do—they would lower cost. They would increase risk pools so that small business would be able to offer health care coverage for their employees. They would have medical malpractice reform so we would be able to lower the cost of frivolous lawsuits, cutting over \$50 billion out of the costs of health care, making it more accessible for more people. They would give tax credits for individuals who would buy their own health care coverage to offset that cost.

None of that would be a big government takeover of health care. That is what we have been trying to put forward here. But we have not had a seat at the table. We have not had the capability to say what our proposals would be because we have not even seen the proposed new bill yet. We have been talking about the tax increases that are going to burden small business at a very hard time for this country's economy and we have also been talking about \$½ trillion in Medicare cuts, which I think has caused many senior citizens to say: Wait a minute, I don't want my Medicare options cut. I don't want Medicare Advantage to be virtually taken away.

That is why we are here today, because the pending business before the Senate is the Hutchison-Thune motion to recommit this bill to do a simple thing. It is to say that you will not start collecting the taxes until the program is in place. It is very simple. It is the American sense of fair play, and that is that you do not start collecting taxes before you have a program that you might want to buy into. That is what the Hutchison-Thune motion to recommit does. It is very simple. It is a matter of fair play. I even question

whether we have the right to pass taxes for 4 years before you would ever see a program put in place.

We are going to try to do what is right by this body. That is to say, the \$100 billion in new taxes that will start next month—3 weeks from now—will not start until there is a program put in place. Because right now \$100 billion in new taxes starts next month but there is no program that anyone can sign up for that will supposedly make it easier to get health care coverage in this country until 2014, 4 years away.

I ask my colleague, the distinguished ranking member of the Finance Committee, if he believes all these new taxes would be fair to start before we could ever see a program—not 1 year from now, not 2, not 3 but 4 years from now. I ask the distinguished ranking member of the Finance Committee if he believes it would be fair for us to start the taxes in 3 weeks and then not start the program for 4 years. Does that seem like a fair concept?

The PRESIDING OFFICER (Mr. CASEY). The Senator from Iowa.

Mr. GRASSLEY. Mr. President, the Senator is absolutely right. Let me emphasize it this way. I was on a radio program in Iowa yesterday, where a lady called me, and I had been saying, as the Senator has just said, that you have to wait until 2014 for this program to go into effect. She said: You are telling me you are going to pass this bill right now, but we have to wait until 2014 until we get any benefit from it? She didn't talk about the taxes, as the Senator is, but the taxes go into effect. Another smokescreen is, you have 10 years of tax increases, fee increases, and the program is 6 years long, but the taxes are 10 years long. So it is nice for the CBO to say: Yes, this is balanced and maybe even has a surplus in it. But over the long term, this program does not cost just \$848 billion. I hope I answered your question.

Mrs. HUTCHISON. You did. It is interesting because you say maybe it is going to be break even. How is it going to break even? I ask my colleague from South Dakota, who is a cosponsor of this motion: How is it going to break even? With \$½ trillion in Medicare cuts, \$½ trillion in tax increases, is that the way we ought to be saying to the American people we will reform health care? Have we lost the purpose of the bill, to make health care more affordable and accessible to the American people? I ask my colleague, the Senator from South Dakota, who has worked on this issue for a long time, is that the concept of break even?

Mr. THUNE. The Senator from Texas has touched on a very important issue. The motion she offers, and which I cosponsor, does lay out what is a simple principle of fairness that most Americans understand. When you implement public policy, if you are going to raise taxes, you ought to align the tax increases and the benefits so they start

at essentially the same time. What this bill does is it starts collecting taxes, increases taxes on Americans 4 years before the major benefit provisions kick in. On January 1 of 2014, 99 percent of the spending under the bill kicks in. But the tax increases begin less than 3 weeks from today. Sixteen days from now is when the tax increases in the bill start. A tax on prescription drugs, a tax on medical devices, a tax on health plans—all begin 16 days from now. A lot of those taxes will be imposed upon the American economy and passed on to people and small businesses in the form of higher premiums. People are going to get higher premiums 4 years before they are likely to see any benefit. Ninety-nine percent of the spending under the bill doesn't kick in until January 1, 2014, or 1,477 days from now. Most Americans, as they listen to the debate, believe as I do, as a simple principle of fairness, you ought to align the benefits and the taxes. We had a vote yesterday on the Crapo motion that would recommit all the tax increases. Many of us believe raising taxes on small businesses when you have an economy in recession is not a smart thing to do; it is going to cost us a lot of jobs. Small businesses have made that clear. I also think, in addition to the principle of fairness that is at play, when it comes to raising taxes 4 years prior to the benefits kicking in, you also need to have a transparent sort of understanding about what the cost of the bill is going to be.

One of the reasons the revenue increases, the tax increases were begun immediately or 16 days from now, but the majority of the spending, 99 percent, doesn't occur until January 1 of 2014 and beyond is to understate the true cost. They wanted to bring the cost of the bill in under \$1 trillion.

If you can see, starting this year and going through 2019, it ends up at about \$1 trillion or \$1.2 trillion on this chart. But if you look at the fully implemented period; that is, 2014, when the benefits and spending begin, and take that through the next 10 years, the total spending in the bill is \$2.5 trillion over a 10-year period.

That is one thing the American people need to know. One of the reasons this is being done, tax increases starting January 1 next year or 16 days from now, most of the benefits not starting until 1,477 days from now, is so they can say this is only a \$1 trillion bill or under \$1 trillion, the way it has been advertised, when, in fact, it is going to cost \$2.5 trillion when fully implemented.

We are here 16 days before the Christmas holiday, and there are things Congress needs to do. There are a number of fairly urgent matters that need to be dealt with before the end of the year, some of which have been mentioned this morning. But trying to jam

through a new health care program, a \$2.5 trillion expansion of the Federal Government in Washington, 70 new government programs, trying to jam it through in the next 9 days or so before Christmas seems to be done more out of a political necessity, the need for a political accomplishment or a political victory, than it does with making good public policy. As the American people are approaching this holiday season, the best thing we can do, the best Christmas gift we could give the people, frankly, is for Congress to adjourn and go home before passing this \$2.5 trillion expansion.

What does it mean? If you are a small businessperson, the Christmas gift you get this year is a big lump of coal from the Congress in the form of higher taxes. If you are a senior citizen, 1 of the 11 million who are on Medicare Advantage and this bill passes, your Christmas gift this year is benefit cuts. The same thing applies to many of our providers—hospitals, nursing homes, home health agencies, hospices. If you are an average American family who is worried about the high cost of health care, your Christmas gift this year is, if this bill passes, that your health insurance premiums will continue to go up year over year at twice the rate of inflation. You lock in higher premiums for most people across the country, you raise taxes on small businesses, you cut benefits to Medicare beneficiaries and, for future generations, you create a \$2.5 trillion new entitlement program they will be paying for, for as far as the eye can see.

The CMS Actuary, last week, said, in addition to all the other things they mentioned—the overall cost of health care is going to go up, 20 percent of hospitals will close—that the Medicare cuts that are being proposed cannot be sustained on a permanent basis. If that is true, how will this be financed? Either with more taxes or borrowing, putting it on the debt and handing the bill to future generations. That is what we are left with. Once you lock in a \$2.5 trillion expansion of the Federal Government, it is going to be hard to reduce the cost. The spending is not going to go away. The way it will be paid for, if the Medicare cuts are not sustainable, is the tax increases. The increases that are already in here would have to be increased even further or, worse yet, for future generations, if you are a young American, it will be put on your bill.

The Senator from Texas and my colleagues who are here this morning all voted yesterday to get rid of the tax increases in the bill. But the motion she offers and that I cosponsor would at least, as a principle of fairness, make sure those tax increases don't begin before the benefits do.

Mrs. HUTCHISON. Mr. President, the 2 physicians out of the 100 Members of Senate are here this morning. They

have talked for a long time about the quality of care. They are the two who have the credibility on this. I would like to ask the Senator from Wyoming, Dr. BARRASSO, to talk about what is going to happen to the quality of health care when you have \$½ trillion in Medicare cuts, which we have discussed, and the bill we are discussing today and the motion Senator THUNE and I are offering, that is going to put a higher cost on every prescription drug, every piece of medical equipment. Perhaps you would expand on what kind of medical equipment is needed for people to have the quality of life we have in our country today and then the insurance companies, which are, of course, going to raise the premium of every person who already has coverage.

I ask the Senator from Wyoming, Dr. BARRASSO, in your experience, how is this going to affect the quality of health care?

Mr. BARRASSO. I am grateful to the Senator for bringing this up. I had a telephone townhall meeting last night, and this specific motion the Senator is bringing today came up with great praise from the people of Wyoming who said: She is doing it right, leading the good fight. After I answer the question, I will ask: How do we know the money is even going to be there? That is the question that came up in my telephone townhall. People of Wyoming are concerned, if this passes, it will make health care harder for people in rural States, such as Wyoming and Montana. My colleague from Montana is on the floor. The doctor shortage will worsen. This is the headline on the front page by the Wyoming Tribune Eagle: "Doctor Shortage Will Worsen." There is a lot of concern for the folks in Wyoming and communities where there is a sole hospital, a sole physician provider trying to recruit nurses and physician assistants and nurse practitioners. The doctor shortage will worsen as we see a situation where they will be cutting Medicare \$500 billion, raising taxes \$500 billion, and people who had insurance on this telephone townhall were very concerned that their insurance premiums are going to go up, in spite of the fact that the President has promised families would see insurance rates go down. We know those rates are going to go way up for people who buy their own insurance. People say: Don't cut Medicare, don't raise taxes, don't make matters worse than they are right now. For the people of Wyoming, they are afraid that matters will be made worse.

The Washington Post had a major poll in the paper today specifically asking seniors the question about Medicare. We are talking about health care quality, the quality of care. The question is: Do you think health care reform will strengthen the Medicare Program or weaken the Medicare Program? They asked specifically and

broke it down to seniors. Only 1 out of 8 seniors in this poll said it actually would get better. But the rest are saying: No, it is going to get worse. The seniors who watch this most carefully know what it means to try to get health care under the Medicare Program, a program that we know is going broke. Yet they are taking all this money not to save Medicare but to start a new program. We know the quality of care is going to go down. That is what the people of my home State and the people I talked to from around the country are concerned about. They are delighted the Senator offered this motion.

I did a poll in the townhall meeting: Are you for or against the bill? Some of them say: What is in it? We don't know. Which is exactly what the junior Senator, a Democrat from Indiana, said in today's national press release: We are all being urged to vote for something, and we don't know the details of what is in it. The junior Senator from Indiana is a Democrat. He doesn't know what is in it. The people of Wyoming don't know what is in it. But they do know taxes start immediately, benefits not for 4 years. That is why they are happy you offered this motion. They want to know: How do we know the money will be there 4 years from now?

Mrs. HUTCHISON. That is a very important question. Here we are going to start collecting the taxes for 4 years before the program is put in place. The distinguished Senator from Oklahoma, the other physician in this body, knows we have had promises from the Federal Government before. But I can't remember a time when we started collecting a tax for a purpose that would be 4 years away. What on Earth could people expect to actually be there when the program kicks in?

The program is going to have to be implemented. It is going to have to be brought up to speed. I am sure there will be changes. What would you think your patients whom you still care for in Oklahoma or the ones, in the experience you have had, how do you think people are going to react to having higher costs in all these areas of health care for 4 years, even a tax on the high-income plans, not high-income people having those plans but high coverage that a union member might have that will start being taxed in 2013, 1 year before the program takes effect?

How do you think that is going to affect the quality of health care people can expect and the cost to them out-of-pocket when there would be nothing even on the drawing boards for 4 years?

Mr. COBURN. To answer the Senator's question, No. 1, as we already know, the Oklahoma State employees' health insurance plan, in 2013, will be considered a Cadillac plan. That is every State worker in the State of Oklahoma. And they can hardly afford

their copays and their premiums in that plan today. So what we know is, we are going to tax all the Oklahoma workers. Many of those are schoolteachers who happen to be my patients, and they are struggling today.

So this disconnect between when the taxes are—

Mrs. HUTCHISON. I ask the Senator from Oklahoma, you are saying that a schoolteacher is probably not making \$200,000 or more?

Mr. COBURN. Not at all.

Mrs. HUTCHISON. Yet we were promised there would be no taxes, no harm to people making under \$200,000. Remind me if there is a teacher in Oklahoma—because I know there is not one in Texas—making over \$200,000.

Mr. COBURN. Well, our teachers wish they made what the teachers in Texas make, but they do not. But they do not make anywhere close to \$200,000. It does not just affect the Department of Human Services workers, it is also going to impact the premium increases that are going to come about before this plan is implemented. We are going to see premium increases. So the small businesses that are now covering people are going to have massive premium increases. The individuals who are buying insurance in the open individual market themselves are going to see premium increases. The fact is, that is all going to happen before the first benefit, the first real benefit—other than preexisting illnesses—before anybody sees any benefit to that.

The other thing that is not talked about is, with the skewing of this and with the relatively low tax on not complying with it, our youngest, healthiest people are going to say: I don't want any insurance because all I have to do is pay, in the first year, \$250—or even less—up to \$750, and I can save thousands of dollars every year by not buying insurance, and buying it when I get sick.

So we are going to see everything skewed in the insurance market. That is what is going to drive up the premiums.

My constituents, plus my patients, are not happy about the delay. If we are going to make this, what I believe, is a fatal mistake for our country in terms of the quality of health care, then we ought to at least match the revenues with the expenses.

Mrs. HUTCHISON. That is exactly what the Senator from South Dakota and I are trying to do. We are trying to make sure Americans will not—will not—pay taxes and increased prices on prescription drugs, on coverage we do have, the policies we do have, and the equipment that is so necessary for health care services.

Senator THUNE and I want to do what is basic fairness and very simple; that is, to say the program starts and the taxes start at the same time. That is a tradition we have had in this country

for years. We do not tax people 4 years from having any kind of program in place that they could choose from that might benefit them. We do not do that. That is not the American way, and it is certainly not anything we have done before.

What in the world would people expect to happen in 4 years? What if this plan is changed? What if the people rise up and say: We don't want this plan, and they say: No way, and they would have been paying higher premiums and higher health care costs already. It is a downpayment where you are not sure what the end is going to be.

It is like buying a house and saying: Now, in 4 years we are going to give you the key to the house, we are going to give you the key to the house that you bought 4 years from now. Oh, maybe there will be a change in condition, but you are going to get it. Maybe it will be damaged. Maybe it will be worn. Maybe it will have a fire that starts in part of it. But you will get those keys and then something will be there for you. We promise you. We are from the government, and we are going to promise you that.

That is not good enough. That is not what we owe the American people. And it is not health care reform.

I would just ask my colleague from South Dakota, who is the cosponsor of this motion, if he agrees that as a matter of simple fairness, openness, and transparency to the American people, health care reform should not mean 4 years of taxes before any program is put in place.

Mr. THUNE. I will say to my colleague from Texas, as to the taxes, the fees, the tax increases, everything in our motion very simply states they ought to be aligned with the beginning of the benefits. The benefits and the exchanges and, frankly, all the major policies—the substance of this bill—begin in 2014; the individual mandate, the State exchanges, the subsidies, as I said, premium tax credits, Medicaid expansion, the employer mandate, 2014; the government plan, 2014. The substance of this bill begins in 2014. Unfortunately, the tax increases begin 4 years earlier, 16 days from now. Sixteen days from now, January 1 of this coming year, is when the taxes start being raised. And, of course, the CBO has said those tax increases are going to be passed on in the form of higher premiums to people across this country. The benefits start 1,477 days from now.

So what we simply say in this motion is, let's commit this bill and bring it back out with the tax increases—if there are going to be tax increases; and many of us believe there should not be any, which is why we voted for the Crapo motion yesterday—but if you are going to raise taxes on America's small businesses, families, and individuals, at least align those so the policy, the substance of this bill, which begins 4 years

from now, is synchronized so we are not slapping a huge new tax increase on America's small businesses in the middle of a recession and passing on those higher costs, which is what they will do, to people in this country in the form of higher insurance premiums.

So I say to the Senator from Texas, this is a very straightforward, simple motion. I hope our colleagues on both sides will support it. It is a matter of principle, of fairness when it comes to making policy that I think the American people have come to expect. We ought to be honest and give the American people a complete understanding of what this bill really costs. Because they have done what they have done—by instituting the tax increases immediately and the spending 4 years from now—it understates the overall cost of this legislation. The American people need to know this is a \$2.5 trillion bill when it is fully implemented. The only reason they can bring that in under that number is because they start raising taxes immediately and do not start paying benefits out for another 4 years.

So I say to the Senator from Texas, I hope when we get to this vote, it will be a big bipartisan vote in the Senate, and I hope we will make a change in this legislation that implements some semblance of fairness and also gives us a true reflection of what the bill really costs.

Mrs. HUTCHISON. I thank the Senator from South Dakota.

Just to recap, the amount that would actually be collected before any program is put in place would be \$73 billion—already collected. That will include, as the Senator from Oklahoma mentioned, schoolteachers from Oklahoma who are considered to have these high-benefit plans, a schoolteacher making \$50,000, \$60,000 a year with a high-benefit plan. And do you know what the tax is on that high-benefit plan? Do you know what the tax is on that Oklahoma schoolteacher? A 40-percent excise tax—40 percent.

The PRESIDING OFFICER. The Senator's time has expired.

Mrs. HUTCHISON. Mr. President, I thank the Senator, and I would just say I hope we get a bipartisan vote on this motion. I hope we get a bipartisan vote to say the one thing we ought to do, if nothing else, is be fair to the American people. You do not pay taxes until the program is up and going.

Thank you, Mr. President.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Mr. President, I ask unanimous consent to offer some unanimous consent requests to the chairman of the Finance Committee.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. COBURN. Mr. President, I offer a unanimous consent request that it not be in order for the duration of the consideration of H.R. 3590 to offer an

amendment that has not been filed at the desk for 72 hours and for which there has not been a complete CBO score.

The PRESIDING OFFICER. Is there objection?

The Senator from Montana.

Mr. BAUCUS. Mr. President, reserving the right to object, I would like to just remind our colleagues, I have sought it, and I think it has been basically a very forthright, open process we have conducted here. Certainly in the Finance Committee—I see my colleague from Iowa on the floor—it was totally transparent for months upon months, with hearing upon hearing. We posted amendments in the Finance Committee on the Internet in advance of consideration.

I have never been part of a more transparent process since I have been here, frankly, at least for something of this magnitude over this period of time. In fact, one reporter even said to me: Senator, is this the new way we do things around here? It is so transparent, so bipartisan, and so forth. I said: I don't know. I sure like it that way.

I also remind all of us that Senator REID's amendment was made available on November 18 of this year, and 3 days later, on the 21st, we voted for cloture on the motion to proceed. Then, 12 days after the Reid amendment was made available, we finally began debate on the bill. And here we are, nearly a month later. So this bill has been out here.

The Senator mentioned, I note, having in mind the managers' amendment, which he has not seen and, frankly, this Senator has not seen either. I have some ideas what is in it, but I have not seen it myself.

I think as a practical matter this will be available for 72 hours, as the Senator suggests. Why do I say that? I say that because it is my expectation that Senator REID's managers' amendment will be filed very quickly, maybe in a day or two. It is also my expectation that we will then proceed, according to expectations here, to the Defense appropriations conference report, which we will then be working on for several days. And probably a cloture motion might be filed on the health care bill—on the managers' amendment probably not until after we do Defense appropriations. So during the interim, everyone is going to be able to see, at least for more than 72 hours, the contents of the managers' amendment in the health care bill which Senator REID is going to be filing. So as a practical matter, I think it is going to happen.

I cannot at this point agree to the request to lock that in for 72 hours, but I think as a practical—

Mr. COBURN. Will the Senator yield for a question?

Mr. BAUCUS. Yes.

Mr. COBURN. One of the reasons I want this, is it not his belief that the

American people ought to get to see this for 72 hours as well and that it ought to be on the Internet and that everybody in America, if we are going to take one-sixth of our economy, ought to have the time to truly read—we are going to have a managers' amendment, and that is actually what mine is focused on.

Mr. BAUCUS. Sure.

Mr. COBURN. But to be able to truly not just read the managers' amendment but then go into the bill where it is going to fix the bill.

Mr. BAUCUS. I think that is a good idea. I think it is going to happen.

Mr. COBURN. But the Senator will not agree to it by unanimous consent?

Mr. BAUCUS. I cannot at this time but, again, saying it is my expectation it will be available for more than 72 hours.

Mr. COBURN. I appreciate the sincerity of the chairman's remarks.

Mr. BAUCUS. I thank the Senator. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. COBURN. Mr. President, I have another unanimous consent request.

The following consent request would be associated with a Coburn amendment that would certify that every Member of the Senate has read the bill and understands it before they vote on the bill. The reason I ask unanimous consent that amendment be agreed to and accepted is that is exactly what the American people expect us to be doing.

So we do not have a bill right now. We do not know what is going to be in the bill. The chairman has a good idea what is going to be in the bill, but he does not know for sure. Only two sets of people—Senator REID and his staff and CBO—know what is going to be in the bill. I suspect somebody at the White House might.

But we ought to take and embrace the idea of transparency and responsibility, that the American people can expect every one of us to have read this bill, plus the amended bill, and certify that we have an understanding for what we are doing to health care in America with this bill.

I ask unanimous consent that be accepted.

The PRESIDING OFFICER. Is there objection?

The Senator from Montana.

Mr. BAUCUS. Mr. President, reserving the right to object, I certainly agree with the basic underlying import that we should know what we are voting on here. But I must say to my good friend from Oklahoma, I cannot certify that Members of the Senate will understand what they are reading. That presumes a certain level of perception on my part in understanding and delving into the minds of Senators that not only have they read but they have taken the time to understand. And what does "understand" mean? Understand the second and third levels, the

fourth level of questions? I think it is a practical impossibility for anybody to certify that any other Senator has fully understood. They may read, but they may not fully understand for a whole variety of reasons. So I cannot certify that.

Mr. COBURN. Could I clarify my request?

Mr. BAUCUS. I have to object.

The PRESIDING OFFICER. Objection is heard.

Mr. COBURN. Let me clarify my request that the individual certify themselves. I am not asking some group of Senators to certify some other Senator. I am saying that Tom Coburn tells his constituency: I have read this puppy. I have spent the time on it. I have read the managers' amendment, and I, in fact, certify to the people of Oklahoma that I know how terrible it is going to be for their health care.

Mr. BAUCUS. The Senator is always free to make any representations he wants. If he wants to certify he has read it and certify that he has understood it, that is the Senator's privilege.

Mr. COBURN. But the Senator won't accept that we as a body, on one-sixth of the economy, ought to say we know what we are doing?

Mr. BAUCUS. I can't certify that every Member of the Senate has done anything around here. Neither can the Senator from Oklahoma. That is an impossibility. But if the Senator wants to certify he has read it, that is great, and understands it fully, that is great, on any measure—not just this measure but any measure. But I can't certify that for 100 different Senators, on any measure. That is up to the individual Senators and that is up to their mental capacities and up to their initiatives and imaginations and conscientiousness and so forth. I can't certify to that.

Mr. COBURN. I thank the chairman.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Senator from Vermont be recognized to proceed for at least a half hour.

The PRESIDING OFFICER. The Senator from Vermont is recognized.

AMENDMENT NO. 2837 TO AMENDMENT NO. 2786

Mr. SANDERS. Madam President, I call up my amendment per the order.

The PRESIDING OFFICER (Mrs. HAGAN). The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Vermont [Mr. SANDERS], for himself, Mr. BURRIS, and Mr. BROWN, proposes an amendment numbered 2837 to amendment No. 2786.

Mr. SANDERS. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Is there objection?

Mr. COBURN. Madam President, I object.

The PRESIDING OFFICER. Objection is heard.

The assistant legislative clerk continued with the reading of the amendment.

Mr. SANDERS. Madam President, I ask unanimous consent that the amendment be considered as read.

The PRESIDING OFFICER. Is there objection?

Mr. COBURN. There is objection.

The PRESIDING OFFICER. Objection is heard.

Mr. SANDERS. Madam President, may I ask my friend from Oklahoma why he is objecting?

Mr. COBURN. Regular order, Madam President.

The PRESIDING OFFICER. Regular order is the reading of the amendment.

The assistant legislative clerk continued with the reading of the amendment.

(The amendment (No. 2837) is printed in the RECORD of Wednesday, December 2, 2009, under "Text of Amendments.")

The PRESIDING OFFICER (Mr. CARDIN). The Senator from Vermont is recognized.

AMENDMENT NO. 2837 WITHDRAWN

Mr. SANDERS. Mr. President, I withdraw my amendment.

Mr. COBURN. Regular order, Mr. President.

The PRESIDING OFFICER. The Senator has that right. The amendment is withdrawn.

Mr. SANDERS. Pursuant to the 30 minutes that I—

The PRESIDING OFFICER (Mrs. SHAHEEN). Under the previous order, the Senator from Vermont is recognized for 30 minutes.

Mr. SANDERS. Madam President, let me begin not by talking about my amendment but by talking about the Republican action that we have seen right here on the floor of the Senate. Everybody in this country understands that our Nation faces a significant number of major crises—whether it is the disintegration of our health care system, the fact that 17 percent of our people are unemployed or underemployed, or the fact that one out of four of our children is living on food stamps. We have two wars, we have global warming, we have a \$12 trillion national debt, and the best the Republicans can do is try to bring the U.S. Government to a halt by forcing a reading of a 700-page amendment. That is an outrage. People can have honest disagreements, but in this moment of crisis it is wrong to bring the U.S. Government to a halt.

I am very disturbed that I am unable to bring the amendment that I wanted to bring to the floor of the Senate. I thank Senator REID for allowing me to try to bring it up before it was obstructed and delayed and prevented by the Republican leadership. My amendment, which was cosponsored by Senators SHERROD BROWN and ROLAND

BURRIS, would have instituted a Medicare-for-all single-payer program. I was more than aware and very proud that, were it not for the Republican's obstructionist tactics, this would have been the first time in American history that a Medicare-for-all single-payer bill was brought to a vote before the floor of the Senate. I was more than aware that this amendment would not win. I knew that. But I am absolutely convinced that this legislation or legislation like it will eventually become the law of the land.

The reason for my optimism that a Medicare-for-all single-payer bill will eventually prevail is that this type of system is and will be the only mechanism we have to provide comprehensive high-quality health care to all of our people in a cost-effective way. It is the only approach that eliminates the hundreds of billions of dollars in waste, administrative costs, bureaucracy, and profiteering by the private insurance companies, and we are not going to provide comprehensive, universal, cost-effective health care to all of our people without eliminating that waste. That is the simple truth.

The day will come, although I recognize it is not today, when the Congress will have the courage to stand up to the private insurance companies and the drug companies and the medical equipment suppliers and all of those who profit and make billions of dollars every single year off of human sickness. On that day, when it comes—and it will come—the U.S. Congress will finally proclaim that health care is a right of all people and not just a privilege. And that day will come, as surely as I stand here today.

There are those who think that Medicare-for-all is some kind of a fringe idea—that there are just a few leftwing folks out there who think this is the way to go. But let me assure you that this is absolutely not the case. The single-payer concept has widespread support from diverse groups from diverse regions throughout the United States. In fact, in a 2007 AP/Yahoo poll, 65 percent of respondents said that the United States should adopt a universal health insurance program in which everyone is covered under a program like Medicare that is run by the Government and financed by taxpayers.

There is also widespread support for a Medicare-for-all approach among those people who understand this issue the most, and that is the medical community. That support goes well beyond the 17,000 doctors in the Physicians for National Health Care Program, who are fighting every day for a single-payer system. It goes beyond the California Nurses Association, the largest nurses union in the country, who are also fighting for a Medicare-for-all, single-payer health care. In March of 2008,

a survey of 2,000 American doctors published in the *Annals of Internal Medicine* concluded that 59 percent of physicians "supported legislation to establish national health insurance."

Madam President, you might be particularly interested to know that the New Hampshire Medical Society surveyed New Hampshire physicians and found that two-thirds of New Hampshire physicians, including 81 percent of primary care clinicians, indicated that they would favor a simplified payer system in which public funds, collected through taxes, were used to pay directly for services to meet the basic health care needs of all citizens. That is New Hampshire.

In 2007, *Minnesota Medicine Magazine* surveyed Minnesota physicians and found that 64 percent favored a single-payer system; 86 percent of physicians also agreed that it is the responsibility of society, through the Government, to ensure that everyone has access to good medical care.

But it is not just doctors, it is not just nurses, it is not just millions of ordinary Americans. What we are seeing now is that national, State, and local organizations representing a wide variety of interests and regions support single payer. These include the U.S. Conference of Mayors, the American Medical Students Association, the AFL/CIO, the United Church of Christ, the UAW, the International Association of Machinists, the United Steelworkers, the United Electrical Workers, the Older Women's League, and so many others that I do not have the time to list them.

I ask unanimous consent to insert a list in the RECORD of all the organizations representing millions and millions of Americans who are sick and tired of the current system and want to move toward a Medicare-for-all single-payer system.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

NATIONAL ORGANIZATIONS SUPPORT SINGLE PAYER

American Federation of Musicians of the United States and Canada, American Medical Students Association, Americans for Democratic Action, American Patients United, All Unions Committee for Single Payer Health Care, Alliance for Democracy, Business Coalition for Single Payer Health Care, California Nurses Association/National Nurse Organizing Committee, Coalition of Black Trade Unionists, Coalition of Labor Union Women, Committee of Presidents, National Association of Letter Carriers, Committees of Correspondence, Earthly Energy Werx, Electrical Workers Minority Caucus, Fellowship of Reconciliation, Feminist Caucus of the American, Humanist Association, and Global Kids Inc.

Global Security Institute, Health Plan Navigator, Healthcare NOW!, Hip Hop Caucus, House of Peace, Institute for Policy Studies, Cities for Progress, Inter-religious Foundation for Community Organization, International Association of Machinists and

Aerospace Workers, League of Independent Voters, National Association for the Advancement of Colored People, National Association of Letter Carriers, National Council on Healthcare for the Homeless, National Economic and Social Rights Initiative, National Education Association, National Organization of Women, National Student Nurses Association, Needed Now, and Older Women's League.

PAGE International Union, Peoples' Health Movement—US Circle, Physicians for a National Health Program, Progressive Christians United, Progressive Democrats of America, The United Church of Christ, United Association of Journeymen & Apprentices of the Plumbing & Pipe Fitting Industry of the United States & Canada, United Automobile Workers, United Automobile Workers, International Union Convention, United Electric Workers, United Federation of Teachers, United Methodist Global Board of Church and Society, United Steelworkers of America, Up for Democracy, Women's Division of The United Methodist Church, Women's Universal Health Initiative, and Young Democrats.

STATE ORGANIZATIONS SUPPORT SINGLE PAYER

1199SEIU United Healthcare Workers East, MD, DC, NY, MA; 1199SEIU Retired Division of New York; American Guild of Musical Artists: Chicago/Midwest Region; American Postal Workers Union (APWU), Michigan State; Arizona AFL-CIO; Arkansas AFL-CIO; California State Pipe Trades Council, United Association; California School Employees Association; Connecticut State Council of Machinists of the IAMAW; Connecticut Medicare for All; Delaware State AFL-CIO; Florida CHAIN; Florida State AFL-CIO; Florida State Alliance for Retired Americans; Health Action New Mexico; Health Care for All California; Health Care for All Colorado; Health Care for All New Jersey; Health Care for All Texas; Health Care for All Washington; Hoosiers for a Common Sense Health Plan; and Iowa Federation of Labor; AFL-CIO.

Kentucky House of Representatives; Kentucky Jobs with Justice; Kentucky State AFL-CIO; Maine Council of United Steelworkers; Maine State AFL-CIO; Maine State Building & Construction Trades Council; Maryland State and District of Columbia AFL-CIO; Massachusetts Nurses Association; Massachusetts State United Auto Workers; Michigan State AFL-CIO Women's Council; Michigan State Association of Letter Carriers; Minnesota DFL Progressive Caucus; Minnesota State AFL-CIO; Missouri State AFL-CIO; New Jersey Media Corps; New Jersey State Industrial Union Council; New York Professional Nurses Union; New York State Nurses Association; North Carolina Fair Share; North Carolina State AFL-CIO; North Dakota State AFL-CIO; Ohio Alliance for Retired Americans.

Ohio State AFL-CIO; Ohio Steelworkers Organization of Active Retirees; Oregon United Methodist Church; Pennsylvania Association of Staff Nurses and Allied Professionals; Pennsylvania State AFL-CIO; SCFL of Wisconsin; SEIU—United Healthcare Workers West; South Carolina State AFL-CIO; South Dakota AFL-CIO; Texas AFL-CIO; Texas Alliance for Retired Americans; Texas Building & Construction Trades Council; The Tennessee Tribune Newspaper; Utah Jobs with Justice; Vermont State Labor Council AFLCIO; Washington State Alliance for Retired Americans; Washington State Building and Construction Trades Council; Washington State Labor Council; West Vir-

ginia State AFL-CIO; Wisconsin Clean Elections Campaign; Wisconsin State AFL-CIO; Wyoming State AFL-CIO.

Mr. SANDERS. There is also significant support in the House of Representatives for a single-payer system. Together, H.R. 676 and H.R. 1200, two different single-payer proposals, have 94 cosponsors.

And let me say a word about State legislatures that have moved forward aggressively toward a single-payer system. In California, our largest State, the State legislature there has on two occasions passed a single-payer program. The largest State in America passed a single-payer program, and on both occasions it was vetoed by the Governor. In New York State, the State Assembly passed a single-payer system. Among other States where single payer has been proposed and seriously discussed are Ohio, Massachusetts, Georgia, Colorado, Maine, Vermont, Illinois, Wisconsin, Oregon, Washington, New Mexico, Minnesota, Indiana, and New Hampshire.

Why is it that we need an entirely new approach for health care in this country? The answer is pretty obvious. Our current system, dominated by profit-making insurance companies, simply does not work. Yes, we have to confess, it does work for the insurance companies that make huge profits and provide their CEOs with extravagant compensation packages. Yes, it does work—and we saw how well it worked right here on the floor yesterday—for the pharmaceutical industry which year after year leads almost every other industry in profit while charging the American people by far—not even close—the highest prices in the world for prescription drugs.

So it works for the insurance companies. It works for the drug companies. It works for the medical equipment suppliers and the many other companies who are making billions of dollars off of our health care system. But it is not working for—in fact, it is a disaster for—ordinary Americans.

Today, 46 million people in our country have no health insurance and an even higher number of people are underinsured, with high deductibles or copayments. Today, as our primary health care system collapses, tens of millions of Americans do not have access to a doctor on a regular basis and, tragically, some 45,000 of our fellow Americans who do not have access to a doctor on a regular basis die every single year. That is 15 times more Americans who die of preventable diseases than were murdered in the horrific 9/11 attack against our country. That takes place every year: the preventable deaths of 45,000 people.

This is not acceptable. These horrific deaths are a manifestation of a collapsing system that needs fundamental change.

A number of months ago I took to the floor to relate stories that I heard

from people throughout the State of Vermont regarding the health care crisis, stories which I published in a small pamphlet and placed on my Web site. Let me tell you one story.

A man from Swanton, VT, in the northern part of our State, wrote to me to tell me the story of his younger brother, a Vietnam veteran, who died 3 weeks after being diagnosed with colon cancer. At the time he was diagnosed, he had been laid off from his job and could not afford COBRA coverage. This is what his brother said:

When he was in enough pain to see a doctor it was too late. He left a wife and two teenage sons in the prime of his life at 50 years old. The attending physician said that, if he had only sought treatment earlier, he would still be alive.

Horribly, tragically, that same story is being told in every State in this country over and over again. If only he had gone to the doctor in time he could have lived, but he didn't have any health insurance. That should not be taking place in the United States of America in the year 2009.

Our health care disaster extends beyond even the thousands who die needlessly every single year. Many others suffer unnecessary disability—strokes that leave them paralyzed because they couldn't afford treatment for their high blood pressure, or amputations, blindness, or kidney failure from untreated diabetes. Infants are born disabled because their mothers couldn't get the kind of prenatal care that every mother should have, and millions with mental illness go without care every single day.

In a town in northern Vermont not far from where I live, a physician told me that one-third of the patients she treats are unable to pay for the prescription drugs she prescribes. Think about the insanity of that. We ask doctors to diagnose our illness, to help us out, she writes the prescription for the drug, and one-third of her patients cannot afford to fill that prescription. That is insane. That is a crumbling health care system. The reason people cannot afford to fill their prescription drugs is that our people, because of pharmaceutical industry greed, are forced to pay by far the highest prices in the world for prescription drugs. This is indefensible. There is nobody who can come to the floor of this Senate and tell me that makes one shred of sense.

The disintegration of our health care system causes not only unnecessary human pain, suffering, and death, but it is also an economic disaster. Talk to small businesses in Vermont, New Hampshire, any place in this country, and they tell you they cannot afford to invest in their companies and create new jobs because all of their profits are going to soaring health care costs—10, 15, 20 percent a year. Talk to the recently bankrupt General Motors and

they will tell you that they spend more money per automobile on health care than they do on steel. GM is forced to pay \$1,500 per car on health care while Mercedes in Germany spends \$419, and Toyota in Japan spends \$97. Try to compete against that.

From an individual economic perspective, it is literally beyond comprehension that of the nearly 1 million people who will file for bankruptcy this year, the vast majority are filing for bankruptcy because of medically related illnesses. Let's take a deep breath and think about this from an emotional point of view. Let's think about the millions of people who are today struggling with cancer, struggling with heart disease, struggling with diabetes or other chronic illnesses. They are not even able to focus on their disease and trying to get well. They are summing half their energy to fight with the insurance companies to make sure they get the coverage they need. That is not civilized. That is not worthy of the United States of America.

In my State of Vermont—and I suspect it is similar in New Hampshire and every other State—I have many times walked into small mom-and-pop stores and seen those little donation jars that say: Help out this or that family because the breadwinner is struggling with cancer and does not have any health insurance or little Sally needs some kind of operation and she doesn't have any health insurance, put in a buck or five bucks to help that family get the health care they need. This is the United States of America. This should and cannot be allowed to continue.

One of the unfortunate things that has occurred during the entire health care debate is that we have largely ignored what is happening in terms of health care around the rest of the world. I have heard some of my Republican colleagues get up and say: We have the best health care system in the world. Yes, we do, if you are a millionaire or a billionaire, but we do not if you are in the middle class, not if you are a working-class person, certainly not if you are low income. It is just not true.

Today, the United States spends almost twice as much per person on health care as any other country. Despite that, we have 46 million uninsured and many more underinsured and our health care outcomes are, in many respects—not all but in many respects—worse than other countries. Other countries, for example, have longer life expectancies than we do. They are better on infant mortality, and they do a lot better job in terms of preventable deaths. At the very beginning of this debate, we should have asked a very simple question: Why is it we are spending almost twice as much per person on health care as any other country with outcomes that, in many respects, are not as good?

According to an OECD report in 2007, the United States spent \$7,290, over \$7,000 per person on health care. Canada spent \$3,895, almost half what we spent. France spent \$3,601, less than half what we spent. The United Kingdom spent less than \$3,000, and Italy spent \$2,600 compared to the more than \$7,000 we spent. Don't you think that maybe the first question we might have asked is: Why is it we spend so much and yet our health care outcomes, in many respects, are worse than other countries? Why is it that that happens?

Let me tell you what other people will not tell you. One key issue that needed to be debated in this health care discussion has not been discussed. The simple reason as to why we spend so much more than any other country with outcomes that are not as good as many other countries is that this legislation, from the very beginning, started with the assumption that we need to maintain the private for-profit health insurance companies. That basic reality that we cannot touch private insurance companies, in fact that we have to dump millions more people into private health insurance companies, that was an issue that could not even be discussed. And as a result, despite all the money we spend, we get poor value for our investment.

According to the World Health Organization, the United States ranks 37th in terms of health system performance compared with five other countries: Australia, Canada, Germany, New Zealand, and the United Kingdom. The U.S. health system ranks less or less than half.

Sometimes these groups poll people. They go around the world and they poll people and they ask: How do you feel about your own health care system? We end up way down below other countries. Recently, while the Canadian health care system was being attacked every single day, they did a poll in Canada. They said to the Canadian people: What do you think about your health care system? People in America say you have a terrible system. Do you want to junk your system and adopt the American system? By overwhelming numbers, the people of Canada said: Thank you, no thank you. We know the American system. We will stay with our system.

I was in the United Kingdom a couple months ago. I had an interesting experience. It was a Parliamentary meeting. I met with a number of people in the Conservative Party—not the liberal Democratic Party, not the Labour Party, the Conservative Party, the party which likely will become the government of that country. The Conservatives were outraged by the kind of attacks being leveled against the national health system in their country, the lies we are being told about their system. In fact, the leader of the Conservative Party got up to defend the

national health system in the United Kingdom and said: If we come to power, we will defend the national health system. Those were the conservatives.

What is the problem with our system which makes it radically different than systems in any other industrialized country? It is that we have allowed for-profit private corporations to develop and run our health care system, and the system that these companies have developed is the most costly, wasteful, complicated, and bureaucratic in the entire world. Everybody knows that. With 1,300 private insurance companies and thousands and thousands of different health benefit programs all designed to maximize profits, private health insurance companies spend an incredible 30 percent of every health care dollar on administration and billing, on exorbitant CEO compensation packages, on advertising, lobbying, and campaign contributions. This amounts to some \$350 billion every single year that is not spent on health care but is spent on wasteful bureaucracy.

It is spent on bureaucrats and on an insurance company telling us why we can't get the insurance we pay for. How many people today are on the phone today arguing with those bureaucrats to try to get the benefits they paid for? It is spent on staff in a physician's office who spend all their time submitting claims. They are not treating people; they are submitting claims. It is spent on hundreds of people working in the basement of hospitals who are not delivering babies, not treating people with cancer. They are not making people well. They are sending out bills. That is the system we have decided to have. We send out bills, and we spend hundreds of billions of dollars doing that rather than bringing primary health care physicians into rural areas, rather than getting the doctors, dentists, and nurses we need.

Let me give a few outrageous examples. Everyone knows this country is in the midst of a major crisis in primary health care. We lack doctors. We lack nurses. We lack dentists—a major crisis getting worse every single day. Yet while we are unable to produce those desperately needed doctors and nurses and dentists, we are producing legions of insurance company bureaucrats.

Here is a chart which deals with that issue. What this chart shows is that over the last three decades, the number of administrative personnel, bureaucrats who do nothing to cure our illnesses or keep us well, the number of bureaucrats has grown by 25 times the number of physicians. This is growth in the number of doctors—nonexistent. This is growth in the number of health care bureaucrats on the phone today telling you why you can't get the health care coverage you paid for or telling you that you have a preexisting condition and throwing you off health care because you committed the crime

last year of getting sick. That growth is through the roof. This is where our health care dollars are going. This is why we need a single-payer system.

According to Dr. Uwe Reinhardt in testimony before Congress, Duke University Hospital, a very fine hospital, has almost 900 billing clerks to deal with hundreds of distinct managed care contracts. Do you know how many beds they have in that hospital? They have 900 beds. They have 900 bureaucrats involved in billing for 900 beds. Tell me that makes sense.

At a time when the middle class is collapsing and when millions of Americans are unable to afford health insurance, the profits of health insurance companies are soaring. From 2003 to 2007, the combined profits of the Nation's major health insurance companies increased by 170 percent. While more and more Americans are losing their jobs, the top executives of the industry are receiving lavish compensation packages. In 2007, despite plans to cut 3 to 4 percent of its workforce, Johnson & Johnson found the cash to pay its CEO Weldon \$31.4 million. Ron Williams of Aetna took home over \$38 million, and the head of CIGNA, Edward Hanway, took away \$120 million over 5 years on, and on and on it goes.

So what is the alternative? Let me briefly describe the main features of a Medicare-for-all single-payer system. In terms of access, people getting into health care, this legislation would provide for all necessary medical care without cost sharing or other barriers to treatment. Every American—not 94 percent but 100 percent of America's citizens—would be entitled to care. In terms of choice, the issue is not choice of insurance companies that our Republican friends talk about. The question is choice of doctors, choice of hospitals, choice of therapeutic treatments. Our single-payer legislation would provide full choice of physicians and other licensed providers and hospitals. Importantly—and I know there is some confusion—a single-payer program is a national health insurance program which utilizes a nonprofit, private delivery system. It is not a government-run health care system. It is a government-run insurance program. In other words, people would still be going to the same doctors, still going to the same hospitals and other medical providers.

The only difference is, instead of thousands of separately administered programs run with outrageous waste, there would be one health insurance program in America for Members of Congress, for the poorest people in our country, for all of us. In that process, we would save hundreds of billions of dollars in bureaucratic waste. In terms of benefits, what would you get? A single-payer program covers all medically necessary care, including primary care, emergency care, hospital services,

mental health services, prescriptions, eye care, dental care, rehabilitation services, and nursing home care as well. In terms of medical decisions, those decisions under a single-payer program would be made by the doctors and the patients, not by bureaucrats in insurance companies.

If we move toward a single-payer program, we could save \$350 billion a year in administrative simplification, bulk purchasing, improved access with greater use of preventative services, and earlier diagnosis of illness.

People will be able to get to the doctor when they need to rather than waiting until they are sick and ending up in a hospital.

Further, and importantly, like other countries with a national health care program, we would be able to negotiate drug prices with the pharmaceutical industry, and we would end the absurdity of Americans being forced to pay two, three, five times more for certain drugs than people around the rest of the world.

Every other industrialized country on Earth primarily funds health care from broad-based taxes in the same way we fund the Defense Department, Social Security, and other agencies of government, and that is how we would fund a national health care program.

Let me be specific about how we would pay for this. What this legislation would do is, No. 1, eliminate—underline “eliminate”—all payments to private insurance companies. So people would not be paying premiums to UnitedHealth, WellPoint, Blue Cross Blue Shield, and other private industry companies—not one penny. The reason for that is that private for-profit health insurance companies in this country would no longer exist.

Instead, this legislation would maintain all of the tax revenue that currently flows into public health programs like Medicare, Medicaid, and CHIP, and it would add to that an income tax increase of 2.2 percent and a payroll tax of 8.7 percent. This payroll tax would replace all other employer expenses for employee health care. In other words, employers in this country, from General Motors to a mom-and-pop store in rural America, would no longer be paying one penny toward private insurance revenue.

The income tax would take the place of all current insurance premiums, copays, deductibles, and all other out-of-pocket payments made by individuals. For the vast majority of people, a 2.2-percent income tax is way less than what they now pay for all of those other things. In other words, yes, you would be paying more in taxes. That is true. But you would no longer have to pay for private health insurance, and, at the end of the day, from both a financial perspective and a health security perspective, we would be better off as individuals and as a nation.

What remains in existence—I should add here—is the Veterans' Administration. I believe, and most of us believe, they have a separate set of issues, and the VA would remain as it is.

Let me bring my remarks to a close by giving you an example of where I think we should be going as a country in terms of health care. Oddly enough, the process that I think we should be using is what a small country of 23 million people—the country of Taiwan—did in 1995. In 1995, Taiwan was where we are right now—massive dissatisfaction with a dysfunctional health care system—and they did what we did not do. They said: Let's put together the best commission we can, the smartest people we know. Let's go all over the world. Let's take the best ideas from countries all over the world.

As Dr. Michael Chen, vice president and CFO of Taiwan's National Health Insurance Bureau, explained in an interview earlier this year, the Taiwanese ultimately chose to model their system—after a worldwide search—on our Medicare Program. That is where they went, except that they chose to insure the entire population rather than just the elderly. After searching the globe, the Taiwanese realized what many Americans already know: a Medicare-for-all, single-payer system is the most effective way to offer quality coverage at a reasonable price.

Taiwan now offers comprehensive health care to all of its people, and it is spending 6 percent of its GDP to do that while we spend 16 percent of our GDP. But, unfortunately, the single-payer model was not ever put on the table here. Maybe we should learn something from our friends in Taiwan.

Let me end by saying this: This country is in the midst of a horrendous health care crisis. We all know that. We can tinker with the system. We can come up with a 2,000-page bill which does this, that, and the other thing. But at the end of the day, if we are going to do what virtually every other country on Earth does—provide comprehensive, universal health care in a cost-effective way, one that does not bankrupt our government or bankrupt individuals—if we are going to do that, we are going to have to take on the private insurance companies and tell them very clearly that they are no longer needed. Thanks for your service. We don't need you anymore.

A Medicare-for-all program is the way to go. I know it is not going to pass today. I know we do not have the votes. I know the insurance company and the drug lobbyists will fight us to the death. But, mark my words, Madam President, the day will come when this country will do the right thing. On that day, we will pass a Medicare-for-all single-payer system.

Mr. LUGAR. Mr. President, I take this opportunity to share with my colleagues a statement I have prepared re-

garding the health care reform debate in which the Senate is currently engaged.

A majority of the Members of Congress share President Obama's humane goal that millions more Americans might enjoy health insurance coverage and that medical care to all Americans might be substantially improved. For the moment, however, President Obama and the Congress must recognize that the overwhelming demand of most Americans is that presidential and congressional leadership should focus each day on restoration of jobs, strengthening of housing opportunities, new growth in small business and large industries, and banks that are not only solvent but confident of normal lending. In essence, the task facing national leadership is truly monumental. A national and international recession has not ended and many economists predict that unemployment, which has exceeded 10 percent in the United States, will continue to grow in coming months.

The President and the current Congress have realized a final deficit for fiscal year 2009 of \$1.4 trillion, with the total national debt now at \$12 trillion. The appropriation bills that Congress has passed and that will make up the next fiscal year's expenditures are predicted to result in another annual deficit of more than \$1 trillion. In fiscal year 2009, Medicaid spending increased by 24.6 percent to \$251 billion. Spending on Food Stamps increased 41 percent to \$56 billion. Unemployment benefits increased almost 155 percent to \$120 billion.

Republicans and Democrats may feel that passing comprehensive health legislation before the end of the year is crucial to the success or failure of the Obama administration and/or party leadership in the Congress.

But I would suggest that successful leadership will be defined, now and historically, by success in bringing a horrendous economic recession to an end, bringing new strength to our economy, and providing vital leadership in international relations as we hope to bring conflicts under control and in some cases, to conclusion.

I appreciate that President Obama has strongly argued that comprehensive health care legislation is an important component to reducing federal deficit spending. He has contended that failure to pass this legislation will increase deficits now and for many years to come. I disagree with the President.

After the economic recession in our country comes to a conclusion, a high priority may be extension of health insurance coverage and reform of many health care practices. When such changes occur, they are likely to be expensive and Americans will need to debate, even then, their priority in comparison to many other national goals. One reason why health care is likely to

remain expensive is that major advances in surgical procedures, prescription drugs, and other health care practices have prolonged the lives of tens of millions of Americans and improved the quality of those additional years. The Washington Post, in a front-page story on July 26, 2009, mentioned that "the fight against heart disease has been slow and incremental. It's also been extremely expensive and wildly successful." Americans should not take for granted all of the advances in health care that have enriched our lives, but we sometimes forget that we require and even pray for much more medical progress in years to come, which is likely to be expensive.

In order to pay for the cost of the nearly \$1 trillion health care legislation, several Members of Congress are suggesting new forms of taxation, reduction of payments to doctors and hospitals, and curtailment of certain types of insurance coverage. These and other suggestions may temporarily bring about cost reduction but will also have some after-effects in the overall economy. In fact, strong financial incentives may be needed to enlist men and women to enter the medical field. Failure to enlist a sufficient number of doctors could lead to rationing of service and longer lines to find someone who will give humane attention.

In the meanwhile, it is possible that the President and Members of Congress might find some inexpensive, incremental improvements that could result in a greater number of Americans being served through health insurance and more efficiently operating health care institutions. The strong desire that most of us have to continue discussing these issues and make improvements need not be postponed even as President Obama and the Congress strive for victory over a devastating national economic recession.

Because our Federal spending deficits have risen so much and are predicted to rise even more, all substantive discussions on health care and other important issues will be conducted during many years of planning and, finally, decisive action to reduce deficit spending and preserve the value and integrity of the dollar as we continue to borrow hundreds of billions of dollars in the form of U.S. Treasury bonds sold to governments and citizens of other countries. They, too, are counting on the integrity of our dollar and our financial system to preserve the value of their financial reserves.

Starting with President Obama and extending to all Members of Congress, we wish that we had inherited a neutral, peaceful playing field. We have not been so fortunate. Our responsibility now is to recognize the extraordinary financial tragedy that has befallen our country and to recognize the unprecedented opportunity that we have to stop the momentum of that

tragedy. We must provide valid hope of constructive vision, idealism, and change in the future. I look forward to working with the President and my colleagues to tackle first things first.

Ms. COLLINS. Madam President, I rise today to speak in favor of the motion to commit offered by Senators HUTCHISON and THUNE.

The Hutchison-Thune motion to commit would send the health care bill to the Senate Finance Committee with instructions to revise the bill in a revenue-neutral manner, to prevent taxes in the bill from going into effect before the exchanges are set up in 2014.

The bill makes Americans wait until 2014 to get insurance through the new "exchanges," but it rolls out new tax hikes starting right away. Unless we take action to change this, Americans will see 4 years of tax increases before the chief benefits of this bill become available.

In the 4 years between now and the time the exchanges come online, Americans will face at least a dozen new or increased taxes and fees costing \$73 billion.

Some of these taxes start in 2 weeks. For example, a new tax on pharmaceutical manufacturers, which will raise an average of \$2.2 billion per year; a new tax on health insurance providers, which will raise \$6.7 billion per year; a new tax on medical device manufacturers, which will raise \$2 billion per year.

Other taxes kick in 1 year from now. These include an increased penalty on withdrawals from Health Savings Accounts and a new \$2,500 cap on FLEX spending accounts.

These new limits and penalties make no sense to me. Why would we want to impose a penalty on Americans who use money from their FLEX spending accounts to buy over-the-counter medicine? How is that going to help make health care more affordable?

But that is not all the bill does with respect to taxes. In 2013, the bill imposes several more taxes, including a reduction in the tax deductibility of medical expenses, a new high cost insurance excise Tax—the so-called Cadillac tax, and an increase in the Medicare payroll tax for high earners.

These tax increases total \$73 billion before 2014, before anyone gets a dollar of subsidy to purchase health insurance in the new exchanges.

These taxes will be paid right away by Americans in the form of higher health insurance premiums. This is not just my opinion; this is what the Congressional Budget concludes too. Here is what the CBO said about the \$6.7 billion annual fee on health insurance providers, which is scheduled to begin next year:

We expect a very large portion of [the] proposed insurance industry fee to be borne by purchasers of insurance in the form of higher premiums.

It is not just taxes on insurance that will be passed on to consumers. Taxes on pharmaceutical manufacturers and medical devices makers will also be passed on.

This means that American consumers will see price increases for everything from insulin pumps, to pacemakers, to power wheelchairs and drugs like Prilosec.

As the CBO Director has said:

Those fees would increase costs for the affected firms, which would be passed on to purchasers and would ultimately raise insurance premiums by a corresponding amount.

The Joint Committee on Taxation shares the CBO's view these tax hikes will be passed along to consumers.

Once again, I do not see how imposing these new taxes now—before the exchanges are set up and the chief benefits of the bill are supposed to become available—makes health care more affordable.

For all of these reasons, I will be voting in favor of the Hutchison-Thune motion to recommit, and I would urge my colleagues to do the same.

MOTION TO COMMIT

Mr. SANDERS. Madam President, I now move to table Senator HUTCHISON's motion to commit, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) and the Senator from Massachusetts (Mr. KERRY) are necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Oklahoma (Mr. INHOFE).

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 56, nays 41, as follows:

[Rollcall Vote No. 379 Leg.]

YEAS—56

Akaka	Gillibrand	Murray
Baucus	Hagan	Nelson (FL)
Begich	Harkin	Pryor
Bennet	Inouye	Reed
Bingaman	Johnson	Reid
Boxer	Kaufman	Rockefeller
Brown	Kirk	Sanders
Burr	Klobuchar	Schumer
Cantwell	Kohl	Shaheen
Cardin	Landrieu	Specter
Carper	Lautenberg	Stabenow
Casey	Leahy	Tester
Conrad	Levin	Udall (CO)
Dodd	Lieberman	Udall (NM)
Dorgan	Lincoln	Warner
Durbin	McCaskill	Webb
Feingold	Menendez	Whitehouse
Feinstein	Merkley	Wyden
Franken	Mikulski	

NAYS—41

Alexander	Crapo	McCain
Barrasso	DeMint	McConnell
Bayh	Ensign	Murkowski
Bennett	Enzi	Nelson (NE)
Bond	Graham	Risch
Brownback	Grassley	Roberts
Bunning	Gregg	Sessions
Burr	Hatch	Shelby
Chambliss	Hutchison	Snowe
Coburn	Isakson	Thune
Cochran	Johanns	Vitter
Collins	Kyl	Voinovich
Corker	LeMieux	Wicker
Cornyn	Lugar	

NOT VOTING—3

Byrd	Inhofe	Kerry
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The motion was agreed to.

Mr. REID. Madam President, I move to reconsider the vote, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

(At the request of Mr. REID, the following statement was ordered to be printed in the RECORD.)

VOTE EXPLANATION

• Mr. KERRY. Madam President, I was necessarily absent for the vote on the motion to table the Hutchison motion to commit to the health care bill, H.R. 3590. If I were able to attend today's session, I would have voted to table the Hutchison motion to commit.●

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 2010

Mr. REID. Madam President, I ask the Chair to lay before the Senate a message from the House with respect to H.R. 3326, the Department of Defense Appropriations Act.

The PRESIDING OFFICER. The Chair lays before the Senate the message from the House.

H.R. 3326

Resolved, That the House agree to the amendment of the Senate to the bill (H.R. 3326) entitled "An Act making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes", with a House amendment to Senate Amendment.

CLOTURE MOTION

Mr. REID. Madam President, I move to concur in the House amendment, and I send a cloture motion to the desk.

The PRESIDING OFFICER. The clerk will report the motion.

The legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the motion to concur in the House amendment to the Senate amendment to H.R. 3326, the Department of Defense Appropriations Act for Fiscal Year 2010.

Daniel K. Inouye, Harry Reid, Max Baucus, Patrick J. Leahy, Sheldon Whitehouse, Carl Levin, Patty Murray, Mark Begich, Maria Cantwell, Mark L. Pryor, Jack Reed, Edward E. Kaufman, Al Franken, Tom Harkin, Jim Webb, Paul G. Kirk, Jr., Michael F. Bennet.

AMENDMENT NO. 3248

Mr. REID. Madam President, I move to concur in the House amendment with an amendment, which is at the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Nevada (Mr. REID) moves to concur in the House amendment to the Senate amendment with an amendment numbered 3248.

Mr. REID. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end of the House amendment, insert the following:

The provisions of this Act shall become effective 5 days after enactment.

Mr. REID. Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3252 TO AMENDMENT NO. 3248

Mr. REID. Madam President, I have an amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The Senator from Nevada (Mr. REID) proposes an amendment numbered 3252 to amendment No. 3248.

Mr. REID. I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

Strike "5 days" and insert "1 day".

MOTION TO REFER/AMENDMENT NO. 3249

Mr. REID. Madam President, I have a motion to refer, with instructions, at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada (Mr. REID) moves to refer H.R. 3326 to the Committee on Appropriations with instructions to report back with the following amendment No. 3249:

At the end, insert the following:

The Appropriations Committee is requested to study the impact of any delay in implementing the provisions of the Act on service members' families.

Mr. REID. Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3250

Mr. REID. Madam President, I have an amendment to my instructions at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada (Mr. REID) proposes an amendment numbered 3250 to the instructions of amendment No. 3249.

Mr. REID. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end, add the following:

"and the health care provided to those service members."

Mr. REID. Madam President, I ask for the yeas and nays on the amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3251 TO AMENDMENT NO. 3250

Mr. REID. Madam President, I have a second-degree amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada (Mr. REID) proposes an amendment numbered 3251 to amendment 3250.

Mr. REID. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end, add the following:

"and the children of service members."

Mr. REID. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DURBIN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

Mr. ENSIGN. I object.

The PRESIDING OFFICER. Objection is heard. The clerk will continue calling the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. REID. It is my understanding that the Senator from Texas wishes to speak for up to 5 minutes. I ask unanimous consent that she be recognized, and following that Senator DURBIN be recognized.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Texas is recognized.

Mrs. HUTCHISON. Madam President, I thank the majority leader for allowing me to speak because I am very concerned about a precedent that has been set on the floor in this last vote.

When the Senator from Vermont withdrew his amendment and started talking, my motion to commit was the measure pending on the floor. I did not

have notice—which is the normal procedure here—to be able to talk on my motion. We had no idea there would be a motion to table my motion before I had a chance to close.

Here is my point. The measure that was tabled, the Hutchison-Thune motion, would have assured the American people that there would not be 4 years of tax collection before any kind of program would be put forward under the health care reform package. I thought it was very important that Senator THUNE and I be able to close on that. That is a concept we have always had in the Senate—that a program starts when it starts. That means if taxes are included, the taxes will start when the program starts. That is not the case in the underlying bill. The underlying health care reform bill has 4 years of taxes. There will be taxes on insurance companies that will surely raise the premium of every insurance policy in America. There are taxes on prescription drug companies, so that prescription drug prices will surely go up. There are taxes on medical device companies, so the prices on health care equipment will also go up. How much are we talking about? We are talking about \$100 billion in taxes that will start in 3 weeks—in January of 2010. Again, we are looking at taxes that will start in 3 weeks, next month, which will accumulate up to \$73 billion before a program is implemented that will give anyone a choice of an affordable health care option.

That is the motion that was tabled 10 minutes ago. I want to make sure everyone knows I never had a chance to close on the motion. Senator THUNE didn't have a chance to close, because it was a motion made that could not be objected to. That is not the way things have operated here in the past, and I think it is time we bring back the traditions of the Senate, where we have time that we agree to, everybody has their say, and then we go forward.

I am very concerned about that process. I hope it is not setting precedent because I think we can resurrect health care reform if we have a bipartisan health care effort. If we have an effort that will bring down the costs, that will increase the risk pools so that an employer will be able to afford to offer employees health care coverage, bring down the costs of health care with medical malpractice reform that would save \$54 billion in the system, we can do things without a government takeover of health care. But the bill that is before us has \$½ trillion in Medicare cuts—Medicare cuts, \$½ trillion—and \$½ trillion in new taxes—taxes on businesses that offer not enough coverage, businesses that offer too much coverage, a 40-percent excise tax on policies that give what is called Cadillac coverage, the high benefit plans. So if you have a good insurance policy, you

have a 40-percent tax on top of the premium you pay. And if you have too little coverage, you also get taxed. You are whipsawed in this bill.

I think the small business people of this country know what this bill is about because that is the comment we are getting. They are the people calling into our offices. They are the people I see on the airplanes as I go back and forth to try to make sure we are covering the bases on this bill and trying to let the American people know what is in it.

I am concerned about the precedent that was set, but more than that, I am concerned that the American people must know that if this bill passes as it is on the floor today, the taxes will take effect in 3 weeks, that insurance premiums will surely go up, prescription drugs will surely go up, prices on medical equipment will surely go up, and there will not be an affordable insurance plan for people to choose to take for 4 years. It is like buying a house and having the mortgage company hand you the keys and say: Come back in 4 years, and we will let you unlock the door.

I don't think that is transparency, and it is certainly not health care reform. I hope there is still a chance that we can bring this body to a bipartisan effort that will allow lower premiums, more health care options for the people of this country but, most important, that will keep the quality of health care, the choices we have in health care that Americans have come to expect and not start going on the road to a single-payer system because in the end, that is what the bill before us will lead to. It will be a single-payer system. It will take choices out. It will take quality out.

It will add taxes and burdens on our small businesses at a time when they need to be able to hire people to get our economy going and to get that jobless rate down. We need them to employ people. We need to encourage our employers to employ people. They cannot do it if we put more taxes and burdens on them, which is what the bill before us does.

I thank the majority leader for allowing me to speak since I did not have a chance to speak before my motion was tabled. I hope the American people are listening because we have a chance to do this right. The bill on the floor today is not that bill.

I yield the floor.

The PRESIDING OFFICER (Mr. BURRIS). The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, I thank the Senator from Texas. I am glad she had an opportunity to speak. We disagree on this issue, but I am glad she had her opportunity to speak.

I hear from different people. Obviously, we must ride on different planes because the people I speak with are

anxious to see some change in this health care system and know that 14,000 Americans lose their health insurance every single day. They know that most people cannot afford health insurance because of the increase in costs.

I say to the Senator from Texas, she is my friend and we have worked on many issues in the past, but we disagree on this issue.

I am coming before the Senate with a holiday proposal. Recently there was a book that was published about World War I. It was about trench warfare that went on and on with horrendous casualties and lives being lost. Then there came a moment, a Christmas moment, when they decided to call a truce because of Christmas and play a soccer game. The Allied and Axis troops came out and, for a brief moment, stopped the war, played the soccer game, and went back to the trenches and the next day started shooting again.

I am looking for a holiday truce here for our troops because what we have before us right now is the Department of Defense appropriations bill. Although Senator HUTCHISON and I clearly disagree and many Members on both sides clearly disagree when it comes to health care, there is no disagreement when it comes to our troops. Every one of us supports our troops. Every one of us wants to make sure they have what they need, the resources they need to perform their mission successfully and come home safely.

This bill that is before us, this Department of Defense appropriations conference report, is an attempt for us to do something to help these troops in time of war. I would hope I could appeal to my colleagues on the other side of the aisle that for one brief, shining moment in the spirit of the holiday we set aside our political differences for the sake of our men and women in uniform.

The point I am getting to is that if we go through the ordinary, tortured procedure and wait, it is going to take us days to complete this bill for our troops. I hope we can show good faith on both sides of the aisle and overcome that. I hope we could enter into a consent agreement among Republicans and Democrats because I know as I stand here that the Republicans feel as the Democrats do—that we should provide funding for our overseas operations of our men and women in uniform.

In this bill, \$101 billion is included for operations and maintenance for ongoing military operations in Iraq and Afghanistan and to support the preparations to continue the withdrawal from Iraq.

In this bill, there is \$23.36 billion for equipment. We want to make sure our men and women in uniform have the equipment they need to make certain they are safe and have what they need to come home safely.

There is also a pay raise in this bill, a 3.4-percent pay raise. Does anyone dispute the need that our military has to be recognized for what they have given our country and be given a pay raise?

When it comes to readiness and training, there is \$154 billion for the defense operation and maintenance account to increase readiness.

In the field of military health care, there is \$29 billion for the Defense Health Program to provide quality care for servicemembers and their families. It includes, incidentally, \$120 million for traumatic brain injury and psychological health research.

These are issues we have all come together on. We are not arguing about these issues, and I do not think we should at this moment.

There is \$472 million for family advocacy programs and full funding for Family Support and Yellow Ribbon to provide support to military families, including quality childcare, job training for spouses, and expanded counseling and outreach.

There is one other section of the bill—and I will yield for a question from my friend from Alaska when I complete this point—there is one other section that relates to the unemployment crisis facing this country. It is a modest extension of the unemployment benefits. The last time it was on the floor, I believe it passed 97 to 0. I do not believe there is any controversy to the fact that we want to extend unemployment insurance benefits through February 28 of next year. It is difficult to envision a situation where we would actually leave here to go home to our families for the holidays and not take care of the unemployed.

There is also a provision for their health insurance under COBRA and for food stamps on which we know so many unemployed families rely. It seems to me if there is one thing in the midst of this political turmoil we can agree on, it is let's stand behind our troops, let's make sure people who are unemployed have a happy holiday season. Why do we want a tortured process to reach a "yes" on this conference report? I appeal to my colleagues on the other side of the aisle to make this a bipartisan effort. Let's do this part. We can return to the health care bill and the debate. But let's get this done and do it without all the necessary motions and time that may be spent.

I yield for a question from the Senator from Alaska.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Mr. BEGICH. Mr. President, I appreciate the Senator from Illinois bringing up what I consider a very most important piece of legislation to Alaska. Eleven percent of our population are veterans. We have thousands of military individuals in our State.

I am new to the process. One of the questions I have for the Senator—and I

hope he can enlighten me and also enlighten the whole public watching—this is probably one of the most important departments at this time. We are in two wars. Can the Senator give me an explanation? In the past—Senator DURBIN started to do it—the Defense bill seemed to be one of those bills where we all came together. It is a bipartisan approach. I know as members of the Armed Services Committee, it seems every time we deal with these issues we are unified.

Help me to understand why this is something that seems to be controversial and yet should be so simple for us to do.

Mr. DURBIN. I say in response to the Senator from Alaska, I think it is the moment. If we were in a different political environment, I think the Republican Senators and Democratic Senators would agree that this should go through and go through quickly. But we have been caught up for weeks now in debate and controversy, and this bill has been tossed into that environment. That is the explanation because I do not think there is a single provision I read here that Republican Senators do not support, as the Democratic Senators support. That is why I made my suggestion.

Mr. BEGICH. Mr. President, if I may ask one more question. That last statement the Senator from Illinois made, I know as a member of the Armed Services Committee, I have not heard complaints about this bill from anyone from the other side. I am asking, from a leadership position, have we heard any complaints on this legislation? Is it just that, it is the moment in time?

Mr. DURBIN. I say in response to the Senator from Alaska, it does include some provisions relative to the unemployed. There were other things that could have been included by the House, but we reached out to the Republican side and asked: Are any of these problematic? By and large, they said here are the things you should not include, and we did not. We did our best to ensure we brought a noncontroversial bill for consideration.

Mr. BEGICH. I thank the Senator.

Ms. STABENOW. Will the Senator yield for a question?

Mr. DURBIN. I am happy to yield to the Senator from Michigan.

Ms. STABENOW. Mr. President, from the Senator's explanation and from what we have been working on, I want the Senator to clarify two things.

First of all, we could do this conference report today if there were a willingness and, secondly, we have a pay raise for our troops that is coming right before Christmas, the holidays, help for families, help for those who have lost their jobs and are trying to figure out how they keep their health care going, and help for people who are trying to put food on the table for the holidays; is that correct? I ask the Sen-

ator to expand. As I understand it, we could actually get this done today and give people some peace of mind going into the holidays.

Mr. DURBIN. I say to the Senator from Michigan, yes, we could enter into a consent agreement now and pass this conference report without controversy, and I bet you it would get a unanimous vote.

As the Senator from Michigan described this, everybody here wants to make sure we take care of our troops. We received a unanimous vote, if memory serves me, the last time we extended unemployment benefits. I think most Members want to stand up and help those who are unemployed through this difficult time of unemployment in our country.

If there ever were a bill to bring us together in those two areas—helping our troops and helping the unemployed—this is the bill.

Ms. STABENOW. Mr. President, I wish to ask another question of the Senator from Illinois. If, in fact, the Senator from Illinois is finding the same thing I am right now—certainly, we have the highest unemployment rate in Michigan—and we are hearing it from all over the country; we are hearing from people that their unemployment benefits are about to expire. They are trying to figure out how they are going to make it through the next few months.

There are particular concerns that if we do not extend it by the end of the year that, in fact, many will have to go out and resign up with a new bureaucracy to continue benefits.

I wonder if the Senator has heard the same kinds of concerns and sense of urgency people have about being able to keep a roof over their head, keep food on the table, and keep their health care going—the same sense of urgency that I know we are feeling from people in Michigan?

Mr. DURBIN. I say in response to the Senator from Michigan, through the Chair, that I am happy to read the latest unemployment statistics showing the number of people declared unemployed each month is going down. We will not feel good about it until it is turned around and we are creating jobs again, which I hope is soon.

In the meantime, we have about six unemployed people for every job that is available. These people are in a market that is terrible, and they are trying their best. Some have gone back to school. Some are getting training courses. Some are trying to keep things together with their family and not lose their home because of unemployment.

I am sure the Senator from Michigan has met with the unemployed in Michigan, as I have in Illinois. Some are, little by little, exhausting the savings they have. Even with COBRA, many people find the COBRA provision,

which gives people a chance to buy insurance at discounts, is still too expensive. They are without a job. They are running the risk of losing their home. They are without health insurance for their children and are desperately looking for a job. We certainly do not want to put them in a situation where there is a question mark as to whether after December 31 the unemployment check will be there next month. I think it is that peace of mind we owe these folks caught up in the bad circumstances of our economy.

Ms. STABENOW. If I may conclude, to clarify, we can get this done today. We can create that peace of mind for families going into the holidays, going into Christmas, into the end of the year. We could actually do that today in the next few hours?

Mr. DURBIN. That is correct, I say to the Senator from Michigan, we can. Earlier we were embroiled in the reading of an amendment that would have literally consumed the entire day and forced us into another day's time and run the risk of not providing money for the troops when the continuing resolution, the funding resolution, ran out.

The Senator from Vermont withdrew his amendment, and now we have moved to this bill. But there is nothing stopping us. A consent agreement can be entered into by both sides of the aisle that can move this through quickly and say to our troops: We are with you.

I yield to the Senator from Rhode Island.

Mr. WHITEHOUSE. Mr. President, will the Senator from Illinois yield for a question?

Mr. DURBIN. I will be happy to yield.

Mr. WHITEHOUSE. I am interested in the parliamentary situation that took place earlier whereby one of our Members was actually obliged to withdraw an amendment that was going to be voted on by all of us because of an insistence on the part of the other side that 800 pages be read by our poor clerk before that vote should take place.

I have also heard the other side say that we want to get going, we want to move toward votes. I would be interested in the reflections of the distinguished majority whip on the extent to which a procedural objection to force the clerk to read 800 pages of an amendment, and deny one of our colleagues his vote, fairly represents a desire to move forward and get through our votes.

Mr. DURBIN. I would say in response to the Senator from Rhode Island, we have heard repeatedly that people want amendment, debate, and a vote. What happened on the floor today, when Senator COBURN of Oklahoma refused to give consent to suspending the reading of the amendment, is that the clerk—clerks, I should say—were forced to start reading. As good as they are at reading, the fact is, it was going to

take up to 10 hours to read this amendment. During that 10-hour period of time, nothing could happen—no debate, no amendments—nothing other than listening to the clerks' melodious voices. Fortunately for us, the Senator from Vermont stepped up and said: I withdraw the amendment. But if there was a true interest in debate and amendments on health care, it is inconsistent to say we are going to take a day out of the whole affair and read an amendment.

I can tell you, as I said to the Senator from Oklahoma, I can't believe there is a person in America who sat glued to the C-SPAN television listening to this amendment so they would understand it. It is a very complicated amendment page by page but, in general, understandable. The Senator from Vermont was seeking a single-payer health care system. It was not likely to pass, but it is something he believes in fervently and he wanted to offer it. So I would say the strategy on the floor today belies any request that we have more debate and more amendments.

Before the Senator from Rhode Island continues, I think this has been cleared on both sides, but I ask unanimous consent that the time until 6:15 p.m. be equally divided between the two sides, with Senators permitted to speak for up to 15 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WHITEHOUSE. If the Senator from Illinois would yield for another question.

I was elected just about 3 years ago, and I came in with the new majority, so I did not have a chance to serve in this body when there was a Republican President and a Republican majority. I wonder if the Senator, who was here at that time, would reflect on how the other side viewed Defense appropriations for our troops during the Iraq war when they were in the majority. Were they desirous of delay and obstruction and debate and procedural maneuver on Defense appropriations at that time or is this a new strategy of theirs?

Mr. DURBIN. I would say to my colleague from Rhode Island that exactly the opposite was true. They wanted to move quickly to pass any appropriations bill to make certain there was no question in the minds of our men and women in uniform that we were standing with them, and we did. I don't believe even those of us who voted against the invasion of Iraq tried to stop the proceedings from funding the troops, regardless of what our votes might be.

So I think it would be consistent now for our colleagues on the other side of the aisle to join us, in a bipartisan fashion, to say whatever differences on other issues, such as health care, let's let the troops know this holiday season we stand behind them—Republicans and Democrats—and let's do it in an efficient and effective way.

Since this unanimous consent request has been granted, I am going to yield the floor and any of my colleagues who wish to speak, it will be equally divided time for the next 2 hours.

At this time, I yield the floor. Mr. President, if no one seeks time, I suggest the absence of a quorum and I ask unanimous consent that during the time of the quorum the time be equally divided between both sides.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. LEMIEUX. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Florida is recognized.

Mr. LEMIEUX. Mr. President, while we have been here discussing health care, the clock has been ticking on our national debt. Just in the first 2 months of this fiscal year, we have accumulated \$296 billion in debt. We took in revenues of \$268 billion, and we spent \$565 billion. We spent double what we took in just in the first 2 months of the fiscal year.

I know you are new to this Chamber, Mr. President, as am I. I have only been here 90 days, but I have been here long enough to know this system is broken. It doesn't work. Neither this body nor the body across the Capitol has an ability to make ends meet. We continue to spend money we do not have. We spend the money of our children and our grandchildren. Right now we have a \$12 trillion debt. It took us 167 years in this country just to amass a \$1 trillion debt in 1982. Now we are at \$12 trillion. Every family in this country is now responsible for \$100,000 of debt.

Where are we getting this money? We are borrowing it from countries such as China, and it is hurting our standing in the world. Central banks that hold American currency are shedding those dollars because they no longer believe our country is a good investment. I worry about our children and our grandchildren. I have three sons, as you know, Max, Taylor and Chase—they are 6, 4 and 2—and we have a baby on the way in March. I am very worried that my children will not be able to experience the American dream like you and I have; to be able to be in the Senate, to be able to achieve all of our goals, whether in public service or in private. I do not believe America is going to be the same place for them, that it is going to hold the same opportunities because I believe this debt is going to strangle us.

If this body and the body across the Capitol don't figure out we need to start making ends meet and stop spending the dollars of future genera-

tions, this country will not be the leader of the world. It will not have the promise we have all enjoyed.

I rise today to speak about S.J. Res. 22, which I filed yesterday. It is a constitutional amendment that requires the Congress to balance its budget and also gives to the President of the United States a line-item veto so he, like most of the Governors in this country, can strike out inappropriate budget items, these earmarks that you hear about.

Senator MCCAIN spoke this weekend about \$2.5 million to the University of Nebraska to study operations and medical procedures in space. We cannot afford that program under any circumstance, and we certainly can't afford programs like that when we are \$12 trillion in debt. These dollar numbers are so big they are hard to comprehend.

What does \$1 trillion mean? What does \$1 billion mean? In Washington we throw these amounts around, and we do not even comprehend them. I know for the American people at home it is hard to get their minds around how much money this is. I have said this on the Senate floor before, and I am going to keep saying it so people understand that every dollar we spend is a choice.

One million dollars laid edge to edge on the ground would cover two football fields. One billion dollars laid edge to edge on the ground would cover the city of Key West, FL, 3.7 square miles. And \$1 trillion would cover the State of Rhode Island—twice. If you stacked them on the ground going up into the sky, it would be 600 miles of one-dollar bills.

Every dollar is a choice, and these numbers are out of control. Just this past Saturday we voted on a spending bill, a spending bill that had a 12-percent increase and \$40 billion more than last year. I want to give the American people the sense of what you could do with this kind of money, what good you could do or, better yet, you could give it back to the American people and they could decide what good they could do with those dollars for their families.

With \$100 billion, we could give every Floridian a \$5,000 tax cut.

With \$200 billion we could pay the salary of every teacher for a year. With \$300 billion we could pay first-year tuition at a university of their choice for every kid who is in K-12. With \$400 billion, we could build high-speed rail for 10,000 miles. We could connect Key West to Anchorage and back.

Every dollar is a choice. We are spending money out of control. Similar to those who have come before me, I will sound the alarm because we still haven't done anything about this problem. There are good measures out

there. Senator GREGG from New Hampshire has a measure, along with Senator CONRAD, to put together a commission. I support that. Senator SESSIONS has a measure to bring caps back. Up until about 2002, we actually were making headway against the budget. Then those caps expired and spending went out of control.

I support all those efforts. I support any effort to bring spending under control. This body doesn't have any leadership on spending. Look at what we spend. We don't look at the revenues coming in the door.

I served as chief of staff to a Governor in Florida. When the budget started to go bad in 2007, I was on the phone monthly with the person who determined our receipts. I knew in Florida we could only spend as much money as we had. This institution does not work that way. No one even checks to see what kind of money we are bringing in. We just spend.

I wish to talk to the American people about articles in the Wall Street Journal of today. This is not a Democratic problem or a Republican problem. This is a problem of this institution. The article is titled "The Audacity of Debt." I wish to read one paragraph. I ask unanimous consent that the full article be printed in the RECORD.

There being no objection, the material was ordered to be printed in the Record, as follows:

[From the Wall Street Journal, Dec. 16, 2009]

THE AUDACITY OF DEBT

COMPARING TODAY'S DEFICITS TO THOSE IN THE 1980S

At least someone in America isn't feeling a credit squeeze: Uncle Sam. This week Congress will vote to raise the national debt ceiling by nearly \$2 trillion, to a total of \$14 trillion. In this economy, everyone de-leverages except government.

It's a sign of how deep the fiscal pathologies run in this Congress that \$2 trillion will buy the federal government only one year before it has to seek another debt hike—conveniently timed to come after the midterm elections. Since Democrats began running Congress again in 2007, the federal debt limit has climbed by 39 percent. The new hike will lift the borrowing cap by another 15 percent.

There is surely bipartisan blame for this government debt boom. George W. Bush approved gigantic spending increases for Medicare and bailouts. He also sponsored the first ineffective "stimulus" in February 2008—consisting of \$168 billion in tax rebates and spending that depleted federal revenues in return for no economic lift.

Democrats ridiculed Mr. Bush as "the most fiscally irresponsible President in history," but then they saw him and raised. They took an \$800 billion deficit and made it \$1.4 trillion in 2009 and perhaps that high again in 2010. In 10 months they have approved more than \$1 trillion in spending that has saved union public jobs but has done little to assist private job creation. Still to come is the multitrillion-dollar health bill and another \$100 billion to \$200 billion "jobs" bill.

We've never obsessed over the budget deficit, because the true cost of government is the amount it spends, not the amount it bor-

rows. Milton Friedman used to say that the nation would be far better off with a budget half the current size but with larger deficits. Mr. Obama and his allies in Congress have done the opposite: They have increased the budget by 50 percent and financed the spending with IOUs.

Our concern is that the Administration and Congress view this debt as a way to force a permanently higher tax base for decades to come. The liberal grand strategy is to use their accidentally large majorities this year to pass new entitlements that start small but will explode in future years. U.S. creditors will then demand higher taxes—taking income taxes back to their pre-Reagan rates and adding a value-added tax too. This would expand federal spending as a share of GDP to as much as 30 percent from the pre-crisis 20 percent.

Remember the 1980s and 1990s when liberals said they worried about the debt? We now know they were faking it. When the Gipper chopped income and business tax rates by roughly 25 percent and then authorized a military build-up, Democrats and their favorite economists predicted doom for a decade. The late Paul Samuelson, the revered dean of the neo-Keynesians, expressed the prevailing view in those days when he called the Reagan deficits "an all-consuming evil."

But wait: Those "evil" Reagan deficits averaged less than \$200 billion a year, or about one-quarter as large in real terms as today's deficit. The national debt held by the public reached its peak in the Reagan years at 40.9 percent, and hit 49.2 percent in 1995—This year debt will hit 61 percent of GDP, heading to 68 percent soon even by the White House's optimistic estimates.

Our view is that there is good and bad public borrowing. In the 1980s federal deficits financed a military buildup that ended the Cold War (leading to an annual peace dividend in the 1990s of 3 percent of GDP), as well as tax cuts that ended the stagflation of the 1970s and began 25 years of prosperity. Those were high return investments.

Today's debt has financed . . . what exactly? The TARP money did undergird the financial system for a time and is now being repaid. But most of the rest has been spent on a political wish list of public programs ranging from unemployment insurance to wind turbines to tax credits for golf carts. Borrowing for such low return purposes makes America poorer in the long run.

By the way, today's spending and debt totals don't account for the higher debt-servicing costs that are sure to come. The President's own budget office forecasts that annual interest payments by 2019 will be \$774 billion, which will be more than the federal government will spend that year on national defense, education, transportation—in fact, all nondefense discretionary programs.

Democrats want to pass the debt limit increase as a stowaway on the defense funding bill, hoping that few will notice while pledging to reduce spending at some future date. Republicans ought to force a long and careful debate that educates the public. Ultimately, the U.S. government has to pay its bills and the debt limit bill will have to pass. But debt limit votes are one of the few times historically when taxpayer advocates have leverage on Capitol Hill. Republicans and Democrats who care should use it to discuss genuine ways to put Washington on a renewed and tighter spending regime.

"Washington is shifting the burden of bad choices today onto the backs of our children and grandchildren," Senator Barack Obama said during the 2006 debt-ceiling debate.

"America has a debt problem and a failure of leadership. Americans deserve better." That was \$2 trillion ago, when someone else was President.

Mr. LEMIEUX. Reading from the Wall Street Journal:

Democrats ridiculed Mr. Bush as "the most fiscally irresponsible President in history," but then they saw him and raised. They took an \$800 billion deficit and made it \$1.4 trillion in 2009 and perhaps that high again in 2010. In 10 months they have approved more than \$1 trillion in spending that has saved union public jobs but has done little to assist private job creation. Still to come is this multitrillion-dollar health care bill and another \$100 billion to \$200 billion "jobs" bill.

We can't afford the programs we have, let alone the programs we want. I filed this joint resolution to have a balanced budget. I filed the joint resolution to give the President the line-item veto like Governors do. I know I am tilting at windmills. I know there are very few people in this Chamber or the Chamber down the hall who have the courage to do this. They are part of the process. They go along and get along. But I am fresh enough to still remember how things work in the real world. We have to change things. Our children are not going to have this great country. I am so afraid that one of my kids is going to come to me when they are 18 or 22 and say: Dad, I am going to go to another country to make my living. I am going to go to Ireland or Chile or India because I have a better opportunity there to succeed. I can't pay 60 percent in taxes. I can't assume what will then be a \$23 or \$30 billion debt.

We are not even talking about all the entitlements we haven't paid for. We are not talking about all the money we have raided out of Medicare and Social Security in order to pay for current expenses. Some people say those obligations are more than \$60 trillion, numbers we can't even comprehend.

I filed this resolution. I will send a letter to every Governor asking them to adopt it in advance of the Congress taking it up. A constitutional amendment requires two-thirds of both Chambers and three-quarters of the States. They can act first. They can send letters and resolutions from their legislators to this legislative body and say: Get your act under control.

It affects them too. This new health care bill is going to send an unfunded mandate to the States and increase Medicaid from 100 percent of poverty to 133 percent. They will have to pay that bill. It is going to cost Florida in 10 years almost \$1 billion. Right now, in Florida, the No. 1 expenditure in our budget is Medicaid. Because we balance our budget, that means we take money away from teachers and education. That means we take money away from law enforcement. It is out of control.

I am here to say the siren is sounding. The ship is going to hit the iceberg. We can't make just incremental

change because then we will just hit the side of the iceberg. We have to make substantial change. The people in this body have to have the courage to do it. We can't just go along and get along as we have before. We cannot be tone deaf. The American people are onto us. They understand we are spending money we don't have. I will not stand by and let this great country fall into decline without at least arguing and pushing as strenuously as I can for a solution. I am willing to work with men and women of good will on both sides of the aisle to solve the problem. I am new here. I might not have all the answers. I probably don't. But I will surely work hard. I know this is one solution. If every State can have a balanced budget amendment and 43 States can have a line-item veto, why can't this body?

I have filed this resolution. I look forward to talking about it more. I hope this body will take it seriously. I see my friend from Massachusetts is here. He also is new to this body, although he spent many years working here. We have to do things differently. We throw around billions and trillions like it is just nickles and dimes in our pockets. It is not. Every dollar is a choice. It is a choice to make. If we don't make the right choice, it will be a choice our children and grandchildren will suffer under.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KIRK. Mr. President, "The need for comprehensive national health insurance and concomitant changes in the organization and delivery of health care in the United States is the single most important issue of health policy today." Those are not my words. Those are the words of Senator Edward M. Kennedy. The "today" of which he spoke was December 16, 1969, exactly 40 years ago today. It was his first major speech on health care reform, and I was privileged to be a young member of his staff. He delivered that speech to a group of physicians at Boston University Medical Center.

Senator Kennedy went on to say:

If we are to reach our goal of bringing adequate health care to all our citizens, we must have full cooperation between Congress, the administration, and the health professionals. We already possess the knowledge and the technology to achieve our goal. All we need is the will. The challenge is enormous, but I am confident that we are all equal to the task.

The world has progressed in many ways since he spoke those words four decades ago, but our health care system has not. In 1969, the United States spent \$18 billion on health care. Today we spend over \$2 trillion a year. Senator Kennedy pointed out, in 1969, that the Nation faced a shortage of primary care doctors. The reimbursement rates for physicians treating Medicare and Medicaid patients were too low. There

was a need to support greater innovation in delivering care, and neighborhood health centers were underfunded. He said we needed to develop an effective means of providing quality, affordable care to all Americans, regardless of their standing in life.

Does all this sound familiar? Yes. But that was then and this is now.

In recent weeks, Senators on both sides of the aisle have come to this floor to debate the merits of the Patient Protection and Affordable Care Act. We have had our differences of opinion, to be sure. But on one issue there is no dispute. When it comes to our health care system, there is no such thing as a status quo. We will move forward or we will continue to fall behind.

Here is what we will face, if we do not pass this reform. Premiums will skyrocket and could consume as much as 45 percent of a median family's income by 2016. Bankruptcies will increase due to families not being able to afford their medical costs. More Americans will be uninsured. Small and large businesses will suffer financially due to health cost increases. Health care could constitute as much as 28 percent of our Nation's GDP by 2030. Fifteen percent of the Federal budget could be dedicated to Medicare and Medicaid by 2040.

Ted Kennedy had a keen sense of history. He knew Germany adopted the idea of national health insurance in the 1880s, that Britain, France, and a number of other European nations embraced the concept after the First World War, that Canada has had a publicly funded system since the 1950s. He would ask, as he did in 1969 and again in 2009: If all these nations understood long ago that their economic health was ultimately tied to the health of their people, why does the United States stand alone as the only major industrial nation in the world that fails to guarantee health care for all its citizens?

It is not that we have never sought this goal in the past. Presidents, Republicans and Democrats, over many decades, have proposed national health insurance in America. Presidents Theodore Roosevelt, Franklin Roosevelt, Harry Truman, John F. Kennedy, Richard Nixon, and Bill Clinton all made health reform a part of their agenda. Now we stand on the threshold of history. Never has this country been so close to bringing affordable, quality health care to millions of America's families. Today, under President Obama's leadership, the goal is within our reach. Failure is not an option. All interested parties have been brought to the table. Physicians, hospitals, insurance companies, small businesses, pharmaceutical companies, and many others have had an opportunity to present their suggestions and offer their input. Dozens of hearings were held on all topics related to this issue.

The House of Representatives has acted. The Senate HELP Committee, through the diligence of Senators Kennedy, DODD, and HARKIN and the Finance Committee, under the leadership of Senator BAUCUS, held lengthy executive sessions that discussed all areas of reform and delivered and developed their respective bills. Due to the hard work and tireless patience of the majority leader, we have one merged bill before us, a single piece of legislation which will improve the lives of millions of Americans in the following ways. It expands coverage to an additional 31 million Americans, bringing health insurance to almost 94 percent of our citizens. It saves money by rewarding the quality and value of care, not the quantity and volume of care. It controls the cost of skyrocketing premiums and limits out-of-pocket expenses. It reduces the Federal deficit by an estimated \$130 billion in the first 10 years and an estimated \$650 billion in the second 10 years. It stimulates competition in the health insurance marketplace through establishment of exchanges. It strengthens Medicare by reducing unnecessary spending, lowering prescription costs, and closing the so-called doughnut hole. It attacks fraudulent and wasteful spending and helps to correct abuses in the system. It rewards wellness and prevention by expanding access to advice on how to live a healthy lifestyle by practicing good nutrition, increasing physical activity, and quitting smoking.

It eliminates unfair discrimination against patients by preventing insurance firms from denying certain coverage to women or to individuals with preexisting conditions.

It promotes flexibility and innovation in new health care technologies. It introduces a self-funded, voluntary choice for long-term services and support for the elderly and disabled. Most of all, it saves lives by providing affordable, quality care for individuals, families, and small businesses.

In my State of Massachusetts, because of our successful reform, the rate of the uninsured has been reduced to 2.7 percent of the population, and the lives of thousands of citizens of our Commonwealth have been immeasurably improved.

Carol's case is one example. Carol did not realize the importance of having quality, affordable health insurance until she was confronted with the gravity of her own health problems. She is a 24-year-old woman suffering from seizures and desperately in need of help.

She remembers having occasional seizures as a child. They occurred mostly when she was overtired. As Carol grew older, the seizures became more frequent. One day, she had an episode when driving her car. Fortunately, her passenger was able to assist her. But that frightening incident convinced Carol to seek professional help.

She learned about the assistance of Health Care For All, the Massachusetts organization dedicated to making quality, affordable health care accessible to everyone. She applied and was declared eligible for Commonwealth Care. She immediately went to see a specialist and was given the health care she needed.

Carol expressed her gratitude in these words:

I definitely feel blessed to be a Massachusetts resident. I can't thank Health Care For All and MassHealth enough for all the support given to me. The Helpline counselors literally held my hands and brought me to live a healthy life, where there is no fear or embarrassment, but there is knowledge and a total control of my seizures. So, thank you so much all of you who make this happen in people's lives.

We should all think about Carol and the millions of working families across the country when we vote for this legislation. It is our responsibility to enact laws that make a positive difference in people's lives, and that is what this bill is all about.

Senator Ted Kennedy envisioned a better America where, as he said:

[E]very American—north, south, east, west, young, old—will have decent, quality health care as a fundamental right and not a privilege.

This is a historic moment in our national life. We have the chance to finally complete the work that a respected Republican President called for over a century ago. Quality health care for all has always been needed in America but never more than now. The finish line is clearly in sight. The momentum and the energy are with us, and it is our obligation to seize this historic moment.

Every Member of this body is aware of the valiant fight Senator Kennedy waged for his own health during the last 15 months of his life. Many of you saw him, after receiving radiation and chemotherapy in the morning in Boston, walk into this Chamber that he loved to cast a deciding vote in the afternoon on the issue he proudly called the cause of his life.

While being treated at Massachusetts General Hospital, Senator Kennedy met a woman named Karen List. Her daughter Emily was one of many patients receiving a similar regimen of exhausting cancer treatments. They came from different walks of life, and cancer had touched them all.

In September 2008, after Emily's long summer of treatments, Karen wrote about Senator Kennedy and other patients he had met during his treatment. She wrote:

Now, it is almost fall, and little Caroline is starting kindergarten. Senator Kennedy, who came from a hospital bed to speak at the convention, is planning his return to the Senate in January. Alex, an Apache helicopter pilot, is back at Fort Campbell and expects to be deployed to Afghanistan in the New Year. And Emily hopes to be well

enough by spring to return to her life in London. The dream, as Senator Kennedy promised, does live on.

Mr. President, I ask unanimous consent that the article by Karen List in the Daily Hampshire Gazette be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Daily Hampshire Gazette, Sept. 8, 2008]

A CHAMPION OF HEALTH COMFORTS HIS
FELLOW PATIENTS

(By Karen List)

As Sen. Ted Kennedy's distinctive voice passed the torch at the Democratic National Convention and promised us that the dream lives on, all I could think of was that same distinctive voice several weeks ago calling out: "Where's Emily?"

Ted was at the other end of the hall in the Proton Therapy Center, Dept. of Radiation Oncology, at Massachusetts General Hospital, where both the senator and my daughter Emily were being treated for cancer.

The proton beam is cutting-edge treatment for certain types of tumors, and the MGH center is one of only five in the country and a handful in the world.

We were lucky to be there, though it was getting increasingly hard to feel lucky as seven weeks of daily treatment took their toll on Emily and the other patients at the center.

They ranged in age from toddlers to the elderly. Little Caroline was 5. Senator Kennedy was 77. In between them were Emily, 23, and Alex, 26, two of just a few young adults in proton beam treatment.

Radiation burn was the worst side effect for many patients, and it was now preventing Emily from eating or talking. She was at a low point, and she needed a lift.

We had seen Teddy come and go for several days, slipping in through a side entrance and out the same way, always accompanied by his wife, Vicki. When our eyes happened to meet, we exchanged a thumb's up and were treated to that Kennedy smile—as distinctive as the voice.

The day before Ted's treatment was to end, Emily's nurse stopped by the room where she was being treated and pulled the curtain aside. Several minutes later we heard him call from the other end of the hallway: "Where's Emily?" And then he was there, talking to her, encouraging her—and just as quickly, he was gone.

Emily was so excited that she was hopping up and down in the bed from a reclining position, if such a thing is possible. But because she couldn't talk, she hadn't been able to say a word to one of the few politicians she really admires.

The next day, our nurse delivered the card we'd written to the senator, explaining how thrilled Emily had been to meet him and how distressed she was that she couldn't tell him so herself. On the card was a photo of Emily at her favorite English pub, smiling her own distinctive smile. She had been home for a short break from her work interning in the London Theater when she'd been diagnosed with cancer. Now she was battling to get her work and her life back.

Teddy had just finished his treatment. This time, as he came down the hall for the last time, Emily was ready. On the slate that she'd been using to communicate, she'd written in purple marker: "We love you, Ted." The senator laughed, walked to her bedside

and whispered to her for a few minutes in solidarity, while Vicki talked to Emily's dad and me. We exchanged heartfelt good wishes for each other as they left the center to return home.

Emily had another week of treatment left. During that time, her nurse told us how concerned Sen. Kennedy had been about the other patients, especially the children and young people—and their parents. He had been through this same experience with his own son decades earlier when only one type of chemotherapy was available, unlike the cocktail of diverse chemo drugs that patients like Emily receive today.

This lifelong champion of health care for all Americans, especially children, had experienced once again—this time as the patient himself—what first-rate cancer care could mean. And he intends to continue fighting for its accessibility to everyone as the senior Democrat on the Health, Education, Labor, and Pensions Committee.

On Emily's last day at the center, there was a special gift waiting for her. Ted had left her a copy of his book, "My Senator and Me: A Dog's-Eye View of Washington, D.C.," written by him and his dog Splash. It was inscribed: "To Emily—Splash and I hope you enjoy."

And she did. Ted had provided just the encouragement she needed. He'd also left a stack of books for other young patients and the book on tape for those whose vision had been compromised by their treatments.

Now it's almost fall, and little Caroline is starting kindergarten. Senator Kennedy, who came from a hospital bed to speak at the convention, is planning his return to the Senate in January. Alex, an Apache helicopter pilot, is back at Ft. Campbell and expects to be deployed to Afghanistan in the New Year. And Emily hopes to be well enough by spring to return to her life in London.

The dream, as Senator Kennedy promised, does live on.

Mr. KIRK. Karen's was a statement of hope—hope and promise for each of these patients in the face of daunting odds. Their age did not matter; their economic status did not matter; each received the highest quality of health care available. And so it should be for all our people.

Senator Kennedy understood that we are all connected to one another. He often referred to President Lincoln's words about our common humanity and the good that can come to us all when touched "by the better angels of our nature." And he knew that on no issue are our futures more connected than on health care.

Ted Kennedy's voice still echoes in this Chamber. His spirit of hope and strength, of determination and perseverance is still felt here. He said:

For all my years in public life, I have believed that America must sail toward the shores of liberty and justice for all. There is no end to that journey, only the next great voyage. We know the future will outlast all of us, but I believe that all of us will live on in the future we make.

Let each of us in this Senate be moved by the better angels of our nature and make that future a better one for our generation and for generations to come. As Ted Kennedy said 40 years

ago: "All we need is the will." This is our time, Mr. President. Let us pass this legislation now.

Mr. President, I ask unanimous consent that the speech delivered by Senator Edward M. Kennedy on December 16, 1969, be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

ADDRESS BY SENATOR EDWARD M. KENNEDY,
LOWELL LECTURE SERIES, BOSTON UNIVERSITY
MEDICAL CENTER—LOWELL INSTITUTE,
DECEMBER 16, 1969

I am delighted to be in Boston today under the auspices of the Boston University Medical Center and the Lowell Institute to address this distinguished audience of medical educators, private physicians, and lay men concerned with the quality of health care in America.

I am particularly pleased to be here because it gives me the opportunity to commend the many worthy accomplishments of the Boston University Medical Center and its School of Medicine. You have succeeded in breaking down walls that for decades have turned medicine inward toward the age-old trinity of patient care, research and teaching. You have expanded your horizon to embrace the equally important area beyond your walls—the community in which we live.

For more than 90 years, your Home Medical Service has taken students into the community and provided model health care and innovative medical services in the home. Your expanding programs of new hospital affiliation have brought modern urban medicine to outlying communities. You have helped to lead the way in efforts throughout the world to unify cancer care with cancer research, so that today's advances in the laboratory become tomorrow's accepted treatment. Your School of Graduate Dentistry, dedicated in September, will provide high quality dental care as part of the Medical Center's total health program for the community.

In the course of the past decade, your pioneering program in community psychiatry and mental health in the South End and Roxbury—launched long before the Great Society and the Office of Economic Opportunity came into being and made such programs fashionable—have become a model for the nation. You helped develop what is now the rallying cry for health planning in America—that new health programs must be designed with the people and by the people, not just for the people. As Dr. Handler has so eloquently stated, your far-reaching role in community involvement is like a man standing by a river watching people drown:

"Medicine traditionally wades in," he said, "and tries to save them one at a time. After doing this repeatedly, you can't help but ask what is happening upstream. It seemed sensible to go back and find out why all the people were falling in, and try to do something about it."

I commend you for your leadership in looking upstream, and for the remarkable efforts you are making in preventive community medicine and all the other major areas of this great center's activity.

Six weeks ago in Springfield, I had the occasion to discuss what I regard as the single overriding economic issue of the day—the war against inflation. As I have frequently stated, the war against inflation is a war that can and must be won without the cost of heavy unemployment. It is a war that can and must be won without cutting back on our important domestic priorities.

Nowhere is the impact of inflation more obvious than in the rising cost of medical care. Never has the gift of good health been more precious:

In the last three years, the cost of health has risen by 22 per cent, or nearly double the rise in general consumer prices.

Hospital daily service charges have soared by the astronomical rate of 55 per cent, or nearly five times the rise in consumer prices. The average cost of a hospital day is now \$68. It will rise to \$74 next year, and to \$98 by 1973.

Physicians' fees have risen by 21 per cent. Doctors line up at lawyers' offices to form corporations and raid the Federal Treasury for hundreds of thousands of dollars a year in deferred taxes.

All of this inflation has occurred during the early years of Medicare and the troubled Medicaid program. The most rewarding experience of Medicare has been its success in solving the serious problem of health costs for our poor and our aged citizens. In spite of inflation, Medicare has been immensely popular. It is liked and accepted by the people.

The most painful experience of Medicare and Medicaid has been their unfulfilled promise. We sought to spread the benefits of medical science and technology to millions of Americans, without considering the anachronistic and obsolete structure of the system by which the health services would be delivered. Unwisely, as many experts have recognized, we assumed that all that stood between our poor and aged citizens and high quality medical care was a money ticket into the mainstream of modern American medicine.

We know now that we were wrong. The money ticket was important, but it was not enough to solve the problem. In the years since Medicare and Medicaid were enacted, we have learned that medical insurance and payment programs could not be translated instantaneously into more doctors, more nurses, more health facilities, or better organization of the delivery system.

In wedding new purchasing power to the already existing demand for health services, we did nothing to solve an already intolerable situation. The cost of health care began to soar. In some cases, the quality of care declined, and an enormous strain was placed on the capacity of our existing health services and facilities. When an already overworked physician goes from seeing one hundred patients a day to seeing two hundred patients a day, the quality of his care is inevitably affected. His only escape is to consign more of his patients to hospital treatment, thereby increasing the strain on hospital facilities and hospital costs.

Today in the United States, health care is big business. Indeed, it is the fastest growing failing business in the nation—a \$60 billion industry that fails to meet the urgent demands of our people. Today, more than ever before, we are spending more on health care and enjoying it less. By 1975, we may be spending \$100 billion a year on health and be worse off than we are now in terms of the quality and responsiveness of our health care system.

Perhaps the most serious fault in the present situation is the failure of the Federal Government to play a greater role in improving the quality of the nation's health care. Health is big business in America, and the Federal Government has become a major partner in this business. The total outlays for medical and health-related activities in the Federal budget estimated for 1970 are \$18 billion, or nearly one-third of the total

health expenditures in the nation. The outlays for 1970 are divided among 14 principal departments and agencies. By far the largest amount—\$13 billion—is expended by the Department of Health, Education and Welfare, but significant amounts are also expended by the Department of Defense—\$2 billion—and the Veterans Administration—\$1.7 billion.

In 1960, the total outlays for health in the Federal budget were only \$3 billion. Thus, in the decade of the Sixties alone, we have had a six-fold increase in total Federal outlays for health. Indeed, almost 10 per cent of the total Federal budget now goes for health. The major share of the rise in recent years has been for Medicare and Medicaid. Yet, in spite of the dramatic increases in the health budget and the large amounts we are now spending, there is almost no one who believes that either the Federal Government or the private citizen is getting full value for his health dollar.

Of course, a significant proportion of the increase in health expenditures is being consumed by rising costs and our growing population. Between 1950 and 1969, personal health care expenditures increased by \$42 billion. Of this increase, 50 per cent was attributable to rising costs, and another 19 per cent was attributable to population growth, so that only 31 per cent of the increase represents real growth in health supplies and services over the past two decades.

Although the conventional wisdom is content to blame our current medical inflation on Medicare and Medicaid and the excess demand created by these programs for health care, there is another, more controversial aspect to the rising prices. At Professor Rashi Fein and other experts in the field of the economics of medicine have made clear, the basic models used by economists are not appropriate when applied to health. The medical market, is characterized by the absence of competition, diverse products, and consumer ignorance. Comparisons of quality and performance are extremely difficult, if not impossible.

In other words, the medical marketplace is an area where the laws of supply and demand do not operate cleanly, and where physicians have a relatively large amount of discretion in setting their fees. Thus, at the time Medicaid and Medicare were instituted, fees rose for a variety of reasons, many of which were unrelated to the creation of excess demand:

Some physicians raised their fees in anticipation of a Federal fee freeze.

Some raised their fees in the face of rising hospital costs, in order simply to preserve their slice of the growing health pie.

Some raised their fees simply because they had the discretion to do so, and decided to take advantage of the instability and price consciousness generated by the new Federal programs.

As in the case of physicians' fees, the economic model of supply and demand does not tell the whole story of rising hospital costs. In part, hospitals took the opportunity to provide substantial—and wholly justified—wage and salary increases to their notoriously underpaid employees. In part, costs rose because the new Federal financing methods contained few incentives for improving efficiency, but simply encouraged hospitals to pass the higher costs on to Washington.

The high cost of medical care is but one aspect of the overall health crisis. In America today, it is clear that we are facing a critical shortage of health manpower. Indeed, at bottom, our crisis in medicine is essentially a crisis in manpower. The need is urgent for

more physicians, more dentists, more nurses, and more allied health professional and technical workers. We must develop new types of health professionals and para-professionals. We must make far more efficient utilization of our existing health manpower. Only if we succeed in these efforts will we be able to free our physicians and highly trained medical experts to perform the sort of intricate operations and sensitive counselling discussed by Dean Redlich in the inaugural lecture in this series.

The need is especially clear in the case of the shortage of doctors. Our low physician-population ratio means that unsatisfactory medical care is a way of life for large numbers of our people in many parts of our nation. In 1967, in the United States as a whole, there were 260,000 private physicians providing patient care for our 200 million people. This is a ratio of 130 physicians for every 100,000 citizens, or one doctor for every 700 people.

At first glance, the ratio appears to be fairly close to the satisfactory ratio generally recommended by many health experts, but the figures are misleading. The family doctor—the general practitioner—is fast disappearing, and is on the verge of becoming an extinct species. At the present time only one out of four of the nation's physicians is engaged in the general practice of medicine. Three out of four are specialists, most of whom accept patients only on a referral basis. The true doctor-population ratio, therefore, is more like one general practitioner per three thousand population, a ratio that is clearly unacceptable for adequate health care for our people. For far too many of our citizens, the only "doctor" they know is the cold and impersonal emergency ward of the municipal hospital.

To make matters worse, the geographic distribution of our doctors is highly uneven. Two-thirds of our physicians serve the more affluent half of our population. In some states, of course, the physician-population ratio is higher than the national average of 130 doctors per 100,000 population. In Washington, D.C., the ratio is 318; in New York it is 199; in Massachusetts, 181.

In sixteen states, however, the physician-population ratio is far below the national average. In Alaska and Mississippi, the ratio is an abysmal 69, or about one-half the national average. In Alabama, it is 75. Even in Texas, it is only 106. Clearly, therefore, extremely large groups of our population are receiving seriously inadequate medical care because of the shortage of physicians.

One of our most urgent needs to meet this crisis is a stronger Federal program to expand existing medical schools and establish new schools. We must substantially increase the output of doctors from our medical schools. At the present time, about 8,000 students are graduated from our medical schools each year. The Association of American Medical Colleges estimates that the number of students entering medical schools will increase by 25 per cent to 50 per cent by 1975, as a result of the construction of new medical schools already begun, and the expansion of existing schools already planned. Yet, if the physician-patient ratio is to be improved substantially, our goal should be to admit double the number of current students by 1975, with special emphasis on medical schools in regions where the physicians-population ratio is too low.

There is another reason why we must increase the enrollment in our medical schools, aside from the need to provide better health care for our people. Today in

America, the medical profession is that one profession that flies in the face of the American credo that every man shall have the opportunity to join the profession of his choice. Today in America, if a poor black or white young American aspires to be a lawyer, he will have the opportunity to enroll in a law school somewhere in the nation that will give him the chance to fulfill his dream. It is the shame of American medicine that no such opportunity exists for the youngster who aspires to enter what is perhaps the most exalted and selfless of all our professions, the healing arts.

Ironically, at the very time we are denying this opportunity to our own citizens, we are importing thousands of foreign-trained doctors each year to meet our manpower crisis. Twenty per cent of the newly licensed physicians each year in the United States are foreign-trained. Forty thousand foreign medical graduates are now practicing medicine in the United States, or about 15 per cent of the total number of doctors providing patient care. Thirty per cent of all our interns and residents are foreign-trained.

These figures are appalling. I believe that at this crucial period in world history, it is deeply immoral for us to be luring physicians from the rest of the world to meet our own doctor shortage, when their services are even more critically needed in their own lands.

The landscape we see is bleak, but it is not without hope. If we are to be equal to the challenge, however, we must be prepared to take major new steps. As Hippocrates himself put it two thousand years ago, where the illness is extreme, extreme treatments may be necessary. I would like, therefore, to share with you my views as to the directions we should begin to take now, if we are to meet the challenge.

First, and perhaps most important, we need a new approach to the politics of health. Our single greatest deficiency in the area of health is our failure to develop a national constituency, committed to a progressive and enlightened health policy. As a prestigious Committee of the National Academy of Sciences has recently and eloquently stated with respect to the problem of the confrontation between technology and society, the issue is far more serious than the simple question of braking the momentum of the status quo. Today, all too often, whether the area be that of medicine, or education, or pollution, the vested interests are strongly ranged against innovation, and there is no champion capable of marshaling the diffuse advocates for progress and reform. When a better teaching organization threatens the bureaucratic status quo in education, we know there will be organized opposition from school officials, but there is seldom organized advocacy by parents and children. When a new and more efficient development is offered that threatens the status quo in health—whether in the organization, financing, or delivery of health care—we know there will be opposition from organized medicine, but there is seldom organized advocacy by health consumers.

In these situations, a thorough consideration of the relative merits of alternative proposals is rendered difficult, if not impossible, by the presence of powerful spokesmen for the old, and the absence of effective spokesmen for the new. If we are to succeed in making basic changes in our health care system, we can do so only by creating the sort of progressive national health constituency that can make itself heard in the halls of Congress and the councils of organized medicine.

To be sure, there is cause for hope. The present generation of medical students is outstanding. They are already beginning to develop the commitments to public causes, the enlightenment and social conscience so desperately needed in the health profession. And, in spite of the heavy responsibility that organized medicine must bear for the inadequacy of our health manpower and other resources, a few leaders have recently made progressive statements suggesting a new recognition and awareness of the problem.

Second, the Federal Government must play a far more active and coherent role in the formulation and implementation of health policy. We must develop a comprehensive and carefully coordinated national health policy, with an administrative structure capable of setting health goals and priorities for the nation. In the spring of 1968, I introduced legislation urging the creation of a National Health Council to be established in the Executive Office of the President with responsibility for setting health policies and making recommendations for the attainment of health goals, including the evaluation, coordination, and consolidation of all Federal health programs and activities. The National Health Council would be modeled along the lines of the Council of Economic Advisors, which has consistently played a superlative role in planning and coordinating the nation's economic policy.

Third, we must move away from our excessive emphasis on high-cost acute-care hospital facilities. We must make more imaginative use of innovative types of low-cost facilities, such as neighborhood health centers and other out-patient facilities, storefront clinics, and group health facilities. In spite of the active opposition of a substantial segment of the medical profession, group practice and hospital-based practice are probably the most efficient and economical means of delivering health care today. In many areas, the ideal arrangement consists of a teaching hospital in a medical center, with affiliations to community hospitals in the surrounding area. In turn, each of the community hospitals serves as the center of a series of satellite group practice clinics that can reach out directly into the entire community.

Fourth, while we are building the nation's overall health policy, we must give special attention to the health of our urban and rural poor. For too many of the poor, the family physician has disappeared, to be replaced by the endless lines and impersonal waiting rooms of huge municipal and county hospitals. Yet, there are few physicians today who were not trained on the wards and charity patients in our teaching hospitals. Too often, as Professor Alonzo Yerby has eloquently stated, our poor have had to barter their bodies and their dignity in return for medical treatment.

In America today, millions of our citizens are sick, and they are sick only because they are poor. We know that illness is twice as frequent among the poor. We know that the poor suffer three times as much heart disease, seven times as many eye defects, five times as much mental retardation and nervous disorders. Although our goal must be one health care system open to all our citizens, we have an obligation now to increase the range and efficiency of the health services and facilities available to the poor, with special emphasis on breaking down the barriers that have for so long divided our society into a two-class system of care—one for the rich and one for the poor, separate and unequal.

Specifically, I urge the Administration to create a National Health Corps, as an alternative to the draft for doctors, and stronger

than the "Project U.S.A." program recently recommended by the AMA. Today, doctors are exempt from the draft if they serve two years in the National Institutes of Health or other branches of the Public Health Service. The same exemption should exist for doctors volunteering for medical service in urban or rural poverty areas. Only in this way will we be able to meet the critical need for health manpower in depressed areas. And, once young physicians are exposed to the problems of health care for the poor, a significant proportion of them will be encouraged to remain and dedicate their careers to this service.

In addition, we should make a substantial new effort to expand the neighborhood health center program. At the present time, less than a dozen medical societies in the nation have become actively involved in neighborhood health centers. Yet, in recent weeks, prominent leaders of the AMA itself have called for a greater role for neighborhood health centers as a means of extending health care to the poor. A few imaginative pilot projects reaching in this direction have recently been funded by the Office of Economic Opportunity, including a program to reorganize the out-patient department at Boston City Hospital as a nucleus for community health care, but our overall effort has been inadequate. Tragically, at a time when even organized medicine is moving forward, we have been unwilling to allocate the resources so urgently needed for this program.

Fifth, within the critical area of health manpower, we must give special attention to training new types of health professionals. In far too many cases, highly trained physicians spend the overwhelming majority of their working day in tasks that do not require their specialized medical skills. One of the most promising methods of easing the shortage of doctors is to train new types of health workers to perform these non-specialized tasks, thereby freeing our physicians for other, more urgent needs. We must develop a broad new range of allied health professionals, such as paramedical aides, pediatric assistants, community service health officers, and family health workers.

At a number of our universities, imaginative new programs are under way to train medical corpsmen from Vietnam as physicians' assistants. In the State of Washington, hospital corpsmen are trained for three months in the medical school, and then sent into the field for nine months' further training in the offices of private physicians. A similar program now exists at Duke University. These programs are unique in their emphasis on combined training in the classroom and in the field. They are programs that must be greatly expanded if we are to meet the urgent demand for more and better trained health manpower.

Sixth, we must restore the severe budget cuts that have been proposed in Federal health programs by the present Administration. Later this week, the full Senate will vote on Federal health appropriations for the current fiscal year, 1970. None of us in Congress can be proud that almost half way through the present fiscal year, we are only now about to vote the funds that may be used. Our error is compounded by the knowledge that at this time of medical crisis, Federal assistance to health programs may be drastically curtailed, especially in the areas of research and manpower training.

Today, when every medical school and every other health school is being urged to expand its manpower programs, the Adminis-

tration is requesting far less funds than Congress authorized as recently as 1968 for these vital programs.

The impact of the proposed cuts will be felt in medical schools, hospitals, research centers, and communities throughout the nation. It will be measured in terms of cancer research cut short, lives lost because coronary care units are unfunded, special hardship for the poor, and the loss of dedicated young students from careers in medicine and medical research.

Seventh, I come to what I believe is the most significant health principle that we as a nation must pursue in the decade of the Seventies. We must begin to move now to establish a comprehensive national health insurance program, capable of bringing the same amount and high quality of health care to every man, woman, and child in the United States.

National health insurance is an idea whose time has been long in coming. More than a millennium ago, Aristotle defined the importance of health in a democratic society, when he said:

"If we believe that men have any personal rights at all as human beings, then they have an absolute moral right to such a measure of good health as society and society alone is able to give them."

Today, the United States is the only major industrial nation in the world that does not have a national health service or a program of national health insurance. The first comprehensive compulsory national health insurance was enacted in Prussia in 1854. Throughout the Twentieth century, proposals have been periodically raised for an American program, but never, until recently, with great chance of success.

National health insurance was a major proposal of Theodore Roosevelt during his campaign for the Presidency in 1912. Shortly before the First World War, a similar proposal managed to gain the support of the American Medical Association, whose orientation then was far different than it is today. During the debate on social security in the Thirties, the issue was again raised, but without success.

Today, the prospect is better. In large part it is better because of the popularity of Medicare and the fact that many other great national health programs have been successfully launched. The need for national health insurance has become more compelling, and its absence is more conspicuous. In part, the prospect is good because the popular demand for change in our existing health system is consolidating urgent and widespread new support for a national health insurance program as a way out of the present crisis.

For more than a year, I have been privileged to serve as a member of the Committee for National Health Insurance, founded by Walter Reuther, whose goal has been to mobilize broad public support for a national health insurance program in the United States. Two months ago in New York City, the Reuther Committee sponsored a major conference, attended by officers and representatives of more than 65 national organizations, to consider a tentative blueprint for a national health insurance program. At the time of the conference, I commended Mr. Reuther for the extraordinary progress his Committee has made. I look forward to the future development of the program. Already, it offers one of the most attractive legislative proposals that is likely to be presented for our consideration next year in Congress.

We must recognize, therefore, that a great deal of solid groundwork has already been

laid toward establishing a national health insurance program. It is for this reason that I believe it is time to transfer the debate from the halls of the universities and the offices of professors to the public arena—to the hearing rooms of Congress and to the offices of your elected representatives.

Early next year, at the beginning of the second session of the 91st Congress, I intend to introduce legislation proposing the sort of comprehensive national health insurance legislation that I believe is most appropriate at the current stage of our thinking. The mandate of the Medicaid Task Force in the Department of Health, Education and Welfare has been expanded to investigate this area, and I urge the Administration to prepare and submit its own proposals.

Senator Ralph Yarborough of Texas has told me that, as Chairman of the Senate Subcommittee on Health, he will schedule comprehensive hearings next year on national health insurance. Our immediate goal should be the enactment of legislation laying the cornerstone for a comprehensive health insurance program before the adjournment of the 91st Congress. This is an issue we can and must take to the people. We can achieve our goal only through the mobilization of millions of decent Americans, concerned with the high cost and inadequate organization and delivery of health care in the nation.

Last week on the floor of the Senate, we witnessed the culmination of what has been one of the most powerful nationwide legislative reform movements since I joined the Senate—the taxpayers' revolution. It now appears likely that by the end of this month, there will be laid on the President's desk the best and most comprehensive tax reform bill in the history of the Federal income tax, a bill that goes far toward producing a more equitable tax system.

We need the same sort of national effort for health—we need a national health revolution, a revolution by the consumers of health care that will stimulate action by Congress and produce a more equitable health system.

Because of the substantial groundwork already laid, I believe that we can agree on three principles we should pursue in preparing an effective program for national health insurance:

First, and most important, our guiding principle should be that the amount and quality of medical care an individual receives is not a function of his income. There should be no difference between health care for the suburbs and health care for the ghetto, between health care for the rich and health care for the poor.

Second, the program should be as broad and as comprehensive as possible, with the maximum free choice available to each health consumer in selecting the care he receives.

Third, the costs of the program should be borne on a progressive basis related to the income level of those who participate in the program.

I believe there is no need now to lock ourselves into a specific method of financing the insurance program. There are distinct advantages and disadvantages to each of the obvious alternative financing methods that have been proposed—financing out of general revenues of the Treasury, out of tax credits, out of the Social Security Trust Fund, or out of another independent trust fund that could be created specifically for the purpose.

At the present time, I lean toward a method of financing that would be based on general Treasury revenues, with sufficient guarantees to avoid the vagaries of the appropriations process that have plagued the Congress so much in recent years.

I recognize the obvious merit of the tax credit and social security approaches. In particular, Social Security financing offers the important advantage that it is a mechanism that Americans know and trust. In the thirty-five years of its existence, Social Security has grown into a program that has the abiding respect and affection of hundreds of millions of Americans. In 1966, it demonstrated its capacity to broaden its horizon by its successful implementation of the Medicare program. To many, therefore, Social Security is the obvious vehicle to embrace a program for national health insurance, and soothe the doubts and suspicions that will inevitably besiege the program when it is launched.

At the same time, however, we must recognize the obvious disadvantages of Social Security financing. Under the Social Security system, the payroll tax is heavily regressive. The poor pay far too high a proportion of their income to Social Security than our middle or upper income citizens. Today, at a time when Congress is about to grant major new tax relief to all income groups, I believe it would be especially inappropriate to finance a national health insurance program through the conventional but regressive procedures of Social Security, rather than through the progressive procedures of the Federal income tax laws.

I wish to make clear, however, that I am not now rejecting an approach that would finance national health insurance by a modified approach through the Social Security System. By the use of payroll tax exemptions and appropriate contributions from the Federal Government, it may be possible to construct a program that will build in the sort of progression that all Americans can accept. The important point here is that we must discuss these possibilities in a national forum, and weigh the alternatives in the critical light of open hearings and national debate.

We must be candid about the costs of national health insurance. In light of our present budgetary restrictions, the price tags applied to the various health insurance programs are too high. They range from about \$10 billion for "Medicredit," the AMA proposal, to about \$40 billion for the Reuther proposal. It is therefore unrealistic to suppose that a total comprehensive program can be implemented all at once.

We can all agree, however, that it is time to begin. In light of the fiscal reality, the most satisfactory approach is to set a goal for full implementation of the program at the earliest opportunity. I believe that the goal should be 1975. The legislation we enact should reflect our firm commitment to this target date. Halfway through the decade of the Seventies, we should have a comprehensive national health insurance, program in full operation for all Americans.

I have already stated my view that legislation establishing the program should be enacted next year. In January, 1971, we should begin to phase-in a program that will reach out to all Americans by the end of 1975. To meet that timetable, we should establish coverage in the first year—1971—for all infants, pre-school children, and adolescents in elementary and secondary schools. In each of the following four years, we should expand the coverage by approximately ten-year age

groups, so that by the end of 1975, all persons up to age 85 will be covered by the program, and the existing Medicare program can be phased in completely with the new comprehensive insurance.

The idea of phasing in children first should receive wide support, both from the population as a whole and from the medical profession as well. As a nation today, the United States is the wealthiest and most highly developed medical society in the world, but we rank 14th among the major industrial nations in the rate of infant mortality, and 12th in the percentage of mothers who die in childbirth. In spite of our wealth and technology, we have tolerated disease and ill-health in generations of our children. We have failed to eliminate the excessive toll of their sickness, retardation, disability and death.

Equally important, we are already close to the level of manpower needed to implement a national health insurance program for our youth. American medicine is equal to the challenge. We have a solid tradition of excellence in pediatric training, with a strong and growing supply of experienced pediatricians, pediatric nurses, and allied manpower.

Moreover, by beginning our new program with youth and child care, it will be easier for the medical profession to implement the changes in the delivery system that must accompany any effective national health insurance program. And, the changes that we make in the delivery system for pediatric care will give us valuable experience and insights into the comparable but far more difficult changes that will be necessary in the delivery of care to adults as the insurance program is phased in over subsequent years.

Finally, by phasing in the insurance program over a period of years, I believe we can avoid a serious objection that will otherwise be raised—that national health insurance will simply exacerbate our current inflation in medical costs by producing even greater demand for medical care without providing essential changes in the organization and delivery system.

We know from recent experience that changes in the organization and delivery of health care in the United States will come only by an excruciating national effort. Throughout our society today, there is perhaps no institution more resistant to change than the organized medical profession. Indeed, because the crisis is so serious in the organization and delivery of health care, there are many who argue that we must make improvements here first, before we can safely embark on national health insurance.

I believe the opposite is true. The fact that the time has come for national health insurance makes it all the more urgent to pour new resources into remaking our present system. The organization and delivery of health care is so obviously inadequate to meet our current health crisis that only the catalyst of national health insurance will be able to produce the sort of basic revolution that is needed if we are to escape the twin evils of a national health disaster or the Federalization of health care in the Seventies. To those who say that national health insurance won't work unless we first have an enormous increase in health manpower and health facilities and a revolution in the delivery of health care, I reply that until we begin moving toward national health insurance, neither Congress nor the medical profession will ever take the basic steps that are essential to reorganize the system. Without national health insurance to galvanize us into action, I fear that we will simply con-

tinue to patch the present system beyond any reasonable hope of survival.

The need for comprehensive national health insurance and concomitant changes in the organization and delivery of health care in the United States is the single most important issue of health policy today. If we are to reach our goal of bringing adequate health care to all our citizens, we must have full and generous cooperation between Congress, the Administration, and the health profession. We already possess the knowledge and the technology to achieve our goal. All we need is the will. The challenge is enormous, but I am confident that we are equal to the task.

Mr. KIRK. Mr. President, I yield the floor.

Mr. President, I suggest the absence of a quorum and ask unanimous consent that the time in the quorum call be divided equally between the majority and minority.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. JOHNSON. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. JOHNSON. Mr. President, I rise to express my support for the Patient Protection and Affordable Care Act and to encourage my colleagues to support this effort to address our health care system's immediate and long-term challenges in a fiscally responsible manner.

For decades, attempts have been made to reform the way our health care system works, but only incremental changes have been made. The result is a broken system where costs are rising out of control and millions of Americans are priced out of the health insurance market.

In the last 8 years, health care premiums have grown four times faster than wages. If health care costs continue to rise at the current rates, without reform, it is projected that the average South Dakota family will be paying nearly \$17,000 in yearly premiums by 2016. That is a 74-percent increase over the current premium costs that so many already struggle to afford.

Throughout the ongoing health reform discussion, I have heard from far too many South Dakotans who currently face barriers in accessing quality health care. This can be due to exorbitant out-of-pocket costs, having no insurance coverage, being denied coverage by insurance companies, or limited or no health care providers in their area. The Patient Protection and Affordable Care Act addresses these barriers in part by extending access to affordable and meaningful health insurance to all Americans.

This legislation stands up on behalf of the American people and puts an end to insurance industry abuses that have

denied coverage to hard-working Americans when they need it most. Insurance companies will no longer be able to deny coverage for preexisting conditions and will not be able to drop coverage just because a patient gets sick. Reform will ensure that families always have guaranteed choices of quality, affordable health insurance whether they lose their job, switch jobs, move, or get sick.

The bill allows Americans to shop for the best health care plan to meet their needs and provides tax credits to help those who need assistance. It strengthens our health care workforce, improves the quality of care, and reduces waste, fraud, and abuse in the health care system.

Every American is adversely affected in some fashion by the shortcomings of our existing system, and far too many have a false sense of security. The system costs us lives, and it costs us money. If we fail to act, health care costs will consume a greater and greater share of our Nation's economy and have tremendous potential to cripple our Nation's future.

The Patient Protection and Affordable Care Act puts our Nation on a more sustainable financial path. The nonpartisan Congressional Budget Office projects that this health reform bill will reduce the Federal deficit by \$130 billion in the next 10 years and as much as \$650 billion in the decade after that. CBO also projects that this bill will result in health care coverage for more than 94 percent of legal residents in our Nation. Our citizens deserve this basic security, while improving current Medicare benefits.

This bill is the product of months of research, committee deliberation, and bipartisan negotiation. I have listened to some of my colleagues' claims that they support health reform yet object to this approach. These protests echo those made nearly 50 years ago when a new program called Medicare was proposed to provide meaningful health benefits to seniors. The increasing cost of health care is unsustainable and the do-nothing approach hurts all Americans by robbing us of this historic opportunity to stop talking about the problems and finally find a solution.

This bill is not perfect, but a "yes" vote will allow the conference committee a chance to improve it. The United States is the only Nation among industrialized democracies to not have some form of national health care. Yet the Senate Republican Party is attempting to deny us the right to vote this historic legislation up or down. They want to kill it even before it has the chance to go to conference.

I urge my colleagues to support the Patient Protection and Affordable Care Act.

Mr. President, I ask unanimous consent that the time be charged equally.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Ohio is recognized.

Mr. VOINOVICH. Thank you, Mr. President. I have been coming to the floor to remind my colleagues and the American people about the fiscal realities our Nation faces and to explain how this health reform legislation would make our fiscal situation worse and our economy suffer even more. I have been here before to highlight how this health care bill is chock-full of budget gimmicks to hide its true unmanageable costs.

As I have said before on the floor of the Senate, as a former mayor and a former Governor, many people have come to me over the years and said: Mayor, you have to do this; Governor, you have to do this. The plea they had was genuine, and the need they expressed was genuine, but the fact is we couldn't afford what they were asking us to do, and I had to say no. Unfortunately, this legislation, in my opinion, will increase the cost of health care, drive up our national debt, and contribute to unbalanced budgets as far as the eye can see in the United States.

As a former Governor and chairman of the National Governors Association, the past chairman of the National League of Cities, one gimmick I am particularly concerned about is the one that puts 14 million additional individuals into the Medicaid Program and then asks the States to pick up a portion of the tab. I am very familiar with what unfunded mandates can do to State and local governments, and I wish to highlight some of the potential consequences of the Medicaid expansion for my colleagues.

At a \$374 billion cost to Federal taxpayers, the health care bill before us would expand Medicaid coverage to all people under 133 percent of the Federal poverty level. Because Medicaid costs are shared by the Federal and State governments, the States will be on the hook for \$25 billion of this expansion during the first 10 years.

To put the \$25 billion into perspective, let me spend a minute explaining the current fiscal situation of most States in this country. Most States such as my State—and I am sure the same is true in the Presiding Officer's State—are struggling to make ends meet. I have never seen anything like it in my entire life.

According to the National Governors Association, the States are in the deepest and longest economic downturn since the Great Depression. In the first two quarters of 2009, State revenues were down 11.7 and 16.6 percent, respectively. At the same time, Medicaid spending is growing, which already makes up, on average, approximately 22 percent of States' budgets, and enrollment in the program is skyrocketing at the levels it is today because more and more people are becoming eligible for Medicaid under the current Federal law.

In Ohio, for example, where the unemployment rate is hovering around 10.5 percent, 154,000 Ohioans enrolled in the Medicaid Program in the last year alone, an 8-percent increase over last year. This is hard to believe, but Medicaid now provides health coverage to nearly 2 million Ohioans, almost one out of five residents. Unbelievable.

Recognizing this increased demand, States have had some help from the Federal Government. Earlier this year, Congress provided \$87 billion in Federal aid to States in the so-called stimulus bill to help States deal with Medicaid costs. Yet this money was not intended to last forever. As it stands right now, in December 2010, States will face—that is next December—States will face a steep budget cliff when the temporary Medicaid payments coming from the stimulus package expire. In facing these realities, Governors across the country are already wondering how they will cover the cost of their existing programs.

I recently met with Ray Scheppach, who is the executive director of the National Governors Association. He said: Senator, Governor, Mayor, we are going to need some help when the money runs out or we will not be able to handle the Medicaid challenges we have.

Not surprisingly, my State's current Governor, Ted Strickland, a Democrat, has told me if Medicaid is expanded, he hopes the Federal Government will assume most, if not all, the costs. In fact, he told the Columbus Dispatch that he has warned officials in Washington that "with our financial challenges right now, we are not in a position to accept additional Medicaid responsibilities."

I suspect that almost every Governor in the country would make that same statement to us in the Senate. By the way, this is both Republican and Democratic Governors.

I ask: How can we in good conscience move forward with this bill and the new mandate it places on States? How can we force the States to make the difficult choices that we are unwilling or unable to make in Washington? Pass it on to them, we will pay for it a while, and then you guys pick up the cost.

I served the people of Ohio as Governor for 8 years, and I was forced to cut my budget in the beginning four times. I will never forget it. There were about 5,000 people outside my office screaming because we had made it more difficult or increased the cost of tuition for our colleges. I had to make countless difficult decisions across the board to be fiscally responsible. I understand the demands of soaring health care costs, and as I called that program then, it devoured—Medicaid devoured up to 30 percent of our State budget, and I referred to it as the Medicaid Pac-Man. I think some people remember Pac-Man. That was the Pac-Man

just eating up money like crazy. It took away money from primary and secondary education, higher education, roads, bridges, county and local government projects, and safety service programs that we wanted to provide for the citizens of Ohio. We had to do it. It was a mandate. It just sucked up that money, and that meant we didn't have money for higher education, secondary and primary education, and some of the other responsibilities of the State.

With this experience, I became particularly concerned with the cost of Federal mandates, and I worked tirelessly with State and local governments to help pass the Unfunded Mandates Reform Act. In fact, the first time I ever set foot on the floor of the Senate is the day the unfunded mandates bill passed the Senate. It was a wonderful day for Ohio and for this country. I was in the Rose Garden representing State and local governments when President Clinton signed the legislation into law in 1995.

After that experience, you can imagine how it pains me to be standing here today debating legislation that provides for the largest single expansion of the Medicaid Program in our country's history and a brandnew fiscal liability for States at a time when the States can least afford it. I have serious concerns if this bill becomes law and States are required to take on more just as the extra stimulus funds disappear—which they are going to have to do or we will have to come up with the money—Congress will be forced to spend billions more to keep the Medicaid safety net from failing completely in the not too distant future.

So what I am basically saying is that when the stimulus money ends in December of next year, the Governors are going to be down here with a bathtub asking us to fill it because if we don't do it, they are going to have to knock off thousands of people, millions in the country, because they don't have the money to provide for the program.

Now, providing extra dollars to States—and I predict it is going to happen. It will become an annual ritual for Congress, just as the doctors fix has become an annual ritual for doctors. Every year they come in. We are not going to cut the annual reimbursement. Next year it is 23 percent, I think. We are not going to fill the hole, and the Governors are going to be asking for the same kind of help. It is not only a mandate for them, it is going to become a mandate for us at a time when we are least able to handle anything like that.

So as a former Governor and a former mayor, a former county commissioner, I urge my colleagues to consider the impact this bill will have on their respective States. Think about it. Talk to your Governors. See what it is going to do to your States. I hope each of my colleagues will give careful thought to

the potentially devastating effects it could have on each of their State budgets and to consult, as I said, with their Governors and to talk about the fact that if this happens, what is going to happen in terms of the Pac-Man eating up more money in their State and their inability to take care of primary and secondary education, higher education, and all of the other responsibilities State governments have.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. INOUE. Mr. President, I rise today to address the Department of Defense appropriations bill for fiscal year 2010.

As my colleagues know, this afternoon the Senate received this measure from the House which represents a compromise between the bill passed by the House last July and what we passed this past October.

Since passage of the Senate measure, Vice Chairman COCHRAN and I and our staffs have spent countless hours in discussion with our colleagues in the House to thrash out the differences between our two bills. The product the Senate will consider represents the work of our discussions. While this is a House measure, I can assure my colleagues it is a very fair and balanced product.

The Defense appropriations portion of this measure totals \$636.3 billion in discretionary spending, including more than \$128 billion for the cost of our ongoing efforts in Iraq and Afghanistan.

In total, the Defense bill is \$3.8 billion below the request of the President and within the subcommittee's allocation.

This bill represents the hard work over the past year of all the members of the Defense subcommittee. It contains funds that we believe will best meet the needs of the men and women who volunteer to serve our Nation in the military. The bill provides funding to increase their pay by 3.4 percent. It provides more than \$30 billion to care for their health and the health of their families.

It provides support to families with loved ones serving in harm's way overseas and funding to ensure that their workplaces and quality of life back home are protected.

Of equal importance, the funding in this bill ensures that our forces in the field have the equipment and other tools required to meet their missions. Funding has been added to the President's request to provide for more MRAP vehicles to protect our forces from IEDs in Afghanistan.

Funds are provided for more medical evacuation and combat rescue helicopters to save our wounded troops. Funds have been added to sustain production of the C-17 Program so our forces in the field can be adequately resupplied, no matter where they are based.

This bill enhances research in life-saving technologies and increases funds to care for our wounded personnel. It fully funds the priorities of Secretary Gates and our military commanders.

While I know some will criticize the fact that funds have been included at the request of Members of Congress, I remind my colleagues that, in total, this amount is less than 1 percent of the funding in the bill.

Moreover, all the so-called earmarks in the defense portion of this bill were in either the House or Senate bills. There are no "airdropped" earmarks in the defense funding included in this measure.

In addition to the defense portion of the bill, the House has added a little more than 1 dozen provisions to provide a 2-month safety net to unemployed and nearly impoverished Americans and to extend critical provisions which are set to expire this month.

For individual Americans, provisions were included to extend, through February 28, 2010, expiring unemployment insurance benefits that were established in the American Recovery and Reinvestment Act.

Likewise, provisions were included to extend the 65-percent COBRA health insurance subsidy from 9 to 15 months for individuals who have lost their jobs and to extend the job lost eligibility date also through February 28, 2010.

Further, a provision was included to freeze the Department of Health and Human Services' poverty guidelines at 2009 levels in order to prevent a reduction in eligibility for programs such as Medicaid, food stamps, and school lunch programs through March 1 of next year.

This provision keeps struggling families from falling through the cracks.

In addition, provisions were included to provide \$125 million to extend the Recovery Act program for small businesses. The program reduces lending fees charged to borrowers under the Small Business Administration's guaranteed loan programs and increases the Federal guarantee on certain small business loans.

The Recovery Act supported a resurgence in SBA small business lending, but funds were exhausted in November. The additional funding in this bill will help support lending for small businesses during the economic recovery by continuing fee relief for borrowers and encouraging lenders to extend credit to small businesses.

Further, this bill includes a short-term extension of the highway, transit, highway safety and truck safety programs. Without this extension, the highway program would be brought to a standstill and the Department of Transportation would be unable to reimburse States for eligible expenses.

In addition, several agencies—including the Federal Highway Administration, the National Highway Traffic

Safety Administration, and the Federal Motor Carrier Safety Administration—would not have the funds necessary to pay their employees.

This is not your typical end-of-the-year Christmas tree; to the contrary, it is the bare minimum of programs which must be continued to provide for our less fortunate and our struggling small businesses.

It also allows for a 2-month extension of laws such as the PATRIOT Act, in order to allow more time for our authorizing committees to come to agreement on more permanent legislation.

The House has passed a compromise measure and forwarded it to the Senate because of the calendar. Today is December 16, and our Department of Defense has been operating on a continuing resolution for more than 2 months.

It is time we get on with the process and get this bill to the President. It is a good measure. Our troops deserve our support. Let's show we support those who volunteered to serve all of us by voting today to send this bill to the President.

As I close, I wish to thank the Defense Subcommittee staff for their dedication and hard work in putting this bill together. I wish to put into the RECORD the names of these staff members who have worked on this bill in a bipartisan fashion. They are:

Charlie Houy, Nicole Diresta, Kate Fitzpatrick, Katy Hagan, Kate Käufer, Ellen Maldonado, Rachel Meyer, Erik Raven, Gary Reese, Betsy Schmid, Renan Snowden, Bridget Zarate, Rob Berschinski, Stewart Holmes, Alycia Farrell, Brian Potts, Brian Wilson and Tom Osterhoudt.

Mr. President, it is my pleasure and privilege to be chairman of the committee. It is a great honor. I wish to make certain we express our gratitude to all these staff people. Without them, I would not be standing here at this moment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Mississippi is recognized.

Mr. COCHRAN. Mr. President, I am glad I was here to hear the remarks of the distinguished Senator from Hawaii. I serve on that subcommittee of Defense Appropriations with him and get to observe, at close range, the skill and effort and courtesy that is reflected in his service as chairman of our committee. It is a pleasure to serve with him and it is an honor. He has provided leadership and cooperation in working with all Senators—not just members of our committee—to move forward in carrying out of duties by the Department of Defense through our appropriations process.

It is very important that the Senate approve, as soon as possible, the funding that is contained in the bill that our committee has reported to the Senate. It will help support and provide the resources necessary to carry out

the missions of our men and women have in Afghanistan, Iraq, and around the world, safeguarding our freedom, protecting our security interests.

The Department of Defense is now operating under a continuing resolution that expires on Friday. This is an inefficient way of managing the support for our Department of Defense. It causes too much effort to be made by employees and men and women in the Defense Department, focusing on management, how to manage day-to-day operating expenses dealing with the challenges that too few dollars are provided in a way that gives people time to plan and then execute efficiently their missions and responsibilities.

This affects the support that is available to the men and women who are overseas and in harm's way.

The act contains funds necessary to provide medical care as well as family support for members of our Armed Forces and their families. During this time of war, it is very important that every effort be made to provide good medical care for those who are injured and wounded serving our country.

It is also important we support the families. There are funds in this legislation that do just that, trying to address the stresses that are associated with combat and deployment and separation.

I am disappointed the normal process has been circumvented, or at least delayed, and the other body has not appointed conferees to the Defense Appropriations conference committee. It is a disappointment also that the Defense Appropriations bill is used as a vehicle to move other initiatives that seem to be slowing down the process. These measures should be considered separately and addressed in a more thoughtful way, based on their own merits, not on the legislation they are tied to, to carry them through the legislative process.

I think attaching nondefense-related legislation to the Defense Appropriations Act for this fiscal year has been a mistake. It has been unnecessary, unfortunate, and it has resulted in delays and uncertainty.

I am sure there are Senators who can make suggestions for improving this bill. We are open to hear those concerns and do our best to respond to the suggestions from all Senators. We don't individually support all aspects of the agreement, but we think that, in total, it is a good bill. It ought to be passed, and it ought to be passed as soon as possible in recognition of our respect for our service members and their families.

Mr. INOUE. Mr. President, there is nothing in rule XLIV which governs a message between the Houses in regard to disclosing earmarks. However, as chairman of the Appropriations Committee it is my belief that the committee should none the less attest that

all earmarks have been fully disclosed. Accordingly I note that in the bill H.R. 3326 as passed by the House and explained in the statement offered by the chairman of the Subcommittee on Defense of the House of Representatives on December 16, 2009, each earmark in the bill has been disclosed in accord with rule XLIV.

Mr. CONRAD. Mr. President, section 401(c)(4) of S. Con. Res. 13, the 2010 budget resolution, permits the Chairman of the Senate Budget Committee to adjust the section 401(b) discretionary spending limits, allocations pursuant to section 302(a) of the Congressional Budget Act of 1974, and aggregates for legislation making appropriations for fiscal years 2009 and 2010 for overseas deployments and other activities by the amounts provided in such legislation for those purposes and so designated pursuant to section 401(c)(4). The adjustment is limited to the total amount of budget authority specified in section 104(21) of S. Con. Res. 13. For 2009, that limitation is \$90.745 billion, and for 2010, it is \$130 billion.

The Senate is considering H.R. 3326, the Department of Defense Appropriations Act, 2010. That legislation includes amounts designated pursuant to section 401(c)(4). Since this is the last of the 12 regular appropriations bills for 2010, I am revising previous adjustments made to the discretionary spending limits and the allocation to the Senate Committee on Appropriations for discretionary budget authority and outlays to reflect the final amount of designations made pursuant to section 401(c)(4). When combined with all previous adjustments, the total amount of adjustments for 2010 is \$130 billion in discretionary budget authority and \$101.178 billion in outlays. In addition, I am also further revising the aggregates for 2010 consistent with section 401(c)(4) to reconcile the amount of outlays estimated by the Congressional Budget Office for designated funding with the amount originally assumed in the 2010 budget resolution.

I ask unanimous consent that the following revisions to S. Con. Res. 13 be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 401(c)(4) ADJUSTMENTS TO SUPPORT ONGOING OVERSEAS DEPLOYMENTS AND OTHER ACTIVITIES

[In billions of dollars]

Section 101	
(1)(A) Federal Revenues:	
FY 2009	1,532.579
FY 2010	1,623.888
FY 2011	1,944.811
FY 2012	2,145.815
FY 2013	2,322.897

<i>Section 101</i>	
FY 2014	2,560.448
(1)(B) Change in Federal Revenues:—	
FY 2009	0.008
FY 2010	–42.098
FY 2011	–143.820
FY 2012	–214.578
FY 2013	–192.440
FY 2014	–73.210
(2) New Budget Authority:—	
FY 2009	3,675.736
FY 2010	2,910.707
FY 2011	2,842.766
FY 2012	2,829.808
FY 2013	2,983.128
FY 2014	3,193.887
(3) Budget Outlays:—	
FY 2009	3,358.952
FY 2010	3,023.691
FY 2011	2,966.921
FY 2012	2,863.655
FY 2013	2,989.852
FY 2014	3,179.437

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 401(c)(4) TO THE ALLOCATION OF BUDGET AUTHORITY AND OUTLAYS TO THE SENATE APPROPRIATIONS COMMITTEE AND THE SECTION 401(b) SENATE DISCRETIONARY SPENDING LIMITS

[In millions of dollars]

	Initial Allocation/Limit	Adjustment	Revised Allocation/Limit
FY 2009 Discretionary Budget Authority	1,482,201	0	1,482,201
FY 2009 Discretionary Outlays	1,247,872	0	1,247,872
FY 2010 Discretionary Budget Authority	1,219,651	1	1,219,652
FY 2010 Discretionary Outlays	1,376,195	–157	1,376,038

The PRESIDING OFFICER. The Republican leader is recognized.

SETTING PRECEDENT

Mr. MCCONNELL. Mr. President, I rise to make some observations about a matter that occurred in the Senate earlier this afternoon.

The plain language of the Senate precedent, the manual that governs Senate procedure, is that unanimous consent of all Members was required before the Senator from Vermont could withdraw his amendment while it was being read—unanimous consent.

Earlier today, the majority somehow convinced the Parliamentarian to break with the longstanding precedent and practice of the Senate in the reading of the amendment.

Senate procedure clearly states:

Under rule 15, paragraph 1, and Senate precedents, an amendment shall be read by the clerk before it is up for consideration or before the same shall be debated unless a request to waive the reading is granted.

It goes on to state that:

... the reading of which may not be dispensed with, except by unanimous consent, and if the request is denied, the amendment must be read and further interruptions are not in order.

Nothing could be more clear.

You may have heard that the majority cites an example in 1992 when the Chair made a mistake and allowed something similar to happen. But one mistake does not a precedent make.

For example, there is precedent for a Senator being beaten with a cane in the Senate. If mistakes were the rule, then the caning of Senators would be in order. Fortunately for all of us, it is not.

It is now perfectly clear that the majority is willing to do anything—anything—to jam through a 2,000-page bill before the American people or any of us have had a chance to read it, including changing the rules in the middle of the game.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Georgia is recognized.

Mr. CHAMBLISS. Mr. President, I rise today to speak about the decision to move the remaining detainees held at Guantanamo Bay Naval facility, or Gitmo, to the Thomson Correctional Center in Illinois.

The decision to transfer Gitmo detainees to the heartland of our country is irresponsible, a waste of taxpayer dollars, and contrary to the wishes of the American people.

Congress has included language permitting the transfer or detention of Gitmo detainees to the United States only under certain limited conditions in every relevant appropriations bill passed this year, including the recently passed Omnibus Appropriations Act. That is one of the reasons I voted against every single one of those bills.

The President now has made the decision to purchase the Thomson Correctional Center from the State of Illinois for the purpose of transferring and detaining Gitmo detainees.

Further, the President stated he will need to expend millions of additional dollars renovating and securing the facility when much has already been invested in the state-of-the-art facility at Guantanamo Bay. This unnecessary spending is an abuse of our tax dollars and one that holds dire national security consequences.

The administration claims that many of these detainees will continue to be held by the military in the same prison where the Department of Justice will hold average, ordinary criminals. What the administration fails to tell the American people is that these detainees will obtain the same rights as U.S. citizens the moment they step inside the United States. We have already seen detainees attempt to gain these same rights as Americans in our courts and have seen the courts grant them limited rights without them being inside the United States.

In habeas corpus cases where the court has ruled, 30 out of 38 Gitmo detainees have been found to be unlawfully detained and their release has been ordered. After reviewing the classified biographies on some of these individuals, it is clear from these decisions that the courts are not in a position to judge matters of war and cannot when they are bound by our criminal justice system.

It is not designed to handle war criminals.

The courts do not adequately consider the threat these individuals pose to U.S. interests or will pose in the future when they return to terrorism. President Obama cites the authorization for the use of military force as legal justification for continuing the detention of these terrorists. However, the courts have already indicated that these detainees cannot be indefinitely held. I wonder if the administration considered this when it decided to move Gitmo detainees to the United States.

This administration may face the same problem as the last administration did in justifying to a U.S. court the continuing detention of these terrorists. Only this time, the court will have a remedy.

It is foreseeable that some, and possibly many, of those detainees will be ordered released by our courts. The administration has tried to assure the public that our immigration laws will prohibit the release of those individuals into the United States. But, once again, this administration fails to appreciate the limits of our legal system. Once these detainees are physically present in the United States, prior judicial precedent indicates that the government can only detain an individual while immigration removal proceedings are ongoing for a maximum of 6 months. If a detainee cannot be transferred or deported, they will be released, freed into the United States, after 6 months. This is much more than just moving Guantanamo north.

On the other hand, if the administration is able to secure the transfer of these detainees to another country, we can be sure to watch the recidivism rates rise. The Department of Defense's last unclassified fact sheet on recidivism reported that 14 percent of the former Gitmo detainees returned to terrorism after their release or their transfer. This is almost one out of every seven detainees transferred. This number is much larger now after 8 months and countless transfers of the most serious terrorists.

Some of the detainees transferred openly admit their affiliation with a terrorist organization or that they were combating U.S. forces in Afghanistan. Confirming this, two former Gitmo detainees transferred to Saudi Arabia announced earlier this year that they were now the leaders of al-Qaida in the Arabian peninsula. Another detainee, Ali bin Ali Aleh, lived with Abu Zubaydah in Pakistan and was identified on a list of names in Khalid Shaikh Mohammed's possession when KSM was captured. Ali bin Ali Aleh was determined not to be an enemy combatant and ordered to be released by a U.S. court in May of this year. He was transferred to Yemen in September.

Maybe some of my colleagues have seen the recent headlines indicating that some European countries are willing to accept these detainees. In fact, detainees have recently been transferred to Belgium, Ireland, Hungary, and Italy. However, the American people are not fooled by these headlines. Of the 779 detainees held since 2001 at Guantanamo Bay, our European partners have accepted only 37. The vast majority of detainees—almost 400—have been transferred to four countries: Afghanistan, Saudi Arabia, Pakistan, and Yemen. These four countries are either currently in conflict or actively combating al-Qaida. In all four of these countries, the threat from al-Qaida and associate militants has done nothing but increase over the past few years. Yet the United States is sending back hundreds of terrorists to the most volatile regions of the world—South Asia, which poses the greatest terrorist threat currently to the homeland and to the Arabian peninsula, which I believe will present itself as the next greatest threat to the United States.

The decision to move these terrorists to the United States may force the administration to choose between freeing terrorists into Illinois or transferring them back to the center of the battle. Is this the policy position we want to put our country in while we are still combating terrorism?

No one doubts the security of our prisons to safely hold these individuals. I doubt the ability of our laws and judicial system to ensure that these terrorists are convicted or kept in prison. Prohibiting the detainees from entering the United States is the only guarantee. However, the decision to move the remaining terrorists at Gitmo to the heart of this country shattered any remaining hope for this guarantee. This is yet another step in a series of poor policy decisions which is leading our country in the wrong direction.

I am disappointed by this decision, obviously. But I can only imagine how the residents of Illinois feel about it. I know Georgians would not be pleased with housing over 200 of the most serious and hardened terrorists in the world in their backyard.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER (Mrs. SHAHEEN). The clerk will call the roll. The assistant legislative clerk proceeded to call the roll.

Mr. DURBIN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DURBIN. Madam President, I wish to respond to my friend from Georgia, who just stepped off the floor, about the transfer of detainees from Guantanamo because he misstated a few things that I do not want to stay on the record.

First, he suggested that these detainees would be freed in Illinois. Not so. The plan of this administration is not to free them; the plan is to imprison them in the most secure prison in the United States of America. It is in Thomson, IL, 150 miles from Chicago. I was there a few weeks ago. It is a supermax prison built 7 years ago and never fully occupied. Now they are going to build an additional fence around it. It will be more secure than any prison in America. They will be freed into the most secure prison in America and they are not coming out until such time as there is a resolution of whatever their issues may be or they pass away.

I might also say that the current law in the United States prohibits the President of the United States from releasing these detainees in the United States. Those statements by the Senator from Georgia are just flat incorrect.

He is entitled to his position—and others share it—that we should not close Guantanamo. I believe we should. On my side of this argument would be the following people who have called for the closure of Guantanamo: President George W. Bush; Secretary of State and former Chairman of the Joint Chiefs of Staff Colin Powell; Secretary of Defense under President Bush and under President Obama, Robert Gates; former Secretary of State and domestic policy adviser Condoleezza Rice; GEN David Petraeus, and 33 other generals, in addition to President Barack Obama.

This argument that closing Guantanamo endangers the United States ignores the obvious. The people entrusted with the responsibility of protecting the United States have called for the closure of Guantanamo. Yesterday, Robert Gibbs, press secretary to President Obama, was asked about this decision to transfer. He said that on more than 30 occasions—I am not sure of the timeframe, whether it was this year or a longer period of time—but on more than 30 occasions, they have found direct linkage of terrorist recruitment activity and the use of Guantanamo as an illustration of why people needed to convert to terrorism around the world. It is still being actively used for recruitment.

If the Senator from Georgia would go back a few weeks and read Newsweek magazine, one of their reporters was captured in Tehran and held in captivity for almost 4 months. He told a story of how he was first incarcerated in a prison in Tehran. As he arrived, his jailer said to him: Welcome to Abu Ghraib and Guantanamo, American.

So for us to believe that the rest of the world does not have a negative image of Guantanamo and it is not being used against our troops is to ignore the obvious.

There are some in this body who are hidebound to keep Guantanamo open

at any costs. I will tell you, the cost is too high. If the continuation of Guantanamo means danger to our troops, we owe it to them to close it. Presidents have reached that conclusion, people in charge of national security have reached that conclusion, and we should as well.

Then there is this notion about the danger of incarcerating terrorists in the United States. For the record, over 350 convicted terrorists are currently imprisoned in the United States, all over the United States. In my home State of Illinois, 35 convicted terrorists are in prison today. The most recent incarceration involves a man arrested shortly after 9/11 in Peoria, IL, an unlikely hotbed of terrorism and spy activity, but, in fact, this man going to school in Peoria, IL, through his communications was linked with al-Qaida. He served time in a Navy brig in South Carolina, if I am not mistaken, and eventually was tried in the courts of Peoria, IL, convicted and now incarcerated in Marion, IL, in southern Illinois.

I heard not one word of criticism when this took place under the previous administration. The belief was this man had to answer for the crimes he was charged with and serve time in our prison system as a result of it. Never—not once, not one time—did I ever hear any Congressman of either political party say: Boy, it is unsafe to try him in Peoria or it is unsafe to incarcerate him in southern Illinois. It has never been said.

What happens to these people when they go into our supermax prisons, where no one has ever escaped? They disappear, as they should. They are where they ought to be—isolated and away from causing harm to anyone.

When President Obama was looking for an alternative to Guantanamo, we came forward. One of the mayors of a small town in Illinois—Thomson, IL—with just several hundred people living there, wrote to the Governor of our State and to me and said: I have a big old prison the State built and never opened—built it in 2001. It has the capacity of several thousand prisoners, and the State could never afford to open it. We had hoped that this prison would create a lot of local jobs for us. Can you find a use for it at the Federal level?

The Obama administration took a hard look at this for a long period of time. Part of it was done confidentially, and then they came out publicly and said: We are seriously interested.

The Senator from Georgia said earlier: Well, the people of Illinois are against this.

Well, I would say to my friend from Georgia, come on down to Thomson, IL. Come down and see the people who are overwhelmingly supportive—and not just Democrats, believe me. Local State representative Jim Sacia is a Republican and a former FBI agent. He

said we would be idiots not to take this offer from the Federal Government. He is right. Three thousand jobs. I don't know that there is a Senator here if you said to him: Would you be interested in 3,000 jobs in the midst of a recession, who wouldn't stand up and say: Let's talk.

Well, we did. So it is 3,000 new jobs at this prison when it is opened as part of the Bureau of Prisons and part of the Department of Defense.

How many Guantanamo detainees will be sent there? Fewer than 100. We have 35 in our prisons already. Life has not changed in my home State of Illinois, nor has it changed in any other State where they are incarcerated. It would not change in Thomson, IL. These people can be held safely and securely. I trust our men and women in the military to do that, and the Members of the Senate should do so as well.

These 3,000 jobs are going to be a Godsend to an area with 11 percent unemployment. First, there will be a lot of construction jobs, and we can use those. Those are good-paying jobs for Americans right here at home. Then those who work for the Bureau of Prisons are going to be paid a good salary and receive good benefits, the kind of salary you can use to build a family, a community, a neighborhood. These will be people who will be buying homes—3,000 of them. They will be buying homes, cars, shopping for appliances, and going to the local shopping malls. Is that going to be good for the economy? You bet it is. It is just what we need, and it is just what this area of the State wants. This argument that we somehow will oppose it is just wrong.

There is a local Congressman, who is a friend of mine—a Republican Congressman—who opposes it. We have talked about it. We just don't see eye to eye on it. But even in Rockford, IL, the largest city in his district, which is northeast of Thomson, the city council in Rockford passed a resolution of approval of this Thomson prison, 12 to 2. In county after county, State and local governments—I should say local county governments are coming out in favor of this Thomson prison. Those who come to the Senate floor and argue otherwise don't know the facts. When they know the facts, they will realize we are prepared to do this.

Now the question is whether the Senate will stand behind the President, stand behind our security advisers who believe this is in the best interest of the United States. I think it is. It isn't the first time Illinois has been called on to do something extraordinary for our country. The first supermax prison in our Federal system was built in Marion, IL, years and years ago. There was controversy. This was the most secure prison in America. But I will tell you, the people of southern Illinois rallied behind it. It has been a prison with

a lot of great professionals who have worked there. They have done their jobs and done them well.

When I go down to Marion, IL, and talk to them about Guantanamo detainees, they say: Senator, listen. Send them here. We will take care of them. We can point out among those who are incarcerated at Marion prison those who were engaged in al-Qaida terrorism, Colombian drug gangs, Mexican drug cartels, some of the meanest, toughest most violent gang bangers from the cities in the Midwest—and they are held safely every day.

I will tell you, when I hear people say they do not trust our prison system to hold a handful or 50 or whatever the number may be—less than 100—of these Guantanamo detainees, they ought to meet the men and women who do it every single day in America, and do it well. They should realize these detainees will be held by our military, the Department of Defense employees. Those are the ones we can trust to do it.

So I would urge my friends and others who have spoken earlier—Senator MCCONNELL came to the Senate floor earlier. It has become, unfortunately, a party position now that it is a bad idea. Earlier, Senator MCCAIN and Senator GRAHAM on the Republican side of the aisle didn't argue against the transfer of these detainees. They understand these prisoners aren't larger than life. They have been in prison for 8 years. Frankly, I don't know how much longer they will stay there. But as long as they are a threat to the United States, they will.

Madam President, I would like to at this point address an issue which came up earlier on the Senate floor.

Something unusual happened on the floor of the Senate today, Madam President. It happens but rarely. Under the rules of the Senate, amendments and bills can be read, if a Member requests, and we usually ask unanimous consent to dispense with the reading. And, routinely, that is done. It is done every day on scores of different things.

Today, Senator SANDERS of Vermont offered an amendment near and dear to his heart on single-payer health care reform, and it turned out to be a voluminous amendment—800 pages long. When the time came to ask consent that it not be read, there was an objection from Senator COBURN of Oklahoma. He insisted that it be read. Our poor clerking staff up here—the clerks of the Senate—started reading this bill, and they read on for almost 2 hours or more.

As they were reading it, it came to our attention that Senator SANDERS of Vermont had authority under the Senate rules to withdraw his amendment and to stop the reading of the amendment.

I wasn't aware of that because I can't recall that has ever happened since I

have been here. But I made a point—since many years ago I was a parliamentarian of the Illinois State Senate and tried to at least read the rules from time to time—to turn to rule XV, section 2, in the Standing Rules of the Senate, and here is what it says:

Any motion, amendment, or resolution may be withdrawn or modified by the mover at any time before a decision, amendment or ordering of the yeas and nays, except a motion to reconsider, which shall not be withdrawn without leave.

In other words, until action was taken on the Sanders amendment, he had the authority under rule XV, paragraph 2 to withdraw his amendment, which he did.

Some have come to the floor and protested and said this was extraordinary, and it can't be backed up by the Senate rules. But I refer them to this rule, which is explicit, and that no action had taken place on this amendment other than the introduction of the amendment and reading. So, as it says here, "any time before a decision, amendment, or ordering of the yeas and nays." I think that is a clear case.

I have since read an earlier ruling by the Chair relative to the same rule that goes back several decades, so the ruling of the Chair today, or at least the finding of the Chair, was consistent with the rules of the Senate. But the strategy that came out in the ordering of this amendment to be read is pretty clear when it comes to health care. The Republican strategy is clear to anyone who is watching the debate: They do not want amendments. In fact, they just don't want us to vote on health care reform. There comes a time when people make the best arguments they can and the Senate makes a decision, and that is what we are facing. That is what we want. We would like to do that in a timely fashion.

Members here believe we can do that in a responsible way and move this health care reform bill to a point of a vote—a cloture vote, with a 60-vote requirement—and do that in a way that we can find the sentiment in the Senate on this important measure and just maybe go home for Christmas, which a lot of us would like to do. We have been away from our families for quite a while.

During the course of this debate, we have been spending a lot of time on the bill itself. I usually like to give people an idea by holding up this 2,074-page bill. It took a lot of work to get to this point. The managers' amendment to this will be several hundred pages, I imagine.

People say: Why is it so big? It is big because we are changing the health care system in America, which is one-sixth of our economy. You can imagine all the different moving parts in this complicated health care system that we address with this bill.

During this period of time, the Republicans have not offered any alternative or substitute. I thought that

would be their first motion, to come forward and say: That is the Democratic plan to change the health care system in America, but you should see the Republican plan, how much better it is. They didn't do that because there is no Republican alternative. There is no Republican substitute.

Last week, when I went to the Senate Republican Web site—and I invite people to do the same—I found there was only one bill printed there on health care reform. It was the Democratic bill, not any bill that has been offered by the Republican side. The reason is this is hard work. Putting a bill like this together, getting experts to look at it and decide whether it is going to save money or cost money, it takes time. We have taken that time to do it, and do it right, and they have not. So they are either not up to the challenge of preparing an alternative bill, or they are content with the current system.

I guess some people are content with the current system. Among those who are content with it are the CEOs of health insurance companies. They like this system. They make a lot of money. They do it at the expense of a lot of people who need health care and end up being turned down. So, unfortunately, the Republicans have no constructive proposals to improve our bill. Each and every amendment, almost without exception, has been to send the bill back to committee; to stop working on it, and let's do this another day. All they want to do on the bill is to delay it, as they tried to do today with the reading of the Sanders amendment.

Senator JUDD GREGG of New Hampshire is a friend of mine. He and his wife Kathy and my wife Loretta and I have traveled together on official business of the Senate. I like him. He is a smart guy. He is going to retire, and he, in his wisdom, decided to leave a playbook for the Republican side of the aisle, which they shared. It is page after page of ways to slow down and stop the Senate from acting. Senator GREGG is entirely within his rights as a Senator to do it. What I read in his memo was accurate, but the intent and motive are clear: He wanted to stop this bill from moving in order, and that became the real cause on the Republican side of the aisle. They took a page out of Senator GREGG's playbook today with Senator COBURN's demanding the amendment be read. But it didn't work.

Madam President, I ask unanimous consent to have printed in the RECORD a colloquy between former Senators Adams and Packwood on the floor of the Senate on September 24, 1992.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

TAX ENTERPRISE ZONES ACT

(Senate—September 24, 1992), [Page: 27573]

The Senate continued with the consideration of the bill.

The PRESIDING OFFICER. The Senator from Washington is recognized.

AMENDMENT NO. 3173

(Purpose: To amend the Internal Revenue Code of 1986 to deny the benefits of certain export subsidies in the case of exports of certain unprocessed timber, and to establish rural development programs for certain rural communities and small businesses that have been adversely affected by a declining timber supply and changes in the timber industry in the Pacific Northwest)

Mr. ADAMS. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Washington [Mr. Adams] proposes an amendment numbered 3173.

Mr. ADAMS. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

Mr. PACKWOOD. Mr. President, I object.

The PRESIDING OFFICER. Objection is heard. The clerk will read the amendment.

The assistant legislative clerk continued reading the amendment.

Mr. ADAMS. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

Mr. PACKWOOD. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. ADAMS. Mr. President, parliamentary inquiry? I have a parliamentary inquiry of the Chair. Is it in order, during the reading of the amendment, without it being dispensed with, for the floor leader and the opponent of the amendment to have a discussion?

The PRESIDING OFFICER. The regular order, as the Chair is advised by the Parliamentarian, is that the amendment is to be read because objection has been heard to the unanimous-consent request.

The clerk will read the amendment.

The assistant legislative clerk continued reading the amendment.

Mr. ADAMS. Mr. President, I ask permission to withdraw the amendment.

The PRESIDING OFFICER. The Senator has a right to withdraw the amendment.

Mr. ADAMS. I withdraw the amendment.

The PRESIDING OFFICER. The amendment is withdrawn.

The amendment (No. 3173) was withdrawn.

The text of the amendment (No. 3173) is as follows:

At the end of title VIII, insert the following new sections:

Mr. DURBIN. Incidentally, Madam President, that is the colloquy I referred to earlier where the Chair made exactly the same ruling on that day as was made today, the finding in terms of rule XV, paragraph 2.

I also ask unanimous consent to have printed in the RECORD the memorandum prepared by Senator GREGG for the Republican side of the aisle concerning the rights of the minority in the Senate, which I have mentioned earlier, and largely includes the rights to slow down and stop the activity of the Senate.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

FOUNDATION FOR THE MINORITY PARTY'S RIGHTS IN THE SENATE (FALL 2009)

The Senate rules are designed to give a minority of Senators the right to insist on a full, complete, and fully informed debate on all measures and issues coming before the Senate. This cornerstone of protection can only be abrogated if 60 or more Senators vote to take these rights away from the minority.

I. Rights Available to Minority Before Measures are Considered on Floor (These rights are normally waived by Unanimous Consent (UC) when time is short, but any Senator can object to the waiver.)

New Legislative Day, An adjournment of the Senate, as opposed to a recess, is required to trigger a new legislative day. A new legislative day starts with the morning hour, a 2-hour period with a number of required procedures. During part of the "morning hour" any Senator may make non-debatable motions to proceed to items on the Senate calendar.

One Day and Two Day Rules—The 1-day rule requires that measures must lie over one "legislative day" before they can be considered. All bills have to lie over one day, whether they were introduced by an individual Senator (Rule XIV) or reported by a committee (Rule XVII). The 2-day rule requires that IF a committee chooses to file a written report, that committee report MUST contain a CBO cost estimate, a regulatory impact statement, and detail what changes the measure makes to current law (or provide a statement why any of these cannot be done), and that report must be available at least 2 calendar days before a bill can be considered on the Senate floor. Senators may block a measure's consideration by raising a point of order if it does not meet one of these requirements.

"Hard" Quorum Calls—Senate operates on a presumptive quorum of 51 senators and quorum calls are routinely dispensed with by unanimous consent. If UC is not granted to dispose of a routine quorum call, then the roll must continue to be called. If a quorum is not present, the only motions the leadership may make are to adjourn, to recess under a previous order, or time-consuming motions to establish a quorum that include requesting, requiring, and then arresting Senators to compel their presence in the Senate chamber.

II. Rights Available to Minority During Consideration of Measures in Senate (Many of these rights are regularly waived by Unanimous Consent.)

Motions to Proceed to Measures—with the exception of Conference Reports and Budget Resolutions, most such motions are fully debatable and 60 votes for cloture is needed to cut off extended debate.

Reading of Amendments and Conference Reports in Entirety—In most circumstances, the reading of the full text of amendments may only be dispensed with by unanimous consent. Any Senator may object to dispensing with the reading. If, as is often the case when the Senate begins consideration of a House-passed vehicle, the Majority Leader offers a full-text substitute amendment, the reading of that full-text substitute amendment can only be waived by unanimous consent. A member may only request the reading of a conference report if it is not available in printed form (100 copies available in the Senate chamber).

Senate Points of Order—A Senator may make a point of order at any point he or she believes that a Senate procedure is being violated, with or without cause. After the

presiding officer rules, any Senator who disagrees with such ruling may appeal the ruling of the chair—that appeal is fully debatable. Some points of order, such as those raised on Constitutional grounds, are not ruled on by the presiding officer and the question is put to the Senate, then the point of order itself is fully debatable. The Senate may dispose of a point of order or an appeal by tabling it; however, delay is created by the two roll call votes in connection with each tabling motion (motion to table and motion to reconsider that vote).

Budget Points of Order—Many legislative proposals (bills, amendments, and conference reports) are subject to a point of order under the Budget Act or budget resolution, most of which can only be waived by 60 votes. If budget points of order lie against a measure, any Senator may raise them, and a measure cannot be passed or disposed of unless the points of order that are raised are waived. (See <http://budget.senate.gov/republican/pressarchive/PointsofOrder.pdf>)

Amendment Process

Amendment Tree Process and/or Filibuster by Amendment—until cloture is invoked, Senators may offer an unlimited number of amendments—germane or non-germane—on any subject. This is the fullest expression of a “full, complete, and informed” debate on a measure. It has been necessary under past Democrat majorities to use the rules governing the amendment process aggressively to ensure that minority Senators get votes on their amendment as originally written (unchanged by the Majority Democrats.)

Substitute Amendments—UC is routinely requested to treat substitute amendments as original text for purposes of further amendment, which makes it easier for the majority to offer 2nd degree amendments to gut 1st degree amendments by the minority. The minority could protect their amendments by objecting to such UC's.

Divisible Amendments—amendments are divisible upon demand by any Senator if they contain two or more parts that can stand independently of one another. This can be used to fight efforts to block the minority from offering all of their amendments, because a single amendment could be drafted, offered at a point when such an amendment is in order, and then divided into multiple component parts for separate consideration and votes. Demanding division of amendments can also be used to extend consideration of a measure. Amendments to strike and insert text cannot be divided.

Motions to Recommit Bills to Committee With or Without Instructions—A Senator may make a motion to recommit a bill to the committee with or without instructions to the Committee to report it back to the Senate with certain changes or additions. Such instructions are amendable.

After Passage: Going to Conference, Motions to Instruct Conferees, Matters Out of Scope of Conference

Going to Conference—The Senate must pass 3 separate motions to go to conference: (1) a motion to insist on its amendments or disagree with the House amendments; (2) a motion to request/agree to a conference; and (3) a motion to authorize the Chair to appoint conferees. The Senate routinely does this by UC, but if a Senator objects the Senate must debate each step and all 3 motions may be filibustered (requiring a cloture vote to end debate).

Motion to Instruct Conferees—Once the Senate adopts the first two motions, Senators may offer an unlimited number of motions to instruct the Senate's conferees. The

motions to instruct are amendable—and divisible upon demand—by Senators if they contain more than one separate and distinct instruction.

Conference Reports, Out of Scope Motions—In addition to demanding a copy of the conference report to be on every Senator's desk and raising Budget points of order against it, Senators may also raise a point of order that it contains matter not related to the matters originally submitted to the conference by either chamber. If the Chair sustains the point of order, the provision(s) is stricken from the conference agreement, and the House would then have to approve the measure absent the stricken provision (even if the House had already acted on the conference report). The scope point of order can be waived by 60 Senators.

Availability of Conference Report Language. The conference report must be publicly available on a website 48 hours in advance prior to the vote on passage.

Mr. DURBIN. Madam President, I would just say that when Senator MCCONNELL came to the floor after the ruling and the decision of the Chair, he said the plain language of the Senate precedent—the manual that governs Senate procedure—is that unanimous consent of all Members was required before the Senator from Vermont could withdraw his amendment while it was being read. He said it required unanimous consent. But that is not what the language of the Senate rules say that I have read. They say a Senator has, as a matter of right under rule XV, paragraph 2, to withdraw his amendment before action is taken. In this case, as I mentioned earlier, the argument back in 1992 backs up the Parliamentarian's decision in that interpretation of the rule.

So I would say it didn't work today to stop or slow down the Senate. Currently, we are not technically debating health care reform. What is before us now is the Department of Defense appropriations bill from the House, which I hope we can move on quickly. I think it is not controversial. It is a matter of finding money for our troops who are risking their lives overseas and supporting their families at home and providing health care for members of the military and their families. I don't think there is much debate about that.

It also extends the unemployment benefits that people need across America, which passed with a 97-to-0 vote, if I am not mistaken, not that long ago—the last time it was considered. So these are matters which should move along, and we should be able to do it in a fairly straightforward way. I would hope we can show some bipartisanship when it comes to our men and women in uniform and approve the Department of Defense appropriations bill, which does not contain anything controversial beyond what I have just described. We can then get back to the health care reform bill. I think it is important that at some point we bring this to a vote, to find if we indeed have the 60 votes for health care reform. I sincerely hope we do.

I will close by saying this health care reform bill has its critics, but it also has several features which can't be denied.

The first of those features that have been verified by the Congressional Budget Office: This bill does not add to the deficit of the United States; it reduces the deficit by \$130 billion over 10 years and \$650 billion, moreover, the following 10 years.

We have also received reports from the Congressional Budget Office that the result of this bill will be a decline in the increase in the cost of health insurance premiums—something we desperately need.

It is a bill that will also extend health insurance coverage to 30 million more Americans who do not have it today—50 million uninsured Americans; 30 million of them, 60 percent of them, will have the protection of health insurance coverage. Ninety percent of Americans will have health insurance coverage—the highest percentage in the history of the United States of America—as a result of this bill.

This bill addresses directly the issue of whether health insurance companies can continue to deny coverage when people need it the most. We know stories from our own life experience and our families' and people who write to our offices, that people in the most need of health insurance protection are often turned down by the companies. They pore through the applications and say: You failed to disclose a preexisting condition. They say: Your amount of coverage has lapsed; your child is too old to be covered by your family plan—the list goes on and on.

Finally, some of the most egregious abuses by health insurance companies are addressed in this bill, and consumers across America are given the legal power to fight back and the legal power to be protected. That is why this bill is important and why it is worth passing, all the criticism notwithstanding.

I might also say that it is a bill that is critically important for the future of Medicare. If we do nothing, Medicare is going broke in 7 or 8 years, but we are told this bill will extend the life of Medicare up to 10 more years. That is good news, to put Medicare on sound financial footing, so our seniors like that.

The majority leader of the Senate came to the floor 2 days ago to announce something else that will be part of the conference committee here. The so-called doughnut hole, that gap in coverage for prescription drugs under Medicare, is going to be filled so that seniors will no longer have that period of uncertainty where their bills have reached a level where they are disqualified from payment—the so-called doughnut hole. It will be filled. It will give them peace of mind that if they have expensive pharmaceuticals, they

will have no interruption in coverage in the future when it comes to those pharmaceuticals.

For seniors, these are two major things—to put Medicare on sound financial footing and to fill the doughnut hole under the Medicare prescription part of the program.

It also is going to give seniors for the first time access to the kind of preventive care—regular checkups—they need for peace of mind and so doctors and professionals can catch problems before they get worse.

This bill is a positive bill, a positive step forward.

Yesterday, we had a chance as a Senate Democratic caucus to meet with President Obama. We went to the White House, the Executive Office Building, and the President talked to us about what this bill means. He reminded us that seven Presidents have tried to do this and failed. He told us when he started this trek that he wanted to be the last President to deal with health care reform because he wanted to get it done. I feel the same way. I think the American people feel the same way.

I am sure there is confusion. There have been a lot of misstatements made about death panels and things that really have no basis in fact. But people should be confident that when the AARP, the American Association of Retired Persons, stands up and says this is a good bill for the seniors in America under Medicare and Social Security and for their families; when medical professionals, doctors and medical professionals, stand up and say this is a good bill, that we have the kind of support we need to say to the American people that this is an important step forward in health care protection in America.

It is time for us to make history and pass this bill. Let's do it and do it in time for Members to enjoy Christmas with their families.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DURBIN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

MORNING BUSINESS

Mr. DURBIN. I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permit to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

HONORING OUR ARMED FORCES

Mrs. BOXER. Madam President, I rise today to pay tribute to three

young Americans who have been killed in Iraq since July 28. This brings to 882 the number of servicemembers either from California or based in California that have been killed while serving our country in Iraq. This represents 20 percent of all U.S. deaths in Iraq.

SPC Lukas C. Hopper, 20, of Merced, CA, died October 30, southeast of Karadah, Iraq, of injuries sustained during a vehicle roll-over. Private First Class Hopper was assigned to the 1st Battalion, 505th Parachute Infantry Regiment, 3rd Brigade Combat Team, 82nd Airborne Division, Fort Bragg, NC.

SPC Christopher M. Cooper, 28, of Oceanside, CA, died October 30 in Babil province, Iraq, of injuries sustained from a noncombat related incident. Specialist Cooper was assigned to the 2nd Battalion, 28th Infantry, 172nd Infantry Brigade, Schweinfurt, Germany.

PVT Jhanner A. Tello, 29, of Los Angeles, CA, died December 10 in Baghdad, Iraq, of injuries sustained from a noncombat related incident. Private Tello was assigned to the 3rd Aviation Support Battalion, 227th Aviation Regiment, 1st Air Cavalry Brigade, 1st Cavalry Division, Fort Hood, TX.

I would also like to pay tribute to the 27 soldiers from California or based in California who have died while serving our country in Operation Enduring Freedom since July 28.

SPC Matthew K.S. Swanson, 20, of Lake Forest, CA, died August 8 at the National Naval Medical Center in Bethesda, MD, of injuries sustained during a vehicle roll-over July 19 in Logar province, Afghanistan. Specialist Swanson was assigned to the 3rd Brigade Special Troops Battalion, 3rd Brigade Combat Team, 10th Mountain Division, Light Infantry, Fort Drum, NY.

LCpl Javier Olvera, 20, of Palmdale, CA, died August 8 while supporting combat operations in Helmand province, Afghanistan. Lance Corporal Olvera was assigned to 2nd Battalion, 8th Marine Regiment, 2nd Marine Division, II Marine Expeditionary Force, Camp Lejeune, NC.

PFC Brian M. Wolverton, 21, of Oak Park, CA, died August 20 in Kunar province, Afghanistan, of wounds suffered when insurgents attacked his unit with indirect fire. Private First Class Wolverton was assigned to the 1st Battalion, 32nd Infantry Regiment, 3rd Brigade Combat Team, 10th Mountain Division, Light Infantry, Fort Drum, NY.

LCpl Donald J. Hogan, 20, of San Clemente, CA, died August 26 while supporting combat operations in Helmand province, Afghanistan. Lance Corporal Hogan was assigned to 1st Battalion, 5th Marine Regiment, 1st Marine Division, I Marine Expeditionary Force, Camp Pendleton, CA.

CPT John L. Hallett III, 30, of Concord, CA, died August 25 in southern Afghanistan, of wounds suffered when

enemy forces attacked his vehicle with an improvised explosive device. Captain Hallett was assigned to the 1st Battalion, 17th Infantry Regiment, 5th Stryker Brigade, 2nd Infantry Division, Fort Lewis, WA.

SPC Tyler R. Walshe, 21, of Shasta, CA, died August 31 in southern Afghanistan, of wounds suffered when enemy forces attacked his unit with an improvised explosive device. Specialist Walshe was assigned to the 1st Battalion, 17th Infantry Regiment, 5th Stryker Brigade, 2nd Infantry Division, Fort Lewis, WA.

SPC Jonathan D. Welch, 19, of Yorba Linda, CA, died August 31 in Shuyene Sufia, Afghanistan, of wounds suffered when enemy forces attacked his unit with an improvised explosive device. Specialist Welch was assigned to the 1st Battalion, 17th Infantry Regiment, 5th Stryker Brigade, 2nd Infantry Division, Fort Lewis, WA.

PO3 James R. Layton, 22, of Riverbank, CA, died September 8 in Kunar province, Afghanistan, while supporting combat operations. Petty Officer 3rd Class Layton was assigned to an embedded training team with Combined Security Transition Command in Afghanistan.

Capt Joshua S. Meadows, 30, of Bastrop, TX, died September 5 while supporting combat operations in Farah province, Afghanistan. Captain Meadows was assigned to 1st Marine Special Operations Battalion, Marine Corps Forces Special Operations Command, Camp Pendleton, CA.

TSgt James R. Hornbarger, 33, of Castle Rock, WA, died September 12 as a result of a non-hostile incident in the Mediterranean. Technical Sergeant Hornbarger was assigned to the 9th Aircraft Maintenance Squadron, Beale Air Force Base, CA.

SGT Joshua M. Hardt, 24, of Applegate, CA, died October 3 in Kamdesh, Afghanistan, of wounds suffered when enemy forces attacked his contingency outpost with small arms, rocket-propelled grenade and indirect fires. Sergeant Hardt was assigned to the 3rd Squadron, 61st Cavalry Regiment, 4th Brigade Combat Team, 4th Infantry Division, Fort Carson, CO.

SSgt Aaron J. Taylor, 27, of Bovey, MN, died October 9 while supporting combat operations in Helmand province, Afghanistan. Staff Sergeant Taylor was assigned to Marine Wing Support Squadron 372, Marine Wing Support Group 37, 3rd Marine Aircraft Wing, I Marine Expeditionary Force, Camp Pendleton, CA.

LCpl Alfonso Ochoa, Jr., 20, of Armona, CA, died October 10 while supporting combat operations in Farah province, Afghanistan. Lance Corporal Ochoa was assigned to 2nd Battalion, 3rd Marine Regiment, 3rd Marine Division, III Marine Expeditionary Force, Marine Corps Base Hawaii, Kaneohe Bay.

SPC Jesus O. Flores, Jr., 28, of La Mirada, CA, died October 15 in Kandahar province, Afghanistan, of wounds suffered when enemy forces attacked his vehicle with an improvised explosive device. Specialist Flores was assigned to the 569th Mobility Augmentation Company, 4th Engineer Battalion, Fort Carson, CO.

SPC Michael A. Dahl, Jr., 23, of Moreno Valley, CA, died October 17 in Argahndab, Afghanistan, of wounds suffered when enemy forces attacked his vehicle with an improvised explosive device. Specialist Dahl was assigned to 1st Battalion, 17th Infantry Regiment, 5th Stryker Brigade, 2nd Infantry Division, Fort Lewis, WA.

LCpl David R. Baker, 22, of Painesville, OH, died October 20 while supporting combat operations in Helmand province, Afghanistan. Lance Corporal Baker was assigned to 1st Battalion, 5th Marine Regiment, 1st Marine Division, I Marine Expeditionary Force, Camp Pendleton, CA.

SPC Kyle A. Coumas, 22, of Lockeford, CA, died October 21 in Kandahar province, Afghanistan, of wounds suffered when enemy forces attacked his vehicle with an improvised explosive device. Specialist Coumas was assigned to 1st Battalion, 17th Infantry Regiment, 5th Stryker Brigade Combat Team, 2nd Infantry Division, Fort Lewis, WA.

Capt Kyle R. Van De Giesen, 29, of North Attleboro, MA, died October 26 while supporting combat operations in Helmand province, Afghanistan. Captain Van De Giesen was assigned to Marine Light Attack Helicopter Squadron 169, Marine Aircraft Group 39, 3rd Marine Aircraft Wing, I Marine Expeditionary Force, Camp Pendleton, CA.

Capt David S. Mitchell, 30, of Loveland, OH, died October 26 while supporting combat operations in Helmand province, Afghanistan. Captain Mitchell was assigned to Marine Light Attack Helicopter Squadron 367, Marine Aircraft Group 39, 3rd Marine Aircraft Wing, I Marine Expeditionary Force, Camp Pendleton, CA.

Capt Eric A. Jones, 29, of Westchester, NY, died October 26 while supporting combat operations in Helmand province, Afghanistan. Captain Jones was assigned to Marine Light Attack Helicopter Squadron 169, Marine Aircraft Group 39, 3rd Marine Aircraft Wing, I Marine Expeditionary Force, Camp Pendleton, CA.

Cpl Gregory M.W. Fleury, 23, of Anchorage, AK, died October 26 while supporting combat operations in Helmand province, Afghanistan. Corporal Fleury was assigned to Marine Light Attack Helicopter Squadron 169, Marine Aircraft Group 39, 3rd Marine Aircraft Wing, I Marine Expeditionary Force, Camp Pendleton, CA.

SGT Eduviges G. Wolf, 24, of Hawthorne, CA, died October 25 in Kunar province, Afghanistan, of wounds suf-

fered when insurgents attacked her vehicle with a rocket-propelled grenade. Sergeant Wolf was assigned to the 704th Brigade Support Battalion, 4th Brigade Combat Team, 4th Infantry Division, Fort Carson, CO.

LCpl Cody R. Stanley, 21, of Rosanky, TX, died October 28 while supporting combat operations in Helmand province, Afghanistan. Lance Corporal Stanley was assigned to 3rd Battalion, 4th Marine Regiment, 1st Marine Division, I Marine Expeditionary Force, Marine Corps Air Ground Combat Center, Twentynine Palms, CA.

SFC David E. Metzger, 32, of San Diego, CA, died October 26 of wounds suffered when the MH-47 helicopter he was aboard crashed in Darreh-ye Bum, Afghanistan. Sergeant First Class Metzger was assigned to the 3rd Battalion, 7th Special Forces Group, Airborne, Fort Bragg, NC.

Sgt Charles I. Cartwright, 26, of Union Bridge, MD, died November 7 while supporting combat operations in Farah province, Afghanistan. Sergeant Cartwright was assigned to 1st Marine Special Operations Battalion, U.S. Marine Corps Forces Special Operations Command, Camp Pendleton, CA.

LCpl Justin J. Swanson, 21, of Anaheim, CA, died November 10 while supporting combat operations in Helmand province, Afghanistan. Lance Corporal Swanson was assigned to 1st Battalion, 5th Marine Regiment, 1st Marine Division, I Marine Expeditionary Force, Camp Pendleton, CA.

PFC Marcus A. Tynes, 19, of Moreno Valley, CA, died November 21 in Kandahar province, Afghanistan, of wounds sustained when enemy forces attacked his vehicle with an improvised explosive device. Private First Class Tynes was assigned to the 2nd Battalion, 508th Parachute Infantry Regiment, 4th Brigade Combat Team, 82nd Airborne Division, Fort Bragg, NC.

COMMITTEE ON AGRICULTURE, NUTRITION AND FORESTRY SUB- COMMITTEE ASSIGNMENTS

Mrs. LINCOLN, Madam President, the Committee on Agriculture, Nutrition and Forestry has amended and adopted subcommittees for the 111th Congress. On behalf of myself and Senator CHAMBLISS, I ask unanimous consent that a copy of the subcommittees be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

UNITED STATES SENATE COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY 111th Congress

SUBCOMMITTEE ASSIGNMENTS

Subcommittee on Rural Revitalization, Conservation, Forestry and Credit: Rural economic revitalization and quality of life; rural job and business growth; rural elec-

trification, telecommunications and utilities; conservation, protection and stewardship of natural resources; state, local and private forests and general forestry; agricultural and rural credit.

Sen. Stabenow, Chair; Sen. Leahy; Sen. Harkin; Sen. Nelson; Sen. Casey; Sen. Bennet; Sen. Cornyn, Ranking; Sen. Cochran; Sen. McConnell; Sen. Grassley; and Sen. Thune.

Subcommittee on Energy, Science and Technology: Renewable energy production and energy efficiency improvement on farms and ranches and in rural communities; food and agricultural research, education, economics and extension; innovation in the use of agricultural commodities and materials.

Sen. Bennet, Chair; Sen. Conrad; Sen. Nelson; Sen. Brown; Sen. Klobuchar; Sen. Stabenow; Sen. Gillibrand; Sen. Thune, Ranking; Sen. Lugar; Sen. Roberts; Sen. Johanns; Sen. Grassley; and Sen. Cornyn.

Subcommittee on Hunger, Nutrition, and Family Farms: Domestic and international nutrition and food assistance and hunger prevention; school and child nutrition programs; local and healthy food initiatives; futures, options and derivatives; pesticides; and general legislation.

Sen. Brown, Chair; Sen. Leahy; Sen. Harkin; Sen. Baucus; Sen. Stabenow; Sen. Casey; Sen. Klobuchar; Sen. Bennet; Sen. Gillibrand; Sen. Lugar, Ranking; Sen. Cochran; Sen. McConnell; and Sen. Cornyn.

Subcommittee on Production, Income Protection and Price Support: Production of agricultural crops, commodities and products; farm and ranch income protection and assistance; commodity price support programs; insurance and risk protection; fresh water food production.

Sen. Casey, Chair; Sen. Leahy; Sen. Harkin; Sen. Conrad; Sen. Baucus; Sen. Brown; Sen. Roberts, Ranking; Sen. Cochran; Sen. Johanns; Sen. Grassley; and Sen. Thune.

Subcommittee on Domestic and Foreign Marketing, Inspection, and Plant and Animal Health: Agricultural trade; foreign market development; domestic marketing and product promotion; marketing orders and regulation of agricultural markets and animal welfare; inspection and certification of plants, animals and products; plant and animal diseases and health protection.

Sen. Gillibrand, Chair; Sen. Conrad; Sen. Baucus; Sen. Nelson; Sen. Klobuchar; Sen. Johanns, Ranking; Sen. Lugar; Sen. McConnell; and Sen. Roberts.

*Senator Lincoln and Senator Chambliss serve as ex officio members of all subcommittees.

ADDITIONAL STATEMENTS

TRIBUTE TO CANADIAN SENATOR JERAHMIEL "JERRY" GRAFSTEIN

• Mr. CARDIN. Madam President, I wish to draw the attention of my colleagues to the retirement of Jerahmiel S. Grafstein from the Canadian Senate.

As a member and now as Chairman of the Helsinki Commission, I have had the privilege to know and work with Jerry Grafstein over the years through participation in the Parliamentary Assembly of the Organization for Security and Cooperation in Europe—the OSCE. I know that my colleague from Ohio, Senator VOINOVICH, also knows Jerry well, having just worked with

him on a resolution at this year's Annual Session of the Assembly in Vilnius, Lithuania, on combating anti-Semitism. I suspect that many of my other Senate colleagues have also worked with him over the years, as have many of our colleagues in the House of Representatives.

Anybody who has met Senator Grafstein immediately recognizes him as a man of tremendous energy, deep commitment and brilliant mind. Commenting on Jerry's career, one of his Canadian Senate colleagues noted the daunting task of paying tribute "to a force of nature disguised as a person." A successful lawyer, businessman and member of the Liberal Party, he was summoned to the Canadian Senate in 1984. Jerry Grafstein's accomplishments over the next 25 years of public service are much more than I can relay here.

I do, however, want to highlight Jerry's prominent work with the 56 countries, 300 member OSCE Parliamentary Assembly. Serving for 6 years as the Assembly's treasurer and then, with me since 2007, as one of nine Vice Presidents, Jerry has understood the potential of this multilateral parliamentary forum to promote human rights, democracy and tolerance. Such a vital forum, however, does not just magically appear for the world's benefit. Someone has to take the time to make it function by participating as an officer, attending countless organizational meetings and, for us and our Canadian neighbors, traveling frequently across the Atlantic to do so. Jerry was one who rose to the challenge and then some.

Even as he helped on organizational matters, Jerry Grafstein found more time than most others to focus on substance. First and foremost, he has helped to lead the charge against rising anti-Semitism across Europe and around the world. Diplomacy has a tendency to soften the criticism and downplay the negative, often until it is too late, but Jerry has helped to ensure that the OSCE did not shy away from dealing directly with this and other manifestations of hate and prejudice that dangerously confront far too many societies. Today, thanks to the vigilance of Jerry Grafstein and others, efforts to promote greater tolerance are now a solid, ongoing and vital aspect of the OSCE's work.

This distinguished Senator from Canada also found time to participate and help lead OSCE PA missions observing elections and referenda in places like Russia, Ukraine, Georgia and Montenegro. By being an international observer, he became a witness to history and, in my view, helped history forward and make the world a more democratic place.

In all his public endeavors, Jerry Grafstein has been a close friend of the United States of America. He has

helped over the years to develop the bilateral dialogue between the U.S. Congress and the Canadian Parliament. He has come here to Washington on many occasions, including as a participant in Helsinki Commission events. He has always made clear that he is Canadian and proud of the country he represents, but that has never kept him from developing areas of common interest and seeking points of agreement even on some issues where our national views may otherwise diverge.

Jerry Grafstein has been and will remain a close personal friend as well, always concerned, always engaging, never pretentious. I wish him and his wife Carole the very best. Although he deserves some time off, I am confident that he will remain prominent in the life of the vibrant city of Toronto.

In noting the many accomplishments of Jerahmiel Grafstein and thanking him for his commitment to public service, I respectfully borrow the Canadian Senate's tradition and join his colleagues in saying: "Hear, Hear!" On a personal level, I believe I speak for numerous colleagues of my own in saying that Jerry will be missed, and always welcome to come and visit.●

TRIBUTE TO TOMÁS VILLANUEVA

● Mrs. MURRAY. Madam President, today I would like to take a moment to recognize a very special advocate, activist, and champion for equal rights in my home State of Washington on his birthday.

Tomás Villanueva has been a farmworkers, warehouse packers, and other economically disadvantaged laborers advocate since the early 1960s. Tomás was one of the first people involved in the United Farmworkers Union in my home State and has fought for years to ensure that workers are treated with dignity, respect, and under the protections of the law.

Tomás' involvement with the human rights movement began in the early 1960s when he was inspired by UFW leader Cesar Chavez. And since that time, Tomás has fought for numerous causes and people while maintaining his reputation as a kind, generous, compassionate and humble leader.

Tomás has also been a close friend and partner of mine for a very long time. He has helped my staff and I recognize the depth of the difficult conditions that farmworkers face, and has been a consistent voice in fighting to improve conditions through the legislative process.

Farmworker housing is a moral issue, an economic issue, and a family issue. Too many workers and their families face very difficult living conditions. Some live in their cars. Others share run-down, overcrowded rooms with other families. These are not the kinds of living conditions we can tolerate in the United States in the 21st

century. They are certainly not suitable for the people who help put food on our tables and who keep our State's economy strong. Tomás knows that we can and must do better.

Tomás Villanueva was 14 when his family emigrated from Mexico. After following the crops for three years, the family settled in Toppenish, Washington in 1958. Tomás spent the next several years working various jobs before earning a high school GED and enrolling in Yakima Valley College.

Hearing about Cesar Chavez's United Farm Workers movement, Tomás travelled to California in 1967 to learn about organizing. Returning to the Yakima Valley, he helped found the United Farm Worker Cooperative, one of the very first Chicano organizations in the State of Washington.

From 1967 to 1974, Tomás devoted himself to farm worker organizing and Chicano movement activism. Out of these efforts came the Yakima Valley Farmworkers Clinic, the United Farm Workers Service Center, a wave of hop harvest strikes in 1969, 1970, 1971, and a successful grape boycott.

In 1974, Tomás started a construction company with his father and brothers, but in the 1980s he was back in the union movement. In 1986 he became the first president of the newly formed United Farm Workers of Washington State. Today he lives in Toppenish and remains active in State and local politics.

Tomás Villanueva continues to be a valued friend, hard-working partner, and widely-respected leader in his community. I am so pleased to recognize his lifetime of achievements on this special day.●

RECOGNIZING SUTHERLAND WESTON MARKETING COMMUNICATIONS

● Ms. SNOWE. Madam President, as we approach the holiday season, we are frequently reminded of the generosity and warmth that Americans demonstrate year in and year out at this most festive time. In particular, we often hear stories of employees at local businesses who graciously donate their time and efforts to help the less fortunate. This week I wish to recognize the employees of one such company who consistently work to improve the lot of everyone in their community.

Sutherland Weston Marketing Communications of Bangor is a cutting-edge firm that specializes in a host of marketing topics, including public relations, media, and branding. Specifically, the company helps its customers design memorable flyers and mailers, effective television advertisements, and state-of-the-art Web sites, and teaches them the increased value of employing popular social media, such as Facebook and Twitter, in their marketing decisions. Since its inception in

2005, Sutherland Weston has assisted dozens of clients throughout Maine seeking ways to enhance their image and broaden their customer base. Among them are local small businesses such as Maine Wood Concepts of Guilford and Raye's Mustard Mill of Eastport; organizations like the Bangor Symphony Orchestra; and institutions such as the University of Maine.

Furthermore, members of the Sutherland Weston team participate regularly in conferences and seminars to better educate the public on how to maximize marketing strategies. One such event is the Social Media 101 seminar, held this past March, where the firm's owners—Elizabeth Sutherland and Cary Weston—presented a workshop designed at increasing the professional use of sites such as Facebook, Twitter, and LinkedIn.

The nine employees of Sutherland Weston are also active members of the greater Bangor community, contributing to various philanthropic endeavors on a regular basis. This past June, the company took part in the 25th Trek Across Maine in support of the American Lung Association. The "Green Marketeers," including Sutherland Weston employees, spouses, and friends, took to their bicycles for the 180-mile trip from Bethel's Sunday River mountain to the coastal town of Belfast, raising nearly \$8,000 in pledges along the way.

Additionally, in recognition of the true meaning of Christmas, the company's employees donated time and talent this year to creating a new, user-friendly Web site called Christmas is for Kids, a critical program that facilitates donations of holiday gifts for underprivileged children across Maine. The Web site allows users to find the name and hometown of a child, as well as the specific gift he or she is requesting, adding a personal touch to the experience. Donors indicate which gift they are willing to purchase so that it can be removed from the listing, doing their best to ensure that no child is left out. Several sponsors have suggested that because of Sutherland Weston's noteworthy Web site, 2009 may be the most successful season in the program's 27-year history.

As we look forward to celebrating the upcoming holidays with our loved ones, let us take a moment to remember those experiencing sorrow during this joyous season. And let us also recognize those who are working in every community across the country to make someone's day brighter through deeds great and small. I thank Elizabeth Sutherland, Cary Weston, and everyone at Sutherland Weston Marketing Communications for their selfless gift this holiday season, and wish them continued success in their future endeavors. ●

MESSAGES FROM THE HOUSE

At 11:49 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 1084. An act to require the Federal Communications Commission to prescribe a standard to preclude commercials from being broadcast at louder volumes than the program material they accompany.

H.R. 1517. An act to allow certain U.S. Customs and Border Protection employees who serve under an overseas limited appointment for at least 2 years, and whose service is rated fully successful or higher throughout that time, to be converted to a permanent appointment in the competitive service.

H.R. 2194. An act to amend the Iran Sanctions Act of 1996 to enhance United States diplomatic efforts with respect to Iran by expanding economic sanctions against Iran.

H.R. 3978. An act to amend the Implementing Recommendations of the 9/11 Commission Act of 2007 to authorize the Secretary of Homeland Security to accept and use gifts for otherwise authorized activities of the Center for Domestic Preparedness that are related to preparedness for and response to terrorism, and for other purposes.

The message also announced that the House has passed the following bill, without amendment:

S. 1472. An act to establish a section within the Criminal Division of the Department of Justice to enforce human rights laws, to make technical and conforming amendments to criminal and immigration laws pertaining to human rights violations, and for other purposes.

The message further announced that the House has agreed to the following concurrent resolution:

H. Con. Res. 223. Concurrent resolution providing for the sine die adjournment of the first session of the One Hundred Eleventh Congress.

At 2:10 p.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House agreed to the amendment of the Senate to the bill (H.R. 3326) making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; with an amendment, in which it requests the concurrence of the Senate.

At 5:29 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 1110. An act to amend title 18, United States Code, to prevent caller ID spoofing, and for other purposes.

H.R. 4314. An act to permit continued financing of Government operations.

H.J. Res. 64. Joint resolution making further continuing appropriations for fiscal year 2010, and for other purposes.

The message also announced that the House has agreed to the following concurrent resolution, in which it requests the concurrence of the Senate:

H. Con. Res. 160. Concurrent resolution recognizing the contributions of the American Kennel Club.

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 1084. An act to require the Federal Communications Commission to prescribe a standard to preclude commercials from being broadcast at louder volumes than the program material they accompany; to the Committee on Commerce, Science, and Transportation.

H.R. 1110. An act to amend title 18, United States Code, to prevent caller ID spoofing, and for other purposes; to the Committee on the Judiciary.

H.R. 1517. An act to allow certain U.S. Customs and Border Protection employees who serve under an overseas limited appointment for at least 2 years, and whose service is rated fully successful or higher throughout that time, to be converted to a permanent appointment in the competitive service; to the Committee on Homeland Security and Governmental Affairs.

H.R. 2194. An act to amend the Iran Sanctions Act of 1996 to enhance United States diplomatic efforts with respect to Iran by expanding economic sanctions against Iran; to the Committee on Banking, Housing, and Urban Affairs.

H.R. 3978. An act to amend the Implementing Recommendations of the 9/11 Commission Act of 2007 to authorize the Secretary of Homeland Security to accept and use gifts for otherwise authorized activities of the Center for Domestic Preparedness that are related to preparedness for and response to terrorism, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

The following concurrent resolution was read, and referred as indicated:

H. Con. Res. 160. Concurrent resolution honoring the American Kennel Club; to the Committee on the Judiciary.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC-4057. A communication from the Acting Administrator, Risk Management Agency, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "Common Crop Insurance Regulations; Basic Provision" ((7 CFR Part 457 (RIN0563-AC23))) received in the Office of the President of the Senate on December 8, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4058. A communication from the Acting Farm Bill Coordinator, Commodity Credit Corporation, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "Agricultural Management Assistance Program" (RIN0578-AA50) received in the Office of the President of the Senate on December 14, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4059. A communication from the Acting Farm Bill Coordinator, Commodity Credit Corporation, Department of Agriculture,

transmitting, pursuant to law, the report of a rule entitled "Regional Equity" (RIN0578-AA44) received in the Office of the President of the Senate on December 14, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4060. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "Potato Research and Promotion Plan; Assessment Increase" (Docket No. AMS-FV-09-0024; FV-09-706FR) received in the Office of the President of the Senate on December 14, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4061. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "Vegetable Import Regulations; Modification of Potato Import Regulations" (Docket No. AMS-FV-08-0018; FV08-980-1 FR) received in the Office of the President of the Senate on December 14, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4062. A communication from the Regulatory Officer, Foreign Agricultural Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "McGovern Dole International Food for Education and Child Nutrition Program and Food for Progress Program" (RIN0551-AA78) received in the Office of the President of the Senate on December 9, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4063. A communication from the Regulatory Officer, Foreign Agricultural Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "Adjustment of Appendices to the Dairy Tariff-Rate Import Quota Licensing Regulation for the 2009 Tariff-Rate Quota Year" (7 CFR Part 6) received in the Office of the President of the Senate on December 9, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4064. A communication from the Regulatory Officer, Foreign Agricultural Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "Technical Assistance for Specialty Crops" (RIN0551-AA71) received in the Office of the President of the Senate on December 9, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4065. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Section 807(e)(4) Exception for Section 338 Regulations" (Notice No. 2010-1) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC-4066. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Remedial Amendment Period and Reliance for Section 403(b) Plans" (Announcement 2009-89) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC-4067. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Interim Guidance on Interactions with Foreign Tax Officials" (LMSB-4-0409-013) received in the Office of

the President of the Senate on December 10, 2009; to the Committee on Finance.

EC-4068. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Revenue Ruling: 94X Examples" (Rev. Rul. 2009-39) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC-4069. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Production Tax Credits for Refined Coal" (Notice No. 2009-90) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC-4070. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "2009 Base Period T-Bill Rate" (Rev. Rul. 2009-36) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC-4071. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Update of Weighted Average Interest Rates, Yield Curves, and Segment Rates" (Notice 2009-96) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC-4072. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Salvage Discount Factors for 2009" (Rev. Proc. 2009-56) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC-4073. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "2010 Standard Mileage Rates" (Rev. Proc. 2009-54) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC-4074. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Extension of Attributed Tip Income Program (ATIP)" (Rev. Proc. 2009-53) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC-4075. A communication from the Chairman of the Securities and Exchange Commission, transmitting, pursuant to law, a report entitled "2008 Annual Report of the Securities Investor Protection Corporation"; to the Committee on Banking, Housing, and Urban Affairs.

EC-4076. A communication from the Acting Assistant Secretary for Export Administration, Bureau of Industry and Security, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled "Implementation of the Wassenaar Arrangement's (WA) Task Force on Editorial Issues (TFEI) Revisions" (RIN0694-AE71) received in the Office of the President of the Senate on December 4, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-4077. A communication from the Assistant to the Board of Governors, Federal Reserve System, transmitting, pursuant to law, the report of a rule entitled "Risk-Based Capital Guidelines; Capital Adequacy Guidelines; Capital Maintenance; Capital—Residential Mortgage Loans Modified Pursuant to the Home Affordable Mortgage Program" (Docket No. R-1361) received in the Office of the President of the Senate on December 4, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-4078. A communication from the Assistant to the Board of Governors, Federal Reserve System, transmitting, pursuant to law, the report of a rule entitled "Risk-Based Capital Guidelines; Capital Adequacy Guidelines; Capital Maintenance; Capital—Residential Mortgage Loans Modified Pursuant to the Home Affordable Mortgage Program" (RIN1550-AC34) received in the Office of the President of the Senate on December 9, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-4079. A communication from the Legal Information Assistant, Office of Thrift Supervision, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Final Model Privacy Form Under the Gramm-Leach-Bliley Act" (RIN1550-AC12) received in the Office of the President of the Senate on December 9, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-4080. A communication from the Deputy to the Chairman for External Affairs, Federal Deposit Insurance Corporation, transmitting, pursuant to law, the report of a rule entitled "Interest on Deposits" (RIN3064-AD46) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-4081. A communication from the Deputy to the Chairman for External Affairs, Federal Deposit Insurance Corporation, transmitting, pursuant to law, the report of a rule entitled "Risk-Based Capital Guidelines; Capital Adequacy Guidelines; Capital Maintenance; Capital—Residential Mortgage Loans Modified Pursuant to the Home Affordable Mortgage Program" (RIN3064-AD42) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-4082. A communication from the Director, Minerals Management Service, Department of the Interior, transmitting, pursuant to law, a report entitled "Report to Congress: Minerals Management Service Royalty in Kind Operation Program" for Fiscal Year 2008; to the Committee on Energy and Natural Resources.

EC-4083. A communication from the Assistant General Counsel for Legislation, Regulation and Energy Efficiency, Department of Energy, transmitting, pursuant to law, the report of a rule entitled "Loan Guarantees for Projects That Employ Innovative Technologies" (RIN1901-AB27) received in the Office of the President of the Senate on December 8, 2009; to the Committee on Energy and Natural Resources.

EC-4084. A communication from the Division Chief of Regulatory Affairs, Bureau of Land Management, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled "Oil and Gas Leasing; National Petroleum Reserve, Alaska" (RIN1004-AD87) received in the Office of the President of the Senate on December 9, 2009; to the Committee on Energy and Natural Resources.

EC-4085. A communication from the General Counsel, Federal Energy Regulatory Commission, transmitting, pursuant to law, the report of a rule entitled "Mandatory Reliability Standards for the Calculation of Available Transfer Capability, Capacity Benefit Margins, Transmission Reliability Margins, Total Transfer Capability, and Existing Transmission Commitments and Mandatory Reliability Standards for the Bulk-Power System" (Docket Nos. RM08-19-000, RM08-19-001, RM09-5-000, RM06-16-005) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Energy and Natural Resources.

EC-4086. A communication from the Director of Congressional Affairs, Office of Administration, Nuclear Regulatory Commission, transmitting, pursuant to law, the report of a rule entitled "Administrative Changes: Clarification of the Location of Guidance for Electronic Submission and other Miscellaneous Corrections" (RIN3150-AI73) received in the Office of the President of the Senate on December 9, 2009; to the Committee on Environment and Public Works.

EC-4087. A communication from the Deputy Assistant Administrator, Bureau for Legislative and Public Affairs, U.S. Agency for International Development, transmitting, pursuant to law, the Agency's response to the GAO report entitled "Rebuilding IRAQ: Improved Management Controls and Iraqi Commitment Needed for Key State and USAID Capacity-Building Programs"; to the Committee on Foreign Relations.

EC-4088. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to law, the report of a rule entitled "Visas: Documentation of Immigrants and Non-immigrants-Visa Classification Symbols" received in the Office of the President of the Senate on December 9, 2009; to the Committee on Foreign Relations.

EC-4089. A communication from the Deputy Director of Regulations and Policy Management Staff, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled "Organ-Specific Warnings; Antipyretic, and Antirheumatic Drug Products for Over-the-Counter Human Use; Final Monograph; Technical Amendment" (Docket No. FDA-1977-N-0013) received in the Office of the President of the Senate on December 9, 2009; to the Committee on Health, Education, Labor, and Pensions.

EC-4090. A communication from the Assistant General Counsel for Regulatory Services, Office of Elementary and Secondary Education, Department of Education, transmitting, pursuant to law, the report of a rule entitled "State Fiscal Stabilization Fund Program" (RIN1810-AB04) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Health, Education, Labor, and Pensions.

EC-4091. A communication from the Director of Regulations and Rulings, Alcohol and Tobacco Tax and Trade Bureau, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Establishment of the Calistoga Viticultural Area (2003R-496P)" (RIN1513-AA92) received in the Office of the President of the Senate on December 10, 2009; to the Committee on the Judiciary.

EC-4092. A communication from the Staff Director, United States Commission on Civil Rights, transmitting, pursuant to law, the report of the appointment of members to the Massachusetts Advisory Committee; to the Committee on the Judiciary.

EC-4093. A communication from the Principal Deputy Assistant Attorney General, Office of Legislative Affairs, Department of Justice, transmitting, pursuant to law, a report entitled "Report to the Nation 2009"; to the Committee on the Judiciary.

EC-4094. A communication from the National Executive Secretary, Navy Club of the United States of America, transmitting, pursuant to law, a report relative to the national financial statement of the organization and national staff and convention minutes for the year ending July 31, 2009; to the Committee on the Judiciary.

EC-4095. A communication from the Chairman of the National Transportation Safety Board, transmitting, pursuant to law, the report of a rule entitled "Notification and Reporting of Aircraft Accidents or Incidents and Overdue Aircraft, and Preservation of Aircraft Wreckage, Mail, Cargo, and Records" received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC-4096. A communication from the Deputy Chief Counsel of the Office of Regulations and Security Standards, Transportation Security Administration, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "False Statements Regarding Security Background Checks" (RIN1652-AA65) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC-4097. A communication from the Trial Attorney, Federal Railroad Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Adjustment of the Monetary Threshold for Reporting Rail Equipment Accidents/Incidents for Calendar Year 2010" (RIN2130-ZA02) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. INOUE, from the Committee on Appropriations:

Special Report entitled "Further Revised Allocation to Subcommittees of Budget Totals From the Concurrent Resolution, Fiscal Year 2010." (Rept. No. 111-109).

By Mrs. LINCOLN, from the Committee on Agriculture, Nutrition, and Forestry, without amendment:

H.R. 310. A bill to provide for the conveyance of approximately 140 acres of land in the Ouachita National Forest in Oklahoma to the Indian Nations Council, Inc., of the Boy Scouts of America, and for other purposes.

H.R. 511. A bill to authorize the Secretary of Agriculture to terminate certain easements held by the Secretary on land owned by the Village of Caseyville, Illinois, and to terminate associated contractual arrangements with the Village.

By Mrs. LINCOLN, from the Committee on Agriculture, Nutrition, and Forestry, without amendment and with a preamble:

S. Res. 374. A resolution recognizing the cooperative efforts of hunters, sportsmen's associations, meat processors, hunger relief organizations, and State wildlife, health, and food safety agencies to establish programs that provide game meat to feed the hungry.

By Mr. BINGAMAN, from the Committee on Energy and Natural Resources, without amendment:

S. 1672. A bill to reauthorize the National Oilheat Research Alliance Act of 2000.

By Mr. DORGAN, from the Committee on Indian Affairs, with amendments:

S. 1790. A bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of nominations were submitted:

By Mrs. LINCOLN for the Committee on Agriculture, Nutrition, and Forestry.

*Jill Long Thompson, of Indiana, to be a Member of the Farm Credit Administration Board, Farm Credit Administration, for a term expiring May 21, 2014.

By Mr. LIEBERMAN for the Committee on Homeland Security and Governmental Affairs.

*Elizabeth M. Harman, of Maryland, to be an Assistant Administrator of the Federal Emergency Management Agency, Department of Homeland Security.

*Grayling Grant Williams, of Maryland, to be Director of the Office of Counternarcotics Enforcement, Department of Homeland Security.

By Mr. AKAKA for the Committee on Veterans' Affairs.

*Robert A. Petzel, of Minnesota, to be Under Secretary for Health of the Department of Veterans Affairs.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Ms. LANDRIEU (for herself and Ms. KLOBUCHAR):

S. 2885. A bill to amend the Omnibus Crime Control and Safe Streets Act of 1968 to provide adequate benefits for public safety officers injured or killed in the line of duty, and for other purposes; to the Committee on the Judiciary.

By Ms. CANTWELL (for herself, Mr. MCCAIN, and Mr. FEINGOLD):

S. 2886. A bill to prohibit certain affiliations (between commercial banking and investment banking companies), and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

By Mrs. MURRAY:

S. 2887. A bill to amend title V of the Elementary and Secondary Education Act of 1965 to reduce class size through the use of highly qualified teachers, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. ROCKEFELLER (for himself, Mrs. HUTCHISON, Mr. LAUTENBERG, Mr. THUNE, and Mr. DORGAN):

S. 2889. A bill to reauthorize the Surface Transportation Board, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mr. FEINGOLD:

S. 2890. A bill to amend the Buy American Act to increase the requirement for American-made content, to tighten the waiver provisions, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

By Mr. REID (for himself, Mr. ENSIGN, Mrs. FEINSTEIN, and Mrs. BOXER):

S. 2891. A bill to further allocate and expand the availability of hydroelectric power generated at Hoover Dam, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. SHELBY (for himself and Mr. SESSIONS):

S. 2892. A bill to establish the Alabama Black Belt National Heritage Area, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. SCHUMER:

S. 2893. A bill to amend the Controlled Substances Import and Export Act to prevent the use of Indian reservations located on the United States borders to facilitate cross-border drug trafficking, and for other purposes; to the Committee on the Judiciary.

By Mrs. GILLIBRAND:

S. 2894. A bill to amend the Internal Revenue Code to provide for a refundable tax credit for heating fuels and to create a grant program for States to provide individuals with loans to weatherize their homes; to the Committee on Finance.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. INOUE (for himself, Mr. GREGG, Mr. LIEBERMAN, and Mr. DURBIN):

S. Res. 376. A resolution honoring the 60th anniversary of the establishment of diplomatic relations between the United States and the Hashemite Kingdom of Jordan, the 10th anniversary of the accession to the throne of His Majesty King Abdullah II Ibn Al Hussein, and for other purposes; considered and agreed to.

By Mr. MENENDEZ:

S. Con. Res. 48. A concurrent resolution recognizing the leadership and historical contributions of Dr. Hector Garcia to the Hispanic community and his remarkable efforts to combat racial and ethnic discrimination in the United States of America; to the Committee on the Judiciary.

ADDITIONAL COSPONSORS

S. 678

At the request of Mr. LEAHY, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of S. 678, a bill to reauthorize and improve the Juvenile Justice and Delinquency Prevention Act of 1974, and for other purposes.

S. 777

At the request of Mr. BROWN, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 777, a bill to promote industry growth and competitiveness and to improve worker training, retention, and advancement, and for other purposes.

S. 1055

At the request of Mrs. BOXER, the name of the Senator from South Da-

kota (Mr. JOHNSON) was added as a cosponsor of S. 1055, a bill to grant the congressional gold medal, collectively, to the 100th Infantry Battalion and the 442nd Regimental Combat Team, United States Army, in recognition of their dedicated service during World War II.

S. 1067

At the request of Mr. BROWNBACK, the name of the Senator from California (Mrs. FEINSTEIN) was withdrawn as a cosponsor of S. 1067, a bill to support stabilization and lasting peace in northern Uganda and areas affected by the Lord's Resistance Army through development of a regional strategy to support multilateral efforts to successfully protect civilians and eliminate the threat posed by the Lord's Resistance Army and to authorize funds for humanitarian relief and reconstruction, reconciliation, and transitional justice, and for other purposes.

S. 1204

At the request of Mrs. MURRAY, the name of the Senator from Alaska (Mr. BEGICH) was added as a cosponsor of S. 1204, a bill to amend the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 to require the provision of chiropractic care and services to veterans at all Department of Veterans Affairs medical centers, and for other purposes.

S. 1492

At the request of Mr. BENNET, his name was added as a cosponsor of S. 1492, a bill to amend the Public Health Service Act to fund breakthroughs in Alzheimer's disease research while providing more help to caregivers and increasing public education about prevention.

S. 1524

At the request of Mr. KERRY, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 1524, a bill to strengthen the capacity, transparency, and accountability of United States foreign assistance programs to effectively adapt and respond to new challenges of the 21st century, and for other purposes.

S. 1743

At the request of Mrs. LINCOLN, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 1743, a bill to amend the Internal Revenue Code of 1986 to expand the rehabilitation credit, and for other purposes.

S. 1809

At the request of Mr. WICKER, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 1809, a bill to amend the Clean Air Act to promote the certification of aftermarket conversion systems and thereby encourage the increased use of alternative fueled vehicles.

S. 1859

At the request of Mr. ROCKEFELLER, the name of the Senator from Ohio

(Mr. BROWN) was added as a cosponsor of S. 1859, a bill to reinstate Federal matching of State spending of child support incentive payments.

S. 2052

At the request of Mr. UDALL of Colorado, the names of the Senator from Louisiana (Ms. LANDRIEU) and the Senator from Idaho (Mr. RISCH) were added as cosponsors of S. 2052, a bill to amend the Energy Policy Act of 2005 to require the Secretary of Energy to carry out a research and development and demonstration program to reduce manufacturing and construction costs relating to nuclear reactors, and for other purposes.

S. 2129

At the request of Ms. COLLINS, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of S. 2129, a bill to authorize the Administrator of General Services to convey a parcel of real property in the District of Columbia to provide for the establishment of a National Women's History Museum.

S. 2847

At the request of Mr. WHITEHOUSE, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 2847, a bill to regulate the volume of audio on commercials.

S. 2852

At the request of Mr. BEGICH, the name of the Senator from Texas (Mrs. HUTCHISON) was added as a cosponsor of S. 2852, a bill to establish, within the National Oceanic and Atmospheric Administration, an integrated and comprehensive ocean, coastal, Great Lakes, and atmospheric research, prediction, and environmental information program to support renewable energy.

S. 2853

At the request of Mr. GREGG, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. 2853, a bill to establish a Bipartisan Task Force for Responsible Fiscal Action, to assure the long-term fiscal stability and economic security of the Federal Government of the United States, and to expand future prosperity growth for all Americans.

S. 2859

At the request of Mr. INOUE, the name of the Senator from Florida (Mr. LEMIEUX) was added as a cosponsor of S. 2859, a bill to reauthorize the Coral Reef Conservation Act of 2000, and for other purposes.

S. 2862

At the request of Ms. SNOWE, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. 2862, a bill to amend the Small Business Act to improve the Office of International Trade, and for other purposes.

S. 2869

At the request of Ms. LANDRIEU, the names of the Senator from Indiana (Mr. BAYH), the Senator from Georgia

(Mr. ISAKSON) and the Senator from California (Mrs. FEINSTEIN) were added as cosponsors of S. 2869, a bill to increase loan limits for small business concerns, to provide for low interest refinancing for small business concerns, and for other purposes.

S. 2871

At the request of Mr. INOUE, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 2871, a bill to make technical corrections to the Western and Central Pacific Fisheries Convention Implementation Act, and for other purposes.

S. RES. 374

At the request of Mrs. LINCOLN, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. Res. 374, a resolution recognizing the cooperative efforts of hunters, sportsmen's associations, meat processors, hunger relief organizations, and State wildlife, health, and food safety agencies to establish programs that provide game meat to feed the hungry.

AMENDMENT NO. 2790

At the request of Mr. CASEY, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of amendment No. 2790 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2866

At the request of Mr. SPECTER, the name of the Senator from Colorado (Mr. UDALL) was added as a cosponsor of amendment No. 2866 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2938

At the request of Mrs. GILLIBRAND, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of amendment No. 2938 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2976

At the request of Mr. CARDIN, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of amendment No. 2976 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2993

At the request of Mr. SCHUMER, the name of the Senator from Indiana (Mr.

BAYH) was added as a cosponsor of amendment No. 2993 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2997

At the request of Ms. KLOBUCHAR, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of amendment No. 2997 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3073

At the request of Mrs. FEINSTEIN, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of amendment No. 3073 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3085

At the request of Mrs. LINCOLN, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of amendment No. 3085 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3136

At the request of Mr. UDALL of New Mexico, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of amendment No. 3136 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3227

At the request of Mr. CARDIN, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of amendment No. 3227 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3228

At the request of Ms. LANDRIEU, the names of the Senator from New York (Mrs. GILLIBRAND) and the Senator from Pennsylvania (Mr. SPECTER) were added as cosponsors of amendment No. 3228 intended to be proposed to H.R.

3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3241

At the request of Mr. CARPER, the name of the Senator from New Hampshire (Mr. GREGG) was added as a cosponsor of amendment No. 3241 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Ms. CANTWELL (for herself, Mr. MCCAIN, and Mr. FEINGOLD):
S. 2886. A bill to prohibit certain affiliations (between commercial banking and investment banking companies), and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

Mr. MCCAIN. Mr. President, I am pleased to be joining my friend and colleague from Washington, Senator CANTWELL, to introduce the Banking Integrity Act of 2009. My reasons for joining this effort are simple—I want to ensure that we never stick the American taxpayer with another \$700 billion tab to bail out the financial industry. If big Wall Street institutions want to take part in risky transactions—fine. But we should not allow them to do so with federally insured deposits.

Paul Volcker, a top economist in the Obama administration and former Federal Reserve Chairman, wants the nation's banks to be prohibited from owning and trading risky securities, the very practice that got the biggest ones into deep trouble in 2008. The administration is saying no, it will not separate commercial banking from investment operations. Mr. Volcker argues that regulation by itself will not work. Sooner or later, the giants, in pursuit of profits, will get into trouble. The administration should accept this and shield commercial banking from Wall Street's wild ways. "The banks are there to serve the public," Mr. Volcker said, "and that is what they should concentrate on. These other activities create conflicts of interest. They create risks, and if you try to control the risks with supervision, that just creates friction and difficulties" and ultimately fails.

The bill we are introducing today precludes any member bank of the Federal Reserve System from being affiliated with any entity or organization that is engaged principally in the issue, flotation, underwriting, public sale or distribution of stocks, bonds, debentures or other securities. Essentially,

commercial banks may no longer intermingle their business activities with investment banks. It is that simple.

Since the repeal of the Glass Steagall Act in 1999, this country has seen a new culture emerge in the financial industry: one of dangerous greed and excessive risk-taking. Commercial banks traditionally used people's deposits for the constructive purpose of main street loans. They did not engage in high risk ventures. Investment banks, however, managed rich people's money—those who can afford to take bigger risks in order to get a bigger return, and who bore their own losses. When these two worlds collided, the investment bank culture prevailed, cutting off the credit lifeblood of main street firms, demanding greater returns that were achievable only through high leverage and huge risk taking, and leaving taxpayers with the fallout.

When the glass wall dividing banks and securities firms was shattered, common sense and caution went out the door. The new mantra of "bigger is better" took over—and the path forward focused on short-term gains rather than long-term planning. Banks became overleveraged in their haste to keep up in the race. The more they lent, the more they made. Aggressive mortgages were underwritten for unqualified individuals who became homeowners saddled with loans they couldn't afford. Banks turned right around and bought portfolios of these shaky loans.

Sub-prime loans made up only five percent of all mortgage lending in 1998, but by the time the financial crisis peaked in late 2008, they were approaching 30 percent. Since January 2008, we have seen 159 state and national banks fail. In my home State of Arizona, five banks have shut their doors, leaving small businesses scrambling to find credit from other banks that may have already been overleveraged.

Banks sold sub-prime mortgages to their affiliates and other securities firms for securitization, while other financial institutions made risky bets on these and other assets for which they had no financial interest. As the market grew bigger, its foundation became shakier. It was like a house of cards waiting to fall, and fall it did.

In October 2008, the financial system was on the brink of collapse when Congress was forced to risk \$700 billion of taxpayer dollars to bail out the industry. These financial institutions had become "too big to fail." In fact, the special inspector general of the Troubled Asset Relief Program, TARP, testified before Congress earlier this year that "total potential Federal Government support could reach \$23.7 trillion" to stabilize and support the financial system. Ironically, some of these "too big to fail" institutions have now become even bigger. An edi-

torial from yesterday's New York Times stated:

The truth is that the taxpayers are still very much on the hook for a banking system that is shaping up to be much riskier than the one that led to disaster.

Big bank profits, for instance, still come mostly courtesy of taxpayers. Their trading earnings are financed by more than a trillion dollars' worth of cheap loans from the Federal Reserve, for which some of their most noxious assets are collateral. They benefit from immense federal loan guarantees, but they are not lending much. Lending to business, notably, is very tight.

What profits the banks make come mostly from trading. Many big banks are happy to depend on the lifeline from the Fed and hang onto their toxic assets hoping for a rebound in prices. And the whole system has grown more concentrated. Bank of America was considered too big to fail before the meltdown. Since then, it has acquired Merrill Lynch. Wells Fargo took over Wachovia. JPMorgan Chase gobbled up Bear Stearns.

If the goal is to reduce the number of huge banks that taxpayers must rescue at any cost, the nation is moving in the wrong direction. The growth of the biggest banks ensures that the next bailout will have to be even bigger. These banks will be more likely to take on excessive risk because they have the implicit assurance of rescue.

Excess was a common theme for banks/financial institutions in the mid-2000s—excessive risk, excessive bonuses. Times were good at Merrill Lynch in 2006 when the firm's risky mortgage business was booming. The firm made record earnings of \$7.5 billion that year and paid out bonuses of \$5 billion to \$6 billion. Fast forward to late 2008 when Merrill's gambling left it in deep financial despair with losses exceeding \$27 billion. Yet we witnessed the firm pay out another \$3.6 billion in bonuses just before it was acquired by Bank of America.

Merrill Lynch wasn't alone in excess and greed. Citigroup posted a net loss of nearly \$28 billion in 2008, yet paid out \$5.3 billion in bonuses. Although Goldman Sachs earned only \$2.3 billion, it paid out \$4.8 billion in bonuses. Morgan Stanley earned \$1.7 billion, and paid out nearly \$4.5 billion in bonuses. JPMorgan Chase earned \$5.6 billion and paid \$8.7 billion in bonuses. If a company doesn't make money, how can it pay these bonuses? In this case, each of these firms was a recipient of billions in taxpayer-funded TARP money.

The Federal Government has set a dangerous precedent here. We sent the wrong message to the financial industry: you engage in bad, risky business practices, and when you get into trouble, the government will be there to save your hide. Many would call it a moral hazard. I call it a taxpayer-funded subsidy for risky behavior.

The consolidation of the banking world was also riddled with conflicts of interest, despite the purported firewalls that were put into place. If an investment bank had underwritten shares for a company that was now in financial trouble, the investment

bank's commercial arm would feel pressure to lend the company money, despite the lack of merits to do so. The Banking Integrity Act of 2009 would eliminate some of these conflicts.

Today, it is time to put a stop to the taxpayer-financed excesses of Wall Street. No single financial institution should be so big that its failure would bring ruin to our economy and destroy millions of American jobs. This country would be better served if we limit the activities of these financial institutions. Banks should accept consumer deposits and invest conservatively, while investment banks engage in underwriting and sales of securities.

I urge my colleagues to support this bill.

By Mr. CARDIN:

S. 2888. A bill to amend section 205 of title 18, United States Code, to exempt qualifying law school students participating in legal clinics from the application of the general conflict of interest rules under such section; to the Committee on the Judiciary.

Mr. CARDIN. Mr. President, I have introduced the Law Student Participation Act of 2009.

The bill creates exceptions to Federal conflicts of interest law which generally prohibits Federal employees from acting as an attorney or agent in a matter adverse to the U.S. government. The legislation directs the exceptions to Federal employees attending law school and participating in legal clinics and employees of the District of Columbia who staff legal clinics. Where the Federal employee has participated personally and substantially in the matter or the matter is before the employee's particular agency or department, specific conflicts of interest provisions still apply. The current law is over broad and denies learning and teaching opportunities where no real conflict may exist.

Law schools, including schools in my home State, have voiced concern over the present law. Some of these schools include the University of Maryland, the University of the District of Columbia, and Georgetown University School of Law. The schools have related stories of students, who are Federal employees, regulated to clinics dealing only with state matters. In other instances a student might start working on a client's matter, but will be unable to continue once the matter goes to trial or before an administrative proceeding. Law schools complain that under such circumstances the client's right to effective counsel is diminished. Due to a requirement I championed, the University of Maryland School of Law faces unique challenges. Each student must provide legal services to the poor or persons who otherwise lack access to justice prior to graduation. Federal employees, unlike other students, must choose

from a smaller selection of clinics due to the current Federal conflicts of interest law. Finally, if Federal employee students seek careers in practice areas where Federal law predominates, they likely will obtain no practical clinic experience in law school.

It should be noted that the Office of Government Ethics, OGE, and the Department of Justice are aware of the text of the bill. Both have conveyed informally that they do not have problems with this legislation. The OGE released a report in 2006 that was critical of current Federal conflict of interest law as being overbroad and specifically pointed out that volunteer work was frequently barred even when no potential for conflict of interest existed.

The current law deprives law students who are Federal employees of valuable practical educational opportunities. Ultimately participation in these clinics would result in better attorneys many of whom later go on to work for the Federal government.

By Mr. FEINGOLD:

S. 2890. A bill to amend the Buy American Act to increase the requirement for American-made content, to tighten the waiver provisions, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

Mr. FEINGOLD. Mr. President, today I am introducing legislation to help American workers and companies.

The bill that I am introducing, the Buy American Improvement Act, focuses on the Federal Government's responsibility to support domestic manufacturers and workers and on the role of Federal procurement policy in achieving this goal. The reintroduction of this bill, which I first introduced in 2003, is part of my ongoing efforts to support American workers and manufacturing.

The Buy American Act of 1933 is the primary statute that governs Federal procurement. The name of this law accurately describes its purpose: to ensure that the Federal Government supports domestic companies and domestic workers by buying American-made goods. Regrettably, this law contains a number of loopholes that make it too easy for government agencies to buy foreign-made goods.

My bill, the Buy American Improvement Act, would strengthen the existing law by tightening its waiver provisions. Currently, the heads of Federal departments and agencies are given broad discretion to waive the act and buy foreign goods with little or no accountability. We should ensure that the Federal Government makes every

effort to give Federal contracts to companies that will perform the work domestically. We should also ensure that certain types of industries do not leave the U.S. completely, thus making the Federal Government dependent on foreign sources for goods, such as plane or ship parts, that our military may need to acquire on short notice.

With unemployed workers in the U.S. facing a double-digit unemployment rate, the highest rate since 1983, it is critical Congress back efforts to support American workers. Many unemployed American workers are currently facing persistently long periods of unemployment; data from the Department of Labor showed that in October of this year, over 35 percent of unemployed workers had been without jobs for at least 27 weeks. Since December of 2007, the number of unemployed workers in the U.S. has grown by over 8 million, with manufacturing and construction workers being particularly hard-hit. We need to do all we can to promote fiscally responsible Federal policies that support the creation of American jobs to help get the unemployed and underemployed back to work. A strong Buy American Act should be part of the Federal effort to create and retain American jobs.

During another period of economic upheaval in the 1930s, Congress passed a series of laws designed to promote job growth in the U.S., including the Buy American Act of 1933, 41 U.S.C. §10a-10d. The Buy American Act requires the Federal Government to support domestic manufacturers and workers by purchasing American-made goods. Over the years, other domestic sourcing legislation has been passed to help support American industry, including the Buy America Act, 23 U.S.C. §313, which applies to Federal transportation funding. In addition, Congress included domestic sourcing requirements in the American Recovery and Reinvestment Act, P.L. 111-5, earlier this year because it recognized the importance of supporting American workers and American industry. My legislation would help American industry by making it more difficult to waive the Buy American Act and help ensure the Federal Government does all it can to support American workers.

I have a long record of supporting efforts to help taxpayers get the most bang for their buck and opposing wasteful Federal spending. I don't think anyone can argue that supporting American jobs is "wasteful." We owe it to American manufacturers and their employees to make sure they get a fair shake. I would not support

awarding a contract to an American company that is price-gouging, but we should make every effort to ensure that domestic sources for goods needed by the Federal Government do not dry up because American companies have been slightly underbid by foreign competitors.

The gaping loopholes in the Buy American Act and the trade agreements and defense procurement agreements that contain additional waivers of domestic source restrictions have combined to weaken our domestic manufacturing base by allowing—and sometimes actually encouraging—the Federal Government to buy foreign-made goods. Congress can and should do more to support American companies and American workers. We must strengthen the Buy American Act and we must stop entering into bad trade agreements that send our jobs overseas and undermine our own domestic preference laws.

By strengthening Federal procurement policy, we can help to bolster our domestic manufacturers during these difficult times. As I have repeatedly noted, Congress cannot simply stand on the sidelines while tens of thousands of American manufacturing jobs have been and continue to be shipped overseas. While there may be no single solution to this problem one way in which Congress should act is by strengthening the Buy American Act.

By Mr. REID (for himself, Mr. ENSIGN, Mrs. FEINSTEIN, and Mrs. BOXER):

S. 2891. A bill to further allocate and expand the availability of hydroelectric power generated at Hoover Dam, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. REID. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2891

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Hoover Power Allocation Act of 2009".

SEC. 2. ALLOCATION OF CONTRACTS FOR POWER.

(a) SCHEDULE A POWER.—Section 105(a)(1)(A) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(a)(1)(A)) is amended—

- (1) by striking "renewal";
- (2) by striking "June 1, 1987" and inserting "October 1, 2017"; and
- (3) by striking Schedule A and inserting the following:

“SCHEDULE A

Long term Schedule A contingent capacity and associated firm energy for offers of contracts to Boulder Canyon project contractors

Contractor	Contingent capacity (kW)	Firm Energy (thousands of kWh)		
		Summer	Winter	Total
Metropolitan Water District of Southern California	249,948	859,163	368,212	1,227,375
City of Los Angeles	495,732	464,108	199,175	663,283
Southern California Edison Company	280,245	166,712	71,448	238,160
City of Glendale	18,178	45,028	19,297	64,325
City of Pasadena	11,108	38,622	16,553	55,175
City of Burbank	5,176	14,070	6,030	20,100
Arizona Power Authority	190,869	429,582	184,107	613,689
Colorado River Commission of Nevada	190,869	429,582	184,107	613,689
United States, for Boulder City	20,198	53,200	22,800	76,000
Totals	1,462,323	2,500,067	1,071,729	3,571,796”.

(b) SCHEDULE B POWER.—Section 105(a)(1)(B) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(a)(1)(B)) is amended to read as follows:

“(B) To each existing contractor for power generated at Hoover Dam, a contract, for delivery commencing October 1, 2017, of the amount of contingent capacity and firm en-

ergy specified for that contractor in the following table:

“SCHEDULE B

Long term Schedule B contingent capacity and associated firm energy for offers of contracts to Boulder Canyon project contractors

Contractor	Contingent capacity (kW)	Firm Energy (thousands of kWh)		
		Summer	Winter	Total
City of Glendale	2,020	2,749	1,194	3,943
City of Pasadena	9,089	2,399	1,041	3,440
City of Burbank	15,149	3,604	1,566	5,170
City of Anaheim	40,396	34,442	14,958	49,400
City of Azusa	4,039	3,312	1,438	4,750
City of Banning	2,020	1,324	576	1,900
City of Colton	3,030	2,650	1,150	3,800
City of Riverside	30,296	25,831	11,219	37,050
City of Vernon	22,218	18,546	8,054	26,600
Arizona	189,860	140,600	60,800	201,400
Nevada	189,860	273,600	117,800	391,400
Totals	507,977	509,057	219,796	728,853”.

(c) SCHEDULE C POWER.—Section 105(a)(1)(C) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(a)(1)(C)) is amended—

(1) by striking “June 1, 1987” and inserting “October 1, 2017”; and

(2) by striking Schedule C and inserting the following:

“SCHEDULE C

Excess Energy

Priority of entitlement to excess energy	State
First: Meeting Arizona’s first priority right to delivery of excess energy which is equal in each year of operation to 200 million kilowatthours: Provided, That in the event excess energy in the amount of 200 million kilowatthours is not generated during any year of operation, Arizona shall accumulate a first right to delivery of excess energy subsequently generated in an amount not to exceed 600 million kilowatthours, inclusive of the current year’s 200 million kilowatthours. Said first right of delivery shall accrue at a rate of 200 million kilowatthours per year for each year excess energy in an amount of 200 million kilowatthours is not generated, less amounts of excess energy delivered.	Arizona
Second: Meeting Hoover Dam contractual obligations under Schedule A of subsection (a)(1)(A), under Schedule B of subsection (a)(1)(B), and under Schedule D of subsection (a)(2), not exceeding 26 million kilowatthours in each year of operation.	Arizona, Nevada, and California
Third: Meeting the energy requirements of the three States, such available excess energy to be divided equally among the States.	Arizona, Nevada, and California”.

(d) SCHEDULE D POWER.—Section 105(a) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(a)) is amended—

(1) by redesignating paragraphs (2), (3), and (4) as paragraphs (3), (4), and (5), respectively; and

(2) by inserting after paragraph (1) the following:

“(2)(A) The Secretary of Energy is authorized to and shall create from the apportioned allocation of contingent capacity and firm energy adjusted from the amounts authorized in this Act in 1984 to the amounts shown

in Schedule A and Schedule B, as modified by the Hoover Power Allocation Act of 2009, a resource pool equal to 5 percent of the full rated capacity of 2,074,000 kilowatts, and associated firm energy, as shown in Schedule D (referred to in this section as ‘Schedule D contingent capacity and firm energy’):

“SCHEDULE D

Long term Schedule D resource pool of contingent capacity and associated firm energy for new allottees

State	Contingent capacity (kW)	Firm Energy (thousands of kWh)		
		Summer	Winter	Total
New Entities Allocated by the Secretary of Energy	69,170	105,637	45,376	151,013
New Entities Allocated by State				
Arizona	11,510	17,580	7,533	25,113
California	11,510	17,580	7,533	25,113
Nevada	11,510	17,580	7,533	25,113
Totals	103,700	158,377	67,975	226,352

“(B) The Secretary of Energy shall offer Schedule D contingency capacity and firm energy to entities not receiving contingent capacity and firm energy under subparagraphs (A) and (B) of paragraph (1) (referred to in this section as ‘new allottees’) for delivery commencing October 1, 2017 pursuant to this subsection. In this subsection, the term ‘the marketing area for the Boulder City Area Projects’ shall have the same meaning as in Appendix A of the General Consolidated Power Marketing Criteria or Regulations for Boulder City Area Projects published in the Federal Register on December 28, 1984 (49 Fed. Reg. 50582 et seq.) (referred to in this section as the ‘Criteria’).”

“(C)(i) Within 18 months of the date of enactment of the Hoover Power Allocation Act of 2009, the Secretary of Energy shall allocate through the Western Area Power Administration (referred to in this section as ‘Western’), for delivery commencing October 1, 2017, for use in the marketing area for the Boulder City Area Projects 66.7 percent of the Schedule D contingent capacity and firm energy to new allottees that are located within the marketing area for the Boulder City Area Projects and that are—

“(I) eligible to enter into contracts under section 5 of the Boulder Canyon Project Act (43 U.S.C. 617d); or

“(II) federally recognized Indian tribes.

“(ii) In the case of Arizona and Nevada, Schedule D contingent capacity and firm energy for new allottees shall be offered through the Arizona Power Authority and the Colorado River Commission of Nevada, respectively.

“(iii) In performing its allocation of Schedule D power provided for in this subparagraph, Western shall apply criteria developed in consultation with the States of Arizona, Nevada, and California.

“(D) Within 1 year of the date of enactment of the Hoover Power Allocation Act of 2009, the Secretary of Energy also shall allocate, for delivery commencing October 1, 2017, for use in the marketing area for the Boulder City Area Projects 11.1 percent of the Schedule D contingent capacity and firm energy to each of—

“(i) the Arizona Power Authority for allocation to new allottees in the State of Arizona;

“(ii) the Colorado River Commission of Nevada for allocation to new allottees in the State of Nevada; and

“(iii) Western for allocation to new allottees within the State of California.

“(E) Each contract offered pursuant to this subsection shall include a provision requiring the new allottee to pay a proportionate share of its State’s respective contribution (determined in accordance with each State’s applicable funding agreement) to the cost of the Lower Colorado River Multi-Species Conservation Program (as defined in section 9401

of the Omnibus Public Land Management Act of 2009 (Public Law 111–11; 123 Stat. 1327)), and to execute the Boulder Canyon Project Implementation Agreement Contract No. 95–PAO–10616 (referred to in this section as the ‘Implementation Agreement’).

“(F) Any of the 66.7 percent of Schedule D contingent capacity and firm energy that is to be allocated by Western that is not allocated and placed under contract by October 1, 2017, shall be returned to those contractors shown in Schedule A and Schedule B in the same proportion as those contractors’ allocations of Schedule A and Schedule B contingent capacity and firm energy. Any of the 33.3 percent of Schedule D contingent capacity and firm energy that is to be distributed within the States of Arizona, Nevada, and California that is not allocated and placed under contract by October 1, 2017, shall be returned to the Schedule A and Schedule B contractors within the State in which the Schedule D contingent capacity and firm energy were to be distributed, in the same proportion as those contractors’ allocations of Schedule A and Schedule B contingent capacity and firm energy.”

(e) TOTAL OBLIGATIONS.—Paragraph (3) of section 105(a) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(a)) (as redesignated as subsection (d)(1)) is amended—

(1) in the first sentence, by striking “schedule A of subsection (a)(1)(A) of this section and schedule B of subsection (a)(1)(B) of this section” and inserting “pursuant to paragraphs (1)(A), (1)(B), and (2)”; and

(2) in the second sentence—

(A) by striking “any” and inserting “each”; and

(B) by striking “schedule C” and inserting “Schedule C”; and

(C) by striking “schedules A and B” and inserting “Schedules A, B, and D”.

(f) POWER MARKETING CRITERIA.—Paragraph (4) of section 105(a) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(a)) (as redesignated as subsection (d)(1)) is amended to read as follows:

“(4) Subdivision E of the Criteria shall be deemed to have been modified to conform to this section, as modified by the Hoover Power Allocation Act of 2009. The Secretary of Energy shall cause to be included in the Federal Register a notice conforming the text of the regulations to such modifications.”

(g) CONTRACT TERMS.—Paragraph (5) of section 105(a) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(a)) (as redesignated as subsection (d)(1)) is amended—

(1) by striking subparagraph (A) and inserting the following:

“(A) in accordance with section 5(a) of the Boulder Canyon Project Act (43 U.S.C. 617d(a)), expire September 30, 2067;”;

(2) in the proviso of subparagraph (B)—

(A) by striking “shall use” and inserting “shall allocate”; and

(B) by striking “and” after the semicolon at the end;

(3) in subparagraph (C), by striking the period at the end and inserting a semicolon; and

(4) by adding at the end the following:

“(D) authorize and require Western to collect from new allottees a pro rata share of Hoover Dam repayable advances paid for by contractors prior to October 1, 2017, and remit such amounts to the contractors that paid such advances in proportion to the amounts paid by such contractors as specified in section 6.4 of the Implementation Agreement;

“(E) permit transactions with an independent system operator; and

“(F) contain the same material terms included in section 5.6 of those long term contracts for purchases from the Hoover Power Plant that were made in accordance with this Act and are in existence on the date of enactment of the Hoover Power Allocation Act of 2009.”

(h) EXISTING RIGHTS.—Section 105(b) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(b)) is amended by striking “2017” and inserting “2067”.

(i) OFFERS.—Section 105(c) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(c)) is amended to read as follows:

“(c) OFFER OF CONTRACT TO OTHER ENTITIES.—If any existing contractor fails to accept an offered contract, the Secretary of Energy shall offer the contingent capacity and firm energy thus available first to other entities in the same State listed in Schedule A and Schedule B, second to other entities listed in Schedule A and Schedule B, third to other entities in the same State which receive contingent capacity and firm energy under subsection (a)(2) of this section, and last to other entities which receive contingent capacity and firm energy under subsection (a)(2) of this section.”

(j) AVAILABILITY OF WATER.—Section 105(d) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(d)) is amended to read as follows:

“(d) WATER AVAILABILITY.—Except with respect to energy purchased at the request of an allottee pursuant to subsection (a)(3), the obligation of the Secretary of Energy to deliver contingent capacity and firm energy pursuant to contracts entered into pursuant to this section shall be subject to availability of the water needed to produce such contingent capacity and firm energy. In the event that water is not available to produce the contingent capacity and firm energy set forth in Schedule A, Schedule B, and Schedule D, the Secretary of Energy shall adjust the contingent capacity and firm energy offered under those Schedules in the same proportion as those contractors’ allocations of Schedule A, Schedule B, and Schedule D contingent capacity and firm energy bears to the full rated contingent capacity and firm energy obligations.”

(k) CONFORMING AMENDMENTS.—Section 105 of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a) is amended—

(1) by striking subsections (e) and (f); and
(2) by redesignating subsections (g), (h), and (i) as subsections (e), (f), and (g), respectively.

(l) CONTINUED CONGRESSIONAL OVERSIGHT.—Subsection (e) of section 105 of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a) (as redesignated by subsection (k)(2)) is amended—

(1) in the first sentence, by striking “the renewal of”; and

(2) in the second sentence, by striking “June 1, 1987, and ending September 30, 2017” and inserting “October 1, 2017, and ending September 30, 2067”.

(m) COURT CHALLENGES.—Subsection (f)(1) of section 105 of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a) (as redesignated by subsection (k)(2)) is amended in the first sentence by striking “this Act” and inserting “the Hoover Power Allocation Act of 2009”.

(n) REAFFIRMATION OF CONGRESSIONAL DECLARATION OF PURPOSE.—Subsection (g) of section 105 of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a) (as redesignated by subsection (k)(2)) is amended—

(1) by striking “subsections (c), (g), and (h) of this section” and inserting “this Act”; and

(2) by striking “June 1, 1987, and ending September 30, 2017” and inserting “October 1, 2017, and ending September 30, 2067”.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 376—HONORING THE 60TH ANNIVERSARY OF THE ESTABLISHMENT OF DIPLOMATIC RELATIONS BETWEEN THE UNITED STATES AND THE HASHEMITE KINGDOM OF JORDAN, THE 10TH ANNIVERSARY OF THE ACCESSION TO THE THRONE OF HIS MAJESTY KING ABDULLAH II IBN AL HUSSEIN, AND FOR OTHER PURPOSES

Mr. INOUE (for himself, Mr. GREGG, Mr. LIEBERMAN, and Mr. DURBIN) submitted the following resolution; which was considered and agreed to:

S. RES. 376

Whereas the Hashemite Kingdom of Jordan achieved independence on May 25, 1946;

Whereas the United States recognized Jordan as an independent state in a White House announcement on January 31, 1949;

Whereas diplomatic relations and the American Legation in Jordan were established on February 18, 1949, when United States diplomat Wells Stabler presented his credentials as Chargé d’Affaires in Amman;

Whereas, for 60 years, the United States and Jordan have enjoyed a close relationship and have worked together to advance issues ranging from the promotion of Middle East peace to advancing the socio-economic development of the people of Jordan, as well as the threat to both posed by al Qaeda and violent extremism;

Whereas, from 1952 to 1999, King Hussein charted a moderate path for his country;

Whereas, for decades, the United States has been Jordan’s strongest international partner;

Whereas, throughout his reign, King Hussein looked for opportunities to realize his

dream of a more peaceful Middle East by working to solve intra-Arab disputes and engaging successive Prime Ministers of Israel in the search for peace;

Whereas King Hussein and Prime Minister of Israel Yitzhak Rabin signed the historic Jordan-Israel peace treaty in 1994, ending nearly 50 years of war between the neighboring countries;

Whereas the United States lost a close friend and a crucial partner when King Hussein passed away in 1999;

Whereas King Hussein was succeeded by his son, King Abdullah II, who has continued his father’s work to improve the lives of the people of Jordan while also seeking to bring peace to the region;

Whereas, in the aftermath of the September 11, 2001, terrorist attacks, the Government of Jordan has been an instrumental partner in the fight against al Qaeda, has provided crucial assistance in Iraq, and has shouldered a heavy burden in providing refuge to a significant portion of the Iraqi refugee population;

Whereas, through his 2004 Amman Message, King Abdullah II has been a leading Arab voice in trying to reaffirm the true path of Islam;

Whereas, in November 2005, al Qaeda terrorists struck three hotels in Amman, Jordan, thereby uniting the people of Jordan and the United States in grief over the lives lost at this act of terrorism; and

Whereas King Abdullah II begins his second decade on the Hashemite throne by redoubling his efforts for peace in the region as the Jordan-United States partnership enters its seventh decade: Now, therefore, be it

Resolved, That the Senate—

(1) commemorates the 60th anniversary of the close relationship between the United States and the Hashemite Kingdom of Jordan;

(2) expresses its profound admiration and gratitude for the friendship of the people of Jordan;

(3) congratulates His Majesty King Abdullah II on 10 years of enlightened and progressive rule; and

(4) shares the hope of His Majesty King Abdullah II and the people of Jordan for a more peaceful Middle East.

SENATE CONCURRENT RESOLUTION 48—RECOGNIZING THE LEADERSHIP AND HISTORICAL CONTRIBUTIONS OF DR. HECTOR GARCIA TO THE HISPANIC COMMUNITY AND HIS REMARKABLE EFFORTS TO COMBAT RACIAL AND ETHNIC DISCRIMINATION IN THE UNITED STATES OF AMERICA

Mr. MENENDEZ submitted the following concurrent resolution; which was referred to the Committee on the Judiciary:

S. CON. RES. 48

Whereas Dr. Hector Garcia changed the lives of Americans from all walks of life;

Whereas Dr. Hector Garcia was born in Mexico on January 17, 1914, and immigrated to Mercedes, Texas, in 1918;

Whereas Dr. Hector Garcia is an honored alumnus of the School of Medicine at the University of Texas Medical Branch, Class of 1940;

Whereas Dr. Hector Garcia fought in World War II, specifically in North Africa and Italy, attained the rank of Major, and was

awarded the Bronze Star with six battle stars;

Whereas once the Army discovered he was a physician, Dr. Hector Garcia was asked to practice his profession by treating his fellow soldiers;

Whereas Dr. Hector Garcia moved to Corpus Christi, Texas, after the war, and opened a medical practice; rarely charged his indigent patients, and was recognized as a passionate and dedicated physician;

Whereas he first became known in south Texas for his public health messages on the radio with topics ranging from infant diarrhea to tuberculosis;

Whereas Dr. Hector Garcia continued his public service and advocacy and became founder of the American G.I. Forum, a Mexican-American veterans association, which initiated countless efforts on behalf of Americans to advance opportunities in health care, veterans’ benefits, and civil rights equality;

Whereas his civil rights movement would then grow to also combat discrimination in housing, jobs, education, and voting rights;

Whereas President Kennedy appointed Dr. Hector Garcia a member of the American Treaty Delegation for the Mutual Defense Agreement between the United States and the Federation of the West Indies;

Whereas in 1967, President Lyndon Johnson appointed Dr. Hector Garcia as alternate ambassador to the United Nations where he gave the first speech by an American before the United Nations in a language other than English;

Whereas Dr. Hector Garcia was named member of the Texas Advisory Committee to the United States Commission on Civil Rights;

Whereas President Reagan presented Dr. Hector Garcia the Nation’s highest civilian award, the Medal of Freedom, in 1984 for meritorious service to his country, the first Mexican American to receive this recognition; and

Whereas Pope John Paul II recognized him with the Pontifical Equestrian Order of Pope Gregory the Great: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That Congress—

(1) encourages—

(A) teachers of primary schools and secondary schools to launch educational campaigns to inform students about the lifetime of accomplishments by Dr. Hector Garcia; and

(B) all people of the United States to educate themselves about the legacy of Dr. Hector Garcia; and

(2) recognizes the leadership and historical contributions of Dr. Hector Garcia to the Hispanic community and his remarkable efforts to combat racial and ethnic discrimination in the United States of America.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3242. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 3243. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr.

HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3244. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3245. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3246. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3247. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3248. Mr. REID proposed an amendment to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes.

SA 3249. Mr. REID proposed an amendment to the bill H.R. 3326, supra.

SA 3250. Mr. REID proposed an amendment to amendment SA 3249 proposed by Mr. REID to the bill H.R. 3326, supra.

SA 3251. Mr. REID proposed an amendment to amendment SA 3250 proposed by Mr. REID to the amendment SA 3249 proposed by Mr. REID to the bill H.R. 3326, supra.

SA 3252. Mr. REID proposed an amendment to amendment SA 3248 proposed by Mr. REID to the bill H.R. 3326, supra.

SA 3253. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 3254. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3255. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3256. Mr. BENNET submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3257. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3258. Mrs. SHAHEEN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 3242. Mr. CRAPO submitted an amendment intended to be proposed to

amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1053, between lines 2 and 3, insert the following:

SEC. 3403A. IMPROVEMENTS TO THE INDEPENDENT MEDICARE ADVISORY BOARD.

Section 1899A of the Social Security Act, as added by section 3403, is amended—

- (1) in subsection (c)—
- (A) in paragraph (1)—
- (i) by redesignating subparagraph (B) as subparagraph (C); and
- (ii) by inserting after subparagraph (A) the following new subparagraph:

“(B) PROMULGATION OF REGULATIONS TO PROVIDE FOUNDATION FOR BOARD PROPOSALS.—

“(i) IN GENERAL.—Before developing any proposal under this section, the Board, after consultation with the Secretary, shall promulgate regulations through which the Board interprets the provisions of this section that concern the duties of the Board in order to provide a substantive and procedural foundation for carrying out such duties. Such regulations shall be promulgated in accordance with the procedures under section 553 of title 5, United States Code, that relate to substantive rules.

“(ii) RULE OF CONSTRUCTION.—Clause (i) may not be construed as requiring that proposals under this section be promulgated in accordance with the rulemaking procedures referred to in clause (i).”;

(B) in paragraph (2), by adding at the end the following new subparagraphs:

“(G) CONSULTATION WITH INDEPENDENT ADVISORY COMMITTEE.—

“(i) IN GENERAL.—Not later than 60 days after the date of the enactment of the Patient Protection and Affordable Care Act, the Secretary shall establish an advisory committee to review, in accordance with procedures established in the Federal Advisory Committee Act, each proposal to be submitted to Congress under this section.

“(ii) COMPOSITION.—The advisory committee under clause (i) (referred to in this subparagraph as the ‘Independent Committee’) shall be composed of not more than 15 members who are medical and scientific experts appointed from among individuals who are not officers or employees of the Federal Government.

“(iii) REVIEW AND REPORT.—The Board shall submit a draft copy of each proposal to be submitted to the President under this section to the Independent Committee for its review. The Board shall submit such draft copy by not later than September 1 of the year preceding the year for which the proposal is to be submitted. Not later than November 1 of such year, the Independent Committee shall submit a report to Congress and the Board on the results of such review, including matters reviewed pursuant to the succeeding provisions of this subparagraph.

“(iv) CLINICAL APPROPRIATENESS OF PAYMENT RESTRICTIONS AND COVERAGE RESTRICTIONS.—The review of the Independent Committee of a recommendation in a proposal under this section shall, with respect to any changes in items or services under this title, include evaluating the differences in treatment guidelines and variables of treatment

costs for items and services under this title that are subject to a reduction in payment or restriction in coverage pursuant to the recommendation. The purpose of such evaluation shall be to ensure that the recommendation applies only to those items and services for which such comparisons may be made in a clinically appropriate manner.

“(v) SUBSTANTIAL EVIDENCE REGARDING CERTAIN RECOMMENDATIONS.—With respect to a recommendation in a proposal of the Board that reduces payment or restricts coverage for items and services under this title, the Independent Committee shall determine whether the recommendation is supported by substantial evidence.

“(vi) SPECIAL POPULATIONS; HEALTH DISPARITIES.—In reviewing a recommendation in a proposal under this section, the Independent Committee shall evaluate the effect on special populations and whether the recommendation is consistent with Federal policies to reduce health disparities.

“(vii) PUBLIC MEETING TO PRESENT AND DISCUSS FINDINGS.—Before issuing a report under clause (iii), the Independent Committee shall hold a public meeting at which it presents the findings of its review under such clause and seeks comments from individuals attending the meeting.

“(H) PUBLICATION OF INITIAL PROPOSAL IN FEDERAL REGISTER.—

“(i) IN GENERAL.—Not later than October 1 preceding the proposal year involved, the Board shall publish in the Federal Register an initial proposal of the Board under this section and shall seek comments from the public on the proposal. The final proposal shall be published in the Federal Register on the same date as the date on which such proposal is submitted to the President under paragraph (3)(A) (or under paragraph (5), as the case may be).

“(ii) LIMITATION ON JUDICIAL REVIEW.—The publication under clause (i) of a final proposal of the Board does not constitute final agency action for purposes of section 704 of title 5, United States Code.”; and

(C) in paragraph (3)(B), by striking clause (ii) and inserting the following new clause:

“(ii) taking into account comments received from the public under paragraph (2)(H)(i), an explanation of each recommendation contained in the proposal and the reasons for including such recommendation, and a statement of whether and to what extent the Board considered it feasible—

“(I) to protect and improve Medicare beneficiaries’ access to necessary and evidence-based items and services, including in rural and frontier areas; and

“(II) to otherwise comply with the requirements of paragraph (2)(B); and”;

(2) in subsection (e), by striking paragraph (5) and inserting the following new paragraph:

“(5) LIMITATION ON REVIEW.—

“(A) IN GENERAL.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the implementation by the Secretary under this subsection of the recommendations contained in a proposal, except as provided in subparagraph (B).

“(B) JUDICIAL REVIEW OF SCOPE OF AGENCY AUTHORITY; COMPLIANCE WITH PROCEDURAL SAFEGUARDS.—

“(i) IN GENERAL.—An aggrieved beneficiary or other party may, in accordance with the procedures that apply under section 1869(f)(3), seek review by a court of competent jurisdiction of the implementation by the Secretary of any recommendation in a

proposal of the Board if the moving party alleges that the only issue of law is the constitutionality of a recommendation, or one or more issues described in clause (ii). For purposes of this subparagraph, a regulation, determination, or ruling by the Secretary under such a recommendation is final agency action within the meaning of section 704 of title 5, United States Code.

“(ii) **RELEVANT ISSUES; PROCEDURAL SAFEGUARDS.**—For purposes of clause (i), the court shall hold unlawful and set aside a regulation, determination, or ruling by the Secretary under a recommendation in a proposal of the Board if the court finds that—

“(I) the regulation, determination, or ruling exceeds the scope of the recommendation;

“(II) the Board failed to promulgate regulations in accordance with subsection (c)(1)(B) (relating to a substantive and procedural foundation for carrying out the duties of the Board);

“(III) the Board failed to comply with subsection (c)(2)(A)(ii) (relating to prohibitions against rationing health care; increasing beneficiary cost-sharing, such as deductibles, coinsurance, and copayments; or otherwise restricting benefits or modifying eligibility criteria);

“(IV) the Board failed to comply with subparagraph (D), (E), (G), or (H) of subsection (c)(2) (relating to review by the Medicare Payment Advisory Board, review by the Secretary, review by an independent advisory panel of experts, and publishing initial and final proposals of the Board in the Federal Register, respectively); or

“(V) the Board failed to comply with subsection (c)(3)(B)(ii) (relating to providing explanations of recommendations, providing statements of whether certain duties are feasible, and taking into account public comments).

“(iii) **SUBSTANTIAL EVIDENCE REGARDING CERTAIN RECOMMENDATIONS.**—With respect to a recommendation in a proposal of the Board under this section that reduces payment or restricts coverage for items and services under this title:

“(I) The review by a court under clause (i) of the implementation by the Secretary of the recommendation shall include a review of the basis of the recommendation.

“(II) The court shall hold unlawful and set aside the recommendation, and any regulation, determination, or ruling by the Secretary under the recommendation, if the court finds that the recommendation is unsupported by substantial evidence within the meaning of section 706 of title 5, United States Code.”.

SA 3243. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1790, between lines 9 and 10, insert the following:

SEC. 6508. REQUIREMENT FOR ALL MEDICAID AND CHIP APPLICANTS TO PRESENT AN IDENTIFICATION DOCUMENT.

(a) **IN GENERAL.**—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by

section 211(a)(1)(A)(i) of Public Law 111-3 and section 2303(a)(2) of this Act, is amended—

(1) in subsection (a)(46), —

(A) in subparagraph (A), by striking “and” after the semicolon;

(B) in subparagraph (B), by adding “and” after the semicolon; and

(C) by adding at the end the following:

“(C) provide that each applicant for medical assistance (or the parent or guardian of an applicant who has not attained age 18), regardless of whether the applicant is described in paragraph (2) of section 1903(x), shall present an identification document described in subsection (jj) when applying for medical assistance (and shall be provided with at least the reasonable opportunity to present such identification as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status;”;

(2) by adding at the end the following:

“(jj) For purposes of subsection (a)(46)(C), a document described in this subsection is—

“(1) in the case of an individual who is a national of the United States—

“(A) a United States passport, or passport card issued pursuant to the Secretary of State’s authority under the first section of the Act of July 3, 1926 (44 Stat. 887, Chapter 772; 22 U.S.C. 211a); or

“(B) a driver’s license or identity card issued by a State, the Commonwealth of the Northern Mariana Islands, or an outlying possession of the United States that—

“(i) contains a photograph of the individual and other identifying information, including the individual’s name, date of birth, gender, and address; and

“(ii) contains security features to make the license or card resistant to tampering, counterfeiting, and fraudulent use;

“(2) in the case of an alien lawfully admitted for permanent residence in the United States, a permanent resident card, as specified by the Secretary of Homeland Security that meets the requirements of clauses (i) and (ii) of paragraph (1)(B);

“(3) in the case of an alien who is authorized to be employed in the United States, an employment authorization card, as specified by the Secretary of Homeland Security that meets the requirements of clauses (i) and (ii) of paragraph (1)(B); or

“(4) in the case of an individual who is unable to obtain a document described in paragraph (1), (2), or (3), a document designated by the Secretary of Homeland Security that meets the requirements of clauses (i) and (ii) of paragraph (1)(B).”.

(b) **APPLICATION TO CHIP.**—Section 2105(c)(9)(A) (42 U.S.C. 1397ee(c)(9)(A)) is amended by striking “section 1902(a)(46)(B)” and inserting “subparagraphs (B) and (C) of subsection (a)(46) and subsection (jj) of section 1902”.

SA 3244. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

Subtitle —Improved Patient Access and Medical Care

PART I—EPSDT BENEFITS FOR CHILDREN
SEC. 101. EPSDT BENEFITS FOR CHILDREN.

Section 1902(gg) of the Social Security Act, as added by section 2001(b)(2) of this Act, is amended by redesignating paragraph (4) as paragraph (5) and inserting after paragraph (3) the following:

“(4) **STATES CERTIFYING ESSENTIAL BENEFITS AND COST-SHARING PROTECTIONS FOR CHILDREN IN FAMILIES WITH INCOME UP TO 300 PERCENT OF THE POVERTY LINE.**—The requirements under paragraphs (1) and (2) and section 2105(d)(3)(A) shall not apply to a State with respect to individuals whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved for any fiscal year or portion of a fiscal year that occurs on or after the date on which the State certifies to the Secretary that—

“(A) coverage available through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act for children who reside in the State, are under 19 years of age, and are in families with income that does not exceed 300 percent of the poverty line (as so defined), is at least the same as the level of benefits and cost-sharing under the State child health plan under title XXI (whether implemented under that title, this title, or both); and

“(B) the State Medicaid agency and qualified health plans offered through such an Exchange have established adequate procedures, with respect to such children, to ensure access to, and the coordinated provision of—

“(i) services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with the requirements of section 1902(a)(43); and

“(ii) cost-sharing protections consistent with section 2103(e) of the Social Security Act.

A State may comply with the requirements of subparagraph (B) by providing the services and cost-sharing protections required under that subparagraph directly under the State plan under title XIX or title XXI of the Social Security, or under arrangements entered into with qualified health plans offered through such an Exchange. Expenditures by the State to provide such services and cost-sharing protections shall be treated as medical assistance for purposes of section 1903(a) and, notwithstanding section 1905(b), the enhanced FMAP under section 2105(b) shall apply to such expenditures. In no event shall a State receive a payment under section 1903(a) for any such expenditures made prior to the date on which an Exchange is established by the State and operating under section 1311 of the Patient Protection and Affordable Care Act.”.

PART II—MEDICAL CARE ACCESS PROTECTION

SEC. 11. SHORT TITLE OF PART.

This part may be cited as the “Medical Care Access Protection Act of 2009” or the “MCAP Act”.

SEC. 12. FINDINGS AND PURPOSE.

(a) **FINDINGS.**—

(1) **EFFECT ON HEALTH CARE ACCESS AND COSTS.**—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly

and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) **EFFECT ON INTERSTATE COMMERCE.**—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) **EFFECT ON FEDERAL SPENDING.**—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) **PURPOSE.**—It is the purpose of this part to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of “defensive medicine” and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 13. DEFINITIONS.

In this part:

(1) **ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.**—The term “alternative dispute resolution system” or “ADR” means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) **CLAIMANT.**—The term “claimant” means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) **COLLATERAL SOURCE BENEFITS.**—The term “collateral source benefits” means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit pro-

vided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers’ compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) **COMPENSATORY DAMAGES.**—The term “compensatory damages” means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) **CONTINGENT FEE.**—The term “contingent fee” includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) **ECONOMIC DAMAGES.**—The term “economic damages” means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) **HEALTH CARE GOODS OR SERVICES.**—The term “health care goods or services” means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(8) **HEALTH CARE INSTITUTION.**—The term “health care institution” means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) **HEALTH CARE LAWSUIT.**—The term “health care lawsuit” means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of

liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) **HEALTH CARE LIABILITY ACTION.**—The term “health care liability action” means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) **HEALTH CARE LIABILITY CLAIM.**—The term “health care liability claim” means a demand by any person, whether or not pursuant to ADR, against a health care provider or health care institution, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) **HEALTH CARE PROVIDER.**—

(A) **IN GENERAL.**—The term “health care provider” means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) **TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.**—For purposes of this part, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) **MALICIOUS INTENT TO INJURE.**—The term “malicious intent to injure” means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) **NONECONOMIC DAMAGES.**—The term “noneconomic damages” means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) **PUNITIVE DAMAGES.**—The term “punitive damages” means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider or health care institution. Punitive damages are neither economic nor noneconomic damages.

(16) **RECOVERY.**—The term “recovery” means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys’ office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(17) STATE.—The term “State” means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 14. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) IN GENERAL.—Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) GENERAL EXCEPTION.—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

- (1) fraud;
- (2) intentional concealment; or
- (3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) MINORS.—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) RULE 11 SANCTIONS.—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this part applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys’ fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. 15. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this part shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) HEALTH CARE PROVIDERS.—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as \$250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) SINGLE INSTITUTION.—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as \$250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) MULTIPLE INSTITUTIONS.—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as \$250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed \$500,000.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations described in subsection (b), the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party’s several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party’s percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant’s harm.

SEC. 16. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—

(1) IN GENERAL.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) CONTINGENCY FEES.—

(A) IN GENERAL.—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant’s damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) LIMITATION.—The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first \$50,000 recovered by the claimant(s).

(ii) 33½ percent of the next \$50,000 recovered by the claimant(s).

(iii) 25 percent of the next \$500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of \$600,000.

(b) APPLICABILITY.—

(1) IN GENERAL.—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) MINORS.—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) REQUIREMENT.—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) PHYSICIAN REVIEW.—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) SPECIALTIES AND SUBSPECIALTIES.—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) LIMITATION.—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. 17. ADDITIONAL HEALTH BENEFITS.

(a) IN GENERAL.—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) PRESERVATION OF CURRENT LAW.—Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) APPLICATION OF PROVISION.—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. 18. PUNITIVE DAMAGES.

(a) PUNITIVE DAMAGES PERMITTED.—

(1) IN GENERAL.—Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) FILING OF LAWSUIT.—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) SEPARATE PROCEEDING.—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or \$250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) LIABILITY OF HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or med-

ical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) MEDICAL PRODUCT.—The term “medical product” means a drug or device intended for humans. The terms “drug” and “device” have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. 19. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding \$50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this part.

SEC. 20. EFFECT ON OTHER LAWS.

(a) GENERAL VACCINE INJURY.—

(1) IN GENERAL.—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this part shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this part in conflict with a rule of law of such title XXI shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this part or otherwise applicable law (as determined under this part) will apply to such aspect of such action.

(b) SMALLPOX VACCINE INJURY.—

(1) IN GENERAL.—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this part shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this part in conflict with a rule of law of such part C shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this part or otherwise applicable law (as determined under this part) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this part shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 21. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this part shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this part. The provisions governing health care lawsuits set forth in this part supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this part; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) PREEMPTION OF CERTAIN STATE LAWS.—

No provision of this part shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this part) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this part, notwithstanding section 15(a).

(c) PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.—

(1) IN GENERAL.—Any issue that is not governed by a provision of law established by or under this part (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this part shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care provider or health care institution from liability, loss, or damages than those provided by this part;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this part;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. 22. APPLICABILITY; EFFECTIVE DATE.

This part shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this part, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this part shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3245. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

Subtitle —Improved Patient Access and Medical Care

PART I—INCREASED MEDICAID PAYMENTS FOR PEDIATRIC CARE

SEC. 01. INCREASED PAYMENTS FOR PEDIATRIC CARE UNDER MEDICAID.

(a) IN GENERAL.—

(1) FEE-FOR-SERVICE PAYMENTS.—Section 1902 of the Social Security Act (42 U.S.C. 1396b), as amended by section 2001(b)(2), is amended—

(A) in subsection (a)(13)—

(i) by striking “and” at the end of subparagraph (A);

(ii) by adding “and” at the end of subparagraph (B); and

(iii) by adding at the end the following new subparagraph:

“(C) payment for pediatric care services (as defined in subsection (hh)(1)) furnished by hospitals or physicians (as defined in section 1861(r)) (or for services furnished by other health care professionals that would be pediatric care services under such subsection if furnished by a physician) at a rate not less than—

“(i) in the case of such services furnished by physicians (or professionals), 80 percent of the payment rate that would be applicable if the adjustment described in subsection (hh)(2) were to apply to such services and physicians or professionals (as the case may be) under part B of title XVIII (or, if there is no payment rate for such services under part B of title XVIII, the payment rate for the most comparable services, as determined by the Secretary in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900 and adjusted as appropriate for a pediatric population) for services furnished in 2010, 90 percent of such adjusted payment rate for services and physicians (or professionals) furnished in 2011, and 100 percent of such adjusted payment rate for services and hospitals or physicians (or professionals) furnished in 2012 and each subsequent year; and

“(ii) in the case of such services furnished by hospitals, 80 percent of the payment rate that would be applicable if such services were furnished under part A of title XVIII (or, if there is no payment rate for such services under part A of title XVIII, the payment rate for the most comparable services, as determined by the Secretary in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900 and adjusted as appropriate for a pediatric population) for services furnished in 2010, 90 percent of such payment rate for services furnished in 2011, and 100 percent of such payment rate for services furnished in 2012 and each subsequent year;”;

(B) by adding at the end the following new subsection:

“(hh) INCREASED PAYMENT FOR PEDIATRIC CARE.—For purposes of subsection (a)(13)(C):

“(1) PEDIATRIC CARE SERVICES DEFINED.—The term ‘pediatric care services’ means evaluation and management services, without regard to the specialty of the physician or hospital furnishing the services, that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified by the Secretary) and that are furnished to an individual who is enrolled in the State plan under this title who has not attained age 19. Such term includes

procedure codes established by the Secretary, in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900, for services furnished under State plans under this title to individuals who have not attained age 19 and for which there is not an a procedure code (or a procedure code that the Secretary, in consultation with such Commission, determines is comparable) established under the Healthcare Common Procedure Coding System.

“(2) ADJUSTMENT.—The adjustment described in this paragraph is the substitution of 1.25 percent for the update otherwise provided under section 1848(d)(4) for each year beginning with 2010.”.

(2) UNDER MEDICAID MANAGED CARE PLANS.—Section 1932(f) of such Act (42 U.S.C. 1396u-2(f)) is amended—

(A) in the heading, by adding at the end the following: “; ADEQUACY OF PAYMENT FOR PEDIATRIC CARE SERVICES”; and

(B) by inserting before the period at the end the following: “and, in the case of pediatric care services described in section 1902(a)(13)(C), consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation)”.

(b) INCREASED FMAP.—Section 1905 of such Act (42 U.S.C. 1396d), as amended by sections 2006 and 4107(a)(2), is amended

(1) in the first sentence of subsection (b), by striking “and” before “(4)” and by inserting before the period at the end the following: “; and (5) 100 percent (for periods beginning with 2010) with respect to amounts described in subsection (cc)”;

(2) by adding at the end the following new subsection:

“(cc) For purposes of section 1905(b)(5), the amounts described in this subsection are the following:

“(1)(A) The portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2010, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f)) exceeds the payment rate applicable to such services under the State plan as of the date of enactment of the Patient Protection and Affordable Care Act.

“(B) Subparagraph (A) shall not be construed as preventing the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified under such subparagraph.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

PART II—MEDICAL CARE ACCESS PROTECTION

SEC. 11. SHORT TITLE OF PART.

This part may be cited as the “Medical Care Access Protection Act of 2009” or the “MCAP Act”.

SEC. 12. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health

care professionals which impedes efforts to improve patient safety and quality of care.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this part to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of “defensive medicine” and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 13. DEFINITIONS.

In this part:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term “alternative dispute resolution system” or “ADR” means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term “claimant” means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term “collateral source benefits” means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) **COMPENSATORY DAMAGES.**—The term "compensatory damages" means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) **CONTINGENT FEE.**—The term "contingent fee" includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) **ECONOMIC DAMAGES.**—The term "economic damages" means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) **HEALTH CARE GOODS OR SERVICES.**—The term "health care goods or services" means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(8) **HEALTH CARE INSTITUTION.**—The term "health care institution" means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) **HEALTH CARE LAWSUIT.**—The term "health care lawsuit" means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) **HEALTH CARE LIABILITY ACTION.**—The term "health care liability action" means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) **HEALTH CARE LIABILITY CLAIM.**—The term "health care liability claim" means a demand by any person, whether or not pursuant to ADR, against a health care provider or health care institution, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) **HEALTH CARE PROVIDER.**—

(A) **IN GENERAL.**—The term "health care provider" means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) **TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.**—For purposes of this part, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) **MALICIOUS INTENT TO INJURE.**—The term "malicious intent to injure" means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) **NONECONOMIC DAMAGES.**—The term "noneconomic damages" means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) **PUNITIVE DAMAGES.**—The term "punitive damages" means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider or health care institution. Punitive damages are neither economic nor noneconomic damages.

(16) **RECOVERY.**—The term "recovery" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(17) **STATE.**—The term "State" means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the

Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 14. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) **IN GENERAL.**—Except as otherwise provided in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) **GENERAL EXCEPTION.**—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) **MINORS.**—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) **RULE 11 SANCTIONS.**—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this part applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. 15. COMPENSATING PATIENT INJURY.

(a) **UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.**—In any health care lawsuit, nothing in this part shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) **ADDITIONAL NONECONOMIC DAMAGES.**—

(1) **HEALTH CARE PROVIDERS.**—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as \$250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) **HEALTH CARE INSTITUTIONS.**—

(A) **SINGLE INSTITUTION.**—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages

recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as \$250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) **MULTIPLE INSTITUTIONS.**—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as \$250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed \$500,000.

(C) **NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.**—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations described in subsection (b), the future noneconomic damages shall be reduced first.

(D) **FAIR SHARE RULE.**—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 16. MAXIMIZING PATIENT RECOVERY.

(A) **COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.**—

(1) **IN GENERAL.**—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) **CONTINGENCY FEES.**—

(A) **IN GENERAL.**—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingency fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) **LIMITATION.**—The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first \$50,000 recovered by the claimant(s).

(ii) 33½ percent of the next \$50,000 recovered by the claimant(s).

(iii) 25 percent of the next \$500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of \$600,000.

(B) **APPLICABILITY.**—

(1) **IN GENERAL.**—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) **MINORS.**—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(C) **EXPERT WITNESSES.**—

(1) **REQUIREMENT.**—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) **PHYSICIAN REVIEW.**—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) **SPECIALTIES AND SUBSPECIALTIES.**—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) **LIMITATION.**—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. 17. ADDITIONAL HEALTH BENEFITS.

(A) **IN GENERAL.**—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(B) **PRESERVATION OF CURRENT LAW.**—Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (A) shall not apply.

(C) **APPLICATION OF PROVISION.**—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. 18. PUNITIVE DAMAGES.

(A) **PUNITIVE DAMAGES PERMITTED.**—

(1) **IN GENERAL.**—Punitive damages may, if otherwise available under applicable State

or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) **FILING OF LAWSUIT.**—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) **SEPARATE PROCEEDING.**—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) **LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.**—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(B) **DETERMINING AMOUNT OF PUNITIVE DAMAGES.**—

(1) **FACTORS CONSIDERED.**—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) **MAXIMUM AWARD.**—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or \$250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(C) **LIABILITY OF HEALTH CARE PROVIDERS.**—

(1) **IN GENERAL.**—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) **MEDICAL PRODUCT.**—The term “medical product” means a drug or device intended for humans. The terms “drug” and “device” have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. 19. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) **IN GENERAL.**—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding \$50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) **APPLICABILITY.**—This section applies to all actions which have not been first set for trial or retrial before the effective date of this part.

SEC. 20. EFFECT ON OTHER LAWS.

(a) **GENERAL VACCINE INJURY.**—

(1) **IN GENERAL.**—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this part shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this part in conflict with a rule of law of such title XXI shall not apply to such action.

(2) **EXCEPTION.**—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this part or otherwise applicable law (as determined under this part) will apply to such aspect of such action.

(b) **SMALLPOX VACCINE INJURY.**—

(1) **IN GENERAL.**—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this part shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this part in conflict with a rule of law of such part C shall not apply to such action.

(2) **EXCEPTION.**—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this part or otherwise applicable law (as determined under this part) will apply to such aspect of such action.

(c) **OTHER FEDERAL LAW.**—Except as provided in this section, nothing in this part shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 21. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) **HEALTH CARE LAWSUITS.**—The provisions governing health care lawsuits set forth in this part shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this part. The provisions governing

health care lawsuits set forth in this part supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this part; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) **PREEMPTION OF CERTAIN STATE LAWS.**—No provision of this part shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this part) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this part, notwithstanding section 15(a).

(c) **PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.**—

(1) **IN GENERAL.**—Any issue that is not governed by a provision of law established by or under this part (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) **RULE OF CONSTRUCTION.**—Nothing in this part shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care provider or health care institution from liability, loss, or damages than those provided by this part;

(B) preempt or supersede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this part;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. 22. APPLICABILITY; EFFECTIVE DATE.

This part shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this part, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this part shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3246. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 974, between lines 9 and 10, insert the following:

SEC. 3315. EXPANSION OF THE DEFINITION OF A COVERED PART D DRUG UNDER THE MEDICARE PROGRAM.

(a) **IN GENERAL.**—Section 1860D-2(e)(1)(A) of the Social Security Act (42 U.S.C. 1395w-102(e)(1)(A)) is amended by inserting “and disposable medical devices which reduce the

side effects associated with the treatment of cancer” after “1927(k)(2)”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to drugs dispensed on or after January 1, 2011.

SA 3247. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, insert the following:

TITLE X—TO EXPAND ACCESS TO PRIMARY CARE SERVICES BY IMPROVING MEDICARE REIMBURSEMENT FOR PRIMARY CARE PRACTITIONERS WITH A SPECIALTY DESIGNATION OF NEUROLOGY

Subtitle A—Access to Primary Care Services

SEC. 10001. IMPROVED REIMBURSEMENT FOR PRIMARY CARE PRACTITIONERS WITH A SPECIALTY DESIGNATION OF NEUROLOGY.

Section 1833(x)(2)(A)(i)(I) of the Social Security Act, as added by section 5501, is amended by striking “or pediatric medicine” and inserting “neurology, or pediatric medicine”.

Subtitle B—Medical Care Access Protection

SEC. 10101. SHORT TITLE.

This subtitle may be cited as the “Medical Care Access Protection Act of 2009” or the “MCAP Act”.

SEC. 10102. FINDINGS AND PURPOSE.

(a) **FINDINGS.**—

(1) **EFFECT ON HEALTH CARE ACCESS AND COSTS.**—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) **EFFECT ON INTERSTATE COMMERCE.**—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) **EFFECT ON FEDERAL SPENDING.**—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for

which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this subtitle to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of “defensive medicine” and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 10103. DEFINITIONS.

In this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term “alternative dispute resolution system” or “ADR” means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term “claimant” means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term “collateral source benefits” means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers’ compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term “compensatory damages” means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consor-

tium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term “contingent fee” includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term “economic damages” means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE GOODS OR SERVICES.—The term “health care goods or services” means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(8) HEALTH CARE INSTITUTION.—The term “health care institution” means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) HEALTH CARE LAWSUIT.—The term “health care lawsuit” means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) HEALTH CARE LIABILITY ACTION.—The term “health care liability action” means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term “health care liability claim” means a demand by any person, whether or not pursuant to ADR, against a health care provider or health care institution, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) HEALTH CARE PROVIDER.—

(A) IN GENERAL.—The term “health care provider” means any person (including but

not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.—For purposes of this subtitle, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) MALICIOUS INTENT TO INJURE.—The term “malicious intent to injure” means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) NONECONOMIC DAMAGES.—The term “noneconomic damages” means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) PUNITIVE DAMAGES.—The term “punitive damages” means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider or health care institution. Punitive damages are neither economic nor noneconomic damages.

(16) RECOVERY.—The term “recovery” means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys’ office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(17) STATE.—The term “State” means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 10104. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) IN GENERAL.—Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) GENERAL EXCEPTION.—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) MINORS.—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except

that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) **RULE 11 SANCTIONS.**—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this subtitle applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. 10105. COMPENSATING PATIENT INJURY.

(a) **UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.**—In any health care lawsuit, nothing in this subtitle shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) **HEALTH CARE PROVIDERS.**—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as \$250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) **SINGLE INSTITUTION.**—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as \$250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) **MULTIPLE INSTITUTIONS.**—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as \$250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed \$500,000.

(c) **NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.**—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations described in subsection (b), the future noneconomic damages shall be reduced first.

(d) **FAIR SHARE RULE.**—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 10106. MAXIMIZING PATIENT RECOVERY.

(a) **COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—**

(1) **IN GENERAL.**—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) CONTINGENCY FEES.—

(A) **IN GENERAL.**—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) **LIMITATION.**—The total of all contingency fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first \$50,000 recovered by the claimant(s).

(ii) 33½ percent of the next \$50,000 recovered by the claimant(s).

(iii) 25 percent of the next \$500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of \$600,000.

(b) APPLICABILITY.—

(1) **IN GENERAL.**—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) **MINORS.**—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) **REQUIREMENT.**—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) **PHYSICIAN REVIEW.**—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) **SPECIALTIES AND SUBSPECIALTIES.**—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) **LIMITATION.**—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. 10107. ADDITIONAL HEALTH BENEFITS.

(a) **IN GENERAL.**—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) **PRESERVATION OF CURRENT LAW.**—Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) **APPLICATION OF PROVISION.**—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. 10108. PUNITIVE DAMAGES.

(a) **PUNITIVE DAMAGES PERMITTED.—**

(1) **IN GENERAL.**—Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) **FILING OF LAWSUIT.**—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) **SEPARATE PROCEEDING.**—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or \$250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) LIABILITY OF HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) MEDICAL PRODUCT.—The term “medical product” means a drug or device intended for humans. The terms “drug” and “device” have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. 10109. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding \$50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this subtitle.

SEC. 10110. EFFECT ON OTHER LAWS.

(a) GENERAL VACCINE INJURY.—

(1) IN GENERAL.—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this subtitle shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such title XXI shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(b) SMALLPOX VACCINE INJURY.—

(1) IN GENERAL.—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this subtitle shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such part C shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this subtitle shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 10111. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this subtitle shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this subtitle. The provisions governing health care lawsuits set forth in this subtitle supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this subtitle; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this subtitle shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this subtitle, notwithstanding section 10105(a).

(c) PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.—

(1) IN GENERAL.—Any issue that is not governed by a provision of law established by or under this subtitle (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care provider or health care institution from liability, loss, or damages than those provided by this subtitle;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this Act;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. 10112. APPLICABILITY; EFFECTIVE DATE.

This subtitle shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3248. Mr. REID proposed an amendment to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; as follows:

At the end of the House Amendment, insert the following:

The provisions of this Act shall become effective 5 days after enactment.

SA 3249. Mr. REID proposed an amendment to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; as follows:

At the end, insert the following:

The Appropriations Committee is requested to study the impact of any delay in implementing the provisions of the Act on service members families.

SA 3250. Mr. REID proposed an amendment SA 3249 proposed by Mr. REID to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; as follows:

At the end, add the following:

“and the health care provided to those service members.”

SA 3251. Mr. REID proposed an amendment to amendment SA 3250 proposed by Mr. REID to the amendment SA 3249 proposed by Mr. REID to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; as follows:

At the end, add the following:
 “and the children of service members.”

SA 3252. Mr. REID proposed an amendment to amendment SA 3248 proposed by Mr. REID to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; as follows:

Strike “5 days” and insert “1 day”.

SA 3253. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

SEC. 3115. INCREASING THE LIMITATION ON CHARGES FOR PHYSICIANS’ SERVICES UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1848(g)(2)(C) of the Social Security Act (42 U.S.C. 1395w-4(g)(2)(C)) is amended by striking “115 percent” and all that follows through the period at the end and inserting “the greater of—

“(i) 115 percent of the recognized payment amount under this part for nonparticipating physicians or for nonparticipating suppliers or other persons; or

“(ii) the average private insurance reimbursement rate for the item or service (as determined by the Secretary for that geographic practice cost index area).”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after the date of the enactment of this Act.

SA 3254. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

SEC. 3115. ALLOWING INDIVIDUALS TO CHOOSE TO OPT OUT OF THE MEDICARE PART A BENEFIT.

Notwithstanding any other provision of law, in the case of an individual who elects to opt-out of benefits under part A of title XVIII of the Social Security Act, such individual shall not be required to—

(1) opt-out of benefits under title II of such Act as a condition for making such election; and

(2) repay any amount paid under such part A for items and services furnished prior to making such election.

SA 3255. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr.

REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title II, insert the following:

SEC. ____ MEDICAL MALPRACTICE REFORM.

Notwithstanding any other provision of this Act, a State that receives Federal funds under any amendment made by this Act to the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to increase eligibility for participation in such program, shall implement reforms in the State medical malpractice litigation system that are designed to achieve cost savings through the development and implementation of alternatives to tort litigation.

SA 3256. Mr. BENNET submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ____ LONG-TERM FISCAL ACCOUNTABILITY.

(a) PURPOSE.—The purpose of this section is—

(1) to provide a fail-safe mechanism for ensuring that actual budgetary savings from this Act equal or exceed initial estimates of such savings;

(2) to create expedited procedures for Congress to consider legislative changes to increase savings to at least the initial estimate of this Act if actual budgetary savings are less than initial estimates; and

(3) to ensure that additional budget savings will further extend the solvency of the HI Trust Fund, lower premiums and other out-of-pocket costs for Medicare beneficiaries, and reduce the national debt.

(b) DEFINITIONS.—For the purposes of this section:

(1) BUDGETARY EFFECTS.—The term “budgetary effects” refers to the sum of the spending reductions and revenue increases for the period 2010 through 2019 from this Act less the sum of the spending increases and revenue reductions resulting from this Act for the same time period. The calculation shall not include an estimate of the change in federal interest payments.

(2) FEDERAL BUDGETARY COMMITMENT TO HEALTH CARE.—The term “Federal budgetary commitment to health care” refers to the sum of net Federal outlays for all Federal programs and tax preferences for health care.

(3) OMB PROPOSAL.—The term “OMB proposal” refers to the proposed legislative language and such proposal as subsequently modified, if modified by amendment in either House required under subsection (e)(2)(C) to carry out recommendations pursuant to subsection (e)(2)(A).

(4) SAVINGS TARGET.—The term “savings target” refers to the net total provided under subsection (d)(1) for the period 2010 through 2019.

(c) CBO ADVISORY REPORTS.—Starting on October 1, 2012, and every 2 years thereafter, through October 1, 2018, not later than 60 days after the start of the fiscal year, the Congressional Budget Office (CBO) shall submit an updated advisory report to Congress and the President. The updated report shall include a detailed estimate of the budgetary effects of this Act based on the information available for the period 2010 through 2019, as well as information on the budgetary effects for the period 2020 through 2029.

(d) OMB COST ESTIMATE REPORTS.—

(1) INITIAL COST ESTIMATE REPORT.—Not later than 60 days after the date of enactment of this Act, the Director of the Office of Management and Budget (OMB) shall submit to Congress a report containing an estimate of the budgetary effects of this Act for 2010 through 2019, as well as information on the budgetary effects for 2020 through 2029. The estimate of net savings produced by this Act for the period 2010 through 2019 period shall serve as the savings target for future cost estimate reports, provided that the OMB estimate is not less than the final CBO estimate of net savings produced by this Act made by CBO prior to its enactment. If the savings estimated by OMB is less than the amount estimated by the CBO, then the estimate of net savings produced by the CBO shall serve as the savings target.

(2) UPDATED COST ESTIMATE REPORTS.—Starting on October 1, 2012, and every 2 years thereafter, through fiscal year 2019, OMB shall reestimate the budgetary effects of this Act based on the information available at that time. The updated cost estimate report shall include a detailed reestimate of the budgetary effects of this Act for the period 2010 through 2019, as well as information on the budgetary effects for the period 2020 through 2029.

(e) BIENNIAL SUBMISSION TO CONGRESS.—

(1) IN GENERAL.—Starting on October 1, 2012, and every 2 years thereafter, through fiscal year 2019, OMB shall submit the following to Congress along with its submission of the upcoming fiscal year budget of the United States Government required pursuant to section 1105 of title 31 of the United States Code:

(A) The updated cost estimate report completed pursuant to subsection (d)(2).

(B) An explanation of any discrepancies between the OMB updated cost estimate report and the updated advisory report prepared by CBO pursuant to subsection (c).

(2) REQUIRED INFORMATION UPON SAVINGS SHORTFALL.—For a fiscal year in which the amount estimated by OMB in its updated cost estimate report for the period 2010 through 2019 is less than the savings target, OMB shall also submit the following:

(A) Recommendations for increasing actual savings to or above the level of the savings target for years where the amount estimated under the updated cost estimate report is less than the savings target.

(B) An explanation of each recommendation.

(C) Proposed legislative language to carry out such recommendations (OMB proposal).

(D) Any other appropriate information.

(3) CONSIDERATIONS.—In developing and submitting the information required under paragraph (2), the OMB shall, to the extent feasible, give priority to recommendations that—

(A) preserve access to affordable health care;

(B) extend the solvency of the Medicare HI Trust Fund; and

(C) strengthen the long-term viability of the programs created under this Act.

(4) CONSULTATION WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND CHIEF ACTUARY OF THE CENTERS OF MEDICARE AND MEDICAID SERVICES.—In carrying out this subsection, OMB shall consult with, including submitting a draft copy of any recommendations and legislation implementing such recommendations to, the Secretary of the Department of Health and Human Services and the Chief Actuary of the Centers of Medicare and Medicaid Services.

(f) EXPEDITED CONSIDERATION OF OMB PROPOSAL.—

(1) INTRODUCTION OF OMB PROPOSAL.—The OMB proposal shall be introduced in the House of Representatives and in the Senate not later than 5 days of session after receipt by the Congress pursuant to subsection (e), by the majority leader of each House of Congress, for himself, the minority leader of each House of Congress, for himself, or any member of the House designated by the majority leader or minority leader. If the OMB proposal is not introduced in accordance with the preceding sentence in either House of Congress, then any Member of that House may introduce the OMB proposal on any day thereafter. Upon introduction, the OMB proposal shall be referred to the relevant committees of jurisdiction.

(2) COMMITTEE CONSIDERATION.—The committees to which the OMB proposal is referred shall report the OMB proposal without any revision and with a favorable recommendation, an unfavorable recommendation, or without recommendation, not later than 30 calendar days after the date of introduction of the bill in that House, or the first day thereafter on which that House is in session. If any committee fails to report the bill within that period, that committee shall be automatically discharged from consideration of the bill, and the bill shall be placed on the appropriate calendar.

(3) FAST TRACK CONSIDERATION IN HOUSE OF REPRESENTATIVES.—

(A) PROCEEDING TO CONSIDERATION.—It shall be in order, not later than 7 days of session after the date on which an OMB proposal is reported or discharged from all committees to which it was referred, for the majority leader of the House of Representatives or the majority leader's designee, to move to proceed to the consideration of the OMB proposal. It shall also be in order for any Member of the House of Representatives to move to proceed to the consideration of the OMB proposal at any time after the conclusion of such 7-day period. All points of order against the motion are waived. Such a motion shall not be in order after the House has disposed of a motion to proceed on the OMB proposal. The previous question shall be considered as ordered on the motion to its adoption without intervening motion. The motion shall not be debatable. A motion to reconsider the vote by which the motion is disposed of shall not be in order.

(B) CONSIDERATION.—The OMB proposal shall be considered as read. The previous question shall be considered as ordered on the OMB proposal to its passage without intervening motion except 50 hours of debate, including the 2 amendments described in subparagraph (E), equally divided and controlled for the proponent and an opponent. A motion to limit debate shall be in order during such debate. A motion to reconsider the vote on passage of the OMB proposal shall not be in order.

(C) APPEALS.—Appeals from decisions of the chair relating to the application of the Rules of the House of Representatives to the procedure relating to the OMB proposal shall be decided without debate.

(D) APPLICATION OF HOUSE RULES.—Except to the extent specifically provided in this paragraph, consideration of an OMB proposal shall be governed by the Rules of the House of Representatives. It shall not be in order in the House of Representatives to consider any OMB proposal introduced pursuant to the provisions of this subsection under a suspension of the rules pursuant to clause 1 of House Rule XV, or under a special rule reported by the House Committee on Rules.

(E) AMENDMENTS.—

(i) IN GENERAL.—It shall be in order for the majority leader, or his designee, and the minority leader, or his designee, to each offer one amendment in the nature of a substitute to the OMB proposal, provided that any such amendment would not have the effect of decreasing any specific budget outlay reductions below the level of such outlay reductions provided in the OMB proposal, or would have the effect of reducing Federal revenue increases below the level of such revenue increases provided in the OMB proposal, unless such amendment makes a reduction in other specific budget outlays related to Federal health expenditures, an increase in other specific Federal revenues related to Federal health expenditures, or a combination thereof, at least equivalent to the sum of any increase in outlays or decrease in revenues provided by such amendment.

(ii) SCORING.—CBO scores of the OMB proposal and any amendment in the nature of a substitute shall be used for the purpose of determining whether such amendment achieves at least the same amount of savings as the OMB proposal.

(iii) MULTIPLE AMENDMENTS.—If more than 1 amendment is offered under this subparagraph, then each amendment shall be considered separately, and the amendment receiving both an affirmative vote of three-fifths of the Members, duly chosen and sworn, and the highest number of votes shall be the amendment adopted.

(F) VOTE ON PASSAGE.—Immediately following the conclusion of consideration of the OMB proposal, the vote on passage of the OMB proposal shall occur without any intervening action or motion and shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn. If the OMB proposal is passed, the Clerk of the House of Representatives shall cause the bill to be transmitted to the Senate before the close of the next day of session of the House.

(4) FAST TRACK CONSIDERATION IN SENATE.—

(A) IN GENERAL.—Notwithstanding rule XXII of the Standing Rules of the Senate, it is in order, not later than 7 days of session after the date on which an OMB proposal is reported or discharged from all committees to which it was referred, for the majority leader of the Senate or the majority leader's designee to move to proceed to the consideration of the OMB proposal. It shall also be in order for any Member of the Senate to move to proceed to the consideration of the OMB proposal at any time after the conclusion of such 7-day period. A motion to proceed is in order even though a previous motion to the same effect has been disagreed to. All points of order against the motion to proceed to the OMB proposal are waived. The motion to proceed is not debatable. The motion is not subject to a motion to postpone. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the OMB proposal is agreed to, the OMB proposal shall remain the unfinished business until disposed of.

(B) DEBATE.—Consideration of an OMB proposal and of all debatable motions and ap-

peals in connection therewith shall not exceed a total of 50 hours. Debate shall be divided equally between the majority and minority leaders or their designees. A motion further to limit debate on the OMB proposal is in order. Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal. All time used for consideration of the OMB proposal, including time used for quorum calls and voting, shall be counted against the total 50 hours of consideration.

(C) AMENDMENTS.—

(i) IN GENERAL.—It shall be in order for the majority leader, or his designee, and the minority leader, or his designee, to each offer one amendment in the nature of a substitute to the OMB proposal, provided that any such amendment would not have the effect of decreasing any specific budget outlay reductions below the level of such outlay reductions provided in OMB proposal, or would have the effect of reducing Federal revenue increases below the level of such revenue increases provided in the OMB proposal, unless such amendment makes a reduction in other specific budget outlays related to Federal health expenditures, an increase in other specific Federal revenues related to Federal health expenditures, or a combination thereof, at least equivalent to the sum of any increase in outlays or decrease in revenues provided by such amendment.

(ii) SCORING.—CBO scores of the OMB proposal and any amendment in the nature of a substitute shall be used for the purpose of determining whether such amendment achieves at least the same amount of savings as the OMB proposal.

(D) VOTE ON PASSAGE.—The vote on passage shall occur immediately following the conclusion of the debate on the OMB proposal and a single quorum call at the conclusion of the debate if requested. Passage shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn.

(E) RULINGS OF THE CHAIR ON PROCEDURE.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate to the procedure relating to a OMB proposal shall be decided without debate.

(5) RULES TO COORDINATE ACTION WITH OTHER HOUSE.—

(A) REFERRAL.—If, before the passage by 1 House of an OMB proposal of that House, that House receives from the other House an OMB proposal, then such proposal from the other House shall not be referred to a committee and shall immediately be placed on the calendar.

(B) TREATMENT OF OMB PROPOSAL OF OTHER HOUSE.—If 1 House fails to introduce or consider a OMB proposal under this section, the OMB proposal of the other House shall be entitled to expedited floor procedures under this section.

(C) PROCEDURE.—

(i) OMB PROPOSAL IN THE SENATE.—If prior to passage of the OMB proposal in the Senate, the Senate receives an OMB proposal from the House, the procedure in the Senate shall be the same as if no OMB proposal had been received from the House except that—

(I) the vote on final passage shall be on the OMB proposal of the House if it is identical to the OMB proposal then pending for passage in the Senate; or

(II) if the OMB proposal from the House is not identical to the OMB proposal then pending for passage in the Senate and the Senate then passes the Senate OMB proposal, the Senate shall be considered to have passed the House OMB proposal as amended by the text of the Senate OMB proposal.

(ii) DISPOSITION OF THE OMB PROPOSAL.—Upon disposition of the OMB proposal received from the House, it shall no longer be in order to consider the OMB proposal originated in the Senate.

(D) TREATMENT OF COMPANION MEASURES IN THE SENATE.—If following passage of the OMB proposal in the Senate, the Senate then receives an OMB proposal from the House of Representatives that is the same as the OMB proposal passed by the House, the House-passed OMB proposal shall not be debatable. If the House-passed OMB proposal is identical to the Senate-passed OMB proposal, the vote on passage of the OMB proposal in the Senate shall be considered to be the vote on passage of the OMB proposal received from the House of Representatives. If it is not identical to the House-passed OMB proposal, then the Senate shall be considered to have passed the OMB proposal of the House as amended by the text of the Senate OMB proposal.

(E) CONSIDERATION IN CONFERENCE.—Upon passage of the OMB proposal, the Senate shall be deemed to have insisted on its amendment and requested a conference with the House of Representatives on the disagreeing votes of the two Houses, and the Chair be authorized to appoint conferees on the part of the Senate, without any intervening action.

(F) ACTION ON CONFERENCE REPORTS IN SENATE.—

(i) MOTION TO PROCEED.—A motion to proceed to the consideration of the conference report on the OMB proposal may be made even though a previous motion to the same effect has been disagreed to.

(ii) CONSIDERATION.—During the consideration in the Senate of the conference report (or a message between Houses) on the OMB proposal, and all amendments in disagreement, and all amendments thereto, and debatable motions and appeals in connection therewith, debate (or consideration) shall be limited to 10 hours, to be equally divided between, and controlled by, the majority leader and minority leader or their designees. Debate on any debatable motion or appeal related to the conference report (or a message between Houses) shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the conference report (or a message between Houses).

(iii) DEBATE IF DEFEATED.—If the conference report is defeated, debate on any request for a new conference and the appointment of conferees shall be limited to 1 hour, to be equally divided between, and controlled by, the manager of the conference report and the minority leader or his designee, and should any motion be made to instruct the conferees before the conferees are named, debate on such motion shall be limited to one-half hour, to be equally divided between, and controlled by, the mover and the manager of the conference report. Debate on any amendment to any such instructions shall be limited to 20 minutes, to be equally divided between and controlled by the mover and the manager of the conference report. In all cases when the manager of the conference report is in favor of any motion, appeal, or amendment, the time in opposition shall be under the control of the minority leader or his designee.

(iv) AMENDMENTS IN DISAGREEMENT.—If there are amendments in disagreement to a conference report on the OMB proposal, time on each amendment shall be limited to 30 minutes, to be equally divided between, and controlled by, the manager of the conference

report and the minority leader or his designee. No amendment that is not germane to the provisions of such amendments shall be received.

(G) VOTE ON CONFERENCE REPORT IN EACH HOUSE.—Passage of the conference in each House shall be by an affirmative vote of three-fifths of the Members of that House, duly chosen and sworn.

(H) VETO.—If the President vetoes the bill debate on a veto message in the Senate under this subsection shall be 1 hour equally divided between the majority and minority leaders or their designees.

(6) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This subsection is enacted by Congress—

(A) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively but applicable only with respect to the procedure to be followed in that House in the case of bill under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

SA 3257. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 352, line 8, strike “50” and insert “500”.

On page 352, line 13, strike “50” and insert “500”.

On page 352, line 16, strike “50” and insert “500”.

On page 352, line 20, strike “50” and insert “500”.

SA 3258. Mrs. SHAHEEN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 869, between lines 14 and 15, insert the following:

SEC. 3143. FLOOR ON AREA WAGE INDEX.

(a) IN GENERAL.—Notwithstanding any other provision of law, beginning with discharges occurring on or after October 1, 2009, for purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)), the area wage index applicable under such section to hospitals with Medicare provider numbers 300001, 300003, 300005, 300011, 300012, 300014, 300017, 300018, 300019, 300020, 300023, 300029, and 300034 shall not be less than the post-reclassification area wage index applicable to the hospital for purposes of deter-

mining payments during the period beginning on or after October 1, 2006, and before October 1, 2007.

(b) IMPLEMENTATION.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall make a proportional adjustment in the standardized amounts determined under section 1886(d)(3) of the Social Security Act (42 U.S.C. 1395ww(d)(3)) to assure that the provisions of this section do not result in aggregate payments under section 1886 of such Act (42 U.S.C. 1395ww) that are greater or less than those that would otherwise be made. Notwithstanding any other provision of law, for purposes of making adjustments under this subsection, the Secretary shall not further adjust the wage index or standardized amounts for any area, State, or region within the United States.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry be authorized to meet during the session of the Senate on December 16, 2009.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ARMED SERVICES

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on December 16, 2009, at 1:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on December 16, at 11:30 a.m., in room SD-366 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on December 16, 2009, at 10 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on December 16, 2009, at 3 p.m., in room SD-226 of the Dirksen Senate Office Building, to conduct a hearing entitled “Judicial Nominations.”

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON VETERANS' AFFAIRS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Veterans' Affairs be authorized to meet during the session of the Senate on December 16, 2009.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs' Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security be authorized to meet during the session of the Senate on December 16, 2009, at 2:30 p.m. to conduct a hearing entitled, "Tools to Combat Deficits and Waste: Enhanced Rescission Authority".

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON HUMAN RIGHTS AND THE LAW

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on the Judiciary, Subcommittee on Human Rights and the Law, be authorized to meet during the session of the Senate on December 16, 2009, at 10:30 a.m., in room SD-226 of the Dirksen Senate Office Building, to conduct a hearing entitled "The Law of the Land: U.S. Implementation of Human Rights Treaties."

The PRESIDING OFFICER. Without objection, it is so ordered.

HONORING THE ESTABLISHMENT OF DIPLOMATIC RELATIONS BETWEEN THE UNITED STATES AND THE HASHEMITE KINGDOM OF JORDAN

Mr. DURBIN. I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 376, submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The assistant legislative clerk read as follows:

A resolution (S. Res. 376) honoring the 60th anniversary of the establishment of diplomatic relations between the United States and the Hashemite Kingdom of Jordan, the 10th anniversary of the accession to the throne of His Majesty King Abdullah II Ibn Al Hussein, and for other purposes.

There being no objection, the Senate proceeded to consider the resolution.

Mr. INOUE. Madam President, today, I am supporting this resolution to honor the 60th anniversary of the establishment of diplomatic relations between the U.S. and the Hashemite Kingdom of Jordan, as well as to honor the 10th anniversary of His Majesty King Abdullah II Ibn Al Hussein's ac-

cession to the throne. I am pleased to be joined in this endeavor by Senator GREGG.

Since establishing diplomatic relations, Jordan has worked together with the U.S. towards the mutual goal of peace in the Middle East. In 1994, King Hussein and Prime Minister of Israel, Yitzhak Rabin, signed the Jordan-Israel peace treaty, ending nearly 50 years of war between the two countries. The government of Jordan has been an instrumental partner in the fight against al-Qaida and terrorism. As a result, the people of Jordan have also suffered devastating losses at the hands of terrorists.

Mr. DURBIN. I ask unanimous consent to be added as a cosponsor to this legislation.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DURBIN. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and any statements be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 376) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 376

Whereas the Hashemite Kingdom of Jordan achieved independence on May 25, 1946;

Whereas the United States recognized Jordan as an independent state in a White House announcement on January 31, 1949;

Whereas diplomatic relations and the American Legation in Jordan were established on February 18, 1949, when United States diplomat Wells Stabler presented his credentials as Chargé d'Affaires in Amman;

Whereas, for 60 years, the United States and Jordan have enjoyed a close relationship and have worked together to advance issues ranging from the promotion of Middle East peace to advancing the socio-economic development of the people of Jordan, as well as the threat to both posed by al Qaeda and violent extremism;

Whereas, from 1952 to 1999, King Hussein charted a moderate path for his country;

Whereas, for decades, the United States has been Jordan's strongest international partner;

Whereas, throughout his reign, King Hussein looked for opportunities to realize his dream of a more peaceful Middle East by working to solve intra-Arab disputes and engaging successive Prime Ministers of Israel in the search for peace;

Whereas King Hussein and Prime Minister of Israel Yitzhak Rabin signed the historic Jordan-Israel peace treaty in 1994, ending nearly 50 years of war between the neighboring countries;

Whereas the United States lost a close friend and a crucial partner when King Hussein passed away in 1999;

Whereas King Hussein was succeeded by his son, King Abdullah II, who has continued his father's work to improve the lives of the

people of Jordan while also seeking to bring peace to the region;

Whereas, in the aftermath of the September 11, 2001, terrorist attacks, the Government of Jordan has been an instrumental partner in the fight against al Qaeda, has provided crucial assistance in Iraq, and has shouldered a heavy burden in providing refuge to a significant portion of the Iraqi refugee population;

Whereas, through his 2004 Amman Message, King Abdullah II has been a leading Arab voice in trying to reaffirm the true path of Islam;

Whereas, in November 2005, al Qaeda terrorists struck three hotels in Amman, Jordan, thereby uniting the people of Jordan and the United States in grief over the lives lost at this act of terrorism; and

Whereas King Abdullah II begins his second decade on the Hashemite throne by redoubling his efforts for peace in the region as the Jordan-United States partnership enters its seventh decade: Now, therefore, be it

Resolved, That the Senate—

(1) commemorates the 60th anniversary of the close relationship between the United States and the Hashemite Kingdom of Jordan;

(2) expresses its profound admiration and gratitude for the friendship of the people of Jordan;

(3) congratulates His Majesty King Abdullah II on 10 years of enlightened and progressive rule; and

(4) shares the hope of His Majesty King Abdullah II and the people of Jordan for a more peaceful Middle East.

ORDERS FOR THURSDAY, DECEMBER 17, 2009

Mr. DURBIN. I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m., Thursday, December 17; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of the House message with respect to H.R. 3326, the Department of Defense appropriations bill, with Senators permitted to speak for up to 10 minutes each; provided further that the first hour be equally divided and controlled between the two leaders or their designees, with the Republicans controlling the first half and the majority controlling the second half.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADJOURNMENT UNTIL 10 A.M. TOMORROW

Mr. DURBIN. Madam President, if there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the previous order.

There being no objection, the Senate, at 6:21 p.m., adjourned until Thursday, December 17, 2009, at 10 a.m.

HOUSE OF REPRESENTATIVES—Wednesday, December 16, 2009

The House met at 10 a.m. and was called to order by the Speaker pro tempore (Ms. BALDWIN).

DESIGNATION OF THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

WASHINGTON, DC,
December 16, 2009.

I hereby appoint the Honorable TAMMY BALDWIN to act as Speaker pro tempore on this day.

NANCY PELOSI,
Speaker of the House of Representatives.

PRAYER

The Chaplain, the Reverend Daniel P. Coughlin, offered the following prayer:

During this season of holidays and holy days, Lord, we pray for families all across this Nation. The times, economics, and unemployment are causing great stress within some families. Military service, sickness, recent deaths, and alienation bring other families to the point of heartbreak and tears. Yet we believe, Lord, that the family is not only the basic social unit upon which our communities and our Nation are built. Family life is the "domestic church" where prayer is practiced and faith is first witnessed.

For You, Lord God, the family itself is a great mystery, our first school of formation, which shapes human values, affirms self-image, and provides a world view. Here one accepts personal independence within a sense of belonging and authority with a sense of humor, bold enough to giggle at life's inconsistencies and laugh at oneself. Daily, children and adults learn self-giving, gratitude, patience, forgiveness, and simple expressions of love and being loved.

Lord, may Congress respect and protect family life in this country. With Your blessing, may every family this season nurture the experience of love: conjugal love, paternal and maternal love, fraternal love, and the love of a community of persons and of generations. May they acknowledge Your Presence in everyone around the table, both now and forever. Amen.

THE JOURNAL

The SPEAKER pro tempore. The Chair has examined the Journal of the last day's proceedings and announces to the House her approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

PLEDGE OF ALLEGIANCE

The SPEAKER pro tempore. Will the gentleman from Kentucky (Mr. YARMUTH) come forward and lead the House in the Pledge of Allegiance.

Mr. YARMUTH led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will entertain up to 15 requests for 1-minute speeches on each side of the aisle.

SACRIFICING THE FUTURE FOR WAR AND WALL STREET

(Mr. KUCINICH asked and was given permission to address the House for 1 minute.)

Mr. KUCINICH. The Greatest Generation sacrificed during their lifetime so future generations could have it better. Here, the "bailout generation" demands the future will be sacrificed for the present with unlimited money from Wall Street and war.

While the government expands the debt for Wall Street and war, people are led to believe that we're doing it for jobs on Main Street. Even today as Congress expands the debt limit, CitiGroup will get billions in new tax breaks. Last week, Congress let Wall Street keep their over-the-counter black box derivatives game going, which will leave the taxpayers exposed to huge losses in the future.

Today, Congress will give the Pentagon another \$550 billion and the wars in Iraq and Afghanistan another \$130 billion, where we expand the national debt, sacrificing the future for the present. In the past 2 years, Congress chose war and Wall Street over jobs and Main Street, expanding the debt, sacrificing the future for the present.

Today's job bill is necessary but will address only a fraction of the unemployed. Rather than prime the pump of the economy and put all of America back to work, we have to sacrifice the future for war and for Wall Street.

OBAMAVILLE IN COLORADO SPRINGS

(Mr. LAMBORN asked and was given permission to address the House for 1 minute.)

Mr. LAMBORN. Madam Speaker, this picture shows what the failed policies of this Congress and administration are doing to America. This sign was put up near a homeless camp in my district. It's next to the highway, down by the river. It says: Welcome to Obamaville—Colorado's fastest growing community.

It's obvious that the liberals' prescription for creating jobs only creates more government by taking hard-earned dollars from families and small businesses for taxes that could have gone into creating real jobs.

When the President said he wanted more jobs through the so-called stimulus, it's mostly meant more bureaucrats, and that's not the jobs Americans want. When Americans lose their jobs in this recession and end up living in a tent, something is wrong.

The policies of this administration and Congress, by raising taxes and putting more regulations in the way of business, will not create the jobs Americans need for the future, but their policies will create tent cities.

HONORING JACKIE HAYS

(Mr. YARMUTH asked and was given permission to address the House for 1 minute.)

Mr. YARMUTH. Madam Speaker, I rise today to pay tribute to Jackie Hays, a broadcasting legend in Louisville, Kentucky, who has served our community for nearly 22 years. Jackie will retire this Friday, and she will be greatly missed.

Over the course of her career at WAVE-TV, Jackie has done it all: flying in Thunderbirds and Blue Angels, covering more than 25 Kentucky Derbies, and joining Louisvillians for our greatest celebrations and darkest tragedies. But most of all, she has endeared herself to Louisvillians because we always knew how much she cared about us. That's why she was selected 16 times as Louisville's favorite female anchor. She proved her love for our community not just by her on-air professionalism, but also by her enthusiastic involvement in civic and charitable activities.

Jackie once said: God isn't going to ask me one day how many newscasts I did or how many stories I broke, but what kind of person I was.

As Jackie's WAVE-3 career comes to an end, I can say without reservation that she is a person that anyone would hold up as a role model, and we are grateful she has called Louisville home so long. I join everyone in Louisville in

wishing her a long and fulfilling retirement.

TIME TO STOP DIGGING THE DEFICIT HOLE

(Mrs. SCHMIDT asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Mrs. SCHMIDT. A few weeks ago, Moody's Investor Services told us that our country's AAA bond rating will be downgraded if we do not get the budget deficit under control. This is because the President and this Congress ran up a record-breaking deficit last year to the tune of \$1.4 trillion, tripling our prior record.

The response from the President and the majority is more spending and absolutely no commitment to do anything to reduce the deficit. In fact, today we're going to be asked to raise our debt ceiling so we can borrow more.

An article in Barron's financial magazine on Monday said this: "Moody's expressed optimism that the U.S. budget deficit would be reined in, helped by quicker-than-expected repayment of funds under the TARP program. But the ink was hardly dry on its report when President Obama, Tuesday, announced a new 'jobs' program, funded in part by the greater-than-anticipated return of TARP funds."

Repaid TARP funds are supposed to be used for deficit reduction. Besides this, I thought the trillion dollar stimulus bill was supposed to create jobs.

You know, when you get yourself into a hole, you have to stop digging.

It's time to stop digging.

JOBS, JOBS, AND JOBS

(Mr. SIRES asked and was given permission to address the House for 1 minute.)

Mr. SIRES. Madam Speaker, while this House has made great strides to improve our economy, our journey towards economic recovery will not be complete until after a robust jobs package is passed. The nearly half a million unemployed New Jerseyans and over 15 million unemployed Americans simply cannot wait. They need jobs now, and they're relying on us to deliver it.

In order to put Americans back to work and lay the groundwork for future growth, we must build on the investments in job creation we have already made; specifically, investments in infrastructure and clean energy: jobs to repair existing roads and bridges, jobs to improve public transportation and water infrastructure, and jobs in alternative energy initiatives, including solar and wind.

In addition to job creation, we must also ensure that the unemployed can make ends meet while searching for

jobs by continuing the extension of unemployment benefits and helping them maintain health care coverage by extending COBRA subsidies that are set to expire.

Madam Speaker, our work is not done. We need to pass a bill that will generate jobs, jobs, and even more jobs—not in a month, not two, but now.

CONSTITUTIONAL BALANCED BUDGET AMENDMENT

(Mr. BUCHANAN asked and was given permission to address the House for 1 minute.)

Mr. BUCHANAN. Madam Speaker, the congressional leaders this week want to raise the Federal debt ceiling \$1.8 trillion. The current debt in the country is over \$12 trillion.

When I first came here 3 years ago, I introduced a constitutional balanced budget amendment. I hear up here the last 3 years that the Democrats are the problem, the Republicans are the problem on the spending. They're both the problem. In the last 50 years, they've only balanced the budget five or six times, yet 49 out of 50 Governors have to balance the budget.

Our State of Florida has had a tough cycle in terms of revenues. They've cut expenses. Families are cutting expenses. Small businesses in our communities are cutting 20, 30 percent in expenses, yet we're raising expenses 12 percent.

The time is now. We almost had a constitutional balanced budget amendment in 1994. That's the only thing that's going to solve the problem. We need to act today as Democrats and Republicans and do what's right for America and Americans.

SS "ST. LOUIS"

(Mr. KLEIN of Florida asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KLEIN of Florida. Madam Speaker, this week I had the chance to meet with some of the survivors of the SS *St. Louis* in my community of south Florida. This was a memorable and moving experience that provides each of us with a powerful lesson about our past.

As you know, the SS *St. Louis* carried nearly 1,000 Jewish refugees from Nazi Germany in 1939, and, shamefully, the United States turned the ship away. Its passengers were sent back to Europe where hundreds of them perished. We cannot forget this dark moment in our Nation's history, and we must remember the story and share it with our next generation in order to keep our promise of "never again."

I'd like to associate myself with Senate Resolution 111 passed by the U.S. Senate, which recognizes the tragedy of the SS *St. Louis* and honors the memory of the passengers who lost

their lives. I join my colleagues and continue to pay tribute to those who did not survive, and I express my gratitude for the opportunity to join the survivors in person this week.

□ 0915

AFGHANISTAN-PAKISTAN BORDER AND U.S.-MEXICO BORDER

(Mr. POE of Texas asked and was given permission to address the House for 1 minute.)

Mr. POE of Texas. Madam Speaker, I had the opportunity to be with our resilient troops last week in Afghanistan near the violent southern border with Pakistan. Part of their mission is to secure the border by preventing drugs, arms, money and Taliban criminals from crossing back and forth through the vast border regions. It's in America's interest to have our military in Afghanistan and protect the sovereignty of that country.

It is ironic, however, we see the need to protect the borders of other nations; but because of political reasons, we don't have the moral will to protect our own borders. This is not the first administration that has given a wink and a nod to our porous borders, but it should be the last.

Our southern border region is a haven for organized criminal cartels, gun smugglers, human smugglers and rogue outlaws that cross as freely as they did in the days of the old west. We should be as concerned about protecting our own border as we are about protecting the borders of Third World countries like Afghanistan. We should put our military on the border if necessary.

After all, the first duty of government is protection of our own homeland.

And that's just the way it is.

JOBS

(Ms. LINDA T. SÁNCHEZ of California asked and was given permission to address the House for 1 minute.)

Ms. LINDA T. SÁNCHEZ of California. Madam Speaker, I rise today for American working men and women who want to work but can't find a job. The Nation's unemployment rate stands at 10 percent, with my home State of California ranking third worst in the country.

While I support a stronger safety net to help families survive, in the end, Americans don't want unemployment checks. They want to work.

That's why I'm proud to support the Jobs for Main Street Act which will put Americans back to work in the most direct way possible: by hiring them. This bill makes overdue investments in America's rails, roads and schools and in well-paying Davis-Bacon-covered jobs for our workers.

The benefits for our economy of encouraging unionized jobs cannot be overstated. As the great Dr. Martin Luther King, Jr., said, "Everyone knows that the labor movement did not diminish the strength of the Nation, but enlarged it. By raising the living standards of millions, labor miraculously created a market for industry and lifted the whole Nation to undreamed of levels of production."

May this bill continue in that tradition.

JOBS

(Ms. FOXX asked and was given permission to address the House for 1 minute.)

Ms. FOXX. Madam Speaker, as we approach the Christmastime, too many Americans are asking, Where are the jobs? In January, the unemployment rate was 7.6 percent. Only 10 months later, the national unemployment reached a whopping 10.2 percent, the highest level since April 1983. That means today there are 15.7 million unemployed Americans looking for work.

House Republicans have an economic recovery plan that will help get Americans back to work. Our economic recovery plan will create twice the jobs at half the cost of the Democrats' failed stimulus plan.

How ironic that our colleagues are coming to the floor today to talk about the need for jobs when it is their votes and the policies of this President that have killed so many jobs.

It's time we started working on behalf of the American people and focus on real commonsense solutions that will help put people get back to work and let them celebrate Christmas in a wonderful way.

JOB CREATION PROGRAM

(Mrs. MALONEY asked and was given permission to address the House for 1 minute.)

Mrs. MALONEY. Madam Speaker, I would like to respond to my good friend on the other side of the aisle from the great State of North Carolina who pointed out that there are many jobless Americans. That's true, but let's put this in perspective. The last month that former President Bush was in office, this country lost over 750,000 jobs.

Under President Barack Obama's leadership, we are trending in the right direction. This last month, we lost 11,000 jobs. The last 5 months of the Bush administration, they lost well over 600,000 jobs.

And as Nobel laureate Joseph Stiglitz pointed out at a joint economic hearing last week, that job creation during the Bush administration was fueled by an artificial bubble. Inflated housing prices and a ballooning real estate market spurred consumption and hir-

ing and put us in a very dangerous position where we find ourselves today.

We owe it to the 15 million jobless Americans to invest in aggressive job creation policies which will be on the floor today in the Democratic jobs program.

STOP THE AUTOMATIC PAY RAISE FOR MEMBERS OF CONGRESS IN FISCAL YEAR 2011 ACT

(Mr. MITCHELL asked and was given permission to address the House for 1 minute.)

Mr. MITCHELL. Madam Speaker, my colleague, Dr. RON PAUL, and I have once again introduced legislation to stop Members of Congress from receiving the next scheduled automatic pay raise. Earlier this year, we introduced legislation to block the fiscal year 2010 pay raise, and we were joined by a bipartisan coalition of more than 100 of our colleagues in the process. Thanks to their help, as well as that of our leadership, the fiscal year 2010 pay raise was blocked.

With unemployment so high and so many families struggling to make ends meet, we believe that it would be wrong for Congress to now raise its own pay in fiscal year 2011. Right now, we need our focus to be on getting people back to work, shoring up the economy, and keeping our families and communities safe, not on giving ourselves a pay raise. The American people are not getting a raise. Neither should Congress.

I encourage my colleagues from both sides of the aisle to do the same and join Dr. RON PAUL and me in stopping the next automatic pay raise from taking effect by supporting H.R. 4255, the Stop the Automatic Pay Raise for Members of Congress in Fiscal Year 2011 Act.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF SENATE AMENDMENT TO H.R. 3326, DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 2010; FOR CONSIDERATION OF HOUSE JOINT RESOLUTION 64, FURTHER CONTINUING APPROPRIATIONS, FISCAL YEAR 2010; FOR CONSIDERATION OF H.R. 4314, PERMITTING CONTINUED FINANCING OF GOVERNMENT OPERATIONS; FOR CONSIDERATION OF SENATE AMENDMENT TO H.R. 2847, COMMERCE, JUSTICE, SCIENCE, AND RELATED AGENCIES APPROPRIATIONS ACT, 2010

Ms. PINGREE of Maine, from the Committee on Rules, submitted a privileged report (Rept. No. 111-380) on the resolution (H. Res. 976) providing for consideration of the Senate amendment to the bill (H.R. 3326) making appropriations for the Department of Defense for the fiscal year ending Sep-

tember 30, 2010, and for other purposes; for consideration of the joint resolution (H.J. Res. 64) making further continuing appropriations for fiscal year 2010, and for other purposes; for consideration of the bill (H.R. 4314) to permit continued financing of Government operations; for consideration of the Senate amendment to the bill (H.R. 2847) making appropriations for the Departments of Commerce and Justice, and Science, and Related Agencies for the fiscal year ending September 30, 2010, and for other purposes, which was referred to the House Calendar and ordered to be printed.

WAIVING REQUIREMENT OF CLAUSE 6(a) OF RULE XIII WITH RESPECT TO CONSIDERATION OF CERTAIN RESOLUTIONS

Ms. PINGREE of Maine. Madam Speaker, by direction of the Committee on Rules, I call up House Resolution 973 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 973

Resolved, That the requirement of clause 6(a) of rule XIII for a two-thirds vote to consider a report from the Committee on Rules on the same day it is presented to the House is waived with respect to any resolution reported on the legislative day of December 16, 2009.

The SPEAKER pro tempore. The gentlewoman from Maine is recognized for 1 hour.

Ms. PINGREE of Maine. Madam Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentlewoman from North Carolina, Dr. FOXX. All time yielded during consideration of the rule is for debate only.

GENERAL LEAVE

Ms. PINGREE of Maine. I also ask unanimous consent that all Members be given 5 legislative days in which to revise and extend their remarks on House Resolution 973.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Maine?

There was no objection.

Ms. PINGREE of Maine. I yield myself such time as I may consume.

Madam Speaker, House Resolution 973 waives clause 6(a) of rule XIII which requires a two-thirds vote to consider a rule on the same day it is reported from the Rules Committee. This waiver applies to any resolutions reported on the legislative day of December 16, 2009. This will allow the House to consider today important legislation, including legislation to ensure the funding of our military in addition to measures to put people back to work.

Madam Speaker, we must act quickly to deliver the bills before us today that will fund our military and get people back to work. Today the House will

take up several measures that will fund our military and make critical investments in the Nation's infrastructure in order to put people back to work. We have the opportunity today to take the bailout money that was used as a lifeline to Wall Street and give that money back to the American people and those who have been hit hardest by these tough economic times.

The legislation that we will take up later today will divert the TARP money to programs that will create and save jobs across the country. We do this by investing \$75 billion of TARP money into highways, to transit, to school renovation, to hiring teachers, police and firefighters, to supporting small businesses, job training and affordable housing.

For those hit hardest by the recession, this bill also provides emergency relief by extending programs like Unemployment Benefits, COBRA and FMAP, which is health care funding for our States, and the child care tax credit. These are measures that we must pass to build a foundation for long-term economic recovery.

This is not an ordinary day; and given the importance of this legislation, I hope Members on both sides of the aisle will support this rule so that we can move quickly to enact these critically important measures.

I wish, as so many of my colleagues wish, that we weren't faced with such difficult problems. I wish that when the Democrats took over the majority, we weren't saddled with two wars, a recession and a \$1.3 trillion deficit. But wishing won't make these problems go away. There is real urgency in the actions before us today, and I truly hope that my colleagues on both sides of the aisle will join me in supporting this rule to allow us to move forward.

Later in the day, we will debate the merits of all of this legislation and the grave implications of not passing these bills. But right now, I urge my colleagues to support this rule and allow us to move forward on the debate to complete the work that we were sent here to do.

I reserve the balance of my time.

Ms. FOXX. Madam Speaker, I appreciate my colleague yielding the time this morning.

I want to say that it seems every time we come here, we have to do a little bit of correcting people's memory and their recollection of history. My colleague just said when they took over the majority, we had a \$1.3 trillion deficit. I think if she will check her facts, she will see that the \$1.3 trillion deficit came about as a result of the Democrats' taking over the majority. She may not have been here in 2007, but when they took over the majority, I believe that the deficit was \$259 billion, and they made it \$1.3 trillion this year with their Democratic President.

We are here considering a same-day martial law rule. Now, I understand

that there are times when we need to move quickly when we are faced with an immediate crisis. However, I think the word "crisis" has been overused particularly this year. We haven't had much by way of crisis this year, and yet they're trying to make it a crisis by bringing in this, again, same-day martial law rule.

The Rules Committee met last night at 8:45. We didn't get the text of the bills that we're going to be debating and the rule that we're going to approve again in a few minutes, or a little while, so we've had very little time to be able to deal with these things. But we've known about this for a long, long time. We've known that the funding for the government would run out Friday night for over a month. So what have we been doing during that period of time when we should have been preparing for this day?

Let me give some ideas on what we've been doing by reading out some of the bills that we've been voting on on the floor: expressing support for designation of November 29, 2009, as "Drive Safer Sunday," surely something that the country could not live without, without our voting on it; expressing support for designation of the week beginning on November 9, 2009, as "National School Psychology Week," another extraordinarily important issue for us to be dealing with; recognizing the 60th anniversary of the Berlin Airlift's success. Certainly I am extremely proud of the fact that Ronald Reagan helped end the Cold War by opening up Berlin. But I don't think that really needed to be done by a vote on this floor.

□ 0930

And then the one that I really think tops the cake and will get the attention of the American people, honoring the 2,560th anniversary of the birth of Confucius and recognizing his invaluable contributions to philosophy and social and political thought. The fact that 2,560 years have passed since the birth of Confucius and we hadn't acknowledged it, I really think that could have waited a little bit longer in terms of the importance of the work that we are doing.

So, here we are again doing what our colleagues across the aisle have been so good at this session, short-circuiting the legislative process so we can jam through another major spending bill without the benefit of Members or, more importantly, the citizens of this country having the opportunity to read it.

This rule enables us to take up the next rule, and that rule will let the House consider more than \$1 trillion in spending, all done almost in the blink of an eye if you put it in the context of the birth of Confucius. But let us not be fooled by this attempt to say that something is a crisis. The reason we

are doing this on the spur of the moment is because our Speaker and several Members are going to leave today to go to Copenhagen to talk with people about climate control. And they're going to emit much, much carbon on their way to do that, which really is sort of hypocritical in terms of what the conference is all about. So we have folks talking out of both sides of their mouths here over and over and over again.

Madam Speaker, I reserve the balance of my time.

Ms. PINGREE of Maine. My good friend from North Carolina has suggested that this isn't an emergency. I would say that I hear every day from constituents in my district who feel that we are in a time of emergency. In Maine, we have 20,000 unemployed workers who are facing the end of their unemployment benefits. A very critical thing that we are about to talk about today is the extension of unemployment benefits.

Now, we are anxious for the economy to improve, but the fact is in my State unemployment benefits are the fourth largest payroll. That is a tragedy that we have to deal with. We have to make sure that those people, in the middle of a cold winter, don't go without their vital support and that our State doesn't go without a critical part of our economy.

Many of those people can't even stand a delay because the fact is if they go for even a few days or weeks without their benefits, they've already hit the end of their credit card limits, they've already gone as far as they can possibly go. Many workers have talked to me about the fact that they are using their COBRA subsidy; they were laid off, and the fact is this extended that as well.

As far as I'm concerned, there are many critical things in this bill. This is the time to get it passed. People say to me all the time, When are you going to get something done in Washington? As far as I'm concerned, this is something we have to get done, and we need to get back to work today.

I reserve the balance of my time.

Ms. FOXX. Madam Speaker, I now yield such time as he may consume to the distinguished gentleman from California and ranking member of the Rules Committee, Mr. DREIER.

Mr. DREIER. Madam Speaker, our friend from Maine is absolutely right. This is a very, very challenging time for people who are dealing with the economic downturn through which we have suffered, and it is essential that we do a number of the things that are before us today.

The national security of the United States of America is priority number one. I always argue that the five most important words in the middle of the preamble of the U.S. Constitution are "provide for the common defense." I

say that, Madam Speaker, because if you think about the issues with which we regularly contend here, nearly all of them can be done either by an individual, within a family, within a church or community, a city, a county, or a State level of governing, but our national defense can only be handled by the Federal Government. So I will acknowledge it is very, very important for us to ensure that our men and women in uniform have what they need. And I will acknowledge that as we deal with the economic downturn, ensuring that people have job opportunities is a very, very, very important priority for us.

I happen to think that we have gone in the exact opposite direction when it comes to the notion of encouraging long-term private sector job creation and economic growth. I believe that we should deal with that issue in a bipartisan way. And when I say bipartisan, I'm referring to two Presidents in the last half century; one is John F. Kennedy, the other Ronald Reagan. John F. Kennedy, when we were dealing with economic challenges in the early 1960s, decided very clearly that the best way to get the economy back on track, the best way to encourage private sector job creation and economic growth was to do what? Bring about broad, marginal tax rate reduction, reducing the top rate on capital gains and taking the top rate on job creators, men and women who are out there working to create more and more opportunity for their fellow Americans.

Well, Madam Speaker, that kind of plan was put into place in the early 1960s with a Democratic Congress and a Democratic President of the United States. And guess what happened? During the decade of the 1960s, we saw a doubling of the flow of revenues to the Federal Treasury because of the heralded John F. Kennedy tax cuts; again, a Democratic President and a Democratic Congress.

Rush forward from the early 1960s to the early 1980s, two decades. I was privileged to be a Member of the 97th Congress which convened in January of 1981. We were dealing with very, very serious economic problems, some of which were even more challenging than exist today. In the early 1980s, people will recall that interest rates were well into double digits, we had an unemployment rate that dramatically exceeded where we are today, and if you look at the overall challenge, it was similar. How did we deal with that, Madam Speaker? We dealt with it by doing, under Ronald Reagan, exactly what President John Kennedy, a great Democratic President, did. Under Ronald Reagan, we saw broad reductions across the board of marginal tax rates, we saw a reduction in the capital gains rate.

And what happened? As we encouraged those job creators out there in our

economy, what happened, Madam Speaker, was we saw, again, a doubling of the flow of revenues to the Federal Treasury and we saw good, long-term private sector jobs created.

Now, the thing that is most troubling about what it is that we are doing is, while we have seen—I am really happy to see this reduction of 10.2 percent to 10 percent, the unemployment rate; it's a positive sign. The problem is that it's not private sector job creation; what we are seeing is public sector job creation.

I will acknowledge that infrastructure spending is important. I represent the Los Angeles Basin, and we have very serious infrastructure problems. And so I recognize that government does have an appropriate role in dealing with infrastructure, and jobs are created when we put resources into infrastructure. I will acknowledge that.

But if you look at the other areas, when the President had his job summit the other day, we had a meeting of Republicans. One of the economists who participated was Kevin Hassett of the American Enterprise Institute, and he provided us with an amazing number. He said that he had his staff at AEI, the American Enterprise Institute, sit down and look at the challenge of the entire nearly \$1 trillion in stimulus spending. He said, Tell me what would happen if we were to have taken that entire stimulus bill and just hired people.

Well, his staff came up with the following conclusion, Madam Speaker. He reported to us that if you look at the average wage rate in the United States, it's \$37,000 a year. That's the average wage rate across the country. If we were to take the entire stimulus bill and simply hire people, guess how many jobs would be created? I was stunned when Mr. Hassett reported to us that that number is 21 million. And when you look at how the stimulus dollars have been expended, we obviously haven't created that many jobs, Madam Speaker. But the fact is, if we were to take all of those resources and just hire people at the average wage rate across the United States of America, it would be 21 million jobs that would have been created.

That is not the way to deal with the challenge of the economic downturn. The way to deal with it is to encourage long-term private sector job creation and economic growth. That is why, when we look at these priorities and the urgency of dealing with the challenges that exist today, that is what we should be doing.

Now, as Ms. Foxx has appropriately said, Madam Speaker, we are here with a virtually unprecedented scenario before us. First, this rule gives something that according to our staff has not happened before, and that is, it gives the Chair the authority to just, without any action by the Members of the

House, adjourn the House. That is a troubling sign. And it is troubling but not terribly surprising based on what we have seen over the past 3 years since we had first unveiled to us a document known as "A New Direction for America." This was the proposal that was put forward by the now-Speaker of the House, who was then minority leader. And as minority leader, she was very concerned.

And I will acknowledge, having done a less than perfect job in my position as chairman of the House Rules Committee, I am proud of what our work product was, but I could have done better, and I will acknowledge that freely here. But it's interesting to note what "A New Direction for America" actually had. I would like to just share a couple of brief lines from that, if I might, Madam Speaker.

It says, Bills should be developed following full hearings and open subcommittee and committee markups, with appropriate referrals to other committees. Members should have at least 24 hours to examine a bill prior to consideration at the subcommittee level. Bills should generally come to the floor under a procedure that allows open, full, and fair debate.

I am going to repeat that, Madam Speaker. It says, Bills should come to the floor under a procedure that allows open, full, and fair debate consisting of a full amendment process that grants the minority the right to offer its alternatives, including a substitute.

Members should have at least 24 hours to examine bill and conference report text prior to floor consideration. Rules governing floor debate must be reported before 10 p.m. for a bill to be considered the following day.

Now, Madam Speaker, as we know, virtually all of that has been thrown out the window.

The other thing that is unprecedented—and I mentioned this in the Rules Committee when I confirmed it with our staff—to my knowledge, this is the first session ever to go through the entire session of Congress without any bill being considered under an open rule. I know that my friend from Maine was there upstairs when I raised this issue, and I hope very much that she does have an opportunity soon, because as we've talked about—and this bill that is coming before us is an appropriations bill—again, for the first time ever we had the appropriations process shut down, shut down, denying Members an opportunity to offer amendments. Never before in the history of the Republic has that taken place, and we now have, unfortunately, seen that.

But as we prepare to extend Christmas and Hanukkah greetings to our colleagues and our friends across the country, it is very unfortunate that we have now—if we do in fact see today as the last day of the first session of this Congress—an entire session without any open rules.

I will tell you that there are many people on the Rules Committee who work long and hard to deal with challenges. We, as Ms. FOXX said, met into the evening last night, and then we were here at 7:30 this morning.

One of our Rules Committee staff members, Shane Chambers, who has worked long and hard, is getting ready to leave. I would like to say, Madam Speaker, how much I appreciate his work. He and his wife and new baby are moving to Dallas, Texas. I am sure that he will have an opportunity—even with a new baby—to get more rest than he does as a staff member on the House Rules Committee. But I would like to express appreciation to those staff members on both sides of the aisle who do work long and hard to address these challenges.

I am going to urge my colleagues to join in voting “no” on this rule because I believe that we can do better. This is not the appropriate way, and it is not what was promised to the American people.

□ 0945

Ms. PINGREE of Maine. Madam Speaker, I do want to thank my colleague, the ranking member on the committee, both for his history lesson and also for extending holiday greetings to those across the country. I do appreciate that, as a new Member, I often learn bits of the past from the things that he discusses with us, and I want to join him in thanking our hard-working staff. He is absolutely right. We were here late into the evening, and we were here early in the morning. I know that my colleagues put in many hours and that our staffs work very hard, and I want them to know I appreciate greatly their hard work on our behalf and for dealing with many of the challenges we often have before us which make our procedural challenges even more difficult as we try to determine how to get so much work done that is before us and with so much more to do. That is why we are here today—to talk about this same-day rule, to talk about the work that is before us.

I yield as much time as he is interested in consuming to my good colleague from Colorado (Mr. PERLMUTTER).

Mr. PERLMUTTER. I appreciate my friend from Maine giving me some time to respond to my friend from California.

Madam Speaker, I think we were getting a little lesson in history about Kennedy, about Reagan, and about the Recovery Act that was passed earlier this session.

I'm glad my friend is now returning, because what he forgot to mention was that, with John Kennedy, when those tax cuts were made, the highest marginal rates were 70 percent. Today's highest marginal rates are half that.

So we need to understand, when those cuts were made, it was a substantial amount higher than what we've experienced today. I would also remind my friend that, in the Recovery Act, which was passed earlier this year, \$300 billion—about 40 percent of that bill—was in the form of tax cuts. So those kinds of efforts are being made.

I would also remind my friend that, when President Reagan came in in 1981, he did take some tough steps in trying to rebuild the economy, which was suffering from high interest rates and from a number of other things, and it wasn't just nirvana the next day. At least in Colorado, we had years of recession that lasted almost until 1990.

So what we see before us, really, I think, as a result of stabilizing the banking system last fall and of rejuvenating the economy in the spring with the Recovery Act, is downward pressure on unemployment. We are not out of the woods, but it is getting better. We can continue to do better than what we saw at the end of the Bush administration.

The SPEAKER pro tempore. The time of the gentleman has expired.

Ms. PINGREE of Maine. I yield the gentleman another 1 minute.

Mr. DREIER. Would the gentleman yield?

Mr. PERLMUTTER. I yield 10 seconds to my friend from California.

Mr. DREIER. I am going to need more than 10 seconds to respond. I would be happy to ask my friend from the Grandfather community if she might yield 1 minute to the gentleman.

Ms. FOXX. I am happy to yield 1 minute to the gentleman from Colorado.

Mr. DREIER. Would the gentleman yield?

Mr. PERLMUTTER. I yield to my friend.

Mr. DREIER. I thank my friend for yielding.

Madam Speaker, let me just say very quickly that, under John F. Kennedy, it's true. We saw a 70 percent marginal rate dramatically reduced. We are not asking for a halving of marginal rates. The \$300 billion in tax cuts have not been focused on job creators, which is exactly what President Kennedy did then.

I also want to say, Madam Speaker, that I recognize very well that, if you look at the provisions that have been put into place within the past year, we've not been focused on that private sector job creation that President Kennedy and President Reagan perceived.

I thank my friend for yielding.

Mr. PERLMUTTER. Reclaiming my time, I appreciate that, but I would disagree with my friend by saying, first of all, we provided tax credits for first-time home buyers to stimulate home construction and home sales. We provided tax credits, net operating loss, carrybacks, and carryforwards for busi-

nesses. We provided tax credits on depreciation. There are many, many business tax credits that have gone to stimulate the economy and to create jobs. So I would disagree.

Mr. DREIER. Will the gentleman further yield?

Mr. PERLMUTTER. Just for a second.

Mr. DREIER. Madam Speaker, let me just say that, again, the example that I used, the bipartisan example of the Kennedy/Reagan tax cuts, were marginal rate reductions for individuals, which encouraged job creation and a reduction of the capital gains rate, and we've chosen to increase taxes.

Mr. PERLMUTTER. I take back my time.

Madam Speaker, the business types of tax cuts as well as individual tax cuts are part of the package that is helping this country recover, but we aren't there yet. We haven't finished yet. We helped Wall Street with TARP money. That same money should be able to be available to Main Street. That's the purpose of today's bill. That's why this rule is important.

I would urge an “aye” vote on this rule as well as an “aye” vote on the underlying bill.

Ms. FOXX. Madam Speaker, I yield 2 minutes to the gentleman from California.

Mr. DREIER. Madam Speaker, I would be happy to engage in a colloquy further with my friend from Colorado to simply say that I believe very, very strongly, Madam Speaker, that it is important for us to recognize what needs to be done to encourage job creation and economic growth. What we have seen in the past year, unfortunately, has been a dramatic expansion of the size and scope and reach of government, which, frankly, I think, would concern both John F. Kennedy and Ronald Reagan.

The fact is the notion of this regulatory burden and tax cuts that are not modeled after the pro-growth model of President Kennedy and President Reagan are not going to create the kind of opportunity that we need. Why? Because we constantly hear this class warfare argument of “tax the rich.”

This week's Economist has a very interesting piece, Madam Speaker, in which it focuses on the bonus tax that Prime Minister Gordon Brown in Great Britain is putting into place. The piece in The Economist is entitled, “Class Warrior.” It focuses on the fact, again, that Prime Minister Brown is trying to, with his policy, get the economy going when the British economy is, in fact, among those in Europe, doing the worst of the economies. We are in a position right now where he is engaging in class warfare, and The Economist has this great line, which reads, “Market reforms are not what class warriors do.”

As we continue to attack job creators, as we continue to attack those at the upper end of the spectrum who are, in fact, struggling right now to get our economy back on track to create the private sector jobs, we've got policies here that are undermining that.

Ms. PINGREE of Maine. Will the gentleman yield?

Mr. DREIER. Of course, I am happy to yield.

Ms. PINGREE of Maine. I am happy to yield back again to my wonderful colleague from Colorado.

Mr. DREIER. I have got time. I will yield to him.

Ms. PINGREE of Maine. We will yield to everybody.

I want to answer one thing. The two of you have been entered into a colloquy, a very interesting one, going back to Kennedy.

The SPEAKER pro tempore. The time of the gentleman from California has expired.

Ms. PINGREE of Maine. I am happy to engage in a colloquy with both of my colleagues here, but let me just make one point to my much more senior and well-informed Members.

Mr. DREIER. If the gentlewoman would yield, that means older.

Ms. PINGREE of Maine. No, I don't think, actually, they are all older.

Anyway, I just want to say that, while this has been a very interesting history lesson and while I greatly appreciate my colleague from Colorado and his understanding of the financial services industry and of this world that we've been working so hard on to both regulate and to deal with, much of my colleague from California's remarks have been referring to President Kennedy and to President Reagan, which were very different eras.

I just want to remind my colleagues on the floor that we are here at the end of the Bush administration. When President Obama came to office, yes, the Democrats had been here for 2 years before and there were things that we were unable to fix when we were simply in the majority. The fact is that President Obama and this particular Congress—and I came here as a freshman—inherited the worst recession since the Great Depression, two wars that weren't paid for, a broken health care system, and a 1950s energy policy. That is what we have had to deal with. As my colleagues know, this has not been an easy year. We are here over and over again, attempting to deal with this.

I yield 1 minute to my colleague from Colorado (Mr. PERLMUTTER).

Mr. PERLMUTTER. I appreciate my friend from Maine yielding.

I would just say to my colleague from Maine, as well as to my colleague from California, that I think that Ms. PINGREE has a very substantial point. My friend from California complained about the regulatory burden.

One of the reasons that this country is facing the recession that we are facing is as a result of the Wild West approach on Wall Street where there was no regulatory burden, or if there was, it was ignored by the regulators under the Bush administration. As a consequence, the private sector was brought to its knees last fall and is just now getting on its feet as a result of the rejuvenation—the Recovery Act—which was passed by this Congress and by President Obama. It is those kinds of things that have required intervention by the Federal Government to get this country back on its feet. We are not there yet, but we are heading in the right direction.

Ms. FOXX. Madam Speaker, I find it very interesting that my colleague from Maine says we find ourselves here at the end of the Bush administration. We have been in the Obama administration for a year, yet our colleagues across the aisle cannot stop hearkening back to President Bush and blaming him for everything that has happened in this country in the last year when President Bush hasn't been in office and while the Republicans have not been in control. The Democrats are in control. They have been in control of the Congress for 3 years.

They actually inherited from President Bush and from the Republican-controlled Congress a very excellent economy—55 straight months of job growth. In the first month that the Democrats took over the Congress, the economy started going downhill, and we can document that very, very easily. It isn't the Bush administration that deserves the blame for the ills of the economy; it's the Democrat-controlled Congress, which began in January of 2007, which is when the economy started going sour.

I want to go back to the issue at hand, which is: Why do we have closed rules? Why do we have a same-day martial law rule? Why isn't there time for us to debate the important issues that the American people want us to be debating?

Why is it, as my colleague from California has pointed out, that our most important function, that being the defense of this Nation and the appropriations for that part of the country—which can be done by no other group of people in this country as the States can't do it and the locals can't do it—is left to be done on a day when everybody is trying to get out for Christmas, and we are doing it in a rush?

The Members aren't allowed to read the bill. The 72-hour rule has gone out the window. Nobody is allowed to read the bill because there is not enough time to do it. We have been operating, as my colleague said, under closed rules with bills with no amendments while we are doing things like recognizing the Grand Concourse on its 100th anniversary as the preeminent thor-

oughfare in the borough of the Bronx and as an important nexus of commerce and culture for the City of New York.

That is how our colleagues want to spend their time, which is by dealing with issues that are not a part of our critical job here in the House of Representatives, by dealing with things that could have been done on a voice vote; but we have to have no amendments allowed and no debate time because there isn't time to do these things, according to the chairman of the Appropriations Committee, and this is what we are doing.

Madam Speaker, I had an opportunity this week to, once more, visit Arlington National Cemetery. It is always a sobering thing to do. I went particularly to the active duty section this time where men and women who are currently serving our country have lost their lives. It gets one's attention. There were parents and relatives there, grieving, who had recently lost loved ones. I visited the eternal flame of John Kennedy. I don't have to be reminded of his comments in his inaugural speech, "Ask not what your country can do for you. Ask what you can do for your country."

□ 1000

We are in a totally different time, as my colleague has said. We are in a time where we have people representing this country who want wealth redistribution. They want to take money from some people and give it to others.

In fact, that seems to be their entire focus, spread the wealth around, take up time on frivolous issues. Don't deal with what's important, don't deal with national security, because we really don't want to talk about that. That's not what's important. But that is what is important to us.

I watched the soldiers who guard the Tomb of the Unknowns, and I was given some insight into the preparation that they have for that job and how difficult it is to get it.

Would that Members of Congress had a tiny little percentage of the dedication that these soldiers have for doing their jobs. They do everything with perfection. Perfection is not just the goal; it is the standard that those people live up to. We are falling far short of the standard that our military people uphold for our country.

We are so fortunate that we have men and women willing to serve and have been willing to serve since the founding of this country. This Congress is falling short of the goals that they set.

I support our military. I support the funding for our military and our troops, the equipment, the medical care and all that we are going to appropriate, but I don't support this martial law way of operating. I don't support the arrogance of this administration

and this Congress to bring things up at the last minute and to disregard the needs of those people.

To put on the bills things that are irrelevant, things they don't think they can pass any other way, what a travesty, what a shame. What a shame on this Congress that we are doing this bill at the last minute and that we are putting these things on here.

We should be voting on appropriations for our military and honoring them here just before the holidays.

Madam Speaker, I will ask my colleagues to vote "no" on this same-day rule and "no" on the next rule so that we could stop and debate this and not be up against a deadline for a group of our Members to go to Copenhagen, adding to the carbon problem while they are going over there to talk about it.

I yield back the balance of my time.

Ms. PINGREE of Maine. Thank you to my colleague from North Carolina for her thoughts. While we don't always agree, I appreciate her reminding us about the soldiers who have fallen, about their families, about her visit to Arlington Cemetery.

I want to concur. I had the privilege of visiting the cemetery myself this week. Not only did I also grieve for those families who were there visiting the gravestones of their loved ones and their family members, and many who were just there to think about the people who they didn't even know who served for us.

I was also tremendously proud to see the thousands of wreaths that decorated those graves that had been brought down from my home State, the State of Maine, in honor of our fallen soldiers. There were 16,000 that were brought to Arlington Cemetery, and there were many people who traveled with them to make sure that we show the proper respect for our military, for our soldiers, and for those who served their country in the past and virtually every day.

I want to just say that we are here today in part to talk about making sure that there is adequate funding for our military. Yes, we all wish that our colleagues in the Senate had acted faster on this bill, that we weren't dealing with continuing resolutions, but this is the particular situation that we are in. It is very important that we finish our work before the end of the year, before the end of the holidays, that we recognize our soldiers, our current military, and many of the other needs in this bill, many of which will be discussed as soon as we finish the debate on this same-day rule.

Madam Speaker, in closing, I just want to say that the rule before us this morning simply allows the consideration of these measures to move forward.

We have heard a lot about the process this morning. I want to simply state for the record in the 109th Con-

gress, before I was a Member of this body, the Republican majority reported out over 20 rules that allowed for same-day consideration.

Madam Speaker, I urge my colleagues to vote for this rule and for the underlying measures before us today. These programs are too important. Our constituents are in too much turmoil to slow this process down any further.

I urge a "yes" vote on the previous question and on the rule.

The material previously referred to by Ms. FOXX is as follows:

AMENDMENT TO H. RES. 973 OFFERED BY MS. FOXX OF NORTH CAROLINA

At the end of the resolution, insert the following new section:

SEC. 2. On the third legislative day after the adoption of this resolution, immediately after the third daily order of business under clause 1 of rule XIV and without intervention of any point of order, the House shall proceed to the consideration of the resolution (H. Res. 554) amending the Rules of the House of Representatives to require that legislation and conference reports be available on the Internet for 72 hours before consideration by the House, and for other purposes. The resolution shall be considered as read. The previous question shall be considered as ordered on the resolution and any amendment thereto to final adoption without intervening motion or demand for division of the question except: (1) one hour of debate equally divided and controlled by the chair and ranking minority member of the Committee on Rules; (2) an amendment, if offered by the Minority Leader or his designee and if printed in that portion of the Congressional Record designated for that purpose in clause 8 of rule XVIII at least one legislative day prior to its consideration; which shall be in order without intervention of any point of order or demand for division of the question, shall be considered as read and shall be separately debatable for twenty minutes equally divided and controlled by the proponent and an opponent; and (3) one motion to recommit which shall not contain instructions. Clause 1(c) of rule XIX shall not apply to the consideration of House Resolution 554.

(The information contained herein was provided by Democratic Minority on multiple occasions throughout the 109th Congress.)

THE VOTE ON THE PREVIOUS QUESTION: WHAT IT REALLY MEANS

This vote, the vote on whether to order the previous question on a special rule, is not merely a procedural vote. A vote against ordering the previous question is a vote against the Democratic majority agenda and a vote to allow the opposition, at least for the moment, to offer an alternative plan. It is a vote about what the House should be debating.

Mr. Clarence Cannon's *Precedents of the House of Representatives*, (VI, 308-311) describes the vote on the previous question on the rule as "a motion to direct or control the consideration of the subject before the House being made by the Member in charge." To defeat the previous question is to give the opposition a chance to decide the subject before the House. Cannon cites the Speaker's ruling of January 13, 1920, to the effect that "the refusal of the House to sustain the demand for the previous question passes the control of the resolution to the opposition" in order to offer an amendment. On March

15, 1909, a member of the majority party offered a rule resolution. The House defeated the previous question and a member of the opposition rose to a parliamentary inquiry, asking who was entitled to recognition. Speaker Joseph G. Cannon (R-Illinois) said: "The previous question having been refused, the gentleman from New York, Mr. Fitzgerald, who had asked the gentleman to yield to him for an amendment, is entitled to the first recognition."

Because the vote today may look bad for the Democratic majority they will say "the vote on the previous question is simply a vote on whether to proceed to an immediate vote on adopting the resolution . . . [and] has no substantive legislative or policy implications whatsoever." But that is not what they have always said. Listen to the definition of the previous question used in the *Floor Procedures Manual* published by the Rules Committee in the 109th Congress, (page 56). Here's how the Rules Committee described the rule using information from *Congressional Quarterly's "American Congressional Dictionary"*: "If the previous question is defeated, control of debate shifts to the leading opposition member (usually the minority Floor Manager) who then manages an hour of debate and may offer a germane amendment to the pending business."

Deschler's *Procedure in the U.S. House of Representatives*, the subchapter titled "Amending Special Rules" states: "a refusal to order the previous question on such a rule [a special rule reported from the Committee on Rules] opens the resolution to amendment and further debate." (Chapter 21, section 21.2) Section 21.3 continues: Upon rejection of the motion for the previous question on a resolution reported from the Committee on Rules, control shifts to the Member leading the opposition to the previous question, who may offer a proper amendment or motion and who controls the time for debate thereon."

Clearly, the vote on the previous question on a rule does have substantive policy implications. It is one of the only available tools for those who oppose the Democratic majority's agenda and allows those with alternative views the opportunity to offer an alternative plan.

Ms. PINGREE of Maine. I yield back the balance of my time, and I move the previous question on the resolution.

The SPEAKER pro tempore. The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Ms. FOXX. Madam Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

PROVIDING FOR THE SINE DIE ADJOURNMENT OF THE FIRST SESSION OF THE 111TH CONGRESS

Ms. PINGREE of Maine. Madam Speaker, I send to the desk a privileged concurrent resolution and ask for its immediate consideration.

The Clerk read the concurrent resolution, as follows:

H. CON. RES. 223

Resolved by the House of Representatives (the Senate concurring), That when the House adjourns on any legislative day from Wednesday, December 16, 2009, through Saturday, January 2, 2010, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand adjourned sine die, or until the time of any reassembly pursuant to section 3 of this concurrent resolution; and that when the Senate adjourns on any day from Friday, December 18, 2009, through Saturday, January 2, 2010, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand adjourned sine die, or until the time of any reassembly pursuant to section 3 of this concurrent resolution.

SEC. 2. When the House adjourns on any legislative day of the second session of the One Hundred Eleventh Congress from Tuesday, January 5, 2010, through Saturday, January 9, 2010, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it shall stand adjourned until noon on Tuesday, January 12, 2010, or until the time of any reassembly pursuant to section 3 of this concurrent resolution, whichever occurs first; and that when the Senate recesses or adjourns on any day of the second session of the One Hundred Eleventh Congress from Tuesday, January 5, 2010, through Saturday, January 9, 2010, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it shall stand recessed or adjourned until noon on Tuesday, January 19, 2010, or until such other time on that day as may be specified by its Majority Leader or his designee in the motion to recess or adjourn, or until the time of any reassembly pursuant to section 3 of this concurrent resolution, whichever occurs first.

SEC. 3. The Speaker of the House and the Majority Leader of the Senate, or their respective designees, acting jointly after consultation with the Minority Leader of the House and the Minority Leader of the Senate, shall notify the Members of the House and the Senate, respectively, to reassemble at such place and time as they may designate if, in their opinion, the public interest shall warrant it.

The SPEAKER pro tempore. The concurrent resolution is not debatable. The question is on the concurrent resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Ms. FOXX. Madam Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, this 15-minute vote on adoption of House Concurrent Resolution 223 will be followed by 5-minute votes on ordering the previous question on H. Res. 973; adoption of H. Res. 973, if ordered; and the motion to suspend the rules on H. Con. Res. 160.

The vote was taken by electronic device, and there were—yeas 222, nays 195, not voting 17, as follows:

[Roll No. 978]

YEAS—222

Abercrombie	Baca	Barrow
Ackerman	Baird	Bean
Andrews	Baldwin	Becerra

Berkley	Heinrich	Pascarell	Flake	Lee (NY)	Price (GA)
Berman	Herseth Sandlin	Pastor (AZ)	Fleming	Lewis (CA)	Putnam
Berry	Higgins	Payne	Forbes	LoBiondo	Rehberg
Bishop (GA)	Hill	Perlmutter	Fortenberry	Lucas	Reichert
Blumenauer	Hinchev	Peterson	Fox	Luetkemeyer	Roe (TN)
Boren	Hinojosa	Pingree (ME)	Franks (AZ)	Lummis	Rogers (AL)
Boswell	Hirono	Polis (CO)	Frelinghuysen	Lungren, Daniel E.	Rogers (KY)
Boucher	Hodes	Pomeroy	Gallegly	Mack	Rogers (MI)
Boyd	Holden	Price (NC)	Garrett (NJ)	Maffei	Rohrabacher
Brady (PA)	Holt	Quigley	Gerlach	Manzullo	Rooney
Braley (IA)	Honda	Rahall	Giffords	Marchant	Ros-Lehtinen
Bright	Hoyer	Rangel	Gingrey (GA)	Markey (CO)	Roskam
Brown, Corrine	Inslee	Reyes	Goodlatte	Massa	Royce
Butterfield	Israel	Richardson	Granger	McCarthy (CA)	Ryan (WI)
Capps	Jackson (IL)	Rodriguez	Graves	McCaul	Scalise
Capuano	Jackson-Lee (TX)	Ross	Guthrie	McClintock	Schmidt
Carnahan	Johnson (GA)	Rothman (NJ)	Hall (TX)	McCotter	Sensenbrenner
Carson (IN)	Johnson (IL)	Roybal-Allard	Harper	McHenry	Sessions
Castor (FL)	Kagen	Ruppersberger	Hastings (WA)	McKeon	Sestak
Chaffetz	Kanjorski	Rush	Heller	McMahon	Shadegg
Chandler	Kennedy	Ryan (OH)	Hensarling	McMorris	Shimkus
Chu	Kildee	Sánchez, Linda T.	Herger	Rodgers	Shuster
Clarke	Kilpatrick (MI)	Sanchez, Loretta	Himes	Mica	Smith (NE)
Cleaver	Kind	Sanbaranes	Hoekstra	Miller (FL)	Smith (NJ)
Clyburn	Kissell	Schakowsky	Hunter	Miller (MI)	Smith (TX)
Cohen	Klein (FL)	Schauer	Inglis	Miller, Gary	Souder
Connolly (VA)	Kucinich	Schiff	Issa	Minnick	Space
Conyers	Langevin	Schrader	Jenkins	Mitchell	Stearns
Cooper	Larsen (WA)	Schwartz	Johnson, Sam	Moran (KS)	Sullivan
Costa	Larson (CT)	Scott (GA)	Jones	Murphy (NY)	Terry
Costello	Lee (CA)	Scott (VA)	Jordan (OH)	Murphy, Tim	Thompson (PA)
Courtney	Levin	Serrano	Kilroy	Myrick	Thornberry
Crowley	Lewis (GA)	Shea-Porter	King (IA)	Neugebauer	Tiahrt
Cuellar	Linder	Sherman	King (NY)	Nunes	Tiberi
Cummings	Lipinski	Shuler	Kingston	Nye	Turner
Davis (AL)	Loebbeck	Sires	Kirk	Paulsen	Upton
Davis (CA)	Lofgren, Zoe	Skelton	Kirkpatrick (AZ)	Pence	Walden
Davis (IL)	Lujan	Slaughter	Kline (MN)	Perriello	Wamp
Davis (TN)	Lynch	Smith (WA)	Kosmas	Peters	Westmoreland
DeFazio	Maloney	Snyder	Kratovil	Petri	Whitfield
DeGette	Marshall	Spratt	Lamborn	Pitts	Wilson (SC)
Delahunt	Matheson	Stark	Lance	Platts	Wittman
DeLauro	Matsui	Stupak	Latham	Poe (TX)	Wolf
Dicks	McCarthy (NY)	Sutton	LaTourette	Posey	Young (FL)
Dingell	McCollum	Tanner	Latta		
Doggett	McDermott	Taylor			
Doyle	McGovern	Teague			
Edwards (MD)	McIntyre	Thompson (CA)	Barrett (SC)	Johnson, E. B.	Radanovich
Edwards (TX)	McNerney	Thompson (MS)	Cardoza	Kaptur	Simpson
Ehlers	Meek (FL)	Tierney	Clay	Markey (MA)	Speier
Ellison	Meeks (NY)	Titus	Engel	Moran (VA)	Wexler
Eshoo	Melancon	Tonko	Filner	Murtha	Young (AK)
Etheridge	Michaud	Towns	Hall (NY)	Paul	
Farr	Miller (NC)	Tsongas			
Fattah	Miller, George	Van Hollen			
Foster	Mollohan	Velázquez			
Frank (MA)	Moore (KS)	Visclosky			
Fudge	Moore (WI)	Walz			
Garamendi	Moore (CT)	Wasserman			
Gohmert	Murphy, Patrick	Schultz			
Gonzalez	Nadler (NY)	Watson			
Gordon (TN)	Napolitano	Watt			
Grayson	Neal (MA)	Waxman			
Green, Al	Oberstar	Weiner			
Green, Gene	Obey	Welch			
Griffith	Olson	Wilson (OH)			
Grijalva	Olver	Woolsey			
Gutierrez	Ortiz	Wu			
Halvorson	Owens	Yarmuth			
Hare	Pallone				
Harman					
Hastings (FL)					

NAYS—195

Aderholt	Bono Mack	Castle
Adler (NJ)	Boozman	Childers
Akin	Boustany	Coble
Alexander	Brady (TX)	Coffman (CO)
Altmire	Brown (GA)	Cole
Arcuri	Brown (SC)	Conaway
Austria	Brown-Waite,	Crenshaw
Bachmann	Ginny	Culberson
Bachus	Buchanan	Dahlkemper
Bartlett	Burgess	Davis (KY)
Barton (TX)	Burton (IN)	Deal (GA)
Biggart	Buyer	Dent
Bilbray	Calvert	Diaz-Balart, L.
Bilirakis	Camp	Diaz-Balart, M.
Bishop (NY)	Campbell	Donnelly (IN)
Bishop (UT)	Cantor	Dreier
Blackburn	Cao	Drieaus
Blunt	Capito	Duncan
Boccieri	Carney	Ellsworth
Boehner	Carter	Emerson
Bonner	Cassidy	Fallin

NOT VOTING—17

Barrett (SC)	Johnson, E. B.	Radanovich
Cardoza	Kaptur	Simpson
Clay	Markey (MA)	Speier
Engel	Moran (VA)	Wexler
Filner	Murtha	Young (AK)
Hall (NY)	Paul	

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1037

Messrs. JORDAN of Ohio, MASSA, MAFFEI, McMAHON and Ms. KILROY changed their vote from “yea” to “nay.”

Mr. GOHMERT changed his vote from “nay” to “yea.”

So the concurrent resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. FILNER. Madam Speaker, on rollcall 978, I was away from the Capitol. Had I been present, I would have voted “yes.”

WAIVING REQUIREMENT OF CLAUSE 6(a) OF RULE XIII WITH RESPECT TO CONSIDERATION OF CERTAIN RESOLUTIONS

The SPEAKER pro tempore. The unfinished business is the vote on ordering the previous question on House Resolution 973, on which the yeas and nays were ordered.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on ordering the previous question.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 226, nays 192, not voting 16, as follows:

[Roll No. 979]

YEAS—226

Abercrombie	Halvorson	Oliver
Ackerman	Hare	Ortiz
Adler (NJ)	Harman	Owens
Andrews	Hastings (FL)	Pallone
Arcuri	Heinrich	Pascarell
Baca	Herseth Sandlin	Pastor (AZ)
Baldwin	Higgins	Payne
Barrow	Himes	Perlmutter
Bean	Hinchey	Peterson
Becerra	Hinojosa	Pingree (ME)
Berkley	Hirono	Polis (CO)
Berman	Hodes	Pomeroy
Berry	Holden	Price (NC)
Bishop (GA)	Holt	Quigley
Blumenauer	Honda	Rahall
Bocchieri	Hoyer	Rangel
Boren	Inslee	Reyes
Boswell	Israel	Richardson
Boucher	Jackson (IL)	Rodriguez
Boyd	Jackson-Lee	Ross
Brady (PA)	(TX)	Rothman (NJ)
Braley (IA)	Johnson (GA)	Roybal-Allard
Brown, Corrine	Kagen	Ruppersberger
Butterfield	Kanjorski	Rush
Capps	Kennedy	Ryan (OH)
Capuano	Kildee	Salazar
Carnahan	Kilpatrick (MI)	Sánchez, Linda
Carson (IN)	Kilroy	T.
Castor (FL)	Kind	Sanchez, Loretta
Chandler	Kissell	Sarbanes
Chu	Klein (FL)	Schauer
Clarke	Kosmas	Schiff
Cleaver	Kucinich	Schrader
Clyburn	Langevin	Schwartz
Cohen	Larsen (WA)	Scott (GA)
Connolly (VA)	Larson (CT)	Scott (VA)
Conyers	Lee (CA)	Serrano
Cooper	Levin	Sestak
Costa	Lewis (GA)	Shea-Porter
Costello	Lipinski	Sherman
Courtney	Loeb sack	Shuler
Crowley	Loifgren, Zoe	Sires
Cuellar	Lowe	Skelton
Cummings	Lujan	Slaghter
Dahlkemper	Lynch	Smith (WA)
Davis (AL)	Maffei	Snyder
Davis (CA)	Maloney	Spratt
Davis (IL)	Markey (CO)	Stark
Davis (TN)	Markey (MA)	Stupak
DeFazio	Marshall	Sutton
DeGette	Massa	Tanner
Delahunt	Matheson	Thompson (CA)
DeLauro	Matsui	Thompson (MS)
Dicks	McCarthy (NY)	Tierney
Dingell	McCollum	Titus
Doggett	McDermott	Tonko
Donnelly (IN)	McGovern	Towns
Doyle	McIntyre	Tsongas
Edwards (MD)	McMahon	Van Hollen
Edwards (TX)	McNerney	Velázquez
Ellison	Meek (FL)	Visclosky
Engel	Meeks (NY)	Walz
Eshoo	Melancon	Wasserman
Etheridge	Michaud	Schultz
Farr	Miller (NC)	Waters
Fattah	Miller, George	Watson
Foster	Mollohan	Watt
Frank (MA)	Moore (KS)	Waxman
Fudge	Moore (WI)	Weiner
Garamendi	Murphy (CT)	Welch
Gonzalez	Murphy (NY)	Wilson (OH)
Gordon (TN)	Murphy, Patrick	Woolsey
Grayson	Nadler (NY)	Wu
Green, Al	Napolitano	Yarmuth
Green, Gene	Neal (MA)	
Grijalva	Oberstar	
Gutierrez	Obey	

NAYS—192

Aderholt	Alexander	Austria
Akin	Altmire	Bachmann

Bachus	Gallegly	Minnick
Baird	Garrett (NJ)	Mitchell
Bartlett	Gerlach	Moran (KS)
Barton (TX)	Giffords	Murphy, Tim
Biggert	Gingrey (GA)	Myrick
Bilbray	Gohmert	Neugebauer
Bilirakis	Goodlatte	Nunes
Bishop (NY)	Granger	Nye
Bishop (UT)	Graves	Olson
Blackburn	Griffith	Paulsen
Blunt	Guthrie	Pence
Boehner	Hall (TX)	Perriello
Bonner	Harper	Peters
Bono Mack	Hastings (WA)	Petri
Boozman	Heller	Pitts
Boustany	Hensarling	Platts
Brady (TX)	Herger	Poe (TX)
Bright	Hill	Posey
Broun (GA)	Hoekstra	Price (GA)
Brown (SC)	Hunter	Putnam
Brown-Waite,	Inglis	Rehberg
Ginny	Issa	Reichert
Buchanan	Jenkins	Roe (TN)
Burgess	Johnson (IL)	Rogers (AL)
Burton (IN)	Johnson, Sam	Rogers (KY)
Buyer	Jones	Rogers (MI)
Calvert	Jordan (OH)	Rohrabacher
Camp	King (IA)	Rooney
Campbell	King (NY)	Ros-Lehtinen
Cantor	Kingston	Roskam
Cao	Kirk	Royce
Capito	Kirkpatrick (AZ)	Ryan (WI)
Carney	Kline (MN)	Scalise
Carter	Kratovil	Schmidt
Cassidy	Lamborn	Schock
Castle	Lance	Sensenbrenner
Chaffetz	Latham	Shadegg
Childers	LaTourette	Shimkus
Coble	Latta	Shuster
Coffman (CO)	Lee (NY)	Smith (NE)
Cole	Lewis (CA)	Smith (NJ)
Conaway	Linder	Smith (TX)
Crenshaw	LoBiondo	Souder
Culberson	Lucas	Stearns
Davis (KY)	Luetkemeyer	Sullivan
Deal (GA)	Lummis	Taylor
Dent	Lungren, Daniel	Teague
Diaz-Balart, L.	E.	Terry
Diaz-Balart, M.	Mack	Thompson (PA)
Dreier	Manzullo	Thornberry
Driehaus	Marchant	Tiahrt
Duncan	McCarthy (CA)	Tiberi
Ehlers	McCauley	Turner
Ellsworth	McClintock	Upton
Emerson	McCotter	Walden
Fallin	McHenry	Wamp
Flake	McKeon	Westmoreland
Fleming	McMorris	Whitfield
Forbes	Rodgers	Wilson (SC)
Fortenberry	Mica	Wittman
Fox	Miller (FL)	Wolf
Franks (AZ)	Miller (MI)	Young (AK)
Frelinghuysen	Miller, Gary	Young (FL)

NOT VOTING—16

Barrett (SC)	Kaptur	Simpson
Cardoza	Moran (VA)	Speier
Clay	Murtha	Thompson (CA)
Filner	Paul	Wexler
Hall (NY)	Radanovich	
Johnson, E. B.	Sessions	

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members have 2 minutes remaining in this vote.

□ 1046

So the previous question was ordered. The result of the vote was announced as above recorded.

Stated for:

Mr. FILNER. Madam Speaker, on rollcall 979, I was away from the Capitol. Had I been present, I would have voted "yes."

The SPEAKER pro tempore. The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Ms. FOXX. Madam Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 218, noes 202, not voting 14, as follows:

[Roll No. 980]

AYES—218

Abercrombie	Grijalva	Ortiz
Ackerman	Gutierrez	Owens
Andrews	Hare	Pallone
Arcuri	Harman	Pascarell
Baca	Hastings (FL)	Pastor (AZ)
Baldwin	Heinrich	Payne
Barrow	Herseth Sandlin	Perlmutter
Bean	Higgins	Peterson
Becerra	Himes	Pingree (ME)
Berkley	Hinchey	Polis (CO)
Berman	Hinojosa	Pomeroy
Berry	Hirono	Price (NC)
Bishop (GA)	Hodes	Rahall
Blumenauer	Holden	Rangel
Bocchieri	Holt	Reyes
Boren	Honda	Richardson
Boswell	Hoyer	Rodriguez
Boucher	Inslee	Ross
Boyd	Israel	Rothman (NJ)
Brady (PA)	Jackson (IL)	Roybal-Allard
Braley (IA)	Jackson-Lee	Ruppersberger
Bright	(TX)	Rush
Brown, Corrine	Johnson (GA)	Ryan (OH)
Butterfield	Kagen	Salazar
Capps	Kanjorski	Sánchez, Linda
Capuano	Kaptur	T.
Carnahan	Kennedy	Sanchez, Loretta
Carson (IN)	Kildee	Sarbanes
Castor (FL)	Kilpatrick (MI)	Schakowsky
Chandler	Kilroy	Schauer
Chu	Kind	Schiff
Clarke	Kissell	Schrader
Cleaver	Klein (FL)	Schwartz
Clyburn	Langevin	Scott (GA)
Cohen	Larsen (WA)	Scott (VA)
Connolly (VA)	Larson (CT)	Serrano
Conyers	Lee (CA)	Sestak
Cooper	Levin	Shea-Porter
Costa	Lewis (GA)	Sherman
Costello	Lipinski	Shuler
Courtney	Loeb sack	Sires
Crowley	Loifgren, Zoe	Skelton
Cuellar	Lowe	Slaghter
Cummings	Lujan	Smith (WA)
Dahlkemper	Lynch	Snyder
Davis (AL)	Maffei	Spratt
Davis (CA)	Maloney	Stark
Davis (IL)	Markey (CO)	Stupak
Davis (TN)	Markey (MA)	Sutton
DeFazio	Marshall	Tanner
DeGette	Massa	Thompson (CA)
Delahunt	Matheson	Thompson (MS)
DeLauro	Matsui	Tierney
Dicks	McCarthy (NY)	Titus
Dingell	McCollum	Tonko
Doggett	McDermott	Towns
Doyle	McGovern	Tsongas
Edwards (MD)	McIntyre	Van Hollen
Edwards (TX)	McNerney	Velázquez
Ellison	Meek (FL)	Visclosky
Engel	Meeks (NY)	Walz
Eshoo	Michaud	Wasserman
Etheridge	Miller (NC)	Schultz
Farr	Miller, George	Waters
Fattah	Mollohan	Watson
Foster	Moore (WI)	Watt
Frank (MA)	Murphy (CT)	Waxman
Fudge	Nadler (NY)	Weiner
Garamendi	Napolitano	Welch
Gonzalez	Neal (MA)	Wilson (OH)
Gordon (TN)	Oberstar	Woolsey
Grayson	Obey	Wu
Green, Al	Oliver	Yarmuth

NOES—202

Aderholt	Austria	Barton (TX)
Adler (NJ)	Bachmann	Biggert
Akin	Bachus	Bilbray
Alexander	Baird	Bilirakis
Altmire	Bartlett	Bishop (NY)

Bishop (UT) Griffith
Blackburn Guthrie
Blunt Hall (TX)
Boehner Halvorson
Bonner Harper
Bono Mack Hastings (WA)
Boozman Heller
Boustany Hensarling
Brady (TX) Herger
Broun (GA) Hill
Brown (SC) Hoekstra
Brown-Waite, Hunter
Ginny Inglis
Buchanan Issa
Burgess Jenkins
Burton (IN) Johnson (IL)
Buyer Johnson, Sam
Calvert Jones
Camp Jordan (OH)
Campbell King (IA)
Cantor King (NY)
Cao Kingston
Capito Kirk
Carney Kirkpatrick (AZ)
Carter Kline (MN)
Cassidy Kosmas
Castle Kratovil
Chaffetz Kucinich
Childers Lamborn
Coble Lance
Coffman (CO) Latham
Cole LaTourette
Conaway Latta
Crenshaw Lee (NY)
Culberson Lewis (CA)
Davis (KY) Linder
Deal (GA) LoBiondo
Dent Lucas
Diaz-Balart, L. Luetkemeyer
Diaz-Balart, M. Lummis
Donnelly (IN) Lungren, Daniel
Dreier E.
Driehaus Mack
Duncan Manzullo
Ehlers Marchant
Ellsworth McCarthy (CA)
Emerson McCaul
Fallin McClintock
Flake McCotter
Fleming McHenry
Forbes McKeon
Fortenberry McMahon
Fox McMorris
Franks (AZ) Rodgers
Frelinghuysen Melancon
Gallegly Mica
Garrett (NJ) Miller (FL)
Gerlach Miller (MI)
Giffords Miller, Gary
Gingrey (GA) Minnick
Gohmert Mitchell
Goodlatte Moran (KS)
Granger Murphy (NY)
Graves Murphy, Tim

NOT VOTING—14

Barrett (SC) Johnson, E. B.
Cardoza Moore (KS)
Clay Moran (VA)
Filner Murtha
Hall (NY) Paul

□ 1054

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. FILNER. Madam Speaker, on rollcall 980, I was away from the Capitol. Had I been present, I would have voted "yes."

HONORING THE AMERICAN KENNEL CLUB

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and agree to the concurrent resolution, H. Con. Res.

160, as amended, on which the yeas and nays were ordered.

The Clerk read the title of the concurrent resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Massachusetts (Mr. LYNCH) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 160, as amended.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 419, nays 0, not voting 15, as follows:

[Roll No. 981]

YEAS—419

Abercrombie Childers
Ackerman Chu
Adherholt Clarke
Adler (NJ) Cleaver
Akin Clyburn
Alexander Coble
Altmire Coffman (CO)
Andrews Cohen
Arcuri Cole
Austria Conaway
Baca Connolly (VA)
Bachmann Conyers
Bachus Cooper
Baird Costa
Baldwin Costello
Barrow Courtney
Bartlett Crenshaw
Barton (TX) Crowley
Bean Cuellar
Becerra Culberson
Berkley Cummings
Berman Dahlkemper
Berry Davis (AL)
Biggett Davis (CA)
Bilbray Davis (IL)
Bilirakis Davis (KY)
Bishop (GA) Davis (TN)
Bishop (NY) Deal (GA)
Bishop (UT) DeFazio
Blackburn DeGette
Blumenauer Delahunt
Blunt DeLauro
Boccheri Dent
Boehner Diaz-Balart, L.
Bonner Diaz-Balart, M.
Bono Mack Dicks
Boozman Dingell
Boren Doggett
Boswell Donnelly (IN)
Boucher Doyle
Boustany Dreier
Boyd Driehaus
Brady (PA) Duncan
Brady (TX) Edwards (MD)
Braley (IA) Edwards (TX)
Bright Ehlers
Broun (GA) Ellison
Brown (SC) Ellsworth
Brown, Corrine Emerson
Brown-Waite, Engel
Ginny Eshoo
Buchanan Etheridge
Burgess Fallin
Burton (IN) Farr
Butterfield Fattah
Buyer Flake
Calvert Fleming
Camp Forbes
Campbell Fortenberry
Cantor Foster
Cao Foy
Capito Frank (MA)
Capps Franks (AZ)
Capuano Frelinghuysen
Carnahan Fudge
Carney Gallegly
Carson (IN) Garamendi
Carter Garrett (NJ)
Cassidy Gerlach
Castle Giffords
Castor (FL) Gingrey (GA)
Chaffetz Gohmert
Chandler Gonzalez

Latham Neugebauer
LaTourette Nunes
Latta Sessions
Lee (CA) Oberstar
Lee (NY) Obey
Levin Olson
Lewis (CA) Olver
Lewis (GA) Ortiz
Linder Owens
Lipinski Pallone
LoBiondo Pascarelli
Loeb sack Pastor (AZ)
Lofgren, Zoe Paulsen
Lowey Payne
Lucas Pence
Luetkemeyer Perlmutter
Lujan Perriello
Lummis Peters
Lungren, Daniel Peterson
E. Petri
Mack Pingree (ME)
Maffei Pitts
Maloney Platts
Manzullo Poe (TX)
Marchant Polis (CO)
Markey (CO) Pomeroy
Markey (MA) Posey
Marshall Price (GA)
Massa Price (NC)
Matheson Putnam
Matsui Quigley
McCarthy (CA) Rahall
McCarthy (NY) Rangel
McCaul Rehberg
McClintock Reichert
McCollum Reyes
McCotter Richardson
McDermott Rodriguez
McGovern Roe (TN)
McHenry Rogers (AL)
McIntyre Rogers (KY)
McKeon Rogers (MI)
McMorris Rohrabacher
Rodgers Rooney
McNerney Ros-Lehtinen
Meek (FL) Roskam
Meeks (NY) Ross
Melancon Rothman (NJ)
Mica Roybal-Allard
Michaud Royce
Miller (FL) Ruppersberger
Miller (MI) Rush
Miller (NC) Ryan (OH)
Miller, Gary Ryan (WI)
Miller, George Salazar
Minnick Sánchez, Linda
Mitchell T.
Mollohan Sanchez, Loretta
Moore (KS) Sarbanes
Moore (WI) Scalise
Moran (KS) Schakowsky
Murphy (CT) Schauer
Murphy (NY) Schiff
Murphy, Patrick Schmidt
Murphy, Tim Schock
Myrick Schrader
Nadler (NY) Schwartz
Napolitano Scott (GA)
Neal (MA) Scott (VA)

NOT VOTING—15

Barrett (SC) Johnson, E. B.
Cardoza Lynch
Clay McMahon
Filner Moran (VA)
Hall (NY) Murtha

□ 1106

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members have 2 minutes remaining on this vote.

So (two-thirds being in the affirmative) the rules were suspended and the concurrent resolution, as amended, was agreed to.

The result of the vote was announced as above recorded.

The title was amended so as to read: "A concurrent resolution recognizing the contributions of the American Kennel Club."

A motion to reconsider was laid on the table.

Stated for:

Mr. FILNER. Madam Speaker, on rollcall 981, I was away from the Capitol. Had I been present, I would have voted "yes."

Ms. SLAUGHTER. Madam Speaker, I was unavoidably detained and missed rollcall vote No. 981. Had I been present, I would have voted "aye" on rollcall vote No. 981.

PERSONAL EXPLANATION

Mr. RADANOVICH. Madam Speaker, I was unable to make today's votes on the House floor due to a family illness. Had I been present I would have voted as follows: "No" on rollcall vote No. 978, the Adjournment Resolution, H. Con. Res. 223; "no" on rollcall vote No. 979, on ordering the previous question on H. Res. 973 for consideration of a same day rule; "no" on rollcall No. 980, on the adoption of H. Res. 973, for consideration of a same day rule; and "aye" on rollcall vote No. 981, on the motion to suspend the rules and agree to H. Con. Res. 160, Honoring the American Kennel Club on its 125th Anniversary.

PERSONAL EXPLANATION

Ms. EDDIE BERNICE JOHNSON of Texas. Madam Speaker, on rollcall Nos. 978, 979, and 981, I would have voted "yea." On rollcall No. 980, I would have voted "aye."

PERSONAL EXPLANATION

Mr. BARRETT of South Carolina. Madam Speaker, unfortunately, I missed the following recorded votes on the House floor on Tuesday, December 15, 2009 and on the morning of Wednesday, December 16, 2009.

On Tuesday, December 15, 2009, had I been present I would have voted "aye" on rollcall vote No. 971 (on motion to suspend the rules and agree to H. Res. 894); "aye" on rollcall vote No. 972 (on motion to suspend the rules and agree to H.R. 1517); "aye" on rollcall vote No. 973 (on motion to suspend the rules and agree to H.R. 3978); "aye" on rollcall vote No. 974 (on motion to suspend the rules and agree to H. Res. 971); "aye" on rollcall vote No. 975 (on motion to suspend the rules and agree to H.R. 2194); "aye" on rollcall vote No. 976 (on motion to suspend the rules and agree to H. Res. 150); "aye" on rollcall vote No. 977 (on motion to suspend the rules and agree to S. 1472).

On December 16, 2009, had I been present I would have voted "no" on rollcall vote No. 978 (on agreeing to H. Con. Res. 223, providing for the sin die adjournment of the first session of the 111th Congress); "no" on rollcall vote No. 979 (on ordering the previous question to H. Res. 973); "no" on rollcall vote No. 980 (on agreeing to H. Res. 973); "aye" on rollcall vote No. 981 (on motion to suspend the rules and agree to H. Con. Res. 160).

PROVIDING FOR CONSIDERATION OF SENATE AMENDMENT TO H.R. 3326, DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 2010; FOR CONSIDERATION OF HOUSE JOINT RESOLUTION 64, FURTHER CONTINUING APPROPRIATIONS, FISCAL YEAR 2010; FOR CONSIDERATION OF H.R. 4314, PERMITTING CONTINUED FINANCING OF GOVERNMENT OPERATIONS; FOR CONSIDERATION OF SENATE AMENDMENT TO H.R. 2847, COMMERCE, JUSTICE, SCIENCE, AND RELATED AGENCIES APPROPRIATIONS ACT, 2010

Ms. PINGREE of Maine. Madam Speaker, by direction of the Committee on Rules, I call up House Resolution 976 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 976

Resolved, That upon adoption of this resolution it shall be in order to take from the Speaker's table the bill (H.R. 3326) making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes, with the Senate amendment thereto, and to consider in the House, without intervention of any point of order except those arising under clause 10 of rule XXI, a motion offered by the chair of the Committee on Appropriations or his designee that the House concur in the Senate amendment with the amendment printed in part A of the report of the Committee on Rules accompanying this resolution. The Senate amendment and the motion shall be considered as read. The motion shall be debatable for one hour equally divided and controlled by the chair and ranking minority member of the Committee on Appropriations. The previous question shall be considered as ordered on the motion to its adoption without intervening motion.

SEC. 2. Upon the adoption of this resolution it shall be in order to consider in the House the joint resolution (H.J. Res. 64) making further continuing appropriations for fiscal year 2010, and for other purposes. All points of order against consideration of the joint resolution are waived except those arising under clause 9 or 10 of rule XXI. The joint resolution shall be considered as read. All points of order against provisions in the joint resolution are waived. The previous question shall be considered as ordered on the joint resolution to final passage without intervening motion except: (1) one hour of debate equally divided and controlled by the chair and ranking minority member of the Committee on Appropriations; and (2) one motion to recommit.

SEC. 3. Upon the adoption of this resolution it shall be in order to consider in the House tie bill (H.R. 4314) to permit continued financing of Government operations. All points of order against consideration of the bill are waived except those arising under clause 9 or 10 of rule XXI. The bill shall be considered as read. All points of order against provisions in the bill are waived. The previous question shall be considered as ordered on the bill to final passage without intervening motion except: (1) one hour of debate equally divided and controlled by the chair and ranking minority member of the Committee on Ways and Means; and (2) one motion to recommit.

SEC. 4. Upon the adoption of this resolution it shall be in order to take from the Speaker's table the bill (H.R. 2847) making appropriations for the Departments of Commerce and Justice, and Science, and Related Agencies for the fiscal year ending September 30, 2010, and for other purposes, with the Senate amendment thereto, and to consider in the House, without intervention of any point of order except those arising under clause 10 of rule XXI, a motion offered by the chair of the Committee on Appropriations or his designee that the House concur in the Senate amendment with the amendment printed in part B of the report of the Committee on Rules. The Senate amendment and the motion shall be considered as read. The motion shall be debatable for one hour equally divided and controlled by the chair and ranking minority member of the Committee on Appropriations. The previous question shall be considered as ordered on the motion to its adoption without intervening motion.

SEC. 5. In the engrossment of the House amendment to the Senate amendment to H.R. 2847, the Clerk shall—

(a) add the text of H.R. 2920, as passed by the House, as new matter at the end of the text proposed to be inserted by the House amendment;

(b) assign appropriate designations to provisions within the engrossment of the text proposed to be inserted by the House; and

(c) conform provisions for short titles within the engrossment of the text proposed to be inserted by the House.

SEC. 6. It shall be in order at any time during the remainder of the first session of the One Hundred Eleventh Congress for the Speaker to entertain motions that the House suspend the rules. The Speaker or her designee shall consult with the Minority Leader or his designee on the selection of any matter for consideration pursuant to this section.

SEC. 7. The requirement of clause 6(a) of rule XIII for a two-thirds vote to consider a report from the Committee on Rules on the same day it is presented to the House is waived for the remainder of the first session of the One Hundred Eleventh Congress.

SEC. 8. The chair of the Committee on Appropriations may insert in the CONGRESSIONAL RECORD at any time during the remainder of the first session of the One Hundred Eleventh Congress such material as he may deem explanatory of the Senate amendments and the motions specified in the first and fourth sections of this resolution.

SEC. 9. On any legislative day of the second session of the One Hundred Eleventh Congress before January 12, 2010, the Speaker at any time may dispense with organizational or legislative business.

SEC. 10. On any legislative day of the second session of the One Hundred Eleventh Congress before January 12, 2010, the Chair at any time may declare the House adjourned or declare the House adjourned pursuant to an applicable concurrent resolution of adjournment.

SEC. 11. (a) On any legislative day of the first session of the One Hundred Eleventh Congress, the Speaker may at any time declare the House adjourned.

(b) When the House adjourns on a motion pursuant to this subsection or a declaration pursuant to subsection (a) on the legislative day of:

(1) Wednesday, December 16, 2009, it shall stand adjourned until 6 p.m. on Saturday, December 19, 2009.

(2) Saturday, December 19, 2009, it shall stand adjourned until noon on Wednesday, December 23, 2009.

(3) Wednesday, December 23, 2009, it shall stand adjourned until 10 a.m. on Saturday, December 26, 2009.

(4) Saturday, December 26, 2009, it shall stand adjourned until noon on Wednesday, December 30, 2009.

(5) Wednesday, December 30, 2009, it shall stand adjourned until 10 a.m. on Saturday, January 2, 2010.

(c) If, during any adjournment addressed by subsection (b), the House has received: (1) confirmation that the President has approved H.R. 3326; (2) a message from the Senate transmitting its passage without amendment of H.R. 4314; and (3) a message from the Senate transmitting its concurrence in an applicable concurrent resolution of adjournment, the House shall stand adjourned pursuant to such concurrent resolution of adjournment.

(d) The Speaker may appoint Members to perform the duties of the Chair for the duration of the period addressed by this section as though under clause 8(a) of rule I.

□ 1115

POINT OF ORDER

Mr. FLAKE. Madam Speaker, I raise a point of order against H. Res. 976 because the resolution violates section 426(a) of the Congressional Budget Act. The resolution contains a waiver of all points of order against consideration of the legislation, which includes a waiver of section 425 of the Congressional Budget Act, which causes a violation of section 426(1).

The SPEAKER pro tempore. The gentleman from Arizona makes a point of order that the resolution violates section 426(a) of the Congressional Budget Act of 1974.

The gentleman has met the threshold burden under the rule, and the gentleman from Arizona and a Member opposed each will control 10 minutes of debate on the question of consideration. After that debate, the Chair will put the question of consideration.

The Chair recognizes the gentleman from Arizona.

Mr. FLAKE. Madam Speaker, approximately 68 years ago, in January of 1941, Sam Rayburn was elected Speaker of the House of Representatives. Just prior to his swearing in, he rose on the House floor and said the following:

"You have elevated me to a position, I must confess, that has been one of the ambitions of my lifetime. The House of Representatives has been my life and my love for this more than a quarter of a century. I love its traditions; I love its precedents; I love its dignity; I glory in the power of the House of Representatives. It is my highest hope and my unswerving aim to preserve, protect, and defend the rights, prerogatives, and the power of the House of Representatives."

What a beautiful statement. You can't help but hear and feel the words of love that Speaker Rayburn felt for this House. As Speaker, he considered himself a custodian of its traditions, its precedents and, as he put it, its dignity.

You might ask why I tell this story, why I raise this point. It is because we

are about to consider a bill that endorses and condones a practice that has placed a dark and ominous cloud over this institution. This practice, for lack of a better term, can be called circular fund-raising. It involves the awarding of earmarks, which are essentially no-bid contracts, in close proximity to the receipt of campaign contributions from the earmark recipients.

This legislation contains more than 500 earmarks where a private, for-profit company is the intended recipient. Let me repeat that. This legislation we are about to consider contains more than 500 earmarks, or no-bid contracts, directed to private companies. In many cases, the Members of the Congress securing these no-bid contracts have either received, or will soon receive after this legislation is enacted into law, large campaign contributions from the executives of these companies and/or the lobbyists that represent them.

By now my colleagues are well aware of the PMA scandal which was largely centered on the practice of circular fund-raising. Since news broke in February 2008 of the FBI's raid of the PMA offices, press reports and editorials from coast to coast have raised questions about the action of that firm and the integrity of this body, sowing public distrust and tarnishing the dignity of the House. Just listen to what is being said off the Hill and beyond the beltway.

ABC's news site, The Blotter, noted that PMA's "operations—millions out to lawmakers, hundreds of millions back in earmarks for clients—have made it, for many observers, the poster child for tacit 'pay-to-play' politics in Washington."

An editorial in The New York Times entitled, "Political Animal 101" referred to "the relationship between campaign donors and the customized appropriations they are fed by grateful lawmakers" as "the ultimate in symbiotic survival" and "cynical influence trading."

An article in The Kansas City Star noted that "the earmark game gets a bit less baffling" when taxpayers consider "the campaign donors that grease political palms."

The Columbus Dispatch summed it up when they noted, "Congress has an abysmal public approval rating of 26 percent as of early November, and the smell of quid pro quo certainly doesn't help."

The embarrassing coverage isn't just limited to domestic press. The Irish Times noted that "U.S. Congressmen tread a fine line between legitimate political fund-raising and influence-peddling, between friendship with lobbyists and outright corruption." They go on, "Now a leaked confidential report, prepared by the committee (on Ethics) in July and detailed in yesterday's Washington Post, has provided a rare glimpse into the cesspool of Capitol Hill politics."

Madam Speaker, I have here that article referred to from The Washington Post dated October 30 of this year. It notes that seven Members who sit on the Appropriations Committee, the Subcommittee on Defense, are "under scrutiny by ethics investigators." The article notes that "Together, the seven legislators have personally steered more than \$200 million in earmarks to clients of the PMA Group in the past 2 years, and received more than \$6.2 million in campaign contributions from PMA and its clients in the past decade."

According to The Wall Street Journal, Members who sit on the Defense Subcommittee have this year alone "received a total of \$141,000 in campaign contributions from companies that received earmarks from the lawmakers."

So here we are today, Madam Speaker, with a backdrop of investigations into the practice of circular fund-raising by the Justice Department and our own Ethics Committee, yet we are poised to pass a Defense appropriations bill that contains more than 500 no-bid contracts for private companies.

In mid-January of 2010, we will see a quarterly report from the Office of Congressional Ethics that will shed light into their investigations. Thereafter, it is likely that our own Ethics Committee will have to provide additional notice of their actions related to the PMA scandal.

If the future is anything like the past, additional scandals will spring from the earmarks that we approve today. We are surely, as the poet said, "traipsing down a flower-strewn path unpricked by thorns of reason."

I should note that circular fund-raising is not a partisan issue; both parties engage in it. The cloud that hangs over this body rains on Republicans and Democrats alike. But it is fair to ask, what about the dignity of this body? Are we appropriately concerned that the words "pay-to-play," "quid pro quo," "swamp" and "cesspool" are increasingly routine in articles describing the appropriations process? Should we have no standard higher than whether the abuse of the process rises to the level of an indictable offense?

One thing is clear: The practice of circular fund-raising will someday end. The question is, who will end it? Will it take us, in our own initiative, to clean our own House, or will we wait for the Justice Department to launch more investigations and take further action?

My own hope is that those who find themselves in leadership positions today will summon the dormant custodial spirit of those who have protected and defended this wonderful institution long before we arrived in this Chamber. We owe it to them to correct the process that led to this flawed piece of legislation before us.

I reserve the balance of my time.

Ms. PINGREE of Maine. Madam Speaker, I claim time in opposition.

The SPEAKER pro tempore. The gentlewoman is recognized for 10 minutes.

Ms. PINGREE of Maine. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, as my colleagues know, we have been here before. This is the same point of order that has been raised against almost every appropriations measure during this Congress, and each time it is used to discuss something other than its intended purpose.

I would want to respond to my good colleague from Arizona that I, too, share concerns about the earmarking process, and I encourage him to become a cosponsor on the fair elections bill. As we have in Maine, public financing takes away much of the scrutiny around the link between campaign contributions and earmarks.

But once again, this particular debate is about delaying consideration of this bill and ultimately stopping it altogether. I hope my colleagues will again vote "yes" so we can consider this important legislation on its merits and not stop it on a procedural motion.

This rule provides for enactment of legislation to fund our Nation's defense. The brave men and women who serve in the military, particularly those who are currently at war in Iraq and Afghanistan, deserve a swift enactment of this legislation.

This legislation that we will take up later today will also divert TARP money to programs that create and save jobs across the country. We do this by investing \$75 billion of TARP money into highways, transit, school renovation, hiring teachers, police, firefighters, supporting our small businesses, funding job training, and affordable housing. And for those hardest hit by the recession, this bill also provides emergency relief by extending programs like unemployment benefits, COBRA, FMAP, our health care funding for the State, and the child care tax credit.

Those who oppose this measure can vote against it on final passage. We must consider this rule, and we must pass this critical legislation today.

I have the right to close, but in the end I will urge my colleagues to vote "yes" and consider the rule.

Madam Speaker, I reserve the balance of my time.

Mr. FLAKE. Madam Speaker, may I inquire as to the time remaining?

The SPEAKER pro tempore. The gentleman from Arizona controls 3 remaining minutes.

Mr. FLAKE. I am accused of using a procedural measure to bring up earmarks again. Let me tell you why I'm doing that. I'm doing that because this year, for the first time in the history of this institution, every appropriations bill that came to the floor—including

this one, including the Defense appropriations bill—came under a structured or closed rule with only certain amendments being offered. That's the first time in the history of this institution where every appropriations bill has come to the floor in that manner.

And so individuals like myself and others were only allowed to offer the amendments that the other side wanted us to offer, the ones that they said we could offer rather than the ones that we ourselves would choose. I was fortunate in that I got 10 of the 550-some amendments I offered on this bill. I offered that many because that's how many no-bid contracts for private companies are contained in the bill, and I thought that they deserved some scrutiny.

I wish that the Appropriations Committee was vetting these earmarks; given this, it's clear that they're not. This is one of hundreds of articles out there. There is a cloud hanging over this institution because of prior Defense bills, and this is going to end up the same way. We are guaranteeing that there will be scandal that springs from earmarks approved in this bill because they haven't been appropriately vetted, and they haven't been because we weren't allowed an open rule for people to bring to the floor amendments that they wanted to offer.

I mentioned that I was fortunate in that I got 10 of them. Some of my colleagues offered multiple amendments on multiple appropriations bills throughout the year and weren't given the opportunity to offer any of them, not one. Here are Members across the country wanting to represent their constituents, and through the entire appropriations process, 12 bills this year, weren't given the opportunity to offer one amendment because we have the equivalent of martial law on appropriations bills.

And why? Because we were told we had to get it done so we wouldn't do any omnibus bills at the end of the year. Well, here we are, we just approved a massive omnibus bill last week, and we're here today because the Defense bill was held just so that we could tag on additional items that people who wouldn't want to vote for them anyway would have to because it's a Defense bill. That's just no way to conduct business. This institution deserves better than this. It deserves better than to have a bill that has more than 500 no-bid contracts for private companies of which articles have been written and will be written, making a cloud hang over this body.

As I mentioned, this isn't a partisan issue. This isn't where one party is in the right and one party is in the wrong. We are both doing this, and we shouldn't. And it will come back to haunt us as surely as other practices have in the past.

Madam Speaker, I yield back the balance of my time.

Ms. PINGREE of Maine. Madam Speaker, again I want to urge my colleagues to vote "yes" on this motion to consider so that we can debate and pass this and the other important items covered by this rule.

Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. All time for debate has expired.

The question is, Shall the House now consider the resolution?

The question of consideration was decided in the affirmative.

The SPEAKER pro tempore. The gentlewoman from Maine (Ms. PINGREE) is recognized for 1 hour.

Ms. PINGREE of Maine. Madam Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentlewoman from North Carolina, Dr. Foxx. All time yielded during consideration of the rule is for debate only.

GENERAL LEAVE

Ms. PINGREE of Maine. I ask unanimous consent that all Members be given 5 legislative days in which to revise and extend their remarks on House Resolution 976.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Maine?

There was no objection.

Ms. PINGREE of Maine. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, House Resolution 976 provides for the consideration of the Senate amendment to H.R. 3326, House Joint Resolution 64, H.R. 4314, and the Senate amendment to H.R. 2847.

For the Senate amendment to H.R. 3326, the rule makes in order a motion to concur in the Senate amendment with the House amendment, provides 1 hour of debate controlled by the Committee on Appropriations, and waives all points of order against consideration of the motion except those arising under clause 10 of rule XXI.

□ 1130

The rule provides for consideration of H.J. Res. 64 under a closed rule. It provides for 1 hour of debate controlled by the Committee on Appropriations. It provides one motion to recommit with or without instructions. It waives all points of order against consideration of the joint resolution except those arising under clause 9 or 10 of rule XXI, and it waives all points of order against provisions in the joint resolution.

The rule provides for consideration of H.R. 4314 under a closed rule. It provides for 1 hour of debate controlled by the Committee on Ways and Means. It provides one motion to recommit with or without instructions. It waives all points of order against consideration of the bill except those arising under clause 9 or 10 of rule XXI, and it waives

all points of order against provisions in the bill.

For the Senate amendment to H.R. 2847, the rule makes in order a motion to concur in the Senate amendment with the House amendment. It provides 1 hour of debate on the motion controlled by the Committee on Appropriations, and it waives all points of order against consideration of the motion except those arising under clause 10 of rule XXI.

The rule provides that in the engrossment of the House amendment to the Senate amendment to H.R. 2847, the Clerk shall add the text of H.R. 2920 as passed by the House.

The rule also provides that measures may be considered under suspension of the rules at any time during the remainder of the first session of the 111th Congress.

The rule waives the requirement of a two-thirds vote to consider a rule on the same day it is reported from the Rules Committee for the remainder of the first session of the 111th Congress.

The rule provides that the Chair of the Committee on Appropriations may insert in the CONGRESSIONAL RECORD explanatory materials on the Senate amendments and the motions regarding H.R. 3326 and H.R. 2847.

The rule provides that, on any legislative day before January 12, 2010, the Speaker may dispense with organizational or legislative business.

The rule provides that, before January 12, 2010, the Chair may declare the House adjourned.

The rule provides for pro forma sessions until the House adjourns sine die.

And finally, the rule provides that, on any legislative day of the first session of the 111th Congress, the Speaker may declare the House adjourned.

Madam Speaker, the rule before us today allows the House to consider the Department of Defense Appropriations Act for fiscal year 2010, which is the last appropriations bill for this fiscal year.

The conference agreement on H.R. 3326 provides over \$363 billion towards protecting our troops abroad and taking better care of their families at home. To help protect our troops, this bill provides increased funding for the Mine Resistant Ambush Protected Vehicle Fund and for the procurement of new Humvees and of new heavy and medium tactical vehicles. This is particularly important given the casualty rate and the difficulties our soldiers are experiencing in Afghanistan.

H.R. 3326 increases pay for all servicemembers by 3.4 percent, and it fully funds the requested end strength levels for active reserve and selected reserve personnel. The bill provides over \$29 billion for top-of-the-line medical care, including \$120 million for traumatic brain injury and psychological health, and it increases funding for the wounded, the ill and injured warrior programs.

The conference agreement also includes over \$472 million for family advocacy programs, and it fully funds the family support and yellow ribbon programs. The bill also includes \$20 million for the Army National Guard family assistance centers and reintegration programs; but this bill cannot provide for the common defense without a common effort.

In my home State of Maine, there are men and women who work every day to help in this effort. The funding in this bill would have been wasted if it weren't for the efforts of the welders, designers, and metal workers of the Bath Ironworks; of the skilled factory workers and assembly men at Vintech in Biddeford, Maine; of the world-class machinists and engineers at Pratt and Whitney in North Berwick; or of the dedicated laborers and nuclear engineers at the Portsmouth Naval Shipyard.

This is a clear example of why the bills before us today are so interconnected. Our economic security and our national security are inextricably linked, and our economic security is still in dire straits.

Madam Speaker, if you were sitting at a boardroom table on Wall Street today, you might hear the employees with Goldman Sachs discussing their \$1 billion in profits or bonuses or you might hear employees of Citibank discussing raises for their top executives. You might also hear that the stock market has gone up 60 percent since the spring. You might even hear terms like "economic recovery" or "rebound." So, if you are sitting at that boardroom table on Wall Street, you might think that the economy has fully bounced back and that we are out of the woods. You may start to believe that there is nothing but smooth sailing ahead.

Yet, if you were at a kitchen table on Main Street in my home State of Maine, you would hear a very different story. Rather than talk of large profits, you would hear families discussing a savings account that has all but disappeared. Instead of listening to talk of raises or bonuses, you would hear families debating cutbacks on food or cutbacks on health care. Instead of hearing phrases like "economic recovery" or "rebound," you would hear terms like "high unemployment" and "mounting debt."

For the big banks on Wall Street, the economic recovery may be at hand, but for the millions of unemployed workers and for the thousands of small businesses that are struggling to get by, the economic recovery is still a long way off. In my State and all across the country, there are millions of Americans who want to get back to work, but they need us to lend the same helping hand that we gave to Wall Street in its time of need.

Madam Speaker, the rule before us today allows for the consideration of

the Jobs for Main Street Act, which will move us down that road. This legislation invests in our Nation's infrastructure, and it puts more Americans back to work by providing \$48 billion to rebuild and repair our national transportation system. This investment provides a measurable return, not only by creating and preserving jobs but by literally building the foundation for a long-term economic recovery. This bill will also preserve the jobs of teachers, of police officers, and of firefighters. For those who have already lost their jobs, the Jobs Act extends unemployment benefits for 2 months, and it maintains the current COBRA subsidy.

These programs—these investments, the economic lifelines—have a real impact. Just this week, I heard from a constituent of mine who said these words: Something needs to be done. There are less than 4 weeks left for my husband's unemployment. After that, we won't be able to pay the rent, and we will be out on the streets with a child under 2 years old. Every day, I wonder what is going to happen next, and I even have nightmares. You bail out these large banks which then only raise our interest rates and lower our credit lines—and for what? That doesn't help the little guy like us. Do something to help us.

Madam Speaker, we have the opportunity and we have the obligation to take the bailout money that was used as a lifeline to Wall Street and to give that money back to the American people and to those who have been hit the hardest by these tough economic times. The COBRA subsidy we passed this spring began expiring a few weeks ago. If we don't act now, it will completely disappear by January 1. In my State, full payment for COBRA uses up nearly 90 percent of the average unemployment benefits. That means out-of-work Mainers end up with only about \$150 a month left after paying the full cost of their health insurance.

We need to act now, and we need to act fast to ensure that Main Street recovers. If we do not act, we will have only assured that Wall Street keeps their bonuses while American families lose their benefits. We will have only watched Wall Street get rid of their debt while watching small businesses take on more.

Madam Speaker, we have already put more than enough into shoring up Wall Street. Now we need to focus on creating jobs for the average American that will rebuild our economy from the bottom up.

I reserve the balance of my time.

Ms. FOXX. I yield myself such time as I may consume.

I thank my colleague from Maine for yielding time.

Madam Speaker, the Department of Defense appropriations bill for fiscal year 2010 is intended to provide equipment and technology for our troops.

Our country's greatest treasure lies in the bravery, in the dedication, and in the ability of our servicemen and -women. These courageous individuals protect our freedoms every day.

We thank them, and we thank their families for their support, dedication, and sacrifice.

This bill provides top-of-the-line medical care for our troops, including funding for traumatic brain injury and psychological health. This bill provides funding for wounded, ill, and injured servicemembers as well as for cancer research. This bill provides our military with a pay increase, and it continues efforts to end the practice of stop loss—compensating troops for every month their terms of service will be involuntarily extended in 2010. This bill includes funding to provide support for our country's military families who sacrifice every day on behalf of our Nation and to whom we owe a great debt. This bill provides our troops with first-class military equipment and readiness training, ensuring they are fully prepared to successfully perform their missions.

However, while this bill contains funding for several important and necessary initiatives, I would be remiss if I did not mention my disappointment in the overall funding levels when compared to the increases we have seen throughout the appropriations season this year. While the bill does receive, roughly, a 4.5 percent increase over last year, this increase is not comparable to nondefense appropriations bills we have voted on this year, which average a 12 percent increase in funding levels. As we have noted before, the Federal Government is the only unit of government to provide for our national security.

These represent the wrong priorities of the Democrats, who are in charge of the Congress, and of the Obama administration. Increasing spending for domestic priorities by double digits while, in comparison, shortchanging national defense represents a dangerous, wrongheaded policy that does not rightly prioritize the security of our Nation.

Thus, while I am pleased that several items in this bill are being funded in order to provide our troops with the tools, training, and medical services they need and deserve, I am disappointed that, after increasing the funding levels for domestic appropriations bills by an average of 12 percent, the Democrats in control decided only to increase our defense spending by 4.5 percent—less than half—for the coming year.

This is the last appropriations bill, and that is because it has been held in order for the majority to put into it things that are not related, which I will be discussing a bit more, but the substance of the DOD appropriations bill is not the source of my concern.

The extent of the closed rule before us today allows for the consideration of a variety of additional legislation that has been cobbled together without committee consideration. As my colleagues have said before, our colleagues across the aisle have gone to great lengths to shut down debate. Therefore, I urge my colleagues to vote “no” on the rule so the bill can be returned to the committee and can be brought back under regular order.

Madam Speaker, I reserve the balance of my time.

Ms. PINGREE of Maine. Madam Speaker, I yield 3 minutes to a member of the Committee on Rules, the gentleman from Massachusetts (Mr. MCGOVERN).

Mr. MCGOVERN. I thank my colleague for yielding.

Madam Speaker, I rise in support of this rule, and specifically, I rise in support of the Jobs for Main Street Act, which we made in order under this rule. This important bill will provide the following:

\$48 billion for highways, transit, and other infrastructure projects; \$27 billion to hire teachers, police, firefighters, and for other job training programs. That's \$75 billion for job-creating programs that are proven successes and that will help put Americans back to work. On top of that, the Jobs for Main Street Act provides \$79 billion in emergency relief funding that will go to critical safety net programs like unemployment benefits, health insurance for unemployed workers, Federal matching funds for Medicaid, and funding for the child tax credit.

All told, Madam Speaker, the Jobs for Main Street Act is a good bill, one that will build on the success of the Recovery Act, which was signed into law earlier this year and which is one that will put people back to work. We know that these are difficult economic times, and we recognize that the American public is hurting. With the Jobs for Main Street Act, we will continue to stimulate the economy, to shrink the unemployment rate, and, more importantly, to create new jobs.

Ten months after President Obama signed the Recovery Act into law, we are seeing real results across the country. According to the Transportation and Infrastructure Committee, real jobs are being created by the Recovery Act, and we are seeing the impact of these jobs in the unemployment figures. Look at the results:

Because of the Recovery Act, we have seen the creation of almost 630,000 direct and indirect jobs in the transportation industry alone. That's 210,000 direct hires alone. The result of these direct hires is a \$1.1 billion payroll. It is \$179 million in unemployment compensation not spent. It is people's insurance restored, health insurance restored, and it is \$230 million in paid

Federal taxes. Additional jobs have been created because of the clean water and high-speed rail projects.

All told, the Transportation and Infrastructure Committee estimates that the Recovery Act has created or has sustained approximately 857,000 jobs. All of this underscores the importance of public infrastructure programs. These aren't projects just for the safety and well-being of our friends and neighbors; they are also projects that put these friends and neighbors back to work.

Madam Speaker, this Congress is acting. This House will pass the Jobs for Main Street Act and even more jobs will be created.

□ 1145

Earlier this year, my Republican friends chose politics over the needs of the American people, and every single one of them opposed the Recovery and Reinvestment Act.

They liked the same old, same old. Well, that was their way of thinking. That's the old way of thinking. That way of thinking took Bill Clinton's accomplishments in creating a record number of jobs and eliminating our deficits and paying down the debt and turned it into George Bush's recession, a recession that cost millions of Americans jobs, a recession that added billions and billions to our debt and added that debt on the backs of our children and our grandchildren.

Madam Speaker, people in this country want us to act. People want us to create jobs, and that's what we are going to do.

Ms. FOXX. Madam Speaker, I would now like to yield 3 minutes to my very distinguished colleague from Texas, one of only five CPAs in the House, Mr. CONAWAY.

Mr. CONAWAY. I thank the gentlewoman from North Carolina.

I want to talk to two aspects of this rule, one that sets up the vote on a trick that allows us to vote on the “son of stimulus” bill that will become before us later on this afternoon, and that is voting, having stripped out the Senate amendment to H.R. 2847 and put in place this other legislation.

This trick silences the minority one more time. It would not allow for a motion to recommit and/or a substitute on that bill.

This legislation of some \$150 billion was apparently thrown together in the dark last night, posted on the Internet about 11:10, so we are now 12 hours and 25 minutes into being able to study this bill, again thrown together. It will increase the deficit in spite of the rhetoric that says we are going to use TARP money to do that.

The intent of TARP all along was once it was paid back was to be back into the Treasury to reduce the amount of money we have to borrow and/or reduce the deficit. There are two

provisions in this slush fund and this bill that you need to be aware of. One is that it creates additional billion-dollar spending in the Barney Frank trust fund, the housing slush fund, and makes ACORN available to get back into the game, much to the chagrin of this body, as we voted on.

It also replaces \$2 billion in the Cash for Clunkers money that came out of the stimulus bill last summer. We were on the bill when the proponents of the Cash for Clunkers said this will not increase the deficit because we will take it out of the stimulus money. Immediately the Speaker came to the floor, along with the others, and said, *au contraire*, we will find a replacement for that \$2 billion, and it's in this bill.

Now the stimulus bill, the first stimulus, is up to 787 billion, because, as you all know we all enjoyed the Cash for Clunkers work, but this money is back in the bill with respect to the new stimulus.

The other bill I would like to talk about is the Defense Department appropriations bill. This rule waives the demand, waives the requirement that the chairman of the Appropriations Committee post on the Internet the earmarks and/or plus-ups, depending on how you want to call those, in this bill, some 1,700 of them, we were told. Some are good, some are bad, but we ought to know what's in there.

They were shortly posted on the Internet last night for a brief period of time and then taken down. Madam Speaker, I would like to know what's in this bill that embarrasses the majority that they will not allow this transparency to come before us to allow us to look at it. Like I said, I am not against or for any of those necessarily, but we don't know what they are.

By not posting them until after this bill is voted on sometime between now and the end of the year, we are going to be voting blind one more time at the specific request of the majority. It is your responsibility, Madam Speaker, through the chairman of the Appropriations Committee, to have posted these earmarks on the Internet so that those of us could look at them and see them.

We are not going to see those. What has been stuck in here in the dark of night between last summer when we passed the bill and when we are going to vote on this afternoon? Why are there things in there that's going to embarrass the majority before we take this vote?

Madam Speaker, I urge my colleagues to vote against this rule and against the underlying bill on the "son of stimulus" bill.

Ms. PINGREE of Maine. Madam Speaker, I yield 3 minutes to the gentleman from New York, a member of the Committee on Rules, Mr. ARCURI.

Mr. ARCURI. I would like to thank my colleague from Maine for yielding.

I rise today in support of consideration of H.R. 3326, the Department of Defense Appropriations Act and the underlying rule, not for the reasons just stated by my friend from Texas, but because the bill ensures that our brave men and women who are in the military are paid what they deserve to be paid for defending us, that they have the tools to fight the war on terror and that they are able to do the things that we ask them to do, and that is to fight terror, to keep us safe. That is why I support this bill and the underlying rule.

I would like to thank and commend the members of the Appropriations Committee in the House and Senate, their counterparts for bringing before us this bipartisan approach that puts the preparedness and safety of our troops first, and also continues President Obama's pledge to put the cost of the war on the books.

The bill does not include funding for an escalation of troops in Afghanistan, and I have heard some of my colleagues on the other side of the aisle criticize that we may have to consider a supplemental measure to provide funds for that purpose. I want to make it very clear. There is a difference between requesting supplemental funding to address changes on the ground and simply using the supplemental appropriation acts to fund the majority of the wars in Iraq and Afghanistan as we have done under the prior administration.

The House passed our version of the Defense Appropriations Act on July 30 of this year. At that time we determined the amount of spending necessary for the ongoing operation in Iraq and Afghanistan. Since that time, our generals have stated that they believe conditions in Afghanistan warrant additional troops. President Obama is listening to those generals in the field and may require additional funds. However, that is what supplemental appropriations acts are intended for, responding to changes in circumstances throughout the year, not for funding ongoing operations.

In addition to ensuring that our troops have first-class weapons and equipment, the bill also includes other important aspects that improve transparency and accountability of the Defense Department procurement process.

For instance, congressional earmarks account for only 1 percent of the total funding of this bill. In addition, for the first time, this House-Senate agreement retains the requirement that has been included in every House-passed appropriations bill this year that requires any earmark for a private company to be competed.

I applaud the leadership of our side of the Capitol to institute this important new measure of accountability in the earmark process, and I hope that it will become a part of all final spending bills as we go forward.

I urge my colleagues to support this rule and the bill.

Ms. FOXX. Madam Speaker, I now would like to yield 3 minutes to another distinguished colleague from Texas (Mr. HENSARLING).

Mr. HENSARLING. I thank the gentlewoman for yielding.

Madam Speaker, apparently the House is due to adjourn for the year today. Before it does, the House will apparently present the American people with a number of Christmas gifts wrapped up in one nice neat little package represented by this rule.

The first Christmas gift that the majority is giving the American people is the fifth, fifth increase in the debt ceiling since they took control of Congress, raising the debt ceiling an additional \$290 billion, more debt to be placed upon the backs of our children and grandchildren.

The second gift for the American people at Christmas time is, guess what, yet another stimulus bill, this one weighing in at \$150 billion. I lose track, Madam Speaker. I don't know if this is stimulus 4, stimulus 5. It's a little bit like those old "Friday the 13th" movies: it just doesn't go away.

The next gift, Madam Speaker, is kind of a recycled gift, one that they have given the American people all year and that is unemployment, double-digit unemployment under the economic policies of this administration, under this Democratic controlled Congress. They continue to give the American people double-digit unemployment.

The rule that is before us, Madam Speaker, allows for more of the same. I would hope, I would hope that one day, for the sake of the country, that my friends on the other side of the aisle will realize that you cannot spend your way into more jobs, you cannot borrow your way into more jobs, you cannot bail out your way into more jobs. That is not the recipe.

We suffer from double-digit unemployment, not through a lack of bailouts in spending and debt, which is the hallmark of this Congress. If we truly want to create jobs, Madam Speaker, the first thing we have to do is show the American people that we are serious about this sea of red ink. Nobody wants to launch a new business enterprise in an economy that is going to be socked with debt and taxes, impossible double-digit inflation as the debt has to be monetized.

The uncertainty and cost of a nationalized health care system, which is going to cost the American people their freedom, their opportunities—not to mention a trillion dollars. There is a \$600 billion energy tax passed by the majority. Last week we just passed the Perpetual Wall Street Bailout and Credit Contraction Act of 2009.

Madam Speaker, where does it all end? If we want jobs, we have to reject

the failed policies. This rule brings more of the same. Let's vote against the spending, against the debt, against the bailouts.

Ms. PINGREE of Maine. Madam Speaker, before I yield to one of my colleagues, I do want to mention one point of concern I have in the bill.

The conference agreement on H.R. 3326 is the first step towards cutting wasteful defense spending, but it is by no means perfect. It is no means the last step that we must take. The conference agreement provides \$465 million for the development of an alternative engine for the F-35 Joint Strike Fighter. This provision represents businesses as usual in Washington for providing funds for an engine that's already being built and already being built well.

There is no need to devote our precious Federal dollars to a wasteful alternative engine program at this time when Americans are struggling to find jobs to pay their medical bills and to put food on the table. Every defense bill that we spend wisely contributes to our national security, and every defense dollar that we waste hampers our economic security.

Madam Speaker, I would like to yield 2 minutes to the gentleman from Illinois (Mr. HARE).

Mr. HARE. Madam Speaker, I rise in strong support of the rule and the underlying bill, the Jobs for Main Street Act.

First I would like to thank all the members of the Democratic leadership for their hard work in putting together a jobs bill, the Jobs for Main Street Act. It is an important step forward.

As we all know, since December of 2007, our Nation has faced the greatest economic crisis since the Great Depression. As a result, 15 million, or 10 percent, of our Americans are out of work. The Jobs for Main Street Act is an important first step in reemploying America and making our families more secure.

Specifically, I want to call attention to several principles that I have championed that have been included in this bill, such as extending the COBRA subsidy. This is a critical safety net for the millions of unemployed across this country, protecting and expanding our Nation's critical workforce with teachers, police and firefighters; putting people to work to improve and rehabilitate our Federal, State and local public lands.

I would also like to commend Chairman OBERSTAR for his leadership on the transportation and infrastructure portion of this bill. There is no better way to invest in our economy and create jobs than by investing in infrastructure.

For example, only 4 percent of the Recovery Act went to programs under the jurisdiction of Chairman OBERSTAR. However, that 4 percent for infra-

structure has created 25 percent of the jobs under the Recovery Act. This is a testament to the effectiveness of investing in infrastructure. Over half of this bill is dedicated to investing in our roads, bridges, trails, transit systems, airports, and waterways.

Madam Speaker, I look forward to working with leadership to ensure that this Congress passes this bill and takes further action in the next session to put Americans back to work.

Ms. FOXX. Madam Speaker, I now would like to yield to a third colleague from Texas (Mr. CULBERSON), who has come to speak against this rule, one of the most fiscally conservative Members of the House, such time as he may consume.

Mr. CULBERSON. Madam Speaker, I want us to slow down for just a minute and think about what is happening here today. The House is scheduled to vote today on a package of four massive bills, spending over \$1.1 trillion hard-earned tax dollars that will be paid for by additional debt that our children must repay.

□ 1200

Worst of all, these bills were only posted on the Internet last night for the American people to see at about 11 o'clock, so literally 13 hours for the public, for the taxpayers, for the Members of Congress to read these bills spending over \$1.1 trillion. And I've scouted around, Madam Speaker, and the only copy of the bill before us, the Defense bill, that anybody can find is the one up there on the Clerk's desk.

These bills were put up on the Internet 13 hours ago. They're not even outside in the House lobby. And it's always tradition that at an absolute minimum that Members of Congress would be able to physically read the bill outside in the lobby. But this is all I found: this empty box outside in the lobby is all we have before us today. And \$1.1 trillion spent in a little over 12 hours. Why the rush? Why are we rushing to do this? So Speaker PELOSI can catch a plane to Copenhagen.

We're spending \$1.1 trillion on top of the \$6.7 trillion that this liberal majority has already spent this year. That means in the course of 12 months, this liberal majority in Congress has already spent in this House nearly \$8 trillion in 12 months. It's unprecedented. It is unsupportable. It will bankrupt this Nation and crush our children under a burden of debt that they cannot possibly repay without crushing tax burdens and massive sacrifices. We may be the first generation in American history that leaves our children worse off than the world we inherited from our parents. It's just unacceptable and outrageous.

My colleague Representative BRIAN BAIRD and I, Madam Speaker, introduced legislation earlier this year to require the House to lay these bills

out, every bill, for at least 72 hours before they can be voted on on the floor.

And I just would ask the Speaker a simple question: what's more important, giving the American people time to read these bills, to give the Members of Congress time to read these bills, or to catch an airplane to a global warming conference? That's really what's going on here today.

I would ask Speaker PELOSI in all sincerity, Madam Speaker, please cancel your flight. Give the American people time to read these spending bills.

It's time to stop forcing Congress to vote blind.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Members are reminded to direct their remarks to the Chair.

Ms. PINGREE of Maine. Madam Speaker, I yield 2 minutes to the gentleman from Washington (Mr. DICKS), a member of the Committee on Appropriations.

Mr. DICKS. I wanted to discuss a change that was made this year in the appropriations process, and I just want to read it into the RECORD to correct something that was said previously.

"Each congressionally directed spending item specified in this Act"—this is the defense bill—"or the explanatory statement regarding this Act that is also identified in Senate report 111-74 and intended for award to a for-profit entity shall be subject to acquisition regulations for full and open competition on the same basis as each spending item intended for a for-profit entity that is contained in the budget request of the President.

"Exceptions: Subsection (a) shall not apply to any contract awarded, (1), by a means that is required by Federal statute, including for a purchase made under a mandated preferential program; (2), pursuant to the Small Business Act (15 U.S.C. 631 et seq.); or (3), in an amount less than the simplified acquisition threshold described in section 302A(a) of the Federal Property and Administrative Services Act of 1949 (41 U.S.C. 252a(a)).

"Any congressionally directed spending item specified in this Act or the explanatory statement regarding this Act that is intended for award to a for-profit entity and is not covered by the competition requirement specified in subsection (a), shall be awarded under full and open competition, except that any contract previously awarded under full and open competition that remains in effect during fiscal year 2010 shall be considered to have satisfied the conditions of full and open competition.

"In this section, the term 'congressionally directed spending item' means the following:

"A congressionally directed spending item, as defined in rule XLIV of the Standing Rules of the Senate; a congressional earmark for purposes of rule XXI of the House of Representatives."

The SPEAKER pro tempore. The time of the gentleman has expired.

Ms. PINGREE of Maine. I yield the gentleman an additional 30 seconds.

Mr. DICKS. I think this clarifies the statement that was made previously by the gentleman from Arizona.

Ms. FOXX. Madam Speaker, the West continues to be well-represented here. I now yield 3 minutes to our colleague from Arizona (Mr. FLAKE).

Mr. FLAKE. I thank the gentleman for yielding.

I had hoped that the gentleman would rise and explain what he just explained.

Now, I will gladly yield to him to explain why this would only apply to earmarks by House Members alone and why the competition requirements don't apply to earmarks that are jointly requested by a House and Senate Member. If we're hanging our hat on language that requires that these earmarks be subject to competition, then surely we would extend it to anything that had our name on it, but we're not.

My understanding is that the language only applies to those earmarks that are requested solely by a House Member, and that if you have a Senate Member on your earmark request, then it is not subject to competition. The language just explained does not apply to it. So you can't have it both ways.

Now, I will argue that it doesn't matter anyway, because right now if you talk to the Department of Defense, and I have, we've held meetings in my office with the procurement officials, and we've asked them, How does this work when these earmarks come over? Are they subject to competition? They said, Yes, we follow the rules. Yet when you ask them to do a cursory examination or a full-fledged examination of those earmarks that were requested in prior years, you will find an uncanny alignment, as you might expect, between the intended recipient and those who actually got the earmarks in the end.

So you can say until you're blue in the face we're going to subject these to full and open competition. The Department of Defense already says that. And these articles that I already talked about, these scandals that are currently underway are under a policy where the Department of Defense already says we subject these to full and open competition. But let me tell you, if an earmark comes over from a Member of Congress, particularly from those on the Appropriations Committee—and I should explain that the majority of these earmarks, a disproportionate number, are from the powerful Members on the Appropriations Committee—believe me, those procurement officials at the Department of Defense take that into account. They know who butters their bread, and they know that they'd better award this contract to the intended

recipient or they might not get funded the next year. If that's not the case, why have we seen so much an uncanny alignment between the intended recipient and those who actually got the earmark in the first place?

So, first, again let me say if we're hanging our hat on the language that says these are subject to competition, then why wouldn't we apply it to every earmark that is contained in this bill? It doesn't apply to Senate earmarks, nor does it apply to earmarks requested by both Senate and House Members. So are we saying, well, we're going to subject some to competition and that means something, but these others, yes, it's okay if there are no-bid contracts? That simply doesn't work.

Ms. PINGREE of Maine. Madam Speaker, I yield 1 minute to the gentleman from Washington (Mr. DICKS).

Mr. DICKS. Again I want to just say this is an initiative that Mr. OBEY put into place this year. This is the first year we've had this initiative. And what it says is that if an earmark is directed to a for-profit company, there must be full and open competition. This was extended to the United States Senate as well.

So, again, the gentleman from Arizona misleads the House of Representatives on a very important and a very sensitive matter.

There ought to be competition on these things, and I thought the gentleman would recognize how important it was and compliment Mr. OBEY for his initiative, but I don't hear that.

Ms. FOXX. Madam Speaker, having a charge of misspeaking is very serious. I would like, therefore, to yield such time as he may consume to the gentleman from Arizona (Mr. FLAKE) to speak again on the rule.

Mr. FLAKE. I thank the gentleman for her indulgence here.

This is important, and I would ask the gentleman and would yield to him to respond, is it your understanding, then, that this language, this new competition language, applies to Senate earmarks as well as earmarks requested by both House and Senate Members?

Mr. DICKS. It is my understanding that the language that came out of conference applies both to the House and Senate earmarks for for-profit companies requiring competition. There are some little variations because of Section 8(a) and other restrictions that the Senate still claims that should be followed, but this is a major step forward, and I think Mr. OBEY deserves great credit for this. So I just want to clear this up, that on district directed for-profit companies there is full and open competition.

Mr. FLAKE. I thank the gentleman. Let me simply say if that is the case, that is in conflict with the agreement that we understand to be in effect.

The agreement we understand to be in effect and what I was told is that

only those earmarks that are requested solely by a House Member has the language that applies to competition. If it is an earmark requested by both a House and a Senate Member, then it does not apply this year, and supposedly it will next year, although obviously there are no guarantees. We can't bind a future session. And that if it is a Senate earmark, they didn't agree to this at all. That's what we understand. If there is some difference there, then please let's have the chairman of the Appropriations Committee explain it.

But, again, the question here is if that language is so important, then why wouldn't we apply it across the board?

And doesn't it strike everybody a little bit funny that you have an earmark that, when a Member requests it from the Appropriations Committee, they say this earmark of this amount, \$500,000, \$2 million, \$2.5 million, whatever, is to go to this company at this address? It's that specific. It goes to that company at that address.

Now, the Appropriations Committee will say we're just providing a look-see, and so the Department of Defense can say, well, we didn't know that that company existed but now we do, and we're doing nothing more than simply giving them a look-see and giving them a chance to see which companies those are. I think that doesn't quite pass the laugh test.

Mr. DICKS. Will the gentleman yield?

Mr. FLAKE. Yes, I will.

Mr. DICKS. I think the gentleman is trying to confuse himself.

Clearly what we're talking about here is that there has been a decision to have full and open competitions. The gentleman has been an advocate for that. It doesn't matter how it's written in. The law says "full and open competition." So please don't try to confuse yourself and the House and the American people. This is a reform that you've been advocating for. You ought to be saying thank you for doing it, and it's the right thing to do. But you'd rather have the issue than to resolve something.

Mr. FLAKE. I thank the gentleman for explaining my motives.

But in truth what I would like to see is no more earmarks in the defense bill because when you have an earmark, you don't have full and open competition. What I'm talking about is I would not like to see no-bid contracts for private companies in the defense bill. When you have that, I don't know how in the world you can say we have full and open competition.

Like I say, I don't believe that that language means much at all, but to the extent that you believe it does mean something, then at least you should apply it across the board, not just to earmarks sought by Members of the

House solely but those earmarks that are requested by Senate Members as well. How can we say with a straight face that, hey, we're doing things right because we're applying that competition language to us, but all you have to do is to get a Senate Member to request it along with you and then you don't have to subject it to full and open competition. It simply doesn't make sense, Madam Speaker.

I thank the gentlewoman for her indulgence and I appreciate this discussion.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair reminds Members to direct their remarks to the Chair.

Ms. PINGREE of Maine. Madam Speaker, I yield 3 minutes to the gentlewoman from Texas (Ms. JACKSON-LEE).

□ 1215

Ms. JACKSON-LEE of Texas. Let me thank the distinguished gentlelady from Maine.

Madam Speaker, I wish to start by wishing America a very Merry Christmas, and to many other Americans, a happy holiday. And I'd like to give my thanks to the Rules Committee and the staff of the Rules Committee for doing an enormous job. Our chairwoman, LOUISE SLAUGHTER, has been at the forefront of the major successes we have had on behalf of the American people. I offer my appreciation as well for Chairman JOHN MURTHA, who, in his astuteness and commitment to the men and women of the United States military, finds many of us today supporting the Defense appropriations bill, even as we begin to consider the next steps in Afghanistan.

But why am I standing here today to be able to speak to my colleagues and the American people? One, because history gets distorted. We are in this predicament because the last administration of Republican leadership took away our surplus that had been created in the 1990s. They dashed and dashed and destroyed and devastated. Isn't it interesting that you'd come now to complain about a leadership, President and Democratic leadership in Congress, that have had to make the political sacrifice to ensure that Americans can work?

And so let me just set the record straight. The American Recovery and Reinvestment Act—that secured no Republican votes—created 3.5 million jobs and gave 95 percent of American workers a tax cut. And today, as we speak, we are cutting the job loss every single month. Why I'm standing here today is because I'm enthusiastically supporting this rule, because we will then pass a jobs bill, and I will be able to go home to those in the 18th Congressional District who told me over the Thanksgiving holiday as I was participating in feeding those on Thanks-

giving Day, I lost my job from a major corporation. Well, I'm going to tell them that because of infrastructure funding, \$48 billion, in fact, that we will be able to invest in highways and mass transit. One billion dollars in Federal investments to highways creates 27,800 jobs. Is there something wrong with that? The wrongness of it is that the other side is not thinking about the American people, and has not had a good thought about how to invest in America.

This jobs bill is going to keep States from cutting teachers and police and firefighters, and it's going to provide job training. I am proud that they have taken my ideas and many of our ideas, but work that I have done on summer youth jobs. They're going to put 150,000 people in job training positions. One of the ideas that can be incorporated that I have put forward in a bill is to make sure that people can keep their unemployment while they are in a job training and receive a stipend. Dignity, jobs, is what we're talking about.

The SPEAKER pro tempore. The time of the gentlewoman has expired.

Ms. PINGREE of Maine. I yield the gentlewoman 15 additional seconds.

Ms. JACKSON-LEE of Texas. And then, my small business friends, once and for all we'll answer your question about getting loans. But the big thing is, Riverside General Hospital, because of the astuteness of those who worked on the Defense bill, will get \$1 million for the first time, an African American hospital, to help our soldiers with post-traumatic stress disorder. I have worked on this for 4 years. It's a celebration. Merry Christmas to America.

Ms. FOXX. Madam Speaker, I want to say thank you to our colleague from Arizona for his very valuable input on the issue of earmarks, and say that I join him in opposing all earmarks in any of our bills until we fix this broken system. And I think what we need is a study of how these specific earmarks then get awarded, since there seems to be open competition. And I would welcome the majority to institute such a study and just see how open the competition is.

I now yield 3 minutes to my colleague from Iowa (Mr. KING).

Mr. KING of Iowa. Madam Speaker, before I take up the subject that I came here to talk about, I can't help but remark that the gentlelady from Texas said that the people on our side had not had a good thought about how to invest in America. Not a good thought. I would submit that the good thoughts are right there on the immigration naturalization flash cards. What is the economic system of America? Flip the card over, and if you want to be naturalized as a citizen, you need to answer the question this way. Free enterprise capitalism.

Free enterprise capitalism has been the enemy of this administration. Tim

Geithner said that free enterprise capitalism is what brought us to the brink of ruin. Can you imagine tearing asunder the very foundation, one of the principal pillars of American exceptionalism, and arguing that those that have stood up and defended it and refurbished it somehow hadn't had a good thought about America.

I would ask again, why do we need African American hospitals? Why can't we have hospitals that take care of God's children? Why can't we all be members of the human race? Why is there any legislation that's brought into this Congress that sets aside special privileges for people based upon their skin color rather than the content of their character? I think that this is the wrong path. We've got to embrace each other as individuals. This wallowing in self-guilt has gone on and on, Madam Speaker.

We had a President—Clinton—that went and apologized to entire continents. Now we have a President Obama that has apologized to entire continents as well for Americanism. In this bill, on page 109 of the bill, we have another apology, an apology from Congress. First, it's got some good things in there. It talks about Native Americans. It recognizes the special legal and political relationship that Indian tribes have in the United States. That's good. It commends the Native Peoples for the thousands of years they have stewarded and protected this land. Part of that's real good. Part of that record's not real good. This doesn't say so. In fact, the third piece says it recognizes that there have been years of official depredations, ill-conceived policies, and the breaking of covenants by the Federal Government regarding Indian tribes. That's true. There's also another side to that thing that isn't negative.

And now it says, on page 109 of the bill, we, as Congress, ask the President—the United States, acting through Congress, actually—to apologize on behalf of the people of the United States to all Native Peoples for the many instances of violence, maltreatment, and neglect inflicted on Native Peoples by citizens of the United States; as if there were no guilt on the other side.

Madam Speaker, I would direct the attention of this body to the Declaration of Independence. And there, on paragraph 29 of 32, as I count them, it says, and I'm going to stop short of violating the political correctness, but I am going to read directly from the Declaration of Independence.

He has excited domestic insurrections among us—speaking of King George—and has endeavored to bring on the inhabitants of our frontiers, and there I stop and commend the text of the Declaration of Independence which apparently violates this bill.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. KING of Iowa. I urge the rejection of this rule for this and many other reasons.

Ms. PINGREE of Maine. Madam Speaker, I yield 2 minutes to the gentleman from Maryland (Mr. CUMMINGS).

Mr. CUMMINGS. Madam Speaker, I rise today in support of the rule and the underlying bill, H.R. 2847, the Jobs for Main Street Act.

As a member of the Transportation and Infrastructure Committee and chairman of the Coast Guard and Maritime Transportation Subcommittee, I've seen hundreds of thousands of jobs created through infrastructure funding. I've seen improvements created by that funding slow the recession and help begin our recovery. However, that recovery is simply not complete. We still have far too many Americans without jobs.

The COBRA, unemployment and food stamp extensions in this bill are crucial to help those who are in need or who have lost a job through no fault of their own. These small lifelines can be immense to those who are suffering. For some Americans who still face foreclosure, this funding can help keep them in their homes so that the loss of their job does not result in the further devastation of an entire family.

Finally, the jobs we create through our work today must be open to all Americans, including the minority communities who are being particularly decimated by unemployment, foreclosure and a crisis of credit.

Before we passed the Recovery Act, I requested bonding assistance, allowing small and disadvantaged businesses to obtain the insurance they needed to win contracts to become prime contractors and to hire workers. The bonding assistance program created in that act led to much-needed jobs in minority communities, and so I requested further such assistance in this act. The \$20 million included in this bill today will ensure that jobs created will be available to every American and every business in every community so they can compete on an even playing field.

I support fair competition for government projects and the jobs that they will create. I encourage all my colleagues to support the underlying bill and the rule that will bring this matter to the floor.

Ms. FOXX. Madam Speaker, you know, I'm sitting here listening to the crocodile tears, particularly of my colleague from Maine who spoke earlier about the many people in her district who want to have jobs. And it is the very policies that she and her party have passed in this session of Congress that have caused those people to lose their jobs. What we need to do is let the American people keep their money. Their money. It is not the government's money. It is the hard-earned money of those who work in this country.

And let me point out, even President Obama has said, and I'm going to quote, November 18, 2009: It is important, though, to recognize if we keep on adding to the debt, even in the midst of this recovery, that at some point people could lose confidence in the U.S. economy in a way that can actually lead to a double dip recession.

But what are we doing today? Adding to the debt, with the support of the President. Do they think the American people are not paying attention? To the contrary, more than ever, the American people are paying attention to what's going on in this Congress, and they have spoken in many, many ways. They have spoken through the polls, they have spoken through election polls in terms of where they're voting, and they're telling us every day this is not what they want this Congress to be doing.

They also are aware of the fact that this Congress is breaking every promise that it made before the majority was elected. And I want to say, with apologies to Elizabeth Barrett Browning and her sonnet No. 43, how many ways can we count the promises that have been broken? Many, many ways. Too many ways to talk about today.

But let me give some examples—one from Majority Leader HOYER:

"I think that is a very important pursuit. Our committees and Members are served on both sides of the aisle by pursuing regular order. Regular order gives to everybody the opportunity to participate in the process in a fashion which will effect, in my opinion, the most consensus and best product."

Again, a letter to Majority Leader HOYER from members of the Democrat Blue Dog and New Democratic Caucuses which said:

"Committees must function thoroughly and inclusively, and cooperation must ensue between the parties and the Houses to ensure that our legislative tactics enable rather than impede progress. In general, we must engender an atmosphere that allows partisan games to cease and collaboration to succeed. We look forward to working with you to restore this institution."

And what are we getting? Just the opposite. Even Speaker PELOSI endorsed the idea of regular order with her spokesperson stating at the time:

"The Speaker prefers to consider legislation in regular order and the committees of jurisdiction held hearings and markups on the current economic recovery bill. In a few cases, because of urgent financial crises, the leadership agreed to use expedited procedures."

Lest we forget, promises Democrats made in their 2006 document entitled *A New Direction for America*, which promised that:

"Bills should be developed following full hearings and open subcommittee and committee markups with appropriate referrals to other committees.

Members should have at least 24 hours to examine a bill prior to consideration at the subcommittee level."

And we've pointed out it's barely been 12 hours since this bill, the bill underlying this rule, was presented.

"Bills should generally come to the floor under a procedure that allows open, full and fair debate, consisting of a full amendment process that grants the minority the right to offer its alternatives, including a substitute."

As Mr. DREIER pointed out earlier, this is the first Congress in the history of this country that has not allowed that.

□ 1230

"Members should have at least 24 hours to examine bill and conference report text prior to floor consideration. Rules governing for debate must be reported before 10 p.m. for a bill to be considered the following day."

We can go on and on and on about promises broken. The President said bills would be available for 72 hours. The President promised he would post bills 5 days before signing them. He said he would read every bill line for line, and he said there would be no earmarks. He would veto bills with earmarks.

This is a bill with 1,700 earmarks. Is he going to veto the bill? I doubt it.

So here we have one promise after another that's broken. How can the American people believe anything that is said by the other side after this?

Again, they're paying attention. I know they're paying attention, and I believe that there will be consequences to the fact that these promises have been broken.

Madam Speaker, I will enter into the RECORD a letter written by Republicans, 173 of us, to Speaker PELOSI on December 11, 2009, asking that we not continue this practice.

WASHINGTON, DC,

December 11, 2009.

Hon. NANCY PELOSI,
Speaker of the House, The Capitol,
Washington, DC.

DEAR MADAM SPEAKER: We write today to express our strong opposition to reports that the Democrat Majority is considering attaching unrelated and extremely controversial proposals, such as an increase in the public debt limit, to the Fiscal Year 2010 Defense Appropriations bill. We object to maneuvers to use our troops as leverage to enact proposals that the Majority either cannot pass on their own or for which they wish to avoid directly voting on and we will oppose a Defense Appropriations package that includes such provisions.

Unfortunately, there seems to be a pattern developing this year of using legislation that supports our men and women in uniform to pass other contentious proposals that are extraneous to our troops. We should supply those who risk their lives for our country with the resources they need without conditions and without using them to accomplish other legislative goals. House Republicans stand ready to help the Majority enact a defense bill that meets the needs of our troops,

but we will not assist your effort to use the troops to enact an increase in our national debt limit so as to finance the irresponsible spending policies of your party.

With that, I reserve the balance of my time.

Ms. PINGREE of Maine. Madam Speaker, I rise to discuss at least one thing my colleague and friend from North Carolina mentioned. I'm a Northerner, so I can't claim to be an expert on crocodiles, but I assume that when you're talking about crocodile tears, you're talking about being insincere, and I want to say I receive letters from my constituents every day about the urgency of what we are doing today. And I have to say that like it or not, I cannot get through the pile of letters without crying tears for real. It's very, very difficult to think about the small businesses, laid-off individuals, individuals worrying about their jobs, what they're going through in my district and the urgency with which they view the actions that we are about to take today and the importance of moving on from this rule and getting to the actual debate.

I want to read one of them that is in front of me here before I yield a little time to my colleague from California.

This one says: "My housemate and I were both laid off, me in September 08 and she in February 09. We have applied diligently for work in and around Portland with no luck. We had to cash in our meager 401(k)'s, and have been very thankful for the COBRA subsidy so that we could afford insurance during this most harsh of times. But our money is running out fast.

"As you know, the subsidy is about to expire, and we cannot afford the huge jump in premium. We cannot afford both the mortgage and the insurance. We cannot afford our prescriptions, and our health care will be at stake, as if things weren't bad enough. We will lose our home.

"PLEASE help push through the COBRA extension and continuation of the ARRA COBRA subsidy. It is an immediate fix for so many families who will surely gain employment over the next 6 months now that the economy has finally taken an upswing."

Madam Speaker, those are the things that make us all cry real tears and make us want to pass this rule and go on to passing this legislation today.

Madam Speaker, I yield 2 minutes to the gentleman from California (Mr. GARAMENDI).

Mr. GARAMENDI. Madam Speaker, I just heard a fine exposition on promises. There is one promise that overrides all of the others, and that's the promise that I think each one of us made to our constituents to do everything that we possibly could to see that they were well cared for and that this government was acting on their behalf. If we are simply looking at a rule and whether it's going to be ap-

plied and that becomes the most important promise of all, then we are forgetting about the well-being of Americans, of whom there are 35 million unemployed, of whom there are, in my district, tens of thousands, more than one out of eight either unemployed or underemployed. My promise to those people is that I will do everything I possibly can to see that they have a job.

This rule allows us to get to that. It allows us to get to the point of providing a jobs program that's going to provide at least \$35 billion for highways and transit, that's going to provide some 500,000 young men and women the opportunity to have summer jobs, to expand AmeriCorps so that people can provide services and employment.

It's also going to take care of those who are unemployed, who, for no reason of their own, have found themselves out of a job. It's time for us to stand for them, and it's, frankly, time for us to move away from the notion of just providing those unemployment benefits to providing a job.

Far better that there be taxpayers than tax receivers. That's what this is about. It gives us an opportunity to do that, and we will do everything we possibly can on our side of the aisle to make the fundamental promise of making sure that the Federal Government is doing everything it possibly can to provide jobs and opportunities for businesses, for employment, and for taxpayers to actually have a job so they can pay taxes.

Ms. FOXX. Madam Speaker, I would just like to point out it's not the role of Federal Government to provide jobs. It's not our job to take money from some and give to others, to try to make them dependent on the government.

I urge my colleagues, Madam Speaker, to defeat the previous question so an amendment can be added to the rule. The amendment to the rule will provide for separate consideration of House Resolution 554, a resolution to require that legislation and conference reports be posted on the Internet for 72 hours prior to consideration by the House, and does not affect the bill made in order by the rule.

I ask unanimous consent to insert the text of the amendment and extraneous materials immediately prior to the vote on the previous question.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from North Carolina?

There was no objection.

Ms. FOXX. I ask my colleagues to vote "no" on the previous question and the rule.

I yield back the balance of my time.

Ms. PINGREE of Maine. Madam Speaker, the legislation we are considering today is about investing in jobs. It is about investing in infrastructure,

and it is about rebalancing our economy. So it's not just the big banks and Wall Street firms that benefit from an economic recovery. This bill is about helping the American family.

This week, a New York Times/CBS News poll surveyed unemployed Americans. Not surprisingly, they found that being unemployed takes a toll far beyond what can be measured in dollars and cents. Half of the people surveyed said they had begun to suffer from depression and anxiety, half said the recession has caused them to make major life changes, and nearly half said they have seen changes in their children's behavior that they know is a result of their difficult financial situation.

We are not just helping men and women who've lost their job, who have suffered from uncertainty, emotional pain, and indignation, but we are helping their families. We are helping their children. It is time for us to invest in the jobs and policies that will get the American Dream back on track and restore the promise of opportunity and prosperity for everyone.

I urge a "yes" vote on the previous question and on the rule.

The material previously referred to by Ms. FOXX is as follows:

AMENDMENT TO H. RES. 976

OFFERED BY MS. FOXX

At the end of the resolution, insert the following new section:

SEC. 32. On the third legislative day after the adoption of this resolution, immediately after the third daily order of business under clause 1 of rule XIV and without intervention of any point of order, the House shall proceed to the consideration of the resolution (H. Res. 554) amending the Rules of the House of Representatives to require that legislation and conference reports be available on the Internet for 72 hours before consideration by the House, and for other purposes. The resolution shall be considered as read. The previous question shall be considered as ordered on the resolution and any amendment thereto to final adoption without intervening motion or demand for division of the question except: (1) one hour of debate equally divided and controlled by the chair and ranking minority member of the Committee on Rules; (2) an amendment, if offered by the Minority Leader or his designee and if printed in that portion of the Congressional Record designated for that purpose in clause 8 of rule XVIII at least one legislative day prior to its consideration, which shall be in order without intervention of any point of order or demand for division of the question, shall be considered as read and shall be separately debatable for twenty minutes equally divided and controlled by the proponent and an opponent; and (3) one motion to recommit which shall not contain instructions. Clause 1(c) of rule XIX shall not apply to the consideration of House Resolution 554.

(The information contained herein was provided by Democratic Minority on multiple occasions throughout the 109th Congress.)

THE VOTE ON THE PREVIOUS QUESTION: WHAT IT REALLY MEANS

This vote, the vote on whether to order the previous question on a special rule, is not

merely a procedural vote. A vote against ordering the previous question is a vote against the Democratic majority agenda and a vote to allow the opposition, at least for the moment, to offer an alternative plan. It is a vote about what the House should be debating.

Mr. Clarence Cannon's Precedents of the House of Representatives, (VI, 308-311) describes the vote on the previous question on the rule as "a motion to direct or control the consideration of the subject before the House being made by the Member in charge." To defeat the previous question is to give the opposition a chance to decide the subject before the House. Cannon cites the Speaker's ruling of January 13, 1920, to the effect that "the refusal of the House to sustain the demand for the previous question passes the control of the resolution to the opposition" in order to offer an amendment. On March 15, 1909, a member of the majority party offered a rule resolution. The House defeated the previous question and a member of the opposition rose to a parliamentary inquiry, asking who was entitled to recognition. Speaker Joseph G. Cannon (R-Illinois) said: "The previous question having been refused, the gentleman from New York, Mr. Fitzgerald, who had asked the gentleman to yield to him for an amendment, is entitled to the first recognition."

Because the vote today may look bad for the Democratic majority they will say "the vote on the previous question is simply a vote on whether to proceed to an immediate vote on adopting the resolution . . . [and] has no substantive legislative or policy implications whatsoever." But that is not what they have always said. Listen to the definition of the previous question used in the Floor Procedures Manual published by the Rules Committee in the 109th Congress, (page 56). Here's how the Rules Committee described the rule using information form Congressional Quarterly's "American Congressional Dictionary": "If the previous question is defeated, control of debate shifts to the leading opposition member (usually the minority Floor Manager) who then manages an hour of debate and may offer a germane amendment to the pending business."

Deschler's Procedure in the U.S. House of Representatives, the subchapter titled "Amending Special Rules" states: "a refusal to order the previous question on such a rule [a special rule reported from the Committee on Rules] opens the resolution to amendment and further debate." (Chapter 21, section 21.2) Section 21.3 continues: "Upon rejection of the motion for the previous question on a resolution reported from the Committee on Rules, control shifts to the Member leading the opposition to the previous question, who may offer a proper amendment or motion and who controls the time for debate thereon."

Clearly, the vote on the previous question on a rule does have substantive policy implications. It is one of the only available tools for those who oppose the Democratic majority's agenda and allows those with alternative views the opportunity to offer an alternative plan.

Ms. PINGREE of Maine. I yield back the balance of my time and move the previous question on the resolution.

The SPEAKER pro tempore. The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Ms. FOXX. Madam Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 and clause 9 of rule XX, this 15-minute vote on ordering the previous question will be followed by 5-minute votes on adoption of H. Res. 976, if ordered, and suspension of the rules with regard to H. Res. 905.

The vote was taken by electronic device, and there were—yeas 235, nays 193, not voting 6, as follows:

[Roll No. 982]

YEAS—235

Abercrombie	Gordon (TN)	Murtha
Ackerman	Grayson	Nadler (NY)
Adler (NJ)	Green, Al	Napolitano
Altmire	Green, Gene	Neal (MA)
Andrews	Grijalva	Nye
Arcuri	Gutierrez	Oberstar
Baca	Hall (NY)	Obey
Baldwin	Halvorson	Oliver
Barrow	Hare	Ortiz
Bean	Harman	Owens
Becerra	Hastings (FL)	Pallone
Berkley	Heinrich	Pascarella
Berman	Hereth Sandlin	Pastor (AZ)
Berry	Higgins	Payne
Bishop (GA)	Hinchey	Perlmutter
Bishop (NY)	Hinojosa	Peters
Blumenauer	Hirono	Peterson
Boccieri	Hodes	Pingree (ME)
Boren	Holden	Polis (CO)
Boswell	Holt	Pomeroy
Boucher	Honda	Price (NC)
Boyd	Hoyer	Quigley
Brady (PA)	Inslee	Rahall
Braley (IA)	Israel	Rangel
Brown, Corrine	Jackson (IL)	Reyes
Butterfield	Jackson-Lee	Richardson
Capps	(TX)	Rodriguez
Capuano	Johnson (GA)	Ross
Carnahan	Johnson, E. B.	Rothman (NJ)
Carney	Kagen	Roybal-Allard
Carson (IN)	Kanjorski	Ruppersberger
Castor (FL)	Kaptur	Rush
Chandler	Kennedy	Ryan (OH)
Childers	Kildee	Salazar
Chu	Kilpatrick (MI)	Sánchez, Linda
Clarke	Kilroy	T.
Clay	Kind	Sanchez, Loretta
Cleaver	Kissell	Sarbanes
Clyburn	Klein (FL)	Schakowsky
Cohen	Kucinich	Schauer
Connolly (VA)	Langevin	Schiff
Conyers	Larsen (WA)	Schrader
Cooper	Lee (CA)	Schwartz
Costa	Levin	Scott (GA)
Costello	Lewis (GA)	Scott (VA)
Courtney	Lipinski	Serrano
Crowley	Loebuck	Sestak
Cuellar	Lofgren, Zoe	Shea-Porter
Cummings	Lowey	Sherman
Davis (AL)	Lujan	Shuler
Davis (CA)	Lynch	Sires
Davis (IL)	Maffei	Skelton
Davis (TN)	Maloney	Slaughter
DeFazio	Markey (CO)	Smith (WA)
DeGette	Markey (MA)	Snyder
Delahunt	Marshall	Spratt
DeLauro	Massa	Stark
Dicks	Matheson	Stupak
Dingell	Matsui	Sutton
Doggett	McCarthy (NY)	Tanner
Donnelly (IN)	McCollum	Taylor
Doyle	McDermott	Teague
Edwards (MD)	McGovern	Thompson (CA)
Edwards (TX)	McIntyre	Thompson (MS)
Ellison	McNerney	Tierney
Engel	Meek (FL)	Titus
Eshoo	Meeks (NY)	Tonko
Etheridge	Michaud	Towns
Farr	Miller (NC)	Tsongas
Fattah	Miller, George	Van Hollen
Filner	Mollohan	Velázquez
Foster	Moore (KS)	Visclosky
Frank (MA)	Moore (WI)	Walz
Fudge	Moran (VA)	Wasserman
Garamendi	Murphy (CT)	Schultz
Gonzalez	Murphy (NY)	Waters

Watson	Welch	Wu
Watt	Wexler	Yarmuth
Waxman	Wilson (OH)	
Weiner	Woolsey	

NAYS—193

Aderholt	Frelinghuysen	Miller (MI)
Akin	Gallegly	Miller, Gary
Alexander	Garrett (NJ)	Minnick
Austria	Gerlach	Mitchell
Bachmann	Giffords	Moran (KS)
Bachus	Gingrey (GA)	Murphy, Tim
Baird	Gohmert	Myrick
Barrett (SC)	Goodlatte	Neugebauer
Bartlett	Granger	Nunes
Barton (TX)	Graves	Olson
Biggert	Griffith	Paul
Bilbray	Guthrie	Paulsen
Bilirakis	Hall (TX)	Pence
Bishop (UT)	Harper	Perriello
Blackburn	Hastings (WA)	Petri
Blunt	Heller	Pitts
Boehner	Hensarling	Platts
Bonner	Herger	Poe (TX)
Bono Mack	Hill	Posey
Boozman	Himes	Price (GA)
Boustany	Hoekstra	Putnam
Brady (TX)	Hunter	Rehberg
Bright	Inglis	Reichert
Brown (GA)	Issa	Roe (TN)
Brown (SC)	Jenkins	Rogers (AL)
Brown-Waite,	Johnson (IL)	Rogers (KY)
Ginny	Johnson, Sam	Rogers (MI)
Buchanan	Jones	Rohrabacher
Burgess	Jordan (OH)	Rooney
Burton (IN)	King (IA)	Ros-Lehtinen
Buyer	King (NY)	Roskam
Calvert	Kingston	Royce
Camp	Kirk	Ryan (WI)
Campbell	Kirkpatrick (AZ)	Scalise
Cantor	Kline (MN)	Schmidt
Cao	Kosmas	Schock
Capito	Kratovil	Sensenbrenner
Carter	Lamborn	Sessions
Cassidy	Lance	Shadegg
Castle	Latham	Shimkus
Chaffetz	LaTourette	Shuster
Coble	Latta	Simpson
Coffman (CO)	Lee (NY)	Smith (NE)
Cole	Lewis (CA)	Smith (NJ)
Conaway	Linder	Smith (TX)
Crenshaw	LoBiondo	Souder
Culberson	Lucas	Space
Dahlkemper	Luetkemeyer	Stearns
Davis (KY)	Lummis	Sullivan
Deal (GA)	Lungren, Daniel	Terry
Dent	E.	Thompson (PA)
Diaz-Balart, L.	Mack	Thornberry
Diaz-Balart, M.	Manzullo	Tiahrt
Dreier	Marchant	Tiberi
Driehaus	McCarthy (CA)	Turner
Duncan	McCaul	Upton
Ehlers	McClintock	Walden
Ellsworth	McCotter	Wamp
Emerson	McHenry	Whitfield
Fallin	McKeon	Wilson (SC)
Flake	McMahon	Wittman
Fleming	McMorris	Wolf
Forbes	Rodgers	Young (AK)
Fortenberry	Melancon	Young (FL)
Fox	Mica	
Franks (AZ)	Miller (FL)	

NOT VOTING—6

Cardoza	Murphy, Patrick	Speier
Larson (CT)	Radanovich	Westmoreland

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining on this vote.

□ 1303

Mr. JONES changed his vote from "yea" to "nay."

So the previous question was ordered. The result of the vote was announced as above recorded.

Stated for:

Mr. LARSON of Connecticut. Madam Speaker, on rollcall No. 982, I was unavoidably detained and missed the vote. Had I been present, I would have voted "yea."

The SPEAKER pro tempore. The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Ms. FOXX. Madam Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 228, noes 201, not voting 5, as follows:

[Roll No. 983]

AYES—228

Abercrombie	Gordon (TN)	Murtha
Ackerman	Grayson	Nadler (NY)
Adler (NJ)	Green, Al	Napolitano
Altmire	Green, Gene	Neal (MA)
Andrews	Grijalva	Nye
Arcuri	Gutierrez	Oberstar
Baca	Hall (NY)	Obey
Baldwin	Hare	Olver
Barrow	Harman	Ortiz
Bean	Hastings (FL)	Owens
Becerra	Heinrich	Pallone
Berkley	Herseht Sandlin	Pascarell
Berman	Higgins	Pastor (AZ)
Berry	Hinchev	Payne
Bishop (GA)	Hinojosa	Perlmutter
Bishop (NY)	Hirono	Perriello
Blumenauer	Hodes	Peterson
Boccheri	Holden	Pingree (ME)
Boren	Holt	Polis (CO)
Boswell	Honda	Pomeroy
Boucher	Hoyer	Price (NC)
Brady (PA)	Inslee	Quigley
Braley (IA)	Israel	Rahall
Brown, Corrine	Jackson (IL)	Rangel
Butterfield	Jackson-Lee	Reyes
Capps	(TX)	Richardson
Capuano	Johnson (GA)	Rodriguez
Carnahan	Johnson, E. B.	Ross
Carney	Kagen	Rothman (NJ)
Carson (IN)	Kanjorski	Roybal-Allard
Castor (FL)	Kaptur	Ruppersberger
Chandler	Kennedy	Rush
Childers	Kildee	Ryan (OH)
Chu	Kilpatrick (MI)	Salazar
Clarke	Kilroy	Sanchez, Linda
Clay	Kind	T.
Cleaver	Kissell	Sanchez, Loretta
Clyburn	Klein (FL)	Sarbanes
Cohen	Langevin	Schakowsky
Connolly (VA)	Larsen (WA)	Schauer
Conyers	Lee (CA)	Schiff
Cooper	Levin	Schrader
Costa	Lewis (GA)	Schwartz
Costello	Lipinski	Scott (GA)
Courtney	Loeb sack	Scott (VA)
Crowley	Lofgren, Zoe	Serrano
Cuellar	Lowey	Sestak
Cummings	Lujan	Shea-Porter
Davis (AL)	Lynch	Sherman
Davis (CA)	Maffei	Shuler
Davis (IL)	Maloney	Sires
Davis (TN)	Markey (CO)	Skelton
DeFazio	Markey (MA)	Slaughter
DeGette	Marshall	Smith (WA)
Delahunt	Massa	Snyder
DeLauro	Matheson	Spratt
Dicks	Matsui	Stupak
Dingell	McCarthy (NY)	Sutton
Doggett	McCollum	Taylor
Doyle	McDermott	Teague
Edwards (MD)	McGovern	Thompson (CA)
Edwards (TX)	McIntyre	Thompson (MS)
Ellison	McNerney	Tierney
Engel	Meek (FL)	Titus
Eshoo	Meeks (NY)	Tonko
Etheridge	Michaud	Towns
Farr	Miller (NC)	Tsongas
Fattah	Miller, George	Van Hollen
Filner	Mollohan	Velázquez
Foster	Moore (KS)	Visclosky
Frank (MA)	Moore (WI)	Walz
Fudge	Moran (VA)	Wasserman
Garamendi	Murphy (CT)	Schultz
Gonzalez	Murphy, Patrick	Waters

Watson
Watt
Waxman

Weiner
Welch
Wexler

Wilson (OH)
Woolsey
Yarmuth

NOES—201

Aderholt	Frelinghuysen	Miller (MI)
Akin	Gallegly	Miller, Gary
Alexander	Garrett (NJ)	Minnick
Austria	Gerlach	Mitchell
Bachmann	Giffords	Moran (KS)
Bachus	Gingrey (GA)	Murphy (NY)
Baird	Gohmert	Murphy, Tim
Barrett (SC)	Goodlatte	Myrick
Bartlett	Granger	Neugebauer
Barton (TX)	Graves	Nunes
Biggert	Griffith	Olson
Bilbray	Guthrie	Paul
Bilirakis	Hall (TX)	Paulsen
Bishop (UT)	Halvorson	Pence
Blackburn	Harper	Peters
Blunt	Hastings (WA)	Petri
Boehner	Heller	Pitts
Bonner	Hensarling	Platts
Bono Mack	Herger	Poe (TX)
Boozman	Hill	Posey
Boustany	Himes	Price (GA)
Boyd	Hoekstra	Putnam
Brady (TX)	Hunter	Rehberg
Bright	Inglis	Reichert
Brown (GA)	Issa	Roe (TN)
Brown (SC)	Jenkins	Rogers (AL)
Brown-Waite,	Johnson (IL)	Rogers (KY)
Ginny	Johnson, Sam	Rogers (MI)
Buchanan	Jones	Rohrabacher
Burgess	Jordan (OH)	Rooney
Burton (IN)	King (IA)	Ros-Lehtinen
Buyer	King (NY)	Roskam
Calvert	Kingston	Royce
Camp	Kirk	Ryan (WI)
Campbell	Kirkpatrick (AZ)	Scalise
Cantor	Kline (MN)	Schmidt
Cao	Kosmas	Schock
Capito	Kratovil	Sensenbrenner
Carter	Kucinich	Sessions
Cassidy	Lamborn	Shadegg
Castle	Lance	Shimkus
Chaffetz	Latham	Shuster
Coble	LaTourette	Simpson
Coffman (CO)	Latta	Smith (NE)
Cole	Lee (NY)	Smith (NJ)
Conaway	Lewis (CA)	Smith (TX)
Crenshaw	Linder	Souder
Culberson	LoBiondo	Space
Dahlkemper	Lucas	Stark
Deal (GA)	Luetkemeyer	Stearns
Dent	Lummis	Tanner
Diaz-Balart, L.	Lungren, Daniel	Terry
Diaz-Balart, M.	E.	Thompson (PA)
Donnelly (IN)	Mack	Thornberry
Dreier	Manzullo	Tiahrt
Driehaus	Marchant	Tiberi
Duncan	McCarthy (CA)	Turner
Ehlers	McCaul	Upton
Ellsworth	McClintock	Walden
Emerson	McCotter	Wamp
Fallin	McHenry	Westmoreland
Flake	McKeon	Whitfield
Fleming	McMahon	Wilson (SC)
Forbes	McMorris	Wittman
Fortenberry	Rodgers	Wolf
Fox	Melancon	Wu
Franks (AZ)	Mica	Young (AK)
	Miller (FL)	Young (FL)

NOT VOTING—5

Cardoza
Larson (CT)

Radanovich
Speier

Sullivan

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining on this vote.

□ 1311

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. LARSON of Connecticut. Madam Speaker, on rollcall No. 983, I was unavoidably detained and unfortunately missed the

vote. Had I been present, I would have voted "aye."

RECOGNIZING 70TH ANNIVERSARY OF RETIREMENT OF JUSTICE LOUIS D. BRANDEIS

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and agree to the resolution, H. Res. 905, on which the yeas and nays were ordered.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Tennessee (Mr. COHEN) that the House suspend the rules and agree to the resolution, H. Res. 905.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 423, nays 1, not voting 10, as follows:

[Roll No. 984]

YEAS—423

Abercrombie	Capito	Engel
Ackerman	Capps	Eshoo
Aderholt	Capuano	Etheridge
Adler (NJ)	Carnahan	Fallin
Akin	Carney	Farr
Alexander	Carson (IN)	Fattah
Altmire	Carter	Filner
Andrews	Cassidy	Flake
Arcuri	Castle	Fleming
Austria	Castor (FL)	Forbes
Baca	Chaffetz	Fortenberry
Bachmann	Chandler	Foster
Bachus	Childers	Fox
Baird	Chu	Frank (MA)
Baldwin	Clarke	Franks (AZ)
Barrett (SC)	Clay	Frelinghuysen
Barrow	Cleaver	Fudge
Bartlett	Clyburn	Gallegly
Barton (TX)	Coble	Garamendi
Bean	Coffman (CO)	Garrett (NJ)
Becerra	Cohen	Gerlach
Berkley	Cole	Giffords
Berman	Conaway	Gingrey (GA)
Berry	Connolly (VA)	Gohmert
Biggert	Cooper	Gonzalez
Bilbray	Costa	Goodlatte
Bilirakis	Costello	Gordon (TN)
Bishop (GA)	Courtney	Granger
Bishop (NY)	Crenshaw	Graves
Bishop (UT)	Crowley	Grayson
Blackburn	Cuellar	Green, Al
Blumenauer	Culberson	Green, Gene
Blunt	Cummings	Griffith
Boccheri	Dahlkemper	Grijalva
Bonner	Davis (AL)	Guthrie
Bono Mack	Davis (CA)	Gutierrez
Boozman	Davis (IL)	Hall (NY)
Boren	Davis (KY)	Hall (TX)
Boswell	Davis (TN)	Halvorson
Boucher	Deal (GA)	Hare
Boustany	DeFazio	Harman
Boyd	DeGette	Harper
Brady (PA)	Delahunt	Hastings (FL)
Brady (TX)	DeLauro	Hastings (WA)
Braley (IA)	Dent	Heinrich
Bright	Diaz-Balart, L.	Heller
Brown (GA)	Diaz-Balart, M.	Hensarling
Brown (SC)	Dicks	Herger
Brown, Corrine	Dingell	Herseht Sandlin
Brown-Waite,	Doggett	Higgins
Ginny	Donnelly (IN)	Hill
Buchanan	Doyle	Himes
Burgess	Dreier	Hinchev
Burton (IN)	Driehaus	Hinojosa
Butterfield	Duncan	Hirono
Buyer	Edwards (MD)	Hodes
Calvert	Edwards (TX)	Hoekstra
Camp	Ehlers	Holden
Campbell	Ellison	Holt
Cantor	Ellsworth	Honda
Cao	Emerson	Hoyer

Hunter
Inglis
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee
(TX)
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (IA)
King (NY)
Kingston
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Larsen (WA)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loebsock
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Luján
Lummis
Lungren, Daniel
E.
Lynch
Mack
Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McClintock
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMorris
Rodgers
McNerney

Meek (FL)
Meeks (NY)
Melancon
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murphy, Tim
Murtha
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye
Oberstar
Obey
Olson
Oliver
Ortiz
Owens
Pallone
Pascarell
Paul
Paulsen
Payne
Pence
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Putnam
Quigley
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rooney
Ros-Lehtinen
Roskam
Ross
Rothman (NJ)
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Salazar
Sánchez, Linda
T.
Sanchez, Loretta

Sarbanes
Scalise
Schakowsky
Schauer
Schiff
Schmidt
Schock
Schradner
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shadegg
Shea-Porter
Sherman
Shimkus
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Space
Spratt
Stark
Stearns
Stupak
Sullivan
Sutton
Tanner
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Petri
Thornberry
Tiahrt
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wamp
Wasserman
Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Westmoreland
Wexler
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Woolsey
Wu
Yarmuth
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members have 2 minutes remaining in this vote.

□ 1317

So (two-thirds being in the affirmative) the rules were suspended and the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. LARSON of Connecticut. Madam Speaker, on rollcall No. 984, I was unavoidably detained and most unfortunately, missed the vote. Had I been present, I would have voted "yea."

PERSONAL EXPLANATION

Mr. RADANOVICH. Madam Speaker, I was unable to make today's votes on the House floor due to a family illness. Had I been present I would have voted as follows:

"Nay" on rollcall vote No. 982, on ordering the previous question on the rule providing consideration for H.R. 3326, H.J. Res. 64, H.R. 4314, and H.R. 2847.

"No" on rollcall vote No. 983, on the adoption of H. Res. 976, the rule for consideration for H.R. 3326, H.J. Res. 64, H.R. 4314, and H.R. 2847.

"Yea" on rollcall vote No. 984, on the motion to suspend the rules and agree to H. Res. 905, recognizing the 70th anniversary of the retirement of Justice Louis D. Brandeis from the United States Supreme Court.

DEPARTMENT OF DEFENSE
APPROPRIATIONS ACT, 2010

Mr. MURTHA. Madam Speaker, pursuant to House Resolution 976, I call up the bill (H.R. 3326) making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes, with a Senate amendment thereto, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The Clerk will designate the Senate amendment.

The text of the Senate amendment is as follows:

Senate amendment:

Strike out all after the enacting clause and insert:

That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the fiscal year ending September 30, 2010, for military functions administered by the Department of Defense and for other purposes, namely:

TITLE I

MILITARY PERSONNEL

MILITARY PERSONNEL, ARMY

For pay, allowances, individual clothing, subsistence, interest on deposits, gratuities, permanent change of station travel (including all expenses thereof for organizational movements), and expenses of temporary duty travel between

permanent duty stations, for members of the Army on active duty, (except members of reserve components provided for elsewhere), cadets, and aviation cadets; for members of the Reserve Officers' Training Corps; and for payments pursuant to section 156 of Public Law 97-377, as amended (42 U.S.C. 402 note), and to the Department of Defense Military Retirement Fund, \$41,267,448,000.

MILITARY PERSONNEL, NAVY

For pay, allowances, individual clothing, subsistence, interest on deposits, gratuities, permanent change of station travel (including all expenses thereof for organizational movements), and expenses of temporary duty travel between permanent duty stations, for members of the Navy on active duty (except members of the Reserve provided for elsewhere), midshipmen, and aviation cadets; for members of the Reserve Officers' Training Corps; and for payments pursuant to section 156 of Public Law 97-377, as amended (42 U.S.C. 402 note), and to the Department of Defense Military Retirement Fund, \$25,440,472,000.

MILITARY PERSONNEL, MARINE CORPS

For pay, allowances, individual clothing, subsistence, interest on deposits, gratuities, permanent change of station travel (including all expenses thereof for organizational movements), and expenses of temporary duty travel between permanent duty stations, for members of the Marine Corps on active duty (except members of the Reserve provided for elsewhere); and for payments pursuant to section 156 of Public Law 97-377, as amended (42 U.S.C. 402 note), and to the Department of Defense Military Retirement Fund, \$12,883,790,000.

MILITARY PERSONNEL, AIR FORCE

For pay, allowances, individual clothing, subsistence, interest on deposits, gratuities, permanent change of station travel (including all expenses thereof for organizational movements), and expenses of temporary duty travel between permanent duty stations, for members of the Air Force on active duty (except members of reserve components provided for elsewhere), cadets, and aviation cadets; for members of the Reserve Officers' Training Corps; and for payments pursuant to section 156 of Public Law 97-377, as amended (42 U.S.C. 402 note), and to the Department of Defense Military Retirement Fund, \$26,378,761,000.

RESERVE PERSONNEL, ARMY

For pay, allowances, clothing, subsistence, gratuities, travel, and related expenses for personnel of the Army Reserve on active duty under sections 10211, 10302, and 3038 of title 10, United States Code, or while serving on active duty under section 12301(d) of title 10, United States Code, in connection with performing duty specified in section 12310(a) of title 10, United States Code, or while undergoing reserve training, or while performing drills or equivalent duty or other duty, and expenses authorized by section 16131 of title 10, United States Code; and for payments to the Department of Defense Military Retirement Fund, \$4,286,656,000.

RESERVE PERSONNEL, NAVY

For pay, allowances, clothing, subsistence, gratuities, travel, and related expenses for personnel of the Navy Reserve on active duty under section 10211 of title 10, United States Code, or while serving on active duty under section 12301(d) of title 10, United States Code, in connection with performing duty specified in section 12310(a) of title 10, United States Code, or while undergoing reserve training, or while performing drills or equivalent duty, and expenses authorized by section 16131 of title 10, United States Code; and for payments to the Department of Defense Military Retirement Fund, \$1,905,166,000.

NAYS—1

Young (AK)

NOT VOTING—10

Boehner
Cardoza
Conyers
Kirk
Larson (CT)
McMahon
Pastor (AZ)
Radanovich
Rohrabacher
Speier

RESERVE PERSONNEL, MARINE CORPS

For pay, allowances, clothing, subsistence, gratuities, travel, and related expenses for personnel of the Marine Corps Reserve on active duty under section 10211 of title 10, United States Code, or while serving on active duty under section 12301(d) of title 10, United States Code, in connection with performing duty specified in section 12310(a) of title 10, United States Code, or while undergoing reserve training, or while performing drills or equivalent duty, and for members of the Marine Corps platoon leaders class, and expenses authorized by section 16131 of title 10, United States Code; and for payments to the Department of Defense Military Retirement Fund, \$611,500,000.

RESERVE PERSONNEL, AIR FORCE

For pay, allowances, clothing, subsistence, gratuities, travel, and related expenses for personnel of the Air Force Reserve on active duty under sections 10211, 10305, and 8038 of title 10, United States Code, or while serving on active duty under section 12301(d) of title 10, United States Code, in connection with performing duty specified in section 12310(a) of title 10, United States Code, or while undergoing reserve training, or while performing drills or equivalent duty or other duty, and expenses authorized by section 16131 of title 10, United States Code; and for payments to the Department of Defense Military Retirement Fund, \$1,584,712,000.

NATIONAL GUARD PERSONNEL, ARMY

For pay, allowances, clothing, subsistence, gratuities, travel, and related expenses for personnel of the Army National Guard while on duty under section 10211, 10302, or 12402 of title 10 or section 708 of title 32, United States Code, or while serving on duty under section 12301(d) of title 10 or section 502(f) of title 32, United States Code, in connection with performing duty specified in section 12310(a) of title 10, United States Code, or while undergoing training, or while performing drills or equivalent duty or other duty, and expenses authorized by section 16131 of title 10, United States Code; and for payments to the Department of Defense Military Retirement Fund, \$7,535,088,000.

NATIONAL GUARD PERSONNEL, AIR FORCE

For pay, allowances, clothing, subsistence, gratuities, travel, and related expenses for personnel of the Air National Guard on duty under section 10211, 10305, or 12402 of title 10 or section 708 of title 32, United States Code, or while serving on duty under section 12301(d) of title 10 or section 502(f) of title 32, United States Code, in connection with performing duty specified in section 12310(a) of title 10, United States Code, or while undergoing training, or while performing drills or equivalent duty or other duty, and expenses authorized by section 16131 of title 10, United States Code; and for payments to the Department of Defense Military Retirement Fund, \$2,923,599,000.

TITLE II

OPERATION AND MAINTENANCE

OPERATION AND MAINTENANCE, ARMY

For expenses, not otherwise provided for, necessary for the operation and maintenance of the Army, as authorized by law; and not to exceed \$12,478,000 can be used for emergencies and extraordinary expenses, to be expended on the approval or authority of the Secretary of the Army, and payments may be made on his certificate of necessity for confidential military purposes, \$30,667,886,000.

OPERATION AND MAINTENANCE, NAVY

For expenses, not otherwise provided for, necessary for the operation and maintenance of the Navy and the Marine Corps, as authorized by law; and not to exceed \$14,657,000 can be used for emergencies and extraordinary expenses, to

be expended on the approval or authority of the Secretary of the Navy, and payments may be made on his certificate of necessity for confidential military purposes, \$34,773,497,000.

OPERATION AND MAINTENANCE, MARINE CORPS

For expenses, not otherwise provided for, necessary for the operation and maintenance of the Marine Corps, as authorized by law, \$5,435,923,000.

OPERATION AND MAINTENANCE, AIR FORCE

For expenses, not otherwise provided for, necessary for the operation and maintenance of the Air Force, as authorized by law; and not to exceed \$7,699,000 can be used for emergencies and extraordinary expenses, to be expended on the approval or authority of the Secretary of the Air Force, and payments may be made on his certificate of necessity for confidential military purposes, \$33,739,447,000.

OPERATION AND MAINTENANCE, DEFENSE-WIDE
(INCLUDING TRANSFER OF FUNDS)

For expenses, not otherwise provided for, necessary for the operation and maintenance of activities and agencies of the Department of Defense (other than the military departments), as authorized by law, \$28,205,050,000: Provided, That not more than \$50,000,000 may be used for the Combatant Commander Initiative Fund authorized under section 166a of title 10, United States Code: Provided further, That not to exceed \$36,000,000 can be used for emergencies and extraordinary expenses, to be expended on the approval or authority of the Secretary of Defense, and payments may be made on his certificate of necessity for confidential military purposes: Provided further, That of the funds provided under this heading, not less than \$29,732,000 shall be made available for the Procurement Technical Assistance Cooperative Agreement Program, of which not less than \$3,600,000 shall be available for centers defined in 10 U.S.C. 2411(1)(D): Provided further, That none of the funds appropriated or otherwise made available by this Act may be used to plan or implement the consolidation of a budget or appropriations liaison office of the Office of the Secretary of Defense, the office of the Secretary of a military department, or the service headquarters of one of the Armed Forces into a legislative affairs or legislative liaison office: Provided further, That \$6,667,000, to remain available until expended, is available only for expenses relating to certain classified activities, and may be transferred as necessary by the Secretary to operation and maintenance appropriations or research, development, test and evaluation appropriations, to be merged with and to be available for the same time period as the appropriations to which transferred: Provided further, That any ceiling on the investment item unit cost of items that may be purchased with operation and maintenance funds shall not apply to the funds described in the preceding proviso: Provided further, That the transfer authority provided under this heading is in addition to any other transfer authority provided elsewhere in this Act.

OPERATION AND MAINTENANCE, ARMY RESERVE

For expenses, not otherwise provided for, necessary for the operation and maintenance, including training, organization, and administration, of the Army Reserve; repair of facilities and equipment; hire of passenger motor vehicles; travel and transportation; care of the dead; recruiting; procurement of services, supplies, and equipment; and communications, \$2,582,624,000.

OPERATION AND MAINTENANCE, NAVY RESERVE

For expenses, not otherwise provided for, necessary for the operation and maintenance, including training, organization, and administration, of the Navy Reserve; repair of facilities and equipment; hire of passenger motor vehicles;

travel and transportation; care of the dead; recruiting; procurement of services, supplies, and equipment; and communications, \$1,272,501,000.

OPERATION AND MAINTENANCE, MARINE CORPS
RESERVE

For expenses, not otherwise provided for, necessary for the operation and maintenance, including training, organization, and administration, of the Marine Corps Reserve; repair of facilities and equipment; hire of passenger motor vehicles; travel and transportation; care of the dead; recruiting; procurement of services, supplies, and equipment; and communications, \$219,425,000.

OPERATION AND MAINTENANCE, AIR FORCE
RESERVE

For expenses, not otherwise provided for, necessary for the operation and maintenance, including training, organization, and administration, of the Air Force Reserve; repair of facilities and equipment; hire of passenger motor vehicles; travel and transportation; care of the dead; recruiting; procurement of services, supplies, and equipment; and communications, \$3,085,700,000.

OPERATION AND MAINTENANCE, ARMY NATIONAL
GUARD

For expenses of training, organizing, and administering the Army National Guard, including medical and hospital treatment and related expenses in non-Federal hospitals; maintenance, operation, and repairs to structures and facilities; hire of passenger motor vehicles; personnel services in the National Guard Bureau; travel expenses (other than mileage), as authorized by law for Army personnel on active duty, for Army National Guard division, regimental, and battalion commanders while inspecting units in compliance with National Guard Bureau regulations when specifically authorized by the Chief, National Guard Bureau; supplying and equipping the Army National Guard as authorized by law; and expenses of repair, modification, maintenance, and issue of supplies and equipment (including aircraft), \$5,989,034,000.

OPERATION AND MAINTENANCE, AIR NATIONAL
GUARD

For expenses of training, organizing, and administering the Air National Guard, including medical and hospital treatment and related expenses in non-Federal hospitals; maintenance, operation, and repairs to structures and facilities; transportation of things, hire of passenger motor vehicles; supplying and equipping the Air National Guard, as authorized by law; expenses for repair, modification, maintenance, and issue of supplies and equipment, including those furnished from stocks under the control of agencies of the Department of Defense; travel expenses (other than mileage) on the same basis as authorized by law for Air National Guard personnel on active Federal duty, for Air National Guard commanders while inspecting units in compliance with National Guard Bureau regulations when specifically authorized by the Chief, National Guard Bureau, \$5,857,011,000.

UNITED STATES COURT OF APPEALS FOR THE
ARMED FORCES

For salaries and expenses necessary for the United States Court of Appeals for the Armed Forces, \$13,932,000, of which not to exceed \$5,000 may be used for official representation purposes.

ENVIRONMENTAL RESTORATION, ARMY
(INCLUDING TRANSFER OF FUNDS)

For the Department of the Army, \$430,864,000, to remain available until transferred: Provided, That the Secretary of the Army shall, upon determining that such funds are required for environmental restoration, reduction and recycling of hazardous waste, removal of unsafe buildings and debris of the Department of the Army, or for similar purposes, transfer the funds made

available by this appropriation to other appropriations made available to the Department of the Army, to be merged with and to be available for the same purposes and for the same time period as the appropriations to which transferred: Provided further, That upon a determination that all or part of the funds transferred from this appropriation are not necessary for the purposes provided herein, such amounts may be transferred back to this appropriation: Provided further, That the transfer authority provided under this heading is in addition to any other transfer authority provided elsewhere in this Act.

ENVIRONMENTAL RESTORATION, NAVY
(INCLUDING TRANSFER OF FUNDS)

For the Department of the Navy, \$285,869,000, to remain available until transferred: Provided, That the Secretary of the Navy shall, upon determining that such funds are required for environmental restoration, reduction and recycling of hazardous waste, removal of unsafe buildings and debris of the Department of the Navy, or for similar purposes, transfer the funds made available by this appropriation to other appropriations made available to the Department of the Navy, to be merged with and to be available for the same purposes and for the same time period as the appropriations to which transferred: Provided further, That upon a determination that all or part of the funds transferred from this appropriation are not necessary for the purposes provided herein, such amounts may be transferred back to this appropriation: Provided further, That the transfer authority provided under this heading is in addition to any other transfer authority provided elsewhere in this Act.

ENVIRONMENTAL RESTORATION, AIR FORCE
(INCLUDING TRANSFER OF FUNDS)

For the Department of the Air Force, \$494,276,000, to remain available until transferred: Provided, That the Secretary of the Air Force shall, upon determining that such funds are required for environmental restoration, reduction and recycling of hazardous waste, removal of unsafe buildings and debris of the Department of the Air Force, or for similar purposes, transfer the funds made available by this appropriation to other appropriations made available to the Department of the Air Force, to be merged with and to be available for the same purposes and for the same time period as the appropriations to which transferred: Provided further, That upon a determination that all or part of the funds transferred from this appropriation are not necessary for the purposes provided herein, such amounts may be transferred back to this appropriation: Provided further, That the transfer authority provided under this heading is in addition to any other transfer authority provided elsewhere in this Act.

ENVIRONMENTAL RESTORATION, DEFENSE-WIDE
(INCLUDING TRANSFER OF FUNDS)

For the Department of Defense, \$11,100,000, to remain available until transferred: Provided, That the Secretary of Defense shall, upon determining that such funds are required for environmental restoration, reduction and recycling of hazardous waste, removal of unsafe buildings and debris of the Department of Defense, or for similar purposes, transfer the funds made available by this appropriation to other appropriations made available to the Department of Defense, to be merged with and to be available for the same purposes and for the same time period as the appropriations to which transferred: Provided further, That upon a determination that all or part of the funds transferred from this appropriation are not necessary for the purposes provided herein, such amounts may be transferred back to this appropriation: Provided fur-

ther, That the transfer authority provided under this heading is in addition to any other transfer authority provided elsewhere in this Act.

ENVIRONMENTAL RESTORATION, FORMERLY USED
DEFENSE SITES
(INCLUDING TRANSFER OF FUNDS)

For the Department of the Army, \$307,700,000, to remain available until transferred: Provided, That the Secretary of the Army shall, upon determining that such funds are required for environmental restoration, reduction and recycling of hazardous waste, removal of unsafe buildings and debris at sites formerly used by the Department of Defense, transfer the funds made available by this appropriation to other appropriations made available to the Department of the Army, to be merged with and to be available for the same purposes and for the same time period as the appropriations to which transferred: Provided further, That upon a determination that all or part of the funds transferred from this appropriation are not necessary for the purposes provided herein, such amounts may be transferred back to this appropriation: Provided further, That the transfer authority provided under this heading is in addition to any other transfer authority provided elsewhere in this Act.

OVERSEAS HUMANITARIAN, DISASTER, AND CIVIC
AID

For expenses relating to the Overseas Humanitarian, Disaster, and Civic Aid programs of the Department of Defense (consisting of the programs provided under sections 401, 402, 404, 407, 2557, and 2561 of title 10, United States Code), \$109,869,000, to remain available until September 30, 2011.

COOPERATIVE THREAT REDUCTION ACCOUNT

For assistance to the republics of the former Soviet Union and, with appropriate authorization by the Department of Defense and Department of State, to countries outside of the former Soviet Union, including assistance provided by contract or by grants, for facilitating the elimination and the safe and secure transportation and storage of nuclear, chemical and other weapons; for establishing programs to prevent the proliferation of weapons, weapons components, and weapon-related technology and expertise; for programs relating to the training and support of defense and military personnel for demilitarization and protection of weapons, weapons components and weapons technology and expertise, and for defense and military contacts, \$424,093,000, to remain available until September 30, 2012: Provided, That of the amounts provided under this heading, not less than \$15,000,000 shall be available only to support the dismantling and disposal of nuclear submarines, submarine reactor components, and security enhancements for transport and storage of nuclear warheads in the Russian Far East and North.

DEPARTMENT OF DEFENSE ACQUISITION
WORKFORCE DEVELOPMENT FUND

For the Department of Defense Acquisition Workforce Development Fund, \$100,000,000.

TITLE III
PROCUREMENT

AIRCRAFT PROCUREMENT, ARMY

For construction, procurement, production, modification, and modernization of aircraft, equipment, including ordnance, ground handling equipment, spare parts, and accessories therefor; specialized equipment and training devices; expansion of public and private plants, including the land necessary therefor, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment,

appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway; and other expenses necessary for the foregoing purposes, \$5,244,252,000, to remain available for obligation until September 30, 2012.

MISSILE PROCUREMENT, ARMY

For construction, procurement, production, modification, and modernization of missiles, equipment, including ordnance, ground handling equipment, spare parts, and accessories therefor; specialized equipment and training devices; expansion of public and private plants, including the land necessary therefor, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway; and other expenses necessary for the foregoing purposes, \$1,257,053,000, to remain available for obligation until September 30, 2012.

PROCUREMENT OF WEAPONS AND TRACKED
COMBAT VEHICLES, ARMY

For construction, procurement, production, and modification of weapons and tracked combat vehicles, equipment, including ordnance, spare parts, and accessories therefor; specialized equipment and training devices; expansion of public and private plants, including the land necessary therefor, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway; and other expenses necessary for the foregoing purposes, \$2,310,007,000, to remain available for obligation until September 30, 2012.

PROCUREMENT OF AMMUNITION, ARMY

For construction, procurement, production, and modification of ammunition, and accessories therefor; specialized equipment and training devices; expansion of public and private plants, including ammunition facilities, authorized by section 2854 of title 10, United States Code, and the land necessary therefor, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway; and other expenses necessary for the foregoing purposes, \$2,049,995,000, to remain available for obligation until September 30, 2012.

OTHER PROCUREMENT, ARMY

For construction, procurement, production, and modification of vehicles, including tactical, support, and non-tracked combat vehicles; the purchase of passenger motor vehicles for replacement only; and the purchase of eight vehicles required for physical security of personnel, notwithstanding price limitations applicable to passenger vehicles but not to exceed \$250,000 per vehicle; communications and electronic equipment; other support equipment; spare parts, ordnance, and accessories therefor; specialized equipment and training devices; expansion of public and private plants, including the land necessary therefor, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned

equipment layaway; and other expenses necessary for the foregoing purposes, \$9,395,444,000, to remain available for obligation until September 30, 2012.

AIRCRAFT PROCUREMENT, NAVY

For construction, procurement, production, modification, and modernization of aircraft, equipment, including ordnance, spare parts, and accessories therefor; specialized equipment; expansion of public and private plants, including the land necessary therefor, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway, \$18,079,312,000, to remain available for obligation until September 30, 2012.

WEAPONS PROCUREMENT, NAVY

For construction, procurement, production, modification, and modernization of missiles, torpedoes, other weapons, and related support equipment including spare parts, and accessories therefor; expansion of public and private plants, including the land necessary therefor, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway, \$3,446,419,000, to remain available for obligation until September 30, 2012.

PROCUREMENT OF AMMUNITION, NAVY AND MARINE CORPS

For construction, procurement, production, and modification of ammunition, and accessories therefor; specialized equipment and training devices; expansion of public and private plants, including ammunition facilities, authorized by section 2854 of title 10, United States Code, and the land necessary therefor, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway; and other expenses necessary for the foregoing purposes, \$814,015,000, to remain available for obligation until September 30, 2012.

SHIPBUILDING AND CONVERSION, NAVY

For expenses necessary for the construction, acquisition, or conversion of vessels as authorized by law, including armor and armament thereof, plant equipment, appliances, and machine tools and installation thereof in public and private plants; reserve plant and Government and contractor-owned equipment layaway; procurement of critical, long lead time components and designs for vessels to be constructed or converted in the future; and expansion of public and private plants, including land necessary therefor, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title, as follows:

Carrier Replacement Program, \$739,269,000;
Carrier Replacement Program (AP), \$484,432,000;
NSSN, \$1,964,317,000;
NSSN (AP), \$1,959,725,000;
CVN Refueling, \$1,563,602,000;
CVN Refuelings (AP), \$211,820,000;
DDG-1000 Program, \$1,393,797,000;
DDG-51 Destroyer, \$3,650,000,000;
DDG-51 Destroyer (AP), \$328,996,000;
Littoral Combat Ship, \$1,080,000,000;
LPD-17, \$872,392,000;
LPD-17 (AP), \$184,555,000;

LHA-R (AP), \$170,000,000;
Intratheater Connector, \$177,956,000;
LCAC Service Life Extension Program, \$63,857,000;

Prior year shipbuilding costs, \$144,950,000;
Service Craft, \$3,694,000; and

For outfitting, post delivery, conversions, and first destination transportation, \$391,238,000.

In all: \$15,384,600,000, to remain available for obligation until September 30, 2014: Provided, That additional obligations may be incurred after September 30, 2014, for engineering services, tests, evaluations, and other such budgeted work that must be performed in the final stage of ship construction: Provided further, That none of the funds provided under this heading for the construction or conversion of any naval vessel to be constructed in shipyards in the United States shall be expended in foreign facilities for the construction of major components of such vessel: Provided further, That none of the funds provided under this heading shall be used for the construction of any naval vessel in foreign shipyards.

OTHER PROCUREMENT, NAVY

For procurement, production, and modernization of support equipment and materials not otherwise provided for, Navy ordnance (except ordnance for new aircraft, new ships, and ships authorized for conversion); the purchase of passenger motor vehicles for replacement only, and the purchase of seven vehicles required for physical security of personnel, notwithstanding price limitations applicable to passenger vehicles but not to exceed \$250,000 per vehicle; expansion of public and private plants, including the land necessary therefor, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway, \$5,499,413,000, to remain available for obligation until September 30, 2012.

PROCUREMENT, MARINE CORPS

For expenses necessary for the procurement, manufacture, and modification of missiles, armament, military equipment, spare parts, and accessories therefor; plant equipment, appliances, and machine tools, and installation thereof in public and private plants; reserve plant and Government and contractor-owned equipment layaway; vehicles for the Marine Corps, including the purchase of passenger motor vehicles for replacement only; and expansion of public and private plants, including land necessary therefor, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title, \$1,550,080,000, to remain available for obligation until September 30, 2012.

AIRCRAFT PROCUREMENT, AIR FORCE

For construction, procurement, and modification of aircraft and equipment, including armor and armament, specialized ground handling equipment, and training devices, spare parts, and accessories therefor; specialized equipment; expansion of public and private plants, Government-owned equipment and installation thereof in such plants, erection of structures, and acquisition of land, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; reserve plant and Government and contractor-owned equipment layaway; and other expenses necessary for the foregoing purposes including rents and transportation of things, \$13,148,720,000, to remain available for obligation until September 30, 2012.

MISSILE PROCUREMENT, AIR FORCE

For construction, procurement, and modification of missiles, spacecraft, rockets, and related

equipment, including spare parts and accessories therefor, ground handling equipment, and training devices; expansion of public and private plants, Government-owned equipment and installation thereof in such plants, erection of structures, and acquisition of land, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; reserve plant and Government and contractor-owned equipment layaway; and other expenses necessary for the foregoing purposes including rents and transportation of things, \$6,070,344,000, to remain available for obligation until September 30, 2012.

PROCUREMENT OF AMMUNITION, AIR FORCE

For construction, procurement, production, and modification of ammunition, and accessories therefor; specialized equipment and training devices; expansion of public and private plants, including ammunition facilities, authorized by section 2854 of title 10, United States Code, and the land necessary therefor, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway; and other expenses necessary for the foregoing purposes, \$815,246,000, to remain available for obligation until September 30, 2012.

OTHER PROCUREMENT, AIR FORCE

For procurement and modification of equipment (including ground guidance and electronic control equipment, and ground electronic and communication equipment), and supplies, materials, and spare parts therefor, not otherwise provided for; the purchase of passenger motor vehicles for replacement only, and the purchase of two vehicles required for physical security of personnel, notwithstanding price limitations applicable to passenger vehicles but not to exceed \$250,000 per vehicle; lease of passenger motor vehicles; and expansion of public and private plants, Government-owned equipment and installation thereof in such plants, erection of structures, and acquisition of land, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon, prior to approval of title; reserve plant and Government and contractor-owned equipment layaway, \$17,283,800,000, to remain available for obligation until September 30, 2012.

PROCUREMENT, DEFENSE-WIDE

For expenses of activities and agencies of the Department of Defense (other than the military departments) necessary for procurement, production, and modification of equipment, supplies, materials, and spare parts therefor, not otherwise provided for; the purchase of passenger motor vehicles for replacement only; expansion of public and private plants, equipment, and installation thereof in such plants, erection of structures, and acquisition of land for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; reserve plant and Government and contractor-owned equipment layaway, \$4,017,697,000, to remain available for obligation until September 30, 2012.

NATIONAL GUARD AND RESERVE EQUIPMENT

For procurement of aircraft, missiles, tracked combat vehicles, ammunition, other weapons, and other procurement for the reserve components of the Armed Forces, \$1,500,000,000, to remain available for obligation until September 30, 2012: Provided, That the Chiefs of the Reserve and National Guard components shall, not later

than 30 days after the enactment of this Act, individually submit to the congressional defense committees the modernization priority assessment for their respective Reserve or National Guard component.

DEFENSE PRODUCTION ACT PURCHASES

For activities by the Department of Defense pursuant to sections 108, 301, 302, and 303 of the Defense Production Act of 1950 (50 U.S.C. App. 2078, 2091, 2092, and 2093), \$149,746,000, to remain available until expended.

TITLE IV

RESEARCH, DEVELOPMENT, TEST AND EVALUATION

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, ARMY

For expenses necessary for basic and applied scientific research, development, test and evaluation, including maintenance, rehabilitation, lease, and operation of facilities and equipment, \$10,653,126,000, to remain available for obligation until September 30, 2011.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, NAVY

For expenses necessary for basic and applied scientific research, development, test and evaluation, including maintenance, rehabilitation, lease, and operation of facilities and equipment, \$19,148,509,000, to remain available for obligation until September 30, 2011: Provided, That funds appropriated in this paragraph which are available for the V-22 may be used to meet unique operational requirements of the Special Operations Forces: Provided further, That funds appropriated in this paragraph shall be available for the Cobra Judy program.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, AIR FORCE

For expenses necessary for basic and applied scientific research, development, test and evaluation, including maintenance, rehabilitation, lease, and operation of facilities and equipment, \$28,049,015,000, to remain available for obligation until September 30, 2011.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, DEFENSE-WIDE

For expenses of activities and agencies of the Department of Defense (other than the military departments), necessary for basic and applied scientific research, development, test and evaluation; advanced research projects as may be designated and determined by the Secretary of Defense, pursuant to law; maintenance, rehabilitation, lease, and operation of facilities and equipment, \$20,408,968,000, to remain available for obligation until September 30, 2011, of which \$2,500,000 shall be available only for the Missile Defense Agency to construct a replacement Patriot launcher pad for the Japanese Ministry of Defense.

OPERATIONAL TEST AND EVALUATION, DEFENSE

For expenses, not otherwise provided for, necessary for the independent activities of the Director, Operational Test and Evaluation, in the direction and supervision of operational test and evaluation, including initial operational test and evaluation which is conducted prior to, and in support of, production decisions; joint operational testing and evaluation; and administrative expenses in connection therewith, \$190,770,000, to remain available for obligation until September 30, 2011.

TITLE V

REVOLVING AND MANAGEMENT FUNDS

DEFENSE WORKING CAPITAL FUNDS

For the Defense Working Capital Funds, \$1,455,004,000.

NATIONAL DEFENSE SEALIFT FUND

For National Defense Sealift Fund programs, projects, and activities, and for expenses of the

National Defense Reserve Fleet, as established by section 11 of the Merchant Ship Sales Act of 1946 (50 U.S.C. App. 1744), and for the necessary expenses to maintain and preserve a U.S.-flag merchant fleet to serve the national security needs of the United States, \$1,242,758,000, to remain available until expended: Provided, That none of the funds provided in this paragraph shall be used to award a new contract that provides for the acquisition of any of the following major components unless such components are manufactured in the United States: auxiliary equipment, including pumps, for all shipboard services; propulsion system components (engines, reduction gears, and propellers); shipboard cranes; and spreaders for shipboard cranes: Provided further, That the exercise of an option in a contract awarded through the obligation of previously appropriated funds shall not be considered to be the award of a new contract: Provided further, That the Secretary of the military department responsible for such procurement may waive the restrictions in the first proviso on a case-by-case basis by certifying in writing to the Committees on Appropriations of the House of Representatives and the Senate that adequate domestic supplies are not available to meet Department of Defense requirements on a timely basis and that such an acquisition must be made in order to acquire capability for national security purposes.

TITLE VI

OTHER DEPARTMENT OF DEFENSE PROGRAMS

DEFENSE HEALTH PROGRAM

For expenses, not otherwise provided for, for medical and health care programs of the Department of Defense as authorized by law, \$28,311,113,000; of which \$26,990,219,000 shall be for operation and maintenance, of which not to exceed one percent shall remain available until September 30, 2011, and of which up to \$15,093,539,000 may be available for contracts entered into under the TRICARE program; of which \$322,142,000, to remain available for obligation until September 30, 2012, shall be for procurement; and of which \$998,752,000, to remain available for obligation until September 30, 2011, shall be for research, development, test and evaluation.

CHEMICAL AGENTS AND MUNITIONS

DESTRUCTION, DEFENSE

For expenses, not otherwise provided for, necessary for the destruction of the United States stockpile of lethal chemical agents and munitions, to include construction of facilities, in accordance with the provisions of section 1412 of the Department of Defense Authorization Act, 1986 (50 U.S.C. 1521), and for the destruction of other chemical warfare materials that are not in the chemical weapon stockpile, \$1,539,869,000, of which \$1,125,911,000 shall be for operation and maintenance, of which no less than \$84,839,000, shall be for the Chemical Stockpile Emergency Preparedness Program, consisting of \$34,905,000 for activities on military installations and \$49,934,000, to remain available until September 30, 2011, to assist State and local governments; \$12,689,000 shall be for procurement, to remain available until September 30, 2012, of which no less than \$12,689,000 shall be for the Chemical Stockpile Emergency Preparedness Program to assist State and local governments; and \$401,269,000, to remain available until September 30, 2011, shall be for research, development, test and evaluation, of which \$398,669,000 shall only be for the Assembled Chemical Weapons Alternatives (ACWA) program.

DRUG INTERDICTION AND COUNTER-DRUG ACTIVITIES, DEFENSE

(INCLUDING TRANSFER OF FUNDS)

For drug interdiction and counter-drug activities of the Department of Defense, for transfer

to appropriations available to the Department of Defense for military personnel of the reserve components serving under the provisions of title 10 and title 32, United States Code; for operation and maintenance; for procurement; and for research, development, test and evaluation, \$1,103,086,000: Provided, That the funds appropriated under this heading shall be available for obligation for the same time period and for the same purpose as the appropriation to which transferred: Provided further, That upon a determination that all or part of the funds transferred from this appropriation are not necessary for the purposes provided herein, such amounts may be transferred back to this appropriation: Provided further, That the transfer authority provided under this heading is in addition to any other transfer authority contained elsewhere in this Act.

OFFICE OF THE INSPECTOR GENERAL

For expenses and activities of the Office of the Inspector General in carrying out the provisions of the Inspector General Act of 1978, as amended, \$288,100,000, of which \$287,100,000 shall be for operation and maintenance, of which not to exceed \$700,000 is available for emergencies and extraordinary expenses to be expended on the approval or authority of the Inspector General, and payments may be made on the Inspector General's certificate of necessity for confidential military purposes; and of which \$1,000,000, to remain available until September 30, 2012, shall be for procurement.

TITLE VII

RELATED AGENCIES

CENTRAL INTELLIGENCE AGENCY RETIREMENT AND DISABILITY SYSTEM FUND

For payment to the Central Intelligence Agency Retirement and Disability System Fund, to maintain the proper funding level for continuing the operation of the Central Intelligence Agency Retirement and Disability System, \$290,900,000.

INTELLIGENCE COMMUNITY MANAGEMENT ACCOUNT

For necessary expenses of the Intelligence Community Management Account, \$750,812,000.

TITLE VIII

GENERAL PROVISIONS

SEC. 8001. No part of any appropriation contained in this Act shall be used for publicity or propaganda purposes not authorized by the Congress.

SEC. 8002. During the current fiscal year, provisions of law prohibiting the payment of compensation to, or employment of, any person not a citizen of the United States shall not apply to personnel of the Department of Defense: Provided, That salary increases granted to direct and indirect hire foreign national employees of the Department of Defense funded by this Act shall not be at a rate in excess of the percentage increase authorized by law for civilian employees of the Department of Defense whose pay is computed under the provisions of section 5332 of title 5, United States Code, or at a rate in excess of the percentage increase provided by the appropriate host nation to its own employees, whichever is higher: Provided further, That this section shall not apply to Department of Defense foreign service national employees serving at United States diplomatic missions whose pay is set by the Department of State under the Foreign Service Act of 1980: Provided further, That the limitations of this provision shall not apply to foreign national employees of the Department of Defense in the Republic of Turkey.

SEC. 8003. No part of any appropriation contained in this Act shall remain available for obligation beyond the current fiscal year, unless expressly so provided herein.

SEC. 8004. No more than 20 percent of the appropriations in this Act which are limited for

obligation during the current fiscal year shall be obligated during the last 2 months of the fiscal year: *Provided*, That this section shall not apply to obligations for support of active duty training of reserve components or summer camp training of the Reserve Officers' Training Corps.

(TRANSFER OF FUNDS)

SEC. 8005. Upon determination by the Secretary of Defense that such action is necessary in the national interest, he may, with the approval of the Office of Management and Budget, transfer not to exceed \$4,000,000,000 of working capital funds of the Department of Defense or funds made available in this Act to the Department of Defense for military functions (except military construction) between such appropriations or funds or any subdivision thereof, to be merged with and to be available for the same purposes, and for the same time period, as the appropriation or fund to which transferred: *Provided*, That such authority to transfer may not be used unless for higher priority items, based on unforeseen military requirements, than those for which originally appropriated and in no case where the item for which funds are requested has been denied by the Congress: *Provided further*, That the Secretary of Defense shall notify the Congress promptly of all transfers made pursuant to this authority or any other authority in this Act: *Provided further*, That no part of the funds in this Act shall be available to prepare or present a request to the Committees on Appropriations for reprogramming of funds, unless for higher priority items, based on unforeseen military requirements, than those for which originally appropriated and in no case where the item for which reprogramming is requested has been denied by the Congress: *Provided further*, That a request for multiple reprogrammings of funds using authority provided in this section must be made prior to June 30, 2010: *Provided further*, That transfers among military personnel appropriations shall not be taken into account for purposes of the limitation on the amount of funds that may be transferred under this section: *Provided further*, That no obligation of funds may be made pursuant to section 1206 of Public Law 109-163 (or any successor provision) unless the Secretary of Defense has notified the congressional defense committees prior to any such obligation.

SEC. 8006. (a) Not later than 60 days after enactment of this Act, the Department of Defense shall submit a report to the congressional defense committees to establish the baseline for application of reprogramming and transfer authorities for fiscal year 2010: *Provided*, That the report shall include—

(1) a table for each appropriation with a separate column to display the President's budget request, adjustments made by Congress, adjustments due to enacted rescissions, if appropriate, and the fiscal year enacted level;

(2) a delineation in the table for each appropriation both by budget activity and program, project, and activity as detailed in the Budget Appendix; and

(3) an identification of items of special congressional interest.

(b) Notwithstanding section 8005 of this Act, none of the funds provided in this Act shall be available for reprogramming or transfer until the report identified in subsection (a) is submitted to the congressional defense committees, unless the Secretary of Defense certifies in writing to the congressional defense committees that such reprogramming or transfer is necessary as an emergency requirement.

SEC. 8007. The Secretaries of the Air Force and the Army are authorized, using funds available under the headings "Operation and Maintenance, Air Force" and "Operation and Maintenance, Army", to complete facility conversions and phased repair projects which may include

upgrades and additions to Alaskan range infrastructure and training areas, and improved access to these ranges.

(TRANSFER OF FUNDS)

SEC. 8008. During the current fiscal year, cash balances in working capital funds of the Department of Defense established pursuant to section 2208 of title 10, United States Code, may be maintained in only such amounts as are necessary at any time for cash disbursements to be made from such funds: *Provided*, That transfers may be made between such funds: *Provided further*, That transfers may be made between working capital funds and the "Foreign Currency Fluctuations, Defense" appropriation and the "Operation and Maintenance" appropriation accounts in such amounts as may be determined by the Secretary of Defense, with the approval of the Office of Management and Budget, except that such transfers may not be made unless the Secretary of Defense has notified the Congress of the proposed transfer. Except in amounts equal to the amounts appropriated to working capital funds in this Act, no obligations may be made against a working capital fund to procure or increase the value of war reserve material inventory, unless the Secretary of Defense has notified the Congress prior to any such obligation.

SEC. 8009. Funds appropriated by this Act may not be used to initiate a special access program without prior notification 30 calendar days in advance to the congressional defense committees.

SEC. 8010. None of the funds provided in this Act shall be available to initiate: (1) a multiyear contract that employs economic order quantity procurement in excess of \$20,000,000 in any one year of the contract or that includes an unfunded contingent liability in excess of \$20,000,000; or (2) a contract for advance procurement leading to a multiyear contract that employs economic order quantity procurement in excess of \$20,000,000 in any one year, unless the congressional defense committees have been notified at least 30 days in advance of the proposed contract award: *Provided*, That no part of any appropriation contained in this Act shall be available to initiate a multiyear contract for which the economic order quantity advance procurement is not funded at least to the limits of the Government's liability: *Provided further*, That no part of any appropriation contained in this Act shall be available to initiate multiyear procurement contracts for any systems or component thereof if the value of the multiyear contract would exceed \$500,000,000 unless specifically provided in this Act: *Provided further*, That no multiyear procurement contract can be terminated without 10-day prior notification to the congressional defense committees: *Provided further*, That the execution of multiyear authority shall require the use of a present value analysis to determine lowest cost compared to an annual procurement: *Provided further*, That none of the funds provided in this Act may be used for a multiyear contract executed after the date of the enactment of this Act unless in the case of any such contract—

(1) the Secretary of Defense has submitted to Congress a budget request for full funding of units to be procured through the contract and, in the case of a contract for procurement of aircraft, that includes, for any aircraft unit to be procured through the contract for which procurement funds are requested in that budget request for production beyond advance procurement activities in the fiscal year covered by the budget, full funding of procurement of such unit in that fiscal year;

(2) cancellation provisions in the contract do not include consideration of recurring manufacturing costs of the contractor associated with the production of unfunded units to be delivered under the contract;

(3) the contract provides that payments to the contractor under the contract shall not be made in advance of incurred costs on funded units; and

(4) the contract does not provide for a price adjustment based on a failure to award a follow-on contract.

SEC. 8011. Within the funds appropriated for the operation and maintenance of the Armed Forces, funds are hereby appropriated pursuant to section 401 of title 10, United States Code, for humanitarian and civic assistance costs under chapter 20 of title 10, United States Code. Such funds may also be obligated for humanitarian and civic assistance costs incidental to authorized operations and pursuant to authority granted in section 401 of chapter 20 of title 10, United States Code, and these obligations shall be reported as required by section 401(d) of title 10, United States Code: *Provided*, That funds available for operation and maintenance shall be available for providing humanitarian and similar assistance by using Civic Action Teams in the Trust Territories of the Pacific Islands and freely associated states of Micronesia, pursuant to the Compact of Free Association as authorized by Public Law 99-239: *Provided further*, That upon a determination by the Secretary of the Army that such action is beneficial for graduate medical education programs conducted at Army medical facilities located in Hawaii, the Secretary of the Army may authorize the provision of medical services at such facilities and transportation to such facilities, on a nonreimbursable basis, for civilian patients from American Samoa, the Commonwealth of the Northern Mariana Islands, the Marshall Islands, the Federated States of Micronesia, Palau, and Guam.

SEC. 8012. (a) During fiscal year 2010, the civilian personnel of the Department of Defense may not be managed on the basis of any end-strength, and the management of such personnel during that fiscal year shall not be subject to any constraint or limitation (known as an end-strength) on the number of such personnel who may be employed on the last day of such fiscal year.

(b) The fiscal year 2011 budget request for the Department of Defense as well as all justification material and other documentation supporting the fiscal year 2011 Department of Defense budget request shall be prepared and submitted to the Congress as if subsections (a) and (b) of this provision were effective with regard to fiscal year 2011.

(c) Nothing in this section shall be construed to apply to military (civilian) technicians.

SEC. 8013. None of the funds made available by this Act shall be used in any way, directly or indirectly, to influence congressional action on any legislation or appropriation matters pending before the Congress.

SEC. 8014. None of the funds appropriated by this Act shall be available for the basic pay and allowances of any member of the Army participating as a full-time student and receiving benefits paid by the Secretary of Veterans Affairs from the Department of Defense Education Benefits Fund when time spent as a full-time student is credited toward completion of a service commitment: *Provided*, That this section shall not apply to those members who have reenlisted with this option prior to October 1, 1987: *Provided further*, That this section applies only to active components of the Army.

SEC. 8015. (a) None of the funds appropriated by this Act shall be available to convert to contractor performance an activity or function of the Department of Defense that, on or after the date of the enactment of this Act, is performed by more than 10 Department of Defense civilian employees unless—

(1) the conversion is based on the result of a public-private competition that includes a most

efficient and cost effective organization plan developed by such activity or function;

(2) the Competitive Sourcing Official determines that, over all performance periods stated in the solicitation of offers for performance of the activity or function, the cost of performance of the activity or function by a contractor would be less costly to the Department of Defense by an amount that equals or exceeds the lesser of—

(A) 10 percent of the most efficient organization's personnel-related costs for performance of that activity or function by Federal employees; or

(B) \$10,000,000; and

(3) the contractor does not receive an advantage for a proposal that would reduce costs for the Department of Defense by—

(A) not making an employer-sponsored health insurance plan available to the workers who are to be employed in the performance of that activity or function under the contract; or

(B) offering to such workers an employer-sponsored health benefits plan that requires the employer to contribute less towards the premium or subscription share than the amount that is paid by the Department of Defense for health benefits for civilian employees under chapter 89 of title 5, United States Code.

(b)(1) The Department of Defense, without regard to subsection (a) of this section or subsection (a), (b), or (c) of section 2461 of title 10, United States Code, and notwithstanding any administrative regulation, requirement, or policy to the contrary shall have full authority to enter into a contract for the performance of any commercial or industrial type function of the Department of Defense that—

(A) is included on the procurement list established pursuant to section 2 of the Javits-Wagner-O'Day Act (41 U.S.C. 47);

(B) is planned to be converted to performance by a qualified nonprofit agency for the blind or by a qualified nonprofit agency for other severely handicapped individuals in accordance with that Act; or

(C) is planned to be converted to performance by a qualified firm under at least 51 percent ownership by an Indian tribe, as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)), or a Native Hawaiian Organization, as defined in section 8(a)(15) of the Small Business Act (15 U.S.C. 637(a)(15)).

(2) This section shall not apply to depot contracts or contracts for depot maintenance as provided in sections 2469 and 2474 of title 10, United States Code.

(c) The conversion of any activity or function of the Department of Defense under the authority provided by this section shall be credited toward any competitive or outsourcing goal, target, or measurement that may be established by statute, regulation, or policy and is deemed to be awarded under the authority of, and in compliance with, subsection (h) of section 2304 of title 10, United States Code, for the competition or outsourcing of commercial activities.

(TRANSFER OF FUNDS)

SEC. 8016. Funds appropriated in title III of this Act for the Department of Defense Pilot Mentor-Protege Program may be transferred to any other appropriation contained in this Act solely for the purpose of implementing a Mentor-Protege Program developmental assistance agreement pursuant to section 831 of the National Defense Authorization Act for Fiscal Year 1991 (Public Law 101-510; 10 U.S.C. 2302 note), as amended, under the authority of this provision or any other transfer authority contained in this Act.

SEC. 8017. None of the funds in this Act may be available for the purchase by the Department of Defense (and its departments and agencies) of welded shipboard anchor and mooring chain 4

inches in diameter and under unless the anchor and mooring chain are manufactured in the United States from components which are substantially manufactured in the United States: Provided, That for the purpose of this section manufactured will include cutting, heat treating, quality control, testing of chain and welding (including the forging and shot blasting process): Provided further, That for the purpose of this section substantially all of the components of anchor and mooring chain shall be considered to be produced or manufactured in the United States if the aggregate cost of the components produced or manufactured in the United States exceeds the aggregate cost of the components produced or manufactured outside the United States: Provided further, That when adequate domestic supplies are not available to meet Department of Defense requirements on a timely basis, the Secretary of the service responsible for the procurement may waive this restriction on a case-by-case basis by certifying in writing to the Committees on Appropriations that such an acquisition must be made in order to acquire capability for national security purposes.

SEC. 8018. None of the funds available to the Department of Defense may be used to demilitarize or dispose of M-1 Carbines, M-1 Garand rifles, M-14 rifles, .22 caliber rifles, .30 caliber rifles, or M-1911 pistols.

SEC. 8019. No more than \$500,000 of the funds appropriated or made available in this Act shall be used during a single fiscal year for any single relocation of an organization, unit, activity or function of the Department of Defense into or within the National Capital Region: Provided, That the Secretary of Defense may waive this restriction on a case-by-case basis by certifying in writing to the congressional defense committees that such a relocation is required in the best interest of the Government.

SEC. 8020. In addition to the funds provided elsewhere in this Act, \$15,000,000 is appropriated only for incentive payments authorized by section 504 of the Indian Financing Act of 1974 (25 U.S.C. 1544): Provided, That a prime contractor or a subcontractor at any tier that makes a subcontract award to any subcontractor or supplier as defined in section 1544 of title 25, United States Code, or a small business owned and controlled by an individual or individuals defined under section 4221(9) of title 25, United States Code, shall be considered a contractor for the purposes of being allowed additional compensation under section 504 of the Indian Financing Act of 1974 (25 U.S.C. 1544) whenever the prime contract or subcontract amount is over \$500,000 and involves the expenditure of funds appropriated by an Act making Appropriations for the Department of Defense with respect to any fiscal year: Provided further, That notwithstanding section 430 of title 41, United States Code, this section shall be applicable to any Department of Defense acquisition of supplies or services, including any contract and any subcontract at any tier for acquisition of commercial items produced or manufactured, in whole or in part by any subcontractor or supplier defined in section 1544 of title 25, United States Code, or a small business owned and controlled by an individual or individuals defined under section 4221(9) of title 25, United States Code.

SEC. 8021. Funds appropriated by this Act for the Defense Media Activity shall not be used for any national or international political or psychological activities.

SEC. 8022. None of the funds appropriated by this Act shall be available to perform any cost study pursuant to the provisions of OMB Circular A-76 if the study being performed exceeds a period of 24 months after initiation of such study with respect to a single function activity or 30 months after initiation of such study for a multi-function activity.

SEC. 8023. During the current fiscal year, the Department of Defense is authorized to incur obligations of not to exceed \$350,000,000 for purposes specified in section 2350j(c) of title 10, United States Code, in anticipation of receipt of contributions, only from the Government of Kuwait, under that section: Provided, That upon receipt, such contributions from the Government of Kuwait shall be credited to the appropriations or fund which incurred such obligations.

SEC. 8024. (a) Of the funds made available in this Act, not less than \$25,756,000 shall be available for the Civil Air Patrol Corporation, of which—

(1) \$22,433,000 shall be available from "Operation and Maintenance, Air Force" to support Civil Air Patrol Corporation operation and maintenance, readiness, counterdrug activities, and drug demand reduction activities involving youth programs;

(2) \$2,426,000 shall be available from "Aircraft Procurement, Air Force"; and

(3) \$897,000 shall be available from "Other Procurement, Air Force" for vehicle procurement.

(b) The Secretary of the Air Force should waive reimbursement for any funds used by the Civil Air Patrol for counter-drug activities in support of Federal, State, and local government agencies.

SEC. 8025. (a) None of the funds appropriated in this Act are available to establish a new Department of Defense (department) federally funded research and development center (FFRDC), either as a new entity, or as a separate entity administrated by an organization managing another FFRDC, or as a nonprofit membership corporation consisting of a consortium of other FFRDCs and other nonprofit entities.

(b) No member of a Board of Directors, Trustees, Overseers, Advisory Group, Special Issues Panel, Visiting Committee, or any similar entity of a defense FFRDC, and no paid consultant to any defense FFRDC, except when acting in a technical advisory capacity, may be compensated for his or her services as a member of such entity, or as a paid consultant by more than one FFRDC in a fiscal year: Provided, That a member of any such entity referred to previously in this subsection shall be allowed travel expenses and per diem as authorized under the Federal Joint Travel Regulations, when engaged in the performance of membership duties.

(c) Notwithstanding any other provision of law, none of the funds available to the department from any source during fiscal year 2010 may be used by a defense FFRDC, through a fee or other payment mechanism, for construction of new buildings, for payment of cost sharing for projects funded by Government grants, for absorption of contract overruns, or for certain charitable contributions, not to include employee participation in community service and/or development.

(d) Notwithstanding any other provision of law, of the funds available to the department during fiscal year 2010, not more than 5,600 staff years of technical effort (staff years) may be funded for defense FFRDCs: Provided, That of the specific amount referred to previously in this subsection, not more than 1,100 staff years may be funded for the defense studies and analysis FFRDCs: Provided further, That this subsection shall not apply to staff years funded in the National Intelligence Program (NIP) and the Military Intelligence Program (MIP).

(e) The Secretary of Defense shall, with the submission of the department's fiscal year 2011 budget request, submit a report presenting the specific amounts of staff years of technical effort to be allocated for each defense FFRDC during that fiscal year and the associated budget estimates.

(f) Notwithstanding any other provision of this Act, the total amount appropriated in this Act for FFRDCs is hereby reduced by \$120,200,000.

SEC. 8026. None of the funds appropriated or made available in this Act shall be used to procure carbon, alloy or armor steel plate for use in any Government-owned facility or property under the control of the Department of Defense which were not melted and rolled in the United States or Canada: Provided, That these procurement restrictions shall apply to any and all Federal Supply Class 9515, American Society of Testing and Materials (ASTM) or American Iron and Steel Institute (AISI) specifications of carbon, alloy or armor steel plate: Provided further, That the Secretary of the military department responsible for the procurement may waive this restriction on a case-by-case basis by certifying in writing to the Committees on Appropriations of the House of Representatives and the Senate that adequate domestic supplies are not available to meet Department of Defense requirements on a timely basis and that such an acquisition must be made in order to acquire capability for national security purposes: Provided further, That these restrictions shall not apply to contracts which are in being as of the date of the enactment of this Act.

SEC. 8027. For the purposes of this Act, the term "congressional defense committees" means the Armed Services Committee of the House of Representatives, the Armed Services Committee of the Senate, the Subcommittee on Defense of the Committee on Appropriations of the Senate, and the Subcommittee on Defense of the Committee on Appropriations of the House of Representatives.

SEC. 8028. During the current fiscal year, the Department of Defense may acquire the modification, depot maintenance and repair of aircraft, vehicles and vessels as well as the production of components and other Defense-related articles, through competition between Department of Defense depot maintenance activities and private firms: Provided, That the Senior Acquisition Executive of the military department or Defense Agency concerned, with power of delegation, shall certify that successful bids include comparable estimates of all direct and indirect costs for both public and private bids: Provided further, That Office of Management and Budget Circular A-76 shall not apply to competitions conducted under this section.

SEC. 8029. (a)(1) If the Secretary of Defense, after consultation with the United States Trade Representative, determines that a foreign country which is party to an agreement described in paragraph (2) has violated the terms of the agreement by discriminating against certain types of products produced in the United States that are covered by the agreement, the Secretary of Defense shall rescind the Secretary's blanket waiver of the Buy American Act with respect to such types of products produced in that foreign country.

(2) An agreement referred to in paragraph (1) is any reciprocal defense procurement memorandum of understanding, between the United States and a foreign country pursuant to which the Secretary of Defense has prospectively waived the Buy American Act for certain products in that country.

(b) The Secretary of Defense shall submit to the Congress a report on the amount of Department of Defense purchases from foreign entities in fiscal year 2010. Such report shall separately indicate the dollar value of items for which the Buy American Act was waived pursuant to any agreement described in subsection (a)(2), the Trade Agreement Act of 1979 (19 U.S.C. 2501 et seq.), or any international agreement to which the United States is a party.

(c) For purposes of this section, the term "Buy American Act" means title III of the Act entitled

"An Act making appropriations for the Treasury and Post Office Departments for the fiscal year ending June 30, 1934, and for other purposes", approved March 3, 1933 (41 U.S.C. 10a et seq.).

SEC. 8030. During the current fiscal year, amounts contained in the Department of Defense Overseas Military Facility Investment Recovery Account established by section 2921(c)(1) of the National Defense Authorization Act of 1991 (Public Law 101-510; 10 U.S.C. 2687 note) shall be available until expended for the payments specified by section 2921(c)(2) of that Act.

SEC. 8031. (a) Notwithstanding any other provision of law, the Secretary of the Air Force may convey at no cost to the Air Force, without consideration, to Indian tribes located in the States of Nevada, Idaho, North Dakota, South Dakota, Montana, Oregon, and Minnesota relocatable military housing units located at Grand Forks Air Force Base, Malmstrom Air Force Base, Mountain Home Air Force Base, Ellsworth Air Force Base, and Minot Air Force Base that are excess to the needs of the Air Force.

(b) The Secretary of the Air Force shall convey, at no cost to the Air Force, military housing units under subsection (a) in accordance with the request for such units that are submitted to the Secretary by the Operation Walking Shield Program on behalf of Indian tribes located in the States of Nevada, Idaho, North Dakota, South Dakota, Montana, Oregon, and Minnesota.

(c) The Operation Walking Shield Program shall resolve any conflicts among requests of Indian tribes for housing units under subsection (a) before submitting requests to the Secretary of the Air Force under subsection (b).

(d) In this section, the term "Indian tribe" means any recognized Indian tribe included on the current list published by the Secretary of the Interior under section 104 of the Federally Recognized Indian Tribe Act of 1994 (Public Law 103-454; 108 Stat. 4792; 25 U.S.C. 479a-1).

SEC. 8032. During the current fiscal year, appropriations which are available to the Department of Defense for operation and maintenance may be used to purchase items having an investment item unit cost of not more than \$250,000.

SEC. 8033. (a) During the current fiscal year, none of the appropriations or funds available to the Department of Defense Working Capital Funds shall be used for the purchase of an investment item for the purpose of acquiring a new inventory item for sale or anticipated sale during the current fiscal year or a subsequent fiscal year to customers of the Department of Defense Working Capital Funds if such an item would not have been chargeable to the Department of Defense Business Operations Fund during fiscal year 1994 and if the purchase of such an investment item would be chargeable during the current fiscal year to appropriations made to the Department of Defense for procurement.

(b) The fiscal year 2011 budget request for the Department of Defense as well as all justification material and other documentation supporting the fiscal year 2011 Department of Defense budget shall be prepared and submitted to the Congress on the basis that any equipment which was classified as an end item and funded in a procurement appropriation contained in this Act shall be budgeted for in a proposed fiscal year 2011 procurement appropriation and not in the supply management business area or any other area or category of the Department of Defense Working Capital Funds.

SEC. 8034. None of the funds appropriated by this Act for programs of the Central Intelligence Agency shall remain available for obligation beyond the current fiscal year, except for funds appropriated for the Reserve for Contingencies, which shall remain available until September 30,

2011: Provided, That funds appropriated, transferred, or otherwise credited to the Central Intelligence Agency Central Services Working Capital Fund during this or any prior or subsequent fiscal year shall remain available until expended: Provided further, That any funds appropriated or transferred to the Central Intelligence Agency for advanced research and development acquisition, for agent operations, and for covert action programs authorized by the President under section 503 of the National Security Act of 1947, as amended, shall remain available until September 30, 2011.

SEC. 8035. Notwithstanding any other provision of law, funds made available in this Act for the Defense Intelligence Agency may be used for the design, development, and deployment of General Defense Intelligence Program intelligence communications and intelligence information systems for the Services, the Unified and Specified Commands, and the component commands.

SEC. 8036. Of the funds appropriated to the Department of Defense under the heading "Operation and Maintenance, Defense-Wide", not less than \$12,000,000 shall be made available only for the mitigation of environmental impacts, including training and technical assistance to tribes, related administrative support, the gathering of information, documenting of environmental damage, and developing a system for prioritization of mitigation and cost to complete estimates for mitigation, on Indian lands resulting from Department of Defense activities.

SEC. 8037. (a) None of the funds appropriated in this Act may be expended by an entity of the Department of Defense unless the entity, in expending the funds, complies with the Buy American Act. For purposes of this subsection, the term "Buy American Act" means title III of the Act entitled "An Act making appropriations for the Treasury and Post Office Departments for the fiscal year ending June 30, 1934, and for other purposes", approved March 3, 1933 (41 U.S.C. 10a et seq.).

(b) If the Secretary of Defense determines that a person has been convicted of intentionally affixing a label bearing a "Made in America" inscription to any product sold in or shipped to the United States that is not made in America, the Secretary shall determine, in accordance with section 2410f of title 10, United States Code, whether the person should be debarred from contracting with the Department of Defense.

(c) In the case of any equipment or products purchased with appropriations provided under this Act, it is the sense of the Congress that any entity of the Department of Defense, in expending the appropriation, purchase only American-made equipment and products, provided that American-made equipment and products are cost-competitive, quality-competitive, and available in a timely fashion.

SEC. 8038. None of the funds appropriated by this Act shall be available for a contract for studies, analysis, or consulting services entered into without competition on the basis of an unsolicited proposal unless the head of the activity responsible for the procurement determines—

(1) as a result of thorough technical evaluation, only one source is found fully qualified to perform the proposed work;

(2) the purpose of the contract is to explore an unsolicited proposal which offers significant scientific or technological promise, represents the product of original thinking, and was submitted in confidence by one source; or

(3) the purpose of the contract is to take advantage of unique and significant industrial accomplishment by a specific concern, or to insure that a new product or idea of a specific concern is given financial support: Provided, That this limitation shall not apply to contracts in an amount of less than \$25,000, contracts related to

improvements of equipment that is in development or production, or contracts as to which a civilian official of the Department of Defense, who has been confirmed by the Senate, determines that the award of such contract is in the interest of the national defense.

SEC. 8039. (a) Except as provided in subsections (b) and (c), none of the funds made available by this Act may be used—

(1) to establish a field operating agency; or
(2) to pay the basic pay of a member of the Armed Forces or civilian employee of the department who is transferred or reassigned from a headquarters activity if the member or employee's place of duty remains at the location of that headquarters.

(b) The Secretary of Defense or Secretary of a military department may waive the limitations in subsection (a), on a case-by-case basis, if the Secretary determines, and certifies to the Committees on Appropriations of the House of Representatives and Senate that the granting of the waiver will reduce the personnel requirements or the financial requirements of the department.

(c) This section does not apply to—

(1) field operating agencies funded within the National Intelligence Program; or

(2) an Army field operating agency established to eliminate, mitigate, or counter the effects of improvised explosive devices, and, as determined by the Secretary of the Army, other similar threats.

(RESCISSIONS)

SEC. 8040. Of the funds appropriated in Department of Defense Appropriations Acts, the following funds are hereby rescinded from the following accounts and programs in the specified amounts:

“Research, Development, Test and Evaluation, Air Force, 2009/2010”, \$110,230,000;

“Research, Development, Test and Evaluation, Defense-Wide, 2009/2010”, \$199,750,000;

“Procurement of Weapons and Tracked Combat Vehicles, Army, 2009/2011”, \$41,087,000;

“Other Procurement, Army, 2009/2011”, \$138,239,000;

“Aircraft Procurement, Air Force, 2009/2011”, \$628,900,000;

“Missile Procurement, Air Force, 2009/2011”, \$147,595,000;

“Other Procurement, Air Force, 2009/2011”, \$5,000,000;

“Procurement, Defense-Wide, 2009/2011”, \$5,200,000; and

“Procurement, Defense-Wide, 2008/2010”, \$2,000,000.

SEC. 8041. None of the funds available in this Act may be used to reduce the authorized positions for military (civilian) technicians of the Army National Guard, Air National Guard, Army Reserve and Air Force Reserve for the purpose of applying any administratively imposed civilian personnel ceiling, freeze, or reduction on military (civilian) technicians, unless such reductions are a direct result of a reduction in military force structure.

SEC. 8042. None of the funds appropriated or otherwise made available in this Act may be obligated or expended for assistance to the Democratic People's Republic of Korea unless specifically appropriated for that purpose.

SEC. 8043. Funds appropriated in this Act for operation and maintenance of the Military Departments, Combatant Commands and Defense Agencies shall be available for reimbursement of pay, allowances and other expenses which would otherwise be incurred against appropriations for the National Guard and Reserve when members of the National Guard and Reserve provide intelligence or counterintelligence support to Combatant Commands, Defense Agencies and Joint Intelligence Activities, including the activities and programs included within the National Intelligence Program and the Military In-

telligence Program: Provided, That nothing in this section authorizes deviation from established Reserve and National Guard personnel and training procedures.

SEC. 8044. During the current fiscal year, none of the funds appropriated in this Act may be used to reduce the civilian medical and medical support personnel assigned to military treatment facilities below the September 30, 2003, level: Provided, That the Service Surgeons General may waive this section by certifying to the congressional defense committees that the beneficiary population is declining in some catchment areas and civilian strength reductions may be consistent with responsible resource stewardship and capitation-based budgeting.

SEC. 8045. (a) None of the funds available to the Department of Defense for any fiscal year for drug interdiction or counter-drug activities may be transferred to any other department or agency of the United States except as specifically provided in an appropriations law.

(b) None of the funds available to the Central Intelligence Agency for any fiscal year for drug interdiction and counter-drug activities may be transferred to any other department or agency of the United States except as specifically provided in an appropriations law.

SEC. 8046. None of the funds appropriated by this Act may be used for the procurement of ball and roller bearings other than those produced by a domestic source and of domestic origin: Provided, That the Secretary of the military department responsible for such procurement may waive this restriction on a case-by-case basis by certifying in writing to the Committees on Appropriations of the House of Representatives and the Senate, that adequate domestic supplies are not available to meet Department of Defense requirements on a timely basis and that such an acquisition must be made in order to acquire capability for national security purposes: Provided further, That this restriction shall not apply to the purchase of “commercial items”, as defined by section 4(12) of the Office of Federal Procurement Policy Act, except that the restriction shall apply to ball or roller bearings purchased as end items.

SEC. 8047. None of the funds in this Act may be used to purchase any supercomputer which is not manufactured in the United States, unless the Secretary of Defense certifies to the congressional defense committees that such an acquisition must be made in order to acquire capability for national security purposes that is not available from United States manufacturers.

SEC. 8048. None of the funds made available in this or any other Act may be used to pay the salary of any officer or employee of the Department of Defense who approves or implements the transfer of administrative responsibilities or budgetary resources of any program, project, or activity financed by this Act to the jurisdiction of another Federal agency not financed by this Act without the express authorization of Congress: Provided, That this limitation shall not apply to transfers of funds expressly provided for in Defense Appropriations Acts, or provisions of Acts providing supplemental appropriations for the Department of Defense.

SEC. 8049. (a) Notwithstanding any other provision of law, none of the funds available to the Department of Defense for the current fiscal year may be obligated or expended to transfer to another nation or an international organization any defense articles or services (other than intelligence services) for use in the activities described in subsection (b) unless the congressional defense committees, the Committee on Foreign Affairs of the House of Representatives, and the Committee on Foreign Relations of the Senate are notified 15 days in advance of such transfer.

(b) This section applies to—

(1) any international peacekeeping or peace-enforcement operation under the authority of chapter VI or chapter VII of the United Nations Charter under the authority of a United Nations Security Council resolution; and

(2) any other international peacekeeping, peace-enforcement, or humanitarian assistance operation.

(c) A notice under subsection (a) shall include the following—

(1) A description of the equipment, supplies, or services to be transferred.

(2) A statement of the value of the equipment, supplies, or services to be transferred.

(3) In the case of a proposed transfer of equipment or supplies—

(A) a statement of whether the inventory requirements of all elements of the Armed Forces (including the reserve components) for the type of equipment or supplies to be transferred have been met; and

(B) a statement of whether the items proposed to be transferred will have to be replaced and, if so, how the President proposes to provide funds for such replacement.

SEC. 8050. None of the funds available to the Department of Defense under this Act shall be obligated or expended to pay a contractor under a contract with the Department of Defense for costs of any amount paid by the contractor to an employee when—

(1) such costs are for a bonus or otherwise in excess of the normal salary paid by the contractor to the employee; and

(2) such bonus is part of restructuring costs associated with a business combination.

(INCLUDING TRANSFER OF FUNDS)

SEC. 8051. During the current fiscal year, no more than \$30,000,000 of appropriations made in this Act under the heading “Operation and Maintenance, Defense-Wide” may be transferred to appropriations available for the pay of military personnel, to be merged with, and to be available for the same time period as the appropriations to which transferred, to be used in support of such personnel in connection with support and services for eligible organizations and activities outside the Department of Defense pursuant to section 2012 of title 10, United States Code.

SEC. 8052. (a) IN GENERAL.—Service as a member of the Alaska Territorial Guard during World War II of any individual who was honorably discharged therefrom under section 8147 of the Department of Defense Appropriations Act, 2001 (Public Law 106-259; 114 Stat. 705) shall be treated as active service for purposes of the computation under chapter 61, 71, 371, 571, 871, or 1223 of title 10, United States Code, as applicable, of the retired pay to which such individual may be entitled under title 10, United States Code.

(b) APPLICABILITY.—Subsection (a) shall apply with respect to amounts of retired pay payable under title 10, United States Code, for months beginning on or after the date of the enactment of this Act. No retired pay shall be paid to any individual by reason of subsection (a) for any period before that date.

(c) WORLD WAR II DEFINED.—In this section, the term “World War II” has the meaning given that term in section 101(8) of title 38, United States Code.

SEC. 8053. (a) Notwithstanding any other provision of law, the Chief of the National Guard Bureau may permit the use of equipment of the National Guard Distance Learning Project by any person or entity on a space-available, reimbursable basis. The Chief of the National Guard Bureau shall establish the amount of reimbursement for such use on a case-by-case basis.

(b) Amounts collected under subsection (a) shall be credited to funds available for the National Guard Distance Learning Project and be

available to defray the costs associated with the use of equipment of the project under that subsection. Such funds shall be available for such purposes without fiscal year limitation.

SEC. 8054. Using funds available by this Act or any other Act, the Secretary of the Air Force, pursuant to a determination under section 2690 of title 10, United States Code, may implement cost-effective agreements for required heating facility modernization in the Kaiserslautern Military Community in the Federal Republic of Germany: Provided, That in the City of Kaiserslautern such agreements will include the use of United States anthracite as the base load energy for municipal district heat to the United States Defense installations: Provided further, That at Landstuhl Army Regional Medical Center and Ramstein Air Base, furnished heat may be obtained from private, regional or municipal services, if provisions are included for the consideration of United States coal as an energy source.

SEC. 8055. None of the funds appropriated in title IV of this Act may be used to procure end-items for delivery to military forces for operational training, operational use or inventory requirements: Provided, That this restriction does not apply to end-items used in development, prototyping, and test activities preceding and leading to acceptance for operational use: Provided further, That this restriction does not apply to programs funded within the National Intelligence Program: Provided further, That the Secretary of Defense may waive this restriction on a case-by-case basis by certifying in writing to the Committees on Appropriations of the House of Representatives and the Senate that it is in the national security interest to do so.

SEC. 8056. None of the funds made available in this Act may be used to approve or license the sale of the F-22A advanced tactical fighter to any foreign government: Provided, That the Department of Defense may conduct or participate in studies, research, design and other activities to define and develop a future export version of the F-22A that protects classified and sensitive information, technologies and U.S. warfighting capabilities.

SEC. 8057. (a) The Secretary of Defense may, on a case-by-case basis, waive with respect to a foreign country each limitation on the procurement of defense items from foreign sources provided in law if the Secretary determines that the application of the limitation with respect to that country would invalidate cooperative programs entered into between the Department of Defense and the foreign country, or would invalidate reciprocal trade agreements for the procurement of defense items entered into under section 2531 of title 10, United States Code, and the country does not discriminate against the same or similar defense items produced in the United States for that country.

(b) Subsection (a) applies with respect to—

(1) contracts and subcontracts entered into on or after the date of the enactment of this Act; and

(2) options for the procurement of items that are exercised after such date under contracts that are entered into before such date if the option prices are adjusted for any reason other than the application of a waiver granted under subsection (a).

(c) Subsection (a) does not apply to a limitation regarding construction of public vessels, ball and roller bearings, food, and clothing or textile materials as defined by section 11 (chapters 50–65) of the Harmonized Tariff Schedule and products classified under headings 4010, 4202, 4203, 6401 through 6406, 6505, 7019, 7218 through 7229, 7304.41 through 7304.49, 7306.40, 7502 through 7508, 8105, 8108, 8109, 8211, 8215, and 9404.

SEC. 8058. (a) None of the funds made available by this Act may be used to support any training program involving a unit of the security forces of a foreign country if the Secretary of Defense has received credible information from the Department of State that the unit has committed a gross violation of human rights, unless all necessary corrective steps have been taken.

(b) The Secretary of Defense, in consultation with the Secretary of State, shall ensure that prior to a decision to conduct any training program referred to in subsection (a), full consideration is given to all credible information available to the Department of State relating to human rights violations by foreign security forces.

(c) The Secretary of Defense, after consultation with the Secretary of State, may waive the prohibition in subsection (a) if he determines that such waiver is required by extraordinary circumstances.

(d) Not more than 15 days after the exercise of any waiver under subsection (c), the Secretary of Defense shall submit a report to the congressional defense committees describing the extraordinary circumstances, the purpose and duration of the training program, the United States forces and the foreign security forces involved in the training program, and the information relating to human rights violations that necessitates the waiver.

SEC. 8059. None of the funds appropriated or made available in this Act to the Department of the Navy shall be used to develop, lease or procure the T-AKE class of ships unless the main propulsion diesel engines and propulsors are manufactured in the United States by a domestically operated entity: Provided, That the Secretary of Defense may waive this restriction on a case-by-case basis by certifying in writing to the Committees on Appropriations of the House of Representatives and the Senate that adequate domestic supplies are not available to meet Department of Defense requirements on a timely basis and that such an acquisition must be made in order to acquire capability for national security purposes or there exists a significant cost or quality difference.

SEC. 8060. None of the funds appropriated or otherwise made available by this or other Department of Defense Appropriations Acts may be obligated or expended for the purpose of performing repairs or maintenance to military family housing units of the Department of Defense, including areas in such military family housing units that may be used for the purpose of conducting official Department of Defense business.

SEC. 8061. Notwithstanding any other provision of law, funds appropriated in this Act under the heading “Research, Development, Test and Evaluation, Defense-Wide” for any new start advanced concept technology demonstration project or joint capability demonstration project may only be obligated 30 days after a report, including a description of the project, the planned acquisition and transition strategy and its estimated annual and total cost, has been provided in writing to the congressional defense committees: Provided, That the Secretary of Defense may waive this restriction on a case-by-case basis by certifying to the congressional defense committees that it is in the national interest to do so.

SEC. 8062. The Secretary of Defense shall provide a classified quarterly report beginning 30 days after enactment of this Act, to the House and Senate Appropriations Committees, Subcommittees on Defense on certain matters as directed in the classified annex accompanying this Act.

SEC. 8063. During the current fiscal year, none of the funds available to the Department of Defense may be used to provide support to another

department or agency of the United States if such department or agency is more than 90 days in arrears in making payment to the Department of Defense for goods or services previously provided to such department or agency on a reimbursable basis: Provided, That this restriction shall not apply if the department is authorized by law to provide support to such department or agency on a nonreimbursable basis, and is providing the requested support pursuant to such authority: Provided further, That the Secretary of Defense may waive this restriction on a case-by-case basis by certifying in writing to the Committees on Appropriations of the House of Representatives and the Senate that it is in the national security interest to do so.

SEC. 8064. Notwithstanding section 12310(b) of title 10, United States Code, a Reserve who is a member of the National Guard serving on full-time National Guard duty under section 502(f) of title 32, United States Code, may perform duties in support of the ground-based elements of the National Ballistic Missile Defense System.

SEC. 8065. None of the funds provided in this Act may be used to transfer to any nongovernmental entity ammunition held by the Department of Defense that has a center-fire cartridge and a United States military nomenclature designation of “armor penetrator”, “armor piercing (AP)”, “armor piercing incendiary (API)”, or “armor-piercing incendiary-tracer (API-T)”, except to an entity performing demilitarization services for the Department of Defense under a contract that requires the entity to demonstrate to the satisfaction of the Department of Defense that armor piercing projectiles are either: (1) rendered incapable of reuse by the demilitarization process; or (2) used to manufacture ammunition pursuant to a contract with the Department of Defense or the manufacture of ammunition for export pursuant to a License for Permanent Export of Unclassified Military Articles issued by the Department of State.

SEC. 8066. Notwithstanding any other provision of law, the Chief of the National Guard Bureau, or his designee, may waive payment of all or part of the consideration that otherwise would be required under section 2667 of title 10, United States Code, in the case of a lease of personal property for a period not in excess of 1 year to any organization specified in section 508(d) of title 32, United States Code, or any other youth, social, or fraternal nonprofit organization as may be approved by the Chief of the National Guard Bureau, or his designee, on a case-by-case basis.

SEC. 8067. None of the funds appropriated by this Act shall be used for the support of any nonappropriated funds activity of the Department of Defense that procures malt beverages and wine with nonappropriated funds for resale (including such alcoholic beverages sold by the drink) on a military installation located in the United States unless such malt beverages and wine are procured within that State, or in the case of the District of Columbia, within the District of Columbia, in which the military installation is located: Provided, That in a case in which the military installation is located in more than one State, purchases may be made in any State in which the installation is located: Provided further, That such local procurement requirements for malt beverages and wine shall apply to all alcoholic beverages only for military installations in States which are not contiguous with another State: Provided further, That alcoholic beverages other than wine and malt beverages, in contiguous States and the District of Columbia shall be procured from the most competitive source, price and other factors considered.

SEC. 8068. Funds available to the Department of Defense for the Global Positioning System during the current fiscal year may be used to

fund civil requirements associated with the satellite and ground control segments of such system's modernization program.

(INCLUDING TRANSFER OF FUNDS)

SEC. 8069. Of the amounts appropriated in this Act under the heading "Operation and Maintenance, Army", \$106,754,000 shall remain available until expended: Provided, That notwithstanding any other provision of law, the Secretary of Defense is authorized to transfer such funds to other activities of the Federal Government: Provided further, That the Secretary of Defense is authorized to enter into and carry out contracts for the acquisition of real property, construction, personal services, and operations related to projects carrying out the purposes of this section: Provided further, That contracts entered into under the authority of this section may provide for such indemnification as the Secretary determines to be necessary: Provided further, That projects authorized by this section shall comply with applicable Federal, State, and local law to the maximum extent consistent with the national security, as determined by the Secretary of Defense.

SEC. 8070. Section 8106 of the Department of Defense Appropriations Act, 1997 (titles I through VIII of the matter under subsection 101(b) of Public Law 104-208; 110 Stat. 3009-111; 10 U.S.C. 113 note) shall continue in effect to apply to disbursements that are made by the Department of Defense in fiscal year 2010.

(INCLUDING TRANSFER OF FUNDS)

SEC. 8071. Of the amounts appropriated in this Act under the heading "Research, Development, Test and Evaluation, Defense-Wide", \$202,434,000 shall be for the Israeli Cooperative Programs: Provided, That of this amount, \$80,092,000 shall be for the Short Range Ballistic Missile Defense (SRBMD) program, \$50,036,000 shall be available for an upper-tier component to the Israeli Missile Defense Architecture, and \$72,306,000 shall be for the Arrow Missile Defense Program, of which \$25,000,000 shall be for producing Arrow missile components in the United States and Arrow missile components in Israel to meet Israel's defense requirements, consistent with each nation's laws, regulations and procedures: Provided further, That funds made available under this provision for production of missiles and missile components may be transferred to appropriations available for the procurement of weapons and equipment, to be merged with and to be available for the same time period and the same purposes as the appropriation to which transferred: Provided further, That the transfer authority provided under this provision is in addition to any other transfer authority contained in this Act.

(INCLUDING TRANSFER OF FUNDS)

SEC. 8072. Of the amounts appropriated in this Act under the heading "Shipbuilding and Conversion, Navy", \$144,950,000 shall be available until September 30, 2010, to fund prior year shipbuilding cost increases: Provided, That upon enactment of this Act, the Secretary of the Navy shall transfer such funds to the following appropriations in the amounts specified: Provided further, That the amounts transferred shall be merged with and be available for the same purposes as the appropriations to which transferred:

To:

Under the heading "Shipbuilding and Conversion, Navy, 2004/2010":

New SSN, \$26,906,000; and

LPD-17 Amphibious Transport Dock Program, \$16,844,000.

Under the heading "Shipbuilding and Conversion, Navy, 2005/2010":

New SSN, \$18,702,000; and

LPD-17 Amphibious Transport Dock Program, \$16,498,000.

Under the heading "Shipbuilding and Conversion, Navy, 2008/2012":

LPD-17 Amphibious Transport Dock Program, \$66,000,000.

SEC. 8073. None of the funds available to the Department of Defense may be obligated to modify command and control relationships to give Fleet Forces Command administrative and operational control of U.S. Navy forces assigned to the Pacific fleet: Provided, That the command and control relationships which existed on October 1, 2004, shall remain in force unless changes are specifically authorized in a subsequent Act.

SEC. 8074. Notwithstanding any other provision of law or regulation, the Secretary of Defense may exercise the provisions of section 7403(g) of title 38, United States Code, for occupations listed in section 7403(a)(2) of title 38, United States Code, as well as the following:

Pharmacists, Audiologists, Psychologists, Social Workers, Othotists/Prosthetists, Occupational Therapists, Physical Therapists, Rehabilitation Therapists, Respiratory Therapists, Speech Pathologists, Dietitian/Nutritionists, Industrial Hygienists, Psychology Technicians, Social Service Assistants, Practical Nurses, Nursing Assistants, and Dental Hygienists:

(A) The requirements of section 7403(g)(1)(A) of title 38, United States Code, shall apply.

(B) The limitations of section 7403(g)(1)(B) of title 38, United States Code, shall not apply.

SEC. 8075. Funds appropriated by this Act, or made available by the transfer of funds in this Act, for intelligence activities are deemed to be specifically authorized by the Congress for purposes of section 504 of the National Security Act of 1947 (50 U.S.C. 414) during fiscal year 2010 until the enactment of the Intelligence Authorization Act for Fiscal Year 2010.

SEC. 8076. None of the funds provided in this Act shall be available for obligation or expenditure through a reprogramming of funds that creates or initiates a new program, project, or activity unless such program, project, or activity must be undertaken immediately in the interest of national security and only after written prior notification to the congressional defense committees.

SEC. 8077. In addition to funds made available elsewhere in this Act, \$5,500,000 is hereby appropriated and shall remain available until expended to provide assistance, by grant or otherwise (such as the provision of funds for information technology and textbook purchases, professional development for educators, and student transition support) to public schools in states that are considered overseas assignments with unusually high concentrations of special needs military dependents enrolled: Provided, That up to 2 percent of the total appropriated funds under this section shall be available for the administration and execution of the programs and/or events that promote the purpose of this appropriation: Provided further, That up to 5 percent of the total appropriated funds under this section shall be available to public schools that have entered into a military partnership: Provided further, That \$1,000,000 shall be available for a nonprofit trust fund to assist in the public-private funding of public school repair and maintenance projects: Provided further, That \$500,000 shall be available to fund an ongoing special education support program in public schools with unusually high concentrations of active duty military dependents enrolled: Provided further, That to the extent a Federal agency provides this assistance by contract, grant, or otherwise, it may accept and expend non-Federal funds in combination with these Federal funds to provide assistance for the authorized purpose.

SEC. 8078. In addition to the amounts appropriated or otherwise made available elsewhere in this Act, \$50,500,000 is hereby appropriated to

the Department of Defense: Provided, That the Secretary of Defense shall make grants in the amounts specified as follows: \$20,000,000 to the Edward M. Kennedy Institute for the Senate; \$5,500,000 to the U.S.S. Missouri Memorial Association; and \$25,000,000 to the National World War II Museum.

SEC. 8079. The budget of the President for fiscal year 2011 submitted to the Congress pursuant to section 1105 of title 31, United States Code, shall include separate budget justification documents for costs of United States Armed Forces' participation in contingency operations for the Military Personnel accounts, the Operation and Maintenance accounts, and the Procurement accounts: Provided, That these documents shall include a description of the funding requested for each contingency operation, for each military service, to include all Active and Reserve components, and for each appropriations account: Provided further, That these documents shall include estimated costs for each element of expense or object class, a reconciliation of increases and decreases for each contingency operation, and programmatic data including, but not limited to, troop strength for each Active and Reserve component, and estimates of the major weapons systems deployed in support of each contingency: Provided further, That these documents shall include budget exhibits OP-5 and OP-32 (as defined in the Department of Defense Financial Management Regulation) for all contingency operations for the budget year and the two preceding fiscal years.

SEC. 8080. None of the funds in this Act may be used for research, development, test, evaluation, procurement or deployment of nuclear armed interceptors of a missile defense system.

SEC. 8081. None of the funds appropriated or made available in this Act shall be used to reduce or disestablish the operation of the 53rd Weather Reconnaissance Squadron of the Air Force Reserve, if such action would reduce the WC-130 Weather Reconnaissance mission below the levels funded in this Act: Provided, That the Air Force shall allow the 53rd Weather Reconnaissance Squadron to perform other missions in support of national defense requirements during the non-hurricane season.

SEC. 8082. None of the funds provided in this Act shall be available for integration of foreign intelligence information unless the information has been lawfully collected and processed during the conduct of authorized foreign intelligence activities: Provided, That information pertaining to United States persons shall only be handled in accordance with protections provided in the Fourth Amendment of the United States Constitution as implemented through Executive Order No. 12333.

SEC. 8083. (a) At the time members of reserve components of the Armed Forces are called or ordered to active duty under section 12302(a) of title 10, United States Code, each member shall be notified in writing of the expected period during which the member will be mobilized.

(b) The Secretary of Defense may waive the requirements of subsection (a) in any case in which the Secretary determines that it is necessary to do so to respond to a national security emergency or to meet dire operational requirements of the Armed Forces.

(INCLUDING TRANSFER OF FUNDS)

SEC. 8084. The Secretary of Defense may transfer funds from any available Department of the Navy appropriation to any available Navy ship construction appropriation for the purpose of liquidating necessary changes resulting from inflation, market fluctuations, or rate adjustments for any ship construction program appropriated in law: Provided, That the Secretary may transfer not to exceed \$100,000,000 under the authority provided by this section: Provided further, That the Secretary may not

transfer any funds until 30 days after the proposed transfer has been reported to the Committees on Appropriations of the House of Representatives and the Senate, unless a response from the Committees is received sooner: Provided further, That the transfer authority provided by this section is in addition to any other transfer authority contained elsewhere in this Act.

SEC. 8085. For purposes of section 612 of title 41, United States Code, any subdivision of appropriations made under the heading "Shipbuilding and Conversion, Navy" that is not closed at the time reimbursement is made shall be available to reimburse the Judgment Fund and shall be considered for the same purposes as any subdivision under the heading "Shipbuilding and Conversion, Navy" appropriations in the current fiscal year or any prior fiscal year.

SEC. 8086. (a) None of the funds appropriated by this Act may be used to transfer research and development, acquisition, or other program authority relating to current tactical unmanned aerial vehicles (TUVs) from the Army.

(b) The Army shall retain responsibility for and operational control of the MQ-1C Sky Warrior Unmanned Aerial Vehicle (UAV) in order to support the Secretary of Defense in matters relating to the employment of unmanned aerial vehicles.

SEC. 8087. Of the funds provided in this Act, \$10,000,000 shall be available for the operations and development of training and technology for the Joint Interagency Training and Education Center and the affiliated Center for National Response at the Memorial Tunnel and for providing homeland defense/security and traditional warfighting training to the Department of Defense, other Federal agencies, and State and local first responder personnel at the Joint Interagency Training and Education Center.

SEC. 8088. Notwithstanding any other provision of law or regulation, the Secretary of Defense may adjust wage rates for civilian employees hired for certain health care occupations as authorized for the Secretary of Veterans Affairs by section 7455 of title 38, United States Code.

SEC. 8089. Up to \$16,000,000 of the funds appropriated under the heading "Operation and Maintenance, Navy" may be made available for the Asia Pacific Regional Initiative Program for the purpose of enabling the Pacific Command to execute Theater Security Cooperation activities such as humanitarian assistance, and payment of incremental and personnel costs of training and exercising with foreign security forces: Provided, That funds made available for this purpose may be used, notwithstanding any other funding authorities for humanitarian assistance, security assistance or combined exercise expenses: Provided further, That funds may not be obligated to provide assistance to any foreign country that is otherwise prohibited from receiving such type of assistance under any other provision of law.

SEC. 8090. None of the funds appropriated by this Act for programs of the Office of the Director of National Intelligence shall remain available for obligation beyond the current fiscal year, except for funds appropriated for research and technology, which shall remain available until September 30, 2011.

SEC. 8091. Notwithstanding any other provision of this Act, to reflect savings from revised economic assumptions, the total amount appropriated in title II of this Act is hereby reduced by \$194,000,000, the total amount appropriated in title III of this Act is hereby reduced by \$322,000,000, the total amount appropriated in title IV of this Act is hereby reduced by \$336,000,000, and the total amount appropriated in title V of this Act is hereby reduced by \$9,000,000: Provided, That the Secretary of Defense shall allocate this reduction proportion-

ally to each budget activity, activity group, sub-activity group, and each program, project, and activity, within each appropriation account.

SEC. 8092. For purposes of section 1553(b) of title 31, United States Code, any subdivision of appropriations made in this Act under the heading "Shipbuilding and Conversion, Navy" shall be considered to be for the same purpose as any subdivision under the heading "Shipbuilding and Conversion, Navy" appropriations in any prior fiscal year, and the 1 percent limitation shall apply to the total amount of the appropriation.

SEC. 8093. Notwithstanding any other provision of law, that not more than 35 percent of funds provided in this Act for environmental remediation may be obligated under indefinite delivery/indefinite quantity contracts with a total contract value of \$130,000,000 or higher.

SEC. 8094. The Director of National Intelligence shall include the budget exhibits identified in paragraphs (1) and (2) as described in the Department of Defense Financial Management Regulation with the congressional budget justification books.

(1) For procurement programs requesting more than \$20,000,000 in any fiscal year, the P-1, Procurement Program; P-5, Cost Analysis; P-5a, Procurement History and Planning; P-21, Production Schedule; and P-40 Budget Item Justification.

(2) For research, development, test and evaluation projects requesting more than \$10,000,000 in any fiscal year, the R-1, RDT&E Program; R-2, RDT&E Budget Item Justification; R-3, RDT&E Project Cost Analysis; and R-4, RDT&E Program Schedule Profile.

SEC. 8095. None of the funds made available in this Act may be used in contravention of the following laws enacted or regulations promulgated to implement the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (done at New York on December 10, 1984):

(1) Section 2340A of title 18, United States Code.

(2) Section 2242 of the Foreign Affairs Reform and Restructuring Act of 1998 (division G of Public Law 105-277; 112 Stat. 2681-822; 8 U.S.C. 1231 note) and regulations prescribed thereto, including regulations under part 208 of title 8, Code of Federal Regulations, and part 95 of title 22, Code of Federal Regulations.

(3) Sections 1002 and 1003 of the Department of Defense, Emergency Supplemental Appropriations to Address Hurricanes in the Gulf of Mexico, and Pandemic Influenza Act, 2006 (Public Law 109-148).

SEC. 8096. (a) Not later than 60 days after enactment of this Act, the Office of the Director of National Intelligence shall submit a report to the congressional intelligence committees to establish the baseline for application of reprogramming and transfer authorities for fiscal year 2010: Provided, That the report shall include—

(1) a table for each appropriation with a separate column to display the President's budget request, adjustments made by Congress, adjustments due to enacted rescissions, if appropriate, and the fiscal year enacted level;

(2) a delineation in the table for each appropriation by Expenditure Center and project; and

(3) an identification of items of special congressional interest.

(b) None of the funds provided for the National Intelligence Program in this Act shall be available for reprogramming or transfer until the report identified in subsection (a) is submitted to the congressional intelligence committees, unless the Director of National Intelligence certifies in writing to the congressional intelligence committees that such reprogramming or transfer is necessary as an emergency requirement.

SEC. 8097. The Director of National Intelligence shall submit to Congress each year, at or about the time that the President's budget is submitted to Congress that year under section 1105(a) of title 31, United States Code, a future-years intelligence program (including associated annexes) reflecting the estimated expenditures and proposed appropriations included in that budget. Any such future-years intelligence program shall cover the fiscal year with respect to which the budget is submitted and at least the four succeeding fiscal years.

SEC. 8098. For the purposes of this Act, the term "congressional intelligence committees" means the Permanent Select Committee on Intelligence of the House of Representatives, the Select Committee on Intelligence of the Senate, the Subcommittee on Defense of the Committee on Appropriations of the House of Representatives, and the Subcommittee on Defense of the Committee on Appropriations of the Senate.

SEC. 8099. The Department of Defense shall continue to report incremental contingency operations costs for Operation Iraqi Freedom and Operation Enduring Freedom on a monthly basis in the Cost of War Execution Report as prescribed in the Department of Defense Financial Management Regulation Department of Defense Instruction 7000.14, Volume 12, Chapter 23 "Contingency Operations", Annex 1, dated September 2005.

SEC. 8100. The amounts appropriated in title II of this Act are hereby reduced by \$500,000,000 to reflect excess cash balances in Department of Defense Working Capital Funds, as follows:

From "Operation and Maintenance, Air Force", \$500,000,000.

SEC. 8101. During the current fiscal year, not to exceed \$10,000,000 from each of the appropriations made in title III of this Act for "Operation and Maintenance, Army", "Operation and Maintenance, Navy", and "Operation and Maintenance, Air Force" may be transferred by the military department concerned to its central fund established for Fisher Houses and Suites pursuant to section 2493(d) of title 10, United States Code.

SEC. 8102. Of the funds appropriated in the Intelligence Community Management Account for the Program Manager for the Information Sharing Environment, \$24,000,000 is available for transfer by the Director of National Intelligence to other departments and agencies for purposes of Government-wide information sharing activities: Provided, That funds transferred under this provision are to be merged with and available for the same purposes and time period as the appropriation to which transferred: Provided further, That the Office of Management and Budget must approve any transfers made under this provision.

SEC. 8103. Funds appropriated by this Act for operation and maintenance shall be available for the purpose of making remittances to the Defense Acquisition Workforce Development Fund in accordance with the requirements of section 1705 of title 10, United States Code.

SEC. 8104. (a) REPORT ON GROUND-BASED INTERCEPTOR MISSILES.—Not later than 60 days after the date of the enactment of this Act, the Director of the Missile Defense Agency shall submit to the congressional defense committees a report on the utilization of funds to maintain the production line of Ground-Based Interceptor (GBI) missiles. The report shall include a plan for the utilization of funds for Ground-Based Interceptor missiles made available by this Act for the Midcourse Defense Segment, including—

(1) the number of Ground-based Interceptor missiles proposed to be produced during fiscal year 2010; and

(2) any plans for maintaining production of such missiles and the subsystems and components of such missiles.

(b) **REPORT ON GROUND-BASED MIDCOURSE DEFENSE SYSTEM.**—Not later than 120 days after the date of the enactment of this Act, the Director of the Missile Defense Agency shall submit to the congressional defense committees a report setting forth the acquisition strategy for the Ground-Based Midcourse Defense (GMD) system during fiscal years 2011 through 2016. The report shall include a description of the plans of the Missile Defense Agency for each of the following:

(1) To maintain the capability for production of Ground-Based Interceptor missiles.

(2) To address modernization and obsolescence of the Ground-Based Midcourse Defense system.

(3) To conduct a robust test program for the Ground-Based Midcourse Defense system.

SEC. 8105. (a) HIGH PRIORITY NATIONAL GUARD COUNTERDRUG PROGRAMS.—Of the amount appropriated or otherwise made available by title VI under the heading “**DRUG INTERDICTION AND COUNTER-DRUG ACTIVITIES, DEFENSE**”, up to \$30,000,000 shall be available for the purpose of High Priority National Guard Counterdrug Programs.

(b) **SUPPLEMENT NOT SUPPLANT.**—The amount made available by subsection (a) for the purpose specified in that subsection is in addition to any other amounts made available by this Act for that purpose.

APOLOGY TO NATIVE PEOPLES OF THE UNITED STATES

SEC. 8106. (a) ACKNOWLEDGMENT AND APOLOGY.—The United States, acting through Congress—

(1) recognizes the special legal and political relationship Indian tribes have with the United States and the solemn covenant with the land we share;

(2) commends and honors Native Peoples for the thousands of years that they have stewarded and protected this land;

(3) recognizes that there have been years of official depredations, ill-conceived policies, and the breaking of covenants by the Federal Government regarding Indian tribes;

(4) apologizes on behalf of the people of the United States to all Native Peoples for the many instances of violence, maltreatment, and neglect inflicted on Native Peoples by citizens of the United States;

(5) expresses its regret for the ramifications of former wrongs and its commitment to build on the positive relationships of the past and present to move toward a brighter future where all the people of this land live reconciled as brothers and sisters, and harmoniously steward and protect this land together;

(6) urges the President to acknowledge the wrongs of the United States against Indian tribes in the history of the United States in order to bring healing to this land; and

(7) commends the State governments that have begun reconciliation efforts with recognized Indian tribes located in their boundaries and encourages all State governments similarly to work toward reconciling relationships with Indian tribes within their boundaries.

(b) **DISCLAIMER.**—Nothing in this section—

(1) authorizes or supports any claim against the United States; or

(2) serves as a settlement of any claim against the United States.

SEC. 8107. (a) REPORT ON USE OF LIVE PRIMATES IN TRAINING RELATING TO CHEMICAL AND BIOLOGICAL AGENTS.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Defense shall submit to the congressional defense committees a report setting forth a detailed description of the requirements for the use by the Department of Defense of live primates at the United States Army Medical Research Institute of Chemical Defense, and elsewhere, to demonstrate the effects of chemical or

biological agents or chemical (such as physostigmine) or biological agent simulants in training programs.

(b) **ELEMENTS.**—The report required by subsection (a) shall include, at a minimum, the following:

(1) The number of live primates used in the training described in subsection (a).

(2) The average lifespan of primates from the point of introduction into such training programs.

(3) An explanation why the use of primates in such training is more advantageous and realistic than the use of human simulators or other alternatives.

(4) An estimate of the cost of converting from the use of primates to human simulators in such training.

SEC. 8108. (a) FINDINGS.—The Senate makes the following findings:

(1) Real time intelligence, surveillance, and reconnaissance (ISR) is critical to our warfighters in fighting the ongoing wars in Iraq and Afghanistan.

(2) Secretary of Defense Gates and the military leadership of the United States have highlighted the importance of collecting and disseminating critical intelligence and battlefield information to our troops on the ground in Iraq and Afghanistan.

(3) The Chief of Staff of the Air Force, General Norton Schwartz, has stated that the Air Force is “all-in” for the joint fight.

(4) One of the most effective and heavily tasked intelligence, surveillance, and reconnaissance assets operating today is the Air Force’s E-8C Joint Surveillance Target Attack Radar System, also known as Joint STARS.

(5) Commanders in the field rely on Joint STARS to give them a long range view of the battlefield and detect moving targets in all weather conditions as well as tactical support to Brigade Combat Teams, Joint Tactical Air Controllers and Special Operations Forces convoy overwatch.

(6) Joint STARS is a joint platform, flown by a mix of active duty Air Force and Air National Guard personnel and operated by a joint Army, Air Force, and Marine crew, supporting missions for all the Armed Forces.

(7) With a limited number of airframes, Joint STARS has flown over 55,000 combat hours and 900 sorties over Iraq and Afghanistan and directly contributed to the discovery of hundreds of Improvised Explosive Devices.

(8) The current engines greatly limit the performance of Joint STARS aircraft and are the highest cause of maintenance problems and mission aborts.

(9) There is no other current or programmed aircraft or weapon system that can provide the detailed, broad-area ground moving target indicator (GMTI) and airborne battle management support for the warfighter that Joint STARS provides.

(10) With the significant operational savings that new engines will bring to the Joint STARS, re-engining Joint STARS will pay for itself by 2017 due to reduced operations, sustainment, and fuel costs.

(11) In December 2002, a JSTARS re-engining study determined that re-engining provided significant benefits and cost savings. However, delays in executing the re-engining program continue to result in increased costs for the re-engining effort.

(12) The budget request for the Department of Defense for fiscal year 2010 included \$205,000,000 in Aircraft Procurement, Air Force, and \$16,000,000 in Research, Development, Test, and Evaluation, Air Force for Joint STARS re-engining.

(13) On September 22, 2009, the Department of Defense re-affirmed their support for the Presi-

dent’s Budget request for Joint STARS re-engining.

(14) On September 30, 2009, the Undersecretary of Defense (Acquisition, Technology, and Logistics) signed an Acquisition Decision Memorandum directing that the Air Force proceed with the Joint STARS re-engining effort, to include expenditure of procurement and research, development, test, and evaluation funds.

(b) **SENSE OF SENATE.**—It is the sense of the Senate that—

(1) Funds for re-engining of the E-8C Joint Surveillance Target Attack Radar System (Joint STARS) should be appropriated in the correct appropriations accounts and in the amounts required in fiscal year 2010 to execute the Joint STARS Re-Engining System Design and Development Program; and

(2) the Air Force should proceed with currently planned efforts to re-engine Joint STARS aircraft, to include expending both procurement and research, development, test, and evaluation funds.

SEC. 8109. (a) Notwithstanding any other provision of this Act and except as provided in subsection (b), any report required to be submitted by a Federal agency or department to the Committee on Appropriations of either the Senate or the House of Representatives in this Act shall be posted on the public website of that agency upon receipt by the committee.

(b) Subsection (a) shall not apply to a report if—

(1) the public posting of the report compromises national security; or

(2) the report contains proprietary information.

SEC. 8110. (a) The Secretary of Defense shall conduct a study on defense contracting fraud and submit a report containing the findings of such study to the congressional defense committees.

(b) The report required under subsection (a) shall include—

(1) an assessment of the total value of Department of Defense contracts entered into to with contractors that have been indicted for, settled charges of, been fined by any Federal department or agency for, or been convicted of fraud in connection with any contract or other transaction entered into with the Federal Government; and

(2) recommendations by the Inspector General of the Department of Defense or other appropriate Department of Defense official regarding how to penalize contractors repeatedly involved in fraud in connection with contracts or other transactions entered into with the Federal Government.

SEC. 8111. Of the amount appropriated or otherwise made available by title IV under the heading “**RESEARCH, DEVELOPMENT, TEST, AND EVALUATION, ARMY**”, \$12,000,000 shall be available for the peer-reviewed Gulf War Illness Research Program of the Army run by Congressionally Directed Medical Research Programs.

SEC. 8112. (a) It is the sense of Congress that—

(1) All of the National Nuclear Security Administration sites, including the Nevada Test Site can play an effective and essential role in developing and demonstrating—

(A) innovative and effective methods for treaty verification and the detection of nuclear weapons and other materials; and

(B) related threat reduction technologies; and

(2) the Administrator for Nuclear Security should expand the mission of the Nevada Test Site to carry out the role described in paragraph (1), including by—

(A) fully utilizing the inherent capabilities and uniquely secure location of the Site;

(B) continuing to support the Nation’s nuclear weapons program and other national security programs; and

(C) renaming the Site to reflect the expanded mission of the Site.

(b) Not later than one year after the date of the enactment of this Act, the Administrator for Nuclear Security shall submit to the congressional defense committees a plan for improving the infrastructure of the Nevada Test Site of the National Nuclear Security Administration and, if the Administrator deems appropriate, all other sites under the jurisdiction of the National Nuclear Security Administration—

(1) to fulfill the expanded mission of the Site described in subsection (a); and

(2) to make the Site available to support the threat reduction programs of the entire national security community, including threat reduction programs of the National Nuclear Security Administration, the Defense Threat Reduction Agency, the Department of Homeland Security, and other agencies as appropriate.

SEC. 8113. Of the amounts appropriated or otherwise made available by title II under the heading “OPERATION AND MAINTENANCE, DEFENSE-WIDE” and available for the Office of the Secretary of Defense, up to \$250,000 may be available to the Under Secretary of Defense for Policy for the declassification of the nuclear posture review conducted under section 1041 of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (as enacted into law by Public Law 106-398; 114 Stat. 1654A-262) upon the release of the nuclear posture review to succeed such nuclear posture review.

SEC. 8114. Of the amount appropriated or otherwise made available by title II under the heading “OPERATION AND MAINTENANCE, DEFENSE-WIDE”, up to \$15,000,000 may be available for the implementation by the Department of Defense of the responsibilities of the Department under the Military and Overseas Voter Empowerment Act and the amendments made by that Act.

SEC. 8115. None of the funds appropriated or otherwise made available by this Act may be used to dispose of claims filed regarding water contamination at Camp Lejeune, North Carolina, until the Agency for Toxic Substances and Disease Registry (ATSDR) fully completes all current, ongoing epidemiological and water modeling studies pending as of the date of the enactment of this Act.

SEC. 8116. (a) LIMITATION ON AVAILABILITY OF FUNDS FOR EXECUTION OF CONTRACTS UNDER LOGCAP.—No later than 90 days after enactment of this Act none of the funds appropriated or otherwise made available by this Act may be obligated or expended for the execution of a contract under the Logistics Civil Augmentation Program (LOGCAP) unless the Secretary of the Army determines that the contract explicitly requires the contractor—

(1) to inspect and immediately correct deficiencies that present an imminent threat of death or serious bodily injury so as to ensure compliance with generally accepted electrical standards as determined by the Secretary of Defense in work under the contract;

(2) monitor and immediately correct deficiencies in the quality of any potable or non-potable water provided under the contract to ensure that safe and sanitary water is provided; and

(3) establish and enforce strict standards for preventing, and immediately addressing and cooperating with the prosecution of, any instances of sexual assault in all of its operations and the operations of its subcontractors.

(b) WAIVER.—The Secretary of the Army may waive the applicability of the limitation in subsection (a) to any contract if the Secretary certifies in writing to Congress that—

(1) the waiver is necessary for the provision of essential services or critical operating facilities for operational missions; or

(2) the work under such contract does not present an imminent threat of death or serious bodily injury.

SEC. 8117. None of the funds appropriated or otherwise made available by this Act may be used by the Secretary of the Army to transfer by sale, lease, loan, or donation government-owned ammunition production equipment or facilities to a private ammunition manufacturer until 60 days after the Secretary submits a certification to the congressional defense committees that the transfer will not increase the cost of ammunition procurement or negatively impact national security, military readiness, government ammunition production or the United States ammunition production industrial base. The certification shall include the Secretary of the Army's assessment of the following:

(1) A cost-benefit risk analysis for converting government-owned ammunition production equipment or facilities to private ammunition manufacturers, including cost-savings comparisons.

(2) A projection of the impact on the ammunition production industrial base in the United States of converting such equipment or facilities to private ammunition manufacturers.

(3) A projection of the capability to meet current and future ammunition production requirements by both government-owned and private ammunition manufacturers, as well as a combination of the two sources of production assets.

(4) Potential impact on national security and military readiness.

SEC. 8118. (a) None of the funds appropriated or otherwise made available by this Act may be used for any existing or new Federal contract if the contractor or a subcontractor at any tier requires that an employee or independent contractor, as a condition of employment, sign a contract that mandates that the employee or independent contractor performing work under the contract or subcontract resolve through arbitration any claim under title VII of the Civil Rights Act of 1964 or any tort related to or arising out of sexual assault or harassment, including assault and battery, intentional infliction of emotional distress, false imprisonment, or negligent hiring, supervision, or retention.

(b) The prohibition in subsection (a) does not apply with respect to employment contracts that may not be enforced in a court of the United States.

SEC. 8119. (a) LIMITATION ON EARLY RETIREMENT OF TACTICAL AIRCRAFT.—The Secretary of the Air Force may not retire any tactical aircraft as announced in the Combat Air Forces structuring plan announced on May 18, 2009, until the Secretary submits to the congressional defense committees the report described in subsection (b).

(b) REPORT.—The report described in this subsection is a report that sets forth the following:

(1) A detailed plan for how the Secretary of the Air Force will fill the force structure and capability gaps resulting from the retirement of tactical aircraft under the structuring plan described in subsection (a).

(2) A description of the follow-on missions for each base affected by the structuring plan.

(3) An explanation of the criteria used for selecting the bases referred to in paragraph (2) and for the selection of tactical aircraft for retirement under the structuring plan.

(4) A plan for the reassignment of the regular and reserve Air Force personnel affected by the retirement of tactical aircraft under the structuring plan.

(5) An estimate of the cost avoidance to be achieved by the retirement of such tactical aircraft, and a description how such funds would be invested under the period covered by the most current future-years defense program.

SEC. 8120. (a) NATURE OF FULL AND OPEN COMPETITION FOR CONGRESSIONALLY DIRECTED

SPENDING ITEMS.—Each congressionally directed spending item specified in this Act or the report accompanying this Act that is intended for award to a for-profit entity shall be subject to acquisition regulations for full and open competition on the same basis as each spending item intended for a for-profit entity that is contained in the budget request of the President.

(b) EXCEPTIONS.—Subsection (a) shall not apply to any contract awarded—

(1) by a means that is required by Federal statute, including for a purchase made under a mandated preferential program;

(2) pursuant to the Small Business Act (15 U.S.C. 631 et seq.); or

(3) in an amount less than the simplified acquisition threshold described in section 302A(a) of the Federal Property and Administrative Services Act of 1949 (41 U.S.C. 252a(a)).

(c) CONGRESSIONALLY DIRECTED SPENDING ITEM DEFINED.—In this section, the term “congressionally directed spending item” means the following:

(1) A congressionally directed spending item, as defined in Rule XLIV of the Standing Rules of the Senate.

(2) A congressional earmark for purposes of rule XXI of the House of Representatives.

SEC. 8121. (a) FUNDING FOR TWO-STAGE GROUND-BASED INTERCEPTOR MISSILE.—Of the amounts appropriated or otherwise made available by this Act for a long-range missile defense system in Europe, or appropriated or otherwise made available for the Department of Defense for a long-range missile defense system in Europe from the Consolidated Security Disaster Assistance, and Continuing Appropriations Act of 2009 (Public Law 110-329) and available for obligation, no less than \$50,000,000, and up to \$151,000,000 shall be available for research, development, test, and evaluation of the two-stage ground-based interceptor missile.

(b) PROHIBITION ON DIVERSION OF FUNDS.—Funds appropriated or otherwise made available by this Act for the Missile Defense Agency for the purpose of research, development, and testing of the two-stage ground based interceptor missile shall be utilized solely for that purpose, and may not be reprogrammed or otherwise utilized for any other purpose.

(c) REPORT.—Not later than February 1, 2010, the Director of the Missile Defense Agency shall submit to the congressional defense committees a report setting forth the following:

(1) A comprehensive plan for the continued development and testing of the two-stage ground-based interceptor missile, including a description how the Missile Defense Agency will leverage the development and testing of such missile to modernize the Ground-based Midcourse Defense component of the ballistic missile defense system.

(2) Options for deploying an additional Ground-based Midcourse Defense site in Europe or the United States to provide enhanced defense in response to future long-range missile threats from Iran, and a description of how such a site may be made interoperable with the planned missile defense architecture for Europe and the United States.

SEC. 8122. (a) AMOUNT FOR EVALUATIONS OF CERTAIN LASER SYSTEMS.—Of the amount appropriated or otherwise made available by title IV under the heading “RESEARCH, DEVELOPMENT, TEST AND EVALUATION, AIR FORCE” and available for Advanced Weapons Technology (PE# 0603605F), up to \$5,000,000 may be available to carry out the evaluations and analyses required by subsection (b).

(b) EVALUATIONS AND ANALYSES OF CERTAIN LASER SYSTEMS.—The Secretary of Defense shall, in a manner consistent with the October 8, 2008, report of the Air Force Scientific Advisory Board entitled “Airborne Tactical Laser (ATL) Feasibility for Gunship Operations”—

(1) carry out additional enhanced user evaluations of the Advanced Tactical Laser system on a variety of instrumented targets; and

(2) enter into an agreement with a federally funded research and development center under which the center shall—

(A) conduct an analysis of the feasibility of integrating solid state laser systems onto C-130, B-1, and F-35 aircraft platforms to provide close air support; and

(B) estimate the cost per unit of such laser systems and the cost of operating and maintaining each such platform with such laser systems.

TITLE IX

OVERSEAS CONTINGENCY OPERATIONS

MILITARY PERSONNEL

MILITARY PERSONNEL, ARMY

For an additional amount for “Military Personnel, Army”, \$9,597,340,000.

MILITARY PERSONNEL, NAVY

For an additional amount for “Military Personnel, Navy”, \$1,175,601,000.

MILITARY PERSONNEL, MARINE CORPS

For an additional amount for “Military Personnel, Marine Corps”, \$670,722,000.

MILITARY PERSONNEL, AIR FORCE

For an additional amount for “Military Personnel, Air Force”, \$1,445,376,000.

RESERVE PERSONNEL, ARMY

For an additional amount for “Reserve Personnel, Army”, \$293,637,000.

RESERVE PERSONNEL, NAVY

For an additional amount for “Reserve Personnel, Navy”, \$37,040,000.

RESERVE PERSONNEL, MARINE CORPS

For an additional amount for “Reserve Personnel, Marine Corps”, \$31,337,000.

RESERVE PERSONNEL, AIR FORCE

For an additional amount for “Reserve Personnel, Air Force”, \$19,822,000.

NATIONAL GUARD PERSONNEL, ARMY

For an additional amount for “National Guard Personnel, Army”, \$824,966,000.

NATIONAL GUARD PERSONNEL, AIR FORCE

For an additional amount for “National Guard Personnel, Air Force”, \$9,500,000.

OPERATION AND MAINTENANCE

OPERATION AND MAINTENANCE, ARMY

For an additional amount for “Operation and Maintenance, Army”, \$51,928,167,000.

OPERATION AND MAINTENANCE, NAVY

For an additional amount for “Operation and Maintenance, Navy”, \$5,899,597,000.

OPERATION AND MAINTENANCE, MARINE CORPS

For an additional amount for “Operation and Maintenance, Marine Corps”, \$3,775,270,000.

OPERATION AND MAINTENANCE, AIR FORCE

For an additional amount for “Operation and Maintenance, Air Force”, \$9,929,868,000.

OPERATION AND MAINTENANCE, DEFENSE-WIDE

For an additional amount for “Operation and Maintenance, Defense-Wide”, \$7,550,900,000, of which:

(1) Not to exceed \$12,500,000 for the Combatant Commander Initiative Fund, to be used in support of Operation Iraqi Freedom and Operation Enduring Freedom; and

(2) Not to exceed \$1,600,000,000, to remain available until expended, for payments to reimburse key cooperating nations for logistical, military, and other support, including access provided to United States military operations in support of Operation Iraqi Freedom and Operation Enduring Freedom, notwithstanding any other provision of law: Provided, That such reimbursement payments may be made in such

amounts as the Secretary of Defense, with the concurrence of the Secretary of State, and in consultation with the Director of the Office of Management and Budget, may determine, in his discretion, based on documentation determined by the Secretary of Defense to adequately account for the support provided, and such determination is final and conclusive upon the accounting officers of the United States, and 15 days following notification to the appropriate congressional committees: Provided further, That these funds may be used for the purpose of providing specialized training and procuring supplies and specialized equipment and providing such supplies and loaning such equipment on a non-reimbursable basis to coalition forces supporting United States military operations in Iraq and Afghanistan, and 15 days following notification to the appropriate congressional committees: Provided further, That the Secretary of Defense shall provide quarterly reports to the congressional defense committees on the use of funds provided in this paragraph.

OPERATION AND MAINTENANCE, ARMY RESERVE

For an additional amount for “Operation and Maintenance, Army Reserve”, \$234,898,000.

OPERATION AND MAINTENANCE, NAVY RESERVE

For an additional amount for “Operation and Maintenance, Navy Reserve”, \$68,059,000.

OPERATION AND MAINTENANCE, MARINE CORPS RESERVE

For an additional amount for “Operation and Maintenance, Marine Corps Reserve”, \$86,667,000.

OPERATION AND MAINTENANCE, AIR FORCE RESERVE

For an additional amount for “Operation and Maintenance, Air Force Reserve”, \$125,925,000.

OPERATION AND MAINTENANCE, ARMY NATIONAL GUARD

For an additional amount for “Operation and Maintenance, Army National Guard”, \$450,246,000.

OPERATION AND MAINTENANCE, AIR NATIONAL GUARD

For an additional amount for “Operation and Maintenance, Air National Guard”, \$289,862,000.

AFGHANISTAN SECURITY FORCES FUND

For the “Afghanistan Security Forces Fund”, \$6,562,769,000, to remain available until September 30, 2011: Provided, That such funds shall be available to the Secretary of Defense, notwithstanding any other provision of law, for the purpose of allowing the Commander, Combined Security Transition Command—Afghanistan, or the Secretary's designee, to provide assistance, with the concurrence of the Secretary of State, to the security forces of Afghanistan, including the provision of equipment, supplies, services, training, facility and infrastructure repair, renovation, and construction, and funding: Provided further, That the authority to provide assistance under this heading is in addition to any other authority to provide assistance to foreign nations: Provided further, That contributions of funds for the purposes provided herein from any person, foreign government, or international organization may be credited to this Fund and used for such purposes: Provided further, That the Secretary of Defense shall notify the congressional defense committees in writing upon the receipt and upon the obligation of any contribution, delineating the sources and amounts of the funds received and the specific use of such contributions: Provided further, That the Secretary of Defense shall, not fewer than 15 days prior to obligating from this appropriation account, notify the congressional defense committees in writing of the details of any such obligation.

PROCUREMENT

AIRCRAFT PROCUREMENT, ARMY

For an additional amount for “Aircraft Procurement, Army”, \$1,119,319,000, to remain available until September 30, 2012.

MISSILE PROCUREMENT, ARMY

For an additional amount for “Missile Procurement, Army”, \$475,954,000, to remain available until September 30, 2012.

PROCUREMENT OF WEAPONS AND TRACKED

COMBAT VEHICLES, ARMY

For an additional amount for “Procurement of Weapons and Tracked Combat Vehicles, Army”, \$875,866,000, to remain available until September 30, 2012.

PROCUREMENT OF AMMUNITION, ARMY

For an additional amount for “Procurement of Ammunition, Army”, \$365,635,000, to remain available until September 30, 2012.

OTHER PROCUREMENT, ARMY

For an additional amount for “Other Procurement, Army”, \$4,874,176,000, to remain available until September 30, 2012.

AIRCRAFT PROCUREMENT, NAVY

For an additional amount for “Aircraft Procurement, Navy”, \$1,342,577,000, to remain available until September 30, 2012.

WEAPONS PROCUREMENT, NAVY

For an additional amount for “Weapons Procurement, Navy”, \$50,700,000, to remain available until September 30, 2012.

PROCUREMENT OF AMMUNITION, NAVY AND MARINE CORPS

For an additional amount for “Procurement of Ammunition, Navy and Marine Corps”, \$681,957,000, to remain available until September 30, 2012.

OTHER PROCUREMENT, NAVY

For an additional amount for “Other Procurement, Navy”, \$260,118,000, to remain available until September 30, 2012.

PROCUREMENT, MARINE CORPS

For an additional amount for “Procurement, Marine Corps”, \$868,197,000, to remain available until September 30, 2012.

AIRCRAFT PROCUREMENT, AIR FORCE

For an additional amount for “Aircraft Procurement, Air Force”, \$736,501,000, to remain available until September 30, 2012.

MISSILE PROCUREMENT, AIR FORCE

For an additional amount for “Missile Procurement, Air Force”, \$36,625,000, to remain available until September 30, 2012.

PROCUREMENT OF AMMUNITION, AIR FORCE

For an additional amount for “Procurement of Ammunition, Air Force”, \$256,819,000, to remain available until September 30, 2012.

OTHER PROCUREMENT, AIR FORCE

For an additional amount for “Other Procurement, Air Force”, \$3,138,021,000, to remain available until September 30, 2012.

PROCUREMENT, DEFENSE-WIDE

For an additional amount for “Procurement, Defense-Wide”, \$480,780,000, to remain available until September 30, 2012.

MINE RESISTANT AMBUSH PROTECTED VEHICLE FUND

(INCLUDING TRANSFER OF FUNDS)

For the Mine Resistant Ambush Protected Vehicle Fund, \$6,656,000,000, to remain available until September 30, 2011: Provided, That such funds shall be available to the Secretary of Defense, notwithstanding any other provision of law, to procure, sustain, transport, and field Mine Resistant Ambush Protected vehicles: Provided further, That the Secretary shall transfer

such funds only to appropriations for operation and maintenance; procurement; research, development, test and evaluation; and defense working capital funds to accomplish the purpose provided herein: Provided further, That this transfer authority is in addition to any other transfer authority available to the Department of Defense: Provided further, That the Secretary shall, not fewer than 10 days prior to making transfers from this appropriation, notify the congressional defense committees in writing of the details of any such transfer.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, ARMY

For an additional amount for "Research, Development, Test and Evaluation, Army", \$57,962,000, to remain available until September 30, 2011.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, NAVY

For an additional amount for "Research, Development, Test and Evaluation, Navy", \$84,180,000, to remain available until September 30, 2011.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, AIR FORCE

For an additional amount for "Research, Development, Test and Evaluation, Air Force", \$39,286,000, to remain available until September 30, 2011.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, DEFENSE-WIDE

For an additional amount for "Research, Development, Test and Evaluation, Defense-Wide", \$112,196,000, to remain available until September 30, 2011.

REVOLVING AND MANAGEMENT FUNDS

DEFENSE WORKING CAPITAL FUNDS

For an additional amount for "Defense Working Capital Funds", \$412,215,000.

OTHER DEPARTMENT OF DEFENSE PROGRAMS

DEFENSE HEALTH PROGRAM

For an additional amount for "Defense Health Program", \$1,563,675,000, which shall be for operation and maintenance.

DRUG INTERDICTION AND COUNTER-DRUG ACTIVITIES

For an additional amount for "Drug Interdiction and Counter-Drug Activities", \$353,603,000, to remain available until September 30, 2011.

JOINT IMPROVISED EXPLOSIVE DEVICE DEFEAT FUND

(INCLUDING TRANSFER OF FUNDS)

For the "Joint Improvised Explosive Device Defeat Fund", \$2,033,560,000, to remain available until September 30, 2012: Provided, That such funds shall be available to the Secretary of Defense, notwithstanding any other provision of law, for the purpose of allowing the Director of the Joint Improvised Explosive Device Defeat Organization to investigate, develop and provide equipment, supplies, services, training, facilities, personnel and funds to assist United States forces in the defeat of improvised explosive devices: Provided further, That within 60 days of the enactment of this Act, a plan for the intended management and use of the amounts provided under this heading shall be submitted to the congressional defense committees: Provided further, That the Secretary of Defense shall submit a report not later than 60 days after the end of each fiscal quarter to the congressional defense committees providing assessments of the evolving threats, individual service requirements to counter the threats, the current strategy for predeployment training of members

of the Armed Forces on improvised explosive devices, and details on the execution of this Fund: Provided further, That the Secretary of Defense may transfer funds provided herein to appropriations for operation and maintenance; procurement; research, development, test and evaluation; and defense working capital funds to accomplish the purpose provided herein: Provided further, That amounts transferred shall be merged with and available for the same purposes and time period as the appropriations to which transferred: Provided further, That this transfer authority is in addition to any other transfer authority available to the Department of Defense: Provided further, That the Secretary of Defense shall, not fewer than 15 days prior to making transfers from this appropriation, notify the congressional defense committees in writing of the details of any such transfer.

OFFICE OF THE INSPECTOR GENERAL

For an additional amount for the "Office of the Inspector General", \$8,876,000.

GENERAL PROVISIONS—THIS TITLE

SEC. 9001. Notwithstanding any other provision of law, funds made available in this title are in addition to amounts appropriated or otherwise made available for the Department of Defense for fiscal year 2010.

(INCLUDING TRANSFER OF FUNDS)

SEC. 9002. Upon the determination of the Secretary of Defense that such action is necessary in the national interest, the Secretary may, with the approval of the Office of Management and Budget, transfer up to \$4,000,000,000 between the appropriations or funds made available to the Department of Defense in this title: Provided, That the Secretary shall notify the Congress promptly of each transfer made pursuant to the authority in this section: Provided further, That the authority provided in this section is in addition to any other transfer authority available to the Department of Defense and is subject to the same terms and conditions as the authority provided in the Department of Defense Appropriations Act, 2010: Provided further, That the amount in this section is designated as being for overseas deployments and other activities pursuant to sections 401(c)(4) and 423(a)(1) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010.

SEC. 9003. Supervision and administration costs associated with a construction project funded with appropriations available for operation and maintenance or the "Afghanistan Security Forces Fund" provided in this Act and executed in direct support of overseas contingency operations in Afghanistan, may be obligated at the time a construction contract is awarded: Provided, That for the purpose of this section, supervision and administration costs include all in-house Government costs.

SEC. 9004. From funds made available in this title, the Secretary of Defense may purchase for use by military and civilian employees of the Department of Defense in Iraq and Afghanistan: (a) passenger motor vehicles up to a limit of \$75,000 per vehicle and (b) heavy and light armored vehicles for the physical security of personnel or for force protection purposes up to a limit of \$250,000 per vehicle, notwithstanding price or other limitations applicable to the purchase of passenger carrying vehicles.

SEC. 9005. Not to exceed \$1,200,000,000 of the amount appropriated in this title under the heading "Operation and Maintenance, Army" may be used, notwithstanding any other provision of law, to fund the Commander's Emergency Response Program, for the purpose of enabling military commanders in Iraq and Afghanistan to respond to urgent humanitarian relief and reconstruction requirements within their areas of responsibility: Provided, That not later than 15 days after the end of each fiscal

year quarter, the Secretary of Defense shall submit to the congressional defense committees a report regarding the source of funds and the allocation and use of funds during that quarter that were made available pursuant to the authority provided in this section or under any other provision of law for the purposes described herein.

SEC. 9006. Funds available to the Department of Defense for operation and maintenance may be used, notwithstanding any other provision of law, to provide supplies, services, transportation, including airlift and sealift, and other logistical support to coalition forces supporting military and stability operations in Iraq and Afghanistan: Provided, That the Secretary of Defense shall provide quarterly reports to the congressional defense committees regarding support provided under this section.

SEC. 9007. Each amount in this title is designated as being for overseas deployments and other activities pursuant to section 401(c)(4) and 423(a)(1) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010.

SEC. 9008. None of the funds appropriated or otherwise made available by this or any other Act shall be obligated or expended by the United States Government for a purpose as follows:

(1) To establish any military installation or base for the purpose of providing for the permanent stationing of United States Armed Forces in Iraq.

(2) To exercise United States control over any oil resource of Iraq.

(3) To establish any military installation or base for the purpose of providing for the permanent stationing of United States Armed Forces in Afghanistan.

SEC. 9009. (a) The Director of the Office of Management and Budget, in consultation with the Secretary of Defense; the Commander of the United States Central Command; the Commander, Multi-National Security Transition Command—Iraq; and the Commander, Combined Security Transition Command—Afghanistan, shall submit to the congressional defense committees not later than 45 days after the end of each fiscal quarter a report on the proposed use of all funds appropriated by this or any prior Act under each of the headings "Iraq Security Forces Fund", "Afghanistan Security Forces Fund", and "Pakistan Counterinsurgency Fund" on a project-by-project basis, for which the obligation of funds is anticipated during the 3-month period from such date, including estimates by the commanders referred to in this section of the costs required to complete each such project.

(b) The report required by this subsection shall include the following:

(1) The use of all funds on a project-by-project basis for which funds appropriated under the headings referred to in subsection (a) were obligated prior to the submission of the report, including estimates by the commanders referred to in subsection (a) of the costs to complete each project.

(2) The use of all funds on a project-by-project basis for which funds were appropriated under the headings referred to in subsection (a) in prior appropriations Acts, or for which funds were made available by transfer, reprogramming, or allocation from other headings in prior appropriations Acts, including estimates by the commanders referred to in subsection (a) of the costs to complete each project.

(3) An estimated total cost to train and equip the Iraq, Afghanistan, and Pakistan security forces, disaggregated by major program and subelements by force, arrayed by fiscal year.

(c) The Secretary of Defense shall notify the congressional defense committees of any proposed new projects or transfers of funds between

sub-activity groups in excess of \$20,000,000 using funds appropriated by this or any prior Act under the headings "Iraq Security Forces Fund", "Afghanistan Security Forces Fund", and "Pakistan Counterinsurgency Fund".

SEC. 9010. (a) None of the funds appropriated or otherwise made available by this Act or any prior Act may be used to transfer, release, or incarcerate any individual who was detained as of October 1, 2009, at Naval Station, Guantanamo Bay, Cuba, to or within the United States or its territories.

(b) In this section, the term "United States" means the several States and the District of Columbia.

SEC. 9011. In addition to amounts made available elsewhere in this title there is hereby appropriated \$329,000,000 for the purchase of fuel to the following accounts in the specified amounts:

"Operation and Maintenance, Army", \$83,552,000;

"Operation and Maintenance, Navy", \$33,889,000;

"Operation and Maintenance, Marine Corps", \$1,619,000;

"Operation and Maintenance, Air Force", \$179,191,000;

"Operation and Maintenance, Army Reserve", \$8,567,000;

"Operation and Maintenance, Navy Reserve", \$3,007,000;

"Operation and Maintenance, Marine Corps Reserve", \$39,000; and

"Operation and Maintenance, Army National Guard", \$19,136,000.

SEC. 9012. None of the funds made available under this Act may be distributed to the Association of Community Organizations for Reform Now (ACORN) or its subsidiaries.

SEC. 9013. The Secretary of Defense may, in consultation with the Secretary of State and the Administrator of the United States Agency for International Development, continue to support requirements for monthly integrated civilian-military training for civilians deploying to Afghanistan at Camp Atterbury, Indiana, including through the allocation of military and civilian personnel, trainers, and other resources for that purpose.

SEC. 9014. (a) **HEARINGS ON STRATEGY AND RESOURCES WITH RESPECT TO AFGHANISTAN AND PAKISTAN.**—Appropriate committees of Congress shall hold hearings, in open and closed session, relating to the strategy and resources of the United States with respect to Afghanistan and Pakistan promptly after the decision by the President on those matters is announced.

(b) **TESTIMONY.**—The hearings described in subsection (a) should include testimony from senior civilian and military officials of the United States, including, but not limited to, the following:

- (1) The Secretary of Defense.
- (2) The Secretary of State
- (3) The Chairman of the Joint Chiefs of Staff.
- (4) The Commander of the United States Central Command.
- (5) The Commander of the United States European Command and Supreme Allied Commander, Europe.
- (6) The Commander of United States Forces-Afghanistan.
- (7) The United States Ambassador to Afghanistan.
- (8) The United States Ambassador to Pakistan.

SEC. 9015. (a) **FUNDING FOR OUTREACH AND REINTEGRATION SERVICES UNDER YELLOW RIBBON REINTEGRATION PROGRAM.**—Of the amounts appropriated or otherwise made available by title IX. \$20,000,000 shall be available for outreach and reintegration services under the Yellow Ribbon Reintegration Program under section 582(h) of the National Defense Authoriza-

tion Act for Fiscal Year 2008 (Public Law 110-181; 122 Stat. 125; 10 U.S.C. 10101 note).

(b) **SUPPLEMENT NOT SUPPLANT.**—The amount made available by subsection (a) for the services described in that subsection is in addition to any other amounts available in this Act for such services.

This Act may be cited as the "Department of Defense Appropriations Act, 2010".

MOTION OFFERED BY MR. MURTHA

Mr. MURTHA. Madam Speaker, I offer the motion at the desk.

The SPEAKER pro tempore. The Clerk will designate the motion.

The text of the motion is as follows:

Mr. Murtha moves that the House concur in the amendment of the Senate with the amendment printed in House Report 111-380.

The SPEAKER pro tempore. The House amendment to the Senate amendment to the bill H.R. 3326 contains an emergency designation for the purposes of pay-as-you-go principles.

Accordingly, the Chair must put the question of consideration under clause 10(c)(3) of rule XXI.

The question is, Will the House now consider the motion to concur in the Senate amendment with an amendment?

The question of consideration was decided in the affirmative.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore. Pursuant to House Resolution 976, the amendment printed in part A of House Report 111-380 and the motion shall be considered as read.

The text of the amendment is as follows:

House amendment to Senate amendment:

In lieu of the matter proposed to be inserted by the amendment of the Senate, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Department of Defense Appropriations Act, 2010".

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

Sec. 1. Short title.

Sec. 2. Table of contents.

Sec. 3. References.

DIVISION A—DEPARTMENT OF DEFENSE APPROPRIATIONS

Title I—Military Personnel

Title II—Operation and Maintenance

Title III—Procurement

Title IV—Research, Development, Test and Evaluation

Title V—Revolving and Management Funds

Title VI—Other Department of Defense Programs

Title VII—Related Agencies

Title VIII—General Provisions

Title IX—Overseas Contingency Operations

DIVISION B—OTHER MATTERS

SEC. 3. REFERENCES.

Except as expressly provided otherwise, any reference to "this Act" contained in any division of this Act shall be treated as referring only to the provisions of that division.

DIVISION A—DEPARTMENT OF DEFENSE APPROPRIATIONS

The following sums are appropriated, out of any money in the Treasury not otherwise

appropriated, for the fiscal year ending September 30, 2010, for military functions administered by the Department of Defense and for other purposes, namely:

TITLE I

MILITARY PERSONNEL

MILITARY PERSONNEL, ARMY

For pay, allowances, individual clothing, subsistence, interest on deposits, gratuities, permanent change of station travel (including all expenses thereof for organizational movements), and expenses of temporary duty travel between permanent duty stations, for members of the Army on active duty, (except members of reserve components provided for elsewhere), cadets, and aviation cadets; for members of the Reserve Officers' Training Corps; and for payments pursuant to section 156 of Public Law 97-377, as amended (42 U.S.C. 402 note), and to the Department of Defense Military Retirement Fund, \$41,005,612,000.

MILITARY PERSONNEL, NAVY

For pay, allowances, individual clothing, subsistence, interest on deposits, gratuities, permanent change of station travel (including all expenses thereof for organizational movements), and expenses of temporary duty travel between permanent duty stations, for members of the Navy on active duty (except members of the Reserve provided for elsewhere), midshipmen, and aviation cadets; for members of the Reserve Officers' Training Corps; and for payments pursuant to section 156 of Public Law 97-377, as amended (42 U.S.C. 402 note), and to the Department of Defense Military Retirement Fund, \$25,289,049,000.

MILITARY PERSONNEL, MARINE CORPS

For pay, allowances, individual clothing, subsistence, interest on deposits, gratuities, permanent change of station travel (including all expenses thereof for organizational movements), and expenses of temporary duty travel between permanent duty stations, for members of the Marine Corps on active duty (except members of the Reserve provided for elsewhere); and for payments pursuant to section 156 of Public Law 97-377, as amended (42 U.S.C. 402 note), and to the Department of Defense Military Retirement Fund, \$12,799,990,000.

MILITARY PERSONNEL, AIR FORCE

For pay, allowances, individual clothing, subsistence, interest on deposits, gratuities, permanent change of station travel (including all expenses thereof for organizational movements), and expenses of temporary duty travel between permanent duty stations, for members of the Air Force on active duty (except members of reserve components provided for elsewhere), cadets, and aviation cadets; for members of the Reserve Officers' Training Corps; and for payments pursuant to section 156 of Public Law 97-377, as amended (42 U.S.C. 402 note), and to the Department of Defense Military Retirement Fund, \$26,174,136,000.

RESERVE PERSONNEL, ARMY

For pay, allowances, clothing, subsistence, gratuities, travel, and related expenses for personnel of the Army Reserve on active duty under sections 10211, 10302, and 3038 of title 10, United States Code, or while serving on active duty under section 12301(d) of title 10, United States Code, in connection with performing duty specified in section 12310(a) of title 10, United States Code, or while undergoing reserve training, or while performing drills or equivalent duty or other duty, and expenses authorized by section

16131 of title 10, United States Code; and for payments to the Department of Defense Military Retirement Fund, \$4,304,713,000.

RESERVE PERSONNEL, NAVY

For pay, allowances, clothing, subsistence, gratuities, travel, and related expenses for personnel of the Navy Reserve on active duty under section 10211 of title 10, United States Code, or while serving on active duty under section 12301(d) of title 10, United States Code, in connection with performing duty specified in section 12310(a) of title 10, United States Code, or while undergoing reserve training, or while performing drills or equivalent duty, and expenses authorized by section 16131 of title 10, United States Code; and for payments to the Department of Defense Military Retirement Fund, \$1,909,301,000.

RESERVE PERSONNEL, MARINE CORPS

For pay, allowances, clothing, subsistence, gratuities, travel, and related expenses for personnel of the Marine Corps Reserve on active duty under section 10211 of title 10, United States Code, or while serving on active duty under section 12301(d) of title 10, United States Code, in connection with performing duty specified in section 12310(a) of title 10, United States Code, or while undergoing reserve training, or while performing drills or equivalent duty, and for members of the Marine Corps platoon leaders class, and expenses authorized by section 16131 of title 10, United States Code; and for payments to the Department of Defense Military Retirement Fund, \$613,500,000.

RESERVE PERSONNEL, AIR FORCE

For pay, allowances, clothing, subsistence, gratuities, travel, and related expenses for personnel of the Air Force Reserve on active duty under sections 10211, 10305, and 8038 of title 10, United States Code, or while serving on active duty under section 12301(d) of title 10, United States Code, in connection with performing duty specified in section 12310(a) of title 10, United States Code, or while undergoing reserve training, or while performing drills or equivalent duty or other duty, and expenses authorized by section 16131 of title 10, United States Code; and for payments to the Department of Defense Military Retirement Fund, \$1,589,412,000.

NATIONAL GUARD PERSONNEL, ARMY

For pay, allowances, clothing, subsistence, gratuities, travel, and related expenses for personnel of the Army National Guard while on duty under section 10211, 10302, or 12402 of title 10 or section 708 of title 32, United States Code, or while serving on duty under section 12301(d) of title 10 or section 502(f) of title 32, United States Code, in connection with performing duty specified in section 12310(a) of title 10, United States Code, or while undergoing training, or while performing drills or equivalent duty or other duty, and expenses authorized by section 16131 of title 10, United States Code; and for payments to the Department of Defense Military Retirement Fund, \$7,546,905,000.

NATIONAL GUARD PERSONNEL, AIR FORCE

For pay, allowances, clothing, subsistence, gratuities, travel, and related expenses for personnel of the Air National Guard on duty under section 10211, 10305, or 12402 of title 10 or section 708 of title 32, United States Code, or while serving on duty under section 12301(d) of title 10 or section 502(f) of title 32, United States Code, in connection with performing duty specified in section 12310(a) of title 10, United States Code, or while undergoing training, or while performing drills or equivalent duty or other duty, and expenses authorized by section 16131 of title 10, United

States Code; and for payments to the Department of Defense Military Retirement Fund, \$2,938,229,000.

TITLE II

OPERATION AND MAINTENANCE

OPERATION AND MAINTENANCE, ARMY

For expenses, not otherwise provided for, necessary for the operation and maintenance of the Army, as authorized by law; and not to exceed \$12,478,000 can be used for emergencies and extraordinary expenses, to be expended on the approval or authority of the Secretary of the Army, and payments may be made on his certificate of necessity for confidential military purposes, \$30,934,550,000.

OPERATION AND MAINTENANCE, NAVY

For expenses, not otherwise provided for, necessary for the operation and maintenance of the Navy and the Marine Corps, as authorized by law; and not to exceed \$14,657,000 can be used for emergencies and extraordinary expenses, to be expended on the approval or authority of the Secretary of the Navy, and payments may be made on his certificate of necessity for confidential military purposes, \$34,714,396,000.

OPERATION AND MAINTENANCE, MARINE CORPS

For expenses, not otherwise provided for, necessary for the operation and maintenance of the Marine Corps, as authorized by law, \$5,539,117,000.

OPERATION AND MAINTENANCE, AIR FORCE

For expenses, not otherwise provided for, necessary for the operation and maintenance of the Air Force, as authorized by law; and not to exceed \$7,699,000 can be used for emergencies and extraordinary expenses, to be expended on the approval or authority of the Secretary of the Air Force, and payments may be made on his certificate of necessity for confidential military purposes, \$33,477,116,000.

OPERATION AND MAINTENANCE, DEFENSE-WIDE (INCLUDING TRANSFER OF FUNDS)

For expenses, not otherwise provided for, necessary for the operation and maintenance of activities and agencies of the Department of Defense (other than the military departments), as authorized by law, \$28,115,793,000: *Provided*, That not more than \$50,000,000 may be used for the Combatant Commander Initiative Fund authorized under section 166a of title 10, United States Code: *Provided further*, That not to exceed \$36,000,000 can be used for emergencies and extraordinary expenses, to be expended on the approval or authority of the Secretary of Defense, and payments may be made on his certificate of necessity for confidential military purposes: *Provided further*, That of the funds provided under this heading, not less than \$29,732,000 shall be made available for the Procurement Technical Assistance Cooperative Agreement Program, of which not less than \$3,600,000 shall be available for centers defined in 10 U.S.C. 2411(1)(D): *Provided further*, That none of the funds appropriated or otherwise made available by this Act may be used to plan or implement the consolidation of a budget or appropriations liaison office of the Office of the Secretary of Defense, the office of the Secretary of a military department, or the service headquarters of one of the Armed Forces into a legislative affairs or legislative liaison office: *Provided further*, That \$6,667,000, to remain available until expended, is available only for expenses relating to certain classified activities, and may be transferred as necessary by the Secretary to operation and maintenance appropriations

or research, development, test and evaluation appropriations, to be merged with and to be available for the same time period as the appropriations to which transferred: *Provided further*, That any ceiling on the investment item unit cost of items that may be purchased with operation and maintenance funds shall not apply to the funds described in the preceding proviso: *Provided further*, That the transfer authority provided under this heading is in addition to any other transfer authority provided elsewhere in this Act.

OPERATION AND MAINTENANCE, ARMY RESERVE

For expenses, not otherwise provided for, necessary for the operation and maintenance, including training, organization, and administration, of the Army Reserve; repair of facilities and equipment; hire of passenger motor vehicles; travel and transportation; care of the dead; recruiting; procurement of services, supplies, and equipment; and communications, \$2,617,496,000.

OPERATION AND MAINTENANCE, NAVY RESERVE

For expenses, not otherwise provided for, necessary for the operation and maintenance, including training, organization, and administration, of the Navy Reserve; repair of facilities and equipment; hire of passenger motor vehicles; travel and transportation; care of the dead; recruiting; procurement of services, supplies, and equipment; and communications, \$1,273,701,000.

OPERATION AND MAINTENANCE, MARINE CORPS RESERVE

For expenses, not otherwise provided for, necessary for the operation and maintenance, including training, organization, and administration, of the Marine Corps Reserve; repair of facilities and equipment; hire of passenger motor vehicles; travel and transportation; care of the dead; recruiting; procurement of services, supplies, and equipment; and communications, \$223,175,000.

OPERATION AND MAINTENANCE, AIR FORCE RESERVE

For expenses, not otherwise provided for, necessary for the operation and maintenance, including training, organization, and administration, of the Air Force Reserve; repair of facilities and equipment; hire of passenger motor vehicles; travel and transportation; care of the dead; recruiting; procurement of services, supplies, and equipment; and communications, \$3,131,200,000.

OPERATION AND MAINTENANCE, ARMY NATIONAL GUARD

For expenses of training, organizing, and administering the Army National Guard, including medical and hospital treatment and related expenses in non-Federal hospitals; maintenance, operation, and repairs to structures and facilities; hire of passenger motor vehicles; personnel services in the National Guard Bureau; travel expenses (other than mileage), as authorized by law for Army personnel on active duty, for Army National Guard division, regimental, and battalion commanders while inspecting units in compliance with National Guard Bureau regulations when specifically authorized by the Chief, National Guard Bureau; supplying and equipping the Army National Guard as authorized by law; and expenses of repair, modification, maintenance, and issue of supplies and equipment (including aircraft), \$6,189,713,000.

OPERATION AND MAINTENANCE, AIR NATIONAL GUARD

For expenses of training, organizing, and administering the Air National Guard, including medical and hospital treatment and

related expenses in non-Federal hospitals; maintenance, operation, and repairs to structures and facilities; transportation of things, hire of passenger motor vehicles; supplying and equipping the Air National Guard, as authorized by law; expenses for repair, modification, maintenance, and issue of supplies and equipment, including those furnished from stocks under the control of agencies of the Department of Defense; travel expenses (other than mileage) on the same basis as authorized by law for Air National Guard personnel on active Federal duty, for Air National Guard commanders while inspecting units in compliance with National Guard Bureau regulations when specifically authorized by the Chief, National Guard Bureau, \$5,882,251,000.

UNITED STATES COURT OF APPEALS FOR THE ARMED FORCES

For salaries and expenses necessary for the United States Court of Appeals for the Armed Forces, \$13,932,000, of which not to exceed \$5,000 may be used for official representation purposes.

ENVIRONMENTAL RESTORATION, ARMY
(INCLUDING TRANSFER OF FUNDS)

For the Department of the Army, \$423,364,000, to remain available until transferred: *Provided*, That the Secretary of the Army shall, upon determining that such funds are required for environmental restoration, reduction and recycling of hazardous waste, removal of unsafe buildings and debris of the Department of the Army, or for similar purposes, transfer the funds made available by this appropriation to other appropriations made available to the Department of the Army, to be merged with and to be available for the same purposes and for the same time period as the appropriations to which transferred: *Provided further*, That upon a determination that all or part of the funds transferred from this appropriation are not necessary for the purposes provided herein, such amounts may be transferred back to this appropriation: *Provided further*, That the transfer authority provided under this heading is in addition to any other transfer authority provided elsewhere in this Act.

ENVIRONMENTAL RESTORATION, NAVY
(INCLUDING TRANSFER OF FUNDS)

For the Department of the Navy, \$285,869,000, to remain available until transferred: *Provided*, That the Secretary of the Navy shall, upon determining that such funds are required for environmental restoration, reduction and recycling of hazardous waste, removal of unsafe buildings and debris of the Department of the Navy, or for similar purposes, transfer the funds made available by this appropriation to other appropriations made available to the Department of the Navy, to be merged with and to be available for the same purposes and for the same time period as the appropriations to which transferred: *Provided further*, That upon a determination that all or part of the funds transferred from this appropriation are not necessary for the purposes provided herein, such amounts may be transferred back to this appropriation: *Provided further*, That the transfer authority provided under this heading is in addition to any other transfer authority provided elsewhere in this Act.

ENVIRONMENTAL RESTORATION, AIR FORCE
(INCLUDING TRANSFER OF FUNDS)

For the Department of the Air Force, \$494,276,000, to remain available until transferred: *Provided*, That the Secretary of the Air Force shall, upon determining that such

funds are required for environmental restoration, reduction and recycling of hazardous waste, removal of unsafe buildings and debris of the Department of the Air Force, or for similar purposes, transfer the funds made available by this appropriation to other appropriations made available to the Department of the Air Force, to be merged with and to be available for the same purposes and for the same time period as the appropriations to which transferred: *Provided further*, That upon a determination that all or part of the funds transferred from this appropriation are not necessary for the purposes provided herein, such amounts may be transferred back to this appropriation: *Provided further*, That the transfer authority provided under this heading is in addition to any other transfer authority provided elsewhere in this Act.

ENVIRONMENTAL RESTORATION, DEFENSE-WIDE
(INCLUDING TRANSFER OF FUNDS)

For the Department of Defense, \$11,100,000, to remain available until transferred: *Provided*, That the Secretary of Defense shall, upon determining that such funds are required for environmental restoration, reduction and recycling of hazardous waste, removal of unsafe buildings and debris of the Department of Defense, or for similar purposes, transfer the funds made available by this appropriation to other appropriations made available to the Department of Defense, to be merged with and to be available for the same purposes and for the same time period as the appropriations to which transferred: *Provided further*, That upon a determination that all or part of the funds transferred from this appropriation are not necessary for the purposes provided herein, such amounts may be transferred back to this appropriation: *Provided further*, That the transfer authority provided under this heading is in addition to any other transfer authority provided elsewhere in this Act.

ENVIRONMENTAL RESTORATION, FORMERLY USED DEFENSE SITES
(INCLUDING TRANSFER OF FUNDS)

For the Department of the Army, \$292,700,000, to remain available until transferred: *Provided*, That the Secretary of the Army shall, upon determining that such funds are required for environmental restoration, reduction and recycling of hazardous waste, removal of unsafe buildings and debris at sites formerly used by the Department of Defense, transfer the funds made available by this appropriation to other appropriations made available to the Department of the Army, to be merged with and to be available for the same purposes and for the same time period as the appropriations to which transferred: *Provided further*, That upon a determination that all or part of the funds transferred from this appropriation are not necessary for the purposes provided herein, such amounts may be transferred back to this appropriation: *Provided further*, That the transfer authority provided under this heading is in addition to any other transfer authority provided elsewhere in this Act.

OVERSEAS HUMANITARIAN, DISASTER, AND CIVIC AID

For expenses relating to the Overseas Humanitarian, Disaster, and Civic Aid programs of the Department of Defense (consisting of the programs provided under sections 401, 402, 404, 407, 2557, and 2561 of title 10, United States Code), \$109,869,000, to remain available until September 30, 2011.

COOPERATIVE THREAT REDUCTION ACCOUNT

For assistance to the republics of the former Soviet Union and, with appropriate

authorization by the Department of Defense and Department of State, to countries outside of the former Soviet Union, including assistance provided by contract or by grants, for facilitating the elimination and the safe and secure transportation and storage of nuclear, chemical and other weapons; for establishing programs to prevent the proliferation of weapons, weapons components, and weapon-related technology and expertise; for programs relating to the training and support of defense and military personnel for demilitarization and protection of weapons, weapons components and weapons technology and expertise, and for defense and military contacts, \$424,093,000, to remain available until September 30, 2012: *Provided*, That of the amounts provided under this heading, not less than \$15,000,000 shall be available only to support the dismantling and disposal of nuclear submarines, submarine reactor components, and security enhancements for transport and storage of nuclear warheads in the Russian Far East and North.

DEPARTMENT OF DEFENSE ACQUISITION
WORKFORCE DEVELOPMENT FUND

For the Department of Defense Acquisition Workforce Development Fund, \$100,000,000.

TITLE III
PROCUREMENT

AIRCRAFT PROCUREMENT, ARMY

For construction, procurement, production, modification, and modernization of aircraft, equipment, including ordnance, ground handling equipment, spare parts, and accessories therefor; specialized equipment and training devices; expansion of public and private plants, including the land necessary therefor, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway; and other expenses necessary for the foregoing purposes, \$5,093,822,000, to remain available for obligation until September 30, 2012.

MISSILE PROCUREMENT, ARMY

For construction, procurement, production, modification, and modernization of missiles, equipment, including ordnance, ground handling equipment, spare parts, and accessories therefor; specialized equipment and training devices; expansion of public and private plants, including the land necessary therefor, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway; and other expenses necessary for the foregoing purposes, \$1,251,053,000, to remain available for obligation until September 30, 2012.

PROCUREMENT OF WEAPONS AND TRACKED COMBAT VEHICLES, ARMY

For construction, procurement, production, and modification of weapons and tracked combat vehicles, equipment, including ordnance, spare parts, and accessories therefor; specialized equipment and training devices; expansion of public and private plants, including the land necessary therefor, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-

owned equipment layaway; and other expenses necessary for the foregoing purposes, \$2,335,807,000, to remain available for obligation until September 30, 2012.

PROCUREMENT OF AMMUNITION, ARMY

For construction, procurement, production, and modification of ammunition, and accessories therefor; specialized equipment and training devices; expansion of public and private plants, including ammunition facilities, authorized by section 2854 of title 10, United States Code, and the land necessary therefor, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway; and other expenses necessary for the foregoing purposes, \$2,056,115,000, to remain available for obligation until September 30, 2012.

OTHER PROCUREMENT, ARMY

For construction, procurement, production, and modification of vehicles, including tactical, support, and non-tracked combat vehicles; the purchase of passenger motor vehicles for replacement only; and the purchase of eight vehicles required for physical security of personnel, notwithstanding price limitations applicable to passenger vehicles but not to exceed \$250,000 per vehicle; communications and electronic equipment; other support equipment; spare parts, ordnance, and accessories therefor; specialized equipment and training devices; expansion of public and private plants, including the land necessary therefor, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway; and other expenses necessary for the foregoing purposes, \$8,582,660,000, to remain available for obligation until September 30, 2012.

AIRCRAFT PROCUREMENT, NAVY

For construction, procurement, production, modification, and modernization of aircraft, equipment, including ordnance, spare parts, and accessories therefor; specialized equipment; expansion of public and private plants, including the land necessary therefor, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway, \$18,643,221,000, to remain available for obligation until September 30, 2012.

WEAPONS PROCUREMENT, NAVY

For construction, procurement, production, modification, and modernization of missiles, torpedoes, other weapons, and related support equipment including spare parts, and accessories therefor; expansion of public and private plants, including the land necessary therefor, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway, \$3,357,572,000, to remain available for obligation until September 30, 2012.

PROCUREMENT OF AMMUNITION, NAVY AND MARINE CORPS

For construction, procurement, production, and modification of ammunition, and accessories therefor; specialized equipment and training devices; expansion of public and private plants, including ammunition facilities, authorized by section 2854 of title 10, United States Code, and the land necessary therefor, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway; and other expenses necessary for the foregoing purposes, \$800,651,000, to remain available for obligation until September 30, 2012.

SHIPBUILDING AND CONVERSION, NAVY

For expenses necessary for the construction, acquisition, or conversion of vessels as authorized by law, including armor and armament thereof, plant equipment, appliances, and machine tools and installation thereof in public and private plants; reserve plant and Government and contractor-owned equipment layaway; procurement of critical, long lead time components and designs for vessels to be constructed or converted in the future; and expansion of public and private plants, including land necessary therefor, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title, as follows:

Carrier Replacement Program, \$739,269,000;
Carrier Replacement Program (AP), \$484,432,000;
NSSN, \$1,964,317,000;
NSSN (AP), \$1,959,725,000;
CVN Refueling, \$1,563,602,000;
CVN Refuelings (AP), \$211,820,000;
DDG-1000 Program, \$1,382,797,000;
DDG-51 Destroyer, \$1,912,267,000;
DDG-51 Destroyer (AP), \$578,996,000;
Littoral Combat Ship, \$1,080,000,000;
LPD-17, \$872,392,000;
LPD-17 (AP), \$184,555,000;
LHA-R (AP), \$170,000,000;
Intratheater Connector, \$177,956,000;
LCAC Service Life Extension Program, \$63,857,000;

Prior year shipbuilding costs, \$144,950,000;
Service Craft, \$3,694,000; and

For outfitting, post delivery, conversions, and first destination transportation, \$386,903,000.

In all: \$13,881,532,000, to remain available for obligation until September 30, 2014: *Provided*, That additional obligations may be incurred after September 30, 2014, for engineering services, tests, evaluations, and other such budgeted work that must be performed in the final stage of ship construction: *Provided further*, That none of the funds provided under this heading for the construction or conversion of any naval vessel to be constructed in shipyards in the United States shall be expended in foreign facilities for the construction of major components of such vessel: *Provided further*, That none of the funds provided under this heading shall be used for the construction of any naval vessel in foreign shipyards.

OTHER PROCUREMENT, NAVY

For procurement, production, and modernization of support equipment and materials not otherwise provided for, Navy ordnance (except ordnance for new aircraft, new ships, and ships authorized for conversion); the purchase of passenger motor vehicles for replacement only, and the purchase of seven

vehicles required for physical security of personnel, notwithstanding price limitations applicable to passenger vehicles but not to exceed \$250,000 per vehicle; expansion of public and private plants, including the land necessary therefor, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway, \$5,441,234,000, to remain available for obligation until September 30, 2012.

PROCUREMENT, MARINE CORPS

For expenses necessary for the procurement, manufacture, and modification of missiles, armament, military equipment, spare parts, and accessories therefor; plant equipment, appliances, and machine tools, and installation thereof in public and private plants; reserve plant and Government and contractor-owned equipment layaway; vehicles for the Marine Corps, including the purchase of passenger motor vehicles for replacement only; and expansion of public and private plants, including land necessary therefor, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title, \$1,521,505,000, to remain available for obligation until September 30, 2012.

AIRCRAFT PROCUREMENT, AIR FORCE

For construction, procurement, and modification of aircraft and equipment, including armor and armament, specialized ground handling equipment, and training devices, spare parts, and accessories therefor; specialized equipment; expansion of public and private plants, Government-owned equipment and installation thereof in such plants, erection of structures, and acquisition of land, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; reserve plant and Government and contractor-owned equipment layaway; and other expenses necessary for the foregoing purposes including rents and transportation of things, \$13,295,474,000, to remain available for obligation until September 30, 2012: *Provided*, That none of the funds provided in this Act for modification of C-17 aircraft may be obligated until all C-17 contracts funded with prior year "Aircraft Procurement, Air Force" appropriated funds are definitized unless the Secretary of the Air Force certifies in writing to the congressional defense committees that each such obligation is necessary to meet the needs of a warfighting requirement or prevents increased costs to the taxpayer and provides the reasons for failing to definitize the prior year contracts along with the prospective contract definitization schedule.

MISSILE PROCUREMENT, AIR FORCE

For construction, procurement, and modification of missiles, spacecraft, rockets, and related equipment, including spare parts and accessories therefor, ground handling equipment, and training devices; expansion of public and private plants, Government-owned equipment and installation thereof in such plants, erection of structures, and acquisition of land, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; reserve plant and Government and contractor-owned equipment layaway; and other expenses necessary for the foregoing purposes including rents and transportation of things, \$5,995,544,000, to remain available for obligation until September 30, 2012.

PROCUREMENT OF AMMUNITION, AIR FORCE

For construction, procurement, production, and modification of ammunition, and accessories therefor; specialized equipment and training devices; expansion of public and private plants, including ammunition facilities, authorized by section 2854 of title 10, United States Code, and the land necessary therefor, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; and procurement and installation of equipment, appliances, and machine tools in public and private plants; reserve plant and Government and contractor-owned equipment layaway; and other expenses necessary for the foregoing purposes, \$801,550,000, to remain available for obligation until September 30, 2012.

OTHER PROCUREMENT, AIR FORCE

For procurement and modification of equipment (including ground guidance and electronic control equipment, and ground electronic and communication equipment), and supplies, materials, and spare parts therefor, not otherwise provided for; the purchase of passenger motor vehicles for replacement only, and the purchase of two vehicles required for physical security of personnel, notwithstanding price limitations applicable to passenger vehicles but not to exceed \$250,000 per vehicle; lease of passenger motor vehicles; and expansion of public and private plants, Government-owned equipment and installation thereof in such plants, erection of structures, and acquisition of land, for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon, prior to approval of title; reserve plant and Government and contractor-owned equipment layaway, \$17,138,239,000, to remain available for obligation until September 30, 2012.

PROCUREMENT, DEFENSE-WIDE

For expenses of activities and agencies of the Department of Defense (other than the military departments) necessary for procurement, production, and modification of equipment, supplies, materials, and spare parts therefor, not otherwise provided for; the purchase of passenger motor vehicles for replacement only; expansion of public and private plants, equipment, and installation thereof in such plants, erection of structures, and acquisition of land for the foregoing purposes, and such lands and interests therein, may be acquired, and construction prosecuted thereon prior to approval of title; reserve plant and Government and contractor-owned equipment layaway, \$4,050,537,000, to remain available for obligation until September 30, 2012.

DEFENSE PRODUCTION ACT PURCHASES

For activities by the Department of Defense pursuant to sections 108, 301, 302, and 303 of the Defense Production Act of 1950 (50 U.S.C. App. 2078, 2091, 2092, and 2093), \$150,746,000, to remain available until expended.

TITLE IV

RESEARCH, DEVELOPMENT, TEST AND EVALUATION

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, ARMY

For expenses necessary for basic and applied scientific research, development, test and evaluation, including maintenance, rehabilitation, lease, and operation of facilities and equipment, \$11,474,180,000, to remain available for obligation until September 30, 2011.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, NAVY

For expenses necessary for basic and applied scientific research, development, test and evaluation, including maintenance, rehabilitation, lease, and operation of facilities and equipment, \$20,003,463,000, to remain available for obligation until September 30, 2011: *Provided*, That funds appropriated in this paragraph which are available for the V-22 may be used to meet unique operational requirements of the Special Operations Forces: *Provided further*, That funds appropriated in this paragraph shall be available for the Cobra Judy program.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, AIR FORCE

For expenses necessary for basic and applied scientific research, development, test and evaluation, including maintenance, rehabilitation, lease, and operation of facilities and equipment, \$28,121,985,000, to remain available for obligation until September 30, 2011.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, DEFENSE-WIDE

For expenses of activities and agencies of the Department of Defense (other than the military departments), necessary for basic and applied scientific research, development, test and evaluation; advanced research projects as may be designated and determined by the Secretary of Defense, pursuant to law; maintenance, rehabilitation, lease, and operation of facilities and equipment, \$20,747,081,000, to remain available for obligation until September 30, 2011, of which \$2,500,000 shall be available only for the Missile Defense Agency to construct a replacement Patriot launcher pad for the Japanese Ministry of Defense.

OPERATIONAL TEST AND EVALUATION, DEFENSE

For expenses, not otherwise provided for, necessary for the independent activities of the Director, Operational Test and Evaluation, in the direction and supervision of operational test and evaluation, including initial operational test and evaluation which is conducted prior to, and in support of, production decisions; joint operational testing and evaluation; and administrative expenses in connection therewith, \$190,770,000, to remain available for obligation until September 30, 2011.

TITLE V

REVOLVING AND MANAGEMENT FUNDS

DEFENSE WORKING CAPITAL FUNDS

For the Defense Working Capital Funds, \$1,455,004,000.

NATIONAL DEFENSE SEALIFT FUND

For National Defense Sealift Fund programs, projects, and activities, and for expenses of the National Defense Reserve Fleet, as established by section 11 of the Merchant Ship Sales Act of 1946 (50 U.S.C. App. 1744), and for the necessary expenses to maintain and preserve a U.S.-flag merchant fleet to serve the national security needs of the United States, \$1,672,758,000, to remain available until expended: *Provided*, That none of the funds provided in this paragraph shall be used to award a new contract that provides for the acquisition of any of the following major components unless such components are manufactured in the United States: auxiliary equipment, including pumps, for all shipboard services; propulsion system components (engines, reduction gears, and propellers); shipboard cranes; and spreaders for shipboard cranes: *Provided fur-*

ther, That the exercise of an option in a contract awarded through the obligation of previously appropriated funds shall not be considered to be the award of a new contract: *Provided further*, That the Secretary of the military department responsible for such procurement may waive the restrictions in the first proviso on a case-by-case basis by certifying in writing to the Committees on Appropriations of the House of Representatives and the Senate that adequate domestic supplies are not available to meet Department of Defense requirements on a timely basis and that such an acquisition must be made in order to acquire capability for national security purposes.

TITLE VI

OTHER DEPARTMENT OF DEFENSE PROGRAMS

DEFENSE HEALTH PROGRAM

For expenses, not otherwise provided for, for medical and health care programs of the Department of Defense as authorized by law, \$29,243,428,000; of which \$27,596,689,000 shall be for operation and maintenance, of which not to exceed one percent shall remain available until September 30, 2011, and of which up to \$15,093,539,000 may be available for contracts entered into under the TRICARE program; of which \$366,692,000, to remain available for obligation until September 30, 2012, shall be for procurement; and of which \$1,280,047,000, to remain available for obligation until September 30, 2011, shall be for research, development, test and evaluation: *Provided*, That, notwithstanding any other provision of law, of the amount made available under this heading for research, development, test and evaluation, not less than \$10,000,000 shall be available for HIV prevention educational activities undertaken in connection with United States military training, exercises, and humanitarian assistance activities conducted primarily in African nations.

CHEMICAL AGENTS AND MUNITIONS

DESTRUCTION, DEFENSE

For expenses, not otherwise provided for, necessary for the destruction of the United States stockpile of lethal chemical agents and munitions, to include construction of facilities, in accordance with the provisions of section 1412 of the Department of Defense Authorization Act, 1986 (50 U.S.C. 1521), and for the destruction of other chemical warfare materials that are not in the chemical weapon stockpile, \$1,560,760,000, of which \$1,146,802,000 shall be for operation and maintenance, of which no less than \$84,839,000, shall be for the Chemical Stockpile Emergency Preparedness Program, consisting of \$34,905,000 for activities on military installations and \$49,934,000, to remain available until September 30, 2011, to assist State and local governments; \$12,689,000 shall be for procurement, to remain available until September 30, 2012, of which no less than \$12,689,000 shall be for the Chemical Stockpile Emergency Preparedness Program to assist State and local governments; and \$401,269,000, to remain available until September 30, 2011, shall be for research, development, test and evaluation, of which \$398,669,000 shall only be for the Assembled Chemical Weapons Alternatives (ACWA) program.

DRUG INTERDICTION AND COUNTER-DRUG ACTIVITIES, DEFENSE

(INCLUDING TRANSFER OF FUNDS)

For drug interdiction and counter-drug activities of the Department of Defense, for transfer to appropriations available to the Department of Defense for military personnel of the reserve components serving

under the provisions of title 10 and title 32, United States Code; for operation and maintenance; for procurement; and for research, development, test and evaluation, \$1,158,226,000: *Provided*, That the funds appropriated under this heading shall be available for obligation for the same time period and for the same purpose as the appropriation to which transferred: *Provided further*, That upon a determination that all or part of the funds transferred from this appropriation are not necessary for the purposes provided herein, such amounts may be transferred back to this appropriation: *Provided further*, That the transfer authority provided under this heading is in addition to any other transfer authority contained elsewhere in this Act.

JOINT IMPROVISED EXPLOSIVE DEVICE DEFEAT FUND

(INCLUDING TRANSFER OF FUNDS)

For the "Joint Improvised Explosive Device Defeat Fund", \$121,550,000 for Staff and Infrastructure: *Provided*, That such funds shall be available to the Secretary of Defense, notwithstanding any other provision of law, for the purpose of allowing the Director of the Joint Improvised Explosive Device Defeat Organization to investigate, develop and provide equipment, supplies, services, training, facilities, personnel and funds to assist United States forces in the defeat of improvised explosive devices: *Provided further*, That within 60 days of the enactment of this Act, a plan for the intended management and use of the amounts provided under this heading shall be submitted to the congressional defense committees: *Provided further*, That the Secretary of Defense shall submit a report not later than 60 days after the end of each fiscal quarter to the congressional defense committees providing assessments of the evolving threats, individual service requirements to counter the threats, the current strategy for predeployment training of members of the Armed Forces on improvised explosive devices, and details on the execution of the Fund: *Provided further*, That the Secretary of Defense may transfer funds provided herein to appropriations for operation and maintenance; procurement; research, development, test and evaluation; and defense working capital funds to accomplish the purpose provided herein: *Provided further*, That amounts transferred shall be merged with and available for the same purposes and time period as the appropriations to which transferred: *Provided further*, That this transfer authority is in addition to any other transfer authority available to the Department of Defense: *Provided further*, That the Secretary of Defense shall, not fewer than 15 days prior to making transfers from this appropriation, notify the congressional defense committees in writing of the details of any such transfer.

OFFICE OF THE INSPECTOR GENERAL

For expenses and activities of the Office of the Inspector General in carrying out the provisions of the Inspector General Act of 1978, as amended, \$288,100,000, of which \$287,100,000 shall be for operation and maintenance, of which not to exceed \$700,000 is available for emergencies and extraordinary expenses to be expended on the approval or authority of the Inspector General, and payments may be made on the Inspector General's certificate of necessity for confidential military purposes; and of which \$1,000,000, to remain available until September 30, 2012, shall be for procurement.

TITLE VII

RELATED AGENCIES

CENTRAL INTELLIGENCE AGENCY RETIREMENT AND DISABILITY SYSTEM FUND

For payment to the Central Intelligence Agency Retirement and Disability System Fund, to maintain the proper funding level for continuing the operation of the Central Intelligence Agency Retirement and Disability System, \$290,900,000.

INTELLIGENCE COMMUNITY MANAGEMENT ACCOUNT

For necessary expenses of the Intelligence Community Management Account, \$707,912,000.

TITLE VIII

GENERAL PROVISIONS

SEC. 8001. No part of any appropriation contained in this Act shall be used for publicity or propaganda purposes not authorized by the Congress.

SEC. 8002. During the current fiscal year, provisions of law prohibiting the payment of compensation to, or employment of, any person not a citizen of the United States shall not apply to personnel of the Department of Defense: *Provided*, That salary increases granted to direct and indirect hire foreign national employees of the Department of Defense funded by this Act shall not be at a rate in excess of the percentage increase authorized by law for civilian employees of the Department of Defense whose pay is computed under the provisions of section 5332 of title 5, United States Code, or at a rate in excess of the percentage increase provided by the appropriate host nation to its own employees, whichever is higher: *Provided further*, That this section shall not apply to Department of Defense foreign service national employees serving at United States diplomatic missions whose pay is set by the Department of State under the Foreign Service Act of 1980: *Provided further*, That the limitations of this provision shall not apply to foreign national employees of the Department of Defense in the Republic of Turkey.

SEC. 8003. No part of any appropriation contained in this Act shall remain available for obligation beyond the current fiscal year, unless expressly so provided herein.

SEC. 8004. No more than 20 percent of the appropriations in this Act which are limited for obligation during the current fiscal year shall be obligated during the last 2 months of the fiscal year: *Provided*, That this section shall not apply to obligations for support of active duty training of reserve components or summer camp training of the Reserve Officers' Training Corps.

(TRANSFER OF FUNDS)

SEC. 8005. Upon determination by the Secretary of Defense that such action is necessary in the national interest, he may, with the approval of the Office of Management and Budget, transfer not to exceed \$4,000,000,000 of working capital funds of the Department of Defense or funds made available in this Act to the Department of Defense for military functions (except military construction) between such appropriations or funds or any subdivision thereof, to be merged with and to be available for the same purposes, and for the same time period, as the appropriation or fund to which transferred: *Provided*, That such authority to transfer may not be used unless for higher priority items, based on unforeseen military requirements, than those for which originally appropriated and in no case where the item for which funds are requested has been denied by the Congress: *Provided further*,

That the Secretary of Defense shall notify the Congress promptly of all transfers made pursuant to this authority or any other authority in this Act: *Provided further*, That no part of the funds in this Act shall be available to prepare or present a request to the Committees on Appropriations for reprogramming of funds, unless for higher priority items, based on unforeseen military requirements, than those for which originally appropriated and in no case where the item for which reprogramming is requested has been denied by the Congress: *Provided further*, That a request for multiple reprogrammings of funds using authority provided in this section shall be made prior to June 30, 2010: *Provided further*, That transfers among military personnel appropriations shall not be taken into account for purposes of the limitation on the amount of funds that may be transferred under this section: *Provided further*, That no obligation of funds may be made pursuant to section 1206 of Public Law 109-163 (or any successor provision) unless the Secretary of Defense has notified the congressional defense committees prior to any such obligation.

SEC. 8006. (a) With regard to the list of specific programs, projects, and activities (and the dollar amounts and adjustments to budget activities corresponding to such programs, projects, and activities) contained in the tables titled "Explanation of Project Level Adjustments" in the explanatory statement regarding this Act, the obligation and expenditure of amounts appropriated or otherwise made available in this Act for those programs, projects, and activities for which the amounts appropriated exceed the amounts requested are hereby required by law to be carried out in the manner provided by such tables to the same extent as if the tables were included in the text of this Act.

(b) Amounts specified in the referenced tables described in subsection (a) shall not be treated as subdivisions of appropriations for purposes of section 8005 of this Act: *Provided*, That section 8005 shall apply when transfers of the amounts described in subsection (a) occur between appropriation accounts.

SEC. 8007. (a) Not later than 60 days after enactment of this Act, the Department of Defense shall submit a report to the congressional defense committees to establish the baseline for application of reprogramming and transfer authorities for fiscal year 2010: *Provided*, That the report shall include—

(1) a table for each appropriation with a separate column to display the President's budget request, adjustments made by Congress, adjustments due to enacted rescissions, if appropriate, and the fiscal year enacted level;

(2) a delineation in the table for each appropriation both by budget activity and program, project, and activity as detailed in the Budget Appendix; and

(3) an identification of items of special congressional interest.

(b) Notwithstanding section 8005 of this Act, none of the funds provided in this Act shall be available for reprogramming or transfer until the report identified in subsection (a) is submitted to the congressional defense committees, unless the Secretary of Defense certifies in writing to the congressional defense committees that such reprogramming or transfer is necessary as an emergency requirement.

SEC. 8008. The Secretaries of the Air Force and the Army are authorized, using funds available under the headings "Operation and Maintenance, Air Force" and "Operation and Maintenance, Army", to complete facility

conversions and phased repair projects which may include upgrades and additions to Alaskan range infrastructure and training areas, and improved access to these ranges.

(TRANSFER OF FUNDS)

SEC. 8009. During the current fiscal year, cash balances in working capital funds of the Department of Defense established pursuant to section 2208 of title 10, United States Code, may be maintained in only such amounts as are necessary at any time for cash disbursements to be made from such funds: *Provided*, That transfers may be made between such funds: *Provided further*, That transfers may be made between working capital funds and the "Foreign Currency Fluctuations, Defense" appropriation and the "Operation and Maintenance" appropriation accounts in such amounts as may be determined by the Secretary of Defense, with the approval of the Office of Management and Budget, except that such transfers may not be made unless the Secretary of Defense has notified the Congress of the proposed transfer. Except in amounts equal to the amounts appropriated to working capital funds in this Act, no obligations may be made against a working capital fund to procure or increase the value of war reserve material inventory, unless the Secretary of Defense has notified the Congress prior to any such obligation.

SEC. 8010. Funds appropriated by this Act may not be used to initiate a special access program without prior notification 30 calendar days in advance to the congressional defense committees.

SEC. 8011. None of the funds provided in this Act shall be available to initiate: (1) a multiyear contract that employs economic order quantity procurement in excess of \$20,000,000 in any one year of the contract or that includes an unfunded contingent liability in excess of \$20,000,000; or (2) a contract for advance procurement leading to a multiyear contract that employs economic order quantity procurement in excess of \$20,000,000 in any one year, unless the congressional defense committees have been notified at least 30 days in advance of the proposed contract award: *Provided*, That no part of any appropriation contained in this Act shall be available to initiate a multiyear contract for which the economic order quantity advance procurement is not funded at least to the limits of the Government's liability: *Provided further*, That no part of any appropriation contained in this Act shall be available to initiate multiyear procurement contracts for any systems or component thereof if the value of the multiyear contract would exceed \$500,000,000 unless specifically provided in this Act: *Provided further*, That no multiyear procurement contract can be terminated without 10-day prior notification to the congressional defense committees: *Provided further*, That the execution of multiyear authority shall require the use of a present value analysis to determine lowest cost compared to an annual procurement: *Provided further*, That none of the funds provided in this Act may be used for a multiyear contract executed after the date of the enactment of this Act unless in the case of any such contract—

(1) the Secretary of Defense has submitted to Congress a report within 30 days of enactment of this Act that certifies full funding of units to be procured through the contract and, in the case of a contract for procurement of aircraft, that includes, for any aircraft unit to be procured through the contract for which procurement funds are identified in that report for production beyond advance procurement activities in the fiscal

year 2010 budget, full funding of procurement of such unit in that fiscal year;

(2) cancellation provisions in the contract do not include consideration of recurring manufacturing costs of the contractor associated with the production of unfunded units to be delivered under the contract;

(3) the contract provides that payments to the contractor under the contract shall not be made in advance of incurred costs on funded units; and

(4) the contract does not provide for a price adjustment based on a failure to award a follow-on contract.

Funds appropriated in title III of this Act may be used for a multiyear procurement contract as follows:

F-18 aircraft variants.

SEC. 8012. Within the funds appropriated for the operation and maintenance of the Armed Forces, funds are hereby appropriated pursuant to section 401 of title 10, United States Code, for humanitarian and civic assistance costs under chapter 20 of title 10, United States Code. Such funds may also be obligated for humanitarian and civic assistance costs incidental to authorized operations and pursuant to authority granted in section 401 of chapter 20 of title 10, United States Code, and these obligations shall be reported as required by section 401(d) of title 10, United States Code: *Provided*, That funds available for operation and maintenance shall be available for providing humanitarian and similar assistance by using Civic Action Teams in the Trust Territories of the Pacific Islands and freely associated states of Micronesia, pursuant to the Compact of Free Association as authorized by Public Law 99-239: *Provided further*, That upon a determination by the Secretary of the Army that such action is beneficial for graduate medical education programs conducted at Army medical facilities located in Hawaii, the Secretary of the Army may authorize the provision of medical services at such facilities and transportation to such facilities, on a nonreimbursable basis, for civilian patients from American Samoa, the Commonwealth of the Northern Mariana Islands, the Marshall Islands, the Federated States of Micronesia, Palau, and Guam.

SEC. 8013. (a) During fiscal year 2010, the civilian personnel of the Department of Defense may not be managed on the basis of any end-strength, and the management of such personnel during that fiscal year shall not be subject to any constraint or limitation (known as an end-strength) on the number of such personnel who may be employed on the last day of such fiscal year.

(b) The fiscal year 2011 budget request for the Department of Defense as well as all justification material and other documentation supporting the fiscal year 2011 Department of Defense budget request shall be prepared and submitted to the Congress as if subsections (a) and (b) of this provision were effective with regard to fiscal year 2011.

(c) Nothing in this section shall be construed to apply to military (civilian) technicians.

SEC. 8014. None of the funds made available by this Act shall be used in any way, directly or indirectly, to influence congressional action on any legislation or appropriation matters pending before the Congress.

SEC. 8015. None of the funds appropriated by this Act shall be available for the basic pay and allowances of any member of the Army participating as a full-time student and receiving benefits paid by the Secretary of Veterans Affairs from the Department of Defense Education Benefits Fund when time

spent as a full-time student is credited toward completion of a service commitment: *Provided*, That this section shall not apply to those members who have reenlisted with this option prior to October 1, 1987: *Provided further*, That this section applies only to active components of the Army.

SEC. 8016. (a) None of the funds appropriated by this Act shall be available to convert to contractor performance an activity or function of the Department of Defense that, on or after the date of the enactment of this Act, is performed by more than 10 Department of Defense civilian employees unless—

(1) the conversion is based on the result of a public-private competition that includes a most efficient and cost effective organization plan developed by such activity or function;

(2) the Competitive Sourcing Official determines that, over all performance periods stated in the solicitation of offers for performance of the activity or function, the cost of performance of the activity or function by a contractor would be less costly to the Department of Defense by an amount that equals or exceeds the lesser of—

(A) 10 percent of the most efficient organization's personnel-related costs for performance of that activity or function by Federal employees; or

(B) \$10,000,000; and

(3) the contractor does not receive an advantage for a proposal that would reduce costs for the Department of Defense by—

(A) not making an employer-sponsored health insurance plan available to the workers who are to be employed in the performance of that activity or function under the contract; or

(B) offering to such workers an employer-sponsored health benefits plan that requires the employer to contribute less towards the premium or subscription share than the amount that is paid by the Department of Defense for health benefits for civilian employees under chapter 89 of title 5, United States Code.

(b)(1) The Department of Defense, without regard to subsection (a) of this section or subsection (a), (b), or (c) of section 2461 of title 10, United States Code, and notwithstanding any administrative regulation, requirement, or policy to the contrary shall have full authority to enter into a contract for the performance of any commercial or industrial type function of the Department of Defense that—

(A) is included on the procurement list established pursuant to section 2 of the Javits-Wagner-O'Day Act (41 U.S.C. 47);

(B) is planned to be converted to performance by a qualified nonprofit agency for the blind or by a qualified nonprofit agency for other severely handicapped individuals in accordance with that Act; or

(C) is planned to be converted to performance by a qualified firm under at least 51 percent ownership by an Indian tribe, as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)), or a Native Hawaiian Organization, as defined in section 8(a)(15) of the Small Business Act (15 U.S.C. 637(a)(15)).

(2) This section shall not apply to depot contracts or contracts for depot maintenance as provided in sections 2469 and 2474 of title 10, United States Code.

(c) The conversion of any activity or function of the Department of Defense under the authority provided by this section shall be credited toward any competitive or outsourcing goal, target, or measurement that

may be established by statute, regulation, or policy and is deemed to be awarded under the authority of, and in compliance with, subsection (h) of section 2304 of title 10, United States Code, for the competition or outsourcing of commercial activities.

(TRANSFER OF FUNDS)

SEC. 8017. Funds appropriated in title III of this Act for the Department of Defense Pilot Mentor-Protégé Program may be transferred to any other appropriation contained in this Act solely for the purpose of implementing a Mentor-Protégé Program developmental assistance agreement pursuant to section 831 of the National Defense Authorization Act for Fiscal Year 1991 (Public Law 101-510; 10 U.S.C. 2302 note), as amended, under the authority of this provision or any other transfer authority contained in this Act.

SEC. 8018. None of the funds in this Act may be available for the purchase by the Department of Defense (and its departments and agencies) of welded shipboard anchor and mooring chain 4 inches in diameter and under unless the anchor and mooring chain are manufactured in the United States from components which are substantially manufactured in the United States: *Provided*, That for the purpose of this section, the term “manufactured” shall include cutting, heat treating, quality control, testing of chain and welding (including the forging and shot blasting process): *Provided further*, That for the purpose of this section substantially all of the components of anchor and mooring chain shall be considered to be produced or manufactured in the United States if the aggregate cost of the components produced or manufactured outside the United States: *Provided further*, That when adequate domestic supplies are not available to meet Department of Defense requirements on a timely basis, the Secretary of the service responsible for the procurement may waive this restriction on a case-by-case basis by certifying in writing to the Committees on Appropriations that such an acquisition must be made in order to acquire capability for national security purposes.

SEC. 8019. None of the funds available to the Department of Defense may be used to demilitarize or dispose of M-1 Carbines, M-1 Garand rifles, M-14 rifles, .22 caliber rifles, .30 caliber rifles, or M-1911 pistols, or to demilitarize or destroy small arms ammunition or ammunition components that are not otherwise prohibited from commercial sale under Federal law, unless the small arms ammunition or ammunition components are certified by the Secretary of the Army or designee as unserviceable or unsafe for further use.

SEC. 8020. No more than \$500,000 of the funds appropriated or made available in this Act shall be used during a single fiscal year for any single relocation of an organization, unit, activity or function of the Department of Defense into or within the National Capital Region: *Provided*, That the Secretary of Defense may waive this restriction on a case-by-case basis by certifying in writing to the congressional defense committees that such a relocation is required in the best interest of the Government.

SEC. 8021. In addition to the funds provided elsewhere in this Act, \$15,000,000 is appropriated only for incentive payments authorized by section 504 of the Indian Financing Act of 1974 (25 U.S.C. 1544): *Provided*, That a prime contractor or a subcontractor at any tier that makes a subcontract award to any subcontractor or supplier as defined in sec-

tion 1544 of title 25, United States Code, or a small business owned and controlled by an individual or individuals defined under section 4221(9) of title 25, United States Code, shall be considered a contractor for the purposes of being allowed additional compensation under section 504 of the Indian Financing Act of 1974 (25 U.S.C. 1544) whenever the prime contract or subcontract amount is over \$500,000 and involves the expenditure of funds appropriated by an Act making Appropriations for the Department of Defense with respect to any fiscal year: *Provided further*, That notwithstanding section 430 of title 41, United States Code, this section shall be applicable to any Department of Defense acquisition of supplies or services, including any contract and any subcontract at any tier for acquisition of commercial items produced or manufactured, in whole or in part by any subcontractor or supplier defined in section 1544 of title 25, United States Code, or a small business owned and controlled by an individual or individuals defined under section 4221(9) of title 25, United States Code.

SEC. 8022. Funds appropriated by this Act for the Defense Media Activity shall not be used for any national or international political or psychological activities.

SEC. 8023. None of the funds appropriated by this Act shall be available to perform any cost study pursuant to the provisions of OMB Circular A-76 if the study being performed exceeds the period permitted by section 322 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111-84).

SEC. 8024. During the current fiscal year, the Department of Defense is authorized to incur obligations of not to exceed \$350,000,000 for purposes specified in section 2350j(c) of title 10, United States Code, in anticipation of receipt of contributions, only from the Government of Kuwait, under that section: *Provided*, That upon receipt, such contributions from the Government of Kuwait shall be credited to the appropriations or fund which incurred such obligations.

SEC. 8025. (a) Of the funds made available in this Act, not less than \$33,756,000 shall be available for the Civil Air Patrol Corporation, of which—

(1) \$26,433,000 shall be available from “Operation and Maintenance, Air Force” to support Civil Air Patrol Corporation operation and maintenance, readiness, counterdrug activities, and drug demand reduction activities involving youth programs;

(2) \$6,426,000 shall be available from “Air-craft Procurement, Air Force”; and

(3) \$997,000 shall be available from “Other Procurement, Air Force” for vehicle procurement.

(b) The Secretary of the Air Force should waive reimbursement for any funds used by the Civil Air Patrol for counter-drug activities in support of Federal, State, and local government agencies.

SEC. 8026. (a) None of the funds appropriated in this Act are available to establish a new Department of Defense (department) federally funded research and development center (FFRDC), either as a new entity, or as a separate entity administrated by an organization managing another FFRDC, or as a nonprofit membership corporation consisting of a consortium of other FFRDCs and other nonprofit entities.

(b) No member of a Board of Directors, Trustees, Overseers, Advisory Group, Special Issues Panel, Visiting Committee, or any similar entity of a defense FFRDC, and no paid consultant to any defense FFRDC, except when acting in a technical advisory capacity, may be compensated for his or her

services as a member of such entity, or as a paid consultant by more than one FFRDC in a fiscal year: *Provided*, That a member of any such entity referred to previously in this subsection shall be allowed travel expenses and per diem as authorized under the Federal Joint Travel Regulations, when engaged in the performance of membership duties.

(c) Notwithstanding any other provision of law, none of the funds available to the department from any source during fiscal year 2010 may be used by a defense FFRDC, through a fee or other payment mechanism, for construction of new buildings, for payment of cost sharing for projects funded by Government grants, for absorption of contract overruns, or for certain charitable contributions, not to include employee participation in community service and/or development.

(d) Notwithstanding any other provision of law, of the funds available to the department during fiscal year 2010, not more than 5,600 staff years of technical effort (staff years) may be funded for defense FFRDCs: *Provided*, That of the specific amount referred to previously in this subsection, not more than 1,100 staff years may be funded for the defense studies and analysis FFRDCs: *Provided further*, That this subsection shall not apply to staff years funded in the National Intelligence Program (NIP) and the Military Intelligence Program (MIP).

(e) The Secretary of Defense shall, with the submission of the department's fiscal year 2011 budget request, submit a report presenting the specific amounts of staff years of technical effort to be allocated for each defense FFRDC during that fiscal year and the associated budget estimates.

(f) Notwithstanding any other provision of this Act, the total amount appropriated in this Act for FFRDCs is hereby reduced by \$125,200,000.

SEC. 8027. None of the funds appropriated or made available in this Act shall be used to procure carbon, alloy or armor steel plate for use in any Government-owned facility or property under the control of the Department of Defense which were not melted and rolled in the United States or Canada: *Provided*, That these procurement restrictions shall apply to any and all Federal Supply Class 9515, American Society of Testing and Materials (ASTM) or American Iron and Steel Institute (AISI) specifications of carbon, alloy or armor steel plate: *Provided further*, That the Secretary of the military department responsible for the procurement may waive this restriction on a case-by-case basis by certifying in writing to the Committees on Appropriations of the House of Representatives and the Senate that adequate domestic supplies are not available to meet Department of Defense requirements on a timely basis and that such an acquisition must be made in order to acquire capability for national security purposes: *Provided further*, That these restrictions shall not apply to contracts which are in being as of the date of the enactment of this Act.

SEC. 8028. For the purposes of this Act, the term “congressional defense committees” means the Armed Services Committee of the House of Representatives, the Armed Services Committee of the Senate, the Subcommittee on Defense of the Committee on Appropriations of the Senate, and the Subcommittee on Defense of the Committee on Appropriations of the House of Representatives.

SEC. 8029. During the current fiscal year, the Department of Defense may acquire the modification, depot maintenance and repair

of aircraft, vehicles and vessels as well as the production of components and other Defense-related articles, through competition between Department of Defense depot maintenance activities and private firms: *Provided*, That the Senior Acquisition Executive of the military department or Defense Agency concerned, with power of delegation, shall certify that successful bids include comparable estimates of all direct and indirect costs for both public and private bids: *Provided further*, That Office of Management and Budget Circular A-76 shall not apply to competitions conducted under this section.

SEC. 8030. (a)(1) If the Secretary of Defense, after consultation with the United States Trade Representative, determines that a foreign country which is party to an agreement described in paragraph (2) has violated the terms of the agreement by discriminating against certain types of products produced in the United States that are covered by the agreement, the Secretary of Defense shall rescind the Secretary's blanket waiver of the Buy American Act with respect to such types of products produced in that foreign country.

(2) An agreement referred to in paragraph (1) is any reciprocal defense procurement memorandum of understanding, between the United States and a foreign country pursuant to which the Secretary of Defense has prospectively waived the Buy American Act for certain products in that country.

(b) The Secretary of Defense shall submit to the Congress a report on the amount of Department of Defense purchases from foreign entities in fiscal year 2010. Such report shall separately indicate the dollar value of items for which the Buy American Act was waived pursuant to any agreement described in subsection (a)(2), the Trade Agreement Act of 1979 (19 U.S.C. 2501 et seq.), or any international agreement to which the United States is a party.

(c) For purposes of this section, the term "Buy American Act" means title III of the Act entitled "An Act making appropriations for the Treasury and Post Office Departments for the fiscal year ending June 30, 1934, and for other purposes", approved March 3, 1933 (41 U.S.C. 10a et seq.).

SEC. 8031. During the current fiscal year, amounts contained in the Department of Defense Overseas Military Facility Investment Recovery Account established by section 2921(c)(1) of the National Defense Authorization Act of 1991 (Public Law 101-510; 10 U.S.C. 2687 note) shall be available until expended for the payments specified by section 2921(c)(2) of that Act.

SEC. 8032. (a) Notwithstanding any other provision of law, the Secretary of the Air Force may convey at no cost to the Air Force, without consideration, to Indian tribes located in the States of Nevada, Idaho, North Dakota, South Dakota, Montana, Oregon, and Minnesota relocatable military housing units located at Grand Forks Air Force Base, Malmstrom Air Force Base, Mountain Home Air Force Base, Ellsworth Air Force Base, and Minot Air Force Base that are excess to the needs of the Air Force.

(b) The Secretary of the Air Force shall convey, at no cost to the Air Force, military housing units under subsection (a) in accordance with the request for such units that are submitted to the Secretary by the Operation Walking Shield Program on behalf of Indian tribes located in the States of Nevada, Idaho, North Dakota, South Dakota, Montana, Oregon, and Minnesota.

(c) The Operation Walking Shield Program shall resolve any conflicts among requests of

Indian tribes for housing units under subsection (a) before submitting requests to the Secretary of the Air Force under subsection (b).

(d) In this section, the term "Indian tribe" means any recognized Indian tribe included on the current list published by the Secretary of the Interior under section 104 of the Federally Recognized Indian Tribe Act of 1994 (Public Law 103-454; 108 Stat. 4792; 25 U.S.C. 479a-1).

SEC. 8033. During the current fiscal year, appropriations which are available to the Department of Defense for operation and maintenance may be used to purchase items having an investment item unit cost of not more than \$250,000.

SEC. 8034. (a) During the current fiscal year, none of the appropriations or funds available to the Department of Defense Working Capital Funds shall be used for the purchase of an investment item for the purpose of acquiring a new inventory item for sale or anticipated sale during the current fiscal year or a subsequent fiscal year to customers of the Department of Defense Working Capital Funds if such an item would not have been chargeable to the Department of Defense Business Operations Fund during fiscal year 1994 and if the purchase of such an investment item would be chargeable during the current fiscal year to appropriations made to the Department of Defense for procurement.

(b) The fiscal year 2011 budget request for the Department of Defense as well as all justification material and other documentation supporting the fiscal year 2011 Department of Defense budget shall be prepared and submitted to the Congress on the basis that any equipment which was classified as an end item and funded in a procurement appropriation contained in this Act shall be budgeted for in a proposed fiscal year 2011 procurement appropriation and not in the supply management business area or any other area or category of the Department of Defense Working Capital Funds.

SEC. 8035. None of the funds appropriated by this Act for programs of the Central Intelligence Agency shall remain available for obligation beyond the current fiscal year, except for funds appropriated for the Reserve for Contingencies, which shall remain available until September 30, 2011: *Provided*, That funds appropriated, transferred, or otherwise credited to the Central Intelligence Agency Central Services Working Capital Fund during this or any prior or subsequent fiscal year shall remain available until expended: *Provided further*, That any funds appropriated or transferred to the Central Intelligence Agency for advanced research and development acquisition, for agent operations, and for covert action programs authorized by the President under section 503 of the National Security Act of 1947, as amended, shall remain available until September 30, 2011.

SEC. 8036. Notwithstanding any other provision of law, funds made available in this Act for the Defense Intelligence Agency may be used for the design, development, and deployment of General Defense Intelligence Program intelligence communications and intelligence information systems for the Services, the Unified and Specified Commands, and the component commands.

SEC. 8037. Of the funds appropriated to the Department of Defense under the heading "Operation and Maintenance, Defense-Wide", not less than \$12,000,000 shall be made available only for the mitigation of environmental impacts, including training and technical assistance to tribes, related adminis-

trative support, the gathering of information, documenting of environmental damage, and developing a system for prioritization of mitigation and cost to complete estimates for mitigation, on Indian lands resulting from Department of Defense activities.

SEC. 8038. (a) None of the funds appropriated in this Act may be expended by an entity of the Department of Defense unless the entity, in expending the funds, complies with the Buy American Act. For purposes of this subsection, the term "Buy American Act" means title III of the Act entitled "An Act making appropriations for the Treasury and Post Office Departments for the fiscal year ending June 30, 1934, and for other purposes", approved March 3, 1933 (41 U.S.C. 10a et seq.).

(b) If the Secretary of Defense determines that a person has been convicted of intentionally affixing a label bearing a "Made in America" inscription to any product sold in or shipped to the United States that is not made in America, the Secretary shall determine, in accordance with section 2410f of title 10, United States Code, whether the person should be debarred from contracting with the Department of Defense.

(c) In the case of any equipment or products purchased with appropriations provided under this Act, it is the sense of the Congress that any entity of the Department of Defense, in expending the appropriation, purchase only American-made equipment and products, provided that American-made equipment and products are cost-competitive, quality-competitive, and available in a timely fashion.

SEC. 8039. None of the funds appropriated by this Act shall be available for a contract for studies, analysis, or consulting services entered into without competition on the basis of an unsolicited proposal unless the head of the activity responsible for the procurement determines—

(1) as a result of thorough technical evaluation, only one source is found fully qualified to perform the proposed work;

(2) the purpose of the contract is to explore an unsolicited proposal which offers significant scientific or technological promise, represents the product of original thinking, and was submitted in confidence by one source; or

(3) the purpose of the contract is to take advantage of unique and significant industrial accomplishment by a specific concern, or to insure that a new product or idea of a specific concern is given financial support: *Provided*, That this limitation shall not apply to contracts in an amount of less than \$25,000, contracts related to improvements of equipment that is in development or production, or contracts as to which a civilian official of the Department of Defense, who has been confirmed by the Senate, determines that the award of such contract is in the interest of the national defense.

SEC. 8040. (a) Except as provided in subsections (b) and (c), none of the funds made available by this Act may be used—

(1) to establish a field operating agency; or

(2) to pay the basic pay of a member of the Armed Forces or civilian employee of the department who is transferred or reassigned from a headquarters activity if the member or employee's place of duty remains at the location of that headquarters.

(b) The Secretary of Defense or Secretary of a military department may waive the limitations in subsection (a), on a case-by-case basis, if the Secretary determines, and certifies to the Committees on Appropriations of the House of Representatives and Senate

that the granting of the waiver will reduce the personnel requirements or the financial requirements of the department.

(c) This section does not apply to—

(1) field operating agencies funded within the National Intelligence Program; or

(2) an Army field operating agency established to eliminate, mitigate, or counter the effects of improvised explosive devices, and, as determined by the Secretary of the Army, other similar threats.

SEC. 8041. The Secretary of Defense, notwithstanding any other provision of law, acting through the Office of Economic Adjustment of the Department of Defense, may use funds made available in this Act under the heading “Operation and Maintenance, Defense-Wide” to make grants and supplement other Federal funds in accordance with the guidance provided in the explanatory statement regarding this Act.

(RESCISSIONS)

SEC. 8042. Of the funds appropriated in Department of Defense Appropriations Acts, the following funds are hereby rescinded from the following accounts and programs in the specified amounts:

“Research, Development, Test and Evaluation, Navy, 2009/2010”, \$20,000,000;

“Research, Development, Test and Evaluation, Air Force, 2009/2010”, \$98,430,000;

“Research, Development, Test and Evaluation, Defense-Wide, 2009/2010”, \$154,457,000;

“Procurement of Weapons and Tracked Combat Vehicles, Army, 2009/2011”, \$41,087,000;

“Other Procurement, Army, 2009/2011”, \$138,239,000;

“Other Procurement, Navy, 2009/2011”, \$84,844,000;

“Aircraft Procurement, Air Force, 2009/2011”, \$628,900,000;

“Missile Procurement, Air Force, 2009/2011”, \$60,000,000;

“Other Procurement, Air Force, 2009/2011”, \$10,900,000;

“Procurement, Defense-Wide, 2009/2011”, \$5,200,000; and

“Procurement, Defense-Wide, 2008/2010”, \$2,000,000.

SEC. 8043. None of the funds available in this Act may be used to reduce the authorized positions for military (civilian) technicians of the Army National Guard, Air National Guard, Army Reserve and Air Force Reserve for the purpose of applying any administratively imposed civilian personnel ceiling, freeze, or reduction on military (civilian) technicians, unless such reductions are a direct result of a reduction in military force structure.

SEC. 8044. None of the funds appropriated or otherwise made available in this Act may be obligated or expended for assistance to the Democratic People's Republic of Korea unless specifically appropriated for that purpose.

SEC. 8045. Funds appropriated in this Act for operation and maintenance of the Military Departments, Combatant Commands and Defense Agencies shall be available for reimbursement of pay, allowances and other expenses which would otherwise be incurred against appropriations for the National Guard and Reserve when members of the National Guard and Reserve provide intelligence or counterintelligence support to Combatant Commands, Defense Agencies and Joint Intelligence Activities, including the activities and programs included within the National Intelligence Program and the Military Intelligence Program: *Provided*, That nothing in this section authorizes deviation from established Reserve and National Guard personnel and training procedures.

SEC. 8046. During the current fiscal year, none of the funds appropriated in this Act may be used to reduce the civilian medical and medical support personnel assigned to military treatment facilities below the September 30, 2003, level: *Provided*, That the Service Surgeons General may waive this section by certifying to the congressional defense committees that the beneficiary population is declining in some catchment areas and civilian strength reductions may be consistent with responsible resource stewardship and capitation-based budgeting.

SEC. 8047. (a) None of the funds available to the Department of Defense for any fiscal year for drug interdiction or counter-drug activities may be transferred to any other department or agency of the United States except as specifically provided in an appropriations law.

(b) None of the funds available to the Central Intelligence Agency for any fiscal year for drug interdiction and counter-drug activities may be transferred to any other department or agency of the United States except as specifically provided in an appropriations law.

SEC. 8048. None of the funds appropriated by this Act may be used for the procurement of ball and roller bearings other than those produced by a domestic source and of domestic origin: *Provided*, That the Secretary of the military department responsible for such procurement may waive this restriction on a case-by-case basis by certifying in writing to the Committees on Appropriations of the House of Representatives and the Senate, that adequate domestic supplies are not available to meet Department of Defense requirements on a timely basis and that such an acquisition must be made in order to acquire capability for national security purposes: *Provided further*, That this restriction shall not apply to the purchase of “commercial items”, as defined by section 4(12) of the Office of Federal Procurement Policy Act, except that the restriction shall apply to ball or roller bearings purchased as end items.

SEC. 8049. None of the funds in this Act may be used to purchase any supercomputer which is not manufactured in the United States, unless the Secretary of Defense certifies to the congressional defense committees that such an acquisition must be made in order to acquire capability for national security purposes that is not available from United States manufacturers.

SEC. 8050. None of the funds made available in this or any other Act may be used to pay the salary of any officer or employee of the Department of Defense who approves or implements the transfer of administrative responsibilities or budgetary resources of any program, project, or activity financed by this Act to the jurisdiction of another Federal agency not financed by this Act without the express authorization of Congress: *Provided*, That this limitation shall not apply to transfers of funds expressly provided for in Defense Appropriations Acts, or provisions of Acts providing supplemental appropriations for the Department of Defense.

SEC. 8051. (a) Notwithstanding any other provision of law, none of the funds available to the Department of Defense for the current fiscal year may be obligated or expended to transfer to another nation or an international organization any defense articles or services (other than intelligence services) for use in the activities described in subsection (b) unless the congressional defense committees, the Committee on Foreign Affairs of the House of Representatives, and the Com-

mittee on Foreign Relations of the Senate are notified 15 days in advance of such transfer.

(b) This section applies to—

(1) any international peacekeeping or peace-enforcement operation under the authority of chapter VI or chapter VII of the United Nations Charter under the authority of a United Nations Security Council resolution; and

(2) any other international peacekeeping, peace-enforcement, or humanitarian assistance operation.

(c) A notice under subsection (a) shall include the following—

(1) A description of the equipment, supplies, or services to be transferred.

(2) A statement of the value of the equipment, supplies, or services to be transferred.

(3) In the case of a proposed transfer of equipment or supplies—

(A) a statement of whether the inventory requirements of all elements of the Armed Forces (including the reserve components) for the type of equipment or supplies to be transferred have been met; and

(B) a statement of whether the items proposed to be transferred will have to be replaced and, if so, how the President proposes to provide funds for such replacement.

SEC. 8052. None of the funds available to the Department of Defense under this Act shall be obligated or expended to pay a contractor under a contract with the Department of Defense for costs of any amount paid by the contractor to an employee when—

(1) such costs are for a bonus or otherwise in excess of the normal salary paid by the contractor to the employee; and

(2) such bonus is part of restructuring costs associated with a business combination.

(INCLUDING TRANSFER OF FUNDS)

SEC. 8053. During the current fiscal year, no more than \$30,000,000 of appropriations made in this Act under the heading “Operation and Maintenance, Defense-Wide” may be transferred to appropriations available for the pay of military personnel, to be merged with, and to be available for the same time period as the appropriations to which transferred, to be used in support of such personnel in connection with support and services for eligible organizations and activities outside the Department of Defense pursuant to section 2012 of title 10, United States Code.

SEC. 8054. During the current fiscal year, in the case of an appropriation account of the Department of Defense for which the period of availability for obligation has expired or which has closed under the provisions of section 1552 of title 31, United States Code, and which has a negative unliquidated or unexpended balance, an obligation or an adjustment of an obligation may be charged to any current appropriation account for the same purpose as the expired or closed account if—

(1) the obligation would have been properly chargeable (except as to amount) to the expired or closed account before the end of the period of availability or closing of that account;

(2) the obligation is not otherwise properly chargeable to any current appropriation account of the Department of Defense; and

(3) in the case of an expired account, the obligation is not chargeable to a current appropriation of the Department of Defense under the provisions of section 1405(b)(8) of the National Defense Authorization Act for Fiscal Year 1991, Public Law 101-510, as amended (31 U.S.C. 1551 note): *Provided*, That in the case of an expired account, if subsequent review or investigation discloses that

there was not in fact a negative unliquidated or unexpended balance in the account, any charge to a current account under the authority of this section shall be reversed and recorded against the expired account: *Provided further*, That the total amount charged to a current appropriation under this section may not exceed an amount equal to 1 percent of the total appropriation for that account.

SEC. 8055. (a) IN GENERAL.—Service as a member of the Alaska Territorial Guard during World War II of any individual who was honorably discharged therefrom under section 8147 of the Department of Defense Appropriations Act, 2001 (Public Law 106-259; 114 Stat. 705) shall be treated as active service for purposes of the computation under chapter 61, 71, 371, 571, 871, or 1223 of title 10, United States Code, as applicable, of the retired pay to which such individual may be entitled under title 10, United States Code.

(b) APPLICABILITY.—Subsection (a) shall apply with respect to amounts of retired pay payable under title 10, United States Code, for months beginning on or after the date of the enactment of this Act. No retired pay shall be paid to any individual by reason of subsection (a) for any period before that date.

(c) WORLD WAR II DEFINED.—In this section, the term “World War II” has the meaning given that term in section 101(8) of title 38, United States Code.

SEC. 8056. (a) Notwithstanding any other provision of law, the Chief of the National Guard Bureau may permit the use of equipment of the National Guard Distance Learning Project by any person or entity on a space-available, reimbursable basis. The Chief of the National Guard Bureau shall establish the amount of reimbursement for such use on a case-by-case basis.

(b) Amounts collected under subsection (a) shall be credited to funds available for the National Guard Distance Learning Project and be available to defray the costs associated with the use of equipment of the project under that subsection. Such funds shall be available for such purposes without fiscal year limitation.

SEC. 8057. Using funds available by this Act or any other Act, the Secretary of the Air Force, pursuant to a determination under section 2690 of title 10, United States Code, may implement cost-effective agreements for required heating facility modernization in the Kaiserslautern Military Community in the Federal Republic of Germany: *Provided*, That in the City of Kaiserslautern such agreements will include the use of United States anthracite as the base load energy for municipal district heat to the United States Defense installations: *Provided further*, That at Landstuhl Army Regional Medical Center and Ramstein Air Base, furnished heat may be obtained from private, regional or municipal services, if provisions are included for the consideration of United States coal as an energy source.

SEC. 8058. None of the funds appropriated in title IV of this Act may be used to procure end-items for delivery to military forces for operational training, operational use or inventory requirements: *Provided*, That this restriction does not apply to end-items used in development, prototyping, and test activities preceding and leading to acceptance for operational use: *Provided further*, That this restriction does not apply to programs funded within the National Intelligence Program: *Provided further*, That the Secretary of Defense may waive this restriction on a case-by-case basis by certifying in writing to the Committees on Appropriations of the House

of Representatives and the Senate that it is in the national security interest to do so.

SEC. 8059. None of the funds made available in this Act may be used to approve or license the sale of the F-22A advanced tactical fighter to any foreign government: *Provided*, That the Department of Defense may conduct or participate in studies, research, design and other activities to define and develop a future export version of the F-22A that protects classified and sensitive information, technologies and U.S. warfighting capabilities.

SEC. 8060. (a) The Secretary of Defense may, on a case-by-case basis, waive with respect to a foreign country each limitation on the procurement of defense items from foreign sources provided in law if the Secretary determines that the application of the limitation with respect to that country would invalidate cooperative programs entered into between the Department of Defense and the foreign country, or would invalidate reciprocal trade agreements for the procurement of defense items entered into under section 2531 of title 10, United States Code, and the country does not discriminate against the same or similar defense items produced in the United States for that country.

(b) Subsection (a) applies with respect to—

(1) contracts and subcontracts entered into on or after the date of the enactment of this Act; and

(2) options for the procurement of items that are exercised after such date under contracts that are entered into before such date if the option prices are adjusted for any reason other than the application of a waiver granted under subsection (a).

(c) Subsection (a) does not apply to a limitation regarding construction of public vessels, ball and roller bearings, food, and clothing or textile materials as defined by section 11 (chapters 50–65) of the Harmonized Tariff Schedule and products classified under headings 4010, 4202, 4203, 6401 through 6406, 6505, 7019, 7218 through 7229, 7304.41 through 7304.49, 7306.40, 7502 through 7508, 8105, 8108, 8109, 8211, 8215, and 9404.

SEC. 8061. (a) None of the funds made available by this Act may be used to support any training program involving a unit of the security forces of a foreign country if the Secretary of Defense has received credible information from the Department of State that the unit has committed a gross violation of human rights, unless all necessary corrective steps have been taken.

(b) The Secretary of Defense, in consultation with the Secretary of State, shall ensure that prior to a decision to conduct any training program referred to in subsection (a), full consideration is given to all credible information available to the Department of State relating to human rights violations by foreign security forces.

(c) The Secretary of Defense, after consultation with the Secretary of State, may waive the prohibition in subsection (a) if he determines that such waiver is required by extraordinary circumstances.

(d) Not more than 15 days after the exercise of any waiver under subsection (c), the Secretary of Defense shall submit a report to the congressional defense committees describing the extraordinary circumstances, the purpose and duration of the training program, the United States forces and the foreign security forces involved in the training program, and the information relating to human rights violations that necessitates the waiver.

SEC. 8062. None of the funds appropriated or made available in this Act to the Depart-

ment of the Navy shall be used to develop, lease or procure the T-AKE class of ships unless the main propulsion diesel engines and propulsors are manufactured in the United States by a domestically operated entity: *Provided*, That the Secretary of Defense may waive this restriction on a case-by-case basis by certifying in writing to the Committees on Appropriations of the House of Representatives and the Senate that adequate domestic supplies are not available to meet Department of Defense requirements on a timely basis and that such an acquisition must be made in order to acquire capability for national security purposes or there exists a significant cost or quality difference.

SEC. 8063. None of the funds appropriated or otherwise made available by this or other Department of Defense Appropriations Acts may be obligated or expended for the purpose of performing repairs or maintenance to military family housing units of the Department of Defense, including areas in such military family housing units that may be used for the purpose of conducting official Department of Defense business.

SEC. 8064. Notwithstanding any other provision of law, funds appropriated in this Act under the heading “Research, Development, Test and Evaluation, Defense-Wide” for any new start advanced concept technology demonstration project or joint capability demonstration project may only be obligated 30 days after a report, including a description of the project, the planned acquisition and transition strategy and its estimated annual and total cost, has been provided in writing to the congressional defense committees: *Provided*, That the Secretary of Defense may waive this restriction on a case-by-case basis by certifying to the congressional defense committees that it is in the national interest to do so.

SEC. 8065. The Secretary of Defense shall provide a classified quarterly report beginning 30 days after enactment of this Act, to the House and Senate Appropriations Committees, Subcommittees on Defense on certain matters as directed in the classified annex accompanying this Act.

SEC. 8066. During the current fiscal year, none of the funds available to the Department of Defense may be used to provide support to another department or agency of the United States if such department or agency is more than 90 days in arrears in making payment to the Department of Defense for goods or services previously provided to such department or agency on a reimbursable basis: *Provided*, That this restriction shall not apply if the department is authorized by law to provide support to such department or agency on a nonreimbursable basis, and is providing the requested support pursuant to such authority: *Provided further*, That the Secretary of Defense may waive this restriction on a case-by-case basis by certifying in writing to the Committees on Appropriations of the House of Representatives and the Senate that it is in the national security interest to do so.

SEC. 8067. Notwithstanding section 12310(b) of title 10, United States Code, a Reserve who is a member of the National Guard serving on full-time National Guard duty under section 502(f) of title 32, United States Code, may perform duties in support of the ground-based elements of the National Ballistic Missile Defense System.

SEC. 8068. None of the funds provided in this Act may be used to transfer to any non-governmental entity ammunition held by the Department of Defense that has a center-fire cartridge and a United States military

nomenclature designation of "armor penetrator", "armor piercing (AP)", "armor piercing incendiary (API)", or "armor-piercing incendiary-tracer (API-T)", except to an entity performing demilitarization services for the Department of Defense under a contract that requires the entity to demonstrate to the satisfaction of the Department of Defense that armor piercing projectiles are either: (1) rendered incapable of reuse by the demilitarization process; or (2) used to manufacture ammunition pursuant to a contract with the Department of Defense or the manufacture of ammunition for export pursuant to a License for Permanent Export of Unclassified Military Articles issued by the Department of State.

SEC. 8069. Notwithstanding any other provision of law, the Chief of the National Guard Bureau, or his designee, may waive payment of all or part of the consideration that otherwise would be required under section 2667 of title 10, United States Code, in the case of a lease of personal property for a period not in excess of 1 year to any organization specified in section 508(d) of title 32, United States Code, or any other youth, social, or fraternal nonprofit organization as may be approved by the Chief of the National Guard Bureau, or his designee, on a case-by-case basis.

SEC. 8070. None of the funds appropriated by this Act shall be used for the support of any nonappropriated funds activity of the Department of Defense that procures malt beverages and wine with nonappropriated funds for resale (including such alcoholic beverages sold by the drink) on a military installation located in the United States unless such malt beverages and wine are procured within that State, or in the case of the District of Columbia, within the District of Columbia, in which the military installation is located: *Provided*, That in a case in which the military installation is located in more than one State, purchases may be made in any State in which the installation is located: *Provided further*, That such local procurement requirements for malt beverages and wine shall apply to all alcoholic beverages only for military installations in States which are not contiguous with another State: *Provided further*, That alcoholic beverages other than wine and malt beverages, in contiguous States and the District of Columbia shall be procured from the most competitive source, price and other factors considered.

SEC. 8071. Funds available to the Department of Defense for the Global Positioning System during the current fiscal year may be used to fund civil requirements associated with the satellite and ground control segments of such system's modernization program.

(INCLUDING TRANSFER OF FUNDS)

SEC. 8072. Of the amounts appropriated in this Act under the heading "Operation and Maintenance, Army", \$106,754,000 shall remain available until expended: *Provided*, That notwithstanding any other provision of law, the Secretary of Defense is authorized to transfer such funds to other activities of the Federal Government: *Provided further*, That the Secretary of Defense is authorized to enter into and carry out contracts for the acquisition of real property, construction, personal services, and operations related to projects carrying out the purposes of this section: *Provided further*, That contracts entered into under the authority of this section may provide for such indemnification as the Secretary determines to be necessary: *Provided further*, That projects authorized by

this section shall comply with applicable Federal, State, and local law to the maximum extent consistent with the national security, as determined by the Secretary of Defense.

SEC. 8073. Section 8106 of the Department of Defense Appropriations Act, 1997 (titles I through VIII of the matter under subsection 101(b) of Public Law 104-208; 110 Stat. 3009-111; 10 U.S.C. 113 note) shall continue in effect to apply to disbursements that are made by the Department of Defense in fiscal year 2010.

SEC. 8074. In addition to amounts provided elsewhere in this Act, \$3,750,000 is hereby appropriated to the Department of Defense, to remain available for obligation until expended: *Provided*, That notwithstanding any other provision of law, these funds shall be available only for a grant to the Fisher House Foundation, Inc., only for the construction and furnishing of additional Fisher Houses to meet the needs of military family members when confronted with the illness or hospitalization of an eligible military beneficiary.

(INCLUDING TRANSFER OF FUNDS)

SEC. 8075. Of the amounts appropriated in this Act under the heading "Research, Development, Test and Evaluation, Defense-Wide", \$202,434,000 shall be for the Israeli Cooperative Programs: *Provided*, That of this amount, \$80,092,000 shall be for the Short Range Ballistic Missile Defense (SRBMD) program, including cruise missile defense research and development under the SRBMD program, \$50,036,000 shall be available for an upper-tier component to the Israeli Missile Defense Architecture, and \$72,306,000 shall be for the Arrow Missile Defense Program, of which \$25,000,000 shall be for producing Arrow missile components in the United States and Arrow missile components in Israel to meet Israel's defense requirements, consistent with each nation's laws, regulations and procedures: *Provided further*, That funds made available under this provision for production of missiles and missile components may be transferred to appropriations available for the procurement of weapons and equipment, to be merged with and to be available for the same time period and the same purposes as the appropriation to which transferred: *Provided further*, That the transfer authority provided under this provision is in addition to any other transfer authority contained in this Act.

(INCLUDING TRANSFER OF FUNDS)

SEC. 8076. Of the amounts appropriated in this Act under the heading "Shipbuilding and Conversion, Navy", \$144,950,000 shall be available until September 30, 2010, to fund prior year shipbuilding cost increases: *Provided*, That upon enactment of this Act, the Secretary of the Navy shall transfer such funds to the following appropriations in the amounts specified: *Provided further*, That the amounts transferred shall be merged with and be available for the same purposes as the appropriations to which transferred:

To:

Under the heading "Shipbuilding and Conversion, Navy, 2004/2010":

New SSN, \$26,906,000; and

LPD-17 Amphibious Transport Dock Program, \$16,844,000.

Under the heading "Shipbuilding and Conversion, Navy, 2005/2010":

New SSN, \$18,702,000; and

LPD-17 Amphibious Transport Dock Program, \$16,498,000.

Under the heading "Shipbuilding and Conversion, Navy, 2008/2012":

LPD-17 Amphibious Transport Dock Program, \$66,000,000.

SEC. 8077. None of the funds available to the Department of Defense may be obligated to modify command and control relationships to give Fleet Forces Command administrative and operational control of U.S. Navy forces assigned to the Pacific fleet: *Provided*, That the command and control relationships which existed on October 1, 2004, shall remain in force unless changes are specifically authorized in a subsequent Act.

SEC. 8078. Notwithstanding any other provision of law or regulation, the Secretary of Defense may exercise the provisions of section 7403(g) of title 38, United States Code, for occupations listed in section 7403(a)(2) of title 38, United States Code, as well as the following:

Pharmacists, Audiologists, Psychologists, Social Workers, Othotists/Prosthetists, Occupational Therapists, Physical Therapists, Rehabilitation Therapists, Respiratory Therapists, Speech Pathologists, Dietitian/Nutritionists, Industrial Hygienists, Psychology Technicians, Social Service Assistants, Practical Nurses, Nursing Assistants, and Dental Hygienists:

(A) The requirements of section 7403(g)(1)(A) of title 38, United States Code, shall apply.

(B) The limitations of section 7403(g)(1)(B) of title 38, United States Code, shall not apply.

SEC. 8079. Funds appropriated by this Act, or made available by the transfer of funds in this Act, for intelligence activities are deemed to be specifically authorized by the Congress for purposes of section 504 of the National Security Act of 1947 (50 U.S.C. 414) during fiscal year 2010 until the enactment of the Intelligence Authorization Act for Fiscal Year 2010.

SEC. 8080. None of the funds provided in this Act shall be available for obligation or expenditure through a reprogramming of funds that creates or initiates a new program, project, or activity unless such program, project, or activity must be undertaken immediately in the interest of national security and only after written prior notification to the congressional defense committees.

SEC. 8081. In addition to funds made available elsewhere in this Act, \$5,500,000 is hereby appropriated and shall remain available until expended to provide assistance, by grant or otherwise (such as the provision of funds for information technology and textbook purchases, professional development for educators, and student transition support) to public schools in states that are considered overseas assignments with unusually high concentrations of special needs military dependents enrolled: *Provided*, That up to 2 percent of the total appropriated funds under this section shall be available for the administration and execution of the programs and/or events that promote the purpose of this appropriation: *Provided further*, That up to 5 percent of the total appropriated funds under this section shall be available to public schools that have entered into a military partnership: *Provided further*, That \$1,000,000 shall be available for a nonprofit trust fund to assist in the public-private funding of public school repair and maintenance projects: *Provided further*, That \$500,000 shall be available to fund an ongoing special education support program in public schools with unusually high concentrations of active duty military dependents enrolled: *Provided further*, That to the extent a Federal agency provides this assistance by contract, grant,

or otherwise, it may accept and expend non-Federal funds in combination with these Federal funds to provide assistance for the authorized purpose.

SEC. 8082. (a) In addition to the amounts provided elsewhere in this Act, \$3,000,000 is hereby appropriated to the Department of Defense for "Operation and Maintenance, Army National Guard". Such amount shall be made available to the Secretary of the Army only to make a grant in the amount of \$3,000,000 to the entity specified in subsection (b) to facilitate access by veterans to opportunities for skilled employment in the construction industry.

(b) The entity referred to in subsection (a) is the Center for Military Recruitment, Assessment and Veterans Employment, a non-profit labor-management cooperation committee provided for by section 302(c)(9) of the Labor-Management Relations Act, 1947 (29 U.S.C. 186(c)(9)), for the purposes set forth in section 6(b) of the Labor Management Cooperation Act of 1978 (29 U.S.C. 175a note).

SEC. 8083. The budget of the President for fiscal year 2011 submitted to the Congress pursuant to section 1105 of title 31, United States Code, shall include separate budget justification documents for costs of United States Armed Forces' participation in contingency operations for the Military Personnel accounts, the Operation and Maintenance accounts, and the Procurement accounts: *Provided*, That these documents shall include a description of the funding requested for each contingency operation, for each military service, to include all Active and Reserve components, and for each appropriations account: *Provided further*, That these documents shall include estimated costs for each element of expense or object class, a reconciliation of increases and decreases for each contingency operation, and programmatic data including, but not limited to, troop strength for each Active and Reserve component, and estimates of the major weapons systems deployed in support of each contingency: *Provided further*, That these documents shall include budget exhibits OP-5 and OP-32 (as defined in the Department of Defense Financial Management Regulation) for all contingency operations for the budget year and the two preceding fiscal years.

SEC. 8084. None of the funds in this Act may be used for research, development, test, evaluation, procurement or deployment of nuclear armed interceptors of a missile defense system.

SEC. 8085. In addition to the amounts appropriated or otherwise made available elsewhere in this Act, \$110,640,000 is hereby appropriated to the Department of Defense: *Provided*, That the Secretary of Defense shall make grants in the amounts specified as follows: \$15,000,000 to the United Service Organizations; \$22,500,000 to the Red Cross; \$6,000,000 to the SOAR Virtual School District; \$5,000,000 to The Presidio Heritage Center; \$5,000,000 to the Paralympics Military Program; \$3,840,000 to the Arrest Deterioration of Ford Island Aviation Control Tower, Pearl Harbor, Hawaii; \$1,500,000 to the Go For Broke program; \$800,000 to Our Military Kids; \$3,000,000 to the New Jersey Technology Center; \$1,600,000 to the Women in Military Service for America Memorial; \$500,000 to the Marshall Legacy Institute; \$1,000,000 to the Vietnam Veterans Memorial Fund for Demining Activities; \$18,900,000 to the Edward M. Kennedy Institute for the Senate; \$5,000,000 to the U.S.S. Missouri Memorial Association; \$20,000,000 to the National World War II Museum; and \$1,000,000 for the River-

side General Hospital in Houston, Texas, for the treatment of psychological health issues.

SEC. 8086. None of the funds appropriated or made available in this Act shall be used to reduce or disestablish the operation of the 53rd Weather Reconnaissance Squadron of the Air Force Reserve, if such action would reduce the WC-130 Weather Reconnaissance mission below the levels funded in this Act: *Provided*, That the Air Force shall allow the 53rd Weather Reconnaissance Squadron to perform other missions in support of national defense requirements during the non-hurricane season.

SEC. 8087. None of the funds provided in this Act shall be available for integration of foreign intelligence information unless the information has been lawfully collected and processed during the conduct of authorized foreign intelligence activities: *Provided*, That information pertaining to United States persons shall only be handled in accordance with protections provided in the Fourth Amendment of the United States Constitution as implemented through Executive Order No. 12333.

SEC. 8088. (a) At the time members of reserve components of the Armed Forces are called or ordered to active duty under section 12302(a) of title 10, United States Code, each member shall be notified in writing of the expected period during which the member will be mobilized.

(b) The Secretary of Defense may waive the requirements of subsection (a) in any case in which the Secretary determines that it is necessary to do so to respond to a national security emergency or to meet dire operational requirements of the Armed Forces.

(INCLUDING TRANSFER OF FUNDS)

SEC. 8089. The Secretary of Defense may transfer funds from any available Department of the Navy appropriation to any available Navy ship construction appropriation for the purpose of liquidating necessary changes resulting from inflation, market fluctuations, or rate adjustments for any ship construction program appropriated in law: *Provided*, That the Secretary may transfer not to exceed \$100,000,000 under the authority provided by this section: *Provided further*, That the Secretary may not transfer any funds until 30 days after the proposed transfer has been reported to the Committees on Appropriations of the House of Representatives and the Senate, unless a response from the Committees is received sooner: *Provided further*, That the transfer authority provided by this section is in addition to any other transfer authority contained elsewhere in this Act.

SEC. 8090. For purposes of section 612 of title 41, United States Code, any subdivision of appropriations made under the heading "Shipbuilding and Conversion, Navy" that is not closed at the time reimbursement is made shall be available to reimburse the Judgment Fund and shall be considered for the same purposes as any subdivision under the heading "Shipbuilding and Conversion, Navy" appropriations in the current fiscal year or any prior fiscal year.

SEC. 8091. (a) None of the funds appropriated by this Act may be used to transfer research and development, acquisition, or other program authority relating to current tactical unmanned aerial vehicles (TUAVs) from the Army.

(b) The Army shall retain responsibility for and operational control of the MQ-1C Sky Warrior Unmanned Aerial Vehicle (UAV) in order to support the Secretary of Defense in matters relating to the employment of unmanned aerial vehicles.

SEC. 8092. Of the funds provided in this Act, \$10,000,000 shall be available for the operations and development of training and technology for the Joint Interagency Training and Education Center and the affiliated Center for National Response at the Memorial Tunnel and for providing homeland defense/security and traditional warfighting training to the Department of Defense, other Federal agencies, and State and local first responder personnel at the Joint Interagency Training and Education Center.

SEC. 8093. Notwithstanding any other provision of law or regulation, the Secretary of Defense may adjust wage rates for civilian employees hired for certain health care occupations as authorized for the Secretary of Veterans Affairs by section 7455 of title 38, United States Code.

SEC. 8094. Up to \$16,000,000 of the funds appropriated under the heading "Operation and Maintenance, Navy" may be made available for the Asia Pacific Regional Initiative Program for the purpose of enabling the Pacific Command to execute Theater Security Cooperation activities such as humanitarian assistance, and payment of incremental and personnel costs of training and exercising with foreign security forces: *Provided*, That funds made available for this purpose may be used, notwithstanding any other funding authorities for humanitarian assistance, security assistance or combined exercise expenses: *Provided further*, That funds may not be obligated to provide assistance to any foreign country that is otherwise prohibited from receiving such type of assistance under any other provision of law.

SEC. 8095. None of the funds appropriated by this Act for programs of the Office of the Director of National Intelligence shall remain available for obligation beyond the current fiscal year, except for funds appropriated for research and technology, which shall remain available until September 30, 2011.

SEC. 8096. For purposes of section 1553(b) of title 31, United States Code, any subdivision of appropriations made in this Act under the heading "Shipbuilding and Conversion, Navy" shall be considered to be for the same purpose as any subdivision under the heading "Shipbuilding and Conversion, Navy" appropriations in any prior fiscal year, and the 1 percent limitation shall apply to the total amount of the appropriation.

SEC. 8097. Notwithstanding any other provision of this Act, to reflect savings from revised economic assumptions, the total amount appropriated in title II of this Act is hereby reduced by \$194,000,000, the total amount appropriated in title III of this Act is hereby reduced by \$322,000,000, the total amount appropriated in title IV of this Act is hereby reduced by \$336,000,000, and the total amount appropriated in title V of this Act is hereby reduced by \$9,000,000: *Provided*, That the Secretary of Defense shall allocate this reduction proportionally to each budget activity, activity group, subactivity group, and each program, project, and activity, within each appropriation account.

SEC. 8098. Notwithstanding any other provision of law, that not more than 35 percent of funds provided in this Act for environmental remediation may be obligated under indefinite delivery/indefinite quantity contracts with a total contract value of \$130,000,000 or higher.

SEC. 8099. The Secretary of Defense shall create a major force program category for space for the Future Years Defense Program of the Department of Defense. The Secretary of Defense shall designate an official in the

Office of the Secretary of Defense to provide overall supervision of the preparation and justification of program recommendations and budget proposals to be included in such major force program category.

SEC. 8100. The Director of National Intelligence shall include the budget exhibits identified in paragraphs (1) and (2) as described in the Department of Defense Financial Management Regulation with the congressional budget justification books.

(1) For procurement programs requesting more than \$20,000,000 in any fiscal year, the P-1, Procurement Program; P-5, Cost Analysis; P-5a, Procurement History and Planning; P-21, Production Schedule; and P-40, Budget Item Justification.

(2) For research, development, test and evaluation projects requesting more than \$10,000,000 in any fiscal year, the R-1, RDT&E Program; R-2, RDT&E Budget Item Justification; R-3, RDT&E Project Cost Analysis; and R-4, RDT&E Program Schedule Profile.

SEC. 8101. Notwithstanding any other provision of law, none of the funds made available in this Act may be used to pay negotiated indirect cost rates on a contract, grant, or cooperative agreement (or similar arrangement) entered into by the Department of Defense and an entity in excess of 35 percent of the total cost of the contract, grant, or agreement (or similar arrangement): *Provided*, That this limitation shall apply only to contracts, grants, or cooperative agreements entered into after the date of enactment of this Act using funds made available in this Act for basic research.

SEC. 8102. The Secretary of Defense shall maintain on the homepage of the Internet website of the Department of Defense a direct link to the Internet website of the Office of Inspector General of the Department of Defense.

SEC. 8103. (a) Not later than 60 days after enactment of this Act, the Office of the Director of National Intelligence shall submit a report to the congressional intelligence committees to establish the baseline for application of reprogramming and transfer authorities for fiscal year 2010: *Provided*, That the report shall include—

(1) a table for each appropriation with a separate column to display the President's budget request, adjustments made by Congress, adjustments due to enacted rescissions, if appropriate, and the fiscal year enacted level;

(2) a delineation in the table for each appropriation by Expenditure Center and project; and

(3) an identification of items of special congressional interest.

(b) None of the funds provided for the National Intelligence Program in this Act shall be available for reprogramming or transfer until the report identified in subsection (a) is submitted to the congressional intelligence committees, unless the Director of National Intelligence certifies in writing to the congressional intelligence committees that such reprogramming or transfer is necessary as an emergency requirement.

SEC. 8104. The Director of National Intelligence shall submit to Congress each year, at or about the time that the President's budget is submitted to Congress that year under section 1105(a) of title 31, United States Code, a future-years intelligence program (including associated annexes) reflecting the estimated expenditures and proposed appropriations included in that budget. Any such future-years intelligence program shall cover the fiscal year with respect to which

the budget is submitted and at least the four succeeding fiscal years.

SEC. 8105. For the purposes of this Act, the term "congressional intelligence committees" means the Permanent Select Committee on Intelligence of the House of Representatives, the Select Committee on Intelligence of the Senate, the Subcommittee on Defense of the Committee on Appropriations of the House of Representatives, and the Subcommittee on Defense of the Committee on Appropriations of the Senate.

SEC. 8106. The Department of Defense shall continue to report incremental contingency operations costs for Operation Iraqi Freedom and Operation Enduring Freedom on a monthly basis in the Cost of War Execution Report as prescribed in the Department of Defense Financial Management Regulation Department of Defense Instruction 7000.14, Volume 12, Chapter 23 "Contingency Operations", Annex 1, dated September 2005.

SEC. 8107. The amounts appropriated in title II of this Act are hereby reduced by \$400,000,000 to reflect excess cash balances in Department of Defense Working Capital Funds, as follows:

(1) From "Operation and Maintenance, Army", \$150,000,000; and

(2) From "Operation and Maintenance, Air Force", \$250,000,000.

(INCLUDING TRANSFER OF FUNDS)

SEC. 8108. (a) CONTINUATION OF STOP-LOSS SPECIAL PAY.—Funds appropriated by this Act, or made available by the transfer of funds in this Act, shall be made available to the Secretaries of the military departments only to provide special pay during fiscal year 2010 to members of the Army, Navy, Air Force, and Marine Corps, including members of their reserve components, who, at any time during fiscal year 2010, serve on active duty while the members' enlistment or period of obligated service is extended, or whose eligibility for retirement is suspended, pursuant to section 123 or 12305 of title 10, United States Code, or any other provision of law (commonly referred to as a "stop-loss authority") authorizing the President to extend an enlistment or period of obligated service, or suspend an eligibility for retirement, of a member of the uniformed services in time of war or of national emergency declared by Congress or the President.

(b) SPECIAL PAY AMOUNT.—The amount of the special pay paid under subsection (a) to or on behalf of an eligible member shall be \$500 per month for each month or portion of a month during fiscal year 2010 that the member is retained on active duty as a result of application of the stop-loss authority.

(c) TREATMENT OF DECEASED MEMBERS.—If an eligible member described in subsection (a) dies before the payment required by this section is made, the Secretary of the military department concerned shall make the payment in accordance with section 2771 of title 10, United States Code.

(d) CLARIFICATION OF RETROACTIVE STOP-LOSS SPECIAL PAY AUTHORITY.—Section 310 of the Supplemental Appropriations Act, 2009 (Public Law 111-32; 123 Stat. 1870) is amended by adding at the end the following new subsection:

"(i) EFFECT OF SUBSEQUENT REENLISTMENT OF VOLUNTARY EXTENSION OF SERVICE.—Members of the Armed Forces, retired members, and former members otherwise described in subsection (a) are not eligible for a payment under this section if the members—

"(1) voluntarily reenlisted or extended their service after their enlistment or period of obligated service was extended, or after

their eligibility for retirement was suspended, pursuant to a stop-loss authority; and

"(2) received a bonus for such reenlistment or extension of service."

(INCLUDING TRANSFER OF FUNDS)

SEC. 8109. During the current fiscal year, not to exceed \$11,000,000 from each of the appropriations made in title II of this Act for "Operation and Maintenance, Army", "Operation and Maintenance, Navy", and "Operation and Maintenance, Air Force" may be transferred by the military department concerned to its central fund established for Fisher Houses and Suites pursuant to section 2493(d) of title 10, United States Code.

(INCLUDING TRANSFER OF FUNDS)

SEC. 8110. Of the funds appropriated in the Intelligence Community Management Account for the Program Manager for the Information Sharing Environment, \$24,000,000 is available for transfer by the Director of National Intelligence to other departments and agencies for purposes of Government-wide information sharing activities: *Provided*, That funds transferred under this provision are to be merged with and available for the same purposes and time period as the appropriation to which transferred: *Provided further*, That the Office of Management and Budget must approve any transfers made under this provision.

SEC. 8111. Funds appropriated by this Act for operation and maintenance may be available for the purpose of making remittances to the Defense Acquisition Workforce Development Fund in accordance with the requirements of section 1705 of title 10, United States Code.

SEC. 8112. (a) HIGH PRIORITY NATIONAL GUARD COUNTERDRUG PROGRAMS.—Of the amount appropriated or otherwise made available by title VI under the heading "Drug Interdiction and Counter-Drug Activities, Defense", up to \$15,000,000 shall be available for the purpose of High Priority National Guard Counterdrug Programs.

(b) SUPPLEMENT NOT SUPPLANT.—The amount made available by subsection (a) for the purpose specified in that subsection is in addition to any other amounts made available by this Act for that purpose.

APOLOGY TO NATIVE PEOPLES OF THE UNITED STATES

SEC. 8113. (a) ACKNOWLEDGMENT AND APOLOGY.—The United States, acting through Congress—

(1) recognizes the special legal and political relationship Indian tribes have with the United States and the solemn covenant with the land we share;

(2) commends and honors Native Peoples for the thousands of years that they have stewarded and protected this land;

(3) recognizes that there have been years of official depredations, ill-conceived policies, and the breaking of covenants by the Federal Government regarding Indian tribes;

(4) apologizes on behalf of the people of the United States to all Native Peoples for the many instances of violence, maltreatment, and neglect inflicted on Native Peoples by citizens of the United States;

(5) expresses its regret for the ramifications of former wrongs and its commitment to build on the positive relationships of the past and present to move toward a brighter future where all the people of this land live reconciled as brothers and sisters, and harmoniously stewarded and protect this land together;

(6) urges the President to acknowledge the wrongs of the United States against Indian

tribes in the history of the United States in order to bring healing to this land; and

(7) commends the State governments that have begun reconciliation efforts with recognized Indian tribes located in their boundaries and encourages all State governments similarly to work toward reconciling relationships with Indian tribes within their boundaries.

(b) **DISCLAIMER.**—Nothing in this section—

(1) authorizes or supports any claim against the United States; or

(2) serves as a settlement of any claim against the United States.

SEC. 8114. (a) Any agency receiving funds made available in this Act, shall, subject to subsections (b) and (c), post on the public website of that agency any report required to be submitted by the Congress in this or any other Act, upon the determination by the head of the agency that it shall serve the national interest.

(b) Subsection (a) shall not apply to a report if—

(1) the public posting of the report compromises national security; or

(2) the report contains proprietary information.

(c) The head of the agency posting such report shall do so only after such report has been made available to the requesting Committee or Committees of Congress for no less than 45 days.

SEC. 8115. (a) It is the sense of Congress that—

(1) All of the National Nuclear Security Administration sites, including the Nevada Test Site can play an effective and essential role in developing and demonstrating—

(A) innovative and effective methods for treaty verification and the detection of nuclear weapons and other materials; and

(B) related threat reduction technologies; and

(2) the Administrator for Nuclear Security should expand the mission of the Nevada Test Site to carry out the role described in paragraph (1), including by—

(A) fully utilizing the inherent capabilities and uniquely secure location of the Site;

(B) continuing to support the Nation's nuclear weapons program and other national security programs; and

(C) renaming the Site to reflect the expanded mission of the Site.

(b) Not later than one year after the date of the enactment of this Act, the Administrator for Nuclear Security shall submit to the congressional defense committees and the Subcommittees on Energy and Water Development of the Committees on Appropriations a plan for improving the infrastructure of the Nevada Test Site of the National Nuclear Security Administration and, if the Administrator deems appropriate, all other sites under the jurisdiction of the National Nuclear Security Administration—

(1) to fulfill the expanded mission of the Site described in subsection (a); and

(2) to make the Site available to support the threat reduction programs of the entire national security community, including threat reduction programs of the National Nuclear Security Administration, the Defense Threat Reduction Agency, the Department of Homeland Security, and other agencies as appropriate.

SEC. 8116. (a) None of the funds appropriated or otherwise made available by this Act may be expended for any Federal contract for an amount in excess of \$1,000,000 that is awarded more than 60 days after the effective date of this Act, unless the contractor agrees not to:

(1) enter into any agreement with any of its employees or independent contractors that requires, as a condition of employment, that the employee or independent contractor agree to resolve through arbitration any claim under title VII of the Civil Rights Act of 1964 or any tort related to or arising out of sexual assault or harassment, including assault and battery, intentional infliction of emotional distress, false imprisonment, or negligent hiring, supervision, or retention; or

(2) take any action to enforce any provision of an existing agreement with an employee or independent contractor that mandates that the employee or independent contractor resolve through arbitration any claim under title VII of the Civil Rights Act of 1964 or any tort related to or arising out of sexual assault or harassment, including assault and battery, intentional infliction of emotional distress, false imprisonment, or negligent hiring, supervision, or retention.

(b) None of the funds appropriated or otherwise made available by this Act may be expended for any Federal contract awarded more than 180 days after the effective date of this Act unless the contractor certifies that it requires each covered subcontractor to agree not to enter into, and not to take any action to enforce any provision of, any agreement as described in paragraphs (1) and (2) of subsection (a), with respect to any employee or independent contractor performing work related to such subcontract. For purposes of this subsection, a "covered subcontractor" is an entity that has a subcontract in excess of \$1,000,000 on a contract subject to subsection (a).

(c) The prohibitions in this section do not apply with respect to a contractor's or subcontractor's agreements with employees or independent contractors that may not be enforced in a court of the United States.

(d) The Secretary of Defense may waive the application of subsection (a) or (b) to a particular contractor or subcontractor for the purposes of a particular contract or subcontract if the Secretary or the Deputy Secretary personally determines that the waiver is necessary to avoid harm to national security interests of the United States, and that the term of the contract or subcontract is not longer than necessary to avoid such harm. The determination shall set forth with specificity the grounds for the waiver and for the contract or subcontract term selected, and shall state any alternatives considered in lieu of a waiver and the reasons each such alternative would not avoid harm to national security interests of the United States. The Secretary of Defense shall transmit to Congress, and simultaneously make public, any determination under this subsection not less than 15 business days before the contract or subcontract addressed in the determination may be awarded.

SEC. 8117. (a) **PROHIBITION ON CONVERSION OF FUNCTIONS PERFORMED BY FEDERAL EMPLOYEES TO CONTRACTOR PERFORMANCE.**—None of the funds appropriated or otherwise made available by this Act, or that remain available for obligation for the Department of Defense from the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (Public Law 110-329), the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and the Supplemental Appropriations Act, 2009 (Public Law 111-32), may be used to begin or announce the competition to award to a contractor or convert to performance by a contractor any functions performed by Federal employees pursuant to a study conducted under Office

of Management and Budget (OMB) Circular A-76.

(b) **EXCEPTION.**—The prohibition in subsection (a) shall not apply to the award of a function to a contractor or the conversion of a function to performance by a contractor pursuant to a study conducted under Office of Management and Budget (OMB) Circular A-76 once all reporting and certifications required by section 325 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111-84) have been satisfactorily completed.

SEC. 8118. (a)(1) No National Intelligence Program funds appropriated in this Act may be used for a mission critical or mission essential business management information technology system that is not registered with the Director of National Intelligence. A system shall be considered to be registered with that officer upon the furnishing notice of the system, together with such information concerning the system as the Director of the Business Transformation Office may prescribe.

(2) During the current fiscal year no funds may be obligated or expended for a financial management automated information system, a mixed information system supporting financial and non-financial systems, or a business system improvement of more than \$3,000,000, within the Intelligence Community without the approval of the Business Transformation Investment Review Board.

(b) The Director of the Business Transformation Office shall provide the congressional intelligence committees a semi-annual report of approvals under paragraph (1) no later than March 30 and September 30 of each year. The report shall include the results of the Business Transformation Investment Review Board's semi-annual activities, and each report shall certify that the following steps have been taken for systems approved under paragraph (1):

(1) Business process reengineering.

(2) An analysis of alternatives and an economic analysis that includes a calculation of the return on investment.

(3) Assurance the system is compatible with the enterprise-wide business architecture.

(4) Performance measures.

(5) An information assurance strategy consistent with the Chief Information Officer of the Intelligence Community.

(c) This section shall not apply to any programmatic or analytic systems or programmatic or analytic system improvements.

(INCLUDING TRANSFER OF FUNDS)

SEC. 8119. In addition to funds made available elsewhere in this Act, there is hereby appropriated \$291,715,000, to remain available until transferred: *Provided*, That these funds are appropriated to the "Tanker Replacement Transfer Fund" (referred to as "the Fund" elsewhere in this section): *Provided further*, That the Secretary of the Air Force may transfer amounts in the Fund to "Operation and Maintenance, Air Force", "Air-craft Procurement, Air Force", and "Research, Development, Test and Evaluation, Air Force", only for the purposes of proceeding with a tanker acquisition program: *Provided further*, That funds transferred shall be merged with and be available for the same purposes and for the same time period as the appropriations or fund to which transferred: *Provided further*, That this transfer authority is in addition to any other transfer authority available to the Department of Defense: *Provided further*, That the Secretary of the Air Force shall, not fewer than 15 days prior to

making transfers using funds provided in this section, notify the congressional defense committees in writing of the details of any such transfer: *Provided further*, That the Secretary shall submit a report no later than 30 days after the end of each fiscal quarter to the congressional defense committees summarizing the details of the transfer of funds from this appropriation.

SEC. 8120. (a) RESETTLEMENT SUPPORT AND OTHER PUBLIC BENEFITS FOR CERTAIN IRAQI REFUGEES.—Section 1224(g) of the Refugee Crisis in Iraq Act of 2007 (subtitle C of title XII of division A of Public Law 110-181; 122 Stat. 398) is amended by striking “for a period not to exceed eight months” and inserting “to the same extent, and for the same periods of time, as such refugees”.

(b) RESETTLEMENT SUPPORT AND OTHER PUBLIC BENEFITS FOR CERTAIN AFGHAN ALLIES.—Section 602(b)(8) of the Afghan Allies Protection Act of 2009 (title VI of division F of Public Law 111-8; 123 Stat. 809) is amended by striking “for a period not to exceed 8 months” and inserting “to the same extent, and for the same periods of time, as such refugees”.

SEC. 8121. (a) Each congressionally directed spending item specified in this Act or the explanatory statement regarding this Act that is also identified in Senate Report 111-74 and intended for award to a for-profit entity shall be subject to acquisition regulations for full and open competition on the same basis as each spending item intended for a for-profit entity that is contained in the budget request of the President.

(b) EXCEPTIONS.—Subsection (a) shall not apply to any contract awarded—

(1) by a means that is required by Federal statute, including for a purchase made under a mandated preferential program;

(2) pursuant to the Small Business Act (15 U.S.C. 631 et seq.); or

(3) in an amount less than the simplified acquisition threshold described in section 302A(a) of the Federal Property and Administrative Services Act of 1949 (41 U.S.C. 252a(a)).

(c) Any congressionally directed spending item specified in this Act or the explanatory statement regarding this Act that is intended for award to a for-profit entity and is not covered by the competition requirement specified in subsection (a), shall be awarded under full and open competition, except that any contract previously awarded under full and open competition that remains in effect during fiscal year 2010 shall be considered to have satisfied the conditions of full and open competition.

(d) In this section, the term “congressionally directed spending item” means the following:

(1) A congressionally directed spending item, as defined in Rule XLIV of the Standing Rules of the Senate.

(2) A congressional earmark for purposes of rule XXI of the House of Representatives.

SEC. 8122. None of the funds appropriated or otherwise made available by this Act may be used to award to a contractor or convert to performance by a contractor any functions pursuant to a study conducted under Office of Management and Budget (OMB) Circular A-76 or as part of a utility privatization authorized under section 2688 of title 10, United States Code or under any other provision of law, that are performed by Federal employees at the United States Military Academy, West Point, as of the date of enactment of this Act.

SEC. 8123. None of the funds made available under this Act may be distributed to the As-

sociation of Community Organizations for Reform Now (ACORN) or its subsidiaries.

SEC. 8124. The explanatory statement regarding this Act printed in the House of Representatives section of the Congressional Record on or about December 16, 2010, by the Chairman of the Subcommittee on Defense of the Committee on Appropriations of the House of Representatives shall have the same effect with respect to the allocation of funds and implementation of this Act as if it were a joint explanatory statement of a committee of conference.

TITLE IX

OVERSEAS CONTINGENCY OPERATIONS MILITARY PERSONNEL

MILITARY PERSONNEL, ARMY

For an additional amount for “Military Personnel, Army”, \$9,958,840,000.

MILITARY PERSONNEL, NAVY

For an additional amount for “Military Personnel, Navy”, \$1,388,601,000.

MILITARY PERSONNEL, MARINE CORPS

For an additional amount for “Military Personnel, Marine Corps”, \$778,722,000.

MILITARY PERSONNEL, AIR FORCE

For an additional amount for “Military Personnel, Air Force”, \$1,667,376,000.

RESERVE PERSONNEL, ARMY

For an additional amount for “Reserve Personnel, Army”, \$293,137,000.

RESERVE PERSONNEL, NAVY

For an additional amount for “Reserve Personnel, Navy”, \$37,040,000.

RESERVE PERSONNEL, MARINE CORPS

For an additional amount for “Reserve Personnel, Marine Corps”, \$31,337,000.

RESERVE PERSONNEL, AIR FORCE

For an additional amount for “Reserve Personnel, Air Force”, \$19,822,000.

NATIONAL GUARD PERSONNEL, ARMY

For an additional amount for “National Guard Personnel, Army”, \$824,966,000.

NATIONAL GUARD PERSONNEL, AIR FORCE

For an additional amount for “National Guard Personnel, Air Force”, \$9,500,000.

OPERATION AND MAINTENANCE

OPERATION AND MAINTENANCE, ARMY

For an additional amount for “Operation and Maintenance, Army”, \$47,821,154,000.

OPERATION AND MAINTENANCE, NAVY

For an additional amount for “Operation and Maintenance, Navy”, \$5,475,925,000.

OPERATION AND MAINTENANCE, MARINE CORPS

For an additional amount for “Operation and Maintenance, Marine Corps”, \$3,430,258,000.

OPERATION AND MAINTENANCE, AIR FORCE

For an additional amount for “Operation and Maintenance, Air Force”, \$9,216,319,000.

OPERATION AND MAINTENANCE, DEFENSE-WIDE

For an additional amount for “Operation and Maintenance, Defense-Wide”, \$7,490,900,000, of which:

(1) Not to exceed \$12,500,000 for the Combatant Commander Initiative Fund, to be used in support of Operation Iraqi Freedom and Operation Enduring Freedom; and

(2) Not to exceed \$1,570,000,000, to remain available until expended, for payments to reimburse key cooperating nations for logistical, military, and other support, including access provided to United States military operations in support of Operation Iraqi Freedom and Operation Enduring Freedom, notwithstanding any other provision of

law: *Provided*, That such reimbursement payments may be made in such amounts as the Secretary of Defense, with the concurrence of the Secretary of State, and in consultation with the Director of the Office of Management and Budget, may determine, in his discretion, based on documentation determined by the Secretary of Defense to adequately account for the support provided, and such determination is final and conclusive upon the accounting officers of the United States, and 15 days following notification to the appropriate congressional committees: *Provided further*, That these funds may be used for the purpose of providing specialized training and procuring supplies and specialized equipment and providing such supplies and loaning such equipment on a non-reimbursable basis to coalition forces supporting United States military operations in Iraq and Afghanistan, and 15 days following notification to the appropriate congressional committees: *Provided further*, That the Secretary of Defense shall provide quarterly reports to the congressional defense committees on the use of funds provided in this paragraph.

OPERATION AND MAINTENANCE, ARMY RESERVE

For an additional amount for “Operation and Maintenance, Army Reserve”, \$204,326,000.

OPERATION AND MAINTENANCE, NAVY RESERVE

For an additional amount for “Operation and Maintenance, Navy Reserve”, \$68,059,000.

OPERATION AND MAINTENANCE, MARINE CORPS RESERVE

For an additional amount for “Operation and Maintenance, Marine Corps Reserve”, \$86,667,000.

OPERATION AND MAINTENANCE, AIR FORCE RESERVE

For an additional amount for “Operation and Maintenance, Air Force Reserve”, \$125,925,000.

OPERATION AND MAINTENANCE, ARMY NATIONAL GUARD

For an additional amount for “Operation and Maintenance, Army National Guard”, \$321,646,000.

OPERATION AND MAINTENANCE, AIR NATIONAL GUARD

For an additional amount for “Operation and Maintenance, Air National Guard”, \$289,862,000.

OVERSEAS CONTINGENCY OPERATIONS TRANSFER FUND

(INCLUDING TRANSFER OF FUNDS)

For an additional amount for expenses directly relating to overseas contingency operations by United States military forces, \$5,000,000,000, to remain available for obligation until expended: *Provided*, That of the funds made available under this heading, the Secretary of Defense may transfer these funds only to military personnel accounts, operation and maintenance accounts, the defense health program appropriation, the Mine Resistant Ambush Protected Vehicle Fund, and working capital funds accounts: *Provided further*, That the funds transferred shall be merged with and shall be available for the same purposes and for the same time period, as the appropriation to which transferred: *Provided further*, That the Secretary shall notify the congressional defense committees 15 days prior to such transfer: *Provided further*, That the transfer authority provided under this heading is in addition to any other transfer authority available to the Department of Defense.

AFGHANISTAN SECURITY FORCES FUND

For the "Afghanistan Security Forces Fund", \$6,562,769,000, to remain available until September 30, 2011: *Provided*, That such funds shall be available to the Secretary of Defense, notwithstanding any other provision of law, for the purpose of allowing the Commander, Combined Security Transition Command—Afghanistan, or the Secretary's designee, to provide assistance, with the concurrence of the Secretary of State, to the security forces of Afghanistan, including the provision of equipment, supplies, services, training, facility and infrastructure repair, renovation, and construction, and funding: *Provided further*, That the authority to provide assistance under this heading is in addition to any other authority to provide assistance to foreign nations: *Provided further*, That contributions of funds for the purposes provided herein from any person, foreign government, or international organization may be credited to this Fund and used for such purposes: *Provided further*, That the Secretary of Defense shall notify the congressional defense committees in writing upon the receipt and upon the obligation of any contribution, delineating the sources and amounts of the funds received and the specific use of such contributions: *Provided further*, That the Secretary of Defense shall, not fewer than 15 days prior to obligating from this appropriation account, notify the congressional defense committees in writing of the details of any such obligation.

PROCUREMENT

AIRCRAFT PROCUREMENT, ARMY

For an additional amount for "Aircraft Procurement, Army", \$1,238,219,000, to remain available until September 30, 2012.

MISSILE PROCUREMENT, ARMY

For an additional amount for "Missile Procurement, Army", \$475,954,000, to remain available until September 30, 2012.

PROCUREMENT OF WEAPONS AND TRACKED COMBAT VEHICLES, ARMY

For an additional amount for "Procurement of Weapons and Tracked Combat Vehicles, Army", \$1,169,466,000, to remain available until September 30, 2012.

PROCUREMENT OF AMMUNITION, ARMY

For an additional amount for "Procurement of Ammunition, Army", \$365,635,000, to remain available until September 30, 2012.

OTHER PROCUREMENT, ARMY

For an additional amount for "Other Procurement, Army", \$5,800,516,000, to remain available until September 30, 2012.

AIRCRAFT PROCUREMENT, NAVY

For an additional amount for "Aircraft Procurement, Navy", \$853,297,000, to remain available until September 30, 2012.

WEAPONS PROCUREMENT, NAVY

For an additional amount for "Weapons Procurement, Navy", \$50,700,000, to remain available until September 30, 2012.

PROCUREMENT OF AMMUNITION, NAVY AND MARINE CORPS

For an additional amount for "Procurement of Ammunition, Navy and Marine Corps", \$675,957,000, to remain available until September 30, 2012.

OTHER PROCUREMENT, NAVY

For an additional amount for "Other Procurement, Navy", \$241,018,000, to remain available until September 30, 2012.

PROCUREMENT, MARINE CORPS

For an additional amount for "Procurement, Marine Corps", \$893,197,000, to remain available until September 30, 2012.

AIRCRAFT PROCUREMENT, AIR FORCE

For an additional amount for "Aircraft Procurement, Air Force", \$736,501,000, to remain available until September 30, 2012.

MISSILE PROCUREMENT, AIR FORCE

For an additional amount for "Missile Procurement, Air Force", \$36,625,000, to remain available until September 30, 2012.

PROCUREMENT OF AMMUNITION, AIR FORCE

For an additional amount for "Procurement of Ammunition, Air Force", \$256,819,000, to remain available until September 30, 2012.

OTHER PROCUREMENT, AIR FORCE

For an additional amount for "Other Procurement, Air Force", \$2,583,421,000, to remain available until September 30, 2012.

PROCUREMENT, DEFENSE-WIDE

For an additional amount for "Procurement, Defense-Wide", \$480,780,000, to remain available until September 30, 2012.

NATIONAL GUARD AND RESERVE EQUIPMENT

For procurement of aircraft, missiles, tracked combat vehicles, ammunition, other weapons and other procurement for the reserve components of the Armed Forces, \$950,000,000, to remain available for obligation until September 30, 2012, of which \$575,000,000 shall be available only for the Army National Guard: *Provided*, That the Chiefs of National Guard and Reserve components shall, not later than 30 days after the enactment of this Act, individually submit to the congressional defense committees the modernization priority assessment for their respective National Guard or Reserve component.

MINE RESISTANT AMBUSH PROTECTED VEHICLE FUND

(INCLUDING TRANSFER OF FUNDS)

For the Mine Resistant Ambush Protected Vehicle Fund, \$6,281,000,000, to remain available until September 30, 2011: *Provided*, That such funds shall be available to the Secretary of Defense, notwithstanding any other provision of law, to procure, sustain, transport, and field Mine Resistant Ambush Protected vehicles: *Provided further*, That the Secretary shall transfer such funds only to appropriations made available in this or any other Act for operation and maintenance; procurement; research, development, test and evaluation; and defense working capital funds to accomplish the purpose provided herein: *Provided further*, That such transferred funds shall be merged with and be available for the same purposes and the same time period as the appropriation to which transferred: *Provided further*, That this transfer authority is in addition to any other transfer authority available to the Department of Defense: *Provided further*, That the Secretary shall, not fewer than 10 days prior to making transfers from this appropriation, notify the congressional defense committees in writing of the details of any such transfer.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, ARMY

For an additional amount for "Research, Development, Test and Evaluation, Army", \$57,962,000, to remain available until September 30, 2011.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, NAVY

For an additional amount for "Research, Development, Test and Evaluation, Navy", \$58,660,000, to remain available until September 30, 2011.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, AIR FORCE

For an additional amount for "Research, Development, Test and Evaluation, Air Force", \$39,286,000, to remain available until September 30, 2011.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, DEFENSE-WIDE

For an additional amount for "Research, Development, Test and Evaluation, Defense-Wide", \$112,196,000, to remain available until September 30, 2011.

REVOLVING AND MANAGEMENT FUNDS

DEFENSE WORKING CAPITAL FUNDS

For an additional amount for "Defense Working Capital Funds", \$412,215,000.

OTHER DEPARTMENT OF DEFENSE PROGRAMS

DEFENSE HEALTH PROGRAM

For an additional amount for "Defense Health Program", \$1,256,675,000, which shall be for operation and maintenance.

DRUG INTERDICTION AND COUNTER-DRUG ACTIVITIES

(INCLUDING TRANSFER OF FUNDS)

For an additional amount for "Drug Interdiction and Counter-Drug Activities", \$346,603,000, to remain available until September 30, 2011.

JOINT IMPROVISED EXPLOSIVE DEVICE DEFEAT FUND

(INCLUDING TRANSFER OF FUNDS)

For an additional amount for "Joint Improvised Explosive Device Defeat Fund", \$1,762,010,000, to remain available until September 30, 2012.

OFFICE OF THE INSPECTOR GENERAL

For an additional amount for the "Office of the Inspector General", \$8,876,000.

GENERAL PROVISIONS—THIS TITLE

SEC. 9001. Notwithstanding any other provision of law, funds made available in this title are in addition to amounts appropriated or otherwise made available for the Department of Defense for fiscal year 2010.

(INCLUDING TRANSFER OF FUNDS)

SEC. 9002. Upon the determination of the Secretary of Defense that such action is necessary in the national interest, the Secretary may, with the approval of the Office of Management and Budget, transfer up to \$4,000,000,000 between the appropriations or funds made available to the Department of Defense in this title: *Provided*, That the Secretary shall notify the Congress promptly of each transfer made pursuant to the authority in this section: *Provided further*, That the authority provided in this section is in addition to any other transfer authority available to the Department of Defense and is subject to the same terms and conditions as the authority provided in the Department of Defense Appropriations Act, 2010: *Provided further*, That the amount in this section is designated as being for overseas deployments and other activities pursuant to sections 401(c)(4) and 423(a)(1) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010.

SEC. 9003. Supervision and administration costs associated with a construction project funded with appropriations available for operation and maintenance or the "Afghanistan Security Forces Fund" provided in this Act and executed in direct support of overseas contingency operations in Afghanistan, may be obligated at the time a construction contract is awarded: *Provided*, That for the purpose of this section, supervision and administration costs include all in-house Government costs.

SEC. 9004. From funds made available in this title, the Secretary of Defense may purchase for use by military and civilian employees of the Department of Defense in Iraq and Afghanistan: (a) passenger motor vehicles up to a limit of \$75,000 per vehicle and (b) heavy and light armored vehicles for the physical security of personnel or for force protection purposes up to a limit of \$250,000 per vehicle, notwithstanding price or other limitations applicable to the purchase of passenger carrying vehicles.

SEC. 9005. Not to exceed \$1,200,000,000 of the amount appropriated in this title under the heading "Operation and Maintenance, Army" may be used, notwithstanding any other provision of law, to fund the Commander's Emergency Response Program, for the purpose of enabling military commanders in Iraq and Afghanistan to respond to urgent humanitarian relief and reconstruction requirements within their areas of responsibility: *Provided*, That not later than 45 days after the end of each fiscal year quarter, the Secretary of Defense shall submit to the congressional defense committees a report regarding the source of funds and the allocation and use of funds during that quarter that were made available pursuant to the authority provided in this section or under any other provision of law for the purposes described herein: *Provided further*, That, of the funds provided, \$500,000,000 shall not be available until 5 days after the Secretary of Defense has completed a thorough review of the Commander's Emergency Response Program and provided a report on his findings to the congressional defense committees.

SEC. 9006. Funds available to the Department of Defense for operation and maintenance may be used, notwithstanding any other provision of law, to provide supplies, services, transportation, including airlift and sealift, and other logistical support to coalition forces supporting military and stability operations in Iraq and Afghanistan: *Provided*, That the Secretary of Defense shall provide quarterly reports to the congressional defense committees regarding support provided under this section.

SEC. 9007. Each amount in this title is designated as being for overseas deployments and other activities pursuant to section 401(c)(4) and 423(a)(1) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010.

SEC. 9008. None of the funds appropriated or otherwise made available by this or any other Act shall be obligated or expended by the United States Government for a purpose as follows:

(1) To establish any military installation or base for the purpose of providing for the permanent stationing of United States Armed Forces in Iraq.

(2) To exercise United States control over any oil resource of Iraq.

(3) To establish any military installation or base for the purpose of providing for the permanent stationing of United States Armed Forces in Afghanistan.

SEC. 9009. None of the funds made available in this Act may be used in contravention of the following laws enacted or regulations promulgated to implement the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (done at New York on December 10, 1984):

(1) Section 2340A of title 18, United States Code.

(2) Section 2242 of the Foreign Affairs Reform and Restructuring Act of 1998 (division G of Public Law 105-277; 112 Stat. 2681-822; 8

U.S.C. 1231 note) and regulations prescribed thereto, including regulations under part 208 of title 8, Code of Federal Regulations, and part 95 of title 22, Code of Federal Regulations.

(3) Sections 1002 and 1003 of the Department of Defense, Emergency Supplemental Appropriations to Address Hurricanes in the Gulf of Mexico, and Pandemic Influenza Act, 2006 (Public Law 109-148).

SEC. 9010. (a) The Director of the Office of Management and Budget, in consultation with the Secretary of Defense; the Commander of the United States Central Command; the Commander, Multi-National Security Transition Command—Iraq; and the Commander, Combined Security Transition Command—Afghanistan, shall submit to the congressional defense committees not later than 45 days after the end of each fiscal quarter a report on the proposed use of all funds appropriated by this or any prior Act under each of the headings "Iraq Security Forces Fund", "Afghanistan Security Forces Fund", and "Pakistan Counterinsurgency Fund" on a project-by-project basis, for which the obligation of funds is anticipated during the 3-month period from such date, including estimates by the commanders referred to in this section of the costs required to complete each such project.

(b) The report required by this subsection shall include the following:

(1) The use of all funds on a project-by-project basis for which funds appropriated under the headings referred to in subsection (a) were obligated prior to the submission of the report, including estimates by the commanders referred to in subsection (a) of the costs to complete each project.

(2) The use of all funds on a project-by-project basis for which funds were appropriated under the headings referred to in subsection (a) in prior appropriations Acts, or for which funds were made available by transfer, reprogramming, or allocation from other headings in prior appropriations Acts, including estimates by the commanders referred to in subsection (a) of the costs to complete each project.

(3) An estimated total cost to train and equip the Iraq, Afghanistan, and Pakistan security forces, disaggregated by major program and sub-elements by force, arrayed by fiscal year.

(c) The Secretary of Defense shall notify the congressional defense committees of any proposed new projects or transfers of funds between sub-activity groups in excess of \$20,000,000 using funds appropriated by this or any prior Act under the headings "Iraq Security Forces Fund", "Afghanistan Security Forces Fund", and "Pakistan Counterinsurgency Fund".

SEC. 9011. (a) None of the funds made available in this or any other Act may be used to release an individual who is detained, as of June 24, 2009, at Naval Station, Guantanamo Bay, Cuba, into the continental United States, Alaska, Hawaii, or the District of Columbia, into any of the United States territories of Guam, American Samoa (AS), the United States Virgin Islands (USVI), the Commonwealth of Puerto Rico and the Commonwealth of the Northern Mariana Islands (CNMI).

(b) None of the funds made available in this or any other Act may be used to transfer an individual who is detained, as of June 24, 2009, at Naval Station, Guantanamo Bay, Cuba, into the continental United States, Alaska, Hawaii, or the District of Columbia, into any of the United States territories of Guam, American Samoa (AS), the United

States Virgin Islands (USVI), the Commonwealth of Puerto Rico and the Commonwealth of the Northern Mariana Islands (CNMI), for the purpose of detention, except as provided in subsection (c).

(c) None of the funds made available in this or any other Act may be used to transfer an individual who is detained, as of June 24, 2009, at Naval Station, Guantanamo Bay, Cuba, into the continental United States, Alaska, Hawaii, or the District of Columbia, into any of the United States territories of Guam, American Samoa (AS), the United States Virgin Islands (USVI), the Commonwealth of Puerto Rico and the Commonwealth of the Northern Mariana Islands (CNMI), for the purposes of prosecuting such individual, or detaining such individual during legal proceedings, until 45 days after the plan described in subsection (d) is received.

(d) The President shall submit to Congress, in classified form, a plan regarding the proposed disposition of any individual covered by subsection (c) who is detained as of June 24, 2009. Such plan shall include, at a minimum, each of the following for each such individual:

(1) A determination of the risk that the individual might instigate an act of terrorism within the continental United States, Alaska, Hawaii, the District of Columbia, or the United States territories if the individual were so transferred.

(2) A determination of the risk that the individual might advocate, coerce, or incite violent extremism, ideologically motivated criminal activity, or acts of terrorism, among inmate populations at incarceration facilities within the continental United States, Alaska, Hawaii, the District of Columbia, or the United States territories if the individual were transferred to such a facility.

(3) The costs associated with transferring the individual in question.

(4) The legal rationale and associated court demands for transfer.

(5) A plan for mitigation of any risks described in paragraphs (1), (2), and (7).

(6) A copy of a notification to the Governor of the State to which the individual will be transferred, to the Mayor of the District of Columbia if the individual will be transferred to the District of Columbia, or to any United States territories with a certification by the Attorney General of the United States in classified form at least 14 days prior to such transfer (together with supporting documentation and justification) that the individual poses little or no security risk to the United States.

(7) An assessment of any risk to the national security of the United States or its citizens, including members of the Armed Services of the United States, that is posed by such transfer and the actions taken to mitigate such risk.

(e) None of the funds made available in this or any other Act may be used to transfer or release an individual detained at Naval Station, Guantanamo Bay, Cuba, as of June 24, 2009, to the country of such individual's nationality or last habitual residence or to any other country other than the United States or to a freely associated State, unless the President submits to the Congress, in classified form, at least 15 days prior to such transfer or release, the following information:

(1) The name of any individual to be transferred or released and the country or the freely associated State to which such individual is to be transferred or released.

(2) An assessment of any risk to the national security of the United States or its

citizens, including members of the Armed Services of the United States, that is posed by such transfer or release and the actions taken to mitigate such risk.

(3) The terms of any agreement with the country or the freely associated State for the acceptance of such individual, including the amount of any financial assistance related to such agreement.

(f) In this section, the term “freely associated States” means the Federated States of Micronesia (FSM), the Republic of the Marshall Islands (RMI), and the Republic of Palau.

(g) Prior to the termination of detention operations at Naval Station, Guantanamo Bay, Cuba, the President shall submit to the Congress a report in classified form describing the disposition or legal status of each individual detained at the facility as of the date of enactment of this Act.

SEC. 9012. (a) FUNDING FOR OUTREACH AND REINTEGRATION SERVICES UNDER YELLOW RIBBON REINTEGRATION PROGRAM.—Of the amounts appropriated or otherwise made available by title IX, up to \$20,000,000 may be available for outreach and reintegration services under the Yellow Ribbon Reintegration Program under section 582(h) of the National Defense Authorization Act for Fiscal Year 2008 (Public Law 110-181; 122 Stat. 125; 10 U.S.C. 10101 note).

(b) SUPPLEMENT NOT SUPPLANT.—The amount made available by subsection (a) for the services described in that subsection is in addition to any other amounts available in this Act for such services.

This division may be cited as the “Department of Defense Appropriations Act, 2010”.

DIVISION B—OTHER MATTERS

SEC. 1001. There are hereby appropriated such sums as may be necessary, for an additional amount for “Food and Nutrition Service—Supplemental Nutrition Assistance Program” for necessary current year expenses to carry out the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.): *Provided*, That such amount shall be used only in such amounts and at such times as may become necessary to carry out program operations: *Provided further*, That amounts so appropriated are designated as emergency requirements and necessary to meet emergency needs pursuant to sections 403 and 423(b) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010.

SEC. 1002. (a) IN GENERAL.—For the costs of State administrative expenses associated with administering the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.), there are hereby appropriated \$400,000,000, which shall remain available until September 30, 2011.

(b) ALLOCATION OF FUNDS.—Funds described in subsection (a) shall be made available as grants to State agencies as follows—

(1) 75 percent of the amounts available shall be allocated to States based on the share of each State of households that participate in the supplemental nutrition assistance program as reported to the Department of Agriculture for the most recent 12-month period for which data are available, adjusted by the Secretary (as of the date of enactment) for participation in disaster programs under section 5(h) of the Food and Nutrition Act of 2008 (7 U.S.C. 2014(h));

(2) 25 percent of the amounts available shall be allocated to States based on the increase in the number of households that participate in the supplemental nutrition assistance program as reported to the Department

of Agriculture over the most recent 12-month period for which data are available, adjusted by the Secretary (as of the date of enactment) for participation in disaster programs under section 5(h) of the Food and Nutrition Act of 2008 (7 U.S.C. 2014(h)); and

(3) Not later than 60 days after the date of enactment of this Act, the Secretary shall make available to States amounts based on paragraphs (1) and (2) of this subparagraph.

(c) REALLOCATION OF FUNDS.—Funds unobligated at the State level in fiscal year 2010 may be recovered and reallocated to the States in fiscal year 2011.

(d) EMERGENCY DESIGNATION.—Amounts in this section are designated as emergency requirements and necessary to meet emergency needs pursuant to sections 403 and 423(b) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010.

SEC. 1003. (a) AMENDMENTS TO SECTION 119 OF TITLE 17, UNITED STATES CODE.—

(1) IN GENERAL.—Section 119 of title 17, United States Code, is amended—

(A) in subsection (c)(1)(E), by striking “December 31, 2009” and inserting “February 28, 2010”; and

(B) in subsection (e), by striking “December 31, 2009” and inserting “February 28, 2010”.

(2) TERMINATION OF LICENSE.—

(A) TERMINATION.—Section 119 of title 17, United States Code, as amended by paragraph (1), shall cease to be effective on February 28, 2010.

(B) CONFORMING AMENDMENT.—Section 4(a) of the Satellite Home Viewer Act of 1994 (17 U.S.C. 119 note; Public Law 103-369) is repealed.

(b) AMENDMENTS TO COMMUNICATIONS ACT OF 1934.—Section 325(b) of the Communications Act of 1934 (47 U.S.C. 325(b)) is amended—

(1) in paragraph (2)(C), by striking “December 31, 2009” and inserting “February 28, 2010”; and

(2) in paragraph (3)(C), by striking “January 1, 2010” each place it appears in clauses (ii) and (iii) and inserting “March 1, 2010”.

(c) EMERGENCY DESIGNATION.—Amounts in this section are designated as emergency requirements and necessary to meet emergency needs pursuant to sections 403 and 423(b) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010.

SEC. 1004. (a) USA PATRIOT IMPROVEMENT AND REAUTHORIZATION ACT OF 2005.—Section 102(b)(1) of the USA PATRIOT Improvement and Reauthorization Act of 2005 (Public Law 109-177; 120 Stat. 195) is amended by striking “December 31, 2009” and inserting “February 28, 2010”.

(b) INTELLIGENCE REFORM AND TERRORISM PREVENTION ACT OF 2004.—Section 6001(b)(1) of the Intelligence Reform and Terrorism Prevention Act of 2004 (Public Law 108-458; 118 Stat. 3742; 50 U.S.C. 1801 note) is amended by striking “December 31, 2009” and inserting “February 28, 2010”.

SEC. 1005. Section 129 of the Continuing Appropriations Resolution, 2010 (Public Law 111-68) is amended by striking “by substituting” and all that follows through the period at the end, and inserting “by substituting February 28, 2010 for the date specified in each such section.”

SEC. 1006. (a) There is hereby appropriated \$125,000,000, for an additional amount for “Small Business Administration—Business Loans Program Account” for fee reductions and eliminations under section 501 of division A of the American Recovery and Rein-

vestment Act of 2009 (Public Law 111-5) and for the cost of guaranteed loans under section 502 of such division: *Provided*, That such cost shall be as defined in section 502 of the Congressional Budget Act of 1974.

(b) Section 502(f) of division A of the American Recovery and Reinvestment Act of 2009 is amended by striking “the date 12 months after the date of enactment of this Act” and inserting “February 28, 2010”.

(c) Amounts in this section are designated as emergency requirements and necessary to meet emergency needs pursuant to sections 403 and 423(b) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010.

SEC. 1007. (a) PAYMENT.—The Secretary of the Interior may make a payment to Swain County, North Carolina, in an amount of \$12,800,000, in connection with the non-construction of the North Shore Road: *Provided*, That \$4,000,000 shall be available for obligation upon enactment of this Act: *Provided further*, That remaining amounts shall not be available for obligation until 120 days following signature of an agreement between the Secretary of the Interior, Swain County, the State of North Carolina, and the Tennessee Valley Authority that supersedes the agreement of July 30, 1943, related to the construction of North Shore Road between the Secretary, the County, the State, and the Authority. For this payment, there is hereby appropriated \$6,800,000, to remain available until expended, and an amount of \$6,000,000 from unobligated balances available to the Department of the Interior from prior appropriations to the “Construction” account for the National Park Service.

(b) RESCISSION.—Of the funds appropriated in the Department of Transportation and Related Agencies Appropriations Act, 2001 (Public Law 106-346), in section 378 for construction of, and improvements to, North Shore Road in Swain County, North Carolina, \$6,800,000 is hereby permanently rescinded.

SEC. 1008. (a) For purposes of the continued extension of surface transportation programs and related authority to make expenditures from the Highway Trust Fund and other trust funds under sections 157 through 162 of the Continuing Appropriations Resolution, 2010, the date specified in section 106(3) of such resolution shall be deemed to be February 28, 2010.

(b) Section 158(c) is amended by striking the period at the end and inserting “except for the rescission made by section 123 of division I of the Omnibus Appropriations Act, 2009. The amount made available for each of the apportioned Federal-aid highway programs under subsection (a) shall be reduced by an amount equaling \$33,401,492 multiplied by the amount calculated under subsection (a) and divided by \$23,941,505,262”.

SEC. 1009. (a)(1) Section 4007 of the Supplemental Appropriations Act, 2008 (Public Law 110-252; 26 U.S.C. 3304 note) is amended—

(A) by striking “December 31, 2009” each place it appears and inserting “February 28, 2010”;

(B) in the heading for subsection (b)(2), by striking “DECEMBER 31, 2009” and inserting “FEBRUARY 28, 2010”; and

(C) in subsection (b)(3), by striking “May 31, 2010” and inserting “July 31, 2010”.

(2) Section 2002(e) of the Assistance for Unemployed Workers and Struggling Families Act, as contained in Public Law 111-5 (26 U.S.C. 3304 note; 123 Stat. 438), is amended—

(A) in paragraph (1)(B), by striking “before January 1, 2010” and inserting “on or before February 28, 2010”;

(B) in the heading for paragraph (2), by striking "JANUARY 1, 2010" and inserting "FEBRUARY 28, 2010"; and

(C) in paragraph (3), by striking "June 30, 2010" and inserting "August 31, 2010".

(3) Section 2005 of the Assistance for Unemployed Workers and Struggling Families Act, as contained in Public Law 111-5 (26 U.S.C. 3304 note; 123 Stat. 444), is amended—

(A) by striking "January 1, 2010" each place it appears and inserting "February 28, 2010"; and

(B) in subsection (c), by striking "June 1, 2010" and inserting "July 31, 2010".

(4) Section 5 of the Unemployment Compensation Extension Act of 2008 (Public Law 110-449; 26 U.S.C. 3304 note) is amended by striking "May 30, 2010" and inserting "July 31, 2010".

(b) Section 4004(e)(1) of the Supplemental Appropriations Act, 2008 (Public Law 110-252; 26 U.S.C. 3304 note) is amended by striking "by reason of" and all that follows and inserting the following: "by reason of—

"(A) the amendments made by section 2001(a) of the Assistance for Unemployed Workers and Struggling Families Act;

"(B) the amendments made by sections 2 through 4 of the Worker, Homeownership, and Business Assistance Act of 2009; and

"(C) the amendments made by section 1009 of the Department of Defense Appropriations Act, 2010; and".

(c) Amounts in this section are designated as emergency requirements and necessary to meet emergency needs pursuant to sections 403 and 423(b) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010.

SEC. 1010. (a) EXTENSION OF ELIGIBILITY PERIOD.—Subsection (a)(3)(A) of section 3001 of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) is amended by striking "December 31, 2009" and inserting "February 28, 2010".

(b) EXTENSION OF MAXIMUM DURATION OF ASSISTANCE.—Subsection (a)(2)(A)(ii)(I) of such section is amended by striking "9 months" and inserting "15 months".

(c) RULES RELATED TO 2009 EXTENSION.—Subsection (a) of such section is further amended by adding at the end the following:

"(16) RULES RELATED TO 2009 EXTENSION.—

"(A) ELECTION TO PAY PREMIUMS RETROACTIVELY AND MAINTAIN COBRA COVERAGE.—In the case of any premium for a period of coverage during an assistance eligible individual's transition period, such individual shall be treated for purposes of any COBRA continuation provision as having timely paid the amount of such premium if—

"(i) such individual was covered under the COBRA continuation coverage to which such premium relates for the period of coverage immediately preceding such transition period, and

"(ii) such individual pays, not later than 60 days after the date of the enactment of this paragraph (or, if later, 30 days after the date of provision of the notification required under subparagraph (D)(ii)), the amount of such premium, after the application of paragraph (1)(A).

"(B) REFUNDS AND CREDITS FOR RETROACTIVE PREMIUM ASSISTANCE ELIGIBILITY.—In the case of an assistance eligible individual who pays, with respect to any period of COBRA continuation coverage during such individual's transition period, the premium amount for such coverage without regard to paragraph (1)(A), rules similar to the rules of paragraph (12)(E) shall apply.

"(C) TRANSITION PERIOD.—

"(i) IN GENERAL.—For purposes of this paragraph, the term 'transition period'

means, with respect to any assistance eligible individual, any period of coverage if—

"(I) such period begins before the date of the enactment of this paragraph, and

"(II) paragraph (1)(A) applies to such period by reason of the amendment made by section 1010(b) of the Department of Defense Appropriations Act, 2010.

"(ii) CONSTRUCTION.—Any period during the period described in subclauses (I) and (II) of clause (i) for which the applicable premium has been paid pursuant to subparagraph (A) shall be treated as a period of coverage referred to in such paragraph, irrespective of any failure to timely pay the applicable premium (other than pursuant to subparagraph (A)) for such period.

"(D) NOTIFICATION.—

"(i) IN GENERAL.—In the case of an individual who was an assistance eligible individual at any time on or after October 31, 2009, or experiences a qualifying event (consisting of termination of employment) relating to COBRA continuation coverage on or after such date, the administrator of the group health plan (or other entity) involved shall provide an additional notification with information regarding the amendments made by section 1010 of the Department of Defense Appropriations Act, 2010, within 60 days after the date of the enactment of such Act or, in the case of a qualifying event occurring after such date of enactment, consistent with the timing of notifications under paragraph (7)(A).

"(ii) TO INDIVIDUALS WHO LOST ASSISTANCE.—In the case of an assistance eligible individual described in subparagraph (A)(i) who did not timely pay the premium for any period of coverage during such individual's transition period or paid the premium for such period without regard to paragraph (1)(A), the administrator of the group health plan (or other entity) involved shall provide to such individual, within the first 60 days of such individual's transition period, an additional notification with information regarding the amendments made by section 1010 of the Department of Defense Appropriations Act, 2010, including information on the ability under subparagraph (A) to make retroactive premium payments with respect to the transition period of the individual in order to maintain COBRA continuation coverage.

"(iii) APPLICATION OF RULES.—Rules similar to the rules of paragraph (7) shall apply with respect to notifications under this subparagraph."

(d) CLARIFICATION THAT ELIGIBILITY AND NOTICE IS BASED ON TIMING OF QUALIFYING EVENT.—Subsection (a) of such section is amended—

(1) in paragraph (3)(A)—

(A) by striking "at any time" and inserting "such qualified beneficiary is eligible for COBRA continuation coverage related to a qualifying event occurring"; and

(B) by striking "such qualified beneficiary is eligible for COBRA continuation coverage"; and

(2) in paragraph (7)(A), by striking "become entitled to elect COBRA continuation coverage" and inserting "have a qualifying event relating to COBRA continuation coverage".

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the provisions of section 3001 of division B of the American Recovery and Reinvestment Act of 2009 to which they relate.

(f) EMERGENCY DESIGNATIONS.—

(1) IN GENERAL.—Amounts in this section are designated as emergency requirements

and necessary to meet emergency needs pursuant to sections 403 and 423(b) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010.

(2) PAYGO.—All applicable provisions in this section are designated as an emergency for purposes of pay-as-you-go principles.

SEC. 1011. (a) IN GENERAL.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w-4(d)) is amended by adding at the end the following new paragraph:

"(10) UPDATE FOR PORTION OF 2010.—

"(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010 for the period beginning on January 1, 2010, and ending on February 28, 2010, the update to the single conversion factor shall be 0 percent for 2010.

"(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR REMAINING PORTION OF 2010 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for the period beginning on March 1, 2010, and ending on December 31, 2010, and for 2011 and subsequent years as if subparagraph (A) had never applied."

(b) FUNDING FROM MEDICARE IMPROVEMENT FUND.—Section 1898(b)(1) of such Act (42 U.S.C. 1395iii(b)(1)) is amended—

(1) in subparagraph (A)—

(A) by striking "\$22,290,000,000" and inserting "\$20,740,000,000"; and

(B) by striking "and" at the end;

(2) by redesignating subparagraph (B) as subparagraph (C); and

(3) by inserting after subparagraph (A) the following new subparagraph:

"(B) fiscal year 2015, \$550,000,000; and".

SEC. 1012. Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not publish updated poverty guidelines for 2010 under section 673(2) of the Omnibus Budget Reconciliation Act of 1981 (42 U.S.C. 9902(2)) before March 1, 2010, and the poverty guidelines published under such section on January 23, 2009, shall remain in effect until updated poverty guidelines are published.

SEC. 1013. From the "National Telecommunications and Information Administration—Digital-to-Analog Converter Box Program" in the Department of Commerce, \$128,000,000 is hereby rescinded.

SEC. 1014. The explanatory statement regarding this Act printed in the House of Representatives section of the Congressional Record on or about December 16, 2010, by the Chairman of the Subcommittee on Defense of the Committee on Appropriations of the House of Representatives shall have the same effect with respect to the allocation of funds and implementation of this Act as if it were a joint explanatory statement of a committee of conference.

The SPEAKER pro tempore. The motion shall be debatable for 1 hour equally divided and controlled by the Chair and ranking minority member of the Committee on Appropriations.

The gentleman from Pennsylvania (Mr. MURTHA) and the gentleman from Florida (Mr. YOUNG) each will control 30 minutes.

The Chair recognizes the gentleman from Pennsylvania.

GENERAL LEAVE

Mr. MURTHA. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to

revise and extend their remarks and to include tabular and extraneous material.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Pennsylvania?

There was no objection.

Mr. MURTHA. I yield myself such time as I may consume.

Madam Speaker, Members of the House, this is the largest appropriations bill that we have ever handled. It was completely bipartisan. We never did anything without working together. It is basically the same bill we voted on before it went to the Senate but with a few minor changes. I am pleased to say that we made some conciliatory changes with the White House and also with the Senate. This, as a matter of fact, is \$625 billion. The House passed \$636 billion. It pays for first-class medical care for military personnel.

I have to say I don't usually talk on any one thing, but having been out at Bethesda in intensive care for 2 days, I have to endorse the money that we have spent on the care at Bethesda. They did a marvelous job, and I am so pleased about the way the money is being handled out there.

Medical research, of course, the committee under my leadership and under the leadership of JERRY LEWIS and BILL YOUNG, has always been in the forefront. There are peer-reviewed programs, which have turned out to be as good as any programs you will find any place. We are supporting military families, operations and maintenance, civilian workforce, and insourcing. We are trying to reduce the contractors, and we are struggling in doing that. The inspector of general oversight, we worked at that for 2 or 3 years. This bill includes the MRAP program and \$526 million for situational awareness.

In other words, this is as good a bill as we could come up with given the amount of money that was apportioned to us.

The Fiscal Year 2010 Defense Appropriations Bill puts troops first, ensuring their readiness, providing them with first class weapons and equipment, and ensuring the availability of care and support for their families.

The bill makes critical investments in the health, well-being and readiness of our armed forces; addressing issues raised by service members, their families, and Department of Defense officials in testimony before the Congress, and discovered through visits to military bases across the United States and overseas. The bill also reins in the use of contractors and begins to return inherently governmental functions to Department of Defense personnel.

For the first time since the beginning of operations in Iraq, this bill includes funding for Overseas Contingency Operations in Afghanistan and Iraq for the upcoming fiscal year; providing \$128.3 billion to support current operations, and to meet the needs of our troops in the field and their families here at home. The bill does not address the President's new

Afghanistan security strategy because the Administration has yet to request funding for that initiative.

[Bill total in billions]

2009 Total Enacted	\$625.3
President's Request	640.1
House Passed	636.3
Senate Passed	636.3
2010 Total Bill	636.3

Military Personnel and Pay: The bill provides a 3.4 percent military pay increase, 0.5 percent above the request. The bill also includes \$1 billion pursuant to an amended budget request in order to increase U.S. Army troop strength.

First Class Medical Care: The bill recommends a total of \$29.2 billion for the Defense Health Program, \$3 billion above fiscal year 2009 and \$1 billion above the 2010 request. The increase includes \$307 million above the request to provide for shortfalls in the TRICARE program. The bill also includes \$300 million above the request for transportation infrastructure issues related to base closure.

To provide quality medical care for service members and their families, and address the serious financial challenges facing the Defense Health Program, the bill recommends the following funding:

HIV Research	\$20,000,000
Wound Care Research	13,000,000
Traumatic Brain Injury and Psychological Health Research (\$372m budget + \$120m over budget)	120,000,000
Global HIV/AIDS Prevention	10,000,000
Peer-Reviewed Medical Research Program	50,000,000
Peer-Reviewed Breast Cancer Research	150,000,000
Peer-Reviewed Ovarian Cancer Research Program	18,750,000
Peer-Reviewed Prostate Cancer Research Program	80,000,000

Supporting Military Families: The bill provides greater support for military families. The bill includes funding for quality child care, job training for spouses, and expanded counseling and outreach to families that have experienced the separation and stress of war. The bill fully funds \$472.4 million for Family Advocacy programs and fully funds Family Support and Yellow Ribbon programs.

Operation and Maintenance: The bill recommends \$154 billion for operation and maintenance, an increase of \$1.3 billion above the fiscal year 2009 enacted level. The recommendation includes funding above the budget request for the following items:

Hybrid Operations Readiness Training (Hybrid—DoD's new terminology for full-spectrum training)	\$43,000,000
Army Helicopter Readiness Training	142,000,000
Navy Aircraft Depot Maintenance	35,000,000
Environmental Restoration	32,500,000

The recommendation rebalances funding from preparing for Cold War-era types of conflicts to the highest priority readiness require-

ments for the hybrid operations that the military services will be facing for the foreseeable future. The bill also includes adjustments based on trends in DoD budget execution.

Civilian Workforce and In-Sourcing: The bill supports increased funding for DoD civilian personnel to in-source workload. The Department estimates that every position converted from contract to federal civilian saves on average \$44,000 per year. Additionally, the bill includes general provisions to suspend further conversions by the Department of Defense from government functions to contractors.

The bill also includes \$100 million, as requested, to fund further development and training for the DoD acquisition workforce.

Inspector General Oversight: the bill includes \$288 million, \$16 million above the request, for the Inspector General to hire additional investigators to ensure proper oversight of DoD acquisition and contracting.

Procurement Programs: The bill recommends \$104.4 billion for procurement, an increase of \$3.46 billion above the fiscal year 2009 enacted level and a decrease of \$816 million below the 2010 request. The bill includes:

\$6.8 billion, the requested amount, for the procurement of 30 F-35 Lightning Aircraft, 16 Short Take-off and Vertical Landing variants for the Marine Corps, 4 Carrier variants for the Navy, and 10 conventional variants for the Air Force.

\$465 million above the request to continue development and initial procurement of the Alternative Engine for the Joint Strike Fighter.

\$2.5 billion above the request for procurement of 10 additional C-17 aircraft.

The bill also includes:

\$6.3 billion for the Mine Resistant Ambush Protected Vehicle Fund, an increase of \$825 million above the request.

\$526 million as requested for Situational Awareness upgrades to 353 Bradley Fighting Vehicles.

\$498 million for the procurement of Family of Medium Tactical Vehicles.

\$613 million for the procurement of Family of Heavy Tactical Vehicles.

\$15 billion, \$120 million above the request, for Navy Shipbuilding and Conversion and the National Defense Sealift Fund for the procurement of 7 Navy ships, including: one DDG-51 Guided Missile Destroyer; one SSN-774 Attack Submarine; two Littoral Combat Ships; and one Intra-theater Connector Ship (joint high speed vessel to move personnel and equipment within theater).

Additionally, this funding provides for the final increments of funding for the CVN-78 Aircraft Carrier, the third DDG-1000 Guided Missile Destroyer, and the tenth LPD-17 Amphibious Transport Dock.

\$30 million, not requested, for the shipbuilding loan guarantee program to assist in stimulating the domestic shipbuilding industry.

\$1.5 billion for the procurement of 18 F/A-18E/F Super Hornet Tactical aircraft, nine above the request.

\$1.6 billion, the requested amount for 22 EA-18G Growler electronic attack aircraft.

\$2.7 billion for the procurement of 30 MV-22 and five CV-22 Osprey aircraft.

\$950 million for National Guard and Reserve Equipment.

Research and Development: The bill recommends \$80.5 billion for research and development, an increase of \$17 million above the fiscal year 2009 enacted level, and a \$2 billion increase over the fiscal year 2010 request. Major funding items include:

\$4 billion for the continued development of the F-35 Lightning Joint Strike Fighter aircraft, \$430 million above the President's request.

\$130 million for Presidential Helicopter, of which \$100 million is for technology capture to recoup investments in research and development of the VH-71, an increase of \$44.8 million above the request.

\$306 million for the development of the Next Generation Aerial Refueling Aircraft.

\$62 million for JSTARS re-engineering research and development, an increase of \$46 million above the request.

\$202 million for the Israeli Cooperative Program (Arrow). The recommendation is \$82.8 million above the President's request.

\$50.5 million, the President's request for Ballistic Missile Defense European Capability.

\$2.2 billion for the continued development of the restructured Future Combat Systems Program.

\$1.2 billion for the continued development of the P-8A Multi-mission Maritime Aircraft.

\$387.5 million, the President's request, starting development of the replacement for the Ohio class ballistic missile submarine.

\$526 million for the continued development of the DDG-1000 Guided Missile Destroyer.

Overseas Contingency Operations: The recommendation addresses a number of policy issues concerning operations in Iraq and Afghanistan including:

A general provision prohibiting the establishment of permanent bases in Iraq or Afghanistan;

A general provision prohibiting the torture of detainees held in U.S. custody;

The bill provides \$1.2 billion, a reduction of \$300 million from the request for the Commanders Emergency Response Program (CERP) authority and fences \$500 million pending a spending plan from the Department of Defense; and

Provides no funds for the closure of the detention facility at Guantanamo Naval base.

EXPLANATORY STATEMENT OF HOUSE AMENDMENT TO THE SENATE AMENDMENT TO H.R. 3326—DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 2010

DIVISION A DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, FISCAL YEAR 2010

Following is an explanation of the effects of Division A, which makes appropriations for the Department of Defense for fiscal year 2010. As provided in Section 8124 of the consolidated bill, this explanatory statement shall have the same effect with respect to the allocation of funds and the implementation of this as if it were a joint explanatory statement of a committee of the conference.

The recommendation on the Department of Defense Appropriations Act, 2010, incorporates some of the provisions of both the House and Senate versions of the bill. The language and allocations set forth in House Report 111-230 and Senate Report 111-74 should be complied with unless specifically addressed to the contrary in the accompanying bill and explanatory statement.

The Senate amendment deleted the entire House bill after the enacting clause and in-

serted new language. The recommendation includes revised language.

DEFINITION OF PROGRAM, PROJECT, AND ACTIVITY

For the purposes of the Balanced Budget and Emergency Deficit Control Act of 1985 (Public Law 99-177) as amended by the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 (Public Law 100-119) and by the Budget Enforcement Act of 1990 (Public Law 101-508), the term program, project, and activity for appropriations contained in this Act shall be defined as the most specific level of budget items identified in the Department of Defense Appropriations Act, 2010, the related classified annexes and explanatory statements, and the P-1 and R-1 budget justification documents as subsequently modified by congressional action. The following exception to the above definition shall apply: for the military personnel and the operation and maintenance accounts, for which the term "program, project, and activity" is defined as the appropriations accounts contained in the Department of Defense Appropriations Act.

At the time the President submits the budget for fiscal year 2011, the Secretary of Defense is directed to transmit to the congressional defense committees budget justification documents to be known as the "M-1" and "O-1" which shall identify, at the budget activity, activity group, and sub-activity group level, the amounts requested by the President to be appropriated to the Department of Defense for military personnel and operation and maintenance in any budget request, or amended budget request, for fiscal year 2011.

CLASSIFIED ANNEX

Adjustments to classified programs are addressed in the accompanying classified annex.

CONGRESSIONAL SPECIAL INTEREST ITEMS

Items for which additional funds have been provided as shown in the project level tables or in paragraphs using the phrase "only for" or "only to" are congressional special interest items for purposes of the Base for Reprogramming (DD Form 1414). Each of these items must be carried on the DD Form 1414 at the stated amount, as specifically addressed in these materials.

REPROGRAMMING GUIDANCE

The Department of Defense is directed to follow the reprogramming guidance for acquisition accounts as contained herein under titles III and IV. For operation and maintenance accounts, the Department shall follow the reprogramming guidelines contained herein under title II. The dollar threshold for reprogramming funds shall remain at \$15,000,000 for operation and maintenance; \$20,000,000 for procurement; and \$10,000,000 for research, development, test and evaluation.

Also, the Under Secretary of Defense (Comptroller) is directed to continue to provide the congressional defense committees quarterly, spreadsheet-based DD Form 1416 reports for service and defense-wide accounts in titles I, II, III and IV of this Act. The Department shall continue to follow the limitation that prior approval reprogrammings are set at either the specified dollar threshold or 20 percent of the procurement or research, development, test and evaluation line, whichever is less. The percentage change limitation applies to both the program increases and decreases. Additionally, this percentage change applies to the program base value at the time the below threshold movement of funds is executed. These thresholds

are cumulative from the base for reprogramming as made by any adjustment action. Therefore, if the combined value of transfers into or out of operation and maintenance (O-1), a procurement (P-1) or research, development, test and evaluation (R-1) line exceed the identified threshold, the Department of Defense must submit a prior approval reprogramming to the congressional defense committees. In addition, guidelines on the application of prior approval reprogramming procedures for congressional special interest items are established elsewhere in these materials.

FUNDING INCREASES

The funding increases outlined in the tables for each appropriation account shall be provided only for the specific purposes indicated in the table.

JOINT SURVEILLANCE-TARGET ATTACK RADAR SYSTEM (JSTARS) PROGRAM

The Department of Defense decision to proceed with the JSTARS re-engineing program is supported in the recommendation. It is noted that the JSTARS program has been used as a source of funds for reprogrammings in the past. The Air Force is encouraged to restore those prior year funds if additional resources are needed. The recommendation provides, \$115,900,000, an increase of \$46,000,000, in the Research, Development, Test and Evaluation funding and provides \$54,000,000 in the Aircraft Procurement, Air Force appropriation.

The recommendation does not include language that restricts the obligation of funds for the JSTARS re-engineing program, as provided in the Senate report.

In addition, the Air Force is not directed to transfer a SYERS-3 sensor to complete the SYERS Demonstration Program. The Air Force should have the sensor for an adequate time, and the necessary financial resources have already been appropriated to ensure completion of the demonstration program. The Secretary of the Air Force is directed to submit a written notification to the congressional defense committees on the status of the demonstration program not later than 60 days after the enactment of this Act.

COMBAT AIR FORCE RESTRUCTURE

The lack of detail and analysis provided to the Congress regarding the Air Force's Combat Air Force restructure plan that would retire 248 legacy F-15, F-16 and A-10 aircraft is concerning. Therefore, it is directed that the reports stipulated in Sec. 1075 of the Conference Report accompanying the National Defense Authorization Act of Fiscal Year 2010 also be transmitted to the Committees on Appropriations of the House and Senate.

Additionally, there is concern with the personnel costs and potential acquisition costs associated with the Air Force proposal to remove the training of F-15 pilots and related personnel from Tyndall Air Force Base. The Secretary of the Air Force is directed to provide a cost-benefit analysis of this proposal regarding Tyndall Air Force Base and Keesley Field in Klamath Falls which shall include an analysis of factors impacting F-15 training quantity and quality at each location, to include training synergies, airspace access and availability. The report shall identify and explain the justification for where F-15 Basic Crew Chief Training, Air Control Squadron Training and Intelligence Formal Training will be established and maintained. The report shall include analysis on simulator and ancillary training access, expected effect on the quality and experience of the instructor base, future military

construction requirements and special considerations and costs required due to the differing training environments and climatology at each base.

Moreover, the Department is requested to identify airfields that share runways for both Air Force and commercial operations within the continental United States. The Department is requested to include Air Force policy on and analysis of the training and operational mission impacts at bases with shared runways.

Additionally, the Secretary of the Air Force is directed to conduct an independent review by a Federally Funded Research and Development Center (FFRDC) on the impact of the restructure on the Nation's combat air forces. The Secretary of the Air Force is directed to provide the three described reports on April 1, 2010. The Secretary of the Air Force is further directed that no funds may be obligated on executing the Combat Air Force restructure until submission to the congressional defense committees of all directed reports.

CONTRACTING FRAUD

The numerous reports and allegations of defense contractors defrauding the government is concerning. Therefore, the Secretary of Defense is encouraged to strengthen policies and safeguards against such abuse. The Secretary of Defense is directed, in coordination with the Department of Defense Inspector General, to report to the congressional defense committees on contracting fraud. The report shall include an assessment of the total value of Department of Defense contracts entered into with contractors that

have been indicted for, settled charges of, been fined by any Federal department or agency for, or been convicted of fraud in connection with any contract or other transaction entered into with the Federal Government over the past ten years. The report shall also include recommendations on how to penalize contractors who are repeatedly involved in contract fraud allegations. Finally, the report shall describe the actions taken to strengthen Department policies and safeguards against contractor fraud. The report should be submitted not later than March 15, 2010.

2001 NUCLEAR POSTURE REVIEW

Section 1041(c) of P.L. 106-398, the National Defense Authorization Act for Fiscal Year 2001, required the Secretary of Defense to submit to Congress, in unclassified and classified forms as necessary, a report on the results of the 2001 Nuclear Posture Review. The Secretary of Defense is encouraged to provide the unclassified report of the 2001 Nuclear Posture Review to the congressional defense committees as soon after submission of the 2009 Nuclear Posture Review as is possible.

SENIOR MENTORS PROGRAM

There is deep concern over the Department of Defense's Senior Mentors Program. The Department spends millions of dollars each year to place retired general officers on contract to act as advisors and mentors. It is of concern that the Department uses large defense industry firms as the prime contractor to serve as third party "go betweens." There is also concern that the contracts and task orders appear to be written almost as per-

sonal services contracts. Therefore, the Department of Defense Inspector General is directed to review the Senior Mentors Program and report to the congressional defense committees no later than March 31, 2010.

INTELLIGENCE, SURVEILLANCE AND RECONNAISSANCE

Senate Report 111-20 directed the Secretary of Defense to submit a report to the congressional defense committees on the strategy to transition the responsibilities of the Intelligence, Surveillance and Reconnaissance (ISR) Task Force. Although the report was supposed to have been submitted no later than October 1, 2009, the Department has only recently begun to address this reporting requirement.

The recommendation reiterates the concerns leading to the reporting requirement, and the Secretary of Defense is directed to submit the report within 30 days of enactment of this Act.

Furthermore, over the past two years, Congress has approved significant increases in ISR collection, processing, and dissemination in support of overseas contingency operations. The Secretary of Defense is directed to provide a classified report to the congressional defense committees within 90 days of enactment of this Act that describes the deployment of additional ISR capabilities, particularly tactical signals intelligence and full motion video, to support combat operations in Afghanistan. The report should address the adequacy of these capabilities to support troop commitments to Afghanistan as well as the plans to correct any shortfalls.

TITLE I - MILITARY PERSONNEL

For Military Personnel, funds are to be available for fiscal year 2010,

as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation

RECAPITULATION				
MILITARY PERSONNEL, ARMY.....	41,312,448	39,901,547	41,267,448	41,005,612
MILITARY PERSONNEL, NAVY.....	25,504,472	25,095,581	25,440,472	25,289,049
MILITARY PERSONNEL, MARINE CORPS.....	12,915,790	12,528,845	12,883,790	12,799,990
MILITARY PERSONNEL, AIR FORCE.....	26,439,761	25,938,850	26,378,761	26,174,136
RESERVE PERSONNEL, ARMY.....	4,336,656	4,308,513	4,286,656	4,304,713
RESERVE PERSONNEL, NAVY.....	1,938,166	1,918,111	1,905,166	1,909,301
RESERVE PERSONNEL, MARINE CORPS.....	617,500	610,580	611,500	613,500
RESERVE PERSONNEL, AIR FORCE.....	1,607,712	1,600,462	1,584,712	1,589,412
NATIONAL GUARD PERSONNEL, ARMY.....	7,621,488	7,525,628	7,535,088	7,546,905
NATIONAL GUARD PERSONNEL, AIR FORCE.....	2,970,949	2,949,899	2,923,599	2,938,229
GRAND TOTAL, MILITARY PERSONNEL.....	125,264,942	122,378,016	124,817,192	124,170,847
	=====	=====	=====	=====

Summary of Military Personnel End Strength

	Fiscal Year 2010		
	Budget		Change
	Request	Recommendation	from Request
Active Forces (End Strength)			
Army.....	562,400	562,400	-
Navy.....	328,800	328,800	-
Marine Corps.....	202,100	202,100	-
Air Force.....	331,700	331,700	-
Total, Active Forces.....	1,425,000	1,425,000	-
Guard and Reserve Forces (End Strength)			
Army Reserve.....	205,000	205,000	-
Navy Reserve.....	65,500	65,500	-
Marine Corps Reserve.....	39,600	39,600	-
Air Force Reserve.....	69,500	69,500	-
Army National Guard.....	358,200	358,200	-
Air National Guard.....	106,700	106,700	-
Total, Selected Reserve.....	844,500	844,500	0
Total, Military Personnel.....	2,269,500	2,269,500	0

Summary of Guard and Reserve Full-Time Support

	Fiscal Year 2010		
	Budget		Change
	Request	Recommendation	from Request
Army Reserve:			
Active Guard and Reserve	16,261	16,261	-
Technicians.....	8,154	8,395	+241
Navy Reserve:			
Active Reserve.....	10,818	10,818	-
Marine Corps Reserve:			
Active Reserve.....	2,261	2,261	-
Air Force Reserve:			
Active Guard and Reserve	2,896	2,896	-
Technicians.....	10,417	10,417	-
Army National Guard:			
Active Guard and Reserve	32,060	32,060	-
Technicians.....	26,901	27,210	+309
Air National Guard:			
Active Guard and Reserve	14,555	14,555	-
Technicians.....	22,313	22,313	-
Totals:			
Active Guard and Reserve/Active Reserve.....	78,851	78,851	-
Technicians.....	67,785	68,335	-
Total Full-Time Support	146,636	147,186	+550

CASH INCENTIVES

The recommendation supports the services' use of cash incentives to meet the extraordinary recruiting and retention challenges they have faced since September 11, 2001. The services are commended for their successful efforts to grow and maintain the finest fighting force in the world under very difficult circumstances. Because the services are generally meeting or exceeding their recruitment and retention goals, it is the belief

that now is an opportune time to examine whether the use and size of these cash incentives can be reduced to maximize their manning utility while lowering costs. Therefore, the Secretary of Defense is directed to provide a report to the Committee on Appropriations of both the House of Representatives and the Senate that describes these cash incentives, to include the number of cash incentives used for recruiting and retention, the average amount provided for each Military Occupational Specialty (MOS),

and the length of contract when these incentive options are accepted by recruits and those reenlisting. This report shall also include a quantitative analysis of the optimal size of these incentives and an actuarially-based estimate of the impact on recruiting and retention of a 10 percent and a 20 percent reduction of the amounts provided per incentive. This report shall be submitted no later than 120 days after the enactment of this Act.

MILITARY PERSONNEL, ARMY

For Military Personnel, Army, funds are to be available for fiscal year

2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
50 MILITARY PERSONNEL, ARMY				
100 ACTIVITY 1: PAY AND ALLOWANCES OF OFFICERS				
150 BASIC PAY.....	6,117,038	6,117,038	6,117,038	6,117,038
200 RETIRED PAY ACCRUAL.....	1,975,804	1,975,804	1,975,804	1,975,804
250 BASIC ALLOWANCE FOR HOUSING.....	1,758,671	1,758,671	1,758,671	1,758,671
300 BASIC ALLOWANCE FOR SUBSISTENCE.....	257,783	257,783	257,783	257,783
350 INCENTIVE PAYS.....	94,613	94,613	94,613	94,613
400 SPECIAL PAYS.....	334,621	310,849	334,621	334,621
450 ALLOWANCES.....	187,541	187,541	187,541	187,541
500 SEPARATION PAY.....	55,893	55,893	55,893	55,893
550 SOCIAL SECURITY TAX.....	466,202	466,202	466,202	466,202
600 TOTAL, BUDGET ACTIVITY 1.....	11,248,166	11,224,394	11,248,166	11,248,166
650 ACTIVITY 2: PAY AND ALLOWANCES OF ENLISTED PERSONNEL				
700 BASIC PAY.....	13,502,642	13,502,642	13,502,642	13,502,642
750 RETIRED PAY ACCRUAL.....	4,361,354	4,361,354	4,361,354	4,361,354
800 BASIC ALLOWANCE FOR HOUSING.....	4,468,975	4,468,975	4,468,975	4,468,975
850 INCENTIVE PAYS.....	107,268	107,268	107,268	107,268
900 SPECIAL PAYS.....	1,235,924	1,087,310	1,235,924	1,220,924
950 ALLOWANCES.....	843,556	843,556	843,556	843,556
1000 SEPARATION PAY.....	236,462	236,462	236,462	236,462
1050 SOCIAL SECURITY TAX.....	1,032,953	1,032,953	1,032,953	1,032,953
1100 TOTAL, BUDGET ACTIVITY 2.....	25,789,134	25,640,520	25,789,134	25,774,134
1150 ACTIVITY 3: PAY AND ALLOW OF CADETS				
1200 ACADEMY CADETS.....	73,317	73,317	73,317	73,317
1250 ACTIVITY 4: SUBSISTENCE OF ENLISTED PERSONNEL				
1300 BASIC ALLOWANCE FOR SUBSISTENCE.....	1,355,930	1,355,930	1,355,930	1,355,930
1350 SUBSISTENCE-IN-KIND.....	948,208	948,208	948,208	948,208
1400 FAMILY SUBSISTENCE SUPPLEMENTAL ALLOWANCE.....	721	721	721	721
1450 TOTAL, BUDGET ACTIVITY 4.....	2,304,859	2,304,859	2,304,859	2,304,859

(In thousands of dollars)

	Budget	House	Senate	Recommendation
1500 ACTIVITY 5: PERMANENT CHANGE OF STATION				
1550 ACCESSION TRAVEL.....	227,127	227,127	227,127	227,127
1600 TRAINING TRAVEL.....	113,575	113,575	113,575	113,575
1650 OPERATIONAL TRAVEL.....	373,132	373,132	373,132	373,132
1700 ROTATIONAL TRAVEL.....	682,978	682,978	682,978	682,978
1750 SEPARATION TRAVEL.....	198,509	198,509	198,509	198,509
1800 TRAVEL OF ORGANIZED UNITS.....	12,702	12,702	12,702	12,702
1850 NON-TEMPORARY STORAGE.....	8,924	8,924	8,924	8,924
1900 TEMPORARY LODGING EXPENSE.....	37,314	37,314	37,314	37,314
1950 TOTAL, BUDGET ACTIVITY 5.....	1,654,261	1,654,261	1,654,261	1,654,261
2000 ACTIVITY 6: OTHER MILITARY PERSONNEL COSTS				
2050 APPREHENSION OF MILITARY DESERTERS.....	1,452	1,452	1,452	1,452
2100 INTEREST ON UNIFORMED SERVICES SAVINGS.....	648	648	648	648
2150 DEATH GRATUITIES.....	45,500	45,500	45,500	45,500
2200 UNEMPLOYMENT BENEFITS.....	180,493	180,493	180,493	180,493
2250 EDUCATION BENEFITS.....	45,288	45,288	45,288	45,288
2300 ADOPTION EXPENSES.....	264	264	264	264
2350 TRANSPORTATION SUBSIDY.....	6,684	6,684	6,684	6,684
2400 PARTIAL DISLOCATION ALLOWANCE.....	326	326	326	326
2450 RESERVE OFFICERS TRAINING CORPS (ROTC).....	143,586	143,586	143,586	143,586
2500 JUNIOR ROTC.....	63,721	63,721	63,721	63,721
2550 TOTAL, BUDGET ACTIVITY 6.....	487,962	487,962	487,962	487,962
2600 LESS REIMBURSABLES.....	-245,251	-245,251	-245,251	-245,251
2650 UNDISTRIBUTED ADJUSTMENT.....	---	-1,238,515	-45,000	-291,836
2700 TOTAL, ACTIVE FORCES, ARMY.....	41,312,448	39,901,547	41,267,448	41,005,612
6300 TOTAL, MILITARY PERSONNEL, ARMY.....	41,312,448	39,901,547	41,267,448	41,005,612

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS

[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
BA-1: PAY AND ALLOWANCES OF OFFICERS				
SPECIAL PAYS	334,621	310,849	334,621	334,621
Hostile Fire Pay - Transferred to Title IX		-4,790		
Hardship Duty Pay - Transferred to Title IX		-7,560		
Foreign Language Proficiency Pay - Transferred to Title IX		-11,422		
BA-2: PAY AND ALLOWANCES OF ENLISTED PERSONNEL				
SPECIAL PAYS	1,235,924	1,087,310	1,235,924	1,220,924
Hostile Fire Pay - Transferred to Title IX		-16,374		
Hardship Duty Pay - Transferred to Title IX		-45,000		
Foreign Language Proficiency Pay - Transferred to Title IX		-25,237		
Enlistment Bonus		-18,203		-5,000
Reenlistment Bonus		-43,800		-10,000
UNDISTRIBUTED ADJUSTMENT		-1,238,515	-45,000	-291,836
Authorized Basic Pay Increase		151,485		137,164
Undistributed Transfer to Title IX		-1,390,000		-407,000
Lower than Budgeted Pay Grade Mix			-45,000	-22,000

MILITARY PERSONNEL, NAVY

For Military Personnel, Navy, funds are to be available for fiscal year

2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
6400 MILITARY PERSONNEL, NAVY				
6450 ACTIVITY 1: PAY AND ALLOWANCES OF OFFICERS				
6500 BASIC PAY.....	3,528,733	3,528,733	3,528,733	3,528,733
6550 RETIRED PAY ACCRUAL.....	1,138,398	1,138,398	1,138,398	1,138,398
6600 BASIC ALLOWANCE FOR HOUSING.....	1,273,135	1,273,135	1,273,135	1,273,135
6650 BASIC ALLOWANCE FOR SUBSISTENCE.....	141,347	141,347	141,347	141,347
6700 INCENTIVE PAYS.....	164,069	164,069	164,069	164,069
6750 SPECIAL PAYS.....	388,642	384,755	388,642	388,642
6800 ALLOWANCES.....	112,740	112,740	112,740	112,740
6850 SEPARATION PAY.....	35,180	35,180	35,180	35,180
6900 SOCIAL SECURITY TAX.....	268,236	268,236	268,236	268,236
6950 TOTAL, BUDGET ACTIVITY 1.....	7,050,480	7,046,593	7,050,480	7,050,480
7000 ACTIVITY 2: PAY AND ALLOWANCES OF ENLISTED PERSONNEL				
7050 BASIC PAY.....	8,111,240	8,111,240	8,111,240	8,111,240
7100 RETIRED PAY ACCRUAL.....	2,619,514	2,619,514	2,619,514	2,619,514
7150 BASIC ALLOWANCE FOR HOUSING.....	3,529,084	3,529,084	3,529,084	3,529,084
7200 INCENTIVE PAYS.....	102,596	102,596	102,596	102,596
7250 SPECIAL PAYS.....	927,245	897,284	897,245	897,245
7300 ALLOWANCES.....	600,091	600,091	596,091	596,091
7350 SEPARATION PAY.....	155,558	155,558	155,558	155,558
7400 SOCIAL SECURITY TAX.....	620,511	620,511	620,511	620,511
7450 TOTAL, BUDGET ACTIVITY 2.....	16,665,839	16,635,878	16,631,839	16,631,839
7500 ACTIVITY 3: PAY AND ALLOWANCES OF MIDSHIPMEN				
7550 MIDSHIPMEN.....	71,932	71,932	71,932	71,932
7600 ACTIVITY 4: SUBSISTENCE OF ENLISTED PERSONNEL				
7650 BASIC ALLOWANCE FOR SUBSISTENCE.....	700,780	700,780	700,780	700,780
7700 SUBSISTENCE-IN-KIND.....	382,605	382,605	382,605	382,605
7750 FAMILY SUBSISTENCE SUPPLEMENTAL ALLOWANCE.....	11	11	11	11
7800 TOTAL, BUDGET ACTIVITY 4.....	1,083,396	1,083,396	1,083,396	1,083,396

(In thousands of dollars)

	Budget	House	Senate	Recommendation
7850 ACTIVITY 5: PERMANENT CHANGE OF STATION				
7900 ACCESSION TRAVEL.....	76,962	76,962	71,962	71,962
7950 TRAINING TRAVEL.....	71,520	71,520	71,520	71,520
8000 OPERATIONAL TRAVEL	205,398	205,398	205,398	205,398
8050 ROTATIONAL TRAVEL	252,327	252,327	252,327	252,327
8100 SEPARATION TRAVEL.....	137,129	137,129	127,129	127,129
8150 TRAVEL OF ORGANIZED UNITS.....	28,136	28,136	28,136	28,136
8200 NON-TEMPORARY STORAGE.....	7,375	7,375	7,375	7,375
8250 TEMPORARY LODGING EXPENSE.....	7,328	7,328	7,328	7,328
8300 OTHER.....	8,579	8,579	8,579	8,579
8350 TOTAL, BUDGET ACTIVITY 5.....	794,754	794,754	779,754	779,754
8400 ACTIVITY 6: OTHER MILITARY PERSONNEL COSTS				
8450 APPREHENSION OF MILITARY DESERTERS.....	421	421	421	421
8500 INTEREST ON UNIFORMED SERVICES SAVINGS.....	1,550	1,550	1,550	1,550
8550 DEATH GRATUITIES.....	25,400	25,400	25,400	25,400
8600 UNEMPLOYMENT BENEFITS.....	107,320	107,320	107,320	107,320
8650 EDUCATION BENEFITS.....	24,538	24,538	24,538	24,538
8700 ADOPTION EXPENSES.....	372	372	372	372
8750 TRANSPORTATION SUBSIDY.....	12,710	12,710	12,710	12,710
8800 PARTIAL DISLOCATION ALLOWANCE.....	572	572	572	572
8900 RESERVE OFFICERS TRAINING CORPS (ROTC).....	22,907	22,907	22,907	22,907
8950 JUNIOR R.O.T.C.....	13,578	13,578	13,578	13,578
9000 TOTAL, BUDGET ACTIVITY 6.....	209,368	209,368	209,368	209,368
9050 LESS REIMBURSABLES.....	-371,297	-371,297	-371,297	-371,297
9100 UNDISTRIBUTED ADJUSTMENT.....	---	-375,043	-15,000	-166,423
9200 TOTAL, ACTIVE FORCES, NAVY.....	25,504,472	25,095,581	25,440,472	25,289,049
11000 TOTAL, MILITARY PERSONNEL, NAVY.....	25,504,472	25,095,581	25,440,472	25,289,049

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
BA-1: PAY AND ALLOWANCES OF OFFICERS				
SPECIAL PAYS	388,642	384,755	388,642	388,642
Hardship Duty Pay - Transferred to Title IX		-899		
Imminent Danger Pay - Transferred to Title IX		-481		
Foreign Language Proficiency Pay - Transferred to Title IX		-2,507		
BA-2: PAY AND ALLOWANCES OF ENLISTED PERSONNEL				
SPECIAL PAYS	927,245	897,284	897,245	897,245
Hardship Duty Pay - Transferred to Title IX		-8,330		
Imminent Danger Pay - Transferred to Title IX		-899		
Foreign Language Proficiency Pay - Transferred to Title IX		-15,000		
Enlistment Bonus		-3,290	-20,000	-20,000
Reenlistment Bonus		-2,442	-10,000	-10,000
ALLOWANCES	600,091	600,091	596,091	596,091
Navy College Fund			-4,000	-4,000
BA-5: PERMANENT CHANGE OF STATION				
ACCESSION TRAVEL	76,962	76,962	71,962	71,962
Excess to Requirement			-5,000	-5,000
SEPARATION TRAVEL	137,129	137,129	127,129	127,129
Excess to Requirement			-10,000	-10,000
UNDISTRIBUTED ADJUSTMENT		-375,043	-15,000	-166,423
Authorized Basic Pay Increase		64,077		64,077
Unexpended/Unobligated Balances		-20,120	-15,000	-17,500
Undistributed Transfer to Title IX		-419,000		-213,000

MILITARY PERSONNEL, MARINE CORPS

For Military Personnel, Marine Corps, funds are to be available for
fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
12000 MILITARY PERSONNEL, MARINE CORPS				
12050 ACTIVITY 1: PAY AND ALLOWANCES OF OFFICERS				
12100 BASIC PAY.....	1,372,496	1,372,496	1,372,496	1,372,496
12150 RETIRED PAY ACCRUAL.....	442,305	442,305	442,305	442,305
12200 BASIC ALLOWANCE FOR HOUSING.....	431,730	431,730	431,730	431,730
12250 BASIC ALLOWANCE FOR SUBSISTENCE.....	59,245	59,245	59,245	59,245
12300 INCENTIVE PAYS.....	46,302	46,302	46,302	46,302
12350 SPECIAL PAYS.....	31,743	16,657	31,743	29,508
12400 ALLOWANCES.....	33,982	33,982	33,982	33,982
12450 SEPARATION PAY.....	14,051	14,051	14,051	14,051
12500 SOCIAL SECURITY TAX.....	104,411	104,411	104,411	104,411
12550 TOTAL, BUDGET ACTIVITY 1.....	2,536,265	2,521,179	2,536,265	2,534,030
12600 ACTIVITY 2: PAY AND ALLOWANCES OF ENLISTED PERSONNEL				
12650 BASIC PAY.....	4,817,896	4,817,896	4,817,896	4,817,896
12700 RETIRED PAY ACCRUAL.....	1,555,752	1,555,752	1,555,752	1,555,752
12750 BASIC ALLOWANCE FOR HOUSING.....	1,495,914	1,495,914	1,495,914	1,495,914
12800 INCENTIVE PAYS.....	8,850	8,850	8,850	8,850
12850 SPECIAL PAYS.....	501,220	472,291	501,220	494,188
12900 ALLOWANCES.....	264,250	264,250	264,250	264,250
12950 SEPARATION PAY.....	60,371	60,371	60,371	60,371
13000 SOCIAL SECURITY TAX.....	368,568	368,568	368,568	368,568
13050 TOTAL, BUDGET ACTIVITY 2.....	9,072,821	9,043,892	9,072,821	9,065,789
13100 ACTIVITY 4: SUBSISTENCE OF ENLISTED PERSONNEL				
13150 BASIC ALLOWANCE FOR SUBSISTENCE.....	504,437	504,437	504,437	504,437
13200 SUBSISTENCE-IN-KIND.....	288,477	288,477	288,477	288,477
13250 FAMILY SUBSISTENCE SUPPLEMENTAL ALLOWANCE.....	750	750	750	750
13300 TOTAL, BUDGET ACTIVITY 4.....	793,664	793,664	793,664	793,664

(In thousands of dollars)

	Budget	House	Senate	Recommendation
13350 ACTIVITY 5: PERMANENT CHANGE OF STATION				
13400 ACCESSION TRAVEL.....	58,170	58,170	58,170	58,170
13450 TRAINING TRAVEL.....	10,948	10,948	10,948	10,948
13500 OPERATIONAL TRAVEL	118,437	118,437	118,437	118,437
13550 ROTATIONAL TRAVEL	145,384	145,384	145,384	145,384
13600 SEPARATION TRAVEL.....	63,205	63,205	63,205	63,205
13650 TRAVEL OF ORGANIZED UNITS.....	1,829	1,829	1,829	1,829
13700 NON-TEMPORARY STORAGE.....	6,297	6,297	6,297	6,297
13750 TEMPORARY LODGING EXPENSE.....	13,477	13,477	13,477	13,477
13800 OTHER.....	427	427	427	9,694
13850 TOTAL, BUDGET ACTIVITY 5.....	418,174	418,174	418,174	427,441
13900 ACTIVITY 6: OTHER MILITARY PERSONNEL COSTS				
13950 APPREHENSION OF MILITARY DESERTERS.....	1,786	1,786	1,786	1,786
14000 INTEREST ON UNIFORMED SERVICES SAVINGS.....	18	18	18	18
14050 DEATH GRATUITIES.....	17,100	17,100	17,100	17,100
14100 UNEMPLOYMENT BENEFITS.....	84,241	84,241	84,241	84,241
14150 EDUCATION BENEFITS.....	3,754	3,754	3,754	3,754
14200 ADOPTION EXPENSES.....	189	189	189	189
14250 TRANSPORTATION SUBSIDY.....	2,095	2,095	2,095	2,095
14300 PARTIAL DISLOCATION ALLOWANCE.....	430	430	430	430
14400 JUNIOR R.O.T.C.....	5,414	5,414	5,414	5,414
14450 TOTAL, BUDGET ACTIVITY 6.....	115,027	115,027	115,027	115,027
14500 LESS REIMBURSABLES.....	-20,161	-20,161	-20,161	-20,161
14600 UNDISTRIBUTED ADJUSTMENT.....	---	-342,930	-32,000	-115,800
14650 TOTAL, ACTIVE FORCES, MARINE CORPS.....	12,915,790	12,528,845	12,883,790	12,799,990
16000 TOTAL, MILITARY PERSONNEL, MARINE CORPS.....	12,915,790	12,528,845	12,883,790	12,799,990

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
BA-1: PAY AND ALLOWANCES OF OFFICERS				
SPECIAL PAYS	31,743	16,657	31,743	29,508
Hardship Duty Pay - Transferred to Title IX		-265		
Imminent Danger Pay - Transferred to Title IX		-8,281		
Foreign Language Proficiency Pay - Transferred to Title IX		-4,305		
Officer Accession Bonus - Transferred to BA-5		-2,235		-2,235
BA-2: PAY AND ALLOWANCES OF ENLISTED PERSONNEL				
SPECIAL PAYS	501,220	472,291	501,220	494,188
Hardship Duty Pay - Transferred to Title IX		-2,602		
Imminent Danger Pay - Transferred to Title IX		-7,655		
Foreign Language Proficiency Pay - Transferred to Title IX		-11,640		
Enlistment Bonus - Transferred to BA-5		-7,032		-7,032
BA-5: PERMANENT CHANGE OF STATION				
OTHER	427	427	427	9,694
Transfer from BA-1 and BA-2				9,267
UNDISTRIBUTED ADJUSTMENT		-342,930	-32,000	-115,800
Authorized Basic Pay Increase		32,200		32,200
Unexpended/Unobligated Balances		-83,130	-32,000	-40,000
Undistributed Transfer to Title IX		-292,000		-108,000

MILITARY PERSONNEL, AIR FORCE

For Military Personnel, Air Force, funds are to be available for fiscal
year 2010, as follows:

(In thousands of dollars)				
	Budget	House	Senate	Recommendation
17000 MILITARY PERSONNEL, AIR FORCE				
17050 ACTIVITY 1: PAY AND ALLOWANCES OF OFFICERS				
17100 BASIC PAY.....	4,652,985	4,652,985	4,652,985	4,652,985
17150 RETIRED PAY ACCRUAL.....	1,493,832	1,493,832	1,493,832	1,493,832
17200 BASIC ALLOWANCE FOR HOUSING.....	1,289,006	1,289,006	1,289,006	1,289,006
17250 BASIC ALLOWANCE FOR SUBSISTENCE.....	185,213	185,213	185,213	185,213
17300 INCENTIVE PAYS.....	261,459	261,459	261,459	261,459
17350 SPECIAL PAYS.....	294,879	282,264	294,879	294,879
17400 ALLOWANCES.....	111,626	111,626	111,626	111,626
17450 SEPARATION PAY	55,780	55,780	55,780	55,780
17500 SOCIAL SECURITY TAX.....	354,018	354,018	354,018	354,018
17550 TOTAL, BUDGET ACTIVITY 1.....	8,698,798	8,686,183	8,698,798	8,698,798
17600 ACTIVITY 2: PAY AND ALLOWANCES OF ENLISTED PERSONNEL				
17650 BASIC PAY.....	8,298,263	8,298,263	8,298,263	8,298,263
17700 RETIRED PAY ACCRUAL.....	2,669,786	2,669,786	2,669,786	2,669,786
17750 BASIC ALLOWANCE FOR HOUSING.....	2,872,747	2,872,747	2,872,747	2,872,747
17800 INCENTIVE PAYS.....	35,381	35,381	35,381	35,381
17850 SPECIAL PAYS.....	379,680	313,334	379,680	379,680
17900 ALLOWANCES.....	519,792	519,792	519,792	519,792
17950 SEPARATION PAY.....	128,577	128,577	128,577	128,577
18000 SOCIAL SECURITY TAX	634,817	634,817	634,817	634,817
18050 TOTAL, BUDGET ACTIVITY 2.....	15,539,043	15,472,697	15,539,043	15,539,043
18100 ACTIVITY 3: PAY AND ALLOWANCES OF CADETS				
18150 ACADEMY CADETS.....	71,044	71,044	71,044	71,044
18200 ACTIVITY 4: SUBSISTENCE OF ENLISTED PERSONNEL				
18250 BASIC ALLOWANCE FOR SUBSISTENCE.....	868,652	868,652	868,652	868,652
18300 SUBSISTENCE-IN-KIND.....	192,965	192,965	192,965	192,965
18350 FAMILY SUBSISTENCE SUPPLEMENTAL ALLOWANCE.....	155	155	155	155
18400 TOTAL, BUDGET ACTIVITY 4.....	1,061,772	1,061,772	1,061,772	1,061,772

(In thousands of dollars)

	Budget	House	Senate	Recommendation
18450 ACTIVITY 5: PERMANENT CHANGE OF STATION				
18500 ACCESSION TRAVEL.....	89,290	89,290	89,290	89,290
18550 TRAINING TRAVEL.....	71,721	71,721	71,721	71,721
18600 OPERATIONAL TRAVEL	306,516	306,516	306,516	306,516
18650 ROTATIONAL TRAVEL	511,777	511,777	511,777	511,777
18700 SEPARATION TRAVEL.....	171,642	171,642	171,642	171,642
18750 TRAVEL OF ORGANIZED UNITS.....	23,317	23,317	23,317	23,317
18800 NON-TEMPORARY STORAGE.....	41,757	41,757	41,757	41,757
18850 TEMPORARY LODGING EXPENSE.....	29,590	29,590	29,590	29,590
18900 OTHER.....	---	---	---	---
18950 TOTAL, BUDGET ACTIVITY 5.....	1,245,610	1,245,610	1,245,610	1,245,610
19000 ACTIVITY 6: OTHER MILITARY PERSONNEL COSTS				
19050 APPREHENSION OF MILITARY DESERTERS.....	95	95	95	95
19100 INTEREST ON UNIFORMED SERVICES SAVINGS.....	1,612	1,612	1,612	1,612
19150 DEATH GRATUITIES.....	19,900	19,900	19,900	19,900
19200 UNEMPLOYMENT BENEFITS.....	44,155	44,155	44,155	44,155
19250 SURVIVOR BENEFITS.....	1,783	1,783	1,783	1,783
19300 EDUCATION BENEFITS.....	331	331	331	331
19350 ADOPTION EXPENSES.....	1,092	1,092	1,092	1,092
19400 TRANSPORTATION SUBSIDY.....	12,034	12,034	12,034	12,034
19450 PARTIAL DISLOCATION ALLOWANCE.....	1,929	1,929	1,929	1,929
19550 RESERVE OFFICERS TRAINING CORPS (ROTC).....	39,397	39,397	39,397	39,397
19600 JUNIOR ROTC.....	20,019	20,019	20,019	20,019
19650 TOTAL, BUDGET ACTIVITY 6.....	142,347	142,347	142,347	142,347
19700 LESS REIMBURSABLES.....	-318,853	-318,853	-318,853	-318,853
19750 UNDISTRIBUTED ADJUSTMENT.....	---	-421,950	-61,000	-265,625
19800 TOTAL, ACTIVE FORCES, AIR FORCE.....	26,439,761	25,938,850	26,378,761	26,174,136
21000 TOTAL, MILITARY PERSONNEL, AIR FORCE.....	26,439,761	25,938,850	26,378,761	26,174,136

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
BA-1: PAY AND ALLOWANCES OF OFFICERS				
SPECIAL PAYS	294,879	282,264	294,879	294,879
Hostile Fire Pay - Transferred to Title IX		-5,501		
Hardship Duty Pay - Transferred to Title IX		-1,808		
Foreign Language Proficiency Pay - Transferred to Title IX		-5,306		
BA-2: PAY AND ALLOWANCES OF ENLISTED PERSONNEL				
SPECIAL PAYS	379,680	313,334	379,680	379,680
Hostile Fire Pay - Transferred to Title IX		-37,935		
Hardship Duty Pay - Transferred to Title IX		-10,848		
Foreign Language Proficiency Pay - Transferred to Title IX		-17,563		
UNDISTRIBUTED ADJUSTMENT		-421,950	-61,000	-265,625
Authorized Basic Pay Increase		52,700		58,700
Unexpended/Unobligated Balances		-143,650		-71,825
Undistributed Transfer to Title IX		-331,000		-222,000
Lower than Budgeted Pay Grade Mix			-61,000	-30,500

RESERVE PERSONNEL, ARMY

For Reserve Personnel, Army, funds are to be available for fiscal year

2010, as follows:

(In thousands of dollars)				
	Budget	House	Senate	Recommendation

23000 RESERVE PERSONNEL, ARMY				
23050 ACTIVITY 1: RESERVE COMPONENT TRAINING AND SUPPORT				
23100 PAY GROUP A TRAINING (15 DAYS & DRILLS 24/48).....	1,236,457	1,236,457	1,236,457	1,236,457
23150 PAY GROUP B TRAINING (BACKFILL FOR ACT DUTY).....	44,224	44,224	44,224	44,224
23200 PAY GROUP F TRAINING (RECRUITS).....	267,251	267,251	267,251	267,251
23250 PAY GROUP P TRAINING (PIPELINE RECRUITS).....	8,621	8,621	8,621	8,621
23300 MOBILIZATION TRAINING	17,597	17,597	17,597	17,597
23350 SCHOOL TRAINING.....	187,023	187,023	187,023	187,023
23400 SPECIAL TRAINING.....	272,105	272,105	272,105	272,105
23450 ADMINISTRATION AND SUPPORT.....	2,098,042	2,098,042	2,098,042	2,098,042
23500 EDUCATION BENEFITS.....	65,457	65,457	65,457	65,457
23550 HEALTH PROFESSION SCHOLARSHIP	62,398	62,398	62,398	62,398
23600 OTHER PROGRAMS	77,481	77,481	77,481	77,481
23650 TOTAL, BUDGET ACTIVITY 1.....	4,336,656	4,336,656	4,336,656	4,336,656
23800 UNDISTRIBUTED ADJUSTMENT.....	---	-28,143	-50,000	-31,943
24000 TOTAL RESERVE PERSONNEL, ARMY.....	4,336,656	4,308,513	4,286,656	4,304,713
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EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
UNDISTRIBUTED ADJUSTMENT		-28,143	-50,000	-31,943
Authorized Basic Pay Increase		14,257		14,257
Unexpended/Unobligated Balances		-42,400	-50,000	-46,200

RESERVE PERSONNEL, NAVY

For Reserve Personnel, Navy, funds are to be available for fiscal year

2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
26000 RESERVE PERSONNEL, NAVY				
26050 ACTIVITY 1: RESERVE COMPONENT TRAINING AND SUPPORT				
26100 PAY GROUP A TRAINING (15 DAYS & DRILLS 24/48).....	619,535	619,535	614,535	614,535
26150 PAY GROUP B TRAINING (BACKFILL FOR ACTIVE DUTY).....	8,888	8,888	8,888	8,888
26200 PAY GROUP F TRAINING (RECRUITS).....	55,636	55,636	55,636	55,636
26250 MOBILIZATION TRAINING.....	8,315	8,315	8,315	8,315
26300 SCHOOL TRAINING.....	43,782	43,782	43,782	43,782
26350 SPECIAL TRAINING.....	79,489	79,489	79,489	79,489
26400 ADMINISTRATION AND SUPPORT.....	1,066,311	1,066,311	1,066,311	1,066,311
26450 EDUCATION BENEFITS.....	6,774	6,774	6,774	6,774
26500 HEALTH PROFESSION SCHOLARSHIP.....	49,436	49,436	49,436	49,436
26550 TOTAL, BUDGET ACTIVITY 1.....	1,938,166	1,938,166	1,933,166	1,933,166
26600 UNDISTRIBUTED ADJUSTMENT.....	---	-20,055	-28,000	-23,865
27000 TOTAL, RESERVE PERSONNEL, NAVY.....	1,938,166	1,918,111	1,905,166	1,909,301

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
PAY GROUP A TRAINING (15 DAYS & DRILLS 24/48)	619,535	619,535	614,535	614,535
Unjustified Growth			-5,000	-5,000
UNDISTRIBUTED ADJUSTMENT		-20,055	-28,000	-23,865
Authorized Basic Pay Increase		4,635		4,635
Unexpended/Unobligated Balances		-24,690	-24,000	-24,500
Lower than Budgeted Pay Grade Mix			-4,000	-4,000

RESERVE PERSONNEL, MARINE CORPS

For Reserve Personnel, Marine Corps, funds are to be available for
fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation

28000 RESERVE PERSONNEL, MARINE CORPS				
28050 ACTIVITY 1: RESERVE COMPONENT TRAINING AND SUPPORT				
28100 PAY GROUP A TRAINING (15 DAYS & DRILLS 24/48).....	171,381	171,381	171,381	171,381
28150 PAY GROUP B TRAINING (BACKFILL FOR ACT DUTY).....	30,901	30,901	30,901	30,901
28200 PAY GROUP F TRAINING (RECRUITS).....	121,402	121,402	121,402	121,402
28300 MOBILIZATION TRAINING.....	4,114	4,114	4,114	4,114
28350 SCHOOL TRAINING.....	16,034	16,034	16,034	16,034
28400 SPECIAL TRAINING.....	26,851	26,851	26,851	26,851
28450 ADMINISTRATION AND SUPPORT.....	215,447	215,447	215,447	215,447
28500 PLATOON LEADER CLASS.....	11,327	11,327	11,327	11,327
28550 EDUCATION BENEFITS.....	20,043	20,043	20,043	20,043

28600 TOTAL, BUDGET ACTIVITY 1.....	617,500	617,500	617,500	617,500
28700 UNDISTRIBUTED ADJUSTMENT.....	---	-6,920	-6,000	-4,000

29000 TOTAL, RESERVE PERSONNEL, MARINE CORPS.....	617,500	610,580	611,500	613,500
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EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
UNDISTRIBUTED ADJUSTMENT		-6,920	-6,000	-4,000
Authorized Basic Pay Increase		1,900		1,900
Unexpended/Unobligated Balances		-5,820	-6,000	-5,900
MIP Marine Corps Reserve Intelligence Program		-3,000		

RESERVE PERSONNEL, AIR FORCE

For Reserve Personnel, Air Force, funds are to be available for fiscal
year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
30000 RESERVE PERSONNEL, AIR FORCE				
30050 ACTIVITY 1: RESERVE COMPONENT TRAINING AND SUPPORT				
30100 PAY GROUP A TRAINING (15 DAYS & DRILLS 24/48).....	637,673	637,673	637,673	637,673
30150 PAY GROUP B TRAINING (BACKFILL FOR ACT DUTY).....	91,119	91,119	91,119	91,119
30200 PAY GROUP F TRAINING (RECRUITS).....	56,926	56,926	56,926	56,926
30250 PAY GROUP P TRAINING (PIPELINE RECRUITS).....	52	52	52	52
30300 MOBILIZATION TRAINING.....	1,800	1,800	1,800	1,800
30350 SCHOOL TRAINING.....	152,674	152,674	152,674	152,674
30400 SPECIAL TRAINING.....	221,085	221,085	221,085	221,085
30450 ADMINISTRATION AND SUPPORT.....	353,905	353,905	353,905	353,905
30500 EDUCATION BENEFITS.....	37,362	37,362	37,362	37,362
30550 HEALTH PROFESSION SCHOLARSHIP.....	49,979	49,979	49,979	49,979
30600 OTHER PROGRAMS (ADMIN & SUPPORT).....	5,137	5,137	5,137	5,137
30650 TOTAL, BUDGET ACTIVITY 1.....	1,607,712	1,607,712	1,607,712	1,607,712
30750 UNDISTRIBUTED ADJUSTMENT.....	---	-7,250	-23,000	-18,300
31000 TOTAL, RESERVE PERSONNEL, AIR FORCE.....	1,607,712	1,600,462	1,584,712	1,589,412

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
UNDISTRIBUTED ADJUSTMENT		-7,250	-23,000	-18,300
Authorized Basic Pay Increase		15,200		4,200
Unexpended/Unobligated Balances		-22,450	-23,000	-22,500

NATIONAL GUARD PERSONNEL, ARMY

For National Guard Personnel, Army, funds are to be available for
fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
32000 NATIONAL GUARD PERSONNEL, ARMY				
32050 ACTIVITY 1: RESERVE COMPONENT TRAINING AND SUPPORT				
32100 PAY GROUP A TRAINING (15 DAYS & DRILLS 24/48).....	2,054,153	2,054,153	2,054,153	2,054,153
32150 PAY GROUP F TRAINING (RECRUITS).....	460,832	460,832	460,832	460,832
32200 PAY GROUP P TRAINING (PIPELINE RECRUITS).....	68,064	68,064	68,064	68,064
32250 SCHOOL TRAINING.....	547,488	547,488	547,488	547,488
32300 SPECIAL TRAINING.....	528,419	528,419	508,419	518,419
32350 ADMINISTRATION AND SUPPORT.....	3,799,749	3,799,749	3,799,749	3,799,749
32400 EDUCATION BENEFITS.....	162,783	162,783	162,783	162,783
32410 RECRUITING/RETENTION.....	---	-52,747	---	-25,000
32450 TOTAL, BUDGET ACTIVITY 1.....	7,621,488	7,568,741	7,601,488	7,586,488
32600 UNDISTRIBUTED ADJUSTMENT.....	---	-43,113	-66,400	-39,583
33000 TOTAL, NATIONAL GUARD PERSONNEL, ARMY.....	7,621,488	7,525,628	7,535,088	7,546,905

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
SPECIAL TRAINING	528,419	528,419	508,419	518,419
Recruiting and Retention Mandays			-20,000	-10,000
RECRUITING AND RETENTION		-52,747		-25,000
UNDISTRIBUTED ADJUSTMENT		-43,113	-66,400	-39,583
Authorized Basic Pay Increase		26,267		26,267
Unexpended/Unobligated Balances		-70,830	-70,000	-70,500
WMD Civil Support Team for Florida		1,200		1,200
WMD Civil Support Team for New York		250		200
Joint Interagency Training and Education Center			3,600	3,250

NATIONAL GUARD PERSONNEL, AIR FORCE

For National Guard Personnel, Air Force, funds are to be available for
fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
34000 NATIONAL GUARD PERSONNEL, AIR FORCE				
34050 ACTIVITY 1: RESERVE COMPONENT TRAINING AND SUPPORT				
34100 PAY GROUP A TRAINING (15 DAYS & DRILLS 24/48).....	961,609	961,609	961,609	961,609
34150 PAY GROUP F TRAINING (RECRUITS).....	64,290	64,290	64,290	64,290
34200 PAY GROUP P TRAINING (PIPELINE RECRUITS).....	209	209	209	209
34250 SCHOOL TRAINING.....	191,646	191,646	191,646	191,646
34300 SPECIAL TRAINING.....	115,083	115,083	115,083	115,083
34350 ADMINISTRATION AND SUPPORT.....	1,598,988	1,598,988	1,594,988	1,594,988
34400 EDUCATION BENEFITS.....	39,124	39,124	39,124	39,124
34450 TOTAL, BUDGET ACTIVITY 1.....	2,970,949	2,970,949	2,966,949	2,966,949
34700 UNDISTRIBUTED ADJUSTMENT.....	---	-21,050	-43,350	-28,720
35000 TOTAL, NATIONAL GUARD PERSONNEL, AIR FORCE.....	2,970,949	2,949,899	2,923,599	2,938,229

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
ADMINISTRATION AND SUPPORT	1,598,988	1,598,988	1,594,988	1,594,988
Non-Prior Service Enlistment Bonus			-4,000	-4,000
UNDISTRIBUTED ADJUSTMENT		-21,050	-43,350	-28,720
Authorized Basic Pay Increase		1,600		6,600
Unexpended/Unobligated Balances		-22,650	-34,000	-28,320
Lower than Budgeted Pay Grade Mix			-10,000	-8,000
Joint Interagency Training and Education Center			650	1,000

TITLE II – OPERATION AND MAINTENANCE

For Operation and Maintenance, funds are to be available for fiscal
year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
RECAPITULATION				
OPERATION & MAINTENANCE, ARMY.....	31,274,882	30,454,152	30,667,886	30,934,550
OPERATION & MAINTENANCE, NAVY.....	35,070,346	34,885,932	34,773,497	34,714,396
OPERATION & MAINTENANCE, MARINE CORPS.....	5,536,223	5,557,510	5,435,923	5,539,117
OPERATION & MAINTENANCE, AIR FORCE.....	34,748,159	33,785,349	33,739,447	33,477,116
OPERATION & MAINTENANCE, DEFENSE-WIDE	28,357,246	27,929,377	28,205,050	28,115,793
OPERATION & MAINTENANCE, ARMY RESERVE.....	2,620,196	2,621,196	2,582,624	2,617,496
OPERATION & MAINTENANCE, NAVY RESERVE.....	1,278,501	1,280,001	1,272,501	1,273,701
OPERATION & MAINTENANCE, MARINE CORPS RESERVE.....	228,925	228,925	219,425	223,175
OPERATION & MAINTENANCE, AIR FORCE RESERVE.....	3,079,228	3,079,228	3,085,700	3,131,200
OPERATION & MAINTENANCE, ARMY NATIONAL GUARD.....	6,257,034	6,353,627	5,989,034	6,189,713
OPERATION & MAINTENANCE, AIR NATIONAL GUARD.....	5,885,761	5,888,741	5,857,011	5,882,251
OVERSEAS CONTINGENCY OPERATIONS TRANSFER ACCOUNT.....	5,000	---	---	---
UNITED STATES COURT OF APPEALS FOR THE ARMED FORCES...	13,932	13,932	13,932	13,932
ENVIRONMENTAL RESTORATION, ARMY	415,864	415,864	430,864	423,364
ENVIRONMENTAL RESTORATION, NAVY.....	285,869	285,869	285,869	285,869
ENVIRONMENTAL RESTORATION, AIR FORCE	494,276	494,276	494,276	494,276
ENVIRONMENTAL RESTORATION, DEFENSE-WIDE.....	11,100	11,100	11,100	11,100
ENVIRONMENTAL RESTORATION, FORMERLY USED DEF. SITES...	267,700	277,700	307,700	292,700
OVERSEAS HUMANITARIAN, DISASTER, AND CIVIC AID.....	109,869	109,869	109,869	109,869
COOPERATIVE THREAT REDUCTION ACCOUNT.....	404,093	404,093	424,093	424,093
DOD ACQUISITION WORKFORCE DEVELOPMENT FUND.....	100,000	100,000	100,000	100,000
GRAND TOTAL, OPERATION & MAINTENANCE.....	156,444,204	154,176,741	154,005,801	154,253,711

UNDISTRIBUTED REDUCTIONS BASED ON HISTORICAL UNDEREXECUTION

Both the House and Senate recommend execution reductions to the operation and maintenance accounts. The House's adjustment is based on the Government Accountability Office's analysis of historical budget execution trends. The Senate's adjustment is based on the historical difference between the request and obligations for restoration and modernization, citing data that the execution of appropriated funds was significantly different than what was requested for certain budget line items. Since the issues behind these recommendations are so similar, the recommendation includes an undistributed reduction to each of the operation and maintenance accounts based on historical underexecution. This reduction shall be applied to any budget line item with the exception of Facilities Sustainment, Restoration and Modernization lines.

FINANCIAL IMPROVEMENT AND AUDIT READINESS

It is concerning that the Department of Defense is not placing enough emphasis on improving financial management processes, internal controls and audit readiness capability. The Department should continue to develop and implement the Financial Improvement and Audit Readiness (FIAR) plan to correct financial management deficiencies and meet audit readiness objectives. Such actions would likely result in significant programmatic savings, increased efficiencies, and an improved ability to properly spend and account for the Department's critical assets and resources. The recommendation supports the Department of Defense's FIAR planning and financial improvement programs.

OPERATION AND MAINTENANCE REPROGRAMMINGS

The recommendation includes a provision identical to the provision enacted in fiscal year 2009 that requires the Department to submit the DD Form 1414, Base for Reprogramming Actions, for each of the fiscal year 2010 appropriations accounts within 60 days after the enactment of this Act. This provision prohibits the Department from executing any reprogramming or transfer of funds for any purpose other than originally appropriated until the aforementioned report is submitted to the House and the Senate Committees on Appropriations.

With respect to the Services' operation and maintenance accounts, the Department shall submit prior approval reprogramming requests to the congressional defense committees for proposed transfers of funds in excess of \$15,000,000 to or from the levels specified for budget activities. In addition, the Department shall follow prior approval reprogramming procedures for transfers in excess of \$15,000,000 out of the following budget sub-activities:

Operation and Maintenance, Army:
Land Forces Depot Maintenance
Operation and Maintenance, Navy:
Aircraft Depot Maintenance
Ship Depot Maintenance
Operation and Maintenance, Marine Corps:
Depot Maintenance
Operation and Maintenance, Air Force:
Air Operations Depot Maintenance
Mobility Operations Depot Maintenance
Basic Skills/Training Depot Maintenance
Logistics Operations Depot Maintenance

In addition, the Department shall follow prior approval reprogramming procedures for transfers in excess of \$15,000,000 into the following budget sub-activity:

Operation and Maintenance, Army National Guard:

Other Personnel Support/Recruiting and Advertising

Further, the Department shall provide written notification of cumulative transfers in excess of \$15,000,000 from the following budget sub-activities:

Operation and Maintenance, Army:

Maneuver Units
Modular Support Brigades
Land Forces Operations Support
Force Readiness Operations Support
Base Operations Support
Facilities, Sustainment, Restoration and Modernization

Operation and Maintenance, Navy:

Facilities Sustainment, Restoration and Modernization

Operation and Maintenance, Marine Corps:

Facilities Sustainment, Restoration and Modernization

Operation and Maintenance, Air Force:

Primary Combat Forces
Combat Enhancement Forces
Combat Communications
Facilities Sustainment, Restoration and Modernization

With respect to Operation and Maintenance, Defense-Wide, proposed transfers of funds to or from the levels specified for defense agencies in excess of \$15,000,000 shall be subject to prior approval reprogramming procedures. In addition, the Department shall provide written notification of cumulative transfers in excess of \$15,000,000 or 20 percent, whichever is less, from the following line items identified in the Operation and Maintenance, Defense-Wide project level table contained in this Act:

Defense Legal Services Agency

Office of the Secretary of Defense:

Acquisition, Technology, and Logistics Programs

Personnel and Readiness

Comptroller and Chief Financial Officer

Under Secretary of Defense (Intelligence)

Under Secretary of Defense (Policy)

Director, Program Analysis and Evaluation

Assistant Secretary for Defense (Networks and Information Integration)

A congressional interest item contained in Operation and Maintenance, Defense-Wide is defined only as a specified increase provided in this Act.

OPERATION AND MAINTENANCE BUDGET EXECUTION DATA

The Secretary of Defense is directed to continue to provide the congressional defense committees with quarterly budget execution data. Such data should be provided not later than 45 days past the close of each quarter for the fiscal year, and shall be provided for each 0-1 budget activity, activity group, and sub-activity group for each of the active, defense-wide, reserve and National Guard components. For each 0-1 budget activity, activity group, and sub-activity group, these reports shall include: the budget request and actual obligations; the Department of Defense distribution of unallocated congressional adjustments to the budget request; all adjustments made in establishing the Base for Reprogramming (DD Form 1414) report; all adjustments resulting from below threshold reprogrammings; and all adjustments resulting from prior approval reprogramming requests.

FEDERAL GOVERNMENT CONTRACTING PROCEDURES

Section 811 of the National Defense Authorization Act for Fiscal Year 2010 (Public

Law 111-84) included a provision amending Federal government contracting procedures for 8(a) Native American sole source Federal contracts. The provision requires that any 8(a) Native American contracts in excess of \$20,000,000 will now be subject to an additional level of review through the Justification and Approval process. The effect that this additional requirement will have on the efficiency of the contracting process and the competitiveness of Native American companies is unknown. Therefore, the Secretary of Defense is directed to submit a report 90 days after the implementation of the new contracting procedures. This report shall detail the impact of the provision on the selection of Native American companies for large dollar contracts; discuss how the provision is affecting the contracting process, whether an excessive administrative burden has been placed on contracting personnel; and provide recommendations for how the provision can be amended to mitigate any unintended negative consequences.

MILITARY TIRES

As part of the Tire Commodity Management Privatization initiative, undertaken in compliance with the Base Realignment and Closure Act of 2005, the Department of Defense shifted responsibility for tire supply, storage, and distribution from the Defense Logistics Agency to a contractor who would be in charge of procuring and distributing all ground and air military tires worldwide for the Department and the military services. It is recognized that the intent of this initiative was to lower costs and streamline the process of getting tires to the warfighter and that the current prime contractor has exceeded expectations. However, having a tire manufacturer as the manager as well as the vendor creates a perception of a lack of competition.

The Secretary of Defense is directed to award new military ground vehicle and aircraft tire management contracts when the existing base contract expires. The new contract should prohibit any tire manufacturer from acting as a prime contractor for the management of the contract. The existing Navy aircraft tire contracts are exempted provided the Department of the Navy certifies that these contracts represent the best value to the government.

INFORMATION OPERATIONS

The Department of Defense must improve both budgetary and policy oversight of its strategic communications and information operations programs. The Department's leadership has only recently become aware of the variety, scope, and magnitude of funding associated with these programs across the services and at all levels within the combatant commands. Fiscal year 2010 Department of Defense budget justification materials provided to the Congress initially indicated the request included nearly one billion dollars across the Department of Defense and within the services for information operations programs. However, after the congressional defense committees made several inquiries during the budget review process, it was determined by the Department that the budget request for these activities was actually \$626,200,000 for fiscal year 2010, \$360,000,000 less than originally indicated.

As part of its own efforts, the Department has improved its ability to account for the vast sums of dollars that have been spent on these programs in the past, and those being requested in the current budget submission. However, throughout the budget review process of the House and Senate Appropriations

Committees, repeated questions to the Department about the execution of appropriated funds and the proposed use of requested funding were too often answered with varied responses or admissions of uncertainty. The Congress cannot be expected to continue supporting programs which lack accountability and clear direction.

The Department of Defense should formulate, coordinate, operate and account for its strategic communications and information operations programs within an enterprise-wide architecture. This should include designating an individual or individuals with authority to ensure that the programs support national security policies and strategies, that they are properly coordinated with other government departments and agencies, and that appropriated dollars are obligated, expended, and accounted for in accordance with the intent justified and communicated to the Congress, and for the purposes appropriated. In this regard, the recommendation concurs with the reporting requirement included in the National Defense Authorization Act for Fiscal Year 2010 regarding the Department's efforts to develop enterprise-wide oversight and coordination mechanisms for military strategic communications and information operations programs. This report should also include an evaluation of proposals to establish or empower an office within the Secretary of Defense with Executive Agent authority over military strategic communications and information operations programs.

The Congress has a need for better budget justification and execution documentation for congressional oversight of information

operations program funds. The classified annex to the Supplemental Appropriations Act for Fiscal Year 2009 included a reporting requirement on Department of Defense strategic communications programs. The Department should submit such a report annually with updated informative materials and data. Accordingly, the Under Secretary of Defense for Policy, in coordination with the Under Secretary of Defense (Comptroller), shall submit a strategic communications and information operations programs report to the congressional defense committees not later than 30 days after the submission of the President's annual budget request to Congress. The report shall include supplemental budget justification materials for strategic communication programs to include information operations, psychological operations, and influence activities of the Department of Defense for which base budget, supplemental, or overseas contingency operation funds have been appropriated or requested over the fiscal year 2007 through 2011 period, including: program strategies, target audiences, goals, and measures of effectiveness; budget exhibits at the appropriations account and sub-activity level; spend plans (including positions and other direct costs and locations. The report shall include an annex for necessary explanatory and supporting classified information. Within this annex the Department should specifically designate, and include a comprehensive explanation of, any programs, activities, or operations where the involvement of the United States Government may be anything less than publicly acknowledged.

Finally, funding requested for United States Central Command (CENTCOM) information operations programs in Afghanistan has grown from \$39,900,000 in fiscal year 2008, to a request of \$243,800,000 in fiscal year 2010, a 500 percent increase. Of the \$109,700,000 specifically appropriated for United States Forces—Afghanistan (USFOR-A) information operations programs in fiscal year 2009, only \$63,400,000 was obligated. The remaining \$46,300,000 (42 percent of the appropriation) was used by CENTCOM and the Army for other purposes in Afghanistan. The large increase in the funding requested and the ability of CENTCOM to execute this funding based on its prior year execution is of concern. Accordingly, the Under Secretary of Defense (Comptroller) is directed to provide a classified quarterly report to the congressional defense committees on the obligation and expenditure of those funds requested and appropriated in Title IX of this Act, "Operation and Maintenance, Army" for CENTCOM's United States Forces—Afghanistan and External Information Program—Afghanistan information operation programs and activities. The report shall identify any of the funds provided that have been obligated or expended for other than information operation activities, or transferred either above or below the reprogramming threshold notification requirements, and the purposes for which the funds were otherwise used.

The recommendation makes the following reductions to the Department of Defense request for information operations and strategic communications programs:

(In thousands of dollars)

Account	Line	Program adjustment	House reduction	Senate reduction	Recommended reduction
Operation and Maintenance, Title II					
O&M Army	134	Information Operations		-18,800	0
O&M Army	138	EUCOM Information Operations			-2,000
O&M Army	138	AFRICOM Information Operations			-3,000
O&M Army	Undistributed	Information Operations	-30,000		0
O&M Air Force	015A	CENTCOM Information Operations			-20,000
O&M Air Force	Undistributed	Information Operations	-49,400		0
O&M DW	SOCOM	Information Operations	-16,000		0
Operation and Maintenance, Title IX					
O&M Air Force	015A	Information Operations	-150,000	-20,000	-25,000
O&M Air Force	Undistributed	Information Operations	-27,000		0
O&M DW	SOCOM	Information Operations	-58,000	-20,000	-50,000

ARMY AND AIR FORCE EXCHANGE SERVICE

There is deep concern that Army and Air Force Exchange Service (AAFES) decisions to construct new restaurants will negatively impact locally-owned restaurants of the same franchise in the community. Such actions, especially in areas with economic con-

ditions that cannot support multiple restaurants of the same franchise, are harmful to the community. As partners with the community, the Department should consider these implications when making decisions about building new retail, restaurant or concessions services on an installation. Accordingly, the Department is directed to report

to the congressional defense committees within 90 days after enactment of this Act on the decision process to open new AAFES restaurants at Fort Stewart, and what considerations were made to account for the potential impact of such openings on the locally-owned restaurants of the same franchise.

OPERATION AND MAINTENANCE, ARMY

For Operation and Maintenance, Army, funds are to be available for
fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
50 OPERATION AND MAINTENANCE, ARMY				
100 BUDGET ACTIVITY 1: OPERATING FORCES				
150 LAND FORCES				
200 MANEUVER UNITS.....	1,020,490	1,031,620	1,020,490	1,026,055
250 MODULAR SUPPORT BRIGADES.....	105,178	116,802	105,178	114,290
300 ECHELONS ABOVE BRIGADES.....	708,038	709,038	708,038	708,838
350 THEATER LEVEL ASSETS.....	718,233	722,733	699,733	721,833
400 LAND FORCES OPERATIONS SUPPORT.....	1,379,529	1,382,029	1,230,257	1,232,757
450 AVIATION ASSETS.....	850,750	850,750	773,350	773,350
500 LAND FORCES READINESS				
550 FORCE READINESS OPERATIONS SUPPORT.....	2,088,233	2,091,733	2,010,342	2,073,033
600 LAND FORCES SYSTEMS READINESS.....	633,704	625,604	633,704	633,704
650 LAND FORCES DEPOT MAINTENANCE.....	692,601	695,601	692,601	695,001
700 LAND FORCES READINESS SUPPORT				
750 BASE OPERATIONS SUPPORT.....	7,586,455	7,593,155	7,364,133	7,526,915
800 FACILITIES SUSTAINMENT, RESTORATION, & MODERNIZATION..	2,221,446	2,229,527	2,230,846	2,231,474
850 MANAGEMENT AND OPERATIONAL HEADQUARTERS.....	333,119	341,119	314,119	339,519
900 COMBATANT COMMANDER'S CORE OPERATIONS.....	123,163	123,163	104,363	123,163
1060 COMBATANT COMMANDERS ANCILLARY MISSIONS.....	460,159	460,159	460,159	455,159
1100 TOTAL, BUDGET ACTIVITY 1.....	18,921,098	18,973,033	18,347,313	18,655,091
1150 BUDGET ACTIVITY 2: MOBILIZATION				
1200 MOBILITY OPERATIONS				
1250 STRATEGIC MOBILITY.....	228,376	218,376	228,376	218,376
1300 ARMY PREPOSITIONED STOCKS.....	98,129	98,129	98,129	98,129
1350 INDUSTRIAL PREPAREDNESS.....	5,705	5,705	5,705	5,705
1400 TOTAL, BUDGET ACTIVITY 2.....	332,210	322,210	332,210	322,210

(In thousands of dollars)

	Budget	House	Senate	Recommendation
1450 BUDGET ACTIVITY 3: TRAINING AND RECRUITING				
1500 ACCESSION TRAINING				
1550 OFFICER ACQUISITION.....	125,615	126,615	125,615	126,415
1600 RECRUIT TRAINING.....	87,488	87,488	88,412	89,888
1650 ONE STATION UNIT TRAINING.....	59,302	62,802	59,302	62,802
1700 SENIOR RESERVE OFFICERS TRAINING CORPS.....	449,397	450,332	451,597	452,092
1750 BASIC SKILL AND ADVANCED TRAINING				
1800 SPECIALIZED SKILL TRAINING.....	970,777	1,018,777	971,277	979,427
1850 FLIGHT TRAINING.....	843,893	843,893	985,693	985,693
1900 PROFESSIONAL DEVELOPMENT EDUCATION.....	166,812	171,912	170,812	171,292
1950 TRAINING SUPPORT.....	702,031	580,231	702,031	703,631
2000 RECRUITING AND OTHER TRAINING AND EDUCATION				
2050 RECRUITING AND ADVERTISING.....	541,852	525,252	541,852	539,852
2100 EXAMINING.....	147,915	147,915	147,915	147,915
2150 OFF-DUTY AND VOLUNTARY EDUCATION.....	238,353	238,353	238,353	238,353
2200 CIVILIAN EDUCATION AND TRAINING.....	217,386	199,386	217,386	217,386
2250 JUNIOR RESERVE OFFICERS TRAINING CORPS.....	156,904	171,904	156,904	168,904
2300 TOTAL, BUDGET ACTIVITY 3.....	4,707,725	4,624,860	4,857,149	4,883,650
2350 BUDGET ACTIVITY 4: ADMIN & SERVICEWIDE ACTIVITIES				
2400 SECURITY PROGRAMS				
2450 SECURITY PROGRAMS.....	1,017,055	1,019,355	1,014,247	1,019,555
2500 LOGISTICS OPERATIONS				
2550 SERVICEWIDE TRANSPORTATION.....	540,249	540,249	540,249	540,249
2600 CENTRAL SUPPLY ACTIVITIES.....	614,093	619,093	614,093	619,093
2650 LOGISTICS SUPPORT ACTIVITIES.....	481,318	489,318	489,618	495,218
2700 AMMUNITION MANAGEMENT.....	434,661	422,861	434,661	434,661

(In thousands of dollars)

	Budget	House	Senate	Recommendation
2750 SERVICEWIDE SUPPORT				
2800 ADMINISTRATION.....	776,866	763,866	776,866	763,866
2850 SERVICEWIDE COMMUNICATIONS.....	1,166,491	1,114,991	1,168,491	1,191,091
2900 MANPOWER MANAGEMENT.....	289,383	289,383	289,383	289,383
2950 OTHER PERSONNEL SUPPORT.....	221,779	221,779	218,652	229,029
3000 OTHER SERVICE SUPPORT.....	993,852	995,352	986,852	988,352
3050 ARMY CLAIMS ACTIVITIES.....	215,168	175,768	215,168	215,168
3100 REAL ESTATE MANAGEMENT.....	118,785	118,785	118,785	118,785
3150 SUPPORT OF OTHER NATIONS				
3200 SUPPORT OF NATO OPERATIONS.....	430,449	430,449	430,449	430,449
3250 MISC. SUPPORT OF OTHER NATIONS.....	13,700	13,700	13,700	13,700
3300 TOTAL, BUDGET ACTIVITY 4.....	7,313,849	7,214,949	7,311,214	7,348,599
3440 ELIMINATE CAAS GROWTH IN OBJECT CLASS.....	---	-50,900	---	-50,900
3445 INFORMATION OPERATIONS.....	---	-30,000	---	---
3450 EXCESS WORKING CAPITAL FUND CASH.....	---	-600,000	---	---
3455 UNDISTRIBUTED REDUCTION DUE TO HISTORIC R&M MIGRATION.	---	---	-180,000	---
3460 UNDISTRIBUTED REDUCTION DUE TO HISTORIC UNDEREXECUTION	---	---	---	-224,100
4000 TOTAL, OPERATION AND MAINTENANCE, ARMY.....	31,274,882	30,454,152	30,667,886	30,934,550

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

O-1	Budget Request	House	Senate	Recommendation
111 MANEUVER UNITS	1,020,490	1,031,620	1,020,490	1,026,055
Program Increase - Irregular warfare		11,130		5,565
112 MODULAR SUPPORT BRIGADES	105,178	116,802	105,178	114,290
Program Increase - Irregular warfare		2,624		1,312
Air-Supported Temper Tent		3,000		3,000
Modular Command Post Tent		6,000		4,800
113 ECHELONS ABOVE BRIGADE	708,038	709,038	708,038	708,838
Army Force Generation Synchronization Tool		1,000		800
114 THEATER LEVEL ASSETS	718,233	722,733	699,733	721,833
Lightweight Tactical Utility Vehicles		4,500		3,600
CASEVAC/Logistics Rotary Wing Contract for OEF-Philippines - Transfer to OCO			-18,500	
115 LAND FORCES OPERATIONS SUPPORT	1,379,529	1,382,029	1,230,257	1,232,757
UH-60 Leak Proof Drip Pans		2,500		2,500
Budget Realignment of Combat Training Center Transportation Funding in Support of Helicopter Training			-64,400	-64,400
Reduction to the Remaining Growth in fiscal year 2010 for Combat Training Center Transportation due to OCO Funding Availability			-36,372	-36,372
Budget Justification does not Match Summary of Price and Program Changes for Other Contracts			-48,500	-48,500
116 AVIATION ASSETS	850,750	850,750	773,350	773,350
Budget Realignment in Support of Helicopter Training			-77,400	-77,400
121 FORCE READINESS OPERATIONS SUPPORT	2,088,233	2,091,733	2,010,342	2,073,033
Fort Hood Training Lands Restoration and Maintenance		2,500		2,000
Operational/Technical Training Validation for Joint Maneuver Forces at Fort Bliss		1,000		800
Family Readiness Support Assistants - Transfer to OCO			-59,891	
Administrative Savings Proposal Increase Number of Soldiers per Chartered Aircraft going on R&R Leave			-15,000	-15,000
Administrative Savings Proposal - Soldier Student Lodging			-3,000	-3,000
122 LAND FORCES SYSTEMS READINESS	633,704	625,604	633,704	633,704
Average Underexecution		-8,100		
123 LAND FORCES DEPOT MAINTENANCE	692,601	695,601	692,601	695,001
Defense Job Creation and Supply Chain Initiative		3,000		2,400
131 BASE OPERATIONS SUPPORT	7,586,455	7,593,155	7,364,133	7,526,915
Fort Benning National Incident Management System Compliant Installation Operations Center		5,000		4,000
Fort Bliss Data Center		1,700		1,360
Budget Justification does not Match Summary of Price and Program Changes for Korea Build-to-Lease Program and TRADOC Lease Reductions			-46,000	-46,000

O-1	Budget Request	House	Senate	Recommendation
Pollution Prevention Reduction not Properly Accounted for in Budget Justification			-22,000	-22,000
Environmental Management Information System (EMIS) - Army Requested Transfer to RDT&E, Army line number 64			-2,000	-2,000
Child Care/Youth Development Programs - Transfer to OCO			-69,320	
Installation Support - Transfer to OCO			-10,088	
Warfighter and Family Services - Transfer to OCO			-78,514	
Army Conservation and Ecosystem Management			4,500	4,000
IT and Information Management Upgrades, Fort Greely, AK			300	300
Post Security Enhancements, Fort Greely, AK			800	800
FACILITIES SUSTAINMENT, RESTORATION, & 132 MODERNIZATION	2,221,446	2,229,527	2,230,846	2,231,474
Americans with Disabilities Act Compliance for the Historical Fort Hamilton Community Club		1,800		1,440
Defense- Fire Alarm / Detection System Installation for the Historical Fort Hamilton Community Club		500		400
Defense- Sprinkler System Installation for the Historical Fort Hamilton Community Club		1,200		960
Repair Heating, Ventilation, Air Conditioning System at Fort Leavenworth		2,796		0
Repair Heating, Ventilation, Air Conditioning System in National Simulations Center		1,785		1,428
Installation Processing Node - Phase IIa			3,600	0
Rock Island Arsenal Building 299 Roof Replacement			5,800	5,800
133 MANAGEMENT AND OPERATIONAL HQ	333,119	341,119	314,119	339,519
Initiative to Increase Minority Participation In Defense		8,000		6,400
Budget Justification does not Match Summary of Price and Program Changes for Management and Professional Services			-19,000	
134 COMBATANT COMMANDERS CORE OPERATIONS	123,163	123,163	104,363	123,163
Information Operations			-18,800	0
138 COMBATANT COMMANDERS ANCILLARY MISSIONS	460,159	460,159	460,159	455,159
EUCOM Information Operations				-2,000
AFRICOM Information Operations				-3,000
211 STRATEGIC MOBILITY	228,376	218,376	228,376	218,376
Lack of Spares to Reset Prepo		-10,000		-10,000
311 OFFICER ACQUISITION	125,615	126,615	125,615	126,415
Diversity Recruitment for West Point Military Academy		1,000		800
312 RECRUIT TRAINING	87,488	87,488	88,412	89,888
Reception Stations - Transfer to OCO			-2,076	
Desert Locust Laser Protective Lens			3,000	2,400
313 ONE STATION UNIT TRAINING	59,302	62,802	59,302	62,802
TRANSIM Driver Training		3,500		3,500
314 SENIOR RESERVE OFFICERS TRAINING CORPS	449,397	450,332	451,597	452,092
US Army ROTC Emergency Facility Renovation		935		935
Air Battle Captain ROTC Helicopter Training			2,200	1,760

O-1	Budget Request	House	Senate	Recommendation
321 SPECIALIZED SKILL TRAINING	970,777	1,018,777	971,277	979,427
Program Increase - Re-balance Training Programs		45,000		5,750
Critical Language Instruction for Military Personnel, Education, Training and Distance Learning		3,000		2,400
Rule of Law			500	500
322 FLIGHT TRAINING	843,893	843,893	985,693	985,693
Budget Realignment in Support of Helicopter Training			141,800	141,800
323 PROFESSIONAL DEVELOPMENT EDUCATION	166,812	171,912	170,812	171,292
Army Command and General Staff College Leadership Training Program		2,000	2,000	2,000
Genocide Prevention Course through Combined Arms Center *		1,600		1,280
ROTC and Reserve Component Strategic Language Hub Pilot		1,500		1,200
Academic Support and Research Compliance for Knowledge Gathering (Transferred to RDT&E, Army line number 4)			2,000	
324 TRAINING SUPPORT	702,031	580,231	702,031	703,631
Average Underexecution		-123,800		
Online Technology Training Program at Joint Base Lewis- McChord		2,000		1,600
331 RECRUITING AND ADVERTISING	541,852	525,252	541,852	539,852
Average Underexecution		-12,600		
Army Experience Center - Eliminate Targeting of 13-17 year olds		-4,000		-2,000
334 CIVILIAN EDUCATION AND TRAINING	217,386	199,386	217,386	217,386
Average Underexecution		-18,000		
335 JUNIOR ROTC	156,904	171,904	156,904	168,904
Program Increase - Junior ROTC		15,000		12,000
411 SECURITY PROGRAMS	1,017,055	1,019,355	1,014,247	1,019,555
Classified Adjustment		2,300	-2,808	2,500
422 CENTRAL SUPPLY ACTIVITIES	614,093	619,093	614,093	619,093
DECA Construction (Transfer)		5,000		5,000
423 LOGISTIC SUPPORT ACTIVITIES	481,318	489,318	489,618	495,218
Anti-Corrosion Nanotechnology Solutions for Logistics		1,000		800
Common Logistics Operating System		2,000		1,600
Logistics Interoperability		1,500		1,200
Net-Centric Decision Support Environment Sense and Respond Logistics		2,500		2,000
Ground Combat System Knowledge Center and Technical Inspection Data Capture		1,000		1,000
Manufacturing Supply Chain Initiative			5,000	4,000
Transformation of ISO Containers to Smart Containers			3,300	3,300

O-1	Budget Request	House	Senate	Recommendation
424 AMMUNITION MANAGEMENT	434,661	422,861	434,661	434,661
Average Underexecution		-14,800		
M24 Sniper Weapons System Upgrade (Transferred to Procurement of Weapons and Tracked Combat Vehicles, Army line number 42)		3,000		
431 ADMINISTRATION	776,866	763,866	776,866	763,866
In-source issuing Common Access Cards		-18,000		-18,000
In-source issuing Common Access Cards		9,000		9,000
Efficiencies of centralized management and tracking of Common Access Cards		-4,000		-4,000
432 SERVICEWIDE COMMUNICATIONS	1,166,491	1,114,991	1,168,491	1,191,091
Average Underexecution		-51,500		
Biometrics Operations Directorate Transition			2,000	1,600
GFEBs transfer request - Transfer from Other Procurement, Army line number 118				23,000
434 OTHER PERSONNEL SUPPORT	221,779	221,779	218,652	229,029
Transferred from O&M, Defense-Wide BTA for DIMHRS			7,250	7,250
Wounded Warrior Program - Transfer to OCO			-10,377	
435 OTHER SERVICE SUPPORT	993,852	995,352	986,852	988,352
Memorial Day Concert		1,500		1,500
Administrative Savings Proposal: Automated Vendor Payments (Wide Area Workflow)			-7,000	-7,000
436 ARMY CLAIMS ACTIVITIES	215,168	175,768	215,168	215,168
Average Underexecution		-39,400		
Eliminate Growth in CAAS Shown in Object Class		-50,900		-50,900
Undistributed Information Operations		-30,000		0
Excess Working Capital Fund Cast		-600,000		0
Undistributed Reduction Due to Historic R&M Migration			-180,000	0
Undistributed Reduction Due to Historic Underexecution				-224,100

ACCOUNTABILITY OF COMMON ACCESS CARDS

House Report 111-230 on the Department of Defense Appropriations Bill, 2010 noted major problems cited by the Department of Defense Inspector General regarding Common Access Card abuses by contractors. A program has been established to provide secure credentials to contractors and is currently being tested at Fort Belvoir, Virginia. These steps to address the force protection deficiencies cited by the Inspector General are encouraging and the Department should work to continue to improve the process for issuing Common Access Cards and to im-

prove the security of Department of Defense facilities.

JUNIOR RESERVE OFFICERS' TRAINING CORPS

The Junior Reserve Officers' Training Corps (JROTC) helps instill the essential qualities of character, citizenship, and fitness in its participants. The Department is commended for JROTC's proven track record of developing leadership potential, logical thinking and enhanced oral and verbal communication skills. JROTC's valuable role is an outlet through which its participants remain engaged, dedicated and disciplined in

their academic and extracurricular endeavors. JROTC's emphasis on the importance of high school graduation, college attendance, and other advanced educational and employment opportunities which contribute to a successful future is to be applauded. In order to extend and enhance the benefits of this invaluable program, the recommendation provides \$12,000,000 above the budget request only for a pilot program of JROTC units that would expand the scope and availability of this program in localities that desire to participate in such a program.

OPERATION AND MAINTENANCE, NAVY

For Operation and Maintenance, Navy, funds are to be available for
fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
4300 OPERATION AND MAINTENANCE, NAVY				
4350 BUDGET ACTIVITY 1: OPERATING FORCES				
4400 AIR OPERATIONS				
4450 MISSION AND OTHER FLIGHT OPERATIONS.....	3,814,000	3,598,672	3,814,000	3,724,004
4500 FLEET AIR TRAINING.....	120,868	120,868	121,668	121,668
4560 AVIATION TECHNICAL DATA AND ENGINEERING SERVICES.....	52,250	52,250	52,250	52,250
4600 AIR OPERATIONS AND SAFETY SUPPORT.....	121,649	121,649	121,649	121,649
4650 AIR SYSTEMS SUPPORT.....	485,321	485,321	485,321	485,321
4700 AIRCRAFT DEPOT MAINTENANCE.....	1,057,747	1,127,774	1,057,747	1,092,747
4750 AIRCRAFT DEPOT OPERATIONS SUPPORT.....	32,083	32,083	32,083	32,083
4800 SHIP OPERATIONS				
4850 MISSION AND OTHER SHIP OPERATIONS.....	3,320,222	3,320,222	3,300,222	3,300,222
4900 SHIP OPERATIONS SUPPORT AND TRAINING.....	699,581	699,581	699,581	699,581
4950 SHIP DEPOT MAINTENANCE.....	4,296,544	4,298,644	4,291,544	4,293,224
5000 SHIP DEPOT OPERATIONS SUPPORT.....	1,170,785	1,171,785	1,170,785	1,171,585
5050 COMBAT COMMUNICATIONS/SUPPORT				
5100 COMBAT COMMUNICATIONS.....	601,595	601,595	601,595	601,595
5150 ELECTRONIC WARFARE.....	86,019	86,019	86,019	86,019
5200 SPACE SYSTEMS AND SURVEILLANCE.....	167,050	167,050	160,050	160,050
5250 WARFARE TACTICS.....	407,674	439,510	407,674	418,592
5300 OPERATIONAL METEOROLOGY AND OCEANOGRAPHY.....	315,228	310,928	315,228	315,228
5350 COMBAT SUPPORT FORCES.....	758,789	779,289	758,789	768,789
5400 EQUIPMENT MAINTENANCE.....	186,794	186,794	186,794	186,794
5450 DEPOT OPERATIONS SUPPORT.....	3,305	5,705	3,305	5,225
5460 COMBATANT COMMANDERS CORE OPERATIONS.....	167,789	167,789	183,789	183,789
5470 COMBATANT COMMANDERS DIRECT MISSION SUPPORT.....	259,188	259,188	250,438	250,438

(In thousands of dollars)

	Budget	House	Senate	Recommendation
5500 WEAPONS SUPPORT				
5550 CRUISE MISSILE.....	131,895	131,895	131,895	131,895
5600 FLEET BALLISTIC MISSILE.....	1,145,020	1,145,020	1,145,020	1,145,020
5650 IN-SERVICE WEAPONS SYSTEMS SUPPORT.....	64,731	64,731	64,731	64,731
5700 WEAPONS MAINTENANCE.....	448,777	448,777	456,377	456,377
5750 OTHER WEAPON SYSTEMS SUPPORT	326,535	326,535	326,535	326,535
5800 BASE SUPPORT				
5850 ENTERPRISE INFORMATION TECHNOLOGY.....	1,095,587	1,095,587	1,072,587	1,072,587
5900 FACILITIES SUSTAINMENT, RESTORATION & MODERNIZATION ..	1,746,418	1,738,618	1,736,418	1,737,018
5950 BASE OPERATING SUPPORT.....	4,058,046	4,036,046	4,058,046	4,062,546
6000 TOTAL, BUDGET ACTIVITY 1.....	27,141,499	27,019,934	27,092,149	27,067,571
6050 BUDGET ACTIVITY 2: MOBILIZATION				
6100 READY RESERVE AND PREPOSITIONING FORCES				
6150 SHIP PREPOSITIONING AND SURGE.....	407,977	407,977	405,977	405,977
6200 ACTIVATIONS/INACTIVATIONS				
6250 AIRCRAFT ACTIVATIONS/INACTIVATIONS.....	7,491	7,491	7,491	7,491
6300 SHIP ACTIVATIONS/INACTIVATIONS.....	192,401	195,401	192,401	194,801
6350 MOBILIZATION PREPAREDNESS				
6400 FLEET HOSPITAL PROGRAM.....	24,546	24,546	24,546	24,546
6450 INDUSTRIAL READINESS.....	2,409	2,409	2,409	2,409
6500 COAST GUARD SUPPORT.....	25,727	25,727	25,727	25,727
6550 TOTAL, BUDGET ACTIVITY 2.....	660,551	663,551	658,551	660,951
6600 BUDGET ACTIVITY 3: TRAINING AND RECRUITING				
6650 ACCESSION TRAINING				
6700 OFFICER ACQUISITION.....	145,027	146,027	145,027	145,827
6750 RECRUIT TRAINING.....	11,011	11,011	11,011	11,011
6800 RESERVE OFFICERS TRAINING CORPS.....	127,490	127,490	127,490	127,490
6850 BASIC SKILLS AND ADVANCED TRAINING				
6900 SPECIALIZED SKILL TRAINING.....	477,383	467,783	477,383	483,343
6950 FLIGHT TRAINING.....	1,268,846	1,268,846	1,268,846	1,268,846
7000 PROFESSIONAL DEVELOPMENT EDUCATION.....	161,922	170,922	161,922	169,122
7050 TRAINING SUPPORT.....	158,685	158,685	158,685	158,685

(In thousands of dollars)

	Budget	House	Senate	Recommendation
7100 RECRUITING, AND OTHER TRAINING AND EDUCATION				
7150 RECRUITING AND ADVERTISING.....	276,564	263,615	271,564	272,150
7200 OFF-DUTY AND VOLUNTARY EDUCATION.....	154,979	154,979	155,479	155,479
7250 CIVILIAN EDUCATION AND TRAINING.....	101,556	101,556	101,556	101,556
7300 JUNIOR ROTC.....	49,161	49,161	49,161	49,161
7350 TOTAL, BUDGET ACTIVITY 3.....	2,932,624	2,920,075	2,928,124	2,942,670
7400 BUDGET ACTIVITY 4: ADMIN & SERVICEWIDE ACTIVITIES				
7450 SERVICEWIDE SUPPORT				
7500 ADMINISTRATION.....	768,048	768,048	766,048	766,048
7550 EXTERNAL RELATIONS.....	6,171	6,171	6,171	6,171
7600 CIVILIAN MANPOWER AND PERSONNEL MANAGEMENT.....	114,675	114,675	114,675	114,675
7650 MILITARY MANPOWER AND PERSONNEL MANAGEMENT.....	182,115	182,115	189,365	189,365
7700 OTHER PERSONNEL SUPPORT.....	298,729	298,729	294,329	298,729
7750 SERVICEWIDE COMMUNICATIONS.....	408,744	353,444	402,244	402,244
7850 LOGISTICS OPERATIONS AND TECHNICAL SUPPORT				
7900 SERVICEWIDE TRANSPORTATION.....	246,989	246,989	246,989	246,989
7950 PLANNING, ENGINEERING AND DESIGN.....	244,337	244,337	244,337	244,337
8000 ACQUISITION AND PROGRAM MANAGEMENT.....	778,501	778,501	768,501	778,501
8050 HULL, MECHANICAL AND ELECTRICAL SUPPORT.....	60,223	60,223	60,223	60,223
8100 COMBAT/WEAPONS SYSTEMS.....	17,328	17,328	17,328	17,328
8150 SPACE AND ELECTRONIC WARFARE SYSTEMS.....	79,065	79,065	79,065	79,065
8200 SECURITY PROGRAMS				
8250 NAVAL INVESTIGATIVE SERVICE.....	515,989	515,989	520,989	519,989
8300 SUPPORT OF OTHER NATIONS				
8350 INTERNATIONAL HEADQUARTERS AND AGENCIES.....	5,918	5,918	5,918	5,918
8400 OTHER PROGRAMS				
8450 OTHER PROGRAMS.....	608,840	610,840	608,491	611,240
8500 TOTAL, BUDGET ACTIVITY 4.....	4,335,672	4,282,372	4,324,673	4,340,822
8575 UNDISTRIBUTED REDUCTION DUE TO HISTORIC R&M MIGRATION.	---	---	-230,000	---
8577 UNDISTRIBUTED REDUCTION DUE TO HISTORIC UNDEREXECUTION	---	---	---	-197,618
8580 CIVILIAN PERSONNEL UNDEREXECUTION.....	---	---	---	-100,000
9100 TOTAL, OPERATION AND MAINTENANCE, NAVY.....	35,070,346	34,885,932	34,773,497	34,714,396

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS

[In thousands of dollars]

O-1	Budget Request	House	Senate	Recommendation
1A1A MISSION AND OTHER FLIGHT OPERATIONS	3,814,000	3,598,672	3,814,000	3,724,004
Average Underexecution		-35,336		
Excessive Flying Hour Growth		-179,992		-89,996
1A2A FLEET AIR TRAINING	120,868	120,868	121,668	121,668
Naval Strike Air Warfare Center OEF/OIF training (Terminal Attack Control)			800	800
1A5A AIRCRAFT DEPOT MAINTENANCE	1,057,747	1,127,774	1,057,747	1,092,747
Aircraft		70,027		35,000
1B1B MISSION AND OTHER SHIP OPERATIONS	3,320,222	3,320,222	3,300,222	3,300,222
Removal of one-time fiscal year 2009 cost			-20,000	-20,000
1B4B SHIP DEPOT MAINTENANCE	4,296,544	4,298,644	4,291,544	4,293,224
Puget Sound Naval Maintenance and Repair Process Improvements		2,100		1,680
Administrative Savings Proposal: Improve Submarine Maintenance Procedures			-5,000	-5,000
1B5B SHIP DEPOT OPERATIONS SUPPORT	1,170,785	1,171,785	1,170,785	1,171,585
ATIS Maintenance and Enhancement Program		1,000		800
1C3C SPACE SYSTEMS AND SURVEILLANCE	167,050	167,050	160,050	160,050
Unjustified Growth for SURTASS			-7,000	-7,000
1C4C WARFARE TACTICS	407,674	439,510	407,674	418,592
Program Increase - Rebalance Training Program		31,836		10,918
1C5C OPERATIONAL METEOROLOGY AND OCEANOGRAPHY	315,228	310,928	315,228	315,228
Average Underexecution		-4,300		
1C6C COMBAT SUPPORT FORCES	758,789	779,289	758,789	768,789
Fleet Forces Command NAVAFAfrica Partnership Station East and West		20,500		10,000
1C8C DEPOT OPERATIONS SUPPORT	3,305	5,705	3,305	5,225
Fleet Readiness Data Assessment		2,400		1,920
1CCH COMBATANT COMMANDERS CORE OPERATIONS	167,789	167,789	183,789	183,789
Asia Pacific Regional Initiative			16,000	16,000
COMBATANT COMMANDERS DIRECT MISSION				
1CCM SUPPORT	259,188	259,188	250,438	250,438
National Program for Small Unit Excellence			-8,750	-8,750
1D4D WEAPONS MAINTENANCE	448,777	448,777	456,377	456,377
Unjustified Growth for STUAS			-4,400	-4,400

O-1	Budget Request	House	Senate	Recommendation
Mk 45 Mod 5" Gun Depot Overhauls			12,000	12,000
BSIT ENTERPRISE INFORMATION	1,095,587	1,095,587	1,072,587	1,072,587
Administrative Savings Proposal: Eliminate Inactive Internet/Intranet Accounts			-5,000	-5,000
Administrative Savings Proposal: Make Corporate Software License Purchases			-18,000	-18,000
BSM1 SUSTAINMENT, RESTORATION AND MODERNIZATION	1,746,418	1,738,618	1,736,418	1,737,018
Average Underexecution		-8,400		
Puget Sound Navy Museum		600		600
Removal of one-time fiscal year 2009 Congressional Increases			-10,000	-10,000
BSS1 BASE OPERATING SUPPORT	4,058,046	4,036,046	4,058,046	4,062,546
Average Underexecution		-27,500		
Brown Tree Snake Program		500		500
Enhanced Navy Shore Readiness Integration		5,000		4,000
2A1F SHIP PREPOSITIONING AND SURGE	407,977	407,977	405,977	405,977
Removal of one-time fiscal year 2009 cost			-2,000	-2,000
2B2G SHIP ACTIVATIONS/INACTIVATIONS	192,401	195,401	192,401	194,801
Navy Ship Disposal - Carrier Demonstration Project		3,000		2,400
3A1J OFFICER ACQUISITION	145,027	146,027	145,027	145,827
Diversity Recruitment for Naval Academy		1,000		800
3B1K SPECIALIZED SKILL TRAINING	477,383	467,783	477,383	483,343
Average Underexecution		-20,800		
Program Increase - Re-balance Training Programs		10,000		5,000
Institute for Threat Reduction and Response- Simulated and Virtual Training Environments		1,200		960
3B3K PROFESSIONAL DEVELOPMENT EDUCATION	161,922	170,922	161,922	169,122
Center for Defense Technology and Education for the Military Services (CDTEMS)		7,000		5,600
Continuing Education - Distance Learning at Military Installations		2,000		1,600
3C1L RECRUITING AND ADVERTISING	276,564	263,615	271,564	272,150
Naval Cadet Corps		651		586
Average Underexecution		-13,600		
Eliminate Requested Program Growth for Advertising			-5,000	-5,000
3C3L OFF-DUTY AND VOLUNTARY EDUCATION	154,979	154,979	155,479	155,479
Energy Education and Training for Military Personnel			500	500
4A1M ADMINISTRATION	768,048	768,048	766,048	766,048
Unjustified Growth			-2,000	-2,000

O-1	Budget Request	House	Senate	Recommendation
4A4M MANAGEMENT	182,115	182,115	189,365	189,365
Transferred from O&M Defense-Wide, BTA for DIMHRS			7,250	7,250
4A5M OTHER PERSONNEL SUPPORT	298,729	298,729	294,329	298,729
Removal of one-time costs Budgeted for Guam			-4,400	0
4A6M SERVICEWIDE COMMUNICATIONS	408,744	353,444	402,244	402,244
Average Underexecution		-55,300		
SPAWAR Business Office Unjustified Increase			-6,500	-6,500
4B3N ACQUISITION AND PROGRAM MANAGEMENT	778,501	778,501	768,501	778,501
Unjustified Growth			-10,000	0
4C1P NAVAL INVESTIGATIVE SERVICE	515,989	515,989	520,989	519,989
Digitization, Integration, and Analyst Access of Investigative Files, Naval Criminal Investigative Services			5,000	4,000
OTHER PROGRAMS	608,840	610,840	608,491	611,240
Classified Adjustment		2,000	-349	2,400
Budget Activity 4	4,335,672	4,282,372	4,324,673	4,340,822
Undistributed Reduction Due to Historic R&M Migration			-230,000	
Undistributed Reduction Due to Historic Underexecution				-197,618
Civilian Personnel Hiring Plan				-100,000

NAVAL AIR STATION, MOFFETT FIELD

The future of the Hanger One site at the former Naval Air Station (NAS) Moffett Field remains uncertain, and the Department of the Navy and the National Aero-

navics and Space Administration are encouraged to continue to work with the Office of Management and Budget to reach an expeditious recommendation for the environmental remediation and restoration of the facility.

JOINT POW/ MIA ACCOUNTING COMMAND

The Secretary of Defense is directed that, of the funds available within Operation and Maintenance, Navy, \$67,417,000 shall be for the Joint POW/MIA Accounting Command.

OPERATION AND MAINTENANCE, MARINE CORPS

For Operation and Maintenance, Marine Corps, funds are to be
available for fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
9250 OPERATION AND MAINTENANCE, MARINE CORPS				
9300 BUDGET ACTIVITY 1: OPERATING FORCES				
9350 EXPEDITIONARY FORCES				
9400 OPERATIONAL FORCES.....	730,931	752,860	738,631	751,396
9450 FIELD LOGISTICS.....	591,020	591,020	591,020	591,020
9500 DEPOT MAINTENANCE.....	80,971	80,971	80,971	80,971
9550 USMC PREPOSITIONING				
9600 MARITIME PREPOSITIONING.....	72,182	72,182	72,182	72,182
9650 NORWAY PREPOSITIONING.....	5,090	5,090	5,090	5,090
9700 FACILITIES SUSTAINMENT, RESTORATION & MODERNIZATION ..	666,330	666,330	660,730	660,730
9750 BASE OPERATING SUPPORT.....	2,250,191	2,250,191	2,156,791	2,242,791
9760 NET ZERO TECHNICAL ADJUSTMENT TO BUDGET ACTIVITY 1....	---	-60,000	-60,000	-60,000
9800 TOTAL, BUDGET ACTIVITY 1.....	4,396,715	4,358,644	4,245,415	4,344,180
9850 BUDGET ACTIVITY 3: TRAINING AND RECRUITING				
9900 ACCESSION TRAINING				
9950 RECRUIT. TRAINING.....	16,129	16,129	16,129	16,129
10000 OFFICER ACQUISITION.....	418	418	418	418
10050 BASIC SKILLS AND ADVANCED TRAINING				
10100 SPECIALIZED SKILLS TRAINING.....	67,336	75,794	67,336	71,565
10150 FLIGHT TRAINING.....	369	269	369	369
10200 PROFESSIONAL DEVELOPMENT EDUCATION.....	28,112	28,112	28,112	28,112
10250 TRAINING SUPPORT.....	330,885	330,885	330,885	330,885
10300 RECRUITING AND OTHER TRAINING EDUCATION				
10350 RECRUITING AND ADVERTISING.....	240,832	240,832	240,832	240,832
10400 OFF-DUTY AND VOLUNTARY EDUCATION.....	64,254	54,854	64,254	64,254
10450 JUNIOR ROTC.....	19,305	19,305	19,305	19,305
10600 TOTAL, BUDGET ACTIVITY 3.....	767,640	766,598	767,640	771,866

(In thousands of dollars)

	Budget	House	Senate	Recommendation

10650 BUDGET ACTIVITY 4: ADMIN & SERVICEWIDE ACTIVITIES				
10700 SERVICEWIDE SUPPORT				
10750 SPECIAL SUPPORT.....	299,065	299,565	299,065	299,565
10800 SERVICEWIDE TRANSPORTATION.....	28,924	28,924	28,924	28,924
10850 ADMINISTRATION.....	43,879	43,779	43,879	43,879
10960 NET ZERO TECHNICAL ADJUSTMENT TO BUDGET ACTIVITY 4....	---	60,000	60,000	60,000
11000 TOTAL, BUDGET ACTIVITY 4.....	371,868	432,268	431,868	432,368
11025 UNDISTRIBUTED REDUCTION DUE TO HISTORIC R&M MIGRATION.	---	---	-9,000	---
11027 UNDISTRIBUTED REDUCTION DUE TO HISTORIC UNDEREXECUTION	---	---	---	-9,300
	=====	=====	=====	=====
11400 TOTAL, OPERATION AND MAINTENANCE, MARINE CORPS.....	5,536,223	5,557,510	5,435,923	5,539,117
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EXPLANATION OF PROJECT LEVEL ADJUSTMENTS

[In thousands of dollars]

O-1	Budget Request	House	Senate	Recommendation
1A1A OPERATIONAL FORCES	730,931	752,860	738,631	751,396
Program Increase - Re-balance Training Programs		13,929		6,965
Flame Resistant High Performance Apparel		1,500		1,200
MGPTS Type III or Rapid Deployable Shelter		3,000		2,400
Ultra Lightweight Camouflage Net System (ULCANS)		3,500		2,800
Family of Shelters and Tents			2,000	1,600
Hemostatic Combat Gauze			1,000	800
Spray Technique Analysis and Research for Defense (STAR4D)			2,200	2,200
Rapid Data Management System			2,500	2,500
BSM1 SUSTAINMENT, RESTORATION, & MODERNIZATION	666,330	666,330	660,730	660,730
Henderson Hall Joint Basing Initiative not Properly Accounted for			-1,200	-1,200
Relocation of Forces Growth not Properly Accounted for			-4,400	-4,400
BSS1 BASE OPERATING SUPPORT	2,250,191	2,250,191	2,156,791	2,242,791
Removal of One-Time Congressional Increases			-4,400	-4,400
Henderson Hall Joint Basing Initiative not Properly Accounted for			-3,000	-3,000
Family Support Programs - Transfer to OCO			-86,000	
Net Zero Technical Adjustment - Undistributed to BA-1		-60,000	-60,000	-60,000
3B1D SPECIALIZED SKILL TRAINING	67,336	75,794	67,336	71,565
Program Increase - Re-balance Training Programs		8,458		4,229
3B2D FLIGHT TRAINING	369	269	369	369
Average Underexecution		-100		
3C2F OFF-DUTY AND VOLUNTARY EDUCATION	64,254	54,854	64,254	64,254
Average Underexecution		-9,400		
4A2G SPECIAL SUPPORT	299,065	299,565	299,065	299,565
Classified Adjustment		500		500
4A4G ADMINISTRATION	43,879	43,779	43,879	43,879
Average Underexecution		-100		
Net Zero Technical Adjustment - Undistributed to BA-4		60,000	60,000	60,000
Undistributed Reduction Due to Historic R&M Migration			-9,000	
Undistributed Reduction Due to Historic Underexecution				-9,300

WATER CONTAMINATION CLAIMS AT CAMP
LEJEUNE.

During fiscal year 2010, the Secretary of
the Navy may not dispose of claims filed re-

garding water contamination at Camp
Lejeune, North Carolina, until the Agency
for Toxic Substances and Disease Registry
(ATSDR) fully completes all current, ongo-

ing epidemiological and water modeling
studies pending as of the date of the enact-
ment of this Act.

OPERATION AND MAINTENANCE, AIR FORCE

For Operation and Maintenance, Air Force, funds are to be available
for fiscal year 2010, as follows:

(In thousands of dollars)				
	Budget	House	Senate	Recommendation

12000 OPERATION AND MAINTENANCE, AIR FORCE				
12050 BUDGET ACTIVITY 1: OPERATING FORCES				
12100 AIR OPERATIONS				
12150 PRIMARY COMBAT FORCES.....	4,017,156	3,917,156	3,936,996	3,936,996
12250 COMBAT ENHANCEMENT FORCES.....	2,754,563	2,676,863	2,754,563	2,754,563
12300 AIR OPERATIONS TRAINING.....	1,414,913	1,416,413	1,414,913	1,416,113
12400 DEPOT MAINTENANCE.....	2,389,738	2,391,978	2,348,426	2,349,666
12450 FACILITIES SUSTAINMENT, RESTORATION & MODERNIZATION ..	1,420,083	1,420,083	1,420,083	1,420,083
12500 BASE OPERATING SUPPORT.....	2,859,943	2,859,943	2,735,301	2,734,911
12550 COMBAT RELATED OPERATIONS				
12600 GLOBAL C3I AND EARLY WARNING.....	1,411,813	1,411,813	1,411,813	1,411,813
12700 OTHER COMBAT OPERATIONS SUPPORT PROGRAMS.....	880,353	880,353	885,284	884,484
12850 TACTICAL INTELLIGENCE AND SPECIAL ACTIVITIES.....	552,148	552,148	552,148	552,148
12900 SPACE OPERATIONS				
12950 LAUNCH FACILITIES.....	356,367	356,367	356,367	356,367
13050 SPACE CONTROL SYSTEMS.....	725,646	725,646	725,646	725,646
13260 COMBATANT COMMANDERS DIRECT MISSION SUPPORT.....	608,796	608,796	608,796	588,796
13270 COMBATANT COMMANDERS CORE OPERATIONS.....	216,073	198,073	216,073	211,073
13280 UNDISTRIBUTED REDUCTION.....	---	-183,000	---	-183,000
13300 TOTAL, BUDGET ACTIVITY 1.....	19,607,592	19,232,632	19,366,409	19,159,659

(In thousands of dollars)

	Budget	House	Senate	Recommendation
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13350 BUDGET ACTIVITY 2: MOBILIZATION				
13400 MOBILITY OPERATIONS				
13450 AIRLIFT OPERATIONS.....	2,932,080	2,936,080	2,932,080	2,925,280
13550 MOBILIZATION PREPAREDNESS.....	211,858	211,858	211,858	211,858
13650 DEPOT MAINTENANCE.....	332,226	332,226	332,226	332,226
13700 FACILITIES SUSTAINMENT, RESTORATION & MODERNIZATION ..	362,954	362,954	362,954	362,954
13750 BASE SUPPORT.....	657,830	657,830	652,038	652,038
13755 UNDISTRIBUTED (AVERAGE UNDEREXECUTION).....	---	-230,000	---	---
13800 TOTAL, BUDGET ACTIVITY 2.....	4,496,948	4,270,948	4,491,156	4,484,356
13850 BUDGET ACTIVITY 3: TRAINING AND RECRUITING				
13900 ACCESSION TRAINING				
13950 OFFICER ACQUISITION.....	120,870	120,870	121,170	121,170
14000 RECRUIT TRAINING.....	18,135	18,135	15,871	15,871
14050 RESERVE OFFICER TRAINING CORPS (ROTC).....	88,414	88,414	88,414	88,414
14100 FACILITIES SUSTAINMENT, RESTORATION & MODERNIZATION ..	372,788	372,788	372,788	372,788
14150 BASE SUPPORT (ACADEMIES ONLY).....	685,029	685,029	643,218	643,218
14200 BASIC SKILLS AND ADVANCED TRAINING				
14250 SPECIALIZED SKILL TRAINING.....	514,048	516,048	482,761	484,361
14300 FLIGHT TRAINING.....	833,005	738,355	833,005	834,005
14350 PROFESSIONAL DEVELOPMENT EDUCATION.....	215,676	217,676	218,676	218,676
14400 TRAINING SUPPORT.....	118,877	118,877	118,877	118,877
14450 DEPOT MAINTENANCE.....	576	576	576	576
14600 RECRUITING, AND OTHER TRAINING AND EDUCATION				
14650 RECRUITING AND ADVERTISING.....	152,983	153,533	145,807	146,357
14700 EXAMINING.....	5,584	5,584	5,584	5,584
14750 OFF DUTY AND VOLUNTARY EDUCATION.....	188,198	188,198	188,198	188,198
14800 CIVILIAN EDUCATION AND TRAINING.....	174,151	174,151	174,151	174,151
14850 JUNIOR ROTC.....	67,549	67,549	67,549	67,549
14900 TOTAL, BUDGET ACTIVITY 3.....	3,555,883	3,465,783	3,476,645	3,479,795

(In thousands of dollars)

	Budget	House	Senate	Recommendation

14950 BUDGET ACTIVITY 4: ADMIN & SERVICEWIDE ACTIVITIES				
15000 LOGISTICS OPERATIONS				
15050 LOGISTICS OPERATIONS.....	1,055,672	1,018,272	1,055,672	1,058,072
15100 TECHNICAL SUPPORT ACTIVITIES.....	735,036	735,036	735,036	735,036
15200 DEPOT MAINTENANCE.....	15,411	15,411	15,411	15,411
15250 FACILITIES SUSTAINMENT, RESTORATION & MODERNIZATION ..	359,562	359,562	359,562	359,562
15300 BASE SUPPORT.....	1,410,097	1,415,097	1,409,192	1,413,192
15350 SERVICEWIDE ACTIVITIES				
15400 ADMINISTRATION.....	646,080	636,080	653,330	651,330
15450 SERVICEWIDE COMMUNICATIONS.....	664,498	579,898	581,951	581,951
15600 OTHER SERVICEWIDE ACTIVITIES.....	1,062,803	1,065,803	1,062,803	1,062,803
15700 CIVIL AIR PATROL CORPORATION.....	22,433	26,433	22,433	26,433
15850 SECURITY PROGRAMS				
15900 SECURITY PROGRAMS.....	1,066,157	1,068,057	1,144,860	1,149,804
15950 SUPPORT TO OTHER NATIONS				
16000 INTERNATIONAL SUPPORT.....	49,987	49,987	49,987	49,987
16050 TOTAL, BUDGET ACTIVITY 4.....	7,087,736	6,969,636	7,090,237	7,103,581
17260 CIVILIAN HIRING PLAN--REDUCE GROWTH FROM 28% TO 18%...	---	-104,250	---	-50,125
17265 CENTCOM INFORMATION OPS MEDIA PRODUCTION.....	---	-49,400	---	---
17285 EXCESS WORKING CAPITAL FUND CARRY OVER.....	---	---	-85,000	-85,000
17290 UNDISTRIBUTED REDUCTION DUE TO HISTORIC R&M MIGRATION.	---	---	-600,000	---
17297 UNDISTRIBUTED REDUCTION DUE TO HISTORIC UNDEREXECUTION	---	---	---	-615,150
	=====	=====	=====	=====
17350 TOTAL, OPERATION AND MAINTENANCE, AIR FORCE.....	34,748,159	33,785,349	33,739,447	33,477,116
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EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

O-1	Budget Request	House	Senate	Recommendation
011A PRIMARY COMBAT FORCES	4,017,156	3,917,156	3,936,996	3,936,996
Average Underexecution		-100,000		
Administrative Savings Proposal - Commercial Jet A Turbine Fuel			-52,000	-52,000
Consolidation of the B-52 Field Training Unit under AFRC (Transferred to O&M, Air Force Reserve)			-28,160	-28,160
011C COMBAT ENHANCEMENT FORCES	2,754,563	2,676,863	2,754,563	2,754,563
Average Underexecution		-77,700		
011D AIR OPERATIONS TRAINING (OJT, MAINTAIN SKILLS)	1,414,913	1,416,413	1,414,913	1,416,113
Air Education and Training Command Range Improvements at the Barry M. Goldwater Range		1,500		1,200
011M DEPOT MAINTENANCE	2,389,738	2,391,978	2,348,426	2,349,666
Joint Aircrew Combined System Tester (JCAST)		2,000		1,600
Wage Issue Modification for USFORAZORES Portuguese National Employees		240		240
Consolidation of the B-52 Field Training Unit under AFRC (Transferred to O&M, Air Force Reserve)			-44,312	-44,312
USAF Engine Trailer Life Extension Program			3,000	2,400
011Z BASE SUPPORT	2,859,943	2,859,943	2,735,301	2,734,911
Eliminate Military Endstrength Drawdown Installation Support Tail			-132,492	-132,492
Administrative Savings Proposal: Web-Enabled Building Control at Vandenberg AFB			-1,000	-1,000
Alaska Joint Command and Control Infrastructure and Physical Security			1,950	1,560
Joint Pacific Alaska Range Complex (JPARC) Enhancements			6,900	6,900
012C OTHER COMBAT OPS SPT PROGRAMS	880,353	880,353	885,284	884,484
Mission Essential Airfield Operations Equipment			931	931
National Center for Integrated Civilian-Military Domestic Disaster Medical Response (Transferred from line number 15B)			4,000	3,200
015A COMBATANT COMMANDERS DIRECT MISSION SUPPORT	608,796	608,796	608,796	588,796
CENTCOM Information Operations				-20,000
015B COMBATANT COMMANDERS CORE OPERATIONS	216,073	198,073	216,073	211,073
U.S. NORTHCOM Staff Operations - unjustified growth in civilian personnel		-10,000		-3,000
HQ USNORTHCOM-National Center for Integrated Civilian-Military Domestic Disaster Medical Response (Transferred to line number 12C)		2,000		
Administrative Efficiencies - U.S. CENTCOM Staff Travel		-10,000		-2,000
Unexecutable Flying Hour Program - Undistributed to BA-		-183,000		-183,000

O-1	Budget Request	House	Senate	Recommendation
021A AIRLIFT OPERATIONS	2,932,080	2,936,080	2,932,080	2,925,280
Warner Robins Air Logistics Center Strategic Airlift Aircraft Availability Improvement		4,000		3,200
Fee for Service Refueling				-10,000
021Z BASE SUPPORT	657,830	657,830	652,038	652,038
Eliminate Military Endstrength Drawdown Installation Support Tail			-5,792	-5,792
031A OFFICER ACQUISITION	120,870	120,870	121,170	121,170
Air Force Academy Space and Defense Studies Research and Curriculum Development			300	300
031B RECRUIT TRAINING	18,135	18,135	15,871	15,871
Active Duty Accessions Increase			-2,264	-2,264
031Z BASE SUPPORT	685,029	685,029	643,218	643,218
Eliminate Military Endstrength Drawdown Installation Support Tail			-41,811	-41,811
032A SPECIALIZED SKILL TRAINING	514,048	516,048	482,761	484,361
Military Medical Training and Disaster Response Program		2,000		1,600
Active Duty Accessions Increase			-31,287	-31,287
032B FLIGHT TRAINING	833,005	738,355	833,005	834,005
Average Underexecution		-95,900		
Minority Aviation Training Program		1,250		1,000
032C PROFESSIONAL DEVELOPMENT EDUCATION	215,676	217,676	218,676	218,676
Defense Critical Languages and Cultures Initiative		2,000	3,000	3,000
033A RECRUITING AND ADVERTISING	152,983	153,533	145,807	146,357
Diversity Recruitment for Air Force Academy		550		550
Active Duty Accessions Increase			-7,176	-7,176
041A LOGISTICS OPERATIONS	1,055,672	1,018,272	1,055,672	1,058,072
Average Underexecution		-40,400		
Advanced Autonomous Robotic Inspections for Aging Aircraft		1,000		800
Expert Knowledge Transformation Project		2,000		1,600
041Z BASE SUPPORT	1,410,097	1,415,097	1,409,192	1,413,192
Demonstration Project for Contractors Employing Persons with Disabilities		4,000		3,200
MacDill Air Force Base Online Technology Program		1,000		800
Eliminate Military Endstrength Drawdown Installation Support Tail			-905	-905

O-1	Budget Request	House	Senate	Recommendation
042A ADMINISTRATION	646,080	636,080	653,330	651,330
Unjustified request for personal delivery systems - Office of the Secretary of the Air Force and Air Staff Operations		-10,000		-2,000
Transferred from O&M, Defense-Wide BTA for DIMHRS			7,250	7,250
042B SERVICEWIDE COMMUNICATIONS	664,498	579,898	581,951	581,951
Average Underexecution		-86,300		
Research Cybersecurity of Critical Control Networks (Transferred to RDT&E, Air Force line number 2)		1,700		
Technical Adjustment per DOD Errata Sheet dated June 3, 2009			-82,547	-82,547
042G OTHER SERVICEWIDE ACTIVITIES	1,062,803	1,065,803	1,062,803	1,062,803
Engine Health Management Plus Data Repository Center (Transferred to RDT &E, Air Force line number 233)		3,000		
042I CIVIL AIR PATROL	22,433	26,433	22,433	26,433
Civil Air Patrol		4,000		4,000
043A SECURITY PROGRAMS	1,066,157	1,068,057	1,144,860	1,149,804
Classified Adjustment		1,900	-3,844	1,100
Technical Adjustment Per DOD Errata Sheet dated 3 June 2009			82,547	82,547
Undistributed Excessive Growth of Civilian Personnel		-104,250		-50,125
Undistributed CENTCOM Information Operations Media Production		-49,400		0
Undistributed Reduction Due to Historic R&M Migration			-600,000	
Undistributed Reduction Due to Historic Underexecution				-615,150
Excess Working Capital Fund Carry Over			-85,000	-85,000

OPERATION AND MAINTENANCE, DEFENSE-WIDE

(INCLUDING TRANSFER OF FUNDS)

For Operation and Maintenance, Defense-Wide, funds are to be
available for fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
18000 OPERATION AND MAINTENANCE, DEFENSE-WIDE				
18050 BUDGET ACTIVITY 1: OPERATING FORCES				
18100 JOINT CHIEFS OF STAFF.....	457,189	432,189	423,479	423,479
18200 SPECIAL OPERATIONS COMMAND.....	3,611,492	3,598,992	3,603,492	3,607,772
18250 TOTAL, BUDGET ACTIVITY 1.....	4,068,681	4,031,181	4,026,971	4,031,251
18400 BUDGET ACTIVITY 3: TRAINING AND RECRUITING				
18450 DEFENSE ACQUISITION UNIVERSITY.....	115,497	115,497	110,497	110,497
18650 NATIONAL DEFENSE UNIVERSITY.....	103,408	103,408	103,408	103,408
18750 TOTAL, BUDGET ACTIVITY 3.....	218,905	218,905	213,905	213,905
18800 BUDGET ACTIVITY 4: ADMIN & SERVICEWIDE ACTIVITIES				
18950 CIVIL MILITARY PROGRAMS.....	132,231	137,231	157,231	147,231
19000 DEFENSE BUSINESS TRANSFORMATION AGENCY.....	139,579	139,579	116,829	116,829
19050 DEFENSE CONTRACT AUDIT AGENCY.....	458,316	458,316	458,316	458,316
19150 DEFENSE INFORMATION SYSTEMS AGENCY.....	1,322,163	1,226,932	1,298,663	1,289,163
19250 DEFENSE LEGAL SERVICES AGENCY.....	42,532	42,532	42,532	42,532
19300 DEFENSE LOGISTICS AGENCY.....	405,873	376,454	413,873	377,454
19350 DEFENSE MEDIA ACTIVITY.....	253,667	253,667	253,667	253,667
19400 DEFENSE POW /MISSING PERSONS OFFICE.....	20,679	20,679	20,679	20,679
19450 DEFENSE TECHNOLOGY SECURITY AGENCY.....	34,325	34,325	34,325	34,325
19500 DEFENSE THREAT REDUCTION AGENCY.....	385,453	378,168	385,453	385,453
19600 DEPARTMENT OF DEFENSE DEPENDENTS EDUCATION.....	2,302,116	2,302,116	2,298,116	2,292,116
19700 DEFENSE HUMAN RESOURCES ACTIVITY.....	665,743	671,343	628,243	632,223
19750 DEFENSE CONTRACT MANAGEMENT AGENCY.....	1,058,721	1,058,721	1,058,721	1,058,721
19850 DEFENSE SECURITY COOPERATION AGENCY.....	721,756	396,756	621,756	621,756
19950 DEFENSE SECURITY SERVICE.....	497,857	487,888	497,857	497,857
20050 OFFICE OF ECONOMIC ADJUSTMENT.....	37,166	167,932	37,166	120,738
20100 OFFICE OF THE SECRETARY OF DEFENSE.....	1,955,985	1,931,024	1,932,985	1,919,985
20250 WASHINGTON HEADQUARTERS SERVICES.....	589,309	589,309	592,509	592,509
20350 TOTAL, BUDGET ACTIVITY 4.....	11,023,471	10,675,002	10,848,921	10,861,554

(In thousands of dollars)

	Budget	House	Senate	Recommendation
20400 IMPACT AID.....	---	44,000	30,000	37,000
20450 IMPACT AID FOR CHILDREN WITH DISABILITIES.....	---	---	5,000	4,000
20500 OTHER PROGRAMS.....	13,046,209	12,954,309	13,080,253	12,963,083
20900 SOLDIER CENTER AT PATRIOT PARK, FT. BENNING.....	---	5,000	---	4,000
20950 MILITARY INTELLIGENCE SERVICE HISTORIC LEARNING CENTER	---	1,000	---	1,000
21550 TOTAL, OPERATION AND MAINTENANCE, DEFENSE-WIDE.....	28,357,246	27,929,377	28,205,050	28,115,793

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
JOINT CHIEFS OF STAFF	457,169	432,169	423,479	423,479
Combatant Commanders Initiative Fund		-25,000	-25,000	-25,000
Budget Justification does not properly account for In-Sourcing adjustment			-8,690	-8,690
SPECIAL OPERATIONS COMMAND	3,611,492	3,598,992	3,603,492	3,607,772
Special Operations Forces Modular Glove System		1,500	5,000	4,780
SOCOM Care Coalition Recovery Programs		2,000		2,000
SOCOM Information Operations		-16,000		0
Program Termination of ASDS			-8,000	-8,000
Budget Justification does not match summary of Price and Program Changes for DISA services			-5,000	-5,000
NSW Protective Combat Uniform (Transferred from Procurement, Defense-Wide line number 87)				2,500
DEFENSE ACQUISITION UNIVERSITY	115,497	115,497	110,497	110,497
Removal of one-time fiscal year 2009 costs			-5,000	-5,000
CIVIL MILITARY PROGRAMS	132,231	137,231	157,231	147,231
National Guard Youth Challenge Program		5,000	25,000	15,000
DEFENSE BUSINESS TRANSFORMATION AGENCY	139,579	139,579	116,829	116,829
Budget Justification does not properly account for In-Sourcing adjustment			-1,000	-1,000
DIMHRS Transferred to Services (Army, Navy and Air Force)			-21,750	-21,750
DEFENSE INFORMATION SYSTEMS AGENCY	1,322,163	1,226,932	1,298,663	1,289,163
Comprehensive National Cybersecurity Initiative -- unexecutable growth		-31,098		-9,500
Shared Service Units/PEOs unjustified program growth		-8,209		
Senior Leadership Enterprise -- unjustified request		-55,924		
Removal of one-time fiscal year 2009 costs for CENTRIX and NCES			-22,000	-22,000
Program adjustment for NECC			-9,602	-9,602
Transfer of NECC Funding to Support GCCS-J Sustainment			9,602	9,602
Budget Justification does not properly account for In-Sourcing adjustment			-1,500	-1,500
DEFENSE LOGISTICS AGENCY	405,873	378,454	413,873	377,454
Facilities Sustainment -- unexecutable increase		-36,419		-36,419
Program Increase - Procurement Technical Assistance Program		9,000	9,000	9,000
Budget Justification does not properly account for In-Sourcing adjustment			-1,000	-1,000
DEFENSE THREAT REDUCTION AGENCY	385,453	378,198	385,453	385,453
WMD Combat Support and Operations -- unjustified growth		-7,255		
DEFENSE DEPENDENTS EDUCATION	2,302,116	2,302,116	2,298,116	2,292,116
Budget Justification does not properly account for In-Sourcing adjustment			-10,000	-10,000
SOAR (Student Online Achievement Resources)			6,000	0
Funded in Section 8083				

	Budget Request	House	Senate	Recommendation
DEFENSE HUMAN RESOURCES ACTIVITY	665,743	671,343	628,243	632,223
Strategic Language Initiative		3,600		2,880
Translation and Interpretation Skills for DoD		2,000		1,600
Cut one-time costs due to realignment of periods of performance for contracts in fiscal year 2009			-30,000	-30,000
Budget Justification does not properly account for In-Sourcing adjustment			-10,000	-10,000
Defense-Critical Languages and Cultures Program			2,500	2,000
DEFENSE SECURITY COOPERATION AGENCY	721,756	396,756	621,756	621,756
Global Train and Equip (1206)		-150,000		
Security and Stabilization (1207)		-175,000	-100,000	-100,000
DEFENSE SECURITY SERVICE	497,857	487,888	497,857	497,857
Security Education Training and Awareness Program – unjustified growth		-5,077		
Counterintelligence Program – unjustified growth		-4,892		
OFFICE OF ECONOMIC ADJUSTMENT	37,166	251,504	37,166	120,738
Community Economic Assistance Grants – restore proposed cut		13,626		7,000
Norton AFB (New and Existing Infrastructure Improvements)		6,000		4,800
George AFB (New and Existing Infrastructure Improvements)		1,000		1,000
McClellan AFB Infrastructure Improvements		1,000		800
Thorium/Magnesium Excavation - Blue Island		2,000		1,600
Almaden AFS Environmental Assessment and Remediation		4,000		3,200
Naval Station Ingleside Redevelopment		1,000		1,000
Phase I of Berth N-2 Reconstruction of MOTBY Ship Repair Facility		4,500		3,600
Castner Range Conservation Conveyance Study		300		300
Drydock #1 Remediation and Disposal		3,000		3,000
Eliminate Public Safety Hazards		1,340		1,072
Hunters Point Naval Shipyard Remediation		9,000		9,000
Remediation of Jet Fuel Contamination at Floyd Bennett Field		3,000		2,400
Centerville Naval Housing Transfer		6,000		4,800
Brigade Basing Remediation - Support to Public Entities		75,000		40,000

	Budget Request	House	Senate	Recommendation
OFFICE OF THE SECRETARY OF DEFENSE	1,955,985	1,931,024	1,932,985	1,919,985
Office of the ASD (Public Affairs) Support – unjustified growth attributed to AFIS consolidation		-3,524		-2,000
CE2T2 – constrained program growth		-29,437		-15,000
Middle East Regional Security Program		3,000		2,400
Critical Language Training		2,000		1,600
Program Increase - OSD Cost Analysis and Program Evaluation (CAPE) Group, Industrial Base Analyses		3,000		0
National Security Space Office (Transferred from RDT&E, Air Force line number 214)				7,000
Budget Justification does not properly account for In-Sourcing adjustment			-48,000	-48,000
Readiness and Environmental Protection Initiative (REPI)			25,000	18,000
WASHINGTON HEADQUARTERS SERVICES	589,309	589,309	592,509	592,509
Wartime Contracting Commission (WHS)			3,200	3,200
OTHER PROGRAMS	13,046,209	12,954,309	13,080,253	12,963,083
Classified Adjustments		-91,900	33,044	-86,526
Armed Forces Health and Food Supply Research			1,000	800
Counter Threat Finance-Global (Transferred from ICMA)				1,600
MS GIS Educational and Research Program (transferred from RDT&E, Defense-Wide line 999)				1,000
IMPACT AID		44,000	30,000	37,000
IMPACT AID FUNDING FOR CHILDREN WITH DISABILITIES			5,000	4,000
UNDISTRIBUTED		6,000		5,000
Soldier Center at Patriot Park, Ft. Benning		5,000		4,000
Military Intelligence Service Historic Learning Center		1,000		1,000

DEFENSE INFORMATION SYSTEMS AGENCY

Funding for the Senior Leadership Enterprise (SLE), in the amount of \$55,924,000 is restored following a briefing by representatives from the Defense Information Systems Agency (DISA). It is concerning that DISA failed to include any information on SLE in either the classified or unclassified budget justification documents. Further, DISA failed to respond to repeated requests for information on SLE prior to the House markup of the fiscal year 2010 Defense Appropriations bill. Because DISA's request for this new program lacked any budget justification or explanation, the House declined to fund the request. The Director, Defense Information Systems Agency is urged to review the organization's legislative affairs operations to ensure more responsive, effective communications with Congress in the future.

SECURITY AND STABILIZATION ASSISTANCE
(SECTION 1207 AUTHORITY)

The recommendation includes \$97,090,000 for the Security and Stabilization Assistance Program. It is not anticipated that additional Department of Defense resources will be provided to this program in the future. The recommendation is \$100,000,000 below the budget request, which is similar to the amount recommended for the Complex Crises Fund and Transitions Initiatives in the Department of State, Foreign Operations, and Related Programs Appropriations Act, 2010. The Complex Crises Fund was recently created to provide the United States Agency for International Development (USAID) and the Department of State with increased resources and flexibility to respond to urgent requirements, in much the same manner and for similar purposes as projects funded under section 207. The establishment of the Complex Crises Fund will enable USAID and the Department of State to meet emergent re-

quirements that fall under their purview without relying on the Department of Defense. The \$97,090,000 recommended for Security and Stabilization Assistance is provided as a bridging mechanism until the Complex Crises Fund is fully implemented. Although future Security and Stabilization Assistance projects should be funded in USAID and Department of State budget requests, the Secretary of Defense, the Director, USAID and the Secretary of State are directed to maintain and strengthen the interagency process created from the section 1207 program when formulating, reviewing, and approving future projects that would have been funded through section 1207.

BRIGADE BASING REMEDIATION

The House report expressed concerns regarding the impact on local communities following a decision by the Secretary of Defense to reverse the planned growth in the number of Army Brigade Combat Teams (BCT) from 45 to 48. The report called for in the House report on efforts by the Department to mitigate the impact of this decision is of great interest, and the Department of Defense is expected to act promptly to prepare this report.

OFFICE OF THE UNDER SECRETARY OF DEFENSE
(COMPTROLLER) AND CHIEF FINANCIAL OFFICER

The recommendation provides \$2,348,000 for the Office of the Under Secretary of Defense (Comptroller) and Chief Financial Officer for the costs associated with the recruitment, hiring, training, retention and pay for additional Federal employees to improve fiscal management and oversight. The Department is strongly urged to exempt the Office of the Under Secretary of Defense (Comptroller) and Chief Financial Officer from internal Department headquarters personnel ceilings if necessary to ensure proper fiscal management and budget oversight.

COMMISSION ON WARTIME CONTRACTING

The recommendation includes an additional \$3,200,000 for the Commission on Wartime Contracting, providing a total of \$12,300,000 for Commission operations in fiscal year 2010.

NATIONAL SECURITY SPACE OFFICE

The recommendation strongly supports an integrated national security space architecture planning function that provides strategic, senior-level decision-making within the Department of Defense with timely and cogent space system architecture alternatives. Therefore, the recommendation provides \$7,000,000 for the National Security Space Office (NSSO) and transfers the management and tasking to the Under Secretary of Defense for Acquisition, Technology, and Logistics (USD (AT&L)), Space and Intelligence Office (SIO). This new arrangement will accomplish the original intent of the office as the Department of Defense's space architecture planning organization. Therefore, the USD(AT&L)/SIO is directed to revise the NSSO charter and provide a roadmap and goals to the congressional defense committees within 180 days of enactment of this Act on how this office will be used in future space system architecture planning.

MILITARY VOTING

A number of new authorities have been established in the National Defense Authorization Act for Fiscal Year 2010 with regard to military voting. The Department of Defense is expected to use the necessary resources to implement these new requirements and to ensure that uniformed servicemembers, their family members, and overseas citizens have the full opportunity to vote, particularly at a time when so many military personnel are serving in combat areas.

OPERATION AND MAINTENANCE, ARMY RESERVE

For Operation and Maintenance, Army Reserve, funds are to be
available for fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
21700 OPERATION AND MAINTENANCE, ARMY RESERVE				
21750 BUDGET ACTIVITY 1: OPERATING FORCES				
21800 LAND FORCES				
21850 MANEUVER UNITS.....	1,403	1,403	1,403	1,403
21900 MODULAR SUPPORT BRIGADES.....	12,707	12,707	12,707	12,707
21950 ECHELONS ABOVE BRIGADES.....	468,288	468,288	468,288	468,288
22000 THEATER LEVEL ASSETS.....	152,439	152,439	152,439	152,439
22050 LAND FORCES OPERATIONS SUPPORT.....	520,420	520,420	520,420	520,420
22100 AVIATION ASSETS.....	61,063	61,063	61,063	61,063
22150 LAND FORCES READINESS				
22200 FORCES READINESS OPERATIONS SUPPORT.....	290,443	290,443	275,142	290,443
22250 LAND FORCES SYSTEM READINESS.....	106,569	106,569	106,569	106,569
22300 DEPOT MAINTENANCE.....	94,499	94,499	94,499	94,499
22350 LAND FORCES READINESS SUPPORT				
22400 BASE OPERATIONS SUPPORT.....	522,310	522,310	522,310	522,310
22450 FACILITIES SUSTAINMENT, RESTORATION & MODERNIZATION ..	234,748	234,748	234,748	234,748
22600 TOTAL, BUDGET ACTIVITY 1.....	2,464,889	2,464,889	2,449,588	2,464,889
22650 BUDGET ACTIVITY 4: ADMIN & SERVICEWIDE ACTIVITIES				
22700 ADMINISTRATION AND SERVICEWIDE ACTIVITIES				
22740 SERVICEWIDE TRANSPORTATION.....	9,291	9,291	9,291	9,291
22750 ADMINISTRATION.....	72,075	72,075	72,075	72,075
22800 SERVICEWIDE COMMUNICATIONS.....	3,635	4,635	3,635	4,435
22850 PERSONNEL/FINANCIAL ADMINISTRATION	9,104	9,104	9,104	9,104
22900 RECRUITING AND ADVERTISING.....	61,202	61,202	45,931	61,202
22950 TOTAL, BUDGET ACTIVITY 4.....	155,307	156,307	140,036	156,107
23430 UNDISTRIBUTED REDUCTION DUE TO HISTORIC R&M MIGRATION.	---	---	-7,000	---
23435 UNDISTRIBUTED REDUCTION DUE TO HISTORIC UNDEREXECUTION	---	---	---	-3,500
23500 TOTAL, OPERATION AND MAINTENANCE, ARMY RESERVE.....	2,620,196	2,621,196	2,582,624	2,617,496

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS

[In thousands of dollars]

O-1	Budget Request	House	Senate	Recommendation
121 FORCE READINESS OPERATIONS SUPPORT	290,443	290,443	275,142	290,443
Family Readiness Support Assistants - Transfer to OCO			-9,829	
Tuition Assistance - Transfer to OCO			-5,472	
432 SERVICEWIDE COMMUNICATIONS	3,635	4,635	3,635	4,435
Nevada National Guard Joint Operations Center		1,000		800
434 RECRUITING AND ADVERTISING	61,202	61,202	45,931	61,202
Chaplain Strong Bonds - Transfer to OCO			-6,093	
Army Reserve Recruiting Assistance Program (AR-RAP) - Transfer to OCO			-9,178	
Undistributed Reduction Due to Historic R&M Migration			-7,000	
Undistributed Reduction Due to Historic Underexecution				-3,500

OPERATION AND MAINTENANCE, NAVY RESERVE

For Operation and Maintenance, Navy Reserve, funds are to be
available for fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation

23650 OPERATION AND MAINTENANCE, NAVY RESERVE				
23700 BUDGET ACTIVITY 1: OPERATING FORCES				
23750 RESERVE AIR OPERATIONS				
23800 MISSION AND OTHER FLIGHT OPERATIONS.....	570,319	570,319	570,319	570,319
23850 INTERMEDIATE MAINTENANCE.....	16,596	16,596	16,596	16,596
23900 AIR OPERATIONS AND SAFETY SUPPORT.....	3,171	3,171	3,171	3,171
23950 AIRCRAFT DEPOT MAINTENANCE.....	125,004	126,504	125,004	126,204
24000 AIRCRAFT DEPOT OPERATIONS SUPPORT.....	397	397	397	397
24050 RESERVE SHIP OPERATIONS				
24100 MISSION AND OTHER SHIP OPERATIONS.....	55,873	55,873	55,873	55,873
24150 SHIP OPERATIONAL SUPPORT AND TRAINING.....	592	592	592	592
24200 SHIP DEPOT MAINTENANCE.....	41,899	41,899	41,899	41,899
24300 RESERVE COMBAT OPERATIONS SUPPORT				
24350 COMBAT COMMUNICATIONS.....	15,241	15,241	15,241	15,241
24400 COMBAT SUPPORT FORCES.....	142,924	142,924	136,924	136,924
24450 RESERVE WEAPONS SUPPORT				
24500 WEAPONS MAINTENANCE.....	5,494	5,494	5,494	5,494
24550 ENTERPRISE INFORMATION TECHNOLOGY.....	83,611	83,611	83,611	83,611
24600 BASE OPERATING SUPPORT				
24650 FACILITIES SUSTAINMENT, RESTORATION & MODERNIZATION ..	69,853	69,853	69,853	69,853
24700 BASE OPERATING SUPPORT.....	124,757	124,757	124,757	124,757
24800 TOTAL, BUDGET ACTIVITY 1.....	1,255,731	1,257,231	1,249,731	1,250,931

(In thousands of dollars)

	Budget	House	Senate	Recommendation

24850 BUDGET ACTIVITY 4: ADMIN & SERVICEWIDE ACTIVITIES				
24900 ADMINISTRATION AND SERVICEWIDE ACTIVITIES				
24950 ADMINISTRATION.....	3,323	3,323	3,323	3,323
25000 MILITARY MANPOWER & PERSONNEL.....	13,897	13,897	13,897	13,897
25050 SERVICEWIDE COMMUNICATIONS.....	1,957	1,957	1,957	1,957
25160 ACQUISITION AND PROGRAM MANAGEMENT.....	3,593	3,593	3,593	3,593
25250 TOTAL, BUDGET ACTIVITY 4.....	22,770	22,770	22,770	22,770
	=====	=====	=====	=====
25500 TOTAL, OPERATION AND MAINTENANCE, NAVY RESERVE.....	1,278,501	1,280,001	1,272,501	1,273,701
	=====	=====	=====	=====

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

O-1	Budget Request	House	Senate	Recommendation
1A5A AIRCRAFT DEPOT MAINTENANCE	125,004	126,504	125,004	126,204
Developing and Testing Environmentally Safe Decontaminating Agents for Bio-defense, Biomedical, and Environmental Use		1,500		1,200
1C6C COMBAT SUPPORT FORCES	142,924	142,924	136,924	136,924
Reduce Program Growth for NECC Based on Historical Availability of Execution Year Adjustments			-6,000	-6,000

OPERATION AND MAINTENANCE, MARINE CORPS RESERVE

For Operation and Maintenance, Marine Corps Reserve, funds are to
be available for fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation

26000 OPERATION AND MAINTENANCE, MARINE CORPS RESERVE				
26050 BUDGET ACTIVITY 1: OPERATING FORCES				
26100 EXPEDITIONARY FORCES				
26150 OPERATING FORCES.....	61,117	61,117	61,117	61,117
26200 DEPOT MAINTENANCE.....	13,217	13,217	13,217	13,217
26250 TRAINING SUPPORT.....	29,373	29,373	29,373	29,373
26300 FACILITIES SUSTAINMENT, RESTORATION & MODERNIZATION ..	25,466	25,466	25,466	25,466
26350 BASE OPERATING SUPPORT.....	73,899	73,899	71,899	71,899
26400 TOTAL, BUDGET ACTIVITY 1.....	203,072	203,072	201,072	201,072
26450 BUDGET ACTIVITY 4: ADMIN & SERVICEWIDE ACTIVITIES				
26500 ADMINISTRATION AND SERVICEWIDE ACTIVITIES				
26550 SPECIAL SUPPORT.....	5,639	5,639	5,639	5,639
26600 SERVICEWIDE TRANSPORTATION.....	818	818	818	818
26650 ADMINISTRATION.....	10,642	10,642	10,642	10,642
26700 RECRUITING AND ADVERTISING.....	8,754	8,754	8,754	8,754
26800 TOTAL, BUDGET ACTIVITY 4.....	25,853	25,853	25,853	25,853
26830 UNDISTRIBUTED REDUCTION DUE TO HISTORIC R&M MIGRATION.	---	---	-7,500	---
26835 UNDISTRIBUTED REDUCTION DUE TO HISTORIC UNDEREXECUTION	---	---	---	-3,750
=====				
27000 TOTAL, OPERATION & MAINTENANCE, MARINE CORPS RESERVE	228,925	228,925	219,425	223,175
=====				

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

O-1	Budget Request	House	Senate	Recommendation
BSS1 BASE OPERATING SUPPORT	73,899	73,899	71,899	71,899
Environmental Program Decrease not Properly Accounted for			-2,000	-2,000
Undistributed Reduction Due to Historic R&M Migration			-7,500	
Undistributed Reduction Due to Historic Underexecution				-3,750

OPERATION AND MAINTENANCE, AIR FORCE RESERVE

For Operation and Maintenance, Air Force Reserve, funds are to be
available for fiscal year 2010, as follows:

	(In thousands of dollars)			
	Budget	House	Senate	Recommendation
28000 OPERATION AND MAINTENANCE, AIR FORCE RESERVE				
28050 BUDGET ACTIVITY 1: OPERATING FORCES				
28100 AIR OPERATIONS				
28150 PRIMARY COMBAT FORCES.....	2,049,303	2,049,303	2,077,463	2,077,463
28200 MISSION SUPPORT OPERATIONS.....	121,417	121,417	121,417	121,417
28250 DEPOT MAINTENANCE.....	441,958	441,958	486,270	486,270
28300 FACILITIES SUSTAINMENT, RESTORATION & MODERNIZATION ..	78,763	78,763	78,763	78,763
28350 BASE OPERATING SUPPORT.....	258,091	258,091	255,091	255,091
28400 TOTAL, BUDGET ACTIVITY 1.....	2,949,532	2,949,532	3,019,004	3,019,004
28450 BUDGET ACTIVITY 4: ADMIN & SERVICEWIDE ACTIVITIES				
28500 ADMINISTRATION AND SERVICEWIDE ACTIVITIES				
28550 ADMINISTRATION.....	77,476	77,476	77,476	77,476
28600 RECRUITING AND ADVERTISING.....	24,553	24,553	24,553	24,553
28650 MILITARY MANPOWER AND PERSONNEL MANAGEMENT.....	20,838	20,838	20,838	20,838
28700 OTHER PERSONNEL SUPPORT.....	6,121	6,121	6,121	6,121
28750 AUDIOVISUAL.....	708	708	708	708
28800 TOTAL, BUDGET ACTIVITY 4.....	129,696	129,696	129,696	129,696
28940 REMOVAL OF ONE-TIME CONGRESSIONAL INCREASES AND				
28945 UNDISTRIBUTED REDUCTION DUE TO HISTORIC R&M MIGRATION.	---	---	-63,000	---
28950 UNDISTRIBUTED REDUCTION DUE TO HISTORIC UNDEREXECUTION	---	---	---	-17,500
29000 TOTAL, OPERATION AND MAINTENANCE, AIR FORCE RESERVE.	3,079,228	3,079,228	3,085,700	3,131,200

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

O-1	Budget Request	House	Senate	Recommendation
011A PRIMARY COMBAT FORCES	2,049,303	2,049,303	2,077,463	2,077,463
Consolidation of the B-52 Field Training Unit under AFRC (Transferred from O&M, Air Force)			28,160	28,160
011M DEPOT MAINTENANCE	441,958	441,958	486,270	486,270
Consolidation of the B-52 Field Training Unit under AFRC (Transferred from O&M, Air Force)			44,312	44,312
011Z BASE SUPPORT	258,091	258,091	255,091	255,091
Environmental Decrease not Accounted for In Budget Justification			-3,000	-3,000
Undistributed Reduction Due to Historic R&M Migration			-63,000	
Undistributed Reduction Due to Historic Underexecution				-17,500

OPERATION AND MAINTENANCE, ARMY NATIONAL GUARD

For Operation and Maintenance, Army National Guard, funds are to
be available for fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation

30000 OPERATION AND MAINTENANCE, ARMY NATIONAL GUARD				
30050 BUDGET ACTIVITY 1: OPERATING FORCES				
30100 LAND FORCES				
30150 MANEUVER UNITS.....	876,269	876,269	876,269	876,269
30200 MODULAR SUPPORT BRIGADES.....	173,843	173,843	173,843	173,843
30250 ECHELONS ABOVE BRIGADE.....	615,160	615,160	612,160	612,160
30300 THEATER LEVEL ASSETS.....	253,997	253,997	253,197	253,197
30350 LAND FORCES OPERATIONS SUPPORT.....	34,441	59,941	25,441	29,941
30400 AVIATION ASSETS.....	819,031	823,781	821,031	824,431
30450 LAND FORCES READINESS				
30500 FORCE READINESS OPERATIONS SUPPORT.....	436,799	442,107	417,999	433,785
30550 LAND FORCES SYSTEMS READINESS.....	99,757	114,843	97,757	107,701
30600 LAND FORCES DEPOT MAINTENANCE.....	379,646	379,646	395,646	395,646
30650 LAND FORCES READINESS SUPPORT				
30700 BASE OPERATIONS SUPPORT.....	798,343	824,343	776,443	801,943
30750 FACILITIES SUSTAINMENT, RESTORATION & MODERNIZATION ..	580,171	595,920	580,271	592,820
30800 MANAGEMENT AND OPERATIONAL HEADQUARTERS.....	573,452	573,452	570,652	570,652
30850 MISCELLANEOUS ACTIVITIES.....	---	4,200	---	---

31000 TOTAL, BUDGET ACTIVITY 1.....	5,640,909	5,737,502	5,600,709	5,672,388

(In thousands of dollars)

	Budget	House	Senate	Recommendation

31050 BUDGET ACTIVITY 4: ADMIN & SERVICEWIDE ACTIVITIES				
31100 ADMINISTRATION AND SERVICEWIDE ACTIVITIES				
31150 ADMINISTRATION.....	119,186	119,186	121,386	120,386
31200 SERVICEWIDE COMMUNICATIONS.....	48,020	48,020	48,020	48,020
31250 MANPOWER MANAGEMENT.....	7,920	7,920	7,920	7,920
31300 RECRUITING AND ADVERTISING.....	440,999	440,999	245,999	440,999
31350 TOTAL, BUDGET ACTIVITY 4.....	616,125	616,125	423,325	617,325
31997 UNDISTRIBUTED REDUCTION DUE TO HISTORIC R&M MIGRATION.	---	---	-35,000	---
31998 UNDISTRIBUTED REDUCTION DUE TO HISTORIC UNDEREXECUTION	---	---	---	-35,000
31999 UNDISTRIBUTED REDUCTION DUE TO HISTORIC R&A MIGRATION.	---	---	---	-65,000
	=====	=====	=====	=====
32000 TOTAL, OPERATION & MAINTENANCE, ARMY NATIONAL GUARD.	6,257,034	6,353,627	5,989,034	6,189,713
	=====	=====	=====	=====

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

O-1	Budget Request	House	Senate	Recommendation
113 ECHELONS ABOVE BRIGADE	615,160	615,160	612,160	612,160
Removal of one-time fiscal year 2009 Congressional Increases			-3,000	-3,000
114 THEATER LEVEL ASSETS	253,997	253,997	253,197	253,197
Removal of one-time fiscal year 2009 Congressional Increases			-800	-800
115 LAND FORCES OPERATIONS SUPPORT	34,441	59,941	25,441	29,941
High-Mobility Multipurpose Wheeled Vehicle Repair (Transferred to line number 123)		20,000		0
WMD Civil Support Team for New York		500		500
Multi-Jurisdictional Counter-Drug Task Force Training		3,500		2,800
National Guard Civil Support Team/CBRNE Enhanced Response Force Package		1,500		1,200
Removal of one-time fiscal year 2009 Congressional Increases			-11,000	-11,000
Marksmanship Skills Trainer			2,000	2,000
116 AVIATION ASSETS	819,031	823,781	821,031	824,431
Joint Command Vehicle and Supporting C3 System		2,250		1,800
UH-60 Leak Proof Drip Pans		2,500		2,000
Tools for Maintenance Conversion			2,000	1,600
121 FORCE READINESS OPERATIONS SUPPORT	436,799	442,107	417,999	433,785
WMD Multi-Sensor Response and Infrastructure Project System		2,000		1,600
WMD Civil Support Team for Florida		2,000		2,000
Training Aid Suite for Vermont NG Training Sites		1,308		1,046
Removal of one-time fiscal year 2009 Congressional Increases			-28,700	-28,700
Family Readiness Support Assistance - Transfer to OCO			-14,700	
ARNG Battery Modernization Program			2,000	1,600
Colorado National Guard Reintegration Program			1,000	1,000
Expandable Light Air Mobility Shelters (ELAMS) and Contingency Response Communications System (CRCS) - Illinois National Guard (ILNG) (Transferred to Other Procurement, Army line number 142)			2,000	
Full Cycle Deployment Support Pilot Program (Transferred from line number 135)			4,000	3,200
Joint Interagency Training and Education Center			5,600	5,600
National Guard and First Responder Resiliency Training			1,500	1,500
North Carolina National Guard Family Assistance Centers			1,600	1,280
Oregon National Guard Reintegration Program (Transferred from line number 135)			400	960
Re-establishing Ties: The Road from Warrior to the Community			3,000	3,000
Vermont National Guard Family Assistance Centers			500	500
Vermont Service Member, Veteran, and Family Member Outreach, Readiness, and Reintegration Program			3,000	2,400

O-1	Budget Request	House	Senate	Recommendation
122 LAND FORCES SYSTEMS READINESS	99,757	114,843	97,757	107,701
Florida Army National Guard Future Soldier Trainer		3,000		2,400
Program Increase - Compliance with Joint Staff J-8 Guidance - Implementation of Communications Process Refinement		3,000		2,000
Regional Geospatial Service Centers		2,156	2,000	2,000
Vermont Army National Guard Security Upgrades		930		744
Advanced Law Enforcement Rapid Response Training		1,000		800
Army National Guard M939A2 Repower Program		5,000		4,000
Removal of one-time fiscal year 2009 Congressional Increases			-4,000	-4,000
123 LAND FORCES DEPOT MAINTENANCE	379,646	379,646	395,646	395,646
Removal of One-Time fiscal year 2009 Congressional Increases			-4,000	-4,000
High-Mobility Multipurpose Wheeled Vehicle Repair (Transferred from line number 115)			20,000	20,000
131 BASE OPERATIONS SUPPORT	798,343	824,343	776,443	801,943
Minnesota National Guard Beyond the Yellow Ribbon Reintegration Program		2,000	2,000	2,000
Advanced Trauma Training Course for the Illinois National Guard		2,500		2,000
Trauma Response Simulation Training (Transferred to RDT&E, Army line number 30)		1,500		
Family Assistance Centers/National Guard Reintegration		20,000		10,000
Removal of one-time fiscal year 2009 Congressional Increases			-12,000	-12,000
Installation Services - Transfer to OCO			-13,900	
Supplemental Child Care Support for Families of Deployed Vermont Reserve Component			2,000	1,600
FACILITIES SUSTAINMENT, RESTORATION, & MODERNIZATION	580,171	595,920	580,271	592,820
Camp Ethan Allen Training Site Road Equipment		300		300
CID Equipment		449		449
Program Increase - Facility Maintenance		15,000		12,000
Removal of one-time fiscal year 2009 Congressional Increases			-2,400	-2,400
Repair of Military Asset Storage Facilities			2,500	2,300
133 MANAGEMENT AND OPERATIONAL HQ	573,452	573,452	570,652	570,652
Removal of one-time fiscal year 2009 Congressional Increases			-2,800	-2,800
136 ADDITIONAL ACTIVITIES		4,200		0
Full Cycle Deployment Support Pilot Program (Transferred to line number 121)		3,000		
Yellow Ribbon Project - Oregon National Guard Reintegration Program (Transferred to line number 121)		1,200		
431 ADMINISTRATION	119,186	119,186	121,386	120,386
Removal of one-time FY 2009 Congressional Increases			-2,800	-2,800
Army National Guard Unit History Records			5,000	4,000

O-1		Budget Request	House	Senate	Recommendation
434	RECRUITING AND ADVERTISING	440,999	440,999	245,999	440,999
	Recruiting and Advertising - Transfer to OCO			-100,000	
	Unjustified Program Growth - Transferred to Undistributed Reductions			-95,000	
	Undistributed Reduction Due to Historic R&M Migration			-35,000	
	Undistributed Reduction Due to Historic Underexecution				-35,000
	Unjustified Program Growth - Transferred from SAG 434				-65,000

ARMY NATIONAL GUARD RECRUITING AND
ADVERTISING

The Senate reduced funding to Sub-activity Group 434, Other Personnel Support, based on unjustified growth in recruiting and advertising between fiscal year 2009 and fiscal year 2010. Since the time of that proposed reduction, the Army National Guard has adequately justified the budget request for re-

cruiting and advertising. The reason for the skewed original analysis was attributed to the amount of funding the Army National Guard realigns into Sub-activity Group 434 in the year of execution. In fiscal years 2007–2009, the Army National Guard realigned between \$100,000,000 and \$200,000,000 each year into recruiting and advertising. Because the Army National Guard has had flexibility to

move a large amount of funding in the past, the recommendation includes an undistributed reduction to Operation and Maintenance, Army National Guard due to the migration of funds from other sources into recruiting and advertising. New prior approval reprogramming guidelines for the Army National Guard are addressed in the operation and maintenance overview.

OPERATION AND MAINTENANCE, AIR NATIONAL GUARD

For Operation and Maintenance, Air National Guard, funds are to be available for fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
33000 OPERATION AND MAINTENANCE, AIR NATIONAL GUARD				
33050 BUDGET ACTIVITY 1: OPERATING FORCES				
33100 AIR OPERATIONS				
33150 AIRCRAFT OPERATIONS.....	3,347,685	3,348,200	3,347,685	3,348,200
33200 MISSION SUPPORT OPERATIONS.....	779,917	779,917	785,267	784,227
33250 DEPOT MAINTENANCE.....	780,347	780,347	780,347	780,347
33300 FACILITIES SUSTAINMENT, RESTORATION & MODERNIZATION ..	302,949	304,949	310,849	311,649
33350 BASE OPERATING SUPPORT.....	606,916	607,381	606,916	607,381
33400 TOTAL, BUDGET ACTIVITY 1.....	5,817,814	5,820,794	5,831,064	5,831,804
33450 BUDGET ACTIVITY 4: ADMIN & SERVICEWIDE ACTIVITIES				
33500 SERVICEWIDE ACTIVITIES				
33550 ADMINISTRATION.....	35,174	35,174	35,174	35,174
33600 RECRUITING AND ADVERTISING.....	32,773	32,773	32,773	32,773
33650 TOTAL, BUDGET ACTIVITY 4.....	67,947	67,947	67,947	67,947
34195 UNDISTRIBUTED REDUCTION DUE TO HISTORIC R&M MIGRATION.	---	---	-42,000	---
34197 UNDISTRIBUTED REDUCTION DUE TO HISTORIC UNDEREXECUTION	---	---	---	-17,500
35000 TOTAL, OPERATION & MAINTENANCE, AIR NATIONAL GUARD..	5,885,761	5,888,741	5,857,011	5,882,251

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS

[In thousands of dollars]

O-1	Budget Request	House	Senate	Recommendation
011F AIRCRAFT OPERATIONS	3,347,685	3,348,200	3,347,685	3,348,200
Joint Interoperability Coordinated Operations and Training Exercise		515		515
011G MISSION SUPPORT OPERATIONS	779,917	779,917	785,267	784,227
Controlled Humidity Protection for McEntire Joint National Guard Base (SCANG Facilities)			2,700	2,160
Critical Infrastructure Interdependencies Vulnerabilities Assessment (CIIVA) Program			2,500	2,000
Joint Interagency Training and Education Center			150	150
FACILITIES SUSTAINMENT, RESTORATION & MODERNIZATION	302,949	304,949	310,849	311,649
190th Air Refueling Wing Squadron Operations Facility		1,000	6,600	6,600
Smoky Hill Range Access Road Improvements		1,000		800
Facility Renovations and Retrofit, 168th Air Refueling Wing			1,300	1,300
011Z BASE SUPPORT	606,916	607,381	606,916	607,381
Force Protection and Training Equipment		465		465
Undistributed Reduction Due to Historic R&M Migration			-42,000	
Undistributed Reduction Due to Historic Underexecution				-17,500

194TH REGIONAL SUPPORT WING

In fiscal year 2010, the Air National Guard had planned to eliminate 98 essential billets from the 194th Regional Support Wing. The National Guard Bureau and the Air National Guard 194th Regional Support Wing are currently in negotiations to resolve the matter but have yet to reach final resolution. For this reason, the Secretary of Defense is directed to retain all of the billets that existed in fiscal year 2009 for the remainder of fiscal year 2010. Additionally, the Chief of the Air National Guard is directed to provide a report on the long term plans for those billets that had been proposed for elimination in fiscal year 2010. The report shall be provided to the House and Senate Committees on Appropriations not later than May 15, 2010. The Committees plan to reexamine this issue as part of the fiscal year 2011 budget consideration and urge both the National Guard Bureau and the 194th Regional Support Wing to make a good faith effort to reach a fair and reasonable solution.

OVERSEAS CONTINGENCY OPERATIONS
TRANSFER ACCOUNT

For the Overseas Contingency Operations Transfer Account, no funds are provided for fiscal year 2010.

UNITED STATES COURT OF APPEALS
FOR THE ARMED FORCES

For the United States Court of Appeals for the Armed Forces, \$13,932,000 is provided for fiscal year 2010.

ENVIRONMENTAL RESTORATION, ARMY
(INCLUDING TRANSFER OF FUNDS)

The recommendation provides \$423,364,000 for Environmental Restoration, Army, instead of \$415,864,000 as proposed by the House and \$430,864,000 as proposed by the Senate.

ENVIRONMENTAL RESTORATION, NAVY
(INCLUDING TRANSFER OF FUNDS)

The recommendation provides \$285,869,000 for Environmental Restoration, Navy, as proposed by both the House and the Senate.

ENVIRONMENTAL RESTORATION, AIR
FORCE

(INCLUDING TRANSFER OF FUNDS)

The recommendation provides \$494,276,000 for Environmental Restoration, Air Force, as proposed by both the House and the Senate.

ENVIRONMENTAL RESTORATION,
DEFENSE-WIDE

(INCLUDING TRANSFER OF FUNDS)

The recommendation provides \$11,100,000 for Environmental Restoration, Defense-Wide, as proposed by both the House and the Senate.

ENVIRONMENTAL RESTORATION,
FORMERLY USED DEFENSE SITES

(INCLUDING TRANSFER OF FUNDS)

The recommendation provides \$292,700,000 for Environmental Restoration, Formerly Used Defense Sites, instead of \$277,700,000 as proposed by the House and \$307,700,000 as proposed by the Senate. The adjustments to the budget for Environmental Restoration, Formerly Used Defense Sites are shown below:

UXO Remediation	\$5,000,000
Other Unfunded Requirements	20,000,000

OVERSEAS HUMANITARIAN, DISASTER,
AND CIVIC AID

For Overseas, Humanitarian, Disaster, and Civic Aid, \$109,869,000 is provided for fiscal year 2010.

COOPERATIVE THREAT REDUCTION
ACCOUNT

For the Cooperation Threat Reduction Account, \$424,093,000 is provided for fiscal year 2010.

DEPARTMENT OF DEFENSE ACQUISITION
WORKFORCE DEVELOPMENT FUND

For the Department of Defense Acquisition Workforce Development Fund, \$100,000,000 is provided for fiscal year 2010.

TITLE III – PROCUREMENT

For Procurement, funds are to be available for fiscal year 2010, as

follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
SUMMARY				
ARMY				
AIRCRAFT.....	5,315,991	5,144,991	5,244,252	5,093,822
MISSILES.....	1,370,109	1,358,609	1,257,053	1,251,053
WEAPONS, TRACKED COMBAT VEHICLES.....	2,451,952	2,681,952	2,310,007	2,335,807
AMMUNITION.....	2,051,895	2,053,395	2,049,995	2,058,115
OTHER.....	9,907,151	9,293,801	9,395,444	8,582,680
TOTAL, ARMY.....	21,097,098	20,532,748	20,256,751	19,319,457
NAVY				
AIRCRAFT.....	18,378,312	18,325,481	18,079,312	18,643,221
WEAPONS.....	3,453,455	3,226,403	3,446,419	3,357,572
AMMUNITION.....	840,675	794,886	814,015	800,651
SHIPS.....	13,776,867	14,721,532	15,384,600	13,881,532
OTHER.....	5,661,176	5,395,081	5,499,413	5,441,234
MARINE CORPS.....	1,600,638	1,563,743	1,550,080	1,521,505
TOTAL, NAVY.....	43,711,123	44,027,126	44,773,839	43,645,715
AIR FORCE				
AIRCRAFT.....	11,966,276	11,956,182	13,148,720	13,295,474
MISSILES.....	6,300,728	6,508,359	6,070,344	5,995,544
AMMUNITION.....	822,462	809,941	815,248	801,550
OTHER.....	17,293,141	16,883,791	17,283,800	17,138,239
TOTAL, AIR FORCE.....	36,382,607	36,158,273	37,318,110	37,230,807
DEFENSE-WIDE				
DEFENSE-WIDE.....	3,984,352	4,036,816	4,017,697	4,050,537
NATIONAL GUARD AND RESERVE EQUIPMENT.....	---	---	1,500,000	---
DEFENSE PRODUCTION ACT PURCHASES.....	38,246	82,846	149,746	150,746
TOTAL PROCUREMENT.....	105,213,426	104,837,809	108,016,143	104,397,262

SPECIAL INTEREST ITEMS

Items for which additional funds have been provided as shown in the project level tables or in paragraphs using the phrase “only for” or “only to” are congressional interest items for purposes of the Base for Reprogramming Department of Defense form (DD Form 1414). Each of these items must be carried on the DD Form 1414 at the stated amount, as specifically addressed in these materials.

C-130 AVIONICS MODERNIZATION PROGRAM

The recommendation provides no funding in Aircraft Procurement, Air Force for the C-130 Avionics Modernization Program given that the fiscal year 2009 funds have thus far not been put on contract due to a delayed Milestone C decision. Based on these delays, the funding requested for fiscal year 2010 is early to need. The Under Secretary of Defense (Acquisition, Technology, and Logistics) is strongly encouraged to make a decision on the acquisition strategy and proceed expeditiously with the program of record in order to provide this needed capability to Active, Guard, and Reserve C-130 aircraft.

C-130 FIREFIGHTING CAPABILITY

The Secretary of the Air Force, the Chief of the Air Force Reserve and the Director of the National Guard Bureau, are directed, within 60 days of enactment of this Act, to create an Integrated Working Group (IWG) in conjunction with the United States Department of Agriculture Forest Service (USDAFS) and the Department of the Interior for the purpose of coordinating the joint use of Federal forest firefighting assets, and, within 90 days after formation of the IWG, to submit a report to the congressional defense committees; the House and Senate Committees on Appropriations, Subcommittees on Interior; the House Energy and Commerce Committee and Senate Energy and Natural Resources Committee, detailing the following:

1. The viability of the Air National Guard, the Air Force Reserve, and the USDAFS to jointly operate a fleet of new C-130s procured for the primary purposes of firefighting duties at the request of the USDAFS, and equipped with the latest proven firefighting technology.

2. Any and all prior analyses done in the past ten years by the Department of the Air Force, the National Guard Bureau or the USDAFS concerning the recapitalization of the national firefighting fleet.

3. A new business case analysis which examines the cost and operational effectiveness of procurement of new C-130 aircraft and joint cooperation between the Department of the Air Force, the National Guard Bureau and the USDAFS for the firefighting mission as compared to the present approach

of utilizing the current fleet of aging firefighting aircraft available via commercial operator contracts.

4. Any existing legislative impediments to interagency cooperation and joint operation of a dedicated firefighting fleet by the Department of the Air Force, the National Guard Bureau and the USDAFS.

5. An assessment and accounting of public-private property losses as well as taxpayer expenses spent annually fighting forest and wildfires and how such losses can be mitigated by the described joint firefighting business model with respect to the Department of the Air Force, the National Guard Bureau and the USDAFS.

An interim report shall be submitted to Congress not later than 90 days after enactment of this Act detailing the progress made on the final report.

NON-INTRUSIVE INSPECTION TECHNOLOGIES

Vehicle and cargo-borne threats to U.S. forward operating bases and unmet requests for fielding non-intrusive inspection (NII) technologies for base access control to detect hidden weapons, explosives and personnel, increase the operating risk for our forces. The Secretary of Defense is directed to prioritize the NII technology needs of the 100 highest-risk bases and submit a schedule for NII technology procurement for these bases to the congressional defense committees not later than 30 days after enactment of this Act.

JOINT STRIKE FIGHTER

Concerns persist regarding the progress of the F-35 Joint Strike Fighter (JSF) program. Last year, the Department of Defense established a Joint Estimating Team (JET) to evaluate this program. The JET reported that the program would cost significantly more and take longer to fully develop and test than the Department was then projecting. Although the JET has yet to officially report out for 2009, the initial indications are that cost growth and schedule issues remain. Nevertheless, the Department insists that the program is on track to achieve both the cost and schedule currently reflected in the program of record.

Therefore, the JSF procurement program is provided \$6,840,478,000, and the JSF program is designated as a congressional special interest item. The Secretary of Defense is directed to ensure that all 30 aircraft be procured as requested in the budget. The Under Secretary of Defense for Acquisition, Technology and Logistics is directed to provide the findings of the JET along with recent studies on the test program and causes of cost growth to the congressional defense committees no later than January 15, 2010.

REPROGRAMMING GUIDANCE FOR ACQUISITION ACCOUNTS

It is the intent of Congress that the program baseline for reprogramming funds reflects all approved adjustment actions: the initial appropriation as well as any rescissions, supplemental appropriations and approved Department of Defense 1415 reprogrammings. The Secretary of Defense is directed to ensure that financial management regulations incorporate approved reprogramming actions as an adjustment to the base for reprogramming value.

The Department of Defense is directed to continue to follow the reprogramming guidance specified in the report accompanying the House version of the fiscal year 2006 Department of Defense Appropriations Act (H.R. 109-119). Specifically, the dollar threshold for reprogramming funds will remain at \$20,000,000 for procurement and \$10,000,000 for research, development, test, and evaluation. The Department shall continue to follow the limitation that prior approval reprogrammings are set at either the specified dollar threshold or 20 percent of the procurement or research, development, test and evaluation line, whichever is less. The percentage change limitation applies to both program increases and decreases. Additionally, this percentage change applies to the program base value at the time the below threshold movement of funds is executed. These thresholds are cumulative from the base for reprogramming value as modified by any adjustment action. Therefore, if the combined value of transfers into or out of a procurement (P-1) or research, development, test, and evaluation (R-1) line exceeds the identified threshold, the Department of Defense must submit a prior approval reprogramming request to the congressional defense committees. In addition, guidelines on the application of prior approval reprogramming procedures for congressional special interest items are established elsewhere in this report. This guidance is effective for fiscal year 2010 and forward.

REPROGRAMMING REPORTING REQUIREMENTS

The Under Secretary of Defense (Comptroller) is directed to continue to provide the congressional defense committees quarterly, spreadsheet-based DD1416 reports for service and defense-wide accounts in titles III and IV of this Act as required in the statement of the managers accompanying the conference report on the Department of Defense Appropriations Act, 2006.

FUNDING INCREASES

The funding increases outlined in these tables shall be provided only for the specific purposes indicated in the table.

AIRCRAFT PROCUREMENT, ARMY

For Aircraft Procurement, Army, funds are to be available for fiscal
year 2010, as follows:

(In thousands of dollars)				
	Budget	House	Senate	Recommendation
AIRCRAFT PROCUREMENT, ARMY				
AIRCRAFT FIXED WING				
3 MQ-1 UAV.....	401,364	238,364	401,364	231,364
4 RQ-11 (RAVEN).....	35,008	35,008	35,008	35,008
ROTARY				
8 HELICOPTER, LIGHT UTILITY (LUH).....	326,040	326,040	326,040	326,040
9 AH-64 APACHE BLOCK III.....	161,280	161,280	161,280	161,280
10 AH-64 APACHE BLOCK III (AP-CY).....	57,890	57,890	57,890	57,890
11 UH-60 BLACKHAWK (HYP).....	1,258,374	1,258,374	1,258,374	1,258,374
12 UH-60 BLACKHAWK (HYP) (AP-CY).....	98,740	98,740	98,740	98,740
13 CH-47 HELICOPTER.....	860,087	847,087	882,087	882,087
14 CH-47 HELICOPTER (AP-CY).....	50,676	50,676	50,676	50,676
15 HELICOPTER NEW TRAINING.....	19,639	19,639	---	---
TOTAL, AIRCRAFT.....	3,269,098	3,093,098	3,271,459	3,101,459
MODIFICATION OF AIRCRAFT				
16 MQ-1 PAYLOAD - UAS.....	87,424	87,424	87,424	87,424
17 MQ-1 WEAPONIZATION - UAS.....	14,832	14,832	14,832	14,832
18 GUARDRAIL MODS (MIP).....	61,517	61,517	61,517	61,517
19 MULTI SENSOR ABN RECON (MIP).....	21,457	21,457	21,457	21,457
20 AH-64 MODS.....	426,415	429,415	426,415	429,415
22 CH-47 CARGO HELICOPTER MODS.....	102,876	83,876	85,776	87,196
24 UTILITY/CARGO AIRPLANE MODS.....	39,547	39,547	39,547	39,547
25 AIRCRAFT LONG RANGE MODS.....	823	823	823	823
26 UTILITY HELICOPTER MODS.....	66,682	87,682	73,682	88,832
27 KIOWA WARRIOR.....	140,768	140,768	80,768	80,768
28 AIRBORNE AVIONICS.....	241,287	241,287	234,287	234,287
29 GATH ROLLUP.....	103,142	103,142	103,142	103,142
30 RQ-7 UAV MODS.....	283,012	283,012	283,012	283,012

(In thousands of dollars)

	Budget	House	Senate	Recommendation
<hr/>				
SPARES AND REPAIR PARTS				
31 SPARE PARTS (AIR).....	7,083	7,083	7,083	7,083
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TOTAL, MODIFICATION OF AIRCRAFT.....	1,596,865	1,601,865	1,519,765	1,539,335
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SUPPORT EQUIPMENT AND FACILITIES				
GROUND SUPPORT AVIONICS				
32 AIRCRAFT SURVIVABILITY EQUIPMENT.....	25,975	25,975	25,975	25,975
33 ASE INFRARED CM.....	186,356	186,356	186,356	186,356
OTHER SUPPORT				
34 AVIONICS SUPPORT EQUIPMENT.....	4,933	4,933	4,933	4,933
35 COMMON GROUND EQUIPMENT.....	87,682	87,682	87,682	87,682
36 AIRCREW INTEGRATED SYSTEMS.....	52,725	52,725	55,725	55,725
37 AIR TRAFFIC CONTROL.....	76,999	76,999	76,999	76,999
38 INDUSTRIAL FACILITIES.....	1,533	1,533	1,533	1,533
39 LAUNCHER, 2.75 ROCKET.....	2,716	2,716	2,716	2,716
40 AIRBORNE COMMUNICATIONS.....	11,109	11,109	11,109	11,109
<hr/>				
TOTAL, SUPPORT EQUIPMENT AND FACILITIES.....	450,028	450,028	453,028	453,028
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TOTAL, AIRCRAFT PROCUREMENT, ARMY.....	5,315,991	5,144,991	5,244,252	5,093,822
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EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

P-1	Budget Request	House	Senate	Recommendation
3 MQ-1 UAV	401,364	238,364	401,364	231,364
Funding ahead of need		-163,000		0
Exceeds production capacity (Transfer from Aircraft Procurement, Army line number 3 Title IX)				-170,000
13 CH-47 HELICOPTER	860,087	847,087	882,087	882,087
Funding ahead of need		-35,000		0
Army requested transfer from Aircraft Procurement, Army line number 22		22,000	22,000	22,000
15 HELICOPTER NEW TRAINING	19,639	19,639	0	0
Unjustified request			-19,639	-19,639
20 AH-64 MODS	426,415	429,415	426,415	429,415
Vibration Management Enhancement Program		3,000		3,000
22 CH-47 CARGO HELICOPTER MODS	102,876	83,876	85,776	87,196
CH-47 Helicopter Forward and Aft Hook Project		3,000		2,400
Army requested transfer to Aircraft Procurement, Army line number 13		-22,000	-22,000	-22,000
Automatic Identification Technology Life Cycle Asset Management			1,500	1,200
CH-47F Common Avionics Architecture System-Pilot Vehicle Interface			3,400	2,720
26 UTILITY HELICOPTER MODS	66,682	87,682	73,682	88,832
Army National Guard UH-60 Rewiring Program		10,000		8,000
Internal Auxiliary Fuel Tank System		3,000		2,400
Civil Support Communications Systems for Kentucky Army National Guard UH-60 Aircraft		2,000		1,600
Program Increase		5,000		3,750
Forward Looking Infrared Sensors for UH-60 Medevac Helicopters for the Minnesota Army National Guard		1,000		800
Air Filtration Systems for National Guard Helicopters			1,000	800
UH-72A Integrated Vehicle Management System			2,000	1,600
Recoil UH-60 Wild Land Fire-Fighting Tank System			4,000	3,200
27 KIOWA WARRIOR	140,768	140,768	80,768	80,768
Excessive Long Lead Items			-60,000	-60,000
28 AIRBORNE AVIONICS	241,287	241,287	234,287	234,287
ATCS - reduction to growth			-7,000	-7,000
36 AIRCREW INTEGRATED SYSTEMS	52,725	52,725	55,725	55,725
Air Warrior Ensemble Generation III			3,000	3,000

MISSILE PROCUREMENT, ARMY

For Missile Procurement, Army, funds are to be available for fiscal
year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
MISSILE PROCUREMENT, ARMY				
OTHER MISSILES				
SURFACE-TO-AIR MISSILE SYSTEM				
1 PATRIOT SYSTEM SUMMARY.....	348,351	338,851	348,351	342,351
2 PATRIOT/HEADS CAP SYSTEM SUMMARY.....	16,406	16,406	---	---
AIR-TO-SURFACE MISSILE SYSTEM				
3 SURFACE-LAUNCHED AMRAAM SYSTEM SUMMARY.....	72,920	72,920	---	---
5 HELLFIRE SYS SUMMARY.....	31,154	29,154	7,424	7,424
ANTI-TANK/ASSAULT MISSILE SYSTEM				
6 JAVELIN (AAWS-M) SYSTEM SUMMARY.....	148,649	148,649	148,649	148,649
7 TOW 2 SYSTEM SUMMARY.....	108,066	108,066	108,066	108,066
8 GUIDED MLRS ROCKET (GMLRS).....	293,617	293,617	293,617	293,617
9 MLRS REDUCED RANGE PRACTICE ROCKETS (RRPR).....	15,663	15,663	15,663	15,663
10 HIGH MOBILITY ARTILLERY ROCKET SYSTEM.....	209,061	209,061	209,061	209,061
TOTAL, OTHER MISSILES.....	1,243,887	1,232,367	1,130,631	1,124,831
MODIFICATION OF MISSILES				
MODIFICATIONS				
12 PATRIOT MODS.....	44,775	44,775	44,775	44,775
13 ITAS/TOW MODS.....	6,983	6,983	6,983	6,983
14 MLRS MODS.....	3,662	3,662	3,662	3,662
15 HIMARS MODIFICATIONS.....	38,690	38,690	38,690	38,690
16 HELLFIRE MODIFICATIONS.....	10	10	10	10
TOTAL, MODIFICATION OF MISSILES.....	94,120	94,120	94,120	94,120

(In thousands of dollars)

	Budget	House	Senate	Recommendation

SPARES AND REPAIR PARTS				
17 SPARES AND REPAIR PARTS.....	22,338	22,338	22,338	22,338
SUPPORT EQUIPMENT AND FACILITIES				
18 AIR DEFENSE TARGETS.....	4,188	4,188	4,188	4,188
19 ITEMS LESS THAN \$5.0M (MISSILES).....	1,178	1,178	1,178	1,178
20 PRODUCTION BASE SUPPORT.....	4,398	4,398	4,398	4,398

TOTAL, SUPPORT EQUIPMENT AND FACILITIES.....	9,764	9,764	9,764	9,764

TOTAL, MISSILE PROCUREMENT, ARMY.....	1,370,109	1,358,609	1,257,053	1,251,053
	=====	=====	=====	=====

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

P-1	Budget Request	House	Senate	Recommendation
1 PATRIOT SYSTEM SUMMARY	348,351	338,851	348,351	342,351
Unjustified cost growth		-9,500		-6,000
PATRIOT/MEADS COMBINED AGGREGATE PROGRAM				
2 SYSTEM SUMMARY	16,406	16,406	0	0
Funding ahead of need			-16,406	-16,406
3 SURFACE-LAUNCHED AMRAAM SYSTEM SUMMARY	72,920	72,920	0	0
Army program adjustment			-37,920	-27,920
Transfer to RDT&E, Army line number 102			-35,000	-45,000
5 HELLFIRE SYSTEM SUMMARY	31,154	29,154	7,424	7,424
Unjustified cost growth		-2,000		0
Unit cost adjustment			-23,730	-23,730

**PROCUREMENT OF WEAPONS AND TRACKED COMBAT
VEHICLES, ARMY**

For Procurement of Weapons and Tracked Combat Vehicles, Army,
funds are to be available for fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation

PROCUREMENT OF W&TCV, ARMY				
TRACKED COMBAT VEHICLES				
4 STRYKER VEHICLE.....	388,596	613,596	364,196	363,896
7 FCS SPIN OUTS.....	285,920	285,920	285,920	285,920
8 FCS SPIN OUTS (AP-CY).....	42,001	42,001	42,001	42,001
MODIFICATION OF TRACKED COMBAT VEHICLES				
9 FIST VEHICLE (MOD).....	34,192	34,192	34,192	34,192
10 BRADLEY PROGRAM (MOD).....	526,356	526,356	500,656	526,356
11 HOWITZER, MED SP FT 155MM M109A6 (MOD).....	96,503	96,503	5,003	5,003
12 IMPROVED RECOVERY VEHICLE (M88A2 HERCULES).....	96,814	96,814	96,814	96,814
13 ARMORED BREACHER VEHICLE.....	63,250	63,250	63,250	63,250
14 JOINT ASSAULT BRIDGE.....	70,637	70,637	70,637	70,637
15 M1 ABRAMS TANK (MOD).....	183,829	183,829	183,829	183,829
16 ABRAMS UPGRADE PROGRAM.....	185,611	185,611	185,611	185,611
SUPPORT EQUIPMENT AND FACILITIES				
18 PRODUCTION BASE SUPPORT (TCV-WTCV).....	6,601	6,601	6,601	6,601

TOTAL, TRACKED COMBAT VEHICLES.....	1,980,310	2,205,310	1,838,710	1,864,110

(In thousands of dollars)

	Budget	House	Senate	Recommendation

WEAPONS AND OTHER COMBAT VEHICLES				
19 HOWITZER, LIGHT, TOWED, 105MM, M119.....	95,631	95,631	95,631	95,631
20 M240 MEDIUM MACHINE GUN (7.62MM).....	32,919	32,919	23,519	23,519
21 MACHINE GUN, CAL .50 M2 ROLL.....	84,588	84,588	84,588	84,588
22 LIGHTWEIGHT .50 CALIBER MACHINE GUN.....	977	977	977	977
23 M249 SAW MACHINE GUN (5.56MM).....	7,535	7,535	7,535	7,535
24 MK-19 GRENADE MACHINE GUN (40MM).....	7,700	7,700	7,700	7,700
25 MORTAR SYSTEMS.....	14,779	14,779	14,779	14,779
26 M107, CAL. 50, SNIPER RIFLE.....	224	224	224	224
27 XM320 GRENADE LAUNCHER MODULE (GLM).....	16,023	16,023	16,023	16,023
28 M110 SEMI-AUTOMATIC SNIPER SYSTEM (SASS).....	6,223	6,223	6,223	6,223
29 M4 CARBINE.....	20,500	20,500	20,500	20,500
30 SHOTGUN, MODULAR ACCESSORY SYSTEM (MASS).....	6,945	6,945	---	---
32 HANDGUN.....	3,389	3,389	3,389	3,389
33 HOWITZER LT WT 155MM (T).....	49,572	49,572	49,572	49,572
MOD OF WEAPONS AND OTHER COMBAT VEH				
34 MK-19 GRENADE MACHINE GUN MODS.....	8,164	8,164	8,164	8,164
35 M4 CARBINE MODS.....	31,472	31,472	31,472	31,472
36 M2 50 CAL MACHINE GUN MODS.....	7,738	7,738	7,738	7,738
37 M249 SAW MACHINE GUN MODS.....	7,833	7,833	7,833	7,833
38 M240 MEDIUM MACHINE GUN MODS.....	17,964	17,964	17,964	17,964
40 M119 MODIFICATIONS.....	25,306	25,306	25,306	25,306
41 M16 RIFLE MODS.....	4,186	4,186	4,186	4,186
42 MODIFICATIONS LESS THAN \$5.0M (WOCV-WTCV).....	6,164	6,164	6,164	8,564
SUPPORT EQUIPMENT AND FACILITIES				
43 ITEMS LESS THAN \$5.0M (WOCV-WTCV).....	551	551	551	551
44 PRODUCTION BASE SUPPORT (WOCV-WTCV).....	9,855	11,855	25,855	23,855
45 INDUSTRIAL PREPAREDNESS.....	392	3,392	392	392
46 SMALL ARMS EQUIPMENT (SOLDIER ENH PROG).....	5,012	5,012	5,012	5,012

TOTAL, WEAPONS AND OTHER COMBAT VEHICLES.....	471,642	476,642	471,297	471,697

TOTAL, PROCUREMENT OF W&TCV, ARMY.....	2,451,952	2,681,952	2,310,007	2,335,807
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EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

P-1	Budget Request	House	Senate	Recommendation
4 STRYKER VEHICLE	388,596	613,596	364,196	363,896
Excessive program management support costs		-25,000	-24,400	-24,700
Additional Stryker Vehicles and production base sustainment (Transferred to WTCV, Army line number 4 Title IX)		250,000		0
10 BRADLEY PROGRAM (MOD)	526,356	526,356	500,656	526,356
Excessive program support costs			-25,700	0
11 HOWITZER, MED SP FT 155MM M109A6 (MOD)	96,503	96,503	5,003	5,003
Army requested transfer to RDT&E, Army line number 114			-91,500	-91,500
20 M240 MEDIUM MACHINE GUN (7.62MM)	32,919	32,919	23,519	23,519
Delayed contract award			-9,400	-9,400
30 SHOTGUN, MODULAR ACCESSORY SYSTEM (MASS)	6,945	6,945	0	0
Delayed contract award			-6,945	-6,945
42 MODIFICATIONS LESS THAN \$5.0M (WOCV-WTCV)	6,164	6,164	6,164	8,564
M24 Sniper Weapons System Upgrade (Transferred from O&M, Army line number 424)				2,400
44 PRODUCTION BASE SUPPORT (WOCV-WTCV)	9,855	11,855	25,855	23,855
Arsenal Support Program Initiative at Rock Island Arsenal		2,000	8,000	7,600
Arsenal Support Program Initiative at Watervliet Arsenal (Includes transfer from line number 45)			8,000	6,400
45 INDUSTRIAL PREPAREDNESS	392	3,392	392	392
Arsenal Support Program Initiative (Transferred to line number 44)		3,000		0

BRADLEY FIGHTING VEHICLE

The various versions of the Bradley Fighting Vehicle family have continued to provide excellent performance in combat operations. The Bradleys have assumed a heavy workload in Iraq and have achieved survivability goals second only to the M1 Abrams Tank. However, there are concerns that the termination of the Future Combat Systems manned ground vehicles has created considerable uncertainty regarding the current Bradley. Congress has been consistent in its strong support for robust Bradley programs, providing \$784,600,000 for Bradley reset and remanufacture in the Supplemental Appropriations Act, 2009. The Army is strongly urged to sustain the Bradley industrial base by accomplishing vehicle restoration and reset efforts to the zero hours, zero miles standard plus survivability upgrades.

The recommendation fully supports the fiscal year 2010 budget request for Bradley modifications of \$526,356,000 in base budget funding, plus \$243,600,000 for overseas contingency operations, for a total of \$769,956,000. The Army is expected to apply the funding to sustain the Bradley industrial base, continue upgrades of Bradley Operation Desert Storm (ODS) variants to the ODS Situational Awareness variant, and reset Bradley

Fighting Vehicles to the zero hours, zero miles standard, plus 963 survivability enhancements. The Army is encouraged to include Bradley Fighting Vehicles from prepositioned equipment sets in the rotation through the reset and remanufacture program.

It is understood that the Army's M-113 divestiture decision will affect approximately 4,100 M-113 type vehicles, including ambulance, mortar, command post and fire support variants. Strong consideration should be given to replacing these vehicles in the Heavy Brigade Combat Teams with a Bradley-based vehicle to leverage the Bradley's track record of proven performance as well as the existing logistics support.

There is a disparity in digital data management between the engineer units in certain Heavy Brigade Combat Teams and the infantry and tank units that they support. The digital brigades have digital Abrams Tanks, matched with digital A3 Bradleys, but the engineers have non-digital Bradley ODS variants, which limits the engineers' ability to be fully integrated into the information network. The Army is urged to procure Bradley A3 variants with digital configuration for engineer units in heavy bri-

gades that have the Bradley A3 and M1A2 System Enhancement Package Abrams tank.

Added survivability enhancements and other improvements have increased the weight of the Bradley Fighting Vehicle and adversely impacted some aspects of performance. The Army is expected to give strong consideration to Space, Weight, and Power improvements with the funds provided in Research, Development, Test and Evaluation, Army and to incorporate these improvements into the fleet at the earliest opportunity.

In addition, the recommendation fully supports the Army's M109 Paladin Howitzer/Field Artillery Ammunition Resupply Vehicle Integrated Management (PIM) program for fiscal year 2010, including a transfer of \$91,500,000 from the procurement request to the Research, Development, Test and Evaluation, Army appropriation. The Vietnam-era M109 Paladin self-propelled howitzer requires major upgrades in mobility, maintainability and reliability and the PIM program, which incorporated an upgraded turret and fire control system with a Bradley Fighting Vehicle chassis, offers vast improvements in mobility and fire support. The Army is urged to move ahead promptly with the Paladin PIM program.

PROCUREMENT OF AMMUNITION, ARMY

For Procurement of Ammunition, Army, funds are to be available for
fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
PROCUREMENT OF AMMUNITION, ARMY				
AMMUNITION				
SMALL/MEDIUM CAL AMMUNITION				
1 CTG, 5.56MM, ALL TYPES.....	207,752	207,752	207,752	207,752
2 CTG, 7.62MM, ALL TYPES.....	77,602	77,602	77,602	77,602
3 CTG, HANDGUN, ALL TYPES.....	5,120	5,120	5,120	5,120
4 CTG, .50 CAL, ALL TYPES.....	162,342	162,342	162,342	162,342
5 CTG, 25MM, ALL TYPES.....	17,054	17,054	17,054	17,054
6 CTG, 30MM, ALL TYPES.....	96,572	86,572	96,572	94,572
7 CTG, 40MM, ALL TYPES.....	172,675	172,675	176,675	176,675
MORTAR AMMUNITION				
8 60MM MORTAR, ALL TYPES.....	23,607	27,607	23,607	26,807
9 81MM MORTAR, ALL TYPES.....	28,719	28,719	28,719	28,719
10 CTG, MORTAR, 120MM, ALL TYPES.....	104,961	104,961	110,161	109,161
TANK AMMUNITION				
11 CTG TANK 105MM: ALL TYPES.....	7,741	7,741	7,741	7,741
12 CTG, TANK, 120MM, ALL TYPES.....	113,483	113,483	113,483	113,483
ARTILLERY AMMUNITION				
13 CTG, ARTY, 75MM: ALL TYPES.....	5,229	5,229	5,229	5,229
14 CTG, ARTY, 105MM: ALL TYPES.....	90,726	75,726	90,726	85,726
15 CTG, ARTY, 155MM, ALL TYPES.....	54,546	54,546	63,546	61,746
16 PROJ 155MM EXTENDED RANGE XM982.....	62,292	62,292	62,292	62,292
17 MODULAR ARTILLERY CHARGE SYSTEM (MACS), ALL T.....	33,441	33,441	25,441	27,441

(in thousands of dollars)

	Budget	House	Senate	Recommendation
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ARTILLERY FUZES				
18 ARTILLERY FUZES, ALL TYPES.....	19,870	19,870	19,870	19,870
MINES				
19 MINES, ALL TYPES.....	815	815	815	815
21 ANTIPERSONNEL LANDMINE ALTERNATIVES.....	56,387	56,387	56,387	56,387
22 INTELLIGENT MUNITIONS SYSTEM (IMS), ALL TYPES.....	19,507	19,507	19,507	19,507
ROCKETS				
23 SHOULDER LAUNCHED MUNITIONS, ALL TYPES.....	45,302	45,302	40,302	42,802
24 ROCKET, HYDRA 70, ALL TYPES.....	99,904	99,904	99,904	99,904
OTHER AMMUNITION				
25 DEMOLITION MUNITIONS, ALL TYPES.....	18,793	27,793	18,793	18,793
26 GRENADES, ALL TYPES.....	49,910	49,910	49,910	49,910
27 SIGNALS, ALL TYPES.....	83,094	83,094	71,094	71,094
28 SIMULATORS, ALL TYPES.....	12,081	12,081	12,081	12,081
MISCELLANEOUS				
29 AMMO COMPONENTS, ALL TYPES.....	17,968	17,968	17,968	17,968
30 NON-LETHAL AMMUNITION, ALL TYPES.....	7,378	7,378	7,378	7,378
31 CAD/PAD ALL TYPES.....	3,353	3,353	3,353	3,353
32 ITEMS LESS THAN \$5 MILLION.....	8,826	8,826	8,826	8,826
33 AMMUNITION PECULIAR EQUIPMENT.....	11,187	14,187	16,087	17,507
34 FIRST DESTINATION TRANSPORTATION (AMMO).....	14,354	14,354	14,354	14,354
35 CLOSEOUT LIABILITIES.....	99	99	99	99
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TOTAL, AMMUNITION.....	1,732,690	1,723,690	1,730,790	1,730,110
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AMMUNITION PRODUCTION BASE SUPPORT				
PRODUCTION BASE SUPPORT				
36 PROVISION OF INDUSTRIAL FACILITIES.....	151,943	162,443	151,943	158,743
37 LAYAWAY OF INDUSTRIAL FACILITIES.....	9,529	9,529	9,529	9,529
38 MAINTENANCE OF INACTIVE FACILITIES.....	8,772	8,772	8,772	8,772
39 CONVENTIONAL MUNITIONS DEMILITARIZATION, ALL.....	145,777	145,777	145,777	145,777
40 ARMS INITIATIVE.....	3,184	3,184	3,184	3,184
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TOTAL, AMMUNITION PRODUCTION BASE SUPPORT.....	319,205	329,705	319,205	326,005
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TOTAL, PROCUREMENT OF AMMUNITION, ARMY.....	2,051,895	2,053,395	2,049,995	2,056,115
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EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

P-1	Budget Request	House	Senate	Recommendation
6 CTG, 30MM, ALL TYPES	96,572	86,572	96,572	94,572
Unjustified program growth		-10,000		-2,000
7 CTG, 40MM, ALL TYPES	172,675	172,675	176,675	176,675
40mm Tactical All Types Mortar Round			4,000	4,000
8 60MM MORTAR, ALL TYPES	23,607	27,607	23,607	26,807
M722 60mm White Phosphorus Smoke Mortar		2,000		1,600
M721 60mm Illuminating Mortar		2,000		1,600
10 CTG, MORTAR, 120MM, ALL TYPES	104,961	104,961	110,161	109,161
CTG, Mortar, 120mm, Illum			5,200	4,200
14 CTG, ARTY, 105MM: ALL TYPES	90,726	75,726	90,726	85,726
Unjustified program growth		-15,000		-5,000
15 CTG, ARTY, 155MM, ALL TYPES	54,546	54,546	63,546	61,746
CTG, Artillery, 155mm Illum			9,000	7,200
17 MODULAR ARTILLERY CHARGE SYSTEM (MACS), ALL	33,441	33,441	25,441	27,441
General Reduction			-8,000	-6,000
23 SHOULDER LAUNCHED MUNITIONS, ALL TYPES	45,302	45,302	40,302	42,802
General Reduction			-5,000	-2,500
25 DEMOLITION MUNITIONS, ALL TYPES	18,793	27,793	18,793	18,793
Magneto Inductive Remote Activation Munitions System (MI-RAMS) M156/M39 Kits and M40 Receivers (Transferred to Other Procurement, Army line number 136)		9,000		0
27 SIGNALS, ALL TYPES	83,094	83,094	71,094	71,094
General Reduction			-12,000	-12,000
33 AMMUNITION PECULIAR EQUIPMENT	11,187	14,187	16,087	17,507
Blue Grass Army Depot Supercritical Water Oxidation- Conventional Demil			4,900	3,920
Blue Grass Army Depot Equipment		3,000		2,400
36 PROVISION OF INDUSTRIAL FACILITIES	151,943	162,443	151,943	158,743
Bomblane Modernization (Transferred to Procurement of Ammunition, Air Force line number 4)		2,000		0
Ammunition Production Base Support (Scranton Army Ammunition Plant)		3,500		2,800
Small Caliber Ammunition Production Modernization		5,000		4,000

AMMUNITION FACILITIES AND EQUIPMENT

The Army is planning to transfer or consolidate government-owned ammunition assets to private ammunition manufacturers. In order to ensure a comprehensive understanding of these plans, the Secretary of the Army is directed to provide a report to the congressional defense committees not later than 60 days after enactment of this Act on any plans to consolidate government-owned ammunition production assets or to transfer by sale, lease, loan or donation government-owned ammunition production equipment or facilities to a private ammunition manufacturer. The report shall include the Secretary of the Army's assessment of the following: a cost-benefit risk analysis for consolidating or transferring government-owned ammunition production equipment or facilities to private ammunition manufacturers, includ-

ing cost-savings comparisons; a projection of the impact on the ammunition production industrial base in the United States of consolidating or transferring such equipment or facilities to private ammunition manufacturers; a projection of the capability to meet current and future ammunition production requirements by both government-owned and private ammunition manufacturers, as well as a combination of the two sources of production assets; and the potential impact on national security and military readiness.

Furthermore, if additional consolidation or transfers are required during fiscal year 2010 and are not addressed in the report submitted to the congressional defense committees, the Secretary of the Army is directed to certify to the congressional defense committees that the transfer or consolidation will not increase the cost of ammunition

procurement or negatively impact national security, military readiness, government ammunition production or the United States ammunition production industrial base.

Finally, there is an existing contract to operate the Milan and Iowa Army Ammunition Plants (AAP) that would transform, at the contractor's expense, the Iowa AAP into a Joint Munitions Load, Assemble and Pack facility and transform the Milan AAP into a Logistics Center of Excellence/Joint Munitions Storage and Distribution Center by 2011. The Secretary of the Army is directed to notify the congressional defense committees not later than 30 days prior to any modification to this contract. In addition, the Government Accountability Office (GAO) is directed to conduct an audit on the amount and sources of funds used in furtherance of this contract.

OTHER PROCUREMENT, ARMY

For Other Procurement, Army, funds are to be available for fiscal year

2010, as follows:

(In thousands of dollars)				
	Budget	House	Senate	Recommendation
OTHER PROCUREMENT, ARMY				
TACTICAL AND SUPPORT VEHICLES				
TACTICAL VEHICLES				
1 TACTICAL TRAILERS/DOLLY SETS.....	95,893	95,893	95,893	95,893
2 SEMITRAILERS, FLATBED:.....	20,870	20,870	20,870	20,870
3 SEMITRAILERS, TANKERS.....	13,217	13,217	13,217	13,217
4 HI MOB MULTI-PURP WHLD VEH (HMMWV).....	281,123	281,123	282,323	282,083
5 FAMILY OF MEDIUM TACTICAL VEH (FMTV).....	1,158,522	965,522	1,033,522	497,822
6 FIRETRUCKS & ASSOCIATED FIREFIGHTING EQUIPMEN.....	17,575	17,575	17,575	17,575
7 FAMILY OF HEAVY TACTICAL VEHICLES (FHTV).....	812,918	786,566	812,918	612,918
8 PLS ESP.....	18,973	18,973	18,973	18,973
9 ARMORED SECURITY VEHICLES (ASV).....	136,605	136,605	136,605	136,605
10 MINE PROTECTION VEHICLE FAMILY.....	402,517	267,797	325,517	279,197
12 TRUCK, TRACTOR, LINE HAUL, M915/M916.....	74,703	74,703	74,703	74,703
13 HVY EXPANDED MOBILE TACTICAL TRUCK EXT SERV.....	180,793	180,793	170,593	170,593
14 HMMWV RECAPITALIZATION PROGRAM.....	2,904	2,904	2,904	2,904
15 MODIFICATION OF IN SVC EQUIP.....	10,314	10,314	---	2,314
16 ITEMS LESS THAN \$5.0M (TAC VEH).....	298	298	5,898	4,778
17 TOWING DEVICE-FIFTH WHEEL.....	414	1,114	414	974
NON-TACTICAL VEHICLES				
18 HEAVY ARMORED SEDAN.....	1,980	1,980	1,980	1,980
19 PASSENGER CARRYING VEHICLES.....	269	269	---	---
20 NONTACTICAL VEHICLES, OTHER.....	3,052	5,052	3,052	3,052
TOTAL, TACTICAL AND SUPPORT VEHICLES.....	3,232,940	2,881,568	3,016,957	2,236,451

(In thousands of dollars)

	Budget	House	Senate	Recommendation
COMMUNICATIONS AND ELECTRONICS EQUIPMENT				
COMM - JOINT COMMUNICATIONS				
22 JOINT COMBAT IDENTIFICATION MARKING SYSTEM.....	11,868	11,868	11,868	11,868
23 WIN-T - GROUND FORCES TACTICAL NETWORK.....	544,202	544,202	544,202	544,202
24 JCSE EQUIPMENT (USREDCOM).....	4,868	4,868	4,868	4,868
COMM - SATELLITE COMMUNICATIONS				
25 DEFENSE ENTERPRISE WIDEBAND SATCOM SYSTEMS.....	145,108	145,108	145,108	145,108
26 SHF TERM.....	90,918	90,918	94,918	94,118
27 SAT TERM, EMUT (SPACE).....	653	653	653	653
28 NAVSTAR GLOBAL POSITIONING SYSTEM (SPACE).....	72,735	72,735	72,735	72,735
29 SMART-T (SPACE).....	61,116	61,116	61,116	61,116
30 SCAMP (SPACE).....	1,834	1,834	1,834	1,834
31 GLOBAL BRDCST SVC - GBS.....	6,849	6,849	6,849	6,849
32 MOD OF IN-SVC EQUIP (TAC SAT).....	2,862	2,862	2,862	2,862
COMM - C3 SYSTEM				
33 ARMY GLOBAL CMD & CONTROL SYS (AGCCS).....	22,996	22,996	22,996	22,996
COMM - COMBAT COMMUNICATIONS				
34 ARMY DATA DISTRIBUTION SYSTEM (DATA RADIO).....	1,705	1,705	1,705	1,705
35 JOINT TACTICAL RADIO SYSTEM.....	90,204	35,040	35,040	35,040
36 RADIO TERMINAL SET, MIDS LVT(2).....	8,549	8,549	8,549	8,549
37 SINCGARS FAMILY.....	6,812	3,000	3,500	3,000
39 MULTI-PURPOSE INFORMATION OPERATIONS SYSTEMS.....	6,164	6,164	6,164	6,164
41 COMMS-ELEC EQUIP FIELDING.....	---	7,360	6,000	8,288
42 SPIDER APLA REMOTE CONTROL UNIT.....	21,820	21,820	21,820	21,820
43 IMS REMOTE CONTROL UNIT.....	9,256	9,256	9,256	9,256
44 SOLDIER ENHANCEMENT PROGRAM COMM/ELECTRONICS.....	4,646	4,646	4,646	4,646
45 COMBAT SURVIVOR EVADER LOCATOR (CSEL).....	2,367	2,367	2,367	2,367
46 RADIO, IMPROVED HF (COTS) FAMILY.....	6,555	6,555	6,555	6,555
47 MEDICAL COMM FOR CBT CASUALTY CARE (MC4).....	18,583	18,583	18,583	18,583
COMM - INTELLIGENCE COMM				
48 CI AUTOMATION ARCHITECTURE (HIP).....	1,414	1,414	1,414	1,414
INFORMATION SECURITY				
49 TSEC - ARMY KEY MGT SYS (AKMS).....	29,525	29,525	29,525	29,525
50 INFORMATION SYSTEM SECURITY PROGRAM-ISSP.....	33,189	33,189	33,189	33,189
COMM - LONG HAUL COMMUNICATIONS				
51 TERRESTRIAL TRANSMISSION.....	1,890	1,890	1,890	1,890
52 BASE SUPPORT COMMUNICATIONS.....	25,525	25,525	25,525	25,525

(In thousands of dollars)

	Budget	House	Senate	Recommendation
54 WW TECH CON IMP PROG (WWTICIP).....	31,256	31,256	31,256	31,256
COMM - BASE COMMUNICATIONS				
55 INFORMATION SYSTEMS.....	216,057	216,057	216,057	216,057
56 DEFENSE MESSAGE SYSTEM (DMS).....	6,203	6,203	6,203	6,203
57 INSTALLATION INFO INFRASTRUCTURE MOD PROGRAM.....	147,111	147,111	147,111	147,111
58 PENTAGON INFORMATION MGT AND TELECOM.....	39,906	39,906	39,906	39,906
ELECT EQUIP - NAT INT PROG (NIP)				
ELECT EQUIP - NAT INTEL PROG (NIP)				
62 JTT/CIBS-M (MIP).....	3,279	3,279	3,279	3,279
63 PROPHET GROUND (MIP).....	64,498	64,498	64,498	64,498
69 DCGS-A (MIP).....	85,354	85,354	85,354	85,354
70 JOINT TACTICAL GROUND STATION (JTACS).....	6,703	6,703	6,703	6,703
71 TROJAN (MIP).....	26,659	26,659	26,659	26,659
72 MOD OF IN-SVC EQUIP (INTEL SPT) (MIP).....	7,021	7,021	7,021	7,021
73 CI HUMINT AUTO REPRTING AND COLL(CHARCS)(MIP).....	4,509	4,509	4,509	4,509
74 SEQUOYAH FOREIGN LANGUAGE TRANSLATION SYSTEM.....	6,420	6,420	---	---
75 ITEMS LESS THAN \$5.0M (MIP).....	17,053	17,053	17,053	17,053
ELECT EQUIP - ELECTRONIC WARFARE (EW)				
76 LIGHTWEIGHT COUNTER MORTAR RADAR.....	31,661	31,661	31,661	31,661
78 COUNTERINTELLIGENCE/SECURITY COUNTERMEASURES.....	1,284	1,284	1,284	1,284
79 CI MODERNIZATION (MIP).....	1,221	1,221	1,221	1,221
ELECT EQUIP - TACTICAL SURV. (TAC SURV)				
80 SENTINEL MODS.....	25,863	25,863	25,863	25,863
81 SENSE THROUGH THE WALL (STTW).....	25,352	25,352	---	---
82 NIGHT VISION DEVICES.....	366,820	191,158	180,458	180,458
83 LONG RANGE ADVANCED SCOUT SURVEILLANCE SYSTEM.....	133,836	133,836	133,836	133,836
84 NIGHT VISION, THERMAL WPN SIGHT.....	313,237	313,237	313,237	313,237
85 SMALL TACTICAL OPTICAL RIFLE MOUNTED MLRF.....	9,179	9,179	9,179	9,179
86 RADIATION MONITORING SYSTEMS.....	2,198	2,198	2,198	2,198
89 ARTILLERY ACCURACY EQUIP.....	5,838	5,838	5,838	5,838
91 ENHANCED PORTABLE INDUCTIVE ARTILLERY FUZE SE.....	1,178	1,178	1,178	1,178
92 PROFILER.....	4,766	4,766	4,766	4,766
93 MOD OF IN-SVC EQUIP (FIREFINDER RADARS).....	2,801	2,801	2,801	2,801
94 FORCE XXI BATTLE CMD BRIGADE & BELOW (FBCB2).....	271,979	271,979	271,979	271,979

(In thousands of dollars)

	Budget	House	Senate	Recommendation
95 JOINT BATTLE COMMAND - PLATFORM (JBC-P).....	17,242	17,242	17,242	17,242
96 LIGHTWEIGHT LASER DESIGNATOR/RANGEFINDER (LLD).....	59,080	59,080	59,080	59,080
98 MORTAR FIRE CONTROL SYSTEM.....	15,520	15,520	17,820	17,820
99 COUNTERFIRE RADARS.....	194,665	194,665	194,665	194,665
101 ENHANCED SENSOR & MONITORING SYSTEM.....	1,944	1,944	1,944	1,944
ELECT EQUIP - TACTICAL C2 SYSTEMS				
102 TACTICAL OPERATIONS CENTERS.....	29,934	32,234	29,934	31,774
103 FIRE SUPPORT C2 FAMILY.....	39,042	39,042	32,742	32,742
104 BATTLE COMMAND SUSTAINMENT SUPPORT SYSTEM.....	31,968	31,968	31,968	31,968
105 FAAD C2.....	8,289	8,289	8,289	8,289
106 AIR & MSL DEFENSE PLANNING & CONTROL SYS (AMD).....	62,439	62,439	62,439	62,439
107 KNIGHT FAMILY.....	80,831	80,831	80,831	80,831
108 LIFE CYCLE SOFTWARE SUPPORT (LCSS).....	1,778	1,778	1,778	1,778
109 AUTOMATIC IDENTIFICATION TECHNOLOGY.....	31,542	31,542	33,542	33,142
110 TC AIMS II.....	11,124	11,124	11,124	11,124
113 NETWORK MANAGEMENT INITIALIZATION AND SERVICE.....	53,898	53,898	53,898	53,898
114 MANEUVER CONTROL SYSTEM (MCS).....	77,646	77,646	77,646	77,646
115 SINGLE ARMY LOGISTICS ENTERPRISE (SALE).....	46,861	46,861	46,861	46,861
116 RECONNAISSANCE AND SURVEYING INSTRUMENT SET.....	11,118	11,118	11,118	11,118
117 MOUNTED BATTLE COMMAND ON THE MOVE (MBCOM).....	926	926	926	926
ELECT EQUIP - AUTOMATION				
118 GENERAL FUND ENTERPRISE BUSINESS SYSTEM.....	85,801	85,801	85,801	44,901
119 ARMY TRAINING MODERNIZATION.....	12,823	12,823	12,823	12,823
120 AUTOMATED DATA PROCESSING EQUIPMENT.....	254,723	179,723	239,723	209,723
121 CSS COMMUNICATIONS.....	33,749	33,749	33,749	33,749
122 RESERVE COMPONENT AUTOMATION SYS (RCAS).....	39,675	39,675	39,675	39,675
ELECT EQUIP - AUDIO VISUAL SYS (A/V)				
124 ITEMS LESS THAN \$5.0M (A/V).....	2,709	2,709	2,709	2,709
125 ITEMS LESS THAN \$5M (SURVEYING EQUIPMENT).....	5,172	5,172	5,172	5,172
ELECT EQUIP - SUPPORT				
128 PRODUCTION BASE SUPPORT (C-E).....	518	518	518	518
TOTAL, COMMUNICATIONS AND ELECTRONICS EQUIPMENT.....	4,304,472	4,004,494	4,020,862	3,952,390

(In thousands of dollars)

	Budget	House	Senate	Recommendation
<hr/>				
OTHER SUPPORT EQUIPMENT				
CHEMICAL DEFENSIVE EQUIPMENT				
129 PROTECTIVE SYSTEMS.....	2,081	2,081	2,081	2,081
130 CBRN SOLDIER PROTECTION.....	108,334	108,334	108,334	108,334
131 SMOKE & OBSCURANT FAMILY: SOF (NON AAO ITEM).....	7,135	7,135	7,135	7,135
BRIDGING EQUIPMENT				
132 TACTICAL BRIDGING.....	58,509	58,509	53,909	53,909
133 TACTICAL BRIDGE, FLOAT-RIBBON.....	135,015	135,015	135,015	135,015
ENGINEER (NON-CONSTRUCTION) EQUIPMENT				
134 HANDHELD STANDOFF MINEFIELD DETECTION SYS-HST.....	42,264	42,264	42,264	42,264
135 GROUND STANDOFF MINE DETECTION SYSTEM (GSTAMIDS).....	56,123	56,123	50,223	50,223
136 EXPLOSIVE ORDNANCE DISPOSAL EQPMT (EOD EQPMT).....	49,333	49,333	49,333	56,533
137 ITEMS LESS THAN \$5M, COUNTERMINE EQUIPMENT.....	3,479	3,479	3,479	3,479
138 AERIAL DETECTION.....	11,200	200	200	200
COMBAT SERVICE SUPPORT EQUIPMENT				
139 HEATERS AND ECU'S.....	11,924	11,924	11,924	11,924
141 SOLDIER ENHANCEMENT.....	4,071	4,071	4,071	4,071
142 LIGHTWEIGHT MAINTENANCE ENCLOSURE (LME).....	---	---	---	1,600
143 PERSONNEL RECOVERY SUPPORT SYSTEM (PRSS).....	6,981	6,981	6,981	6,981
144 GROUND SOLDIER SYSTEM.....	1,809	1,809	---	1,809
145 MOUNTED SOLDIER SYSTEM.....	1,085	1,085	---	1,085
147 FIELD FEEDING EQUIPMENT.....	57,872	61,372	57,872	60,672
148 CARGO AERIAL DEL & PERSONNEL PARACHUTE SYSTEM.....	66,381	66,381	61,581	63,981
149 MOBILE INTEGRATED REMAINS COLLECTION SYSTEM:.....	16,585	16,585	16,585	16,585
150 ITEMS LESS THAN \$5M (ENG SPT).....	25,531	25,531	25,531	25,531
PETROLEUM EQUIPMENT				
152 DISTRIBUTION SYSTEMS, PETROLEUM & WATER.....	84,019	84,019	84,019	84,019
WATER EQUIPMENT				
153 WATER PURIFICATION SYSTEMS.....	7,173	7,173	7,173	7,173
MEDICAL EQUIPMENT				
154 COMBAT SUPPORT MEDICAL.....	33,694	34,694	36,694	36,894
MAINTENANCE EQUIPMENT				
155 MOBILE MAINTENANCE EQUIPMENT SYSTEMS.....	137,002	137,002	137,002	137,002
156 ITEMS LESS THAN \$5.0M (MAINT EQ).....	812	5,812	812	3,312
CONSTRUCTION EQUIPMENT				
157 GRADER, ROAD MTZD, HVY, 6X4 (CCE).....	50,897	50,897	44,297	44,297
158 SKID STEER LOADER (SSL) FAMILY OF SYSTEM.....	18,387	18,387	18,387	18,387

(In thousands of dollars)

	Budget	House	Senate	Recommendation
161 MISSION MODULES - ENGINEERING.....	44,420	44,420	44,420	44,420
162 LOADERS.....	20,824	20,824	20,824	20,824
163 HYDRAULIC EXCAVATOR.....	18,785	18,785	18,785	18,785
164 TRACTOR, FULL TRACKED.....	50,102	50,102	50,102	50,102
166 PLANT, ASPHALT MIXING.....	12,915	12,915	12,915	12,915
167 HIGH MOBILITY ENGINEER EXCAVATOR (HME) FOS.....	36,451	36,451	36,451	36,451
168 CONST EQUIP ESP.....	8,391	8,391	8,391	8,391
169 ITEMS LESS THAN \$5.0M (CONST EQUIP).....	12,562	12,562	12,562	12,562
RAIL FLOAT CONTAINERIZATION EQUIPMENT				
170 JOINT HIGH SPEED VESSEL (JHSV).....	183,668	183,666	183,666	183,666
171 HARBORMASTER COMMAND AND CONTROL CENTER(HCCC).....	10,962	10,962	10,962	10,962
172 ITEMS LESS THAN \$5.0M (FLOAT/RAIL).....	6,785	6,785	6,785	6,785
GENERATORS				
173 GENERATORS AND ASSOCIATED EQUIPMENT.....	146,067	152,067	146,067	150,867
MATERIAL HANDLING EQUIPMENT				
174 ROUGH TERRAIN CONTAINER HANDLER (RTCH).....	41,239	41,239	41,239	41,239
175 ALL TERRAIN LIFTING ARMY SYSTEM.....	44,898	44,898	44,898	44,898
TRAINING EQUIPMENT				
176 COMBAT TRAINING CENTERS SUPPORT.....	22,967	22,967	22,967	22,967
177 TRAINING DEVICES, NONSYSTEM.....	261,348	292,848	303,798	309,228
178 CLOSE COMBAT TACTICAL TRAINER.....	65,155	65,155	65,155	65,155
179 AVIATION COMBINED ARMS TACTICAL TRAINER (AVCA).....	12,794	12,794	12,794	12,794
180 GAMING TECHNOLOGY IN SUPPORT OF ARMY TRAINING.....	7,870	7,870	7,870	7,870
TEST MEASURE AND DIG EQUIPMENT (TMD)				
181 CALIBRATION SETS EQUIPMENT.....	16,844	16,844	16,844	16,844
182 INTEGRATED FAMILY OF TEST EQUIPMENT (IFTE).....	101,320	101,320	101,320	101,320
183 TEST EQUIPMENT MODERNIZATION (TEMOD).....	15,526	15,526	15,526	15,526
OTHER SUPPORT EQUIPMENT				
184 RAPID EQUIPPING SOLDIER SUPPORT EQUIPMENT.....	21,770	23,770	---	6,370
185 PHYSICAL SECURITY SYSTEMS (OPA3).....	49,758	49,758	49,758	49,758
186 BASE LEVEL COM'L EQUIPMENT.....	1,303	1,303	1,303	1,303
187 MODIFICATION OF IN-SVC EQUIPMENT (OPA-3).....	53,884	53,884	53,884	53,884
188 PRODUCTION BASE SUPPORT (OTH).....	3,050	3,050	3,050	3,050
190 SPECIAL EQUIPMENT FOR USER TESTING.....	45,516	45,516	45,516	45,516
191 AMC CRITICAL ITEMS OPA3.....	12,232	12,232	12,232	12,232

(In thousands of dollars)

	Budget	House	Senate	Recommendation
192 MA8975.....	4,492	4,492	4,492	4,492
TOTAL, OTHER SUPPORT EQUIPMENT.....	2,331,592	2,369,592	2,319,478	2,355,672
SPARE AND REPAIR PARTS				
193 INITIAL SPARES - C&E.....	25,867	25,867	25,867	25,867
194 WIN-T INCREMENT 2 SPARES.....	9,758	9,758	9,758	9,758
TOTAL, SPARE AND REPAIR PARTS.....	35,625	35,625	35,625	35,625
CLASSIFIED PROGRAMS.....	2,522	2,522	2,522	2,522
TOTAL, OTHER PROCUREMENT, ARMY.....	9,907,151	9,293,801	9,395,444	8,582,660

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

P-1	Budget Request	House	Senate	Recommendation
HIGH MOBILITY MULTI-PURPOSE WHEELED VEHICLE				
4 (HMMWV)	281,123	281,123	282,323	282,083
HMMWV Egress Assistance Trainer for the Tennessee National Guard			200	160
Reinforcement HMMWV Repair Hood Kits			1,000	800
5 FAMILY OF MEDIUM TACTICAL VEHICLES (FMTV)	1,158,522	965,522	1,033,522	497,822
Schedule slip		-193,000		-174,000
Program reduction			-125,000	0
Transfer to Other Procurement, Army line number 5 in Title IX				-486,700
7 FAMILY OF HEAVY TACTICAL VEHICLES (FHTV)	812,918	786,566	812,918	612,918
Funding ahead of need		-26,352		0
Transfer to Other Procurement, Army line number 7 in Title IX				-200,000
10 MINE PROTECTION VEHICLE FAMILY	402,517	267,797	325,517	279,197
Funding in excess of need		-134,720		-134,720
Authorization Adjustment			-90,000	0
Mine Resistant Ambush Protected Vehicle Virtual Trainers for the Illinois National Guard			8,000	6,400
Mine Resistant Ambush Protected Vehicle Virtual Trainers for the Tennessee National Guard			5,000	5,000
HEAVY EXPANDED MOBILE TACTICAL TRUCK				
13 EXTENDED SERVICE	180,793	180,793	170,593	170,593
Pricing adjustment			-10,200	-10,200
15 MODIFICATION OF IN SERVICE EQUIPMENT	10,314	10,314	0	2,314
Prior year funds are available			-10,314	-8,000
16 ITEMS LESS THAN \$5.0M (TAC VEH)	298	298	5,898	4,778
Ultra Light Utility Vehicles for the National Guard (Includes transfer from line number 20)			5,600	4,480
17 TOWING DEVICE-FIFTH WHEEL	414	1,114	414	974
Fifth-Wheel Towing Devices for the Puerto Rico Army National Guard		700		560
19 PASSENGER CARRYING VEHICLES	269	269	0	0
Prior year funds are available			-269	-269
20 NONTACTICAL VEHICLES, OTHER	3,052	5,052	3,052	3,052
Ultralight Utility Vehicles for the National Guard (Transferred to line number 16)		2,000		0
26 SUPER HIGH FREQUENCY TERMINALS	90,918	90,918	94,918	94,118
Phoenix Quad-Band Satellite Receiver for the Delaware National Guard			4,000	3,200
35 JOINT TACTICAL RADIO SYSTEM	90,204	35,040	35,040	35,040
Funding ahead of need		-55,164		0
Delay in JTRS Ground Mobile Radio			-55,164	-55,164

P-1	Budget Request	House	Senate	Recommendation
37 SINGARS FAMILY	6,812	3,000	3,500	3,000
Funding in excess of need		-6,812	-6,812	-6,812
Radio Personality Modules for SINGARS Test Sets		3,000	3,500	3,000
COMMUNICATIONS-ELECTRONICS EQUIPMENT				
41 FIELDING	0	7,360	6,000	8,288
Communications Aerial Platforms for Increased Situational Awareness for the Minnesota National Guard		2,360		1,888
Regional Emergency Response Network Emergency Cell Phone Capability		5,000	3,000	4,000
Tactical/Crew Served Weapon Illumination Systems			3,000	2,400
SEQUOYAH FOREIGN LANGUAGE TRANSLATION SYSTEM				
74	6,420	6,420	0	0
Funding ahead of need			-6,420	-6,420
SENSE THROUGH THE WALL (STTW)				
81	25,352	25,352	0	0
Funding ahead of need			-25,352	-25,352
NIGHT VISION DEVICES				
82	366,820	191,168	180,458	180,458
Funding ahead of need		-175,662		0
Funding in excess of need			-186,362	-186,362
MORTAR FIRE CONTROL SYSTEM				
98	15,520	15,520	17,820	17,820
Accelerated Precision Mortar Initiative			2,300	2,300
TACTICAL OPERATIONS CENTERS				
102	29,934	32,234	29,934	31,774
Tactical Operations Center for the Washington National Guard		2,300		1,840
FIRE SUPPORT C2 FAMILY				
103	39,042	39,042	32,742	32,742
Pricing adjustment			-6,300	-6,300
AUTOMATIC IDENTIFICATION TECHNOLOGY				
109	31,542	31,542	33,542	33,142
Red River Army Depot Modernization			2,000	1,600
GENERAL FUND ENTERPRISE BUSINESS SYSTEM				
118	85,801	85,801	85,801	44,901
Army requested transfer to RDT&E, Army line number 111				-17,900
Army requested transfer to O&M, Army line number 432				-23,000
AUTOMATED DATA PROCESSING EQUIP				
120	254,723	179,723	239,723	209,723
Unjustified growth		-75,000	-15,000	-45,000
TACTICAL BRIDGING				
132	58,509	58,509	53,909	53,909
Pricing adjustment			-4,600	-4,600
GROUND STANDOFF MINE DETECTION SYSTEM				
135	56,123	56,123	50,223	50,223
Funding ahead of need			-8,900	-8,900
FIDO Explosives Detector			3,000	3,000

P-1	Budget Request	House	Senate	Recommendation
136 EXPLOSIVE ORDNANCE DISPOSAL EQUIPMENT	49,333	49,333	49,333	56,533
Magneto Inductive Remote Activation Munitions System (MI-RAMS) M156/M39 Kits and M40 Receivers (Transferred from Procurement of Ammunition, Army line number 25)				7,200
138 AERIAL DETECTION	11,200	200	200	200
Funding ahead of need		-11,000	-11,000	-11,000
142 LIGHTWEIGHT MAINTENANCE ENCLOSURE (LME)	0	0	0	1,600
Expandable Light Air Mobility Shelters (ELAMs) and Contingency Response Communications System (CRCS) for the Illinois National Guard (Transferred from O&M, Army National Guard line number 121)				1,600
144 GROUND SOLDIER SYSTEM	1,809	1,809	0	1,809
Funding ahead of need			-1,809	0
145 MOUNTED SOLDIER SYSTEM	1,085	1,085	0	1,085
Funding ahead of need			-1,085	0
147 FIELD FEEDING EQUIPMENT	57,872	61,372	57,872	60,672
Multi-Temperature Refrigerated Container System		3,500		2,800
CARGO AERIAL DELIVERY AND PERSONNEL				
148 PARACHUTE SYSTEM	66,381	66,381	61,581	63,981
Pricing adjustment			-4,800	-2,400
154 COMBAT SUPPORT MEDICAL	33,694	34,694	36,694	36,894
Life Support for Trauma and Transport		1,000		800
Combat Casualty Care Upgrade Program			3,000	2,400
156 ITEMS LESS THAN \$5.0M (MAINTENANCE EQUIPMENT)	812	5,812	812	3,312
Program Increase - Classified Waste Destruction		5,000		2,500
157 GRADER, ROAD MTZD, HVY, 6X4 (CCE)	50,897	50,897	44,297	44,297
Pricing adjustment			-6,600	-6,600
173 GENERATORS AND ASSOCIATED EQUIPMENT	146,067	152,067	146,067	150,867
Kentucky National Guard Emergency Response Generator Stockpile		6,000		4,800
177 TRAINING DEVICES, NONSYSTEM	261,348	292,848	303,798	309,228
Combat Skills Marksmanship Trainer		4,000	3,600	4,000
Combined Arms Virtual Trainers for the New Mexico National Guard		500		400
Combined Arms Virtual Trainers for the Tennessee National Guard		5,000	5,000	5,000
Program Increase - Training Simulators for the National Guard		9,000		4,000
Fort Bragg Range 74 Combined Arms Collective Training Facility		1,000		800
Individual Gunnery; Tank Gunnery; and Tabletop Full-Fidelity Trainers for the New Mexico National Guard		2,000		1,600
Laser Marksmanship Training System		2,000		2,000
Machine Gun Training System for the Pennsylvania National Guard		3,000		2,400
Mobile Firing Range for the Texas National Guard		1,500		1,500
Virtual Convoy Operations Trainer for the New Mexico National Guard		1,500		1,200

P-1	Budget Request	House	Senate	Recommendation
Virtual Interactive Combat Environment Training System for the Virginia National Guard		2,000	2,000	2,000
Call for Fire Trainer II/Joint Fires and Effects Trainer System			5,000	5,000
Immersive Group Simulation Virtual Training System for the Hawaii National Guard			2,500	2,300
Muscatatuck Urban Training Center Instrumentation for the National Guard			2,000	2,000
Training Range Enhancements			15,000	7,500
US Army Operator Driving Simulator for the Tennessee National Guard			350	280
Virtual Convoy Operations Trainers for the Illinois National Guard			3,000	2,400
Virtual Interactive Combat Environment for the New Jersey National Guard			4,000	3,500
184 RAPID EQUIPPING SOLDIER SUPPORT EQUIPMENT	21,770	23,770	0	6,370
Prior year funds are available			-21,770	-17,000
Mobile Defensive Fighting Position		2,000		1,600

ARMY TRUCK PROGRAM

Concerns persist regarding the absence of an overall truck acquisition strategy to guide the Army's plans and programs. It is not clear that the Army has conducted the needed analyses for sound acquisition plans or to reap potential savings. Not later than 180 days after the enactment of this Act, the Secretary of the Army shall provide a report to the congressional defense committees detailing the Army's acquisition strategy for future truck procurement.

NETWORKED COMMUNICATIONS CAPABILITIES

The recommendation continues to support the overall objectives of the Joint Tactical Radio System (JTRS) program, but concerns remain about the technical risk, cost and availability of the JTRS radios. While the JTRS family of radios and waveforms has successfully tested several variants and demonstrated key networking waveforms, full testing objectives have not been realized. The Secretary of Defense is encouraged to examine lower-risk approaches to bridge the networked communications gap while providing interoperability and moving toward a competitive radio business model. Competition is encouraged between legacy and com-

mercially available radios and waveforms that meet the majority of JTRS approved standards until such time as the JTRS radios are fielded. Additionally, the Assistant Secretary of Defense for Networks and Information Integration is encouraged to examine the cost effectiveness of such an approach and to submit a report to the congressional defense committees not later than March 15, 2010, with recommendations for closing any networked communications capability gap with commercially available and legacy radios and waveforms.

MODIFICATION OF IN-SERVICE EQUIPMENT

According to accounting reports, the Army has over \$1,284,000,000 in prior year funding available for Modification of In-Service Equipment, Budget Activity-1. Therefore, the recommendation provides \$2,314,000 for this program in fiscal year 2010, a reduction of \$8,000,000. Additionally, due to the large prior year funding balance, the recommendation includes a reduction of \$195,950,000 in the title IX portion of this program.

RAPID EQUIPPING FORCE

For fiscal year 2010, the recommendation provides \$13,370,000 for Rapid Equipping Force funding, a reduction of \$35,400,000 from

the budget request due to funding available in prior year accounts. There is concern with the Army's demand driven approach in providing Soldier Wearable Acoustic Targeting Systems (SWATS) to soldiers, and a strong belief that the equipment should be made available to all deploying units, not just those units submitting Urgent Needs Statements.

The Supplemental Appropriations Act, 2009 provided \$50,000,000 for SWATS. However, the slow pace of obligating available funding for the life-saving SWATS, and the lack of urgency in establishing a basis of issue plan and making it a Program of Record causes concern. The Army is expected to correct the situation quickly.

The Secretary of the Army has yet to provide a report on the acquisition objective and basis of issue plan for both vehicular and soldier wearable sniper detection equipment as directed in the Joint Explanatory Statement accompanying the Supplemental Appropriations Act, 2009. The report shall be provided to the congressional defense committees not later than 60 days after enactment of this Act.

AIRCRAFT PROCUREMENT, NAVY

For Aircraft Procurement, Navy, funds are to be available for fiscal
year 2010, as follows:

(In thousands of dollars)				
	Budget	House	Senate	Recommendation
AIRCRAFT PROCUREMENT, NAVY				
COMBAT AIRCRAFT				
2 EA-18G.....	1,611,837	1,611,837	1,611,837	1,611,837
3 EA-18G (AP-CY).....	20,559	20,559	20,559	20,559
4 F/A-18E/F (FIGHTER) HORNET (MYP).....	1,009,537	1,504,537	1,009,537	1,504,537
5 F/A-18E/F (FIGHTER) HORNET (MYP) (AP-CY).....	51,431	159,431	51,431	51,431
6 JOINT STRIKE FIGHTER	3,997,048	3,576,448	3,997,048	3,997,048
7 JOINT STRIKE FIGHTER ADVANCE PROCUREMENT (CY).....	481,000	481,000	481,000	481,000
8 V-22 (MEDIUM LIFT).....	2,215,829	2,215,829	2,215,829	2,215,829
9 V-22 (MEDIUM LIFT) (AP-CY).....	84,342	84,342	84,342	84,342
10 UH-1Y/AH-1Z.....	709,801	609,801	544,801	584,801
11 UH-1Y/AH-1Z (AP-CY).....	70,550	35,550	70,550	50,550
12 MH-60S (MYP).....	414,145	414,145	374,145	394,145
13 MH-60S (MYP) (AP-CY).....	78,830	78,830	78,830	78,830
14 MH-60R.....	811,781	818,281	811,781	816,281
15 MH-60R (AP-CY).....	131,504	131,504	118,304	118,304
16 P-8A POSEIDON.....	1,664,525	1,664,525	1,664,525	1,664,525
17 P-8A POSEIDON (ADVANCED PROCUREMENT).....	160,526	138,445	149,626	138,425
18 E-2C (EARLY WARNING) HAWKEYE (MYP).....	511,245	649,445	511,245	649,445
19 E-2C (EARLY WARNING) HAWKEYE (MYP) (AP-CY).....	94,924	94,924	57,524	94,924
TOTAL, COMBAT AIRCRAFT.....	14,119,414	14,289,433	13,852,914	14,556,813
AIRLIFT AIRCRAFT				
20 C-40A.....	74,381	74,381	74,381	74,381
TOTAL, AIRLIFT AIRCRAFT.....	74,381	74,381	74,381	74,381

(In thousands of dollars)

	Budget	House	Senate	Recommendation
<hr/>				
TRAINER AIRCRAFT				
22 JPATS.....	266,539	257,939	260,539	256,239
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TOTAL, TRAINER AIRCRAFT.....	266,539	257,939	260,539	256,239
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OTHER AIRCRAFT				
25 RQ-7 UAV.....	56,797	51,547	53,797	51,547
26 MQ-8 UAV.....	77,616	64,316	77,616	77,616
OTHER SUPPORT AIRCRAFT.....	---	---	6,200	1,980
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TOTAL, OTHER AIRCRAFT.....	134,413	115,863	137,613	131,123
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MODIFICATION OF AIRCRAFT				
28 EA-6 SERIES.....	39,977	39,977	39,977	39,977
29 AV-8 SERIES.....	35,668	31,868	35,668	31,868
30 F-18 SERIES.....	484,129	396,929	463,729	432,929
31 H-46 SERIES.....	35,325	35,325	35,325	35,325
32 AH-1W SERIES.....	66,461	66,461	33,061	33,061
33 H-53 SERIES.....	68,197	68,197	68,197	68,197
34 SH-60 SERIES.....	82,253	82,253	82,253	82,253
35 H-1 SERIES.....	20,040	20,040	20,040	20,040
36 EP-3 SERIES.....	92,530	92,530	92,530	92,530
37 P-3 SERIES.....	485,171	428,371	485,171	428,371
39 E-2 SERIES.....	22,853	22,853	42,853	32,853
40 TRAINER A/C SERIES.....	20,907	20,907	17,207	17,207
41 C-2A.....	21,343	21,343	21,343	21,343
42 C-130 SERIES.....	22,449	22,449	22,449	22,449

(In thousands of dollars)

	Budget	House	Senate	Recommendation
43 FEWSG.....	9,486	9,486	9,486	9,486
44 CARGO/TRANSPORT A/C SERIES.....	19,429	19,429	19,429	19,429
45 E-6 SERIES.....	102,646	102,646	102,646	102,646
46 EXECUTIVE HELICOPTERS SERIES.....	42,456	42,456	42,456	42,456
47 SPECIAL PROJECT AIRCRAFT.....	14,869	12,369	14,869	12,369
48 T-45 SERIES.....	51,484	49,184	51,484	48,984
49 POWER PLANT CHANGES.....	26,395	26,395	26,395	26,395
50 JPATS SERIES.....	4,922	4,922	4,922	4,922
51 AVIATION LIFE SUPPORT MODS.....	5,594	5,594	5,594	5,594
52 COMMON ECM EQUIPMENT.....	47,419	51,219	48,919	49,819
53 COMMON AVIONICS CHANGES.....	151,112	142,812	151,112	142,812
55 ID SYSTEMS.....	24,125	24,125	24,125	24,125
56 V-22 (TILT/ROTOR ACFT) OSPREY.....	24,502	24,502	24,502	24,502
TOTAL, MODIFICATION OF AIRCRAFT.....	2,021,742	1,864,642	1,985,742	1,871,942
AIRCRAFT SPARES AND REPAIR PARTS				
57 SPARES AND REPAIR PARTS.....	1,264,012	1,223,412	1,272,812	1,258,212
AIRCRAFT SUPPORT EQUIPMENT AND FACILITIES				
58 COMMON GROUND EQUIPMENT.....	363,588	365,588	361,088	360,288
59 AIRCRAFT INDUSTRIAL FACILITIES.....	11,075	11,075	11,075	11,075
60 WAR CONSUMABLES.....	55,406	55,406	55,406	55,406
61 OTHER PRODUCTION CHARGES.....	23,861	23,861	23,861	23,861
62 SPECIAL SUPPORT EQUIPMENT.....	42,147	42,147	42,147	42,147
63 FIRST DESTINATION TRANSPORTATION.....	1,734	1,734	1,734	1,734
TOTAL, AIRCRAFT SUPPORT EQUIPMENT & FACILITIES.....	497,811	499,811	495,311	494,511
TOTAL, AIRCRAFT PROCUREMENT, NAVY.....	18,378,312	18,325,481	18,079,312	18,643,221

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

P-1	Budget Request	House	Senate	Recommendation
4 F/A-18E/F (FIGHTER) HORNET (MYP) Funding for nine additional aircraft	1,009,537	1,504,537 495,000	1,009,537	1,504,537 495,000
5 F/A-18E/F (FIGHTER) HORNET (MYP) (AP-CY) Economic Order Quantity and Cost Reduction Initiative funding for Multi-year Procurement	51,431	159,431 108,000	51,431	51,431
6 JOINT STRIKE FIGHTER Reduction of two aircraft - no fiscal year 2009 advance procurement Non-recurring equipment execution	3,997,048	3,576,448 -300,000 -120,600	3,997,048	3,997,048
10 UH-1Y/AH-1Z Reduction of four aircraft Reduction of six aircraft Reduction of five aircraft	709,801	609,801 -100,000	544,801 -165,000	584,801 -125,000
11 UH-1Y/AH-1Z (AP-CY) Excess advance procurement	70,550	35,550 -35,000	70,550	50,550 -20,000
12 MH-60S (MYP) Funding ahead of need	414,145	414,145	374,145 -40,000	394,145 -20,000
14 MH-60R Multi-Mission Helicopter Avionics System Test Bed Program Increase - Airborne Sonar	811,781	818,281 1,500 5,000	811,781	816,281 1,500 3,000
15 MH-60R (AP-CY) Excess to requirement	131,504	131,504	118,304 -13,200	118,304 -13,200
17 P-8A POSEIDON (ADVANCE PROCUREMENT) Excessive advance procurement growth Funding for production line slots	160,526	138,445 -7,680 -14,401	149,626 -7,700 -3,200	138,425 -7,700 -14,401
18 E-2C (EARLY WARNING) HAWKEYE (MYP) Engineering Change Orders growth Funding for one additional aircraft	511,245	649,445 -3,800 142,000	511,245	649,445 -3,800 142,000
19 E-2C (EARLY WARNING) HAWKEYE (MYP) (AP-CY) Unjustified growth	94,924	94,924	57,524 -37,400	94,924
22 JPATS Airframe unit cost growth Support funding carryover	266,539	257,939 -4,300 -4,300	260,539 -6,000	256,239 -6,000 -4,300
25 RQ-7 UAV Attrition vehicles	56,797	51,547 -5,250	53,797 -3,000	51,547 -5,250
26 MQ-8 UAV Maintain minimum sustaining rate due to Littoral Combat Ship delays	77,616	64,316 -13,300	77,616	77,616

P-1	Budget Request	House	Senate	Recommendation
27 OTHER SUPPORT AIRCRAFT	0	0	6,200	1,960
EL/M-2032 Radar Upgrade to Navy Adversary Aircraft			2,000	
UC-12 Replacement Aircraft			4,200	1,960
29 AV-8 SERIES	35,668	31,868	35,668	31,868
Other support funding growth within obsolescence				
replacement Operational Safety Improvement Program		-1,800		-1,800
Engine Management System contract delay		-2,000		-2,000
30 F-18 SERIES	484,129	396,929	463,729	432,929
Excessive growth of IR Marker ECP		-3,400	-3,400	-3,400
Radar upgrades ahead of need		-78,800		
Engineering Change Orders excessive growth		-5,000		-5,000
SLMP kits ahead of need			-4,700	-4,700
Delay in MIDS/JTR development schedule			-12,300	-12,300
Radome and Weapon Ready Assembly funding ahead of need				-25,800
32 AH-1W SERIES	66,461	66,461	33,061	33,061
Delay in A/C and T700 engine modification			-33,400	-33,400
37 P-3 SERIES	485,171	428,371	485,171	428,371
Outer wing replacement kits cost growth		-56,800		-56,800
39 E-2 SERIES	22,853	22,853	42,853	32,853
Reliability enhancements for E-2C			20,000	10,000
40 TRAINER A/C SERIES	20,907	20,907	17,207	17,207
Program delay			-3,700	-3,700
47 SPECIAL PROJECT AIRCRAFT	14,869	12,369	14,869	12,369
Support funding growth within intelligence sensors				
Operational Safety Improvement Program		-2,500		-2,500
48 T-45 SERIES	51,484	49,184	51,484	48,984
Avionics Modernization Program kits ahead of need		-3,300		-3,300
Universal Avionics Recorder Wireless Flight Download Data		1,000		800
52 COMMON ECM EQUIPMENT	47,419	51,219	48,919	49,819
ALE-47 retrofit kits ahead of need		-3,200		-3,200
AN/AAR-47D(V)X Missile Warning System		5,000		4,000
Crane Integrated Defensive Electronic Countermeasures				
Depot Capability		2,000	1,500	1,600
53 COMMON AVIONICS CHANGES	151,112	142,812	151,112	142,812
Other support funding growth within Global Positioning				
System Operational Safety Improvement Program		-3,400		-3,400
CNS/ATM installation kits cost growth		-2,500		-2,500
Advanced Mission Computer and Display Kits ahead of need		-2,400		-2,400
57 SPARES AND REPAIR PARTS	1,264,012	1,223,412	1,272,812	1,258,212
UH-1Y/AH-1Z reduction		-1,600	-2,400	-2,000
E-2D spares growth		-15,000		-15,000
Joint Strike Fighter reduction		-24,000		
Additional F-18 Aircraft			11,200	11,200

P-1		Budget Request	House	Senate	Recommendation
58	COMMON GROUND EQUIPMENT	363,588	365,588	361,088	360,288
	Advanced Skills Management Command Portal - Fleet Readiness Centers		2,000	2,000	2,000
	Excessive growth in production engineering support			-8,500	-8,500
	Direct Squadron Support Readiness Training Program			4,000	3,200

F-18 AIRCRAFT

The variants of the F-18 aircraft have been the workhorses of the Navy's aviation fleet

for a generation. Consistent with the National Defense Authorization Act for Fiscal Year 2010, a multi-year procurement strategy has been approved to complete the pro-

curement of the F-18E/F/G aircraft as the Navy transitions to the Joint Strike Fighter aircraft.

WEAPONS PROCUREMENT, NAVY

For Weapons Procurement, Navy, funds are to be available for fiscal
year 2010, as follows:

(In thousands of dollars)				
	Budget	House	Senate	Recommendation
WEAPONS PROCUREMENT, NAVY				
BALLISTIC MISSILES MODIFICATION OF MISSILES				
1 TRIDENT II MODS.....	1,060,504	1,055,504	1,060,504	1,055,504
SUPPORT EQUIPMENT AND FACILITIES				
2 MISSILE INDUSTRIAL FACILITIES.....	3,447	3,447	3,447	3,447
TOTAL, BALLISTIC MISSILES.....	1,063,951	1,058,951	1,063,951	1,058,951
OTHER MISSILES STRATEGIC MISSILES				
3 TOMAHAWK.....	283,055	273,655	283,055	277,355
TACTICAL MISSILES				
4 AHRAAM.....	145,506	134,506	140,506	138,506
5 SIDEWINDER.....	56,845	53,845	56,845	53,845
6 JSOW.....	145,336	123,536	145,336	142,436
8 STANDARD MISSILE.....	249,233	131,604	249,233	189,233
9 RAM.....	74,784	69,944	74,784	69,944
10 HELLFIRE.....	59,411	56,911	59,411	59,411
11 AERIAL TARGETS.....	47,003	43,483	47,003	43,483
12 OTHER MISSILE SUPPORT.....	3,928	3,928	3,928	3,928
MODIFICATION OF MISSILES				
13 ESSM.....	51,388	51,388	51,388	51,388
14 HARM MODS.....	47,973	44,973	47,973	47,973
15 STANDARD MISSILES MODS.....	81,451	81,451	81,451	81,451
SUPPORT EQUIPMENT AND FACILITIES				
16 WEAPONS INDUSTRIAL FACILITIES.....	3,211	3,211	13,211	12,711
17 FLEET SATELLITE COMM FOLLOW-ON.....	487,280	482,593	487,280	482,593
18 FLEET SATELLITE COMM FOLLOW-ON (AP-CY).....	28,847	28,847	28,847	28,847
ORDNANCE SUPPORT EQUIPMENT				
19 ORDNANCE SUPPORT EQUIPMENT.....	48,883	48,883	48,883	48,883
TOTAL, OTHER MISSILES.....	1,814,134	1,632,758	1,819,134	1,731,967

(In thousands of dollars)

	Budget	House	Senate	Recommendation
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TORPEDOES AND RELATED EQUIPMENT				
TORPEDOES AND RELATED EQUIP				
21 ASW TARGETS.....	9,288	9,288	9,288	9,288
MOD OF TORPEDOES AND RELATED EQUIP				
22 MK-46 TORPEDO MODS.....	94,159	96,823	82,423	90,263
23 MK-48 TORPEDO ADCAP MODS.....	61,608	56,308	56,308	56,308
24 QUICKSTRIKE MINE.....	4,680	4,680	4,680	4,680
SUPPORT EQUIPMENT				
25 TORPEDO SUPPORT EQUIPMENT.....	39,869	35,329	39,869	35,329
26 ASW RANGE SUPPORT.....	10,044	10,044	10,044	10,044
DESTINATION TRANSPORTATION				
27 FIRST DESTINATION TRANSPORTATION.....	3,434	3,434	3,434	3,434
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TOTAL, TORPEDOES AND RELATED EQUIPMENT.....	223,082	215,906	206,046	209,346
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OTHER WEAPONS				
GUNS AND GUN MOUNTS				
28 SMALL ARMS AND WEAPONS.....	12,742	12,742	12,742	12,742
MODIFICATION OF GUNS AND GUN MOUNTS				
29 CIWS MODS.....	158,896	125,396	158,896	158,896
30 COAST GUARD WEAPONS.....	21,157	21,157	21,157	21,157
31 GUN MOUNT MODS.....	30,761	30,761	35,761	35,761
33 CRUISER MODERNIZATION WEAPONS.....	51,227	51,227	51,227	51,227
34 AIRBORNE MINE NEUTRALIZATION SYSTEMS.....	12,309	12,309	12,309	12,309
OTHER				
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TOTAL, OTHER WEAPONS.....	287,092	253,592	292,092	292,092
37 SPARES AND REPAIR PARTS.....	65,196	65,196	65,196	65,196
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TOTAL, WEAPONS PROCUREMENT, NAVY.....	3,453,455	3,226,403	3,446,419	3,357,572
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EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

P-1	Budget Request	House	Senate	Recommendation
1 TRIDENT II MODS	1,060,504	1,055,504	1,060,504	1,055,504
Support funding growth		-5,000		-5,000
3 TOMAHAWK	283,055	273,655	283,055	277,355
Missile hardware and capsule cost growth		-5,400		-2,700
Product improvement		-4,000		-3,000
4 AMRAAM	145,506	134,506	140,506	138,506
Diminished manufacturing sources funding ahead of need		-11,000	-5,000	-7,000
5 SIDEWINDER	56,845	53,845	56,845	53,845
Support funding carryover		-3,000		-3,000
6 JSOW	145,336	123,536	145,336	142,436
All up round missile cost growth		-18,900		
Support funding carryover		-2,900		-2,900
8 STANDARD MISSILE	249,233	131,604	249,233	189,233
SM-6 missile contract delay		-117,629		-60,000
9 RAM	74,784	69,944	74,784	69,944
Missile component cost growth		-1,740		-1,740
Support funding carryover		-3,100		-3,100
10 HELLFIRE	59,411	56,911	59,411	59,411
Support funding carryover		-2,500		
11 AERIAL TARGETS	47,003	43,483	47,003	43,483
Excess sub-sonic target support funding		-2,020		-2,020
Support funding carryover		-1,500		-1,500
14 HARM MODS	47,973	44,973	47,973	47,973
Production engineering carryover		-3,000		
16 WEAPONS INDUSTRIAL FACILITIES	3,211	3,211	13,211	12,711
Allegany Ballistics Laboratory Facility Restoration Plan			10,000	9,500
17 FLEET SATELLITE COMM FOLLOW-ON	487,280	482,593	487,280	482,593
Support funding carryover		-4,687		-4,687
22 MK-46 TORPEDO MODS	94,159	96,823	82,423	90,263
Support funding carryover		-7,136	-7,136	-7,136
Intelligent Graphics Torpedo Test Set Troubleshooting				
Maintainers Aid		5,000		4,000
Lightweight Torpedo P5U Test Equipment Modernization		4,800		3,840
Excess Test and Evaluation funding			-4,600	-4,600
23 MK-48 TORPEDO ADCAP MODS	61,608	56,308	56,308	56,308
Support funding carryover		-5,300	-5,300	-5,300
25 TORPEDO SUPPORT EQUIPMENT	39,869	35,329	39,869	35,329
Otto fuel cost growth		-2,740		-2,740
Support funding carryover		-1,800		-1,800

P-1		Budget Request	House	Senate	Recommendation
29	CIWS MODS	158,896	125,396	158,896	158,896
	Block 1B modification kits ahead of need		-19,000		
	Engineering Change Orders growth		-14,500		
31	GUN MOUNT MODS	30,761	30,761	35,761	35,761
	MK-110 57mm Naval Gun			2,000	2,000
	MK-38 Minor Caliber Gun System			3,000	3,000

PROCUREMENT OF AMMUNITION, NAVY AND MARINE CORPS

For Procurement of Ammunition, Navy and Marine Corps, funds are
to be available for fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
PROCUREMENT OF AMMO, NAVY & MARINE CORPS				
PROC AMMO, NAVY				
NAVY AMMUNITION				
1 GENERAL PURPOSE BOMBS.....	75,227	73,227	75,227	73,227
2 JDAM.....	1,968	1,968	1,968	1,968
3 AIRBORNE ROCKETS, ALL TYPES.....	38,643	38,643	38,643	38,643
4 MACHINE GUN AMMUNITION.....	19,622	12,062	12,062	12,062
5 PRACTICE BOMBS.....	33,803	29,003	24,503	28,103
6 CARTRIDGES & CART ACTUATED DEVICES.....	50,600	48,000	50,600	48,000
7 AIR EXPENDABLE COUNTERMEASURES.....	79,102	64,302	69,302	64,302
8 JATOS.....	3,230	3,230	3,230	3,230
9 5 INCH/54 GUN AMMUNITION.....	27,483	23,083	27,483	23,083
10 INTERMEDIATE CALIBER GUN AMMUNITION.....	25,974	25,974	25,974	25,974
11 OTHER SHIP GUN AMMUNITION.....	35,934	35,934	35,934	35,934
12 SMALL ARMS & LANDING PARTY AMMO.....	43,490	33,861	43,490	40,526
13 PYROTECHNIC AND DEMOLITION.....	10,623	10,623	10,623	10,623
14 AMMUNITION LESS THAN \$5 MILLION.....	3,214	3,214	3,214	3,214
TOTAL, PROC AMMO, NAVY.....	448,913	403,124	422,253	406,889

(In thousands of dollars)

	Budget	House	Senate	Recommendation
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PROC AMMO, MARINE CORPS				
MARINE CORPS AMMUNITION				
15 SMALL ARMS AMMUNITION.....	87,781	87,781	87,781	87,781
16 LINEAR CHARGES, ALL TYPES.....	23,582	23,582	23,582	23,582
17 40 MM, ALL TYPES.....	57,291	57,291	57,291	57,291
18 60MM, ALL TYPES.....	22,037	22,037	22,037	22,037
19 81MM, ALL TYPES.....	54,869	54,869	54,869	54,869
20 120MM, ALL TYPES.....	29,579	29,579	29,579	29,579
21 CTG 25MM, ALL TYPES.....	2,259	2,259	2,259	2,259
22 GRENADES, ALL TYPES.....	10,694	10,694	10,694	10,694
23 ROCKETS, ALL TYPES.....	13,948	13,948	13,948	13,948
24 ARTILLERY, ALL TYPES.....	57,948	57,948	57,948	57,948
26 DEMOLITION MUNITIONS, ALL TYPES.....	14,886	14,886	14,886	14,886
27 FUZE, ALL TYPES.....	575	575	575	575
28 NON LETHALS.....	3,034	3,034	3,034	3,034
29 AMMO MODERNIZATION.....	8,886	8,886	8,886	8,886
30 ITEMS LESS THAN \$5 MILLION.....	4,393	4,393	4,393	4,393
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TOTAL, PROC AMMO, MARINE CORPS.....	391,762	391,762	391,762	391,762
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TOTAL, PROCUREMENT OF AMMO, NAVY & MARINE CORPS.....	840,675	794,886	814,015	800,651
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EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

P-1	Budget Request	House	Senate	Recommendation
1 GENERAL PURPOSE BOMBS	75,227	73,227	75,227	73,227
Direct attack cost growth		-2,000		-2,000
4 MACHINE GUN AMMUNITION	19,622	12,062	12,062	12,062
20MM linkless TP cost growth		-2,900	-2,900	-2,900
20MM linked TP cost growth		-1,990	-1,990	-1,990
20MM linked HEI cost growth		-2,670	-2,670	-2,670
5 PRACTICE BOMBS	33,803	29,003	24,503	28,103
Enhanced Laser Guided Training Round cost growth		-9,300	-9,300	-9,300
Enhanced Laser Guided Training Round		4,500		3,600
6 CARTRIDGES & CART ACTUATED DEVICES	50,600	48,000	50,600	48,000
Support funding carryover		-2,600		-2,600
7 AIR EXPENDABLE COUNTERMEASURES	79,102	64,302	69,302	64,302
MJU55 contract delay		-9,800		
Support funding carryover		-5,000		-5,000
MJU-55 production termination			-9,800	-9,800
9 5 INCH/54 GUN AMMUNITION	27,483	23,083	27,483	23,083
Multi-option fuze cost growth		-4,400		-4,400
12 SMALL ARMS & LANDING PARTY AMMO	43,490	33,861	43,490	40,526
Tracer cartridge cost growth		-1,300		-1,300
APIT cartridge contract delay		-8,329		
APIT cartridge cost growth				-1,664

SHIPBUILDING AND CONVERSION, NAVY

For Shipbuilding and Conversion, Navy, funds are to be available for
fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
SHIPBUILDING & CONVERSION, NAVY				
OTHER WARSHIPS				
1 CARRIER REPLACEMENT PROGRAM.....	739,269	739,269	739,269	739,269
2 CARRIER REPLACEMENT PROGRAM (AP-CY).....	484,432	484,432	484,432	484,432
3 VIRGINIA CLASS SUBMARINE.....	1,964,317	1,964,317	1,964,317	1,964,317
4 VIRGINIA CLASS SUBMARINE (AP-CY).....	1,959,725	1,959,725	1,959,725	1,959,725
5 CVN REFUELING OVERHAUL.....	1,563,602	1,563,602	1,563,602	1,563,602
6 CVN REFUELING OVERHAULS (AP-CY).....	211,820	211,820	211,820	211,820
9 DDG 1000.....	1,084,161	1,073,161	1,393,797	1,382,797
11 DDG-51.....	1,912,267	1,912,267	3,650,000	1,912,267
12 DDG-51 (AP-CY).....	328,996	328,996	328,996	578,996
13 LITTORAL COMBAT SHIP.....	1,380,000	2,160,000	1,080,000	1,080,000
TOTAL, OTHER WARSHIPS.....	11,628,589	12,397,589	13,375,958	11,877,225
AMPHIBIOUS SHIPS				
14 LPD-17.....	872,392	872,392	872,392	872,392
15 LPD-17(AP-CY).....	184,555	184,555	184,555	184,555
16 LHA REPLACEMENT (AP-CY).....	---	---	170,000	170,000
18 INTRATHEATER CONNECTOR.....	177,956	357,956	177,956	177,956
TOTAL, AMPHIBIOUS SHIPS.....	1,234,903	1,414,903	1,404,903	1,404,903
AUXILIARIES, CRAFT, AND PRIOR-YEAR PROGRAM COSTS				
19 OUTFITTING.....	391,238	386,903	391,238	386,903
20 SERVICE CRAFT.....	3,694	3,694	3,694	3,694
21 LCAC SLEP.....	63,857	63,857	63,857	63,857
22 COMPLETION OF PY SHIPBUILDING PROGRAMS.....	454,586	454,586	144,950	144,950
TOTAL, AUXILIARIES, CRAFT, AND PRIOR-YEAR PROGRAM...	913,375	909,040	603,739	599,404
TOTAL, SHIPBUILDING & CONVERSION, NAVY.....	13,776,867	14,721,532	15,384,600	13,881,532

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

P-1	Budget Request	House	Senate	Recommendation
9 DDG 1000	1,084,161	1,073,161	1,393,797	1,382,797
Excess change order funding		-11,000		-11,000
Transfer from Line number 22			309,636	309,636
11 DDG-51	1,912,267	1,912,267	3,650,000	1,912,267
Add second ship			1,737,733	
12 DDG-51 (AP-CY)	328,996	328,996	328,996	578,996
Additional advance procurement				250,000
13 LITTORAL COMBAT SHIP	1,380,000	2,160,000	1,080,000	1,080,000
Properly price fiscal year 2010 ships		240,000		
Funding for one additional vessel		540,000		
Reprice request; fund two ships			-300,000	-300,000
17 LHA REPLACEMENT (AP)	0	0	170,000	170,000
Additional advance procurement			170,000	170,000
18 INTRATHEATER CONNECTOR	177,956	357,956	177,956	177,956
Funding for one additional Joint High Speed Vessel		180,000		
19 OUTFITTING	391,238	386,903	391,238	386,903
DDG -1000 outfitting ahead of need		-4,335		-4,335
22 COMPLETION OF PY SHIPBUILDING PROGRAMS	454,586	454,586	144,950	144,950
Transfer to line number 9			-309,636	-309,636

SHIPBUILDING

The fiscal year 2010 shipbuilding budget request from the Department once again falls short of the quantity of ten ships nominally required to reach and maintain the required fleet size of 313 ships. Further, the Department's revised acquisition strategy for the Littoral Combat Ship, solidified after the submission of the budget, has reduced the requested number of ships from a quantity of eight to a quantity of seven. In an effort to position the Department to request additional ship quantities in fiscal year 2011, the recommendation includes an additional \$170,000,000 of advance procurement funding for the LHA (Replacement) helicopter assault ship and \$250,000,000 of additional advance procurement funding for the DDG-51 Guided Missile Destroyer program.

COMMON HULL FORMS

The Navy has discussed in testimony the use of existing hull forms for the design of future ships in an effort to reduce the cost of these ships. Candidate ships include, but are not limited to the replacement command ship, future dock landing ships, future surface combatant, and hospital ships. Candidate hull forms include, but are not limited to, the LPD-17, T-AKE, National Security Cutter, Patrol Coastal and DDG-51 hull forms all currently in use. This initiative continues to have strong support and the Secretary of the Navy is directed to submit

a report that outlines the benefits of using an existing hull form for future ship construction. The report should include candidate hull forms, candidate ship classes (including survivability requirements), potential cost savings (including under multi-year procurement authority), and the timeframe of when the decision would be made to use an existing hull form for future designs. This report should be submitted to the congressional defense committees not later than March 15th, 2010.

LITTORAL COMBAT SHIP (LCS)

The recommendation includes \$1,080,000,000 for the construction of two Littoral Combat Ships (LCS), a reduction of \$300,000,000 and one ship from the budget request. This adjustment properly prices the program and is consistent with the Navy's revised acquisition strategy for the LCS program which calls for down selecting to a single ship design in fiscal year 2010, versus the two designs that the program has been carrying. The recommendation supports this strategy which should result in reduced program costs as a result of reducing the overhead within the program. Further, the recommendation provides an additional \$60,000,000 to the LCS research and development program for the development of a technical data package that will allow a future second source of the winning LCS design.

Additionally, in compliance with previous congressional direction, the Assistant Secretary of the Navy for Research, Development, and Acquisition (ASN (RDA)) provides the congressional defense committees a monthly progress report on LCS construction costs. Presently, these reports provide cost information only for the first two LCS platforms (LCS-1 and LCS-2). The ASN (RDA) is directed to provide the same monthly cost reports for LCS-3 and LCS-4 upon enactment of this Act.

LEASING OF FOREIGN BUILT SHIPS

There exists strong interest in the impact that the review of future requirements in the Quadrennial Defense Review will have on the Navy's practice of leasing foreign built ships. Therefore, the Secretary of the Navy is directed to update its March 2008 report on the use of such leases and address impacts on American seafarers, sealift capabilities, and naval shipbuilding.

DDG-51 GUIDED MISSILE DESTROYER

The recommendation includes \$578,996,000, an increase of \$250,000,000 above the budget request, for advance procurement of components for the two DDG-51 destroyers planned in fiscal year 2011. The recommendation fully supports re-start of the DDG-51 program and provides additional funding in an effort to re-start the program in a more efficient and cost effective manner.

OTHER PROCUREMENT, NAVY

For Other Procurement, Navy, funds are to be available for fiscal year

2010, as follows:

(In thousands of dollars)				
	Budget	House	Senate	Recommendation
OTHER PROCUREMENT, NAVY				
SHIPS SUPPORT EQUIPMENT				
SHIP PROPULSION EQUIPMENT				
1 LM-2500 GAS TURBINE.....	8,014	8,014	8,014	8,014
2 ALLISON 501K GAS TURBINE.....	9,162	9,162	9,162	9,162
3 OTHER PROPULSION EQUIPMENT.....	---	2,000	4,000	4,800
NAVIGATION EQUIPMENT				
4 OTHER NAVIGATION EQUIPMENT.....	34,743	32,249	34,743	32,249
PERISCOPES				
5 SUB PERISCOPES & IMAGING EQUIP.....	75,127	70,027	70,127	70,027
OTHER SHIPBOARD EQUIPMENT				
6 DDG MOD.....	142,262	111,366	145,362	144,742
7 FIREFIGHTING EQUIPMENT.....	11,423	11,423	11,423	11,423
8 COMMAND AND CONTROL SWITCHBOARD.....	4,383	4,383	4,383	4,383
9 POLLUTION CONTROL EQUIPMENT.....	24,992	23,832	24,992	23,832
10 SUBMARINE SUPPORT EQUIPMENT.....	16,867	16,867	16,867	16,867
11 VIRGINIA CLASS SUPPORT EQUIPMENT.....	103,153	103,153	93,673	93,673
12 SUBMARINE BATTERIES.....	51,482	41,582	51,482	45,082
13 STRATEGIC PLATFORM SUPPORT EQUIP.....	15,672	12,372	15,672	12,372
14 DSSP EQUIPMENT.....	10,641	10,641	10,641	10,641
15 CG-MODERNIZATION.....	315,323	314,123	315,323	314,123
16 LCAC.....	6,642	6,642	6,642	6,642
18 UNDERWATER EOD PROGRAMS.....	19,232	16,182	19,232	19,232
19 ITEMS LESS THAN \$5 MILLION.....	127,554	123,388	121,030	118,808
20 CHEMICAL WARFARE DETECTORS.....	8,899	8,899	8,899	8,899
21 SUBMARINE LIFE SUPPORT SYSTEM.....	14,721	14,721	14,721	14,721

(In thousands of dollars)

	Budget	House	Senate	Recommendation
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REACTOR PLANT EQUIPMENT				
23 REACTOR COMPONENTS.....	262,354	262,354	262,354	262,354
OCEAN ENGINEERING				
24 DIVING AND SALVAGE EQUIPMENT.....	5,304	5,304	5,304	5,304
SMALL BOATS				
25 STANDARD BOATS.....	35,318	37,318	68,518	52,018
TRAINING EQUIPMENT				
26 OTHER SHIPS TRAINING EQUIPMENT.....	15,113	13,507	15,113	13,507
PRODUCTION FACILITIES EQUIPMENT				
27 OPERATING FORCES IPE.....	47,172	47,172	51,372	51,372
OTHER SHIP SUPPORT				
28 NUCLEAR ALTERATIONS.....	136,683	136,683	136,683	136,683
29 LCS MODULES.....	137,259	92,204	52,926	117,259
30 LSD MIDLIFE.....	117,856	116,786	117,856	116,786
29 TOTAL, SHIPS SUPPORT EQUIPMENT.....	1,757,351	1,652,354	1,696,514	1,724,975
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COMMUNICATIONS AND ELECTRONICS EQUIPMENT				
SHIP RADARS				
31 RADAR SUPPORT.....	9,968	13,968	9,968	13,168
SHIP SONARS				
32 SPQ-9B RADAR.....	13,476	13,476	13,476	13,476
33 AN/SQQ-89 SURF ASW COMBAT SYSTEM.....	111,093	77,362	95,593	77,362
34 SSN ACOUSTICS.....	299,962	291,832	303,962	297,682
35 UNDERSEA WARFARE SUPPORT EQUIPMENT.....	38,705	30,548	38,705	30,548
36 SONAR SWITCHES AND TRANSDUCERS.....	13,537	11,894	13,537	11,894
ASW ELECTRONIC EQUIPMENT				
37 SUBMARINE ACOUSTIC WARFARE SYSTEM.....	20,681	22,681	12,881	13,481
38 SSTO.....	2,184	17,184	2,184	10,184
39 FIXED SURVEILLANCE SYSTEM.....	63,017	63,017	63,017	63,017
40 SURTASS.....	24,108	24,108	24,108	24,108
41 TACTICAL SUPPORT CENTER.....	22,464	22,464	22,464	22,464
ELECTRONIC WARFARE EQUIPMENT				
42 AN/SLQ-32.....	34,264	31,267	34,264	31,267
RECONNAISSANCE EQUIPMENT				
43 SHIPBOARD IW EXPLOIT.....	105,883	106,883	88,883	89,683
SUBMARINE SURVEILLANCE EQUIPMENT				
44 SUBMARINE SUPPORT EQUIPMENT PROG.....	98,645	83,495	86,495	86,495
OTHER SHIP ELECTRONIC EQUIPMENT				
46 COOPERATIVE ENGAGEMENT CAPABILITY.....	30,522	28,922	30,522	28,922
47 GCCS-M EQUIPMENT.....	13,594	13,594	13,594	13,594

(In thousands of dollars)

	Budget	House	Senate	Recommendation
48 NAVAL TACTICAL COMMAND SUPPORT SYSTEM (NTCSS).....	35,933	35,933	35,933	35,933
49 ATDLS.....	7,314	7,314	4,314	4,314
50 MINESWEEPING SYSTEM REPLACEMENT.....	79,091	69,285	74,291	72,285
51 SHALLOW WATER MCM.....	7,835	7,835	7,835	7,835
52 NAVSTAR GPS RECEIVERS (SPACE).....	10,845	7,965	10,845	7,965
53 ARMED FORCES RADIO AND TV.....	3,333	3,333	3,333	3,333
54 STRATEGIC PLATFORM SUPPORT EQUIP.....	4,149	4,149	4,149	4,149
TRAINING EQUIPMENT				
55 OTHER TRAINING EQUIPMENT.....	36,784	35,654	36,784	35,654
AVIATION ELECTRONIC EQUIPMENT				
56 MATCALs.....	17,468	12,168	17,468	14,768
57 SHIPBOARD AIR TRAFFIC CONTROL.....	7,970	7,970	7,970	7,970
58 AUTOMATIC CARRIER LANDING SYSTEM.....	18,878	17,878	18,878	17,878
59 NATIONAL AIR SPACE SYSTEM.....	28,988	28,988	28,988	28,988
60 AIR STATION SUPPORT EQUIPMENT.....	8,203	8,203	8,203	8,203
61 MICROWAVE LANDING SYSTEM.....	10,526	10,526	10,526	10,526
62 ID SYSTEMS.....	38,682	38,682	38,682	38,682
63 TAC A/C MISSION PLANNING SYS(TAMPS).....	9,102	9,102	9,102	9,102
OTHER SHORE ELECTRONIC EQUIPMENT				
64 DEPLOYABLE JOINT COMMAND AND CONT.....	8,719	11,719	8,719	11,119
65 TADIX-B.....	793	793	793	793
66 GCCS-M EQUIPMENT TACTICAL/MOBILE.....	11,820	11,820	11,820	11,820
67 COMMON IMAGERY GROUND SURFACE SYSTEMS.....	27,632	27,632	27,632	27,632
68 CANES.....	1,181	1,181	1,181	1,181
69 RADIAC.....	5,990	5,990	5,990	5,990
70 GPETE.....	3,737	3,737	3,737	3,737
71 INTEG COMBAT SYSTEM TEST FACILITY.....	4,423	4,423	4,423	4,423
72 EMI CONTROL INSTRUMENTATION.....	4,778	4,778	4,778	4,778
73 ITEMS LESS THAN \$5 MILLION.....	65,760	57,706	68,760	60,106
SHIPBOARD COMMUNICATIONS				
76 SHIP COMMUNICATIONS AUTOMATION.....	310,605	263,625	290,305	282,105
77 AN/URC-82 RADIO.....	4,913	4,913	4,913	4,913
78 COMMUNICATIONS ITEMS UNDER \$5M.....	25,314	25,314	26,554	26,054

(In thousands of dollars)

	Budget	House	Senate	Recommendation
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SUBMARINE COMMUNICATIONS				
79 SUBMARINE BROADCAST SUPPORT.....	105	105	105	105
80 SUBMARINE COMMUNICATION EQUIPMENT.....	48,729	48,729	48,729	48,729
SATELLITE COMMUNICATIONS				
81 SATELLITE COMMUNICATIONS SYSTEMS.....	50,172	43,747	48,572	48,572
82 NAVY MULTIBAND TERMINAL (NMT).....	72,496	72,496	63,196	63,196
SHORE COMMUNICATIONS				
83 JCS COMMUNICATIONS EQUIPMENT.....	2,322	2,322	2,322	2,322
84 ELECTRICAL POWER SYSTEMS.....	1,293	1,293	1,293	1,293
85 NAVAL SHORE COMMUNICATIONS.....	2,542	2,542	2,542	2,542
CRYPTOGRAPHIC EQUIPMENT				
86 INFO SYSTEMS SECURITY PROGRAM (ISSP).....	119,054	116,754	110,554	110,554
CRYPTOLOGIC EQUIPMENT				
87 CRYPTOLOGIC COMMUNICATIONS EQUIP.....	16,839	16,839	16,839	16,839
OTHER ELECTRONIC SUPPORT				
88 COAST GUARD EQUIPMENT.....	18,892	18,892	18,892	18,892
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TOTAL, COMMUNICATIONS AND ELECTRONICS EQUIPMENT.....	2,035,313	1,905,030	1,943,603	1,892,625
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AVIATION SUPPORT EQUIPMENT				
SONOBUOYS				
90 SONOBUOYS - ALL TYPES.....	91,976	89,976	91,976	89,976
AIRCRAFT SUPPORT EQUIPMENT				
91 WEAPONS RANGE SUPPORT EQUIPMENT.....	75,329	72,829	92,329	88,929
92 EXPEDITIONARY AIRFIELDS.....	8,343	8,343	8,343	8,343
93 AIRCRAFT REARMING EQUIPMENT.....	12,850	12,850	12,850	12,850
94 AIRCRAFT LAUNCH & RECOVERY EQUIPMENT.....	48,670	44,849	46,849	39,806
95 METEOROLOGICAL EQUIPMENT.....	21,458	21,458	14,558	14,558
96 OTHER PHOTOGRAPHIC EQUIPMENT.....	1,582	1,582	1,582	1,582
97 AVIATION LIFE SUPPORT.....	27,367	29,867	32,367	30,367
98 AIRBORNE MINE COUNTERMEASURES.....	55,408	55,408	51,408	51,408
99 LAMPS MK III SHIPBOARD EQUIPMENT.....	23,694	23,694	23,694	23,694
100 PORTABLE ELECTRONIC MAINTENANCE AIDS.....	9,710	9,710	4,910	4,910
101 OTHER AVIATION SUPPORT EQUIPMENT.....	16,541	13,541	16,541	13,541
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TOTAL, AVIATION SUPPORT EQUIPMENT.....	392,928	384,107	397,407	379,964

(In thousands of dollars)

	Budget	House	Senate	Recommendation
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ORDNANCE SUPPORT EQUIPMENT				
SHIP GUN SYSTEM EQUIPMENT				
102 NAVAL FIRES CONTROL SYSTEM.....	1,391	1,391	1,391	1,391
103 GUN FIRE CONTROL EQUIPMENT.....	7,891	7,891	7,891	7,891
SHIP MISSILE SYSTEMS EQUIPMENT				
104 NATO SEASPARROW.....	13,556	13,556	13,556	13,556
105 RAM GMLS.....	7,762	7,762	8,762	8,762
106 SHIP SELF DEFENSE SYSTEM.....	34,079	34,079	34,079	34,079
107 AEGIS SUPPORT EQUIPMENT.....	108,886	101,733	108,886	101,733
108 TOMAHAWK SUPPORT EQUIPMENT.....	88,475	88,475	88,475	88,475
109 VERTICAL LAUNCH SYSTEMS.....	5,513	5,513	5,513	5,513
FBM SUPPORT EQUIPMENT				
110 STRATEGIC MISSILE SYSTEMS EQUIP.....	155,579	155,579	155,579	155,579
ASW SUPPORT EQUIPMENT				
111 SSN COMBAT CONTROL SYSTEMS.....	118,528	113,563	118,528	113,563
112 SUBMARINE ASW SUPPORT EQUIPMENT.....	5,200	5,200	5,200	5,200
113 SURFACE ASW SUPPORT EQUIPMENT.....	13,646	13,646	13,646	13,646
114 ASW RANGE SUPPORT EQUIPMENT.....	7,256	7,256	7,256	7,256
OTHER ORDNANCE SUPPORT EQUIPMENT				
115 EXPLOSIVE ORDNANCE DISPOSAL EQUIP.....	54,069	54,069	54,069	54,069
116 ITEMS LESS THAN \$5 MILLION.....	3,478	3,478	3,478	3,478
OTHER EXPENDABLE ORDNANCE				
117 ANTI-SHIP MISSILE DECOY SYSTEM.....	37,128	29,978	37,128	33,628
118 SURFACE TRAINING DEVICE MODS.....	7,430	7,430	7,430	7,430
119 SUBMARINE TRAINING DEVICE MODS.....	25,271	25,271	25,271	25,271
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TOTAL, ORDNANCE SUPPORT EQUIPMENT.....	695,138	675,870	696,138	680,520
CIVIL ENGINEERING SUPPORT EQUIPMENT				
120 PASSENGER CARRYING VEHICLES.....	4,139	4,139	4,139	4,139
121 GENERAL PURPOSE TRUCKS.....	1,731	1,731	1,731	1,731
122 CONSTRUCTION & MAINTENANCE EQUIP.....	12,931	12,931	12,931	12,931
123 FIRE FIGHTING EQUIPMENT.....	12,976	12,976	12,976	12,976
124 TACTICAL VEHICLES.....	25,352	25,352	25,352	25,352
125 AMPHIBIOUS EQUIPMENT.....	2,950	2,950	2,950	2,950

(In thousands of dollars)

	Budget	House	Senate	Recommendation
126 POLLUTION CONTROL EQUIPMENT.....	5,097	5,097	5,097	5,097
127 ITEMS UNDER \$5 MILLION.....	23,787	23,787	23,787	23,787
128 PHYSICAL SECURITY VEHICLES.....	1,115	1,115	1,115	1,115
TOTAL, CIVIL ENGINEERING SUPPORT EQUIPMENT.....	90,078	90,078	90,078	90,078
SUPPLY SUPPORT EQUIPMENT				
SUPPLY SUPPORT EQUIPMENT				
129 MATERIALS HANDLING EQUIPMENT.....	17,153	17,153	17,153	17,153
130 OTHER SUPPLY SUPPORT EQUIPMENT.....	6,368	6,368	10,368	9,568
131 FIRST DESTINATION TRANSPORTATION.....	6,217	6,217	6,217	6,217
132 SPECIAL PURPOSE SUPPLY SYSTEMS.....	71,597	71,597	71,597	71,597
TOTAL, SUPPLY SUPPORT EQUIPMENT.....	101,335	101,335	105,335	104,535
PERSONNEL AND COMMAND SUPPORT EQUIPMENT				
TRAINING DEVICES				
133 TRAINING SUPPORT EQUIPMENT.....	12,944	11,728	12,944	11,728
COMMAND SUPPORT EQUIPMENT				
134 COMMAND SUPPORT EQUIPMENT.....	55,267	51,682	52,267	48,682
135 EDUCATION SUPPORT EQUIPMENT.....	2,084	2,084	2,084	2,084
136 MEDICAL SUPPORT EQUIPMENT.....	5,517	2,092	5,517	5,517
137 NAVAL MIP SUPPORT EQUIPMENT.....	1,537	1,537	1,537	1,537
139 OPERATING FORCES SUPPORT EQUIPMENT.....	12,250	12,250	12,250	12,250
140 C4ISR EQUIPMENT.....	5,324	5,324	5,324	5,324
141 ENVIRONMENTAL SUPPORT EQUIPMENT.....	18,183	18,183	16,488	16,488
142 PHYSICAL SECURITY EQUIPMENT.....	128,921	126,921	128,921	126,921
143 ENTERPRISE INFORMATION TECHNOLOGY.....	79,747	87,247	65,747	70,747
TOTAL, PERSONNEL AND COMMAND SUPPORT EQUIPMENT.....	321,774	319,048	303,079	301,278
145 SPARES AND REPAIR PARTS.....	247,796	247,796	247,796	247,796
999 CLASSIFIED PROGRAMS.....	19,463	19,463	19,463	19,463
TOTAL, OTHER PROCUREMENT, NAVY.....	5,661,178	5,395,081	5,499,413	5,441,234

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

P-1	Budget Request	House	Senate	Recommendation
3 OTHER PROPULSION EQUIPMENT	0	2,000	4,000	4,800
LSD-41/49 Diesel Engine Low Load Upgrade Kit		2,000		1,600
LCS-1 Waterjet Spares			4,000	3,200
4 OTHER NAVIGATION EQUIPMENT	34,743	32,249	34,743	32,249
ECDIS-N units ahead of need		-1,494		-1,494
Support funding carryover		-1,000		-1,000
5 SUB PERISCOPES & IMAGING EQUIP	75,127	70,027	70,127	70,027
Digital periscope contract delay		-5,100		-5,100
ISNS contract delay			-5,000	
6 DDG MOD	142,262	111,366	145,362	144,742
Modernization equipment ahead of need		-30,896		
Smart Valve Automatic Fire Suppression System			3,100	2,480
9 POLLUTION CONTROL EQUIPMENT	24,992	23,832	24,992	23,832
R-114 air conditioning units ahead of need		-1,160		-1,160
11 VIRGINIA CLASS SUPPORT EQUIPMENT	103,153	103,153	93,673	93,673
HM&E/NPES tech refresh contract delay			-9,480	-9,480
12 SUBMARINE BATTERIES	51,482	41,582	51,482	45,082
688 class installation funding ahead of need		-4,900		-4,900
Ohio class installation funding ahead of need		-3,500		
Support funding carryover		-1,500		-1,500
13 STRATEGIC PLATFORM SUPPORT EQUIP	15,672	12,372	15,672	12,372
Incremental funding of SSTG rotors		-3,300		-3,300
15 CG-MODERNIZATION	315,323	314,123	315,323	314,123
Properly price SPQ-9B radar equipment		-1,200		-1,200
18 UNDERWATER EOD PROGRAMS	19,232	16,182	19,232	19,232
UUV, diver safety, and life support equipment cost growth		-3,050		
19 ITEMS LESS THAN \$5 MILLION	127,554	123,388	121,030	118,808
FFG-7 class diesel cost growth		-494		-494
CVN Smartship modification cost growth		-1,369		-1,369
CVN auto voltage regulators ahead of need		-3,600		-3,600
AS-39 elevator upgrade ahead of need		-703		-703
Secure Remote Monitoring Systems		2,000		1,600
Canned Lube Pumps LHD-1 Class			1,000	800
Remote Monitoring and Troubleshooting Project			2,900	2,320
Auto voltage regulator reduction to growth			-3,124	
LPD-17 Forcenet installation ahead of need			-3,800	-3,800
Machinery Plant Upgrades installation ahead of need			-3,500	-3,500
25 STANDARD BOATS	35,318	37,318	68,518	52,018
Force Protection Boats (Small)		2,000	2,000	2,000
Range support craft recapitalization			25,000	8,500
Dive Boats			2,000	2,000
Fuel Oil Barge (YON)			4,200	4,200

P-1	Budget Request	House	Senate	Recommendation
26 OTHER SHIPS TRAINING EQUIPMENT	15,113	13,507	15,113	13,507
Virginia class submarine air conditioner trainer cost growth		-1,606		-1,606
27 OPERATING FORCES IPE	47,172	47,172	51,372	51,372
Pearl Harbor Naval Shipyard Equipment Modernization			4,200	4,200
29 LCS MODULES	137,259	92,204	52,926	117,259
Mission Package Integration funding		-17,955		-12,000
Align Mission Package procurement with LCS schedule		-27,100		
Defer MCM Mission Package			-76,333	
RMS transfer to RDTE, Navy line number 32			-8,000	-8,000
30 LSD MIDLIFE	117,856	116,786	117,856	116,786
30 ton deck crane ahead of need		-1,070		-1,070
31 RADAR SUPPORT	9,968	13,968	9,968	13,168
Enhanced Detection Adjunct Processor		4,000		3,200
33 AN/SQQ-89 SURF ASW COMBAT SYSTEM	111,093	77,362	95,593	77,362
SQQ-89 backfit suites ahead of need		-23,250		-23,250
SQQ-89 backfit suites cost growth		-1,230		-1,230
SQQ-89 IPS suites ahead of need		-7,751		-7,751
Support funding carryover		-1,500		-1,500
Contract delay			-15,500	
34 SSN ACOUSTICS	299,962	291,832	303,962	297,682
TB-33 fiber optic array receivers cost growth		-1,850		
BQS-15A EC-20 processor cost growth		-1,590		-1,590
Phase III/IV technology insertion upgrade cost growth		-1,590		-1,590
Support funding carryover		-3,100		-3,100
TB-33 Thinline Towed Array			4,000	4,000
35 UNDERSEA WARFARE SUPPORT EQUIPMENT	38,705	30,548	38,705	30,548
CVN tactical support center modifications ahead of need		-8,157		-8,157
36 SONAR SWITCHES AND TRANSDUCERS	13,537	11,894	13,537	11,894
DT-699A and DT-592 component cost growth		-1,643		-1,643
37 SUBMARINE ACOUSTIC WARFARE SYSTEM	20,681	22,681	12,881	13,481
Hydroacoustic Low Frequency Source Generation Systems		2,000	1,000	1,600
Contract delays			-8,800	-8,800
38 SSTD	2,184	17,184	2,184	10,184
Program Increase		15,000		8,000
42 AN/SLQ-32	34,264	31,267	34,264	31,267
Support funding growth		-1,500		-1,500
Block 1B2 specific emitter identification systems ahead of need		-1,497		-1,497
43 SHIPBOARD IW EXPLOIT	105,883	106,883	88,883	89,683
AN/USQ-167 COMSEC Upgrade		1,000		800
SSEE Inc F slow production ramp			-16,000	-16,000
AIS funding carryover			-1,000	-1,000

P-1	Budget Request	House	Senate	Recommendation
44 SUBMARINE SUPPORT EQUIPMENT PROG	98,645	83,495	86,495	86,495
Multi-function Modular Mast units ahead of need		-15,150		
Multi-function Modular Mast contract delay			-15,150	-15,150
AN/BLQ-10A(V) Wideband Signal Processor			3,000	3,000
46 COOPERATIVE ENGAGEMENT CAPABILITY	30,522	28,922	30,522	28,922
Support funding carryover		-1,600		-1,600
49 ATDLS	7,314	7,314	4,314	4,314
Installation delays			-3,000	-3,000
50 MINESWEEPING SYSTEM REPLACEMENT	79,091	69,285	74,291	72,285
Magnetic silencing facility upgrades support funding growth		-5,000		-2,000
Remote minehunting system upgrades		-4,806		-4,806
RMS restructure			-4,800	
52 NAVSTAR GPS RECEIVERS (SPACE)	10,845	7,965	10,845	7,965
Anti-jam antennas ahead of need		-2,880		-2,880
55 OTHER TRAINING EQUIPMENT	36,784	35,654	36,784	35,654
Battle force tactical training and encryptor systems ahead of need		-1,130		-1,130
56 MATCALs	17,468	12,168	17,468	14,768
Air Surveillance and Precision Approach Radar cost growth		-5,300		-2,700
58 AUTOMATIC CARRIER LANDING SYSTEM	18,878	17,878	18,878	17,878
AN/URN-25 TACAN upgrade cost growth		-1,000		-1,000
64 DEPLOYABLE JOINT COMMAND AND CONTROL	8,719	11,719	8,719	11,119
Deployable Joint Command and Control Shelter Upgrade Program		3,000		2,400
73 ITEMS LESS THAN \$5 MILLION	65,760	57,706	68,760	60,106
AN/APA reliability kits ahead of need		-6,054		-6,054
Radar support growth		-2,000		-2,000
Radar Product Support System			3,000	2,400
76 SHIP COMMUNICATIONS AUTOMATION	310,605	263,625	290,305	282,105
Shipboard network systems ahead of need		-20,300		
SCI network modifications ahead of need		-6,200		-6,200
Digital network modifications ahead of need		-18,480		
Network operations center modifications ahead of need		-2,000		-2,000
ISNS Afloat early to need			-20,300	-20,300
78 COMMUNICATIONS ITEMS UNDER \$5M	25,314	25,314	26,554	26,054
HF ALE contract delay			-1,260	-1,260
Intelligraf Training and Maintenance Aid for Above Water Sensors			2,500	2,000
81 SATELLITE COMMUNICATIONS SYSTEMS	50,172	43,747	48,572	48,572
SUBHDR SHF modification kits ahead of need		-2,025		
Broadband satellite network modifications ahead of need		-4,400		
CBSP installation delays			-1,600	-1,600
82 NAVY MULTIBAND TERMINAL (NMT)	72,496	72,496	63,196	63,196
NMT Ship ahead of need			-9,300	-9,300

P-1	Budget Request	House	Senate	Recommendation
86 INFO SYSTEMS SECURITY PROGRAM (ISSP)	119,054	116,754	110,554	110,554
Computer network defense systems ahead of need		-2,300		
CND program delay			-4,000	-4,000
KMI ahead of need			-4,500	-4,500
90 SONOBUOYS - ALL TYPES	91,976	89,976	91,976	89,976
Production engineering carryover		-2,000		-2,000
91 WEAPONS RANGE SUPPORT EQUIPMENT	75,329	72,829	92,329	88,929
Production engineering carryover		-2,500		-1,000
Range Support Enhancements			15,000	13,000
Hawaiian Range Complex			2,000	1,600
94 AIRCRAFT LAUNCH & RECOVERY EQUIPMENT	48,670	44,849	46,849	39,806
ADMACS Block II upgrade cost growth		-1,821		
Production engineering carryover		-2,000		-2,000
ADMACS Block 2 program delay			-1,821	-6,864
95 METEOROLOGICAL EQUIPMENT	21,458	21,458	14,558	14,558
Defer METMF LRIP			-6,900	-6,900
97 AVIATION LIFE SUPPORT	27,367	29,867	32,367	30,367
Multi-Climate Protection System		2,500	8,000	6,400
Advanced Mission Extender Device Kits			2,000	1,600
JHMCS Night Vision contract delay			-5,000	-5,000
98 AIRBORNE MINE COUNTERMEASURES	55,408	55,408	51,408	51,408
AMNS funding carryover			-4,000	-4,000
100 PORTABLE ELECTRONIC MAINTENANCE AIDS	9,710	9,710	4,910	4,910
Reduction to growth			-4,800	-4,800
101 OTHER AVIATION SUPPORT EQUIPMENT	16,541	13,541	16,541	13,541
Program growth		-3,000		-3,000
105 RAM GMLS	7,762	7,762	8,762	8,762
RAM Mark 49 Mod 3 Launcher Obsolescence/Affordability			1,000	1,000
107 AEGIS SUPPORT EQUIPMENT	108,886	101,733	108,886	101,733
Smartship modifications ahead of need		-8,153		-8,153
Adaptive Diagnostic Electronic Portable Testset		1,000		1,000
111 SSN COMBAT CONTROL SYSTEMS	118,528	113,563	118,528	113,563
SSN 688 class technology insertion upgrade cost growth		-4,965		-4,965
117 ANTI-SHIP MISSILE DECOY SYSTEM	37,128	29,978	37,128	33,628
Nulka decoy cost growth		-7,150		-3,500
130 OTHER SUPPLY SUPPORT EQUIPMENT	6,368	6,368	10,368	9,568
Navy AIT Logistics Modernization			4,000	3,200
133 TRAINING SUPPORT EQUIPMENT	12,944	11,728	12,944	11,728
Continuing training environment equipment cost growth		-1,216		-1,216
134 COMMAND SUPPORT EQUIPMENT	55,267	51,682	52,267	48,682
MH/MOC upgrades cost growth		-3,585		-3,585
National Small Unit Center of Excellence			-3,000	-3,000

P-1	Budget Request	House	Senate	Recommendation
136 MEDICAL SUPPORT EQUIPMENT	5,517	2,092	5,517	5,517
Commercial broadband satellite program		-3,425		
141 ENVIRONMENTAL SUPPORT EQUIPMENT	18,183	18,183	16,488	16,488
Wx Detection Display and Shallow Water Seismic System ahead of need			-1,695	-1,695
142 PHYSICAL SECURITY EQUIPMENT	128,921	126,921	128,921	126,921
Maritime Civil Affairs Group Activities growth		-2,000		-2,000
143 ENTERPRISE INFORMATION TECHNOLOGY	79,747	87,247	65,747	70,747
SPAWAR Systems Center (SSC/ITC) New Orleans		7,500	1,000	6,000
Base Level Information Infrastructure contract delay			-15,000	-15,000

SHIP SERVICE TURBINE GENERATOR ROTORS

The budget request includes \$3,330,000 for an Ohio-class submarine Ship's Service Turbine Generator (SSTG) rotor. The recommendation provides no funds for the rotor because the procurement does not result in a usable end item in violation of the full funding policy. The Secretary of the Navy is

urged to submit a fiscal year 2010 reprogramming request that fully funds the SSTG rotor in order to support the planned installation schedule.

WEAPONS RANGE SUPPORT EQUIPMENT

Due to carryover of production engineering funding in the weapons range support equip-

ment program, the recommendation reduces the program by \$1,000,000. This reduction is to be applied only against the fiscal year 2010 production engineering funding and shall not reduce funds available for completion of auxiliary systems in support of Magnetic Silencing Facility military construction.

PROCUREMENT, MARINE CORPS

For Procurement, Marine Corps, funds are to be available for fiscal
year 2010, as follows:

(In thousands of dollars)				
	Budget	House	Senate	Recommendation
PROCUREMENT, MARINE CORPS				
WEAPONS AND COMBAT VEHICLES				
TRACKED COMBAT VEHICLES				
1 AAV7A1 PIP.....	9,127	9,127	6,154	6,154
2 LAV PIP.....	34,969	34,969	34,969	34,969
ARTILLERY AND OTHER WEAPONS				
5 EXPEDITIONARY FIRE SUPPORT SYSTEM.....	19,591	19,591	19,591	19,591
6 155MM LIGHTWEIGHT TOWED HOWITZER.....	7,420	---	7,420	7,420
7 HIGH MOBILITY ARTILLERY ROCKET SYSTEM.....	71,476	71,476	71,476	71,476
8 WEAPONS AND COMBAT VEHICLES UNDER \$5 MILLION.....	25,949	25,949	16,158	16,158
WEAPONS				
OTHER SUPPORT				
10 MODIFICATION KITS.....	33,990	34,990	33,990	34,790
11 WEAPONS ENHANCEMENT PROGRAM.....	22,238	22,238	22,238	22,238
TOTAL, WEAPONS AND COMBAT VEHICLES.....	224,760	218,340	211,996	212,796
GUIDED MISSILES AND EQUIPMENT				
GUIDED MISSILES				
12 GROUND BASED AIR DEFENSE.....	11,387	11,387	11,387	11,387
14 FOLLOW ON TO SHAW.....	25,333	25,333	---	---
15 ANTI-ARMOR WEAPONS SYSTEM-HEAVY (AAWS-H).....	71,225	71,225	71,225	71,225
OTHER SUPPORT				
16 MODIFICATION KITS.....	2,114	2,114	2,114	2,114
TOTAL, GUIDED MISSILES AND EQUIPMENT.....	110,059	110,059	84,726	84,726

(In thousands of dollars)

	Budget	House	Senate	Recommendation
COMMUNICATIONS AND ELECTRONICS EQUIPMENT				
COMMAND AND CONTROL SYSTEMS				
17 COMBAT OPERATIONS CENTER.....	19,832	19,832	19,832	19,832
REPAIR AND TEST EQUIPMENT				
18 REPAIR AND TEST EQUIPMENT.....	31,087	32,587	31,087	32,287
OTHER SUPPORT (TEL)				
19 COMBAT SUPPORT SYSTEM.....	11,368	11,368	11,368	11,368
21 ITEMS UNDER \$5 MILLION (COMM & ELEC).....	3,531	3,531	3,531	3,531
22 AIR OPERATIONS C2 SYSTEMS.....	45,084	45,084	45,084	45,084
RADAR + EQUIPMENT (NON-TEL)				
23 RADAR SYSTEMS.....	7,428	7,428	7,428	7,428
INTELL/COMM EQUIPMENT (NON-TEL)				
24 FIRE SUPPORT SYSTEM.....	2,580	2,580	2,580	2,580
25 INTELLIGENCE SUPPORT EQUIPMENT.....	37,581	37,581	33,270	33,270
26 RQ-11 UAV.....	42,403	42,403	28,580	28,580
OTHER COMM/ELEC EQUIPMENT (NON-TEL)				
27 NIGHT VISION EQUIPMENT.....	10,360	10,360	10,360	10,360
OTHER SUPPORT (NON-TEL)				
28 COMMON COMPUTER RESOURCES.....	115,263	115,263	115,263	115,263
29 COMMAND POST SYSTEMS.....	49,820	49,820	49,820	49,820
30 RADIO SYSTEMS.....	61,954	49,090	61,954	49,090
31 COMM SWITCHING & CONTROL SYSTEMS.....	98,254	92,254	98,254	92,254
32 COMM & ELEC INFRASTRUCTURE SUPPORT.....	15,531	15,531	15,531	15,531
TOTAL, COMMUNICATIONS AND ELECTRONICS EQUIPMENT.....	552,076	534,712	533,942	516,278

(In thousands of dollars)

	Budget	House	Senate	Recommendation
SUPPORT VEHICLES				
ADMINISTRATIVE VEHICLES				
33 COMMERCIAL PASSENGER VEHICLES.....	1,265	1,265	1,265	1,265
34 COMMERCIAL CARGO VEHICLES.....	13,610	13,610	13,610	13,610
TACTICAL VEHICLES				
35 5/4T TRUCK HMMWV (MYP).....	9,796	9,796	9,796	9,796
36 MOTOR TRANSPORT MODIFICATIONS.....	6,111	---	6,111	3,000
37 MEDIUM TACTICAL VEHICLE REPLACEMENT.....	10,792	10,792	10,792	10,792
38 LOGISTICS VEHICLE SYSTEM REP.....	217,390	220,390	217,390	217,390
39 FAMILY OF TACTICAL TRAILERS.....	26,497	26,497	19,070	21,470
40 TRAILERS.....	18,122	18,122	18,122	18,122
OTHER SUPPORT				
41 ITEMS LESS THAN \$5 MILLION.....	5,948	5,948	5,948	5,948
TOTAL, SUPPORT VEHICLES.....	309,531	306,420	302,104	301,393
ENGINEER AND OTHER EQUIPMENT				
ENGINEER AND OTHER EQUIPMENT				
42 ENVIRONMENTAL CONTROL EQUIP ASSORT.....	5,121	5,121	5,121	5,121
43 BULK LIQUID EQUIPMENT.....	13,035	13,035	16,135	16,135
44 TACTICAL FUEL SYSTEMS.....	35,059	35,059	35,059	35,059
45 POWER EQUIPMENT ASSORTED.....	21,033	21,033	31,033	30,033
46 AMPHIBIOUS SUPPORT EQUIPMENT.....	39,876	28,876	39,876	28,876
47 EOD SYSTEMS.....	93,335	93,335	93,335	93,335
MATERIALS HANDLING EQUIPMENT				
48 PHYSICAL SECURITY EQUIPMENT.....	12,169	13,169	12,169	13,169
49 GARRISON MOBILE ENGR EQUIP.....	11,825	11,825	11,825	11,825
50 MATERIAL HANDLING EQUIP.....	41,430	41,430	41,430	41,430
51 FIRST DESTINATION TRANSPORTATION.....	5,301	5,301	5,301	5,301

(In thousands of dollars)

	Budget	House	Senate	Recommendation

GENERAL PROPERTY				
52 FIELD MEDICAL EQUIPMENT.....	6,811	6,811	6,811	6,811
53 TRAINING DEVICES.....	14,854	14,854	14,854	14,854
54 CONTAINER FAMILY.....	3,770	3,770	3,770	3,770
55 FAMILY OF CONSTRUCTION EQUIPMENT.....	37,735	37,735	37,735	37,735
56 FAMILY OF INTERNALLY TRANSPORTABLE VEH (ITV).....	10,360	10,360	10,360	10,360
58 RAPID DEPLOYABLE KITCHEN.....	2,159	2,159	2,159	2,159
OTHER SUPPORT				
59 ITEMS LESS THAN \$5 MILLION.....	8,792	8,792	8,792	8,792

TOTAL, ENGINEER AND OTHER EQUIPMENT.....	362,665	352,665	375,765	364,765
60 SPARES AND REPAIR PARTS.....	41,547	41,547	41,547	41,547

TOTAL, PROCUREMENT, MARINE CORPS.....	1,600,638	1,563,743	1,550,080	1,521,505
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EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

P-1	Budget Request	House	Senate	Recommendation
1 AAV7A1 PIP	9,127	9,127	6,154	6,154
Survivability, C4I and Environment upgrade - funding ahead of need			-2,973	-2,973
6 155MM LIGHTWEIGHT TOWED HOWITZER	7,420	0	7,420	7,420
Items previously purchased in the fiscal year 2009 supplemental		-7,420		0
WEAPONS AND COMBAT VEHICLES UNDER \$5 8 MILLION	25,949	25,949	16,158	16,158
Multiple Shot Grenade Launcher contract award delays			-9,791	-9,791
10 MODIFICATION KITS	33,990	34,990	33,990	34,790
Microclimate Cooling Unit for M1 Abrams Tank		1,000		800
14 FOLLOW ON TO SMAW	25,333	25,333	0	0
Funding ahead of need			-25,333	-25,333
18 REPAIR AND TEST EQUIPMENT	31,087	32,587	31,087	32,287
Portable Military Radio Communications Test Set		1,500		1,200
25 INTELLIGENCE SUPPORT EQUIPMENT	37,581	37,581	33,270	33,270
Wide Field of View Persistent Surveillance - requirement suspended			-4,311	-4,311
26 RQ-11 UAV	42,403	42,403	28,580	28,580
Tier II UAS procurement funding ahead of need			-13,823	-13,823
30 RADIO SYSTEMS	61,954	49,090	61,954	49,090
Unjustified miscellaneous funding requirements		-12,864		-12,864
31 COMM SWITCHING & CONTROL SYSTEMS	98,254	92,254	98,254	92,254
Items previously purchased in the fiscal year 2009 supplemental		-6,000		-6,000
36 MOTOR TRANSPORT MODIFICATIONS	6,111	0	6,111	3,000
Items previously purchased in the fiscal year 2009 supplemental		-6,111		-3,111
38 LOGISTICS VEHICLE SYSTEM REPLACEMENT	217,390	220,390	217,390	217,390
Marine Corps MK 1077 Flatracks (Transferred to line number 39)		3,000		0
39 FAMILY OF TACTICAL TRAILERS	26,497	26,497	19,070	21,470
Flat Rack Refueling capability - production delays			-7,427	-7,427
Marine Corps MK 1077 Flatracks (Transferred from line number 38)				2,400
43 BULK LIQUID EQUIPMENT	13,035	13,035	16,135	16,135
Nitrile Rubber Collapsible Fuel Bladders			3,100	3,100
45 POWER EQUIPMENT ASSORTED	21,033	21,033	31,033	30,033
On Board Vehicle Power Kits for USMC MTRV Trucks			10,000	9,000

P-1		Budget Request	House	Senate	Recommendation
46	AMPHIBIOUS SUPPORT EQUIPMENT	39,876	28,876	39,876	28,876
	Items previously purchased in the fiscal year 2009 supplemental		-11,000		-11,000
48	PHYSICAL SECURITY EQUIPMENT	12,169	13,169	12,169	13,169
	Portable Armored Wall System		1,000		1,000

AIRCRAFT PROCUREMENT, AIR FORCE

For Aircraft Procurement, Air Force, funds are to be available for
fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
AIRCRAFT PROCUREMENT, AIR FORCE				
COMBAT AIRCRAFT				
TACTICAL FORCES				
1 F-35.....	2,048,830	2,067,430	2,048,830	2,083,830
2 F-35 (AP-CY).....	300,600	278,600	278,600	278,600
3 F-22A.....	95,163	31,163	95,163	95,163
4 F-22A (AP-CY).....	---	368,800	---	---
TOTAL, COMBAT AIRCRAFT.....	2,444,593	2,745,993	2,422,593	2,457,593
AIRLIFT AIRCRAFT				
TACTICAL AIRLIFT				
5 C-17A (MYP).....	88,510	762,610	2,588,510	2,588,510
OTHER AIRLIFT				
6 C-130J.....	285,632	285,632	285,632	285,632
7 C-130J ADVANCE PROCUREMENT (CY).....	108,000	108,000	108,000	108,000
8 HC/MC-130 RECAP.....	879,231	375,231	375,231	375,231
9 HC/MC-130 RECAP (AP-CY).....	137,360	137,360	137,360	137,360
10 JOINT CARGO AIRCRAFT.....	319,050	319,050	319,050	319,050
TOTAL, AIRLIFT AIRCRAFT.....	1,817,783	1,987,883	3,813,783	3,813,783
TRAINER AIRCRAFT				
11 USAFA POWERED FLIGHT PROGRAM.....	4,144	4,144	4,144	4,144
OPERATIONAL TRAINERS				
12 JPATS.....	15,711	15,711	15,711	15,711
OTHER AIRCRAFT				
HELICOPTERS				
13 V-22 OSPREY.....	437,272	437,272	437,272	437,272
14 V-22 OSPREY (AP-CY).....	13,835	13,835	13,835	13,835
14A HH-60H.....	---	140,000	75,000	95,200
MISSION SUPPORT AIRCRAFT				
21 C-37.....	66,400	199,200	66,400	66,400
17 C-40.....	154,044	354,044	154,044	154,044
18 CIVIL AIR PATROL A/C.....	2,426	7,426	2,426	6,426

(In thousands of dollars)

	Budget	House	Senate	Recommendation
<hr/>				
OTHER AIRCRAFT				
20 TARGET DRONES.....	78,511	78,511	74,711	74,711
22 GLOBAL HAWK.....	554,775	275,118	554,775	554,775
23 GLOBAL HAWK (AP-CY).....	113,049	63,049	113,049	113,049
25 MQ-9.....	489,469	489,469	489,469	489,469
23 TOTAL, OTHER AIRCRAFT.....	1,909,781	2,057,924	1,980,981	2,005,181
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MODIFICATION OF INSERVICE AIRCRAFT				
STRATEGIC AIRCRAFT				
26 B-2A.....	283,955	264,155	247,855	247,855
28 B-1B.....	107,558	78,558	78,558	78,558
29 B-52.....	78,788	61,466	61,466	61,466
TACTICAL AIRCRAFT				
30 A-10.....	252,488	252,488	252,488	252,488
31 F-15.....	92,921	132,271	92,921	119,171
32 F-16.....	224,642	221,875	223,875	223,475
33 F-22A.....	350,735	187,295	177,335	177,335
AIRLIFT AIRCRAFT				
34 C-5.....	606,993	550,414	561,893	561,893
35 C-5 (AP-CY).....	108,300	108,300	108,300	108,300
36 C-9C.....	10	10	10	10
37 C-17A.....	469,731	317,174	424,431	352,331
38 C-21.....	562	562	562	562
39 C-32A.....	10,644	10,644	1,744	1,744
40 C-37A.....	4,336	4,336	436	436
TRAINER AIRCRAFT				
41 GLIDER MODS.....	119	119	119	119
42 T6.....	33,074	33,074	33,074	33,074
43 T-1.....	35	35	35	35
44 T-38.....	75,274	61,057	61,057	61,057
OTHER AIRCRAFT				
46 KC-10A (ATCA).....	9,441	9,441	9,441	9,441
47 C-12.....	472	472	472	472
48 MC-12W.....	63,000	63,000	63,000	63,000
49 C-20 MODS.....	734	734	734	734
50 VC-25A MOD.....	15,610	15,610	15,610	15,610
51 C-40.....	9,162	9,162	262	262

(In thousands of dollars)

	Budget	House	Senate	Recommendation
52 C-130.....	354,421	99,965	146,171	181,675
53 C130J MODS.....	13,627	13,627	8,527	8,527
54 C-135.....	150,425	119,725	150,425	131,625
55 COMPASS CALL MODS.....	29,187	29,187	29,187	29,187
56 DARP.....	107,859	54,810	107,859	107,859
57 E-3.....	79,263	79,263	79,263	79,263
58 E-4.....	73,058	73,058	73,058	73,058
59 E-8.....	225,973	225,973	21,073	75,073
60 H-1.....	18,280	18,280	18,280	18,280
61 H-60.....	14,201	115,401	14,201	64,201
62 GLOBAL HAWK MODS.....	134,864	134,864	134,864	134,864
63 HC/MC-130 MODIFICATIONS.....	1,964	1,964	1,964	1,964
64 OTHER AIRCRAFT.....	103,274	103,274	103,274	103,274
65 MQ-1 MODS.....	123,889	144,889	123,889	123,889
66 MQ-9 MODS.....	48,837	54,037	48,837	48,837
67 CV-22 MODS.....	24,429	24,429	24,429	24,429
OTHER MODIFICATIONS				
TOTAL, MODIFICATION OF INSERVICE AIRCRAFT.....	4,302,135	3,674,998	3,500,979	3,575,433
AIRCRAFT SPARES AND REPAIR PARTS				
68 INITIAL SPARES/REPAIR PARTS.....	418,604	487,604	418,604	456,604
TOTAL, AIRCRAFT SPARES AND REPAIR PARTS.....	418,604	487,604	418,604	456,604
AIRCRAFT SUPPORT EQUIPMENT AND FACILITIES				
COMMON SUPPORT EQUIPMENT				
69 AIRCRAFT REPLACEMENT SUPPORT EQUIP.....	105,820	105,820	115,820	106,820
POST PRODUCTION SUPPORT				
70 B-1.....	3,929	3,929	3,929	3,929
72 B-2A.....	24,481	24,481	24,481	24,481
73 C-5.....	2,259	2,259	2,259	2,259
74 C-5.....	11,787	11,787	11,787	7,787
75 KC-10A (ATCA).....	4,125	4,125	4,125	4,125
76 C-17A.....	91,400	---	---	---
77 C-130.....	28,092	28,092	28,092	28,092
78 EC-130J.....	5,283	5,283	5,283	5,283
78A B-2 POST PRODUCTION.....	---	19,800	19,800	19,800

(In thousands of dollars)

	Budget	House	Senate	Recommendation
79 F-15 POST PRODUCTION SUPPORT.....	15,744	15,744	15,744	15,744
80 F-16 POST PRODUCTION SUPPORT.....	19,951	19,951	12,951	12,951
81 OTHER AIRCRAFT.....	51,980	51,980	51,980	51,980
INDUSTRIAL PREPAREDNESS.....				
83 INDUSTRIAL PREPAREDNESS.....	25,529	25,529	25,529	25,529
WAR CONSUMABLES				
84 WAR CONSUMABLES.....	134,427	134,427	136,427	136,027
OTHER PRODUCTION CHARGES				
85 OTHER PRODUCTION CHARGES.....	490,344	490,344	495,344	483,844
DARP				
88 DARP.....	15,323	15,323	15,323	15,323
TOTAL, AIRCRAFT SUPPORT EQUIPMENT AND FACILITIES....	1,030,474	958,874	968,874	943,974
999 CLASSIFIED PROGRAMS.....	23,051	23,051	23,051	23,051
TOTAL, AIRCRAFT PROCUREMENT, AIR FORCE.....	11,966,276	11,956,182	13,148,720	13,295,474

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

P-1	Budget Request	House	Senate	Recommendation
1 F-35	2,048,830	2,067,430	2,048,830	2,083,830
Reduction to non-recurring engineering		-111,400		0
Alternate Engine		130,000		35,000
2 F-35 (AP-CY)	300,600	278,600	278,600	278,600
Reduction of two aircraft previously funded in fiscal year 2009		-22,000	-22,000	-22,000
3 F-22A	95,163	31,163	95,163	95,163
Program reduction		-64,000		0
4 F-22A (AP-CY)	0	368,800	0	0
Advance Procurement for 12 aircraft		368,800		0
5 C-17A (MYP)	88,510	762,610	2,588,510	2,588,510
Program Increase - Provides for 10 C-17A aircraft		674,100	2,500,000	2,500,000
8 HC/MC-130 RECAP	879,231	375,231	375,231	375,231
Funded in fiscal year 2009 supplemental		-504,000	-504,000	-504,000
XX HH-60M		140,000	75,000	95,200
Program Increase - Provides for four HH-60M aircraft for combat loss replacement		140,000	75,000	95,200
21 C-37	66,400	199,200	66,400	66,400
Program Increase - C-37B (Note: One aircraft each for the 201st Airlift Squadron and 89th Airlift Wing)		132,800		0
17 C-40	154,044	354,044	154,044	154,044
Program Increase - Two C-40C for Scott Air Force Base		200,000		0
18 CIVIL AIR PATROL A/C	2,426	7,426	2,426	6,426
Civil Air Patrol		5,000		4,000
20 TARGET DRONES	78,511	78,511	74,711	74,711
Pricing adjustment			-3,800	-3,800
22 GLOBAL HAWK	554,775	275,118	554,775	554,775
Block 40 Program Delay		-279,657		0
23 GLOBAL HAWK (AP-CY)	113,049	63,049	113,049	113,049
Unjustified program growth		-50,000		0
26 B-2A	283,955	264,155	247,855	247,855
Air Force requested transfer to line number 78A B-2 Post Production Support for the B-2 Weapon System Support Center		-19,800	-19,800	-19,800
Funding requested ahead of need			-16,300	-16,300
28 B-1B	107,558	78,558	78,558	78,558
Program delay for various programs - Funding transferred to RDT&E, Air Force Line number 119		-29,000	-29,000	-29,000

P-1	Budget Request	House	Senate	Recommendation
29 B-52	78,788	61,466	61,466	61,466
Air Force identified excess		-17,322	-17,322	-17,322
31 F-15	92,921	132,271	92,921	119,171
Funding installs ahead of need - Digital Video Recorder Installs		-3,250		-3,250
Program growth - Low Cost Mods for Other Government Costs		-1,000		-500
Program Increase - Advanced Radar Development for Active and ANG aircraft		43,600		30,000
32 F-16	224,642	221,875	223,875	223,475
Funding ahead of need - BLOS Installs		-2,767	-2,767	-2,767
ARC 210 Radios for ANG F-16s			2,000	1,600
33 F-22A	350,735	187,295	177,335	177,335
Common Configuration - Early to need		-158,399	-158,400	-158,400
Warfighter Urgent Requirements		-5,041		
Insufficient justification			-15,000	-15,000
34 C-5	606,993	550,414	561,893	561,893
Unjustified program		-56,579	-28,000	-28,000
Excessive Other Government costs			-10,000	-10,000
Excess in C-5 AMP program			-7,100	-7,100
37 C-17A	469,731	317,174	424,431	352,331
Reduction for Other Government Costs - LAIRCM		-4,023		0
Excess install funding for Pylon Stubs		-800		0
Funding prior to installs ELT Frequency Change		-1,586		0
Excess install funding for Block 13 to 17 Retrofits		-115,748		0
Excess install funding for OBIGGS II		-7,700		0
Excess install funding for Extended Range Retrofit		-22,700		0
Funding requested ahead of need			-45,300	-133,400
LAIRCM for the ANG (Transferred from House General Provision 8120)				16,000
39 C-32A	10,644	10,644	1,744	1,744
Contract delay			-8,900	-8,900
40 C-37A	4,336	4,336	436	436
Contract delay			-3,900	-3,900
44 T-38	75,274	61,057	61,057	61,057
Improved Brake System Program Termination		-14,217	-14,217	-14,217
51 C-40	9,162	9,162	262	262
Contract delay			-8,900	-8,900
52 C-130	354,421	99,965	146,171	181,675
Reduction due to low execution		-209,509	-209,500	-209,500
Centerwing Replacements - Early to need		-42,846	-19,000	-42,846
LAIRCM - Other Government Cost		-5,101		0
C-130 Active Noise Cancellation System		3,000		2,400

P-1	Budget Request	House	Senate	Recommendation
Scathe View Hyper-Spectral Imagery Upgrade for Nevada ANG (Includes transfer from Other Procurement, Air Force line number 45)			4,500	3,600
Senior Scout, Electro-Optical Infrared Capability			6,000	4,800
Senior Scout, Line of Sight Datalink			3,000	2,400
Senior Scout, Remote Operations Capability			3,000	2,400
Support Equipment for Time Critical Targeting, Senior Scout			3,750	3,000
LAIRCM for ANG HC/MC-130 aircraft (Transferred from House General Provision 8120)				33,000
Air Force requested transfer from RDT&E, Air Force line number 218 for avionics modernization of special mission aircraft				28,000
53 C130J MODS	13,627	13,627	8,527	8,527
Excess funding for other government costs			-5,100	-5,100
54 C-135	150,425	119,725	150,425	131,625
Excess program funding		-32,200		-20,000
Large Aircraft Podded Infrared Countermeasures Systems for Air Force Reserve KC-135		1,500		1,200
56 DARP	107,859	54,810	107,859	107,859
Reduction for installs		-53,049		0
59 E-8	225,973	225,973	21,073	75,073
Partial transfer of re-engining funds to RDT&E, Air Force line number 157			-204,900	-150,900
61 H-60	14,201	115,401	14,201	64,201
Program Increase - HH-60G Machine Gun		20,200		10,000
Program Increase - HH-60G Forward Looking Infrared Radar		81,000		40,000
65 MQ-1 MODS	123,889	144,889	123,889	123,889
Program Increase		21,000		0
66 MQ-9 MODS	48,837	54,037	48,837	48,837
Program Increase		5,200		0
68 INITIAL SPARES/REPAIR PARTS	418,604	487,604	418,604	456,604
ANG Block 42 F-16 Engine Upgrade		69,000		38,000
69 AIRCRAFT REPLACEMENT SUPPORT EQUIP	105,820	105,820	115,820	106,820
Initiate depot repair capability for Predator			10,000	10,000
Program reduction				-9,000
74 C-5	11,787	11,787	11,787	7,787
Program Reduction				-4,000
76 C-17A	91,400	0	0	0
Program Reduction		-91,400	-91,400	-91,400

P-1	Budget Request	House	Senate	Recommendation
78A B-2 POST PRODUCTION SUPPORT		19,800	19,800	19,800
Air Force requested transfer from line number 26 for the B-2 Weapon System Support Center		19,800	19,800	19,800
80 F-16 POST PRODUCTION SUPPORT	19,951	19,951	12,951	12,951
Funding requested ahead of need			-7,000	-7,000
84 WAR CONSUMABLES	134,427	134,427	136,427	136,027
Miniature Air-Launched Decoy			2,000	1,600
85 OTHER PRODUCTION CHARGES	490,344	490,344	495,344	483,844
LITENING 4th Generation Kit Upgrades			2,000	2,000
P5CTS Equipment for the MT Joint Training Environment (Transferred to RDT&E, Air Force line number 81)			3,000	
Advance Targeting Pods (Transferred from House General Provision 8120)				18,500
Program Reduction				-27,000

C-17 GLOBEMASTER III

The recent actions of the Air Force to address and curtail the wide use of undefinitized contract actions (UCA) are encouraging. To further encourage a sense of urgency to reduce the number of UCAs, bill language has been included that limits obligations for modifications until all C-17 UCAs funded with prior year "Aircraft Procurement, Air Force" funds are definitized or certifications of need are made by the Secretary of the Air Force.

The Under Secretary of Defense (Acquisition, Technology and Logistics) (USD(AT&L)) is directed to review contracting procedures within the Air Force and provide a report to the congressional defense committees not later than 90 days after en-

actment of this Act detailing a strategy to reduce current and minimize further undefinitized contracts in the Air Force. Additionally, the USD(AT&L) is directed to provide to the congressional defense committees a consolidated list of undefinitized contracts within the Department of Defense by November 15 and April 15 of each year.

The recommendation provides an additional \$2,500,000,000 for the procurement of ten C-17 aircraft, associated spares, support equipment and training equipment as required.

OPERATIONAL SUPPORT AND VIP SPECIAL
AIRLIFT MISSION AIRCRAFT

The recommendation includes \$220,444,000 for operational support and VIP special mission aircraft, which is the amount and quan-

tity requested by the President. The Department of Defense maintains a number of aircraft to provide safe and secure transportation for senior government officials as well as the Combatant Commanders and other senior military leadership. The fleet of aircraft is aging creating maintenance and reliability issues. For example, the Department of Defense grounded the C-9 aircraft within the fleet due to several safety of flight issues. Accordingly, the Secretary of Defense is directed to provide a report on the health of the fleet, inventory requirements and the plans to sustain and upgrade the aircraft in the future to the congressional defense committees, within 90 days after enactment of this Act.

MISSILE PROCUREMENT, AIR FORCE

For Missile Procurement, Air Force, funds are to be available for
fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
MISSILE PROCUREMENT, AIR FORCE				
BALLISTIC MISSILES				
MISSILE REPLACEMENT EQUIPMENT - BALLISTIC				
1 MISSILE REPLACEMENT EQ-BALLISTIC.....	58,139	58,139	58,139	58,139
OTHER MISSILES				
TACTICAL				
2 JASSM.....	52,666	52,666	52,666	52,666
3 SIDEWINDER (AIM-9X).....	78,753	78,753	78,753	78,753
4 AMRAAM.....	291,827	282,827	275,497	273,497
5 PREDATOR HELLFIRE MISSILE.....	79,699	64,530	57,545	57,545
6 SMALL DIAMETER BOMB.....	134,801	134,801	134,801	134,801
INDUSTRIAL FACILITIES				
7 INDUSTRIAL PREPAREDNESS/POLLUTION PREVENTION.....	841	841	841	841
TOTAL, OTHER MISSILES.....	638,587	614,418	600,103	598,103
MODIFICATION OF INSERVICE MISSILES				
CLASS IV				
8 ADVANCED CRUISE MISSILE.....	32	32	32	32
9 MM III MODIFICATIONS.....	199,484	199,484	199,484	199,484
10 AGM-65D MAVERICK.....	258	258	258	258
11 AGM-88A HARM.....	30,280	30,280	30,280	30,280
TOTAL, MODIFICATION OF INSERVICE MISSILES.....	230,054	230,054	230,054	230,054

(In thousands of dollars)

	Budget	House	Senate	Recommendation
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SPARES AND REPAIR PARTS				
13 INITIAL SPARES/REPAIR PARTS.....	70,185	70,185	70,185	70,185
OTHER SUPPORT				
SPACE PROGRAMS				
14 ADVANCED EHF.....	1,843,475	1,843,475	1,843,475	1,843,475
16 WIDEBAND GAPFILLER SATELLITES.....	201,671	626,671	151,671	151,671
17 WIDEBAND GAPFILLER SATELLITES (AP-CY).....	62,380	62,380	62,380	62,380
18 SPACEBORNE EQUIP (COMSEC).....	9,871	9,871	9,871	9,871
19 GLOBAL POSITIONING (SPACE).....	53,140	53,140	53,140	53,140
22 DEF METEOROLOGICAL SAT PROG (SPACE).....	97,764	97,764	97,764	97,764
24 EVOLVED EXPENDABLE LAUNCH VEH (SPACE).....	1,295,325	1,351,015	1,189,925	1,102,125
26 SBIR HIGH (SPACE) (AP-CY).....	307,456	307,456	307,456	307,456
27 SBIR HIGH (SPACE).....	159,000	159,000	159,000	159,000
28 NATL POLAR-ORBITING OP ENV SATELLITE.....	3,900	3,900	3,900	3,900
SPECIAL PROGRAMS				
29 DEFENSE SPACE RECONN PROGRAM.....	105,152	105,152	105,152	105,152
31 SPECIAL UPDATE PROGRAMS.....	311,070	311,070	311,070	311,070
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TOTAL, OTHER SUPPORT.....	4,450,204	4,930,894	4,294,804	4,207,004
999 CLASSIFIED PROGRAMS.....	853,559	604,669	817,059	832,059
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TOTAL, MISSILE PROCUREMENT, AIR FORCE.....	6,300,728	6,508,359	6,070,344	5,995,544
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EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

P-1		Budget Request	House	Senate	Recommendation
4	AMRAAM	291,827	282,827	275,497	273,497
	Funding ahead of need for DMS		-9,000	-5,000	-7,000
	Training Equipment Program Reduction			-11,330	-11,330
5	PREDATOR HELLFIRE MISSILE	79,699	64,530	57,545	57,545
	Updated pricing		-15,169	-22,154	-22,154
16	WIDEBAND GAPFILLER SATELLITES	201,671	626,671	151,671	151,671
	Program delay		-50,000		0
	WGS-7, full funding		475,000		0
	Premature Request - transferred to RDT&E, Air Force line number 61A			-50,000	-50,000
24	EVOLVED EXPENDABLE LAUNCH VEH (SPACE)	1,295,325	1,351,015	1,189,925	1,102,125
	Reduction for AFSPC-4 and GPS IIF-8 boosters		-193,200		-193,200
	ELC transfer from classified programs		248,890		0
	Reduction for AFSPC-4			-105,400	0
999	CLASSIFIED PROGRAMS	853,559	604,669	817,059	832,059
	Classified adjustment		-248,890	-36,500	-21,500

EVOLVED EXPENDABLE LAUNCH VEHICLE

There is concern that the Air Force has not established a robust process for managing content on the Evolved Expendable Launch Vehicle (EELV) Launch Capabilities contract. Therefore, the Secretary of the Air Force is directed to establish a formal systems engineering process which includes the National Reconnaissance Office as the func-

tional manager for space launch for the Intelligence Community, as a voting member, in order to prioritize and manage all efforts encompassed by the EELV Launch Capabilities contract.

MULTI-SATELLITE VEHICLE PROCUREMENT STRATEGIES

The language on multi-satellite vehicle procurement strategy as described in House

Report 111-230 is supported in the recommendation. In addition to the programs listed in House Report 111-230, the five year investment strategy is also directed to consider Wideband Global Satellite and Advanced Extremely High Frequency satellite systems for future multi-vehicle purchases.

PROCUREMENT OF AMMUNITION, AIR FORCE

For Procurement of Ammunition, Air Force, funds are to be available
for fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
PROCUREMENT OF AMMUNITION, AIR FORCE				
1 PROCUREMENT OF AMMO, AIR FORCE				
ROCKETS.....	43,461	40,661	43,461	40,661
2 CARTRIDGES.....	123,886	123,886	123,886	123,886
BOMBS				
3 PRACTICE BOMBS.....	52,459	52,459	52,459	52,459
4 GENERAL PURPOSE BOMBS.....	225,145	215,424	226,145	217,249
5 JOINT DIRECT ATTACK MUNITION.....	103,041	103,041	92,825	92,825
FLARE, IR MJU-7B				
6 CAD/PAD.....	40,522	40,522	40,522	40,522
7 EXPLOSIVE ORDNANCE DISPOSAL (EOD).....	3,302	3,302	3,302	3,302
8 SPARES AND REPAIR PARTS.....	4,582	4,582	4,582	4,582
9 MODIFICATIONS.....	1,289	1,289	1,289	1,289
10 ITEMS LESS THAN \$5,000,000.....	5,061	5,061	5,061	5,061
FUZES				
11 FLARES.....	152,515	152,515	152,515	152,515
12 FUZES.....	61,037	61,037	61,037	61,037
TOTAL, PROCUREMENT OF AMMO, AIR FORCE.....	816,300	803,779	809,084	795,388
WEAPONS				
13 SMALL ARMS.....	6,162	6,162	6,162	6,162
TOTAL, PROCUREMENT OF AMMUNITION, AIR FORCE.....	822,462	809,941	815,246	801,550

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

P-1	Budget Request	House	Senate	Recommendation
1 ROCKETS	43,461	40,661	43,461	40,661
Rockets (2.75 Rocket Motor) Inflation Adjustment		-1,400		-1,400
Rockets (2.75 WHD SP Smoke) Inflation Adjustment		-1,400		-1,400
4 GENERAL PURPOSE BOMBS	225,145	214,849	228,145	217,249
BLU-109 2000 Pound Hard Target Bomb Inflation Adjustment		-8,721		-8,721
BLU-117 2000 Pound Hard Target Bomb Inflation Adjustment		-575		-575
MCAAP Bomb Line Modernization (Note: Includes transfer from Procurement of Ammunition, Army line number 36)			3,000	2,400
5 JOINT DIRECT ATTACK MUNITION	103,041	103,041	92,825	92,825
Unit Cost Adjustment			-10,216	-10,216

OTHER PROCUREMENT, AIR FORCE

For Other Procurement, Air Force, funds are to be available for fiscal
year 2010, as follows:

(In thousands of dollars)				
	Budget	House	Senate	Recommendation
OTHER PROCUREMENT, AIR FORCE				
VEHICULAR EQUIPMENT				
PASSENGER CARRYING VEHICLES				
2 PASSENGER CARRYING VEHICLE.....	18,163	---	18,163	18,163
CARGO + UTILITY VEHICLES				
2 FAMILY MEDIUM TACTICAL VEHICLE.....	25,922	25,922	25,922	25,922
3 CAP VEHICLES.....	897	897	897	897
SPECIAL PURPOSE VEHICLES				
4 SECURITY AND TACTICAL VEHICLES.....	44,603	44,603	44,603	44,603
FIRE FIGHTING EQUIPMENT				
5 FIRE FIGHTING/CRASH RESCUE VEHICLES.....	27,760	27,760	27,760	27,760
MATERIALS HANDLING EQUIPMENT				
BASE MAINTENANCE SUPPORT				
7 RUNWAY SNOW REMOVAL & CLEANING EQUIP.....	24,884	24,884	26,029	25,800
8 ITEMS LESS THAN \$5M.....	57,243	40,243	41,667	41,362
TOTAL, VEHICULAR EQUIPMENT.....	199,472	164,309	185,041	184,527
ELECTRONICS AND TELECOMMUNICATIONS EQUIP				
COMM SECURITY EQUIPMENT (COMSEC)				
9 COMSEC EQUIPMENT.....	209,249	209,249	209,249	209,249
10 MODIFICATIONS (COMSEC).....	1,570	1,570	1,570	1,570
INTELLIGENCE PROGRAMS				
11 INTELLIGENCE TRAINING EQUIPMENT.....	4,230	4,230	4,230	4,230
12 INTELLIGENCE COMM EQUIP.....	21,965	27,965	24,965	29,165
ELECTRONICS PROGRAMS				
13 TRAFFIC CONTROL/LANDING.....	22,591	22,591	22,591	22,591
14 NATIONAL AIRSPACE SYSTEM.....	47,670	47,670	47,670	47,670
15 THEATER AIR CONTROL SYS IMPRO.....	56,776	56,776	56,776	56,776
16 WEATHER OBSERVATION FORECAST.....	19,357	19,357	19,357	19,357
17 STRATEGIC COMMAND AND CONTROL.....	35,116	35,116	35,116	35,116
18 CHEYENNE MOUNTAIN COMPLEX.....	28,608	28,608	28,608	28,608
19 DRUG INTERDICTION SUPPORT.....	452	452	---	---

(In thousands of dollars)

	Budget	House	Senate	Recommendation
SPECIAL COMM-ELECTRONICS PROJECTS				
20 GENERAL INFORMATION TECHNOLOGY.....	111,282	116,782	111,282	115,982
21 AF GLOBAL COMMAND & CONTROL SYSTEM.....	15,499	15,499	15,499	15,499
22 MOBILITY COMMAND AND CONTROL.....	8,610	8,610	8,610	8,610
23 AIR FORCE PHYSICAL SECURITY SYSTEM.....	137,293	77,293	77,293	77,293
24 COMBAT TRAINING RANGES.....	40,633	41,633	73,133	66,513
25 C3 COUNTERMEASURES.....	8,177	8,177	8,177	8,177
26 GCSS-AF FOS.....	81,579	37,079	81,579	37,079
27 THEATER BATTLE MGT C2 SYS.....	29,687	29,687	29,687	29,687
28 AIR OPERATIONS CENTER (AOC).....	54,093	54,093	54,093	58,093
AIR FORCE COMMUNICATIONS				
29 BASE INFORMATION INFRASTRUCTURE.....	433,859	333,859	384,859	333,859
30 USCENTCOM.....	38,958	38,958	38,958	38,958
DISA PROGRAMS				
32 SPACE BASED IR SENSOR PROG SPACE.....	34,440	34,440	2,000	2,000
33 NAVSTAR GPS SPACE.....	6,415	6,415	6,415	6,415
34 NUDET DETECTION SYS (NDS) SPACE.....	15,436	15,436	15,436	15,436
35 AF SATELLITE CONTROL NETWORK SPACE.....	58,865	58,865	58,865	58,865
36 SPACELIFT RANGE SYSTEM SPACE.....	100,275	100,275	100,275	100,275
37 MILSATCOM SPACE.....	110,575	110,575	108,075	108,075
38 SPACE MODS SPACE.....	30,594	30,594	30,594	30,594
39 COUNTERSPACE SYSTEM.....	29,793	29,793	29,793	29,793
ORGANIZATION AND BASE				
40 TACTICAL C-E EQUIPMENT.....	240,890	207,890	207,890	207,890
41 COMBAT SURVIVOR EVADER LOCATER.....	35,029	35,029	35,029	35,029
42 RADIO EQUIPMENT.....	15,536	15,536	15,536	15,536
44 CCTV/AUDIOVISUAL EQUIPMENT.....	12,961	12,961	12,961	12,961
45 BASE COMM INFRASTRUCTURE.....	121,049	122,049	121,049	121,049
50 ITEMS LESS THAN \$5M.....	---	3,000	---	2,400
MODIFICATIONS				
46 COMM ELECT MODS.....	64,087	64,087	64,087	64,087
TOTAL, ELECTRONICS AND TELECOMMUNICATIONS EQUIP.....	2,283,199	2,062,199	2,141,307	2,054,487

(In thousands of dollars)

	Budget	House	Senate	Recommendation
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OTHER BASE MAINTENANCE AND SUPPORT EQUIP				
PERSONAL SAFETY AND RESCUE EQUIP				
47 NIGHT VISION GOGGLES.....	28,226	28,226	28,226	28,226
48 ITEMS LESS THAN \$5,000,000 (SAFETY).....	17,223	17,223	17,223	17,223
DEPOT PLANT + MATERIALS HANDLING EQ				
49 MECHANIZED MATERIAL HANDLING.....	15,449	15,449	15,449	15,449
BASE SUPPORT EQUIPMENT				
50 BASE PROCURED EQUIPMENT.....	14,300	14,300	14,300	14,300
51 CONTINGENCY OPERATIONS.....	22,973	10,000	10,000	10,000
52 PRODUCTIVITY CAPITAL INVESTMENT.....	3,020	3,020	3,020	3,020
53 MOBILITY EQUIPMENT.....	32,855	32,855	28,355	28,355
54 ITEMS LESS THAN \$5M (BASE SUPPORT).....	8,195	8,195	8,195	8,195
SPECIAL SUPPORT PROJECTS				
56 DARP RC135.....	23,132	23,132	23,132	23,132
57 DISTRIBUTED GROUND SYSTEMS.....	293,640	293,640	293,640	293,640
59 SPECIAL UPDATE PROGRAM.....	471,234	471,234	471,234	471,234
60 DEFENSE SPACE RECONNAISSANCE PROGRAM.....	30,041	30,041	30,041	30,041
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TOTAL, OTHER BASE MAINTENANCE AND SUPPORT EQUIP.....	960,288	947,315	942,815	942,815
SPARE AND REPAIR PARTS				
61 SPARES AND REPAIR PARTS.....	19,460	19,460	19,460	19,460
999 CLASSIFIED PROGRAMS.....	13,830,722	13,690,508	13,995,177	13,936,950
<hr/>				
TOTAL, OTHER PROCUREMENT, AIR FORCE.....	17,293,141	16,883,791	17,283,800	17,138,239
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EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

P-1	Budget Request	House	Senate	Recommendation
7 RUNWAY SNOW REMOVAL & CLEANING EQUIP	24,884	24,884	26,029	25,800
Mission Essential Airfield Operations Equipment			1,145	916
8 ITEMS LESS THAN \$5M	57,243	40,243	41,667	41,382
Reduce program growth		-17,000	-17,000	-17,000
Mission Essential Airfield Operations Equipment			1,424	1,139
12 INTELLIGENCE COMM EQUIP	21,965	27,965	24,965	29,165
Eagle Vision III		6,000		4,800
Eagle Vision for the Hawaii Air National Guard			3,000	2,400
19 DRUG INTERDICTION SUPPORT	452	452	0	0
Transferred to Drug Interdiction & Counter-Drug Activities, Defense			-452	-452
20 GENERAL INFORMATION TECHNOLOGY	111,282	116,782	111,282	115,982
Eagle Vision Program		1,500		1,500
One AF/One Network Infrastructure		2,000		1,600
One AF/One Network Infrastructure for the Pennsylvania National Guard		2,000		1,600
23 AIR FORCE PHYSICAL SECURITY SYSTEM	137,293	77,293	77,293	77,293
Weapons Storage Area - Request ahead of need		-60,000	-60,000	-60,000
24 COMBAT TRAINING RANGES	40,633	41,633	73,133	66,513
Air National Guard Joint Threat Emitter - Savannah				
Combat Readiness Training Centers		1,000		800
Training Range Enhancements			15,000	10,000
Unmanned Threat Emitters (UMTE) Modernization			3,000	2,400
Joint Pacific Alaska Range Complex (JPARC) Enhancements			14,500	12,680
26 GCSS-AF FOS	81,579	37,079	81,579	37,079
ECSS Program restructure		-44,500		-44,500
28 AIR OPERATIONS CENTER (AOC)	54,093	54,093	54,093	58,093
Joint Threat Emitters (Note: Includes transfer from RDT&E,A line number 120).				4,000
29 BASE INFORMATION INFRASTRUCTURE	433,859	333,859	384,859	333,859
Reduce program growth		-100,000	-49,000	-100,000
ANG Infrastructure				[100,000]
32 SPACE BASED IR SENSOR PROG SPACE	34,440	34,440	2,000	2,000
Premature request			-32,440	-32,440
37 MILSATCOM SPACE	110,575	110,575	108,075	108,075
Funding ahead of need			-2,500	-2,500

P-1	Budget Request	House	Senate	Recommendation
40 TACTICAL C-E EQUIPMENT	240,890	207,890	207,890	207,890
Reduce Vehicle Communication Systems		-33,000	-33,000	-33,000
45 BASE COMM INFRASTRUCTURE	121,049	122,049	121,049	121,049
Nevada Air National Guard Scathe View (Note: transferred to Air Procurement, Air Force line number 52)		1,000		
50 ITEMS LESS THAN \$5M	0	3,000	0	2,400
Aircrew Body Armor and Load Carriage Vest System		3,000		2,400
51 CONTINGENCY OPERATIONS	22,973	10,000	10,000	10,000
Reduce program growth		-12,973	-12,973	-12,973
53 MOBILITY EQUIPMENT	32,855	32,855	28,355	28,355
Excess funding for EALS			-4,500	-4,500
999 CLASSIFIED PROGRAMS	13,830,722	13,690,508	13,995,177	13,936,950
Classified adjustment		-158,377	164,455	106,228

BASE INFORMATION INFRASTRUCTURE

The fiscal year 2010 budget request includes \$425,780,000 for the Combat Information Transport System (CITS), an increase of \$88,590,000 from the amount appropriated in fiscal year 2009. This requested increase stemmed from a requirement to modernize

the information transport system at stand-alone Air National Guard (ANG) bases. While there is support for funding the ANG requirement, it is recognized that the CITS program has yet to obligate \$126,700,000 in fiscal year 2008 funding, and, despite reallocating over \$90,000,000 away from CITS, the service has

yet to obligate an additional \$87,500,000 in fiscal year 2009 funding. Therefore, the Base Information Infrastructure request is reduced by \$100,000,000, and the Secretary of the Air Force is directed to allocate no less than \$100,000,000 of the appropriated amount to Air National Guard modernization.

PROCUREMENT, DEFENSE-WIDE

For Procurement, Defense-Wide, funds are to be available for fiscal
year 2010, as follows:

(In thousands of dollars)				
	Budget	House	Senate	Recommendation
PROCUREMENT, DEFENSE-WIDE				
MAJOR EQUIPMENT				
MAJOR EQUIPMENT, OSD				
47 MAJOR EQUIPMENT, OSD.....	111,487	111,487	111,487	111,487
MAJOR EQUIPMENT, NSA				
44 INFORMATION SYSTEMS SECURITY PROGRAM (ISSP).....	4,013	4,013	4,013	4,013
MAJOR EQUIPMENT, WHS				
50 MAJOR EQUIPMENT, WHS.....	26,945	26,945	26,945	26,945
MAJOR EQUIPMENT, DISA				
18 INFORMATION SYSTEMS SECURITY.....	13,449	13,449	10,449	10,449
19 GLOBAL COMMAND AND CONTROL SYS.....	7,053	7,053	7,053	7,053
20 GLOBAL COMBAT SUPPORT SYSTEM.....	2,820	2,820	2,820	2,820
21 TELEPORT PROGRAM.....	68,037	68,037	68,037	68,037
22 ITEMS LESS THAN \$5M.....	196,232	196,232	196,232	196,232
23 NET CENTRIC ENTERPRISE SERVICES (NCES).....	3,051	3,051	3,051	3,051
24 DEFENSE INFORMATION SYSTEMS NETWORK.....	89,725	89,725	89,725	89,725
25 PUBLIC KEY INFRASTRUCTURE.....	1,780	1,780	1,780	1,780
26 JOINT COMMAND AND CONTROL PROGRAM.....	2,835	2,835	---	---
27 CYBER SECURITY INITIATIVE.....	18,188	18,188	18,188	18,188
MAJOR EQUIPMENT, DLA				
28 MAJOR EQUIPMENT.....	7,728	7,728	7,728	7,728
MAJOR EQUIPMENT, DCAA				
3 MAJOR EQUIPMENT ITEMS LESS THAN \$5M.....	1,489	1,489	1,489	1,489
MAJOR EQUIPMENT, TJS				
48 MAJOR EQUIPMENT, TJS.....	12,065	12,065	12,065	12,065
MAJOR EQUIPMENT, DHRA				
5 PERSONNEL ADMINISTRATION.....	10,431	10,431	10,431	10,431
MAJOR EQUIPMENT, DEFENSE THREAT REDUCTION AGENCY				
32 VEHICLES.....	50	50	50	50
33 OTHER MAJOR EQUIPMENT.....	7,447	7,447	7,447	7,447
MAJOR EQUIPMENT, DODDE				
30 AUTOMATION/EDUCATIONAL SUPPORT & LOGISTICS.....	1,463	1,463	1,463	1,463
MAJOR EQUIPMENT, DCMA				
4 MAJOR EQUIPMENT.....	2,012	2,012	2,012	2,012
MAJOR EQUIPMENT, DTSA				
34 MAJOR EQUIPMENT.....	436	436	436	436

(In thousands of dollars)

	Budget	House	Senate	Recommendation
<hr/>				
MAJOR EQUIPMENT, BTA				
2 MAJOR EQUIPMENT, BTA.....	8,858	8,858	8,858	8,858
MAJOR EQUIPMENT, DMACT				
29 A - WEAPON SYSTEM COST.....	10,149	10,149	10,149	10,149
35 THAAD SYSTEM.....	420,300	420,300	420,300	420,300
36 SM-3.....	168,723	168,723	226,323	226,323
36A TPY-2 RADAR.....	---	---	41,000	---
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TOTAL, MAJOR EQUIPMENT.....	1,196,766	1,196,766	1,289,531	1,248,531
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SPECIAL OPERATIONS COMMAND				
AVIATION PROGRAMS				
51 SOF ROTARY WING UPGRADES AND SUSTAINMENT.....	101,936	90,936	101,936	90,936
52 MH-47 SERVICE LIFE EXTENSION PROGRAM.....	22,958	22,958	28,858	28,858
53 MH-60 SOF MODERNIZATION PROGRAM.....	146,820	146,820	146,820	146,820
54 NON-STANDARD AVIATION.....	227,552	197,552	152,552	177,552
56 SOF TANKER RECAPITALIZATION.....	34,200	34,200	34,200	34,200
57 SOF U-28.....	2,518	2,518	2,518	2,518
59 CV-22 SOF MODIFICATION.....	114,553	114,553	114,553	114,553
60 MQ-1 UAV.....	10,930	10,930	10,930	10,930
61 MQ-9 UAV.....	12,671	12,671	12,671	12,671
62 STUASLO.....	12,223	12,223	12,223	12,223
63 C-130 MODIFICATIONS.....	59,950	145,950	54,816	59,650
64 AIRCRAFT SUPPORT.....	973	973	973	973
SHIPBUILDING				
65 ADVANCED SEAL DELIVERY SYS (ASDS).....	5,236	---	---	---
66 MK VIII MOD 1 - SEAL DELIVERY VEH.....	1,463	1,463	1,463	1,463
AMMUNITION PROGRAMS				
67 SOF ORDNANCE REPLENISHMENT.....	61,360	61,360	61,360	61,360
68 SOF ORDNANCE ACQUISITION.....	26,791	26,791	26,791	26,791

(In thousands of dollars)

	Budget	House	Senate	Recommendation

OTHER PROCUREMENT PROGRAMS				
69 COMM EQUIPMENT & ELECTRONICS.....	55,080	55,080	55,080	55,080
70 SOF INTELLIGENCE SYSTEMS.....	72,811	72,811	72,811	72,811
71 SMALL ARMS & WEAPONS.....	35,235	40,235	35,635	41,635
72 MARITIME EQUIPMENT MODS.....	791	791	791	791
74 SOF COMBATANT CRAFT SYSTEMS.....	6,156	6,156	16,156	11,156
75 SPARES AND REPAIR PARTS.....	2,010	2,010	2,010	2,010
76 TACTICAL VEHICLES.....	18,821	20,821	15,821	19,421
77 MISSION TRAINING AND PREPARATIONS SYSTEMS.....	17,265	17,265	21,265	20,865
78 COMBAT MISSION REQUIREMENTS.....	20,000	20,000	20,000	20,000
79 MILCON COLLATERAL EQUIPMENT.....	6,835	6,835	6,835	6,835
81 SOF AUTOMATION SYSTEMS.....	60,836	49,136	60,836	55,136
82 SOF GLOBAL VIDEO SURVEILLANCE ACTIVITIES.....	12,401	12,401	12,401	12,401
83 SOF OPERATIONAL ENHANCEMENTS INTELLIGENCE.....	26,070	26,070	31,270	26,070
84 SOF SOLDIER PROTECTION AND SURVIVAL SYSTEMS.....	550	550	550	550
85 SOF VISUAL AUGMENTATION, LASERS AND SENSOR SY.....	33,741	33,741	43,741	39,341
86 SOF TACTICAL RADIO SYSTEMS.....	53,034	60,034	57,034	57,034
87 SOF MARITIME EQUIPMENT.....	2,777	5,277	2,777	2,777
89 MISCELLANEOUS EQUIPMENT.....	7,576	9,576	7,576	9,176
90 SOF OPERATIONAL ENHANCEMENTS.....	273,998	280,898	277,498	286,498
91 PSYOP EQUIPMENT.....	43,081	52,081	43,081	43,081

TOTAL, SPECIAL OPERATIONS COMMAND.....	1,591,202	1,653,666	1,545,832	1,564,166

(In thousands of dollars)

	Budget	House	Senate	Recommendation
CHEMICAL/BIOLOGICAL DEFENSE				
92 INSTALLATION FORCE PROTECTION.....	65,590	65,590	65,590	65,590
93 INDIVIDUAL PROTECTION.....	92,004	92,004	92,004	92,004
94 DECONTAMINATION.....	22,008	22,008	27,608	26,488
95 JOINT BIOLOGICAL DEFENSE PROGRAM.....	12,740	12,740	12,740	12,740
96 COLLECTIVE PROTECTION.....	27,938	27,938	32,938	32,938
97 CONTAMINATION AVOIDANCE.....	151,765	151,765	127,115	127,115
TOTAL, CHEMICAL/BIOLOGICAL DEFENSE.....	372,045	372,045	357,995	356,875
999 CLASSIFIED PROGRAMS.....	824,339	814,339	824,339	880,965
TOTAL, PROCUREMENT, DEFENSE-WIDE.....	3,984,352	4,036,816	4,017,697	4,050,537

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS

[In thousands of dollars]

P-1	Budget Request	House	Senate	Recommendation
18 INFORMATION SYSTEMS SECURITY	13,449	13,449	10,449	10,449
Contract delays			-3,000	-3,000
26 JOINT COMMAND AND CONTROL PROGRAM	2,835	2,835	0	0
NECC program adjustment			-2,835	-2,835
36 SM-3	168,723	168,723	226,323	226,323
Addition of six SM-3 Block 1A missiles			57,600	57,600
36a ADVANCED PROCUREMENT FUNDING FOR TPY-2 RADARS			41,000	0
51 SOF ROTARY WING UPGRADES AND SUSTAINMENT	101,936	90,936	101,936	90,936
SIRFC execution		-11,000		-11,000
52 MH-47 SERVICE LIFE EXTENSION PROGRAM	22,958	22,958	28,858	28,858
Program shortfall transferred from OCO line number 52			5,900	5,900
54 NON-STANDARD AVIATION	227,552	197,552	152,552	177,552
Procurement schedule		-30,000		-50,000
Medium non-standard aircraft			-75,000	0
63 C-130 MODIFICATIONS	59,950	145,950	54,816	59,650
MC-130W Dragon Spear Modifications		85,000		0
Intelligence Broadcast Receiver for AFSOC MC-130		1,000		800
Carryover of fiscal year 2008 funds for center wing box replacement			-5,134	-1,100
65 ADVANCED SEAL DELIVERY SYSTEM (ASDS)	5,236	0	0	0
SECDEF Program Termination		-5,236	-5,236	-5,236
71 SMALL ARMS & WEAPONS	35,235	40,235	35,635	41,635
SOPMOD II (M4 Carbine Rail System)		2,500		2,000
Special Operations Forces Combat Assault Rifle		2,500		2,000
Contracting delays			-9,000	-7,000
MK47 Mod 0 Advanced Lightweight Grenade Launcher			6,000	6,000
M4 Weapons Shot Counter			3,400	3,400
74 SOF COMBATANT CRAFT SYSTEMS	6,156	6,156	16,156	11,156
Special Operations Craft - Riverine			10,000	5,000
76 TACTICAL VEHICLES	18,821	20,821	15,821	19,421
Light Mobility Vehicle - Internally Transportable Vehicle		2,000		1,600
Contract delays			-3,000	-1,000
77 MISSION TRAINING AND PREPARATIONS SYSTEMS	17,265	17,265	21,265	20,865
Special Operations Live Rehearsal System			2,000	1,600
Small Arms Training Ranges			2,000	2,000
81 SOF AUTOMATION SYSTEMS	60,836	49,136	60,836	55,136
Distributive Data Center		-11,700		-5,700
83 SOF OPERATIONAL ENHANCEMENTS INTELLIGENCE	26,070	26,070	31,270	26,070
Mission Helmet Recording System (Transferred to line number 90)			5,200	0

P-1	Budget Request	House	Senate	Recommendation
SOF VISUAL AUGMENTATION, LASERS AND SENSOR				
85 SYSTEMS	33,741	33,741	43,741	39,341
Fusion Goggle System (Transferred to line number 90)			3,000	0
Overt Small Laser Marker			2,000	1,600
SOVAS-Hand Held Imager/Long Range			5,000	4,000
86 SOF TACTICAL RADIO SYSTEMS	53,034	60,034	57,034	57,034
AN/PRC-148 MBITR/JTRS Enhanced MBITR		10,000	4,000	4,000
Next Generation Communication System		-3,000		0
87 SOF MARITIME EQUIPMENT	2,777	5,277	2,777	2,777
NSW Protective Combat Uniform (Transferred to O&M Defense-Wide)		2,500		0
89 MISCELLANEOUS EQUIPMENT	7,576	9,576	7,576	9,176
Expansion of the Forensic Intelligence Technologies and Training Support Center of Excellence		2,000		1,600
90 SOF OPERATIONAL ENHANCEMENTS	273,998	280,898	277,498	286,498
Program Increase - Unfunded Requirement - Processing, Exploiting, and Dissemination Enhanced Capability		6,900		2,500
Special Operations High Performance In-Line Sniper Scope			3,500	2,400
Mission Helmet Recording System (Transferred from line number 83)				5,200
Fusion Goggle System (Transferred from line number 85)				2,400
91 PSYOP EQUIPMENT	43,081	52,081	43,081	43,081
Program Increase - Airborne Psyop Equipment		9,000		0
94 DECONTAMINATION	22,008	22,008	27,608	26,488
Reactive Skin Decontamination Lotion			5,600	4,480
96 COLLECTIVE PROTECTION	27,938	27,938	27,938	32,938
Chemical and Biological Protective Shelter			5,000	5,000
97 CONTAMINATION AVOIDANCE	151,765	151,765	127,115	127,115
JBPDS excessive engineering change orders			-3,000	-3,000
JNBCRS contract delays			-21,650	-21,650
999 CLASSIFIED PROGRAMS	824,339	814,339	824,339	880,965
Classified Adjustments		-10,000		56,626

COMBAT MISSION REQUIREMENTS

The Commander, Special Operations Command, is directed to submit quarterly re-

ports to the congressional defense committees on the use of funds provided in this title for Special Operations Command combat

mission requirements.

NATIONAL GUARD AND RESERVE EQUIPMENT

Funding for National Guard and Reserve Equipment is addressed in
Title IX of this Act.

(In thousands of dollars)

	Budget	House	Senate	Recommendation
NATIONAL GUARD & RESERVE EQUIPMENT				
RESERVE EQUIPMENT				
ARMY RESERVE				
1 MISCELLANEOUS EQUIPMENT.....	---	---	135,000	---
NAVY RESERVE				
2 MISCELLANEOUS EQUIPMENT.....	---	---	70,000	---
MARINE CORPS RESERVE				
3 MISCELLANEOUS EQUIPMENT.....	---	---	50,000	---
AIR FORCE RESERVE				
4 MISCELLANEOUS EQUIPMENT.....	---	---	70,000	---
TOTAL, RESERVE EQUIPMENT.....	---	---	325,000	---
NATIONAL GUARD EQUIPMENT				
ARMY NATIONAL GUARD				
5 MISCELLANEOUS EQUIPMENT.....	---	---	1,000,000	---
AIR NATIONAL GUARD				
6 MISCELLANEOUS EQUIPMENT.....	---	---	175,000	---
TOTAL, NATIONAL GUARD EQUIPMENT.....	---	---	1,175,000	---
TOTAL, NATIONAL GUARD & RESERVE EQUIPMENT.....	---	---	1,500,000	---

DEFENSE PRODUCTION ACT PURCHASES

For Defense Production Act Purchases, \$150,746,000 is available for
fiscal year 2010, as follows:

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
(in thousands of dollars)

	Budget Request	House	Senate	Recommendation
BERYLLIUM SUPPLY INDUSTRIAL BASE	19,500	19,500	19,500	19,500
GALLIUM NITRIDE X-BAND MONOLITHIC MICROWAVE INTEGRATED CIRCUITS	2,500	2,500	2,500	2,500
GALLIUM NITRIDE ELECTRONIC WARFARE	120	120	120	120
POWER AND ENERGY SYSTEMS PRODUCTION INITIATIVE	9,086	9,086	9,086	9,086
RADIATION HARDENED MICROELECTRONICS MODERNIZATION	3,000	3,000	3,000	3,000
LITHIUM ION (LI ION) BATTERY PRODUCTION	4,040	6,040	54,040	31,040
Program Increase - Lithium Ion Battery Production		2,000	50,000	27,000
ALUMINUM OXY-NITRIDE AND SPINEL OPTICAL CERAMICS		3,000		2,400
ARMOR AND STRUCTURES TRANSFORMATION INITIATIVE - STEEL TO TITANIUM		8,100		8,100
FLEXIBLE AEROGEL MATERIALS SUPPLIER INITIATIVE		2,000	3,000	2,400
HIGH PERFORMANCE THERMAL BATTERY INFRASTRUCTURE PROJECT		3,000		3,000
INVENTORY FOR DEFENSE APPLICATIONS TO ENSURE RELIABILITY OF SHORT LEAD TIMES		10,000		10,000
LOW COST MILITARY GLOBAL POSITIONING SYSTEM (GPS) RECEIVER		4,000		3,200
METAL INJECTION MOLDING TECHNOLOGICAL IMPROVEMENTS		1,000		800
MILITARY LENS FABRICATION AND ASSEMBLY		4,000		3,200

	Budget Request	House	Senate	Recommendation
NAVY PRODUCTION CAPACITY IMPROVEMENT PROJECT		1,000	4,000	3,200
PRODUCTION OF MINIATURE COMPRESSORS FOR ELECTRONICS AND PERSONAL COOLING		4,500		3,600
RADIATION HARDENED CRYOGENIC READ OUT INTEGRATED CIRCUITS		2,000		1,600
ADVANCED CARBON NANOTUBE VOLUME PRODUCTION FACILITY			3,000	2,400
AUTOMATED COMPOSITE TECHNOLOGIES AND MANUFACTURING CENTER			12,000	9,600
BIO-SYNTHETIC PARAFFINIC KEROSENE PRODUCTION			5,000	4,000
CONDUCTIVE COMPOSITES NANO-MATERIALS SCALE-UP INITIATIVE			3,500	2,800
EXTREMELY LARGE, DOMESTIC EXPENDABLE AND REUSABLE STRUCTURES MANUFACTURING CENTER			9,800	7,840
GOODRICH TERAHERTZ SPECTROMETER			5,000	4,000
HIGH HOMOGENEITY OPTICAL GLASS			4,000	3,200
LIGHTWEIGHT SMALL CALIBER AMMUNITION PRODUCTION INITIATIVE			4,200	3,760
TITANIUM METAL MATRIX COMPOSITE AND NANO- ENHANCED TITANIUM DEVELOPMENT			8,000	6,400
TOTAL DPA	38,246	82,846	149,746	150,746

TITLE IV - RESEARCH, DEVELOPMENT, TEST AND EVALUATION

For Research, Development, Test and Evaluation, funds are to be
available for fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
RECAPITULATION				
RESEARCH, DEVELOPMENT, TEST AND EVALUATION, ARMY.....	10,438,218	11,151,884	10,653,126	11,474,180
RESEARCH, DEVELOPMENT, TEST AND EVALUATION, NAVY.....	19,270,932	20,197,300	19,148,509	20,003,463
RESEARCH, DEVELOPMENT, TEST AND EVALUATION, AIR FORCE.	27,992,827	27,976,278	28,049,015	28,121,985
RESEARCH, DEVELOPMENT, TEST AND EVALUATION, DEFENSE-WIDE.....	20,741,542	20,721,723	20,408,968	20,747,081
OPERATIONAL TEST AND EVALUATION, DEFENSE.....	190,770	190,770	190,770	190,770
GRAND TOTAL, RDT&E.....	78,634,289	80,237,955	78,450,388	80,537,479

JOINT LIGHT TACTICAL VEHICLE

The budget request includes a total of \$90,099,000 to continue technology development for the Joint Light Tactical Vehicle (JLTV). The acquisition strategy involves competitive prototyping of vehicles from three contractors, followed by a down-select to two vehicles in fiscal year 2011 to proceed into the engineering and manufacturing development phase of the program. The recommendation fully supports this development strategy, which shares a number of elements of the reforms that have been written into law by the Weapon Systems Acquisition Reform Act of 2009. However, the program has yet to demonstrate itself as a model for a successful development program despite the reformed acquisition strategy. The funding profile has not changed despite a four month delay in initiating the program. Deficiencies in billings have resulted in the program falling far behind the financial benchmarks established by the Department of Defense. Program management has been complicated due to the different funding strategies pursued by the Army and the Marine Corps. There is great concern that of the \$217,255,000 Congress has approved for JLTV since fiscal year 2007, only \$53,128,000 had been expended through the end of fiscal year 2009. Despite these challenges, information has been provided that the program is proceeding in accordance with its revised schedule, billing errors are being addressed, budget execution is being corrected and prior year funding will be exhausted in 2010. Based upon these assurances, the recommendation contains full funding for the budget request. Careful oversight of program execution and military requirements will continue to ensure the commitment of the Army and Marine Corps to the success of the program.

EJECTION SEATS

The US16E ejection seat was competitively selected as the ejection seat for the F-35 Joint Strike Fighter. The progress made on this ejection seat is encouraging and the program of record is fully supported.

ENERGETICS

House language noted that the efforts of the military Services as coordinated through the Office of the Secretary of Defense, with the Department of Energy, have led to steady progress in the last decade in advancing the science of energetics and revitalizing the research and development workforce.

However, a report on energetics in the Department of Defense, as directed in House

Report 110-652, and which was to be provided to the congressional defense committees not later than March 1, 2009, was completed June 2009, and was finally delivered September 2, 2009.

House language recommended that the Department of Defense capitalize on best practices within the individual Services to advance the state of the energetics field, and directed that no funds be expended for the creation of a new Executive Agent or Executive Director for Advanced Energetics. The Senate included no similar language.

The recommendation includes no language regarding the use of funds for the creation of a new Executive Agent or Executive Director for Advanced Energetics and directs instead that the Secretary of Defense shall provide a report to the congressional defense committees not later than October 1, 2010, on progress being made on the findings and actions in the June 2009 report.

DOMESTIC ENERGY PRODUCTION

There is concern that a plan has not been presented to fund continued development and risk mitigation of domestic gas centrifuge enrichment technology during fiscal year 2010. Despite that, there is support for efforts to develop domestic gas centrifuge enrichment technology so that it can move to commercial scale uranium enrichment operations and potentially serve as a domestic source of fuel for nuclear power and the enrichment requirements of the defense community. Therefore, the Secretary of Defense, in consultation with the Department of Energy, is urged to explore utilizing all possible existing statutory authority to fund this important activity and to report to the Committees on Appropriations of both the House and Senate no later than 30 days following enactment of this Act regarding funding options.

SPECIAL INTEREST ITEMS

Items for which additional funds have been provided as shown in the project level tables or in paragraphs using the phrase "only for" or "only to" are congressional interest items for purposes of the Base for Reprogramming Department of Defense form (DD Form 1414). Each of these items must be carried on the DD Form 1414 at the stated amount, as specifically addressed in these materials.

REPROGRAMMING GUIDANCE FOR ACQUISITION ACCOUNTS

It is the intent of Congress that the program baseline for reprogramming funds reflects all approved adjustment actions: the

initial appropriation as well as any rescissions, supplemental appropriations and approved Department of Defense 1415 reprogrammings. The Secretary of Defense is directed to ensure that financial management regulations incorporate approved reprogramming actions as an adjustment to the base for reprogramming value.

The Department of Defense is directed to continue to follow the reprogramming guidance specified in the report accompanying the House version of the fiscal year 2006 Department of Defense Appropriations Act (H.R. 109-119). Specifically, the dollar threshold for reprogramming funds will remain at \$20,000,000 for procurement and \$10,000,000 for research, development, test, and evaluation. The Department shall continue to follow the limitation that prior approval reprogrammings are set at either the specified dollar threshold or 20 percent of the procurement or research, development, test and evaluation line, whichever is less. The percentage change limitation applies to both program increases and decreases. Additionally, this percentage change applies to the program base value at the time the below threshold movement of funds is executed. These thresholds are cumulative from the base for reprogramming value as modified by any adjustment action. Therefore, if the combined value of transfers into or out of a procurement (P-1) or research, development, test, and evaluation (R-1) line exceeds the identified threshold, the Department of Defense must submit a prior approval reprogramming request to the congressional defense committees. In addition, guidelines on the application of prior approval reprogramming procedures for congressional special interest items are established elsewhere in this report. This guidance is effective for fiscal year 2010 and forward.

REPROGRAMMING REPORTING REQUIREMENTS

The Under Secretary of Defense (Comptroller) is directed to continue to provide the congressional defense committees quarterly, spreadsheet-based DD 1416 reports for service and defense-wide accounts in titles III and IV of this Act as required in the statement of the managers accompanying the conference report on the Department of Defense Appropriations Act, 2006.

FUNDING INCREASES

The funding increases outlined in these tables shall be provided only for the specific purposes indicated in the table.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, ARMY

For Research, Development, Test and Evaluation, Army, funds are to be available for fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
RESEARCH, DEVELOPMENT, TEST & EVAL, ARMY				
BASIC RESEARCH				
1 IN-HOUSE LABORATORY INDEPENDENT RESEARCH.....	19,671	19,671	19,671	19,671
2 DEFENSE RESEARCH SCIENCES.....	173,024	196,074	183,324	198,504
3 UNIVERSITY RESEARCH INITIATIVES.....	88,421	110,421	87,921	99,921
4 UNIVERSITY AND INDUSTRY RESEARCH CENTERS.....	96,144	114,844	103,144	115,944
TOTAL, BASIC RESEARCH.....	377,260	441,010	394,060	434,040
APPLIED RESEARCH				
5 MATERIALS TECHNOLOGY.....	27,206	68,256	81,606	99,906
6 SENSORS AND ELECTRONIC SURVIVABILITY.....	50,641	67,641	58,641	70,641
7 TRACTOR HIP.....	14,324	14,324	14,324	14,324
8 AVIATION TECHNOLOGY.....	41,332	50,832	44,332	49,532
9 ELECTRONIC WARFARE TECHNOLOGY.....	16,119	24,119	16,119	22,419
10 MISSILE TECHNOLOGY.....	50,716	64,816	65,716	71,296
11 ADVANCED WEAPONS TECHNOLOGY.....	19,678	22,678	19,678	22,078
12 ADVANCED CONCEPTS AND SIMULATION.....	17,473	26,973	23,473	27,473
13 COMBAT VEHICLE AND AUTOMOTIVE TECHNOLOGY.....	55,937	74,437	66,437	79,337
14 BALLISTICS TECHNOLOGY.....	61,843	79,843	64,843	78,443
15 CHEMICAL, SMOKE AND EQUIPMENT DEFEATING TECHNOLOGY....	5,293	13,293	7,293	13,693
16 JOINT SERVICE SMALL ARMS PROGRAM.....	7,674	7,674	7,674	7,674
17 WEAPONS AND MUNITIONS TECHNOLOGY.....	41,085	124,585	88,985	145,625
18 ELECTRONICS AND ELECTRONIC DEVICES.....	61,404	115,454	107,204	135,234
19 NIGHT VISION TECHNOLOGY.....	26,893	48,893	35,893	51,143
20 COUNTERMINE SYSTEMS.....	18,945	20,945	22,945	23,745
21 HUMAN FACTORS ENGINEERING TECHNOLOGY.....	18,605	33,605	18,605	30,605
22 ENVIRONMENTAL QUALITY TECHNOLOGY.....	15,902	19,402	23,402	25,602
23 COMMAND, CONTROL, COMMUNICATIONS TECHNOLOGY.....	24,833	31,533	24,833	30,193
24 COMPUTER AND SOFTWARE TECHNOLOGY.....	5,639	5,639	5,639	5,639
25 MILITARY ENGINEERING TECHNOLOGY.....	54,818	61,918	57,818	61,098
26 MANPOWER/PERSONNEL/TRAINING TECHNOLOGY.....	18,701	18,701	16,701	16,701

(In thousands of dollars)

	Budget	House	Senate	Recommendation
27 WARFIGHTER TECHNOLOGY.....	27,109	31,909	38,109	38,549
28 MEDICAL TECHNOLOGY.....	99,027	195,942	165,387	223,107
TOTAL, APPLIED RESEARCH.....	781,197	1,223,412	1,075,857	1,344,117
ADVANCED TECHNOLOGY DEVELOPMENT				
29 WARFIGHTER ADVANCED TECHNOLOGY.....	37,574	54,524	41,874	54,574
30 MEDICAL ADVANCED TECHNOLOGY.....	72,940	301,866	196,040	341,531
31 AVIATION ADVANCED TECHNOLOGY.....	60,097	87,097	104,697	112,977
32 WEAPONS AND MUNITIONS ADVANCED TECHNOLOGY.....	66,410	89,910	71,210	90,330
33 COMBAT VEHICLE AND AUTOMOTIVE ADVANCED TECHNOLOGY.....	89,586	162,186	182,886	241,446
34 COMMAND, CONTROL, COMMUNICATIONS ADVANCED TECHNOLOGY..	8,667	13,667	8,667	12,417
35 MANPOWER, PERSONNEL AND TRAINING ADVANCED TECHNOLOGY..	7,410	7,410	7,410	7,410
36 ELECTRONIC WARFARE ADVANCED TECHNOLOGY.....	50,458	57,258	58,458	57,498
37 TRACTOR HIKE.....	11,328	11,328	11,328	11,328
38 NEXT GENERATION TRAINING & SIMULATION SYSTEMS.....	19,415	23,915	22,415	25,495
39 TRACTOR ROSE.....	14,569	14,569	14,569	14,569
40 EXPLOSIVES DEMILITARIZATION TECHNOLOGY.....	---	3,500	12,200	12,560
41 MILITARY HIV RESEARCH.....	6,657	29,657	6,657	29,657
42 COMBATING TERRORISM, TECHNOLOGY DEVELOPMENT.....	11,989	11,989	36,989	11,989
43 ELECTRONIC WARFARE TECHNOLOGY.....	19,192	22,692	19,192	21,992
44 MISSILE AND ROCKET ADVANCED TECHNOLOGY.....	63,951	75,751	79,451	87,011
45 TRACTOR CAGE.....	12,154	12,154	12,154	12,154
46 LANDMINE WARFARE AND BARRIER ADVANCED TECHNOLOGY.....	30,317	30,317	36,217	35,037
47 JOINT SERVICE SMALL ARMS PROGRAM.....	8,996	8,996	8,996	8,996
48 NIGHT VISION ADVANCED TECHNOLOGY.....	40,329	64,829	57,329	72,629
49 ENVIRONMENTAL QUALITY TECHNOLOGY DEMONSTRATIONS.....	15,706	15,706	16,206	16,206
50 MILITARY ENGINEERING ADVANCED TECHNOLOGY.....	5,911	45,461	17,511	45,631
51 ADVANCED TACTICAL COMPUTER SCIENCE & SENSOR TECHNOLOGY	41,561	60,061	47,061	57,361
TOTAL, ADVANCED TECHNOLOGY DEVELOPMENT.....	695,217	1,204,843	1,069,517	1,380,798

(In thousands of dollars)

	Budget	House	Senate	Recommendation
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DEMONSTRATION & VALIDATION				
52 UNIQUE ITEM IDENTIFICATION (UID).....	---	2,500	---	2,000
53 ARMY MISSILE DEFENSE SYSTEMS INTEGRATION.....	14,683	31,683	74,783	72,163
54 ARMY MISSILE DEFENSE SYSTEMS INTEGRATION (SPACE).....	117,471	120,471	118,671	119,231
55 AIR AND MISSILE DEFENSE SYSTEMS ENGINEERING.....	209,531	110,531	211,531	166,931
57 LANDMINE WARFARE AND BARRIER - ADV DEV.....	17,536	17,536	17,536	17,536
58 SHOKE, OBSCURANT AND TARGET DEFEATING SYS-ADV DEV.....	4,920	4,920	4,920	4,920
59 TANK AND MEDIUM CALIBER AMMUNITION.....	33,934	33,934	33,934	33,934
60 ADVANCED TANK ARMAMENT SYSTEM (ATAS).....	90,299	90,299	90,299	90,299
61 SOLDIER SUPPORT AND SURVIVABILITY.....	31,752	31,752	33,752	33,352
62 TACTICAL ELECTRONIC SURVEILLANCE SYSTEM - AD.....	18,228	18,228	12,228	12,228
64 ENVIRONMENTAL QUALITY TECHNOLOGY.....	4,770	19,770	6,770	18,470
65 WARFIGHTER INFORMATION NETWORK-TACTICAL.....	180,673	165,673	180,673	170,673
66 NATO RESEARCH AND DEVELOPMENT.....	5,048	5,048	5,048	5,048
67 AVIATION - ADV DEV.....	8,537	8,537	8,537	8,537
68 LOGISTICS AND ENGINEER EQUIPMENT - ADV DEV.....	56,373	57,373	49,873	59,973
69 COMBAT SERVICE SUPPORT CONTROL SYSTEM EVALUATION.....	9,868	9,868	9,868	9,868
70 MEDICAL SYSTEMS - ADV DEV.....	31,275	37,275	33,275	36,075
71 SOLDIER SYSTEMS - ADVANCED DEVELOPMENT.....	71,832	71,007	71,832	74,172
72 INTEGRATED BROADCAST SERVICE.....	1,476	1,476	1,476	1,476
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TOTAL, DEMONSTRATION & VALIDATION.....	908,206	837,881	965,006	936,886

(In thousands of dollars)

	Budget	House	Senate	Recommendation

ENGINEERING & MANUFACTURING DEVELOPMENT				
73 AIRCRAFT AVIONICS.....	92,977	88,977	92,977	89,977
74 ARMED, DEPLOYABLE OH-58D.....	65,515	70,515	61,236	66,515
75 ELECTRONIC WARFARE DEVELOPMENT.....	248,463	248,463	197,463	202,063
76 ALL SOURCE ANALYSIS SYSTEM.....	13,107	13,107	13,107	13,107
77 TRACTOR CAGE.....	16,286	16,286	16,286	16,286
78 INFANTRY SUPPORT WEAPONS.....	74,814	76,814	82,814	83,614
79 MEDIUM TACTICAL VEHICLES.....	5,683	5,683	5,683	5,683
80 SMOKE, OBSCURANT AND TARGET DEFEATING SYS-SDD.....	978	978	978	978
81 FAMILY OF HEAVY TACTICAL VEHICLES.....	7,477	10,477	7,477	9,877
82 AIR TRAFFIC CONTROL.....	7,578	7,578	7,578	7,578
83 NON-LIGHT OF SIGHT LAUNCH SYSTEM.....	88,660	88,660	92,460	91,700
84 NON-LINE OF SIGHT CANNON.....	58,216	31,216	58,216	48,216
85 FCS MANNED GRD VEHICLES & COMMON GRD VEHICLE.....	368,557	184,557	368,557	276,557
86 FCS SYSTEMS OF SYSTEMS ENGR & PROGRAM MGMT.....	1,067,191	1,067,191	868,191	917,191
87 FCS RECONNAISSANCE (UAV) PLATFORMS.....	68,701	68,701	78,001	75,501
88 FCS UNMANNED GROUND VEHICLES.....	125,616	125,616	125,616	125,616
89 FCS UNATTENDED GROUND SENSORS.....	26,919	26,919	26,919	26,919
90 FCS SUSTAINMENT & TRAINING R&D.....	749,182	749,182	567,182	659,182
92 NIGHT VISION SYSTEMS - SDD.....	55,410	57,910	55,410	57,410
93 COMBAT FEEDING, CLOTHING, AND EQUIPMENT.....	2,092	2,092	2,092	2,092
94 NON-SYSTEM TRAINING DEVICES - SDD.....	30,209	30,209	30,209	30,209
95 AIR DEFENSE COMMAND, CONTROL AND INTELLIGENCE -SDD....	28,936	28,936	28,936	28,936
96 CONSTRUCTIVE SIMULATION SYSTEMS DEVELOPMENT.....	33,213	33,213	33,213	33,213
97 AUTOMATIC TEST EQUIPMENT DEVELOPMENT.....	15,320	15,320	15,320	15,320
98 DISTRIBUTIVE INTERACTIVE SIMULATIONS (DIS) - SDD.....	15,727	15,727	15,727	15,727
99 POSITIONING SYSTEMS DEVELOPMENT (SPACE).....	9,446	9,446	9,446	9,446
100 COMBINED ARMS TACTICAL TRAINER (CATT) CORE.....	26,243	26,243	26,243	26,243
102 WEAPONS AND MUNITIONS - SDD.....	34,878	44,378	69,878	87,478
103 LOGISTICS AND ENGINEER EQUIPMENT - SDD.....	36,018	37,518	36,018	37,218

(In thousands of dollars)

	Budget	House	Senate	Recommendation
104 COMMAND, CONTROL, COMMUNICATIONS SYSTEMS - SDD.....	88,995	88,995	43,995	58,995
105 MEDICAL MATERIEL/MEDICAL BIOLOGICAL DEFENSE EQUIPMENT.	33,893	40,293	37,393	42,013
106 LANDMINE WARFARE/BARRIER - SDD.....	82,260	60,960	82,260	72,760
107 ARTILLERY MUNITIONS.....	42,452	42,452	42,452	42,452
108 COMBAT IDENTIFICATION.....	20,070	20,070	10,070	10,070
109 ARMY TACTICAL COMMAND & CONTROL HARDWARE & SOFTWARE...	90,864	85,364	78,072	79,864
111 GENERAL FUND ENTERPRISE BUSINESS SYSTEM (GFEBs).....	6,002	6,002	6,002	23,902
112 FIREFINDER.....	20,333	20,333	20,333	20,333
113 SOLDIER SYSTEMS - WARRIOR DEM/VAL.....	19,786	19,786	19,786	19,786
114 ARTILLERY SYSTEMS.....	23,318	34,318	114,818	116,418
115 PATRIOT/MEADS COMBINED AGGREGATE PROGRAM (CAP).....	569,182	569,182	569,182	569,182
116 NUCLEAR ARMS CONTROL MONITORING SENSOR NETWORK.....	7,140	7,140	7,140	7,140
117 INFORMATION TECHNOLOGY DEVELOPMENT.....	35,309	35,309	67,109	66,909
118 JOINT AIR-TO-GROUND MISSILE (JAGM).....	127,439	127,439	127,439	127,439
119 MANNED GROUND VEHICLE.....	100,000	50,000	100,000	80,000
TOTAL, ENGINEERING & MANUFACTURING DEVELOPMENT.....	4,640,455	4,389,555	4,319,284	4,397,115
RDT&E MANAGEMENT SUPPORT				
120 THREAT SIMULATOR DEVELOPMENT.....	22,222	30,222	22,222	25,222
121 TARGET SYSTEMS DEVELOPMENT.....	13,615	13,615	13,615	13,615
122 MAJOR T&E INVESTMENT.....	51,846	51,846	51,846	51,846
123 RAND ARROYO CENTER.....	16,305	16,305	18,305	17,905
124 ARMY KWAJALEIN ATOLL.....	163,514	163,514	163,514	163,514
125 CONCEPTS EXPERIMENTATION PROGRAM.....	23,445	23,445	26,945	26,545
127 ARMY TEST RANGES AND FACILITIES.....	354,693	354,693	354,693	354,693
128 ARMY TECHNICAL TEST INSTRUMENTATION AND TARGETS.....	72,911	75,111	86,611	84,831
129 SURVIVABILITY/LETHALITY ANALYSIS.....	45,016	45,016	45,016	45,016
130 DOD HIGH ENERGY LASER TEST FACILITY.....	2,891	2,891	8,891	7,391
131 AIRCRAFT CERTIFICATION.....	3,766	3,766	3,766	3,766
132 METEOROLOGICAL SUPPORT TO RDT&E ACTIVITIES.....	8,391	8,391	8,391	8,391
133 MATERIEL SYSTEMS ANALYSIS.....	19,969	19,969	19,969	19,969

(In thousands of dollars)

	Budget	House	Senate	Recommendation
134 EXPLOITATION OF FOREIGN ITEMS.....	5,432	5,432	5,432	5,432
135 SUPPORT OF OPERATIONAL TESTING.....	77,877	77,877	77,877	77,877
136 ARMY EVALUATION CENTER.....	66,309	68,309	66,309	67,909
137 SIMULATION & MODELING FOR ACQ, RQTS, & TNG (SMART)....	5,357	5,357	5,357	5,357
138 PROGRAMWIDE ACTIVITIES.....	77,823	77,823	77,823	77,823
139 TECHNICAL INFORMATION ACTIVITIES.....	51,620	51,620	51,620	51,620
140 MUNITIONS STANDARDIZATION, EFFECTIVENESS AND SAFETY...	45,053	70,653	56,153	73,233
141 ENVIRONMENTAL QUALITY TECHNOLOGY MGMT SUPPORT.....	5,191	5,191	5,191	5,191
142 MANAGEMENT HEADQUARTERS (RESEARCH AND DEVELOPMENT)....	15,866	15,866	15,866	15,866
TOTAL, RDT&E MANAGEMENT SUPPORT.....	1,149,112	1,186,912	1,185,412	1,203,012
OPERATIONAL SYSTEMS DEVELOPMENT				
144 MLRS PRODUCT IMPROVEMENT PROGRAM.....	27,693	27,693	27,693	27,693
146 AEROSTAT JOINT PROJECT OFFICE.....	360,076	288,076	360,076	330,076
147 ADV FIELD ARTILLERY TACTICAL DATA SYSTEM.....	23,727	30,727	23,727	29,327
148 COMBAT VEHICLE IMPROVEMENT PROGRAMS.....	190,301	192,301	197,201	197,421
149 MANEUVER CONTROL SYSTEM.....	21,394	21,394	21,394	21,394
150 AIRCRAFT MODIFICATIONS/PRODUCT IMPROVEMENT PROGRAMS...	209,401	209,401	214,817	214,107
151 AIRCRAFT ENGINE COMPONENT IMPROVEMENT PROGRAM.....	792	792	792	792
152 DIGITIZATION.....	10,692	10,692	10,692	10,692
154 MISSILE/AIR DEFENSE PRODUCT IMPROVEMENT PROGRAM.....	39,273	39,273	39,273	39,273
155 OTHER MISSILE PRODUCT IMPROVEMENT PROGRAMS.....	---	5,000	---	4,000
156 TRACTOR CARD.....	20,035	20,035	20,035	20,035
158 JOINT TACTICAL GROUND SYSTEM.....	13,258	13,258	13,258	13,258
159 JOINT HIGH SPEED VESSEL (JHSV).....	3,082	3,082	3,082	3,082
161 SECURITY AND INTELLIGENCE ACTIVITIES.....	2,144	2,144	2,144	2,144
162 INFORMATION SYSTEMS SECURITY PROGRAM.....	74,355	74,355	61,455	58,955
163 GLOBAL COMBAT SUPPORT SYSTEM.....	144,733	144,733	144,733	144,733
164 SATCOM GROUND ENVIRONMENT (SPACE).....	40,097	40,097	40,097	40,097
165 WWMCCS/GLOBAL COMMAND AND CONTROL SYSTEM.....	12,034	12,034	12,034	12,034

(In thousands of dollars)

	Budget	House	Senate	Recommendation
166 JOINT COMMAND AND CONTROL PROGRAM (JC2).....	20,365	20,365	---	---
167 TACTICAL UNMANNED AERIAL VEHICLES.....	202,521	172,521	172,124	173,521
168 DISTRIBUTED COMMON GROUND/SURFACE SYSTEMS.....	188,414	188,414	189,714	189,454
170 AERIAL COMMON SENSOR (ACS).....	210,035	210,035	---	116,035
172 END ITEM INDUSTRIAL PREPAREDNESS ACTIVITIES.....	68,466	94,466	85,766	103,406
TOTAL, OPERATIONAL SYSTEMS DEVELOPMENT.....	1,882,888	1,820,888	1,640,107	1,751,529
999 CLASSIFIED PROGRAMS.....	3,883	47,383	3,883	26,683
TOTAL, RESEARCH, DEVELOPMENT, TEST & EVAL, ARMY.....	10,438,218	11,151,884	10,653,126	11,474,180

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

R-1	Budget Request	House	Senate	Recommendation
2 DEFENSE RESEARCH SCIENCES	173,024	196,074	183,324	198,504
Cyber Threat Analytics		3,000		2,400
Organic Semiconductor Modeling and Simulation		1,100		880
Perpetually Available and Secure Information Systems		4,000		3,200
Maine Center for Toxicology and Environmental Health, Toxic Particles Research and Equipment		2,000		1,600
Nanocrystal Source Display		950		760
Secure Open Source Initiative		3,000		2,400
Sustainable Alternative Energy		2,000		2,000
Lightweight Polymer Designs for Soldier Combat Optics		1,000		800
Combat Mental Health Initiative		2,000		1,600
Vision Integrating Strategies in Ophthalmology and Neurochemistry		4,000	2,000	3,200
Bioactive Polymers and Coating Systems for Protection Against Bio-Threats			4,500	3,600
High Frequency Devices and Circuits for Nanotubes and Nanowires			1,800	1,440
Integrated Flexible Electronics			2,000	1,600
3 UNIVERSITY RESEARCH INITIATIVES	88,421	110,421	87,921	99,921
Antennas for Unmanned Aerial Vehicles		1,000		1,000
Collaboration Skills Training for Time-Critical Teams, Squads and Workgroups		2,000		1,600
Construct Training Program		1,500	2,000	1,600
Cooperative Developmental Energy Program		2,000		1,600
Laboratory for Engineered Human Protection		2,000		1,600
Manufacturing Lab for Next Generation Engineers		2,000		1,600
Military Family Coping Patterns		500		400
National Biodefense Training Center (Transferred to line number 30)		5,000		0
Molecular Electronics for Flash Memory Production (Includes transfer from RDT&E, Navy line number 1)		2,000		2,400
Science, Technology, Engineering, Mathematics (STEM) at Coppin University		1,000		800
Battlefield Exercise and Combat Related Spinal Cord Injury Research		3,000		2,400
V72			-7,500	-7,500
Burn and Shock Trauma Institute			2,000	1,600
Hi-Tech Eyes for the Battlefield			2,000	1,600
Open Source Intelligence for Force Protection and Intelligence Analysis			1,000	800
4 UNIVERSITY AND INDUSTRY RESEARCH CENTERS	96,144	114,844	103,144	115,944
Advanced Polymer Systems for Defense Application - Power Generation, Protection and Sensing		3,000		2,400
Center for Hetero-Functional Materials		1,000		800
Center for Nanoscale Bio-Sensors as a Defense against Biological Threats		3,000	3,000	3,000
Development of Enabling Chemical Technologies for Power from Green Sources		1,500		1,200

R-1	Budget Request	House	Senate	Recommendation
High Performance Computing in Biomedical Engineering and Health Sciences		1,500		1,200
Intelligent Network-Centric Sensor Development Program		1,500		1,200
Ink-Based Desktop Electronic Material Technology		2,000		1,600
Manufacturing and Industrial Technology Center		500		400
Materials Processing and Applications Development Center of Excellence for Industry		1,500		1,200
DoD Diabetes Research and Development Initiative (DRDI)		3,200		2,560
H50/J22 Network Science - fiscal year 2009 execution delays and excessive growth			-6,000	-6,000
ARL-ONAMI Center for Nanoarchitectures for Enhanced Performance			1,000	800
Academic Support and Research Compliance for Knowledge Gathering (Transferred from O&M, Army line number 323)				2,000
Army Material Degradation			800	640
MEMS Antenna for Wireless Communications				
Supporting UAVs in the Battlefield			3,000	2,400
Nanotubes Optimized for Lightweight Exceptional Strength (NOLES)			4,000	3,200
Visualization for Training and Simulation in Urban Terrains at Fort Knox			1,200	1,200
5 MATERIALS TECHNOLOGY	27,206	68,256	81,806	99,966
Advanced Composite Research for Vehicles		5,000		4,000
Advanced Conductivity Program		1,000		1,000
Advanced Nanocomposite Materials for Lightweight Integrated Armor Systems		2,000		1,600
Aluminum Armor Project		1,050		840
Ballistic Armor Research		1,000	4,000	3,200
Capabilities Expansion of Spinel Transparent Armor Manufacturing		2,000		1,600
Composite Applied Research and Technology for FCS and Tactical Vehicle Survivability		1,500	4,000	3,200
Development of Improved Lighter-Weight IED/EPF Armor Solutions		2,000		1,600
Distributed, Networked, Unmanned Ground Systems		2,000	4,000	3,200
Dual Stage Variable Energy Absorber		3,000		2,400
Fused Silica for Large-Format Transparent Armor		4,000		3,200
High Strength Glass Production and Qualification for Armor Applications		2,000		1,600
Large-Scale Manufacturing of Revolutionary Nanostructured Materials		1,500		1,200
Lightweight Metal Alloy Foam for Armor		4,000		3,200
Modeling and Testing of Next Generation Body Armor		1,500	2,500	2,000
Multi-Utility Materials for Future Combat Systems		1,000	9,000	7,200
Nanomanufacturing of Multifunctional Sensors		2,000	4,000	4,000
One-Step JP-8 Bio-Diesel Fuel		2,000		1,600
Reactive Materials		1,500		1,200
Ultra Light Metallic Armor		1,000		800
Affordable Light-Weight Metal Matrix Composite (MMC) Armor			2,500	2,500

R-1	Budget Request	House	Senate	Recommendation
Development, Optimization, and Transfer of a Reliable Testing Technology for Materials Designed to Protect Warfighters Against Toxic Chemical Warfare Agents			600	480
Lattice Block Structures for AM2 Matting Replacement			2,000	1,600
Materials Technology for LED Lighting Applications			3,000	2,400
Moldable Fabric Armor (Includes transfer from RDT&E, Defense-Wide line number 18)			2,000	2,240
Nanoelectronic Memory, Sensor and Energy Devices			7,000	6,300
Next Generation High Strength Glass Fibers for Ballistic Armor Applications			2,000	1,600
Next Generation Lightweight Drive System for Army Weapons Systems			2,000	1,600
Renewable Jet Fuel from Lignocellulosic Feedstocks			3,000	2,400
Smart Integrated Systems: Materials, Manufacturing Methods, and Structures			1,000	1,000
Ultrasonic Impact Technology			2,000	2,000
6 SENSORS AND ELECTRONIC SURVIVABILITY	50,641	67,641	58,641	70,641
Advanced Bonded Diamond for Optical Applications		2,500		2,000
Advanced Communications for Mobile Networks		4,000		3,200
Advanced Composite Nickel-Manganese-Cobalt and other Lithium Ion Battery Technologies using Nano Crystal Scission Process		3,000		2,400
Advanced Detection of Explosives		2,000		1,600
Advanced Tactical Laser Flashlight		1,000		800
Next Generation Wearable Video Capture System		1,000		800
Surveillance Augmentation Vehicle		1,500		1,200
Terahertz Sensing and Imaging Technology		2,000		1,600
Advanced UV Light Diode Development			1,000	800
Diamond Lens Elements for High Powered Laser			1,000	800
Electronic Keel			2,000	1,600
Force Protection Radar for Forward Operating Bases			2,000	1,600
Nanophotonic Devices			2,000	1,600
8 AVIATION TECHNOLOGY	41,332	50,832	44,332	49,532
Composite Small Main Rotor Blades		3,000	3,000	3,000
Intensive Quenching for Advanced Weapon Systems		1,500		1,200
OMNI Active Vibration Control System		3,000		2,400
Technologies for Military Equipment Replenishment		2,000		1,600
9 ELECTRONIC WARFARE TECHNOLOGY	16,119	24,119	16,119	22,419
Short Wave Infrared Hostile Fire Indicator for Aircraft		2,000		1,500
Integrated Information Technology Policy Analysis Research and Technology Commercialization and Management Network		4,000		3,200
Silver Fox and Manta Unmanned Aerial Systems		2,000		1,600
10 MISSILE TECHNOLOGY	50,716	64,816	65,716	71,296
Electrically Charged Mesh Defense Net Troop Protection System		7,500		6,000
Mariah Hypersonic Wind Tunnel Development Program		4,000	9,500	7,600
Portable Sensor for Toxic Gas Detection		2,600		2,080

R-1	Budget Request	House	Senate	Recommendation
Novel Endothermic Armor Material for Insensitive Munitions Protection of Tactical Missiles and Tubes			2,500	2,500
Swarms Defense System			3,000	2,400
11 ADVANCED WEAPONS TECHNOLOGY	19,678	22,678	19,678	22,078
Integrated Family of Test Equipment V6 Product Improvement Program		3,000		2,400
12 ADVANCED CONCEPTS AND SIMULATION	17,473	26,973	23,473	27,473
Advanced Live, Virtual, and Constructive Training Systems		3,500		2,800
Cognitive Based Modeling and Simulation for Tactical Decision Support		2,000		1,600
Compact Biothreat Rapid Analysis Concept		3,000	6,000	4,800
Protective Gear Development through Man-In-Simulant-Test Chamber		1,000		800
13 COMBAT VEHICLE AND AUTOMOTIVE TECHNOLOGY	55,937	74,437	66,437	79,337
Advanced Composite Materials Research for Land, Marine, and Air Vehicles		3,500		2,800
Automotive Technology Tactical Metal Fabrication System		2,500		2,500
Automotive Tribology Center		2,000		1,600
Nanofluid Coolants		500	500	500
Smart Oil Sensor		3,000		2,400
Tactical Metal Fabrication System (TacFab)		1,000		800
Turbo Fuel Cell Engine		4,000		3,200
Ultra Light Weight Transmissions		2,000		1,600
Vehicle Systems Engineering and Integration Activities			10,000	8,000
14 BALLISTICS TECHNOLOGY	61,843	79,843	64,843	78,443
Advanced Composite Armor for Force Protection		2,000		1,600
Beneficial Infrastructure for Rotorcraft Risk Reduction		1,000		800
Direct Carbon Fuel Cell		3,500		2,800
Enabling Optimization of Reactive Armor		3,000	3,000	3,000
Eye-Safe Standoff Fusion Detection of CBE Threats		2,500		2,000
Flexible Solar Cell for Man-portable Power Generator		1,000		800
SHARK Precision Guided Artillery Round - 105mm		5,000		4,000
EMG - lack of authorization			-2,000	0
5.56mm Aluminum Cartridge Case			2,000	1,600
CHEMICAL, SMOKE AND EQUIPMENT DEFEATING TECHNOLOGY	5,293	13,293	7,293	13,693
Highlander Electro-Optical Sensors		2,000		1,600
Locating and Tracking Explosive Threats with Wireless Sensors and Networks		6,000		4,800
Missouri Multi-Threat Detection Initiative (M2TDI)			2,000	2,000
17 WEAPONS AND MUNITIONS TECHNOLOGY	41,085	124,585	88,985	145,625
Advanced Rarefaction Weapon Engineered System		4,000		3,200
Advanced Technology, Energy Manufacturing Sciences		7,000		7,000
Air Drop Mortar Guided Munition for the Tactical UAV		3,000		2,400
Armament System Engineering and Integration Initiative		2,000		1,600
Armaments Academy		3,000		3,000

R-1	Budget Request	House	Senate	Recommendation
Army Center of Excellence in Acoustics, National Center for Physical Acoustics		4,000	4,100	4,000
Defense Support for Civil Authorities for Key Resource Protection		1,000		800
Developmental Mission Integration		7,000		5,600
Effects Based Operations Decision Support Services		2,000		1,600
Green Armament and RangeSafe Technology Initiatives		2,000		1,600
Highly Integrated Lethality Systems Development		4,000		4,000
Highly Integrated Production for Expediting Reset		2,500		2,000
Mortar Anti-Personnel/Anti-Materiel Technology		4,000		3,200
Project National Shield Integration Center		1,500		1,200
Rare Earth Mining Separation and Metal Production		3,000		2,400
Rapid Response Force Projection Systems		2,000		1,600
Reliability and Affordability Enhancement for Precision Guided Munition Systems		6,000		4,800
Scaleable Efficient Power for Armament Systems and Vehicles Dual Use		5,000		4,000
Specialized Compact Automated Mechanical Clearance Platform		4,000		3,200
Tamper Proof Organic Packaging as Applied to Remote Armament Systems		6,000		4,800
Technology Development at the Quad Cities Manufacturing Laboratory (Transferred to line number 32)		2,000		0
Threat Detection and Neutralization		4,000		3,200
Tungsten Heavy Alloy Penetrator and Warhead Development		1,500		1,200
Accelerated Materials Development for Army Cannon Systems			3,000	2,400
Acoustic Gun Detection System for Tracked Combat Vehicles			2,000	1,600
Advanced Materials and Process for Armament Structures (AMPAS)			4,000	3,200
Building a Unified Information Framework			2,000	1,600
Center for Borane Technology			2,000	2,000
Exploding Foil Initiators (EFI) with Nanomaterial-Based Circuits			3,000	2,400
Kinetic Energy Enhanced Lethality and Protection Materials			2,000	2,000
Laser-Guided Energy (LGE) Demonstrator			2,800	2,240
Multifunctional Nanomaterials for Homeland Defense, Counter-Terrorism and Dual-Use Applications			2,500	2,000
Nanotechnology Enterprise Consortium (NTEC)			5,000	5,000
Perimeter Security Systems			5,000	4,500
Projectile Unmanned Aerial Systems		3,000	2,000	2,400
Ripsaw Unmanned Ground Vehicle (UGV) Weaponization			2,500	2,000
Titanium Extraction, Mining and Process Engineering Research			6,000	4,800
18 ELECTRONICS AND ELECTRONIC DEVICES	61,404	115,454	107,204	135,234
Advanced Flexible Solar Photovoltaic Technologies		3,000		2,400
Advanced Power Generation Unit for Military Applications		650		650

R-1	Budget Request	House	Senate	Recommendation
Advanced Power Source for Future Soldiers		1,500		1,200
Bio Battery		1,000		800
Program Increase - SOF Technology Insertion		10,000		6,000
Portable Fuel Cell Power Source		3,000		2,400
High-Volume Manufacturing Development for Thin-film Lithium Stack Battery Technologies		1,000		800
Integrated Lightweight Tracker System		2,000		2,000
Intelligent Energy Control Systems		3,000		2,400
Internal Base Facility Energy Independence		3,200		2,560
Large Format Li-Ion Battery		600	6,200	4,960
Market Viable, Dual-Use, Advanced Energy Storage Solutions Development		5,000		4,000
Micromachined Switches in Support of Transformational Communications Architecture		3,000		2,400
Mid-Infrared Super Continuum Laser		1,000		800
Military Fuel Cell Genset Technology Demonstration		2,500		2,000
Multi-Campus Base Facility Energy Independence		4,000		3,200
Novel Zinc Air Power Sources for Military Applications		2,500		2,000
ONAMI Miniaturized Tactical Energy Systems Development		2,500	3,000	2,500
Printed and Conformal Electronics for Military Applications		2,000		1,600
Soldier Situational Awareness Wristband		1,400		1,120
Solid Oxide Fuel Cell Powered Tactical Charger		1,200		960
Unmanned System Algorithm Development		4,000		3,200
Unjustified program growth		-5,000		-5,000
Tactical Cogeneration System		1,000	3,000	2,400
Advanced Hybrid Chemistry for Portable Power			3,200	2,560
Advanced Soldier-Portable Power Systems Technologies			3,100	2,480
Advanced Wearable Power System Manufacturing			2,000	1,600
Army Asset Visibility Enhancement			1,000	800
Ceramic Membrane – 10(X) Times More Energy for Battery Systems			3,000	2,400
Cogeneration for Enhanced Cooling and Heating of Advanced Tactical Vehicles			4,000	3,200
Eye Safe Laser Range Finder			3,000	2,400
High-Frequency, High-Power Electronic and Optoelectronic Devices on Aluminum Nitride (AlN)			4,000	3,200
Light Weight Nanophosphate Battery with Improved Energy Density			3,000	2,000
Maryland Proof of Concept Alliance for Defense Technologies			2,000	1,600
Self Powered, Lightweight, Flexible Display Unit on a Plastic Substrate			3,800	3,040
Stabilized Enzyme Biofuel Cell (SEBC) for Unmanned Ground Sensors			1,500	1,200
19 NIGHT VISION TECHNOLOGY	26,893	48,893	35,893	51,143
IR-Vascular Facial Fingerprinting		3,000		2,400
Next Generation Communications System		1,000		800
Personal Miniature Thermal Viewer		1,000		800
Program Increase		11,000		8,250
Standoff Improvised Explosive Detection Program		6,000		4,800
Materials for Infrared Night Vision Equipment			9,000	7,200

R-1	Budget Request	House	Senate	Recommendation
20 COUNTERMINE SYSTEMS	18,945	20,945	22,945	23,745
Spectroscopic Materials Identification Center		2,000		1,600
Standoff Sensors, Detection of Explosives and Explosive Devices (IEDs)			4,000	3,200
21 HUMAN FACTORS ENGINEERING TECHNOLOGY	18,605	33,605	18,605	30,605
Leonard Wood Institute		15,000		12,000
22 ENVIRONMENTAL QUALITY TECHNOLOGY	15,902	19,402	23,402	25,602
Biowaste-to-Bioenergy Center		2,500		2,000
Rocket Motor Contained System		1,000		800
Chemical Materials and Environmental Modeling Project			2,000	2,000
Cluster Bomb Unit and Combined Effects Munitions Demilitarization			1,000	800
MLRS Disposal System			2,500	2,500
Navy Gun Ammunition Demilitarization and Recycling			2,000	1,600
COMMAND, CONTROL, COMMUNICATIONS				
23 TECHNOLOGY	24,833	31,533	24,833	30,193
Command, Control, Communications Technology		2,000		1,600
Lightweight 10-meter Antenna Mast		2,500		2,000
Mobile Mesh Network Node		2,200		1,760
25 MILITARY ENGINEERING TECHNOLOGY	54,818	61,918	57,818	61,098
Cellulose Nanocomposites Panels for Ballistic Protection		2,000		1,600
Environmentally Intelligent Moisture and Corrosion Control for Concrete		2,100		1,680
Geosciences/Atmospheric Research		3,000	3,000	3,000
26 MANPOWER/PERSONNEL/TRAINING TECHNOLOGY	18,701	18,701	16,701	16,701
Premature Growth			-2,000	-2,000
27 WARFIGHTER TECHNOLOGY	27,109	31,909	38,109	38,549
Improved Thermal Resistant Nylon for Enhanced Durability and Thermal Protection in Combat Uniforms		1,500	4,000	3,200
Injection Molded Ceramic Body Armor		1,000		800
Joint Precision Airdrop Systems-Wind Profiling Portable Radar		2,300		1,840
Biosecurity Research for Soldier Food Safety			2,000	1,600
Carbon Nanotube Production			2,000	1,600
Nano-enabled Ultra High Storage Density Non-volatile Memory for Commander's Digital Assistant			3,000	2,400
28 MEDICAL TECHNOLOGY	99,027	195,942	165,387	223,107
Advanced Bio-Engineering for Enhancement of Soldier Survivability		3,000	2,500	2,500
Advanced Functional Nanomaterials for Biological Processes		2,500	2,400	2,400
Alginate Oligomers to Treat Infectious Microbial Biofilms		2,000		1,600
Battlefield Research Accelerating Virtual Environments for Military Individual Neuro Disorders (BRAVEMIND)		1,000		1,000

R-1	Budget Request	House	Senate	Recommendation
Protein Hydrogel for Surgical Repair of Battlefield Injuries	1,000			800
Cancer Prevention through Remote Biological Sensing	2,000			1,600
Carbide Derived Carbon for Treatment of Combat Related Sepsis	1,000			800
Center for Bone Repair and Military Readiness	1,500			1,200
Center for Injury Biomechanics	4,000		4,000	4,000
Womens Cancer Genomics Center	3,000			2,400
Clinical Trial to Investigate Efficacy of Human Skin Substitute	1,000			800
Control of Vector-Borne Diseases	3,000			2,400
Diabetes Care in the Military	2,000			1,600
Flu Vaccine Technology Program	1,500			1,200
Epigenetic Disease Research	2,000			1,600
Evaluation of Integrative Approaches to Resilience	2,000			1,600
Extended Duration Silver Wound Dressing - Phase II	1,000			800
Eye Trauma and Visual Restoration	1,000			800
Florida Trauma Rehabilitation Institute for Returning Military Personnel	3,000			2,400
Framework for Electronic Health Record-Linked Predictive Models	3,000			2,400
Human Organ and Tissue Preservation Technology	2,000			1,600
Improving Soldier Recovery from Catastrophic Bone Injuries	4,000		3,000	3,200
Jackson Health System Military Trauma Training Enhancement Initiative	2,500			2,000
Lifestyle Modifications to Reduce Chronic Disease in Military Personnel	1,500			1,500
Lightweight, Battery Driven, and Battlefield Deployment Ready NG Feeding Tube Cleaner	500			500
Myositis Association-exposure to environmental toxins	1,250			1,000
Nanofiber Based Synthetic Bone Repair Device for Limb Salvage	1,000			1,000
Nano-Imaging Agents for Early Disease Detection	1,000			800
National Eye Evaluation and Research Network	3,000			2,400
Neuro-Performance Research	2,000			1,600
Neuroscience Research Consortium to Study Spinal Cord Injury	1,500			1,200
New York Medical College Bioterrorism Research	165			132
Non-Leaching Antimicrobial Surface for Orthopedic Devices	1,500			1,200
Operating Room of the Future (Includes transfer from Defense Health Program RDT&E)	2,500			2,000
Portable Low-Volume Therapy for Severe Blood Loss	2,000			1,600
Positron Capture and Storage (Transferred to line number 54)	1,500			0
Rapid Wound Healing Cell Technology	2,500			2,000
Regenerative Medicine Research	2,000			1,600
Research to Develop Strategies to Improve Prognosis of Soldiers Suffering Abdominal Trauma	2,000			1,600
Research to Treat Cancerous Brain Tumors using Neural Stem Cells	2,000			1,600
School of Nursing Advancement	2,000			2,000

R-1	Budget Request	House	Senate	Recommendation
Self Powered Prosthetic Limb Technology		2,000	1,000	1,600
Synchrotron-Based Scanning Research Neuroscience and Proton Institute		6,000		6,000
Technology Solutions for Brain Cancer Detection and Treatment		1,500		1,200
Understanding Blast Induced Brain Injury		3,000		2,400
University of Miami Ryder Trauma Center/ William Lehman Injury Research Center		4,000		3,200
Westchester County Medical Center Health Imaging Upgrades		1,500		1,200
Biometric Signature and Passive Physiological Monitoring (Transferred to RDT&E, Air Force line number 238)			5,000	0
Center for Advanced Emergency Response (Transferred from RDT&E, Defense-Wide line number 32)				4,000
Center for Engineered Biomedical Devices			360	288
Center for Respiratory Biodefense			3,000	2,400
Cleveland Clinic Rehabilitation Research			1,000	800
Complimentary and Alternative Medicine Research for Military Operations and Healthcare (MIL-CAM)			6,500	5,200
Development of Drugs for Malaria and Leishmaniasis			3,400	3,120
Expansion and Development of Bionic Limbs for US Military Personnel			2,500	2,000
Identification of New Drug Targets in Multi-Drug Resistant Bacterial Infections (Includes transfer from RDT&E, Defense-Wide line number 26)			2,500	2,000
Lightweight Medical Devices			2,000	1,600
Long-term Pain and Infection Management for Combat Casualty Care			2,900	2,320
Military Family Empowerment Initiative			1,000	800
Minimizing Shock in Battlefield Injuries			1,900	1,900
New Vaccines to Fight Respiratory Disease and Central Nervous Disorders			6,000	4,800
Online Health Services Optimization			3,900	3,120
Optical Neural Techniques for Combat and Post-Trauma Healthcare			4,000	3,500
Regenerative Medicine for Battlefield Injuries			1,000	1,000
Stabilized Hemoglobin Wound Healing Development			1,500	1,200
SupportNet for Frontline Providers			3,000	2,400
The Center for Neuroprosthetics and BioMEMS			2,000	1,600
29 WARFIGHTER ADVANCED TECHNOLOGY	37,574	54,524	41,874	54,574
Advanced Packaging Materials for Combat Rations		1,000		800
Compostable and Recyclable Fiberboard Material for Secondary Packaging		2,500		2,000
Multi-layer Co-extrusion for High Performance Packaging		2,000		1,600
Next Generation Precision Airdrop System		2,500		2,000
Precision Guided Airdropped Equipment		1,500		1,200
Predictive Casting Process Modeling for Rapid Production of Critical Defense Components		2,000		1,600
Reducing First Responder Casualties with Physiological Monitoring		1,500		1,200

R-1	Budget Request	House	Senate	Recommendation
Remote Environmental Monitoring and Diagnostics in the Perishables Supply Chain	2,750			2,200
Soldier Personal Cooling System	1,200			960
High Pressure Pasteurization and Pressure Assisted Thermal Sterilization Project			4,300	3,440
30 MEDICAL ADVANCED TECHNOLOGY	301,866	196,040		341,531
Advanced Cancer Genome Institute	2,500			2,000
Advanced Diagnostic and Therapeutic Digital Technologies	2,000			1,600
Advanced Military Wound Healing Research and Treatment	1,000			800
Alliance for Nanohealth	5,000			4,000
ALS Therapy Development Institute -Gulf War Illness Research Project	2,000			1,600
Anti-Microbial Bone Graft Product	2,000			1,600
Antioxidant Micronutrient Therapeutic Countermeasures	1,000			800
Automated Portable Field System for Rapid Detection and Diagnosis of Endemic Diseases and Other Pathogens	2,000			1,600
Battlefield Nursing	2,000			1,600
Battlefield Related Injury Translational Research Strategies	2,250			1,800
Bio-Printing of Skin for Battlefield Burn Repairs	1,000		2,000	2,000
Blood and Bone Marrow Collection Fellowship	2,500			2,000
Blood Safety and Decontamination Technology	3,000			2,400
Brain Interventional Surgical Hybrid Initiative	3,000			2,400
Brain Safety Net	3,000			2,400
Breast Cancer Medical Information Network Decision Support	1,000			800
Cellular Therapy for Battlefield Wounds	3,500			2,800
Center for Cancer Immunology Research	2,000			1,600
Center for Genetic Origins of Cancer	2,500			2,000
Center for Integration of Medicine and Innovative Technology	9,000		10,000	9,000
Center for Ophthalmic Innovation	3,000			2,400
Center of Excellence in Infectious Diseases and Human Microbiome	3,000			2,400
Center for Virtual Reality Medical Simulation Training	1,500			1,200
Clinical Technology Integration for Military Health	2,000			1,600
Chronic Tinnitus Treatment Program	1,000			800
Collagen-Based Wound Dressing	1,000			800
Combat Wound Initiative	3,000			2,400
Customized Nursing Programs for Fort Benning	2,000			1,600
Enhancing Military Ophthalmic Education and Overcoming Urban Healthcare Disparities with Telemedicine	3,000			2,400
Enhancing Wound Healing, Tissue Regeneration, and Biomarker Discovery	2,500		2,000	2,000
Exceptional Family Transitional Training Program for US Military Soldiers, Sailors, Marines and Airmen	800			640
Hadron Particle Therapy	2,000			1,600
Human Genomics, Molecular Epidemiology, and Clinical Diagnostics for Infectious Diseases	1,500			1,200
Health Disparities in Troop Readiness	8,000			8,000
Imaging and Cognitive Evaluation of Soldiers	800			640

R-1	Budget Request	House	Senate	Recommendation
Infection Prevention Program for Battlefield Wounds	2,000			1,600
Infectious and Airborne Pathogen Reduction	2,800			2,240
Institute for Simulation and Interprofessional Studies	5,800			4,640
Advancement of Bloodless Medicine	1,866			1,493
Intelligent Orthopedic Fracture Implant Program	1,000			800
Integrated Patient Electronic Record System	2,000			1,600
Joint Medical Simulation Technology Center (Transferred to line number 38)	1,600			0
Linear Accelerator Cancer Research Project	1,000			800
Maine Institute for Human Genetics and Health	2,000			1,600
Malaria Vaccine Development	2,000		5,000	4,000
Marty Driesler Lung Cancer Project	2,000			1,600
Mass Casualty First Responders Disaster Surge Technology Program	3,000			2,400
Medical Biosurveillance and Efficiency Program	2,000			1,600
Medical Errors Reduction Initiative	2,500			2,000
Microencapsulation and Vaccine Delivery Research	1,000			800
Midwest Traumatic Injury Rehabilitation Center	1,460			1,168
Military Burn Trauma Research Program	2,000		6,000	4,500
Military Low Vision Research	3,000			2,400
Military Drug Management System	3,000			2,400
Military Mental Health Initiative	750			600
Military Pediatric Training and Support	5,000			4,000
Mission Hospital Computerized Physician Order Entry	1,000			800
Mobile Integrated Diagnostic and Data Analysis	2,000			1,600
Montefiore Critical Looking Glass	1,500			1,200
Multiplexed Human Fungal Infection Diagnostic	2,000			1,600
Musculoskeletal Interdisciplinary Research Initiative	2,000			1,600
National Biodefense Training Center (Includes transfer from line number 3)			5,000	5,000
National Functional Genomics Center	6,000			6,000
National Oncogenomics and Molecular Imaging Center	5,950			4,760
Northern Illinois Proton Treatment and Research Center	3,500			2,800
NAU-TGen North Dangerous Pathogens DNA Forensics Center Upgrades	2,000			1,600
Near Infrared Spectroscopy Military Personnel Assessment	1,000			800
Neural Control of External Devices	1,000		2,000	2,000
Neuroimaging and Neuropsychiatric Trauma in US Warfighters	6,250		5,000	6,250
Nursing Teaching and Leadership Program	1,000			800
Nicholson Center for Surgical Advancement Medical Robotics and Simulation	5,250			4,200
Personal Status Monitor	1,000			800
Nurse Education Center of Excellence for Remote and Medically Underserved Populations	2,000			1,600
Operation Re-Entry NC	3,000		2,000	2,400
Parsons Institute for Information Mapping	1,500			1,200
Pediatric Cancer Research and Clinical Trials	2,000			1,600
Plant-Based Vaccine Research	2,500			2,000
Plug-In Architecture for DOD Medical Imaging	1,500			1,200
Power Efficient Microdisplay Development for US Army Night Vision	3,000			2,400

R-1	Budget Request	House	Senate	Recommendation
Prader Willi Syndrome Research	2,000			1,600
Pride Center for America's Wounded Veterans	2,000			1,600
Remote Bio-Medical Detector	3,500			2,800
Rural Health Center of Excellence for Remote and Medically Underserved Populations	2,000			1,600
Sensor Tape Physiological Monitoring	2,500			2,000
Smart Wound Dressing for MRSA Infected Battlefield Wounds	1,000			800
Spinal Cord Restoration Therapies	1,000		2,000	1,600
Spinal Muscular Atrophy Research Program	3,000			3,000
Stress Disorders Research Initiative at Fort Hood	3,000			2,400
Dermal Matrix Research	2,000		2,000	2,000
Techniques to Manage Noncompressible Hemorrhage Following Combat Injury	2,500			2,000
Telepharmacy Robotic Medicine Device Unit	1,000			800
Testing of Microneedle Device for Multiple Applications	1,200			960
Translational Research for Muscular Dystrophy	2,000			1,600
Transportable Renal Replacement Therapy for Battlefield Applications	1,000			800
Trauma Response Simulation Training (Transferred from O&M, Army National Guard line number 131)				1,200
Treatment of Battlefield Spinal Cord and Burn Injuries	450			360
VTOL Man-Rated UAV and UGV for Medical Multi-Missions and CASEVAC	1,000			800
Vanadium Safety Readiness	4,200			3,360
Wounded Servicemember Bioelectrics Research	1,500		1,000	1,200
101st Airborne/Air Assault Injury Prevention and Performance Enhancement Initiative			3,000	3,000
Advanced Lower Limb Prostheses for Battlefield Amputees			4,000	3,200
Advanced Regenerative Medicine Therapies for Combat Injuries			4,000	3,200
Bio-Surveillance in a Highly Mobile Population			2,000	1,600
Blood, Medical and Food Safety via Eco-Friendly Wireless Sensing (Phase II)			2,000	1,600
Clinical Development of a Norovirus Gastroenteritis Vaccine			4,500	3,600
Cooperative International Neuromuscular Research Group (CINRG)			4,100	3,280
Countermeasures to Hemorrhaging (Liquid Bandage and Tissue Regeneration)			7,200	5,760
Fibrin Adhesive Stat (FAST) Dressing			3,000	2,400
Health Sciences Regenerative Medicine Center - Autologous Tissues Research			4,000	3,200
Highly Functional Neurally Controlled Skeletally Attached and Intelligent Prosthetic Devices			3,800	3,040
Identification of Pain Mechanisms and Therapeutic Targets			1,000	800
In-Field Body Temperature Conditioner			3,000	2,400
Military Medical Decontamination System			4,500	4,500
Military Nutrition Research: Four Tasks to Address Personnel Readiness			1,000	800
Mobile Aerosol Monitoring System for the Department of Defense			1,500	1,200

R-1	Budget Request	House	Senate	Recommendation
Multi-Dose Closed Loop pH Monitoring System for Platelets			2,000	1,600
Rapid Burn Wound Therapies			2,000	2,000
Regenerative Medicine for Acute Deafness			3,000	2,400
Rugged Electronic Textile Vital Signs Monitoring			3,000	2,400
Silicon Nanomaterial for Battlefield Medical Devices			3,500	2,800
Staph Vaccine			8,000	6,400
Trauma Care, Research and Training			3,000	2,400
US Army Vascular Graft Research Project			2,000	1,600
31 AVIATION ADVANCED TECHNOLOGY	60,097	87,097	104,697	112,977
Advanced Affordable Turbine Engine Program		4,000	5,000	4,000
Crewmember Alert Display Development Program		2,000		1,600
Drive System Composite Structural Component Risk Reduction Program		3,000		2,400
Fighting Combat-Related Fatigue Syndrome		1,000		800
Inter Turbine Burner for Turbo Shaft Engines		3,000		2,400
Next Generation Green, Economical and Automated Production of Composite Structures for Aerospace		1,000		1,000
Qualification and Insertion of New High Temperature Domestic Sourced PES for Military Aircraft		3,000		2,400
Heavy Fuel Engine Family for Unmanned Systems		4,000		3,200
UH-60 Transmission/Gearbox Galvanic Corrosion Reduction		1,500	1,500	1,500
Wireless HUMS for Condition Based Maintenance of Army Helicopters		2,000		1,600
Universal Control		2,500	9,000	7,200
Autonomous Cargo Acquisition for Rotorcraft Unmanned Aerial Vehicles			1,600	1,280
Enhanced-Rapid Tactical Integration for Fielding of Systems Initiative			3,900	3,120
Parts-on-Demand from CONUS Operations			5,000	4,500
Robust Composite Structural Core for Army Helicopters			2,000	1,600
Transitioning Stretch Broken Carbon Fiber to Production Programs			4,000	3,200
Unmanned Aerial Systems Ground Based Sense and Avoid Capability Development for Integration into the National Air Space			3,600	2,880
Unmanned Aerial Vehicle Resupply (UAVR) - BURRO			4,000	3,200
Vectored Thrust Ducted Compound Helicopter			5,000	5,000
WEAPONS AND MUNITIONS ADVANCED				
32 TECHNOLOGY	66,410	89,910	71,210	90,330
Advanced Lightweight Gunner Protection Kit for Lightweight MRAP Vehicle		1,000		800
Lens-Less Dual-Mode Micro Seeker for Medium-Caliber Guided Projectiles		2,500		2,000
Lightweight Munitions and Surveillance System for Unmanned Air and Ground Vehicles		4,800		3,840
Micro Inertial Navigation Unit Technology		1,500		1,200
Nanotechnology Fuze		2,000		1,600
Next Generation Machining Technology and Equipment		2,000		1,600
Rapid Insertion of Developmental Technologies into Fielded Systems		2,000		1,600

R-1	Budget Request	House	Senate	Recommendation
Recovery, Recycle, and Reuse of DOE Metals for DoD Applications (Transferred to RDT&E, Defense-Wide line number 26)		2,400		0
Soldier Protection through Unmanned Ground Vehicles		1,500		1,200
Titanium Powder Advanced Forged Parts Program		3,800		3,040
EMG - lack of authorization			-11,500	-5,500
Biosensor, Communicator and Controller System			3,500	3,500
Advanced Prototyping with Non Traditional Suppliers			1,500	0
Advanced Robot and Sensor Technology for Surveillance and Energy Efficiency Applications			1,500	1,200
Lightweight Reliable Materials for Military Systems			3,500	2,800
Technology Development at the Quad Cities Manufacturing Laboratory (Includes transfer from line number 17)			6,300	5,040
33 COMBAT VEHICLE AND AUTOMOTIVE ADVANCED TECHNOLOGY	89,586	162,186	182,886	241,446
Advanced Battery Materials and Manufacturing		5,000		4,000
Advanced Carbon Hybrid Battery for Hybrid Electric Vehicles		1,000		800
Advanced Composites for Light Weight, Low Cost Transportation Systems using a 3+ Ring Extruder		3,000		2,400
Advanced Digital Hydraulic Drive System		2,500		2,000
Advanced Lightweight Multifunctional Multi-Threat Composite Armor Material Technology		3,000		2,400
Advanced Lithium Ion Phosphate Battery System for Army Combat Hybrid HMMWV and Other Army Vehicle Platforms		2,000	3,000	2,400
Advanced Technology for Energy Storage		2,000		1,600
Advanced Thermal Management System		3,000		2,400
All Composite Bus Program		2,500		2,000
Ceramic and Metal Matrix Composites Armor Development using Ring Extruder Technology		1,000		800
Army Vehicle Condition Based Maintenance		5,000		4,000
Electric All Terrain Ultra Light Vehicle for the Minnesota National Guard		2,000		1,600
Fire Shield		4,000		3,200
Friction Stir Welding Program		3,000		2,400
Fuel System Component Technology Research		2,000		1,600
Fully Burdened Cost of Fuel and Alternative Energy Methodology and Conceptual Model		3,500		2,800
Hybrid Electric Drive All Terrain Vehicle		2,000		1,600
Hybrid Electric Heavy Truck Vehicle		2,000		1,600
Integrated Defense Technical Information		2,000		1,600
Logistical Fuel Processors Development		1,500		1,200
Networked Reliability and Safety Early Evaluation System		2,000		1,600
Protective 3-D Armor Structure to Safeguard Military Vehicles and Troops		2,000		1,600
Smart Plug-In Hybrid Vehicle Program		4,100	3,000	3,280
Silent Watch, IB NPS 1160 Lithium-Ion Advanced Battery		1,000		800
Superlattice Semiconductors for Mobile SS Lighting and Solar Power Applications		3,500		2,800

R-1	Budget Request	House	Senate	Recommendation
Unmanned Robotic System Utilizing a Hydrocarbon Fueled Solid Oxide Fuel Cell System		3,000		2,400
Program Increase		5,000		3,750
30-Kilowatt Auxiliary Power Unit for Armored Combat Vehicles			2,000	1,600
Advanced Battery Development Program			10,000	9,000
Advanced Corrosion Protection for Military Vehicles and Equipment			3,000	2,400
Advanced Suspension System For Heavy Vehicles			2,700	2,160
Alternative Energy Advanced Technology Development/Demonstration (Transferred from line number 42)				18,250
All Composite Lightweight Military Vehicle			2,000	1,600
Antiballistic Windshield Armor			3,000	2,400
Compact 10 Kilowatt Generator Set for Army and Marine Combat Vehicles			2,000	1,600
Defense Advanced Transportation Technology Program Hybrid Truck Users Forum			6,000	4,800
Enhanced Military Vehicle Maintenance System Demonstration Project			2,800	2,800
Field Deployable Fleet Hydrogen Fueling			3,000	2,400
Future Tactical Truck Carbon Composite Shelter and Retrofit of Current Vehicle Shelters			2,000	1,600
Ground-forces Readiness Enabler for Advanced Tactical Vehicles (GREAT-V)			1,000	800
Hybrid Engine Development Program			4,000	3,200
Hydraulic Hybrid Vehicles for the Tactical Wheeled Fleet			3,500	2,800
JAMMA Family of Vehicles			1,000	800
Military Installation Electric Vehicle Demonstration Project			2,000	1,600
On-Board Vehicle Power Systems Development			3,100	2,480
Plug-in Hybrid Electric Vehicle			4,000	4,000
Pre-Discharge Threat Cues			2,000	1,600
Simulation Based Reliability and Safety (SimBRS) Program			4,900	4,900
Unmanned Ground Vehicle Initiative			12,000	11,000
VePro - Vehicle Health Usage Monitoring and Prognostics			3,100	2,880
VSIL: Armored Vehicle Components and Systems Simulated In Cost-Effective Virtual Design and Test Environment			4,000	3,200
Zouline Armor			4,200	3,360
COMMAND, CONTROL, COMMUNICATIONS				
34 ADVANCED TECHNOLOGY	8,667	13,667	8,667	12,417
Program Increase		5,000		3,750
36 ELECTRONIC WARFARE ADVANCED TECHNOLOGY	50,458	57,258	58,458	57,498
Applied Communication and Information Networking		3,800	3,000	3,040
Portable Mobile Emergency Broadband Systems		3,000	4,000	3,200
Cybersecurity in Tactical Environments			1,000	800

R-1	Budget Request	House	Senate	Recommendation
NEXT GENERATION TRAINING AND SIMULATION				
38 SYSTEMS	19,415	23,915	22,415	25,495
Combat Medic Trainer		2,000	2,000	2,000
Joint Fires and Effects Trainer System Enhancements		2,500		2,000
Joint Medical Simulation Technology Center (Transferred from line number 30)				1,280
HapMed Combat Medic Trainer			1,000	800
40 EXPLOSIVES DEMILITARIZATION TECHNOLOGY	0	3,500	12,200	12,560
Advanced Reactive Armor Systems		2,000		1,600
Zumwalt National Program for Countermeasures to Biological and Chemical Threats		1,500		1,200
Cryofracture/Plasma Arc Demilitarization Program			8,000	6,400
Ultra Wideband Active RF Detection of IEDs			2,200	1,760
Unserviceable Ammunition Demilitarization via Chemical Dissolution at Tooele Army Depot			2,000	1,600
41 MILITARY HIV RESEARCH	6,657	29,657	6,657	29,657
HIV Prevention and Reducing Risk to US Military Personnel		3,000		3,000
Program Increase		20,000		20,000
COMBATING TERRORISM, TECHNOLOGY				
42 DEVELOPMENT	11,989	11,989	36,989	11,989
Alternative Energy Advanced Technology Development/Demonstration (Transferred to line number 33)			25,000	0
43 ELECTRONIC WARFARE TECHNOLOGY	19,192	22,692	19,192	21,992
Advanced Ground EW and Signals Intelligence System		2,500		2,000
AN/ALQ 211 Networked EW Controller		1,000		800
44 MISSILE AND ROCKET ADVANCED TECHNOLOGY	63,951	75,751	79,451	87,011
Anti-Tamper Research and Development		3,800		3,040
Captive Carry Sensor Test-Bed		3,000		2,400
Foil Bearing Supported UAV Engine		1,000		800
Waterside Wide Area Tactical Coverage and Homing		4,000		3,200
Advanced Commercial Technology Insertion			3,100	3,100
Army Responsive Tactical Space System Exerciser			3,000	3,000
Long Range Hypersonic Interceptor			2,000	1,600
Rapid Response Hostile Fire Detection and Active Protection of Ground and Air Vehicles Sensor Demonstration			3,200	2,560
Scenario Generation for Integrated Air and Missile Defense Evaluation			4,200	3,360
LANDMINE WARFARE AND BARRIER ADVANCED				
46 TECHNOLOGY	30,317	30,317	36,217	35,037
Advanced Demining Technology			5,900	4,720
48 NIGHT VISION ADVANCED TECHNOLOGY	40,329	64,829	57,329	72,629
Brownout Situational Awareness Sensor		3,000		2,400
Buster/Blacklight UAV Development		1,000		800
Enhanced Driver Situational Awareness		1,000		800
Hyper Spectral Sensor for Improved Force Protection		2,000		1,600
Program Increase		15,000		9,000

R-1	Budget Request	House	Senate	Recommendation
Night Vision and Electronic Sensors Directorate		2,500		2,000
Bradley Third Generation FLIR			5,000	4,500
Compact Airborne Multi-Mission Payload (CAMP) (Transferred from line number 51)				1,600
Microterrain Persistent Surveillance			2,000	1,600
Smart Sensor Supercomputing Center			10,000	8,000
ENVIRONMENTAL QUALITY TECHNOLOGY				
49 DEMONSTRATIONS	15,706	15,706	16,206	16,206
Permafrost Tunnel			500	500
50 MILITARY ENGINEERING ADVANCED TECHNOLOGY	5,911	45,461	17,511	45,631
Conversion of Municipal Solid Waste to Renewable Diesel Fuel		3,150		2,520
Defense Support to Civil Authorities Automated Support System		2,000		1,600
Demonstration of Thin Film Solar Modules as a Renewable Energy Source		1,000		800
Distributed Power from Wastewater		2,500		2,000
Enhancing the Commercial Joint Mapping Toolkit to Support Tactical Military Operations		4,000		3,200
Field Deployable Hologram Production System		4,800		3,840
Gas Engine Driven Air Conditioning		3,000		2,400
Hybrid Energy Systems Design and Testing		2,000		2,000
Lightweight Protective Roofing		1,500		1,200
Nanotechnology for Potable Water and Waste Treatment		2,000		1,600
Optimization of the US Army Topographic Data Management Enterprise		2,600		2,080
Pacific Command Renewable Energy Security Systems		3,000		2,400
Ruggedized Military Laptop Fuel Cell Power Supply- Project Phase 3		4,000	2,000	3,200
University Center for Disaster Preparedness and Emergency Response		1,500		1,200
Zinc-Flow Electrical Energy Storage		2,500		2,000
Advanced Tactical Fuels for the US Military			4,000	3,200
Amorphous Si Flexible Photovoltaics for Grid Parity			2,000	1,600
Integrated Alternative Power Systems			2,600	2,080
Natural Gas Firetube Boiler Demonstration			1,000	800
ADVANCED TACTICAL COMPUTER SCIENCE AND 51 SENSOR TECHNOLOGY	41,561	60,061	47,061	57,361
Advanced Radar Transceiver Integrated Circuit Development		1,000		800
CERDEC Integrated Tool Control System		2,000		1,600
Foliage Penetrating, Reconnaissance, Surveillance, Tracking, and Engagement Radar (FORESTER) Phase II		2,000		1,600
Intelligence, Surveillance and Reconnaissance (ISR) Simulation Integration Laboratory		2,000		1,600
Optimizing Natural Language Processing of Open Source Intelligence		1,500		1,200
Reduced Manning Situational Awareness		5,000		4,000
Shared Vision		3,000	2,000	2,400
Video Compression Technology		2,000		1,400

R-1	Budget Request	House	Senate	Recommendation
Compact Airborne Multi-mission Payload (CAMP) (Transferred to line number 48)			2,000	0
Mobile Localization (M-LOC)			1,500	1,200
52 UNIQUE ITEM IDENTIFICATION (UID)	0	2,500	0	2,000
UID Data Platform		2,500		2,000
53 ARMY MISSILE DEFENSE SYSTEMS INTEGRATION	14,683	31,683	74,783	72,163
Advanced Fuel Cell Research Program		4,000	2,000	3,200
Alternative Power Technology for Missile Defense		1,000	4,000	3,200
Biological Air Filtering System Technology		3,000	3,000	3,000
Compact Pulsed Power Initiative		4,000	3,000	3,200
Geospatial Airship Research Platform		4,000		3,200
Remote Explosive Analysis and Detection System		1,000		800
Adaptive Lightweight Materials Technology for Missile Defense			4,000	3,200
Adaptive Robotics Technology for Space, Air and Missiles (ART-SAM)			4,200	3,360
Advanced Cavitation Power Technology			4,800	3,840
Advanced Electronics Rosebud Integration			3,000	3,000
Continuous Threat Alert Sensing System (CTASS)			1,700	1,360
High Speed Digital Imaging			3,000	2,400
High Temp Polymers for Missile System Applications			4,900	3,920
On-Board Hybrid Power Unit (OBHPU)			1,300	1,040
Orion High Altitude Long Endurance UAV Risk Reduction Effort			9,700	7,760
Standoff Hazardous Agent Detection and Evaluation System			9,000	8,500
Discriminatory Imaging and Network Advancement for Missiles, Aviation and Space			2,500	2,500
ARMY MISSILE DEFENSE SYSTEMS INTEGRATION (SPACE)	117,471	120,471	118,671	119,231
Advanced Power Technologies for Nano-Satellites		2,000		1,600
Tactical Overwatch High Altitude System		1,000		800
Space Control - excessive program delays			-10,500	-10,000
HiSentinel Stratospheric Airship			3,000	2,400
Low Cost Interceptor			2,100	1,680
Missile Attack Early Warning System			2,600	2,080
Nanocomposite Enhanced Radar and Aerospace Materials (NERAM)			1,000	800
Positron Capture and Storage (Includes transfer from line number 28)			3,000	2,400
55 AIR AND MISSILE DEFENSE SYSTEMS ENGINEERING	209,531	110,531	211,531	166,931
Center for Defense Systems Research		1,000		800
Excessive project cost growth and large unobligated balances		-100,000		-45,000
Advanced Environmental Control Systems			2,000	1,600
61 SOLDIER SUPPORT AND SURVIVABILITY	31,752	31,752	33,752	33,352
Squad Mission Support System (SMSS)			2,000	1,600

R-1	Budget Request	House	Senate	Recommendation
TACTICAL ELECTRONIC SURVEILLANCE				
62 SYSTEM - AD	18,228	18,228	12,228	12,228
Unsustained growth			-6,000	-6,000
64 ENVIRONMENTAL QUALITY TECHNOLOGY	4,770	19,770	6,770	18,470
Cadmium Emissions Reduction - Letterkenny Army Depot		1,000		1,000
Program Increase		10,000		7,500
Renewable Energy Testing Center		1,000		800
Vanadium Technology Program		3,000		2,400
Environmental Management Information System (EMIS) (Army requested transfer from O&M, Army line number 131)			2,000	2,000
65 WARFIGHTER INFORMATION NETWORK-TACTICAL	180,673	165,673	180,673	170,673
Program adjustment for FCS termination		-15,000		-10,000
LOGISTICS AND ENGINEER EQUIPMENT - ADVANCED DEVELOPMENT				
68 DEVELOPMENT	56,373	57,373	49,873	59,973
In-Theater Evaluation of Ballistic Protection		1,000		800
JLTV unjustified growth			-10,000	0
Expeditionary Water Reclamation Process using Supercritical Water Oxidation			3,500	2,800
70 MEDICAL SYSTEMS - ADVANCED DEVELOPMENT	31,275	37,275	33,275	36,075
Execution of a Quality Systems Program for FDA Regulation Activities		1,500		1,200
Model for Green Laboratories and Clean Rooms		1,500		1,200
Wireless Medical Monitoring System		3,000	2,000	2,400
71 SOLDIER SYSTEMS - ADVANCED DEVELOPMENT	71,832	71,007	71,832	74,172
Unexecutable growth		-5,000		-1,000
Acid Alkaline Direct Methanol Fuel Cell		2,000		1,600
Fire Suppression System		1,425		1,140
Improved HELLHOUND 40mm Low Velocity High Explosive Ammunition		750		600
73 AIRCRAFT AVIONICS	92,977	88,977	92,977	89,977
Unjustified program growth		-4,000		-3,000
74 ARMED, DEPLOYABLE OH-58D	65,515	70,515	61,236	66,515
Advanced Composite Ammunition Magazine/Mount System		2,000		1,600
LW25 Gun System and Demonstration		3,000		2,400
Kiowa Warrior Replacement funds requested ahead of Analysis of Alternatives completion			-4,279	-3,000
75 ELECTRONIC WARFARE DEVELOPMENT	248,463	248,463	197,463	202,063
L12 unjustified growth			-18,000	-18,000
Excessive CIRCM management services			-35,000	-30,000
Hostile Fire Indicator			2,000	1,600
78 INFANTRY SUPPORT WEAPONS	74,814	76,814	82,814	83,614
Headborne Energy Analysis and Diagnostic System		2,000		1,600
Composite Bottles for Survival Egress Air			4,000	4,000
Lightweight Caliber .50 Machine Gun			4,000	3,200

R-1	Budget Request	House	Senate	Recommendation
81 FAMILY OF HEAVY TACTICAL VEHICLES	7,477	10,477	7,477	9,877
Mobile Power 30 Kilowatt System Power Control Unit Development Project		1,000		800
RDT&E for the Family of Heavy Tactical Vehicles (FHTV)		2,000		1,600
83 NON-LINE OF SIGHT LAUNCH SYSTEM	88,660	88,660	92,460	91,700
NLOS-LS Anti-Tamper Initiative			3,800	3,040
84 NON-LINE OF SIGHT CANNON	58,216	31,216	58,216	48,216
Unjustified termination costs		-27,000		-10,000
FCS MANNED GROUND VEHICLES AND COMMON				
85 GROUND VEHICLE	368,557	184,557	368,557	276,557
Unjustified termination costs		-184,000		-92,000
FCS SYSTEMS OF SYSTEMS ENGINEERING AND				
86 PROGRAM MANAGEMENT	1,067,191	1,067,191	868,191	917,191
Contractor fee reduction due to contract restructure			-199,000	-150,000
87 FCS RECONNAISSANCE (UAV) PLATFORMS	68,701	68,701	78,001	75,501
MQ-8B Fire Scout Army			9,300	6,800
90 FCS SUSTAINMENT & TRAINING R&D	749,182	749,182	567,182	659,182
Program adjustment			-182,000	-90,000
92 NIGHT VISION SYSTEMS - SDD	55,410	57,910	55,410	57,410
Standard Ground Station - Enhancement Program		2,500		2,000
102 WEAPONS AND MUNITIONS - SDD	34,878	44,378	69,878	87,478
Lightweight Packaging System for Enhancing Combat Munitions Logistics		2,000		1,600
Precision Guidance Kit Technology Development		7,500		6,000
SLAMRAAM (Transferred from Missile Procurement, Army line number 3)			35,000	45,000
103 LOGISTICS AND ENGINEER EQUIPMENT - SDD	36,018	37,518	36,018	37,218
Autonomous Sustainment Cargo Container		1,500		1,200
COMMAND, CONTROL, COMMUNICATIONS SYSTEMS				
104 - SDD	88,995	88,995	43,995	58,995
JBC-P lack of justification			-45,000	-30,000
MEDICAL MATERIEL/MEDICAL BIOLOGICAL DEFENSE				
105 EQUIPMENT	33,893	40,293	37,393	42,013
Army Portable Oxygen Concentration System		1,500		1,200
Nanophotonic Biosensor Detection of Bioagents and Pathogens		1,900		1,520
Plasma Sterilizer		3,000		2,400
Military Applications for Medical Grade Chitosan			3,500	3,000
106 LANDMINE WARFARE/BARRIER - SDD	82,260	60,960	82,260	72,760
Program adjustment for FCS termination		-21,300		-9,500
108 COMBAT IDENTIFICATION	20,070	20,070	10,070	10,070
JCTI-G lack of acquisition strategy			-10,000	-10,000

R-1	Budget Request	House	Senate	Recommendation
ARMY TACTICAL COMMAND AND CONTROL				
109 HARDWARE AND SOFTWARE	90,864	85,364	78,072	79,864
Unjustified program growth		-5,500		-3,000
Fiscal year 2011 operational testing funds requested ahead of need			-12,792	-8,000
GENERAL FUND ENTERPRISE BUSINESS SYSTEM				
111 (GFEBS)	6,002	6,002	6,002	23,902
Army requested transfer from Other Procurement, Army line number 118				17,900
114 ARTILLERY SYSTEMS	23,318	34,318	114,818	116,418
M109A6 Paladin		2,000		1,600
Program Increase		9,000		0
Army requested transfer from Weapons and Tracked Combat Vehicles, Army line number 11, for Paladin Integrated Management			91,500	91,500
117 INFORMATION TECHNOLOGY DEVELOPMENT	35,309	35,309	67,109	66,909
DIMHRS (Transferred from RDT&E, Defense-Wide line number 117)			30,800	30,800
Electronic Commodity Project			1,000	800
119 MANNED GROUND VEHICLE	100,000	50,000	100,000	80,000
Unjustified program growth		-50,000		-20,000
120 THREAT SIMULATOR DEVELOPMENT	22,222	30,222	22,222	25,222
Electronic Combat and Counter Terrorism Threat Developments to Support Joint Forces		3,000		3,000
Joint Threat Emitters (Transferred to Other Procurement, Air Force line number 28)		5,000		0
123 RAND ARROYO CENTER	16,305	16,305	18,305	17,905
Rand Arroyo Center			2,000	1,600
125 CONCEPTS EXPERIMENTATION PROGRAM	23,445	23,445	26,945	26,545
Automated Communications Support Systems for WARFIGHTERS, Intelligence Community, Linguists, and Analysts			1,500	1,500
Technology for Rapid Foreign Language Acquisition for Specialized Military and Intelligence Purposes			2,000	1,600
ARMY TECHNICAL TEST INSTRUMENTATION AND				
128 TARGETS	72,911	75,111	86,611	84,831
Define Renewable Energy Sources for Base Energy Independence		1,000	2,000	1,600
MOTS All Sky Imager		1,200		960
Dugway Field Test Improvements			4,500	3,600
Multiple Source Data Fusion for Dugway Proving Ground			2,500	2,000
Phase II, Regional Partnership – Ft. Bliss, WSMR, Holloman			4,700	3,760
130 DOD HIGH ENERGY LASER TEST FACILITY	2,891	2,891	8,891	7,391
High Energy Laser System Test Facility- HELSTF / HELTD			6,000	4,500

R-1	Budget Request	House	Senate	Recommendation
136 ARMY EVALUATION CENTER	66,309	68,309	66,309	67,909
Tire to Track Transformer System for Light Vehicles		2,000		1,600
MUNITIONS STANDARDIZATION, EFFECTIVENESS				
140 AND SAFETY	45,053	70,653	56,153	73,233
Defense Metals Technology Center		2,500		2,000
Atomized Magnesium Domestic Production Design and Development		2,000		1,600
Domestic Production of Nanodiamond for Military Applications		2,000		1,600
Improved Thermal Batteries for Guided Munitions		3,000		2,400
Joint Munitions and Lethality Mission Integration		2,000		1,600
Medium Caliber Metal Parts Upgrade		3,100	3,000	3,000
Nano Advanced Cluster Energetics		2,000		1,600
Nanotechnology-Enabled Self-Healing Anti-Corrosion Coating Products		2,000		1,400
Program Increase - Protective Armor Systems		5,000		5,000
Self-Powered Sensor System for Munition Guidance and Health Monitoring		2,000		1,500
3D Woven Preform Technology for Army Munitions Applications			2,000	1,600
Army Range Technology Program (ARTP)			6,100	4,880
146 AEROSTAT JOINT PROJECT OFFICE	360,076	288,076	360,076	330,076
Funding ahead of need		-72,000		-30,000
147 ADV FIELD ARTILLERY TACTICAL DATA SYSTEM	23,727	30,727	23,727	29,327
Advanced Field Artillery Tactical Data System		4,500		3,600
Voice Recognition and Cross Platform Speech Interface System		2,500		2,000
148 COMBAT VEHICLE IMPROVEMENT PROGRAMS	190,301	192,301	197,201	197,421
Current Force Common Active Protection System Radar		2,000		1,600
Combat Vehicle Electrical Power-21st Century (CVEP-21)			3,900	3,120
Vibration Management Enhancement Program			3,000	2,400
AIRCRAFT MODIFICATIONS/PRODUCT IMPROVEMENT				
150 PROGRAMS	209,401	209,401	214,817	214,107
D18 - JCA PQT and LFT&E non-Army requirements			-984	-984
UH-60 Aviation Software Performance Assessment Test Bed			6,400	5,680
OTHER MISSILE PRODUCT IMPROVEMENT				
155 PROGRAMS	0	5,000	0	4,000
Javelin Warhead Improvement Program		5,000		4,000
162 INFORMATION SYSTEMS SECURITY PROGRAM	74,355	74,355	61,455	58,955
BEC EMD contract funds requested ahead of need			-10,100	-10,100
JPlv2 EMD contract funds requested ahead of need			-6,800	-6,800
Biometrics DNA Applications			4,000	1,500
166 JOINT COMMAND AND CONTROL PROGRAM (JC2)	20,365	20,365	0	0
NECC program adjustment			-20,365	-20,365

R-1	Budget Request	House	Senate	Recommendation
167 TACTICAL UNMANNED AERIAL VEHICLES	202,521	172,521	172,124	173,521
Unjustified program growth		-30,000		-20,000
UGCS lack of synchronization with Department-wide enterprise			-15,000	-15,000
D09 IOT&E funds requested ahead of need			-22,897	0
4th Generation Wireless Exploitation			3,000	2,400
Shadow TUAS Flight in the National Air Space			2,500	2,000
Tactical UAV, Heavy Fuel Engine			2,000	1,600
DISTRIBUTED COMMON GROUND/SURFACE				
168 SYSTEMS	188,414	188,414	189,714	189,454
Heuristic Internet Protocol Packet Inspection Engine (HIPPIE)			1,300	1,040
170 AERIAL COMMON SENSOR (ACS)	210,035	210,035	0	116,035
Program adjustment			-210,035	-94,000
172 END ITEM INDUSTRIAL PREPAREDNESS ACTIVITIES	68,466	94,466	85,766	103,406
Achieving Lightweight Casting Solutions		2,000		1,600
ARL 3D Model-Based Inspection and Scanning		3,000		2,400
De-Weighting Military Vehicles through Advanced Composites Manufacturing Technology		2,000	3,700	2,960
High Performance Alloy Materials and Advanced Manufacturing of Steel Castings for New Light Weight and Robotic Weapon Systems		3,000		2,400
Lightweight Magnesium Parts for Military Applications		2,000		1,600
National Center for Defense Manufacturing and Machining		2,000		1,600
Network Centric Prototype Manufacturing		4,000		4,000
Polymeric Web Run-Flat Tire Inserts for Convoy Protection		3,500		3,500
Smart Machine Platform Initiative		3,000		2,400
Solid State Processing of Titanium Alloys for Advanced Materiel Armaments		1,500		1,200
Aging and Battle Damaged Weapon Systems Repair			1,500	1,200
Improved Manufacturing Processes Demonstration Program for Army Tactical Vehicles			2,000	1,600
Large Structure Titanium Machining Initiative			1,000	800
Legacy Aerospace Gear Drive Re-Engineering Initiative			2,000	2,000
Precision Strike Munitions Advancement with Integrated Millimeter Wave Power Sources to Satisfy Army Strategic Goals			4,100	3,280
Spinel Transparent Armor Production Technology			1,000	800
Superior Weapons Systems through Castings			2,000	1,600
999 CLASSIFIED PROGRAMS	3,883	47,383	3,883	26,683
Asymmetric Threat Response and Analysis Project		2,500		2,000
Army/Joint STARS Surveillance and Control Data Link Technology Refresh		1,000		800
Classified adjustment		40,000		20,000

ENHANCED MEDIUM ALTITUDE
RECONNAISSANCE AND SURVEILLANCE SYSTEM

The fiscal year 2010 budget request includes \$210,035,000 in Research, Development, Test and Evaluation, Army to initiate the restructured Aerial Common Sensor (ACS) program. However, the Department of Defense has advised that the ACS has been terminated as a program of record and established in its place the Enhanced Medium Altitude Reconnaissance and Surveillance System (EMARSS), which provides a fixed-wing, multi-sensor, integrated intelligence, surveillance and reconnaissance capability to the warfighter. Additionally, the fiscal year 2010 Overseas Contingency Operations (OCO) budget request includes \$105,000,000 to procure EMARSS C-12 aircraft and to modify those aircraft with special mission hardware as a quick reaction capability to satisfy theater-based requirements. The Department based its OCO request on the assumption that ACS would not deliver capability to the war fighter for several years. However, with EMARSS selected as a new program of

record in lieu of ACS, the EMARSS quick reaction capability request is duplicative of the program of record, and under current schedules, system deliveries for the program of record are expected shortly after deliveries of the so-called quick reaction capability. Accordingly, the recommendation provides no funding in the OCO title for procurement and modification of C-12 aircraft. In order to establish EMARSS as a program of record while fulfilling urgent theater-based fielding requirements, the recommendation includes \$116,035,000 in Research, Development, Test and Evaluation, Army, to fully fund the new EMARSS program of record and to accelerate its fielding while establishing a standardized, sustainable intelligence, surveillance and reconnaissance program.

REPORT ON THE USE OF LIVE PRIMATES IN
TRAINING RELATING TO CHEMICAL AND BIO-
LOGICAL AGENTS

The Secretary of Defense is directed to submit to the congressional defense commit-

tees, not later than 90 days after the date of the enactment of this Act, a report setting forth a detailed description of the requirements for use by the Department of Defense of live primates at the United States Army Medical Research Institute of Chemical Defense, and elsewhere, to demonstrate the effects of chemical or biological agents or chemical (such as physostigmine) or biological agent simulants in training programs. The report shall include, at a minimum, the following:

- (1) The number of live primates used in the training;
- (2) The average lifespan of primates from the point of introduction into such training programs;
- (3) An explanation as to why the use of primates in such training is more advantageous and realistic than the use of human simulators or other alternatives; and
- (4) An estimate of the cost of converting from the use of primates to human simulators in such training.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, NAVY

For Research, Development, Test and Evaluation, Navy, funds are to be available for fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
RESEARCH, DEVELOPMENT, TEST & EVAL, NAVY				
BASIC RESEARCH				
1 UNIVERSITY RESEARCH INITIATIVES.....	99,472	103,472	102,472	102,672
2 IN-HOUSE LABORATORY INDEPENDENT RESEARCH.....	18,076	18,076	18,076	18,076
3 DEFENSE RESEARCH SCIENCES.....	413,743	426,143	423,643	430,903
TOTAL, BASIC RESEARCH.....	531,291	547,691	544,191	551,651
APPLIED RESEARCH				
4 POWER PROJECTION APPLIED RESEARCH.....	59,787	68,787	72,287	77,547
5 FORCE PROTECTION APPLIED RESEARCH.....	91,400	124,900	135,900	146,700
6 MARINE CORPS LANDING FORCE TECHNOLOGY.....	39,308	39,308	46,808	45,808
7 MATERIALS, ELECTRONICS AND COMPUTER TECHNOLOGY.....	---	3,500	---	2,800
8 COMMON PICTURE APPLIED RESEARCH.....	83,163	85,983	89,663	90,903
9 WARFIGHTER SUSTAINMENT APPLIED RESEARCH.....	104,169	104,169	122,569	119,269
10 RF SYSTEMS APPLIED RESEARCH.....	64,816	68,316	66,816	69,616
11 OCEAN WARFIGHTING ENVIRONMENT APPLIED RESEARCH.....	48,750	53,750	51,750	53,950
12 JOINT NON-LETHAL WEAPONS APPLIED RESEARCH.....	6,008	6,008	6,008	6,008
13 UNDERSEA WARFARE APPLIED RESEARCH.....	55,694	60,194	63,194	65,294
14 MINE AND EXPEDITIONARY WARFARE APPLIED RESEARCH.....	40,880	40,880	44,380	44,080
TOTAL, APPLIED RESEARCH.....	593,975	655,775	699,375	721,995
ADVANCED TECHNOLOGY DEVELOPMENT				
15 POWER PROJECTION ADVANCED TECHNOLOGY.....	107,969	125,869	106,869	116,689
16 FORCE PROTECTION ADVANCED TECHNOLOGY.....	66,035	91,935	75,235	93,355
17 COMMON PICTURE ADVANCED TECHNOLOGY.....	108,394	49,284	110,394	109,994
18 WARFIGHTER SUSTAINMENT ADVANCED TECHNOLOGY.....	86,239	95,039	86,239	93,279
19 ELECTROMAGNETIC SYSTEMS ADVANCED TECHNOLOGY.....	65,827	65,827	76,327	75,827
20 MARINE CORPS ADVANCED TECHNOLOGY DEMONSTRATION (ATD)...	107,363	114,863	115,363	121,063
21 JOINT NON-LETHAL WEAPONS TECHNOLOGY DEVELOPMENT.....	10,998	11,998	10,998	11,798
22 WARFIGHTER PROTECTION ADVANCED TECHNOLOGY.....	18,609	52,609	20,609	52,109
23 UNDERSEA WARFARE ADVANCED TECHNOLOGY.....	68,037	76,037	68,037	74,037
24 NAVY WARFIGHTING EXPERIMENTS AND DEMONSTRATIONS.....	52,643	52,643	52,643	52,643

(In thousands of dollars)

	Budget	House	Senate	Recommendation
25 MINE AND EXPEDITIONARY WARFARE ADVANCED TECHNOLOGY....	28,782	30,782	28,782	30,382
TOTAL, ADVANCED TECHNOLOGY DEVELOPMENT.....	720,896	766,886	751,496	831,176
DEMONSTRATION & VALIDATION				
26 AIR/OCEAN TACTICAL APPLICATIONS.....	116,082	117,982	117,482	119,002
27 AVIATION SURVIVABILITY.....	6,505	19,505	18,005	27,405
28 DEPLOYABLE JOINT COMMAND AND CONTROL.....	6,032	9,832	6,032	9,072
29 ASW SYSTEMS DEVELOPMENT.....	16,585	26,455	19,585	25,680
30 TACTICAL AIRBORNE RECONNAISSANCE.....	7,713	10,213	7,713	9,713
31 ADVANCED COMBAT SYSTEMS TECHNOLOGY.....	1,677	4,177	1,677	3,677
32 SURFACE AND SHALLOW WATER MINE COUNTERMEASURES.....	76,739	86,739	84,739	92,739
33 SURFACE SHIP TORPEDO DEFENSE.....	57,538	70,038	57,538	67,538
34 CARRIER SYSTEMS DEVELOPMENT.....	173,594	173,594	176,794	176,554
35 SHIPBOARD SYSTEM COMPONENT DEVELOPMENT.....	1,691	13,791	21,491	30,351
36 PILOT FISH.....	79,194	79,194	79,194	79,194
37 RETRACT LARCH.....	99,757	99,757	99,757	109,757
38 RETRACT JUNIPER.....	120,752	120,752	114,752	114,752
39 RADIOLOGICAL CONTROL.....	1,372	1,372	1,372	1,372
40 SURFACE ASW.....	21,995	23,995	21,995	23,595
41 ADVANCED SUBMARINE SYSTEM DEVELOPMENT.....	551,836	554,836	550,836	551,836
42 SUBMARINE TACTICAL WARFARE SYSTEMS.....	10,172	11,172	12,172	12,572
43 SHIP CONCEPT ADVANCED DESIGN.....	22,541	22,541	22,541	22,541
44 SHIP PRELIMINARY DESIGN & FEASIBILITY STUDIES.....	28,135	40,935	28,135	38,375
45 ADVANCED NUCLEAR POWER SYSTEMS.....	259,887	259,887	259,887	259,887
46 ADVANCED SURFACE MACHINERY SYSTEMS.....	5,599	13,199	19,399	20,639
47 CHALK EAGLE.....	443,555	443,555	443,555	443,555
48 LITTORAL COMBAT SHIP (LCS).....	360,518	366,918	360,518	424,518
49 COMBAT SYSTEM INTEGRATION.....	22,558	22,558	22,558	22,558
50 CONVENTIONAL MUNITIONS.....	3,458	4,458	3,458	4,258
51 MARINE CORPS ASSAULT VEHICLES.....	293,466	243,466	293,466	293,466
53 MARINE CORPS GROUND COMBAT/SUPPORT SYSTEM.....	73,798	73,798	59,798	78,598

(In thousands of dollars)

	Budget	House	Senate	Recommendation
54 JOINT SERVICE EXPLOSIVE ORDNANCE DEVELOPMENT.....	21,054	21,054	21,054	21,054
55 COOPERATIVE ENGAGEMENT.....	56,586	61,586	56,586	60,586
56 OCEAN ENGINEERING TECHNOLOGY DEVELOPMENT.....	17,328	17,328	17,328	17,328
57 ENVIRONMENTAL PROTECTION.....	20,661	20,661	21,661	21,461
58 NAVY ENERGY PROGRAM.....	8,476	13,476	17,876	18,996
59 FACILITIES IMPROVEMENT.....	4,002	9,202	7,402	10,082
60 CHALK CORAL.....	70,772	70,772	70,772	70,772
61 NAVY LOGISTIC PRODUCTIVITY.....	4,301	7,101	16,001	15,101
62 RETRACT MAPLE.....	210,237	210,237	210,237	210,237
63 LINK PLUMERIA.....	69,313	69,313	63,313	63,313
64 RETRACT ELM.....	152,151	152,151	152,151	152,151
65 SHIP SELF DEFENSE.....	6,960	6,960	6,960	6,960
66 LINK EVERGREEN.....	123,660	123,660	123,660	123,660
67 SPECIAL PROCESSES.....	54,115	54,115	54,115	54,115
68 NATO RESEARCH AND DEVELOPMENT.....	10,194	10,194	10,194	10,194
69 LAND ATTACK TECHNOLOGY.....	1,238	8,238	1,238	6,838
70 NONLETHAL WEAPONS.....	46,871	49,871	46,871	49,291
71 JOINT PRECISION APPROACH AND LANDING SYSTEMS.....	150,304	150,304	150,304	150,304
72 SINGLE INTEGRATED AIR PICTURE (SIAP) SYSTEM ENGINEER..	52,716	52,716	52,716	52,716
74 DIRECTED ENERGY AND ELECTRIC WEAPON SYSTEMS.....	5,003	22,003	8,003	19,303
75 TACTICAL AIR DIRECTIONAL INFRARED COUNTERMEASURES.....	63,702	63,702	50,702	50,702
77 JOINT COUNTER RADIO CONTROLLED IED ELECTRONIC WARFARE..	67,843	67,843	32,843	55,843
78 PRECISION STRIKE WEAPONS DEVELOPMENT PROGRAM.....	40,926	40,926	40,926	40,926
79 SPACE & ELECTRONIC WARFARE (SEW) ARCHITECTURE/ENGINE..	42,533	42,533	40,533	40,533
TOTAL, DEMONSTRATION & VALIDATION.....	4,163,795	4,260,665	4,177,995	4,385,670
ENGINEERING & MANUFACTURING DEVELOPMENT				
80 OTHER HELO DEVELOPMENT.....	54,092	54,092	54,092	54,092
81 AV-8B AIRCRAFT - ENG DEV.....	20,886	20,886	20,886	20,886
82 STANDARDS DEVELOPMENT.....	53,540	59,340	53,540	59,340

(In thousands of dollars)

	Budget	House	Senate	Recommendation
83 MULTI-MISSION HELICOPTER UPGRADE DEVELOPMENT.....	81,953	81,953	76,553	75,613
84 AIR/OCEAN EQUIPMENT ENGINEERING.....	7,485	7,485	7,485	7,485
85 P-3 MODERNIZATION PROGRAM.....	3,659	3,659	3,659	3,659
86 WARFARE SUPPORT SYSTEM.....	6,307	6,307	6,307	6,307
87 TACTICAL COMMAND SYSTEM.....	86,462	95,462	86,462	92,862
88 ADVANCED HAWKEYE.....	364,557	362,557	364,557	362,557
89 H-1 UPGRADES.....	32,830	25,830	32,830	32,830
90 ACOUSTIC SEARCH SENSORS.....	56,369	56,369	56,369	56,369
91 V-22A.....	89,512	89,512	64,512	77,012
92 AIR CREW SYSTEMS DEVELOPMENT.....	14,265	12,565	14,265	12,565
93 EA-18.....	55,446	57,446	55,446	57,046
94 ELECTRONIC WARFARE DEVELOPMENT.....	97,635	101,635	102,635	105,635
95 VHXX EXECUTIVE HELO DEVELOPMENT.....	85,240	485,240	30,000	130,000
96 NEXT GENERATION JAMMER (NGJ).....	127,970	117,970	127,970	117,970
97 JOINT TACTICAL RADIO SYSTEM - NAVY (JTRS-NAVY).....	876,374	880,874	876,374	879,974
98 SC-21 TOTAL SHIP SYSTEM ENGINEERING.....	---	5,000	5,000	8,000
99 SURFACE COMBATANT COMBAT SYSTEM ENGINEERING.....	178,459	185,459	178,459	184,059
100 LPD-17 CLASS SYSTEMS INTEGRATION.....	5,304	5,304	5,304	5,304
101 SMALL DIAMETER BOMB (SDB).....	43,902	43,902	43,902	43,902
102 STANDARD MISSILE IMPROVEMENTS.....	182,197	168,197	182,197	167,997
103 AIRBORNE MCM.....	48,712	51,712	48,712	51,112
104 NAVAL INTEGRATED FIRE CONTROL-COUNTER AIR SYSTEMS ENG.	11,727	11,727	11,727	11,727
105 ADVANCED ABOVE WATER SENSORS.....	236,078	259,078	236,078	252,478
106 SSN-688 AND TRIDENT MODERNIZATION.....	122,733	122,733	121,733	121,333
107 AIR CONTROL.....	6,533	6,533	6,533	6,533
108 SHIPBOARD AVIATION SYSTEMS.....	80,623	82,123	77,623	78,823
109 COMBAT INFORMATION CENTER CONVERSION.....	13,305	13,305	13,305	13,305
110 NEW DESIGN SSN.....	154,756	195,256	162,756	185,156
112 SUBMARINE TACTICAL WARFARE SYSTEM.....	59,703	62,203	66,703	67,303

(In thousands of dollars)

	Budget	House	Senate	Recommendation
113 SHIP CONTRACT DESIGN/LIVE FIRE T&E.....	89,988	92,488	91,988	91,988
114 NAVY TACTICAL COMPUTER RESOURCES.....	4,620	4,620	4,620	4,620
115 MINE DEVELOPMENT.....	2,249	2,249	2,249	2,249
116 LIGHTWEIGHT TORPEDO DEVELOPMENT.....	21,105	21,105	24,105	23,505
117 JOINT SERVICE EXPLOSIVE ORDNANCE DEVELOPMENT.....	10,327	10,327	10,327	10,327
118 PERSONNEL, TRAINING, SIMULATION, AND HUMAN FACTORS....	5,898	6,898	5,898	6,698
119 JOINT STANDOFF WEAPON SYSTEMS.....	10,022	10,022	10,022	10,022
120 SHIP SELF DEFENSE (DETECT & CONTROL).....	35,459	37,459	46,459	44,559
121 SHIP SELF DEFENSE (ENGAGE: HARD KILL).....	34,236	35,736	46,236	46,236
122 SHIP SELF DEFENSE (ENGAGE: SOFT KILL/EW).....	88,895	88,895	88,895	88,895
123 INTELLIGENCE ENGINEERING.....	14,438	14,438	14,438	14,438
124 MEDICAL DEVELOPMENT.....	9,888	33,788	22,288	56,928
125 NAVIGATION/ID SYSTEM.....	63,184	63,184	63,184	63,184
127 JOINT STRIKE FIGHTER (JSF).....	1,741,296	1,956,296	1,663,296	1,956,296
128 INFORMATION TECHNOLOGY DEVELOPMENT.....	9,868	9,868	9,868	9,868
129 INFORMATION TECHNOLOGY DEVELOPMENT.....	69,026	75,826	90,126	91,866
130 CH-53K.....	554,827	524,443	554,827	524,443
132 JOINT AIR-TO-GROUND MISSILE (JAGM).....	81,434	77,734	81,434	77,734
133 MULTI-MISSION MARITIME AIRCRAFT (MMA).....	1,162,417	1,182,417	1,162,417	1,175,417
134 CG(X).....	150,022	110,022	86,022	46,022
135 DDG-1000.....	539,053	539,053	526,453	526,453
136 TACTICAL CRYPTOLOGIC SYSTEMS.....	19,016	20,516	19,016	19,916
TOTAL, ENGINEERING & MANUFACTURING DEVELOPMENT.....	7,975,882	8,649,098	7,818,142	8,240,898
RDT&E MANAGEMENT SUPPORT				
137 THREAT SIMULATOR DEVELOPMENT.....	25,534	27,534	25,534	27,134
138 TARGET SYSTEMS DEVELOPMENT.....	79,603	79,603	79,603	79,603
139 MAJOR T&E INVESTMENT.....	44,844	51,544	49,844	51,844
140 STUDIES AND ANALYSIS SUPPORT - NAVY.....	11,422	12,422	11,422	12,422
141 CENTER FOR NAVAL ANALYSES.....	49,821	49,821	49,821	49,821

(In thousands of dollars)

	Budget	House	Senate	Recommendation
142 SMALL BUSINESS INNOVATIVE RESEARCH.....	---	---	2,000	1,600
143 TECHNICAL INFORMATION SERVICES.....	735	4,735	19,735	20,835
144 MANAGEMENT, TECHNICAL & INTERNATIONAL SUPPORT.....	60,590	60,590	60,590	60,590
145 STRATEGIC TECHNICAL SUPPORT.....	3,633	3,633	3,633	3,633
146 RDT&E SCIENCE AND TECHNOLOGY MANAGEMENT.....	70,942	70,942	70,942	70,942
148 RDT&E SHIP AND AIRCRAFT SUPPORT.....	193,353	193,353	183,353	193,353
149 TEST AND EVALUATION SUPPORT.....	380,733	380,733	380,733	370,733
150 OPERATIONAL TEST AND EVALUATION CAPABILITY.....	12,010	12,010	12,010	12,010
151 NAVY SPACE AND ELECTRONIC WARFARE (SEW) SUPPORT.....	2,703	2,703	2,703	2,703
152 SEW SURVEILLANCE/RECONNAISSANCE SUPPORT.....	20,921	20,921	20,921	20,921
153 MARINE CORPS PROGRAM WIDE SUPPORT.....	19,004	20,004	19,004	19,804
154 TACTICAL CRYPTOLOGIC ACTIVITIES.....	2,464	2,464	2,464	2,464
155 SERVICE SUPPORT TO JFCOM, JNTC.....	4,197	4,197	4,197	4,197
TOTAL, RDT&E MANAGEMENT SUPPORT.....	982,509	997,209	998,509	1,004,609
OPERATIONAL SYSTEMS DEVELOPMENT				
159 UNMANNED COMBAT AIR VEHICLE (UCAV) ADVANCED COMPONENT.....	311,204	306,204	311,204	306,204
160 STRATEGIC SUB & WEAPONS SYSTEM SUPPORT.....	74,939	76,139	69,439	69,699
161 SSBN SECURITY TECHNOLOGY PROGRAM.....	34,479	34,479	34,479	34,479
162 SUBMARINE ACOUSTIC WARFARE DEVELOPMENT.....	7,211	7,211	7,211	7,211
163 NAVY STRATEGIC COMMUNICATIONS.....	43,982	23,982	46,982	46,382
164 RAPID TECHNOLOGY TRANSITION (RTT).....	39,125	39,125	39,125	39,125
165 F/A-18 SQUADRONS.....	127,733	127,733	122,333	121,613
166 E-2 SQUADRONS.....	63,058	63,058	63,058	63,058
167 FLEET TELECOMMUNICATIONS (TACTICAL).....	37,431	37,431	37,431	37,031
168 TOMAHAWK AND TOMAHAWK MISSION PLANNING CENTER (TMPC).....	13,238	14,038	17,338	17,158
169 INTEGRATED SURVEILLANCE SYSTEM.....	24,835	26,835	24,835	26,435
170 AMPHIBIOUS TACTICAL SUPPORT UNITS.....	2,324	2,324	2,324	2,324
171 CONSOLIDATED TRAINING SYSTEMS DEVELOPMENT.....	49,293	52,293	39,293	41,693
172 CRYPTOLOGIC DIRECT SUPPORT.....	1,609	1,609	1,609	1,609
173 ELECTRONIC WARFARE (EW) READINESS SUPPORT.....	37,524	37,524	37,524	37,524

(In thousands of dollars)

	Budget	House	Senate	Recommendation
174 HARM IMPROVEMENT.....	30,045	30,045	30,045	30,045
175 TACTICAL DATA LINKS.....	25,003	25,003	15,003	15,003
176 SURFACE ASW COMBAT SYSTEM INTEGRATION.....	41,803	41,803	41,803	41,803
177 MK-48 ADCAP.....	28,438	38,438	28,438	34,438
178 AVIATION IMPROVEMENTS.....	135,840	127,349	134,149	135,189
179 NAVY SCIENCE ASSISTANCE PROGRAM.....	3,716	3,716	3,716	3,716
180 OPERATIONAL NUCLEAR POWER SYSTEMS.....	72,031	72,031	72,031	72,031
181 MARINE CORPS COMMUNICATIONS SYSTEMS.....	287,348	291,848	277,348	280,748
182 MARINE CORPS GROUND COMBAT/SUPPORTING ARMS SYSTEMS....	120,379	124,179	106,479	109,319
183 MARINE CORPS COMBAT SERVICES SUPPORT.....	17,057	17,057	21,457	20,577
184 USMC INTELLIGENCE/ELECTRONIC WARFARE SYSTEMS (MIP)....	30,167	29,900	30,167	29,900
185 TACTICAL AIM MISSILES.....	2,298	2,298	2,298	2,298
186 ADVANCED MEDIUM RANGE AIR-TO-AIR MISSILE (AMRAAM)....	3,604	3,604	3,604	3,604
187 JOINT HIGH SPEED VESSEL (JHSV).....	8,431	8,431	8,431	8,431
192 SATELLITE COMMUNICATIONS (SPACE).....	474,009	474,009	474,009	474,009
193 CONSOLIDATED AFLOAT NETWORK ENTERPRISE SERVICES.....	45,513	45,513	45,513	45,513
194 INFORMATION SYSTEMS SECURITY PROGRAM.....	24,226	24,226	29,226	29,226
195 JOINT COMMAND AND CONTROL PROGRAM (JC2).....	2,453	2,453	---	---
196 JOINT COMMAND AND CONTROL PROGRAM (JC2).....	4,139	4,139	---	---
197 COBRA JUDY.....	62,061	62,061	62,061	62,061
198 NAVY METEOROLOGICAL AND OCEAN SENSORS-SPACE (METOC)...	28,094	29,094	28,094	28,894
199 JOINT MILITARY INTELLIGENCE PROGRAMS.....	4,600	7,000	4,600	6,520
200 TACTICAL UNMANNED AERIAL VEHICLES.....	8,971	8,971	8,871	8,871
202 AIRBORNE RECONNAISSANCE SYSTEMS.....	46,208	52,458	50,558	55,558
203 MANNED RECONNAISSANCE SYSTEMS.....	22,599	19,899	22,599	19,899
204 DISTRIBUTED COMMON GROUND SYSTEMS.....	18,079	12,379	18,079	12,379
205 RQ-4 UAV.....	465,839	380,839	465,839	440,839
206 MQ-8 UAV.....	25,639	25,639	25,639	25,639
207 RQ-11 UAV.....	553	553	553	553

(In thousands of dollars)

	Budget	House	Senate	Recommendation
208 RQ-7 UAV.....	986	986	986	986
209 SMALL (LEVEL 0) TACTICAL UAS (STUASLO).....	18,763	18,763	18,763	18,763
210 SMALL (LEVEL 0) TACTICAL UAS (STUASLO).....	23,594	23,594	23,594	23,594
212 EP-3E REPLACEMENT (EPX).....	11,976	11,976	11,976	11,976
213 MODELING AND SIMULATION SUPPORT.....	8,028	8,028	8,028	8,028
214 DEPOT MAINTENANCE (NON-IF).....	14,675	14,675	14,675	14,675
215 AVIONICS COMPONENT IMPROVEMENT PROGRAM.....	2,725	3,725	2,725	3,525
216 INDUSTRIAL PREPAREDNESS.....	56,691	69,191	66,941	75,191
MARITIME TECHNOLOGY (MARITECH).....	---	1,000	4,000	4,100
TOTAL, OPERATIONAL SYSTEMS DEVELOPMENT.....	3,044,566	2,966,858	3,016,483	3,009,446
999 CLASSIFIED PROGRAMS.....	1,258,018	1,353,118	1,142,318	1,258,018
TOTAL, RESEARCH, DEVELOPMENT, TEST & EVAL, NAVY.....	19,270,932	20,197,300	19,148,509	20,003,463

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

R-1	Budget Request	House	Senate	Recommendation
1 UNIVERSITY RESEARCH INITIATIVES	99,472	103,472	102,472	102,672
Center for Assured Critical Application and Infrastructure Security		1,500		1,200
Ship Model Testing		2,500		2,000
Molecular Electronics for Flash Memory Production (transferred to RDT&E, Army line number 3)			3,000	
3 DEFENSE RESEARCH SCIENCES	413,743	426,143	423,643	430,903
Characterization and Exploitation of Magnetic and Electric Fields in the Coastal Ocean Environment		2,500		2,000
Energetics S&T Workforce Development		3,500		3,500
Next Generation Manufacturing Processes and Systems		1,500		1,200
ONAMI Nanoelectronics, Nanometrology and Nanobiotechnology Initiative		2,500	4,800	3,840
Shock and Vibration Modeling of Marine Composites		2,400		1,920
Waves, Wind and Scavengers: Next Generation			2,000	2,000
Renewable Energy Systems for Naval Applications			2,000	1,600
Texas Microfactory			1,100	1,100
Human Neural Cell-Based Biosensor				
4 POWER PROJECTION APPLIED RESEARCH	59,787	68,787	72,287	77,547
Aging Military Aircraft Fleet Support		2,000		1,600
Electronic Motion Actuation Systems		1,000		800
Multifunctional Materials, Devices, and Applications		2,000		1,600
Strike Weapon Propulsion		4,000		3,200
Advanced Helicopter Landing Aid			800	800
Combustion Light Gas Gun Projectile			5,000	4,000
Enhanced EO/IR Sensors			3,000	2,400
Naval Advanced Electric Launcher System			2,000	2,000
Millimeter Wave Imaging			1,700	1,360
5 FORCE PROTECTION APPLIED RESEARCH	91,400	124,900	135,900	146,700
Advanced Battery System for Military Avionics Power Systems		2,000		1,600
Advanced Energetics Initiative		4,000		4,000
Advanced Simulation Tools for Composite Aircraft Structures		2,000		1,600
Energetic Nano-Materials Agent Defeat Initiative		2,000		1,600
Center for Autonomous Solar Power - Supercapacitors for Integrated Power Storage		5,000	2,500	4,000
Advanced Composite Manufacturing for Composite High- Speed Boat Design		2,000		1,600
Non Traditional Ballistic Fiber and Fabric Weaving Application for Force Protection		2,500		2,000
Integration of Electro-Kinetic Weapons into Next Generation Navy Ships		5,000	4,000	4,000
Lithium Ion Storage Advancement for Aircraft Applications		2,500		2,000
Multi-Mission Unmanned Surface Vessel		2,500		2,000
Program Increase - Hybrid Power Systems		4,000		2,000
Alternative Energy Research			25,000	18,500
Carbon Composite Thin Films for Power Generation and Energy Storage			2,000	1,600
Magnetic Refrigeration Technology for Naval Applications			5,000	4,000

R-1	Budget Request	House	Senate	Recommendation
Fuel Efficient, High Specific Power Free Piston Engine for USSVs			2,000	1,600
Harbor Shield - Homeland Defense Port Security Initiative			2,000	1,600
Proton Exchange Membrane Fuel Cell for Underwater Vehicles			2,000	1,600
6 MARINE CORPS LANDING FORCE TECHNOLOGY	39,308	39,308	46,808	45,808
Warfighter Rapid Awareness Processing Technologies			5,000	4,500
High Power Ultra Lightweight Zinc-Air Battery			2,500	2,000
MATERIALS, ELECTRONICS AND COMPUTER				
7 TECHNOLOGY	0	3,500	0	2,800
Infrared Materials Laboratory		3,500		2,800
8 COMMON PICTURE APPLIED RESEARCH	83,163	85,963	89,663	90,903
Cognitive Radio Institute		1,000		800
Sensor Integration Framework		1,800		1,440
Intelligent Decision Exploration			4,500	3,900
Head Attitude Tracking System			2,000	1,600
9 WARFIGHTER SUSTAINMENT APPLIED RESEARCH	104,169	104,169	122,569	119,289
Composite Materials Enhancements through Polymer Science R&D			5,900	5,120
Productization of Anti-fouling and Fouling Release Coating Systems			3,500	2,800
Nanotechnology for Anti-Reverse Engineering			3,000	2,400
Biosensors for Defense Applications			1,000	800
Managing and Extending DoD Asset Lifecycles			2,000	1,600
Advanced Composite Maritime Manufacturing			2,000	1,600
Assistive Technologies for Injured Service Members			1,000	800
10 RF SYSTEMS APPLIED RESEARCH	64,816	68,316	66,816	69,616
Gallium Nitride (GaN) Power Technology		2,000		1,600
Silicon Carbide Wafer Production - Process Development for Low Defect Power Electronics		1,500		1,200
National Initiatives for Applications of Multifunctional Materials			2,000	2,000
OCEAN WARFIGHTING ENVIRONMENT APPLIED				
11 RESEARCH	48,750	53,750	51,750	53,950
Autonomous Marine Sensors and Networks for Rapid Littoral Assessment		3,000		2,400
Underwater Imaging and Communications Using Lasers		2,000	2,000	2,000
Unmanned Undersea Vehicle Submerged Long Range Positioning			1,000	800
13 UNDERSEA WARFARE APPLIED RESEARCH	55,694	60,194	63,194	65,294
Autonomous UUV Delivery and Communication System Integration		4,500		3,600
Advanced High Energy Density Surveillance Power Module			4,000	3,200
Gallienol Energy Harvesting			3,500	2,800
MINE AND EXPEDITIONARY WARFARE APPLIED				
14 RESEARCH	40,880	40,880	44,380	44,080
Electromagnetic Signatures Assessment System Using Multiple Autonomous Undersea Vehicles, Phase III			2,000	2,000
Virtual Onboard Analyst for Multi-Sensor Mine Detection			1,500	1,200

R-1	Budget Request	House	Senate	Recommendation
15 POWER PROJECTION ADVANCED TECHNOLOGY	107,969	125,869	106,869	116,689
AARGM Counter Air Defense Future Capabilities		2,500		2,000
Countermine LIDAR UAV-Based Systems		2,000	1,400	1,600
Flow Path Analysis Tool		2,000		1,600
Moving Target Indicator Scout Radar		1,000		800
Quiet Drive Advanced Rotary Actuator		2,000		1,600
Smart Instrument Development for the Magdalena Ridge Observatory		2,000	5,000	4,000
Tactical High Speed Anti-Radiation Missile Propulsion Demonstration		1,900		1,520
X-49A Envelope Expansion Modifications		4,500		3,600
Reduction to growth			-10,000	-10,000
Detection, Tracking, and Identification for ISRTE of Mobile and Asymmetric Targets			2,500	2,000
16 FORCE PROTECTION ADVANCED TECHNOLOGY	66,035	91,935	75,235	93,355
Accelerating Fuel Cells Manufacturability		2,000		1,600
Advanced Logistics Fuel Reformer for Fuel Cells (Phase II)		3,000		2,400
Agile Port and High Speed Ship Technology		2,000		1,600
HBCU Applied Research Incubator		1,000		800
High Power Density Motor Drive		3,600		2,880
High Temperature Radar Dome Materials		2,000		1,600
High Temperature Superconductor Trap Field Magnet Motor		1,000		800
Multi-Element Structured Filter Arrays for Naval Platforms		4,300		3,440
NAVAIR Project for Land/Sea-Based Air Systems Maintenance and Air Worthiness		2,000	2,000	2,000
Pure Hydrogen Supply from Logistic Fuels		3,000		2,400
Wide Area Sensor Force Protection Targeting		2,000		1,600
Single Generator Operations Lithium Ion Battery			5,000	4,000
Captive Air Amphibious Transporter			2,200	2,200
17 COMMON PICTURE ADVANCED TECHNOLOGY	108,394	49,284	110,394	109,994
High Integrity Global Positioning System		-59,110		
4-D Data Fusion Visualization			2,000	1,600
WARFIGHTER SUSTAINMENT ADVANCED TECHNOLOGY	86,239	95,039	86,239	93,279
Intelligent Retrieval of Imagery		2,500		2,000
Marine Corps Cultural and Language Training Platform		800		640
Nanofluidic Lubricants for Increased Fuel Efficiency in Heavy Duty Vehicles		1,500		1,200
Environmentally Sealed, Ruggedized Avionics Displays		4,000		3,200
ELECTROMAGNETIC SYSTEMS ADVANCED TECHNOLOGY	65,827	65,827	76,327	75,827
Reduction to new starts			-7,000	-7,000
Pacific Airborne Surveillance and Testing			17,500	17,000
MARINE CORPS ADVANCED TECHNOLOGY DEMONSTRATION (ATD)	107,363	114,863	115,363	121,063
California Central Coast Partnership Research		3,500		2,800
Enhanced Small Arms Protective Insert		2,000		1,600
Near Infrared Optical Augmentation System		2,000		1,600
Ground Warfare Acoustical Combat Systems of Netted Sensors			5,000	5,000
Marine Air-Ground Task Force Situational Awareness			3,000	2,700

R-1		Budget Request	House	Senate	Recommendation
	JOINT NON-LETHAL WEAPONS TECHNOLOGY				
21	DEVELOPMENT	10,998	11,998	10,998	11,798
	Dynamic Eye-Safe Imaging Laser		1,000		800
	WARFIGHTER PROTECTION ADVANCED TECHNOLOGY				
22	TECHNOLOGY	18,609	52,609	20,609	52,109
	Navy Special Warfare Performance and Injury Prevention Program for Special Boat Team 22		2,500	2,000	2,000
	C.W. Bill Young Bone Marrow Donor Recruitment and Research Program		31,500		31,500
23	UNDERSEA WARFARE ADVANCED TECHNOLOGY	68,037	76,037	68,037	74,037
	Underwater Explosives and Warhead Research		3,000		3,000
	Program Increase - ASW Research		5,000		3,000
	MINE AND EXPEDITIONARY WARFARE ADVANCED TECHNOLOGY				
25	TECHNOLOGY	28,782	30,782	28,782	30,382
	Joint Explosive Ordnance Disposal Diver Situational Awareness System		2,000		1,600
26	AIR/OCEAN TACTICAL APPLICATIONS	116,082	117,982	117,482	119,002
	Non-Gasoline Burning Outboard Engine		1,900		1,520
	Semi-Submersible UUV for Sensor Enhancements			1,400	1,400
27	AVIATION SURVIVABILITY	6,505	19,505	18,005	27,405
	Common Safety System Controller		3,000		2,400
	Improved Capabilities for Irregular Warfare Platforms		4,000		4,000
	Lighter-than-Air Stratospheric Unmanned Aerial Vehicle for Persistent Communications Relay and Surveillance		3,000		2,400
	Military Upset Recovery Training		1,000		800
	Modular Advanced Vision System		2,000		1,600
	Integrated Manifold and Tube Ceramic Oxygen Generator			6,000	4,800
	Conformal Ceramics for Enhanced Aviation Armor Systems			2,500	2,500
	Unmanned Vehicle Sensor Optimization Technologies Program			3,000	2,400
28	DEPLOYABLE JOINT COMMAND AND CONTROL	6,032	9,832	6,032	9,072
	Deployable Command and Control Vehicle		3,800		3,040
29	ASW SYSTEMS DEVELOPMENT	16,585	26,455	19,585	25,680
	Air Readiness/Effectiveness Measurement Program		2,000		1,600
	Marine Mammal Awareness, Alert and Response Systems		3,000		2,400
	Marine Mammal Detection System		2,000	2,000	2,000
	Marine Species Mitigation		2,870		2,295
	Sonobuoy Wave-Energy Module			1,000	800
30	TACTICAL AIRBORNE RECONNAISSANCE	7,713	10,213	7,713	9,713
	Precision Engagement Technologies for Unmanned Systems		2,500		2,000
31	ADVANCED COMBAT SYSTEMS TECHNOLOGY	1,677	4,177	1,677	3,677
	Maintenance Free Operating Period		2,500		2,000

R-1	Budget Request	House	Senate	Recommendation
SURFACE AND SHALLOW WATER MINE				
32 COUNTERMEASURES	76,739	86,739	84,739	92,739
Persistent Autonomous Maritime Surveillance		5,000		5,000
Program Increase - Minehunting Sonar		5,000		3,000
RMS transfer from Other Procurement ,Navy line number 29			8,000	8,000
33 SURFACE SHIP TORPEDO DEFENSE	57,538	70,038	57,538	67,538
AN/SLQ-25D Integration		8,000		6,400
Continuous Active Sonar for Torpedo DCL Systems		4,500		3,600
34 CARRIER SYSTEMS DEVELOPMENT	173,594	173,594	176,794	176,554
Composite Mast for CVNs			3,200	2,960
35 SHIPBOARD SYSTEM COMPONENT DEVELOPMENT	1,691	13,791	21,491	30,351
Advanced Fuel Filtration System		1,500		1,200
High-Shock 100 Amp Current Limiting Circuit Breaker		600		600
Integrated Condition Assessment and Reliability Engineering		1,000		800
Integrated Power System Power Dense Harmonic Filter Design		2,000		1,600
IP over Power Line Carrier Network Integration with ICAS		2,000		1,600
Landing Craft Composite Lift Fan		1,500		1,200
Shipboard Wireless Maintenance Assistant		1,500		1,200
Integrated Power System Converter		2,000		1,600
DDG-51 Hybrid Drive System			8,100	8,100
Advanced Steam Turbine			4,000	4,000
Propulsion Manufacturing Technology Development			4,700	3,760
Advanced Fluid Controls for Shipboard Application			3,000	3,000
37 RETRACT LARCH	99,757	99,757	99,757	109,757
Transfer from RDT&E, Defense-Wide line number 70				10,000
38 RETRACT JUNIPER	120,752	120,752	114,752	114,752
Program adjustment			-6,000	-6,000
40 SURFACE ASW	21,995	23,995	21,995	23,595
Low Frequency Active Towed Sonar System Organic ASW Capability		2,000		1,600
41 ADVANCED SUBMARINE SYSTEM DEVELOPMENT	551,836	554,836	550,836	551,836
Program delay		-4,000		-4,000
SSBN(X) Systems Development		2,500		2,000
Submarine Fatline Vector Sensor Towed Array		2,000		1,600
Underwater Explosion Modeling and Simulation for Ohio Class Replacement Composite Non-Pressure Hull Fairing		2,500		2,000
Organic Submarine ISRT Demonstration (IRST OSAID)			3,000	2,400
Undersea Superiority program support			-4,000	-4,000
42 SUBMARINE TACTICAL WARFARE SYSTEMS	10,172	11,172	12,172	12,572
Submarine Panoramic Awareness System		1,000		800
High Torque, Low Speed, Direct Drive Electric Motor Technology			2,000	1,600
44 SHIP PRELIMINARY DESIGN & FEASIBILITY STUDIES	28,135	40,935	28,135	38,375
Bow Lifting Body Project		4,000		3,200
Low Signature Defensive Weapon System for Surface Combatant Craft		4,800		3,840
Naval Ship Hydrodynamic Test Facilities		4,000		3,200

R-1	Budget Request	House	Senate	Recommendation
46 ADVANCED SURFACE MACHINERY SYSTEMS	5,599	13,199	19,399	20,639
High Density Power Conversion and Distribution Equipment		1,500		1,200
Hybrid Propulsion/Power Generation for Increased Fuel Efficiency for Surface Combatants		2,000	8,000	6,400
Integrated Advanced Ship Control		1,500		1,200
Micro-Drive for Future HVAC Systems		600	2,400	1,920
Next Generation Shipboard Integrated Power-Fuel Efficiency and Advanced Capability Enhancer		2,000		1,600
Fan Coil Assembly of the Future			3,400	2,720
48 LITTORAL COMBAT SHIP (LCS)	360,518	366,918	360,518	424,518
Program Increase - Mine Warfare Modules		6,400		4,000
Revised acquisition strategy				60,000
50 CONVENTIONAL MUNITIONS	3,458	4,458	3,458	4,258
Improved Kinetic Energy Cargo Round		1,000		800
51 MARINE CORPS ASSAULT VEHICLES	293,466	243,466	293,466	293,466
Program delay		-50,000		
MARINE CORPS GROUND COMBAT/SUPPORT				
53 SYSTEM	73,798	73,798	59,798	78,598
Expeditionary Capabilities Laboratory			3,000	2,400
Marine Expeditionary Rifle Squad Reconfigurable Vehicle Simulator			3,000	2,400
JLTV program delay			-20,000	
55 COOPERATIVE ENGAGEMENT	56,586	61,586	56,586	60,586
Cooperative Engagement Capability		5,000		4,000
57 ENVIRONMENTAL PROTECTION	20,661	20,661	21,661	21,461
Compliance Tools Development for Metals in Antifouling Paints			1,000	800
58 NAVY ENERGY PROGRAM	8,476	13,476	17,876	18,996
Program Increase - Alternative and Renewable Energy Sources		5,000		3,000
Solar Heat Reflective Film for Energy and Fuel Efficiency in Buildings and Vehicles			4,900	3,920
Molten Carbonate Fuel Cell Demonstrator			4,500	3,600
59 FACILITIES IMPROVEMENT	4,002	9,202	7,402	10,082
Kinetic Hydropower System Turbine		2,000		1,600
Photovoltaic Rooftop Systems for Military Housing		1,500		1,200
Regenerative Fuel Cell Back-up Power		1,700	1,000	1,360
Permanent Magnet Generator - Wave Energy Buoy			2,400	1,920

R-1	Budget Request	House	Senate	Recommendation
61 NAVY LOGISTIC PRODUCTIVITY	4,301	7,101	16,001	15,101
Highly Integrated Siloxane Optical Interconnect for Military Avionics		1,000		800
NSWC Corona Item Unique Identification Center		1,800		1,440
Advanced Naval Logistics			3,000	2,400
Hawaii National Guard Integrated Information Command System			1,600	1,280
Photonic Integration Foundry			3,000	2,400
Thin Film Materials for Advanced Applications, Advanced IED and Anti-Personnel Sensors			1,600	1,280
Radio Frequency Identification (RFID) Technologies (transferred to RDT&E, Defense-Wide line number 41)			1,000	
Real-time Tactical Intelligence Collection System			1,500	1,200
63 LINK PLUMERIA	69,313	69,313	63,313	63,313
Program adjustment			-6,000	-6,000
69 LAND ATTACK TECHNOLOGY	1,238	8,238	1,238	6,838
76mm Swarbuster Capability		2,000		1,600
Hybrid Propellant for Medium and Large Caliber Ammunition		5,000		4,000
70 NONLETHAL WEAPONS	46,971	49,871	46,971	49,291
Non-Lethal Defense Technologies		2,900		2,320
DIRECTED ENERGY AND ELECTRIC WEAPON SYSTEMS	5,003	22,003	8,003	19,303
Joint Technology Insertion and Accelerated System Integration Capability for Electronic Warfare		2,000		1,600
Program Increase - Directed Energy Weapons		15,000		10,000
Global Law Enforcement Support for Counter-Narcotics			1,500	1,500
Maritime Directed Energy Test and Evaluation Center			1,500	1,200
TACTICAL AIR DIRECTIONAL INFRARED COUNTERMEASURES	63,702	63,702	50,702	50,702
TADIRCM program delay			-13,000	-13,000
JOINT COUNTER RADIO CONTROLLED IED ELECTRONIC WARFARE	67,843	67,843	32,843	55,843
JCREW 3.3 contract delay			-35,000	-12,000
SPACE & ELECTRONIC WARFARE (SEW) ARCHITECTURE/ENGINE	42,533	42,533	40,533	40,533
Funding carryover due to fleet schedules			-2,000	-2,000
82 STANDARDS DEVELOPMENT	53,540	59,340	53,540	59,340
Measurement Standards Research and Development		5,800		5,800
MULTI-MISSION HELICOPTER UPGRADE DEVELOPMENT	81,953	81,953	76,553	75,613
M230 30mm Chain Gun Automatic Cannon			4,700	3,760
Defer IFF Mode 5			-10,100	-10,100
87 TACTICAL COMMAND SYSTEM	86,462	95,462	86,462	92,862
Shipboard Wireless Network		3,000		2,400
Program Increase - ISR Enhancements		6,000		4,000
88 ADVANCED HAWKEYE	364,557	362,557	364,557	362,557
Engineering support growth		-2,000		-2,000

R-1	Budget Request	House	Senate	Recommendation
89 H-1 UPGRADES	32,830	25,830	32,830	32,830
Excessive program growth		-7,000		
91 V-22A	89,512	89,512	64,512	77,012
Reduction to growth			-25,000	-12,500
92 AIR CREW SYSTEMS DEVELOPMENT	14,265	12,565	14,265	12,565
Common Mobile Aircrew Restraint System contract delay		-1,700		-1,700
93 EA-18	55,446	57,446	55,446	57,046
Next Generation Electronic Warfare Simulator		2,000		1,600
94 ELECTRONIC WARFARE DEVELOPMENT	97,635	101,635	102,635	105,635
NAWCWD Point Mugu Electronic Warfare Laboratory Upgrade		4,000		3,200
Small Survivable Jammer			1,000	800
F/A-18 Countermeasures Improvement			4,000	4,000
95 VHXX EXECUTIVE HELO DEVELOPMENT	85,240	485,240	30,000	130,000
Continue Increment One Development		400,000		
Termination costs funded ahead of estimate			-55,240	-55,240
Technology capture				100,000
96 NEXT GENERATION JAMMER (NGJ)	127,970	117,970	127,970	117,970
Program growth		-10,000		-10,000
97 JOINT TACTICAL RADIO SYSTEM - NAVY (JTRS-NAVY)	876,374	880,874	876,374	879,974
Joint Tactical Radio System Handheld Manpack Small Form Factor Radio System		4,500		3,600
98 SC-21 TOTAL SHIP SYSTEM ENGINEERING	0	5,000	5,000	8,000
Floating Area Network Littoral Sensor Grid		5,000		4,000
Guidance, Navigation, Control, and Targeting			5,000	4,000
SURFACE COMBATANT COMBAT SYSTEM				
99 ENGINEERING	178,459	185,459	178,459	184,059
Advanced Capability Build 12 and 14		2,000		1,600
Aegis Research and Development		5,000		4,000
102 STANDARD MISSILE IMPROVEMENTS	182,197	168,197	182,197	167,997
SM-6 program execution		-15,000		-15,000
Automated Missile Tracking		1,000		800
103 AIRBORNE MCM	48,712	51,712	48,712	51,112
Common Air Mine Countermeasures Tow Cable		3,000		2,400
105 ADVANCED ABOVE WATER SENSORS	236,078	259,078	236,078	252,478
Common Digital Sensor Architecture		3,000		2,400
Submarine Navigation Decision Aids		5,000		4,000
Program Increase - Advanced Sensor Development		15,000		10,000
106 SSN-688 AND TRIDENT MODERNIZATION	122,733	122,733	121,733	121,333
Improved Submarine Towed Array Systems			2,000	1,600
OE-538/OE-592 funding carryover			-3,000	-3,000
108 SHIPBOARD AVIATION SYSTEMS	80,623	82,123	77,623	78,823
Voyage Repair Team Tool Management		1,500		1,200
ADMACS Block 3 program delay			-3,000	-3,000

R-1	Budget Request	House	Senate	Recommendation
110 NEW DESIGN SSN	154,756	195,256	162,756	185,156
Advanced Manufacturing for Submarine Bow Domes and Rubber Boots		2,000		1,600
Common Command and Control System Module		4,000	6,000	4,800
Mold-in-Place Coating Development for the US Submarine Fleet		2,000	2,000	2,000
Submarine Automated Test and Re-Test		2,500		2,000
Small Business Technology Insertion		30,000		20,000
112 SUBMARINE TACTICAL WARFARE SYSTEM	59,703	62,203	66,703	67,303
Submarine System Biometrics Access Control		2,500		2,000
Artificial Intelligence-Based Combat System Kernel			4,000	3,200
Submarine Environment for Evaluation and Development			3,000	2,400
113 SHIP CONTRACT DESIGN/ LIVE FIRE T&E	89,988	92,488	91,988	91,988
Automated Fiber Optic Manufacturing Initiative for Navy Ships		2,500	2,000	2,000
116 LIGHTWEIGHT TORPEDO DEVELOPMENT	21,105	21,105	24,105	23,505
Weapon Acquisition and Firing System			3,000	2,400
PERSONNEL, TRAINING, SIMULATION, AND HUMAN FACTORS	5,898	6,898	5,898	6,698
Workforce Requirements Planning - Team Enhancement		1,000		800
120 SHIP SELF DEFENSE (DETECT & CONTROL)	35,459	37,459	46,459	44,559
Persistent Surveillance Wave Powerbuoy System		2,000	4,000	3,200
Autonomous Unmanned Surface Vehicle			3,000	2,700
Expeditionary Swimmer Defense System			4,000	3,200
121 SHIP SELF DEFENSE (ENGAGE: HARD KILL)	34,236	35,736	46,236	46,236
Laser Phalanx		1,500	12,000	12,000
124 MEDICAL DEVELOPMENT	9,888	33,788	22,288	56,928
Advanced Molecular Medicine Initiative		1,000		800
Hampton University Proton Cancer Treatment Initiative		5,000		4,000
Deployment Health and Chronic Disease Surveillance		1,000		800
Integrated Psycho-Social Health Care Demonstration Program		1,000		1,000
Management of Lung Injury by Micronutrients		1,500		1,200
Mobile Oxygen, Ventilation, and External Suction (MOVES) System		3,400	2,000	2,720
National Functional Genomics Center Collaborating Site		4,000		3,200
On-Demand Custom Body Implants/Prosthesis for Injured Personnel		2,000		1,600
U.S. Navy Pandemic Influenza Vaccine Program		2,000		1,600
U.S. Navy Cancer Vaccine Program		3,000		2,400
Biocidal Wound Dressings			1,500	1,200
Simplified Orthopedic Surgery			5,300	4,240
Composite Tissue Transplantation for Combat Wounded Repair			2,000	2,000
Multivalent Dengue Vaccine Program			1,600	1,280
Military Dental Research (transferred from Defense Health Program)				6,000
Wound Care Research (transferred from Defense Health Program)				13,000
127 JOINT STRIKE FIGHTER (JSF)	1,741,296	1,956,296	1,663,296	1,956,296
Alternate Engine Development		215,000		215,000
Excess to need			-78,000	

R-1	Budget Request	House	Senate	Recommendation
129 INFORMATION TECHNOLOGY DEVELOPMENT	69,026	75,826	90,126	91,866
Instrumented Underwater Training Systems		2,800		2,240
Integrated Manufacturing Systems 3D Simulation and Modeling Project		2,500		2,000
Maintenance Planning and Assessment Technology Insertion		1,500		1,200
Condition-Based Maintenance Enabling Technologies Program			3,000	2,400
Digitization, Integration, and Analyst Access of Investigative Files, NCIS			1,500	1,200
Integration of Logistics Information of Knowledge Projection and Readiness Assessment Program			2,000	1,600
METOC Integrated Network-Centric Technology Systems			2,600	2,600
Supply Chain Logistics Capability at the ABL NIROP			8,000	6,400
SPAWAR Systems Center/ITC New Orleans			4,000	3,200
130 CH-53K	554,827	524,443	554,827	524,443
Program execution		-30,384		-30,384
132 JOINT AIR-TO-GROUND MISSILE (JAGM)	81,434	77,734	81,434	77,734
Program delay		-3,700		-3,700
133 MULTI-MISSION MARITIME AIRCRAFT (MMA)	1,162,417	1,182,417	1,162,417	1,175,417
Small Business Technology Insertion		20,000		13,000
134 CG(X)	150,022	110,022	86,022	46,022
Program delay		-40,000		-40,000
Propulsion development ahead of material solution decision			-24,000	-24,000
Unjustified request			-40,000	-40,000
135 DDG-1000	539,053	539,053	526,453	526,453
FSST alternative initiative			-12,600	-12,600
136 TACTICAL CRYPTOLOGIC SYSTEMS	19,016	20,516	19,016	19,916
Engineering support growth		-1,500		-1,500
Paragon (Frequency Extension)		3,000		2,400
137 THREAT SIMULATOR DEVELOPMENT	25,534	27,534	25,534	27,134
Navy Advanced Threat Simulator		2,000		1,600
139 MAJOR T&E INVESTMENT	44,844	51,544	49,844	51,844
Joint Mission Battle-Space to Support Net-Ready Key Performance Parameters		2,000		2,000
National Aviation Enterprise Interoperability with Carrier Strike and Expeditionary Group Forces		4,700	5,000	5,000
140 STUDIES AND ANALYSIS SUPPORT - NAVY	11,422	12,422	11,422	12,422
Joint Heavy-Lift Rotocraft Research		1,000		1,000
142 SMALL BUSINESS INNOVATIVE RESEARCH	0	0	2,000	1,600
Wave Energy Harvesting for Buoy Applications			2,000	1,600
143 TECHNICAL INFORMATION SERVICES	735	4,735	19,735	20,835
Center for Commercialization of Advanced Technology		2,500		2,000
Technology Transfer Office		1,500	1,500	1,500
Hawaii Technology Development Venture			10,500	10,000
Integrated Manufacturing Enterprise			5,000	5,000
Virtual Business Accelerator for the Silicon Prairie			2,000	1,600

R-1	Budget Request	House	Senate	Recommendation
148 RDT&E SHIP AND AIRCRAFT SUPPORT MRTFB additional aircraft support early to need (transferred to line number 149)	193,353	193,353	183,353 -10,000	193,353
149 TEST AND EVALUATION SUPPORT MRTFB additional aircraft support early to need (transferred from line number 148)	380,733	380,733	380,733	370,733 -10,000
153 MARINE CORPS PROGRAM WIDE SUPPORT Global Supply Chain Management	19,004	20,004 1,000	19,004	19,804 800
UNMANNED COMBAT AIR VEHICLE (UCAV)				
159 ADVANCED COMPONENT Engineering support growth	311,204	306,204 -5,000	311,204	306,204 -5,000
160 STRATEGIC SUB & WEAPONS SYSTEM SUPPORT Advanced Linear Accelerator Facility Adelos Program: Nuclear Security Sensor System Joint Warhead Fuze Sustainment growth	74,939	76,139 1,200	69,439 3,500 -9,000	69,699 960 2,800 -9,000
163 NAVY STRATEGIC COMMUNICATIONS Block 1A contract delay E-6B Strategic Communications Upgrade	43,982	23,982 -20,000	46,982 3,000	46,382 2,400
165 F/A-18 SQUADRONS Fighter Jet Noise Reduction Under Carrier Deck Operational Environment IRST contract delay	127,733	127,733	122,333 3,600 -9,000	121,613 2,880 -9,000
167 FLEET TELECOMMUNICATIONS (TACTICAL) Shipboard Automated Radio Room System NC3-LTS late Milestone B	37,431	37,431	37,431 2,000 -2,000	37,031 1,600 -2,000
TOMAHAWK AND TOMAHAWK MISSION PLANNING				
168 CENTER (TMPC) Image-Based Navigation and Precision Targeting Tomahawk Cost Reduction Initiative	13,238	14,038 800	17,338 4,100	17,158 640 3,280
169 INTEGRATED SURVEILLANCE SYSTEM Autonomous Anti-Submarine Warfare Vertical Beam Array Sonar	24,835	26,835 2,000	24,835	26,435 1,600
171 CONSOLIDATED TRAINING SYSTEMS DEVELOPMENT NAVAIR High Fidelity Oceanographic Library Reduction to growth	49,293	52,293 3,000	39,293 -10,000	41,693 2,400 -10,000
175 TACTICAL DATA LINKS Increment 3 program uncertainty	25,003	25,003	15,003 -10,000	15,003 -10,000
177 MK-48 ADCAP Small Business Technology Insertion	28,438	38,438 10,000	28,438	34,438 6,000

R-1	Budget Request	House	Senate	Recommendation
178 AVIATION IMPROVEMENTS	135,840	127,349	134,149	135,189
F-135 engine funding ahead of need		-12,491	-12,491	-12,491
Arc Fault Circuit Breaker with Arc Location		1,000		800
Lightweight Composite Structure Development for Aerospace Vehicles		3,000		2,400
Highly Conductive Lightweight Aircraft Sealant			1,200	960
Laser Peening for P-3 Life Extension			1,600	1,280
Vet-Biz Initiative for National Sustainment			5,000	4,000
Wireless Sensors for Navy Aircraft			3,000	2,400
181 MARINE CORPS COMMUNICATIONS SYSTEMS	287,348	291,848	277,348	280,748
Battlefield Sensor Netting		3,000		2,400
Media Exploitation Tool Integration with Intelligence C2 Systems		1,500		1,200
Mobile Modular Command Center (M2C2)			3,000	2,800
DCGS-MC tech development excessive growth			-5,000	-5,000
C2 Warfare Systems reduce growth			-8,000	-8,000
MARINE CORPS GROUND COMBAT/SUPPORTING				
182 ARMS SYSTEMS	120,379	124,179	106,479	109,319
Remote Aiming and Sighting Optical Retrofit		3,800		3,040
Expandable Rigid Wall Composite Shelter			1,000	800
LAV Indirect Fire Modernization			-12,200	-12,200
Battlefield Target Identification Device program uncertainty			-2,700	-2,700
183 MARINE CORPS COMBAT SERVICES SUPPORT	17,057	17,057	21,457	20,577
High Performance Capabilities for Military Vehicles Project			1,400	1,120
Marine Personnel Carrier Support System			3,000	2,400
USMC INTELLIGENCE/ELECTRONIC WARFARE				
184 SYSTEMS (MIP)	30,167	29,900	30,167	29,900
Angelfire program cancellation		-267		-267
194 INFORMATION SYSTEMS SECURITY PROGRAM	24,226	24,226	29,226	29,226
Trusted Discovery/Universal Description Discovery and Integration UDDI			5,000	5,000
195 JOINT COMMAND AND CONTROL PROGRAM (JC2)	2,453	2,453	0	0
Program delay			-2,453	-2,453
196 JOINT COMMAND AND CONTROL PROGRAM (JC2)	4,139	4,139	0	0
Program delay			-4,139	-4,139
NAVY METEOROLOGICAL AND OCEAN SENSORS-				
198 SPACE (METOC)	28,094	29,094	28,094	28,894
Integration of Advanced Wide Field of View Sensor with Reusable, Reconfigurable Payload Processing Testbed System		1,000		800
199 JOINT MILITARY INTELLIGENCE PROGRAMS	4,600	7,000	4,600	6,520
Open Source Naval and Missile Database Reporting System		2,400		1,920
200 TACTICAL UNMANNED AERIAL VEHICLES	8,971	8,971	8,871	8,871
New start UAS			-100	-100

R-1	Budget Request	House	Senate	Recommendation
202 AIRBORNE RECONNAISSANCE SYSTEMS	46,208	52,458	50,558	55,558
EP-3E Requirements Capability Migration Systems Integration Lab		6,250		5,000
FEATHAR — Fusion, Exploitation, Algorithm, Targeting High-Altitude Reconnaissance			4,350	4,350
203 MANNED RECONNAISSANCE SYSTEMS	22,599	19,899	22,599	19,899
RF research growth		-2,700		-2,700
204 DISTRIBUTED COMMON GROUND SYSTEMS	18,079	12,379	18,079	12,379
Program delay		-5,700		-5,700
205 RQ-4 UAV	465,839	380,839	465,839	440,839
Program execution		-85,000		-25,000
215 AVIONICS COMPONENT IMPROVEMENT PROGRAM	2,725	3,725	2,725	3,525
Avionics Life Extension		1,000		800
216 INDUSTRIAL PREPAREDNESS	56,691	69,191	66,941	75,191
Laser Optimization Remote Lighting System		2,500		2,000
Manufacturing S&T for Next-Generation Energetics		5,000		5,000
Next Generation Scalable Lean Manufacturing Initiative - Phase Two		3,000		2,400
Out of Autoclave Composite Processing		2,000	2,000	2,000
Low Acoustic and Thermal Signature Battlefield Power Source			4,000	3,200
Life Extension of Weapon Systems Through Advanced Materials Processing			2,500	2,500
Flight/Hangar Deck Cleaner			1,750	1,400
217 MARITIME TECHNOLOGY (MARITECH)	0	1,000	4,000	4,100
Passive RFID Development		1,000		900
National Shipbuilding Research Program Advanced Shipbuilding Enterprise			4,000	3,200
999 CLASSIFIED PROGRAMS	1,258,018	1,353,118	1,142,318	1,258,018
Classified adjustment		95,100	-115,700	0

PRESIDENTIAL HELICOPTER

The House report directed the Secretary of Defense to report on the use of certain funds for the VH-71 Presidential Helicopter. The Senate report contained no similar language. The recommendation does not retain the House language.

BONE MARROW REGISTRY

The recommendation includes \$31,500,000 for the Department of the Navy, to be administered by the C.W. Bill Young Marrow Donor Recruitment and Research Program, also known as and referred to within the Naval Medical Research Center as the Bone Marrow Registry. Funds appropriated for the

C.W. Bill Young Marrow Donor Recruitment and Research Program shall remain available only for the purposes for which they were appropriated, and may only be obligated for the C.W. Bill Young Marrow Program. This donor center has recruited more than 525,000 Department of Defense volunteers and provides more marrow donors per week than any other donor center in the nation. More than 3,360 servicemembers and other Department volunteers from this donor center have provided marrow to save the lives of patients. The success of this national and international life-saving program for military and civilian patients, which now

includes more than 7,500,000 potential volunteer donors, is admirable. Further, the agencies involved in contingency planning are encouraged to continue to include the C.W. Bill Young Marrow Donor Recruitment and Research Program in the development and testing of their contingency plans. The Department of Defense form (DD Form 1414) shall show this as a congressional interest item. The Department of Defense is further directed to release all the funds appropriated for this purpose to the C.W. Bill Young Marrow Donor Recruitment and Research Program within 60 days of the enactment of this Act.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, AIR FORCE

For Research, Development, Test and Evaluation, Air Force, funds are
to be available for fiscal year 2010, as follows:

(In thousands of dollars)				
	Budget	House	Senate	Recommendation
RESEARCH, DEVELOPMENT, TEST & EVAL, AIR FORCE				
BASIC RESEARCH				
1 DEFENSE RESEARCH SCIENCES.....	321,028	323,528	331,028	329,828
2 UNIVERSITY RESEARCH INITIATIVES.....	132,249	140,449	136,949	142,109
3 HIGH ENERGY LASER RESEARCH INITIATIVES.....	12,834	12,834	12,834	12,834
TOTAL, BASIC RESEARCH.....	466,111	476,811	480,811	484,771
APPLIED RESEARCH				
7 MATERIALS.....	127,957	155,707	168,957	179,157
8 AEROSPACE VEHICLE TECHNOLOGIES.....	127,129	129,129	138,529	139,149
9 HUMAN EFFECTIVENESS APPLIED RESEARCH.....	85,122	85,122	96,122	93,922
10 AEROSPACE PROPULSION.....	196,529	226,669	199,529	221,641
11 AEROSPACE SENSORS.....	121,768	129,768	135,668	136,588
12 SPACE TECHNOLOGY.....	104,148	116,248	110,148	119,628
13 CONVENTIONAL MUNITIONS.....	58,289	58,289	58,289	58,289
14 DIRECTED ENERGY TECHNOLOGY.....	105,677	106,677	99,927	106,477
15 COMMAND CONTROL AND COMMUNICATIONS.....	---	2,500	---	2,000
16 DOMINANT INFORMATION SCIENCES AND METHODS.....	115,278	115,278	115,278	115,278
17 HIGH ENERGY LASER RESEARCH.....	52,754	61,254	46,654	53,454
TOTAL, APPLIED RESEARCH.....	1,084,651	1,186,641	1,169,101	1,225,583
ADVANCED TECHNOLOGY DEVELOPMENT				
18 ADVANCED MATERIALS FOR WEAPON SYSTEMS.....	37,901	56,301	64,501	71,901
19 SUSTAINMENT SCIENCE AND TECHNOLOGY (S&T).....	2,955	2,955	2,955	2,955
20 ADVANCED AEROSPACE SENSORS.....	51,482	53,482	51,482	53,082
21 AEROSPACE TECHNOLOGY DEV/DEMO.....	76,844	91,844	76,844	88,594
22 AEROSPACE PROPULSION AND POWER TECHNOLOGY.....	175,676	191,176	178,676	189,576
23 CREW SYSTEMS AND PERSONNEL PROTECTION TECHNOLOGY.....	---	---	3,000	2,940
24 ELECTRONIC COMBAT TECHNOLOGY.....	31,021	32,521	31,021	32,221
25 ADVANCED SPACECRAFT TECHNOLOGY.....	83,909	98,609	90,409	99,269
26 HAWAII SPACE SURVEILLANCE SYSTEM (HSSS).....	5,813	5,813	37,813	36,813
27 HUMAN EFFECTIVENESS ADVANCED TECHNOLOGY DEVELOPMENT.....	24,565	24,565	24,565	24,565

(In thousands of dollars)

	Budget	House	Senate	Recommendation
28 CONVENTIONAL WEAPONS TECHNOLOGY.....	14,356	16,556	14,356	16,116
29 ADVANCED WEAPONS TECHNOLOGY.....	30,056	30,056	44,556	44,996
30 MANUFACTURING TECHNOLOGY PROGRAM.....	39,913	41,913	44,913	45,513
31 BATTLESPACE KNOWLEDGE DEVELOPMENT & DEMONSTRATION.....	39,708	39,708	39,708	39,708
32 C3I ADVANCED DEVELOPMENT.....	---	4,000	2,900	6,900
33 HIGH ENERGY LASER ADVANCED TECHNOLOGY PROGRAM.....	3,831	3,831	3,831	3,831
TOTAL, ADVANCED TECHNOLOGY DEVELOPMENT.....	618,030	693,330	711,530	758,980
DEMONSTRATION & VALIDATION				
34 INTELLIGENCE ADVANCED DEVELOPMENT.....	5,009	6,009	5,009	5,809
35 PHYSICAL SECURITY EQUIPMENT.....	3,623	3,623	3,623	3,623
36 ADVANCED EHF MILSATCOM (SPACE).....	464,335	464,335	464,335	464,335
39 POLAR MILSATCOM (SPACE).....	253,150	253,150	253,150	253,150
40 SPACE CONTROL TECHNOLOGY.....	97,701	97,701	102,701	101,701
41 COMBAT IDENTIFICATION TECHNOLOGY.....	27,252	27,252	29,252	28,852
42 NATO RESEARCH AND DEVELOPMENT.....	4,351	4,351	4,351	4,351
43 INTERNATIONAL SPACE COOPERATIVE R&D.....	632	632	632	632
45 INTEGRATED BROADCAST SERVICE.....	20,739	20,739	20,739	20,739
46 INTERCONTINENTAL BALLISTIC MISSILE.....	66,079	69,079	66,079	68,479
47 WIDEBAND GAPFILLER SYSTEM RDT&E (SPACE).....	70,956	70,956	70,956	70,956
48 POLLUTION PREVENTION (DEM/VAL).....	2,896	12,896	2,896	10,396
49 JOINT PRECISION APPROACH AND LANDING SYSTEMS.....	23,174	23,174	23,174	23,174
51 BATTLE MGMT COM & CTRL SENSOR DEVELOPMENT.....	22,612	---	72,612	22,612
52 HARD AND DEEPLY BURIED TARGET DEFEAT SYSTEM.....	20,891	20,891	20,891	20,891
53 JOINT DUAL ROLE AIR DOMINANCE MISSILE.....	6,882	6,882	6,882	6,882
54 REQUIREMENTS ANALYSIS AND MATURATION.....	35,533	35,533	35,533	35,533
55 GROUND ATTACK WEAPONS FUZE DEVELOPMENT.....	18,778	18,778	18,778	18,778
56 ALTERNATIVE FUELS.....	89,020	94,020	69,020	73,020
57 AUTOMATED AIR-TO-AIR REFUELING.....	43,158	43,158	43,158	43,158
59 OPERATIONALLY RESPONSIVE SPACE.....	112,861	114,361	125,861	125,211
60 TECH TRANSITION PROGRAM.....	9,611	9,611	9,611	9,611

(In thousands of dollars)

	Budget	House	Senate	Recommendation
61 NATIONAL POLAR-ORBITING OPERATIONAL ENVIRONMENTAL SAT.	396,641	396,641	396,641	396,641
61A NEXT GENERATION MILSATCOM TECHNOLOGY DEVELOPMENT.....	---	---	50,000	50,000
TOTAL, DEMONSTRATION & VALIDATION.....	1,795,884	1,793,772	1,895,884	1,858,534
ENGINEERING & MANUFACTURING DEVELOPMENT				
62 GLOBAL BROADCAST SERVICE (GBS).....	31,124	31,124	31,124	31,124
63 NUCLEAR WEAPONS SUPPORT.....	37,860	42,860	37,860	41,860
65 SPECIALIZED UNDERGRADUATE FLIGHT TRAINING.....	6,227	10,862	7,862	10,862
66 ELECTRONIC WARFARE DEVELOPMENT.....	97,275	97,275	80,275	80,275
69 TACTICAL DATA NETWORKS ENTERPRISE.....	88,444	88,444	82,944	87,444
70 PHYSICAL SECURITY EQUIPMENT.....	50	50	50	50
71 SMALL DIAMETER BOMB (SDB).....	153,815	155,815	153,815	155,415
72 COUNTERSPACE SYSTEMS.....	64,248	64,248	64,248	64,248
73 SPACE SITUATION AWARENESS SYSTEMS.....	308,134	207,834	269,534	239,534
74 AIRBORNE ELECTRONIC ATTACK.....	11,107	11,107	11,107	11,107
75 SPACE BASED INFRARED SYSTEM (SBIRS) HIGH EMD.....	512,642	526,442	512,642	526,442
76 THIRD GENERATION INFRARED SURVEILLANCE (3GIRS).....	143,169	39,169	143,169	73,369
77 ARMAMENT/ORDNANCE DEVELOPMENT.....	18,671	18,671	18,671	18,671
78 SUBMUNITIONS.....	1,784	1,784	1,784	1,784
79 AGILE COMBAT SUPPORT.....	11,261	11,261	11,261	11,261
80 LIFE SUPPORT SYSTEMS.....	10,711	11,911	14,111	14,331
81 COMBAT TRAINING RANGES.....	29,718	29,718	14,718	22,718
82 INTEGRATED COMMAND & CONTROL APPLICATIONS (IC2A).....	10	9,010	10	6,960
83 INTELLIGENCE EQUIPMENT.....	1,495	1,495	1,495	1,495
84 JOINT STRIKE FIGHTER (JSF).....	1,858,055	2,073,055	1,780,055	2,073,055
85 INTERCONTINENTAL BALLISTIC MISSILE.....	60,010	60,010	60,010	60,010
86 EVOLVED EXPENDABLE LAUNCH VEHICLE PROGRAM (SPACE).....	26,545	51,545	26,545	46,545
88 NEXT GENERATION AERIAL REFUELING AIRCRAFT.....	439,615	---	409,615	15,000
89 CSAR-X RDT&E.....	89,975	9,975	---	---
89a HH-60 RDT&E.....	---	---	14,975	14,975

(In thousands of dollars)

	Budget	House	Senate	Recommendation
90 HC/MC-130 RECAP RDT&E.....	20,582	20,582	20,582	20,582
91 JOINT SIAP EXECUTIVE PROGRAM OFFICE.....	34,877	34,877	14,877	14,877
92 LINK-16 SUPPORT AND SUSTAINMENT.....	---	---	79,300	79,300
94 SINGLE INTEGRATED AIR PICTURE (SIAP).....	13,466	13,466	13,466	13,466
95 FULL COMBAT MISSION TRAINING.....	99,807	99,807	79,807	79,807
97 JOINT CARGO AIRCRAFT (JCA).....	9,353	9,353	9,353	9,353
98 CV-22.....	19,640	19,640	19,640	19,640
99 AIRBORNE SENIOR LEADER C3 (SLC3S).....	20,056	20,056	20,056	20,056
TOTAL, ENGINEERING & MANUFACTURING DEVELOPMENT.....	4,219,726	3,771,446	4,004,961	3,865,616
RD&E MANAGEMENT SUPPORT				
100 THREAT SIMULATOR DEVELOPMENT.....	27,789	27,789	27,789	27,789
101 MAJOR T&E INVESTMENT.....	60,824	63,324	67,824	67,824
102 RAND PROJECT AIR FORCE.....	27,501	27,501	29,501	29,101
104 INITIAL OPERATIONAL TEST & EVALUATION.....	25,833	25,833	25,833	25,833
105 TEST AND EVALUATION SUPPORT.....	736,488	736,488	755,788	746,488
106 ROCKET SYSTEMS LAUNCH PROGRAM (SPACE).....	14,637	14,637	14,637	14,637
107 SPACE TEST PROGRAM (STP).....	47,215	47,215	47,215	47,215
108 FACILITIES RESTORATION & MODERNIZATION - TEST & EVAL..	52,409	60,409	52,409	58,809
109 FACILITIES SUSTAINMENT - TEST AND EVALUATION SUPPORT..	29,683	29,683	34,683	33,683
110 ACQUISITION AND MANAGEMENT SUPPORT.....	18,947	18,947	18,947	18,947
111 GENERAL SKILL TRAINING.....	1,450	1,450	1,450	1,450
113 INTERNATIONAL ACTIVITIES.....	3,748	3,748	3,748	3,748
TOTAL, RDT&E MANAGEMENT SUPPORT.....	1,046,524	1,057,024	1,079,824	1,075,524
OPERATIONAL SYSTEMS DEVELOPMENT				
114 COMMON VERTICAL LIFT SUPPORT PLATFORM.....	9,513	2,000	5,513	4,000
115 ANTI-TAMPER TECHNOLOGY EXECUTIVE AGENCY.....	47,276	47,276	47,276	47,276
117 B-52 SQUADRONS.....	93,930	102,930	99,930	102,330
118 AIR-LAUNCHED CRUISE MISSILE (ALCM).....	3,652	3,652	3,652	3,652
119 B-1B SQUADRONS.....	148,025	178,025	179,025	179,025
120 B-2 SQUADRONS.....	415,414	436,714	397,414	407,189

(In thousands of dollars)

	Budget	House	Senate	Recommendation
121 STRAT WAR PLANNING SYSTEM - USSTRATCOM.....	33,836	33,836	33,836	33,836
122 NIGHT FIST - USSTRATCOM.....	5,328	5,328	5,328	5,328
124 ATMOSPHERIC EARLY WARNING SYSTEM.....	9,832	9,832	9,832	9,832
125 REGION/SECTOR OPERATION CONTROL CENTER MODERNIZATION..	25,734	25,734	25,734	25,734
126 STRATEGIC AEROSPACE INTELLIGENCE SYSTEM ACTIVITIES....	18	18	18	18
127 WARFIGHTER RAPID ACQUISITION PROCESS (WRAP) RAPID TRAN	11,996	11,996	11,996	11,996
128 MQ-9 UAV.....	39,245	109,245	39,245	91,745
129 MULTI-PLATFORM ELECTRONIC WARFARE EQUIPMENT.....	14,747	14,747	14,747	14,747
130 A-10 SQUADRONS.....	9,697	9,697	12,197	12,197
131 F-16 SQUADRONS.....	141,020	141,020	143,020	142,620
132 F-15E SQUADRONS.....	311,167	320,167	323,167	319,967
133 MANNED DESTRUCTIVE SUPPRESSION.....	10,748	10,748	8,748	9,748
134 F-22 SQUADRONS.....	569,345	569,345	569,345	569,345
135 TACTICAL AIM MISSILES.....	5,915	5,915	5,915	5,915
136 ADVANCED MEDIUM RANGE AIR-TO-AIR MISSILE (AMRAAM)....	49,971	49,971	49,971	49,971
137 JOINT HELMET MOUNTED CUEING SYSTEM (JHMCS).....	2,529	2,529	2,529	2,529
138 COMBAT RESCUE - PARARESCUE.....	2,950	2,950	2,950	2,950
139 AF TENCAP.....	11,643	11,643	11,643	11,643
140 PRECISION ATTACK SYSTEMS PROCUREMENT.....	2,950	2,950	2,950	2,950
141 COMPASS CALL.....	13,019	13,019	13,019	13,019
142 AIRCRAFT ENGINE COMPONENT IMPROVEMENT PROGRAM.....	166,563	157,563	154,563	156,963
143 CSAF INNOVATION PROGRAM.....	4,621	4,621	12,921	11,261
144 JOINT AIR-TO-SURFACE STANDOFF MISSILE (JASSM).....	29,494	29,494	29,494	29,494
145 AIR AND SPACE OPERATIONS CENTER (AOC).....	99,405	101,405	103,405	102,605
146 CONTROL AND REPORTING CENTER (CRC).....	52,508	52,508	52,508	52,508
147 AIRBORNE WARNING AND CONTROL SYSTEM (AWACS).....	176,040	176,040	176,040	176,040
149 ADVANCED COMMUNICATIONS SYSTEMS.....	63,782	63,782	63,782	63,782
151 COMBAT AIR INTELLIGENCE SYSTEM ACTIVITIES.....	1,475	1,475	1,475	1,475
152 THEATER BATTLE MANAGEMENT (TBM) C4I.....	19,067	19,067	19,067	19,067

(In thousands of dollars)

	Budget	House	Senate	Recommendation
153 FIGHTER TACTICAL DATA LINK.....	72,106	72,106	62,106	67,106
155 C2ISR TACTICAL DATA LINK.....	1,667	1,667	1,667	1,667
156 COMMAND AND CONTROL (C2) CONSTELLATION.....	26,792	31,792	26,792	30,792
157 JOINT SURVEILLANCE AND TARGET ATTACK RADAR SYSTEM.....	140,670	140,670	175,670	186,670
158 SEEK EAGLE.....	22,071	22,071	22,071	22,071
159 USAF MODELING AND SIMULATION.....	27,245	27,245	27,245	27,245
160 WARGAMING AND SIMULATION CENTERS.....	7,018	7,018	7,018	7,018
161 DISTRIBUTED TRAINING AND EXERCISES.....	6,740	6,740	6,740	6,740
162 MISSION PLANNING SYSTEMS.....	91,995	91,995	41,995	81,995
163 INFORMATION WARFARE SUPPORT.....	12,271	14,271	12,271	13,871
170 E-4B NATIONAL AIRBORNE OPERATIONS CENTER (NAOC).....	26,107	26,107	26,107	26,107
172 MINIMUM ESSENTIAL EMERGENCY COMMUNICATIONS NETWORK....	72,694	72,694	72,694	72,694
173 INFORMATION SYSTEMS SECURITY PROGRAM.....	196,621	196,621	136,621	166,621
174 GLOBAL COMBAT SUPPORT SYSTEM.....	3,375	3,375	3,375	3,375
175 GLOBAL COMMAND AND CONTROL SYSTEM.....	3,149	7,149	3,149	6,349
176 JOINT COMMAND AND CONTROL PROGRAM (JC2).....	3,087	3,087	---	---
177 MILSATCOM TERMINALS.....	257,693	257,693	257,693	257,693
179 AIRBORNE SIGINT ENTERPRISE.....	176,989	176,989	166,989	166,989
181 ADVANCED GEOSPATIAL INTELLIGENCE.....	---	---	6,500	5,200
182 GLOBAL AIR TRAFFIC MANAGEMENT (GATH).....	6,028	6,028	6,028	6,028
183 CYBER SECURITY INITIATIVE.....	2,065	2,065	7,065	2,065
184 SATELLITE CONTROL NETWORK (SPACE).....	20,991	20,991	20,991	20,991
185 WEATHER SERVICE.....	33,531	33,531	33,531	33,531
186 AIR TRAFFIC CONTROL, APPROACH, & LANDING SYSTEM (ATC).....	9,006	9,006	12,006	11,406
187 AERIAL TARGETS.....	54,807	54,807	54,807	54,807
190 SECURITY AND INVESTIGATIVE ACTIVITIES.....	742	742	742	742
192 DEFENSE JOINT COUNTERINTELLIGENCE ACTIVITIES.....	39	39	39	39
194 NAVSTAR GLOBAL POSITIONING SYSTEM (USER EQUIPMENT)....	137,692	137,692	137,692	137,692
195 NAVSTAR GLOBAL POSITIONING SYSTEM (SPACE AND CONTROL).....	52,039	52,039	52,039	52,039
197 SPACE AND MISSILE TEST AND EVALUATION CENTER.....	3,599	3,599	3,599	3,599

(In thousands of dollars)

	Budget	House	Senate	Recommendation
198 SPACE WARFARE CENTER.....	3,009	3,009	3,009	3,009
199 SPACELIFT RANGE SYSTEM (SPACE).....	9,957	9,957	9,957	9,957
200 INTELLIGENCE SUPPORT TO INFORMATION OPERATIONS.....	1,240	2,240	1,240	2,240
202 ENDURANCE UNMANNED AERIAL VEHICLES.....	73,736	73,736	38,736	48,736
203 AIRBORNE RECONNAISSANCE SYSTEMS.....	143,892	145,892	143,892	145,492
204 MANNED RECONNAISSANCE SYSTEMS.....	12,846	15,346	12,846	14,846
205 DISTRIBUTED COMMON GROUND/SURFACE SYSTEMS.....	82,765	82,765	82,765	82,765
206 PREDATOR UAV (JMIP).....	18,101	24,301	22,101	23,776
207 RQ-4 UAV.....	317,316	317,316	317,316	317,316
208 NETWORK-CENTRIC COLLABORATIVE TARGET (TIARA).....	8,160	8,160	8,160	8,160
209 GPS III SPACE SEGMENT.....	815,095	717,695	425,695	425,695
209 GPS CONTROL SEGMENT (OCX).....	---	---	292,000	292,000
210 JSPOC MISSION SYSTEM.....	131,271	131,271	137,271	136,271
211 INTELLIGENCE SUPPORT TO INFORMATION WARFARE.....	5,267	5,267	5,267	5,267
213 NUDET DETECTION SYSTEM (SPACE).....	84,021	84,021	84,021	84,021
214 NATIONAL SECURITY SPACE OFFICE.....	10,634	---	10,634	---
215 SPACE SITUATION AWARENESS OPERATIONS.....	54,648	54,648	54,648	54,648
216 NASS, IO TECHNOLOGY INTEGRATION & TOOL DEV.....	30,076	30,076	30,076	30,076
217 SHARED EARLY WARNING (SEW).....	3,082	3,082	3,082	3,082
218 C-130 AIRLIFT SQUADRON.....	201,250	201,250	182,250	109,250
219 C-5 AIRLIFT SQUADRONS.....	95,266	95,266	85,266	85,266
220 C-17 AIRCRAFT.....	161,855	161,855	161,855	161,855
221 C-130J PROGRAM.....	30,019	30,019	30,019	30,019
222 LARGE AIRCRAFT IR COUNTERMEASURES (LAIRCM).....	31,784	31,784	26,784	26,784
223 KC-135S.....	10,297	10,297	10,297	10,297
224 KC-10S.....	35,586	35,586	35,586	35,586
226 OPERATIONAL SUPPORT AIRLIFT.....	4,916	4,916	4,916	4,916
228 SPECIAL TACTICS / COMBAT CONTROL.....	8,222	10,222	10,222	11,422
229 DEPOT MAINTENANCE (NON-IF).....	1,508	1,508	1,508	1,508

(In thousands of dollars)

	Budget	House	Senate	Recommendation
231 INDUSTRIAL PREPAREDNESS.....	---	4,000	1,000	4,000
232 LOGISTICS INFORMATION TECHNOLOGY (LOGIT).....	246,483	246,483	246,483	246,483
233 SUPPORT SYSTEMS DEVELOPMENT.....	6,288	12,788	38,188	38,258
234 OTHER FLIGHT TRAINING.....	805	805	805	805
235 JOINT NATIONAL TRAINING CENTER.....	3,220	3,220	3,220	3,220
236 TRAINING DEVELOPMENTS.....	1,769	1,769	1,769	1,769
237 OTHER PERSONNEL ACTIVITIES.....	116	116	116	116
238 JOINT PERSONNEL RECOVERY AGENCY.....	6,376	6,376	6,376	11,376
239 SERVICE-WIDE SUPPORT (NOT OTHERWISE ACCOUNTED FOR)....	---	---	---	---
240 CIVILIAN COMPENSATION PROGRAM.....	8,174	8,174	8,174	8,174
241 PERSONNEL ADMINISTRATION.....	10,492	10,492	30,982	30,982
242 FINANCIAL MANAGEMENT INFORMATION SYSTEMS DEVELOPMENT..	55,991	55,991	55,991	55,991
TOTAL, OPERATIONAL SYSTEMS DEVELOPMENT.....	6,796,817	6,848,770	6,642,020	6,731,333
999 CLASSIFIED PROGRAMS.....	11,955,084	12,148,484	12,064,884	12,121,644
TOTAL, RESEARCH, DEVELOPMENT, TEST & EVAL, AIR FORCE	27,992,827	27,976,278	28,049,015	28,121,985

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

R-1	Budget Request	House	Senate	Recommendation
1 DEFENSE RESEARCH SCIENCES	321,028	323,528	331,028	329,828
Process Integrated Mechanism for Human-Computer Collaboration and Coordination		1,000		800
Safeguarding End-User Military Software		1,500	5,000	4,000
Coal Transformation Laboratory			1,000	800
Development and Validation of Advanced Design Technologies for Hypersonic Research			2,000	1,600
Development of Deployable Biosensors			2,000	1,600
2 UNIVERSITY RESEARCH INITIATIVES	132,249	140,449	136,949	142,109
Cyber Security Research Program/Cyber Security Laboratory		1,500	1,000	1,200
Unmanned Aerial Systems Mission Planning and Operation Center		3,500		2,800
Energy and Sensor Informatics Research and Translation		1,000		800
Frank R. Seaver Science and Engineering Initiative		2,200		1,760
Cyber Innovation Center (CIC) Research and Development Seed Fund			1,000	800
Cybersecurity of Security Control Networks (Note: Includes transfer from O&M, Air Force)			1,700	1,700
High Temperature Hydrogen Energy Production Facility			1,000	800
7 MATERIALS	127,957	155,707	168,957	179,157
Accelerated Insertion of Advanced Materials and Certification for Military Aircraft Structure Material Substitution and Repair		2,500		2,000
Advanced Aerospace Carbon Foam Heat Exchangers		750	4,000	3,200
Aerospace Laser Micro Engineering Station		1,000		800
Fine Water Mist Fire Suppression Technology to Replace Halon		2,500		2,000
Gallium Nitride (GaN) Microelectronics and Materials		2,000		1,600
Institute for Science and Engineering Simulation/Aircraft Fatigue Modeling and Simulation		4,500	3,000	3,600
Large Area, APVT Materials Development for High Power Devices		2,000		1,600
Low-Defect Density Gallium Nitride Materials for High-Performance Electronic Devices		3,500		2,800
ONAMI Safer Nanomaterials and Nanomanufacturing Partnership for Energy and Automation Technologies		2,000	4,400	3,520
Pennsylvania Nanomaterials Commercialization Center		1,000		800
Ultra-High Temperature Materials for Hypersonic Aerospace Vehicles		3,000		2,400
Carbon Nanomaterials for Advanced Aerospace Applications		1,000		800
Air Force Minority Leaders Program			6,000	4,800
Conducting Polymer Stress and Polymer Damage Sensors for Composites			3,600	2,880
Consortium for Nanomaterials for Aerospace Commerce and Technology (CONTACT)			4,000	3,200
Development of Mobile Wind Turbine Systems to Power Forward Bases			1,500	1,200
Energy Efficiency, Recovery and Generation (ENERGY)			1,000	1,000
Fire and Blast Resistant Materials for Force Protection			4,000	3,200
Hybrid Materials Integration (HMI)			2,500	2,000

R-1	Budget Request	House	Senate	Recommendation
LGX High Temperature Acoustic Wave Sensors			2,000	1,600
Lightning Protection of Composites			3,000	3,000
Mid-IR Laser Materials			1,000	800
Temperature Resistant Landing Pad Jet Blast Protection			1,000	800
8 AEROSPACE VEHICLE TECHNOLOGIES	127,129	129,129	138,529	139,149
Unmanned Sense, Track, and Avoid Radar		2,000		1,600
Materials Integrity Management Research for the Air Force			3,000	3,000
UAV Sensor and Maintenance Development Center			4,900	3,920
Unmanned Aerial System Exploitation			3,500	3,500
9 HUMAN EFFECTIVENESS APPLIED RESEARCH	85,122	85,122	96,122	93,922
Advanced Night Vision System - Cockpit Integration			1,000	800
Imaging Tools for Human Performance Enhancement and Diagnostics			2,000	1,600
Center for UAS Research, Education and Training (Includes transfer from line number 206)			8,000	6,400
10 AEROSPACE PROPULSION	196,529	226,669	199,529	221,641
Advanced Lithium Battery Scale-up and Manufacturing		2,000		1,600
Advanced Vehicle Propulsion Center		3,000		2,400
Aerospace Lab Equipment Upgrade		1,500		1,200
AFRL Edwards Rocket Test Stand 2-A Technical Improvements (Includes transfer from line number 11)		1,500		3,200
Development and Testing of Advanced Hybrid Rockets for Space Applications		3,500		2,800
High Energy Li-Ion Technology for Aviation Batteries		1,500		1,200
Integrated Engine Starter/Generator		2,000		1,600
Integrated Propulsion Analysis and Spacecraft Engineering Tools (IPAT/SET)		6,000		4,800
Multi-Mode Propulsion Phase IIA: High Performance Green Propellant		2,000		1,600
National Test Facility for Aerospace Fuels Propulsion		1,640		1,312
Thermal and Energy Management for Aerospace		4,000	3,000	3,200
Wavelength Agile Spectral Harmonic Oxygen Sensor and Cell-Level Battery Controller		1,500		1,200
Energy Superior Lithium Battery Technology for Defense Applications			2,000	1,600
HEETE - funded in P.L. 111-5			-5,000	-5,000
Next Generation Solar Electric In-Space Propulsion			1,000	800
Split Discharge Variable Delivery Pump for Military Aircraft			2,000	1,600
11 AEROSPACE SENSORS	121,768	129,768	135,668	136,588
Advanced Electronic Components for Sensor Arrays		3,000		2,400
Net-Centric Sensor Grids		3,000		2,400
Watchkeeper		2,000		1,600
Advanced Integrated Microsystems for Military Electronic Systems			3,100	2,480
Edwards Rocket Test Stand 2-A Improvements (Transferred to line number 10)			4,000	
Information Quality Tools for Persistent Surveillance Data Sets			1,800	1,440
On-Chip Integrated Photonic Polymer Transceiver			5,000	4,500

R-1	Budget Request	House	Senate	Recommendation
12 SPACE TECHNOLOGY	104,148	116,248	110,148	119,628
Advanced Modular Avionics for Operationally Responsive Satellite Use		3,100		2,480
Center for Solar Electricity and Hydrogen		5,000		4,000
Center for Space Entrepreneurship		2,000		1,600
Mission Design and Analysis Tool		2,000		1,600
AFRL Seismic Research Program			5,000	5,000
Reconfigurable Electronics and Non-Volatile Memory Research			1,000	800
14 DIRECTED ENERGY TECHNOLOGY	105,677	106,677	99,927	106,477
Hybrid Nanoparticle-based Coolant Technology Development and Manufacturing		1,000		800
Chemical Laser Technology - authorization adjustment			-5,750	0
15 COMMAND CONTROL AND COMMUNICATIONS	0	2,500	0	2,000
Efficient Utilization of Transmission Hyperspace		2,500		2,000
17 HIGH ENERGY LASER RESEARCH	52,754	61,254	46,654	53,454
Advanced Deformable Mirrors for High Energy Laser Weapons		2,000		1,600
High Bandwidth, High Energy Storage, Exawatt Laser Glass Development		3,500		2,800
Planar Lightwave Circuit Development for High Power Military Laser Applications		3,000		2,400
Chemical Laser Technology - authorization adjustment			-6,100	-6,100
18 ADVANCED MATERIALS FOR WEAPON SYSTEMS	37,901	56,301	64,501	71,901
EMI Grid Fabrication Technology		3,000		2,400
Hawaii Microalgae Biofuel Project		4,400		3,520
Hybrid Bearings		1,000		800
Metals Affordability Initiative		10,000	5,000	10,000
Aircraft Evaluation Readiness Initiative			3,000	2,400
Automated Processing of Advanced Low Observables (RAPALO)			1,500	1,200
Military Waste-to-Energy Project using the Hydro-Thermal Energy Conversion (Hy-TEC) Process			2,000	1,600
Sewage-Derived Biofuels Project			4,800	3,840
SiC - RF Power for Airborne Avionics Systems			2,000	1,600
Silicon Carbide Electronics Material Producibility Initiative			6,300	5,040
Strategic Biofuels Supply System			2,000	1,600
20 ADVANCED AEROSPACE SENSORS	51,482	53,482	51,482	53,082
Reconfigurable Secure Computing		2,000		1,600
21 AEROSPACE TECHNOLOGY DEV/DEMO	76,844	91,844	76,844	88,594
3D Bias Woven Perform Development		3,000		2,400
Big Antennas Small Structures Efficient Tactical UAV		2,000		1,600
Long-Loiter, Load Bearing Antenna Platform for Pervasive Airborne Intelligence		5,000		4,000
Program Increase		5,000		3,750
AEROSPACE PROPULSION AND POWER TECHNOLOGY	175,676	191,176	178,676	189,576
Algal-Derived Jet Fuel for Air Force Applications		3,000		2,700
Bio-JP8 Fuel Development		5,000		4,000
Renewable Hydrocarbon Fuels for Military Applications		2,500		2,000

R-1	Budget Request	House	Senate	Recommendation
Small Turbofan Versatile Affordable Advanced Turbine Engine Program		4,000		3,200
Texas Research Institute for Environmental Studies		1,000		800
ADVENT - funded in P.L. 111-5			-6,000	-6,000
Algal Biofuels for Aviation			3,000	2,400
Methanol Fuel Cell Development for USAF Battlefield Renewable Integrated Tactical Energy System (BRITES)			3,000	2,400
Silicon Carbide Power Modules for the F-35 Joint Strike Fighter			3,000	2,400
CREW SYSTEMS AND PERSONNEL PROTECTION				
23 TECHNOLOGY	0	0	3,000	2,940
Water for Injection and Air Purification with Carbon Nanotube Nanostructured Material			3,000	2,940
24 ELECTRONIC COMBAT TECHNOLOGY	31,021	32,521	31,021	32,221
Advanced Electromagnetic Location of IEDs Defeat System		1,500		1,200
25 ADVANCED SPACECRAFT TECHNOLOGY	83,909	98,609	90,409	99,269
Ballistic Missile Technology		2,000		1,600
Domestic Manufacturing of 45nm Electronics		2,000	4,000	3,200
Florida National Guard Total Force Integration		3,000		2,400
Integrated Passive Electronic Components		1,700		1,360
Micromachined Switches for Next Generation Modular Satellites		3,000		2,400
Small Responsive Spacecraft at Low-Cost		3,000		2,400
P-Net Ballistic Missile Technology			2,500	2,000
26 MAUI SPACE SURVEILLANCE SYSTEM (MSSS)	5,813	5,813	37,813	36,813
FLASH Hyper-Dimensional Imaging for Near Space Surveillance and Ballistic Missile Defense			2,000	2,000
Maui Space Surveillance System Operations and Research			20,000	19,500
PanSTARRS			10,000	9,500
28 CONVENTIONAL WEAPONS TECHNOLOGY	14,356	16,556	14,356	16,116
Body Armor Improved Ballistic Protection, Research and Development		2,200		1,760
29 ADVANCED WEAPONS TECHNOLOGY	30,056	30,056	44,556	44,996
Advanced Fiber Lasers Systems and Components			4,000	3,200
Applications of LIDAR to Vehicles with Analysis			6,500	6,000
Real-time Optical Surveillance Applications			4,000	3,500
Advanced Tactical Laser (Note: transferred from Senate General Provision 8122)				2,240
30 MANUFACTURING TECHNOLOGY PROGRAM	39,913	41,913	44,913	45,513
Production of Nanocomposites for Aerospace Applications		2,000		1,600
Next Generation Casting Initiative			5,000	4,000
32 C3I ADVANCED DEVELOPMENT	0	4,000	2,900	6,900
Cyber Attack and Security Environment (Note: Includes transfer from line number 183)		4,000		4,000
MPOI for Battlespace Information Exchange			2,900	2,900

R-1	Budget Request	House	Senate	Recommendation
34 INTELLIGENCE ADVANCED DEVELOPMENT	5,009	6,009	5,009	5,809
Multilingual Text Mining Platform for Intelligence Analysts		1,000		800
40 SPACE CONTROL TECHNOLOGY	97,701	97,701	102,701	101,701
Space Situational Awareness			5,000	4,000
41 COMBAT IDENTIFICATION TECHNOLOGY	27,252	27,252	29,252	28,852
Advanced Fast Steering Mirror Applications for 3-D LADAR in LITENING Pod			2,000	1,600
46 INTERCONTINENTAL BALLISTIC MISSILE	66,079	69,079	66,079	68,479
Minuteman III Advanced Third Stage Domestic Fiber Motor Case Development		3,000		2,400
48 POLLUTION PREVENTION (DEM/VAL)	2,896	12,896	2,896	10,396
Program Increase		10,000		7,500
51 BATTLE MGMT COM & CTRL SENSOR DEVELOPMENT	22,612	0	72,612	22,612
Early to need		-22,612		0
RTIP development for large aircraft platform			50,000	0
56 ALTERNATIVE FUELS	89,020	94,020	69,020	73,020
Synthetic Liquid Fuels		3,000		2,400
Advance Propulsion Non-Tactical Vehicle		2,000		1,600
Excess to need			-20,000	-20,000
59 OPERATIONALLY RESPONSIVE SPACE	112,861	114,361	125,861	125,211
Micro-Satellite Serial Manufacturing to Include Academic Outreach Educational Program		1,500		1,200
Low-Earth Orbit Nanosatellite Integrated Defense Autonomous Systems (LEONIDAS)			5,000	4,750
Rapid Small Satellite Development Test Facilities			2,000	1,600
Space Sensor Data Link Technology			6,000	4,800
61A NEXT GENERATION MILSATCOM TECHNOLOGY DEVELOPMENT			50,000	50,000
Next generation MILSATCOM technology development (Transferred from Missile Procurement, Air Force line number 16)			50,000	50,000
63 NUCLEAR WEAPONS SUPPORT	37,860	42,860	37,860	41,860
Nuclear Enterprise Surety Tracking		5,000		4,000
65 SPECIALIZED UNDERGRADUATE FLIGHT TRAINING	6,227	10,862	7,862	10,862
Improved Brake System Program Termination		-2,365	-2,365	-2,365
AT-6B Demonstration for ANG		7,000	4,000	7,000
68 ELECTRONIC WARFARE DEVELOPMENT	97,275	97,275	80,275	80,275
MALD-J excess to Air Force requirement			-17,000	-17,000
69 TACTICAL DATA NETWORKS ENTERPRISE	88,444	88,444	82,944	87,444
Excess to need			-10,000	-5,000
Global UAS Networking and Interoperability System (GUNIS)			4,500	4,000
71 SMALL DIAMETER BOMB (SDB)	153,815	155,815	153,815	155,415
High Pressure Pure Air Generator System		2,000		1,600

R-1	Budget Request	House	Senate	Recommendation
73 SPACE SITUATION AWARENESS SYSTEMS	308,134	207,834	269,534	239,534
Space Fence Program Reduction		-45,200		-30,000
Space Based Space Surveillance Follow-on		-55,100	-36,700	-36,700
High Accuracy Network Determination System-Intelligent Optical Network for Space Situational Awareness (Includes transfer from RDT&E, Defense-Wide line number 34)			5,000	5,000
Space Surveillance Telescope (SST)			-6,900	-6,900
75 SPACE BASED INFRARED SYSTEM (SBIRS) HIGH EMD Ground Development (Transferred from line number 76)	512,642	526,442	512,642	526,442
		13,800		13,800
THIRD GENERATION INFRARED SURVEILLANCE (3GIRS)				
76	143,169	39,169	143,169	73,369
Third Generation Infrared System		-90,200		-56,000
Ground Development (Transfer to line number 75)		-13,800		-13,800
80 LIFE SUPPORT SYSTEMS	10,711	11,911	14,111	14,331
Program Increase - Bomber Crew Safety Study		1,200		900
ACES 5 Ejection Seat			2,400	1,920
Backpack Medical Oxygen System (BMOS)			1,000	800
81 COMBAT TRAINING RANGES	29,718	29,718	14,718	22,718
ACTS Range Threat Systems - program delay			-15,000	-10,000
P5CTS Equipment for the MT Joint Training Environment (Transferred from Aircraft Procurement, Air Force line number 85)				3,000
INTEGRATED COMMAND & CONTROL APPLICATIONS (IC2A)				
82	10	9,010	10	6,960
Distributed Mission Interoperability Toolkit (DMIT)		4,000		3,200
Program Increase		5,000		3,750
84 JOINT STRIKE FIGHTER (JSF)	1,858,055	2,073,055	1,780,055	2,073,055
Alternate Engine Development		215,000		215,000
Excess to need			-78,000	0
EVOLVED EXPENDABLE LAUNCH VEHICLE PROGRAM (SPACE)				
86	26,545	51,545	26,545	46,545
Program Increase		25,000		20,000
88 NEXT GENERATION AERIAL REFUELING AIRCRAFT	439,615	0	409,615	15,000
Transferred to Title VIII		-439,615		-394,615
Contract award delay			-30,000	-30,000
89 CSAR-X RDT&E	89,975	9,975	0	0
Program terminated		-80,000		0
Air Force requested transfer to line number 89A and Aircraft Procurement, Air Force line number 14			-89,975	-89,975
89A HH-60 RDT&E			14,975	14,975
HH-60 Replacements - Air Force requested transfer from line number 89			14,975	14,975
91 JOINT SIAP EXECUTIVE PROGRAM OFFICE	34,877	34,877	14,877	14,877
Unjustified request			-20,000	-20,000

R-1	Budget Request	House	Senate	Recommendation
92 LINK-16 SUPPORT AND SUSTAINMENT	0	0	79,300	79,300
DOD requested transfer from Title VI Rapid Acquisition Fund for BACN			79,300	79,300
95 FULL COMBAT MISSION TRAINING	99,807	99,807	79,807	79,807
Contract award delay			-20,000	-20,000
101 MAJOR T&E INVESTMENT	60,824	63,324	67,824	67,824
Eglin AFB Range Operations Control Center		2,500		2,000
Holloman High Speed Test Track			7,000	5,000
102 RAND PROJECT AIR FORCE	27,501	27,501	29,501	29,101
RAND Project Air Force			2,000	1,600
105 TEST AND EVALUATION SUPPORT	736,488	736,488	755,788	746,488
Authorization increase - Test Resources Management Center			19,300	10,000
FACILITIES RESTORATION & MODERNIZATION - TEST & EVAL	52,409	60,409	52,409	58,809
Base Facility Energy Independence, Stewart Air National Guard Base		5,000		4,000
Inter-Base Facility Energy Independence		3,000		2,400
FACILITIES SUSTAINMENT - TEST AND EVALUATION SUPPORT	29,683	29,683	34,683	33,683
Sustainable Energy Vermont National Guard			5,000	4,000
114 COMMON VERTICAL LIFT SUPPORT PLATFORM	9,513	2,000	5,513	4,000
Unjustified program/Excess to need		-7,513	-4,000	-5,513
117 B-52 SQUADRONS	93,930	102,930	99,930	102,330
B-52 Tactical Data Link Capability		6,000	6,000	6,000
Reconstitution of B-52 Nuclear Capability Study		3,000		2,400
119 B-1B SQUADRONS	148,025	178,025	179,025	179,025
Transferred from Aircraft Procurement, Air Force line number 28		29,000	29,000	29,000
B-1 AESA Radar Operational Utility Evaluation		1,000	2,000	2,000
120 B-2 SQUADRONS	415,414	436,714	397,414	407,189
Program Increase		15,300		12,175
B-2 Advanced Tactical Data Link		6,000	12,000	9,600
EHF SATCOM Increment 2 - premature request			-30,000	-30,000
128 MQ-9 UAV	39,245	109,245	39,245	91,745
Program Increase		70,000		52,500
130 A-10 SQUADRONS	9,697	9,697	12,197	12,197
CAD/CAM Aircraft Structural Overhaul Work Center			2,500	2,500
131 F-16 SQUADRONS	141,020	141,020	143,020	142,620
Thunder Radar Pod			2,000	1,600
132 F-15E SQUADRONS	311,167	312,167	323,167	319,967
Corrosion Detection and Visualization Program		1,000		800
F-15C AESA Classified Demo		8,000	12,000	8,000

R-1	Budget Request	House	Senate	Recommendation
133 MANNED DESTRUCTIVE SUPPRESSION	10,748	10,748	8,748	9,748
Funding ahead of need			-2,000	-1,000
AIRCRAFT ENGINE COMPONENT IMPROVEMENT				
142 PROGRAM	166,563	157,563	154,563	156,963
F-135 Engine - Early to need		-12,000	-12,000	-12,000
Senior Scout Communications Intelligence (COMINT)				
Capability Upgrade		3,000		2,400
143 CSAF INNOVATION PROGRAM	4,621	4,621	12,821	11,261
Eagle Vision III Upgrades			8,000	4,800
Multiband Realtime Hyperspectral Targeting Sensor			2,300	1,840
145 AIR AND SPACE OPERATIONS CENTER (AOC)	99,405	101,405	103,405	102,605
COTS Technology for Space Command and Control		2,000	4,000	3,200
153 FIGHTER TACTICAL DATA LINK	72,106	72,106	62,106	67,106
Excess to need			-10,000	-5,000
156 COMMAND AND CONTROL (C2) CONSTELLATION	26,792	31,792	26,792	30,792
GAPS/AWS Horizontal Integration		5,000		4,000
JOINT SURVEILLANCE AND TARGET ATTACK RADAR				
157 SYSTEM	140,670	140,670	175,670	186,670
Re-engining program (Transferred from Aircraft Procurement, Air Force line number 59)			35,000	46,000
162 MISSION PLANNING SYSTEMS	91,995	91,995	41,995	81,995
Program delay			-50,000	-10,000
163 INFORMATION WARFARE SUPPORT	12,271	14,271	12,271	13,871
Electromagnetic Battlespace Management		2,000		1,600
173 INFORMATION SYSTEMS SECURITY PROGRAM	196,621	196,621	136,621	166,621
Restructure of Cryptographic Modernization program			-35,000	-10,000
Premature request			-25,000	-20,000
175 GLOBAL COMMAND AND CONTROL SYSTEM	3,149	7,149	3,149	6,349
Command and Control Service Level Management (C2SLM) Program		4,000		3,200
176 JOINT COMMAND AND CONTROL PROGRAM (JC2)	3,087	3,087	0	0
Program termination			-3,087	-3,087
179 AIRBORNE SIGINT ENTERPRISE	176,989	176,989	166,989	166,989
ASIP RQ-4 program delay			-10,000	-10,000
181 ADVANCED GEOSPATIAL INTELLIGENCE	0	0	6,500	5,200
Advanced Technical Intelligence Center (ATIC)			6,500	5,200
183 CYBER SECURITY INITIATIVE	2,065	2,065	7,065	2,065
Cyber Attack and Security Environment (CASE)				
(Transferred to line number 32)			5,000	0
AIR TRAFFIC CONTROL, APPROACH, & LANDING				
186 SYSTEM (ATC)	9,006	9,006	12,006	11,406
Transportable Transponder Landing System			3,000	2,400

R-1	Budget Request	House	Senate	Recommendation
200 INTELLIGENCE SUPPORT TO INFORMATION Open Source Research Centers	1,240	2,240 1,000	1,240	2,240 1,000
202 ENDURANCE UNMANNED AERIAL VEHICLES ISIS - authorization adjustment	73,736	73,736	38,736 -35,000	48,736 -25,000
203 AIRBORNE RECONNAISSANCE SYSTEMS Multiple UAS Cooperative Concentrated Observation and Engagement Against a Common Ground Objective	143,892	145,892 2,000	143,892	145,492 1,600
204 MANNED RECONNAISSANCE SYSTEMS Rivet Joint Services Oriented Architecture	12,846	15,346 2,500	12,846	14,846 2,000
206 PREDATOR UAV (JMIP) Predator C Center for UAS Research, Education and Training Infrastructure (Transferred to line number 9) Program increase Multi Sensor Detect, Sense and Avoid (MSDSA)	18,101	24,301 1,500 3,000 1,700	22,101 4,000	23,776 1,200 0 1,275 3,200
209 GPS III SPACE SEGMENT GPS Control Segment (OCX) GPS Control Segment (OCX) (Transferred to line number 209A)	815,095	717,695 -97,400	425,695 -389,400	425,695 0 -389,400
209A GPS Control Segment (OCX) GPS Control Segment (OCX) (Transferred from line number 209 - reduction due to contract award delay)			292,000 292,000	292,000 292,000
210 JSPOC MISSION SYSTEM Project Karnac - authorization adjustment	131,271	131,271	137,271 6,000	136,271 5,000
214 NATIONAL SECURITY SPACE OFFICE Program transferred to O&M, Defense-Wide	10,634	0 -10,634	10,634	0 -10,634
218 C-130 AIRLIFT SQUADRON Funded in prior year reprogramming Air Force requested transfer to Aircraft Procurement, Air Force line number 52 for avionics modernization of special mission aircraft	201,250	201,250	182,250 -19,000	109,250 -19,000 -73,000
219 C-5 AIRLIFT SQUADRONS C-5 RERP - program underexecution	95,266	95,266	85,266 -10,000	85,266 -10,000
222 LARGE AIRCRAFT IR COUNTERMEASURES (LAIRCM) Program underexecution	31,784	31,784	26,784 -5,000	26,784 -5,000
228 SPECIAL TACTICS / COMBAT CONTROL BATMAV Program Miniature Digital Data Link Next Generation Simulation Training for Pararescue Forces	8,222	10,222 2,000	10,222 2,000	11,422 1,600 1,600
231 INDUSTRIAL PREPAREDNESS Laser Peening for Friction Stir Welded Aerospace Structures Wire Integrity Technology Mobile Laser Systems for Aircraft Structures (MLSAS)	0	4,000, 2,000 2,000	1,000 1,000	4,000 1,600 1,600 800

R-1	Budget Request	House	Senate	Recommendation
233 SUPPORT SYSTEMS DEVELOPMENT	6,288	12,788	38,188	38,258
Accelerator-Driven Non-Destructive Testing		2,000		2,000
ALC Logistics Integration Environment		1,000		800
Demonstration and Validation of Renewable Energy Technology		1,000		800
Technical Order Modernization Environment		1,500		1,200
Mitigating RoHS Lead-Free Issues in Aerospace Circuit Board Manufacturing		1,000		800
Alternative energy research and integration			25,000	18,450
Assessment of Alternative Energy for Aircraft Ground Equipment (AGE)			2,000	1,600
Freedom Fuels/Coal Fuel Alliance			4,900	3,920
Engine Health Management Plus Data Repository Center (Transferred from O&M, Air Force)				2,400
238 JOINT PERSONNEL RECOVERY AGENCY	6,376	6,376	6,376	11,376
Biometric Signature and Passive Physiological Monitoring (Transferred from RDT&E, Army line number 28)				5,000
241 PERSONNEL ADMINISTRATION	10,492	10,492	30,982	30,982
DIMHRS (OSD requested transfer from RDT&E, Defense-Wide line number 117)			20,490	20,490
999 CLASSIFIED PROGRAMS	11,955,084	12,148,484	12,064,884	12,121,644
Classified adjustment		-27,800	-30,200	1,600
Carbon Nanotube Enhanced Power Sources for Space		2,000		1,600
Remote Language-Independent Suspect Identification		3,200		2,560
Close Proximity Space Situational Awareness		1,000		800
Classified Program		215,000	140,000	160,000

AERIAL REFUELING TANKER PROGRAM

The recommendation includes \$15,000,000 in Research, Development, Test and Evaluation, Air Force for program management and a general provision providing \$291,715,000 in a Tanker Replacement Transfer Fund.

Not later than 10 days after the release of the final request for proposal soliciting bids for an aerial tanker replacement aircraft, the Secretary of the Air Force is directed to submit a report to the congressional defense committees that includes a description of changes from the draft proposal to the final request for proposal and the rationale for each change.

The Secretary of the Air Force is encouraged to pursue tanker recapitalization at a rate of 36 aircraft per year instead of 12 or 15 aircraft in the current plan. This quantity will recapitalize the fleet in one-third the time and allow for a rapid retirement of the aging KC-135 aircraft. Furthermore, a more accelerated procurement strategy will avoid the large sustainment and modernization costs associated with keeping the legacy KC-135 fleet in the inventory longer.

MODULAR AERIAL SPRAY SYSTEM (MASS)
REPLACEMENT

The modular aerial spray system (MASS) is maintained by the Air Force Reserve and is the only fixed-wing aerial spray capability in the Department of the Defense. The current program is over 20 years old and is becoming increasingly difficult to maintain, leading to increased cost and the inability to conduct required missions. There is presently no recapitalization plan to replace the system. The Secretary of the Air Force is encouraged to pursue a recapitalization program in order to maintain this needed capability.

EVOLVED EXPENDABLE LAUNCH VEHICLE
COMMON UPPER STAGE

The recommendation includes \$20,000,000 to study options and begin research and development to achieve a common upper stage between the Atlas and Delta launch vehicle families. The Air Force is urged to develop a process to modify Delta IV RL-10 upper stage engines to the Atlas V RL-10 configuration to enable more efficient use of the existing RL-10 inventory. The study shall also investigate how to modify the upper stage(s) to enable Centaur and the Delta Cryogenic Second Stage to use a common RL-10 engine and other potential modifications to achieve a truly common upper stage.

EVOLVED EXPENDABLE LAUNCH VEHICLE
SUSTAINMENT PLAN

The Secretary of the Air Force, in consultation with the Director of the National Reconnaissance Office, is directed to submit an Evolved Expendable Launch Vehicle sustainment plan as described in House Report 111-230 to the congressional defense committees with the fiscal year 2011 budget submission.

15-YEAR SPACE SYSTEM INVESTMENT
STRATEGY

The recommendation supports language on a long-term space system investment strategy as described in House Report 111-230. The investment strategy is directed to span 15 years rather than the originally proposed 30 years. In addition, the Under Secretary of Defense (Acquisition, Technology and Logistics) is directed, in coordination with the Secretary of the Air Force and the Under Secretary of Defense (Intelligence), to deliver this Space System Investment Strategy to the congressional defense committees not later than May 1, 2010. As necessary, the report should contain a classified appendix.

NATIONAL POLAR-ORBITING OPERATIONAL
ENVIRONMENTAL SATELLITE SYSTEM

There is concern about the executability and management of the National Polar-orbiting Operational Environmental Satellite System (NPOESS) program. Therefore, it is directed that not more than 50 percent of the funds made available to the Department of Defense for the NPOESS program shall be obligated or expended until the Under Secretary of Defense (Acquisition, Technology and Logistics) certifies in writing to the congressional defense committees that the NPOESS program is being executed in support of the requirements, timelines and acquisition policies needed to meet Department of Defense missions.

The Secretary of Defense is directed, in consultation with the National Oceanic and Atmospheric Administration and the National Aeronautics and Space Administration, to perform an independent cost analysis of all recommended programmatic and acquisition alternatives. This analysis shall be submitted to the Committee on Appropriations, Subcommittees on Defense and Commerce, Justice, Science and Related Agencies, of both the House and Senate, in addition to any other congressional oversight committee before any contract changes are signed and any major documents are revised by the government.

OPERATIONALLY RESPONSIVE SPACE

The Director of the Operationally Responsive Space program office is urged to provide the congressional defense committees with independent cost, schedule and performance estimates prior to initiating any satellite development activity.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION, DEFENSE-WIDE

For Research, Development, Test and Evaluation, Defense-Wide,
funds are to be available for fiscal year 2010, as follows:

(In thousands of dollars)				
	Budget	House	Senate	Recommendation
RESEARCH, DEVELOPMENT, TEST & EVAL, DEFENSE-WIDE				
BASIC RESEARCH				
1 DTRA UNIVERSITY STRATEGIC PARTNERSHIP BASIC RESEARCH..	48,544	48,544	33,544	41,044
2 DEFENSE RESEARCH SCIENCES.....	226,125	242,825	194,218	206,778
3 GOVT/INDUSTRY COSPONSORSHIP OF UNIVERSITY RESEARCH....	---	5,000	---	4,800
5 NATIONAL DEFENSE EDUCATION PROGRAM.....	89,980	89,980	69,980	79,980
6 CHEMICAL AND BIOLOGICAL DEFENSE PROGRAM.....	58,974	79,474	67,874	79,094
TOTAL, BASIC RESEARCH.....	423,623	465,823	365,616	411,696
APPLIED RESEARCH				
7 INSENSITIVE MUNITIONS--EXPLORATORY DEVELOPMENT.....	22,669	18,961	15,112	18,861
9 HISTORICALLY BLACK COLLEGES & UNIV (HBCU) SCIENCE.....	15,164	65,521	18,464	67,096
10 LINCOLN LABORATORY RESEARCH PROGRAM.....	34,034	34,034	34,034	34,034
11 INFORMATION AND COMMUNICATIONS TECHNOLOGY.....	282,749	285,749	255,931	273,331
12 COGNITIVE COMPUTING SYSTEMS.....	142,840	144,840	142,840	144,840
13 BIOLOGICAL WARFARE DEFENSE.....	40,587	40,587	40,587	40,587
14 CHEMICAL AND BIOLOGICAL DEFENSE PROGRAM.....	209,072	226,572	215,972	225,772
15 JOINT DATA MANAGEMENT ADVANCED DEVELOPMENT.....	4,940	4,940	---	---
16 HUMAN, SOCIAL AND CULTURE BEHAVIOR MODELING (HSCB) APP	9,446	9,446	7,946	7,946
17 TACTICAL TECHNOLOGY.....	276,075	276,075	241,125	249,725
18 MATERIALS AND BIOLOGICAL TECHNOLOGY.....	268,859	268,959	272,359	271,339
19 ELECTRONICS TECHNOLOGY.....	223,841	225,841	170,154	180,154
20 WEAPONS OF MASS DESTRUCTION DEFEAT TECHNOLOGIES.....	219,130	220,630	221,530	222,250
21 SPECIAL OPERATIONS TECHNOLOGY DEVELOPMENT.....	27,384	33,884	24,884	30,734
22 SOF MEDICAL TECHNOLOGY DEVELOPMENT.....	---	3,000	---	2,400
TOTAL, APPLIED RESEARCH.....	1,776,790	1,861,039	1,660,938	1,769,169

(In thousands of dollars)

	Budget	House	Senate	Recommendation
ADVANCED TECHNOLOGY DEVELOPMENT				
23 JOINT MUNITIONS ADVANCED TECH INSENSITIVE MUNITIONS AD	23,538	16,754	10,428	13,644
24 SO/LIC ADVANCED DEVELOPMENT.....	43,808	43,808	43,808	43,808
25 COMBATING TERRORISM TECHNOLOGY SUPPORT.....	81,868	102,368	106,268	118,108
26 COUNTERPROLIFERATION INITIATIVES--PROLIF PREV & DEFEAT	233,203	241,203	233,203	239,923
27 BALLISTIC MISSILE DEFENSE TECHNOLOGY.....	109,760	109,760	104,760	190,260
28 JOINT ADVANCED CONCEPTS.....	7,817	3,909	7,817	3,909
29 JOINT DOD-DOE MUNITIONS TECHNOLOGY DEVELOPMENT.....	23,276	23,276	23,276	23,276
30 ADVANCED AEROSPACE SYSTEMS.....	338,360	338,360	249,360	259,360
31 SPACE PROGRAMS AND TECHNOLOGY.....	200,612	202,612	189,312	190,912
32 CHEMICAL AND BIOLOGICAL DEFENSE PROGRAM - ADVANCED DEV	282,235	297,735	296,235	300,935
33 JOINT ELECTRONIC ADVANCED TECHNOLOGY.....	10,838	10,838	10,838	10,838
34 JOINT CAPABILITY TECHNOLOGY DEMONSTRATIONS.....	198,352	202,352	143,467	169,952
35 NETWORKED COMMUNICATIONS CAPABILITIES.....	28,212	28,212	28,212	28,212
36 JOINT DATA MANAGEMENT RESEARCH.....	4,935	4,935	4,935	4,935
37 BIOMETRICS SCIENCE AND TECHNOLOGY.....	10,993	10,993	10,993	10,993
38 HUMAN, SOCIAL AND CULTURE BEHAVIOR MODELING (HSCB) ADV	11,480	11,480	9,980	10,480
39 DEFENSE-WIDE MANUFACTURING SCIENCE AND TECHNOLOGY PROG	14,638	16,638	24,638	23,738
40 JOINT ROBOTICS PROGRAM/AUTONOMOUS SYSTEMS.....	9,110	11,610	9,110	11,110
41 GENERIC LOGISTICS R&D TECHNOLOGY DEMONSTRATIONS.....	19,043	34,043	42,643	52,123
42 DEPLOYMENT AND DISTRIBUTION ENTERPRISE TECHNOLOGY.....	29,356	29,356	29,356	29,356
43 STRATEGIC ENVIRONMENTAL RESEARCH PROGRAM.....	69,175	69,175	67,675	67,675
44 MICROELECTRONIC TECHNOLOGY DEVELOPMENT AND SUPPORT....	26,310	51,810	55,210	70,830
45 JOINT WARFIGHTING PROGRAM.....	11,135	11,135	11,135	11,135
46 ADVANCED ELECTRONICS TECHNOLOGIES.....	205,912	207,912	179,907	194,907
47 SYNTHETIC APERTURE RADAR (SAR) COHERENT CHANGE DETECT.	4,864	4,864	4,864	4,864
49 HIGH PERFORMANCE COMPUTING MODERNIZATION PROGRAM.....	221,286	221,286	245,186	237,406
50 COMMAND, CONTROL AND COMMUNICATIONS SYSTEMS.....	293,476	293,476	270,326	270,326
52 CLASSIFIED DARPA PROGRAMS.....	186,526	186,526	178,326	178,326
53 NETWORK-CENTRIC WARFARE TECHNOLOGY.....	135,941	135,941	135,941	138,941

(In thousands of dollars)

	Budget	House	Senate	Recommendation
54 SENSOR TECHNOLOGY.....	243,056	243,056	223,800	223,800
55 GUIDANCE TECHNOLOGY.....	37,040	37,040	37,040	37,040
56 DISTRIBUTED LEARNING ADVANCED TECHNOLOGY DEVELOPMENT..	13,822	13,822	13,822	13,822
57 SOFTWARE ENGINEERING INSTITUTE.....	31,298	31,298	31,298	31,298
59 QUICK REACTION SPECIAL PROJECTS.....	107,984	92,984	69,484	74,184
60 JOINT EXPERIMENTATION.....	124,480	107,380	109,480	108,800
61 JOINT WARGAMING SIMULATION MANAGEMENT OFFICE.....	38,505	38,505	34,505	34,505
62 TEST & EVALUATION SCIENCE & TECHNOLOGY.....	95,734	95,734	95,734	95,734
63 TECHNOLOGY TRANSFER.....	2,219	12,219	8,319	13,669
65 SPECIAL OPERATIONS ADVANCED TECHNOLOGY DEVELOPMENT....	31,675	57,175	36,975	56,965
66 SPECIAL OPERATIONS ADVANCED TECHNOLOGY DEVELOPMENT....	3,544	3,544	3,544	3,544
67 SOF INFORMATION & BROADCAST SYSTEMS ADVANCED TECHNOLOG	4,988	4,988	4,988	4,988
TOTAL, ADVANCED TECHNOLOGY DEVELOPMENT.....	3,570,404	3,660,112	3,396,198	3,606,631
DEMONSTRATION & VALIDATION				
68 NUCLEAR AND CONVENTIONAL PHYSICAL SECURITY EQUIPMENT..	36,019	39,019	46,219	46,179
70 RETRACT LARCH.....	21,718	21,718	37,218	21,718
71 JOINT ROBOTICS PROGRAM.....	11,803	15,803	11,803	15,403
72 ADVANCE SENSOR APPLICATIONS PROGRAM.....	17,771	17,771	17,771	17,771
73 ENVIRONMENTAL SECURITY TECHNICAL CERTIFICATION PROGRAM	31,613	36,613	37,013	41,113
74 BALLISTIC MISSILE DEFENSE TERMINAL DEFENSE SEGMENT....	719,465	719,465	719,465	719,465
75 BALLISTIC MISSILE DEFENSE MIDCOURSE DEFENSE SEGMENT...	982,922	982,922	1,032,922	1,032,922
76 BALLISTIC MISSILE DEFENSE BOOST DEFENSE SEGMENT.....	186,697	186,697	186,697	183,297
77 CHEMICAL AND BIOLOGICAL DEFENSE PROGRAM.....	205,952	210,952	205,952	210,152
78 BALLISTIC MISSILE DEFENSE SENSORS.....	636,856	636,856	626,856	624,156
79 BALLISTIC MISSILE DEFENSE SYSTEM INTERCEPTOR.....	---	80,000	---	---
80 BALLISTIC MISSILE DEFENSE TEST & TARGETS.....	966,752	940,752	778,652	827,752
81 BALLISTIC MISSILE DEFENSE SYSTEMS CORE.....	369,145	358,645	358,145	360,645
82 SPECIAL PROGRAMS - MDA.....	301,566	286,566	251,566	251,566
83 AEGIS BMD.....	1,690,758	1,670,758	1,468,358	1,443,358
183 AEGIS SM-3 BLOCK IIA CO-DEVELOPMENT.....	---	---	257,400	257,400

(In thousands of dollars)

	Budget	House	Senate	Recommendation
84 SPACE SURVEILLANCE & TRACKING SYSTEM.....	180,000	160,000	173,200	162,500
86 BALLISTIC MISSILE DEFENSE SYSTEM SPACE PROGRAMS.....	12,549	12,549	12,549	12,549
87 BALLISTIC MISSILE DEFENSE C2BMC.....	340,014	340,014	340,014	336,514
88 BALLISTIC MISSILE DEFENSE HERCULES.....	48,186	48,186	48,186	48,186
89 BALLISTIC MISSILE DEFENSE JOINT WARFIGHTER SUPPORT....	60,921	61,421	60,921	61,421
90 BALLISTIC MISSILE DEFENSE JOINT NATIONAL INTERGRATION.	86,949	86,949	86,949	86,949
91 REGARDING TRENCH.....	6,164	6,164	6,164	6,164
92 SEA BASED X-BAND RADAR (SBX).....	174,576	161,576	174,576	168,076
95 BMD EUROPEAN CAPABILITY.....	50,504	50,504	50,504	50,504
97 ISRAELI COOPERATIVE PROGRAMS.....	119,634	202,434	202,434	202,434
98 HUMANITARIAN DEMINING.....	14,687	14,687	14,687	14,687
99 COALITION WARFARE.....	13,885	13,885	13,885	13,885
100 DEPARTMENT OF DEFENSE CORROSION PROGRAM.....	4,887	6,387	21,487	22,287
101 DOD UNMANNED AIRCRAFT SYSTEM (UAS) COMMON DEVELOPMENT.	55,289	65,289	55,289	61,289
102 JOINT CAPABILITY TECHNOLOGY DEMONSTRATIONS.....	18,577	3,577	18,577	11,077
103 HUMAN, SOCIAL AND CULTURE BEHAVIOR MODELING (HSCB) RES	7,006	7,006	7,006	7,006
104 JOINT SYSTEMS INTEGRATION COMMAND (JSIC).....	19,744	19,744	19,744	19,744
105 JOINT FIRES INTEGRATION & INTEROPERABILITY TEAM.....	16,972	16,972	16,972	16,972
106 REDUCTION OF TOTAL OWNERSHIP COST.....	24,647	24,647	24,647	24,647
107 JOINT ELECTROMAGNETIC TECHNOLOGY (JET) PROGRAM.....	3,949	6,949	3,949	6,349
108 DEFENSE ACQUISITION CHALLENGE PROGRAM (DACP).....	28,862	28,862	28,862	28,862
109 NUCLEAR AND CONVENTIONAL PHYSICAL SECURITY EQUIPMENT .	7,628	7,628	7,628	7,628
110 PROMPT GLOBAL STRIKE CAPABILITY DEVELOPMENT.....	166,913	166,913	166,913	166,913
TOTAL, DEMONSTRATION & VALIDATION.....	7,641,580	7,716,880	7,591,180	7,589,540
ENGINEERING & MANUFACTURING DEVELOPMENT				
111 CHEMICAL AND BIOLOGICAL DEFENSE PROGRAM.....	332,895	339,895	296,595	301,575
112 JOINT ROBOTICS PROGRAM.....	5,127	5,127	5,127	5,127
113 ADVANCED IT SERVICES JOINT PROGRAM OFFICE (AITS-JPO)..	39,911	39,911	15,157	15,157
114 JOINT TACTICAL INFORMATION DISTRIBUTION SYSTEM (JTIDS)	20,633	20,633	20,633	20,633

(In thousands of dollars)

	Budget	House	Senate	Recommendation
115 WEAPONS OF MASS DESTRUCTION DEFEAT CAPABILITIES.....	8,735	8,735	9,735	9,535
116 INFORMATION TECHNOLOGY DEVELOPMENT.....	11,705	15,205	11,705	14,505
117 DEFENSE INTEGRATED MILITARY HUMAN RESOURCES SYSTEM....	70,000	70,000	18,710	18,710
118 BUSINESS TRANSFORMATION AGENCY R&D ACTIVITIES.....	197,008	197,008	192,508	192,508
119 HOMELAND PERSONNEL SECURITY INITIATIVE.....	395	395	395	395
120 OUSD(C) IT DEVELOPMENT INITIATIVES.....	5,000	5,000	5,000	5,000
121 TRUSTED FOUNDRY.....	41,223	41,223	51,223	51,223
122 DEFENSE ACQUISITION EXECUTIVE (DAE) PILOT PROGRAM.....	4,267	4,267	4,267	4,267
123 GLOBAL COMBAT SUPPORT SYSTEM.....	18,431	18,431	18,431	18,431
124 JOINT COMMAND AND CONTROL PROGRAM (JC2).....	49,047	49,047	---	---
125 WOUNDED ILL AND INJURED SENIOR OVERSIGHT COMMITTEE OFF	1,609	1,609	1,609	1,609
TOTAL, ENGINEERING & MANUFACTURING DEVELOPMENT.....	805,986	816,486	651,095	658,675
RDT&E MANAGEMENT SUPPORT				
126 GENERIC LOGISTICS TECHNOLOGY DEMONSTRATIONS.....	---	2,000	---	---
127 DEFENSE READINESS REPORTING SYSTEM (DRRS).....	13,121	16,121	13,121	15,371
128 JOINT SYSTEMS ARCHITECTURE DEVELOPMENT.....	15,247	15,247	7,430	11,339
129 CENTRAL TEST AND EVALUATION INVESTMENT DEVELOPMENT....	145,052	152,552	157,452	162,272
130 THERMAL VICAR.....	9,045	12,045	9,045	11,445
131 JOINT MISSION ENVIRONMENT TEST CAPABILITY (JMETC).....	9,455	9,455	9,455	9,455
132 TECHNICAL STUDIES, SUPPORT AND ANALYSIS.....	44,760	44,760	44,760	44,760
133 USD(A&T)--CRITICAL TECHNOLOGY SUPPORT.....	4,914	4,914	4,914	4,914
134 FOREIGN MATERIAL ACQUISITION AND EXPLOITATION.....	94,921	94,921	94,921	94,921
135 JOINT THEATER AIR AND MISSILE DEFENSE ORGANIZATION....	96,909	96,909	96,909	96,909
136 CLASSIFIED PROGRAM USD(P).....	---	95,637	95,637	95,637
137 FOREIGN COMPARATIVE TESTING.....	35,054	35,054	35,054	35,054
138 NUCLEAR MATTERS - PHYSICAL SECURITY.....	6,474	6,474	6,474	6,474
139 SUPPORT TO NETWORKS AND INFORMATION INTEGRATION.....	14,916	14,916	14,916	14,916
140 GENERAL SUPPORT TO USD (INTELLIGENCE).....	5,888	5,888	5,888	5,888
141 CHEMICAL AND BIOLOGICAL DEFENSE PROGRAM.....	106,477	106,477	106,477	106,477
147 SMALL BUSINESS INNOVATION RESEARCH/CHALLENGE ADMINISTR	2,163	3,163	4,063	4,683

(In thousands of dollars)

	Budget	House	Senate	Recommendation
148 DEFENSE TECHNOLOGY ANALYSIS.....	11,005	11,805	11,005	11,805
150 FORCE TRANSFORMATION DIRECTORATE.....	19,981	24,981	19,981	23,981
151 DEFENSE TECHNICAL INFORMATION CENTER (DTIC).....	54,411	49,411	54,411	49,411
152 R&D IN SUPPORT OF DOD ENLISTMENT, TESTING & EVALUATION	19,554	19,554	19,554	19,554
153 DEVELOPMENT TEST AND EVALUATION.....	23,512	23,512	23,512	23,512
154 DARPA AGENCY RELOCATION.....	45,000	45,000	15,000	45,000
155 MANAGEMENT HEADQUARTERS (RESEARCH & DEVELOPMENT).....	51,055	51,055	51,055	51,055
156 BUDGET AND PROGRAM ASSESSMENTS.....	5,929	5,929	5,929	5,929
157 AVIATION SAFETY TECHNOLOGIES.....	8,000	8,000	8,000	8,000
158 JOINT STAFF ANALYTICAL SUPPORT.....	1,250	1,250	1,250	1,250
161 SUPPORT TO INFORMATION OPERATIONS (IO) CAPABILITIES...	30,604	25,904	36,504	30,624
162 INFORMATION TECHNOLOGY RAPID ACQUISITION.....	4,667	4,667	4,667	4,667
163 CYBER SECURITY INITIATIVE.....	50,000	50,000	50,000	50,000
164 INTELLIGENCE SUPPORT TO INFORMATION OPERATIONS (IO)...	20,648	22,648	20,648	20,648
166 WARFIGHTING AND INTELLIGENCE-RELATED SUPPORT.....	829	829	829	829
167 COCOM EXERCISE ENGAGEMENT AND TRAINING TRANSFORMATION.	34,306	34,306	41,806	40,706
168 PENTAGON RESERVATION.....	19,709	---	19,709	19,709
169 MANAGEMENT HEADQUARTERS - MDA.....	57,403	52,403	57,403	52,403
170 IT SOFTWARE DEV INITIATIVES.....	980	980	980	980
TOTAL, RDT&E MANAGEMENT SUPPORT.....	1,063,239	1,148,767	1,148,759	1,180,578
OPERATIONAL SYSTEMS DEVELOPMENT				
171 DEFENSE INFORMATION SYSTEM FOR SECURITY (DISS).....	1,384	1,384	1,384	1,384
172 REGIONAL INTERNATIONAL OUTREACH & PARTNERSHIP FOR PEAC	2,001	2,001	2,001	2,001
173 OVERSEAS HUMANITARIAN ASSISTANCE SHARED INFORMATION SY	292	292	292	292
174 CHEMICAL AND BIOLOGICAL DEFENSE (OPERATIONAL SYSTEMS D	6,198	6,198	6,198	6,198
175 JOINT INTEGRATION AND INTEROPERABILITY.....	46,214	46,214	46,214	46,214
177 CLASSIFIED PROGRAMS.....	2,179	2,179	2,179	2,179
178 C4I INTEROPERABILITY.....	74,786	74,786	74,786	74,786
180 JOINT/ALLIED COALITION INFORMATION SHARING.....	10,767	10,767	10,767	10,767

(In thousands of dollars)

	Budget	House	Senate	Recommendation
187 NATIONAL MILITARY COMMAND SYSTEM-WIDE SUPPORT.....	548	548	548	548
188 DEFENSE INFO INFRASTRUCTURE ENGINEERING AND INTEGRATIO	17,655	17,655	17,655	17,655
189 LONG HAUL COMMUNICATIONS (DCS).....	9,406	9,406	9,406	9,406
190 MINIMUM ESSENTIAL EMERGENCY COMMUNICATIONS NETWORK....	9,830	9,830	9,830	9,830
191 PUBLIC KEY INFRASTRUCTURE (PKI).....	8,116	8,116	8,116	8,116
192 KEY MANAGEMENT INFRASTRUCTURE (KMI).....	41,002	41,002	41,002	41,002
193 INFORMATION SYSTEMS SECURITY PROGRAM.....	13,477	13,477	15,477	15,077
194 INFORMATION SYSTEMS SECURITY PROGRAM.....	408,316	408,316	408,316	408,316
196 DISA MISSION SUPPORT OPERATIONS.....	1,205	1,205	1,205	1,205
197 C4I FOR THE WARRIOR.....	4,098	4,098	4,098	4,098
198 GLOBAL COMMAND AND CONTROL SYSTEM.....	23,761	23,761	34,761	34,761
199 JOINT SPECTRUM CENTER.....	18,944	18,944	18,944	18,944
200 NET-CENTRIC ENTERPRISE SERVICES (NCES).....	1,782	1,782	1,782	1,782
201 JOINT MILITARY DECEPTION INITIATIVE.....	942	942	942	942
202 TELEPORT PROGRAM.....	5,239	5,239	5,239	5,239
203 SPECIAL APPLICATIONS FOR CONTINGENCIES.....	16,381	30,381	16,381	27,581
206 CYBER SECURITY INITIATIVE.....	993	993	993	993
208 CYBER SECURITY INITIATIVE.....	10,080	10,080	10,080	10,080
209 CRITICAL INFRASTRUCTURE PROTECTION (CIP).....	12,725	12,725	17,725	16,725
215 POLICY R&D PROGRAMS.....	6,948	6,948	6,948	6,948
217 NET CENTRICITY.....	1,479	1,479	1,479	1,479
221 DISTRIBUTED COMMON GROUND/SURFACE SYSTEMS.....	1,407	9,407	1,407	7,407
224 DISTRIBUTED COMMON GROUND/SURFACE SYSTEMS.....	3,158	3,158	3,158	3,158
226 MQ-1 PREDATOR A UAV.....	2,067	2,067	2,067	2,067
228 HOMELAND DEFENSE TECHNOLOGY TRANSFER PROGRAM.....	2,963	2,963	2,963	2,963
229 INT'L INTELLIGENCE TECHNOLOGY ASSESSMENT, ADVANCEMENT.	1,389	1,389	1,389	1,389
238 INDUSTRIAL PREPAREDNESS.....	20,514	28,014	50,514	46,514
239 LOGISTICS SUPPORT ACTIVITIES.....	2,798	2,798	2,798	2,798
240 MANAGEMENT HEADQUARTERS (JCS).....	8,303	8,303	8,303	8,303
241 NATO AGS.....	74,485	74,485	66,485	69,485

(In thousands of dollars)

	Budget	House	Senate	Recommendation
242 MQ-9 UAV.....	4,380	4,380	4,380	4,380
245 SPECIAL OPERATIONS TECHNOLOGY DEVELOPMENT.....	82,621	74,121	67,592	72,612
246 SPECIAL OPERATIONS TACTICAL SYSTEMS DEVELOPMENT.....	6,182	2,594	7,494	6,874
247 SPECIAL OPERATIONS INTELLIGENCE SYSTEMS DEVELOPMENT...	21,273	21,780	36,173	41,393
248 SOF OPERATIONAL ENHANCEMENTS.....	60,310	64,310	60,310	63,310
249 SPECIAL OPERATIONS CV-22 DEVELOPMENT.....	12,687	12,687	12,687	12,687
250 JOINT MULTI-MISSION SUBMERSIBLE.....	43,412	23,412	43,412	33,412
252 OPS ADVANCED SEAL DELIVERY SYSTEM (ASDS) DEVELOPMENT..	1,321	3,500	1,600	3,500
253 MISSION TRAINING AND PREPARATION SYSTEMS (MTPS).....	3,192	3,192	3,192	3,192
254 UNMANNED VEHICLES (UV).....	---	1,000	---	1,000
255 MC130J SOF TANKER RECAPITALIZATION.....	5,957	5,957	5,957	5,957
256 SOF COMMUNICATIONS EQUIPMENT AND ELECTRONICS SYSTEMS..	733	733	733	733
257 SOF TACTICAL RADIO SYSTEMS.....	2,368	2,368	2,368	2,368
258 SOF WEAPONS SYSTEMS.....	1,081	1,081	1,081	1,081
259 SOF SOLDIER PROTECTION AND SURVIVAL SYSTEMS.....	597	597	597	597
260 SOF VISUAL AUGMENTATION, LASERS & SENSOR SYSTEMS.....	3,369	6,869	6,369	8,569
261 SOF TACTICAL VEHICLES.....	1,973	1,973	1,973	1,973
262 SOF ROTARY WING AVIATION.....	18,863	18,863	18,863	18,863
263 SOF UNDERWATER SYSTEMS.....	3,452	13,000	12,452	18,852
264 SOF SURFACE CRAFT.....	12,250	10,000	12,250	10,000
265 SOF PSYOP.....	9,887	9,887	9,887	9,887
266 SOF GLOBAL VIDEO SURVEILLANCE ACTIVITIES.....	4,944	4,944	4,944	4,944
267 SOF OPERATIONAL ENHANCEMENTS INTELLIGENCE.....	11,547	11,547	11,547	11,547
TOTAL, OPERATIONAL SYSTEMS DEVELOPMENT.....	1,186,231	1,202,127	1,239,693	1,266,363
999 CLASSIFIED PROGRAMS.....	4,273,689	4,050,489	4,355,489	4,264,429
DARPA UNDISTRIBUTED REDUCTION.....	---	-200,000	---	---
TOTAL, RESEARCH, DEVELOPMENT, TEST & EVAL, DEF-WIDE.	20,741,542	20,721,723	20,408,968	20,747,081

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

R-1	Budget Request	House	Senate	Recommendation
DTRA UNIVERSITY STRATEGIC PARTNERSHIP BASIC				
1 RESEARCH	48,544	48,544	33,544	41,044
Excessive growth ahead of program assessment			-15,000	-7,500
2 DEFENSE RESEARCH SCIENCES	226,125	242,825	194,218	206,778
Laboratory for Advanced Photonic Composites Research		1,800		1,280
Hydrogen Fuel Cell Research		4,000		4,000
Institute for Collaborative Sciences Research		2,600		2,080
Science, Technology, Engineering and Mathematics Initiative		2,000		1,600
Solid Oxide Fuel Technology		1,000		1,000
American Museum of Natural History Infectious Disease Research		1,500		1,200
Countermeasures to Combat Protozoan Parasites (Toxoplasmosis and Malaria)		2,000		1,600
UAV Systems and Operations Validation Program (Transferred to line number 129)		2,000		0
Fiscal year 2009 new start execution delays			-16,750	-16,750
Reduction to requested fiscal year 2010 new starts			-20,057	-20,057
Advanced Materials Research Institute (AMRI)			1,000	800
Security Protection using Ballistic CORE Technology			3,900	3,900
GOVERNMENT/INDUSTRY COSPONSORSHIP OF				
3 UNIVERSITY RESEARCH	0	5,000	0	4,800
High Efficiency Solar Energy Generation and Storage		1,000		800
Integrated Cryo-cooled High Power Density Systems		4,000		3,200
Center for Research on Minority Health Prostate Cancer Outreach Project		1,000		800
5 NATIONAL DEFENSE EDUCATION PROGRAM	89,980	89,980	69,980	79,980
Premature funding increase			-20,000	-10,000
6 CHEMICAL AND BIOLOGICAL DEFENSE PROGRAM	58,974	79,474	67,874	79,094
Joint Services Aircrew Mask Don/Doff Inflight (Transferred to line number 111)		1,500		0
Advanced Development of Antiviral Prophylactics and Therapeutics		3,000		3,000
Countermeasures to Chemical and Biological Controls-Rapid Response		3,500		2,800
MEMS Sensors for Real-Time Sensing of Weaponized Pathogens		2,500		2,000
Mismatch Repair Driven Antibody Medicines to Treat Staphylococcus-derived Bioweapons		1,000		1,000
Portable Rapid Bacterial Warfare Detection Unit		4,000	5,000	4,000
Potent Human Monoclonal Antibodies Against BoNT A, B and E Suited for Mass Production and Treatment of Large Populations		1,000		1,000
Synchrotron Beamline Experimental Station		4,000		3,200
High Speed, High Volume Laboratory Network for Infectious Disease			2,000	1,600
InVitro Models for Biodefense Vaccines			1,900	1,520

R-1	Budget Request	House	Senate	Recommendation
INSENSITIVE MUNITIONS--EXPLORATORY				
7 DEVELOPMENT	22,669	18,961	15,112	18,961
Partial Program growth reduction		-3,708		-3,708
P-204 - new start			-7,557	0
HISTORICALLY BLACK COLLEGES & UNIVERSITIES				
9 (HBCU) SCIENCE	15,164	65,521	18,464	67,096
Reappropriation of fiscal year 2008 account level		34,457		34,457
Program Increase		9,400		9,400
Active Duty Training and Education Program		2,000		2,000
Morehouse College, John H. Hopps Defense Research Scholars Program		3,000		2,400
Thurgood Marshall College Fund Defense Leadership and Technology Initiative		1,500		1,200
Instrumentation Program for Tribal Colleges			3,300	2,475
11 INFORMATION AND COMMUNICATIONS TECHNOLOGY	282,749	285,749	255,931	273,331
High Speed Optical Interconnects for Next Generation Supercomputing		1,500		1,200
Intelligent Remote Sensing for Urban Warfare Operations II		1,500		1,200
Fiscal year 2009 new start execution delays			-8,196	-8,196
Reduction to requested fiscal year 2010 new starts			-18,622	-18,622
Fiscal year 2010 new starts				15,000
12 COGNITIVE COMPUTING SYSTEMS	142,840	144,840	142,840	144,840
BioButanol Production Research		2,000		2,000
14 CHEMICAL AND BIOLOGICAL DEFENSE PROGRAM	209,072	226,572	215,972	225,772
Self-decontaminating Polymer System for Chemical and Biological Warfare Agents (Transferred to line number 111)		3,500		0
Botulinum Neurotoxin Research		2,500		2,000
Botulinum Toxin Treatment Therapy		1,000		800
Chemical and Biological Agent Fate Appropriate Response Operational Tool		2,000		1,600
Chemical and Biological Resistant Clothing		2,000		1,600
Anti-viral vaccine development		4,500	1,000	3,600
Miniaturized Chemical Detector for Chemical Warfare Protection		2,000		1,600
Chemical and Biological Infrared Detection System			1,900	1,900
Contaminated Human Remains Pouch			2,000	1,600
PaintShield for Protecting People from Microbial Threats			2,000	2,000
JOINT DATA MANAGEMENT ADVANCED				
15 DEVELOPMENT	4,940	4,940	0	0
Redundancy with other DoD programs			-4,940	-4,940
HUMAN, SOCIAL AND CULTURE BEHAVIOR				
16 MODELING (HSCB) APP	9,446	9,446	7,946	7,946
Unexecutable growth			-1,500	-1,500

R-1	Budget Request	House	Senate	Recommendation
17 TACTICAL TECHNOLOGY	276,075	278,075	241,125	249,725
Sea Catcher UAS Launch and Recovery System		2,000		1,600
Fiscal year 2009 new start execution delays			-31,950	-31,950
Reduction to requested fiscal year 2010 new starts			-24,000	-24,000
Fiscal year 2010 new starts			12,000	20,000
Center of Excellence for Research in Ocean Sciences (CEROS)			9,000	8,000
18 MATERIALS AND BIOLOGICAL TECHNOLOGY	268,859	268,959	272,359	271,339
Moldable Fabric Armor (Transferred to RDT&E, Army line number 5)		2,800		0
Photovoltaic Ribbon Solar Cell Technology Project		3,600		2,880
Center for Nonproliferation Studies, Monterey Institute for International Affairs		2,000		1,600
Bioinspired Sensors - excessive program growth		-5,000		-5,000
Biological Interfaces - excessive program growth		-3,300		0
Fiscal year 2009 new start execution delays			-2,000	-2,000
Strategic Materials			5,500	5,000
19 ELECTRONICS TECHNOLOGY	223,841	225,841	170,154	180,154
3-D Technology for Advanced Sensor Systems		2,000		2,000
Fiscal year 2009 new start execution delays			-39,500	-39,500
Reduction to requested fiscal year 2010 new starts			-26,187	-26,187
Fiscal year 2010 new starts			12,000	20,000
WEAPONS OF MASS DESTRUCTION DEFEAT				
20 TECHNOLOGIES	219,130	220,630	221,530	222,250
National Center for Blast Mitigation		1,500		1,200
University Strategic Partnership			2,400	1,920
21 SPECIAL OPERATIONS TECHNOLOGY DEVELOPMENT	27,384	33,884	24,884	30,734
Flashlight Soldier-to-Soldier Combat Identification System		4,500	2,000	4,500
United States Special Operations Command - USSOCOM / STAR-TEC Partnership Program		2,000		1,600
REITS unjustified new starts			-4,500	-2,750
22 SOF MEDICAL TECHNOLOGY DEVELOPMENT	0	3,000	0	2,400
Personalized Medicine Initiative		3,000		2,400
JOINT MUNITIONS ADVANCED TECHNOLOGY,				
23 INSENSITIVE MUNITIONS - ADVANCED	23,538	16,754	10,428	13,644
Partial Program growth reduction		-6,784	-10,000	-6,784
P301 new start			-3,110	-3,110
25 COMBATING TERRORISM TECHNOLOGY SUPPORT	81,868	102,368	106,268	118,108
Affordable Robust Mid-Sized Unmanned Ground Vehicle		2,000		1,600
Comprehensive and Integrated Procedures for Risk Assessment and Resource Allocation		2,500		2,000
Facility Security Using Tactical Surveys		4,500		3,600
Integrated Rugged Checkpoint Container		2,500	1,600	2,000
Low Cost Stabilized Turret		1,000		800
Military/Law Enforcement Counterterrorism Test Bed		3,000		2,400
Radio Inter-Operability System		2,000		1,600
Ultra Low Profile EARS Gunshot Localization System		1,500		1,200
Remote VBIED Detection and Defeat System		1,500		1,200

R-1	Budget Request	House	Senate	Recommendation
BOPPER/COPPER - Bioterrorism Operations Policy for Public Emergency/Chemoterrorism Operations Policy for Public Emergency			1,000	1,000
Covert Sensing and Tagging System			1,500	1,200
Dynamic Data Flow Management System			2,000	1,600
Emergency Egress System			2,000	1,600
Expeditionary Surveillance and Reconnaissance Program			5,000	4,000
IdentClarity-Identity Resolution			1,800	1,440
MARCENT Thermal Imaging Suite			3,000	3,000
Omni Directional Relay and Conformal Antenna			2,500	2,500
Reconnaissance and Data Exploitation (REX) System			4,000	3,500
COUNTERPROLIFERATION INITIATIVES--				
26 PROLIFERATION PREVENTION & DEFEAT	233,203	241,203	233,203	239,923
AELED IED/WMD Electronic Signature Detection		6,000		4,800
New Drug Targets in Multi-Drug Resistant Bacteria (Transferred to RDT&E, Army line number 28)		2,000		0
Recovery, Recycle and Reuse of DOE Metals for DoD Applications (Transferred from RDT&E, Army line number 32)				1,920
27 BALLISTIC MISSILE DEFENSE TECHNOLOGY	109,760	109,760	104,760	190,260
Reduce program growth to support near-term missile defense programs		-5,000	-10,000	-7,500
Advanced Battery Technology		2,000		1,600
Missile Activity and Characteristics - Releasable		3,000		2,400
Multiple-Target-Tracking Optical Sensor-Array Technology (MOST)			5,000	4,000
Early Interceptor (Transferred from line number 79)				80,000
28 JOINT ADVANCED CONCEPTS	7,817	3,909	7,817	3,909
Excessive program growth		-3,908		-3,908
30 ADVANCED AEROSPACE SYSTEMS	338,360	338,360	249,360	259,360
Vulture contract award delay			-17,000	-17,000
Reduction for high speed engines			-40,000	-30,000
Rapid Eye excessive growth without acquisition strategy			-25,000	-25,000
Reduction to requested fiscal year 2010 new starts			-7,000	-7,000
31 SPACE PROGRAMS AND TECHNOLOGY	200,612	202,612	189,312	190,912
Mosaic Camera Technology Transition		2,000		1,600
Fiscal year 2009 new start execution delays			-4,500	-4,500
Reduction to requested fiscal year 2010 new starts			-6,800	-6,800
CHEMICAL AND BIOLOGICAL DEFENSE PROGRAM -				
32 ADVANCED DEVELOPMENT	282,235	297,735	296,235	300,935
Multi-target Shipping Container Interrogation System				
Mobile Continuous Air Monitor		2,000		1,600
Hand-Held Apparatus for Mobile Mapping and Expedited Reporting		3,500		2,800
Regenerative Filtration System for CBRN Defense		3,000		2,700
Total Perimeter Surveillance		2,000		1,600
Unified Management Infrastructure System		1,000		800
Advanced Development of Mobile Rapid Response Prototypes		2,000	3,000	2,400
Chemical and Biological Defense Program - Advanced Development		2,000		2,000

R-1	Budget Request	House	Senate	Recommendation
Army Plant Vaccine Development Program			2,000	1,600
Center for Advanced Emergency Response (Transferred to RDT&E, Army line number 28)			5,000	0
NIDS Handheld Common Identifier for Biological Agents			3,000	2,400
Water Purification System for Natural Disasters			1,000	800
34 JOINT CAPABILITY TECHNOLOGY DEMONSTRATIONS	198,352	202,352	143,467	169,952
Distributed Network Switching and Security		2,000		1,600
High Accuracy Network Determination System - Intelligent Optical Networks (Transferred to RDT&E, Air Force line number 73)		2,000		0
Fiscal year 2010 JCTD New Starts			-54,885	-30,000
HUMAN, SOCIAL AND CULTURE BEHAVIOR				
38 MODELING (HSCB) ADVANCED DEVELOPMENT	11,480	11,480	9,980	10,480
Unexecutable growth			-1,500	-1,000
DEFENSE-WIDE MANUFACTURING SCIENCE AND TECHNOLOGY PROGRAM	14,638	16,638	24,638	23,738
California Enhanced Defense Small Manufacturing Suppliers Program		2,000		1,600
High Performance Manufacturing Technology Initiative			10,000	7,500
JOINT ROBOTICS PROGRAM/AUTONOMOUS SYSTEMS	9,110	11,610	9,110	11,110
Autonomous Control and Video Sensing for Robots		1,000		800
Battle-Proven Packbot		1,500		1,200
GENERIC LOGISTICS R&D TECHNOLOGY DEMONSTRATIONS	19,043	34,043	42,643	52,123
Aging Systems Sustainment and Enabling Technologies		3,000		2,400
Progressive Research for Sustainable Manufacturing		1,500		1,200
Reduced Cost Supply Readiness		1,500		1,200
Alternative Energy from Organic Sources		6,000		6,000
Cellulosic-Derived Biofuels Research		3,000		2,400
Biofuels Program			2,000	1,600
Commodity Management Systems Consolidation Program			2,000	1,600
Continuous Acquisition and Life-Cycle Support (CALS)				
Integrated Data Environment and Defense Logistics Enterprise Services Program (DLES)			4,000	3,200
Fuel Cell Hybrid Battery Manufacturing for Defense Operations			1,000	800
Fuelcell Locomotive			3,000	2,400
Next Generation Manufacturing Technologies Initiative			2,000	1,600
Vehicle Fuel Cell and Hydrogen Logistics Program			8,000	6,400
Woody Biomass Conversion to JP-8 Fuel			1,600	1,280
Radio Frequency Identification Technologies (Transferred from line number 63 and RDT&E, Navy line number 61)				1,000
43 STRATEGIC ENVIRONMENTAL RESEARCH PROGRAM	69,175	69,175	67,675	67,675
Execution adjustment			-1,500	-1,500

R-1	Budget Request	House	Senate	Recommendation
MICROELECTRONIC TECHNOLOGY DEVELOPMENT				
44 AND SUPPORT	26,310	51,810	55,210	70,830
3-D Electronics and Power		6,000		4,800
AESA Technology Insertion Program		3,000		2,400
Carbon Nanotube Thin Film Near Infrared Detector		2,000		1,600
End to End Semi Fab Alpha Tool		2,000		1,600
Feature Size Yield Enhancement Advanced				
Reconfigurable Manufacturing for Semiconductors				
Foundry		3,000		2,400
Heterogeneous Gallium Nitride/Silicon Microcircuit				
Technology		2,000		1,600
Spintronics Memory Storage Technology		3,500		2,800
Superconducting Quantum Information Technology		1,000		800
X-Band/W-Band Solid State Power Amplifier		1,000		1,000
Semiconductor Photomask Technology Infrastructure				
Initiative		2,000		1,600
Electronics and Materials for Flexible Sensors and				
Transponders (EMFST)			6,000	4,800
High Performance Tunable Materials - Combinatorial				
Development of Advanced Dielectrics			4,500	3,600
Shipping Container Security System Field Evaluation			4,500	3,600
Smart Bomb Targeting Radar System			2,900	2,320
Tunable MicroRadio for Military Systems			7,000	5,600
Vehicle and Dismount Exploitation Radar (VADER)			4,000	4,000
46 ADVANCED ELECTRONICS TECHNOLOGIES	205,912	207,912	179,907	194,907
Hybrid Power Generating System		2,000		0
Fiscal year 2009 new start execution delays			-11,000	-11,000
Reduction to requested fiscal year 2010 new starts			-22,005	-22,005
Institute of Advanced Flexible Manufacturing Systems			7,000	7,000
Fiscal year 2010 new starts				15,000
HIGH PERFORMANCE COMPUTING MODERNIZATION				
49 PROGRAM	221,286	221,286	245,186	237,406
Program adjustment			20,000	13,000
High Performance Computational Design of Novel				
Materials			3,900	3,120
COMMAND, CONTROL AND COMMUNICATIONS				
50 SYSTEMS	293,476	293,476	270,326	270,326
Fiscal year 2009 new start execution delays			-2,000	-2,000
CCC-CLS execution delays			-18,150	-18,150
Reduction to requested fiscal year 2010 new starts			-3,000	-3,000
52 CLASSIFIED DARPA PROGRAMS	186,526	186,526	178,326	178,326
Program terminated by DARPA			-8,200	-8,200
53 NETWORK-CENTRIC WARFARE TECHNOLOGY	135,941	135,941	135,941	138,941
Fiscal year 2009 new start execution delays			-9,500	-9,500
Reduction to requested fiscal year 2010 new starts			-2,500	-2,500
Fiscal year 2010 new starts			12,000	15,000
54 SENSOR TECHNOLOGY	243,056	243,056	223,800	223,800
Fiscal year 2009 new start execution delays			-4,256	-4,256
SEN-CLS execution delays			-10,000	-10,000
Reduction to requested fiscal year 2010 new starts			-5,000	-5,000

R-1		Budget Request	House	Senate	Recommendation
59	QUICK REACTION SPECIAL PROJECTS	107,984	92,984	69,484	74,184
	Reduction from Technology Transition Initiative		-15,000		-10,000
	QRF fiscal year 2010 new starts			-15,000	-10,000
	RRF fiscal year 2010 new starts			-25,000	-15,000
	Small Craft Threat Identification Program			1,500	1,200
60	JOINT EXPERIMENTATION	124,480	107,380	109,480	106,800
	Reduction for National Center for Small Unit Excellence		-20,000	-5,000	-10,000
	Tidewater Full Scale Exercise		2,900		2,320
	Unexecutable program growth			-10,000	-10,000
	JOINT WARGAMING SIMULATION MANAGEMENT				
61	OFFICE	38,505	38,505	34,505	34,505
	Unexecutable growth			-4,000	-4,000
63	TECHNOLOGY TRANSFER	2,219	12,219	8,319	13,669
	National Radio Frequency Research, Development and Technology Transfer		5,000	1,400	4,000
	Radio Frequency Identification Technologies (Transferred to line number 41)		1,000		0
	FirstLink Technology Transfer Program		3,000		2,400
	Program Increase		1,000		750
	Center for Innovation at Arlington			2,700	2,700
	MilTech Expansion Program			2,000	1,600
	SPECIAL OPERATIONS ADVANCED TECHNOLOGY DEVELOPMENT				
65	DEVELOPMENT	31,675	57,175	36,975	56,965
	Affordable Miniature FOPEN Radar for Special Operations Craft - Riverine		3,500		2,800
	Optical Surveillance Equipment		2,000		2,000
	Field Experiment Program for Special Operations		2,000		1,600
	CBRN Detection Unmanned Aircraft		2,000		1,600
	Intelligence, Surveillance, and Reconnaissance Global Sensors Architecture		2,000		1,600
	Partnership for Defense Innovation Wi-Fi Laboratory Testing and Assessment Center		1,500	3,500	2,800
	Program Increase Helicopter Situational Awareness and Survivability		12,500		10,000
	REITS unjustified new starts			-4,500	-2,750
	Advanced Distributed Aperture System (ADAS)/Hostile Fire Indicating System (HFIS)			1,300	1,040
	Antennas and other CNT Devices for Intelligence/Special Military			3,000	3,000
	Tiger Moth Air-Launched Off Board Sensing Small Unmanned Aerial System			2,000	1,600
	NUCLEAR AND CONVENTIONAL PHYSICAL SECURITY EQUIPMENT				
68	EQUIPMENT	36,019	39,019	46,219	46,179
	Under-Vehicle Inspection System		3,000	1,500	2,400
	Advance Detection of Special Nuclear Materials			2,000	2,000
	Pacific Data Conversion and Technology Program			2,000	2,000
	Wyoming Army National Guard Joint Training and Experimentation Center (JTEC)			4,700	3,760
70	RETRACT LARCH	21,718	21,718	37,218	21,718
	Program adjustment (Transferred to RDT&E, Navy line number 37)			15,500	0

R-1	Budget Request	House	Senate	Recommendation
71 JOINT ROBOTICS PROGRAM	11,803	15,803	11,803	15,403
Autonomous Machine Vision for Mapping and Investigation of Remote Sites		2,000		1,600
Joint Robotics Training Program		2,000		2,000
ENVIRONMENTAL SECURITY TECHNICAL				
73 CERTIFICATION PROGRAM	31,613	36,613	37,013	41,113
Environmentally Friendly Nanometal Electroplating Processes for Cadmium and Chromium Replacement		3,000		3,000
Wellhead Treatment of Perchlorate Contaminated Wells		2,000		1,600
Alternative Energy Study			1,400	1,400
Inland Empire Perchlorate Remediation			4,000	3,500
BALLISTIC MISSILE DEFENSE MIDCOURSE DEFENSE				
75 SEGMENT	982,922	982,922	1,032,922	1,032,922
GBI vendor base sustainment			50,000	50,000
BALLISTIC MISSILE DEFENSE BOOST DEFENSE				
76 SEGMENT	186,697	186,697	186,697	183,297
Support for FTS-01				-3,400
77 CHEMICAL AND BIOLOGICAL DEFENSE PROGRAM	205,952	210,952	205,952	210,152
Automated Sample Preparation for Biological Detection		1,000		800
Broad Spectrum Therapeutic Countermeasures to OP Nerve Agents		2,000		1,600
Tactical, Cargo, and Rotary Wing Aircraft Decon		2,000		1,800
78 BALLISTIC MISSILE DEFENSE SENSORS	636,856	636,856	626,856	624,156
Replacement Patriot Launcher Pad for Japan - MDA requested adjustment			[2,500]	[2,500]
System Engineering and Unifying Missile Defense Functions-reduce program growth to support near-term missile defense programs			-10,000	-10,000
Support for FTS-01				-2,700
79 BALLISTIC MISSILE DEFENSE SYSTEM INTERCEPTOR	0	80,000	0	0
Program Increase - Early Interceptor Program (Transferred to line number 27)		80,000		0
80 BALLISTIC MISSILE DEFENSE TEST & TARGETS	966,752	940,752	778,652	827,752
Target Synchronization with Test Schedule		-26,000		0
Premature Request			-151,100	-135,800
STSS Targets - FTS-01			-37,000	-3,200
81 BALLISTIC MISSILE DEFENSE SYSTEMS CORE	369,145	358,645	358,145	360,645
General Reduction		-25,000	-15,000	-20,000
Next Generation Sensor Producability-Flight 2		10,000		7,500
Advanced Decision Support System		2,500		2,000
Miniature Divert and Altitude Controls System Thruster		2,000		1,600
Advanced Composite Radome			4,000	3,200
Support for FTS-01				-2,800
82 SPECIAL PROGRAMS - MDA	301,566	286,566	251,566	251,566
Program decrease due to excessive growth		-15,000	-50,000	-50,000

R-1	Budget Request	House	Senate	Recommendation
83 AEGIS BMD	1,690,758	1,670,758	1,468,358	1,443,358
New Operational Configuration for six additional Aegis Cruisers and New Missile Type for Block 5.2 not determined		-50,000		-30,000
Ballistic Signal Processor/Open Architecture		30,000		20,000
Transfer to line 83A			-257,400	-257,400
SM-3 Development			35,000	20,000
83A AEGIS BMD SM-3 Block IIA co-development	0	0	257,400	257,400
Transferred from line 83	0	0	257,400	257,400
84 SPACE SURVEILLANCE & TRACKING SYSTEM	180,000	160,000	173,200	162,500
Demonstration Satellites		-20,000		-10,000
Support for FTS-01			-6,800	-7,500
87 BALLISTIC MISSILE DEFENSE C2BMC	340,014	340,014	340,014	336,514
Support for FTS-01				-3,500
BALLISTIC MISSILE DEFENSE JOINT WARFIGHTER				
89 SUPPORT	60,921	61,421	60,921	61,421
Independent Advisory Group to Review Ballistic Missile Defense Training Needs		500		500
92 SEA BASED X-BAND RADAR (SBX)	174,576	161,576	174,576	168,076
General Reduction		-13,000		-6,500
97 ISRAELI COOPERATIVE PROGRAMS	119,634	202,434	202,434	202,434
Arrow 3		12,500	12,500	12,500
Arrow 2 Development		26,000	26,000	26,000
Arrow 2 Co-Production		10,000	10,000	10,000
David's Sling		34,300	34,300	34,300
100 DEPARTMENT OF DEFENSE CORROSION PROGRAM	4,887	6,387	21,487	22,287
Corrosion Training Simulation Program		1,500		1,200
Center for Education and Research on Corrosion and Materials Performance			2,000	1,600
Department of Defense Corrosion Prevention and Control Program			14,600	14,600
DOD UNMANNED AIRCRAFT SYSTEM (UAS) COMMON				
101 DEVELOPMENT	55,289	65,289	55,289	61,289
Small Business Technology Insertion		10,000		6,000
102 JOINT CAPABILITY TECHNOLOGY DEMONSTRATIONS	18,577	3,577	18,577	11,077
Reduction due to obligation and expenditure		-15,000		-7,500
JOINT ELECTROMAGNETIC TECHNOLOGY (JET)				
107 PROGRAM	3,949	6,949	3,949	6,349
Lifetime Power for Wireless Control Sensors		1,000		800
Secure, Miniaturized, Hybrid, Free Space, Optical Communications		2,000		1,600
111 CHEMICAL AND BIOLOGICAL DEFENSE PROGRAM	332,895	339,895	296,595	301,575
Chemical and Biological Threat Reduction Coating		3,000		2,400
Detection and Remediation of Bio/Chemical Weapons Program		2,000		2,000
Protective Self-Decontaminating Surfaces		2,000		1,600
Lack of justification for core program growth			-47,400	-47,400

R-1	Budget Request	House	Senate	Recommendation
Joint Services Aircrew Mask (JSAM) Don/Doff In-flight Upgrade (Includes transfer from line number 6)			3,000	2,400
Self-Decontaminating Polymer System for Chemical and Biological Warfare Agents (Includes transfer from line number 14)			2,000	2,800
Man Portable Sensors for Dismounted Reconnaissance			2,500	2,000
Real Time Test Monitoring of Chemical Agents, Chemical Agent Stimulants and Toxic Industrial Chemicals			1,600	1,280
Self-Contained Automated Vehicle Washing Systems with Microwave Decontamination			2,000	1,600
ADVANCED IT SERVICES JOINT PROGRAM OFFICE				
113 (AITS-JPO)	39,911	39,911	15,157	15,157
Rapid Technology Insertion Fund			-24,754	-24,754
WEAPONS OF MASS DESTRUCTION DEFEAT				
115 CAPABILITIES	8,735	8,735	9,735	9,535
Electric Grid Reliability/Assurance			1,000	800
116 INFORMATION TECHNOLOGY DEVELOPMENT	11,705	15,205	11,705	14,505
National Terrorism Preparedness Institute, Anti-Terrorism/Counter-Terrorism Technology Development and Training		3,500		2,800
DEFENSE INTEGRATED MILITARY HUMAN				
117 RESOURCES SYSTEM	70,000	70,000	18,710	18,710
Transfer to RDT&E, Army line number 117 for DIMHRS execution			-30,800	-30,800
Transfer to RDT&E, Air Force line number 241 for DIMHRS execution			-20,490	-20,490
BUSINESS TRANSFORMATION AGENCY R&D				
118 ACTIVITIES	197,008	197,008	192,508	192,508
DAI - Defer one major fielding			-4,500	-4,500
121 TRUSTED foundry	41,223	41,223	51,223	51,223
Trusted Foundry			10,000	10,000
124 JOINT COMMAND AND CONTROL PROGRAM (JC2)	49,047	49,047	0	0
Program adjustment			-38,047	-38,047
Transfer to line number 198			-11,000	-11,000
GENERIC LOGISTICS R&D TECHNOLOGY				
126 DEMONSTRATIONS	0	2,000	0	0
Integrated Analysis Environment (Transferred to line number 167)		2,000		0
127 DEFENSE READINESS REPORTING SYSTEM (DRRS)	13,121	16,121	13,121	15,371
Program Increase		3,000		2,250
128 JOINT SYSTEMS ARCHITECTURE DEVELOPMENT	15,247	15,247	7,430	11,330
Duplicate funding			-7,817	-3,908

R-1	Budget Request	House	Senate	Recommendation
CENTRAL TEST AND EVALUATION INVESTMENT				
129 DEVELOPMENT	145,052	152,552	157,462	162,272
Gulf Range Mobile Instrumentation Capability		3,000		2,400
Savannah CRTC Training Enabled Maneuver Instrumentation (STEM)		4,500		3,600
Advanced SAM Hardware Simulator Development			4,000	4,000
Border Security and Defense Systems Research			2,000	1,600
Pacific Region Interoperability Test and Evaluation Capability			3,500	3,300
UAV Systems and Operations Validation Program (Includes transfer from line number 2)			2,900	2,320
130 THERMAL VICAR	9,045	12,045	9,045	11,445
Joint Gulf Range Complex Test and Training		3,000		2,400
136 CLASSIFIED PROGRAM USD(P)	0	95,637	95,637	95,637
Classified Program USD(P)		95,637	95,637	95,637
SMALL BUSINESS INNOVATION				
147 RESEARCH/CHALLENGE ADMINISTRATION	2,163	3,163	4,063	4,683
UAV Directed Energy Weapons Systems Payloads		1,000		1,000
Random Obfuscating Compiler Anti-Tamper Software			1,900	1,520
148 DEFENSE TECHNOLOGY ANALYSIS	11,005	11,805	11,005	11,805
Modeling and Simulation Standards Study		800		800
150 FORCE TRANSFORMATION DIRECTORATE	19,981	24,981	19,981	23,981
Rigid Aeroshell Variable Buoyancy Air Vehicle		5,000		4,000
151 DEFENSE TECHNICAL INFORMATION CENTER (DTIC)	54,411	49,411	54,411	49,411
General Reduction		-5,000		-5,000
154 DARPA AGENCY RELOCATION	45,000	45,000	15,000	45,000
Delay to project initiation			-30,000	0
SUPPORT TO INFORMATION OPERATIONS (IO)				
161 CAPABILITIES	30,604	25,904	36,504	30,624
Excess Funding		-4,700		-4,700
Enhanced Simulation for Information Operations Capabilities			5,900	4,720
INTELLIGENCE SUPPORT TO INFORMATION				
164 OPERATIONS (IO)	20,648	22,648	20,648	20,648
Biological and Chemical Warfare Online Repository of Technical Holdings (Transferred to line number 999)		2,000		0
167 COCOM EXERCISE ENGAGEMENT AND TRAINING	34,306	34,306	41,806	40,706
Agile Software Capability Intervention (ASCI)			1,500	1,200
Integrated Analysis Environment (Includes transfer from line number 126)			2,000	2,000
Playas Training and Research Center			4,000	3,200
168 PENTAGON RESERVATION	19,709	0	19,709	19,709
Duplicative Maintenance and Facilities Support Costs for FOB 2		-19,709	0	0
169 MANAGEMENT HEADQUARTERS - MDA	57,403	52,403	57,403	52,403
General Reduction		-5,000		-5,000

R-1	Budget Request	House	Senate	Recommendation
193 INFORMATION SYSTEMS SECURITY PROGRAM	13,477	13,477	15,477	15,077
IASTAR Federal Information Security Management Act Compliance			2,000	1,600
198 GLOBAL COMMAND AND CONTROL SYSTEM	23,761	23,761	34,761	34,761
Transfer from line number 124 for program enhancements			11,000	11,000
203 SPECIAL APPLICATIONS FOR CONTINGENCIES	16,381	30,381	16,381	27,581
Advanced Technologies Sensors and Payloads/Unattended SIGINT Node		6,000		4,800
Comprehensive Maritime Domain Awareness		4,000		3,200
GMTI Radar for Class II UAVs		1,000		800
UAV/UAS Test Facility		3,000		2,400
209 CRITICAL INFRASTRUCTURE PROTECTION (CIP)	12,725	12,725	17,725	16,725
Disaster Response: Communications and Other Infrastructure Restoration			5,000	4,000
221 DISTRIBUTED COMMON GROUND/SURFACE	1,407	9,407	1,407	7,407
Program Increase - DCGS Capabilities Modernization		8,000		6,000
238 INDUSTRIAL PREPAREDNESS	20,514	28,014	50,514	46,514
Copper-base Casting Technology Applications		2,000		1,600
Corrosion Resistant Ultrahigh-Strength Steel for Landing Gear		2,000		1,600
DLA VetBiz Initiative for National Sustainment		1,000		800
Northwest Manufacturing Initiative		2,500		2,000
Industrial Base Innovation Fund			30,000	20,000
241 NATO AGS	74,485	74,485	66,485	69,485
Excess to requirement			-8,000	-5,000
245 SPECIAL OPERATIONS TECHNOLOGY DEVELOPMENT	82,621	74,121	67,592	72,612
Avionics Modernization Program		-10,000	-20,029	-15,209
Helicopter Cable Warning and Obstacle Avoidance		1,500		1,200
EC-130J Multi-Mission Upgrades			5,000	4,000
SPECIAL OPERATIONS TACTICAL SYSTEMS				
246 DEVELOPMENT	6,182	2,594	7,494	6,874
SOF Resource Business Information System		-4,588	-4,588	-4,588
Covert Waveform for Software Defined Radios		1,000	2,800	2,800
SOC-R Armor Development for Small Arms Armor Piercing Ammo			3,100	2,480
SPECIAL OPERATIONS INTELLIGENCE SYSTEMS				
247 DEVELOPMENT	21,273	21,780	36,173	41,393
Counterproliferation Analysis and Planning System Program Review		-14,993		0
Advanced, Long Endurance Unattended Ground Sensor Technologies		2,000	4,900	3,920
Biometric Optical Surveillance System		5,000	6,000	6,000
Counterproliferation Analysis and Planning System		5,000		4,000
United States Special Operations Command SOCRATES				
High Assurance Platform Program		1,000		1,000
University Multi-Spectral Laboratories		2,500		2,000
Picoceptor and Processor for Man-portable Threat Warning			4,000	3,200

R-1	Budget Request	House	Senate	Recommendation
248 SOF OPERATIONAL ENHANCEMENTS	60,310	64,310	60,310	63,310
USSOCOM Medical Research		4,000		3,000
250 JOINT MULTI-MISSION SUBMERSIBLE	43,412	23,412	43,412	33,412
Fiscal year 2009 new start execution delays		-20,000		-10,000
OPS ADVANCED SEAL DELIVERY SYSTEM (ASDS)				
252 DEVELOPMENT	1,321	3,500	1,600	3,500
ASDS Program Termination		-1,321	-1,321	-1,321
Lithium-ion Battery Safety Detection and Control of Impending Failures		1,500	1,600	1,500
Material, Design and Fabrication Solutions for Advanced SEAL Delivery System External Structural Components		2,000		2,000
254 UNMANNED VEHICLES (UV)	0	1,000	0	1,000
Hand-held, Lethal Small Unmanned Aircraft System		1,000		1,000
SOF VISUAL AUGMENTATION, LASERS & SENSOR SYSTEMS				
260 SYSTEMS	3,369	6,869	6,369	8,569
Miniature Day Night Sight for Crew Served Weapons		1,500		1,200
Thermal Pointer/Illuminator for Force Protection		2,000		1,600
ASIC Miniaturization for Lasers and Sensors Development			3,000	2,400
263 SOF UNDERWATER SYSTEMS	3,452	13,000	12,452	18,852
Fiscal year 2009 new start execution delays		-1,452		0
Alternative SOF Submersible Concept Design Study		1,000	1,000	1,000
Non-Gasoline Burning Outboard Engine		1,900		1,520
Technology for Shallow Water Special Operation Forces Mobility		3,600		2,880
Transformer Technology for Combat Submersibles		4,500		3,600
Future Dry Deck Shelter			5,500	4,400
Undersea Special Warfare Engineering Support Office			2,500	2,000
264 SOF SURFACE CRAFT	12,250	10,000	12,250	10,000
Fiscal year 2009 new start execution delays		-2,250		-2,250
999 CLASSIFIED PROGRAMS	4,273,689	4,050,489	4,355,489	4,264,429
Classified Adjustments		-251,500	52,900	-57,100
Laser Ablation Resonance Ionization Mass Spectrometer		3,000		2,400
Portable Device for Latent Fingerprint Identification		1,800		1,440
Advanced Scientific Missile Intelligence Preparation of the Battlespace		2,500		2,000
Security for Critical Communication Networks		7,000		5,600
Cybersecurity and Operational Identity Management		2,000		1,600
Improving Support to the Warfighter		7,000		7,000
MS GIS Educational and Research Program (Transferred to O&M Def-wide)		1,000		0
Enhancement of Geo-location Systems		4,000		3,200
Armed Forces Health and Food Supply Research			5,000	4,000
Center for Intelligence and Security Studies			2,400	2,400
Hawaii Advanced Laboratory for Information Integration			2,500	2,000
Initiative to Advance Adaptive Petascale Supercomputing			10,000	8,000
Intelligent Explosives Detection			4,000	3,200
Technology Applications for Security Enhancement			3,000	3,000
Biological and Chemical Warfare Online Repository of Technical Holdings (Includes transfer from line number 164)			2,000	2,000
DARPA Undistributed Reduction		-200,000	0	0

DARPA NEW START PROGRAMS

The Defense Advanced Research Projects Agency's (DARPA's) fiscal year 2010 budget request includes \$135,170,000 for new start programs, a significant increase over the \$28,000,000 executed for new starts in fiscal year 2009 and the \$16,000,000 executed for new starts in fiscal year 2008. The recently appointed Director of DARPA did not have an opportunity to adjust DARPA's fiscal year 2010 budget submission to reflect the new administration's priorities. Additionally, management changes instituted to address DARPA's historic budget execution challenges are likely to require some time before taking effect.

Therefore, the recommendation denies all funding for the requested new start programs. Instead, following the receipt of additional information from the new DARPA Director, the recommendation provides \$85,000,000 in multiple program elements, as requested by the Director, for fiscal year 2010 new starts to be selected by the Director in fiscal year 2010. None of these funds may be obligated until the Director provides details to the congressional defense committees on the programs to be initiated, to include descriptions, program objectives, the expected duration of the DARPA effort and associated out-year funding requirements and planned technology readiness levels to be achieved by DARPA and Service transition partners. This is an exception to conventional budgeting procedures and the Director of DARPA is directed to use established budgeting procedures for its fiscal year 2011 budget submission.

RAPID EXPLOITATION OF INNOVATIVE TECHNOLOGIES IN ALL AREAS OF SCIENCE AND TECHNOLOGY

The recommendation provides \$4,500,000 for fiscal year 2010 new starts in Rapid Exploitation of Innovative Technologies (REITS) and directs the Commander, Special Operations Command, to provide quarterly reports to the congressional defense committees on the use of any current fiscal year or prior year funds provided for REITS, to include individual project schedules, cost estimates and transition plans. The Commander, Special Operations Command, is further directed to submit an annual report to the congressional defense committees on the actual cost, schedule to complete and transition to operational use or further development for all projects for which REITS funds were executed.

GROUND-BASED MISSILE DEFENSE

In addition to the reporting requirements contained in Sections 232 and 233 of H.R. 2647,

the National Defense Authorization Act for Fiscal Year 2010, the Director of the Missile Defense Agency (MDA) is directed to provide a report on how MDA will utilize the funds in the Ground-based Midcourse Defense (GMD) program in fiscal year 2010 to maintain the Ground-Based Interceptor (GBI) production line. The report shall identify the number of GBIs that are being produced in fiscal year 2010. Furthermore, the report shall include a discussion of MDA's GMD Analysis of Alternatives that was conducted as a result of U.S. Northern Command's Ballistic Missile Defense study that was provided to MDA in October 2008. These reports shall be submitted to the congressional defense committees at the same time the President submits the fiscal year 2011 budget request to Congress.

BALLISTIC MISSILE DEFENSE TEST AND TARGETS

There is strong support for a robust testing program for the Missile Defense Agency (MDA). In December of 2008, the Director of MDA initiated a review of the entire Ballistic Missile Defense test program and developed the Integrated Master Test Plan (IMTP) that was signed in late July 2009, well after the submission of the fiscal year 2010 budget request. The IMTP's primary purpose is to establish and document the executable test baseline program from fiscal year 2010 and out to satisfy critical engagement conditions and empirical measurement events data collection requirements.

Since the plan was submitted, it has become known that some tests scheduled for fiscal year 2010 have slipped to fiscal year 2011 and that target synchronization with the new test plan still needs clarification. Furthermore, the fiscal year 2010 budget requests an increase of \$50,000,000 over last year's funding level. However, MDA has not expended over \$500,000,000 of fiscal year 2009 funds and those funds will be carried over into fiscal year 2010 in the test and target program. Therefore, the recommendation reduces the budget request by \$135,800,000 due to a premature request of funding.

EARLY INTERCEPTOR

The Director of the Missile Defense Agency (MDA) is conducting a 90-day study on the different components of the early interceptor to evaluate how best to incorporate them into the Integrated Master Test Plan and MDA's new focus on early/ascent-phase intercept. The recommendation includes \$80,000,000 in Line 27, Ballistic Missile Defense Technology, only for the development of the relevant technologies and incorpora-

tion of existing technologies to support the early intercept program. Additionally, MDA is urged to use previously appropriated funds in other program elements that would be complimentary or enhance the relevant technologies for early/ascent-phase intercept.

TWO-STAGE GROUND-BASED INTERCEPTOR

The Missile Defense Agency (MDA) is encouraged to continue developing and testing the two-stage ground-based interceptor. It is understood that over \$173,000,000 has already been obligated in prior year funding to support development and testing. MDA is encouraged to provide at least \$50,000,000 in fiscal year 2010 funds to continue the two-stage interceptor program.

Furthermore, the Under Secretary of Defense for Policy is directed to submit a report to the congressional defense committees by June 1, 2010. The report shall include a plan for the continuation of the two-stage ground-based interceptor program as well as how MDA plans to leverage the development and testing of the interceptor to modernize the Ground-based Midcourse Defense system. If the report recommends continuation of the two-stage interceptor program, it shall address any options for basing two-stage interceptors in Europe or the United States to provide enhanced defense in response to future long-range missile threats from Iran. The report shall also include a description of how such a site may be made interoperable with the planned missile defense architecture for Europe and the United States. Finally, the report shall include an independent cost estimate for the two-stage ground-based interceptor plan that is recommended.

GLOBAL SUPPLY CHAIN SECURITY

The national security establishment currently relies on electronic and computer components manufactured predominately overseas. The Department of Defense requires a trusted procurement process to provide classified handling, chain of custody, tracking and vital control of mission critical information technology system components. Accordingly, the Department is urged to provide the necessary resources to establish a Secure Procurement Logistics pilot project within the Cyber Security Initiative to perform secure procurement and logistics support for mission critical information technology.

OPERATIONAL TEST AND EVALUATION, DEFENSE

For Operational Test and Evaluation, Defense, funds are to be
available for fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
OPERATIONAL TEST & EVAL, DEFENSE				
1 RDT&E MANAGEMENT SUPPORT				
1 OPERATIONAL TEST AND EVALUATION.....	58,647	58,647	58,647	58,647
2 LIVE FIRE TESTING.....	12,285	12,285	12,285	12,285
3 OPERATIONAL TEST ACTIVITIES AND ANALYSES.....	119,838	119,838	119,838	119,838

TOTAL, RDT&E MANAGEMENT SUPPORT.....	190,770	190,770	190,770	190,770

TOTAL, OPERATIONAL TEST & EVAL, DEFENSE.....	190,770	190,770	190,770	190,770
=====				

TITLE V - REVOLVING AND MANAGEMENT FUNDS

For Revolving and Management Funds, funds are to be available for
fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
<hr/>				
TITLE V				
REVOLVING AND MANAGEMENT FUNDS				
Defense Working Capital Funds.....	1,455,004	1,455,004	1,455,004	1,455,004
National Defense Sealift Fund.....	1,642,758	1,692,758	1,242,758	1,672,758
Defense Coalition Support Fund.....	22,000	---	---	---
<hr/>				
Total, title V, Revolving and Management Funds..	3,119,762	3,147,762	2,697,762	3,127,762
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DEFENSE WORKING CAPITAL FUNDS

For the Defense Working Capital Funds, \$1,455,004,000 is provided for fiscal year 2010.

NATIONAL DEFENSE SEALIFT FUND

For the National Defense Sealift Fund, \$1,672,758,000 is provided for fiscal year 2010.

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
STRATEGIC SHIP ACQUISITION	1,089,902	1,089,902	689,902	1,089,902
Reduce one ship			-400,000	
DoD MOBILIZATION ASSETS	199,595	199,595	199,595	199,595
STRATEGIC SEALIFT SUPPORT	4,794	4,794	4,794	4,794
SEALIFT RESEARCH AND DEVELOPMENT	72,983	72,983	72,983	72,983
READY RESERVE FORCE OPERATIONS AND MAINTENANCE	275,484	275,484	275,484	275,484
MARITIME ADMINISTRATION SHIP FINANCING GUARANTEE PROGRAM	0	50,000	0	30,000
Total NDSF	1,637,964	1,692,758	1,242,758	1,672,758

TITLE VI - OTHER DEPARTMENT OF DEFENSE PROGRAMS

For Other Department of Defense Programs, funds are to be available
for fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
TITLE VI				
OTHER DEPARTMENT OF DEFENSE PROGRAMS				
Defense Health Program:				
Operation and maintenance.....	26,967,919	28,257,565	26,990,219	27,596,689
Procurement.....	322,142	384,142	322,142	366,692
Research, development, test and evaluation.....	613,102	1,249,402	998,752	1,280,047
Total, Defense Health Program.....	27,903,163	29,891,109	28,311,113	29,243,428
Chemical Agents and Munitions Destruction, Defense:				
Operation and maintenance.....	1,146,802	1,146,802	1,125,911	1,146,802
Procurement.....	12,689	12,689	12,689	12,689
Research, development, test and evaluation.....	401,269	351,269	401,269	401,269
Total, Chemical Agents 1/.....	1,560,760	1,510,760	1,539,869	1,560,760
Drug Interdiction and Counter-Drug Activities, Defense	1,058,984	1,237,684	1,103,088	1,158,226
Joint Improvised Explosive Device Defeat Fund 1/.....	564,850	364,550	---	121,550
Rapid Acquisition Fund 1/.....	79,300	---	---	---
Office of the Inspector General 1/.....	272,444	288,100	288,100	288,100
Total, title VI, Other Department of Defense Programs.....	31,439,501	33,292,203	31,242,168	32,372,064

DEFENSE HEALTH PROGRAM

For the Defense Health Program, funds are to be available for fiscal
year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
Defense Health Program:				
Operation and maintenance.....	26,967,919	28,257,565	26,990,219	27,596,689
Procurement.....	322,142	384,142	322,142	366,692
Research, development, test and evaluation.....	613,102	1,249,402	998,752	1,280,047
Total, Defense Health Program.....	27,903,163	29,891,109	28,311,113	29,243,428

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
OPERATION AND MAINTENANCE	26,967,919	28,257,565	26,990,219	27,596,689
IN-HOUSE CARE	6,914,373	6,918,303	6,917,373	6,917,303
Fort Drum Regional Health Planning Organization		430		430
Madigan Army Medical Center Trauma Assistance		2,500	3,000	2,500
Military Physician Combat Medical Training (Transferred to Education and Training)		1,000		
PRIVATE SECTOR CARE	14,255,972	15,537,688	14,562,972	14,562,972
Federal Pricing Rebates		760,716		0
TRICARE Shortfall		521,000	307,000	307,000
CONSOLIDATED HEALTH CARE	1,938,305	1,938,305	1,647,205	1,951,025
TBI/PH and WII requirements (Transferred to OCO)			-307,000	0
AFIP/Joint Pathology Center Records Digitization and Repository Modernization			15,000	12,000
Epidemiologic Health Survey			900	720
INFORMATION MANAGEMENT/IT	1,315,645	1,315,645	1,318,045	1,317,565
Enhanced Medical Situational Awareness			2,400	1,920
MANAGEMENT HEADQUARTERS	277,810	277,810	277,810	277,810
EDUCATION AND TRAINING	625,802	629,802	626,802	630,002
Web-Based Teaching Programs for Military Social Work		4,000		3,200
Military Physician Combat Medical Training			1,000	1,000
BASE OPERATIONS AND COMMUNICATIONS	1,640,012	1,640,012	1,640,012	1,940,012
Medical Transportation Infrastructure				300,000
PROCUREMENT	322,142	384,142	322,142	366,692
Composite Operational Health and Occupational Risk Tracking System (Transferred to R&D)		3,000		0
Initial Outfitting and Equipping Items		53,000		39,750
Shock Trauma Center Operating Suites		3,000		2,400
Wide Area Virtual Environment Simulation for Medical Readiness Training		3,000		2,400
RESEARCH AND DEVELOPMENT	613,102	1,249,402	998,752	1,280,047
ALS		10,000		7,500
Program Increase - Army Reserve Component Personal Empowerment Package (ARCPEP)		4,500		3,375
Autism Research		8,000		8,000
Bone Marrow Failure Disease Research Program		5,000		3,750
Breast Cancer Center (VRAMC/WRNMMC)	5,310	15,000		15,000
Composite Operational Health and Occupational Risk Tracking System (Transferred from Procurement)				2,400
Duchenne Muscular Dystrophy		5,000		3,750
Genetics Studies of Food Allergies		2,500		1,875

	Budget Request	House	Senate	Recommendation
Global HIV/AIDS Prevention		10,000		10,000
Gynecological Cancer Center (WRAMC/WRNMMC)	4,820	6,000		6,000
Hand Transplant Research		6,000		4,500
Integrative Cardiac Health Care (WRAMC/WRNMMC)	3,490	7,000		7,000
Military Dental Research (Transferred to RDT&E, Navy line number 124)		8,000		0
Multiple Sclerosis		6,000		4,500
National Diabetes Model Program (Note: of which \$4 million is available for Type I)		15,000		15,000
Pain and Neuroscience Center (WRAMC/WRNMMC)	4,000	8,000		8,000
Peer-Reviewed Breast Cancer Research Program		150,000	150,000	150,000
Peer-Reviewed Cancer Research Program		20,000		15,000
Peer Reviewed Lung Cancer Research		15,000		15,000
Peer-Reviewed Orthopedic Research		30,000		22,500
Peer-Reviewed Ovarian Cancer Research Program		25,000	10,000	18,750
Peer-Reviewed Prostate Cancer Research Program		80,000	80,000	80,000
Peer-Reviewed Spinal Cord Research Program		15,000		11,250
Peer-Reviewed Vision Research		5,000		3,750
Prostate Cancer Center (WRAMC/WRNMMC)	3,380	4,000		4,000
Research in Alcohol and Substance Use Disorders		8,500		6,375
Program Increase - Assistive Technology Research		3,000		3,000
Gulf War Illness Peer-Reviewed Research Program		8,000	12,000	8,000
Peer-Reviewed Neurofibromatosis (NF) Research		25,000		13,750
Peer-Reviewed Neurotoxin Exposure Treatment				
Parkinsons Research Program		25,000		25,000
Traumatic Brain Injury and Psychological Health		127,800	60,500	120,000
Military Medical Research (including the continuation of Traumatic Brain Injury and Psychological Health Research)	372,200			372,200
Tuberous Sclerosis Complex (TSC)		8,000		6,000
US Military Cancer Institute		5,000		5,000
Wound Care Research (Transferred to RDT&E, Navy line number 24)		13,000		0
Hawaii Federal Health Care Network			24,500	23,000
Lung Injury Management			1,450	1,160
Patient Care Improvement Project at Keesler Medical Center			4,100	3,280
Regional Telepathology Initiative at Keesler AFB			2,100	1,680
Security Solutions from Life in Extreme Environments Center			1,000	800
Operating Room of the Future (Transferred to RDT&E, Army line number 28)			2,000	0
Peer-Reviewed Medical Research Program			50,000	50,000

DEFENSE HEALTH PROGRAM REPROGRAMMING
PROCEDURES

There is concern regarding the transfer of funds from Direct (or In-house) Care to pay for contractor-provided medical care. To limit such transfers and continue oversight within the Defense Health Program operation and maintenance account, the explanatory statement includes language which limits the funds available for Private Sector Care under the TRICARE program subject to prior approval reprogramming procedures. The bill language and accompanying recommendation should not be interpreted by the Department as limiting the amount of funds that may be transferred to the Direct Care System from other budget activities within the Defense Health Program. In addition, the Services are not properly budgeting for actual execution levels among the budget activity groups and, therefore, the Direct Care System is continued as a special interest item. Any transfer of funds from the Direct (or In-house) Care budget activity into the Private Sector Care budget activity or any other budget activity will require the Department of Defense to follow prior approval reprogramming procedures.

CARRYOVER

For fiscal year 2010, the recommendation includes a one percent carryover authority for the Defense Health Program. The Assistant Secretary of Defense for Health Affairs is directed to submit a detailed spending plan for any fiscal year 2009 designated carryover funds to the congressional defense committees by January 4, 2010. In addition, the Department shall, not fewer than 30 days prior to executing the carryover funds, notify the congressional defense committees in writing of the details of any such obligation. Finally, to address the continuing funding shortfalls in medical information technology, the Department is directed to use available carryover funds to address this deficit.

MEDICAL INFORMATION TECHNOLOGY

Over the past few years, criticism regarding the Department of Defense and the Department of Veterans Affairs medical information technology has grown. Both Departments developed their current systems and infrastructure independent of one another, primarily using proprietary technology and hardware that is costly, not user-friendly and technologically unsustainable. As such, both Departments have now chosen to modernize their systems and infrastructure to address many of those issues, as well as addressing the issues surrounding interoperability between both Departments and the private sector. These systems must also address new requirements made evident by continuing overseas operations, including the ability to expand based on future technology requirements.

Unfortunately, it appears that both Departments are not sufficiently coordinating their efforts, and that lessons learned are not being used to develop an efficient and cost-effective means for data interoperability and information technology modernization. The recommendation recognizes that each Department has unique system requirements; however, both Departments do have common functions that should result in the development of common technology solutions and architecture. Areas that should be joint business practices include lab work,

pharmacy orders, digital radiology transmittal, third-party collections and patient appointment scheduling. Both Departments are continuing to work on interoperability between their current systems and improving the transmittal of medical records from one system to another. However, there is significant concern that the necessary efforts being made to jointly develop the required future systems are inadequate. Therefore, the Joint Executive Council (JEC) and the Health Executive Council (HEC) are directed to report to the Committees on Appropriations of the House and the Senate not later than January 11, 2010, on a complete and thorough review of the technology requirements of each Department. The report shall detail each requirement, to include those that are deemed unique to each Department, include a justification of why the requirement can or cannot be developed jointly, and identify the path forward to develop such joint technology. In addition, the JEC and the HEC are directed to coordinate this report with the Department of Health and Human Services as it seeks to modernize electronic health records throughout the private sector. If done correctly and efficiently, the efforts of both Departments can be used as an example of how to modernize medical information technology.

MILITARY MEDICAL RESEARCH

The recommendation provides \$120,000,000 for Traumatic Brain Injury (TBI) and Psychological Health research and treatment efforts. The fiscal year 2010 budget submission included \$372,000,000 to address numerous unique military medical areas of concern including TBI and Psychological Health. The Department is encouraged to refer to the language in the House and Senate reports regarding gaps in research that need to be addressed within this funding to close those disparities.

It is understood that the Department of Defense is putting pressure on Health Affairs to obligate these funds in an expedited manner during fiscal year 2010 and as a result, Requests for Information (RFI) on grant proposals for this funding have already been published prior to the completion of the Department of Defense Appropriations Act, 2010. These actions are not supported by this recommendation since funding has not been appropriated and the Committees on Appropriations of the House and Senate were never notified of a new start request. Since the submission of the President's budget request, the Department has been repeatedly asked for a distributable list of medical research capability gaps that will be addressed with the additional \$372,000,000. Therefore, the Secretary of Defense is directed to provide a distributable list of medical research capability gaps that will be addressed using these funds not later than 15 days after enactment of this Act.

PEER-REVIEWED MEDICAL RESEARCH PROGRAM

The recommendation provides \$50,000,000 for a Peer-Reviewed Medical Research Program. The Secretary of Defense, in conjunction with the Service Surgeons General, is directed to select medical research projects of clear scientific merit and direct relevance to military health. Research areas considered under this funding are restricted to: Blood Cancer, Chronic Migraine and Post-traumatic headache, Dystonia, Drug Abuse, Epilepsy, Fragile X Syndrome, Inflam-

matory Bowel Disease, Interstitial Cystitis, Kidney Cancer, Lupus, Melanoma, Mesothelioma, Neuroblastoma, Osteoporosis and related bone disease, Padgett's Disease, Pheochromocytoma, Polycystic Kidney Disease, Post Traumatic Osteoarthritis, Scleroderma, Social Work Research, and Tinnitus. The recommendation emphasizes that the additional funding provided under the Peer-Reviewed Medical Research Program shall be devoted only to the purposes listed above.

HYPERBARIC OXYGEN THERAPY

The Secretary of Defense, not later than 60 days after enactment of this Act, shall submit to the congressional defense committees a report on the use of hyperbaric oxygen therapy (HBOT). The report shall include the number of members of the Armed Forces, veterans and civilians being treated with HBOT; the types of conditions being treated and the respective success rate for each condition; the current inventory, location, and rate of use for hyperbaric oxygen chambers; and any plans for expanding the use of HBOT for treatment.

DIRECT HIRE AUTHORITY

The Secretary of Defense is directed to immediately implement Section 1107 of the National Defense Authorization Act, 2008 (Public Law 110-181) which provides adequate authority for the medical specialty hiring needs of the Department of Defense. The Secretary of Defense is further directed that no later than 30 days after enactment of this Act the Department shall notify the congressional defense committees the action has been taken to implement the direct hire authority across the Department, including the civilian entities.

REDUCING SCAR FORMATION

The United States Army Institute of Surgical Research and the Armed Forces Institute of Regenerative Medicine is currently doing research to reduce scarring following battlefield injuries in conjunction with academia. The Surgeon General of the Army is urged to use funds provided for continuation of studies into new methods for wound healing and scar reduction capabilities including proceeding to a clinical study and for further product development.

MEDICAL TRANSPORTATION INFRASTRUCTURE

After reviewing the Base Realignment and Closure (BRAC) Health Systems Advisory Subcommittee's (the Committee) review of the design plans for medical centers, including the responses from the Department of Defense and the Committee, there remains deep concern about the state of the master plan to complete world class medical facilities. Failures to implement the recommendations of this plan may lead to degraded medical care for military personnel, their dependents and retirees.

The recommendation includes \$300,000,000 in the Defense Health Program operation and maintenance account for transportation issues stemming from the realignments associated with the 2005 BRAC. The Secretary of Defense is directed to provide a report to the House and Senate Committees on Appropriations detailing the status of the implementation of the BRAC Health Systems Advisory Subcommittee's plan, and on plans for the recommended funding increase, no later than 90 days after the enactment of this Act.

CHEMICAL AGENTS AND MUNITIONS DESTRUCTION, DEFENSE

For Chemical Agents and Munitions Destruction, Defense, funds are
to be available for fiscal year 2010, as follows:

(In thousands of dollars)

	Budget	House	Senate	Recommendation
CHEMICAL AGENTS & MUNITIONS DESTRUCTION, DEFENSE				
CHEM DEMILITARIZATION - OPERATION AND MAINTENANCE.....	1,146,802	1,146,802	1,125,911	1,146,802
CHEM DEMILITARIZATION - PROCUREMENT.....	12,689	12,689	12,689	12,689
CHEM DEMILITARIZATION - RESEARCH, DEV, TEST & EVAL....	401,269	351,269	401,269	401,269
TOTAL, CHEM AGENTS & MUNITIONS DESTRUCTION, DEFENSE.	1,560,760	1,510,760	1,539,869	1,560,760

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
Chem Demilitarization-O&M	1,146,802	1,146,802	1,125,911	1,146,802
Tooete Chemical Agent Disposal Facility Heel Transfer System - Already Funded in Previous fiscal year			-20,891	
Chem Demilitarization-Procurement	12,689	12,689	12,689	12,689
Chem Demilitarization-RDT&E	401,269	351,269	401,269	401,269
Transferred from Sec. 8123 of HR 3326		50,000		
Total, Chem Agents & Munitions Destruction, Defense	1,560,760	1,510,760	1,539,869	1,560,760

DRUG INTERDICTION AND COUNTER-DRUG ACTIVITIES,

DEFENSE

(INCLUDING TRANSFER OF FUNDS)

For Drug Interdiction and Counter-Drug Activities, Defense,

\$1,158,226,000 is provided for fiscal year 2010.

DRUG INTERDICTION AND COUNTER-DRUG ACTIVITIES, DEFENSE

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS

[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
COUNTER NARCOTICS	1,058,984	1,238,684	1,103,088	1,158,226
PC8804 Demand Reduction-Civilian Agency Drug Testing - NSA		-1,000		-1,000
PC9205 EUCOM CN Operational Support - excessive growth		-2,000	-5,000	-5,000
PC9206 AFRICOM CN Operational Support - excessive growth		-2,000	-5,000	-5,000
PC9301 CENTCOM Counterthreat Finance Unit		-2,000		0
PC2366 EUCOM Interagency Fusion Centers			-750	-750
Delaware National Guard Counter-Drug Task Force		300	300	300
Western Region Counter-Drug Training Center		2,500	2,500	2,500
Kentucky National Guard Counter-Drug Program		3,500	3,800	3,800
Florida Counter-Drug Program		2,900		2,900
Nevada National Guard Counter-Drug Program		4,000	4,200	4,000
North Carolina Counter-Drug Task Force		1,000		800
Tennessee National Guard Appalachia High Intensity Drug Trafficking Area		4,000	4,000	4,000
Regional Counter-Drug Training Academy - Meridian		1,500	3,000	2,800
Indiana National Guard Counter-Drug Program		3,000		2,400
Young Marines Program		4,000		4,000
Digital Communications		169,000		50,000
Alaska National Guard Counter-Drug Program			3,000	2,400
Hawaii National Guard Counter-Drug Program			3,000	3,000
HERON Maritime UAS for SOUTHCOM			9,800	9,340
Midwest Counter-Drug Training Center			6,000	6,000
Minnesota National Guard Counter-Drug Program			2,000	1,800
Montana National Guard Counter-Drug Task Force			1,000	800
New Mexico National Guard Counter-Drug Program			6,000	4,800
Northeast Counter-Drug Training Center			5,000	4,500
West Virginia Counter-Drug Program			1,000	800
Joint Task Force-North, Drug Interdiction Support (Transferred from Other Procurement, Air Force line 19)			452	452

COUNTER-DRUG BUDGET JUSTIFICATION MATERIALS

There is concern that the budget justification materials submitted do not provide sufficient information for appropriate oversight and understanding of program objectives and metrics. Therefore, the Secretary of Defense is directed that beginning with the fiscal year 2011 budget, the budget justification materials shall ensure that each project code

include, at a minimum: a detailed explanation of program increases and decreases including displays and explanations of program and price growth; a display showing the number of full-time equivalent (FTE) employees; average grade for government employees and number of contractor FTEs; justification of planned equipment buys for items costing more than \$250,000, including quantities and unit costs; and justification and descriptions of research and develop-

ment activities, including anticipated program accomplishments, contract awards and a description of government costs.

JOINT IMPROVISED EXPLOSIVE DEVICE DEFEAT FUND

(INCLUDING TRANSFER OF FUNDS)

For the Joint Improvised Explosive Device Defeat Fund, funds are to be available for fiscal year 2010, as follows:

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS				
[In thousands of dollars]				
	Budget Request	House	Senate	Recommendation
Attack the Network	203,100	183,000	.....	0
Transfer to Title IX .....	.....	.....	.....	-53,100
Unjustified request .....	.....	.....	.....	-150,000
Defeat the Device	199,100	25,000	.....	0
Transfer to Title IX .....	.....	.....	.....	-199,100
Train the Force	41,100	35,000	.....	0
Transfer to Title IX .....	.....	.....	.....	-41,100
Staff and Infrastructure	121,550	121,550	.....	121,550
Total, Joint Improvised Explosive Device Defeat Fund	564,850	364,550	0	121,550

The recommendation provides funds in the base budget for the Staff and Infrastructure line of operation. These funds are provided with the same time limitation as traditional operation and maintenance funds.

The reporting requirements directed under the Supplemental Appropriations Act, 2009 (Public Law 111-32), were not adhered to, but efforts are underway to improve that status.

The Director, Joint Improvised Explosive Device Defeat Organization (JIEDDO) is directed to submit monthly commitment, obligation, and expenditure data by line of operation and by year of appropriation to the congressional defense committees. Further, the Director, JIEDDO is directed to submit monthly reports of obligation data on a project-by-project basis by line of operation

to the congressional defense committees. The Director, JIEDDO is also directed to follow standard reprogramming procedures when transferring a cumulative amount of \$20,000,000 or more between lines of operation.

OFFICE OF THE INSPECTOR GENERAL

For the Office of the Inspector General, \$288,100,000 is provided for fiscal year 2010.

[In thousands of dollars]				
	Budget	House	Senate	Recommendation
Office of the Inspector General:				
Operation and Maintenance	271,444	287,100	287,100	287,100
Procurement	1,000	1,000	1,000	1,000
Total, Office of the Inspector General	272,444	288,100	288,100	288,100

TITLE VII—RELATED AGENCIES

For Related Agencies, funds are to be available for fiscal year 2010, as follows:

[In thousands of dollars]				
	Budget	House	Senate	Recommendation
TITLE VII—RELATED AGENCIES				
Central Intelligence Agency Retirement and Disability System Fund	290,900	290,900	290,900	290,900
Intelligence Community Management Account (ICMA)	672,812	611,002	750,812	707,912
Transfer to Department of Justice .....	.....	.....	.....	.....
Total, title VII, Related agencies	963,712	901,902	1,041,712	998,812

CLASSIFIED ANNEX

Adjustments to the classified programs are addressed in a separate detailed and comprehensive classified annex. The Intelligence Community, Department of Defense and other organizations are expected to fully comply with the recommendations and directions in the classified annex accompanying

the Department of Defense Appropriations Act, 2010.

CENTRAL INTELLIGENCE AGENCY RETIREMENT AND DISABILITY SYSTEM FUND

For the Central Intelligence Agency Retirement and Disability System Fund, \$290,900,000 is provided for fiscal year 2010.

INTELLIGENCE COMMUNITY MANAGEMENT ACCOUNT

For the Intelligence Community Management Account, \$707,912,000 is provided for fiscal year 2010, as follows:

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS				
[In thousands of dollars]				
	Budget Request	House	Senate	Recommendation
Intelligence Community Management Account	672,812	672,812	672,812	672,812
Classified Adjustment .....	.....	-64,810	78,000	34,300
Language Mentorship Program incorporating an electronic portfolio .....	.....	1,000	.....	800
Counter-Threat Finance-Global (Transferred to O&M, Defense-Wide) .....	.....	2,000	.....	0
TOTAL, ICMA	672,812	611,002	750,812	707,912

INTELLIGENCE COMMUNITY'S BUSINESS TRANSFORMATION OFFICE

The Director of National Intelligence is directed to submit a report 90 days after the enactment of this Act that: 1) addresses the

procurement challenges facing the Business Transformation Office; 2) explains where the most efficient and secure place to store the Community's business data will be for the foreseeable future; and 3) reviews the process

for hiring highly qualified experts and provides recommendations that streamline the

current bureaucratic process to one that allows the Director of the Business Transformation Office to efficiently build an effective staff. Finally, the report should provide a target date when all National Intelligence Program funds will achieve a sustainable unqualified audit opinion.

INTELLIGENCE COMMUNITY EDUCATION AND TRAINING STRATEGIC DESIGN

The lack of a strategic plan for the Intelligence Community training programs and professional education curriculum is concerning. The current patchwork of courses, language training efforts and schools is the result of multiple programs and initiatives instead of a coherent strategy. The Director of National Intelligence needs to benchmark successful programs such as the Department of Defense's National Defense University, and develop an appropriate educational and professional development strategy for the Community to create an innovative and competitive 21st century professional intelligence workforce. The Director of National Intelligence is encouraged to take steps to establish the Intelligence Community's capstone school in a manner that takes best advantage of opportunities for learning synergies and a transformative learning environment with other national security students. Further, no later than March 1, 2010, the Director of National Intelligence is directed to submit a report to the intelligence oversight committees on the feasibility of evolving the National Defense Intelligence College to a fee-for-service program.

TITLE VIII—GENERAL PROVISIONS

The recommendation incorporates general provisions from the House and Senate versions of the bill which were not amended. Those general provisions that were addressed follow:

The recommendation modifies a general provision proposed by the House specifying that adjustments to programs, projects, and activities included in the "Explanation of Project Level Adjustments" that are increases above the budget are incorporated into law. Transfers within an appropriation account, among programs, projects and activities do not require general transfer authority as stipulated in Section 8005 of the accompanying Act. However, such transfers are subject to normal prior approval reprogramming procedures if such transfers exceed thresholds described elsewhere in this statement. Transfers between appropriation accounts are subject to the provisions of Section 8005 of the accompanying Act and are also subject to prior congressional approval. The Senate bill contained no similar provision.

The recommendation retains a provision proposed by the Senate that provides for upgrades to military ranges in Alaska. The House bill contained no similar provision.

The recommendation retains a provision proposed by the Senate that provides for limitations on the use and transfer authority of working capital fund cash balances. The House bill contained a similar provision.

The recommendation retains a provision proposed by the House that provides limitations and conditions on the use of funds made available in this Act to initiate multi-year contracts. The Senate bill contained a similar provision.

The recommendation retains a provision proposed by the House that provides for the Department of Defense to purchase anchor and mooring chains manufactured only in the United States. The Senate bill included a similar provision.

The recommendation modifies a provision proposed by both the House and Senate that prohibits funds made available to the Department of Defense from being used to demilitarize or dispose of surplus firearms.

The recommendation modifies a provision proposed by the House and Senate that restricts funds from being used to perform cost studies under OMB Circular A-76.

The recommendation modifies a provision proposed by both the House and Senate which provided funding from various appropriations for the Civil Air Patrol Corporation.

The recommendation modifies a provision proposed by both the House and Senate that provides for the number of staff years of technical effort that may be funded for defense Federally Funded Research and Development Centers (FFRDC).

The recommendation retains a provision proposed by the Senate which provides for the conveyance, without consideration, of relocatable housing units. The House bill contained a similar provision.

The recommendation modifies a provision proposed by the House which provides grant authorities for the Department of Defense acting through the Office of Economic Adjustment. The Senate contained no similar provision.

(RESCISSIONS)

The recommendation modifies a provision proposed by both the House and the Senate recommending rescissions. The rescissions agreed to are:

2008 Appropriations:

Procurement, Defense-Wide:

ASDS \$2,000,000

2009 Appropriations:

Procurement of Weapons and Tracked Combat Vehicles, Army:

Future Combat Systems Advance Procurement 26,087,000

Joint Assault Bridge ... 15,000,000

Other Procurement,

Army:

Night Vision Devices ... 131,900,000

Sequoyah Foreign Language Translation System 6,339,000

Other Procurement,

Navy:

Other Propulsion

Equipment 18,844,000

LCS Mission Modules .. 66,000,000

Aircraft Procurement,

Air Force:

B-52 Modifications 12,800,000

C-130 Modifications 8,000,000

C-130J Advance Procurement 60,000,000

F-22 Advance Procurement 383,000,000

Predator 159,800,000

T-38 Modifications 5,300,000

Missile Procurement, Air Force:

JASSM 60,000,000

Other Procurement, Air Force:

Global Combat Support System 8,800,000

Global Command and Control System 2,100,000

Procurement, Defense-Wide:

ASDS 5,200,000

Research, Development, Test and Evaluation,

Navy:

Surface and Shallow Water MCM 20,000,000

Research, Development, Test and Evaluation, Air Force:

C-17 22,403,000

Combat Training Ranges 6,000,000

Advanced Medium Range Air-to-Air Missile 5,000,000

Control and Reporting Center 15,000,000

Information Systems Security Program 11,827,000

Aerial Targets 7,000,000

C-130 Airlift Squadron Logistics Information Technology (LOGIT) 10,000,000

RDT&E for Aging Aircraft 3,200,000

Research, Development, Test and Evaluation, Defense-Wide:

HBCU 34,457,000

DARPA 100,000,000

Kinetic Energy Interceptor 20,000,000

The recommendation retains a provision proposed by the House that provides for the Department of Defense to dispose of negative unliquidated or unexpended balances for expired or closed accounts. The Senate bill contained no similar provision.

The recommendation retains a provision proposed by the Senate that clarifies the military status of World War II Alaska Territorial Guardsmen. The House bill contained no similar provision.

The recommendation retains a provision proposed by both the House and the Senate that prohibits the use of funds made available in this Act from being used to approve or license the sale of the F-22 fighter aircraft. Additionally, the recommendation retains language proposed by the Senate that permits the Department of Defense to conduct studies and design activities to develop a future export version of the aircraft that protects classified and sensitive information. Assuming that there will be an export version of the F-22A, nothing in this provision shall restrict the Department of Defense from sharing information regarding the future export version of the F-22 pursuant to an inquiry from a foreign government that is intended to inform that government's decision regarding whether to pursue purchase of a future export version of the F-22.

The recommendation modifies a provision proposed by the House which provides \$3,750,000 only for the construction and furnishing of additional Fisher Houses. The Senate bill contained no similar provision.

The recommendation modifies a provision proposed by both the House and Senate which provides funding and transfer authority for the Arrow Missile Defense Program.

The recommendation retains a provision proposed by the Senate that provides for the transfer of funds to properly complete prior year shipbuilding programs. The House bill contained a similar provision.

The recommendation retains a provision proposed by the Senate that none of the funds available to the Department of Defense may be obligated to modify command and control relationships to give Fleet Forces Command administrative and operational control of U.S. Navy forces assigned to the Pacific Fleet. The House bill contained a similar provision.

The recommendation retains a provision proposed by the Senate that provides for the noncompetitive appointments of certain medical occupational specialties, as prescribed by section 7403(g) of Title 38, United

States Code. The House bill contained a similar provision.

The recommendation retains a provision proposed by the Senate which makes available funds for public schools with unusually high concentrations of special needs military dependents enrolled. The House bill contained no similar provision.

The recommendation retains a provision proposed by the House which provides authority for the Secretary of the Army to make a grant only to the Center for Military Recruitment, Assessment and Veterans Employment. The Senate bill contained no similar provision.

The recommendation does not retain a provision proposed by the House that permits Operation and Maintenance, Navy funds to be used to repair, maintain and operate flood control systems adjacent to the Pacific Missile Range Facility. The Senate bill contained no similar provision.

The recommendation modifies a provision proposed by both the House and the Senate providing funds for specific grants.

The recommendation retains a provision proposed by the Senate relating to the prohibition on transfer of program authorities relating to current tactical unmanned aerial vehicles (TUAV) from the Army. The House bill contained a similar provision.

The recommendation retains a provision proposed by the Senate that provides authorities to the Joint Interagency Training and Education Center, for homeland defense/security and traditional warfighting training. The House bill contained no similar provision.

The recommendation retains a provision proposed by the Senate that makes funds available in "Operation and Maintenance, Navy" for the Asia Pacific Regional Initiative Program. The House bill contained a similar provision.

The recommendation retains a provision proposed by the Senate that reduces funding by specified amounts due to updated economic assumptions. The House bill contained no similar provision.

The recommendation retains a provision proposed by the House that provides for the creation of a major force program category for space for the Future Year Defense Program of the Department of Defense. The Senate bill contained no similar provision.

The recommendation retains a provision proposed by the House that established requirements for Director National Intelligence budget exhibits. The Senate bill contained a similar provision.

The recommendation does not retain a provision proposed by the Senate that prohibits the use of funds made available in this Act to contravene laws enacted or regulations promulgated to implement the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The House contained the same provision in Title IX. The issue is addressed in Title IX.

The recommendation modifies a provision proposed by the House that prohibits award fees to any defense contractor contrary to the provisions of section 814 of the National Defense Authorization Act, Fiscal Year 2007 (Public Law 109-364). The Senate bill contained no similar provision.

The recommendation retains a provision proposed by the House which directs the Secretary of Defense to maintain on the Department of Defense website a link to Office of the Inspector General of the Department of Defense. The Senate bill contained no similar provision.

The recommendation modifies a provision proposed by the Senate that provides for a reduction of excess cash balances in the Department of Defense Working Capital Funds. The House bill contained no similar provision.

The recommendation modifies a provision proposed by the House which provides for the continuation of stop loss special pay. The Senate bill contained no similar provision.

The recommendation does not retain a provision proposed by the House which provides for the use of funds for purchase of armored vehicles for force protection purposes. The Senate bill contained no similar provision.

The recommendation modifies a provision proposed by both the House and the Senate which authorizes the transfer of funds made available in title II to the Services' central fund established for Fisher Houses and Suites pursuant to section 2493(d) 10 U.S.C.

The recommendation modifies a provision proposed by the House that authorizes the transfer of funds from the Intelligence Community Management Account for the Program Manager for the Information Sharing Environment to other departments and agencies, for certain purposes. The Senate bill contained a similar provision.

The recommendation modifies a provision proposed by the Senate regarding the availability of operation and maintenance funding to make remittances to the Acquisition Workforce Development Fund. The House bill contained no similar provision.

The recommendation does not retain a provision proposed by the Senate that requires reports on certain elements of the ballistic missile defense system. The House bill contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation modifies a provision proposed by the Senate that not less than \$15,000,000 be made available for high priority National Guard counter-drug programs. The House bill contained no similar provision.

The recommendation retains a provision proposed by the Senate that provides an apology to the Native Peoples of the United States. The House bill contained no similar provision.

The recommendation does not retain a provision proposed by the Senate that requires a report on the use of live primates in training relating to chemical and biological agents. The House bill contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation does not retain a provision proposed by the Senate that expresses the sense of the Senate on Joint STARS re-engining. The House bill contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation modifies a provision proposed by the Senate that requires public disclosure of certain reports. The House bill contained no similar provision.

The recommendation does not retain a provision proposed by the Senate that requires a report on Federal contracting fraud. The House bill contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation does not retain a provision proposed by the Senate that makes funds available for Gulf War Illness Research. The House bill contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation modifies a provision proposed by the Senate that expresses the sense of Congress and requires a report on the Nevada Test Site. The House bill contained no similar provision.

The recommendation does not retain a provision proposed by the Senate that makes funds available from the Office of the Secretary of Defense for declassification of the 2001 nuclear posture review. The House bill contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation does not retain a provision proposed by the Senate that makes funds available from Operation and Maintenance, Defense-Wide for a Military and Overseas Voter Empowerment Act. The House bill contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation does not retain a provision proposed by the Senate that restricts funding to dispose of claims filed regarding water contamination. The House bill contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation does not retain a provision proposed by the Senate that work under Logistics Civil Augmentation Program complies with standards. This issue is addressed in Title II of this statement.

The recommendation modifies a provision proposed by the Senate that prohibits any funds to be used for any Federal contract with specified entities if such entities require their employees to sign mandatory arbitration clauses. The House bill contained no similar provision.

The recommendation does not retain a provision proposed by the Senate that limits the early retirement of tactical aircraft. The House bill contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation does not retain a provision proposed by the Senate that restores funding for the two-stage ground-based interceptor program. The House bill contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation does not retain a provision proposed by the Senate that makes funds available for the evaluations and analyses of certain laser systems. The House bill contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation does not retain a provision proposed by the House that places restrictions on reprogramming funds provided for the National Intelligence Program. The Senate bill contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation modifies a provision proposed by the House that prohibits the award to a contractor or conversion to performance by a contractor of any functions performed by Federal employees pursuant to a study conducted under OMB circular A-76 as of the date of enactment of this Act. The Senate bill contained no similar provision.

The recommendation does not retain a provision proposed by the House authorizing the Secretary of Defense to transfer to the appropriation "Foreign Currency Fluctuations, Defense" unobligated funds appropriated for Operation and Maintenance and Military Personnel. The Senate bill contained no similar provision.

The recommendation does not retain a provision proposed by the House that reduces amounts appropriated in title II of this Act to reflect excess cash balances in Department of Defense Working Capital Funds. The Senate bill contained no similar provision.

The recommendation modifies a provision proposed by the House that prohibits the use of National Intelligence Program funds appropriated in this Act for certain purposes. The Senate bill contained no similar provision.

The recommendation modifies a provision proposed by the House that appropriates funds to the "Tanker Replacement Transfer Fund" and authorizes their transfer under certain circumstances for specified purposes.

The recommendation does not retain a provision proposed by the House that provides benefits to any member or former member of the Armed Forces who would have qualified for a day of administrative absence under the Post-Deployment/Mobilization Respite Absence program. The Senate bill contained no similar provision.

The recommendation retains a provision proposed by the House that provides resettlement support for certain refugees. The Senate bill contained no similar provision.

The recommendation modifies a provision proposed by both the House and Senate that requires congressional earmarks, when awarded to a for-profit entity, to be awarded under full and open competition.

The recommendation does not retain a provision proposed by the House that reduces amounts appropriated in title II of this Act. The Senate bill contained no similar provision. The issue is addressed in Title IX.

The recommendation does not retain a provision proposed by the House that sets certain criteria for the appointment of members of integration panels overseeing Congressionally Directed Medical Research programs related to breast cancer. The Senate bill contained no similar provision.

The recommendation does not retain a provision proposed by the House that prohibits the use of funds to eliminate any personnel positions from the 194th Regional Support Wing of the Air National Guard as of the date of enactment of this Act. The Senate bill contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation does not retain a provision proposed by the House regarding the release and transfer of detainees from Naval Station Guantanamo Bay, Cuba. The Senate bill contained a similar provision in Title IX. The issue is addressed in Title IX.

The recommendation does not retain a provision proposed by the House that prohibits the use of funds for advance procurement of the F-22 and provides that funds made available in title III under the heading "Aircraft Procurement, Air Force" may be available for other specified purposes. The Senate bill contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation does not retain a provision proposed by the House which reduces funds for the Defense Health Program in operation and maintenance and increases funds in research, development, test and evaluation. The Senate bill contained no similar provision.

The recommendation modifies a provision proposed by the House that prohibits the awarding to a contractor, or convert to performance by a contractor, any function at the United States Military Academy at West Point. The Senate bill contained no similar provision.

The recommendation does not retain a provision proposed by the House that reduces funds in Operation and Maintenance, Air Force and increases funds in Chemical Agents and Munitions Destruction, Defense. The Senate bill contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation does not retain a provision proposed by the House that prohibits the privatization of government-owned ammunition production assets. The Senate bill

contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation does not retain a provision proposed by the Senate that requires the Secretary of the Army to certify any transfers to private ammunition manufacturers. The House bill contained no similar provision. The issue is addressed elsewhere in the statement.

The recommendation retains a provision proposed by the Senate that prohibits funding of the Association of Community Organizations for Reform Now. The House bill contained no similar provision. The Senate bill addressed this issue in Title IX.

TITLE IX—OVERSEAS CONTINGENCY OPERATIONS

REPORTING REQUIREMENTS

The Secretary of Defense is directed to provide a report to the congressional defense committees within 30 days of the enactment of this Act on the allocation of the funds within the accounts listed in this title. The Secretary shall submit updated reports 30 days after the end of each fiscal quarter until funds listed in this title are no longer available for obligation. This report shall include: a detailed accounting of obligations and expenditures of appropriations provided in this title by program and sub-activity group for the continuation of military operations in Iraq and Afghanistan; and a listing of equipment procured using funds provided in this title.

Additionally, the Secretary of Defense is directed to continue to report incremental contingency operations costs for Operation Iraqi Freedom and Operation Enduring Freedom on a monthly basis in the Cost of War Execution report as required by Department of Defense Financial Management Regulation, chapter 23, volume 12. Further, the Secretary of Defense is directed to continue to provide the Cost of War reports to the congressional defense committees that include the following information by appropriation: funding appropriated, funding allocated, monthly obligations, monthly disbursements, cumulative fiscal year obligations and cumulative fiscal year disbursements.

In order to meet unanticipated requirements, the Department of Defense may need to transfer funds within these appropriations accounts for purposes other than those specified in this report. The Secretary of Defense is directed to follow normal prior approval reprogramming procedures should it be necessary to transfer funding between different appropriations accounts in this title.

PROGRESS REPORT ON IRAQ

Section 316 of Public Law 111-32, Supplemental Appropriations Act, 2009 directed the Secretary of Defense to submit to Congress on a quarterly basis a report on "Iraq Troop Drawdown Status, Goals and Timetable." Section 316 requires this report to be prepared and submitted every 90 days through September 30, 2010. The recommendation does not repeat section 9010 from the House-passed Department of Defense Appropriations Act, 2010 which repeated this requirement. It is expected that the Department will continue to submit the report as required through September 30, 2010.

BUDGET AMENDMENT

The recommendation fully funds an increase in the Army's end strength, as requested by the Department of Defense in a formal budget amendment submitted on August 13, 2009, after the House had already completed consideration of the Department

of Defense Appropriations Act, 2010. The budget amendment, which provides \$1,012,600,000 to recruit, retain and support an additional 15,000 soldiers in fiscal year 2010, has been accepted. It is understood that these additional soldiers, and the 7,000 additional soldiers the Department plans to add in fiscal year 2011, are needed temporarily to allow existing Brigade Combat Teams to deploy at full strength. There is a concern about the strain on the Army imposed by the on-going high operations tempo in Iraq and the increased demand in Afghanistan. There is also concern about the Department's decision to fund this temporary growth in end-strength by reducing funding for much-needed trucks and tactical vehicles. While it is believed that combat units in the theater of operations are being provided with the required quantity of high-quality tactical vehicles, concern remains that the Department is not requesting adequate funding to reset and replenish damaged and worn-out vehicles or addressing vehicle shortages in the National Guard and the reserve forces. Accordingly, the recommendation provides funding of \$1,063,038,000 for High Mobility Multipurpose Wheeled Vehicles (HMMWV), and \$863,357,000 for the Family of Medium Tactical Vehicles. The recommendation provides much needed trucks for the active Army, the Army National Guard and the Army Reserve.

MI-17 HELICOPTERS

There is concern with the Department's growing reliance on the Mi-17 helicopter to meet critical tactical lift requirements for Afghanistan, Iraq and Pakistan security forces. This platform has exceptionally-high maintenance requirements. Parts and service are not readily available in the theater of operations. Furthermore, the Mi-17 is in high demand by U.S. forces operating in and training for Afghanistan, but there are only two foreign-owned plants producing new aircraft at this time. Therefore, the Secretary of Defense is directed to report to the congressional defense committees not later than sixty days after the enactment of this Act on the Department of Defense's current and anticipated demand for Mi-17s for U.S., Afghanistan, Iraq and Pakistan security forces, the anticipated availability or shortage of additional airframes, the sustainability of the airframes currently slated for use by Afghanistan and Iraq security forces, an analysis of alternative airframes, and the future costs and funding sources available for procuring Mi-17s.

MEDICAL TREATMENT FOR CONTRACTORS

There is concern that American workers are not getting reasonable medical treatment for injuries they have suffered while working in a combat zone. Accordingly, the Department is urged to encourage Federal contractors to provide access to the most effective treatment available for injuries suffered while working outside the United States in support of military operations, including Operation Iraqi Freedom and Operation Enduring Freedom; and encourage Federal contractors performing a Federal contract outside the United States to ensure that American workers performing the contract receive the same benefits for injuries suffered outside the United States that they would receive if they were working within the United States.

MILITARY PERSONNEL

For Military Personnel, funds are to be available for fiscal year 2010, as follows:

	Budget request	House	Senate	Recommendation
Military Personnel, Army				
BA-1: PAY AND ALLOWANCES OF OFFICERS				
BASIC PAY	1,092,996	957,492	1,092,996	1,092,996
RETIRED PAY ACCRUAL	278,338	234,598	278,338	278,338
BASIC ALLOWANCE FOR HOUSING	307,496	270,307	307,496	307,496
BASIC ALLOWANCE FOR SUBSISTENCE	39,353	34,932	39,353	39,353
INCENTIVE PAYS	9,733	7,682	9,733	9,733
SPECIAL PAYS	145,278	158,837	145,278	145,278
Hostile Fire Pay-Transferred from Title I		4,790		
Hardship Duty Pay-Transferred from Title I		7,560		
Foreign Language Proficiency Pay-Transferred from Title I		11,422		
ALLOWANCES	71,925	63,526	71,925	71,925
SEPARATION PAY	15,209	14,495	15,209	15,209
SOCIAL SECURITY TAX	83,526	73,253	83,526	83,526
TOTAL BA-1	2,043,854	1,815,122	2,043,854	2,043,854
BA-2: PAY AND ALLOWANCES OF ENLISTED PERSONNEL				
BASIC PAY	2,198,707	2,033,050	2,198,707	2,198,707
RETIRED PAY ACCRUAL	551,605	498,098	551,605	551,605
BASIC ALLOWANCE FOR HOUSING	881,953	851,950	881,953	881,953
INCENTIVE PAYS	18,335	102,619	18,335	18,335
SPECIAL PAYS	730,018	672,799	721,018	675,518
Hostile Fire Pay-Transferred from Title I		16,374		
Hardship Duty Pay-Transferred from Title I		45,000		
Foreign Language Proficiency Pay-Transferred from Title I		25,237		
Stop Loss/Stabilization Pay - Excess to Requirement		-46,000		-46,000
Stop Loss/Stabilization Pay - Transfer to Reserve Personnel, Army		-8,000	-9,000	-8,500
ALLOWANCES	286,973	281,133	286,973	286,973
SEPARATION PAY	23,793	22,937	23,793	23,793
SOCIAL SECURITY TAX	168,228	155,533	168,228	168,228
TOTAL BA-2	4,859,612	4,618,119	4,850,612	4,805,112
BA-4: SUBSISTENCE OF ENLISTED PERSONNEL				
BASIC ALLOWANCE FOR SUBSISTENCE	448,940	427,578	448,940	448,940
SUBSISTENCE-IN-KIND	1,728,276	1,716,246	1,728,276	1,728,276
TOTAL BA-4	2,177,216	2,143,824	2,177,216	2,177,216
BA-5: PERMANENT CHANGE OF STATION TRAVEL				
OPERATIONAL TRAVEL	82,714	82,714	82,714	82,714
ROTATIONAL TRAVEL	68,271	68,271	68,271	68,271
TOTAL BA-5	150,985	150,985	150,985	150,985
BA-6: OTHER MILITARY PERSONNEL COSTS				
INTEREST ON UNIFORMED SERVICE SAVINGS	16,000	16,000	16,000	16,000
DEATH GRATUITIES	96,000	96,000	96,000	96,000
UNEMPLOYMENT BENEFITS	91,134	91,134	91,134	91,134
RESERVE INCOME REPLACEMENT PROGRAM	800	800	800	800
SGLI EXTRA HAZARD PAYMENTS	170,739	170,739	170,739	170,739
TOTAL BA-6	374,673	374,673	374,673	374,673
Undistributed Transfer from Title I		1,390,000		407,000
Total Military Personnel, Army	9,606,340	10,492,723	9,597,340	9,958,840

	Budget request	House	Senate	Recommendation
Military Personnel, Navy				
BA-1: PAY AND ALLOWANCES OF OFFICERS				
BASIC PAY	215,202	215,202	215,202	215,202
RETIRED PAY ACCRUAL	59,329	59,329	59,329	59,329
BASIC ALLOWANCE FOR HOUSING	66,622	66,622	66,622	66,622
BASIC ALLOWANCE FOR SUBSISTENCE	7,559	7,559	7,559	7,559
INCENTIVE PAYS	999	999	999	999
SPECIAL PAYS	17,584	21,471	17,584	17,584
Hardship Duty Pay-Transferred from Title I		899		
Imminent Danger Pay-Transferred from Title I		481		
Foreign Language Proficiency Pay-Transferred from Title I		2,507		
ALLOWANCES	15,301	15,301	15,301	15,301
SEPARATION PAY	7	7	7	7
SOCIAL SECURITY TAX	16,463	16,463	16,463	16,463
TOTAL BA-1	399,066	402,953	399,066	399,066
BA-2: PAY AND ALLOWANCES OF ENLISTED PERSONNEL				
BASIC PAY	248,916	248,916	248,916	248,916
RETIRED PAY ACCRUAL	69,363	69,363	69,363	69,363
BASIC ALLOWANCE FOR HOUSING	118,130	118,130	118,130	118,130
INCENTIVE PAYS	360	360	360	360
SPECIAL PAYS	92,218	116,447	92,218	92,218
Hardship Duty Pay-Transferred from Title I		8,330		
Imminent Danger Pay-Transferred from Title I		899		
Foreign Language Proficiency Pay-Transferred from Title I		15,000		
ALLOWANCES	29,292	29,292	29,292	29,292
SEPARATION PAY	3,690	3,690	3,690	3,690
SOCIAL SECURITY TAX	19,042	19,042	19,042	19,042
TOTAL BA-2	581,011	605,240	581,011	581,011
BA-4: SUBSISTENCE OF ENLISTED PERSONNEL				
BASIC ALLOWANCE FOR SUBSISTENCE	29,573	29,573	29,573	29,573
SUBSISTENCE-IN-KIND	13,021	13,021	13,021	13,021
TOTAL BA-4	42,594	42,594	42,594	42,594
BA-5: PERMANENT CHANGE OF STATION TRAVEL				
ACCESSION TRAVEL	4,951	4,951	4,951	4,951
OPERATIONAL TRAVEL	22,700	22,700	22,700	22,700
ROTATIONAL TRAVEL	28,660	28,660	28,660	28,660
SEPARATION TRAVEL	2,977	2,977	2,977	2,977
TOTAL BA-5	59,288	59,288	59,288	59,288
BA-6: OTHER MILITARY PERSONNEL COSTS				
DEATH GRATUITIES	3,800	3,800	3,800	3,800
UNEMPLOYMENT BENEFITS	36,624	36,624	36,624	36,624
SGLI EXTRA HAZARD PAYMENTS	53,218	53,218	53,218	53,218
TOTAL BA-6	93,642	93,642	93,642	93,642
Undistributed Transfer from Title I		419,000		213,000
Total Military Personnel, Navy	1,175,601	1,622,717	1,175,601	1,388,601

	Budget request	House	Senate	Recommendation
Military Personnel, Marine Corps				
BA-1: PAY AND ALLOWANCES OF OFFICERS				
BASIC PAY	60,845	60,845	60,845	60,845
RETIRED PAY ACCRUAL	14,907	14,907	14,907	14,907
BASIC ALLOWANCE FOR HOUSING	21,186	21,186	21,186	21,186
BASIC ALLOWANCE FOR SUBSISTENCE	2,439	2,439	2,439	2,439
SPECIAL PAYS	11,708	24,559	11,708	11,708
Hardship Duty Pay-Transferred from Title I		265		
Imminent Danger Pay-Transferred from Title I		8,281		
Foreign Language Proficiency Pay-Transferred from Title I		4,305		
ALLOWANCES	4,752	4,752	4,752	4,752
SOCIAL SECURITY TAX	4,655	4,655	4,655	4,655
TOTAL BA-1	120,492	133,343	120,492	120,492
BA-2: PAY AND ALLOWANCES OF ENLISTED PERSONNEL				
BASIC PAY	203,422	203,422	203,422	203,422
RETIRED PAY ACCRUAL	49,838	49,838	49,838	49,838
BASIC ALLOWANCE FOR HOUSING	53,860	53,860	53,860	53,860
SPECIAL PAYS	86,151	108,048	86,151	86,151
Hardship Duty Pay-Transferred from Title I		2,602		
Imminent Danger Pay-Transferred from Title I		7,655		
Foreign Language Proficiency Pay-Transferred from Title I		11,640		
ALLOWANCES	35,331	35,331	35,331	35,331
SEPARATION PAY	3,017	3,017	3,017	3,017
SOCIAL SECURITY TAX	15,562	15,562	15,562	15,562
TOTAL BA-2	447,181	469,078	447,181	447,181
BA-4: SUBSISTENCE OF ENLISTED PERSONNEL				
BASIC ALLOWANCE FOR SUBSISTENCE	24,472	24,472	24,472	24,472
TOTAL BA-4	24,472	24,472	24,472	24,472
BA-5: PERMANENT CHANGE OF STATION TRAVEL				
ACCESSION TRAVEL	3,451	3,451	3,451	3,451
TOTAL BA-5	3,451	3,451	3,451	3,451
BA-6: OTHER MILITARY PERSONNEL COSTS				
DEATH GRATUITIES	18,000	18,000	18,000	18,000
UNEMPLOYMENT BENEFITS	20,500	20,500	20,500	20,500
SGLI EXTRA HAZARD PAYMENTS	36,626	36,626	36,626	36,626
TOTAL BA-6	75,126	75,126	75,126	75,126
Undistributed Transfer from Title I		292,000		108,000
Total Military Personnel, Marine Corps	670,722	997,470	670,722	778,722

	Budget request	House	Senate	Recommendation
Military Personnel, Air Force				
BA-1: PAY AND ALLOWANCES OF OFFICERS				
BASIC PAY	190,761	190,761	190,761	190,761
RETIRED PAY ACCRUAL	46,736	46,736	46,736	46,736
BASIC ALLOWANCE FOR HOUSING	61,363	61,363	61,363	61,363
BASIC ALLOWANCE FOR SUBSISTENCE	7,819	7,819	7,819	7,819
SPECIAL PAYS	15,428	28,043	15,428	15,428
Hostile Fire Pay-Transferred from Title I		5,501		
Hardship Duty Pay-Transferred from Title I		1,808		
Foreign Language Proficiency Pay-Transferred from Title I		5,306		
ALLOWANCES	6,831	6,831	6,831	6,831
SOCIAL SECURITY TAX	14,593	14,593	14,593	14,593
TOTAL BA-1	343,531	356,146	343,531	343,531
BA-2: PAY AND ALLOWANCES OF ENLISTED PERSONNEL				
BASIC PAY	481,323	481,323	481,323	481,323
RETIRED PAY ACCRUAL	117,924	117,924	117,924	117,924
BASIC ALLOWANCE FOR HOUSING	179,800	179,800	179,800	179,800
SPECIAL PAYS	61,617	127,963	61,617	61,617
Hostile Fire Pay-Transferred from Title I		37,935		
Hardship Duty Pay-Transferred from Title I		10,848		
Foreign Language Proficiency Pay-Transferred from Title I		17,563		
ALLOWANCES	22,458	22,458	22,458	22,458
SOCIAL SECURITY TAX	36,821	36,821	36,821	36,821
TOTAL BA-2	899,943	966,289	899,943	899,943
BA-4: SUBSISTENCE OF ENLISTED PERSONNEL				
BASIC ALLOWANCE FOR SUBSISTENCE	41,213	41,213	41,213	41,213
SUBSISTENCE-IN-KIND	70,563	70,563	70,563	70,563
TOTAL BA-4	111,776	111,776	111,776	111,776
BA-5: PERMANENT CHANGE OF STATION TRAVEL				
OPERATIONAL TRAVEL	5,848	5,848	5,848	5,848
TOTAL BA-5	5,848	5,848	5,848	5,848
BA-6: OTHER MILITARY PERSONNEL COSTS				
DEATH GRATUITIES	2,000	2,000	2,000	2,000
UNEMPLOYMENT BENEFITS	16,244	16,244	16,244	16,244
SGLI EXTRA HAZARD PAYMENTS	66,034	66,034	66,034	66,034
TOTAL BA-6	84,278	84,278	84,278	84,278
Undistributed Transfer from Title I		331,000		222,000
Total Military Personnel, Air Force	1,445,376	1,855,337	1,445,376	1,667,376
Reserve Personnel, Army				
BA-1: UNIT AND INDIVIDUAL TRAINING				
PAY GROUP A TRAINING (15 DAYS and DRILLS 24/48)	128,666	128,666	118,666	118,666
Excess to Requirement			-10,000	-10,000
SCHOOL TRAINING	11,200	11,200	11,200	11,200
SPECIAL TRAINING	154,771	154,771	154,771	154,771
UNDISTRIBUTED ADJUSTMENT		8,000	9,000	8,500
Stop Loss/Stabilization Pay Program		8,000	9,000	8,500
Total Reserve Personnel, Army	294,637	302,637	293,637	293,137

	Budget request	House	Senate	Recommendation
Reserve Personnel, Navy				
BA-1: UNIT AND INDIVIDUAL TRAINING				
SCHOOL TRAINING	5,000	5,000	5,000	5,000
SPECIAL TRAINING	33,400	33,400	31,400	31,400
Excess to Requirement			-2,000	-2,000
ADMINISTRATION AND SUPPORT	640	640	640	640
Total Reserve Personnel, Navy	39,040	39,040	37,040	37,040
Reserve Personnel, Marine Corps				
BA-1: UNIT AND INDIVIDUAL TRAINING				
SCHOOL TRAINING	5,887	5,887	5,887	5,887
SPECIAL TRAINING	25,450	25,450	25,450	25,450
Total Reserve Personnel, Marine Corps	31,337	31,337	31,337	31,337
Reserve Personnel, Air Force				
BA-1: UNIT AND INDIVIDUAL TRAINING				
SPECIAL TRAINING	24,822	24,822	19,822	19,822
Excess to Requirement			-5,000	-5,000
Total Reserve Personnel, Air Force	24,822	24,822	19,822	19,822
National Guard Personnel, Army				
BA-1: UNIT AND INDIVIDUAL TRAINING				
PAY GROUP A TRAINING (15 DAYS and DRILLS 24/48)	478,203	478,203	463,203	463,203
Excess to Requirement			-15,000	-15,000
SPECIAL TRAINING	361,763	361,763	361,763	361,763
Total National Guard Personnel, Army	839,966	839,966	824,966	824,966
National Guard Personnel, Air Force				
BA-1: UNIT AND INDIVIDUAL TRAINING				
SPECIAL TRAINING	18,500	18,500	9,500	9,500
Excess to Requirement			-9,000	-9,000
Total National Guard Personnel, Air Force	18,500	18,500	9,500	9,500

OPERATION AND MAINTENANCE

For Operation and Maintenance, funds are
to be available for fiscal year 2010, as follows:

O-1		Budget Request	House	Senate	Recommendation
OPERATION & MAINTENANCE, ARMY					
135	ADDITIONAL ACTIVITIES	36,526,999	29,064,719	36,388,405	36,139,639
	Transfer to OCOTF		-7,266,180		
	Reduce LOGCAP Growth			-400,000	-400,000
	Army Asymmetric Warfare Office			-17,000	-17,000
	Transfer from Base: CASEVAC/Logistics Rotary Wing				
	Contract for OEF-Philippines			18,500	
	Transfer from Base: Family Readiness Support Assistants			59,891	
	Transfer from Base: Child Care/Youth Development Programs			69,320	
	Transfer from Base: Installation Support			10,088	
	Transfer from Base: Warfighter and Family Services			78,514	
	Transfer from Base: Reception Stations			2,076	
	Transfer from Base: Wounded Warrior Program			10,377	
	Transfer from JIEDDO: OPS - US Army Home Station C-IED Lanes II			8,100	8,100
	Transfer from JIEDDO: JCOE - C-IED Live-Fire Environment			500	500
	Transfer from JIEDDO: JCOE - Biometrics Training Integration			1,000	1,000
	Transfer from JIEDDO: JCOE - First Army CTC Leveling			3,100	3,100
	Transfer from JIEDDO: JCOE - JRTC Simulated Radio Infrastructure Expansion			260	260
	Transfer from JIEDDO: OPS - Joint Total Entity Tracking for Instrumented Battlefield			770	770
	Transfer from JIEDDO: JCOE - USA Company Intel Support Teams (ColST)			2,250	2,250
	Transfer from JIEDDO: OPS - Biometrics MTT			1,870	1,870
	Transfer from JIEDDO: OPS - Battlefield Forensics MTT Course			6,790	6,790
	Transfer from JIEDDO: OPS - JTTP Modeling and Simulation			5,000	5,000
136	COMMANDERS EMERGENCY RESPONSE PROGRAM	1,500,000	1,300,000	1,200,000	1,200,000
	Unjustified request		-200,000		-300,000
	Transfer to MRAP Fund for Urgent Unfunded Requirement			-300,000	
137	RESET	7,867,551	6,254,041	7,867,551	7,867,551
	Transfer to OCOTF		-1,573,510		
411	SECURITY PROGRAMS	1,426,309	1,140,547	1,426,309	1,426,309
	Transfer to OCOTF		-285,262		
	Classified Adjustments		-500		
421	SERVICEWIDE TRANSPORTATION	5,045,902	4,036,722	5,045,902	5,045,902
	Transfer to OCOTF		-1,009,180		
	TRANSFER TO OCOTF				-3,628,247
	UNJUSTIFIED REQUEST FOR CONTRACTED SUPPORT IN THEATER				-230,000
TOTAL, OPERATION & MAINTENANCE, ARMY		52,366,761	41,836,029	51,928,167	47,821,154

O-1	Budget Request	House	Senate	Recommendation
OPERATION & MAINTENANCE, NAVY				
1A1A MISSION AND OTHER FLIGHT OPERATIONS	1,138,398	910,718	1,138,398	1,138,398
Transfer to OCOTF		-227,680		
1A2A FLEET AIR TRAINING	2,640	2,112	2,640	2,640
Transfer to OCOTF		-528		
1A3A AVIATION TECHNICAL DATA & ENGINEERING SERVICES	1,212	970	1,212	1,212
Transfer to OCOTF		-242		
1A4A AIR OPERATIONS AND SAFETY SUPPORT	26,815	21,452	26,815	26,815
Transfer to OCOTF		-5,363		
1A4N AIR SYSTEMS SUPPORT	44,532	35,626	44,532	44,532
Transfer to OCOTF		-8,906		
1A5A AIRCRAFT DEPOT MAINTENANCE	158,559	126,847	158,559	158,559
Transfer to OCOTF		-31,712		
1B1B MISSION AND OTHER SHIP OPERATIONS	651,209	520,967	651,209	651,209
Transfer to OCOTF		-130,242		
1B2B SHIP OPERATIONS SUPPORT & TRAINING	22,489	17,991	22,489	22,489
Transfer to OCOTF		-4,498		
1B4B SHIP DEPOT MAINTENANCE	1,001,037	800,830	1,001,037	1,001,037
Transfer to OCOTF		-200,207		
1C1C COMBAT COMMUNICATIONS	20,704	16,563	20,704	20,704
Transfer to OCOTF		-4,141		
1C4C WARFARE TACTICS	15,918	12,734	15,918	15,918
Transfer to OCOTF		-3,184		
1C5C OPERATIONAL METEOROLOGY AND OCEANOGRAPHY	16,889	13,511	16,889	16,889
Transfer to OCOTF		-3,378		
1C6C COMBAT SUPPORT FORCES	1,891,799	1,513,439	1,818,779	1,809,299
Transfer to OCOTF		-378,360		
Unjustified Growth Based on Allocation and Execution Data	—		-100,000	-100,000
Transfer from JIEDDO: OPS - Joint Training COIC (JTCOIC) (Proof of Concept)	—		17,500	17,500
Transfer from JIEDDO: OPS - Future Immersive Training Environment (FITE) (Transferred to RDT&E, Navy line number 20)	—		9,480	

O-1		Budget Request	House	Senate	Recommendation
1C7C	EQUIPMENT MAINTENANCE Transfer to OCOTF	306	245 -61	306	306
1CCH	COMBATANT COMMANDERS CORE OPERATIONS Transfer to OCOTF	6,929	5,543 -1,386	6,929	6,929
1CCM	COMBATANT COMMANDERS DIRECT MISSION SUPPORT Transfer to OCOTF	7,344	5,875 -1,469	7,344	7,344
1D3D	IN-SERVICE WEAPONS SYSTEMS SUPPORT Transfer to OCOTF	68,759	55,007 -13,752	68,759	68,759
1D4D	WEAPONS MAINTENANCE Transfer to OCOTF	82,496	65,997 -16,499	82,496	82,496
1D7D	OTHER WEAPON SYSTEMS SUPPORT Transfer to OCOTF	16,902	13,522 -3,380	16,902	16,902
BSM1	FACILITIES, SUSTAINMENT, RESTORATION AND MODERNIZATION Transfer to OCOTF	7,629	6,103 -1,526	7,629	7,629
BSS1	BASE OPERATING SUPPORT Transfer to OCOTF	338,604	270,883 -67,721	338,604	338,604
2A1F	SHIP PREPOSITIONING AND SURGE Transfer to OCOTF	27,290	21,832 -5,458	27,290	27,290
2C1H	FLEET HOSPITAL PROGRAM Transfer to OCOTF	4,336	3,469 -867	4,336	4,336
2C3H	COAST GUARD SUPPORT Transfer to OCOTF Transfer to Department of Homeland Security	245,039	196,031 -49,008	3,536 -241,503	3,536 -241,503
3B1K	SPECIALIZED SKILL TRAINING Transfer to OCOTF	97,995	78,396 -19,599	97,995	97,995
3B4K	TRAINING SUPPORT Transfer to OCOTF Training Support—Baseline Budget Requirement	5,463	4,370 -1,093	0 -5,463	0 -5,463
4A1M	ADMINISTRATION Transfer to OCOTF	3,899	3,119 -780	3,899	3,899
4A2M	EXTERNAL RELATIONS Transfer to OCOTF	463	370 -93	463	463

O-1	Budget Request	House	Senate	Recommendation
4A4M MILITARY MANPOWER AND PERSONNEL MANAGEMENT	563	450	563	563
Transfer to OCOTF		-113		
4A5M OTHER PERSONNEL SUPPORT	2,525	2,020	2,525	2,525
Transfer to OCOTF		-505		
4A6M SERVICEWIDE COMMUNICATIONS	23,557	18,846	23,557	23,557
Transfer to OCOTF		-4,711		
4B1N SERVICEWIDE TRANSPORTATION	223,890	179,112	223,890	223,890
Transfer to OCOTF		-44,778		
4B3N ACQUISITION AND PROGRAM MANAGEMENT	642	514	642	642
Transfer to OCOTF		-128		
4C1P NAVAL INVESTIGATIVE SERVICE	37,452	29,962	37,452	37,452
Transfer to OCOTF		-7,490		
999 OTHER PROGRAMS	25,299	20,239	25,299	25,299
Transfer to OCOTF		-5,060		
TRANSFER TO OCOTF				-414,192
TOTAL, OPERATION & MAINTENANCE, NAVY	6,219,583	4,975,666	5,899,597	5,475,925
OPERATION & MAINTENANCE, MARINE CORPS				
1A1A OPERATIONAL FORCES	2,048,844	1,639,075	2,048,844	2,048,844
Transfer to OCOTF		-409,769		
1A2A FIELD LOGISTICS	486,014	388,811	493,684	493,684
Transfer to OCOTF		-97,203		
Transfer from JIEDDO: OPS - Infantry Immersion Trainer			3,900	3,900
Transfer from JIEDDO: JCOE - C-IED Live-Fire Environment			500	500
Transfer from JIEDDO: OPS - Joint Total Entity Tracking for Instrumented Battlefield			350	350
Transfer from JIEDDO: JCOE - USMC-Company Intelligence Support Teams - CLIC			2,920	2,920
1A3A DEPOT MAINTENANCE	554,000	443,200	554,000	554,000
Transfer to OCOTF		-110,800		
1B2B NORWAY PREPOSITIONING	950	760	950	950
Transfer to OCOTF		-190		

O-1	Budget Request	House	Senate	Recommendation
BSS1 BASE OPERATING SUPPORT	121,700	97,360	187,700	101,700
Transfer to OCOTF		-24,340		
Unjustified Growth			-20,000	-20,000
Transfer from Base: Family Support Programs			86,000	
3B1D SPECIALIZED SKILL TRAINING	6,303	5,042	6,303	6,303
Transfer to OCOTF		-1,261		
3B3D PROFESSIONAL DEVELOPMENT EDUCATION	923	738	923	923
Transfer to OCOTF		-185		
3B4D TRAINING SUPPORT	205,625	164,500	205,625	205,625
Transfer to OCOTF		-41,125		
4A2G SPECIAL SUPPORT	2,576	2,061	2,576	2,576
Transfer to OCOTF		-515		
4A3G SERVICEWIDE TRANSPORTATION	269,415	215,532	269,415	269,415
Transfer to OCOTF		-53,883		
4A4G ADMINISTRATION	5,250	4,200	5,250	5,250
Transfer to OCOTF		-1,050		
TRANSFER TO OCOTF				-259,012
TOTAL, OPERATION & MAINTENANCE, MARINE CORPS	3,701,600	2,961,279	3,775,270	3,430,258
OPERATION & MAINTENANCE, AIR FORCE				
011A PRIMARY COMBAT FORCES	1,582,431	1,265,945	1,582,431	1,582,431
Transfer to OCOTF		-316,486		
011C COMBAT ENHANCEMENT FORCES	1,460,018	1,168,014	1,460,018	1,460,018
Transfer to OCOTF		-292,004		
011D AIR OPERATIONS TRAINING (OJT, MAINTAIN SKILLS)	109,255	87,404	109,255	109,255
Transfer to OCOTF		-21,851		
011M DEPOT MAINTENANCE	304,540	243,632	304,540	304,540
Transfer to OCOTF		-60,908		
011R FACILITIES SUSTAINMENT, RESTORATION & MODERNIZATION	121,881	97,505	121,881	121,881
Transfer to OCOTF		-24,376		
011Z BASE SUPPORT	1,394,809	1,115,847	1,394,809	1,394,809
Transfer to OCOTF		-278,962		

O-1	Budget Request	House	Senate	Recommendation
012A GLOBAL C3I AND EARLY WARNING	130,885	104,708	130,885	130,885
Transfer to OCOTF		-26,177		
012C OTHER COMBAT OPS SPT PROGRAMS	407,554	326,043	409,554	409,554
Transfer to OCOTF		-81,511		
Transfer from JIEDDO: JCOE - C-IED ISR Integration			2,000	2,000
013C SPACE CONTROL SYSTEMS	38,677	30,942	38,677	38,677
Transfer to OCOTF		-7,735		
015A COMBATANT COMMANDERS DIRECT MISSION SUPPORT	157,000	0	137,000	132,000
Transfer to OCOTF		-7,000		
CENTCOM Information Operations		-150,000	-20,000	-25,000
021A AIRLIFT OPERATIONS	3,171,148	2,536,918	3,171,148	3,171,148
Transfer to OCOTF		-634,230		
021D MOBILIZATION PREPAREDNESS	169,659	135,727	169,659	169,659
Transfer to OCOTF		-33,932		
021M DEPOT MAINTENANCE	167,070	133,656	167,070	167,070
Transfer to OCOTF		-33,414		
021R FACILITIES SUSTAINMENT, RESTORATION & MODERNIZATION	942	754	942	942
Transfer to OCOTF		-188		
021Z BASE SUPPORT	45,998	36,798	45,998	45,998
Transfer to OCOTF		-9,200		
031R FACILITIES SUSTAINMENT, RESTORATION & MODERNIZATION	1,019	815	1,019	1,019
Transfer to OCOTF		-204		
031Z BASE SUPPORT	19,361	15,489	19,361	19,361
Transfer to OCOTF		-3,872		
032A SPECIALIZED SKILL TRAINING	48,442	38,754	39,442	39,442
Transfer to OCOTF		-9,688		
Unjustified Growth in Operating Support Costs			-9,000	-9,000
032B FLIGHT TRAINING	291	233	291	291
Transfer to OCOTF		-58		
032C PROFESSIONAL DEVELOPMENT EDUCATION	1,500	1,200	1,500	1,500
Transfer to OCOTF		-300		
032D TRAINING SUPPORT	1,427	1,142	1,427	1,427
Transfer to OCOTF		-285		

O-1	Budget Request	House	Senate	Recommendation
041A LOGISTICS OPERATIONS	328,009	262,407	328,009	328,009
Transfer to OCOTF		-65,602		
041Z BASE SUPPORT	35,322	28,258	35,322	35,322
Transfer to OCOTF		-7,064		
042A ADMINISTRATION	9,000	7,200	9,000	9,000
Transfer to OCOTF		-1,800		
042B SERVICEWIDE COMMUNICATIONS	178,470	142,776	108,470	108,470
Transfer to OCOTF		-35,694		
Unjustified Growth in Operating Support Costs			-70,000	-70,000
043A SECURITY PROGRAMS	142,160	103,728	142,160	132,160
Classified Adjustment		-10,000		-10,000
Transfer to OCOTF		-28,432		
CENTCOM Information Operations Media Production		-27,000		0
TRANSFER TO OCOTF				-698,549
TOTAL, OPERATION & MAINTENANCE, AIR FORCE	10,026,868	7,858,895	9,929,868	9,216,319
OPERATION & MAINTENANCE, DEFENSE-WIDE				
JOINT CHIEFS OF STAFF	25,000	12,500	12,500	12,500
Combatant Commander's Initiative Fund		-12,500	-12,500	-12,500
SPECIAL OPERATIONS COMMAND	2,519,935	2,461,935	2,499,935	2,469,935
SOCOM Information Operations		-58,000	-20,000	-50,000
DEFENSE MEDIA ACTIVITY	13,364	13,364	13,364	13,364
DEFENSE CONTRACT AUDIT AGENCY	13,908	13,908	13,908	13,908
DEFENSE CONTRACT MANAGEMENT AGENCY	63,130	63,130	63,130	63,130
DEFENSE INFORMATION SYSTEMS AGENCY	245,117	245,117	245,117	245,117
DEFENSE LEGAL SERVICES AGENCY	115,000	115,000	115,000	115,000
DEFENSE DEPENDENTS EDUCATION	558,700	553,600	558,700	558,700
DEFENSE SECURITY COOPERATION AGENCY	1,950,000	1,840,000	1,950,000	1,920,000
Coalition Support Funds	1,600,000	-60,000		-30,000
Lift and Sustain		-50,000		
DEFENSE THREAT REDUCTION AGENCY	2,018	2,018	2,018	2,018
OFFICE OF THE SECRETARY OF DEFENSE	79,047	79,047	79,047	79,047

O-1	Budget Request	House	Senate	Recommendation
OTHER PROGRAMS	1,998,181	1,998,181	1,998,181	1,998,181
TOTAL, OPERATION & MAINTENANCE, DEFENSE-WIDE	7,583,400	7,397,800	7,550,900	7,490,900
OPERATION & MAINTENANCE, ARMY RESERVE				
113 ECHELONS ABOVE BRIGADE Transfer to OCOTF	86,881	69,505 -17,376	86,881	86,881
115 LAND FORCES OPERATIONS SUPPORT Transfer to OCOTF	40,675	32,540 -8,135	40,675	40,675
121 FORCE READINESS OPERATIONS SUPPORT Transfer to OCOTF Transfer from Base: Family Readiness Support Assistants Transfer from Base: Tuition Assistance	21,270	17,016 -4,254	36,571 9,829 5,472	21,270
122 LAND FORCES SYSTEMS READINESS Transfer to OCOTF	17,500	14,000 -3,500	17,500	17,500
131 BASE OPERATIONS SUPPORT Transfer to OCOTF	38,000	30,408 -7,600	38,000	38,000
434 OTHER PERSONNEL SUPPORT Transfer from Base: Chaplain Strong Bonds Transfer from Base: Army Reserve Recruiting Assistance Program			15,271 6,093 9,178	0
TOTAL, OPERATION & MAINTENANCE, ARMY RESERVE	204,326	163,461	234,898	204,326
OPERATION & MAINTENANCE, NAVY RESERVE				
1A1A MISSION AND OTHER FLIGHT OPERATIONS Transfer to OCOTF	26,673	21,338 -5,335	26,673	26,673
1A3A INTERMEDIATE MAINTENANCE Transfer to OCOTF	400	320 -80	400	400
1A5A AIRCRAFT DEPOT MAINTENANCE Transfer to OCOTF	3,600	2,880 -720	3,600	3,600
1B1B MISSION AND OTHER SHIP OPERATIONS Transfer to OCOTF	7,416	5,933 -1,483	7,416	7,416
1B4B SHIP DEPOT MAINTENANCE Transfer to OCOTF	8,917	7,134 -1,783	8,917	8,917

O-1		Budget Request	House	Senate	Recommendation
1C1C	COMBAT COMMUNICATIONS Transfer to OCOTF	3,147	2,518 -629	3,147	3,147
1C6C	COMBAT SUPPORT FORCES Transfer to OCOTF	13,428	10,742 -2,686	13,428	13,428
BSSR	BASE OPERATING SUPPORT Transfer to OCOTF	4,478	3,582 -896	4,478	4,478
TOTAL, OPERATION & MAINTENANCE, NAVY RESERVE		68,059	54,447	68,059	68,059
OPERATION & MAINTENANCE, MARINE CORPS RESERVE					
1A1A	OPERATING FORCES Transfer to OCOTF	77,849	62,279 -15,570	77,849	77,849
BSS1	BASE OPERATING SUPPORT Transfer to OCOTF	8,818	7,054 -1,764	8,818	8,818
TOTAL, OPERATION & MAINTENANCE, MARINE CORPS RESERVE		86,667	69,333	86,667	86,667
OPERATION & MAINTENANCE, AIR FORCE RESERVE					
011A	PRIMARY COMBAT FORCES Transfer to OCOTF	3,618	2,894 -724	3,618	3,618
011G	MISSION SUPPORT OPERATIONS Transfer to OCOTF	7,276	5,821 -1,455	7,276	7,276
011M	DEPOT MAINTENANCE Transfer to OCOTF	114,531	91,625 -22,906	114,531	114,531
011Z	BASE SUPPORT Transfer to OCOTF	500	400 -100	500	500
TOTAL, OPERATION & MAINTENANCE, AIR FORCE RESERVE		125,925	100,740	125,925	125,925
OPERATION & MAINTENANCE, ARMY NATIONAL GUARD					
111	MANEUVER UNITS Transfer to OCOTF	89,666	71,733 -17,933	89,666	89,666
112	MODULAR SUPPORT BRIGADES Transfer to OCOTF	1,196	957 -239	1,196	1,196
113	ECHELONS ABOVE BRIGADE Transfer to OCOTF	18,360	14,688 -3,672	18,360	18,360

O-1		Budget Request	House	Senate	Recommendation
114	THEATER LEVEL ASSETS	380	304	380	380
	Transfer to OCOTF		-76		
116	AVIATION ASSETS	59,357	47,486	59,357	59,357
	Transfer to OCOTF		-11,871		
121	FORCE READINESS OPERATIONS SUPPORT	94,458	75,566	109,158	94,458
	Transfer to OCOTF		-18,892		
	Transfer from Base: Family Readiness Support Assistance			14,700	
131	BASE OPERATIONS SUPPORT	22,536	18,029	36,436	22,536
	Transfer to OCOTF		-4,507		
	Transfer from Base: Installation Services			13,900	
133	MANAGEMENT AND OPERATIONAL HQ	35,693	28,554	35,693	35,693
	Transfer to OCOTF		-7,139		
434	RECRUITING AND ADVERTISING			100,000	0
	Transfer from Base: Recruiting and Advertising			100,000	
TOTAL, OPERATION & MAINTENANCE, ARMY NATIONAL GUARD		321,646	257,317	450,246	321,646
OPERATION & MAINTENANCE, AIR NATIONAL GUARD					
011F	AIRCRAFT OPERATIONS	103,259	82,607	103,259	103,259
	Transfer to OCOTF		-20,652		
011G	MISSION SUPPORT OPERATIONS	51,300	41,040	51,300	51,300
	Transfer to OCOTF		-10,260		
011M	DEPOT MAINTENANCE	135,303	108,242	135,303	135,303
	Transfer to OCOTF		-27,061		
TOTAL, OPERATION & MAINTENANCE, AIR NATIONAL GUARD		289,862	231,889	289,862	289,862
OVERSEAS CONTINGENCY OPERATIONS TRANSFER FUND					
OVERSEAS CONTINGENCY OPERATIONS TRANSFER FUND		0	14,636,901		5,000,000
	Transfer to OCOTF		14,636,901		5,000,000
TOTAL, OVERSEAS CONTINGENCY OPERATIONS TRANSFER FUND		0	14,636,901		5,000,000
OPERATION AND MAINTENANCE, MISCELLANEOUS					

O-1	Budget Request	House	Senate	Recommendation
IRAQ FREEDOM FUND	115,300	0	0	0
Transportation of Fallen Heroes – transfer to Transportation Working Capital Fund	15,300	-15,300	-15,300	-15,300
Disposition of Guantanamo Detainees – unspecified increase	100,000	-100,000	-100,000	-100,000
AFGHANISTAN SECURITY FORCES FUND	7,462,769	7,462,769	6,562,769	6,562,769
Infrastructure	868,320	868,320	868,320	868,320
Equipment and Transportation	1,615,192	1,615,192	1,615,192	1,615,192
Training and Operations	272,998	272,998	272,998	272,998
Sustainment	1,945,887	1,945,887	1,395,887	1,395,887
Transfer to MRAP Fund for Urgent Unfunded Requirement			-550,000	-550,000
Subtotal, Ministry of Defense	4,702,397	4,702,397	4,152,397	4,152,397
Infrastructure	605,584	605,584	605,584	605,584
Equipment and Transportation	279,186	279,186	279,186	279,186
Training and Operations	648,217	648,217	648,217	648,217
Sustainment	1,219,966	1,219,966	869,966	869,966
Transfer to MRAP Fund for Urgent Unfunded Requirement			-350,000	-350,000
Subtotal, Ministry of Interior	2,752,953	2,752,953	2,402,953	2,402,953
Detainee Operations – Training and Operations	1,500	1,500	1,500	1,500
Detainee Operations – Sustainment	5,919	5,919	5,919	5,919
Subtotal, Associated Activities	7,419	7,419	7,419	7,419

COMMANDER'S EMERGENCY RESPONSE
PROGRAM

The recommendation provides \$1,200,000,000 for the Commander's Emergency Response Program (CERP) in fiscal year 2010, \$300,000,000 below the request. Included in this amount is \$1,000,000,000 for CERP in Afghanistan and \$200,000,000 for CERP in Iraq. The amount provided for CERP in Afghanistan effectively doubles what has been committed in Afghanistan for fiscal year 2009. Additionally, with the redeployment from Iraq and withdrawal from the major cities, CERP requirements in that theater of operations will decrease significantly in fiscal year 2010. Of the funds provided for CERP, \$500,000,000 shall be withheld pending completion and submission of the report described below.

The Department of Defense needs to greatly improve its management and oversight of CERP and its justifications of CERP budget requests. Additionally, there is concern that the Department's plan to significantly increase the use of CERP in Afghanistan does not yet include an increase in the number of personnel qualified to conduct proper oversight and management of those funds. Therefore, the Secretary of Defense is directed to conduct a thorough review of CERP and sub-

mit a report to the congressional defense committees not later than 180 days after enactment of this Act. This report shall include: the process by which CERP budget requests are generated and justified; existing management and oversight of CERP funds and contracts by the Department of the Army, the Undersecretary of Defense, Comptroller, and U.S. Central Command; the number of personnel required and the number of personnel currently deployed to Afghanistan with Joint Contracting Command and U.S. Forces—Afghanistan specifically in support of CERP; a separate assessment for Iraq and Afghanistan of the goals, purpose and expected requirement for CERP funds in the coming year; the coordination process of projects with other U.S. government agencies and Non-Governmental Organizations carrying out projects in Iraq and Afghanistan; the requirements for the sustainment of projects carried out under CERP; the procedures for ensuring that projects carried out under CERP are coordinated with the host governments and local community leaders; and the process and systems for tracking projects carried out under CERP. Additionally, the Secretary of Defense is directed, as part of the program review, to report on the advisability of establishing a program office

for CERP to be responsible for the development of budgets, strategic plans, program controls, requirements for program coordination, and standards for training.

The Secretary of the Army is directed to submit monthly commitment, obligation and expenditure data for CERP in Iraq and Afghanistan to the congressional defense committees not later than 30 days after each month. Finally, the Secretary of Defense is directed to submit the required quarterly report in a searchable database form in addition to the paper report.

CIVILIAN-MILITARY TRAINING

The Secretary of Defense is directed, in conjunction with the Secretary of State and the Administrator of the United States Agency for International Development, to continue to support the requirements for monthly integrated civilian-military training for civilians deploying to Afghanistan at Camp Atterbury, Indiana, including through the allocation of military and civilian personnel, trainers, and other resources for that purpose.

PROCUREMENT 963 408

For Procurement, funds are to be available for fiscal year 2010, as follows:

P-1	Budget Request	House	Senate	Recommendation
AIRCRAFT PROCUREMENT, ARMY				
3 MQ-1 UAV	250,000	250,000	32,100	250,000
Exceeds production capacity (Transferred to Aircraft Procurement, Army line number 3 Title III)			-217,900	0
4 RQ-11 (RAVEN)	44,640	44,640	44,640	44,640
5A C-12A	45,000	45,000	45,000	0
Reduction due to initiation of Program of Record				-45,000
11 UH-60 BLACKHAWK	74,340	74,340	37,170	37,170
Reduction to projected battle losses			-37,170	-37,170
13 CH-47 HELICOPTER	141,200	141,200	70,600	70,600
Reduction to projected battle losses			-70,600	-70,600
18 GUARDRAIL MODS (MIP)	50,210	50,210	50,210	50,210
19 MULTI SENSOR ABN RECON (MIP)	54,000	54,000	54,000	54,000
20 AH-64 MODS	315,300	315,300	161,100	161,100
Reduction to projected battle losses			-69,200	-69,200
VUIT-2 procurement ahead of need			-85,000	-85,000
26 UTILITY HELICOPTER MODS	2,500	2,500	2,500	2,500
27 KIOWA WARRIOR	94,335	94,335	94,335	94,335
29 GATM Rollup		326,400	0	0
29A RQ-7 UAV MODS	326,400		326,400	326,400
29B C-12A MODS	60,000	60,000	60,000	0
Reduction due to initiation of Program of Record				-60,000
30 SPARE PARTS (AIR)	18,200	18,200	18,200	18,200
AIRCRAFT SURVIVABILITY INFRARED COUNTER MEASURES	111,600	111,600	99,360	99,360
Unobligated fiscal year 2009 ATIRCM funds			-12,240	-12,240
34 COMMON GROUND EQUIPMENT	23,704	23,704	23,704	23,704
35 AIRCREW INTEGRATED SYSTEMS	24,800	24,800	0	6,000
Defer non-emergency upgrades			-24,800	-18,800
TOTAL, AIRCRAFT PROCUREMENT, ARMY	1,636,229	1,636,229	1,119,319	1,238,219
MISSILE PROCUREMENT, ARMY				
5 HELLFIRE SYSTEM SUMMARY	219,700	207,600	219,700	219,700
Unjustified cost growth		-12,100		0
6 JAVELIN (AAWS-M) SYSTEM SUMMARY	140,979	115,979	110,363	110,363
Excess to requirement for CLU			-5,616	-5,616
Funding ahead of need		-25,000	-25,000	-25,000
7 TOW 2 SYSTEM SUMMARY	59,200	34,200	34,200	34,200
Funding ahead of need		-25,000	-25,000	-25,000
8 GUIDED MULTIPLE LAUNCH ROCKET	60,600	60,600	60,600	60,600
14 MODIFICATIONS	18,772	18,772	18,772	18,772
HIGH MOBILITY ARTILLERY ROCKET SYSTEM				
15 MODIFICATIONS	32,319	32,319	32,319	32,319
TOTAL, MISSILE PROCUREMENT, ARMY	531,570	469,470	475,954	475,954
PROCUREMENT OF W&TCV, ARMY				
4 STRYKER VEHICLE	0	0	0	150,000
Transfer from WTCV, Army line number 4 Title III				150,000
9 FIST VEHICLE	36,000	36,000	36,000	36,000
10 BRADLEY PROGRAM MODS	243,600	243,600	0	243,600
Funded in the Supplemental Appropriations Act, 2009			-243,600	
11 HOWITZER, MED SP FT 155MM M109A6	37,620	37,620	37,620	37,620

P-1	Budget Request	House	Senate	Recommendation
27 XM320 GRENADE LAUNCHER MODULE	13,900	13,900	13,900	13,900
31 COMMON REMOTELY OPERATED WEAPONS STATION	235,000	695,000	595,000	495,000
Transfer from Other Procurement, Army line number 187		360,000	360,000	360,000
Program reduction				-100,000
Program increase		100,000		0
33 HOWITZER LT WT 155MM (T)	107,996	107,996	107,996	107,996
36 M2 50 CAL MACHINE GUN MODS	27,600	27,600	27,600	27,600
37 M249 SAW MACHINE GUN MODS	20,900	20,900	20,900	20,900
38 M240 MEDIUM MACHINE GUN MODS	4,800	4,800	4,800	4,800
40 M119 MODIFICATIONS	21,250	21,250	21,250	21,250
41 M16 RIFLE MODS	5,800	5,800	5,800	5,800
43 ITEMS LESS THAN \$5.0M (WOCV-WTCV)	5,000	5,000	5,000	5,000
TOTAL, PROCUREMENT OF W&TCV, ARMY	759,466	1,219,466	875,866	1,169,466
PROCUREMENT OF AMMUNITION, ARMY				
1 CTG, 5.56MM, ALL TYPES	22,000	22,000	22,000	22,000
2 CTG, 7.62MM, ALL TYPES	8,300	8,300	8,300	8,300
3 CTG, HANDGUN, ALL TYPES	500	500	500	500
4 CTG, .50 CAL, ALL TYPES	26,500	26,500	26,500	26,500
6 CTG, 30MM, ALL TYPES	530	530	530	530
8 60MM MORTAR, ALL TYPES	20,000	20,000	20,000	20,000
14 CTG, ARTY, 105MM: ALL TYPES	9,200	9,200	9,200	9,200
16 PROJ 155MM EXTENDED RANGE XM982	52,200	52,200	52,200	52,200
17 MODULAR ARTILLERY CHARGE SYSTEM, ALL TYPES	10,000	10,000	10,000	10,000
18 ARTILLERY FUZES, ALL TYPES	7,800	7,800	7,800	7,800
19 MINES, ALL TYPES	5,000	5,000	5,000	5,000
20 MINE, CLEARING CHARGE, ALL TYPES	7,000	7,000	2,000	2,000
Funds exceed requirement			-5,000	-5,000
24 ROCKET, HYDRA 70, ALL TYPES	169,505	169,505	169,505	169,505
27 SIGNALS, ALL TYPES	100	100	100	100
30 NON-LETHAL AMMUNITION, ALL TYPES	32,000	32,000	32,000	32,000
TOTAL, PROCUREMENT OF AMMUNITION, ARMY	370,635	370,635	365,635	365,635
OTHER PROCUREMENT, ARMY				
1 TACTICAL TRAILERS/DOLLY SETS	1,948	1,948	1,948	1,948
2 SEMITRAILERS, FLATBED	40,403	40,403	40,403	40,403
3 SEMITRAILERS, TANKERS	8,651	8,651	8,651	8,651
4 HI MOB MULTI-PURPOSE WHEELED VEHICLE (HMMWV)	875,718	1,251,038	875,718	1,063,038
Program adjustment				187,320
5 FAMILY OF MEDIUM TACTICAL VEHICLES	286,337	461,657	286,337	863,357
Program adjustment				90,320
Transfer from Other Procurement, Army line number 5 Title III				486,700
7 FAMILY OF HEAVY TACTICAL VEHICLES	623,230	520,750	623,230	803,230
Schedule delay		-102,480		0
Transfer from Other Procurement, Army line number 7 Title III				180,000
9 ARMORED SECURITY VEHICLES (ASV)	13,206	13,206	13,206	13,206
12 TRUCK, TRACTOR, LINE HAUL, M915/M916	62,654	62,654	62,654	62,654
15 MODIFICATION OF IN SERVICE EQUIPMENT	0	195,950	0	0
Army requested transfer from Other Procurement, Army line number 187		195,950		0

P-1	Budget Request	House	Senate	Recommendation
23 WIN-T GROUND FORCES TACTICAL NETWORK	13,500	13,500	13,500	13,500
28 NAVSTAR GLOBAL POSITIONING SYSTEM	53,486	53,486	53,486	53,486
29 SMART-T (SPACE)	26,000	26,000	26,000	26,000
32 MOD OF IN-SERVICE EQUIPMENT (TAC SAT)	23,900	23,900	23,900	23,900
MOD-IN-SERVICE PROFILER	6,070	6,070	6,070	6,070
34 ARMY DATA DISTRIBUTION SYSTEM	239	239	239	239
37 SINCGARS FAMILY	128,180	0	53,180	18,180
Funding ahead of need		-128,180	-75,000	-110,000
38 AMC CRITICAL ITEMS - OPA2	100,000	100,000	48,000	54,000
Funding ahead of need			-52,000	-46,000
46 RADIO, IMPROVED HIGH FREQUENCY (COTS) FAMILY	11,286	11,286	11,286	11,286
MEDICAL COMMUNICATIONS FOR COMBAT				
47 CASUALTY CARE	18	18	18	18
50 INFORMATION SYSTEM SECURITY PROGRAM	32,095	32,095	32,095	32,095
55 INFORMATION SYSTEMS	330,342	330,342	330,342	330,342
57 INSTALLATION INFO INFRASTRUCTURE MOD	227,733	227,733	227,733	227,733
JOINT TACTICAL TERMINAL COMMON INTEGRATED				
62 BROADCAST SERVICE - MODULES (MIP)	1,660	1,660	1,660	1,660
66 DIGITAL TOPOGRAPHIC SPT SYS (DTSS)	265	265	265	265
DISTRIBUTED COMMON GROUND SYSTEM - ARMY				
69 (MIP)	167,100	167,100	167,100	167,100
73 CI HUMINT AUTO REPRTING AND COLL	34,208	34,208	34,208	34,208
75 ITEMS LESS THAN \$5.0M	5,064	5,064	5,064	5,064
76 LIGHTWEIGHT COUNTER MORTAR RADAR	58,590	58,590	58,590	58,590
77 WARLOCK	164,435	164,435	164,435	164,435
COUNTERINTELLIGENCE/SECURITY				
78 COUNTERMEASURES	126,030	126,030	126,030	126,030
82 NIGHT VISION DEVICES	93,183	93,183	93,183	93,183
84 NIGHT VISION, THERMAL WPN SIGHT	25,000	25,000	25,000	25,000
85 SMALL TACTICAL OPTICAL RIFLE MOUNTED MLRF	15,000	15,000	15,000	15,000
87 COUNTER-ROCKET, ARTILLERY & MORTAR (C-RAM)	150,400	150,400	144,400	148,400
Excess program office costs			-6,000	-2,000
91 PORTABLE INDUCTIVE ARTILLERY FUZE	1,900	1,900	1,900	1,900
94 BELOW	242,999	242,999	242,999	242,999
96 LIGHTWEIGHT LASER DESIGNATOR/RANGEFINDER	97,020	97,020	97,020	97,020
97 COMPUTER BALLISTICS: LHMBC XM32	3,780	3,780	3,780	3,780
99 COUNTERFIRE RADARS	26,000	26,000	26,000	26,000
103 FIRE SUPPORT C2 FAMILY	14,840	14,840	14,840	14,840
104 BATTLE COMMAND SUSTAINMENT SUPPORT SYS	16	16	16	16
107 KNIGHT FAMILY	178,500	178,500	127,000	127,000
Excess to need			-51,500	-51,500
NETWORK MANAGEMENT INITIALIZATION AND				
113 SERVICE	58,900	58,900	25,200	25,200
Excess to need			-33,700	-33,700
114 MANEUVER CONTROL SYSTEM	5,000	5,000	5,000	5,000
115 SINGLE ARMY LOGISTICS ENTERPRISE (SALE)	1,440	1,440	1,440	1,440
129 PROTECTIVE SYSTEMS	44,460	44,460	44,460	44,460
130 CBRN SOLDIER PROTECTION	38,811	38,811	38,811	38,811
133 TACTICAL BRIDGING	13,525	13,525	13,525	13,525
136 EXPLOSIVE ORDNANCE DISPOSAL EQPMT	10,800	10,800	10,800	10,800
140 LAUNDRIES, SHOWERS AND LATRINES	21,561	21,561	21,561	21,561
142 LIGHTWEIGHT MAINTENANCE ENCLOSURE	1,955	1,955	1,955	1,955
146 FORCE PROVIDER	245,382	245,382	245,382	245,382
147 FIELD FEEDING EQUIPMENT	4,011	4,011	4,011	4,011
150 ITEMS LESS THAN \$5M (ENG SPT)	4,987	4,987	4,987	4,987
152 DISTRIBUTION SYSTEMS, PETROLEUM & WATER	58,554	58,554	58,554	58,554

P-1	Budget Request	House	Senate	Recommendation
153 WATER PURIFICATION SYSTEMS	3,017	3,017	3,017	3,017
154 COMBAT SUPPORT MEDICAL	11,386	11,386	11,386	11,386
155 MOBILE MAINTENANCE EQUIPMENT SYSTEMS	12,365	12,365	12,365	12,365
ITEMS LESS THAN \$5.0M (MAINTENANCE				
156 EQUIPMENT)	546	546	546	546
162 LOADERS	1,100	1,100	1,100	1,100
163 HYDRAULIC EXCAVATOR	290	290	290	290
166 PLANT, ASPHALT MIXING	2,500	2,500	2,500	2,500
HIGH MOBILITY ENGINEER EXCAVATOR FAMILY OF				
167 SYSTEMS	16,500	16,500	16,500	16,500
ITEMS LESS THAN \$5.0M (CONSTRUCTION				
169 EQUIPMENT)	360	360	360	360
172 ITEMS LESS THAN \$5.0M (FLOAT/RAIL)	3,550	3,550	3,550	3,550
173 GENERATORS AND ASSOCIATED EQUIP	62,210	62,210	62,210	62,210
174 ROUGH TERRAIN CONTAINER HANDLER	54,360	54,360	54,360	54,360
175 ALL TERRAIN LIFTING ARMY SYSTEM	49,319	49,319	49,319	49,319
176 COMBAT TRAINING CENTERS SUPPORT	60,200	60,200	60,200	60,200
177 TRAINING DEVICES, NONSYSTEM	28,200	28,200	28,200	28,200
182 INTEGRATED FAMILY OF TEST EQUIPMENT	1,524	1,524	1,524	1,524
183 TEST EQUIPMENT MODERNIZATION	3,817	3,817	3,817	3,817
184 RAPID EQUIPPING SOLDIER SUPPORT EQUIPMENT	27,000	27,000	0	7,000
Funding available from prior years			-27,000	-20,000
187 MODIFICATION OF IN-SVC EQUIPMENT (OPA-3)	555,950	0	0	0
Army requested transfer to Procurement of Weapons				
and Tracked Combat Vehicles, Army line number 31		-360,000	-360,000	-360,000
Army requested transfer to Other Procurement, Army line				
number 15		-195,950		0
Excess to need			-195,950	-195,950
CLASSIFIED PROGRAMS	760	760	760	760
TOTAL, OTHER PROCUREMENT, ARMY	5,675,326	5,635,306	4,874,176	5,800,516
AIRCRAFT PROCUREMENT, NAVY				
4 F/A-18E/F HORNET	0	0	512,280	0
Add nine aircraft (Funded in Title III, Aircraft				
Procurement, Navy)			512,280	0
10 UH-1Y/AH-1Z	55,006	55,006	55,006	55,006
28 EA-6 SERIES	45,000	45,000	45,000	45,000
29 AV-8 SERIES	28,296	19,396	19,396	19,396
ALE-47 upgrades complete		-8,900	-8,900	-8,900
30 F-18 SERIES	96,000	96,000	96,000	96,000
31 H-46 SERIES	17,485	17,485	17,485	17,485
33 H-53 SERIES	164,730	164,730	164,730	164,730
34 SH-60 SERIES	11,192	11,192	11,192	11,192
35 H-1 SERIES	11,217	11,217	11,217	11,217
37 P-3 SERIES	74,900	74,900	35,300	35,300
Funding ahead of need			-39,600	-39,600
39 E-2 SERIES	17,200	17,200	17,200	17,200
41 C-2A	14,100	0	14,100	7,100
Non-emergency upgrades		-14,100		-7,000
42 C-130 SERIES	52,324	52,324	52,324	52,324
49 POWER PLANT CHANGES	4,456	0	0	0
Non-emergency modifications		-4,456	-4,456	-4,456
52 COMMON ECM EQUIPMENT	263,382	263,382	260,082	260,082
ALE-47 kits ahead of need			-3,300	-3,300

P-1	Budget Request	House	Senate	Recommendation
54 COMMON DEFENSIVE WEAPON SYSTEM	5,500	5,500	5,500	5,500
56 V-22 (TILT/ROTOR ACFT) OSPREY	53,500	53,500	23,500	53,500
Interim gun funding ahead of need			-30,000	
57 SPARES AND REPAIR PARTS	2,265	2,265	2,265	2,265
TOTAL, AIRCRAFT PROCUREMENT, NAVY	916,553	889,097	1,342,577	853,297
WEAPONS PROCUREMENT, NAVY				
10 HELLFIRE	50,700	73,700	50,700	50,700
TOTAL, WEAPONS PROCUREMENT, NAVY	50,700	73,700	50,700	50,700
PROCUREMENT OF AMMO, NAVY & MARINE CORPS				
1 GENERAL PURPOSE BOMBS	40,500	40,500	40,500	40,500
3 AIRBORNE ROCKETS, ALL TYPES	42,510	30,510	42,510	36,510
2.75" rocket launcher growth		-12,000		-6,000
4 MACHINE GUN AMMUNITION	80,377	109,200	80,377	80,377
7 AIR EXPENDABLE COUNTERMEASURES	5,501	5,501	5,501	5,501
9 5 INCH/54 GUN AMMUNITION	352	352	352	352
11 OTHER SHIP GUN AMMUNITION	2,835	2,835	2,835	2,835
12 SMALL ARMS & LANDING PARTY AMMO	14,229	14,229	14,229	14,229
13 PYROTECHNIC AND DEMOLITION	1,442	1,442	1,442	1,442
15 SMALL ARMS AMMUNITION	16,930	16,930	16,930	16,930
16 LINEAR CHARGES, ALL TYPES	5,881	5,881	5,881	5,881
17 40 MM, ALL TYPES	104,824	104,824	104,824	104,824
18 60MM, ALL TYPES	43,623	43,623	43,623	43,623
19 81MM, ALL TYPES	103,647	103,647	103,647	103,647
20 120MM, ALL TYPES	62,265	62,265	62,265	62,265
21 CTG 25MM, ALL TYPES	563	563	563	563
22 GRENADES, ALL TYPES	6,074	6,074	6,074	6,074
23 ROCKETS, ALL TYPES	8,117	8,117	8,117	8,117
24 ARTILLERY, ALL TYPES	81,975	81,975	81,975	81,975
26 DEMOLITION MUNITIONS, ALL TYPES	9,241	9,241	9,241	9,241
27 FUZE, ALL TYPES	51,071	51,071	51,071	51,071
TOTAL, PROCUREMENT OF AMMO, NAVY & MARINE CORPS	681,957	698,780	681,957	675,957
OTHER PROCUREMENT, NAVY				
18 UNDERWATER EOD PROGRAMS	12,040	12,040	12,040	12,040
25 STANDARD BOATS	13,000	13,000	0	0
Undefined requirement			-13,000	-13,000
56 MATCALs	400	400	400	400
76 SHIP COMMUNICATIONS AUTOMATION	1,500	1,500	1,500	1,500
92 EXPEDITIONARY AIRFIELDS	37,345	37,345	37,345	37,345
97 AVIATION LIFE SUPPORT	17,883	17,883	17,883	17,883
115 EXPLOSIVE ORDNANCE DISPOSAL EQUIP	43,650	43,650	23,750	23,750
Anechoic Chamber			-1,900	-1,900
UAS funded to requirement			-18,000	-18,000
120 PASSENGER CARRYING VEHICLES	25	25	25	25
121 GENERAL PURPOSE TRUCKS	93	93	93	93
122 CONSTRUCTION & MAINTENANCE EQUIP	11,167	11,167	11,167	11,167
124 TACTICAL VEHICLES	54,008	54,008	54,008	54,008
127 ITEMS UNDER \$5 MILLION	10,842	10,842	10,842	10,842
128 PHYSICAL SECURITY VEHICLES	1,130	1,130	1,130	1,130

P-1	Budget Request	House	Senate	Recommendation
129 MATERIALS HANDLING EQUIPMENT	25	25	25	25
134 COMMAND SUPPORT EQUIPMENT	4,000	0	4,000	0
Non-emergency upgrades		-4,000		-4,000
139 OPERATING FORCES SUPPORT EQUIPMENT	15,452	15,452	15,452	15,452
140 C4ISR EQUIPMENT	3,100	0	3,100	0
Non-emergency modifications		-3,100		-3,100
142 PHYSICAL SECURITY EQUIPMENT	89,521	39,400	64,521	52,521
Unjustified contingency funding		-50,121	-25,000	-37,000
145 SPARES AND REPAIR PARTS	2,837	2,837	2,837	2,837
TOTAL, OTHER PROCUREMENT, NAVY	318,018	260,797	260,118	241,018
PROCUREMENT, MARINE CORPS				
2 LAV PIP	58,229	58,229	39,358	39,358
Previously funded combat losses			-18,871	-18,871
6 155MM LIGHTWEIGHT TOWED HOWITZER	0	0	54,000	54,000
Advance funded in FY 2009 Supplemental		-54,000	54,000	54,000
8 WEAPONS & COMBAT VEHICLES UNDER \$5 M	3,351	3,351	3,351	3,351
10 MODIFICATION KITS	20,183	20,183	20,183	20,183
11 WEAPONS ENHANCEMENT PROGRAM	9,151	9,151	9,151	9,151
16 MODIFICATION KITS	8,506	8,506	8,506	8,506
18 REPAIR AND TEST EQUIPMENT	11,741	11,741	11,741	11,741
19 COMBAT SUPPORT SYSTEM	462	462	462	462
21 ITEMS UNDER \$5 MILLION (COMM & ELEC)	4,153	4,153	4,153	4,153
22 AIR OPERATIONS C2 SYSTEMS	3,096	3,096	3,096	3,096
23 RADAR SYSTEMS	3,417	3,417	3,417	3,417
24 FIRE SUPPORT SYSTEM	521	521	521	521
25 INTELLIGENCE SUPPORT EQUIPMENT	37,547	37,547	37,547	37,547
26 RQ-11 UAV	13,000	13,000	13,000	13,000
27 NIGHT VISION EQUIPMENT	0	12,570	0	0
28 COMMON COMPUTER RESOURCES	23,105	23,105	23,105	23,105
29 COMMAND POST SYSTEMS	23,041	23,041	23,041	23,041
30 RADIO SYSTEMS	32,497	32,497	32,497	32,497
31 COMM SWITCHING & CONTROL SYSTEMS	2,044	2,044	2,044	2,044
32 COMM & ELEC INFRASTRUCTURE SUPPORT	64	64	64	64
35 5/4T TRUCK HMMWV (MYP)	205,036	205,036	27,836	27,836
Applied previously appropriated funding			-177,200	-177,200
36 MOTOR TRANSPORT MODIFICATIONS	0	0	0	0
Advance funded in FY 2009 Supplemental		-10,177		
37 MEDIUM TACTICAL VEHICLE REPLACEMENT	131,044	131,044	131,044	131,044
38 LOGISTICS VEHICLE SYSTEM REP	59,219	59,219	59,219	59,219
39 FAMILY OF TACTICAL TRAILERS	13,388	13,388	13,388	13,388
42 ENVIRONMENTAL CONTROL EQUIP ASSORT	5,119	5,119	5,119	5,119
43 BULK LIQUID EQUIPMENT	4,549	4,549	4,549	4,549
44 TACTICAL FUEL SYSTEMS	33,421	33,421	33,421	33,421
45 POWER EQUIPMENT ASSORTED	24,860	24,860	24,860	24,860
47 EOD SYSTEMS	47,697	47,697	47,697	47,697
48 PHYSICAL SECURITY EQUIPMENT	2,720	19,720	2,720	2,720
50 MATERIAL HANDLING EQUIP	56,875	56,875	56,875	56,875
53 TRAINING DEVICES	147,304	157,734	147,304	122,304
Execution Delays			-50,000	-25,000
55 FAMILY OF CONSTRUCTION EQUIPMENT	35,818	35,818	35,818	35,818
58 RAPID DEPLOYABLE KITCHEN	55	55	55	55
59 ITEMS LESS THAN \$5 MILLION	39,055	39,055	39,055	39,055
TOTAL, PROCUREMENT, MARINE CORPS	1,060,268	1,100,268	918,197	893,197

P-1	Budget Request	House	Senate	Recommendation
AIRCRAFT PROCUREMENT, AIR FORCE				
6 C-130J	72,000	72,000	72,000	72,000
28 B-1B	20,500	20,500	20,500	20,500
30 A-10	10,000	10,000	10,000	10,000
32 F-16		20,025	0	0
34 C-5	57,400	57,400	57,400	57,400
37 C-17A	120,725	132,300	120,725	120,725
48 MC-12W			29,000	29,000
Retrofit first seven aircraft			29,000	29,000
52 C-130	86,400	187,277	86,400	86,400
Requests install funding prior to delivery of kits		-23,523		0
54 C-135	16,916	16,916	16,916	16,916
56 DARP	10,300	10,300	10,300	10,300
63 HC/MC-130 MODIFICATIONS	7,000	7,000	5,660	5,660
Requests install funding prior to delivery of kits			-1,340	-1,340
64 OTHER AIRCRAFT	90,000	90,000	90,000	90,000
65 MQ-1 MODS	65,000	65,000	65,000	65,000
66 MQ-9 MODS	99,200	12,000	27,600	27,600
Reduction for sensor - Early to need		-87,200		
Air Force requested transfer to RDTE,AF Line 128			-71,600	-71,600
76 C-17A	11,000	11,000	11,000	11,000
85 OTHER PRODUCTION CHARGES	114,000	114,000	114,000	114,000
TOTAL, AIRCRAFT PROCUREMENT, AIR FORCE	780,441	825,718	736,501	736,501
MISSILE PROCUREMENT, AIR FORCE				
5 PREDATOR HELLFIRE MISSILE	29,325	29,325	29,325	29,325
6 SMALL DIAMETER BOMB	7,300	7,300	7,300	7,300
TOTAL, MISSILE PROCUREMENT, AIR FORCE	36,625	36,625	36,625	36,625
PROCUREMENT OF AMMUNITION, AIR FORCE				
1 ROCKETS	3,488	3,488	3,488	3,488
2 CARTRIDGES	39,236	39,236	39,236	39,236
4 GENERAL PURPOSE BOMBS	34,085	34,085	34,085	34,085
5 JOINT DIRECT ATTACK MUNITION	97,978	97,978	97,978	97,978
7 EXPLOSIVE ORDNANCE DISPOSAL	4,800	4,800	4,800	4,800
11 FLARES	41,000	41,000	41,000	41,000
12 FUZES	14,595	14,595	14,595	14,595
13 SMALL ARMS	21,637	21,637	21,637	21,637
TOTAL, PROCUREMENT OF AMMUNITION, AIR	256,819	256,819	256,819	256,819
OTHER PROCUREMENT, AIR FORCE				
2 MEDIUM TACTICAL VEHICLE	3,364	3,364	3,364	3,364
4 SECURITY AND TACTICAL VEHICLES	11,337	11,337	11,337	11,337
5 FIRE FIGHTING/CRASH RESCUE VEHICLES	8,626	8,626	8,626	8,626
23 AIR FORCE PHYSICAL SECURITY SYSTEM	1,600	1,600	1,600	1,600
37 MILSATCOM SPACE	714	714	714	714
47 NIGHT VISION GOGGLES	14,528	14,528	0	0
Request ahead of need			-14,528	-14,528

P-1	Budget Request	House	Senate	Recommendation
48 ITEMS LESS THAN \$5,000,000 (SAFETY)	4,900	4,900	4,900	4,900
51 CONTINGENCY OPERATIONS	11,300	11,300	11,300	11,300
60 DEFENSE SPACE RECONNAISSANCE PROG	34,400	34,400	34,400	34,400
999 OTHER PROGRAMS	2,230,780	2,184,469	3,061,780	2,507,180
		-46,311		276,400
TOTAL, OTHER PROCUREMENT, AIR FORCE	2,321,549	2,275,238	3,138,021	2,583,421
PROCUREMENT, DEFENSE-WIDE				
19 GLOBAL COMMAND AND CONTROL SYS	1,500	1,500	1,500	1,500
21 TELEPORT PROGRAM	7,411	7,411	7,411	7,411
52 MH-47 SERVICE LIFE EXTENSION PROG	5,900	5,900	0	0
Program shortfall tranferred to Titel III, Procurement, Defense-Wide line number 52			-5,900	-5,900
57 SOF U-28	3,000	3,000	3,000	3,000
60 MQ-1 UAV	1,450	0	0	0
Funding Early to Need		-1,450	-1,450	-1,450
62 STUASLO	12,000	12,000	12,000	12,000
63 C-130 MODIFICATIONS	19,500	19,500	19,500	19,500
67 SOF ORDNANCE REPLENISHMENT	51,156	51,156	47,856	47,856
SOPGM funded in reprogramming action			-3,300	-3,300
68 SOF ORDNANCE ACQUISITION	17,560	17,560	17,560	17,560
69 COMMUNICATIONS EQUIPMENT & ELECTRONICS	2,000	2,000	2,000	2,000
70 SOF INTELLIGENCE SYSTEMS	23,260	23,260	23,260	23,260
71 SMALL ARMS & WEAPONS	3,800	3,800	3,800	3,800
76 TACTICAL VEHICLES	6,865	6,865	6,865	6,865
83 SOF OPERATIONAL ENHANCEMENTS INTELLIGENCE	11,000	11,000	11,000	11,000
86 SOF TACTICAL RADIO SYSTEMS	5,448	5,448	5,448	5,448
90 SOF OPERATIONAL ENHANCEMENTS	11,900	11,900	11,900	11,900
999 CLASSIFIED PROGRAMS	307,680	307,680	307,680	307,680
TOTAL, PROCUREMENT, DEFENSE-WIDE	491,430	489,980	480,780	480,780
MINE RESISTANT AMBUSH PROTECTED VEHICLE FUND				
MINE RESISTANT AMBUSH PROTECTED VEHICLE FUND	5,456,000	3,606,000	6,656,000	6,281,000
Advance funded in FY 2009 Supplemental		-1,850,000	1,200,000	825,000
TOTAL, MINE RESISTANT AMBUSH PROTECTED VEHICLE FUND		3,606,000	6,656,000	6,281,000
RAPID ACQUISITION FUND				
RAPID ACQUISITION FUND				
Rapid Acquisition Fund	0	40,000	0	0
Transferred from Title III, RDT&E, Defense-Wide		40,000	0	0
TOTAL, RAPID ACQUISITION FUND		40,000	0	0
NATIONAL GUARD AND RESERVE EQUIPMENT				
ARMY NATIONAL GUARD		300,000	0	575,000
Miscellaneous equipment (Includes transfer from title III)		300,000	0	575,000
AIR NATIONAL GUARD		50,000	0	135,000
Miscellaneous equipment (Includes transfer from title III)		50,000	0	135,000

P-1	Budget Request	House	Senate	Recommendation
ARMY RESERVE	80,000	0	0	85,000
Miscellaneous equipment (Includes transfer from title III)	80,000	0	0	85,000
NAVY RESERVE	25,000	0	0	55,000
Miscellaneous equipment (Includes transfer from title III)	25,000	0	0	55,000
MARINE CORPS RESERVE	20,000	0	0	45,000
Miscellaneous equipment (Includes transfer from title III)	20,000	0	0	45,000
AIR FORCE RESERVE	25,000	0	0	55,000
Miscellaneous equipment (Includes transfer from title III)	25,000	0	0	55,000
TOTAL, NATIONAL GUARD & RESERVE EQUIPMENT	500,000	0	0	950,000

UP ARMORED HMMWVs

The fiscal year 2010 budget request for Overseas Contingency Operations includes funding for the procurement of up-armored HMMWVs. At the request of the Marine Corps, Congress appropriated \$177,200,000 in fiscal year 2009 supplemental funding for the procurement of Frag Kit 4 underbody armor protection for M114 vehicles in theater. However, it is understood that the Marine Corps has rescinded that requirement due to technical difficulties and will not procure any Frag Kit 4 kits. Therefore, the Commandant of the Marine Corps is directed to apply the funds previously appropriated for the procurement of Frag Kit 4 kits for the procurement of up-armored HMMWVs for contingency operations instead.

FAMILY OF HEAVY TACTICAL VEHICLES

The recommendation includes \$803,230,000 for the Family of Heavy Tactical Vehicles. The funding provides for the purchase of a variety of heavy trucks, tractors and trailers including Heavy Expanded Mobility Tactical Trucks; Heavy Equipment Transporter Tractors; Heavy Equipment Transporter Trailers; and other heavy transport systems to support line haul, local haul, unit resupply and other missions. These trucks and trailers provide critical support to units in the field. The Army is expected to promptly procure these heavy trucks and trailers as described in budget justification materials.

COMMON REMOTELY OPERATED WEAPONS STATION

The recommendation provides \$495,000,000 for Common Remotely Operated Weapons Stations (CROWS), which includes the \$235,000,000 in the budget request, a transfer of \$360,000,000 from Other Procurement, Army, and a program reduction of \$100,000,000. Although there is strong support for the CROWS program, this reduction will avoid funding ahead of need. It is understood

that funding for CROWS systems is available in the funding lines for other weapons systems and tactical vehicles. Should additional CROWS funding be required in fiscal year 2010, the Army should reprogram internally to meet the demand. The Army is encouraged to make the CROWS System a Program of Record.

MINE RESISTANT AMBUSH PROTECTED (MRAP) AND MINE RESISTANT AMBUSH PROTECTED ALL TERRAIN VEHICLES (M-ATVs)

The recommendation provides \$6,281,000,000, an increase of \$825,000,000 over the request to address additional M-ATV vehicle requirements, as identified by the Department. The Department shall continue to adhere to the execution and reporting requirements contained in section 8122 of Public Law 110-116.

TRAINING DEVICES FOR MINE RESISTANT AMBUSH PROTECTED (MRAP) AND MINE RESISTANT AMBUSH PROTECTED ALL TERRAIN VEHICLES (M-ATVs)

In response to the threat of Improvised Explosive Devices (IEDs) to Forces in theater, the Department of Defense has procured more than 16,000 MRAPs, and recently validated a requirement of more than 6,000 lightweight MRAPs, M-ATVs, for operations in Afghanistan.

Due to the weight of the heavy armor and high center of gravity, the driving characteristics of both the MRAP and M-ATV are considerably different from other vehicles that are in use by the military. Aggressive safety training helps avoid casualties due to roll-overs and other types of accidents. Emergency egress training, including the emergency operation of the heavy armored doors is essential. It is understood that MRAP vehicles and virtual trainers have been provided to home station training facilities for active component, National Guard and Reserve units to prepare service members to

operate and maintain these vehicles, which they will receive upon their arrival in the combat theaters. The military services are encouraged to take maximum advantage of these training devices to prepare servicemembers for operations in and around MRAPs and M-ATVs. The Department is expected to use funds available in this Act to procure additional training devices, including virtual vehicle trainers if required.

NATIONAL GUARD AND RESERVE EQUIPMENT

The recommendation provides \$950,000,000 for the National Guard and Reserve Equipment Account. Of that amount, \$575,000,000 is for the Army National Guard; \$135,000,000 for the Air National Guard; \$85,000,000 for the U.S. Army Reserve; \$55,000,000 for the Navy Reserve; \$45,000,000 for the Marine Corps Reserve; and \$55,000,000 for the Air Force Reserve to meet urgent equipment needs that may arise this fiscal year.

This funding will allow the Guard and reserve components to procure high priority equipment that will complement the combined State and Federal missions.

MODERNIZATION PRIORITIES

Each National Guard and reserve component Chief shall submit to the congressional defense committees a detailed assessment of that component's modernization priorities not later than 30 days after enactment of this Act. The National Guard and reserve component Chiefs should exercise control of the funds provided in this account, to better ensure that the most urgent National Guard and reserve equipment modernization priorities are addressed with the funding provided in this appropriation.

RESEARCH, DEVELOPMENT, TEST AND EVALUATION

For Research, Development, Test and Evaluation, funds are to be available for fiscal year 2010, as follows:

R-1	Budget Request	House	Senate	Recommendation
RESEARCH, DEVELOPMENT, TEST & EVALUATION, ARMY				
75 ELECTRONIC WARFARE DEVELOPMENT	18,598	18,598	18,598	18,598
161 SECURITY AND INTELLIGENCE ACTIVITIES	7,644	7,644	7,644	7,644
162 INFORMATION SYSTEMS SECURITY PROGRAM	2,220	2,220	2,220	2,220
167 TACTICAL UNMANNED AERIAL VEHICLES	29,500	29,500	29,500	29,500
TOTAL, RESEARCH, DEVELOPMENT, TEST & EVALUATION, ARMY	57,962	57,962	57,962	57,962
RESEARCH, DEVELOPMENT, TEST & EVALUATION, NAVY				
20 USMC Advanced Technology Demonstration				9,480
Future Immersive Training (Transfer from Operation and Maintenance, Navy)				9,480
27 AVIATION SURVIVABILITY	8,000	0	0	0
Non-emergency development funding		-8,000	-8,000	-8,000
41 ADVANCED SUBMARINE SYSTEM DEVELOPMENT	9,000	0	0	0
Non-emergency development funding		-9,000	-9,000	-9,000
203 MANNED RECONNAISSANCE SYSTEMS	51,900	0	0	16,900
Insufficient justification		-51,900	-51,900	-35,000
210 SMALL (LEVEL 0) TACTICAL UAS (STUASLO)	6,000	6,000	0	0
Unjustified request			-6,000	-6,000
999 OTHER PROGRAMS	32,280	32,280	32,280	32,280
TOTAL, RESEARCH, DEVELOPMENT, TEST & EVALUATION, NAVY	107,180	38,280	32,280	58,660
RESEARCH, DEVELOPMENT, TEST & EVALUATION, AIR FORCE				
128 MQ9 UAV	1,400	1,400	1,400	1,400
149 ADVANCED COMMUNICATIONS SYSTEMS	9,375	9,375	9,375	9,375
206 MQ-1 PREDATOR A UAV	1,400	1,400	11,400	11,400
999 OTHER PROGRAMS	17,111	17,111	17,111	17,111
TOTAL, RESEARCH, DEVELOPMENT, TEST & EVALUATION, AIR FORCE	29,286	29,286	39,286	39,286
RESEARCH, DEVELOPMENT, TEST & EVALUATION, DEFENSE-WIDE				
139 GLOBAL COMMAND AND CONTROL SYSTEM	2,750	2,750	2,750	2,750
999 OTHER PROGRAMS	113,076	113,076	109,446	109,446
Program adjustment			-3,630	-3,630
TOTAL, RESEARCH, DEVELOPMENT, TEST & EVALUATION, DEFENSE-WIDE	115,826	115,826	112,196	112,196

SABER FOCUS

The Saber Focus demonstration program is envisioned to provide a much needed capability to the warfighter. The Congress has provided over \$200,000,000 for this effort, funded entirely outside the normal budg-

eting process. The Department has been given numerous opportunities to fund this potentially game-changing program in its base budget but has chosen not to do so, largely due to schedule slips with the actual demonstration. The demonstration is currently scheduled in fiscal year 2010 and will

utilize funding carried over from fiscal year 2009. Therefore, the recommendation provides \$16,900,000 for the Saber Focus program, a reduction of \$35,000,000, which should be sufficient to finally transition the program to a Program of Record.

REVOLVING AND MANAGEMENT FUNDS

DEFENSE WORKING CAPITAL FUNDS

For the Defense Working Capital Fund, \$412, 215,000 is provided for fiscal year 2010.

		Budget Request	House	Senate	Recommendation
AIR FORCE WORKING CAPITAL FUNDS					
TWCF	TRANSPORTATION WORKING CAPITAL FUND	0			15,300
	Transportation of Fallen Heroes (transferred from Iraq Freedom Fund)		15,300	15,300	
TOTAL, AIR FORCE WORKING CAPITAL FUNDS		0	15,300	15,300	15,300
DEFENSE-WIDE WORKING CAPITAL FUNDS					
DWCF	DEFENSE-WIDE WORKING CAPITAL FUNDS	396,915	396,915	396,915	396,915
TOTAL, DEFENSE-WIDE WORKING CAPITAL FUNDS		396,915	396,915	396,915	396,915
TOTAL, DEFENSE WORKING CAPITAL FUNDS		396,915	412,215	412,215	412,215

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OTHER DEPARTMENT OF DEFENSE
PROGRAMS

DEFENSE HEALTH PROGRAM

For the Defense Health Program,
\$1,256,675,000 is provided for fiscal year 2010,
as follows:

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
OPERATION AND MAINTENANCE	1,155,235	1,155,235	1,563,675	1,256,675
IN-HOUSE CARE	503,500	503,500	569,030	569,030
PRIVATE SECTOR CARE	494,657	494,657	530,567	530,567
CONSOLIDATED HEALTH CARE	134,392	134,392	441,392	134,392
TBI/PH and WII requirements transfer from base			307,000	0
INFORMATION MANAGEMENT/IT	3,032	3,032	3,032	3,032
MANAGEMENT HEADQUARTERS	1,246	1,246	1,246	1,246
EDUCATION AND TRAINING	16,599	16,599	16,599	16,599
BASE OPERATIONS AND COMMUNICATIONS	1,809	1,809	1,809	1,809

DRUG INTERDICTION AND COUNTER-DRUG
ACTIVITIES, DEFENSE

(INCLUDING TRANSFER OF FUNDS)

For Drug Interdiction and Counter-Drug
Activities, \$346,603,000 is provided for fiscal
year 2010, as follows:

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
PC9204	324,603	317,603	353,603	346,603
AFGHANISTAN	270,403	263,403	299,403	292,403
Afghanistan Border facilities - new construction locations not determined		-5,000		-5,000
New CNP-A Internal Polygraph Program		-2,000		-2,000
NIU/CNP-A Air Mobility (CONUS) Partial Year Savings			-3,000	-3,000
Replacement Helicopters			32,000	32,000
KAZAKHSTAN	4,000	4,000	4,000	4,000
KYRGYZSTAN	3,000	3,000	3,000	3,000
PAKISTAN	38,400	38,400	38,400	38,400
TAJIKISTAN	4,000	4,000	4,000	4,000
TURKMENISTAN	4,800	4,800	4,800	4,800

JOINT IMPROVISED EXPLOSIVE DEVICE DEFEAT
FUND

(INCLUDING TRANSFER OF FUNDS)

For the Joint Improvised Explosive Device Defeat Fund, funds are to be available for fiscal year 2010, as follows:

EXPLANATION OF PROJECT LEVEL ADJUSTMENTS
[In thousands of dollars]

	Budget Request	House	Senate	Recommendation
Attack the Network	812,000	730,000	1,015,100	865,100
Transfer from Title VI			203,100	53,100
Defeat the Device	536,000	600,000	735,100	735,100
Transfer from Title VI			199,100	199,100
Train the Force	187,000	160,000	161,810	161,810
Transfer from Title VI			41,100	41,100
Transfer to Service OCO accounts for proper execution			-66,290	-66,290
Staff and Infrastructure	0	0	121,550	0
Transfer from Title VI			121,550	
Total, Joint Improvised Explosive Device Defeat Fund	1,535,000	1,490,000	2,033,560	1,762,010

The Director, Joint Improvised Explosive Device Defeat Organization (JIEDDO) is directed to continue to submit monthly commitment, obligation, and expenditure data by line of operation and by year of appropriation to the congressional defense committees. Further, the Director, JIEDDO is directed to submit monthly reports of obligation data on a project-by-project basis by line of operation to the congressional defense committees. The Director, JIEDDO is also directed to follow standard reprogramming procedures when transferring a cumulative amount of \$20,000,000 or more between lines of operation.

OFFICE OF THE INSPECTOR GENERAL

For the Office of the Inspector General, \$8,876,000 is provided for fiscal year 2010.

TITLE IX—GENERAL PROVISIONS

The recommendation incorporates general provisions from the House and Senate versions of the bill which were not amended. Those general provisions that were addressed follow:

The recommendation retains a provision proposed by the Senate that provides for special transfer authority for this title. The House bill contained a similar provision.

The recommendation retains a provision proposed by the Senate that provides authority for the supervisory and administrative costs associated with construction projects in Afghanistan funded with operation and maintenance funds, that may be obligated when the contract is awarded. The House bill contained a similar provision.

The recommendation retains a provision proposed by the Senate that provides for the procurement of passenger motor vehicles for the physical security of personnel. The House bill contained a similar provision.

The recommendation modifies a provision proposed by the House and the Senate which

provides funding under “Operation and Maintenance, Army” to fund the Commander’s Emergency Response Program (CERP) and requires quarterly reports to the congressional defense committees.

The recommendation does not retain a provision proposed by the House that provides for a transfer from the Defense Cooperation Account. The Senate bill contained no similar provision.

The recommendation retains a provision proposed by the Senate that designates funds in this title for overseas deployments and other activities. The House bill contained a similar provision.

The recommendation retains a provision proposed by the House that prohibits the use of funds made available in this Act to contravene laws enacted or regulations promulgated to implement the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The Senate bill contained the same provision in Title VIII.

The recommendation does not retain a provision proposed by the House that requires a report on the timetable for Iraq troop draw down. The Senate bill contained no similar provision. The issue is addressed elsewhere in this statement.

The recommendation retains a provision proposed by the Senate that provides reporting requirements and reprogramming thresholds for Iraq and Afghanistan Security Forces Funds and Pakistan Counterinsurgency Fund. The House bill contained no similar provision.

The recommendation includes a provision that restricts the transfer or release into the United States of any individual who was detained at Naval Station, Guantanamo Bay, Cuba.

The recommendation does not retain a provision proposed by the Senate that provides

funding for fuel requirements. The House bill contained no similar provision.

The recommendation retains a provision proposed by the Senate that prohibits funding of the Association Community Organizations for Reform Now. The House bill contained no similar provision. The issue is addressed in Title VIII.

The recommendation does not retain a provision proposed by the Senate that provides for the support of certain civilian-military training for citizens deploying to Afghanistan. The House bill contained no similar provision. This issue is addressed elsewhere in the statement.

The recommendation does not retain a provision proposed by the Senate to hold open and closed hearings on strategy and resources of the United States with respect to Afghanistan and Pakistan. The House bill contained no similar provision.

The recommendation modifies a provision proposed by the Senate that makes available funding for outreach and reintegration services under the Yellow Ribbon Reintegration Program. The House bill contained no similar provision.

TITLE X—GENERAL PROVISIONS

The recommendation incorporates general provisions from the House and Senate versions of the bill which were not amended. Those general provisions that were addressed follow:

The recommendation does not retain a provision proposed by the House concerning hyperbaric chambers for treatment of traumatic brain injury. The Senate bill contained no similar provision. The issue is addressed elsewhere in the statement.

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT-FY 2010
(Amounts in thousands)

	FY 2009 Enacted	FY 2010 Request	House	Senate	Recommendation	Recommendation vs. Enacted
TITLE I						
MILITARY PERSONNEL						
Military Personnel, Army.....	36,382,736	41,312,448	39,991,647	41,267,446	41,086,612	+4,622,876
Military Personnel, Navy.....	24,037,663	26,504,472	25,098,891	26,446,472	25,286,049	+1,251,490
Military Personnel, Marine Corps.....	11,792,974	12,915,790	12,526,846	12,893,790	12,799,999	+1,007,010
Military Personnel, Air Force.....	25,103,789	26,439,761	25,938,896	26,379,761	26,174,136	+1,070,347
Reserve Personnel, Army.....	3,904,296	4,336,066	4,366,613	4,296,066	4,364,713	+466,417
Reserve Personnel, Navy.....	1,858,968	1,938,196	1,916,111	1,906,196	1,906,361	+53,333
Reserve Personnel, Marine Corps.....	584,910	617,600	616,660	611,600	612,600	+26,690
Reserve Personnel, Air Force.....	1,423,976	1,907,712	1,806,462	1,864,712	1,866,412	+165,736
National Guard Personnel, Army.....	6,616,220	7,621,488	7,525,629	7,536,099	7,546,995	+930,865
National Guard Personnel, Air Force.....	2,741,768	2,970,949	2,946,666	2,923,699	2,936,220	+196,461
Total, title I, Military Personnel.....	114,443,690	126,284,942	122,378,616	124,617,192	124,176,647	+8,726,957
TITLE II						
OPERATION AND MAINTENANCE						
Operation and Maintenance, Army.....	31,297,243	31,274,882	30,464,162	30,667,696	30,934,669	-272,663
Operation and Maintenance, Navy.....	34,410,773	35,070,348	34,885,932	34,773,467	34,714,396	+303,622
Operation and Maintenance, Marine Corps.....	8,519,232	8,536,223	8,567,519	8,436,923	8,536,117	+19,885
Operation and Maintenance, Air Force.....	34,866,964	34,748,169	33,786,349	33,739,447	33,477,116	+1,388,848
Operation and Maintenance, Defense-Wide.....	25,639,466	26,367,246	27,029,377	26,206,660	26,116,793	+2,176,327
Operation and Maintenance, Army Reserve.....	2,626,896	2,626,196	2,621,196	2,662,624	2,617,496	+11,460
Operation and Maintenance, Navy Reserve.....	1,306,141	1,278,501	1,286,001	1,272,601	1,273,791	-34,460
Operation and Maintenance, Marine Corps Reserve.....	212,467	226,926	226,926	219,426	223,176	+10,668
Operation and Maintenance, Air Force Reserve.....	3,016,151	3,079,229	3,079,229	3,065,796	3,131,369	+113,046
Operation and Maintenance, Army National Guard.....	6,666,303	6,267,034	6,363,627	6,889,934	6,166,713	+321,416
Operation and Maintenance, Air National Guard.....	6,991,044	6,866,761	6,866,741	6,867,611	6,862,261	+16,763
Overseas Contingency Operations Transfer Account.....	---	5,000	---	---	---	---
United States Court of Appeals for the Armed Forces.....	13,264	13,932	13,932	13,932	13,932	+670
Environmental Restoration, Army.....	467,776	416,864	416,864	436,864	422,364	-34,412
Environmental Restoration, Navy.....	290,819	266,669	266,669	266,669	266,669	-4,066
Environmental Restoration, Air Force.....	494,276	494,276	494,276	494,276	494,276	-2,001
Environmental Restoration, Defense-Wide.....	13,176	11,100	11,100	11,100	11,100	-2,076
Environmental Restoration, Formerly Used Defense Sites.....	291,266	267,706	277,706	307,706	292,706	+1,464
Overseas Humanitarian, Disaster, and Civic Aid.....	83,273	109,869	109,869	109,869	109,869	+26,596
Cooperative Threat Reduction Account.....	434,135	404,093	404,093	424,093	424,093	-16,642
Department of Defense Acquisition Workforce Development Fund.....	---	100,000	100,000	100,000	100,000	+100,000
Total, title II, Operation and maintenance.....	152,949,706	166,444,204	164,178,741	164,006,901	164,253,711	+1,304,006
TITLE III						
PROCUREMENT						
Aircraft Procurement, Army.....	4,906,636	5,315,991	5,144,991	5,244,282	5,093,622	+192,967
Missile Procurement, Army.....	2,185,060	1,370,196	1,366,099	1,257,663	1,251,663	-634,907
Procurement of Weapons and Tracked Combat Vehicles, Army.....	3,189,128	2,461,962	2,601,962	2,319,967	2,336,967	-833,321
Procurement of Ammunition, Army.....	2,267,996	2,051,896	2,063,396	2,046,996	2,066,116	-231,263
Other Procurement, Army.....	10,664,614	9,907,161	9,293,691	9,396,444	8,662,669	-2,161,364
Aircraft Procurement, Navy.....	14,141,916	16,378,312	16,326,481	16,078,312	16,643,221	+4,501,903
Weapons Procurement, Navy.....	3,292,672	3,463,466	3,226,463	3,446,419	3,367,672	+44,006
Procurement of Ammunition, Navy and Marine Corps.....	1,065,166	840,676	784,866	814,016	860,661	-264,569
Shipbuilding and Conversion, Navy.....	13,064,367	13,776,867	14,721,632	15,364,699	13,661,632	+827,166
Other Procurement, Navy.....	6,260,627	5,661,176	5,366,661	5,496,413	5,441,234	+190,607
Procurement, Marine Corps.....	1,376,917	1,600,636	1,663,743	1,560,699	1,621,696	+144,668
Aircraft Procurement, Air Force.....	13,112,617	11,966,276	11,966,162	13,148,729	13,296,474	+182,667
Missile Procurement, Air Force.....	6,442,428	6,360,726	6,606,366	6,076,344	6,066,644	+663,116
Procurement of Ammunition, Air Force.....	859,466	822,462	809,641	815,246	801,666	+67,916
Other Procurement, Air Force.....	16,662,669	17,293,141	16,663,791	17,263,699	17,139,339	+1,066,679
Procurement, Defense-Wide.....	3,306,269	3,984,352	4,036,616	4,017,697	4,066,637	+744,266
National Guard and Reserve Equipment.....	750,000	---	---	1,500,000	---	-750,000
Defense Production Act Purchases.....	100,666	36,246	82,646	149,746	169,746	+69,161
Total, title III, Procurement.....	101,061,706	106,213,426	104,937,696	108,016,143	104,367,262	+3,346,664
TITLE IV						
RESEARCH, DEVELOPMENT, TEST AND EVALUATION						
Research, Development, Test and Evaluation, Army.....	12,066,111	10,436,216	11,161,664	10,663,126	11,474,169	-666,931
Research, Development, Test and Evaluation, Navy.....	16,764,276	19,270,932	20,197,399	19,146,699	20,063,463	+239,167
Research, Development, Test and Evaluation, Air Force.....	27,064,340	27,992,627	27,976,276	28,649,616	28,121,666	+1,637,646
Research, Development, Test and Evaluation, Defense-Wide.....	21,423,336	20,741,642	20,721,723	20,406,666	20,747,061	-676,267
Operational Test and Evaluation, Defense.....	166,772	190,770	190,770	190,770	190,770	+1,000
Total, title IV, Research, Development, Test and Evaluation.....	80,626,637	78,634,266	80,237,666	78,450,366	80,637,479	+16,642

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT-FY 2010
(Amounts in thousands)

	FY 2009 Enacted	FY 2010 Request	House	Senate	Recommendation	Recommendation vs. Enacted
TITLE V						
REVOLVING AND MANAGEMENT FUNDS						
Defense Working Capital Funds.....	1,489,234	1,455,004	1,455,004	1,455,004	1,455,004	-34,230
National Defense Sealift Fund.....	1,666,572	1,642,758	1,662,758	1,242,758	1,672,758	+6,186
Defense Coalition Support Fund.....	---	22,000	---	---	---	---
Total, title V, Revolving and Management Funds..	3,155,806	3,119,762	3,147,762	2,697,762	3,127,762	-28,044
TITLE VI						
OTHER DEPARTMENT OF DEFENSE PROGRAMS						
Defense Health Program:						
Operation and maintenance.....	24,611,389	26,947,919	26,267,646	26,990,219	27,696,699	+2,985,320
Procurement.....	311,905	322,142	384,142	322,142	398,692	+64,787
Research, development, test and evaluation.....	902,668	613,102	1,249,402	998,762	1,280,047	+377,689
Total, Defense Health Program.....	25,825,932	27,903,163	28,891,190	28,311,113	29,243,428	+3,417,596
National Defense Stockpile Transaction Fund transfer to Defense Health program.....	-1,300,000	---	---	---	---	+1,300,000
Chemical Agents and Munitions Destruction, Defense:						
Operation and maintenance.....	1,152,888	1,148,802	1,148,802	1,125,911	1,148,802	-5,886
Procurement.....	84,085	12,689	12,689	12,689	12,689	-61,396
Research, development, test and evaluation.....	288,881	401,299	381,299	401,299	401,299	+112,388
Total, Chemical Agents 1/.....	1,505,834	1,560,790	1,510,790	1,539,899	1,560,790	+55,126
Drug Interdiction and Counter-Drug Activities, Defense						
Joint Improvised Explosive Device Defeat Fund 1/.....	1,096,743	1,058,984	1,237,684	1,193,086	1,188,226	+61,463
Rapid Acquisition Fund 1/.....	---	584,650	384,650	---	121,650	+121,650
Office of the Inspector General 1/.....	---	79,308	---	---	---	---
Office of the Inspector General 1/.....	271,846	272,444	288,100	288,100	288,100	+16,256
Total, title VI, Other Department of Defense Programs.....	27,400,054	31,439,501	33,292,203	31,242,168	32,372,064	+4,872,016
TITLE VII						
RELATED AGENCIES						
Central Intelligence Agency Retirement and Disability System Fund.....	279,209	290,900	290,900	290,900	290,900	+11,700
Intelligence Community Management Account (ICMA).....	710,042	672,812	611,002	750,812	707,812	-2,130
Transfer to Department of Justice.....	(44,000)	---	---	---	---	(-44,000)
Total, title VII, Related agencies.....	989,242	963,712	901,902	1,041,712	998,812	+9,570
TITLE VIII						
GENERAL PROVISIONS						
Additional transfer authority (Sec. 8005).....	(4,100,000)	(5,000,000)	(4,000,000)	(4,000,000)	(4,000,000)	(-100,000)
Indian Financing Act incentives (Sec. 8021).....	15,000	---	15,000	15,000	15,000	---
FFRDC (Sec. 8026).....	-84,000	---	-125,200	-120,200	-125,200	-41,200
Overseas Military Facility Invest Recovery (Sec. 8031)	1,000	1,000	1,000	1,000	1,000	---
Rescissions (Sec. 8042).....	-1,320,473	---	-1,391,339	-1,278,061	-1,244,057	+76,416
O&M, Def-wide transfer authority (Sec. 8053).....	(30,000)	(30,000)	(30,000)	(30,000)	(30,000)	---
Fisher House Foundation (Sec. 8074).....	8,000	---	8,000	---	3,750	-4,250
Special needs students (Sec. 8081).....	5,500	---	---	5,500	5,500	---
Military Recruitment Assessment & Vet Empl (Sec. 8082)	3,000	---	3,000	---	3,000	---
Various grants (Sec. 8085).....	112,489	---	88,700	80,500	119,840	-1,760
Shipbuilding & conversion funds, Navy (Sec. 8096).....	10,000	10,000	10,000	10,000	10,000	---
Revised economic assumptions (Sec. 8097).....	---	---	---	-881,000	-881,000	-881,000
Working Capital Fund excess cash (Sec. 8107).....	-859,000	---	---	-500,000	-490,000	+499,000
Stop Loss transfer fund (Sec. 8108).....	72,000	---	8,300	---	---	-72,000
Fisher House transfer authority (Sec. 8109).....	---	(10,000)	(12,000)	(10,000)	(11,000)	(+11,000)
ICMA transfer authority (Sec. 8110).....	---	(24,000)	(24,000)	(24,000)	(24,000)	(+24,000)
Foreign Currency Fluctuations, Defense.....	---	---	400,000	---	---	---
Excess fuel funding (MCF cash).....	---	---	-289,570	---	---	---
Tanker Replacement Transfer Fund (Sec. 8119).....	---	---	439,815	---	291,715	+291,715
Iraqi/Afghan Refugee Resettlement Support (Sec. 8120)	---	---	4,000	---	4,000	+4,000
Contractor inventory.....	-829,780	---	-550,000	---	---	+829,780
Defense Health Program, O&M.....	---	---	-28,000	---	---	---
Defense Health Program, RDT&E.....	---	---	26,000	---	---	---
Operation & Maintenance, Air Force.....	---	---	-50,000	---	---	---
Chemical Agents & Munitions Destruction, DE.....	---	---	50,000	---	---	---
Total, Title VIII, General Provisions.....	-2,866,353	11,000	-1,391,494	-2,677,201	-2,185,682	+690,701

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT-FY 2010
(Amounts in thousands)

	FY 2009 Enacted	FY 2010 Request	House	Senate	Recommendation	Recommendation vs. Enacted
TITLE IX						
OVERSEAS CONTINGENCY OPERATIONS (OCO) 2/						
DEPARTMENT OF DEFENSE--MILITARY						
Military Personnel						
Military Personnel, Army (DDOA).....	---	9,808,340	10,482,723	9,697,340	9,959,848	+9,959,848
Military Personnel, Navy (DDOA).....	---	1,175,801	1,822,717	1,175,801	1,388,801	+1,388,801
Military Personnel, Marine Corps (DDOA).....	---	870,722	987,478	870,722	778,722	-778,722
Military Personnel, Air Force (DDOA).....	---	1,445,378	1,855,337	1,445,378	1,867,378	+1,867,378
Reserve Personnel, Army (DDOA).....	---	294,837	302,637	293,637	293,137	-293,137
Reserve Personnel, Navy (DDOA).....	---	39,040	39,040	37,040	37,040	-37,040
Reserve Personnel, Marine Corps (DDOA).....	---	31,337	31,337	31,337	31,337	-31,337
Reserve Personnel, Air Force (DDOA).....	---	24,822	24,822	19,822	19,822	-19,822
National Guard Personnel, Army (DDOA).....	---	839,988	839,988	824,988	824,988	-824,988
National Guard Personnel, Air Force (DDOA).....	---	18,500	18,500	9,500	9,500	-9,500
Total, Military Personnel.....	---	14,146,341	18,224,540	14,106,341	15,008,341	+15,008,341
Operation and Maintenance						
Operation & Maintenance, Army (DDOA).....	---	52,386,781	41,836,829	51,828,187	47,821,184	-47,821,184
Operation & Maintenance, Navy (DDOA).....	---	6,219,583	4,975,885	5,899,697	5,476,825	-5,476,825
Coast Guard (by transfer) (DDOA).....	---	(241,503)	(241,503)	---	---	---
Operation & Maintenance, Marine Corps (DDOA).....	---	3,701,800	2,961,279	3,775,279	3,430,288	-3,430,288
Operation & Maintenance, Air Force (DDOA).....	---	10,028,888	7,858,888	9,929,888	9,218,319	-9,218,319
Operation & Maintenance, Defense-Wide (DDOA).....	---	7,583,400	7,397,808	7,550,900	7,490,900	-7,490,900
Coalition support funds (DDOA).....	---	(1,800,000)	(1,840,000)	(1,800,000)	(1,870,000)	-(1,870,000)
Operation & Maintenance, Army Reserve (DDOA).....	---	204,328	183,481	234,888	204,328	-204,328
Operation & Maintenance, Navy Reserve (DDOA).....	---	88,088	84,447	88,088	88,088	-88,088
Operation & Maintenance, Marine Corps Reserve (DDOA).....	---	88,887	88,333	88,887	88,887	-88,887
Operation & Maintenance, Air Force Reserve (DDOA).....	---	125,825	106,740	125,825	125,825	-125,825
Operation & Maintenance, Army National Guard (DDOA).....	---	321,848	257,317	450,248	321,848	-321,848
Operation & Maintenance, Air National Guard (DDOA).....	---	289,882	231,888	289,882	289,882	-289,882
Overseas Contingency Operations Transfer Fund.....	---	---	14,838,901	---	5,000,000	-5,000,000
Subtotal, Operation and Maintenance.....	---	80,994,887	80,543,766	80,339,488	78,531,041	+78,531,041
Iraq Freedom Fund (DDOA).....	---	115,300	---	---	---	---
Afghanistan Security Forces Fund (DDOA).....	---	7,462,789	7,462,789	8,582,789	8,582,789	-8,582,789
Pakistan Counterinsurgency Capability Fund (DDOA).....	---	700,000	---	---	---	---
Total, Operation and Maintenance.....	---	89,272,786	88,006,525	88,902,226	86,093,810	+86,093,810
Procurement						
Aircraft Procurement, Army (DDOA).....	---	1,838,229	1,838,229	1,119,319	1,238,219	-1,238,219
Missile Procurement, Army (DDOA).....	---	531,570	489,478	475,984	475,984	-475,984
Procurement of Weapons and Tracked Combat Vehicles, Army (DDOA).....	---	759,488	1,219,488	875,888	1,189,488	-1,189,488
Procurement of Ammunition, Army (DDOA).....	---	370,635	370,635	385,635	385,635	-385,635
Other Procurement, Army (DDOA).....	---	5,875,328	5,835,308	4,874,178	5,890,516	-5,890,516
Aircraft Procurement, Navy (DDOA).....	---	916,553	888,987	1,342,577	853,287	-853,287
Weapons Procurement, Navy (DDOA).....	---	50,700	73,708	50,708	50,708	-50,708
Procurement of Ammunition, Navy and Marine Corps (DDOA).....	---	681,957	688,780	681,957	675,957	-675,957
Other Procurement, Navy (DDOA).....	---	318,018	280,797	280,118	241,018	-241,018
Procurement, Marine Corps (DDOA).....	---	1,080,288	1,100,288	888,187	893,187	-893,187
Aircraft Procurement, Air Force (DDOA).....	---	780,441	825,718	738,501	738,501	-738,501
Missile Procurement, Air Force (DDOA).....	---	38,825	38,825	38,825	38,825	-38,825
Procurement of Ammunition, Air Force (DDOA).....	---	258,819	258,819	258,819	258,819	-258,819
Other Procurement, Air Force (DDOA).....	---	2,321,548	2,278,234	3,138,021	2,583,421	-2,583,421
Procurement, Defense-Wide (DDOA).....	---	491,430	489,980	480,780	489,780	-489,780
National Guard and Reserve Equipment (DDOA).....	---	---	500,000	---	950,000	-950,000
Mine Resistant Ambush Protected Vehicle Fund (DDOA).....	---	5,456,000	3,808,000	6,658,000	6,281,000	-6,281,000
Rapid Acquisition Fund (DDOA).....	---	---	40,000	---	---	---
Total, Procurement.....	---	21,343,688	20,384,128	22,219,245	23,080,108	+23,080,108
Research, Development, Test and Evaluation						
Research, Development, Test & Evaluation, Army (DDOA).....	---	57,982	57,982	57,982	57,982	-57,982
Research, Development, Test & Evaluation, Navy (DDOA).....	---	107,180	38,280	84,180	58,680	-58,680
Research, Development, Test & Evaluation, Air Force (DDOA).....	---	29,288	29,288	39,288	39,288	-39,288
Research, Development, Test and Evaluation, Defense-Wide (DDOA).....	---	115,828	115,828	112,186	112,186	-112,186
Total, Research, Development, Test and Evaluation.....	---	310,254	241,354	293,624	268,104	+268,104

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT-FY 2010
(Amounts in thousands)

	FY 2009 Enacted	FY 2010 Request	House	Senate	Recommendation	Recommendation vs. Enacted
Revolving and Management Funds						
Defense Working Capital Funds (DDOA).....	---	396,915	412,215	412,215	412,215	+412,215
Total, Revolving and Management Funds.....	---	396,915	412,215	412,215	412,215	+412,215
Other Department of Defense Programs						
Defense Health Program (DDOA).....	---	1,256,675	1,155,235	1,563,675	1,256,675	+1,256,675
Drug Interdiction and Counter-Drug Activities, Defense (DDOA).....	---	324,803	317,803	353,803	348,803	+348,803
Joint IED Defeat Fund (DDOA).....	---	1,535,000	1,400,000	2,033,500	1,762,010	+1,762,010
Office of the Inspector General (DDOA).....	---	8,876	8,876	8,876	8,876	+8,876
Total, Other Department of Defense Programs.....	---	3,125,154	2,871,714	3,959,714	3,374,164	+3,374,164
TITLE IX General Provisions						
Additional transfer authority (DDOA) (Sec. 9002).....	---	(4,000,000)	(3,000,000)	(4,000,000)	(4,000,000)	(+4,000,000)
Fuel.....	---	---	---	329,000	---	---
Defense Cooperation Account (DDOA)	---	---	8,509	---	---	---
Total, General Provisions.....	---	---	8,509	329,000	---	---
Total, Title IX	---	128,685,016	128,248,065	128,221,367	128,248,739	+128,248,739
Total for the bill (net).....	477,844,889	629,685,862	625,837,879	625,815,332	625,919,024	+148,274,135
OTHER APPROPRIATIONS						
SUPPLEMENTAL APPROPRIATIONS ACT, 2008 (PL 110-252)						
Title IX, Defense Matters						
Chapter 2, Defense Bridge Fund Appropriations for FY 2008 (emergency).....	85,921,157	---	---	---	---	-85,921,157
Special transfer authority (emergency).....	(4,000,000)	---	---	---	---	(-4,000,000)
Subtotal, Chapter 2, FY 2008 (emergency).....	85,921,157	---	---	---	---	-85,921,157
Total, Public Law 110-252 (emergency).....	85,921,157	---	---	---	---	-85,921,157
AMERICAN RECOVERY & REINVESTMENT ACT, 2009 (PL 111-5)						
Title III, Department of Defense						
Operation and Maintenance (emergency).....	3,840,000	---	---	---	---	-3,840,000
Research, Development, Test and Evaluation (emergency)...	300,000	---	---	---	---	-300,000
Other Department of Defense programs (emergency).....	415,000	---	---	---	---	-415,000
Total, Public Law 111-5 (emergency).....	4,555,000	---	---	---	---	-4,555,000
SUPPLEMENTAL APPROPRIATIONS ACT, 2009 (PL 111-32)						
TITLE III DEPARTMENT OF DEFENSE						
Military Personnel (DDOA).....	19,726,160	---	---	---	---	-19,726,160
Operation & Maintenance (DDOA).....	28,540,175	---	---	---	---	-28,540,175
Afghanistan Security Forces Fund (DDOA).....	3,606,839	---	---	---	---	-3,606,839
Pakistan Counterinsurgency Fund (DDOA).....	400,000	---	---	---	---	-400,000
Procurement (DDOA).....	25,846,715	---	---	---	---	-25,846,715
Research, Development, Test and Evaluation (DDOA).....	833,499	---	---	---	---	-833,499
Revolving and Management Funds (DDOA).....	861,726	---	---	---	---	-861,726
Other Department of Defense Programs (DDOA).....	2,301,982	---	---	---	---	-2,301,982
Special DE transfer authority (this title only).....	(2,500,000)	---	---	---	---	(-2,500,000)
Defense Cooperation Account (DDOA).....	8,509	---	---	---	---	-8,509
Iraq Security Forces Fund (emergency).....	1,000,000	---	---	---	---	-1,000,000
(rescission) (emergency).....	-1,000,000	---	---	---	---	+1,000,000
Fuel (rescission).....	-1,003,607	---	---	---	---	+1,003,607
(overseas deployments and activities) (rescission)...	-1,006,993	---	---	---	---	+1,006,993
Classified and other (DDOA) (rescission).....	-1,051,180	---	---	---	---	+1,051,180
Procurement, Army (DDOA) (rescission).....	-354,000	---	---	---	---	+354,000
Operation & maintenance, Def-Wide (DDOA) (rescission)	-181,500	---	---	---	---	+181,500
Stop Loss Transfer Fund (DDOA).....	534,400	---	---	---	---	-534,400
Total, Public Law 111-32 (DDOA).....	77,161,439	---	---	---	---	-77,161,439
Total, Other Appropriations.....	147,637,696	---	---	---	---	-147,637,696
Net grand total (including other appropriations)	625,282,485	629,685,862	625,837,879	625,815,332	625,919,024	+636,539

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT-FY 2010
(Amounts in thousands)

	FY 2009 Enacted	FY 2010 Request	House	Senate	Recommendation	Recommendation vs. Enacted
CONGRESSIONAL BUDGET RECAP						
Scorekeeping adjustments:						
Lease of defense real property (permanent).....	3,000	3,000	3,000	3,000	3,000	---
Disposal of defense real property (permanent).....	17,000	31,000	31,000	31,000	31,000	+14,000
O&M, Army transfer to National Park Service:						
Defense function.....	-2,500	---	---	---	---	+2,500
Non-defense function.....	2,500	---	---	---	---	-2,500
Tricare accrual (permanent, indefinite auth.) 3/..	10,351,000	10,707,000	10,707,000	10,707,000	10,707,000	+356,000
Retired/retainer pay (PL 111-32 Sec 318)(ODDA).....	---	5,000	5,000	5,000	5,000	+5,000
Less emergency appropriations	-70,476,157	---	---	---	---	+70,476,157
Total, scorekeeping adjustments.....	-60,105,157	10,746,000	10,746,000	10,746,000	10,746,000	+70,851,157
Adjusted total (includ. scorekeeping adjustments)	565,177,328	640,431,852	636,583,878	636,561,332	636,685,024	+71,487,696
Appropriations.....	(567,500,808)	(640,431,852)	(637,975,218)	(637,839,333)	(637,909,081)	(+70,406,273)
Rescissions.....	(-2,323,480)	---	(-1,391,338)	(-1,278,001)	(-1,244,067)	(+1,078,423)
Total (including scorekeeping adjustments).....	565,177,328	640,431,852	636,583,878	636,561,332	636,685,024	+71,487,696
Amount in this bill.....	(625,282,485)	(629,685,852)	(625,637,878)	(625,815,332)	(625,919,024)	(+636,536)
Scorekeeping adjustments.....	(-60,105,157)	(10,746,000)	(10,746,000)	(10,746,000)	(10,746,000)	(+70,851,157)
Total mandatory and discretionary.....	565,177,328	640,431,852	636,583,878	636,561,332	636,685,024	+71,487,696
Mandatory.....	279,200	290,900	290,900	290,900	290,900	+11,700
Discretionary.....	564,898,128	640,140,952	636,292,978	636,270,432	636,374,124	+71,476,996
RECAPITULATION						
Title I - Military Personnel.....	114,443,890	125,264,842	122,378,016	124,817,182	124,170,847	+8,726,957
Title II - Operation and Maintenance.....	152,949,705	156,444,204	154,176,741	154,005,801	154,263,711	+1,304,006
Title III - Procurement.....	101,051,708	105,213,426	104,837,609	106,016,143	104,397,262	+3,346,554
Title IV - Research, Development, Test and Evaluation.....	80,520,837	78,634,288	80,237,955	78,450,386	80,537,479	+19,642
Title V - Revolving and Management Funds.....	3,155,806	3,119,782	3,147,782	2,997,782	3,127,782	-29,044
Title VI - Other Department of Defense Programs.....	27,400,054	31,439,501	33,292,203	31,242,166	32,372,084	+4,972,010
Title VII - Related Agencies.....	989,242	983,712	901,902	1,041,712	998,812	+9,870
Title VIII - General Provisions (net).....	-2,898,353	11,000	-1,381,494	-2,877,201	-2,165,652	+680,701
Title IX - Overseas Deployments and Other Activities.....	---	128,595,016	128,246,886	128,221,367	128,246,739	+128,246,739
Total, Department of Defense.....	477,644,889	629,685,852	625,637,878	625,815,332	625,919,024	+148,274,136
Other defense appropriations.....	147,637,596	---	---	---	---	-147,637,596
Total funding available (net).....	625,282,485	629,685,852	625,637,878	625,815,332	625,919,024	+636,536
Scorekeeping adjustments.....	-60,105,157	10,746,000	10,746,000	10,746,000	10,746,000	+70,851,157
Total mandatory and discretionary.....	565,177,328	640,431,852	636,583,878	636,561,332	636,685,024	+71,487,696

FOOTNOTES:

- 1/ Included in Budget under Procurement title.
2/ Overseas Deployments and Other Activities (ODDA)
pursuant to FY 2010 concurrent budget resolution.
3/ Contributions to Department of Defense Retiree
Health Care Fund (Sec. 726, P.L. 108-375)(CBO est)

DIVISION B—OTHER MATTERS

Section 1001 provides such sums as are necessary for the Supplemental Nutrition Assistance Program (SNAP), to be held in reserve for use in such amounts and at such times as may be necessary to carry out the program. The fiscal year 2010 appropriation for SNAP was based on the latest official projection available to Congress at that time—the Office of Management and Budget's Mid-Session Review—and can support a large increase in participation over fiscal year 2009. However, increases in participation levels in the latter part of fiscal year 2009 were very high. If those rates of increase continue, the current appropriation level would not be sufficient to meet program participation.

Section 1002 provides \$400,000,000 in additional funding for state administrative expenses under the Supplemental Nutrition Assistance Program, to assist states in dealing with high program participation levels, designated as an emergency requirement.

Section 1003 extends the authorization for compulsory copyright license used by satellite television providers to February 28, 2010. Funding is fully offset.

Section 1004 provides extension to certain provisions of the USA PATRIOT Improvement and Reauthorization Act of 2005 and the Intelligence Reform and Terrorism Prevention Act of 2004 until February 28, 2010.

Section 1005 extends the National Flood Insurance Program through February 28, 2010.

Section 1006 provides \$125,000,000 to the Small Business Administration (SBA), to continue two temporary enhancements to SBA loan guarantee programs made by the American Recovery and Reinvestment Act of

2009 and which are nearly out of funding. One of the enhancements being extended allows the SBA to guarantee 90 percent of certain small business loans, instead of the 75 percent allowed under permanent law (or 85 percent for small loans), thereby encouraging banks to make these loans by reducing the amount they have at risk and the reserves they must hold. The other reduces fees paid by lenders and borrowers. The funding provided in the bill is estimated to be sufficient to continue both items through February 28, 2010. The bill also extends the expiration date of the authorization for the 90 percent loan guarantees from February 17 to February 28, 2010. Funding is fully offset.

Section 1007 will release upon enactment to Swain County, North Carolina \$4,000,000 of previously appropriated funds, with the remaining \$8,800,000 to be made available 120 days after the County, the state of North Carolina, the Interior Department and the Tennessee Valley Authority reach a settlement.

Section 1008 extends the authorization for the highway, transit, highway safety and motor carrier safety programs of the Department of Transportation until February 28, 2010.

Section 1009 provides an extension of expiring UI benefit provisions that were established or continued in the American Recovery and Reinvestment Act, including the Emergency Unemployment Compensation program, 100 percent Federal funding for the Extended Benefits program, and the extra \$25 weekly UI benefit through February 28, 2010.

Section 1010 extends the 65 percent COBRA health insurance subsidy from nine to 15 months for individuals who have lost their

jobs. The job lost eligibility date is extended in the provision through February 28, 2010.

Section 1011 delays a scheduled 21.2 percent reduction in Medicare's 2010 physician payments through February 28, 2010.

Section 1012 includes a provision to freeze the Department of Health and Human Services poverty guidelines at 2009 levels in order to prevent a reduction in eligibility for certain means-tested programs, including Medicaid, Supplemental Nutrition Assistance Program (SNAP), and child nutrition, through March 1, 2010.

Section 1013 rescinds funds from the digital television conversion coupon program.

Section 1014 provides that explanatory statement submitted by the Chairman of the Defense Subcommittee shall have the same effect as a joint explanatory statement.

DISCLOSURE OF CONGRESSIONAL EARMARKS AND CONGRESSIONALLY DIRECTED SPENDING ITEMS

Following is a list of congressional earmarks and congressionally directed spending items (as defined in clause 9 of rule XXI of the Rules of the House of Representatives and rule XLIV of the Standing Rules of the Senate, respectively) included in the amended bill or the explanatory statement, along with the name of each Senator, House Member, Delegate, or Resident Commissioner who submitted a request to the Committee of jurisdiction for each item so identified. Neither the amended bill nor the explanatory statement contains any limited tax benefits or limited tariff benefits as defined in the applicable House or Senate rules.

DEFENSE

[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
AP,A	Air Filtration Systems for National Guard Helicopters	\$800,000	Akin	Bond
AP,A	Air Warrior Ensemble Generation III	\$3,000,000		Warner; Webb
AP,A	Army National Guard UH-60 Rewiring Program	\$8,000,000	Granger	
AP,A	Automatic Identification Technology Life Cycle Asset Management	\$1,200,000		Shelby
AP,A	CH-47 Helicopter Forward and Aft Hook Project	\$2,400,000	Baird	
AP,A	CH-47F Common Avionics Architecture System-Pilot Vehicle Interface	\$2,720,000	Hinchey; Latham; McHugh	Grassley; Sessions
AP,A	Civil Support Communications Systems for Kentucky Army National Guard UH-60 Aircraft	\$1,600,000	Rogers (KY)	Bunning
AP,A	Forward Looking Infrared Sensors for UH-60 Medevac Helicopters for the Minnesota National Guard	\$800,000	Oberstar	Klobuchar
AP,A	Internal Auxiliary Fuel Tank System	\$2,400,000	Franks (AZ); Bishop (UT); Pastor (AZ)	Bennett; Hatch; Leahy
AP,A	Recoil UH-60 Wild Land Fire-Fighting Tank System	\$3,200,000		Merkley; Wyden
AP,A	UH-72A Integrated Vehicle Management System	\$1,600,000		Johnson; Leahy
AP,A	Vibration Management Enhancement Program	\$3,000,000	Clyburn; Wilson (SC)	
AP,AF	ARC 210 Radios for ANG F-16s	\$1,600,000		Brownback; Harkin; Hatch; Merkley; Nelson (FL); Wyden
AP,AF	C-130 Active Noise Cancellation System	\$2,400,000	Tiahrt	Brownback; Roberts
AP,AF	Civil Air Patrol	\$4,000,000	Tiahrt	Roberts
AP,AF	Large Aircraft Podded Infrared Countermeasures Systems for Air Force Reserve KC-135	\$1,200,000	Bean	
AP,AF	LITENING 4th Generation Kit Upgrades	\$2,000,000	Boozman; Herseth Sandlin	Johnson; Landrieu; Thune

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
AP,AF	Miniature Air-Launched Decoy	\$1,600,000		Warner; Webb
AP,AF	Scathe View Hyper-Spectral Imagery Upgrade for Nevada ANG	\$3,600,000	Titus; Berkley; Heller	Reid
AP,AF	Senior Scout, Electro-Optical Infrared Capability	\$4,800,000	Bishop (UT)	Bennett; Hatch
AP,AF	Senior Scout, Line of Sight Datalink	\$2,400,000	Bishop (UT)	Bennett; Hatch
AP,AF	Senior Scout, Remote Operations Capability	\$2,400,000	Bishop (UT)	Bennett; Hatch
AP,AF	Support Equipment for Time Critical Targeting, Senior Scout	\$3,000,000		Bennett; Crapo; Risch
AP,N	Advanced Skills Management Command Portal—Fleet Readiness Centers	\$2,000,000	Dicks	Cantwell
AP,N	AN / AAR-47D(V)X Missile Warning System	\$4,000,000	Young (FL)	Nelson (FL)
AP,N	Crane Integrated Defensive Electronic Countermeasures Depot Capability	\$1,600,000	Ellsworth	Lugar
AP,N	Direct Squadron Support Readiness Training Program	\$3,200,000		Byrd
AP,N	Multi-Mission Helicopter Avionics System Test Bed	\$1,500,000	Hoyer	
AP,N	UC-12 Replacement Aircraft	\$1,960,000		Brownback
AP,N	Universal Avionics Recorder Wireless Flight Download Data	\$800,000	Harman	
DHP	AFIP / Joint Pathology Center Records Digitization and Repository Modernization	\$12,000,000		Byrd
DHP	Composite Operational Health and Occupational Risk Tracking System	\$2,400,000	Tiahrt	Brownback
DHP	Enhanced Medical Situational Awareness	\$1,920,000		Kohl
DHP	Epidemiologic Health Survey	\$720,000	Loebsack	Grassley; Harkin
DHP	Fort Drum Regional Health Planning Organization	\$430,000	McHugh	Schumer
DHP	Hawaii Federal Health Care Network	\$23,000,000		Inouye
DHP	Lung Injury Management	\$1,160,000		Corker
DHP	Madigan Army Medical Center Trauma Assistance	\$2,500,000	Dicks; Smith (WA)	Cantwell; Murray
DHP	Military Physician Combat Medical Training	\$1,000,000	Brown, Corrine (FL)	Nelson (FL)
DHP	Patient Care Improvement Project at Keesler Medical Center	\$3,280,000		Cochran
DHP	Regional Telepathology Initiative at Keesler AFB	\$1,680,000		Cochran
DHP	Security Solutions from Life in Extreme Environments Center	\$800,000	Cummings	Crapo; Risch
DHP	Shock Trauma Center Operating Suites	\$2,400,000	Ruppersberger; Cummings	
DHP	Web-Based Teaching Programs for Military Social Work	\$3,200,000	Roybal-Allard	Boxer
DHP	Wide Area Virtual Environment Simulation for Medical Readiness Training	\$2,400,000	Van Hollen	
DPA	Advanced Carbon Nanotube Volume Production Facility	\$2,400,000	Hodes	Gregg; Shaheen
DPA	Aluminum Oxy-Nitride and Spinel Optical Ceramics	\$2,400,000	Bono Mack; Higgins; Tierney	Schumer
DPA	Armor and Structures Transformation Initiative-Steel to Titanium	\$8,100,000	Murtha	
DPA	Automated Composite Technologies and Manufacturing Center	\$9,600,000	Bishop (UT)	Bennett; Hatch
DPA	Bio-synthetic Paraffinic Kerosene Production	\$4,000,000		Burr
DPA	Conductive Composites Nano-Materials Scale-Up Initiative	\$2,800,000		Bennett; Hatch
DPA	Extremely Large, Domestic Expendable and Reusable Structures Manufacturing Center	\$7,840,000	Aderholt; Griffith	Cochran; Shelby; Wicker
DPA	Flexible Aerogel Materials Supplier Initiative	\$2,400,000	Kennedy	Reed; Whitehouse
DPA	Goodrich Terahertz Spectrometer	\$4,000,000		Dodd; Lieberman
DPA	High Homogeneity Optical Glass	\$3,200,000		Casey; Specter
DPA	High Performance Thermal Battery Infrastructure Project	\$3,000,000	Young (FL)	

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
DPA	Inventory for Defense Applications to Ensure Reliability of Short Lead Times	\$10,000,000	Murtha	
DPA	Lightweight Small Caliber Ammunition Production Initiative	\$3,760,000	Taylor	Cochran; Wicker
DPA	Low Cost Military Global Positioning System (GPS) Receiver	\$3,200,000	Loeb sack; Latham	Grassley; Harkin
DPA	Metal Injection Molding Technological Improvements	\$800,000	Pascrell	
DPA	Military Lens System Fabrication and Assembly	\$3,200,000	Murtha	
DPA	Navy Production Capacity Improvement Project	\$3,200,000	Dent	Casey; Specter
DPA	Production of Miniature Compressors for Electronics and Personal Cooling	\$3,600,000	Rogers (KY)	
DPA	Radiation Hardened Cryogenic Read Out Integrated Circuits	\$1,600,000	Simpson	
DPA	Titanium Metal Matrix Composite and Nano-Enhanced Titanium Development	\$6,400,000		Byrd
DRUGS	Alaska National Guard Counter-Drug Program	\$2,400,000		Begich
DRUGS	Delaware National Guard Counter-Drug Task Force	\$300,000	Castle	Carper; Kaufman
DRUGS	Florida Counter-Drug Program	\$2,900,000	Putnam; Brown, Corrine (FL); Young (FL)	Nelson (FL)
DRUGS	Hawaii National Guard Counter-Drug Program	\$3,000,000		Inouye
DRUGS	HERON Maritime UAS for SOUTHCOM	\$9,340,000	Childers	Cochran; Wicker
DRUGS	Indiana National Guard Counter-Drug Program	\$2,400,000	Visclosky	
DRUGS	Kentucky National Guard Counter-Drug Program	\$3,600,000	Rogers (KY)	McConnell
DRUGS	Midwest Counter-Drug Training Center	\$6,000,000		Grassley; Harkin
DRUGS	Minnesota National Guard Counter-Drug Program	\$1,600,000	Oberstar	Klobuchar
DRUGS	Montana National Guard Counter-Drug Task Force	\$800,000		Tester
DRUGS	Nevada National Guard Counter-Drug Program	\$4,000,000	Titus; Berkley	Reid
DRUGS	New Mexico National Guard Counter-Drug Program	\$4,800,000	Teague	Bingaman; Udall (NM)
DRUGS	North Carolina Counter-Drug Task Force	\$800,000	Jones (NC); Butterfield; Shuler	Hagan
DRUGS	Northeast Counter-Drug Training Center	\$4,500,000		Casey; Specter
DRUGS	Regional Counter-Drug Training Academy—Meridian	\$2,800,000	Harper	Cochran
DRUGS	Tennessee National Guard Appalachia High Intensity Drug Trafficking Area	\$4,000,000	Tanner; Davis (TN)	Alexander; Corker
DRUGS	West Virginia Counter-Drug Program	\$800,000		Byrd
DRUGS	Western Region Counter-Drug Training Center	\$2,500,000	Dicks; Baird; Larsen (WA); McDermott; Smith (WA)	Cantwell; Murray
GP	Alaska Territorial Guard			Begich; Murkowski
GP	Arrest Deterioration of Ford Island Aviation Control Tower, Pearl Harbor, HI	\$3,840,000	Abercrombie	
GP	Center for Military Recruitment, Assessment and Employment	\$3,000,000	Roskam	
GP	Edward M. Kennedy Institute for the Senate	\$18,900,000	Markey (MA)	Inouye; Kerry; Kirk
GP	Joint Venture Education Program	\$5,500,000		Inouye
GP	Marshall Legacy Institute	\$500,000	Murtha	
GP	National World War II Museum	\$20,000,000	Cao	Landrieu; Vitter
GP	New Jersey Technology Center	\$3,000,000	Holt; Pallone	Lautenberg; Menendez
GP	Our Military Kids	\$800,000	Connolly; Kennedy; Kilroy; Moran (VA); Ortiz	
GP	Paralympics Military Program	\$5,000,000	Kennedy; Langevin	Reed

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
GP	Riverside General Hospital, Houston, TX	\$1,000,000	Jackson-Lee (TX)	
GP	SOAR Virtual School District	\$6,000,000	Braley	Grassley, Harkin
GP	The Presidio Heritage Center	\$5,000,000	Pelosi	
GP	Training Range Upgrades			Murkowski
GP	U.S.S. Missouri Memorial Association	\$5,000,000		Inouye
GP	Vietnam Veterans Memorial Fund for De-mining Activities	\$1,000,000	Murtha	
GP	Women In Military Service for America Memorial	\$1,600,000	Richardson; Bordallo; Granger; Schakowsky	
ICMA	Language Mentorship Program incorporating an electronic portfolio	\$800,000	Boswell	
MILPERS, ANG	Joint Interagency Training and Education Center	\$1,000,000		Byrd
MILPERS, ARNG	Joint Interagency Training and Education Center	\$3,250,000		Byrd
MILPERS, ARNG	WMD Civil Support Team for Florida	\$1,200,000	Young (FL)	
MILPERS, ARNG	WMD Civil Support Team for New York	\$200,000	McMahon; Hall (NY); Hinchey	Gillibrand
OM,A	Air Battle Captain ROTC Helicopter Training	\$1,760,000	Pomeroy	Conrad; Dorgan
OM,A	Air-Supported Temper Tent	\$3,000,000	Rogers (KY)	
OM,A	Americans with Disabilities Act Compliance for the Historical Fort Hamilton Community Club	\$1,440,000	McMahon	Schumer
OM,A	Anti-Corrosion Nanotechnology Solutions for Logistics	\$800,000	Rahall	
OM,A	Army Command and General Staff College Leadership Training Program	\$2,000,000	Jenkins	Brownback; Roberts
OM,A	Army Conservation and Ecosystem Management	\$4,000,000		Inouye
OM,A	Army Force Generation Synchronization Tool	\$800,000	Dent; Bishop (UT); Dingell	Bennett; Casey; Levin; Specter; Stabenow
OM,A	Biometrics Operations Directorate Transition	\$1,600,000		Byrd
OM,A	Common Logistics Operating System	\$1,600,000	Bishop (GA)	
OM,A	Critical Language Instruction for Military Personnel, Education, Training and Distance Learning	\$2,400,000	Putnam	
OM,A	Defense—Fire Alarm / Detection System Installation for the Historical Fort Hamilton Community Club	\$400,000	McMahon	Schumer
OM,A	Defense Job Creation and Supply Chain Initiative	\$2,400,000	Posey; Brown, Corrine (FL)	
OM,A	Defense—Sprinkler System Installation for the Historical Fort Hamilton Community Club	\$960,000	McMahon	Schumer
OM,A	Desert Locust Laser Protective Lens	\$2,400,000		Leahy
OM,A	Diversity Recruitment for West Point Military Academy	\$800,000	Hall (NY)	Schumer
OM,A	Fort Benning National Incident Management System Compliant Installation Operations Center	\$4,000,000	Bishop (GA); Rogers (AL)	Chambliss
OM,A	Fort Bliss Data Center	\$1,360,000	Reyes	
OM,A	Fort Hood Training Lands Restoration and Maintenance	\$2,000,000	Carter; Edwards (TX)	
OM,A	Genocide Prevention Course through Combined Arms Center	\$1,280,000	Israel	Schumer
OM,A	Ground Combat System Knowledge Center and Technical Inspection Data Capture	\$1,000,000	Moran (VA)	
OM,A	Initiative to Increase Minority Participation In Defense	\$6,400,000	Fattah	
OM,A	IT and Information Management Upgrades, Fort Greely, AK	\$300,000		Murkowski
OM,A	Lightweight Tactical Utility Vehicles	\$3,600,000	Petri, Kissell	
OM,A	Logistics Interoperability	\$1,200,000	Rahall	

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
OM,A	Modular Command Post Tent	\$4,800,000	Rogers (KY)	
OM,A	Net-Centric Decision Support Environment Sense and Respond Logistics	\$2,000,000	Bishop (GA)	
OM,A	Online Technology Training Program at Joint Base Lewis-McChord	\$1,600,000	Dicks	
OM,A	Operational/Technical Training Validation for Joint Maneuver Forces at Fort Bliss	\$800,000	Reyes	
OM,A	Post Security Enhancements, Fort Greely, AK	\$800,000		Murkowski
OM,A	Repair Heating, Ventilation, Air Conditioning System in National Simulations Center	\$1,428,000	Jenkins	
OM,A	Rock Island Arsenal Building 299 Roof Replacement	\$5,800,000	Braley	Grassley; Harkin
OM,A	ROTC and Reserve Component Strategic Language Hub Pilot	\$1,200,000	Deal, Marshall	
OM,A	Rule of Law	\$500,000		Graham
OM,A	Transformation of ISO Containers to Smart Containers	\$3,300,000		Burr
OM,A	TRANSIM Driver Training	\$3,500,000	Kingston; Bishop (UT); Mathe- son	
OM,A	UH-60 Leak Proof Drip Pans	\$2,500,000	Rogers (KY)	
OM,A	US Army ROTC Emergency Facility Renovation	\$935,000	Posey	
OM,AF	Advanced Autonomous Robotic Inspections for Aging Aircraft	\$800,000	Cole; Fallin	
OM,AF	Air Education and Training Command Range Improvements at the Barry M. Goldwater Range	\$1,200,000	Giffords; Franks (AZ); Grijalva; Pastor (AZ)	
OM,AF	Air Force Academy Space and Defense Studies Research and Curriculum Development	\$300,000		Bennet; Udall (CO)
OM,AF	Alaska Joint Command and Control Infrastructure and Physical Security	\$1,560,000		Murkowski
OM,AF	Defense Critical Languages and Cultures Initiative	\$3,000,000	Conaway	Cornyn; Hutchison
OM,AF	Demonstration Project for Contractors Employing Persons with Disabilities	\$3,200,000	Tiahrt	Brownback
OM,AF	Diversity Recruitment for Air Force Academy	\$550,000	Becerra	
OM,AF	Expert Knowledge Transformation Project	\$1,600,000	Gonzalez	
OM,AF	Joint Aircrew Combined System Tester (JCAST)	\$1,600,000	Biggert	
OM,AF	Joint Pacific Alaska Range Complex (JPARC) Enhancements	\$6,900,000		Murkowski
OM,AF	MacDill Air Force Base Online Technology Program	\$800,000	Castor (FL)	
OM,AF	Military Medical Training and Disaster Response Program	\$1,600,000	Mitchell	
OM,AF	Minority Aviation Training Program	\$1,000,000	Meek (FL)	
OM,AF	Mission Essential Airfield Operations Equipment	\$931,000		Reid
OM,AF	National Center for Integrated Civilian-Military Domestic Disaster Medical Response	\$3,200,000	DeLauro	Dodd; Lieberman
OM,AF	USAF Engine Trailer Life Extension Program	\$2,400,000		Reid
OM,AF	Wage Issue Modification for USFORAZORES Portuguese National Employees	\$240,000	Frank (MA)	
OM,AF	Warner Robins Air Logistics Center Strategic Airlift Aircraft Availability Improvement	\$3,200,000	Kingston; Marshall	Isakson
OM,ANG	190th Air Refueling Wing Squadron Operations Facility	\$6,600,000	Jenkins	Brownback
OM,ANG	Controlled Humidity Protection for McEntire Joint National Guard Base (SCANG Facilities)	\$2,160,000	Wilson (SC)	Graham
OM,ANG	Critical Infrastructure Interdependencies Vulnerabilities Assessment (CIIVA) Program	\$2,000,000		Murray
OM,ANG	Facility Renovations and Retrofit, 168th Air Refueling Wing	\$1,300,000		Murkowski
OM,ANG	Force Protection and Training Equipment	\$465,000	Graves	
OM,ANG	Joint Interagency Training and Education Center	\$150,000		Byrd
OM,ANG	Joint Interoperability Coordinated Operations and Training Exercise	\$515,000	Kingston	

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
OM,ANG	Smoky Hill Range Access Road Improvements	\$800,000	Moran (KS)	Brownback
OM,AR	Nevada National Guard Joint Operations Center	\$800,000	Heller	Reid
OM,ARNG	Advanced Law Enforcement Rapid Response Training	\$800,000	Doggett	
OM,ARNG	Advanced Trauma Training Course for the Illinois National Guard	\$2,000,000	Davis (IL); Jackson (IL)	Burris
OM,ARNG	Army National Guard M939A2 Repower Program	\$4,000,000	Carter	
OM,ARNG	Army National Guard Unit History Records	\$4,000,000		Bennett
OM,ARNG	ARNG Battery Modernization Program	\$1,600,000		Bond
OM,ARNG	Camp Ethan Allen Training Site Road Equipment	\$300,000	Welch	Leahy; Sanders
OM,ARNG	CID Equipment	\$449,000	Cuellar	
OM,ARNG	Colorado National Guard Reintegration Program	\$1,000,000		Bennet; Udall (CO)
OM,ARNG	Florida Army National Guard Future Soldier Trainer	\$2,400,000	Meek (FL)	
OM,ARNG	Full Cycle Deployment Support Pilot Program	\$3,200,000	Hodes; Shea-Porter	Gregg; Shaheen
OM,ARNG	High-Mobility Multipurpose Wheeled Vehicle Repair	\$20,000,000		Collins; Snowe
OM,ARNG	Joint Command Vehicle and Supporting C3 System	\$1,800,000	Shea-Porter; Hodes	
OM,ARNG	Joint Interagency Training and Education Center	\$5,600,000		Byrd
OM,ARNG	Marksmanship Skills Trainer	\$2,000,000	Conaway; Ortiz	Cornyn
OM,ARNG	Minnesota National Guard Beyond the Yellow Ribbon Reintegration Program	\$2,000,000	Walz; Ellison; Oberstar; Paulsen; Peterson	Klobuchar
OM,ARNG	Multi-Jurisdictional Counter-Drug Task Force Training	\$2,800,000	Young (FL)	
OM,ARNG	National Guard and First Responder Resiliency Training	\$1,500,000		Brownback
OM,ARNG	National Guard Civil Support Team / CBRNE Enhanced Response Force Package	\$1,200,000	Dicks; Hastings (WA)	
OM,ARNG	North Carolina National Guard Family Assistance Centers	\$1,280,000	Butterfield; Etheridge; McIntyre; Miller (NC); Price (NC); Shuler; Watt	Burr; Hagan
OM,ARNG	Oregon National Guard Reintegration Program	\$960,000	Schrader	Merkley; Wyden
OM,ARNG	Re-establishing Ties: The Road from Warrior to the Community	\$3,000,000	Adler; Smith (NJ)	Lautenberg; Menendez
OM,ARNG	Regional Geospatial Service Centers	\$2,000,000	Gohmert	Hutchison
OM,ARNG	Repair of Military Asset Storage Facilities	\$2,300,000		Byrd
OM,ARNG	Supplemental Child Care Support for Families of Deployed Vermont Reserve Component	\$1,600,000		Sanders
OM,ARNG	Tools for Maintenance Conversion	\$1,600,000		Burris
OM,ARNG	Training Aid Suite for Vermont NG Training Sites	\$1,046,400	Welch	Sanders
OM,ARNG	UH-60 Leak Proof Drip Pans	\$2,000,000	Rogers (KY)	
OM,ARNG	Vermont Army National Guard Security Upgrades	\$744,000	Welch	Leahy; Sanders
OM,ARNG	Vermont National Guard Family Assistance Centers	\$500,000		Sanders
OM,ARNG	Vermont Service Member, Veteran, and Family Member Outreach, Readiness, and Reintegration Program	\$2,400,000		Leahy; Sanders
OM,ARNG	WMD Civil Support Team for Florida	\$2,000,000	Young (FL)	
OM,ARNG	WMD Civil Support Team for New York	\$500,000	McMahon; Hinchey	Schumer
OM,ARNG	WMD Multi-Sensor Response and Infrastructure Project System	\$1,600,000	Fallin	
OM,DW	Almaden AFS Environmental Assessment and Remediation	\$3,200,000	Honda; Lofgren	Boxer; Feinstein
OM,DW	Armed Forces Health and Food Supply Research	\$800,000		Roberts

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
OM,DW	Castner Range Conservation Conveyance Study	\$300,000	Reyes	
OM,DW	Centerville Naval Housing Transfer	\$4,800,000	Thompson (CA)	
OM,DW	Counter Threat Finance—Global	\$1,600,000	Ryan (OH)	
OM,DW	Critical Language Training	\$1,600,000	Davis (CA)	
OM,DW	Defense-Critical Languages and Cultures Program	\$2,000,000	Rehberg	Baucus; Tester
OM,DW	Drydock #1 Remediation and Disposal	\$3,000,000	Pelosi	
OM,DW	Eliminate Public Safety Hazards	\$1,072,000	Slaughter	Schumer
OM,DW	George AFB (New and Existing Infrastructure Improvements)	\$1,000,000	McKeon	
OM,DW	Hunters Point Naval Shipyard Remediation	\$9,000,000	Pelosi	
OM,DW	McClellan AFB Infrastructure Improvements	\$800,000	Matsui	Boxer
OM,DW	Middle East Regional Security Program	\$2,400,000	Berman	
OM,DW	Military Intelligence Service Historic Learning Center	\$1,000,000	Pelosi	
OM,DW	MS GIS Educational and Research Program	\$1,000,000	Lewis (CA)	
OM,DW	Naval Station Ingleside Redevelopment	\$1,000,000	Ortiz	Hutchison
OM,DW	Norton AFB (New and Existing Infrastructure Improvements)	\$4,800,000	Lewis (CA)	
OM,DW	NSW Protective Combat Uniform	\$2,500,000	Granger	
OM,DW	Phase I of Berth N-2 Reconstruction of MOTBY Ship Repair Facility	\$3,600,000	Sires	Lautenberg; Menendez
OM,DW	Remediation of Jet Fuel Contamination at Floyd Bennett Field	\$2,400,000	Weiner	Schumer
OM,DW	Soldier Center at Patriot Park, Ft. Benning	\$4,000,000	Bishop (GA)	
OM,DW	Special Operations Forces Modular Glove System	\$4,780,000	Kratovil; Baird; Castle; McDermott	Carper; Kaufman; Mikulski; Murray; Reed
OM,DW	Strategic Language Initiative	\$2,880,000	Richardson; Royce; Watson	Boxer
OM,DW	Thorium / Magnesium Excavation—Blue Island	\$1,600,000	Jackson (IL)	
OM,DW	Translation and Interpretation Skills for DoD	\$1,600,000	Farr	
OM,MC	Family of Shelters and Tents	\$1,600,000		Warner; Webb
OM,MC	Flame Resistant High Performance Apparel	\$1,200,000	Kissell	Burr; Hagan
OM,MC	Hemostatic Combat Gauze	\$800,000	DeLauro	Dodd; Lieberman
OM,MC	MGPTS Type III or Rapid Deployable Shelter	\$2,400,000	Hinchey	Schumer
OM,MC	Rapid Data Management System	\$2,500,000		Gregg
OM,MC	Spray Technique Analysis and Research for Defense (STAR4D)	\$2,200,000	Braley	Grassley; Harkin
OM,MC	Ultra Lightweight Camouflage Net System (ULCANS)	\$2,800,000	Etheridge; Coble	Burr; Hagan
OM,N	ATIS Maintenance and Enhancement Program	\$800,000	Rahall	
OM,N	Brown Tree Snake Program	\$500,000	Bordallo	
OM,N	Center for Defense Technology and Education for the Military Services (CDTEMS)	\$5,600,000	Farr	
OM,N	Continuing Education—Distance Learning at Military Installations	\$1,600,000	Brown-Waite, Ginny (FL)	
OM,N	Digitization, Integration, and Analyst Access of Investigative Files, Naval Criminal Investigative Services	\$4,000,000		Byrd
OM,N	Diversity Recruitment for Naval Academy	\$800,000	Becerra	
OM,N	Energy Education and Training for Military Personnel	\$500,000	Pomeroy	Conrad; Dorgan
OM,N	Enhanced Navy Shore Readiness Integration	\$4,000,000	Dicks	

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
OM,N	Fleet Readiness Data Assessment	\$1,920,000	Calvert	
OM,N	Institute for Threat Reduction and Response—Simulated and Virtual Training Environments	\$960,000	Brown, Corrine (FL)	
OM,N	Mk 45 Mod 5 Gun Depot Overhauls	\$12,000,000		McConnell
OM,N	Naval Strike Air Warfare Center OEF/OIF training (Terminal Attack Control)	\$800,000		Reid
OM,N	Navy Ship Disposal—Carrier Demonstration Project	\$2,400,000	Ortiz	
OM,N	Puget Sound Naval Maintenance and Repair Process Improvements	\$1,680,000	Dicks	Cantwell
OM,N	Puget Sound Navy Museum	\$600,000	Dicks	
OM,NR	Developing and Testing Environmentally Safe Decontaminating Agents for Bio-defense, Biomedical, and Environmental Use	\$1,200,000	Diaz-Balart, Mario (FL)	
OP,A	Call for Fire Trainer II/Joint Fires and Effects Trainer System	\$5,000,000	Cole	Inhofe
OP,A	Combat Casualty Care Upgrade Program	\$2,400,000	Barrett	Graham
OP,A	Combat Skills Marksmanship Trainer	\$4,000,000	Kingston; Gingrey (GA)	Chambliss; Isakson
OP,A	Combined Arms Virtual Trainers for the New Mexico National Guard	\$400,000	Lujan	
OP,A	Combined Arms Virtual Trainers for the Tennessee National Guard	\$5,000,000	Davis (TN); Wamp; Duncan	Alexander
OP,A	Communications Aerial Platforms for Increased Situational Awareness for the Minnesota National Guard	\$1,888,000	Paulsen; Oberstar; Walz	Klobuchar
OP,A	Expandable Light Air Mobility Shelters (ELAMS) and Contingency Response Communications System (CRCS)—Illinois National Guard (ILNG)	\$1,600,000		Levin; Stabenow
OP,A	FIDO Explosives Detector	\$3,000,000	Fallin	Inhofe
OP,A	Fifth-Wheel Towing Devices for the Puerto Rico Army National Guard	\$560,000	Pierluisi	
OP,A	Fort Bragg Range 74 Combined Arms Collective Training Facility	\$800,000	Kissell	Hagan
OP,A	HMMWV Egress Assistance Trainer for the Tennessee National Guard	\$160,000		Corker
OP,A	Immersive Group Simulation Virtual Training System for the Hawaii National Guard	\$2,300,000	Abercrombie	Akaka
OP,A	Individual Gunnery; Tank Gunnery; and Tabletop Full-Fidelity Trainers for the New Mexico National Guard	\$1,600,000	Lujan	
OP,A	Kentucky National Guard Emergency Response Generator Stockpile	\$4,800,000	Rogers (KY)	
OP,A	Laser Marksmanship Training System	\$2,000,000	Kennedy	Reed
OP,A	Life Support for Trauma and Transport	\$800,000	Sanchez, Loretta (CA); Reyes	
OP,A	Machine Gun Training System for the Pennsylvania National Guard	\$2,400,000	Holden	
OP,A	Magneto Inductive Remote Activation Munitions System (MI—RAMS) M156/M39 Kits and M40 Receivers	\$7,200,000	Lewis (CA)	
OP,A	Mine Resistant Ambush Protected Vehicle Virtual Trainers for the Illinois National Guard	\$6,400,000	Hare	Durbin
OP,A	Mine Resistant Ambush Protected Vehicle Virtual Trainers for the Tennessee National Guard	\$5,000,000	Davis (TN); Duncan; Tanner	Alexander; Corker
OP,A	Mobile Defensive Fighting Position	\$1,600,000	Maffei	Schumer
OP,A	Mobile Firing Range for the Texas National Guard	\$1,500,000	Conaway; Granger	
OP,A	Multi-Temperature Refrigerated Container System	\$2,800,000	Davis (KY)	
OP,A	Muscatatuck Urban Training Center Instrumentation for the National Guard	\$2,000,000	Ellsworth	Lugar
OP,A	Phoenix Quad-Band Satellite Receiver for the Delaware National Guard	\$3,200,000		Carper; Kaufman
OP,A	Radio Personality Modules for SINCGARS Test Sets	\$3,000,000	Tiahrt	Brownback
OP,A	Red River Army Depot Modernization	\$1,600,000		Bond
OP,A	Regional Emergency Response Network Emergency Cell Phone Capability	\$4,000,000	Hastings (FL); Stearns; Brown, Corrine (FL); Young (FL)	Nelson (FL)

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
OP,A	Reinforcement HMMWV Repair Hood Kits	\$800,000		Merkley; Wyden
OP,A	Tactical Operations Center for the Washington National Guard	\$1,840,000	Reichert, Baird, McDermott	Cantwell; Murray
OP,A	Tactical/Crew Served Weapon Illumination Systems	\$2,400,000		Ensign; Reid
OP,A	Ultra Light Utility Vehicles for the National Guard	\$4,480,000	Obey	Harkin; Klobuchar
OP,A	US Army Operator Driving Simulator for the Tennessee National Guard	\$280,000		Corker; Levin
OP,A	Virtual Convoy Operations Trainer for the New Mexico National Guard	\$1,200,000	Lujan	
OP,A	Virtual Convoy Operations Trainers for the Illinois National Guard	\$2,400,000	Hare	Durbin
OP,A	Virtual Interactive Combat Environment for the New Jersey National Guard	\$3,500,000	Rothman	Lautenberg; Menendez
OP,A	Virtual Interactive Combat Environment Training System for the Virginia National Guard	\$2,000,000	Connolly; Moran (VA)	Warner; Webb
OP,AF	Air National Guard Joint Threat Emitter—Savannah Combat Readiness Training Centers	\$800,000	Lee (NY)	Schumer
OP,AF	Aircrew Body Armor and Load Carriage Vest System	\$2,400,000	Akin	Bond
OP,AF	Eagle Vision for the Hawaii Air National Guard	\$2,400,000		Inouye
OP,AF	Eagle Vision III	\$4,800,000	Bilbray; Davis (CA)	
OP,AF	Eagle Vision Program	\$1,500,000	Clyburn; Wilson (SC)	
OP,AF	Joint Pacific Alaska Range Complex (JPARC) Enhancements	\$12,680,000		Murkowski
OP,AF	Joint Threat Emitters	\$4,000,000	Kingston	
OP,AF	Mission Essential Airfield Operations Equipment	\$916,000		Reid
OP,AF	Mission Essential Airfield Operations Equipment	\$1,139,000		Reid
OP,AF	One AF/One Network Infrastructure	\$1,600,000	Olson; Rothman	
OP,AF	One AF/One Network Infrastructure for the Pennsylvania National Guard	\$1,600,000	Schwartz	
OP,AF	Unmanned Threat Emitters (UMTE) Modernization	\$2,400,000		Reid
OP,N	Adaptive Diagnostic Electronic Portable Testset	\$1,000,000	Young (FL)	Nelson (FL)
OP,N	Advanced Mission Extender Device Kits	\$1,600,000		Leahy
OP,N	AN/BLQ-10A(V) Wideband Signal Processor	\$3,000,000	Marshall	Chambliss
OP,N	AN/USQ-167 COMSEC Upgrade	\$800,000	Filner	
OP,N	Canned Lube Pumps LHD-1 Class	\$800,000	Kissell	Burr
OP,N	Deployable Joint Command and Control Shelter Upgrade Program	\$2,400,000	Salazar	Bingaman; Udall (NM)
OP,N	Dive Boats	\$2,000,000		Burr
OP,N	Enhanced Detection Adjunct Processor	\$3,200,000	Kaptur	Brown
OP,N	Force Protection Boats (Small)	\$2,000,000	Melancon	Landrieu; Vitter
OP,N	Fuel Oil Barge (YON)	\$4,200,000	Brown (SC)	Graham
OP,N	Hawaiian Range Complex	\$1,600,000		Inouye
OP,N	Hydroacoustic Low Frequency Source Generation Systems	\$1,600,000	Massa; Lee (NY)	Schumer
OP,N	Intelligraf Training and Maintenance Aid for Above Water Sensors	\$2,000,000		Murray
OP,N	LCS-1 Waterjet Spares	\$3,200,000	Lynch	Kerry; Kirk
OP,N	LSD-41/49 Diesel Engine Low Load Upgrade Kit	\$1,600,000	Baldwin	Kohl
OP,N	Multi-Climate Protection System	\$6,400,000	Rogers (MI); Hodes, Shea-Porter; Tsongas	Gregg; Kerry; Kirk; Levin; Shaheen; Stabenow
OP,N	Navy AIT Logistics Modernization	\$3,200,000	Kagen; Larsen (WA); Loeb sack	Grassley; Harkin; Murray; Reed; Whitehouse

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
OP,N	Pearl Harbor Navy Shipyard Equipment Modernization	\$4,200,000		Inouye
OP,N	Radar Product Support System	\$2,400,000		Dodd
OP,N	RAM Mark 49 Mod 3 Launcher Obsolescence/Affordability	\$1,000,000		McConnell
OP,N	Remote Monitoring and Troubleshooting Project	\$2,320,000	Aderholt	Sessions; Shelby
OP,N	Secure Remote Monitoring Systems	\$1,600,000	Moran (VA)	
OP,N	Smart Valve Automatic Fire Suppression System	\$2,480,000		Collins; Snowe
OP,N	SPAWAR Systems Center (SSC/ITC) New Orleans	\$6,000,000	Cao; Scalise	Landrieu; Vitter
OP,N	TB-33 Thinline Towed Array	\$4,000,000		Dodd; Lieberman; Reed; Whitehouse
P,DW	AN/PRC-148 MBITR/JTRS Enhanced MBITR	\$4,000,000		Mikulski
P,DW	Chemical and Biological Protective Shelter	\$5,000,000	Bartlett; Kratovil; Ruppersberger	Mikulski
P,DW	Expansion of the Forensic Intelligence Technologies and Training Support Center of Excellence	\$1,600,000	Young (FL)	
P,DW	Fusion Goggle System	\$2,400,000		Gregg
P,DW	Intelligence Broadcast Receiver for AFSOC MC-130	\$800,000	Miller (FL)	
P,DW	Light Mobility Vehicle—Internally Transportable Vehicle	\$1,600,000	Waters	
P,DW	M4 Weapons Shot Counter	\$3,400,000		McConnell
P,DW	Mission Helmet Recording System	\$5,200,000	Shea-Porter	Collins; Gregg; Snowe
P,DW	MK47 Mod 0 Advanced Lightweight Grenade Launcher	\$6,000,000	Michaud; Pingree (ME)	Collins; Snowe
P,DW	Overt Small Laser Marker	\$1,600,000		Gregg
P,DW	Reactive Skin Decontamination Lotion	\$4,480,000		Cochran
P,DW	Small Arms Training Ranges	\$2,000,000		Ensign; Reid
P,DW	SOPMOD II (M4 Carbine Rail System)	\$2,000,000	Kingston	
P,DW	SOVAS-Hand Held Imager/Long Range	\$4,000,000	Rehberg	Baucus; Kerry; Kirk; Tester
P,DW	Special Operations Craft—Riverine	\$5,000,000		Cochran; Wicker
P,DW	Special Operations Forces Combat Assault Rifle	\$2,000,000	Wilson (SC)	Graham
P,DW	Special Operations High Performance In-Line Sniper Scope	\$2,400,000	Tsongas	Kerry; Kirk
P,DW	Special Operations Live Rehearsal System	\$1,600,000		Nelson (FL)
P,MC	Marine Corps MK 1077 Flatracks	\$2,400,000	Aderholt	
P,MC	Microclimate Cooling Unit for M1 Abrams Tank	\$800,000	Lee (NY); Higgins	Schumer
P,MC	Nitrile Rubber Collapsible Fuel Bladders	\$3,100,000		Cochran
P,MC	On Board Vehicle Power Kits for USMC MTRV Trucks	\$9,000,000		Kohl
P,MC	Portable Armored Wall System	\$1,000,000	Adler; Bishop (UT)	
P,MC	Portable Military Radio Communications Test Set	\$1,200,000	Tiahrt	Roberts
PA,A	40mm Tactical All Types Mortar Round	\$4,000,000		Alexander
PA,A	Ammunition Production Base Support (Scranton Army Ammunition Plant)	\$2,800,000	Kanjorski; Carney	Casey; Specter
PA,A	Blue Grass Army Depot Equipment	\$2,400,000	Chandler	
PA,A	Blue Grass Army Depot Supercritical Water Oxidation—Conventional Demil	\$3,920,000	Rogers (KY)	Bunning
PA,A	CTG, Arty, 155mm, Illum	\$7,200,000		Lincoln; Pryor
PA,A	CTG, Mortar, 120MM, Illum	\$4,200,000	Ross	Lincoln; Pryor

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
PA,A	M721 60mm Illuminating Mortar	\$1,600,000	Ross	Lincoln; Pryor
PA,A	M722 60mm White Phosphorus Smoke Mortar	\$1,600,000	Ross	Lincoln; Pryor
PA,A	Small Caliber Ammunition Production Modernization	\$4,000,000	Graves; Cleaver	
PA,AF	MCAAP Bomb Line Modernization	\$2,400,000	Boren	Inhofe
PANMC	Enhanced Laser Guided Training Round	\$3,600,000	Carney	
RDTE,A	Compact Airborne Mui-Mission Payload (CAMP)	\$1,600,000		Bond
RDTE,A	101st Airborne / Air Assault Injury Prevention and Performance Enhancement Initiative	\$3,000,000		Corker; Specter
RDTE,A	30-kW Auxiliary Power Unit for Armored Combat Vehicles	\$1,600,000		Nelson (FL)
RDTE,A	3D Woven Preform Technology for Army Munitions Applications	\$1,600,000	Kennedy	Reed; Whitehouse
RDTE,A	4th Generation Wireless Exploitation	\$2,400,000	Hodes	Gregg
RDTE,A	5.56mm Aluminum Cartridge Case	\$1,600,000		Crapo; Risch
RDTE,A	Academic Support and Research Compliance for Knowledge Gathering	\$2,000,000		Roberts
RDTE,A	Accelerated Materials Development for Army Cannon Systems	\$2,400,000	Herseth Sandlin	Johnson
RDTE,A	Achieving Lightweight Casting Solutions	\$1,600,000	Schock	Burris
RDTE,A	Acid Alkaline Direct Methanol Fuel Cell	\$1,600,000	McIntyre	Hagan
RDTE,A	Acoustic Gun Detection System for Tracked Combat Vehicles	\$1,600,000	Capuano	Kerry; Kirk
RDTE,A	Adaptive Lightweight Materials Technology for Missile Defense	\$3,200,000	Rehberg	Baucus; Tester
RDTE,A	Adaptive Robotics Technology for Space, Air, and Missiles (ART-SAM)	\$3,360,000	Aderholt; Rogers (AL)	Sessions
RDTE,A	Advanced Affordable Turbine Engine Program	\$4,000,000	Larson (CT); Courtney; DeLauro; Pastor (AZ)	Dodd; Lieberman
RDTE,A	Advanced Battery Development Program	\$9,000,000		Levin
RDTE,A	Advanced Battery Materials and Manufacturing	\$4,000,000	Halvorson, Biggert	
RDTE,A	Advanced Bio-Engineering for Enhancement of Soldier Survivability	\$2,500,000	Johnson (GA); Bishop (GA); Gingrey (GA); Kingston; Lewis (GA); Scott (GA)	Chambliss; Isakson
RDTE,A	Advanced Bonded Diamond for Optical Applications	\$2,000,000	Kingston	Chambliss
RDTE,A	Advanced Cancer Genome Institute	\$2,000,000	Higgins; Lee (NY); Slaughter	Schumer
RDTE,A	Advanced Carbon Hybrid Battery for Hybrid Electric Vehicles	\$800,000	Bishop (GA)	Chambliss
RDTE,A	Advanced Cavitation Power Technology	\$3,840,000		Cochran
RDTE,A	Advanced Commercial Technology Insertion	\$3,100,000		Sessions; Shelby
RDTE,A	Advanced Communications for Mobile Networks	\$3,200,000	Mollohan	
RDTE,A	Advanced Composite Ammunition Magazine / Mount System	\$1,600,000	Obey	
RDTE,A	Advanced Composite Armor for Force Protection	\$1,600,000	Coble	
RDTE,A	Advanced Composite Materials Research for Land, Marine, and Air Vehicles	\$2,800,000	Rogers (MI)	Levin; Stabenow
RDTE,A	Advanced Composite Research for Vehicles	\$4,000,000	Kilpatrick	Levin
RDTE,A	Advanced Composites for Light Weight, Low Cost Transportation Systems using a 3+ Ring Extruder	\$2,400,000	Stupak	Levin
RDTE,A	Advanced Conductivity Program	\$1,000,000	Young (FL)	
RDTE,A	Advanced Corrosion Protection for Military Vehicles and Equipment	\$2,400,000		Kohl
RDTE,A	Advanced Demining Technology	\$4,720,000		Leahy
RDTE,A	Advanced Detection of Explosives	\$1,600,000	Young (FL)	

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	Advanced Diagnostic and Therapeutic Digital Technologies	\$1,600,000	Capuano; Cummings; Watson	Kerry
RDTE,A	Advanced Digital Hydraulic Drive System	\$2,000,000	Upton	Grassley; Klobuchar; Levin; Stabenow
RDTE,A	Advanced Electronics Rosebud Integration	\$3,000,000	Hereth Sandlin	Johnson; Thune
RDTE,A	Advanced Environmental Control Systems	\$1,600,000		Reid
RDTE,A	Advanced Field Artillery Tactical Data System	\$3,600,000	Souder	
RDTE,A	Advanced Flexible Solar Photovoltaic Technologies	\$2,400,000	Obey	
RDTE,A	Advanced Fuel Cell Research Program	\$3,200,000	Poe	Cornyn; Hutchison
RDTE,A	Advanced Functional Nanomaterials for Biological Processes	\$2,400,000	Snyder	Lincoln; Pryor
RDTE,A	Advanced Ground EW and Signals Intelligence System	\$2,000,000	Larsen (WA); Smith (WA)	Murray
RDTE,A	Advanced Hybrid Chemistry for Portable Power	\$2,560,000		Brownback; Roberts
RDTE,A	Advanced Lightweight Gunner Protection Kit for Lightweight MRAP Vehicle	\$800,000	Altmire	
RDTE,A	Advanced Lightweight Multifunctional Multi-Threat Composite Armor Material Technology	\$2,400,000	Rangel	Schumer
RDTE,A	Advanced Lithium Ion Phosphate Battery System for Army Combat Hybrid HMMWV and Other Army Vehicle Platforms	\$2,400,000	Dingell	Levin; Stabenow
RDTE,A	Advanced Live, Virtual, and Constructive Training Systems	\$2,800,000	Latham	Grassley; Harkin
RDTE,A	Advanced Lower Limb Prostheses for Battlefield Amputees	\$3,200,000	Markey (MA); McGovern	Kerry; Kirk
RDTE,A	Advanced Materials and Process for Armament Structures (AMPAS)	\$3,200,000	Sutton	Brown
RDTE,A	Advanced Military Wound Healing Research and Treatment	\$800,000	Lee (NY)	Schumer
RDTE,A	Advanced Nanocomposite Materials for Lightweight Integrated Armor Systems	\$1,600,000	Ryan (OH)	
RDTE,A	Advanced Packaging Materials for Combat Rations	\$800,000	Gingrey (GA)	Chambliss; Isakson
RDTE,A	Advanced Polymer Systems for Defense Application—Power Generation, Protection and Sensing	\$2,400,000	Emerson	
RDTE,A	Advanced Power Generation Unit for Military Applications	\$650,000	Roskam	
RDTE,A	Advanced Power Source for Future Soldiers	\$1,200,000	Carson	Lugar
RDTE,A	Advanced Power Technologies for Nano-Satellites	\$1,600,000	Rogers (KY)	
RDTE,A	Advanced Radar Transceiver Integrated Circuit Development	\$800,000	Harman	
RDTE,A	Advanced Rarefaction Weapon Engineered System	\$3,200,000	Kaptur	
RDTE,A	Advanced Reactive Armor Systems	\$1,600,000	Hinchey	Schumer
RDTE,A	Advanced Regenerative Medicine Therapies for Combat Injuries	\$3,200,000	Doyle	Casey; Specter
RDTE,A	Advanced Robot and Sensor Technology for Surveillance and Energy Efficiency Applications	\$1,200,000	Hereth Sandlin	Johnson
RDTE,A	Advanced Soldier-Portable Power Systems Technologies	\$2,480,000	Childers	Cochran; Wicker
RDTE,A	Advanced Suspension System for Heavy Vehicles	\$2,160,000		Reid
RDTE,A	Advanced Tactical Fuels for the US Military	\$3,200,000	Pomeroy	Conrad; Dorgan
RDTE,A	Advanced Tactical Laser Flashlight	\$800,000	Kilpatrick	Levin; Stabenow
RDTE,A	Advanced Technology for Energy Storage	\$1,600,000	Visclosky	
RDTE,A	Advanced Technology, Energy Manufacturing Sciences	\$7,000,000	Frelinghuysen	
RDTE,A	Advanced Thermal Management System	\$2,400,000	Stupak	Levin; Stabenow
RDTE,A	Advanced UV Light Diode Development	\$800,000		Graham
RDTE,A	Advanced Wearable Power System Manufacturing	\$1,600,000		Tester

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	Advanced Composite Nickel-Manganese-Cobalt and other Lithium Ion Battery Technologies using Nano Crystal Scission Process	\$2,400,000	Hinchey	Schumer
RDTE,A	Advancement of Bloodless Medicine	\$1,492,800	Rothman	Lautenberg; Menendez
RDTE,A	Affordable Light-Weight Metal Matrix Composite (MMC) Armor	\$2,500,000		Ensign; Reid
RDTE,A	Aging and Battle Damaged Weapon Systems Repair	\$1,200,000	Herseth Sandlin	Johnson; Thune
RDTE,A	Air Drop Mortar Guided Munition for the Tactical UAV	\$2,400,000	Hastings (WA)	
RDTE,A	Alginate Oligomers to Treat Infectious Microbial Biofilms	\$1,600,000	Kilroy	
RDTE,A	All Composite Bus Program	\$2,000,000	Kennedy	
RDTE,A	All Composite Lightweight Military Vehicle	\$1,600,000		Reed
RDTE,A	Alliance for Nanohealth	\$4,000,000	Culberson	
RDTE,A	ALS Therapy Development Institute—Gulf War Illness Research Project	\$1,600,000	Capuano; Brown (SC)	Kerry
RDTE,A	Alternative Power Technology for Missile Defense	\$3,200,000	Herseth Sandlin	Johnson; Thune
RDTE,A	Aluminum Armor Project	\$840,000	Capito	
RDTE,A	Amorphous Si Flexible Photovoltaics for Grid Parity	\$1,600,000		Levin
RDTE,A	AN / ALQ 211 Networked EW Controller	\$800,000	Pascrell	Lautenberg; Menendez
RDTE,A	Antennas for Unmanned Aerial Vehicles	\$1,000,000	Bonner	
RDTE,A	Antiballistic Windshield Armor	\$2,400,000		Lugar
RDTE,A	Anti-Microbial Bone Graft Product	\$1,600,000	Crenshaw; Stearns	Nelson (FL)
RDTE,A	Antioxidant Micronutrient Therapeutic Countermeasures	\$800,000	McCarthy (NY)	
RDTE,A	Anti-Tamper Research and Development	\$3,040,000	Alexander	Landrieu; Vitter
RDTE,A	Applied Communication and Information Networking	\$3,040,000	Andrews; LoBiondo	Lautenberg; Menendez
RDTE,A	ARL 3D Model-Based Inspection and Scanning	\$2,400,000	Ryan (OH)	
RDTE,A	ARL-ONAMI Center for Nanoarchitectures for Enhanced Performance	\$800,000		Merkley; Wyden
RDTE,A	Armament System Engineering and Integration Initiative	\$1,600,000	Frelinghuysen; Sires	
RDTE,A	Armaments Academy	\$3,000,000	Frelinghuysen	
RDTE,A	Army Asset Visibility Enhancement	\$800,000	Berkley	Reid
RDTE,A	Army Center of Excellence in Acoustics, National Center for Physical Acoustics	\$4,000,000	Childers	Cochran; Wicker
RDTE,A	Army Material Degradation	\$640,000		Conrad; Dorgan
RDTE,A	Army Portable Oxygen Concentration System	\$1,200,000	Moran (VA)	
RDTE,A	Army Range Technology Program (ARTP)	\$4,880,000		Cochran
RDTE,A	Army Responsive Tactical Space System Exerciser	\$3,000,000	Aderholt	Sessions; Shelby
RDTE,A	Army Vehicle Condition Based Maintenance	\$4,000,000	Murtha	
RDTE,A	Army / Joint STARS Surveillance and Control Data Link Technology Refresh	\$800,000	Davis (CA)	
RDTE,A	Asymmetric Threat Response and Analysis Project	\$2,000,000	Giffords	
RDTE,A	Atomized Magnesium Domestic Production Design and Development	\$1,600,000	Kaptur	
RDTE,A	Automated Communications Support Systems for WARFIGHTERS, Intelligence Community, Linguists, and Analysts	\$1,500,000		Chambliss; Isakson
RDTE,A	Automated Portable Field System for Rapid Detection and Diagnosis of Endemic Diseases and Other Pathogens	\$1,600,000	Massa	Schumer
RDTE,A	Automotive Technology Tactical Metal Fabrication System	\$2,500,000	Clyburn; Brown (SC)	

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	Automotive Tribology Center	\$1,600,000	Peters	Levin; Stabenow
RDTE,A	Autonomous Cargo Acquisition for Rotorcraft Unmanned Aerial Vehicles	\$1,280,000	Aderholt	Shelby
RDTE,A	Autonomous Sustainment Cargo Container	\$1,200,000	Bartlett	
RDTE,A	Ballistic Armor Research	\$3,200,000	Dent	Specter
RDTE,A	Battlefield Exercise and Combat Related Spinal Cord Injury Research	\$2,400,000	Brown-Waite, Ginny (FL)	
RDTE,A	Battlefield Nursing	\$1,600,000	Cohen	
RDTE,A	Battlefield Related Injury Translational Research Strategies	\$1,800,000	Castor (FL)	
RDTE,A	Battlefield Research Accelerating Virtual Environments for Military Individual Neuro Disorders (BRAVEMIND)	\$1,000,000	Harman	Boxer
RDTE,A	Beneficial Infrastructure for Rotorcraft Risk Reduction	\$800,000	Sestak	
RDTE,A	Bio Battery	\$800,000	Griffith	
RDTE,A	Bioactive Polymers and Coating Systems for Protection Against Bio-Threats	\$3,600,000	Pomeroy	Conrad; Dorgan
RDTE,A	Biological Air Filtering System Technology	\$3,000,000	Berry	Lincoln; Pryor
RDTE,A	Biometrics DNA Applications	\$1,500,000		Byrd
RDTE,A	Bio-Printing of Skin for Battlefield Burn Repairs	\$2,000,000	Johnson, Sam (TX)	Cornyn
RDTE,A	Biosecurity Research for Soldier Food Safety	\$1,600,000		Roberts
RDTE,A	Biosensor, Communicator and Controller System	\$3,500,000		Reid
RDTE,A	Bio-Surveillance in a Highly Mobile Population	\$1,600,000		Reid
RDTE,A	Biowaste-to-Bioenergy Center	\$2,000,000	Murphy (NY); Tonko	Gillibrand; Schumer
RDTE,A	Blood and Bone Marrow Collection Fellowship	\$2,000,000	Bishop (GA)	
RDTE,A	Blood Safety and Decontamination Technology	\$2,400,000	Gerlach; DeLauro; Fattah; Markey (MA); McDermott; Tonko	Chambliss; Feinstein; Schumer; Specter
RDTE,A	Blood, Medical and Food Safety via Eco-Friendly Wireless Sensing (Phase II)	\$1,600,000		Klobuchar
RDTE,A	Bradley Third Generation FLIR	\$4,500,000		Nelson (FL)
RDTE,A	Brain Interventional Surgical Hybrid Initiative	\$2,400,000	Wasserman Schultz	
RDTE,A	Brain Safety Net	\$2,400,000	Walden; Blumenauer; DeFazio; Wu	Merkley; Wyden
RDTE,A	Breast Cancer Medical Information Network Decision Support	\$800,000	Berman	
RDTE,A	Brownout Situational Awareness Sensor	\$2,400,000	Hunter; Olver	
RDTE,A	Building a Unified Information Framework	\$1,600,000	Andrews	Lautenberg; Menendez
RDTE,A	Burn and Shock Trauma Institute	\$1,600,000		Durbin
RDTE,A	Buster / Blacklight UAV Development	\$800,000	Gonzalez; Ortiz; Rodriguez	
RDTE,A	Cadmium Emissions Reduction—Letterkenny Army Depot	\$1,000,000	Shuster	
RDTE,A	Cancer Prevention through Remote Biological Sensing	\$1,600,000	Bishop (NY)	Schumer
RDTE,A	Capabilities Expansion of Spinel Transparent Armor Manufacturing	\$1,600,000	Perlmutter	
RDTE,A	Captive Carry Sensor Test-Bed	\$2,400,000	Davis (AL); Bachus	
RDTE,A	Carbide Derived Carbon for Treatment of Combat Related Sepsis	\$800,000	Sestak	Specter
RDTE,A	Carbon Nanotube Production	\$1,600,000		Hutchison
RDTE,A	Cellular Therapy for Battlefield Wounds	\$2,800,000	Fudge	
RDTE,A	Cellulose Nanocomposites Panels for Ballistic Protection	\$1,600,000	Michaud; Pingree (ME)	Collins; Snowe

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	Center for Advanced Emergency Response	\$4,000,000		Durbin
RDTE,A	Center for Bone Repair and Military Readiness	\$1,200,000	Cleaver	
RDTE,A	Center for Borane Technology	\$2,000,000		Bond
RDTE,A	Center for Cancer Immunology Research	\$1,600,000	Culberson	
RDTE,A	Center for Defense Systems Research	\$800,000	Reyes	
RDTE,A	Center for Engineered Biomedical Device	\$288,000	Herseth Sandlin	Johnson; Thune
RDTE,A	Center for Genetic Origins of Cancer	\$2,000,000	Dingell; Upton	Levin; Stabenow
RDTE,A	Center for Hetero-Functional Materials	\$800,000	Doggett; Conaway; Rodriguez	
RDTE,A	Center for Injury Biomechanics	\$4,000,000	Boucher	Warner; Webb
RDTE,A	Center for Integration of Medicine and Innovative Technology	\$9,000,000	Capuano; Lynch	Kerry; Kirk
RDTE,A	Center for Nanoscale Bio-Sensors as a Defense against Biological Threats	\$3,000,000	Boozman	Lincoln; Pryor
RDTE,A	Center for Ophthalmic Innovation	\$2,400,000	Diaz-Balart, Mario (FL); Ros-Lehtinen	Nelson (FL)
RDTE,A	Center for Respiratory Biodefense	\$2,400,000		Bennet
RDTE,A	Center for Virtual Reality Medical Simulation Training	\$1,200,000	Bachus; Davis (AL)	
RDTE,A	Center of Excellence in Infectious Diseases and Human Microbiome	\$2,400,000	Maloney; King (NY)	Schumer
RDTE,A	Ceramic and Metal Matrix Composites Armor Development using Ring Extruder Technology	\$800,000	Stupak	Levin
RDTE,A	Ceramic Membrane—10(X) Times More Energy for Battery Systems	\$2,400,000	Schwartz	Casey; Specter
RDTE,A	CERDEC Integrated Tool Control System	\$1,600,000	Pallone	
RDTE,A	Chemical Materials and Environmental Modeling Project	\$2,000,000		Cochran; Wicker
RDTE,A	Chronic Tinnitus Treatment Program	\$800,000	Dent	
RDTE,A	Cleveland Clinic Rehabilitation Research	\$800,000		Voinovich
RDTE,A	Clinical Development of a Norovirus Gastroenteritis Vaccine	\$3,600,000		Baucus
RDTE,A	Clinical Technology Integration for Military Health	\$1,600,000	Markey (MA)	Kerry
RDTE,A	Clinical Trial to Investigate Efficacy of Human Skin Substitute	\$800,000	Baldwin	
RDTE,A	Cluster Bomb Unit and Combined Effects Munitions Demilitarization	\$800,000	Brady (PA)	Reid
RDTE,A	Cogeneration for Enhanced Cooling and Heating of Advanced Tactical Vehicles	\$3,200,000		Kohl
RDTE,A	Cognitive Based Modeling and Simulation for Tactical Decision Support	\$1,600,000	Bishop (GA)	
RDTE,A	Collaboration Skills Training for Time-Critical Teams, Squads and Workgroups	\$1,600,000	Davis (IL)	
RDTE,A	Collagen-Based Wound Dressing	\$800,000	Altmire	
RDTE,A	Combat Medic Trainer	\$2,000,000	Schwartz; Hunter	Casey; Specter
RDTE,A	Combat Mental Health Initiative	\$1,600,000	Kaptur	
RDTE,A	Combat Vehicle Electrical Power-21st Century (CVEP-21)	\$3,120,000		Lugar
RDTE,A	Combat Wound Initiative	\$2,400,000	Kennedy	
RDTE,A	Command, Control, Communications Technology	\$1,600,000	Pascrell	
RDTE,A	Compact 10 Kilowatt Generator Set for Army and Marine Combat Vehicles	\$1,600,000		Nelson (FL)
RDTE,A	Compact Biothreat Rapid Analysis Concept	\$4,800,000	Capuano	Kerry; Kirk
RDTE,A	Compact Pulsed Power Initiative	\$3,200,000	Conaway	Hutchison
RDTE,A	Complimentary and Alternative Medicine Research for Military Operations and Healthcare (MIL-CAM)	\$5,200,000		Harkin

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[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	Composite Applied Research and Technology for FCS and Tactical Vehicle Survivability	\$3,200,000	Castle	Carper; Kaufman
RDTE,A	Composite Bottles for Survival Egress Air	\$4,000,000		Crapo; Risch
RDTE,A	Composite Small Main Rotor Blades	\$3,000,000	Tiahrt	Brownback; Dodd; Roberts
RDTE,A	Compostable and Recyclable Fiberboard Material for Secondary Packaging	\$2,000,000	Obey	
RDTE,A	Construct Training Program	\$1,600,000	Gutierrez; Jackson (IL)	Durbin
RDTE,A	Continuous Threat Alert Sensing System (CTASS)	\$1,360,000		Reid
RDTE,A	Control of Vector-Borne Diseases	\$2,400,000	Visclosky	
RDTE,A	Conversion of Municipal Solid Waste to Renewable Diesel Fuel	\$2,520,000	Rothman; Lance; Sires	Kerry; Specter
RDTE,A	Cooperative Developmental Energy Program	\$1,600,000	Bishop (GA)	
RDTE,A	Cooperative International Neuromuscular Research Group (CINRG)	\$3,280,000	Aderholt	Cochran; Wicker
RDTE,A	Countermeasures to Hemorrhaging (Liquid Bandage and Tissue Regeneration)	\$5,760,000		Nelson (NE)
RDTE,A	Crewmember Alert Display Development Program	\$1,600,000	Kingston	
RDTE,A	Cryofracture / Plasma Arc Demilitarization Program	\$6,400,000	Rehberg	Baucus; Tester
RDTE,A	Current Force Common Active Protection System Radar	\$1,600,000	Johnson, Sam (TX); Hall (TX); Johnson, Eddie Bernice (TX)	
RDTE,A	Customized Nursing Programs for Fort Benning	\$1,600,000	Bishop (GA)	Chambliss; Isakson
RDTE,A	Cyber Threat Analytics	\$2,400,000	Lewis (CA)	
RDTE,A	Cybersecurity in Tactical Environments	\$800,000	Castle	Carper; Kaufman
RDTE,A	Defense Advanced Transportation Technology Program Hybrid Truck Users Forum	\$4,800,000		Boxer
RDTE,A	Defense Metals Technology Center	\$2,000,000	Boccieri; Ryan (OH)	Brown
RDTE,A	Defense Support for Civil Authorities for Key Resource Protection	\$800,000	Shuster	
RDTE,A	Defense Support to Civil Authorities Automated Support System	\$1,600,000	Moran (VA)	
RDTE,A	Define Renewable Energy Sources for Base Energy Independence	\$1,600,000	Teague	Bingaman; Udall (NM)
RDTE,A	Demonstration of Thin Film Solar Modules as a Renewable Energy Source	\$800,000	Reyes	
RDTE,A	Dermal Matrix Research	\$2,000,000	Lance	Lautenberg; Menendez
RDTE,A	Development of Drugs for Malaria and Leishmaniasis	\$3,120,000	Childers	Cochran
RDTE,A	Development of Enabling Chemical Technologies for Power from Green Sources	\$1,200,000	Olver	
RDTE,A	Development of Improved Lighter-Weight IED / EFP Armor Solutions	\$1,600,000	Tiahrt	Roberts
RDTE,A	Development, Optimization, and Transfer of a Reliable Testing Technology for Materials Designed to Protect Warfighters Against Toxic Chemical Warfare Agents	\$480,000	Herseth Sandlin	Johnson; Thune
RDTE,A	Developmental Mission Integration	\$5,600,000	Frelinghuysen	
RDTE,A	De-Weighting Military Vehicles through Advanced Composites Manufacturing Technology	\$2,960,000	Davis (KY)	Bunning
RDTE,A	Diabetes Care in the Military	\$1,600,000	Kilpatrick	Levin
RDTE,A	Diamond Lens Elements for High Powered Laser	\$800,000	McGovern	Kerry; Kirk
RDTE,A	Direct Carbon Fuel Cell	\$2,800,000	Capito	
RDTE,A	Discriminatory Imaging and Network Advancement for Missiles, Aviation and Space	\$2,500,000		McConnell
RDTE,A	Distributed Power from Wastewater	\$2,000,000	Wilson (OH); Space	Voinovich
RDTE,A	Distributed, Networked, Unmanned Ground Systems	\$3,200,000	Matheson	Bennett; Hatch
RDTE,A	DoD Diabetes Research and Development Initiative (DRDI)	\$2,560,000	Dicks	
RDTE,A	Domestic Production of Nanodiamond for Military Applications	\$1,600,000	Thompson (PA)	Casey; Specter

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[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	Drive System Composite Structural Component Risk Reduction Program	\$2,400,000	Brady (PA)	Casey; Specter
RDTE,A	Dual Stage Variable Energy Absorber	\$2,400,000	Murphy, Patrick (PA)	
RDTE,A	Dugway Field Test Improvements	\$3,600,000	Bishop (UT)	Bennett; Hatch
RDTE,A	Effects Based Operations Decision Support Services	\$1,600,000	Moran (VA)	
RDTE,A	Electric All Terrain Ultra Light Vehicle for the Minnesota National Guard	\$1,600,000	Oberstar	
RDTE,A	Electrically Charged Mesh Defense Net Troop Protection System	\$6,000,000	Aderholt	Sessions
RDTE,A	Electronic Combat and Counter Terrorism Threat Developments to Support Joint Forces	\$3,000,000	Kingston	
RDTE,A	Electronic Commodity Project	\$800,000		Byrd
RDTE,A	Electronic Keel	\$1,600,000		Casey; Specter
RDTE,A	Enabling Optimization of Reactive Armor	\$3,000,000	Whitfield; Rogers (KY)	Bunning; Dodd; Lieberman; McConnell
RDTE,A	Enhanced Driver Situational Awareness	\$800,000	Kennedy	
RDTE,A	Enhanced Military Vehicle Maintenance System Demonstration Project	\$2,800,000	Rogers (AL)	Sessions; Shelby
RDTE,A	Enhanced-Rapid Tactical Integration for Fielding of Systems Initiative	\$3,120,000	Aderholt; Rogers (AL)	Sessions; Shelby
RDTE,A	Enhancing Military Ophthalmic Education and Overcoming Urban Healthcare Disparities with Telemedicine	\$2,400,000	Brady (PA)	
RDTE,A	Enhancing the Commercial Joint Mapping Toolkit to Support Tactical Military Operations	\$3,200,000	Lewis (CA)	
RDTE,A	Enhancing Wound Healing, Tissue Regeneration, and Biomarker Discovery	\$2,000,000	Berkley; Titus	Ensign; Reid
RDTE,A	Environmentally Intelligent Moisture and Corrosion Control for Concrete	\$1,680,000	Rothman	Lautenberg; Menendez
RDTE,A	Epigenetic Disease Research	\$1,600,000	McMorris Rodgers	Cantwell; Murray
RDTE,A	Evaluation of Integrative Approaches to Resilience	\$1,600,000	Moran (VA)	
RDTE,A	Exceptional Family Transitional Training Program for US Military Soldiers, Sailors, Marines and Airmen	\$640,000	Murtha	
RDTE,A	Execution of a Quality Systems Program for FDA Regulation Activities	\$1,200,000	Bishop (GA)	
RDTE,A	Expansion and Development of Bionic Limbs for U.S. Military Personnel	\$2,000,000	Davis (IL)	Durbin
RDTE,A	Expeditionary Water Reclamation Process using Supercritical Water Oxidation	\$2,800,000		Bond
RDTE,A	Exploding Foil Initiators (EFI) with Nanomaterial-Based Circuits	\$2,400,000	Herseth Sandlin	Johnson
RDTE,A	Extended Duration Silver Wound Dressing—Phase II	\$800,000	Shuler	Hagan
RDTE,A	Eye Safe Laser Range Finder	\$2,400,000	Baldwin	Kohl
RDTE,A	Eye Trauma and Visual Restoration	\$800,000	Schiff	
RDTE,A	Eye-Safe Standoff Fusion Detection of CBE Threats	\$2,000,000	Doyle	Specter
RDTE,A	Fibrin Adhesive Stat (FAST) Dressing	\$2,400,000		Cardin
RDTE,A	Field Deployable Fleet Hydrogen Fueling	\$2,400,000		Dodd; Lieberman
RDTE,A	Field Deployable Hologram Production System	\$3,840,000	Granger; Conaway	
RDTE,A	Fighting Combat-Related Fatigue Syndrome	\$800,000	Kosmas; Brown, Corrine (FL)	Nelson (FL)
RDTE,A	Fire Shield	\$3,200,000	Dreier	
RDTE,A	Fire Suppression System	\$1,140,000	Sullivan	
RDTE,A	Flexible Solar Cell for Man-portable Power Generator	\$800,000	Jackson (IL); Rush	
RDTE,A	Florida Trauma Rehabilitation Institute for Returning Military Personnel	\$2,400,000	Bilirakis	
RDTE,A	Flu Vaccine Technology Program	\$1,200,000	Rahall	
RDTE,A	Foil Bearing Supported UAV Engine	\$800,000	Larson (CT)	

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[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	Foliage Penetrating, Reconnaissance, Surveillance, Tracking, and Engagement Radar (FORESTER) Phase II	\$1,600,000	Maffei; McHugh	Schumer
RDTE,A	Force Protection Radar for Forward Operating Bases	\$1,600,000		Murray
RDTE,A	Framework for Electronic Health Record-Linked Predictive Models	\$2,400,000	Murtha	
RDTE,A	Friction Stir Welding Program	\$2,400,000	Jordan; Kaptur	
RDTE,A	Fuel System Component Technology Research	\$1,600,000	Manzullo	
RDTE,A	Fully Burdened Cost of Fuel and Alternative Energy Methodology and Conceptual Model	\$2,800,000	Kaptur	
RDTE,A	Fused Silica for Large-Format Transparent Armor	\$3,200,000	Space	
RDTE,A	Future Tactical Truck Carbon Composite Shelter and Retrofit of Current Vehicle Shelters	\$1,600,000		Begich
RDTE,A	Gas Engine Driven Air Conditioning	\$2,400,000	Pastor (AZ); Berkley; Franks (AZ)	Reid
RDTE,A	Geosciences / Atmospheric Research	\$3,000,000	Markey (CO); Salazar	Bennet; Udall (CO)
RDTE,A	Geospatial Airship Research Platform	\$3,200,000	Kaptur	
RDTE,A	Green Armament and RangeSafe Technology Initiatives	\$1,600,000	Frelinghuysen; Sires	Menendez
RDTE,A	Ground-forces Readiness Enabler for Advanced Tactical Vehicles (GREAT-V)	\$800,000		Hutchison
RDTE,A	Hadron Particle Therapy	\$1,600,000	Foster	Durbin
RDTE,A	HapMed Combat Medic Trainer	\$800,000		Nelson (FL)
RDTE,A	Headborne Energy Analysis and Diagnostic System	\$1,600,000	Carney	
RDTE,A	Health Disparities in Troop Readiness	\$8,000,000	Clyburn	
RDTE,A	Health Sciences Regenerative Medicine Center—Autologous Tissues Research	\$3,200,000		Burr; Hagan
RDTE,A	Heavy Fuel Engine Family for Unmanned Systems	\$3,200,000	Hoekstra	Levin; Stabenow
RDTE,A	Heuristic Internet Protocol Packet Inspection Engine (HIPPIE)	\$1,040,000	Akin	Bond
RDTE,A	High Energy Laser System Test Facility—HELSTF/HELTD	\$4,500,000		Bingaman; Udall (NM)
RDTE,A	High Frequency Devices and Circuits for Nanotubes and Nanowires	\$1,440,000	Boozman	Lincoln; Pryor
RDTE,A	High Performance Alloy Materials and Advanced Manufacturing of Steel Castings for New Light Weight and Robotic Weapon Systems	\$2,400,000	Emerson	
RDTE,A	High Performance Computing in Biomedical Engineering and Health Sciences	\$1,200,000	Watt	
RDTE,A	High Pressure Pasteurization and Pressure Assisted Thermal Sterilization Project	\$3,440,000	Ellsworth	Lugar
RDTE,A	High Speed Digital Imaging	\$2,400,000		Gregg
RDTE,A	High Strength Glass Production and Qualification for Armor Applications	\$1,600,000	Tonko	Schumer
RDTE,A	High Temp Polymers for Missile System Applications	\$3,920,000		Cochran; Wicker
RDTE,A	High-Frequency, High-Power Electronic and Optoelectronic Devices on Aluminum Nitride (AlN)	\$3,200,000	Price (NC)	Burr
RDTE,A	Highlander Electro-Optical Sensors	\$1,600,000	Moran (VA)	
RDTE,A	Highly Functional Neurally Controlled Skeletally Attached and Intelligent Prosthetic Devices	\$3,040,000		Bennett
RDTE,A	Highly Integrated Lethality Systems Development	\$4,000,000	Frelinghuysen	
RDTE,A	Highly Integrated Production for Expediting Reset	\$2,000,000	Brown (SC); Altmire; Rogers (AL); Wilson (SC)	Casey; Sessions; Stabenow
RDTE,A	High-Volume Manufacturing Development for Thin-film Lithium Stack Battery Technologies	\$800,000	Honda; Carter	
RDTE,A	HiSentinel Stratospheric Airship	\$2,400,000	Herseth Sandlin	Johnson
RDTE,A	Hi-Tech Eyes for the Battlefield	\$1,600,000		Hutchison
RDTE,A	HIV Prevention and Reducing Risk to US Military Personnel	\$3,000,000	Pelosi	

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	Hostile Fire Indicator	\$1,600,000	Hodes	Gregg; Shaheen
RDTE,A	Human Genomics, Molecular Epidemiology, and Clinical Diagnostics for Infectious Diseases	\$1,200,000	Pastor (AZ)	
RDTE,A	Human Organ and Tissue Preservation Technology	\$1,600,000	Wilson (SC)	
RDTE,A	Hybrid Electric Drive All Terrain Vehicle	\$1,600,000	Peters	Levin
RDTE,A	Hybrid Electric Heavy Truck Vehicle	\$1,600,000	Bartlett	Cardin
RDTE,A	Hybrid Energy Systems Design and Testing	\$2,000,000	Simpson	Crapo; Risch
RDTE,A	Hybrid Engine Development Program	\$3,200,000		Levin
RDTE,A	Hydraulic Hybrid Vehicles for the Tactical Wheeled Fleet	\$2,800,000	Peters	Levin; Lugar; Stabenow
RDTE,A	Hyper Spectral Sensor for Improved Force Protection	\$1,600,000	Akin	
RDTE,A	Identification of New Drug Targets in Multi-Drug Resistant Bacterial Infections	\$2,000,000	Slaughter, Lee (NY)	Gillibrand; Schumer
RDTE,A	Identification of Pain Mechanisms and Therapeutic Targets	\$800,000		Durbin
RDTE,A	Imaging and Cognitive Evaluation of Soldiers	\$640,000	Kilpatrick	Levin; Stabenow
RDTE,A	Improved HELLHOUND 40mm Low Velocity High Explosive Ammunition	\$600,000	Boyd	Nelson (FL)
RDTE,A	Improved Manufacturing Processes Demonstration Program for Army Tactical Vehicles	\$1,600,000		Bond
RDTE,A	Improved Thermal Batteries for Guided Munitions	\$2,400,000	Schwartz	Specter
RDTE,A	Improved Thermal Resistant Nylon for Enhanced Durability and Thermal Protection in Combat Uniforms	\$3,200,000	Castle; Barrett	Carper; Graham; Kaufman
RDTE,A	Improving Soldier Recovery from Catastrophic Bone Injuries	\$3,200,000	Murphy (CT)	Lieberman
RDTE,A	Infection Prevention Program for Battlefield Wounds	\$1,600,000	McGovern	Kerry
RDTE,A	Infectious and Airborne Pathogen Reduction	\$2,240,000	Whitfield; Arcuri; Childers; Higgins	Schumer
RDTE,A	In-Field Body Temperature Conditioner	\$2,400,000		Reid
RDTE,A	Injection Molded Ceramic Body Armor	\$800,000	Olver	
RDTE,A	Ink-based Desktop Electronic Material Technology	\$1,600,000	Frelinghuysen	
RDTE,A	Institute for Simulation and Interprofessional Studies	\$4,640,000	Dicks; McDermott; McMorris Rodgers; Smith (WA)	Cantwell; Murray
RDTE,A	Integrated Alternative Power Systems	\$2,080,000		Kohl
RDTE,A	Integrated Defense Technical Information	\$1,600,000	Rogers (KY)	
RDTE,A	Integrated Family of Test Equipment V6 Product Improvement Program	\$2,400,000	Kingston	Chambliss
RDTE,A	Integrated Flexible Electronics	\$1,600,000		Specter
RDTE,A	Integrated Information Technology Policy Analysis Research and Technology Commercialization and Management Network	\$3,200,000	Lewis (CA)	
RDTE,A	Integrated Lightweight Tracker System	\$2,000,000	Obey	
RDTE,A	Integrated Patient Electronic Record System	\$1,600,000	Lee (CA)	
RDTE,A	Intelligence, Surveillance and Reconnaissance (ISR) Simulation Integration Laboratory	\$1,600,000	Smith (NJ)	
RDTE,A	Intelligent Energy Control Systems	\$2,400,000	Granger	
RDTE,A	Intelligent Network-Centric Sensor Development Program	\$1,200,000	Cohen	
RDTE,A	Intelligent Orthopedic Fracture Implant Program	\$800,000	Kildee	Levin; Stabenow
RDTE,A	Intensive Quenching for Advanced Weapon Systems	\$1,200,000	Sutton; Ryan (OH); Tonko	Schumer; Stabenow
RDTE,A	Inter Turbine Burner for Turbo Shaft Engines	\$2,400,000	Lewis (CA)	
RDTE,A	Internal Base Facility Energy Independence	\$2,560,000	Kaptur	

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[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	In-Theater Evaluation of Ballistic Protection	\$800,000	Michaud; Pingree (ME)	Collins; Snowe
RDTE,A	IR-Vascular Facial Fingerprinting	\$2,400,000	Moran (VA)	
RDTE,A	IUID Data Platform	\$2,000,000	Kennedy	Reed
RDTE,A	Jackson Health System Military Trauma Training Enhancement Initiative	\$2,000,000	Meek (FL); Wasserman Schultz	Nelson (FL)
RDTE,A	JAMMA Family of Vehicles	\$800,000		Bennett
RDTE,A	Javelin Warhead Improvement Program	\$4,000,000	Bright; Brown, Corrine (FL)	Nelson (FL); Sessions; Shelby
RDTE,A	Joint Fires and Effects Trainer System Enhancements	\$2,000,000	Cole; Fallin	Inhofe
RDTE,A	Joint Medical Simulation Technology Center	\$1,280,000	Kosmas	
RDTE,A	Joint Munitions and Lethality Mission Integration	\$1,600,000	Frelinghuysen	
RDTE,A	Joint Precision AirDrop Systems-Wind Profiling Portable Radar	\$1,840,000	Murtha	
RDTE,A	Kinetic Energy Enhanced Lethality and Protection Materials	\$2,000,000		Alexander; Corker
RDTE,A	Laboratory for Engineered Human Protection	\$1,600,000	Fattah	
RDTE,A	Large Format Li-Ion Battery	\$4,960,000	Moore (WI)	Kohl
RDTE,A	Large Structure Titanium Machining Initiative	\$800,000		Klobuchar; Stabenow
RDTE,A	Large-Scale Manufacturing of Revolutionary Nanostructured Materials	\$1,200,000	Moore (WI)	
RDTE,A	Laser-Guided Energy (LGE) Demonstrator	\$2,240,000		Cochran
RDTE,A	Lattice Block Structures for AM2 Matting Replacement	\$1,600,000	Hodes	Gregg; Shaheen
RDTE,A	Legacy Aerospace Gear Drive Re-Engineering Initiative	\$2,000,000	Larson (CT)	Dodd
RDTE,A	Lens-Less Dual-Mode Micro Seeker for Medium-Caliber Guided Projectiles	\$2,000,000	Dreier	
RDTE,A	Leonard Wood Institute	\$12,000,000	Skelton	
RDTE,A	Lifestyle Modifications to Reduce Chronic Disease in Military Personnel	\$1,500,000	Pelosi	
RDTE,A	Light Weight Nanophosphate Battery with Improved Energy Density	\$2,000,000	Markey (MA)	Kerry; Kirk
RDTE,A	Lightweight 10-meter Antenna Mast	\$2,000,000	Obey	
RDTE,A	Lightweight Caliber .50 Machine Gun	\$3,200,000	Michaud; Pingree (ME)	Collins; Leahy; Snowe
RDTE,A	Lightweight Magnesium Parts for Military Applications	\$1,600,000	Holden	Casey
RDTE,A	Lightweight Medical Devices	\$1,600,000		Brownback
RDTE,A	Lightweight Metal Alloy Foam for Armor	\$3,200,000	Kaptur	
RDTE,A	Lightweight Munitions and Surveillance System for Unmanned Air and Ground Vehicles	\$3,840,000	Garrett	Lautenberg; Menendez
RDTE,A	Lightweight Packaging System for Enhancing Combat Munitions Logistics	\$1,600,000	Frelinghuysen; Rothman	Lautenberg; Menendez
RDTE,A	Lightweight Polymer Designs for Soldier Combat Optics	\$800,000	Olver	Kerry
RDTE,A	Lightweight Protective Roofing	\$1,200,000	Moran (VA)	
RDTE,A	Lightweight Reliable Materials for Military Systems	\$2,800,000		Conrad; Dorgan
RDTE,A	Lightweight, Battery Driven, and Battlefield Deployment Ready NG Feeding Tube Cleaner	\$500,000	Thompson (PA)	
RDTE,A	Linear Accelerator Cancer Research Project	\$800,000	Rangel; Lowey; Maloney	Schumer
RDTE,A	Locating and Tracking Explosive Threats with Wireless Sensors and Networks	\$4,800,000	Emerson	
RDTE,A	Logistical Fuel Processors Development	\$1,200,000	Bachus; Rogers (AL)	
RDTE,A	Long Range Hypersonic Interceptor	\$1,600,000		Brownback; Roberts
RDTE,A	Long-term Pain and Infection Management for Combat Casualty Care	\$2,320,000		Cochran; Wicker
RDTE,A	Low Cost Interceptor	\$1,680,000		Shelby

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[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	LW25 Gun System and Demonstration	\$2,400,000	Kingston	
RDTE,A	M109A6 Paladin	\$1,600,000	Rogers (AL)	
RDTE,A	Maine Center for Toxicology and Environmental Health, Toxic Particles Research and Equipment	\$1,600,000	Pingree (ME)	
RDTE,A	Maine Institute for Human Genetics and Health	\$1,600,000	Michaud	Collins; Snowe
RDTE,A	Malaria Vaccine Development	\$4,000,000	McDermott; Smith (WA)	Cantwell; Murray
RDTE,A	Manufacturing and Industrial Technology Center	\$400,000	Boyd	Nelson (FL)
RDTE,A	Manufacturing Lab for Next Generation Engineers	\$1,600,000	Schock	
RDTE,A	Mariah Hypersonic Wind Tunnel Development Program	\$7,600,000	Rehberg	Baucus; Tester
RDTE,A	Market Viable, Dual-Use, Advanced Energy Storage Solutions Development	\$4,000,000	Hinchey	Schumer
RDTE,A	Marty Driesler Lung Cancer Project	\$1,600,000	Rogers (KY)	
RDTE,A	Maryland Proof of Concept Alliance for Defense Technologies	\$1,600,000		Mikulski
RDTE,A	Mass Casualty First Responders Disaster Surge Technology Program	\$2,400,000	Pallone; Rothman	Lautenberg; Menendez
RDTE,A	Materials for Infrared Night Vision Equipment	\$7,200,000		Durbin
RDTE,A	Materials Processing and Applications Development Center of Excellence for Industry	\$1,200,000	Bachus	
RDTE,A	Materials Technology for LED Lighting Applications	\$2,400,000	Rehberg	Tester
RDTE,A	Medical Biosurveillance and Efficiency Program	\$1,600,000	Altmire	
RDTE,A	Medical Errors Reduction Initiative	\$2,000,000	Rothman	
RDTE,A	Medium Caliber Metal Parts Upgrade	\$3,000,000	Kanjorski	Casey; Specter
RDTE,A	MEMS Antenna for Wireless Communications Supporting UAVs in the Battlefield	\$2,400,000	Pomeroy	Conrad; Dorgan
RDTE,A	Micro Inertial Navigation Unit Technology	\$1,200,000	Doyle	Specter
RDTE,A	Microencapsulation and Vaccine Delivery Research	\$800,000	Edwards (TX)	
RDTE,A	Micromachined Switches in Support of Transformational Communications Architecture	\$2,400,000	Miller, George (CA)	
RDTE,A	Microterrain Persistent Surveillance	\$1,600,000		Bond
RDTE,A	Mid-Infrared Super Continuum Laser	\$800,000	Kilpatrick; Dingell	Levin; Stabenow
RDTE,A	Midwest Traumatic Injury Rehabilitation Center	\$1,168,000	Ehlers	Levin
RDTE,A	Military Applications for Medical Grade Chitosan	\$3,000,000		Inouye
RDTE,A	Military Burn Trauma Research Program	\$4,500,000	Matsui; Lungren	Begich; Boxer; Brown; Burris; Cantwell; Gillibrand; Hatch; Kerry; Lieberman; Menendez; Reed; Sanders; Schumer; Whitehouse
RDTE,A	Military Drug Management System	\$2,400,000	Mollohan	
RDTE,A	Military Family Coping Patterns	\$400,000	Edwards (TX)	Cornyn
RDTE,A	Military Family Empowerment Initiative	\$800,000		Mikulski
RDTE,A	Military Fuel Cell Genset Technology Demonstration	\$2,000,000	Boccieri	
RDTE,A	Military Installation Electric Vehicle Demonstration Project	\$1,600,000		Bond
RDTE,A	Military Low Vision Research	\$2,400,000	Lynch; Capuano	Kerry
RDTE,A	Military Medical Decontamination System	\$4,500,000		Brown; Voinovich
RDTE,A	Military Mental Health Initiative	\$600,000	Kilpatrick; Dingell	Levin; Stabenow
RDTE,A	Military Nutrition Research: Four Tasks to Address Personnel Readiness	\$800,000	Alexander	Landrieu; Vitter
RDTE,A	Military Pediatric Training and Support	\$4,000,000	Norton	

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[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	Minimizing Shock in Battlefield Injuries	\$1,900,000		McConnell
RDTE,A	Missile Attack Early Warning System	\$2,080,000		Shelby
RDTE,A	Mission Hospital Computerized Physician Order Entry	\$800,000	Shuler	
RDTE,A	Missouri Multi-Threat Detection Initiative (M2TDI)	\$2,000,000		Bond
RDTE,A	MLRS Disposal System	\$2,500,000		Ensign; Reid
RDTE,A	Mobile Aerosol Monitoring System for the Department of Defense	\$1,200,000		Reid
RDTE,A	Mobile Integrated Diagnostic and Data Analysis	\$1,600,000	Adler	
RDTE,A	Mobile Localization (M—LOC)	\$1,200,000		Inouye
RDTE,A	Mobile Mesh Network Node	\$1,760,000	Obey	
RDTE,A	Mobile Power 30 Kilowatt System Power Control Unit Development Project	\$800,000	Harman	
RDTE,A	Model for Green Laboratories and Clean Rooms	\$1,200,000	Bishop (GA)	
RDTE,A	Modeling and Testing of Next Generation Body Armor	\$2,000,000	Rush	Durbin
RDTE,A	Moldable Fabric Armor	\$2,240,000	Ingليس	Graham
RDTE,A	Molecular Electronics for Flash Memory Production	\$2,400,000	Lipinski	Durbin
RDTE,A	Montefiore Critical Looking Glass	\$1,200,000	Engel	Schumer
RDTE,A	Mortar Anti-Personnel / Anti-Materiel Technology	\$3,200,000	Rothman	Klobuchar; Lautenberg; Menendez
RDTE,A	MOTS All Sky Imager	\$960,000	Reyes; Rodriguez	
RDTE,A	MQ-8B Fire Scout Army	\$6,800,000		Cochran; Schumer; Wicker
RDTE,A	Multi-Campus Base Facility Energy Independence	\$3,200,000	Kaptur	
RDTE,A	Multi-Dose Closed Loop pH Monitoring System for Platelets	\$1,600,000	McDermott; Smith (WA)	Murray
RDTE,A	Multifunctional Nanomaterials for Homeland Defense, Counter-Terrorism and Dual-Use Applications	\$2,000,000		Lautenberg; Menendez
RDTE,A	Multi-layer Co-extrusion for High Performance Packaging	\$1,600,000	Obey	
RDTE,A	Multiple Source Data Fusion for Dugway Proving Ground	\$2,000,000	Bishop (UT)	Bennett; Hatch
RDTE,A	Multiplexed Human Fungal Infection Diagnostic	\$1,600,000	Frank (MA)	Kerry
RDTE,A	Multi-Utility Materials for Future Combat Systems	\$7,200,000	Herseth Sandlin; Brown, Corrine (FL); Latham; Meek	Grassley; Harkin; Johnson
RDTE,A	Musculoskeletal Interdisciplinary Research Initiative	\$1,600,000	Bilirakis	
RDTE,A	Myositis Association—exposure to environmental toxins	\$1,000,000	Israel	Schumer
RDTE,A	Nano Advanced Cluster Energetics	\$1,600,000	Frelinghuysen	
RDTE,A	Nanocomposite Enhanced Radar and Aerospace Materials (NERAM)	\$800,000		Hutchison
RDTE,A	Nanocrystal Source Display	\$760,000	Markey (MA)	Kerry
RDTE,A	Nanoelectronic Memory, Sensor and Energy Devices	\$6,300,000		Nelson (NE)
RDTE,A	Nano-enabled Ultra High Storage Density Non-volatile Memory for Commander's Digital Assistant	\$2,400,000		Feinstein
RDTE,A	Nanofiber Based Synthetic Bone Repair Device for Limb Salvage	\$1,000,000	Wamp	
RDTE,A	Nanofluid Coolants	\$500,000	Davis (KY)	Bunning
RDTE,A	Nano-Imaging Agents for Early Disease Detection	\$800,000	Green, Al (TX); Culberson	
RDTE,A	Nanomanufacturing of Multifunctional Sensors	\$4,000,000	Tsongas	Kerry; Kirk
RDTE,A	Nanophotonic Biosensor Detection of Bioagents and Pathogens	\$1,520,000	Kingston; Bishop (GA)	Chambliss; Isakson
RDTE,A	Nanophotonic Devices	\$1,600,000		Hutchison

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[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	Nanotechnology Enterprise Consortium (NTEC)	\$5,000,000		Bond
RDTE,A	Nanotechnology for Potable Water and Waste Treatment	\$1,600,000	Sutton; Murphy, Tim (PA)	Landrieu
RDTE,A	Nanotechnology Fuze	\$1,600,000	Obey	
RDTE,A	Nanotechnology-Enabled Self-Healing Anti-Corrosion Coating Products	\$1,400,000	Holt	Lautenberg; Menendez
RDTE,A	Nanotubes Optimized for Lightweight Exceptional Strength (NOLES)	\$3,200,000	Crenshaw	Nelson (FL)
RDTE,A	National Biodefense Training Center	\$5,000,000	Olson	Hutchison
RDTE,A	National Center for Defense Manufacturing and Machining	\$1,600,000	Murphy, Tim (PA)	Casey; Specter
RDTE,A	National Eye Evaluation and Research Network	\$2,400,000	Lewis (CA); Sarbanes	Harkin
RDTE,A	National Functional Genomics Center	\$6,000,000	Bilirakis; Castor (FL); Young (FL)	Nelson (FL)
RDTE,A	National Oncogenomics and Molecular Imaging Center	\$4,760,000	Kilpatrick	Levin; Stabenow
RDTE,A	Natural Gas Firetube Boiler Demonstration	\$800,000	Hare	Durbin; Harkin
RDTE,A	NAU-TGen North Dangerous Pathogens DNA Forensics Center Upgrades	\$1,600,000	Kirkpatrick	
RDTE,A	Navy Gun Ammunition Demilitarization and Recycling	\$1,600,000		Reid
RDTE,A	Near Infrared Spectroscopy Military Personnel Assessment	\$800,000	Castor (FL)	Nelson (FL)
RDTE,A	Networked Reliability and Safety Early Evaluation System	\$1,600,000	Dent	Specter
RDTE,A	Neural Control of External Devices	\$2,000,000	Kennedy	Bennett; Hatch; Kerry; Kirk
RDTE,A	Neuroimaging and Neuropsychiatric Trauma in US Warfighters	\$6,250,000	Pelosi	Boxer; Feinstein
RDTE,A	Neuro-Performance Research	\$1,600,000	Moran (VA)	
RDTE,A	Neuroscience Research Consortium to Study Spinal Cord Injury	\$1,200,000	Diaz-Balart, Lincoln (FL); Ros-Lehtinen; Wasserman Schultz	Nelson (FL)
RDTE,A	New Vaccines to Fight Respiratory Disease and Central Nervous Disorders	\$4,800,000	Latham	Grassley; Harkin
RDTE,A	New York Medical College Bioterrorism Research	\$132,000	Lowey	Schumer
RDTE,A	Next Generation Communications System	\$800,000	Altmire	Casey; Specter
RDTE,A	Next Generation Green, Economical and Automated Production of Composite Structures for Aerospace	\$1,000,000	Grijalva	
RDTE,A	Next Generation High Strength Glass Fibers for Ballistic Armor Applications	\$1,600,000	Wilson (SC)	Graham
RDTE,A	Next Generation Lightweight Drive System for Army Weapons Systems	\$1,600,000	Herseth Sandlin	Johnson; Thune
RDTE,A	Next Generation Machining Technology and Equipment	\$1,600,000	Murphy (NY)	Schumer
RDTE,A	Next Generation Precision Airdrop System	\$2,000,000	Larson (CT)	
RDTE,A	Next Generation Wearable Video Capture System	\$800,000	Stupak	Levin
RDTE,A	Nicholson Center for Surgical Advancement Medical Robotics and Simulation	\$4,200,000	Grayson	Nelson (FL)
RDTE,A	Night Vision and Electronic Sensors Directorate	\$2,000,000	Olver	
RDTE,A	NLOS-LS Anti-Tamper Initiative	\$3,040,000		Lugar
RDTE,A	Non-Leaching Antimicrobial Surface for Orthopedic Devices	\$1,200,000	Capuano	Kerry
RDTE,A	Northern Illinois Proton Treatment and Research Center	\$2,800,000	Foster	
RDTE,A	Novel Endothermic Armor Material for Insensitive Munitions Protection of Tactical Missiles and Tubes	\$2,500,000		Ensign; Reid
RDTE,A	Novel Zinc Air Power Sources for Military Applications	\$2,000,000	Rogers (AL)	
RDTE,A	Nurse Education Center of Excellence for Remote and Medically Underserved Populations	\$1,600,000	Shuster	
RDTE,A	Nursing Teaching and Leadership Program	\$800,000	McDermott	
RDTE,A	OMNI Active Vibration Control System	\$2,400,000	Dahlkemper	Casey; Specter

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Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	ONAMI Miniaturized Tactical Energy Systems Development	\$2,500,000	Schrader; Blumenauer; DeFazio; Walden; Wu	Merkley; Wyden
RDTE,A	On-Board Hybrid Power Unit (OBHPU)	\$1,040,000	Harper	Cochran; Wicker
RDTE,A	On-Board Vehicle Power Systems Development	\$2,480,000	Aderholt	Sessions; Shelby
RDTE,A	One-Step JP-8 Bio-Diesel Fuel	\$1,600,000	Obey	
RDTE,A	Online Health Services Optimization	\$3,120,000		Cochran
RDTE,A	Open Source Intelligence for Force Protection and Intelligence Analysis	\$800,000	DeLauro	Hutchison
RDTE,A	Operating Room of the Future	\$2,000,000	Berman	Boxer
RDTE,A	Operation Re-Entry NC	\$2,400,000	Butterfield	Hagan
RDTE,A	Optical Neural Techniques for Combat and Post-Trauma Healthcare	\$3,500,000	Inslee; McDermott; Smith (WA)	Cantwell; Murray
RDTE,A	Optimization of the US Army Topographic Data Management Enterprise	\$2,080,000	Murtha; Moran (VA)	
RDTE,A	Optimizing Natural Language Processing of Open Source Intelligence	\$1,200,000	Bishop (UT)	Bennett; Hatch
RDTE,A	Organic Semiconductor Modeling and Simulation	\$880,000	Gohmert	
RDTE,A	Orion High Altitude Long Endurance UAV Risk Reduction Effort	\$7,760,000		Cochran; Wicker
RDTE,A	Pacific Command Renewable Energy Security Systems	\$2,400,000	Abercrombie	
RDTE,A	Parsons Institute for Information Mapping	\$1,200,000	Nadler	Schumer
RDTE,A	Parts-on-Demand from CONUS Operations	\$4,500,000	Pomeroy	Conrad; Dorgan
RDTE,A	Pediatric Cancer Research and Clinical Trials	\$1,600,000	Ryan (OH); Culberson; Rothman; Van Hollen	Crapo; Risch
RDTE,A	Perimeter Security Systems	\$4,500,000		Lautenberg; Menendez
RDTE,A	Permafrost Tunnel	\$500,000		Begich
RDTE,A	Perpetually Available and Secure Information Systems	\$3,200,000	Doyle	
RDTE,A	Personal Miniature Thermal Viewer	\$800,000	Michaud	
RDTE,A	Personal Status Monitor	\$800,000	Maffei; McHugh	Schumer
RDTE,A	Phase II, Regional Partnership—Ft. Bliss, WSMR, Holloman	\$3,760,000	Teague	Bingaman; Udall (NM)
RDTE,A	Plant-Based Vaccine Research	\$2,000,000	Guthrie	
RDTE,A	Plasma Sterilizer	\$2,400,000	Ellison; McCollum	Klobuchar
RDTE,A	Plug-in Architecture for DOD Medical Imaging	\$1,200,000	Moran (VA)	
RDTE,A	Plug-in Hybrid Electric Vehicle	\$4,000,000		Lugar
RDTE,A	Polymeric Web Run-Flat Tire Inserts for Convoy Protection	\$3,500,000	Obey	
RDTE,A	Portable Fuel Cell Power Source	\$2,400,000	Price (NC)	
RDTE,A	Portable Low-Volume Therapy for Severe Blood Loss	\$1,600,000	Oberstar	
RDTE,A	Portable Mobile Emergency Broadband Systems	\$3,200,000	Gerlach; Sestak	Casey; Specter
RDTE,A	Portable Sensor for Toxic Gas Detection	\$2,080,000	Granger	
RDTE,A	Positron Capture and Storage	\$2,400,000	McMorris Rodgers	Murray
RDTE,A	Power Efficient Microdisplay Development for US Army Night Vision	\$2,400,000	Hall (NY)	Schumer
RDTE,A	Prader Willi Syndrome Research	\$1,600,000	Royce	
RDTE,A	Precision Guidance Kit Technology Development	\$6,000,000	Mollohan; Bartlett	Inhofe
RDTE,A	Precision Guided Airdropped Equipment	\$1,200,000	Velázquez; Towns	Schumer

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	Precision Strike Munitions Advancement with Integrated Millimeter Wave Power Sources to Satisfy Army Strategic Goals	\$3,280,000	Bishop (UT)	Bennett; Hatch
RDTE,A	Predictive Casting Process Modeling for Rapid Production of Critical Defense Components	\$1,600,000	Hall (TX)	
RDTE,A	Pre-Discharge Threat Cues	\$1,600,000		Levin; Stabenow
RDTE,A	Pride Center for America's Wounded Veterans	\$1,600,000	Berry	
RDTE,A	Printed and Conformal Electronics for Military Applications	\$1,600,000	Mitchell; Lance; Lofgren; Ryan (OH); Schakowsky; Tonko	Feinstein; Johnson; Schumer
RDTE,A	Project National Shield Integration Center	\$1,200,000	Capito	
RDTE,A	Projectile Unmanned Aerial Systems	\$2,400,000	Larson (CT); Courtney	Dodd; Lieberman
RDTE,A	Protective 3-D Armor Structure to Safeguard Military Vehicles and Troops	\$1,600,000	Levin	Levin; Stabenow
RDTE,A	Protective Gear Development through Man-In-Simulant-Test Chamber	\$800,000	Etheridge; Miller (NC)	
RDTE,A	Protein Hydrogel for Surgical Repair of Battlefield Injuries	\$800,000	Gingrey (GA)	Chambliss; Isakson
RDTE,A	Qualification and Insertion of New High Temperature Domestic Sourced PES for Military Aircraft	\$2,400,000	Johnson, Eddie Bernice (TX)	
RDTE,A	RAND Arroyo Center	\$1,600,000	Moran (VA)	Feinstein
RDTE,A	Rapid Burn Wound Therapies	\$2,000,000		Bennett; Hatch
RDTE,A	Rapid Insertion of Developmental Technologies into Fielded Systems	\$1,600,000	Frelinghuysen; Sires	
RDTE,A	Rapid Response Force Projection Systems	\$1,600,000	Rothman	
RDTE,A	Rapid Response Hostile Fire Detection and Active Protection of Ground and Air Vehicles Sensor Demonstration	\$2,560,000		Shelby
RDTE,A	Rapid Wound Healing Cell Technology	\$2,000,000	Doyle	Casey
RDTE,A	Rare Earth Mining Separation and Metal Production	\$2,400,000	Lewis (CA)	
RDTE,A	RDT&E for the Family of Heavy Tactical Vehicles (FHTV)	\$1,600,000	Kagen	Kohl
RDTE,A	Reactive Materials	\$1,200,000	Barton	
RDTE,A	Reduced Manning Situational Awareness	\$4,000,000	Young (FL)	
RDTE,A	Reducing First Responder Casualties with Physiological Monitoring	\$1,200,000	Hodes	
RDTE,A	Regenerative Medicine for Acute Deafness	\$2,400,000	Inslee; McDermott; Smith (WA)	Murray
RDTE,A	Regenerative Medicine for Battlefield Injuries	\$1,000,000	Carson	Lugar
RDTE,A	Regenerative Medicine Research	\$1,600,000	Michaud	
RDTE,A	Reliability and Affordability Enhancement for Precision Guided Munition Systems	\$4,800,000	Frelinghuysen	
RDTE,A	Remote Bio-Medical Detector	\$2,800,000	Murtha	
RDTE,A	Remote Environmental Monitoring and Diagnostics in the Perishables Supply Chain	\$2,200,000	Stearns	Nelson (FL)
RDTE,A	Remote Explosive Analysis and Detection System	\$800,000	Griffith	
RDTE,A	Renewable Energy Testing Center	\$800,000	Matsui; Lungren	
RDTE,A	Renewable Jet Fuel from Lignocellulosic Feedstocks	\$2,400,000	Herseth Sandlin	Johnson; Thune
RDTE,A	Research to Develop Strategies to Improve Prognosis of Soldiers Suffering Abdominal Trauma	\$1,600,000	Yarmuth	
RDTE,A	Research to Treat Cancerous Brain Tumors using Neural Stem Cells	\$1,600,000	Lewis (CA)	
RDTE,A	Ripsaw Unmanned Ground Vehicle (UGV) Weaponization	\$2,000,000	Pingree (ME)	Collins; Snowe
RDTE,A	Robust Composite Structural Core for Army Helicopters	\$1,600,000	Shea-Porter	Gregg; Shaheen
RDTE,A	Rocket Motor Contained System	\$800,000	Heller	Reid
RDTE,A	Rugged Electronic Textile Vital Signs Monitoring	\$2,400,000	Kennedy	Reed; Whitehouse

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[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	Ruggedized Military Laptop Fuel Cell Power Supply—Project Phase 3	\$3,200,000	Brown, Corrine (FL); Crenshaw	Nelson (FL)
RDTE,A	Rural Health Center of Excellence for Remote and Medically Underserved Populations	\$1,600,000	Shuster	Casey
RDTE,A	Scaleable Efficient Power for Armament Systems and Vehicles Dual Use	\$4,000,000	Rothman	Lautenberg
RDTE,A	Scenario Generation for Integrated Air and Missile Defense Evaluation	\$3,360,000	Aderholt; Reyes; Rogers (AL)	Sessions; Shelby
RDTE,A	School of Nursing Advancement	\$2,000,000	Pelosi	
RDTE,A	Science, Technology, Engineering, Mathematics (STEM) at Coppin University	\$800,000	Cummings	
RDTE,A	Secure Open Source Initiative	\$2,400,000	Price (NC); Miller (NC)	
RDTE,A	Self Powered Prosthetic Limb Technology	\$1,600,000	Thompson (PA)	Casey; Specter
RDTE,A	Self Powered, Lightweight, Flexible Display Unit on a Plastic Substrate	\$3,040,000		Grassley; Harkin
RDTE,A	Self-Powered Sensor System for Munition Guidance and Health Monitoring	\$1,500,000	Holt	Lautenberg; Menendez
RDTE,A	Sensor Tape Physiological Monitoring	\$2,000,000	Bishop (GA)	
RDTE,A	Shadow TUAS Flight in the National Air Space	\$2,000,000	Kratovil	Cardin; Mikulski
RDTE,A	Shared Vision	\$2,400,000	Latham	Grassley; Harkin
RDTE,A	SHARK Precision Guided Artillery Round—105mm	\$4,000,000	Young (FL)	
RDTE,A	Shortwave Infrared Hostile Fire Indicator for Aircraft	\$1,500,000	Holt	Lautenberg; Menendez
RDTE,A	Silent Watch, IB NPS 1160 Lithium-Ion Advanced Battery	\$800,000	Dent	
RDTE,A	Silicon Nanomaterial for Battlefield Medical Devices	\$2,800,000		Conrad; Dorgan
RDTE,A	Silver Fox and Manta Unmanned Aerial Systems	\$1,600,000	Franks (AZ)	
RDTE,A	Simulation Based Reliability and Safety (SimBRS) Program	\$4,900,000	Harper	Cochran; Wicker
RDTE,A	Smart Integrated Systems: Materials, Manufacturing Methods, and Structures	\$1,000,000	Herseth Sandlin	Johnson; Thune
RDTE,A	Smart Machine Platform Initiative	\$2,400,000	Driehaus; Tonko	Brown; Schumer; Voinovich
RDTE,A	Smart Oil Sensor	\$2,400,000	Thompson (PA)	Casey; Specter
RDTE,A	Smart Plug-In Hybrid Vehicle Program	\$3,280,000	Kilpatrick; Conyers; Dingell; Rogers (MI)	Levin; Stabenow
RDTE,A	Smart Sensor Supercomputing Center	\$8,000,000		Byrd
RDTE,A	Smart Wound Dressing for MRSA Infected Battlefield Wounds	\$800,000	Driehaus; Cummings; Ruppersberger; Scott (VA)	Cardin; Kerry; Voinovich; Warner; Webb
RDTE,A	Soldier Personal Cooling System	\$960,000	Kosmas	Nelson (FL)
RDTE,A	Soldier Protection through Unmanned Ground Vehicles	\$1,200,000	Nye	
RDTE,A	Soldier Situational Awareness Wristband	\$1,120,000	Capuano	
RDTE,A	Solid Oxide Fuel Cell Powered Tactical Charger	\$960,000	Maffei	Schumer
RDTE,A	Solid State Processing of Titanium Alloys for Advanced Materiel Armaments	\$1,200,000	Kaptur; LaTourette	
RDTE,A	Specialized Compact Automated Mechanical Clearance Platform	\$3,200,000	Murphy, Patrick (PA)	
RDTE,A	Spectroscopic Materials Identification Center	\$1,600,000	Berry	Lincoln; Pryor
RDTE,A	Spinal Cord Restoration Therapies	\$1,600,000	Hoyer; Cummings; Ruppersberger	Cardin
RDTE,A	Spinal Muscular Atrophy Research Program	\$3,000,000	Pelosi; Nadler; Rangel	Schumer
RDTE,A	Spinel Transparent Armor Production Technology	\$800,000	Ruppersberger	Cardin; Mikulski
RDTE,A	Squad Mission Support System (SMSS)	\$1,600,000		Cornyn
RDTE,A	Stabilized Enzyme Biofuel Cell (SEBC) for Unmanned Ground Sensors	\$1,200,000		Bond

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[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	Stabilized Hemoglobin Wound Healing Development	\$1,200,000	Herseht Sandlin	Johnson; Thune
RDTE,A	Standard Ground Station—Enhancement Program	\$2,000,000	Lance; Rothman	
RDTE,A	Standoff Hazardous Agent Detection and Evaluation System	\$8,500,000	Berry	Lincoln; Pryor
RDTE,A	Standoff Improvised Explosive Detection Program	\$4,800,000	Boyd; Berry; Brown, Corrine (FL); Hirono; Meek	Akaka; Lincoln; Nelson (FL); Pryor
RDTE,A	Standoff Sensors, Detection of Explosives and Explosive Devices (IEDs)	\$3,200,000	Kennedy; Langevin; Tsongas	Kerry; Kirk; Whitehouse
RDTE,A	Staph Vaccine	\$6,400,000		Conrad; Dorgan
RDTE,A	Stress Disorders Research Initiative at Fort Hood	\$2,400,000	Edwards (TX)	
RDTE,A	Superior Weapons Systems through Castings	\$1,600,000		Brownback; Roberts
RDTE,A	Superlattice Semiconductors for Mobile SS Lighting and Solar Power Applications	\$2,800,000	Hinchey	Schumer
RDTE,A	SupportNet for Frontline Providers	\$2,400,000	Lamborn; Perlmutter; Salazar	Udall (CO)
RDTE,A	Surveillance Augmentation Vehicle	\$1,200,000	Childers	Cochran; Wicker
RDTE,A	Sustainable Alternative Energy	\$2,000,000	Obey	
RDTE,A	Swarms Defense System	\$2,400,000	Aderholt	Shelby
RDTE,A	Synchrotron-Based Scanning Research Neuroscience and Proton Institute	\$6,000,000	Lewis (CA)	
RDTE,A	Tactical Cogeneration System	\$2,400,000	Hastings (WA)	Murray
RDTE,A	Tactical Metal Fabrication System (TacFab)	\$800,000	Turner; Adler; Andrews; Cole; Lance; Markey (MA); Ryan (OH); Tsongas	Inhofe; Kerry; Lautenberg; Menendez
RDTE,A	Tactical Overwatch High Altitude System	\$800,000	Griffith	
RDTE,A	Tactical UAV, Heavy Fuel Engine	\$1,600,000	Aderholt; Wilson (SC)	Graham; Shelby
RDTE,A	Tamper Proof Organic Packaging as Applied to Remote Armament Systems	\$4,800,000	Hinchey	Schumer
RDTE,A	Techniques to Manage Noncompressible Hemorrhage Following Combat Injury	\$2,000,000	Smith (TX); Carter; Gonzalez; Rodriguez	
RDTE,A	Technologies for Military Equipment Replenishment	\$1,600,000	Obey	Kohl
RDTE,A	Technology Development at the Quad Cities Manufacturing Laboratory	\$5,040,000	Hare	Grassley
RDTE,A	Technology for Rapid Foreign Language Acquisition for Specialized Military Intelligence Purposes	\$1,600,000		Gregg; Shaheen
RDTE,A	Technology Solutions for Brain Cancer Detection and Treatment	\$1,200,000	Cohen	
RDTE,A	Telepharmacy Robotic Medicine Device Unit	\$800,000	Brady (PA)	Casey; Specter
RDTE,A	Terahertz Sensing and Imaging Technology	\$1,600,000	Boozman	Lincoln; Pryor
RDTE,A	Testing of Microneedle Device for Multiple Applications	\$960,000	Baldwin	
RDTE,A	The Center for Neuroprosthetics and BioMEMS	\$1,600,000	McGovern	Kerry; Kirk
RDTE,A	Threat Detection and Neutralization	\$3,200,000	Mollohan	
RDTE,A	Tire to Track Transformer System for Light Vehicles	\$1,600,000	Peterson	Klobuchar
RDTE,A	Titanium Extraction, Mining and Process Engineering Research	\$4,800,000	Rehberg	Baucus; Tester
RDTE,A	Titanium Powder Advanced Forged Parts Program	\$3,040,000	Murtha	
RDTE,A	Transitioning Stretch Broken Carbon Fiber to Production Programs	\$3,200,000	Aderholt; Bishop (UT)	Bennett; Hatch
RDTE,A	Translational Research for Muscular Dystrophy	\$1,600,000	Michaud; Pingree (ME)	
RDTE,A	Transportable Renal Replacement Therapy for Battlefield Applications	\$800,000	Altmire	
RDTE,A	Trauma Care, Research and Training	\$2,400,000		Hutchison
RDTE,A	Trauma Response Simulation Training	\$1,200,000	Boswell	Harkin

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	Treatment of Battlefield Spinal Cord and Burn Injuries	\$360,000	Wu; Baird; Blumenauer; Schrader	Merkley; Murray; Wyden
RDTE,A	Tungsten Heavy Alloy Penetrator and Warhead Development	\$1,200,000	Carney	Specter
RDTE,A	Turbo Fuel Cell Engine	\$3,200,000	Murtha	
RDTE,A	UH-60 Aviation Software Performance Assessment Test Bed	\$5,690,000		Sessions; Shelby
RDTE,A	UH-60 Transmission / Gearbox Galvanic Corrosion Reduction	\$1,500,000	Kissell	Burr; Hagan
RDTE,A	Ultra Light Metallic Armor	\$800,000	Costello	Burris
RDTE,A	Ultra Light Weight Transmissions	\$1,600,000	Schauer	Levin; Stabenow
RDTE,A	Ultra Wideband Active RF Detection of IEDs	\$1,760,000		Tester
RDTE,A	Ultrasonic Impact Technology	\$2,000,000		Shelby
RDTE,A	Understanding Blast Induced Brain Injury	\$2,400,000	Fortenberry	Nelson (NE)
RDTE,A	Universal Control	\$7,200,000	Larson (CT)	Dodd; Lieberman
RDTE,A	University Center for Disaster Preparedness and Emergency Response	\$1,200,000	Pallone; Holt	
RDTE,A	University of Miami Ryder Trauma Center / William Lehman Injury Research Center	\$3,200,000	Diaz-Balart, Lincoln (FL)	
RDTE,A	Unmanned Aerial Systems Ground Based Sense and Avoid Capability Development for Integration into the National Air Space	\$2,880,000		Shelby
RDTE,A	Unmanned Aerial Vehicle Resupply (UAVR)—BURRO	\$3,200,000	Larson (CT)	Dodd; Lieberman
RDTE,A	Unmanned Ground Vehicle Initiative	\$11,000,000		Levin
RDTE,A	Unmanned Robotic System Utilizing a Hydrocarbon Fueled Solid Oxide Fuel Cell System	\$2,400,000	Dingell	Levin; Stabenow
RDTE,A	Unmanned System Algorithm Development	\$3,200,000	Mollohan	
RDTE,A	Unserviceable Ammunition Demilitarization via Chemical Dissolution at Tooele Army Depot	\$1,600,000	Bishop (UT)	Bennett; Hatch
RDTE,A	US Army Vascular Graft Research Project	\$1,600,000	Rehberg	Baucus; Tester
RDTE,A	Vanadium Safety Readiness	\$3,360,000	Dahlkemper; Paul; Space	
RDTE,A	Vanadium Technology Program	\$2,400,000	Wilson (SC)	
RDTE,A	Vectored Thrust Ducted Compound Helicopter	\$5,000,000		Carper; Casey; Cochran; Kaufman; Specter
RDTE,A	Vehicle Systems Engineering and Integration Activities	\$8,000,000		Levin
RDTE,A	VePro—Health Usage Monitoring and Vehicle Prognostics	\$2,880,000	Childers; Harper	Cochran; Levin; Wicker
RDTE,A	Vibration Management Enhancement Program	\$2,400,000		Feinstein
RDTE,A	Video Compression Technology	\$1,400,000	Holt	
RDTE,A	Vision Integrating Strategies in Ophthalmology and Neurochemistry	\$3,200,000	Granger	Cornyn
RDTE,A	Visualization for Training and Simulation in Urban Terrains at Fort Knox	\$1,200,000		McConnell
RDTE,A	Voice Recognition and Cross Platform Speech Interface System	\$2,000,000	Shuster	
RDTE,A	VSIL: Armored Vehicle Components and Systems Simulated In Cost-Effective Virtual Design and Test Environment	\$3,200,000		Levin; Stabenow
RDTE,A	VTOL Man-Rated UAV and UGV for Medical Multi-Missions and CASEVAC	\$800,000	Harman	
RDTE,A	Waterside Wide Area Tactical Coverage and Homing	\$3,200,000	Aderholt	
RDTE,A	Westchester County Medical Center Health Imaging Upgrades	\$1,200,000	Lowey	Schumer
RDTE,A	Wireless HUMS for Condition Based Maintenance of Army Helicopters	\$1,600,000	Rothman	Lautenberg; Menendez
RDTE,A	Wireless Medical Monitoring System	\$2,400,000	Boswell; Latham; Miller, Gary (CA)	Grassley; Harkin

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[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,A	Womens Cancer Genomics Center	\$2,400,000	McCarthy (NY); Lowey	Schumer
RDTE,A	Wounded Servicemember Bioelectrics Research	\$1,200,000	Nye	Warner; Webb
RDTE,A	Zinc-Flow Electrical Energy Storage	\$2,000,000	Johnson (IL)	
RDTE,A	Zouline Armor	\$3,360,000		Bond
RDTE,A	Zumwalt National Program for Countermeasures to Biological and Chemical Threats	\$1,200,000	Neugebauer	
RDTE,AF	3D Bias Woven Perform Development	\$2,400,000	Schwartz; Gerlach; Sestak	Specter
RDTE,AF	Accelerated Insertion of Advanced Materials and Certification for Military Aircraft Structure Material Substitution and Repair	\$2,000,000	Tiahrt	Brownback; Roberts
RDTE,AF	Accelerator-Driven Non-Destructive Testing	\$2,000,000	Simpson	Crapo; Risch
RDTE,AF	ACES 5 Ejection Seat	\$1,920,000	Lamborn; Pastor (AZ); Tauscher	Bennett; Burr; Cochran; Dodd; Hatch; Lieberman; Wicker
RDTE,AF	Advance Propulsion Non-Tactical Vehicle	\$1,600,000	Massa	Bingaman; Schumer; Udall (NM)
RDTE,AF	Advanced Aerospace Carbon Foam Heat Exchangers	\$3,200,000	Wilson (OH)	Voinovich
RDTE,AF	Advanced Deformable Mirrors for High Energy Laser Weapons	\$1,600,000	Heinrich	Bingaman; Udall (NM)
RDTE,AF	Advanced Electromagnetic Location of IEDs Defeat System	\$1,200,000	Kaptur	
RDTE,AF	Advanced Electronic Components for Sensor Arrays	\$2,400,000	Young (FL)	
RDTE,AF	Advanced Fast Steering Mirror Applications for 3-D LADAR in LITENING Pod	\$1,600,000		Conrad; Dorgan
RDTE,AF	Advanced Fiber Lasers Systems and Components	\$3,200,000		Murray
RDTE,AF	Advanced Integrated Microsystems for Military Electronic Systems	\$2,480,000		Cochran; Wicker
RDTE,AF	Advanced Lithium Battery Scale-up and Manufacturing	\$1,600,000	Scott (GA); Bishop (GA); Johnson (GA)	Chambliss
RDTE,AF	Advanced Modular Avionics for Operationally Responsive Satellite Use	\$2,480,000	Heinrich	Bingaman; Udall (NM)
RDTE,AF	Advanced Night Vision System—Cockpit Integration	\$800,000		Murray
RDTE,AF	Advanced Tactical Laser	\$2,240,000		Bingaman; Udall (NM)
RDTE,AF	Advanced Technical Intelligence Center (ATIC)	\$5,200,000	Turner	Brown; Voinovich
RDTE,AF	Advanced Vehicle Propulsion Center	\$2,400,000	McKeon	
RDTE,AF	Aerospace Lab Equipment Upgrade	\$1,200,000	Napolitano	
RDTE,AF	Aerospace Laser Micro Engineering Station	\$800,000	Wittman; Nye; Scott (VA)	
RDTE,AF	AFRL Edwards Rocket Test Stand 2-A Technical Improvements	\$3,200,000	McCarthy (CA)	Feinstein
RDTE,AF	AFRL Seismic Research Program	\$5,000,000	Markey (MA)	Kerry; Kirk; Leahy
RDTE,AF	Air Force Minority Leaders Program	\$4,800,000	Abercrombie	Alexander; Corker; Hutchison; Landrieu
RDTE,AF	Aircraft Evaluation Readiness Initiative	\$2,400,000	Latham	Grassley; Harkin
RDTE,AF	ALC Logistics Integration Environment	\$800,000	Shuster	
RDTE,AF	Algal Biofuels for Aviation	\$2,400,000	Teague	Bingaman; Udall (NM)
RDTE,AF	Algal-Derived Jet Fuel for Air Force Applications	\$2,700,000	LaTourette	
RDTE,AF	Applications of LIDAR to Vehicles with Analysis	\$6,000,000		Inouye
RDTE,AF	Assessment of Alternative Energy for Aircraft Ground Equipment (AGE)	\$1,600,000	Wu	Merkley; Wyden
RDTE,AF	AT-6B Demonstration for ANG	\$7,000,000	Tiahrt	Brownback; Roberts
RDTE,AF	Automated Processing of Advanced Low Observables (RAPALO)	\$1,200,000		Brown

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Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,AF	B-1 AESA Radar Operational Utility Evaluation	\$2,000,000	Herseeth Sandlin	Johnson; Thune
RDTE,AF	B-2 Advanced Tactical Data Link	\$9,600,000	McKeon	Feinstein
RDTE,AF	B-52 Tactical Data Link Capability	\$6,000,000	Tiahrt	Brownback; Roberts
RDTE,AF	Backpack Medical Oxygen System (BMOS)	\$800,000	Akin	Bond
RDTE,AF	Ballistic Missile Technology	\$1,600,000	Young (FL)	Nelson (FL)
RDTE,AF	Base Facility Energy Independence, Stewart Air National Guard Base	\$4,000,000	Hinchey	Schumer
RDTE,AF	BATMAV Program Miniature Digital Data Link	\$1,600,000	Young (FL)	
RDTE,AF	Big Antennas Small Structures Efficient Tactical UAV	\$1,600,000	Harman	
RDTE,AF	Bio-JP8 Fuel Development	\$4,000,000	Boyd	Nelson (FL)
RDTE,AF	Biometric Signature and Passive Physiological Monitoring	\$5,000,000	Berkley	Reid
RDTE,AF	Body Armor Improved Ballistic Protection, Research and Development	\$1,760,000	Murtha	
RDTE,AF	CAD / CAM Aircraft Structural Overhaul Work Center	\$2,500,000	Bishop (UT)	Bennett
RDTE,AF	Carbon Nano-Materials for Advanced Aerospace Applications	\$800,000	Culberson	
RDTE,AF	Carbon Nanotube Enhanced Power Sources for Space	\$1,600,000	Markey (MA)	Kerry
RDTE,AF	Center for Solar Electricity and Hydrogen	\$4,000,000	Kaptur	
RDTE,AF	Center for Space Entrepreneurship	\$1,600,000	Polis	
RDTE,AF	Center for UAS Research, Education and Training	\$6,400,000	Pomeroy	Conrad; Dorgan
RDTE,AF	Close Proximity Space Situational Awareness	\$800,000	Edwards (TX)	
RDTE,AF	Coal Transformation Laboratory	\$800,000		Lugar
RDTE,AF	Command and Control Service Level Management (C2SLM) Program	\$3,200,000	Blunt	
RDTE,AF	Conducting Polymer Stress and Polymer Damage Sensors for Composites	\$2,880,000		Cochran; Wicker
RDTE,AF	Consortium for Nanomaterials for Aerospace Commerce and Technology (CONTACT)	\$3,200,000	Culberson	Hutchison
RDTE,AF	Corrosion Detection and Visualization Program	\$800,000	Smith (WA)	Murray
RDTE,AF	COTS Technology for Space Command and Control	\$3,200,000	Gerlach	Specter
RDTE,AF	Cyber Attack and Security Environment	\$4,000,000	McHugh; Arcuri	Gillibrand; Schumer
RDTE,AF	Cyber Innovation Center (CIC) Research and Development Seed Fund	\$800,000		Landrieu; Vitter
RDTE,AF	Cyber Security Research Program / Cyber Security Laboratory	\$1,200,000	Alexander	Landrieu
RDTE,AF	Cybersecurity of Security Control Networks	\$1,700,000	Terry	Nelson (NE)
RDTE,AF	Demonstration and Validation of Renewable Energy Technology	\$800,000	Bishop (GA)	
RDTE,AF	Development and Testing of Advanced Hybrid Rockets for Space Applications	\$2,800,000	Lofgren	
RDTE,AF	Development and Validation of Advanced Design Technologies for Hypersonic Research	\$1,600,000		Klobuchar
RDTE,AF	Development of Deployable Biosensors	\$1,600,000		Reid
RDTE,AF	Development of Mobile Wind Turbine Systems to Power Forward Bases	\$1,200,000		Brown
RDTE,AF	Distributed Mission Interoperability Toolkit (DMIT)	\$3,200,000	LoBiondo; Andrews; Sestak	
RDTE,AF	Domestic Manufacturing of 45nm Electronics	\$3,200,000	Simpson	Crapo; Risch
RDTE,AF	Eagle Vision III Upgrades	\$4,800,000		Boxer; Feinstein
RDTE,AF	Efficient Utilization of Transmission Hyperspace	\$2,000,000	Arcuri	Schumer
RDTE,AF	Eglin AFB Range Operations Control Center	\$2,000,000	Miller (FL)	
RDTE,AF	Electromagnetic Battlespace Management	\$1,600,000	Edwards (TX)	

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[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,AF	EMI Grid Fabrication Technology	\$2,400,000	Bono Mack	
RDTE,AF	Energy and Sensor Informatics Research and Translation	\$800,000	Lee (NY)	Schumer
RDTE,AF	Energy Efficiency, Recovery and Generation (ENERGY)	\$1,000,000	Herseth Sandlin	Johnson; Thune
RDTE,AF	Energy Superior Lithium Battery Technology for Defense Applications	\$1,600,000		Bond
RDTE,AF	Engine Health Management Plus Data Repository Center	\$2,400,000	Murtha	
RDTE,AF	F-15C AESA Classified Demo	\$8,000,000	Harper	Cochran; Wicker
RDTE,AF	Fine Water Mist Fire Suppression Technology to Replace Halon	\$2,000,000	Boyd	Nelson (FL)
RDTE,AF	Fire and Blast Resistant Materials for Force Protection	\$3,200,000		Kerry; Kirk; Kohl
RDTE,AF	FLASH Hyper-Dimensional Imaging for Near Space Surveillance and Ballistic Missile Defense	\$2,000,000		Akaka; Inouye
RDTE,AF	Florida National Guard Total Force Integration	\$2,400,000	Young (FL)	
RDTE,AF	Frank R. Seaver Science and Engineering Initiative	\$1,760,000	Waters	
RDTE,AF	Freedom Fuels/Coal Fuel Alliance	\$3,920,000	Davis (KY)	Bunning
RDTE,AF	Gallium Nitride (GaN) Microelectronics and Materials	\$1,600,000	Coble	Hagan
RDTE,AF	GAPS/AWS Horizontal Integration	\$4,000,000	Murtha	
RDTE,AF	Global UAS Networking and Interoperability System (GUNIS)	\$4,000,000		Murray
RDTE,AF	Hawaii Microalgae Biofuel Project	\$3,520,000	Hirono	Inouye
RDTE,AF	High Accuracy Network Determination System—Intelligent Optical Network for Space Situational Awareness	\$5,000,000	Abercrombie	Inouye
RDTE,AF	High Bandwidth, High Energy Storage, Exawatt Laser Glass Development	\$2,800,000	Kanjorski	
RDTE,AF	High Energy Li-Ion Technology for Aviation Batteries	\$1,200,000	Bishop (GA)	Chambliss; Isakson
RDTE,AF	High Pressure Pure Air Generator System	\$1,600,000	Frelinghuysen	
RDTE,AF	High Temperature Hydrogen Energy Production Facility	\$800,000		Hutchison
RDTE,AF	Holloman High Speed Test Track	\$5,000,000	Teague	Bingaman; Udall (NM)
RDTE,AF	Hybrid Bearings	\$800,000	Shuler; Coble; Wilson (OH)	Dodd; Gregg; Hagan; Lieberman; Shaheen
RDTE,AF	Hybrid Materials Integration (HMI)	\$2,000,000	Kilroy	Brown; Voinovich
RDTE,AF	Hybrid Nanoparticle-based Coolant Technology Development and Manufacturing	\$800,000	Dent	
RDTE,AF	Imaging Tools for Human Performance Enhancement and Diagnostics	\$1,600,000		Voinovich
RDTE,AF	Information Quality Tools for Persistent Surveillance Data Sets	\$1,440,000	Snyder	Lincoln; Pryor
RDTE,AF	Institute for Science and Engineering Simulation/Aircraft Fatigue Modeling and Simulation	\$3,600,000	Burgess	Hutchison
RDTE,AF	Integrated Engine Starter/Generator	\$1,600,000	Turner	Brown; Voinovich
RDTE,AF	Integrated Passive Electronic Components	\$1,360,000	Simpson	Crapo; Risch
RDTE,AF	Integrated Propulsion Analysis and Spacecraft Engineering Tools (IPAT/ISSET)	\$4,800,000	Lewis (CA)	
RDTE,AF	Inter-Base Facility Energy Independence	\$2,400,000	Kaptur	
RDTE,AF	Large Area, APVT Materials Development for High Power Devices	\$1,600,000	Frelinghuysen	Lautenberg; Menendez
RDTE,AF	Laser Peening for Friction Stir Welded Aerospace Structures	\$1,600,000	Tiahrt	Roberts
RDTE,AF	LGX High Temperature Acoustic Wave Sensors	\$1,600,000	Michaud; Pingree (ME)	Collins; Snowe
RDTE,AF	Lightning Protection of Composites	\$3,000,000		Brownback
RDTE,AF	Long-Loiter, Load Bearing Antenna Platform for Pervasive Airborne Intelligence	\$4,000,000	Blunt	
RDTE,AF	Low-Defect Density Gallium Nitride Materials for High-Performance Electronic Devices	\$2,800,000	Price (NC)	

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,AF	Low-Earth Orbit Nanosatellite Integrated Defense Autonomous Systems (LEONIDAS)	\$4,750,000		Inouye
RDTE,AF	Materials Integrity Management Research for the Air Force	\$3,000,000		Roberts
RDTE,AF	Maui Space Surveillance System Operations and Research	\$19,500,000		Inouye
RDTE,AF	Methanol Fuel Cell Development for USAF Battlefield Renewable Integrated Tactical Energy System (BRITES)	\$2,400,000	Tauscher	Feinstein
RDTE,AF	Micromachined Switches for Next Generation Modular Satellites	\$2,400,000	Miller, George (CA)	
RDTE,AF	Micro-Satellite Serial Manufacturing to Include Academic Outreach Educational Program	\$1,200,000	Harman	
RDTE,AF	Mid-IR Laser Materials	\$800,000		Lautenberg; Menendez
RDTE,AF	Military Waste-to-Energy Project using the Hydro-Thermal Energy Conversion (Hy-TEC) Process	\$1,600,000		Johnson; Thune
RDTE,AF	Minuteman III Advanced Third Stage Domestic Fiber Motor Case Development	\$2,400,000	Lungren	
RDTE,AF	Mission Design and Analysis Tool	\$1,600,000	Kingston	
RDTE,AF	Mitigating RoHS Lead-Free Issues in Aerospace Circuit Board Manufacturing	\$800,000	Kaptur; Sutton	Voinovich
RDTE,AF	Mobile Laser Systems for Aircraft Structures (MLSAS)	\$800,000		Voinovich
RDTE,AF	MPOI for Battlespace Information Exchange	\$2,900,000		Reid
RDTE,AF	Multi Sensor Detect, Sense and Avoid (MSDSA)	\$3,200,000		Reid
RDTE,AF	Multiband Realtime Hyperspectral Targeting Sensor	\$1,840,000	Hodes	Gregg; Shaheen
RDTE,AF	Multilingual Text Mining Platform for Intelligence Analysts	\$800,000	Lee (NY)	
RDTE,AF	Multi-Mode Propulsion Phase IIA: High Performance Green Propellant	\$1,600,000	Kratovil	
RDTE,AF	Multiple UAS Cooperative Concentrated Observation and Engagement Against a Common Ground Objective	\$1,600,000	Bartlett	
RDTE,AF	National Test Facility for Aerospace Fuels Propulsion	\$1,312,000	Buyer	
RDTE,AF	Net-Centric Sensor Grids	\$2,400,000	Hill	Lugar
RDTE,AF	Next Generation Casting Initiative	\$4,000,000	Blumenauer	Levin; Reid; Stabenow
RDTE,AF	Next Generation Simulation Training for Pararescue Forces	\$1,600,000	Rehberg	Baucus; Tester
RDTE,AF	Next Generation Solar Electric In-Space Propulsion	\$800,000	Inslee	Murray
RDTE,AF	Nuclear Enterprise Surety Tracking	\$4,000,000	Fleming	
RDTE,AF	ONAMI Safer Nanomaterials and Nanomanufacturing	\$3,520,000	DeFazio; Blumenauer; Schrader; Walden; Wu	Merkley; Wyden
RDTE,AF	On-Chip Integrated Photonic Polymer Transceiver	\$4,500,000		Murray
RDTE,AF	Open Source Research Centers	\$1,000,000	Turner	
RDTE,AF	P5CTS Equipment for the MT Joint Training Environment	\$3,000,000		Baucus
RDTE,AF	PanSTARRS	\$9,500,000		Inouye
RDTE,AF	Partnership for Energy and Automation Technologies	\$1,600,000	Duncan	Corker
RDTE,AF	Pennsylvania NanoMaterials Commercialization Center	\$800,000	Doyle	
RDTE,AF	Planar Lightwave Circuit Development for High Power Military Laser Applications	\$2,400,000	Lance; Rothman	Lautenberg; Menendez
RDTE,AF	P-Net Ballistic Missile Technology	\$2,000,000		Murkowski
RDTE,AF	Predator C	\$1,200,000	Bilbray; Hunter; McKeon	
RDTE,AF	Process Integrated Mechanism for Human-Computer Collaboration and Coordination	\$800,000	Stearns	
RDTE,AF	Production of Nanocomposites for Aerospace Applications	\$1,600,000	Turner	
RDTE,AF	RAND Project Air Force	\$1,600,000	Moran (VA)	Feinstein

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,AF	Rapid Small Satellite Development Test Facilities	\$1,600,000		Gregg
RDTE,AF	Real-time Optical Surveillance Applications	\$3,500,000		Inouye
RDTE,AF	Reconfigurable Electronics and Non-Volatile Memory Research	\$800,000		Crapo; Risch
RDTE,AF	Reconfigurable Secure Computing	\$1,600,000	Moran (VA)	Warner; Webb
RDTE,AF	Reconstitution of B-52 Nuclear Capability Study	\$2,400,000	Fleming	
RDTE,AF	Remote Language-Independent Suspect Identification	\$2,560,000	Alexander	Landrieu
RDTE,AF	Renewable Hydrocarbon Fuels for Military Applications	\$2,000,000	Kucinich; Kaptur	Brown
RDTE,AF	Rivet Joint Services Oriented Architecture	\$2,000,000	Hall (TX)	
RDTE,AF	Safeguarding End-User Military Software	\$4,000,000	Fortenberry	Nelson (NE)
RDTE,AF	Senior Scout Communications Intelligence (COMINT) Capability Upgrade	\$2,400,000	Andrews; LoBiondo	
RDTE,AF	Sewage-Derived Biofuels Project	\$3,840,000		Cochran; Wicker
RDTE,AF	SiC—RF Power for Airborne Avionics Systems	\$1,600,000		Merkley; Wyden
RDTE,AF	Silicon Carbide Electronics Material Producibility Initiative	\$5,040,000	Harper	Cochran; Wicker
RDTE,AF	Silicon Carbide Power Modules for the F-35 Joint Strike Fighter	\$2,400,000	Boozman	Lincoln; Pryor
RDTE,AF	Small Responsive Spacecraft at Low-Cost	\$2,400,000	Bishop (UT)	
RDTE,AF	Small Turbofan Versatile Affordable Advanced Turbine Engine Program	\$3,200,000	Pastor (AZ)	
RDTE,AF	Space Sensor Data Link Technology	\$4,800,000		Bennett
RDTE,AF	Space Situational Awareness	\$4,000,000	Markey (MA)	Kerry; Kirk
RDTE,AF	Split Discharge Variable Delivery Pump for Military Aircraft	\$1,600,000		Dodd
RDTE,AF	Strategic Biofuels Supply System	\$1,600,000	Rodriguez	Cornyn
RDTE,AF	Sustainable Energy Vermont National Guard	\$4,000,000		Sanders
RDTE,AF	Synthetic Liquid Fuels	\$2,400,000	Young (AK)	
RDTE,AF	Technical Order Modernization Environment	\$1,200,000	Kaptur	
RDTE,AF	Temperature Resistant Landing Pad Jet Blast Protection	\$800,000		Casey; Specter
RDTE,AF	Texas Research Institute for Environmental Studies	\$800,000	Rodriguez	
RDTE,AF	Thermal and Energy Management for Aerospace	\$3,200,000	Manzullo	Burris; Durbin
RDTE,AF	Thunder Radar Pod	\$1,600,000	Blunt	Bond
RDTE,AF	Transportable Transponder Landing System	\$2,400,000		Merkley; Wyden
RDTE,AF	UAV Sensor and Maintenance Development Center	\$3,920,000	Bishop (UT)	Hatch
RDTE,AF	Ultra-High Temperature Materials for Hypersonic Aerospace Vehicles	\$2,400,000	Emerson	
RDTE,AF	Unmanned Aerial System Exploitation	\$3,500,000		Voinovich
RDTE,AF	Unmanned Aerial Systems Mission Planning and Operation Center	\$2,800,000	Moran (KS)	
RDTE,AF	Unmanned Sense, Track, and Avoid Radar	\$1,600,000	Lamborn	
RDTE,AF	Watchkeeper	\$1,600,000	Rehberg	
RDTE,AF	Water for Injection and Air Purification with Carbon Nanotube Nanostructured Material	\$2,940,000		Leahy
RDTE,AF	Wavelength Agile Spectral Harmonic Oxygen Sensor and Cell-Level Battery Controller	\$1,200,000	Dreier	
RDTE,AF	Wire Integrity Technology	\$1,600,000	Marshall; Bishop (GA)	
RDTE,DW	3-D Electronics and Power	\$4,800,000	Calvert	
RDTE,DW	3-D Technology for Advanced Sensor Systems	\$2,000,000	Simpson	Crapo; Risch

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[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,DW	Active Duty Training and Education Program	\$2,000,000	Clyburn	
RDTE,DW	Advance Detection of Special Nuclear Materials	\$2,000,000		Lugar
RDTE,DW	Advanced Battery Technology	\$1,600,000	Young (FL)	
RDTE,DW	Advanced Composite Radome	\$3,200,000		Gregg
RDTE,DW	Advanced Decision Support System	\$2,000,000	Rothman; Payne	Menendez
RDTE,DW	Advanced Development of Antiviral Prophylactics and Therapeutics	\$3,000,000	Pelosi	
RDTE,DW	Advanced Development of Mobile Rapid Response Prototypes	\$2,400,000	Rothman	Lautenberg; Menendez
RDTE,DW	Advanced Distributed Aperture System (ADAS) / Hostile Fire Indicating System (HFIS)	\$1,040,000		Hutchison
RDTE,DW	Advanced Materials Research Institute (AMRI)	\$800,000		Landrieu; Vitter
RDTE,DW	Advanced SAM Hardware Simulator Development	\$4,000,000	Bishop (GA); Johnson (GA); Scott (GA)	Chambliss; Isakson
RDTE,DW	Advanced Scientific Missile Intelligence Preparation of the Battlespace	\$2,000,000	Griffith	
RDTE,DW	Advanced Technologies Sensors and Payloads / Unattended SIGINT Node	\$4,800,000	Lewis (CA)	
RDTE,DW	Advanced, Long Endurance Unattended Ground Sensor Technologies	\$3,920,000	Harper; Childers; Taylor	Cochran; Wicker
RDTE,DW	AELED IED / WMD Electronic Signature Detection	\$4,800,000	Murtha	
RDTE,DW	AESA Technology Insertion Program	\$2,400,000	Ackerman; McCarthy (NY)	Schumer
RDTE,DW	Affordable Miniature FOPEN Radar for Special Operations Craft—Riverine	\$2,800,000	Murtha	
RDTE,DW	Affordable Robust Mid-Sized Unmanned Ground Vehicle	\$1,600,000	Tsongas	
RDTE,DW	Agile Software Capability Intervention (ASCI)	\$1,200,000		Bond
RDTE,DW	Aging Systems Sustainment and Enabling Technologies	\$2,400,000	Lucas	Inhofe
RDTE,DW	Alternative Energy Study	\$1,400,000		Feinstein
RDTE,DW	Alternative SOF Submersible Concept Design Study	\$1,000,000	Scalise	Landrieu; Vitter
RDTE,DW	American Museum of Natural History Infectious Disease Research	\$1,200,000	Lowey; Nadler	Schumer
RDTE,DW	Antennas and other CNT Devices for Intelligence / Special Military	\$3,000,000		Bond
RDTE,DW	Anti-viral Vaccine Development	\$3,600,000	Latham	Grassley; Harkin
RDTE,DW	Armed Forces Health and Food Supply Research	\$4,000,000		Roberts
RDTE,DW	Army Plant Vaccine Development Program	\$1,600,000		Carper; Kaufman
RDTE,DW	ASIC Miniaturization for Lasers and Sensors Development	\$2,400,000		Leahy
RDTE,DW	Automated Sample Preparation for Biological Detection	\$800,000	Slaughter; Bartlett	Gillibrand; Schumer
RDTE,DW	Autonomous Control and Video Sensing for Robots	\$800,000	Lee (NY)	Schumer
RDTE,DW	Autonomous Machine Vision for Mapping and Investigation of Remote Sites	\$1,600,000	Davis (CA)	
RDTE,DW	Battle-Proven Packbot	\$1,200,000	Tierney	Kerry
RDTE,DW	BioButanol Production Research	\$2,000,000	Clyburn	
RDTE,DW	Biofuels Program	\$1,600,000		Levin
RDTE,DW	Biological and Chemical Warfare Online Repository of Technical Holdings	\$2,000,000	Hastings (WA)	Murray
RDTE,DW	Biometric Optical Surveillance System	\$6,000,000	Guthrie	McConnell
RDTE,DW	BOPPER / COPPER—Bioterrorism Operations Policy for Public Emergency / Chemoterrorism Operations Policy for Public Emergency	\$1,000,000		Burr
RDTE,DW	Border Security and Defense Systems Research	\$1,600,000		Hutchison
RDTE,DW	Botulinum Neurotoxin Research	\$2,000,000	Baldwin	

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,DW	Botulinum Toxin Treatment Therapy	\$800,000	Bishop (GA)	
RDTE,DW	Broad Spectrum Therapeutic Countermeasure to OP Nerve Agents	\$1,600,000	DeLauro	Dodd
RDTE,DW	California Enhanced Defense Small Manufacturing Suppliers Program	\$1,600,000	Roybal-Allard	
RDTE,DW	Carbon Nanotube Thin Film Near Infrared Detector	\$1,600,000	Lewis (CA)	
RDTE,DW	CBRN Detection Unmanned Aircraft	\$1,600,000	Young (FL)	
RDTE,DW	Cellulosic-Derived Biofuels Research	\$2,400,000	Chandler	
RDTE,DW	Center for Education and Research on Corrosion and Materials Performance	\$1,600,000	Ryan (OH); Sutton	Brown
RDTE,DW	Center for Innovation at Arlington	\$2,700,000		Hutchison
RDTE,DW	Center for Intelligence and Security Studies	\$2,400,000		Cochran; Wicker
RDTE,DW	Center for Nonproliferation Studies, Monterey Institute for International Affairs	\$1,600,000	Berman	
RDTE,DW	Center for Research on Minority Health Prostate Cancer Outreach Project	\$800,000	Jackson-Lee (TX); Green, Al (TX)	
RDTE,DW	Center of Excellence for Research in Ocean Sciences (CEROS)	\$8,000,000		Inouye
RDTE,DW	Chemical and Biological Agent Fate Appropriate Response Operational Tool	\$1,600,000	Kildee	Levin; Stabenow
RDTE,DW	Chemical and Biological Defense Program—Advanced Development	\$2,000,000	Baldwin	
RDTE,DW	Chemical and Biological Infrared Detection System	\$1,900,000		Collins
RDTE,DW	Chemical and Biological Resistant Clothing	\$1,600,000	Sestak; Gerlach	Casey; Specter
RDTE,DW	Chemical and Biological Threat Reduction Coating	\$2,400,000	Barrett	
RDTE,DW	Commodity Management Systems Consolidation Program	\$1,600,000		Byrd
RDTE,DW	Comprehensive and Integrated Procedures for Risk Assessment and Resource Allocation	\$2,000,000	Brady (PA)	
RDTE,DW	Comprehensive Maritime Domain Awareness	\$3,200,000	Young (FL)	
RDTE,DW	Contaminated Human Remains Pouch	\$1,600,000		Brownback; Roberts
RDTE,DW	Continuous Acquisition and Life-Cycle Support (CALS) Integrated Data Environment and Defense Logistics Enterprise Services Program (DLES)	\$3,200,000		Byrd
RDTE,DW	Copper-base Casting Technology Applications	\$1,600,000	Perlmutter	
RDTE,DW	Corrosion Resistant Ultrahigh-Strength Steel for Landing Gear	\$1,600,000	Schakowsky	
RDTE,DW	Corrosion Training Simulation Program	\$1,200,000	Oberstar	Klobuchar
RDTE,DW	Countermeasures to Chemical and Biological Controls—Rapid Response	\$2,800,000	Young (FL)	Nelson (FL)
RDTE,DW	Countermeasures to Combat Protozoan Parasites (Toxoplasmosis and Malaria)	\$1,600,000	Young (FL)	
RDTE,DW	Counterproliferation Analysis and Planning System	\$4,000,000	McNerney; Tauscher	
RDTE,DW	Covert Sensing and Tagging System	\$1,200,000		Akaka; Inouye
RDTE,DW	Covert Waveform for Software Defined Radios	\$2,800,000	Gingrey (GA)	Isakson
RDTE,DW	Cybersecurity and Operational Identity Management	\$1,600,000	Farr	
RDTE,DW	Detection and Remediation of Bio/Chemical Weapons Program	\$2,000,000	Clyburn	
RDTE,DW	Disaster Response: Communications and Other Infrastructure Restoration	\$4,000,000		Crapo; Risch
RDTE,DW	Distributed Network Switching and Security	\$1,600,000	Sanchez, Loretta (CA)	
RDTE,DW	DLA VetBiz Initiative for National Sustainment	\$800,000	Sarbanes	
RDTE,DW	Dynamic Data Flow Management System	\$1,600,000	Pomeroy	Conrad; Dorgan
RDTE,DW	EC-130J Multi-Mission Upgrades	\$4,000,000		Specter
RDTE,DW	Electric Grid Reliability/Assurance	\$800,000		Crapo; Risch

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,DW	Electronics and Materials for Flexible Sensors and Transponders (EMFST)	\$4,800,000	Pomeroy	Conrad; Dorgan
RDTE,DW	Emergency Egress System	\$1,600,000		Leahy
RDTE,DW	End to End Semi Fab Alpha Tool	\$1,600,000	Sanchez, Loretta (CA)	
RDTE,DW	Enhanced Simulation for Information Operations Capabilities	\$4,720,000		Cochran
RDTE,DW	Enhancement of Geo-location Systems	\$3,200,000	Posey	
RDTE,DW	Environmentally Friendly Nanometal Electroplating Processes for Cadmium and Chromium Replacement	\$3,000,000	Obey	
RDTE,DW	Expeditionary Surveillance and Reconnaissance Program	\$4,000,000		Byrd
RDTE,DW	Facility Security Using Tactical Surveys	\$3,600,000	Lewis (CA)	
RDTE,DW	Feature Size Yield Enhancement Advanced Reconfigurable Manufacturing for Semiconductors Foundry	\$2,400,000	Lungren; Matsui	
RDTE,DW	Field Experiment Program for Special Operations	\$1,600,000	Farr	
RDTE,DW	FirstLink Technology Transfer Program	\$2,400,000	Murtha	
RDTE,DW	Flashlight Soldier-to-Soldier Combat Identification System	\$4,500,000	Granger; Rodriguez	Cornyn
RDTE,DW	Fuel Cell Hybrid Battery Manufacturing for Defense Operations	\$800,000		Cardin; Mikulski
RDTE,DW	Fuelcell Locomotive	\$2,400,000		Brownback
RDTE,DW	Future Dry Deck Shelter	\$4,400,000	Courtney; Kennedy	Dodd; Lieberman; Reed
RDTE,DW	GMTI Radar for Class II UAVs	\$800,000	Moran (VA)	
RDTE,DW	Gulf Range Mobile Instrumentation Capability	\$2,400,000	Miller (FL)	
RDTE,DW	Hand-Held Apparatus for Mobile Mapping and Expedited Reporting	\$2,800,000	Murtha	Casey
RDTE,DW	Hand-held, Lethal Small Unmanned Aircraft System	\$1,000,000	Dreier	
RDTE,DW	Hawaii Advanced Laboratory for Information Integration	\$2,000,000		Inouye
RDTE,DW	Helicopter Cable Warning and Obstacle Avoidance	\$1,200,000	Harman	Isakson
RDTE,DW	Heterogeneous Gallium Nitride/Silicon Microcircuit Technology	\$1,600,000	Lungren	
RDTE,DW	High Efficiency Solar Energy Generation and Storage	\$800,000	Jackson-Lee (TX)	
RDTE,DW	High Performance Computational Design of Novel Materials	\$3,120,000		Cochran; Wicker
RDTE,DW	High Performance Tunable Materials—Combinatorial Development of Advanced Dielectrics	\$3,600,000	Pomeroy	Conrad; Dorgan
RDTE,DW	High Speed Optical Interconnects for Next Generation Supercomputing	\$1,200,000	Dent	Specter
RDTE,DW	High Speed, High Volume Laboratory Network for Infectious Disease	\$1,600,000		Boxer
RDTE,DW	Hydrogen Fuel Cell Research	\$4,000,000	Clyburn	
RDTE,DW	IASTAR Federal Information Security Management Act Compliance	\$1,600,000		Bond
RDTE,DW	IdentClarity-Identity Resolution	\$1,440,000		Lincoln; Pryor
RDTE,DW	Improving Support to the Warfighter	\$7,000,000	Lewis (CA)	
RDTE,DW	Independent Advisory Group to Review Ballistic Missile Defense Training Needs	\$500,000	Lamborn	
RDTE,DW	Initiative to Advance Adaptive Petascale Supercomputing	\$8,000,000	Ruppersberger; Wu	Alexander; Corker
RDTE,DW	Inland Empire Perchlorate Remediation	\$3,500,000		Boxer
RDTE,DW	Institute for Collaborative Sciences Research	\$2,080,000	Diaz-Balart, Lincoln (FL); Meek; Wasserman Schultz	Nelson (FL)
RDTE,DW	Institute of Advanced Flexible Manufacturing Systems	\$7,000,000		Byrd
RDTE,DW	Integrated Analysis Environment	\$2,000,000	Moran (VA)	Warner; Webb
RDTE,DW	Integrated Cryo-cooled High Power Density Systems	\$3,200,000	Boyd	Nelson (FL)

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,DW	Integrated Rugged Checkpoint Container	\$2,000,000	Taylor	Cochran; Wicker
RDTE,DW	Intelligence, Surveillance, and Reconnaissance Global Sensors Architecture	\$1,600,000	Young (FL)	
RDTE,DW	Intelligent Explosives Detection	\$3,200,000	Bartlett; Ruppersberger; Sarbanes	Cardin
RDTE,DW	Intelligent Remote Sensing for Urban Warfare Operations II	\$1,200,000	Sestak	Casey
RDTE,DW	InVitro Models for Biodefense Vaccines	\$1,520,000	Brown, Corrine (FL)	Nelson (FL)
RDTE,DW	Joint Gulf Range Complex Test and Training	\$2,400,000	Miller (FL)	
RDTE,DW	Joint Robotics Training Program	\$2,000,000	Clyburn	
RDTE,DW	Joint Services Aircrew Mask Don/Doff Inflight Upgrade	\$2,400,000	Castle	Carper; Kaufman
RDTE,DW	Laboratory for Advanced Photonic Composites Research	\$1,280,000	Barrett	
RDTE,DW	Laser Ablation Resonance Ionization Mass Spectrometer	\$2,400,000	Polis	
RDTE,DW	Lifetime Power for Wireless Control Sensors	\$800,000	Altmire	
RDTE,DW	Lithium-ion Battery Safety Detection and Control of Impending Failures	\$1,500,000	Carson	Lugar
RDTE,DW	Low Cost Stabilized Turret	\$800,000	Crenshaw	
RDTE,DW	Man Portable Sensors for Dismounted Reconnaissance	\$2,000,000		Mikulski
RDTE,DW	MARCENT Thermal Imaging Suite	\$3,000,000		Gregg
RDTE,DW	Material, Design and Fabrication Solutions for Advanced SEAL Delivery System External Structural Components	\$2,000,000	Simpson	Crapo; Risch
RDTE,DW	MEMS Sensors for Real-Time Sensing of Weaponized Pathogens	\$2,000,000	Biggert; Lipinski	
RDTE,DW	Military/Law Enforcement Counterterrorism Test Bed	\$2,400,000	Young (FL)	
RDTE,DW	MiTech Expansion Program	\$1,600,000	Rehberg	Baucus; Tester
RDTE,DW	Miniature Day Night Sight for Crew Served Weapons	\$1,200,000	Sestak	
RDTE,DW	Miniature Divert and Altitude Controls System Thruster	\$1,600,000	McKeon	
RDTE,DW	Miniaturized Chemical Detector for Chemical Warfare Protection	\$1,600,000	McGovern	
RDTE,DW	Mismatch Repair Derived Antibody Medicines to Treat Staphylococcus-derived Bioweapons	\$1,000,000	Sestak	Specter
RDTE,DW	Missile Activity and Characteristics—Releasable	\$2,400,000	Perriello	
RDTE,DW	Modeling and Simulation Standards Study	\$800,000	Forbes	
RDTE,DW	Morehouse College, John H. Hopps Defense Research Scholars Program	\$2,400,000	Lewis (GA); Bishop (GA); Kingston; Scott (GA)	Chambliss; Isakson
RDTE,DW	Mosaic Camera Technology Transition	\$1,600,000	Doyle	
RDTE,DW	Multiple-Target-Tracking Optical Sensor-Array Technology (MOST)	\$4,000,000		Akaka; Inouye
RDTE,DW	Multi-target Shipping Container Interrogation System Mobile Continuous Air Monitor	\$1,600,000	Brown, Corrine (FL)	
RDTE,DW	National Center for Blast Mitigation	\$1,200,000	Moran (VA)	Warner; Webb
RDTE,DW	National Radio Frequency Research, Development and Technology Transfer	\$4,000,000	Buyer; Ellsworth	Lugar
RDTE,DW	National Terrorism Preparedness Institute, Anti-Terrorism/Counter-Terrorism Technology Development and Training	\$2,800,000	Young (FL)	
RDTE,DW	Next Generation Manufacturing Technologies Initiative	\$1,600,000	Loeb sack	Grassley; Harkin
RDTE,DW	NIDS Handheld Common Identifier for Biological Agents	\$2,400,000	Castle	Carper; Kaufman
RDTE,DW	Non-Gasoline Burning Outboard Engine	\$1,520,000	Mollohan; Wilson (SC)	
RDTE,DW	Northwest Manufacturing Initiative	\$2,000,000	Blumenauer; DeFazio; Schrader; Walden; Wu	Merkley; Murray; Wyden

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,DW	Omni Directional Relay and Conformal Antenna	\$2,500,000		Mikulski
RDTE,DW	Optical Surveillance Equipment	\$2,000,000	Duncan	
RDTE,DW	Pacific Data Conversion and Technology Program	\$2,000,000		Akaka
RDTE,DW	Pacific Region Interoperability Test and Evaluation Capability	\$3,300,000		Inouye
RDTE,DW	PaintShield for Protecting People from Microbial Threats	\$2,000,000	Fudge; Jackson	Brown; Voinovich
RDTE,DW	Partnership for Defense Innovation Wi-Fi Laboratory Testing and Assessment Center	\$2,800,000	Kissell; Etheridge; McIntyre	Burr
RDTE,DW	Personalized Medicine Initiative	\$2,400,000	Edwards (MD)	
RDTE,DW	Photovoltaic Ribbon Solar Cell Technology Project	\$2,880,000	Hinchey	Schumer
RDTE,DW	Picoceptor and Processor for Man-portable Threat Warning	\$3,200,000		Gregg
RDTE,DW	Playas Training and Research Center	\$3,200,000	Teague	Bingaman; Udall (NM)
RDTE,DW	Portable Device for Latent Fingerprint Identification	\$1,440,000	Smith (WA)	Murray
RDTE,DW	Portable Rapid Bacterial Warfare Detection Unit	\$4,000,000	Latham; Boswell	Grassley; Harkin
RDTE,DW	Potent Human Monoclonal Antibodies Against BoNT A, B and E Suited for Mass Production and Treatment of Large Populations	\$1,000,000	Gerlach	
RDTE,DW	Progressive Research for Sustainable Manufacturing	\$1,200,000	Rogers (KY)	Bunning
RDTE,DW	Protective Self-Decontaminating Surfaces	\$1,600,000	Grijalva; Aderholt	
RDTE,DW	Radio Frequency Identification Technologies	\$1,000,000	Yarmuth	Bunning; McConnell
RDTE,DW	Radio Inter-Operability System	\$1,600,000	Moran (VA)	
RDTE,DW	Random Obfuscating Compiler Anti-Tamper Software	\$1,520,000	Michaud	Collins; Snowe
RDTE,DW	Real Time Test Monitoring of Chemical Agents, Chemical Agent Stimulants and Toxic Industrial Chemicals	\$1,280,000		Collins
RDTE,DW	Reconnaissance and Data Exploitation (REX) System	\$3,500,000		Akaka
RDTE,DW	Recovery, Recycle, and Reuse of DOE Metals for DoD Applications	\$1,920,000	Granger	
RDTE,DW	Reduced Cost Supply Readiness	\$1,200,000	Lynch	Kerry
RDTE,DW	Regenerative Filtration System for CBRN Defense	\$2,700,000	LaTourette	Brown
RDTE,DW	Remote VBIED Detection and Defeat System	\$1,200,000	Doyle	
RDTE,DW	Rigid Aeroshell Variable Buoyancy Air Vehicle	\$4,000,000	Sherman; Napolitano	
RDTE,DW	Savannah CRTC Training Enabled Maneuver Instrumentation (STEM)	\$3,600,000	Kingston	
RDTE,DW	Science, Technology, Engineering and Mathematics Initiative	\$1,600,000	Green, Gene (TX); Green, Al (TX); Jackson-Lee (TX)	
RDTE,DW	Sea Catcher UAS Launch and Recovery System	\$1,600,000	Sarbanes	
RDTE,DW	Secure, Miniaturized, Hybrid, Free Space, Optical Communications	\$1,600,000	Rothman; Lance	Lautenberg; Menendez
RDTE,DW	Security for Critical Communication Networks	\$5,600,000	Rothman; Sires	Menendez
RDTE,DW	Security Protection using Ballistic CORE Technology	\$3,900,000		Collins
RDTE,DW	Self-Contained Automated Vehicle Washing Systems with Microwave Decontamination	\$1,600,000		Johnson
RDTE,DW	Self-decontaminating Polymer System for Chemical and Biological Warfare Agents	\$2,800,000	Blunt	Crapo; Risch
RDTE,DW	Semiconductor Photomask Technology Infrastructure Initiative	\$1,600,000	Tauscher	
RDTE,DW	Shipping Container Security System Field Evaluation	\$3,600,000		Reid
RDTE,DW	Small Craft Threat Identification Program	\$1,200,000	Pingree (ME)	Collins; Snowe
RDTE,DW	Smart Bomb Targeting Radar System	\$2,320,000		Cochran; Wicker

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,DW	SOC—R Armor Development for Small Arms Armor Piercing Ammo	\$2,480,000		Cochran; Wicker
RDTE,DW	Solid Oxide Fuel Technology	\$1,000,000	Clyburn	
RDTE,DW	Spintronics Memory Storage Technology	\$2,800,000	Lewis (CA)	
RDTE,DW	Strategic Materials	\$5,000,000		Inouye
RDTE,DW	Superconducting Quantum Information Technology	\$800,000	Moore (KS)	
RDTE,DW	Synchrotron Beamline Experimental Station	\$3,200,000	Clarke; Ackerman; Bishop (NY); McCarthy (NY); Tonko; Towns	Schumer
RDTE,DW	Tactical, Cargo, and Rotary Wing Aircraft Decon	\$1,800,000	LaTourette	
RDTE,DW	Technology Applications for Security Enhancement	\$3,000,000	Lucas	Inhofe
RDTE,DW	Technology for Shallow Water Special Operation Forces Mobility	\$2,880,000	Boyd	Nelson (FL)
RDTE,DW	Thermal Pointer/Illuminator for Force Protection	\$1,600,000	Reichert	
RDTE,DW	Thurgood Marshall College Fund Defense Leadership and Technology Initiative	\$1,200,000	Bishop (GA)	
RDTE,DW	Tidewater Full Scale Exercise	\$2,320,000	Forbes	Warner; Webb
RDTE,DW	Tiger Moth Air-Launched Off Board Sensing Small Unmanned Aerial System	\$1,600,000		Lugar
RDTE,DW	Total Perimeter Surveillance	\$1,600,000	Schauer	Levin; Stabenow
RDTE,DW	Transformer Technology for Combat Submersibles	\$3,600,000	Ros-Lehtinen; Bishop (NY)	Schumer
RDTE,DW	Trusted Foundry	\$10,000,000		Gillibrand; Leahy; Schumer
RDTE,DW	Tunable MicroRadio for Military Systems	\$5,600,000		Conrad; Dorgan
RDTE,DW	UAV Directed Energy Weapons Systems Payloads	\$1,000,000	Tiahrt	
RDTE,DW	UAV Systems and Operations Validation Program	\$2,320,000	Teague	Bingaman; Udall (NM)
RDTE,DW	UAV / UAS Test Facility	\$2,400,000	Cole	Inhofe
RDTE,DW	Ultra Low Profile EARS Gunshot Localization System	\$1,200,000	Moran (VA)	
RDTE,DW	Undersea Special Warfare Engineering Support Office	\$2,000,000		Inouye
RDTE,DW	Under-Vehicle Inspection System	\$2,400,000	Young (AK); Bishop (UT)	Begich; Bennett; Murkowski
RDTE,DW	Unified Management Infrastructure System	\$800,000	Schakowsky	
RDTE,DW	United States Special Operations Command—USSOCOM/STAR-TEC Partnership Program	\$1,600,000	Young (FL)	
RDTE,DW	United States Special Operations Command SOCRATES High Assurance Platform Program	\$1,000,000	Young (FL)	
RDTE,DW	University Multi-Spectral Laboratories	\$2,000,000	Lucas	
RDTE,DW	University Strategic Partnership	\$1,920,000	Heinrich	Bingaman; Udall (NM)
RDTE,DW	Vehicle and Dismount Exploitation Radar (VADER)	\$4,000,000	Kratovil; Ruppersberger; Sarbanes	Cardin; Mikulski
RDTE,DW	Vehicle Fuel Cell and Hydrogen Logistics Program	\$6,400,000		Levin
RDTE,DW	Water Purification System for Natural Disasters	\$800,000		Cochran; Landrieu
RDTE,DW	Wellhead Treatment of Perchlorate Contaminated Wells	\$1,600,000	Baca	
RDTE,DW	Woody Biomass Conversion to JP-8 Fuel	\$1,280,000	Michaud; Pingree (ME)	Collins; Snowe
RDTE,DW	Wyoming Army National Guard Joint Training and Experimentation Center (JTEC)	\$3,760,000		Barrasso
RDTE,DW	X-Band / W-Band Solid State Power Amplifier	\$1,000,000	Young (FL)	
RDTE,N	4-D Data Fusion Visualization	\$1,600,000		Inouye
RDTE,N	76mm Swarbuster Capability	\$1,600,000	Crenshaw	
RDTE,N	AARGM Counter Air Defense Future Capabilities	\$2,000,000	Mollohan	

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,N	Accelerating Fuel Cells Manufacturability	\$1,600,000	Slaughter	Schumer
RDTE,N	Adelos Program: Nuclear Security Sensor System	\$2,800,000	Rehberg	Baucus; Tester
RDTE,N	Advanced Battery System for Military Avionics Power Systems	\$1,600,000	Sherman	
RDTE,N	Advanced Capability Build 12 and 14	\$1,600,000	Adler	
RDTE,N	Advanced Composite Manufacturing for Composite High-Speed Boat Design	\$1,600,000	Pingree (ME)	Collins; Snowe
RDTE,N	Advanced Composite Maritime Manufacturing	\$1,600,000	Castle	Carper; Kaufman
RDTE,N	Advanced Energetics Initiative	\$4,000,000	Hoyer	
RDTE,N	Advanced Fluid Controls for Shipboard Application	\$3,000,000		Lautenberg; Menendez
RDTE,N	Advanced Fuel Filtration System	\$1,200,000	Neal; Frelinghuysen	Kerry; Lautenberg; Menendez
RDTE,N	Advanced Helicopter Landing Aid	\$800,000	Rehberg	Tester
RDTE,N	Advanced High Energy Density Surveillance Power Module	\$3,200,000		Kohl
RDTE,N	Advanced Linear Accelerator Facility	\$960,000	Hill	Lugar
RDTE,N	Advanced Logistics Fuel Reformer for Fuel Cells (Phase II)	\$2,400,000	DeLauro	Dodd
RDTE,N	Advanced Manufacturing for Submarine Bow Domes and Rubber Boots	\$1,600,000	Crenshaw	Nelson (FL)
RDTE,N	Advanced Molecular Medicine Initiative	\$800,000	Schiff; Chu; Dreier	
RDTE,N	Advanced Naval Logistics	\$2,400,000		Specter
RDTE,N	Advanced Simulation Tools for Composite Aircraft Structures	\$1,600,000	Clay	Bond
RDTE,N	Advanced Steam Turbine	\$4,000,000	Massa; Olver; Tsongas	Kerry; Kirk; Schumer
RDTE,N	Aegis Research and Development	\$4,000,000	Miller, Gary (CA)	
RDTE,N	Agile Port and High Speed Ship Technology	\$1,600,000	Sánchez, Linda (CA)	
RDTE,N	Aging Military Aircraft Fleet Support	\$1,600,000	Tiahrt	Brownback; Roberts
RDTE,N	Air Readiness / Effectiveness Measurement Program	\$1,600,000	Moran (VA); Nye	
RDTE,N	AN / SLQ—25D Integration	\$6,400,000	Murtha	
RDTE,N	Arc Fault Circuit Breaker with Arc Location	\$800,000	Matheson	Bennett; Hatch
RDTE,N	Artificial Intelligence—Based Combat System Kernel	\$3,200,000	Kennedy	Reed
RDTE,N	Assistive Technologies for Injured Service Members	\$800,000		Nelson (FL)
RDTE,N	Automated Fiber Optic Manufacturing Initiative for Navy Ships	\$2,000,000	Nye; Tsongas	Kerry; Kirk; Warner; Webb
RDTE,N	Automated Missile Tracking	\$800,000	Moran (VA)	
RDTE,N	Autonomous Anti-Submarine Warfare Vertical Beam Array Sonar	\$1,600,000	Miller (NC); Coble	Burr
RDTE,N	Autonomous Marine Sensors and Networks for Rapid Littoral Assessment	\$2,400,000	Young (FL)	
RDTE,N	Autonomous Unmanned Surface Vehicle	\$2,700,000		Akaka
RDTE,N	Autonomous UUV Delivery and Communication System Integration	\$3,600,000	Dicks	Murray
RDTE,N	Avionics Life Extension	\$800,000	Edwards (TX)	
RDTE,N	Battlefield Sensor Netting	\$2,400,000	Young (FL)	
RDTE,N	Biocidal Wound Dressings	\$1,200,000		Leahy
RDTE,N	Biosensors for Defense Applications	\$800,000	Cao; Melancon; Scalise	Landrieu
RDTE,N	Bow Lifting Body Project	\$3,200,000	Kagen; Stupak	Inouye; Levin
RDTE,N	California Central Coast Partnership Research	\$2,800,000	McCarthy (CA)	
RDTE,N	Captive Air Amphibious Transporter	\$2,200,000		Inouye

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,N	Carbon Composite Thin Films for Power Generation and Energy Storage	\$1,600,000		Hutchison
RDTE,N	Center for Assured Critical Application and Infrastructure Security	\$1,200,000	Johnson (IL)	
RDTE,N	Center for Autonomous Solar Power—Supercapacitors for Integrated Power Storage	\$4,000,000	Hinchey	Gillibrand; Schumer
RDTE,N	Center for Commercialization of Advanced Technology	\$2,000,000	Lewis (CA); Davis (CA)	
RDTE,N	Characterization and Exploitation of Magnetic and Electric Fields in the Coastal Ocean Environment	\$2,000,000	Klein (FL); Wasserman Schultz; Wexler	Nelson (FL)
RDTE,N	Cognitive Radio Institute	\$800,000	Gordon	
RDTE,N	Combustion Light Gas Gun Projectile	\$4,000,000		Byrd
RDTE,N	Common Air Mine Countermeasures Tow Cable	\$2,400,000	Boyd	
RDTE,N	Common Command and Control System Module	\$4,800,000	Langevin; Courtney; Kennedy	Dodd; Lieberman; Reed
RDTE,N	Common Digital Sensor Architecture	\$2,400,000	Obey	Kohl
RDTE,N	Common Safety System Controller	\$2,400,000	Pastor (AZ)	
RDTE,N	Compliance Tools Development for Metals in Antifouling Paints	\$800,000	Bishop (UT); Rehberg	Tester
RDTE,N	Composite Mast for CVNs	\$2,960,000		Cochran; Wicker
RDTE,N	Composite Materials Enhancements through Polymer Science R&D	\$5,120,000		Cochran; Wicker
RDTE,N	Composite Tissue Transplantation for Combat Wounded Repair	\$2,000,000	Lewis (GA)	Chambliss
RDTE,N	Condition-Based Maintenance Enabling Technologies Program	\$2,400,000		Byrd
RDTE,N	Conformal Ceramics for Enhanced Aviation Armor Systems	\$2,500,000		Chambliss; Isakson
RDTE,N	Continuous Active Sonar for Torpedo DCL Systems	\$3,600,000	Courtney	Dodd; Lieberman
RDTE,N	Cooperative Engagement Capability	\$4,000,000	Young (FL)	
RDTE,N	Countermining LIDAR UAV-Based Systems	\$1,600,000	Taylor	Cochran
RDTE,N	DDG-51 Hybrid Drive System	\$8,100,000	Childers	Cochran; Kerry; Kirk; Wicker
RDTE,N	Deployable Command and Control Vehicle	\$3,040,000	Boyd	
RDTE,N	Deployment Health and Chronic Disease Surveillance	\$800,000	Moran (VA)	
RDTE,N	Detection, Tracking, and Identification for ISRTE of Mobile and Asymmetric Targets	\$2,000,000	Abercrombie	Akaka
RDTE,N	Digitization, Integration, and Analyst Access of Investigative Files, NCIS	\$1,200,000		Byrd
RDTE,N	Dynamic Eye-Safe Imaging Laser	\$800,000	Reichert	
RDTE,N	E-6B Strategic Communications Upgrade	\$2,400,000	Fallin; Loebbeck; Johnson, Sam (TX)	Harkin; Inhofe
RDTE,N	Electromagnetic Signatures Assessment System Using Multiple Autonomous Undersea Vehicles, Phase III	\$2,000,000		Crapo; Risch
RDTE,N	Electronic Motion Actuation Systems	\$800,000	Shuler; Bishop (UT)	Bennett; Brown; Hatch; Voinovich
RDTE,N	Energetic Nano-Materials Agent Defeat Initiative	\$1,600,000	Rothman; Payne	
RDTE,N	Energetics S&T Workforce Development	\$3,500,000	Hoyer	Cardin
RDTE,N	Enhanced EO/IR Sensors	\$2,400,000	Hodes	Gregg; Shaheen
RDTE,N	Enhanced Small Arms Protective Insert	\$1,600,000	King (NY)	Schumer
RDTE,N	Environmentally Sealed, Ruggedized Avionics Displays	\$3,200,000	Butterfield	Burr; Hagan
RDTE,N	EP-3E Requirements Capability Migration Systems Integration Lab	\$5,000,000	Edwards (TX)	
RDTE,N	Expandable Rigid Wall Composite Shelter	\$800,000	Young (AK)	Begich
RDTE,N	Expeditionary Capabilities Laboratory	\$2,400,000		Brownback; Roberts

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,N	Expeditionary Swimmer Defense System	\$3,200,000		Murray
RDTE,N	F/A—18 Countermeasures Improvement	\$4,000,000		Gregg
RDTE,N	Fan Coil Assembly of the Future	\$2,720,000		Dodd; Kerry; Kirk; Kohl; Lieberman
RDTE,N	FEATHAR—Fusion, Exploitation, Algorithm, Targeting High-Altitude Reconnaissance	\$4,350,000		Bennett
RDTE,N	Fighter Jet Noise Reduction Under Carrier Deck Operational Environment	\$2,880,000		Cochran
RDTE,N	Flight/Hangar Deck Cleaner	\$1,400,000		Begich
RDTE,N	Floating Area Network Littoral Sensor Grid	\$4,000,000	Dicks	
RDTE,N	Flow Path Analysis Tool	\$1,600,000	Lewis (CA); McCarthy (CA)	
RDTE,N	Fuel Efficient, High Specific Power Free Piston Engine for USSVs	\$1,600,000	Pingree (ME)	Collins; Snowe
RDTE,N	Galfenol Energy Harvesting	\$2,800,000	Latham	Grassley; Harkin
RDTE,N	Gallium Nitride (GaN) Power Technology	\$1,600,000	Coble	
RDTE,N	Global Law Enforcement Support for Counter-Narcotics	\$1,500,000		Burr
RDTE,N	Global Supply Chain Management	\$800,000	Bishop (GA)	
RDTE,N	Ground Warfare Acoustical Combat Systems of Netted Sensors	\$5,000,000	Boren; Sullivan	Inhofe
RDTE,N	Guidance, Navigation, Control, and Targeting	\$4,000,000		Leahy
RDTE,N	Hampton University Proton Cancer Treatment Initiative	\$4,000,000	Scott (VA); Moran (VA)	Warner; Webb
RDTE,N	Harbor Shield—Homeland Defense Port Security Initiative	\$1,600,000	Kilroy; Langevin	Reed; Voinovich; Whitehouse
RDTE,N	Hawaii National Guard Integrated Information Command System	\$1,280,000		Inouye
RDTE,N	Hawaii Technology Development Venture	\$10,000,000		Inouye
RDTE,N	HBCU Applied Research Incubator	\$800,000	Kilpatrick; Connolly; Cummings; Thompson (MS)	Cochran; Wicker
RDTE,N	Head Attitude Tracking System	\$1,600,000		Conrad; Dorgan
RDTE,N	High Density Power Conversion and Distribution Equipment	\$1,200,000	Sullivan; Boren	
RDTE,N	High Performance Capabilities for Military Vehicles Project	\$1,120,000		Hagan
RDTE,N	High Power Density Motor Drive	\$2,880,000	Murphy, Tim (PA)	
RDTE,N	High Power Ultra Lightweight Zinc-Air Battery	\$2,000,000	Coble; Kucinich; Sutton	Leahy
RDTE,N	High Temperature Radar Dome Materials	\$1,600,000	Giffords	
RDTE,N	High Temperature Superconductor Trap Field Magnet Motor	\$800,000	Carter	
RDTE,N	High Torque, Low Speed, Direct Drive Electric Motor Technology	\$1,600,000		Durbin
RDTE,N	Highly Conductive Lightweight Aircraft Sealant	\$960,000		Burr
RDTE,N	Highly Integrated Siloxane Optical Interconnect for Military Avionics	\$800,000	Stupak	Levin; Stabenow
RDTE,N	High-Shock 100 Amp Current Limiting Circuit Breaker	\$600,000	Murphy, Tim (PA)	Casey; Specter
RDTE,N	Human Neural Cell-Based Biosensor	\$1,100,000		Isakson
RDTE,N	Hybrid Propellant for Medium and Large Caliber Ammunition	\$4,000,000	Boyd	
RDTE,N	Hybrid Propulsion/Power Generation for Increased Fuel Efficiency for Surface Combatants	\$6,400,000	Sanchez, Loretta (CA); Miller, Gary (CA)	Feinstein
RDTE,N	Image-Based Navigation and Precision Targeting	\$640,000	Markey (MA)	Kerry
RDTE,N	Improved Capabilities for Irregular Warfare Platforms	\$4,000,000	Hoyer	Cardin
RDTE,N	Improved Kinetic Energy Cargo Round	\$800,000	Lee (NY)	Schumer

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,N	Improved Submarine Towed Array Systems	\$1,600,000		Reed
RDTE,N	Infrared Materials Laboratory	\$2,800,000	Cole	
RDTE,N	Instrumented Underwater Training Systems	\$2,240,000	Ros-Lehtinen	
RDTE,N	Integrated Advanced Ship Control	\$1,200,000	Tierney	Kerry
RDTE,N	Integrated Condition Assessment and Reliability Engineering	\$800,000	Connolly	
RDTE,N	Integrated Manifold and Tube Ceramic Oxygen Generator	\$4,800,000		Grassley; Harkin
RDTE,N	Integrated Manufacturing Enterprise	\$5,000,000		Landrieu; Vitter
RDTE,N	Integrated Manufacturing Systems 3D Simulation and Modeling Project	\$2,000,000	Scalise; Melancon	Landrieu
RDTE,N	Integrated Power System Converter	\$1,600,000	Murphy, Tim (PA)	Casey; Specter
RDTE,N	Integrated Power System Power Dense Harmonic Filter Design	\$1,600,000	Altmire	
RDTE,N	Integrated Psycho-Social Healthcare Demonstration Project	\$1,000,000	Young (FL)	Nelson (FL)
RDTE,N	Integration of Advanced Wide Field of View Sensor with Reusable, Reconfigurable Payload Processing Testbed System	\$800,000	Holden	
RDTE,N	Integration of Electro-Kinetic Weapons into Next Generation Navy Ships	\$4,000,000	Boyd	Nelson (FL)
RDTE,N	Integration of Logistics Information of Knowledge Projection and Readiness Assessment Program	\$1,600,000		Byrd
RDTE,N	Intelligent Decision Exploration	\$3,900,000		Inouye
RDTE,N	Intelligent Retrieval of Imagery	\$2,000,000	Moran (VA)	
RDTE,N	IP over Power Line Carrier Network Integration with ICAS	\$1,600,000	McIntyre	
RDTE,N	Joint Explosive Ordnance Disposal Diver Situational Awareness System	\$1,600,000	Moran (VA)	
RDTE,N	Joint Heavy-Lift Rotocraft Research	\$1,000,000	Hoyer	
RDTE,N	Joint Mission Battle-Space to Support Net-Ready Key Performance Parameters	\$2,000,000	Hoyer	Cardin
RDTE,N	Joint Tactical Radio System Handheld Manpack Small Form Factor Radio System	\$3,600,000	Wasserman Schultz	
RDTE,N	Joint Technology Insertion and Accelerated System Integration Capability for Electronic Warfare	\$1,600,000	Ellsworth	Lugar
RDTE,N	Kinetic Hydropower System Turbine	\$1,600,000	Inslee; Engel; Tonko; Towns	Murray; Schumer
RDTE,N	Landing Craft Composite Lift Fan	\$1,200,000	Garrett; Dent	Lautenberg; Menendez
RDTE,N	Laser Optimization Remote Lighting System	\$2,000,000	Larson (CT)	
RDTE,N	Laser Peening for P-3 Life Extension	\$1,280,000		Feinstein
RDTE,N	Laser Phalanx	\$12,000,000	Crowley; Bishop (UT)	Bennett; Bunning; Hatch; McConnell; Schumer
RDTE,N	Life Extension of Weapon Systems Through Advanced Materials Processing	\$2,500,000	Herseth Sandlin	Johnson; Thune
RDTE,N	Lighter-than-Air Stratospheric Unmanned Aerial Vehicle for Persistent Communications Relay and Surveillance	\$2,400,000	Lamborn	
RDTE,N	Lightweight Composite Structure Development for Aerospace Vehicles	\$2,400,000	Sullivan	Inhofe
RDTE,N	Lithium Ion Storage Advancement for Aircraft Applications	\$2,000,000	Blunt	
RDTE,N	Low Acoustic and Thermal Signature Battlefield Power Source	\$3,200,000	Rehberg	Baucus; Tester
RDTE,N	Low Frequency Active Towed Sonar System Organic ASW Capability	\$1,600,000	Crenshaw	
RDTE,N	Low Signature Defensive Weapon System for Surface Combatant Craft	\$3,840,000	Hinchey	Schumer
RDTE,N	M230 30mm Chain Gun Automatic Cannon	\$3,760,000		Reid
RDTE,N	Magnetic Refrigeration Technology for Naval Applications	\$4,000,000	Baldwin	Kohl
RDTE,N	Maintenance Free Operating Period	\$2,000,000	Moran (VA)	

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[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,N	Maintenance Planning and Assessment Technology Insertion	\$1,200,000	Brady (PA)	
RDTE,N	Management of Lung Injury by Micronutrients	\$1,200,000	Meeks (NY)	Schumer
RDTE,N	Managing and Extending DoD Asset Lifecycles	\$1,600,000	Abercrombie	Akaka
RDTE,N	Manufacturing S&T for Next-Generation Energetics	\$5,000,000	Hoyer	
RDTE,N	Marine Air-Ground Task Force Situational Awareness	\$2,700,000		Inouye
RDTE,N	Marine Corps Cultural and Language Training Platform	\$640,000	Maffei	Schumer
RDTE,N	Marine Expeditionary Rifle Squad Reconfigurable Vehicle Simulator	\$2,400,000	Rehberg	Baucus; Tester
RDTE,N	Marine Mammal Awareness, Alert and Response Systems	\$2,400,000	Abercrombie	
RDTE,N	Marine Mammal Detection System	\$2,000,000	Smith (NJ)	Lautenberg; Menendez
RDTE,N	Marine Personnel Carrier Support System	\$2,400,000	Kennedy	Reed
RDTE,N	Marine Species Mitigation	\$2,295,000	Brown, Corrine (FL)	Nelson (FL)
RDTE,N	Maritime Directed Energy Test and Evaluation Center	\$1,200,000		Inouye
RDTE,N	Measurement Standards Research and Development	\$5,800,000	Calvert	
RDTE,N	Media Exploitation Tool Integration with Intelligence C2 Systems	\$1,200,000	Kosmas	
RDTE,N	METOC Integrated Network-Centric Technology Systems	\$2,600,000		Vitter
RDTE,N	Micro-Drive for Future HVAC Systems	\$1,920,000	Moore (WI)	Kohl
RDTE,N	Military Upset Recovery Training	\$800,000	Lee (NY)	Schumer
RDTE,N	Millimeter Wave Imaging	\$1,360,000	Castle	Carper; Kaufman
RDTE,N	Mobile Modular Command Center (M2C2)	\$2,800,000		Inouye
RDTE,N	Mobile, Oxygen, Ventilation and External Suction (MOVES) System	\$2,720,000	Granger; Johnson (TX)	Cornyn
RDTE,N	Modular Advanced Vision System	\$1,600,000	Carney	
RDTE,N	Mold-in-Place Coating Development for the US Submarine Fleet	\$2,000,000	Taylor	Cochran; Wicker
RDTE,N	Molten Carbonate Fuel Cell Demonstrator	\$3,600,000		Dodd; Lieberman
RDTE,N	Moving Target Indicator Scout Radar	\$800,000	Johnson, Sam (TX); Hall (TX); Johnson, Eddie Bernice (TX)	
RDTE,N	Multi-Element Structured Filter Arrays for Naval Platforms	\$3,440,000	Bonner	
RDTE,N	Multifunctional Materials, Devices, and Applications	\$1,600,000	Kilroy	
RDTE,N	Multi-Mission Unmanned Surface Vessel	\$2,000,000	Granger	
RDTE,N	Multivalent Dengue Vaccine Program	\$1,280,000	Brown (SC)	Graham
RDTE,N	Nanofluidic Lubricants for Increased Fuel Efficiency in Heavy Duty Vehicles	\$1,200,000	Price (NC)	
RDTE,N	Nanotechnology for Anti-Reverse Engineering	\$2,400,000	Boozman	Lincoln; Pryor
RDTE,N	National Aviation Enterprise Interoperability with Carrier Strike and Expeditionary Group Forces	\$5,000,000	Hoyer	Cardin; Mikulski
RDTE,N	National Functional Genomics Center Collaborating Site	\$3,200,000	Holden	
RDTE,N	National Initiatives for Applications of Multifunctional Materials	\$2,000,000		Hutchison
RDTE,N	National Shipbuilding Research Program Advanced Shipbuilding Enterprise	\$3,200,000		Sessions; Wicker
RDTE,N	NAVAIR High Fidelity Oceanographic Library	\$2,400,000	Rehberg	
RDTE,N	NAVAIR Project for Land/Sea-Based Air Systems Maintenance and Air Worthiness	\$2,000,000	Conyers; Dingell; Levin	Levin; Stabenow
RDTE,N	Naval Advanced Electric Launcher System	\$2,000,000		Bond
RDTE,N	Naval Ship Hydrodynamic Test Facilities	\$3,200,000	Van Hollen	Cardin

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,N	Navy Advanced Threat Simulator	\$1,600,000	McCarthy (CA)	
RDTE,N	Navy Special Warfare Performance and Injury Prevention Program for Special Boat Team 22	\$2,000,000	Taylor	Cochran; Wicker
RDTE,N	NAWCWD Point Mugu Electronic Warfare Laboratory Upgrade	\$3,200,000	Gallegly	
RDTE,N	Near Infrared Optical Augmentation System	\$1,600,000	Moran (VA)	
RDTE,N	Next Generation Electronic Warfare Simulator	\$1,600,000	McCarthy (CA); Ruppersberger	
RDTE,N	Next Generation Manufacturing Processes and Systems	\$1,200,000	Smith (TX)	
RDTE,N	Next Generation Scalable Lean Manufacturing Initiative—Phase Two	\$2,400,000	Young (FL)	
RDTE,N	Next Generation Shipboard Integrated Power—Fuel Efficiency and Advanced Capability Enhancer	\$1,600,000	Bartlett	
RDTE,N	Non Traditional Ballistic Fiber and Fabric Weaving Application for Force Protection	\$2,000,000	LoBiondo; Andrews; Rothman	Lautenberg; Menendez
RDTE,N	Non-Gasoline Burning Outboard Engine	\$1,520,000	Boyd	
RDTE,N	Non-Lethal Defense Technologies	\$2,320,000	Murtha	
RDTE,N	NSWC Corona Item Unique Identification Center	\$1,440,000	Calvert	
RDTE,N	ONAMI Nanoelectronics, Nanometrology and Nanobiotechnology Initiative	\$3,840,000	Wu; Blumenauer; DeFazio; Schrader; Walden	Merkley; Wyden
RDTE,N	On-Demand Custom Body Implants/Prosthesis for Injured Personnel	\$1,600,000	Dingell; Levin	Levin; Stabenow
RDTE,N	Open Source Naval and Missile Database Reporting System	\$1,920,000	Dicks	
RDTE,N	Organic Submarine IRST Demonstration (ISRT OSAID)	\$2,400,000		Reed
RDTE,N	Out of Autoclave Composite Processing	\$2,000,000	Clay	Bond
RDTE,N	Pacific Airborne Surveillance and Testing	\$17,000,000		Inouye
RDTE,N	Paragon (Frequency Extension)	\$2,400,000	Connolly; Moran (VA)	
RDTE,N	Passive RFID Development	\$900,000	LaTourette	
RDTE,N	Permanent Magnet Generator—Wave Energy Buoy	\$1,920,000	Schrader	Merkley; Wyden
RDTE,N	Persistent Autonomous Maritime Surveillance	\$5,000,000	Rogers (KY)	
RDTE,N	Persistent Surveillance Wave Powerbuoy System	\$3,200,000	Holt	Lautenberg; Menendez
RDTE,N	Photonic Integration Foundry	\$2,400,000		Casey; Specter
RDTE,N	Photovoltaic Rooftop Systems for Military Housing	\$1,200,000	Peters; Schauer	Levin
RDTE,N	Precision Engagement Technologies for Unmanned Systems	\$2,000,000	Ehlers	Levin
RDTE,N	Productization of Anti-fouling and Fouling Release Coating Systems	\$2,800,000	Pomeroy	Conrad; Dorgan
RDTE,N	Propulsion Manufacturing Technology Development	\$3,760,000		Cochran; Wicker
RDTE,N	Proton Exchange Membrane Fuel Cell for Underwater Vehicles	\$1,600,000		Lieberman
RDTE,N	Pure Hydrogen Supply from Logistic Fuels	\$2,400,000	Murphy, Patrick (PA)	Casey
RDTE,N	Quiet Drive Advanced Rotary Actuator	\$1,600,000	Sestak; Harman; Higgins; Lee (NY); Sherman; Slaughter	Schumer; Warner; Webb
RDTE,N	Real-time Tactical Intelligence Collection System	\$1,200,000	Kennedy; Sarbanes	Cardin; Mikulski
RDTE,N	Regenerative Fuel Cell Back-up Power	\$1,360,000	Larson (CT)	Dodd
RDTE,N	Remote Aiming and Sighting Optical Retrofit	\$3,040,000	Granger; Johnson (TX)	
RDTE,N	Semi-Submersible UUV for Sensor Enhancements	\$1,400,000	Alexander	Vitter
RDTE,N	Sensor Integration Framework	\$1,440,000	Boyd	Nelson (FL)
RDTE,N	Ship Model Testing	\$2,000,000	King (NY)	Gillibrand; Schumer
RDTE,N	Shipboard Automated Radio Room System	\$1,600,000		Lautenberg; Menendez

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,N	Shipboard Wireless Maintenance Assistant	\$1,200,000	Schauer; Dingell	Levin
RDTE,N	Shipboard Wireless Network	\$2,400,000	Rothman	
RDTE,N	Shock and Vibration Modeling of Marine Composites	\$1,920,000	Towns	Schumer
RDTE,N	Silicon Carbide Wafer Production—Process Development for Low Defect Power Electronics	\$1,200,000	Hinchey	Schumer
RDTE,N	Simplified Orthopedic Surgery	\$4,240,000		Nelson (NE)
RDTE,N	Single Generator Operations Lithium Ion Battery	\$4,000,000		Lugar; Reid
RDTE,N	Small Survivable Jammer	\$800,000		Feinstein
RDTE,N	Smart Instrument Development for the Magdalena Ridge Observatory	\$4,000,000	Teague	Bingaman; Udall (NM)
RDTE,N	Solar Heat Reflective Film for Energy and Fuel Efficiency in Buildings and Vehicles	\$3,920,000		Sessions
RDTE,N	Sonobuoy Wave-Energy Module	\$800,000	Alexander	Landrieu; Vitter
RDTE,N	SPAWAR Systems Center/ITC New Orleans	\$3,200,000	Cao; Scalise	Landrieu; Vitter
RDTE,N	SSBN(X) Systems Development	\$2,000,000	Wittman	
RDTE,N	Strike Weapon Propulsion	\$3,200,000	Barton	
RDTE,N	Submarine Automated Test and Re-Test	\$2,000,000	Moran (VA)	
RDTE,N	Submarine Environment for Evaluation and Development	\$2,400,000		Reed
RDTE,N	Submarine Fatline Vector Sensor Towed Array	\$1,600,000	Kratovil	Cardin
RDTE,N	Submarine Navigation Decision Aids	\$4,000,000	Murtha	
RDTE,N	Submarine Panoramic Awareness System	\$800,000	Sherman	
RDTE,N	Submarine System Biometrics Access Control	\$2,000,000	Rogers (KY)	Bunning
RDTE,N	Supply Chain Logistics Capability at the ABL NIROP	\$6,400,000		Byrd
RDTE,N	Tactical High Speed Anti-Radiation Missile Propulsion Demonstration	\$1,520,000	McKeon; Connolly	
RDTE,N	Technology Transfer Office	\$1,500,000	Hoyer	Mikulski
RDTE,N	Texas Microfactory	\$1,600,000		Hutchison
RDTE,N	Thin Film Materials for Advanced Applications, Advanced IED and Anti-Personnel Sensors	\$1,280,000		Leahy
RDTE,N	Tomahawk Cost Reduction Initiative	\$3,280,000	Bishop (UT)	Bennett; Hatch; Levin; Stabenow
RDTE,N	Trusted Discovery/Universal Description Discovery and Integration UDDI	\$5,000,000		Conrad; Dorgan
RDTE,N	U.S. Navy Cancer Vaccine Program	\$2,400,000	Jones (NC); Miller, Gary (CA)	Landrieu
RDTE,N	U.S. Navy Pandemic Influenza Vaccine Program	\$1,600,000	McHugh	Gillibrand; Schumer
RDTE,N	Underwater Explosion Modeling and Simulation for Ohio Class Replacement Composite Non-Pressure Hull Fairing	\$2,000,000	Perriello	
RDTE,N	Underwater Explosives and Warhead Research	\$3,000,000	Hoyer	
RDTE,N	Underwater Imaging and Communications Using Lasers	\$2,000,000	Wexler; Wasserman Schultz	Nelson (FL)
RDTE,N	Unmanned Undersea Vehicle Submerged Long Range Positioning	\$800,000		Landrieu
RDTE,N	Unmanned Vehicle Sensor Optimization Technologies Program	\$2,400,000		Byrd
RDTE,N	Vet-Biz Initiative for National Sustainment	\$4,000,000	Salazar	Udall (CO)
RDTE,N	Virtual Business Accelerator for the Silicon Prairie	\$1,600,000		Nelson (NE)
RDTE,N	Virtual Onboard Analyst for Multi-Sensor Mine Detection	\$1,200,000		Inouye
RDTE,N	Voyage Repair Team Tool Management	\$1,200,000	Adler	
RDTE,N	Warfighter Rapid Awareness Processing Technologies	\$4,500,000		Akaka

DEFENSE—Continued
[Congressionally Directed Spending Items]

Account	Project	Amount	Requester(s)	
			House	Senate
RDTE,N	Wave Energy Harvesting for Buoy Applications	\$1,600,000		Reed
RDTE,N	Waves, Wind and Scavengers: Next Generation Renewable Energy Systems for Naval Applications	\$2,000,000		Bond
RDTE,N	Weapon Acquisition and Firing System	\$2,400,000	Kennedy	Reed; Whitehouse
RDTE,N	Wide Area Sensor Force Protection Targeting	\$1,600,000	Bean	
RDTE,N	Wireless Sensors for Navy Aircraft	\$2,400,000		Leahy
RDTE,N	Workforce Requirements Planning—Team Enhancement	\$800,000	Inslee	
RDTE,N	X-49A Envelope Expansion Modifications	\$3,600,000	Brady (PA); Andrews; Castle; Higgins; Larson (CT); Sestak; Slaughter	Schumer
WP,N	Allegany Ballistics Laboratory Facility Restoration Plan	\$9,500,000		Byrd
WP,N	Intelligent Graphics Torpedo Test Set Troubleshooting Maintainers Aid	\$4,000,000	Dicks	
WP,N	Lightweight Torpedo P5U Test Equipment Modernization	\$3,840,000	Dicks	
WP,N	MK-110 57mm Naval Gun	\$2,000,000		McConnell
WP,N	MK-38 Minor Caliber Gun System	\$3,000,000		McConnell
WTCV,A	Arsenal Support Program Initiative at Rock Island Arsenal	\$7,600,000	Hare; Braley	Burr; Durbin; Grassley; Harkin
WTCV,A	Arsenal Support Program Initiative at Watervliet Arsenal	\$6,400,000	Tonko	Gillibrand; Schumer
WTCV,A	M24 Sniper Weapons System Upgrade	\$2,400,000	Arcuri	Schumer

Though clause 9(b) of rule XXI of the Rules of the House of Representatives technically only applies to conference reports, the following is a list of congressional earmarks,

limited tax benefits, or limited tariff benefits that were neither (1) included in the House bill or Senate amendment on H.R. 3326, nor (2) in a report of a committee of ei-

ther House on this bill or on a companion measure.

[Congressionally Directed Spending Items]

Agency	Account	Project	Amount	Requester(s)	
				House	Senate
National Park Service	Construction	Swain County, NC		Shuler	

I reserve the balance of my time.

Mr. YOUNG of Florida. I yield myself such time as I may consume.

Madam Speaker, I want to congratulate all of the members of the subcommittee for having worked so hard all year long to get this product to where we finally have final passage on the issue.

The House passed this bill 4½ months ago. The Senate passed it in September. It has been a bit of a painful process along the way because a lot of suggestions and a lot of ideas were raised of which we could agree to some and could not agree to others.

Anyway, we have produced what I think is a good package. I may not be as enthusiastic about this one as I have been for many others in the past, but it is a good bill. It does provide what our soldiers, what our sailors, what our marines, and what our airmen need in order to do their jobs and to protect themselves while they're at it.

I would have said "Coast Guard," but we don't have the jurisdiction in this

subcommittee for the Coast Guard. Yet we recognize the importance of the United States Coast Guard as well.

The bill is not too much different from the House bill that we passed 4½ months ago. There has had to be some negotiation, obviously, but I think we provided what our soldiers need and what our country needs. There is a 3.4 percent pay raise for the members of our military. It wasn't quite that big when it came to us, but we increased it to give a little more of a substantial pay raise to the members of our military.

There is one point that I was questioned about which I need to make clear: There is no money in this bill to move detainees from Guantanamo or to buy or build new facilities in the United States for detaining Guantanamo detainees. So there is no money in this bill for that purpose.

All in all, it's a good bill and one that I can support enthusiastically. As I think most of the Members know, Madam Speaker, a number of other

temporary issues have been added to this bill at the leadership level, and we do not object to that. We think that that is perfectly acceptable. In fact, I think it's a good idea in some of the cases.

I yield to the ranking member on the full committee, who chaired this subcommittee for quite a few years, the gentleman from California (Mr. LEWIS), who has been a major player in our Defense appropriations for years.

Mr. LEWIS of California. I very much appreciate my colleague for yielding.

Madam Speaker, my friend, Mr. MURTHA, has spent some time at Bethesda, and I would like to recognize the contributions that he has made to this bill and to the work he has done with Mr. YOUNG.

Madam Speaker, it has taken months to get to this point but I'm pleased to see that we are finally considering a Defense Appropriations bill to provide funds for the men and women of our armed forces and the national security needs of our country.

We should have been on the House floor months ago—months ago—passing a clean Defense funding bill. Like many Members, I questioned the priorities of the Democrat leadership in moving this year's funding bills, particularly the decision to send the President the Legislative Branch conference report as our first completed bill. It sent an unmistakable signal that the House majority was putting the needs of Congress first and placing the needs of our troops at the end of the line.

I know there has been great temptation to use the Defense bill as the vehicle to carry many unrelated legislative items that could not and would not muster enough support to pass on their own. And while this package before us is far from clean, it's a streamlined version of what was, just a few days ago, shaping up to be the mother of all Christmas tree bills.

It was Chairman OBEY who, on December 18th, 2005 said, and I quote, "The defense bill ought to be about delivering equipment and supporting our troops. There is something especially outrageous and callous about the willingness of the majority party leadership to allow the Defense Department bill in a time of war to be held hostage to totally unrelated legislative items."

But that is precisely what we are doing by including a variety of non-defense related legislative provisions in this package. Some items like COBRA, food stamps, and so-called "poverty guidelines" have been manipulated in a way to suit the Chairman's purposes for redistributing income in America but do not reflect the agreement reached to garner bipartisan support on this bill.

We are also designating as emergency spending an additional \$20 billion worth of program extensions. I'm not arguing that some of these are unworthy but merely pointing out that they should have no place in a defense spending bill. At the very least, we should pay for them honestly rather than continuing to add to our mountain of debt.

More curious to me is the fact that buried within this legislation is an airdropped Member project in the form of bill language authorizing the payment of nearly \$13 million to a county in North Carolina. I can only assume that this project meets all of the necessary requirements for congressional projects. No one seems to know how or why this project was included in this package but it's there in black and white for the world to see.

Also disconcerting is the fact that the underlying defense spending bill fails to include funding needed for additional MRAPS to support the 30,000 troop surge in Afghanistan. My understanding is that the House and Senate majority and minority were in full agreement to funding an additional 4,000 MRAPS—and yet a decision was made at another level—perhaps even at a staff level—to leave this vital funding out of this package. Again, it's a decision like this that causes me to scratch my head and question the priorities of this majority leadership.

At the end of the day, this legislation is far from perfect; I would vote against Division B if given the opportunity. But it is a vast improvement over the massive train wreck that was heading our way earlier this week. I strongly support the underlying defense portion of this package and ask our colleagues to support

our troops who are defending freedom at home and abroad.

Mr. CONYERS. Madam Speaker, I rise in opposition to H.R. 3326, the Fiscal Year 2010 Department of Defense Appropriations Act.

The President's announcement last week came as no surprise to me and many of my colleagues; he has consistently stated throughout the Presidential campaign and during his first year in office that he is committed to shifting military resources from Iraq into Afghanistan. Nonetheless, I am disappointed the President has moved ahead with, what I believe to be, an incorrect course of action.

As we move forward in this process, it is imperative that the House consider all options about how to best succeed in Afghanistan. It is in this spirit today that I want to announce the creation of a new "Peace and Progress in Afghanistan Caucus" that will give Democrats and Republicans a place to organize and advocate for a new strategy that recognizes the need to redeploy our troops, while strengthening our civilian and diplomatic approaches.

The presence of military troops in Afghanistan is having a detrimental effect on our efforts to secure a lasting peace in the region and diffuse the threat of international terrorism. Our military presence only inflames anti-American resentment.

Only by pursuing a wide-ranging policy that focuses on reorienting the United States' commitment to the Afghan government and people by emphasizing indigenous reconciliation and reconstruction strategies, rigorous regional diplomacy, and swift redeployment of the US military, will we ultimately succeed in Afghanistan."

I was extremely heartened that two of the three prongs of the President's new strategy focus on a civilian surge and on diplomacy with Pakistan. It is a shame that the funding in this bill will not support these worthy approaches. The President believes that the United States can transform resentment into hope by working with our humanitarian and local government partners on the ground to give the Afghan people access to education, strong civic institutions, and a sustainable, legitimate source of income.

I believe that a new focus on a civilian surge should also empower local NGOs and initiatives that directly benefit the Afghan people, like the highly successful National Solidarity Project, an Afghan-run community development program.

Similarly, if the Pakistani people understand that we are committed to helping secure their safety and prosperity, they will step up their efforts to combat terrorism within their borders. Additionally, I believe we must expand our thinking beyond Pakistan to include other actors and countries that affect the greater region. One of the least discussed aspects of this conflict is the role India must play in promoting regional peace. For years, the Pakistani military and intelligence services have been hesitant to crack down on Taliban militants operating in the tribal regions because they fear the establishment of an Afghan government that would be susceptible to Indian influence. Such a worst case scenario, in their view, would give one of their traditional regional foes a foothold on both their northern and southern borders.

In order to secure a long-term regional peace, the President must engage India and Pakistan to seek a final political agreement on Kashmir. Only when Pakistan feels secure in the south, will the Pakistani army be able to focus its efforts on defeating the Taliban who dwell along the Afghan border.

I look forward to working with the President to promote and expand these critical approaches to securing victory.

The President has committed to ending the war in a responsible manner. Although we disagree on the means being employed to reach that laudable goal at the moment, I believe that I and other pro-peace, pro-national security Members of Congress can help him can craft a successful policy that will bring our troops home as soon as possible.

In the meantime, I will continue to oppose funding a war that emphasizes a heavy military footprint. No amount of additional troops can bring a war with no military solution to an end.

Mr. BLUMENAUER. Madam Speaker, as we enter the final days of 2009, I'm pleased to join my colleagues in Congress to pass a series of bills that will protect jobs, spur employment, and strengthen the ability of families to make it through economic hardship. Among these measures is H.R. 3326, the "Fiscal Year 2010 Department of Defense Appropriations Act." Although I remain extremely frustrated by large portions of this bill that spend too much on the wrong things, I voted for it to provide resources for our troops, including hundreds of Oregonians stationed abroad, and for Oregon's economy.

The bill includes a number of hard-fought provisions that will make a difference for Oregon's economy. Universities like Portland State, Oregon, and Oregon State, local companies like Precision Castparts and our regional manufacturing initiative, the Manufacturing 21 Coalition, will see needed investment in programs to treat traumatic brain injury and develop a skilled workforce. These are the right investments—targeted and timely. Spending billions of dollars on items that the Pentagon doesn't need and the President didn't want takes resources away from addressing the deficit, or from critical investments like our own people.

This bill is also a vehicle for making sure that millions of people can bridge this economic downturn. This legislation ensures that ordinary Americans do not lose unemployment benefits, that the unemployed have access to health care, that doctors in Oregon and around the country are not subjected to the egregious Medicare reimbursement cuts. These efforts demand support.

I look forward to swift enactment of these much-needed provisions. Grinding the legislative process to a halt only short-changes honest Americans. It is my sincere wish that in the New Year we renew a spirit of cooperation in the Senate and across the aisle.

Mr. BRALEY of Iowa. Madam Speaker, I rise today to express my support for the Defense Appropriations Act for FY10 and am glad that it includes extensions of several laws that are set to expire, such as extending unemployment benefits and COBRA health insurance. I am also pleased that it includes important items such as a delay of the scheduled 21 percent cut in Medicare payments to

doctors and an extension of highway programs.

I am disappointed, however, that several tax extenders that were passed by the House last week as part of the Tax Extenders Act will not be considered before the end of the year, such as the biodiesel tax credit. Although there has been some discussion to pass these extenders retroactively early next year, Congress' failure to extend the current credit before the end of the year could cause harm to the biodiesel facilities in my District. Unlike other tax extenders, the biodiesel tax credit is liquid and a retroactive tax bill is still not as effective as ensuring the tax credit continues uninterrupted. We not only need to get this extended in the short-term, but we need to come up with a longer-term plan to provide more security for investment in biodiesel which is good for the economy, the environment, and energy security.

I am also concerned that Congress has failed to extend the 1.0 Floor on the Work Geographic Practice Cost Index (GPCI) under Medicare Part B, which expires at the end of this year. This is exactly why we need to address these unfair GPCIs once and for all, which only serve to penalize Iowa medical providers who choose to accept Medicare patients. I have called for a permanent extension of the 1.0 Floor, and I have secured language in the Health Care Reform bill to address geographic disparities in Medicare. However, the current floor is still set to expire at the end of this year. I will continue to urge my colleagues to address this problem through a retroactive fix as soon as possible next year, and through a permanent fix of the unfair geographic adjusters under Medicare.

To help Iowa's farmers, it is also essential to extend the five-year depreciation for farming business machinery and equipment, as well as extensions of provisions encouraging farmers to set aside land for conservation. As we continue to work our way out of the harshest economic climate since the Great Depression, these tax credits will play a tremendous role in encouraging job creation and strengthening Iowa's middle class families. We also need to extend the Research and Development tax credit. By renewing this credit, we are taking meaningful steps to encourage companies to hire Iowa's educated and experienced workers for good-paying 21st century jobs that can't be outsourced.

Thanks again, Madam Speaker, for your leadership. We have gotten a lot accomplished this year, but it is critical that we make the tax extenders package a high priority item. I encourage you to work with the Senate to get this passed into law so that we don't lose jobs in the industries that rely on these credits at the same time that we are working so hard to create them.

Mr. VAN HOLLEN. Madam Speaker, I rise in support of the 2010 Department of Defense Appropriations Act.

This measure represents Congress's commitment to the millions of dedicated men and women, in and out of uniform, throughout the Department of Defense, who work to address the national security challenges of the country. This bill also expresses our commitment to their families, whose service to the country is recognized and greatly appreciated.

In total, the act appropriates \$636.3 billion for DoD programs, operations and troop support. This represents a 2 percent increase of current funding levels, and while not including funding for the President's proposed troop increase in Afghanistan, includes \$128.2 billion for military operations in Iraq and Afghanistan.

The bill contains funds to meet the logistical needs of our military including new and updated equipment, combat vehicles and battle gear. The measure also includes funding for military pay raises, military health care benefits and quality of life improvements for the troops and their families.

Since first clearing this chamber in July, there have been important add-ons made to the bill. These add-ons include a number of non-defense provisions—such as an extension of certain emergency unemployment insurance benefits; an extension of a 65 percent premium subsidy for COBRA health insurance, allowing recipients to obtain the subsidized insurance coverage for six additional months; a delay, until February, of a scheduled 21 percent cut in Medicare payments to doctors; funding for nutrition assistance; and \$400 million for state administrative expenses.

Additionally, I am especially pleased that today's DoD Appropriations bill includes an unprecedented fund of \$300 million set aside for the purpose of mitigating BRAC-related transportation and community impacts at the new Walter Reed National Military Medical Center and Fort Belvoir. Congress is committed to building world class facilities for our wounded warriors in the national capital region, and these funds are an integral part of that effort. I want to thank Congressman MORAN, Chairman MURTHA, and Chairman OBEY, as well as Senator MIKULSKI and Senator CARDIN, for their partnership on this initiative. I look forward to working with our Senate colleagues, the Department of Defense, and other stakeholders to make these funds available for their intended purpose at the soonest possible date.

Madam Speaker, as the country prepares to ask even more of our service members, it is our responsibility to do all we can to honor our commitments to them and their families—While we can never fully repay the debt we owe them, we can work to ensure that they have the resources they need to do their jobs abroad and the resources they need to meet their obligations here at home.

I encourage my colleagues join me in support of the bill.

Mr. YOUNG of Alaska. Madam Speaker, I rise to discuss the \$2.4 million that was included at my request in the FY10 Defense Appropriations Bill for Synthetic Liquid Fuels.

Considering the large amounts of potential CO₂ emissions produced by a coal or a natural gas-to-liquids facility, technologies will have to be developed to ascertain the feasibility of sequestering the CO₂.

Recent investigations by the U.S. Department of Energy have shown that between 8 and 12 billion barrels of additional oil can be recovered from the existing Alaska North Slope oil fields with using CO₂ enhanced oil recovery technology. Alaska North Slope oil reservoirs present a potentially large target or "sink" for sequestering the CO₂ generated in a Fairbanks-based coal-to-liquids or a coal/

gas-to-liquids plant, thereby enhancing conventional oil recovery as a by-product. However, very little practical study of CO₂ sequestration has directly addressed the Alaska North Slope area. Moreover, in the present case, effective CO₂ sequestration is highly dependent on the technologically and economically-feasible transportation of CO₂ from the Fairbanks source to the Alaska North Slope. Additionally, for the Alaska Natural Gas Pipeline proposed to bring the Alaska North Slope natural gas to world markets, to be successful, accommodation for the handling of about 480 mmscf CO₂/day, assuming 4 bscf/day of natural gas, from the Prudhoe Bay Unit must be considered.

The study paid for by these monies would investigate the feasibility of gathering, delivering and utilizing the resultant CO₂ from the plant for enhanced oil recovery on the North Slope of Alaska, thereby simultaneously sequestering CO₂ and increasing domestic oil production. If this proves feasible, the construction of the proposed would supply the U.S. military with domestically produced synthetic fuel and greatly increase U.S. oil production from existing oil fields.

Mr. MICA. Madam Speaker, although I voted "yes" in support of H.R. 3326, the Defense Appropriations Bill, and consider myself a strong advocate for those in military service to our nation, I want to express my opposition to funds appropriated in this measure to move and house Terrorists from Guantanamo to Illinois. Having personally visited Guantanamo I can attest that prisoners and detainees have accommodations for better than many seniors, veterans and law-abiding Americans. These terrorists are enemy combatants who committed international acts of war and terror and should not be entitled to our civil or criminal system of justice.

Furthermore after spending nearly half a billion dollars on the Guantanamo facility to now waste a half a billion dollars more on that scum of the earth is a horrible insult to all Americans and every taxpayer. When you think that this administration cannot possibly come up with another dramatic waste of public funds it seems today in this rarified air in Washington one never ceases to be stunned and annoyed.

Unfortunately, the wasteful action and insult relating to Guantanamo is only one of a number of unacceptable provisions that have been tucked into the Defense Appropriations Bill.

Mr. FRELINGHUYSEN. Madam Speaker, I want to echo the comments of my Ranking Members, Mr. YOUNG and Mr. LEWIS. This is a good bill, thanks to the hard work of our Chairman JACK MURTHA, his Ranking Member BILL YOUNG and their capable staffs.

Clearly, had I written the bill, I would have written it differently in certain areas. (I certainly would not have tacked on a record increase in the debt limit!)

My major regret is that we should have done more.

This bill started out \$3.5 billion short of the President's request—despite the fact that we are engaged in two, hard-fought wars.

And now, we have a larger mission in Afghanistan involving more soldiers and Marines and a more complex and expensive operations to support and resupply them.

At a time when this Congress has found the 'will and the wallet' to throw billions of borrowed dollars at every domestic program under the sun, our leaders are finding ways to cut defense—sometimes subtle, sometimes blatant.

I tell my Colleagues who have pledged to support a strong national defense, that this bill is the high water mark. It's all downhill from here.

With that said, Madam Speaker, there is much to like in the base bill.

I support reform of our military acquisition processes.

I support Secretary Gates' program to re-examine our national security priorities in light of the new irregular challenges and threats that are proliferating well beyond Iraq and Afghanistan.

I support funding in the bill for: a 3.4 percent pay raise for our troops (all volunteers); over \$29 billion to provide first class medical care through our Defense Health program; \$15 billion to allow the Navy to build seven ships; funding for more F/A-18 aircraft. We also set the stage for a future multi-year procurement of the F-18 aircraft to begin to close the Navy's "fighter gap;" \$6.3 billion for 6,600 more lightweight MRAPs for Afghanistan. These vehicles are badly needed as IED's have proliferated;

However, I wish we could find a way to restore the cuts to missile defense and ensure that the F-22 assembly line keeps rolling.

In this context, Madam Speaker, I worry that this Administration is not making the investments today to ensure that we will be prepared to defend our interests against all threats in the years to come.

I must also add that I am very concerned about the Majority's insistence on using this bill, and our troops, to pass unrelated, and sometimes controversial provisions. For example, this bill should not be the vehicle to legislate Medicare doctor's payments, COBRA, Satellite television, nutrition assistance reauthorization, the PATRIOT Act and other provisions.

In closing, I thank Chairman MURTHA and Ranking Member YOUNG for their leadership.

Ms. RICHARDSON. Madam Speaker, I rise in strong support of H.R. 3326, the FY2010 Defense Appropriations Act," which provides \$636.3 billion in defense funding. This bill keeps faith with our troops and provides the funding needed to ensure they are the best trained, best prepared, best equipped, and best cared for fighting force in the history of the world. That is the least we can do for those who willingly risk their lives to keep us safe.

Madam Speaker, I also support the bill because it makes the needed investments to keep our nation strong, safe, and respected in the world. One of the most important investments is the \$2.5 billion in funding provided to build and maintain 10 C-17 Air Force cargo aircraft, which is assembled in my district but serves the nation and helps protect the peace the world over.

I want to thank Chairman MURTHA and Chairman OBEY for working with me to secure this funding and also for masterly shepherding this legislation to the floor.

Madam Speaker, in my remaining time let me briefly explain why I fight so hard for the

C-17, as Chairman MURTHA can attest: Airlift is the enabler of global reach, global power, and global vigilance. This is what makes us a superpower.

The C-17 is the best airlift aircraft in the world because of its ability to fly long distances and land in remote airfields in rough, land-locked regions.

The C-17 is the premier transporter for military, humanitarian and peacekeeping missions because it can:

Take off from a 7,600-ft. airfield, carry a payload of 160,000 pounds, fly 2,400 nautical miles, refuel while in flight and land in 3,000 ft. or less on a small unpaved or paved airfield in day or night.

In addition to the wars in Afghanistan and Iraq, the C-17 has proved its mettle in humanitarian missions to Darfur, Myanmar, China, and Georgia in the former Soviet Union.

The men and women who design and build the C-17 represent a critical component of our nation's industrial base and a workforce that is second to none.

At a time when we are adding to our troop strength in the Army and Marine Corps overall, and expanding our deployment to Afghanistan, it only makes sense to continue production of the C-17, the only program that provides for strategic airlift over the long term.

For California alone, the C-17 program at Long Beach contributes almost 14,000 direct jobs and an economic impact of \$2 billion.

In conclusion, Madam Speaker, I support this bill because it restores and enhances the readiness of our troops, equipment, and defense infrastructure. It takes care of our military personnel and their families. And it authorizes the needed investments to keep our nation strong, safe, and respected in the world.

I urge my colleagues to join me in voting for the bill on final passage.

Mr. HOLT. Madam Speaker, I rise in support of this important bill.

To help support our troops and their families, this bill provides a much-deserved 3.4 percent military pay increase, as well as \$472.4 million for Family Advocacy programs and full funding for Family Support and Yellow Ribbon to provide support to military families, including quality child care, job training for spouses, and expanded counseling and outreach to families experiencing the separation and stress of war. Additionally, H.R. 3326 provides \$29.2 billion (\$3 billion above the 2009 level) for the Defense Health Program to provide quality medical care for servicemembers and their including \$120 million for Traumatic Brain Injury and Psychological Health Research.

Regarding the Defense Department's operations, I'm pleased that the bill provides \$5 billion to allow defense personnel, not contractors, to perform critical department functions. The Department estimates that every position that is converted from contract to federal civilian saves on average \$44,000 per year. Additionally, the bill reduces contracted advisory and assistance services by \$51 million, and includes general provisions to stop further conversions by the Department of Defense from government functions to contractors. The bill also contains important policy provisions I support, including a bar on the establishment of

permanent bases in Iraq or Afghanistan, and the continuation of a general requirement prohibiting the torture of detainees held in U.S. custody.

I am disappointed that we were forced to include in this bill a 60 day extension of three expiring Patriot Act authorities. The very good Patriot Act reform bill reported out of the Judiciary Committee eliminates over-broad surveillance authorities, tightens requirements for the issuance of national security letters, and contains important oversight requirements that will help us protect our people from both potential terrorists and an out-of-control executive branch. That bill should be passed by the House in January 2010 and the Senate should adopt it.

Some non-defense policy items are also attached to this bill, including expanded unemployment benefits, including increased payouts and longer duration of benefits, through February 28, 2010. The bill also extends from nine to 15 months (to February 28, 2010) the 65 percent COBRA health insurance subsidy for individuals who have lost their jobs. The COBRA subsidy extension would help New Jersey families between jobs immediately, as without this subsidy the average New Jersey family would pay \$1,156 a month for COBRA coverage, which would consume over two-thirds of their unemployment benefits.

Overall, this bill meets important national security and domestic policy needs, and I urge my colleagues to join me in supporting this bill.

Mr. BOYD. Madam Speaker, I want to thank Chairman MURTHA and Ranking Member YOUNG for their work on the Fiscal Year 2010 Defense Appropriations Act. This bill will ensure that our military members have the equipment, training and resources they need to continue to defend our great nation, particularly in light of the continuing engagements in Iraq and Afghanistan. As a Vietnam veteran, I understand the sacrifices our troops are making and they are never far from my mind in the work I do here.

I specifically want to highlight the section in the bill under consideration today regarding the Combat Air Force restructure plan and thank the Chairman for his work with me on this provision to delay the early retirement of F-15s from Tyndall Air Force Base. I also want to acknowledge and thank the Secretary of the Air Force and the Chief of Staff for their incredible dedication and willingness to resolve this tough issue with me.

This six month delay of the Combat Air Force restructure plan stipulated in H.R. 3326 represents a tremendous legislative victory for Bay County and is the result of a year's worth of efforts by our community. Working together, we have put Tyndall in a strategic position to be a key component of the Air Force's next generation fighter infrastructure. It has been made clear from the very highest levels of the Air Force, from the Chief and Secretary, that Tyndall is a national jewel that plays, and will continue to play, a valuable role in our country's defense.

I also want to thank the people of Bay County, particularly the Bay Defense Alliance, who have been partners with me as we worked together to protect the economic interest of our community and security interests of

our country. It is no secret from the halls of Congress to the halls of the Pentagon that the community supporting Tyndall Air Force Base is top notch.

Additionally, I look forward to the results of the reporting requirements in this bill that will help us all better understand the Air Force's fighter requirements and the impact that the drawdown would have on our nation's combat air forces and the communities that support them.

In summary, this bill will make sure that our nation remains the strongest military in the world and I strongly support it.

Mr. ETHERIDGE. Madam Speaker, I am pleased once again to rise in support of H.R. 3326 the Fiscal Year 2010 Defense Appropriations Act. In addition to making important investments to keep the American people safe, strengthen our military, and support our troops, this amended bill makes sure that the American economy is safe, strengthens our recovery, and supports those in need.

As a veteran of the U.S. Army, and the representative of Fort Bragg and Pope Air Force Base, I am proud of our troops who serve our country, and pleased that we are completing our work on funding their efforts in Iraq and Afghanistan, meeting their equipment needs at home, and fulfilling our commitment to our troops and their families. I spoke about many of those provisions when this bill first passed in July.

This amended bill also keeps our commitment to the working men and women of America who deserve support in this economic downturn. As the representative of a state with one of the highest unemployment rates in the nation, I am proud that this bill will provide a degree of economic security for workers who are struggling during this holiday season. Extending benefits for folks who are having trouble finding a job is the right thing to do for families and our recovering economy. The temporary support in this bill will help North Carolinians maintain health care coverage and pay their bills while they get back on their feet and find their next job opportunity.

This bill continues our efforts to get the economy back on track and create jobs. The families who receive extended benefits will be putting money right back into our local economy—buying groceries, filling their cars with gas, and making their mortgage payments on time. The bill also extends improvements to Small Business Administration guaranteed loans so that small businesses can secure the financing they need in these tight economic times. Small business are a major engine of our economy, and are responsible for almost all year-over-year job growth. We must make sure they can get the funding they need to create jobs so we can reduce unemployment and restore our economy.

Madam Speaker, this bill already made sure our Armed forces have the support they need to protect the American people. The amendments we are voting on today also make sure we preserve our economic safety net and promote American prosperity.

I urge my colleagues to join me in support of H.R. 3326.

Mrs. BACHMANN. Madam Speaker, I rise today in support of H.R. 3326, the Fiscal Year 2010 Department of Defense Appropriations

Act, as amended by the Senate. However, while I applaud the hard work of House leadership in bringing this much needed legislation to the floor, I regret that an opportunity to more fully address the threat posed by suspected terrorists currently under detention by the United States government has been missed.

The United States military is responsible for keeping Americans safe. And in light of the challenge that we face in Iraq and Afghanistan, the Federal Government's commitment to our soldiers has never been more important. As such, I'm pleased we're working to ensure that the promises we've made to those who serve in our Armed Forces are kept. Whether it's the 3.4 percent military pay increase or the \$104 billion to improve military equipment, I believe we must ensure our troops receive the support they deserve for the great sacrifice they have made by serving our country, and clearly this bill represents a strong show of that support.

However, while H.R. 3326, as passed, is a strong bill, I was disappointed that one of the most troubling issues of the day was not addressed. Critical to ensuring individual Americans' safety is the future treatment of the dangerous enemy combatants housed at the Guantanamo detention facility. Rather than allowing Khalid Sheikh Mohammed to be tried in New York City through our civilian court system and transporting Guantanamo detainees to Thomson Correctional Institution in Illinois, Congress should unequivocally restrict enemy combatants to trial by military commission and permanently deny funding to transport them into our country.

Madam Speaker, we are at a critical juncture in our nation's history. However, as we work to bolster a strong national defense, we cannot ignore the ever-present threat posed by those rogue agents who wish to do us harm. I believe a cornerstone of addressing this threat is to remove the current legal ambiguity with regard to detainee treatment. By trying these detainees in a civilian setting, we are allowing them to exploit our judicial system for personal gain and undermine the work of our military commissions, which have served our nation for centuries.

So while I am pleased to be here on the floor today supporting our troops, it is my sincere hope that the questions surrounding America's prosecution of enemy combatants will be answered in a way that best ensures our national security.

Mr. TIAHRT. Madam Speaker, the base bill of H.R. 3326, the FY2010 Defense Appropriations bill, effectively meets the needs of our men and women in uniform. Although not perfect, H.R. 3326 takes important steps to invest in the people and equipment of the United States Armed Forces. Sadly, Democrat leadership has once again decided to use this vital and non-partisan piece of legislation to enact controversial measures, such as bringing terrorists to U.S. soil.

The United States military is the strongest in the world due to our people, training and equipment. I am happy to say that each of those is strongly supported in this legislation.

Our military men and women are patriots and the world's finest soldiers, sailors, airmen and Marines. Congress has a moral obligation

to offer them our thanks and unwavering support. Although we can never fully repay their sacrifice and commitment, H.R. 3326 at least provides a pay raise. The bill provides a 3.4 percent pay raise for all servicemembers, which is 0.5% higher than that proposed by the Obama administration.

Our military and their families deserve the world's finest medical care. H.R. 3326 makes a \$30 billion investment to care for sick and wounded servicemembers and their families. This includes \$370 million for medical research and \$120 million for Traumatic Brain Injury and psychological health research.

The legislation also provides \$500 million for family advocacy programs that support military families. With so many servicemen and women deployed overseas, our military families are under particular strain. Whether at Fort Riley or McConnell Air Force Base, Kansas families need this extra assistance when their loved ones are deployed. The bill makes the right investments to ensure they are protected and supported.

Given the diverse roles our military performs—from safeguarding nuclear weapons to fighting terrorists in the jungles of the Philippines—rigorous training is essential to ensure our troops are ready for action and come home safely when the job is done. To achieve this objective, H.R. 3326 provides \$154 billion for operations and maintenance accounts. During the 1990s, our nation had a “hollow military”—filled with people and equipment, but lacking the necessary training and readiness to be successful. We must never allow this to occur again.

Ensuring that our military has the finest equipment available is essential, and H.R. 3326 makes some necessary investments. With funding for the Next Generation Aerial Refueling Aircraft replacement, the Navy's Multi-mission Maritime Aircraft, and additional C-17 aircraft, among many other programs, our troops will have the most advanced equipment to effectively carry out the will of this nation and return home safely. These programs also create high-paying Kansas jobs that we so desperately need.

While this legislation makes the right investments in our fighting men and women and their families, it also includes a dangerous provision for our nation: allowing terrorists detainees currently held at Guantanamo Bay to be brought to the United States.

Terrorists do not belong in the streets or prisons of America. Following the dangerous decision to house unrepentant terrorists in the Midwest, this legislation does nothing to restrict the president's obsession with closing the detention facility at Guantanamo Bay and bringing terrorists to the United States. We have the most secure, state-of-the-art detention and interrogation facility in the world at Guantanamo Bay. That is where the terrorists should remain. They should never be brought to the United States.

Although Democrats continue to play politics with this spending bill, I cannot do the same. Our men and women in uniform deserve the resources to carry out the will of this nation, and this bill provides those. Therefore, I intend to vote for H.R. 3326 and I encourage my colleagues to do the same.

Mr. STARK. Madam Speaker, I rise to oppose yet another increase in war and defense

spending. I have never voted for a Defense Appropriations bill. I will not start today. Throwing more money toward a war in Iraq that should never have been started and a war in Afghanistan that should be over diminishes our ability to address the real issues impacting families.

War spending already swallows over 50 percent of our discretionary budget. This bill will add \$11 billion to an already bloated Defense budget, as President Obama eyes billions more for a troop increase in Afghanistan.

There are good things in this bill. I helped write provisions that will extend COBRA subsidies and prevent pay-cuts to Medicare physicians. The bill also extends unemployment benefits at a time when Americans are struggling to find jobs. While I support these provisions, I cannot support a bill where the good provisions are dwarfed by the \$636.3 billion outlay for defense.

The right priorities for Congress are addressed in another bill we will consider today, the Jobs for Main Street Act (H.R. 2847). This legislation would put people to work rebuilding our country. It would invest in building schools, improving our transit systems, and upgrading our water infrastructure. It would prevent the lay-offs of teachers, police, and firefighters.

The Jobs for Main Street Act also would provide better protections for laid-off workers than the provisions in the Defense bill. It would extend emergency unemployment insurance benefits for an additional six months, and allow millions to maintain health care by expanding the COBRA subsidy to 15 months and extending the eligibility period to June 30th. This is the type of escalation our country needs.

Congress should not be giving more money to the Pentagon to wage war. We should be focused on creating jobs, providing health care for all Americans, and improving our education system. That is why I am voting for the Jobs for Main Street Act and against the wasteful Defense Appropriations bill.

Ms. JACKSON-LEE of Texas. Madam Speaker, I rise as a Member of the Foreign Affairs Committee to support House passage H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010. I urge the Congress to support the President's initiatives to terminate or reduce programs that fund narrowly focused activities, duplicate existing programs, or that have outlived their usefulness, specifically including the Kinetic Energy Interceptor program. The Congress is encouraged to adopt proposals made by the administration that would better target scarce resources and redirect funds to programs with greater potential for results.

I believe in a strong procurement approach that takes advantage of the efficiencies associated with an award to a single contractor.

I look forward to working with the Congress to address concerns regarding statutory direction to re-organize certain offices within the Office of the Director of National Intelligence (ODNI), reductions to cyber security programs, and cuts to classified activities in ODNI.

The measure provides more funding for equipment depleted by the wars in Iraq and Afghanistan, special pay raises, and quality of life improvements for the troops and their fam-

ilies. It partially offsets these increases by cutting funding from current levels for missile defense and futuristic programs like the Future Combat System of new vehicles. I support the President in adding more money into the budget for our military families. I am disappointed that this bill appropriates no funds for the closure of the prison at Guantanamo, and blocks the transfer of prisoners. The bill references a detailed plan for the disposition of the detainees to be submitted and I look forward to seeing this plan. It also provides a 3.4% pay increase for military personnel, and a 2% pay raise for civilian federal employees which is vital in maintaining the morale of the troops and the federal law enforcement personnel that help secure America.

Finally, this bill prohibits the use of funds in the bill to establish permanent military bases in Iraq or U.S. control of Iraqi oil resources.

The bill also continues the prohibition on the use of funds provided for the Iraq Security Forces for the construction of facilities for the Iraqi government.

I support all provisions that require the Defense secretary to report to Congress on troop drawdown status and goals relating to the withdrawal of U.S. forces from Iraq by the end of 2011. The report, which is due 90 days after enactment and every 90 days thereafter, must include the following:

A detailed, month-by-month description of the transition of U.S. military forces and equipment out of Iraq;

A detailed, month-by-month description of the transition of U.S. contractors out of Iraq; and

How the Iraqi government is assuming the responsibility for reconciliation initiatives as the U.S. role transitions.

It is absolutely imperative that the U.S. Congress and the President agree on an eventual drawdown and removal of our forces from Iraq.

I am proud of the support to the military and their children that the FY 2010 Defense Appropriations bill provides. Congress approved a 3.4 percent increase in military pay, 0.5 percent above the Department of Defense request. This bill includes \$29.2 billion for medical care for the Defense Health Program, which provides medical care for members of the armed services and their families. Included in the health care funding are \$372 million for military medical research and \$120 million for Traumatic Brain Injury and Psychological Health Research.

The FY10 Defense Appropriations bill included \$472.4 million for Family Advocacy programs including Family Support and Yellow Ribbon. These programs include quality child care, job training for spouses, and an expansion of counseling services. For the families that experience the daily heartache of having a loved one far away, these programs reach out and provide support. I want to thank Chairman MURTHA for his untiring support of our troops and their families.

I want to stress that none of these funds will go toward the administration's plan to send 30,000 additional troops to Afghanistan, and I will continue to scrutinize the economic, military and social impacts of the administration's request. I am concerned about the cost of sending additional troops, as well as the effect

that a larger presence in Afghanistan will have on troop morale. The White House estimates that it will cost \$1 million per year for each additional soldier deployed, and I believe that \$30 billion would be better spent on developing new jobs, and fixing our broken healthcare system, as well as in using "smart power" to peacefully work on the Afghan cease-fire.

The cost and the long-term commitment were given renewed significance on Tuesday, December 9, 2009 when Afghan President Hamid Karzai said, as reported in the New York Times, that "Afghanistan would not be able to pay for its own security until at least 2024." Secretary Robert Gates echoed that sentiment when he said that "For another 15 to 20 years, Afghanistan will not be able to sustain a force of that nature and capacity with its own resources." If our strategy is to use \$50 billion to build up Afghanistan's police and military forces as well as a decades-long commitment, I am not sure that the American people will support such an effort.

Yet, no matter your opinion on their role in conflict, it is important that our troops are prepared for the current combat environment. As such, the Defense appropriations bill includes \$154 billion to increase the readiness of our armed forces, helping to refocus our military away from the Cold-War era type of conflict.

A bill of this magnitude must include safeguards against waste, abuse, and fraud. Not only does this bill increase the resources at the disposal of the Department of Defense (DOD) Inspector General, it also enhances the focus on taking inherently governmental functions out of the hands of contractors.

Finally, it will be a great celebration in Houston with the establishment of the Riverside General Hospital Post Traumatic Stress Disorder Center with a \$1 million grant. Additionally, I have received over \$4 million in green job, technology, and medical research funding. These dollars will work for the 18th Congressional District and the American people.

Ms. WOOLSEY. Madam Speaker, I rise in opposition to H.R. 3326, the Department of Defense Appropriations Act.

The bill extends unemployment and COBRA benefits, which I have fought for and continue to support.

It also funds a number of employment, medical, and transportation programs that I also support.

Nevertheless, I urge my colleagues to oppose this bill because it continues funding for our futile efforts in Iraq and Afghanistan, which have already cost our country too much in blood and treasure.

Instead of pursuing military action where there is no military solution, we need a new strategy that relies on the effective tools of what I call smart security.

These tools include diplomacy, humanitarian aid, economic development, education, civil affairs, and better intelligence and police work to search out and capture extremists.

In the case of Afghanistan, for example, a great majority of all further funding should be devoted to these smart security efforts.

Madam Speaker, let's change our strategy before it's too late. We can begin by voting against this bill.

Ms. MCCOLLUM. Madam Speaker, I rise to express my support for H.R. 3326, the Department of Defense Appropriations Act for Fiscal

Year 2010. This legislation provides the needed support, resources, and equipment for America's brave men and women in uniform.

With the passage of H.R. 3326, Congress will affirm its commitment to America's Armed Forces, both overseas in a theater of war and here at home when they return from duty. I am pleased that this bill recognizes the incredible sacrifice made by our troops and their families. It provides an increase in military pay, first-class medical care, and expanded support and counseling for military families enduring the burdens of war.

But the sacrifices made for national security should not be for our troops and their families to bear alone. When the country commits to fighting a war, it must also commit to paying for it. All additional funding necessary for stability in Afghanistan and Pakistan must be paid for today, rather than added to America's mounting debt. That is why I joined my colleagues in cosponsoring H.R. 4130, a bill that would establish a temporary surtax to pay for the war in Afghanistan.

Madam Speaker, I am also pleased that H.R. 3326 increases oversight of the Department of Defense to reign in waste, fraud, and abuse. It ensures that defense personnel—not outside contractors—perform the department's most critical functions, and calls for additional investigators to oversee those contracts that are outsourced.

Finally, in addition to critical spending for our national defense, this package contains key items to help Americans during our economic downturn. H.R. 3326 will extend expanded unemployment benefits, health insurance for unemployed workers, and enhancements for small business loans. It will delay cuts to Medicare physician payment extensions, and help meet the growing demand for nutrition assistance for low- and middle-income Americans.

Ms. LEE of California. Madam Speaker, I rise today in opposition to H.R. 3326, the Department of Defense Appropriations Act for FY 2010.

Critical provisions have been added to this bill in order to help those facing incredible hardships during this difficult economic time.

The extension of expanded unemployment benefits until the end of February is a vital stopgap measure for those in dire need, and I would like to stress that this is only a piece of our urgent responsibility to restore the economic livelihood, and promise of opportunity to so many individuals and communities across the country.

I am also pleased to see that H.R. 3326 includes language prohibiting the establishment of permanent military bases in Iraq or Afghanistan.

Unfortunately, I cannot support the \$125 billion included in this bill for ongoing military operations in Iraq and Afghanistan, nor can I support a continuation of runaway defense spending especially at a time when individuals and families across this nation are facing enormous challenges in simply trying to make ends meet.

Madam Speaker, I have been clear in my respectful disagreement with the President's decision to escalate the United States military presence in Afghanistan, as well as my belief that the situation in Afghanistan will not be solved with a military solution.

This bill does not include additional funding for the proposed troop deployments, and I am hopeful Congress will hold an honest debate and up-or-down vote on the issue of a military escalation prior to obligating federal resources.

The direct costs of two wars in Iraq and Afghanistan have reached nearly \$1 trillion, and the indirect costs to our national security, our economy, and to our brave men and women in uniform are immeasurable.

We further cannot afford to squander our resources on costly cold-war era weapons that in many cases are outdated and truthfully inappropriate for reducing the real threats facing our nation.

The fact is, as we work to reform our nation's healthcare and education systems, invest in housing and infrastructure, and put American's back to work, sending more than 50 percent of the federal discretionary budget to the Pentagon represents a clear and unacceptable tradeoff.

For those reasons I cannot support this bill.

Mr. YOUNG of Florida. Madam Speaker, I yield back the balance of my time.

Mr. MURTHA. I yield back the balance of my time, Madam Speaker.

The SPEAKER pro tempore. Pursuant to House Resolution 976, the previous question is ordered.

The question is on the motion offered by the gentleman from Pennsylvania (Mr. MURTHA).

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. YOUNG of Florida. Madam Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, this 15-minute vote on adoption of the motion will be followed by a 5-minute vote on the motion to suspend the rules with regard to H.R. 1110, if ordered.

The vote was taken by electronic device, and there were—yeas 395, nays 34, not voting 5, as follows:

[Roll No. 985]

YEAS—395

Abercrombie	Blackburn	Camp	Johnson (GA)	Nye
Ackerman	Blumenauer	Cantor	Johnson, E. B.	Oberstar
Adersholt	Blunt	Cao	Johnson, Sam	Obey
Adler (NJ)	Bocchieri	Capito	Jones	Olson
Akin	Boehner	Capps	Jordan (OH)	Olver
Alexander	Bonner	Capuano	Kanjorski	Ortiz
Altmire	Bono Mack	Cardoza	Kaptur	Owens
Andrews	Boozman	Carnahan	Kennedy	Pallone
Arcuri	Boren	Carney	Kildee	Pascarell
Austria	Boswell	Carson (IN)	Kilpatrick (MI)	Pastor (AZ)
Baca	Boucher	Carter	Kilroy	Paulsen
Bachmann	Boustany	Cassidy	Kind	Pence
Bachus	Boyd	Castle	King (IA)	Perlmutter
Baird	Brady (PA)	Castro (FL)	King (NY)	Perriello
Barrett (SC)	Brady (TX)	Chandler	Kingston	Peters
Barrow	Braley (IA)	Childers	Kirk	Peterson
Bartlett	Bright	Chu	Kirkpatrick (AZ)	Petri
Barton (TX)	Brown (GA)	Clay	Kissell	Pingree (ME)
Bean	Brown (SC)	Cleaver	Klein (FL)	Pitts
Becerra	Brown, Corrine	Clyburn	Kline (MN)	Platts
Berkley	Brown-Waite,	Coble	Kosmas	Poe (TX)
Berman	Ginny	Coffman (CO)	Kratovil	Pomeroy
Berry	Buchanan	Cohen	Lamborn	Posey
Biggert	Burgess	Cole	Lance	Price (GA)
Bilbray	Burton (IN)	Conaway	Langevin	Price (NC)
Bilirakis	Butterfield	Connolly (VA)	Larsen (WA)	Putnam
Bishop (GA)	Buyer	Conyers	Larson (CT)	Rahall
Bishop (NY)	Calvert	Cooper	Latham	Rangel
			LaTourette	Rehberg
			Latta	Reichert
			Lee (NY)	Reyes
			Levin	Richardson
			Lewis (CA)	Rodriguez
			Linder	Roe (TN)
			Lipinski	Rogers (AL)
			LoBiondo	Rogers (KY)
			Loeback	Rogers (MI)
			Lowey	Rohrabacher
			Lucas	Rooney
			Luetkemeyer	Ros-Lehtinen
			Lujan	Roskam
			Lungren, Daniel	Ross
			E.	Rothman (NJ)
			Lynch	Roybal-Allard
			Mack	Royce
			Maffei	Ruppersberger
			Maloney	Rush
			Manzullo	Ryan (OH)
			Marchant	Ryan (WI)
			Markey (CO)	Salazar
			Markey (MA)	Sanchez, Linda
			Marshall	T.
			Massa	Sanchez, Loretta
			Matheson	Sarbanes
			Matsui	Scalise
			McCarthy (CA)	Schakowsky
			McCarthy (NY)	Schauer
			McCauley	Schiff
			McClintock	Schmidt
			McCollum	Schock
			McCotter	Schrader
			McGovern	Schwartz
			McHenry	Scott (GA)
			McIntyre	Scott (VA)
			McKeon	Sensenbrenner
			McMahon	Sessions
			McMorris	Sestak
			Rodgers	Shadegg
			McNerney	Shea-Porter
			Meek (FL)	Sherman
			Meeks (NY)	Shuler
			Melancon	Shuster
			Mica	Simpson
			Michaud	Sires
			Miller (FL)	Skelton
			Miller (MI)	Slaughter
			Miller (NC)	Smith (NE)
			Miller, Gary	Smith (NJ)
			Miller, George	Smith (TX)
			Minnick	Smith (WA)
			Mitchell	Snyder
			Mollohan	Space
			Moore (KS)	Spratt
			Moore (WI)	Stearns
			Moran (KS)	Stupak
			Moran (VA)	Sullivan
			Murphy (CT)	Sutton
			Murphy (NY)	Tanner
			Murphy, Patrick	Taylor
			Murphy, Tim	Teague
			Murtha	Terry
			Myrick	Thompson (CA)
			Napolitano	Thompson (MS)
			Neal (MA)	Thompson (PA)
			Neugebauer	Thornberry
			Nunes	Tiahrt
			Jackson (IL)	
			Jackson-Lee	
			(TX)	
			Jenkins	

Tiberi
Tierney
Titus
Tonko
Tsongas
Turner
Upton
Van Hollen
Visclosky
Walden

Walz
Wamp
Wasserman
Schultz
Waters
Watson
Watt
Waxman
Weiner
Westmoreland

Wexler
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Yarmuth
Young (AK)
Young (FL)

NAYS—34

Baldwin
Bishop (UT)
Campbell
Chaffetz
Clarke
Costello
Duncan
Ehlers
Ellison
Filner
Flake
Gohmert

Grayson
Johnson (IL)
Kagen
Kucinich
Lee (CA)
Lewis (GA)
Lofgren, Zoe
Lummis
McDermott
Nadler (NY)
Paul
Payne

Polis (CO)
Quigley
Serrano
Shimkus
Stark
Towns
Velázquez
Welch
Woolsey
Wu

NOT VOTING—5

Eshoo
Hirono

Radanovich
Souder

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1400

Messrs. COSTELLO, SHIMKUS, CHAFFETZ, LEWIS of Georgia, KAGEN, Ms. VELÁZQUEZ, Messrs. PAYNE, TOWNS, and Ms. CLARKE changed their vote from “yea” to “nay.”

Messrs. TURNER and RYAN of Wisconsin changed their vote from “nay” to “yea.”

So the motion was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Ms. ESHOO. Madam Speaker. I was not present during rollcall vote No. 985 on December 16, 2009 because I was in a secure room for a restricted briefing.

On rollcall vote No. 985, I would have voted “yea.”

Stated against:

Mr. CONYERS. Madam Speaker, today, I inadvertently cast a “yea” vote during rollcall vote 985. My intention was to cast a “nay” vote on H.R. 3326, a bill making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes.

PHONE ACT OF 2009

The SPEAKER pro tempore. The unfinished business is the question on suspending the rules and passing the bill, H.R. 1110, as amended.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Michigan (Mr. CONYERS) that the House suspend the rules and pass the bill, H.R. 1110, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

RECORDED VOTE

Mr. TIM MURPHY of Pennsylvania. Madam Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 418, noes 1, not voting 15, as follows:

[Roll No. 986]

AYES—418

Abercrombie
Ackerman
Aderholt
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Barrett (SC)
Barrow
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggett
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Bocieri
Boehner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Brady (TX)
Braley (IA)
Bright
Broun (GA)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Capps
Capuano
Cardoza
Carnahan
Carney
Carson (IN)
Carter
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver

Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dingell
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah
Filner
Flake
Fleming
Forbes
Fortenberry
Foster
Foxy
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallegly
Garamendi
Garrett (NJ)
Gerlach
Giffords
Gohmert
Gonzalez
Goodlatte
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)

Hall (TX)
Halvorson
Hare
Harman
Harper
Hastings (FL)
Hastings (WA)
Heinrich
Hensarling
Herger
Herseth Sandlin
Higgins
Hill
Hinchey
Hinojosa
Hodes
Hoekstra
Holden
Holt
Hoyer
Hunter
Inglis
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee
Jenkins
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (IA)
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovic
Kucinich
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Lipinski
LoBiondo
Loebach
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Lujan
Lummis
Lungren, Daniel
E.
Lynch
Mack

Maffei
Maloney
Manzullo
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McClintock
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris
Rodgers
McNerney
Meek (FL)
Meeks (NY)
Melancon
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murphy, Tim
Murtha
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye
Oberstar
Obey
Olson
Olver
Ortiz
Owens
Pallone
Pascrell
Paulsen

Payne
Pence
Perlmuter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Putnam
Quigley
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Rothman (NJ)
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Salazar
Sanchez, Linda
T.
Sanchez, Loretta
Sarbanes
Scalise
Schakowsky
Schauer
Schiff
Schmidt
Schock
Schrader
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shadeeg
Shea-Porter
Sherman

Shimkus
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Space
Spratt
Stark
Stearns
Stupak
Sullivan
Sutton
Tanner
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wamp
Wasserman
Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Westmoreland
Wexler
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Woolsey
Wu
Yarmuth
Young (AK)

NOES—1

Paul

NOT VOTING—15

Bonner
Conyers
Dicks
Gingrey (GA)
Heller

Himes
Hirono
Honda
Kaptur
Linder

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members have 2 minutes remaining in this vote.

□ 1407

So (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. RADANOVICH. Madam Speaker, I was unable to make today's votes on the House

floor due to a family illness. Had I been present I would have voted as follows:

"Yea" on rollcall vote No. 985, on the motion to concur in the Senate Amendment with a House Amendment to H.R. 3326, the Department of Defense Appropriations Act of 2010.

"Aye" on rollcall vote No. 986, to suspend the rules and adopt H.R. 1110, the PHONE Act of 2009.

PERSONAL EXPLANATION

Ms. HIRONO. Madam Speaker, on rollcall No. 985 and 986, had I been present, I would have voted "yes" on both.

FURTHER CONTINUING APPROPRIATIONS, FISCAL YEAR 2010

Mr. OBEY. Madam Speaker, pursuant to House Resolution 976, I call up the joint resolution (H.J. Res. 64) making further continuing appropriations for fiscal year 2010, and for other purposes, and ask for its immediate consideration.

The Clerk read the title of the joint resolution.

The SPEAKER pro tempore. Pursuant to House Resolution 976, the joint resolution is considered read.

The text of the joint resolution is as follows:

H.J. RES. 64

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the Continuing Appropriations Resolution, 2010 (division B of Public Law 111-68) is further amended by striking the date specified in section 106(3) and inserting "December 23, 2009".

The SPEAKER pro tempore. The gentleman from Wisconsin (Mr. OBEY) and the gentleman from California (Mr. LEWIS) each will control 30 minutes.

The Chair recognizes the gentleman from Wisconsin.

Mr. OBEY. Madam Speaker, before I start, I don't see either one of them on the House floor now, but I just want to take this time to note that today is the birthday of the distinguished gentleman from Florida (Mr. YOUNG), the ranking member of the Defense appropriations subcommittee, and also of the gentleman from Washington (Mr. DICKS), who is the second ranking Democrat on the same subcommittee. So in their absence, I think we wanted to wish them well.

With that, Madam Speaker, I would simply say this is a simple joint resolution, a continuing resolution, which takes the Congress to December 23, next Wednesday. It is made necessary by the fact that it is just possible that the Senate might not finish its work before the 18th. They have been known for their speed, but this may be an exception. It is also useful in order to give the President additional time to review the Defense bill before he signs it.

With that, I would urge support, and I am prepared to yield back after the gentleman has made his remarks.

Mr. LEWIS of California. Madam Speaker, this is a simple 5-day CR, and I happily yield back the balance of my time.

Mr. OBEY. Madam Speaker, I would again urge support for the resolution, and I would yield back the balance of my time.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 976, the previous question is ordered.

The question is on the engrossment and third reading of the joint resolution.

The joint resolution was ordered to be engrossed and read a third time, was read the third time, and passed, and a motion to reconsider was laid on the table.

PERMITTING CONTINUED FINANCING OF GOVERNMENT OPERATIONS

Mr. STARK. Madam Speaker, pursuant to House Resolution 976, I call up the bill (H.R. 4314) to permit continued financing of Government operations, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Pursuant to House Resolution 976, the bill is considered read.

The text of the bill is as follows:

H.R. 4314

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. CONTINUED FINANCING OF GOVERNMENT OPERATIONS.

Subsection (b) of section 3101 of title 31, United States Code, is amended by striking the dollar amount contained therein and inserting "\$12,394,000,000,000".

The SPEAKER pro tempore. The gentleman from California (Mr. STARK) and the gentleman from Nevada (Mr. HELLER) each will control 30 minutes.

The Chair recognizes the gentleman from California.

□ 1415

Mr. STARK. I yield myself such time as I may consume.

This bill is necessary to allow the government to keep operating past the new year so that we can adjourn for the year. The Treasury Department has told us we will reach our current limit on the national debt on December 31—Happy New Year. Unlike past years, the Treasury Department has informed us they don't have the ability to maneuver and buy more time, so the United States would begin to default on its debt if we do not act.

The bill would raise the debt limit by \$290 billion, enough to last through February 11. Unfortunately, we will have to revisit this issue early next year. I wish we could have avoided that, but to do so, we would have had to resolve differences with the Senate

over a budget commission and a statutory PAYGO. With the Senate preoccupied on other matters, that would be impossible before the holidays. Even if the Senate were to pass the larger debt limit increase we sent over to them, we would still have to act again next year.

It's important that we do this, as I said, to keep the government running. I don't like to raise the debt limit, but I do like being in the majority, and I do like seeing us pay our bills because we have an international obligation to many of our creditors.

I reserve the balance of my time.

Mr. HELLER. Madam Speaker, I yield myself 2 minutes.

Madam Speaker, here we go again. Christmas is a week away and Congress is scrambling at the last minute just so we can go home. While Americans are doing last-minute holiday shopping, the majority party is doing its last-minute spending. This year, many families are cutting back on their holiday shopping. The average holiday spending by Americans this year has dropped to \$343 per person from \$372 a year ago. You would think that during these tough times when most Americans are forced to tighten their belts, Congress would do the same. No chance under this majority.

This majority stumbled into 2009 with a budget that raised the deficit by \$1.8 trillion. Then Congress decided to pass an \$800 billion stimulus bill, \$3 billion on Cash for Clunkers, \$1.3 trillion on the Democratic health care bill, a trillion dollars on cap-and-trade and, recently, another \$447 billion was spent on Washington, D.C., bureaucrats. After all this spending, the national debt is now \$12 trillion. Every American citizen will now owe more than \$39,000 to pay for Washington's spending.

Now Democrats want to raise the debt limit to allow even more spending in 2010. The real fat cat is the Federal Government which spends, spends, spends while the American public gets stuck with the bill.

I urge my colleagues to reject raising the debt limit. Give the gift that America deserves: a responsible Federal budget.

Merry Christmas to everyone.

I reserve the balance of my time.

Mr. STARK. Madam Speaker, I ask unanimous consent that the distinguished committee member of Ways and Means, Mr. NEAL of Massachusetts, be allowed to control the time for our side.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

Mr. NEAL of Massachusetts. Madam Speaker, I yield myself such time as I might consume.

Madam Speaker, I rise in support of the debt limit legislation we are considering today, and I want to thank Mr.

RANGEL for his hard work on the bill in the waning days of the Congress this first session.

Let me talk about what the bill does. This bill is simply about continuing operations for the Federal Government. That is the title of the legislation. "Continuing operations" means getting the Social Security checks out on time, an almost sacred duty that we have. This means providing support for our troops and keeping our museums and our parks open. That is what an increase in the debt limit will allow. Simply stated, this is about bills that have already been incurred.

Now, I will, during my time here, resist the temptation to become overly partisan and speak specifically to the issue that is in front of us until there is a misstatement of the facts in opposition.

What this bill does not do is increase or decrease spending. That is a key consideration. Those decisions have already been made through the regular order. Let me emphasize the following: This bill does not raise nor does it cut taxes. That is different legislation. I respect the opinion of all Members here—who, by the way, my hunch is have been on all sides of this issue during their time here in the Congress. But we all desire the same, and that is to bring our budget into balance with the future. Beyond that, there is broad agreement. But this bill is simply paying the check after the items have already been ordered. This bill would raise the limit by \$290 billion, which is estimated to allow the government to operate through February 11 and allow us to adjourn for the year.

Despite what some might say, the Treasury Department will reach the current limit on the national debt by December 31, and they have told us that there is no ability to do extraordinary measures that will, indeed, stretch that out.

Now, I hope that the offering that I make to resist demagoguery on this issue will be met. If not, we certainly will have an opportunity during the course of the next hour to slug it out based upon the facts, and I hope that we will regard Social Security and veterans bills that have already been incurred to be paid. We certainly can have moments of instructions here—we're all indeed prepared for that on all sides—but I hope that the opportunity to resist the temptation to dismiss the reality of what we're doing here will be before all of us.

I reserve my time.

Mr. HELLER. Madam Speaker, I yield 1 minute to the gentleman from California (Mr. HERGER).

Mr. HERGER. Madam Speaker, President Obama and congressional Democrats have maxed out the national credit card with reckless spending, and they're back for more.

The American people are tired of overspending and tired of policies that

have done nothing to lift us out of this economic downturn. Democrats rammed through a so-called stimulus that left us asking: Where are the jobs? Now congressional Democrats are asking for more money that they will turn around later this afternoon and spend on another stimulus bill that spends even more on failed policies.

Madam Speaker, it's time for Congress to say "no" to endless debt that is an albatross around the neck of our Nation's economy and future generations. Vote "no" on this increased debt limit.

Mr. NEAL of Massachusetts. Madam Speaker, I would like to yield to a voice of fiscal responsibility here in the House, to Mr. BOYD, the gentleman from Florida, for 2 minutes.

Mr. BOYD. I thank my friend, Mr. NEAL, for yielding.

I think all of us here today—certainly in this game of inside baseball—understand that we have to raise the debt limit. We don't have a choice to let our Nation go into default on its bonds.

But I do come today to ask you to support it. I come reluctantly. And I am glad to hear that my friends on both sides of the aisle now are for fiscal responsibility.

I think many of us over here have been saying for years—particularly for the last 8, 9 years—that policies that we were pursuing starting in 2001 of spending more than we were taking in on an annual basis had to stop. We found ourselves in pretty good shape in 2001, and then we changed the policies, and you know the rest of the story, the history of that.

Many of us have been working all during that 8-year period to try to re-install the tools that we could use to return fiscal discipline to our government: the tools such as pay-as-you-go rules, something that we had in place in the 1990s that was allowed to expire by the Congress and the administration in 2002; discretionary spending limit.

There are lots of tools that can be used, but in the last 9 years, this Congress and the administrations have rejected those tools, and it's time for us to put those back into place.

We don't have the will here at the United States Congress to discipline ourselves. I think both parties have proven that over the years. So we have to come back with those tools such as pay-as-you-go, discretionary spending caps, sequestration, whatever it takes. There's a good idea floating around on both sides of the Capitol here. It's called the SAFE Commission.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. NEAL of Massachusetts. I yield the gentleman an additional 1 minute.

Mr. BOYD. So what we're trying to do here is hit the pause button for less than 60 days, and we will move forward, break for the Christmas holiday,

and then come back, and we have to focus on this issue of fiscal responsibility.

I have said to my party leaders, as I have said to the other party leaders over the last 8 years, we have to look beyond the ends of our nose and we have to focus on fiscal responsibility. And the first step we have to do is keep our country from going into default on its bonds. And then we have to move forward to reinstall such tools as PAYGO, commissions, whatever it takes to get us focused on getting our government back to the point of acting in a responsible way for fiscal matters.

Mr. HERGER. Madam Speaker, I yield 3 minutes to the Republican Conference Chair, the gentleman from Indiana (Mr. PENCE).

Mr. PENCE. I thank the gentleman for yielding.

I rise today in opposition to H.R. 4314. It is a bill that will increase the statutory limit on the national debt by \$290 billion.

Now, my distinguished colleague and friend just called that "hitting the pause button," and that was evidence of his characteristic candor, because as everybody in this body knows, this \$290 billion increase in the statutory limit on the national debt is simply a down payment on the nearly \$2 trillion increase in the national debt that this Democratic majority intends to move in this Congress after the first of the year.

Increasing the national debt. You know, it's moments like this that I have really got to say that the American people have had it. I mean, at a time of economic difficulty for working families, small businesses, and family farmers all across this country, a time when families are sitting down at kitchen tables, huddled around aluminum desks in small businesses, in basements with fluorescent lights hanging, they're figuring out where to cut back. They're figuring out what expenses to put off. They're just figuring out how to make it from one month to the next.

And those families and those small businesses don't have the ability to walk down to the bank and just increase their debt limit with the wave of the hand. I mean, they have got to make hard choices. And to their undying credit, the American people are making those hard choices. And the reason they're so frustrated looking at Washington, D.C., today is because they see a national government that is completely out of step with the character and the values and the sacrifice that the American people are practicing every day—not that it's anything new.

As the distinguished chairman just said a few moments ago, when Republicans were in control, we did our share of spending and overspending. Republicans doubled the national debt in the

8 years of the last administration. But this Democratic majority just passed a budget that will double the national debt in the next 5 years and triple it in 10.

□ 1430

After 3 years of Democratic control in the House, the national debt has increased by 39 percent. The national deficit hit a record of \$1.4 trillion. In this fiscal year, it's expected to reach a new record of \$1.8 trillion. Millions of Americans are asking, Madam Speaker, when will it stop? When will Washington get the message that we can't borrow, spend and bail our way back to a growing America, that we've got to begin, Republicans and Democrats, to practice what we so love to preach when we are home: fiscal discipline, fiscal responsibility? And then we come here right before the Christmas break on the day we are probably headed out of this building, and we're going to pass a \$290 billion increase in the statutory limit on the national debt.

The American people don't want more debt for Christmas. This Congress ought to be sticking around, making the hard choices, reducing the size and scope of government and reforming these entitlements. Do the work the way the American people are doing the work, so help us, God.

Mr. NEAL of Massachusetts. Madam Speaker, before I come to my friend's comments, I want to yield myself such time as I might consume.

Madam Speaker, I spoke with Chairman RANGEL earlier, and it is our intention, as we did this month in passing the Tax Extenders Act of 2009, to make sure that those provisions hold. That bill contains a 1-year extension of dozens of important expiring provisions, including the popular R&D credit, the sales tax deduction and the college tuition deduction, among many others.

We are now hearing the Senate may not take up this provision, or provisions, and pass the bill before they expire on December 31. It is our intention to insist upon the House position and to work to ensure that our bill providing a seamless extension of these tax benefits will be enacted as soon as possible in the new year.

These provisions are crucial for both American business and individual taxpayers, and I am pleased that we were able to get the House to pass this bill before the year concluded, but it is disappointing that the other body will not be able to take it up this year. It is our goal, however, to ensure that this bill will provide a seamless extension when enacted based upon the House measure.

Madam Speaker, I want to thank Mr. PENCE because I thought that the tone of what he offered was entirely reasonable because he didn't pass out partisan blame in the instance that brings us here at this time. But a gentle re-

minder, I don't know how you could have voted for the war in Iraq and not vote now to pay the bill, because that's part of what we are being asked to do today. I understand how difficult this is, why it causes heartburn. But having said that, how can you say that you were willing to commit 160,000 soldiers to Iraq, and when the bill comes due, not pay it? That essentially is the argument that is in front of us today.

And I understand the arguments about those American families who are having a difficult time as we proceed to this holiday season, and we want to be as helpful to them as we can. And as they gather around the kitchen table to talk about the problems they have, we understand that we want to provide as much support for them as we can. But let's not forget the Social Security recipients who are currently sitting around the table as they watch this debate, wondering if their checks are going to be mailed to them on time at the first of the year.

With that, I reserve the balance of my time.

Mr. HELLER. Madam Speaker, I yield such time as he may consume to the ranking member of Ways and Means, the gentleman from Michigan (Mr. CAMP).

Mr. CAMP. I thank the gentleman from Nevada for yielding, and also I want to thank him for his leadership on the Ways and Means Committee this year.

The bill before us is a candid admission by the majority that their tax, borrow, and spend ways have driven America deeper and deeper into debt. In fact, because of the failed trillion-dollar stimulus spending bill, America's unemployment is higher than predicted and revenues are lower. But that hasn't stopped the majority from continuing to spend, spend, spend.

Just last week, the majority rolled six major spending bills into one omnibus bill that increased, on average, Federal spending by 11 percent. Now, the bill before us asks us to increase the debt limit another \$290 billion. The American people are asking: where are the jobs? But all they have been shown is more deficits and more debt.

Let's be honest with the American people. It really isn't \$290 billion the majority wants to increase the debt limit by. It's more like \$1.8 trillion. In a few short months, we'll be right back here voting on another bill to increase the debt limit, probably by another \$1.5 trillion.

At the end of 2007, the public debt equaled 65 percent of our gross domestic product, or GDP. By the end of 2009, the figure will exceed 83 percent, and according to President Obama's own budget projections, it will exceed 100 percent of gross domestic product by 2011. Think about it: at the rate the majority is spending, the Federal debt in 2011 will exceed the value of all

goods and services produced by the economy that year.

This isn't just a Democrat or a Republican problem. It's a huge problem for every single American. It threatens our economic recovery and our future prosperity. So let's remember the words of then-Senator Obama in 2006 who warned of the dangers of raising the debt limit without addressing the underlying cause. Here is what he said: "The fact that we are here today to debate raising America's debt limit is a sign of leadership failure. It is a sign that the U.S. Government can't pay its own bills. It is a sign that we now depend on ongoing financial assistance from foreign countries to finance our government's reckless fiscal policies."

"Increasing America's debt weakens us domestically and internationally. Leadership means 'that the buck stops here.' Instead, Washington is shifting the burden of bad choices today onto the backs of our children and grandchildren. America has a debt problem and a failure of leadership. Americans deserve better."

Americans do indeed deserve better than what they have received this year. But rather than heed that warning, Appropriations Committee Chairman OBEY recently said: "We don't really have a choice. The bill's already been run up; the credit card has already been used. When you get the bill in the mail, you need to pay it."

The gentleman from Wisconsin was correct: the credit card has been used. But this legislation doesn't pay the bill. It doesn't even make the minimum monthly payment. It simply asks for more credit.

After going on a \$1.4 trillion deficit spending binge and maxing out the taxpayers' credit cards, Democrats are now asking to increase the credit limit. We should not be asking for more credit. We should be developing a plan to control Federal spending so that future generations are not trapped under this mountain of debt.

Until we see a plan to actually address this underlying problem, as then-Senator Obama warned we must, I cannot, in good conscience, vote for this legislation.

I urge my colleagues to vote "no."

Mr. NEAL of Massachusetts. Madam Speaker, at this time, I would like to yield 4 minutes to my friend, the gentleman from Tennessee (Mr. TANNER) who was my classmate here 21 years ago and is, in my judgment, as thoughtful as any Member of this House on the issues of the national debt.

Mr. TANNER. Thank you, Mr. NEAL.

Madam Speaker, what we are seeing today is the culmination of a decade-long mismanagement of our Nation's finances. In the year 2000, the revenue and expenditure stream coming to Washington were both around 19 percent of gross domestic product. In

other words, we were breaking even. The second worse thing that happened in 2001 after, of course, 9/11 happened, in February when the Congressional Budget Office said that their forecast would be a \$5 trillion surplus over the next 10 years. People around here became euphoric. We are filthy rich. We can cut taxes. We can do everything, and we are going to be fine. In fact, the first Bush Secretary of the Treasury came before the Ways and Means Committee and said he was concerned that we would pay off the national debt so quickly that we would have to pay a premium to get our paper back.

Well, in June of 2001, we embarked on a new economic game plan for this country. Two and a half months later, 9/11, every assumption that went into the conclusion there would be a \$5 trillion surplus over the next 10 years was no longer valid. But what did Congress do? Kept right on going. By 2003, if you look at the Treasury records, by 2003, income coming into Washington was down to 16.3 percent of gross domestic product, and expenditures were over 20 percent because we had gone to war in Afghanistan and Iraq, among other reasons.

What did we do? We borrowed the gap. We started borrowing in 2002, -3, -4, -5, a decade-long mismanagement by both parties. And for the people who just last week stripped out to pay for and added another \$70 billion on a motion to recommit and to talk about debt and deficits now, when they ought to be trying to help us, what we're doing, as ALLEN BOYD said earlier, we're putting the pause button on this.

We must have statutory PAYGO that was allowed to lapse in 2002 so that you didn't have to pay for anything. You could just blithely pass tax cuts, increase spending and borrow the difference, because do you know something? The people we're borrowing it from aren't here. They don't have a vote.

I remember one time he said, will you vote for a supermajority to raise taxes? I said, no. There's plenty of pressure in the system not to raise taxes. I will vote not to borrow money because there's nobody here protesting what we're doing to the children of this country and the children yet to be born here.

And so, Madam Speaker, it's the responsible thing to do today. But I tell you, this is very short term, like 60 days. When we come back, we've got to insist on a commission or on a statutory PAYGO, on something to break this business-as-usual gridlock that has been going on here this entire decade.

And I defy anybody to argue honestly that it is not a decade-old problem. The last time we broke even, basically, was the fiscal year 2001. And so we have to do this; but when we get back here, when the final chapter is written of

this book, I hope we have the ability to come together, and we need the help, we need the help of the Republicans to help us put in statutory PAYGO and the commission, some of these things that will do it.

The problem is not what we're doing. We have a structural deficit. Income right now is about 17½ percent of gross domestic product. Expenditures are over 20.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. NEAL of Massachusetts. I yield the gentleman 2 additional minutes.

Mr. TANNER. It's a structural deficit. When one considers that Social Security, Medicare, Medicaid, interest on the debt and the national defense account for 85 cents out of every dollar, you can't cut enough out of the 15 percent to take care of this problem. It's not what we're doing. It's not what we're spending. It's what we're not doing, and that is we are not addressing the structural deficit.

And the only way we are going to get at that is through either statutory PAYGO or an entitlement commission, and hopefully both. It's not what we're doing, it's what we're not doing, and it is a decade-old problem that is getting worse every year. And until this Congress can come together, Democrats and Republicans, what we have around here is too many Republican Americans or too many Democratic Americans instead of American Democrats and American Republicans.

I'm telling you, the time is now for American Democrats and American Republicans to get together over the next 60 days and figure out what we're going to do, because we are on an unsustainable financial course.

Mr. HELLER. Madam Speaker, I yield 1½ minutes to the gentleman from Texas, a colleague of mine on Ways and Means, Mr. BRADY.

Mr. BRADY of Texas. Madam Speaker, it is interesting to hear our Democrat friend's newfound interest in paying for the war. That hasn't always been the case. Here is what the current majority leader said on this House floor in 2004 when the debt limit was proposed to be raised and we were at war. What now-majority leader Mr. HOYER said: raising the debt limit is immoral. Its disastrous consequence has threatened to cripple our future prosperity and haunt future generations. He said this policy of borrow and spend is not only irresponsible, it is immoral, and it must stop. We are literally mortgaging our future.

These are their words, not ours.

The truth of the matter is, what we are voting on today is a down payment, a two-step, \$2 trillion increase in our debt, two-step, \$2 trillion increase in our debt. And what it means for American families is that the day NANCY PELOSI took the gavel to become Speaker of this House, every man,

woman and child in America owed \$29,000 in debt. Today, as a result of this vote and next year's debt limit, every person in America will owe \$45,000 in public debt.

□ 1445

Three years, we've increased to \$45,000 in public debt. It is responsible to pay our bills; it's irresponsible to keep going into debt and asking for more credit while we do it. It's time to stop spending.

Mr. NEAL of Massachusetts. Madam Speaker, I yield 3 minutes to my friend, the gentleman from New Jersey (Mr. ANDREWS).

Mr. ANDREWS. I thank my friend for yielding.

A tired old tradition is being carried out on the House floor today. When it comes time to extend the national debt ceiling, the Members in the minority get up and express outrage, and enough Members in the majority get up and show responsibility and vote to do what needs to be done to pay the Nation's bills.

Madam Speaker, I know a lot of people watching this are scratching their heads and saying, how did we get to such a terrible predicament? Whose fault is it? And I think they're tired of hearing whose fault it is because, frankly, when the other side is in the majority, we say it's their fault; when they're in the minority, they say it's our fault.

I think a history lesson is in order. In 2001, as Mr. TANNER said, we were looking at a projected \$5 trillion surplus over the decade that we're now closing out. We're going to take in \$5 trillion more than we spent. There were three things that happened in that decade that injured that prospect. The first was horrific, unavoidable, and the fault of no one in this room; it was the terrorist attack on the country on September 11, 2001, which had and still has negative economic consequences as well as security consequences for the country.

The second thing that happened, in my view, is that two disastrous choices were made. The first was to launch two wars by borrowing the money to pay for those wars in Iraq and in Afghanistan. We certainly can disagree—and we have around here a lot—as to whether or not those wars were or were not in the national interest, but I think we should have understood that it was absolutely not in the national interest to defy historic tradition and finance those wars by borrowing money, unlike more responsible predecessors of ours had done in other times.

The second disastrous decision was a tax cut, a huge majority of which benefited the wealthiest 5 or 10 percent of people in this country. That created a mountain of debt that shifted us from a projected \$5 trillion surplus to a projected deficit instead.

Then followed the financial meltdown of the fall of 2008. The Treasury Secretary told us in no uncertain terms that he felt that we were perhaps a few days away from the collapse of the global economy. So to this floor came a \$700 billion bailout bill for the banking industry, and a lot of Members on both sides voted for it. I think it was the right vote because I do think it staved off that calamity from happening, and that added to the national debt. And yes, there were decisions made since the new administration came in to do the stimulus bill in a way that was not paid for.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. NEAL of Massachusetts. Madam Speaker, I yield the gentleman from New Jersey 1 additional minute.

Mr. ANDREWS. And I know there is disagreement over whether that was the right thing to do. I think it was absolutely the right thing to do because it stimulated between 600,000 and 1.6 million jobs thus far being saved or created.

Let me say this to you: irrespective of how you recount the history as to how we got here, here we are. And to deal with this problem it seems to me there are three inescapable things we have to do. The first is to get entitlement spending under control. Frankly, our side believes the health care reform bill does exactly that, and the Congressional Budget Office would concur—nearly \$500 billion in entitlement reductions over a 10-year period. Second, you have to get revenue back on track. Our budget calls for a repeal of the tax reductions for those that are in the top 5 percent or so of the country. I think that is the responsible thing to do. No one on the other side voted for that. And finally, we have to stop spending \$300 or \$400 billion a year to buy oil from other parts of the world. We had legislation here that would put us on that path and build American jobs. Almost no one—single digits—on the other side voted for that.

So this is the day when the minority expresses outrage. There ought to be some other days when the minority expresses some ideas, some plans on how to fix the problem.

Vote “yes.”

Mr. HELLER. Madam Speaker, I yield 2 minutes to the gentleman from Maryland (Mr. BARTLETT).

Mr. BARTLETT. Madam Speaker, during the Clinton administration, Washington was telling America that we had a budget surplus and we were paying down the debt. Now, while we were telling America that, we had the embarrassing necessity of raising the debt limit ceiling. Why would you have to raise the debt limit ceiling if you're paying down the debt? Surprise, surprise; Washington was not being truthful.

What we were doing was taking money from lockboxes, surplus trust

fund moneys, Social Security and Medicare, and paying down the public debt—one more dollar of debt in the trust funds, one less dollar of debt in the public debt. That did nothing to reduce the national debt. And we had other trust fund surpluses for which there was no lockbox. We happily took and spent that money. If we kept our books on the accrual method, there never was a moment in time when we, in fact, reduced the national debt.

Now, talking about accounting methods, our government keeps Enron kind of books. If we kept our books the way we force all but the smallest businesses to keep their books, using the accrual method, we would be showing about \$60 trillion in debt. That's \$200,000 in debt for every man, woman, and child. Clearly, clearly unmanageable.

We should be ashamed that we're here today talking about raising the debt limit ceiling once again. We should be here debating how we're going to balance the budget and then pay down the debt, because I have 10 kids, 17 grandkids, and two great-grandkids, and we have already mortgaged their future. We don't need to do anymore.

Mr. NEAL of Massachusetts. Madam Speaker, I yield 2 minutes to the distinguished chairman of the Ways and Means Committee, the gentleman from New York (Mr. RANGEL).

Mr. RANGEL. Let me first thank Chairman NEAL for the great job that he has done over the years in terms of presenting legislation that is so sorely needed in this House. And let me speculate in terms of how far is it going to go that we are going to have this partisanship in the House of Representatives.

You know, we have a saying that once we're overseas, we leave the Democratic label and the Republican label behind us. But believe me, the flag and the credibility of the United States' credit is on the line. And whether it's the Chinese, the Japanese, or the European Union, it seems to me that the pride that we once had in terms of being the leader of the world, not only in fiscal policy, but in foreign policy, is on the line.

No one out there in our communities is going to look at this as a Republican issue or a Democratic issue. They're going to look at it as an American issue. And they're going to look at the Congress. Why? Because we have the full faith and credit of the United States of America in our hand. People have political problems with raising the debt limit, but our country has fiscal problems. And Treasury has assured us, as he has the minority, that they don't have these fiscal gimmicks in order to play around with it.

I know a lot of people know it's going to pass, and so, therefore, they're not going to vote for it. But somebody—maybe our kids and grandkids—is

going to ask, Did the United States of America ever forfeit and didn't pay its debts? And some historian teacher will say, yes, they did. And they will want to know what Congress did it, and who did it; they're not going to ask whether you're a Democrat or Republican.

So we've got plenty of time to fight—we have at least a year. But, please, when the credibility of the United States of America is on the line, don't ask which side you're on; be with your country.

Mr. HELLER. Madam Speaker, I yield 2 minutes to the gentlewoman from Florida (Ms. GINNY BROWN-WAITE).

Ms. GINNY BROWN-WAITE of Florida. I thank the gentleman.

Madam Speaker, I rise today in opposition to H.R. 4314, which, according to the majority, “permits continued funding for government operations.” That sure sounds a lot better than H.R. 4314, a bill to borrow another \$300 billion from China. Or we could also entitle it, H.R. 4314, a license to keep spending like a teenager with a credit card.

Madam Speaker, the United States is already paying \$250 billion per year in interest payments alone on the debt. We are paying more for that interest by borrowing more. That just doesn't make sense.

The argument that we have already spent the money, and when the bill comes in the mail we have to pay it, is misleading. Every American with a maxed out credit card would love to be able to pay his bills by simply raising his limit. That is what we're doing here today, ladies and gentlemen. That includes the 15 million unemployed Americans who are still wondering when the so-called stimulus is going to create or save their jobs.

I urge my colleagues to vote against more borrowing and to certainly vote against this bill. America does not want more debt.

Mr. NEAL of Massachusetts. Madam Speaker, might I inquire as to how much time remains on both sides?

The SPEAKER pro tempore. The gentleman from Massachusetts controls 9 minutes; the gentleman from Nevada controls 16 minutes.

Mr. NEAL of Massachusetts. I reserve the balance of my time.

Mr. HELLER. Madam Speaker, I yield 1 minute to the gentleman from Texas (Mr. HENSARLING).

Mr. HENSARLING. Madam Speaker, never in history have so few acted so fast to indebt so many. Since the Democrats have taken control of Congress, this is the fifth time that they have come here to raise the debt ceiling—today, \$290 billion more.

Under their watch, the national debt has increased \$3.4 trillion, or almost \$30,000 for every household in America. Under their fiscal policies, we now have a \$1.4 trillion deficit, our Nation's first. They passed a budget that will triple

the national debt in just 10 years, and they are causing us to borrow 40 cents on the dollar from the Chinese and send the bill to our children and grandchildren.

Now, when Republicans controlled this body and the deficit was \$300 billion and falling, the now-majority leader said, "That's fiscal child abuse," and the now-Speaker called it "immoral." And now under their watch it's five times greater, and all we hear is a chorus of "que sera, sera."

It's Christmastime, and the Democrats give us \$290 billion more of debt. Merry Christmas.

Mr. NEAL of Massachusetts. Madam Speaker, I yield 2 minutes to my friend, the gentleman from New York, a voice of good sense on the issues of debt, Mr. CROWLEY.

Mr. CROWLEY. I thank my good friend from Massachusetts for yielding me the time.

The Republicans keep claiming that Federal spending and deficits are growing under the Democrats, but let's look at the facts.

Republican Conference Chairman MIKE PENCE said just a few minutes ago that they, the Republicans, doubled the national debt in 8 years to almost \$12 trillion. And you know what? MIKE is right. About an hour or so ago Republican JEFF FLAKE said spending was out of control when Republicans were in charge of Congress and the White House. And you know what? He was right as well. And the funny thing, when President George Bush was voted into office he inherited a multi-trillion dollar surplus of funds from President Clinton and the Democrats. So the party who borrowed and spent and squandered surpluses is now standing in the way of moving forward in the right path.

The very Republicans who refused to run the country like our constituents have to run their households—buying only what they can afford—are opposed to legislation that will ensure all new spending and tax cuts are paid for. This would prevent us from adding to the deficit, yet Republicans are opposed, arguing they should be allowed to tax and borrow from the Chinese at will, but only for their priorities.

So the hangover from President Bush and Republican control of Congress still lingers. It was Republicans who pushed a \$700 billion bailout package for the banks, a package that Democrats and President Obama are demanding be paid back—and with interest—from those very same banks. Then we had tax cuts for the wealthiest in America, with no assistance to the middle class, and then a refusal to fund the wars in Afghanistan and Iraq. Democrats are correcting these disastrous decisions by our Republican colleagues.

The only thing more galling than the inaccuracy and denial of the Repub-

licans of their own records and votes is their hypocrisy on this issue of their own out-of-control spending and legacy of deficits.

□ 1500

Mr. HELLER. I yield 1 minute to the gentleman from Louisiana (Mr. SCALISE).

Mr. SCALISE. I want to thank the gentleman from Nevada for yielding.

Madam Speaker, this is my congressional voting card. Unfortunately, some of the liberals running this Congress think that this is a credit card that has an unlimited balance. Today, they stand before us, trying to add another \$290 billion of limit onto their credit cards because they have maxed out the previous at \$12 trillion. The American people are saying enough is enough. They want us to cap the debt, and we need to.

We filed legislation that has over 70 cosponsors that would do just that—that would cap the debt and say now let's start paying it down. The first rule of hole says, when you find yourself in a hole, the first thing you do is stop digging. The American people are saying stop the massive spending. Stop adding to our debt. Stop throwing more and more spending and debt onto the backs of our children and our grandchildren. Let's rein in fiscal irresponsibility.

That's why we are opposing this legislation. We proposed responsible alternatives like the CAP the DEBT Act. Of course, they don't want to bring it up because all they want to do is walk around here, thinking that they're Santa Claus at Christmastime, borrowing more money and spending more money that we don't have.

Mr. NEAL of Massachusetts. Madam Speaker, I will remind the gentleman it wasn't a liberal sitting in the White House who decided to invade Iraq for which the costs have now come due.

I reserve the balance of my time.

Mr. HELLER. Madam Speaker, I yield 2 minutes to a friend of mine, a colleague on the Ways and Means Committee, the gentleman from Illinois (Mr. ROSKAM).

Mr. ROSKAM. I thank the gentleman for yielding.

Madam Speaker, it is the holiday season, and the majority is saying, Cheers.

Here we are, and it's really been an unbelievable party, hasn't it? I mean here we are, and you have all of these folks who have come together, doubling the national debt, as was described, over a 5-year period. The majority will now triple the national debt, and it is as if all they can do is keep serving. No discipline. Hey, cheers. Here you go. Enjoy. Well, here is what happens at the end of that binge. Here is what happens at the end of that kegger:

Ultimately, the old man drives up into the driveway and looks around,

and the party is going to be over. Who is going to be there to clean it up? Our children and our grandchildren, Madam Speaker. They are the ones who will be there, taking care of this mess over a long period of time.

So we ought not be continuing serving a government that has been overserved time and time and time again. Instead, what we ought to do is avoid the generational theft, do what is right by our children and grandchildren and not increase this debt.

Mr. NEAL of Massachusetts. I yield myself 1 minute.

Madam Speaker, this is not a cheery time for the American people. This is a very difficult time. A reminder: The legislation in front of us now is to pay for the war in Iraq, to pay for the war in Afghanistan, to pay for our veterans' hospitals, and to pay for next month's Social Security recipients to receive their checks on time.

I reserve the balance of my time.

Mr. HELLER. Madam Speaker, I yield 1½ minutes to the gentleman from Texas (Mr. GOHMERT).

Mr. GOHMERT. Madam Speaker, we were asked: How can we vote to have troops go to Iraq and not be willing to pay for them?

Well, the problem is we keep having things added to the bills that will pay for these things. We keep adding things like Gitmo language, like we're going to move the people from Gitmo and spend tens or hundreds of millions of dollars unnecessarily just to make some political point.

We hear people across the aisle say, Gee. You know, we can't afford to lose respect around the world if we forfeit on the debt. Don't forfeit on the debt. You don't gain respect when you keep calling the credit card company and saying, I know I'm not making any payments, but if you'll just keep increasing my debt limit, I know you'll have more respect for me. No, that's not how it works.

We are told across the aisle we have no solutions. Go look at the bills that are waiting to come to the floor. I've got a zero baseline budget that doesn't allow the automatic increases. That would make a huge contribution, and we could bring down the debt. Yet there are no indications, nothing to indicate that the spending is going to be controlled. It is outrageous what we are doing to future generations. Any parent who would go in and tell the bank, Keep loaning to me, and I promise my kids will repay it, would be considered an unfit parent.

Yes, the people in America were promised change. What they have gotten is exponentially more spending than Republicans had done before. It's time for a change. Stop spending. Vote this down.

Mr. NEAL of Massachusetts. I yield myself 30 seconds.

Madam Speaker, the war in Iraq is going to cost more than \$1 trillion. The

VA hospital commitment that we are going to make for the next 30 years to our well-deserving veterans is going to cost an additional \$1 trillion. That is the issue that is before us this afternoon.

I reserve the balance of my time.

Mr. HELLER. Madam Speaker, I yield 1 minute to the gentleman from Indiana (Mr. BURTON).

Mr. BURTON of Indiana. I thank the gentleman for yielding.

Madam Speaker, I was just thinking about the people back home who may be watching this. They hear the Democrats blaming the Republicans for all of these things that are costing so much money, and that's the reason we have to raise the national debt. You know, I looked at a \$1.4 trillion deficit last year, and we're already ahead of that this year. We are not in charge. You folks are.

The health care bill that you're trying to ram through is going to cost \$1 trillion to \$3 trillion, and the stimulus bill is going to cost over \$1 trillion when you add interest.

The bottom line is we have got to stop spending. We are spending too much money. Whether you are a Democrat or a Republican, the American people back home are saying, Get your house in order. Quit spending so much money. Live within your means like we have to.

We have 10 percent unemployment right now, and the people back home don't want us wasting money that will end up resulting in our having to raise taxes, which we don't want to do and which I won't vote for, and end up resulting in inflation, which is going to be hung on our kids in the future. So we have to quit spending instead of just raising the debt.

Mr. NEAL of Massachusetts. Madam Speaker, I reserve the balance of my time.

Mr. HELLER. Madam Speaker, I yield 2 minutes to the gentleman from Florida (Mr. STEARNS).

Mr. STEARNS. Madam Speaker, let me say to my colleague from Massachusetts that he and I came in together. Back in 1988, we were both elected, and he and I served in the same class together. As I recollect, he was mayor of Springfield.

You balanced your budget as mayor. You had to balance your budget. Now, we've been up here trying to balance the budget, you and I, for almost 21 years. It has not been successful. I supported a balanced budget—both a constitutional amendment as well as a legislative balanced budget. I don't believe you or your colleagues did. I say this because, frankly, we have been talking about deficit as long as you and I have been in Congress. We can blame Republicans. We can blame Democrats, but let's just look at the record for a second.

When you and I came in under Bush I, do you remember those deficits?

They talked about \$250 billion, and we just lamented about it and lamented about it, and we complained about it. Well, you know, that's what happened. It has exploded. So now we're looking at deficits that are a lot larger, as my colleague mentioned, \$1.4 trillion.

When you look at Bush II, George W. Bush, he had deficits of \$600 billion. I remember the folks on that side were complaining about how terrible that was at \$600 billion.

Well, the problem is now we're talking almost two, three times that amount of money. Actually, when you go back and look at when Ronald Reagan was President, critics called great criticism to him. They said the deficit was out of control in this country. The deficits were about \$250 billion. So the point I am trying to make is that the deficit under Republican Presidents and even under Republican control of the House and the Senate and the White House was small, very small, to what we have today.

You can say that there is good reason for this vote today because you support our troops and our wars, and you also support veterans. I think that's true. Yet there has been no effort by your side to hold the appropriations bill.

I have been on the House floor, and I say to my colleague, your appropriations bills are 13 percent larger than last year's. Almost every one of them was 13, 18—One was almost 20 percent. How in the world can you justify appropriations bills that are so large?

So in the end, Democrats are not trying to reduce costs nor balance the budget. In fact, they are recklessly encouraging more government spending. That is why they need to increase the debt ceiling.

Mr. NEAL of Massachusetts. Mr. STEARNS is, indeed, my friend, and we are classmates.

Madam Speaker, he conveniently left out those 4 years when Bill Clinton left a balanced budget to America, when the deficits were eliminated and when the debt was coming down. That's the key consideration here as we begin this debate. Indeed, this is about paying for our veterans' hospitals, paying for the war in Iraq, paying for the war in Afghanistan, and making sure that those Social Security checks get out on January 1.

Mr. HELLER. Madam Speaker, may I inquire as to the time remaining on both sides?

The SPEAKER pro tempore. The gentleman from Nevada controls 8½ minutes, and the gentleman from Massachusetts controls 5¾ minutes.

Mr. HELLER. Madam Speaker, I yield 2 minutes to the Republican policy Chair, the gentleman from Michigan (Mr. McCOTTER).

Mr. McCOTTER. I thank the gentleman.

Madam Speaker, a quick point that was raised by our esteemed colleague

from Massachusetts about how President Clinton left 4 years of balanced budgets: It was with the assistance of a Republican majority in the Congress, which is an exceptional precedent, you'll remember, as we head to the polls in 2010.

As we address this issue of raising the debt ceiling, let us be charitable in this, the giving season. Let us recall that, as the Democratic Party's argument today is "the same but more," let us look at what they have tried to give the American people over the course of the past year for stocking stuffers.

First, Americans got higher unemployment, higher spending, higher deficits, and higher taxes.

Secondly, senior citizens got a \$500 billion cut in Medicare. Terrorists got new rights, new trials, and new cells on American soil, and Federal Government bureaucrats got raises.

I think that we should question our priorities and the direction in which we are taking ourselves before we decide to spend more money on this. It strikes me that it is very justifiable for the American people to watch this debate, to watch the debt ceiling be raised, and to come to the distinct conclusion that the Democratic majority in Congress has proven itself too costly and too crazy too quickly.

Mr. NEAL of Massachusetts. Madam Speaker, I reserve the balance of my time.

Mr. HELLER. Madam Speaker, I yield 1 minute to the gentleman from Utah (Mr. CHAFFETZ).

Mr. CHAFFETZ. I thank the gentleman.

Madam Speaker, I am a freshman in this body. I didn't help create this mess, but I am here to help clean it up. The fact of the matter is we have to spend less than we are spending now. We have to be responsible stewards of the American people's money.

We are \$12 trillion in debt. Remember, if you spend \$1 million a day every day, it would take you nearly 3,000 years just to get to \$1 trillion, and we are \$12 trillion in debt. When is this body going to say no?

This body is not making difficult decisions. I am sorry, but the Democrats in control have refused to find a solution to things that don't cost literally hundreds of billions of dollars every time we turn around. We can't be all things to all people. We have to learn to say "no." At what point will there actually be a cap? At what point will there actually be a ceiling? We see no hope on the horizon for that.

We have got to be responsible stewards of the American people's money. We cannot be all things to all people. We are spending nearly \$600 million a day just in interest on our debt.

GENERAL LEAVE

Mr. NEAL of Massachusetts. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative

days in which to revise and extend their remarks and to include extraneous material on H.R. 4314.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Massachusetts?

There was no objection.

CALL OF THE HOUSE

Mr. NEAL of Massachusetts. Madam Speaker, pursuant to clause 7 of rule XX, I move a call of the House.

The SPEAKER pro tempore. The previous question being ordered, the Chair notes the absence of a quorum in accord with clause 7(c) of rule XX and chooses to entertain a motion for a call of the House pursuant to clause 7(b) of rule XX.

A call of the House was ordered.

The call was taken by electronic device, and the following Members responded to their names:

[Roll No. 987]

Abercrombie
Ackerman
Aderholt
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Barrett (SC)
Barrow
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Brady (TX)
Braley (IA)
Bright
Broun (GA)
Brown (SC)
Brown-Waite,
Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Capps

Capuano
Cardoza
Carnahan
Carney
Carson (IN)
Carter
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clever
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Conyers
Cooper
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (KY)
Davis (TN)
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah

Johnson, E. B.
Johnson, Sam
Jones
Jordan (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (IA)
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Larsen (WA)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loebach
Lofgren, Zoe
Lowey
Lucas
Luetkemeyer
Lujan
Lummis
Lungren, Daniel
E.
Lynch
Mack
Maffei
Manzullo
Marchant
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McClintock
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris
Rodgers
McNerney
Meek (FL)
Meeks (NY)
Melancon
Mica
Michaud

Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murphy, Tim
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye
Oberstar
Olson
Oliver
Ortiz
Owens
Pallone
Pascarella
Pastor (AZ)
Paul
Paulsen
Payne
Pence
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Pitts
Platts
Poe (TX)
Polis (CO)
Pomeroy
Posey
Price (GA)
Price (NC)
Putnam
Quigley
Rahall
Rangel
Rehberg
Reichert
Reyes
Richardson
Rodriguez
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Rothman (NJ)
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Salazar
Sánchez, Linda
T.
Sanchez, Loretta
Sarbanes

Scalise
Schakowsky
Schauer
Schiff
Schmidt
Schock
Schrader
Schwartz
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Sestak
Shadegg
Shea-Porter
Sherman
Shimkus
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Space
Spratt
Stearns
Stupak
Sullivan
Sutton
Tanner
Taylor
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Upton
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wamp
Wasserman
Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Westmoreland
Whitfield
Wilson (OH)
Wilson (SC)
Wittman
Wolf
Woolsey
Wu
Yarmuth
Young (AK)

PERMITTING CONTINUED FINANCING OF GOVERNMENT OPERATIONS

The SPEAKER pro tempore. The Chair recognizes the gentleman from Massachusetts.

Mr. NEAL of Massachusetts. Madam Speaker, I would like to reserve the balance of my time.

Mr. HELLER. Madam Speaker, I yield 1 minute to the Republican leader, the gentleman from Ohio (Mr. BOEHNER).

Mr. BOEHNER. My colleagues, there's been a lot of lecturing on the House floor today from my Democrat colleagues about fiscal responsibility. And I heard a lot of about fiscal responsibility in 2005 and 2006 when the then-minority wanted to take the majority.

I think it's time for everyone in this room to take their fair share of blame for the spending that's gone on in this town for far too long. For 36 of the last 40 years, we've spent more than what we've taken in. There's not a household in America that could get by with this. There's not a company in America that could get by with it. And certainly, this government can't get by with it.

For the last 3 years, the Democrat majority, though, after having run on this mantra of fiscal responsibility, has done nothing more than spend, spend, spend and spend. Now, we did our best in 2007 and 2008 to put the brakes on all that spending, and succeeded somewhat. But after this year, for you to criticize us about fiscal responsibility and to lecture us about fiscal responsibility after spending \$1 trillion on a stimulus bill that was supposed to be about creating jobs, and what have we done? We've created more unemployment. We've not put anyone back to work. And we're asking our kids and grandkids to pay \$1 trillion in principal and interest for a bill that's not doing anything other than increasing spending.

But what makes this bill that's on the floor here today to increase the debt limit by \$290 billion a real joke is that as soon as this vote is over, we're going to take up Stimulus II or, as we like to call it, Son of Stimulus. We're going to take up Son of Stimulus, which is going to spend \$150 billion on the same kind of failed spending programs that we passed earlier this year.

And what are we going to do? We're going to use that TARP money that those banks and those financial institutions have paid back. Well, where'd that money come from? We had to go borrow it. Everybody knows, everybody that voted for or against TARP in this Chamber, knows that money was intended to go to pay down the deficit. And to take that \$150 billion and spend it on more wasteful Washington spending is putting it right on the backs of our kids and grandkids. That's going to happen right after this vote.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the call). There are 2 minutes remaining.

□ 1548

The SPEAKER pro tempore. 415 Members have recorded their presence. A quorum is present.

Who are we kidding? We're not kidding anybody. I just think it's time to put the brakes on all of it. Let's get really serious about cutting spending. And the way we start is by saying no to increasing the debt limit.

Mr. NEAL of Massachusetts. Madam Speaker, let me recognize for 1 minute the Majority Leader, the gentleman from Maryland (Mr. HOYER), a voice for fiscal reason in this institution.

Mr. HOYER. I thank the gentleman for yielding.

A little over a year ago, Mr. BOEHNER and I spoke on a bill that I said would be noted as a day of consequence in the House of Representatives. That bill was to, at the request of President Bush and Secretary Paulson and Ben Bernanke, give some \$700 billion to the Treasury to try to stabilize the financial sector of our economy. Mr. BOEHNER voted for that. My friend, Mr. BLUNT, voted for that. I believe Mr. CANTOR voted for that. Others of you voted for that. And many on our side voted for that bill. It failed.

And we came back here a few days later, on Friday, and that bill was called up again. It was called up again because we knew that there really wasn't an option. Mr. Bernanke, President Bush's appointee as Chairman of the Federal Reserve, said that we were at risk of going into a depression if we did not vote for that bill. Nobody wanted to vote for that bill on either side of the aisle. That was a bill that we ultimately concluded on that Friday, approximately half of the Republican side of the aisle, a little more than half on my side of the aisle, was a bill that we needed to pass to avoid the risk of depression.

Since that time, over the next 4 months, we saw an erosion in the economy, not a depression, but the worst recession we had seen in 8 years. Now I have a speech here that we've prepared. I'm not going to give it because it, to some degree, points the finger at one another. And I agree with Mr. BOEHNER. There's blame to go around. We have been concerned about cutting revenues and increasing spending during the first part of this decade. You have been concerned about the spending that we believed was necessary to make to try to create jobs and bring our economy back.

Mr. BOEHNER and I disagree on the impact of the Recovery and Reinvestment Act. Since its passage, the stock market has gone from 6,500 to 10,500. Anybody who opens up their 401(k) or Keogh or Thrift Savings Plan believes that we've made progress on that because their value has gone up about 60 percent. That's progress, but not success. We want to get back to where it was in terms of the value of those plans.

In addition, in the last month of the Bush administration, we lost 741,000 jobs, after adopting a policy that many

believed, on your side of the aisle, would lift our economy. And, in fact, it did for a while. But it did not create the kind of jobs you wanted. And, in fact, on average, over the 8 years of the Bush administration, it produced approximately 4,200 jobs per month, on average, in comparison with the 216,000 jobs, on average, per month that the Clinton administration saw during its term.

So we could point fingers, but that would not be particularly useful. I have listened to this debate, and I am chagrined. And I want to plead guilty, because I've demagogued this issue as well. We had a quote presented about the morality of incurring debt. It was taken a little out of context, but we all say things that we look back on. And I voted against increasing the debt. It was a demagoguing vote. I voted four times against raising the debt. It was a demagoguing vote. I want to admit that and tell people. Why? Because I didn't believe then, nor do I believe now, that not paying America's bills is an option that Americans expect of us. Americans expect us to pay our bills. Some Americans would like us not to incur some bills for war, but if we do incur bills for war, they would like us to pay for it. Some Americans would not like us to incur bills for nutritional programs or education or whatever else may be, too much, too little, but if we do incur those bills, Americans expect us to pay the bill.

I have a list here of everybody who spoke who was here who voted to increase the debt limit four times during the time that you were in charge of the House and of the Presidency. And we didn't support it. My suspicion is that we will find ourselves in the same place today. You all are not responsible for the running of the government or the passing of policy. We are. I understand that. And so my presumption is, perhaps, to a person, as we did on this side of the aisle, you will vote against this bill.

And so I say to my friends on this side of the aisle, the American people have given us a responsibility. The American people have reposed in us a trust. And this year, in meeting that confidence and trust, we have taken some very tough votes. One of the things I said that was quoted that was immoral, that's the quote you used, and if you take out the whole quote, which a lot of times none of us do, we take the part of the quote that we like, I said that not to pay for what we buy, and to jettison PAYGO, was not right.

□ 1600

One of the reasons that we find ourselves in this position is because we haven't adopted a statutory PAYGO, and we should adopt statutory PAYGO. I understand my friends on this side of the aisle are not clapping. And the reason you're not clapping is because you

believe, correctly, that that will constrain you in effecting tax cuts, because you believe that cutting taxes does not create debt.

The tragedy is, during the 8 years President Bush was President and you were in charge—because we couldn't pass any economic policy past President Bush's budget veto—you incurred \$2 trillion of debt as you cut revenues and increased spending at a greater rate than was increased under the Clinton administration, and you were in charge of everything. But Mr. BOEHNER is correct, my grandchildren and his don't care whether you did it, we did it, or we did it together.

But my colleagues on this side of the aisle, if we take seriously that oath to protect and preserve this Nation, there is no one on either side of the aisle, Republican or Democrat, conservative or liberal, who will rationalize that America's not paying its debt is a good policy, because all of us know it is a disastrous policy and that the consequences of not passing this bill, in the stock market, globally with our creditors, and, yes, with Mom and Pop running that store in my town and your town, will be very substantial and unacceptable.

So we come, as I said on the TARP vote, to a day of consequences. Not every day is a day of consequence in this House, the people's House. We vote on suspension bills and post offices and this, that, and the other. And even the bills that we'll consider next, we'll send it to the Senate or we won't send it to the Senate, and the world will little note nor long remember, as Abraham Lincoln said. But if America and its duly elected Representatives say to the rest of the world, We will not pay our bills, that will be of consequence.

It is not about pointing fingers. It is about taking responsibility. It is about showing courage to do what all of us know. Whatever the rhetoric on this floor has been today, what all of us know is the only option for a responsible country, for a country that is perceived around the world as the wealthiest country on the face of the Earth, and for us to say this day, We will not pay our bills, that the consequences in January to the person who receives Social Security, the consequences to the Defense Department—not that they won't pay their bills. They're going to have to under the emergency clause. But the fact of the matter is, my friends, this is absolutely essential to do.

Therefore, on my side of the aisle, I ask us to do it. And don't point fingers at their side if they don't do it, because we didn't do it. And very frankly, my friends, we have to stop that. We have to stop it for whoever is in charge, because Americans expect better of us.

I ask you, therefore, as we consider this, we ought to vote on it not because we agreed with policy A or policy B or

tax cut Y or tax increase Z, but because we know—and I tell my young friend who spoke on the floor about fiscal responsibility who is here for the first time—as we debate these issues on spending and cutting, that they are legitimate to debate, discuss, and vote however one believes is necessary.

But in the final analysis, when the roll is called as to whether America will be a responsible debtor, whether we incurred that debt as a result of decreasing taxes, which we did, or increased spending, which we have, it matters not. What matters is that America pays its bills. Vote for this bill.

Mr. BLUMENAUER. Madam Speaker, I voted for legislation increasing the debt ceiling that will get us two months into the next year. We are dealing with the sad consequence of Americans living beyond their means for the last eight years. Even though I have argued and voted against these expansions, such as an unfunded and ill-advised war, an unfunded expansion of Medicare, and tax cuts that were not sustainable, I nonetheless feel an obligation to increase the debt ceiling so that the federal government can continue to operate.

This vote allows the government to continue to pay Social Security benefits, Medicaid and Medicare support, and the salaries of those serving in our uniformed services.

At a time of continued challenge for the economy, we have higher demands for countercyclical programs like food stamps, unemployment benefits and support for state and local infrastructure projects. Unemployment and the economy would be much worse had we not made the recovery investment early this year, but even that has not been sufficient for the economy to fully rebound. It would be the height of irresponsibility for Congress to shut down the government, especially while we face these incredible challenges.

In the long run, Congress will have to address comprehensively the level of government service, the nature of our revenue system, and how we extract more value from federal investments. It is in this context that we can constructively address our economic challenges, including our investments in job creation and reducing the federal deficit. This has been my top priority in this Congress as in previous sessions and should be at the top of the congressional agenda as we move forward. In the meantime, raising the debt ceiling is a critical factor to keep the economy recovering and the government functioning.

Mr. HOLT. Madam Speaker, I rise today to vote against allowing the United States to default on its debt, although not otherwise in favor of increasing the debt ceiling. As my colleagues know, this is the fourth time we've done that since enactment of the Housing and Economic Recovery Act in July 2008, just as the economic crisis was exploding upon us. Although a comprehensive and expeditious response was necessary, each such increase has represented hundreds of billions of dollars in additional debt.

In July 2008 Congress increased the debt ceiling by \$800 billion. A mere three months later, in October 2008, the Emergency Economic Stabilization Act increased the debt ceil-

ing by another \$700 billion all because of President Bush's decision to pursue two wars on borrowed money. Four months after that, in February 2009, the American Recovery and Reinvestment Act increased the debt ceiling yet again by \$789 billion because of the continued decline of the economy and efforts to deal with it. And today, we increase it by \$290 billion more, to bring the ceiling to a staggering \$12,394,000,000,000. The fact that the current increase is much smaller than the previous increases is no consolation, since the Treasury Department has indicated that it will only cover obligations due until February 11, 2010—a mere two months from now. Not to mention the fact that the entire debt ceiling was only about that much—\$300 billion—during World War II.

These increases don't come for free—we're mortgaging our future on them. We have voted to accelerate inflation and increase our long-term fiscal challenges. Before next February arrives, we must all give intensive thought to how to return this country to the surplus conditions in enjoyed in the late 1990s. Between fiscal years 1998 and 2001, the federal government ran at a surplus and the debt ceiling only increased by \$450 billion. The surplus vanished after fiscal year 2001, and the debt ceiling has increased by more than ten times that amount (\$44.66 trillion) since then.

This deficit spending has provided much-needed economic stimulus in a time of crippling economic recession, and there is no dispute that we urgently needed to implement such stimulus measures over the course of the past year. But we are now in recovery, and it is time to get this economic train back on the right track. I support this increase with no pleasure, and I look forward to working with all my colleagues to bring down the debt ceiling as soon as possible.

Mr. LANGEVIN. Madam Speaker, it is with great reservation that I vote for H.R. 4314, a bill to increase the statutory debt limit by \$290 billion. While I am keenly aware of the need for such action to ensure that the Federal Government doesn't default on its obligations, this represents a greater problem of borrowing and spending that we must begin to address now.

There is no doubt in my mind that the actions taken by this Congress over the past year prevented a serious recession from turning into a calamitous economic depression. I also know that there are many families in my State that will require continued support and assistance as we cope with a 12.9 percent unemployment rate. However, as we attempt to enact policies that further stimulate the economy and get people back to work, we cannot lose sight of our fiscal challenges. We must refocus on deficit reduction and chart a course to a sustainable budgetary path.

That is why I was pleased to vote for the Statutory Pay-As-You-Go Act, PAYGO, Act, which passed the House on July 22nd. This bill reestablishes the same rules enacted in the 1990's which led to record surpluses, by requiring that new mandatory spending increases or tax reductions be fully offset. Unfortunately, the Senate has not yet acted on this measure, but I look forward to working with them and my colleagues in the House to

ensure that we reduce our deficit and debt obligations as we achieve continued economic stability.

Mr. VAN HOLLEN. Madam Speaker, I rise in support of H.R. 4314, which will increase the statutory debt limit by an amount sufficient to cover obligations through February 11, 2010.

As we take concrete steps to bolster our economic recovery while getting the nation's fiscal house in order, this measure will ensure the uninterrupted operation of government into the first part of next year. Insodoing, it affirms the full faith and credit of the United States, supports job creation and economic growth, and gives the House and Senate additional time to reach agreement on appropriate budget targets for the out years. Importantly, this temporary legislation is also offered alongside the House's twice-expressed commitment to statutory PAYGO legislation, whose use has been demonstrated to bring our budgets back into balance over time.

Accordingly, I urge a "yes" vote.

Mr. HELLER. Madam Speaker, I yield back the balance of my time.

Mr. NEAL of Massachusetts. Madam Speaker, I urge adoption of the resolution and yield back the balance of my time.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 976, the previous question is ordered on the bill.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. HELLER. Madam Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, this 15-minute vote on passage of H.R. 4314 will be followed by a 5-minute vote on the motion to suspend the rules and pass H.R. 3714, if ordered.

The vote was taken by electronic device, and there were—ayes 218, noes 214, not voting 3, as follows:

[Roll No. 988]

AYES—218

Abercrombie	Boren	Clay
Ackerman	Boswell	Cleaver
Altmire	Boucher	Clyburn
Andrews	Boyd	Cohen
Arcuri	Brady (PA)	Connolly (VA)
Baca	Braley (IA)	Conyers
Baird	Brown, Corrine	Cooper
Baldwin	Butterfield	Costa
Barrow	Capps	Costello
Bean	Capuano	Courtney
Becerra	Cardoza	Crowley
Berkley	Carnahan	Cuellar
Berman	Carson (IN)	Cummings
Berry	Castor (FL)	Dahlkemper
Bishop (GA)	Chandler	Davis (AL)
Bishop (NY)	Chu	Davis (CA)
Blumenauer	Clarke	Davis (IL)

Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Doyle
Edwards (MD)
Edwards (TX)
Ellison
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Frank (MA)
Fudge
Garamendi
Gonzalez
Gordon (TN)
Green, Al
Green, Gene
Grijalva
Gutierrez
Hall (NY)
Hare
Harman
Hastings (FL)
Heinrich
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Holden
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee
(TX)
Johnson (GA)
Johnson, E. B.
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy

Kind
Klein (FL)
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Lipinski
Loeb sack
Lofgren, Zoe
Lowey
Luján
Lynch
Maloney
Markey (MA)
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McMahon
Meeks (NY)
Michaud
Miller (NC)
Miller, George
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Oberstar
Obey
Oliver
Ortiz
Pallone
Pascarell
Pastor (AZ)
Payne
Pelosi
Perlmutter
Peterson
Pingree (ME)
Polis (CO)
Pomeroy
Price (NC)
Quigley
Rahall
Rangel
Reyes

NOES—214

Aderholt
Adler (NJ)
Akin
Alexander
Austria
Bachmann
Bachus
Barrett (SC)
Bartlett
Barton (TX)
Biggart
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Blunt
Bocciari
Boehner
Bonner
Bono Mack
Boozman
Boustany
Brady (TX)
Bright
Broun (GA)
Brown (SC)
Brown-Waite,
Ginny
Buchanan
Burgess
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cantor

Richardson
Rodriguez
Ross
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda
T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Shuler
Sires
Skelton
Slaughter
Smith (WA)
Snyder
Spratt
Stark
Stupak
Sutton
Tanner
Thompson (CA)
Thompson (MS)
Tierney
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Walz
Wasserman
Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Wilson (OH)
Woolsey
Wu
Yarmuth

Garrett (NJ)
Gerlach
Giffords
Gingrey (GA)
Gohmert
Goodlatte
Granger
Graves
Grayson
Griffith
Guthrie
Hall (TX)
Halvorson
Harper
Hastings (WA)
Heller
Hensarling
Herger
Hodes
Hoekstra
Hunter
Inglis
Issa
Jenkins
Johnson (IL)
Johnson, Sam
Jones
Jordan (OH)
King (IA)
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Kline (MN)
Kosmas

Kratovil
Kucinich
Lamborn
Lance
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
Linder
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel
E.
Mack
Maffei
Manzullo
Marchant
Markey (CO)
Massa
McCarthy (CA)
McCaul
McClintock
McCotter
McHenry
McIntyre
McKeon
McMorris
Rodgers
McNerney
Meek (FL)
Melancon
Mica
Miller (FL)
Miller (MI)

NOT VOTING—3
Radanovich
Speier
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members have 2 minutes remaining in this vote.

□ 1625

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

DANIEL PEARL FREEDOM OF THE PRESS ACT OF 2009

The SPEAKER pro tempore. The unfinished business is the question on suspending the rules and passing the bill, H.R. 3714, as amended.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California (Mr. BERMAN) that the House suspend the rules and pass the bill, H.R. 3714, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

RECORDED VOTE

Ms. DEGETTE. Madam Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 403, noes 12, not voting 19, as follows:

[Roll No. 989]

AYES—403

Davis (KY)
Davis (TN)
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah
Filner
Flake
Fleming
Forbes
Fortenberry
Foster
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallely
Garamendi
Gerlach
Giffords
Gingrey (GA)
Gonzalez
Goodlatte
Gordon (TN)
Granger
Graves
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)
Hall (TX)
Halvorson
Hare
Harman
McHenry
McIntyre
McKeon
McMahon
McMorris
Rodgers
McNerney
Meek (FL)
Meeks (NY)
Melancon
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Moran (VA)
Murphy (CT)
Murphy, Patrick
Murphy, Tim
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye

Johnson, Sam
Jones
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilroy
Kind
King (NY)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Latham
LaTourette
Latta
Lee (CA)
Lee (NY)
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loeb sack
Lofgren, Zoe
Lucas
Luetkemeyer
Lujan
Lungren, Daniel
E.
Lynch
Mack
Maloney
Manzullo
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul
McCollum
McCotter
McDermott
McGovern
McHenry
McIntyre
McKeon
McMahon
McMorris
Rodgers
McNerney
Meek (FL)
Meeks (NY)
Melancon
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Moran (VA)
Murphy (CT)
Murphy, Patrick
Murphy, Tim
Myrick
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nunes
Nye

Oberstar	Rothman (NJ)	Spratt
Obey	Roybal-Allard	Stark
Olson	Royce	Stearns
Olver	Ruppersberger	Stupak
Ortiz	Rush	Sullivan
Owens	Ryan (OH)	Sutton
Pallone	Ryan (WI)	Tanner
Pascarell	Salazar	Taylor
Pastor (AZ)	Sánchez, Linda	Teague
Paulsen	T.	Terry
Payne	Sanchez, Loretta	Thompson (CA)
Pence	Sarbanes	Thompson (MS)
Perlmutter	Scalise	Thompson (PA)
Perriello	Schakowsky	Thornberry
Peters	Schauer	Tiahrt
Petri	Schiff	Tiberi
Pingree (ME)	Schmidt	Tierney
Pitts	Schock	Tonko
Platts	Schrader	Towns
Poe (TX)	Schwartz	Tsongas
Polis (CO)	Scott (GA)	Turner
Pomeroy	Scott (VA)	Upton
Posey	Sensenbrenner	Van Hollen
Price (GA)	Serrano	Velázquez
Price (NC)	Sessions	Visclosky
Putnam	Sestak	Walden
Quigley	Shadegg	Walz
Rahall	Shea-Porter	Wamp
Rangel	Sherman	Waters
Rehberg	Shimkus	Watson
Reichert	Shuler	Watt
Reyes	Shuster	Weiner
Richardson	Simpson	Welch
Rodriguez	Sires	Westmoreland
Roe (TN)	Skelton	Wexler
Rogers (AL)	Slaughter	Wilson (SC)
Rogers (KY)	Smith (NE)	Wittman
Rogers (MI)	Smith (NJ)	Wolf
Rohrabacher	Smith (TX)	Woolsey
Rooney	Smith (WA)	Wu
Ros-Lehtinen	Snyder	Yarmuth
Roskam	Souder	Young (AK)
Ross	Space	

NOES—12

Barton (TX)	Duncan	Marchant
Brown (GA)	Foxx	McClintock
Brown-Waite,	Garrett (NJ)	Paul
Ginny	Gohmert	
Conaway	Lummis	

NOT VOTING—19

Bishop (UT)	Maffei	Wasserman
Boehner	Murphy (NY)	Schultz
Buyer	Murtha	Waxman
Jordan (OH)	Peterson	Whitfield
Kilpatrick (MI)	Radanovich	Wilson (OH)
King (IA)	Speier	Young (FL)
Lowey	Titus	

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members have 2 minutes remaining in this vote.

□ 1636

So (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

The title was amended so as to read: "A bill to amend the Foreign Assistance Act of 1961 to include in the Annual Country Reports on Human Rights Practices information about freedom of the press in foreign countries, and for other purposes."

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. RADANOVICH. Madam Speaker, I was unable to make today's votes on the House floor due to a family illness. Had I been present I would have voted as follows:

"Present" on rollcall vote No. 987, on the Quorum call.

"No" on rollcall vote No. 988, the motion to adopt H.R. 4314, to permit continued financing of government operations which is done by increasing the national debt limit.

"Yes" on rollcall vote No. 989, to suspend the rules and adopt H.R. 3714, the Daniel Pearl Freedom of the Press Act of 2009.

COMMERCE, JUSTICE, SCIENCE, AND RELATED AGENCIES APPROPRIATIONS ACT, 2010

Mr. OBEY. Madam Speaker, pursuant to House Resolution 976, I call up the bill (H.R. 2847) making appropriations for the Departments of Commerce and Justice, and Science, and Related Agencies for the fiscal year ending September 30, 2010, and for other purposes, with a Senate amendment thereto, and offer the motion at the desk.

The SPEAKER pro tempore. The Clerk will report the title of the bill, designate the Senate amendment, and designate the motion.

The Clerk read the title of the bill.

The text of the Senate amendment is as follows:

Senate amendment:

Strike out all after the enacting clause and insert:

That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the fiscal year ending September 30, 2010, and for other purposes, namely:

TITLE I

DEPARTMENT OF COMMERCE

INTERNATIONAL TRADE ADMINISTRATION

OPERATIONS AND ADMINISTRATION

For necessary expenses for international trade activities of the Department of Commerce provided for by law, and for engaging in trade promotional activities abroad, including expenses of grants and cooperative agreements for the purpose of promoting exports of United States firms, without regard to 44 U.S.C. 3702 and 3703; full medical coverage for dependent members of immediate families of employees stationed overseas and employees temporarily posted overseas; travel and transportation of employees of the International Trade Administration between two points abroad, without regard to 49 U.S.C. 40118; employment of Americans and aliens by contract for services; rental of space abroad for periods not exceeding 10 years, and expenses of alteration, repair, or improvement; purchase or construction of temporary demountable exhibition structures for use abroad; payment of tort claims, in the manner authorized in the first paragraph of 28 U.S.C. 2672 when such claims arise in foreign countries; not to exceed \$327,000 for official representation expenses abroad; purchase of passenger motor vehicles for official use abroad, not to exceed \$45,000 per vehicle; obtaining insurance on official motor vehicles; and rental of tie lines, \$455,704,000, to remain available until September 30, 2011, of which \$9,439,000 is to be derived from fees to be retained and used by the International Trade Administration, notwithstanding 31 U.S.C. 3302: Provided, That not less than \$49,530,000 shall be for Manufacturing and Services; not less than \$43,212,000 shall be for Market Access and Compliance; not less than \$68,290,000 shall be for the Import Administration; not less than \$257,938,000 shall be for the Trade Promotion and United States and Foreign Commercial Service; and not less than \$27,295,000 shall be for Executive Direction and Administration: Provided further, That the pro-

visions of the first sentence of section 105(f) and all of section 108(c) of the Mutual Educational and Cultural Exchange Act of 1961 (22 U.S.C. 2455(f) and 2458(c)) shall apply in carrying out these activities without regard to section 5412 of the Omnibus Trade and Competitiveness Act of 1988 (15 U.S.C. 4912); and that for the purpose of this Act, contributions under the provisions of the Mutual Educational and Cultural Exchange Act of 1961 shall include payment for assessments for services provided as part of these activities: Provided further, That negotiations shall be conducted within the World Trade Organization to recognize the right of members to distribute monies collected from antidumping and countervailing duties: Provided further, That negotiations shall be conducted within the World Trade Organization consistent with the negotiating objectives contained in the Trade Act of 2002, Public Law 107-210, to maintain strong U.S. remedies laws, correct the problem of overreaching by World Trade Organization Panels and Appellate Body, and prevent the creation of obligation never negotiated or expressly agreed to by the United States: Provided further, That within the amounts appropriated, \$1,500,000 shall be used for the projects, and in the amounts, specified in the table entitled "Congressionally designated projects" in the report of the Committee on Appropriations of the Senate to accompany this Act.

BUREAU OF INDUSTRY AND SECURITY

OPERATIONS AND ADMINISTRATION

For necessary expenses for export administration and national security activities of the Department of Commerce, including costs associated with the performance of export administration field activities both domestically and abroad; full medical coverage for dependent members of immediate families of employees stationed overseas; employment of Americans and aliens by contract for services abroad; payment of tort claims, in the manner authorized in the first paragraph of 28 U.S.C. 2672 when such claims arise in foreign countries; not to exceed \$15,000 for official representation expenses abroad; awards of compensation to informers under the Export Administration Act of 1979, and as authorized by 22 U.S.C. 401(b); and purchase of passenger motor vehicles for official use and motor vehicles for law enforcement use with special requirement vehicles eligible for purchase without regard to any price limitation otherwise established by law, \$100,342,000, to remain available until expended, of which \$14,767,000 shall be for inspections and other activities related to national security: Provided, That the provisions of the first sentence of section 105(f) and all of section 108(c) of the Mutual Educational and Cultural Exchange Act of 1961 (22 U.S.C. 2455(f) and 2458(c)) shall apply in carrying out these activities: Provided further, That payments and contributions collected and accepted for materials or services provided as part of such activities may be retained for use in covering the cost of such activities, and for providing information to the public with respect to the export administration and national security activities of the Department of Commerce and other export control programs of the United States and other governments.

ECONOMIC DEVELOPMENT ADMINISTRATION

ECONOMIC DEVELOPMENT ASSISTANCE PROGRAMS

For grants for economic development assistance as provided by the Public Works and Economic Development Act of 1965, and for trade adjustment assistance, \$200,000,000, to remain available until expended: Provided, That of the amounts provided, no more than \$4,000,000 may be transferred to "Economic Development Administration, Salaries and Expenses" to conduct management oversight and administration of public works grants.

SALARIES AND EXPENSES

For necessary expenses of administering the economic development assistance programs as provided for by law, \$38,000,000: Provided, That these funds may be used to monitor projects approved pursuant to title I of the Public Works Employment Act of 1976, title II of the Trade Act of 1974, and the Community Emergency Drought Relief Act of 1977.

MINORITY BUSINESS DEVELOPMENT AGENCY
MINORITY BUSINESS DEVELOPMENT

For necessary expenses of the Department of Commerce in fostering, promoting, and developing minority business enterprise, including expenses of grants, contracts, and other agreements with public or private organizations, \$31,200,000: Provided, That within the amounts appropriated, \$200,000 shall be used for the projects, and in the amounts, specified in the table entitled, "Congressionally designated projects" in the report of the Committee on Appropriations of the Senate to accompany this Act.

ECONOMIC AND STATISTICAL ANALYSIS

SALARIES AND EXPENSES

For necessary expenses, as authorized by law, of economic and statistical analysis programs of the Department of Commerce, \$100,600,000, to remain available until September 30, 2011.

BUREAU OF THE CENSUS

SALARIES AND EXPENSES

For expenses necessary for collecting, compiling, analyzing, preparing, and publishing statistics, provided for by law, \$259,024,000.

PERIODIC CENSUSES AND PROGRAMS

For necessary expenses to collect and publish statistics for periodic censuses and programs provided for by law, \$7,065,707,000, to remain available until September 30, 2011: Provided, That none of the funds provided in this or any other Act for any fiscal year may be used for the collection of census data on race identification that does not include "some other race" as a category: Provided further, That from amounts provided herein, funds may be used for additional promotion, outreach, and marketing activities.

NATIONAL TELECOMMUNICATIONS AND
INFORMATION ADMINISTRATION

SALARIES AND EXPENSES

For necessary expenses, as provided for by law, of the National Telecommunications and Information Administration (NTIA), \$19,999,000, to remain available until September 30, 2011: Provided, That, notwithstanding 31 U.S.C. 1535(d), the Secretary of Commerce shall charge Federal agencies for costs incurred in spectrum management, analysis, operations, and related services, and such fees shall be retained and used as offsetting collections for costs of such spectrum services, to remain available until expended: Provided further, That the Secretary of Commerce is authorized to retain and use as offsetting collections all funds transferred, or previously transferred, from other Government agencies for all costs incurred in telecommunications research, engineering, and related activities by the Institute for Telecommunication Sciences of NTIA, in furtherance of its assigned functions under this paragraph, and such funds received from other government agencies shall remain available until expended.

PUBLIC TELECOMMUNICATIONS FACILITIES,
PLANNING AND CONSTRUCTION

For the administration of grants, authorized by section 392 of the Communications Act of 1934, \$20,000,000, to remain available until expended as authorized by section 391 of the Act: Provided, That not to exceed \$2,000,000 shall be available for program administration as author-

ized by section 391 of the Act: Provided further, That, notwithstanding the provisions of section 391 of the Act, the prior year unobligated balances may be made available for grants for projects for which applications have been submitted and approved during any fiscal year.

UNITED STATES PATENT AND TRADEMARK OFFICE
SALARIES AND EXPENSES

For necessary expenses of the United States Patent and Trademark Office (USPTO) provided for by law, including defense of suits instituted against the Under Secretary of Commerce for Intellectual Property and Director of the United States Patent and Trademark Office, \$1,930,361,000, to remain available until expended: Provided, That the sum herein appropriated from the general fund shall be reduced as offsetting collections assessed and collected pursuant to 15 U.S.C. 1113 and 35 U.S.C. 41 and 376 are received during fiscal year 2010, so as to result in a fiscal year 2010 appropriation from the general fund estimated at \$0: Provided further, That during fiscal year 2010, should the total amount of offsetting fee collections be less than \$1,930,361,000, this amount shall be reduced accordingly: Provided further, That of the amount received in excess of \$1,930,361,000 in fiscal year 2010, in an amount up to \$100,000,000 shall remain until expended: Provided further, That from amounts provided herein, not to exceed \$1,000 shall be made available in fiscal year 2010 for official reception and representation expenses: Provided further, That of the amounts provided to the USPTO within this account, \$25,000,000 shall not become available for obligation until the Director of the USPTO has completed a comprehensive review of the assumptions behind the patent examiner expectancy goals and adopted a revised set of expectancy goals for patent examination: Provided further, That in fiscal year 2010 from the amounts made available for "Salaries and Expenses" for the USPTO, the amounts necessary to pay: (1) the difference between the percentage of basic pay contributed by the USPTO and employees under section 8334(a) of title 5, United States Code, and the normal cost percentage (as defined by section 8331(17) of that title) of basic pay, of employees subject to subchapter III of chapter 83 of that title; and (2) the present value of the otherwise unfunded accruing costs, as determined by the Office of Personnel Management, of post-retirement life insurance and post-retirement health benefits coverage for all USPTO employees, shall be transferred to the Civil Service Retirement and Disability Fund, the Employees Life Insurance Fund, and the Employees Health Benefits Fund, as appropriate, and shall be available for the authorized purposes of those accounts: Provided further, That sections 801, 802, and 803 of division B, Public Law 108-447 shall remain in effect during fiscal year 2010: Provided further, That the Director may, this year, reduce by regulation fees payable for documents in patent and trademark matters, in connection with the filing of documents filed electronically in a form prescribed by the Director: Provided further, That \$2,000,000 shall be transferred to "Office of Inspector General" for activities associated with carrying out investigations and audits related to the USPTO.

NATIONAL INSTITUTE OF STANDARDS AND
TECHNOLOGYSCIENTIFIC AND TECHNICAL RESEARCH AND
SERVICES

For necessary expenses of the National Institute of Standards and Technology, \$520,300,000, to remain available until expended, of which not to exceed \$9,000,000 may be transferred to the "Working Capital Fund": Provided, That not to exceed \$5,000 shall be for official reception and representation expenses: Provided further, That within the amounts appropriated,

\$10,500,000 shall be used for the projects, and in the amounts, specified in the table entitled "Congressionally designated projects" in the report of the Committee on Appropriations of the Senate to accompany this Act.

INDUSTRIAL TECHNOLOGY SERVICES

For necessary expenses of the Hollings Manufacturing Extension Partnership of the National Institute of Standards and Technology, \$124,700,000, to remain available until expended. In addition, for necessary expenses of the Technology Innovation Program of the National Institute of Standards and Technology, \$69,900,000, to remain available until expended.

CONSTRUCTION OF RESEARCH FACILITIES

For construction of new research facilities, including architectural and engineering design, and for renovation and maintenance of existing facilities, not otherwise provided for the National Institute of Standards and Technology, as authorized by 15 U.S.C. 278c-278e, \$163,900,000, to remain available until expended: Provided, That within the amounts appropriated, \$47,000,000 shall be used for the projects, and in the amounts, specified in the table entitled "Congressionally designated projects" in the report of the Committee on Appropriations of the Senate to accompany this Act: Provided further, That the Secretary of Commerce shall include in the budget justification materials that the Secretary submits to Congress in support of the Department of Commerce budget (as submitted with the budget of the President under section 1105(a) of title 31, United States Code) an estimate for each National Institute of Standards and Technology construction project having a total multi-year program cost of more than \$5,000,000 and simultaneously the budget justification materials shall include an estimate of the budgetary requirements for each such project for each of the five subsequent fiscal years.

NATIONAL OCEANIC AND ATMOSPHERIC
ADMINISTRATIONOPERATIONS, RESEARCH, AND FACILITIES
(INCLUDING TRANSFERS OF FUNDS)

For necessary expenses of activities authorized by law for the National Oceanic and Atmospheric Administration, including maintenance, operation, and hire of aircraft and vessels; grants, contracts, or other payments to nonprofit organizations for the purposes of conducting activities pursuant to cooperative agreements; and relocation of facilities, \$3,301,131,000, to remain available until September 30, 2011, except for funds provided for cooperative enforcement, which shall remain available until September 30, 2012: Provided, That fees and donations received by the National Ocean Service for the management of national marine sanctuaries may be retained and used for the salaries and expenses associated with those activities, notwithstanding 31 U.S.C. 3302: Provided further, That in addition, \$3,000,000 shall be derived by transfer from the fund entitled "Coastal Zone Management" and in addition \$104,600,000 shall be derived by transfer from the fund entitled "Promote and Develop Fishery Products and Research Pertaining to American Fisheries": Provided further, That of the \$3,304,131,000 provided for in direct obligations under this heading \$3,301,131,000 is appropriated from the general fund, \$3,000,000 is provided by transfer: Provided further, That the total amount available for the National Oceanic and Atmospheric Administration corporate services administrative support costs shall not exceed \$226,809,000: Provided further, That payments of funds made available under this heading to the Department of Commerce Working Capital Fund including Department of Commerce General Counsel legal services shall not exceed \$36,583,000: Provided

further, That within the amounts appropriated, \$57,725,000 shall be used for the projects, and in the amounts, specified in the table entitled "Congressionally designated projects" in the report of the Committee on Appropriations of the Senate to accompany this Act: Provided further, That any deviation from the amounts designated for specific activities in the report accompanying this Act, or any use of deobligated balances of funds provided under this heading in previous years, shall be subject to the procedures set forth in section 505 of this Act: Provided further, That in allocating grants under sections 306 and 306A of the Coastal Zone Management Act of 1972, as amended, no coastal State shall receive more than 5 percent or less than 1 percent of increased funds appropriated over the previous fiscal year.

In addition, for necessary retired pay expenses under the Retired Serviceman's Family Protection and Survivor Benefits Plan, and for payments for the medical care of retired personnel and their dependents under the Dependents Medical Care Act (10 U.S.C. 55), such sums as may be necessary.

PROCUREMENT, ACQUISITION AND CONSTRUCTION

For procurement, acquisition and construction of capital assets, including alteration and modification costs, of the National Oceanic and Atmospheric Administration, \$1,397,685,000, to remain available until September 30, 2012, except funds provided for construction of facilities which shall remain available until expended: Provided, That of the amounts provided for the National Polar-orbiting Operational Environmental Satellite System, funds shall only be made available on a dollar-for-dollar matching basis with funds provided for the same purpose by the Department of Defense: Provided further, That except to the extent expressly prohibited by any other law, the Department of Defense may delegate procurement functions related to the National Polar-orbiting Operational Environmental Satellite System to officials of the Department of Commerce pursuant to section 2311 of title 10, United States Code: Provided further, That any deviation from the amounts designated for specific activities in the report accompanying this Act, or any use of deobligated balances of funds provided under this heading in previous years, shall be subject to the procedures set forth in section 505 of this Act: Provided further, That the Secretary of Commerce is authorized to enter into a lease, at no cost to the United States Government, with the Regents of the University of Alabama for a term of not less than 55 years, with two successive options each of 5 years, for land situated on the campus of University of Alabama in Tuscaloosa to house the Cooperative Institute and Research Center for Southeast Weather and Hydrology: Provided further, That within the amounts appropriated, \$19,000,000 shall be used for the projects, and in the amounts, specified in the table entitled "Congressionally designated projects" in the report of the Committee on Appropriations of the Senate to accompany this Act.

PACIFIC COASTAL SALMON RECOVERY

For necessary expenses associated with the restoration of Pacific salmon populations, \$80,000,000, to remain available until September 30, 2011: Provided, That of the funds provided herein the Secretary of Commerce may issue grants to the States of Washington, Oregon, Idaho, Nevada, California, and Alaska, and federally recognized tribes of the Columbia River and Pacific Coast for projects necessary for conservation of salmon and steelhead populations that are listed as threatened or endangered, or identified by a State as at-risk to be so-listed, for maintaining populations necessary for exercise of tribal treaty fishing rights or native subsistence fishing, or for conservation of Pacific

coastal salmon and steelhead habitat, based on guidelines to be developed by the Secretary of Commerce: Provided further, That funds disbursed to States shall be subject to a matching requirement of funds or documented in-kind contributions of at least 33 percent of the Federal funds.

COASTAL ZONE MANAGEMENT FUND

(INCLUDING TRANSFER OF FUNDS)

Of amounts collected pursuant to section 308 of the Coastal Zone Management Act of 1972 (16 U.S.C. 1456a), not to exceed \$3,000,000 shall be transferred to the "Operations, Research, and Facilities" account to offset the costs of implementing such Act.

FISHERIES FINANCE PROGRAM ACCOUNT

Subject to section 502 of the Congressional Budget Act of 1974, during fiscal year 2010, obligations of direct loans may not exceed \$16,000,000 for Individual Fishing Quota loans and not to exceed \$59,000,000 for traditional direct loans as authorized by the Merchant Marine Act of 1936: Provided, That none of the funds made available under this heading may be used for direct loans for any new fishing vessel that will increase the harvesting capacity in any United States fishery.

DEPARTMENTAL MANAGEMENT

SALARIES AND EXPENSES

For expenses necessary for the departmental management of the Department of Commerce provided for by law, including not to exceed \$5,000 for official reception and representation, \$61,000,000: Provided, That the Secretary, within 120 days of enactment of this Act, shall provide a report to the Committee on Appropriations of the Senate that audits and evaluates all decision documents and expenditures by the Bureau of the Census as they relate to the 2010 Census: Provided further, That of the amounts provided to the Secretary within this account, \$5,000,000 shall not become available for obligation until the Secretary certifies to the Committee on Appropriations of the Senate that the Bureau of the Census has followed and met all standards and best practices, and all Office of Management and Budget guidelines related to information technology projects and contract management.

HERBERT C. HOOVER BUILDING RENOVATION AND MODERNIZATION

For expenses necessary, including blast windows, for the renovation and modernization of the Herbert C. Hoover Building, \$22,500,000, to remain available until expended.

OFFICE OF INSPECTOR GENERAL

For necessary expenses of the Office of Inspector General in carrying out the provisions of the Inspector General Act of 1978 (5 U.S.C. App.), \$27,000,000.

GENERAL PROVISIONS—DEPARTMENT OF COMMERCE

(INCLUDING TRANSFER OF FUNDS)

SEC. 101. During the current fiscal year, applicable appropriations and funds made available to the Department of Commerce by this Act shall be available for the activities specified in the Act of October 26, 1949 (15 U.S.C. 1514), to the extent and in the manner prescribed by the Act, and, notwithstanding 31 U.S.C. 3324, may be used for advanced payments not otherwise authorized only upon the certification of officials designated by the Secretary of Commerce that such payments are in the public interest.

SEC. 102. During the current fiscal year, appropriations made available to the Department of Commerce by this Act for salaries and expenses shall be available for hire of passenger motor vehicles as authorized by 31 U.S.C. 1343 and 1344; services as authorized by 5 U.S.C. 3109; and uniforms or allowances therefor, as authorized by law (5 U.S.C. 5901–5902).

SEC. 103. Not to exceed 5 percent of any appropriation made available for the current fiscal year for the Department of Commerce in this Act may be transferred between such appropriations, but no such appropriation shall be increased by more than 10 percent by any such transfers: Provided, That any transfer pursuant to this section shall be treated as a reprogramming of funds under section 505 of this Act and shall not be available for obligation or expenditure except in compliance with the procedures set forth in that section: Provided further, That the Secretary of Commerce shall notify the Committees on Appropriations at least 15 days in advance of the acquisition or disposal of any capital asset (including land, structures, and equipment) not specifically provided for in this Act or any other law appropriating funds for the Department of Commerce: Provided further, That for the National Oceanic and Atmospheric Administration this section shall provide for transfers among appropriations made only to the National Oceanic and Atmospheric Administration and such appropriations may not be transferred and reprogrammed to other Department of Commerce bureaus and appropriation accounts.

SEC. 104. Any costs incurred by a department or agency funded under this title resulting from personnel actions taken in response to funding reductions included in this title or from actions taken for the care and protection of loan collateral or grant property shall be absorbed within the total budgetary resources available to such department or agency: Provided, That the authority to transfer funds between appropriations accounts as may be necessary to carry out this section is provided in addition to authorities included elsewhere in this Act: Provided further, That use of funds to carry out this section shall be treated as a reprogramming of funds under section 505 of this Act and shall not be available for obligation or expenditure except in compliance with the procedures set forth in that section.

SEC. 105. The requirements set forth by section 112 of division B of Public Law 110–161 are hereby adopted by reference.

SEC. 106. Notwithstanding any other law, the Secretary may furnish services (including but not limited to utilities, telecommunications, and security services) necessary to support the operation, maintenance, and improvement of space that persons, firms or organizations are authorized pursuant to the Public Buildings Cooperative Use Act of 1976 or other authority to use or occupy in the Herbert C. Hoover Building, Washington, DC, or other buildings, the maintenance, operation, and protection of which has been delegated to the Secretary from the Administrator of General Services pursuant to the Federal Property and Administrative Services Act of 1949, as amended, on a reimbursable or non-reimbursable basis. Amounts received as reimbursement for services provided under this section or the authority under which the use or occupancy of the space is authorized, up to \$200,000, shall be credited to the appropriation or fund which initially bears the costs of such services.

SEC. 107. With the consent of the President, the Secretary of Commerce shall represent the United States Government in negotiating and monitoring international agreements regarding fisheries, marine mammals, or sea turtles: Provided, That the Secretary of Commerce shall be responsible for the development and interdepartmental coordination of the policies of the United States with respect to the international negotiations and agreements referred to in this section.

SEC. 108. Section 101(k) of the Emergency Steel Loan Guarantee Act of 1999 (15 U.S.C. 1841 note) is amended by striking "2009" and inserting "2011".

SEC. 109. Nothing in this title shall be construed to prevent a grant recipient from deterring child pornography, copyright infringement, or any other unlawful activity over its networks.

SEC. 110. The National Marine Fisheries Service is authorized to accept land, buildings, equipment, and other contributions including funding, from public and private sources, which shall be available until expended without further appropriation to conduct work associated with existing authorities.

This title may be cited as the "Department of Commerce Appropriations Act, 2010".

TITLE II

DEPARTMENT OF JUSTICE

GENERAL ADMINISTRATION

SALARIES AND EXPENSES

For expenses necessary for the administration of the Department of Justice, \$118,488,000, of which not to exceed \$4,000,000 for security and construction of Department of Justice facilities shall remain available until expended: Provided, That the Attorney General is authorized to transfer funds appropriated within General Administration to any office in this account: Provided further, That \$18,693,000 is for Department Leadership; \$8,101,000 is for Intergovernmental Relations/External Affairs; \$12,715,000 is for Executive Support/Professional Responsibility; and \$78,979,000 is for the Justice Management Division: Provided further, That any change in amounts specified in the preceding proviso greater than 5 percent shall be submitted for approval to the House and Senate Committees on Appropriations consistent with the terms of section 505 of this Act: Provided further, That this transfer authority is in addition to transfers authorized under section 505 of this Act.

JUSTICE INFORMATION SHARING TECHNOLOGY

For necessary expenses for information sharing technology, including planning, development, deployment and departmental direction, \$95,000,000, to remain available until expended, of which \$21,132,000 is for the unified financial management system.

TACTICAL LAW ENFORCEMENT WIRELESS COMMUNICATIONS

For the costs of developing and implementing a nation-wide Integrated Wireless Network supporting Federal law enforcement communications, and for the costs of operations and maintenance of existing Land Mobile Radio legacy systems, \$206,143,000, to remain available until expended: Provided, That the Attorney General shall transfer to this account all funds made available to the Department of Justice for the purchase of portable and mobile radios: Provided further, That any transfer made under the preceding proviso shall be subject to section 505 of this Act.

ADMINISTRATIVE REVIEW AND APPEALS

For expenses necessary for the administration of pardon and clemency petitions and immigration-related activities, \$300,685,000, of which \$4,000,000 shall be derived by transfer from the Executive Office for Immigration Review fees deposited in the "Immigration Examinations Fee" account.

DETENTION TRUSTEE

For necessary expenses of the Federal Detention Trustee, \$1,438,663,000, to remain available until expended: Provided, That the Trustee shall be responsible for managing the Justice Prisoner and Alien Transportation System: Provided further, That not to exceed \$5,000,000 shall be considered "funds appropriated for State and local law enforcement assistance" pursuant to 18 U.S.C. 4013(b).

OFFICE OF INSPECTOR GENERAL

For necessary expenses of the Office of Inspector General, \$84,368,000, including not to ex-

ceed \$10,000 to meet unforeseen emergencies of a confidential character, of which \$2,000,000 is designated as being for overseas deployments and other activities pursuant to sections 401(c)(4) and 423(a)(1) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010.

UNITED STATES PAROLE COMMISSION

SALARIES AND EXPENSES

For necessary expenses of the United States Parole Commission as authorized, \$12,859,000.

LEGAL ACTIVITIES

SALARIES AND EXPENSES, GENERAL LEGAL ACTIVITIES

(INCLUDING TRANSFER OF FUNDS)

For expenses necessary for the legal activities of the Department of Justice, not otherwise provided for, including not to exceed \$20,000 for expenses of collecting evidence, to be expended under the direction of, and to be accounted for solely under the certificate of, the Attorney General; and rent of private or Government-owned space in the District of Columbia, \$875,097,000, of which \$2,500,000 is designated as being for overseas deployments and other activities pursuant to sections 401(c)(4) and 423(a)(1) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010; and of which not to exceed \$10,000,000 for litigation support contracts shall remain available until expended: Provided, That of the total amount appropriated, not to exceed \$10,000 shall be available to the United States National Central Bureau, INTERPOL, for official reception and representation expenses: Provided further, That notwithstanding section 205 of this Act, upon a determination by the Attorney General that emergent circumstances require additional funding for litigation activities of the Civil Division, the Attorney General may transfer such amounts to "Salaries and Expenses, General Legal Activities" from available appropriations for the current fiscal year for the Department of Justice, as may be necessary to respond to such circumstances: Provided further, That any transfer pursuant to the previous proviso shall be treated as a reprogramming under section 505 of this Act and shall not be available for obligation or expenditure except in compliance with the procedures set forth in that section: Provided further, That of the amount appropriated, such sums as may be necessary shall be available to reimburse the Office of Personnel Management for salaries and expenses associated with the election monitoring program under section 8 of the Voting Rights Act of 1965 (42 U.S.C. 1973f): Provided further, That of the amounts provided under this heading for the election monitoring program \$3,390,000 shall remain available until expended.

In addition, for reimbursement of expenses of the Department of Justice associated with processing cases under the National Childhood Vaccine Injury Act of 1986, not to exceed \$7,833,000, to be appropriated from the Vaccine Injury Compensation Trust Fund.

SALARIES AND EXPENSES, ANTITRUST DIVISION

For expenses necessary for the enforcement of antitrust and kindred laws, \$163,170,000, to remain available until expended: Provided, That notwithstanding any other provision of law, fees collected for premerger notification filings under the Hart-Scott-Rodino Antitrust Improvements Act of 1976 (15 U.S.C. 18a), regardless of the year of collection (and estimated to be \$102,000,000 in fiscal year 2010), shall be retained and used for necessary expenses in this appropriation, and shall remain available until expended: Provided further, That the sum herein appropriated from the general fund shall be reduced as such offsetting collections are received during fiscal year 2010, so as to result in

a final fiscal year 2010 appropriation from the general fund estimated at \$61,170,000.

SALARIES AND EXPENSES, UNITED STATES ATTORNEYS

For necessary expenses of the Offices of the United States Attorneys, including inter-governmental and cooperative agreements, \$1,926,003,000: Provided, That of the total amount appropriated, not to exceed \$8,000 shall be available for official reception and representation expenses: Provided further, That not to exceed \$25,000,000 shall remain available until expended: Provided further, That of the amount provided under this heading, not less than \$36,980,000 shall be used for salaries and expenses for assistant U.S. Attorneys to carry out section 704 of the Adam Walsh Child Protection and Safety Act of 2006 (Public Law 109-248) concerning the prosecution of offenses relating to the sexual exploitation of children.

UNITED STATES TRUSTEE SYSTEM FUND

For necessary expenses of the United States Trustee Program, as authorized, \$224,488,000, to remain available until expended and to be derived from the United States Trustee System Fund: Provided, That notwithstanding any other provision of law, deposits to the Fund shall be available in such amounts as may be necessary to pay refunds due depositors: Provided further, That, notwithstanding any other provision of law, \$210,000,000 of offsetting collections pursuant to 28 U.S.C. 589a(b) shall be retained and used for necessary expenses in this appropriation and shall remain available until expended: Provided further, That the sum herein appropriated from the Fund shall be reduced as such offsetting collections are received during fiscal year 2010, so as to result in a final fiscal year 2010 appropriation from the Fund estimated at \$9,488,000.

SALARIES AND EXPENSES, FOREIGN CLAIMS SETTLEMENT COMMISSION

For expenses necessary to carry out the activities of the Foreign Claims Settlement Commission, including services as authorized by section 3109 of title 5, United States Code, \$2,117,000.

FEES AND EXPENSES OF WITNESSES

For fees and expenses of witnesses, for expenses of contracts for the procurement and supervision of expert witnesses, for private counsel expenses, including advances, and for expenses of foreign counsel, \$168,300,000, to remain available until expended: Provided, That not to exceed \$10,000,000 may be made available for construction of buildings for protected witness safesites: Provided further, That not to exceed \$3,000,000 may be made available for the purchase and maintenance of armored and other vehicles for witness security caravans: Provided further, That not to exceed \$11,000,000 may be made available for the purchase, installation, maintenance, and upgrade of secure telecommunications equipment and a secure automated information network to store and retrieve the identities and locations of protected witnesses.

SALARIES AND EXPENSES, COMMUNITY RELATIONS SERVICE

For necessary expenses of the Community Relations Service, \$11,479,000: Provided, That notwithstanding section 205 of this Act, upon a determination by the Attorney General that emergent circumstances require additional funding for conflict resolution and violence prevention activities of the Community Relations Service, the Attorney General may transfer such amounts to the Community Relations Service, from available appropriations for the current fiscal year for the Department of Justice, as may be necessary to respond to such circumstances: Provided further, That any transfer pursuant to the preceding proviso shall be treated as a reprogramming under section 505 of this Act and

shall not be available for obligation or expenditure except in compliance with the procedures set forth in that section.

ASSETS FORFEITURE FUND

For expenses authorized by 28 U.S.C. 524(c)(1)(B), (F), and (G), \$20,990,000, to be derived from the Department of Justice Assets Forfeiture Fund.

UNITED STATES MARSHALS SERVICE

SALARIES AND EXPENSES

For necessary expenses of the United States Marshals Service, \$1,125,763,000; of which not to exceed \$30,000 shall be available for official reception and representation expenses; of which not to exceed \$4,000,000 shall remain available until expended for information technology systems.

CONSTRUCTION

For construction in space controlled, occupied or utilized by the United States Marshals Service for prisoner holding and related support, \$26,625,000, to remain available until expended; and of which not less than \$12,625,000 shall be available for the costs of courthouse security equipment, including furnishings, relocations, and telephone systems and cabling.

NATIONAL SECURITY DIVISION

SALARIES AND EXPENSES

For expenses necessary to carry out the activities of the National Security Division, \$87,938,000; of which not to exceed \$5,000,000 for information technology systems shall remain available until expended: Provided, That notwithstanding section 205 of this Act, upon a determination by the Attorney General that emergent circumstances require additional funding for the activities of the National Security Division, the Attorney General may transfer such amounts to this heading from available appropriations for the current fiscal year for the Department of Justice, as may be necessary to respond to such circumstances: Provided further, That any transfer pursuant to the preceding proviso shall be treated as a reprogramming under section 505 of this Act and shall not be available for obligation or expenditure except in compliance with the procedures set forth in that section.

INTERAGENCY LAW ENFORCEMENT

INTERAGENCY CRIME AND DRUG ENFORCEMENT

For necessary expenses for the identification, investigation, and prosecution of individuals associated with the most significant drug trafficking and affiliated money laundering organizations not otherwise provided for, to include inter-governmental agreements with State and local law enforcement agencies engaged in the investigation and prosecution of individuals involved in organized crime drug trafficking, \$515,000,000, of which \$50,000,000 shall remain available until expended: Provided, That any amounts obligated from appropriations under this heading may be used under authorities available to the organizations reimbursed from this appropriation.

FEDERAL BUREAU OF INVESTIGATION

SALARIES AND EXPENSES

For necessary expenses of the Federal Bureau of Investigation for detection, investigation, and prosecution of crimes against the United States; \$7,668,622,000, of which \$101,066,000 is designated as being for overseas deployments and other activities pursuant to sections 401(c)(4) and 423(a)(1) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010; and of which not to exceed \$150,000,000 shall remain available until expended: Provided, That not to exceed \$205,000 shall be available for official reception and representation expenses: Provided further, That

notwithstanding section 205 of this Act, the Director of the Federal Bureau of Investigation, upon a determination that additional funding is necessary to carry out construction of the Biometrics Technology Center, may transfer from amounts available for "Salaries and Expenses" to amounts available for "Construction" up to \$30,000,000 in fees collected to defray expenses for the automation of fingerprint identification and criminal justice information services and associated costs: Provided further, That any transfer made pursuant to the previous proviso shall be subject to section 505 of this Act.

CONSTRUCTION

For all necessary expenses, to include the cost of equipment, furniture, and information technology requirements, related to construction or acquisition of buildings, facilities and sites by purchase, or as otherwise authorized by law; conversion, modification and extension of federally owned buildings; and preliminary planning and design of projects; \$244,915,000, to remain available until expended.

DRUG ENFORCEMENT ADMINISTRATION

SALARIES AND EXPENSES

For necessary expenses of the Drug Enforcement Administration, including not to exceed \$70,000 to meet unforeseen emergencies of a confidential character pursuant to 28 U.S.C. 530C; and expenses for conducting drug education and training programs, including travel and related expenses for participants in such programs and the distribution of items of token value that promote the goals of such programs, \$2,014,682,000; of which \$10,000,000 is designated as being for overseas deployments and other activities pursuant to sections 401(c)(4) and 423(a)(1) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010; and of which not to exceed \$75,000,000 shall remain available until expended; and of which not to exceed \$100,000 shall be available for official reception and representation expenses.

BUREAU OF ALCOHOL, TOBACCO, FIREARMS AND EXPLOSIVES

SALARIES AND EXPENSES

For necessary expenses of the Bureau of Alcohol, Tobacco, Firearms and Explosives, not to exceed \$40,000 for official reception and representation expenses; for training of State and local law enforcement agencies with or without reimbursement, including training in connection with the training and acquisition of canines for explosives and fire accelerants detection; and for provision of laboratory assistance to State and local law enforcement agencies, with or without reimbursement, \$1,114,772,000, of which not to exceed \$1,000,000 shall be available for the payment of attorneys' fees as provided by section 924(d)(2) of title 18, United States Code; and of which \$10,000,000 shall remain available until expended: Provided, That no funds appropriated herein shall be available for salaries or administrative expenses in connection with consolidating or centralizing, within the Department of Justice, the records, or any portion thereof, of acquisition and disposition of firearms maintained by Federal firearms licensees: Provided further, That no funds appropriated herein shall be used to pay administrative expenses or the compensation of any officer or employee of the United States to implement an amendment or amendments to 27 CFR 478.118 or to change the definition of "Curios or relics" in 27 CFR 478.11 or remove any item from ATF Publication 5300.11 as it existed on January 1, 1994: Provided further, That none of the funds appropriated herein shall be available to investigate or act upon applications for relief from Federal firearms disabilities under 18 U.S.C. 925(c): Provided further, That such funds shall

be available to investigate and act upon applications filed by corporations for relief from Federal firearms disabilities under section 925(c) of title 18, United States Code: Provided further, That no funds made available by this or any other Act may be used to transfer the functions, missions, or activities of the Bureau of Alcohol, Tobacco, Firearms and Explosives to other agencies or Departments in fiscal year 2010: Provided further, That, beginning in fiscal year 2010 and thereafter, no funds appropriated under this or any other Act may be used to disclose part or all of the contents of the Firearms Trace System database maintained by the National Trace Center of the Bureau of Alcohol, Tobacco, Firearms and Explosives or any information required to be kept by licensees pursuant to section 923(g) of title 18, United States Code, or required to be reported pursuant to paragraphs (3) and (7) of such section 923(g), except to: (1) a Federal, State, local, tribal, or foreign law enforcement agency, or a Federal, State, or local prosecutor; or (2) a foreign law enforcement agency solely in connection with or for use in a criminal investigation or prosecution; or solely in connection with and for use in a criminal investigation or prosecution; or (3) a Federal agency for a national security or intelligence purpose; unless such disclosure of such data to any of the entities described in (1), (2) or (3) of this proviso would compromise the identity of any undercover law enforcement officer or confidential informant, or interfere with any case under investigation; and no person or entity described in (1), (2) or (3) shall knowingly or publicly disclose such data; and all such data shall be immune from legal process, shall not be subject to subpoena or other discovery, shall be inadmissible in evidence, and shall not be used, relied on, or disclosed in any manner, nor shall testimony or other evidence be permitted based on the data, in a civil action in any State (including the District of Columbia) or Federal court or in an administrative proceeding other than a proceeding commenced by the Bureau of Alcohol, Tobacco, Firearms and Explosives to enforce the provisions of chapter 44 of such title, or a review of such an action or proceeding; except that this proviso shall not be construed to prevent: (A) the disclosure of statistical information concerning total production, importation, and exportation by each licensed importer (as defined in section 921(a)(9) of such title) and licensed manufacturer (as defined in section 921(a)(10) of such title); (B) the sharing or exchange of such information among and between Federal, State, local, or foreign law enforcement agencies, Federal, State, or local prosecutors, and Federal national security, intelligence, or counterterrorism officials; or (C) the publication of annual statistical reports on products regulated by the Bureau of Alcohol, Tobacco, Firearms and Explosives, including total production, importation, and exportation by each licensed importer (as so defined) and licensed manufacturer (as so defined), or statistical aggregate data regarding firearms traffickers and trafficking channels, or firearms misuse, felons, and trafficking investigations: Provided further, That no funds made available by this or any other Act shall be expended to promulgate or implement any rule requiring a physical inventory of any business licensed under section 923 of title 18, United States Code: Provided further, That no funds under this Act may be used to electronically retrieve information gathered pursuant to 18 U.S.C. 923(g)(4) by name or any personal identification code: Provided further, That no funds authorized or made available under this or any other Act may be used to deny any application for a license under section 923 of title 18, United States Code, or renewal of such a license due to a lack of business activity, provided that the applicant is otherwise eligible

to receive such a license, and is eligible to report business income or to claim an income tax deduction for business expenses under the Internal Revenue Code of 1986.

CONSTRUCTION

For necessary expenses to construct or acquire buildings and sites to purchase, or as otherwise authorized by law (including equipment for such buildings); conversion and extension of federally owned buildings; and preliminary planning and design of projects; \$6,000,000, to remain until expended.

FEDERAL PRISON SYSTEM

SALARIES AND EXPENSES

For necessary expenses of the Federal Prison System for the administration, operation, and maintenance of Federal penal and correctional institutions, including purchase (not to exceed \$31, of which 743 are for replacement only) and hire of law enforcement and passenger motor vehicles, and for the provision of technical assistance and advice on corrections related issues to foreign governments, \$5,979,831,000, of which \$10,500,000 is designated as being for overseas deployments and other activities pursuant to sections 401(c)(4) and 423(a)(1) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010: Provided, That the Attorney General may transfer to the Health Resources and Services Administration such amounts as may be necessary for direct expenditures by that Administration for medical relief for inmates of Federal penal and correctional institutions: Provided further, That the Director of the Federal Prison System, where necessary, may enter into contracts with a fiscal agent or fiscal intermediary claims processor to determine the amounts payable to persons who, on behalf of the Federal Prison System, furnish health services to individuals committed to the custody of the Federal Prison System: Provided further, That not to exceed \$6,000 shall be available for official reception and representation expenses: Provided further, That not to exceed \$50,000,000 shall remain available for necessary operations until September 30, 2011: Provided further, That, of the amounts provided for contract confinement, not to exceed \$20,000,000 shall remain available until expended to make payments in advance for grants, contracts and reimbursable agreements, and other expenses authorized by section 501(c) of the Refugee Education Assistance Act of 1980 (8 U.S.C. 1522 note), for the care and security in the United States of Cuban and Haitian entrants: Provided further, That the Director of the Federal Prison System may accept donated property and services relating to the operation of the prison card program from a not-for-profit entity which has operated such program in the past notwithstanding the fact that such not-for-profit entity furnishes services under contracts to the Federal Prison System relating to the operation of pre-release services, halfway houses, or other custodial facilities.

BUILDINGS AND FACILITIES

For planning, acquisition of sites and construction of new facilities; purchase and acquisition of facilities and remodeling, and equipping of such facilities for penal and correctional use, including all necessary expenses incident thereto, by contract or force account; and constructing, remodeling, and equipping necessary buildings and facilities at existing penal and correctional institutions, including all necessary expenses incident thereto, by contract or force account, \$99,155,000, to remain available until expended, of which not less than \$73,769,000 shall be available only for modernization, maintenance and repair, and of which not to exceed \$14,000,000 shall be available to construct areas for inmate work programs: Provided, That labor of United States prisoners may be used for work performed under this appropriation.

FEDERAL PRISON INDUSTRIES, INCORPORATED

The Federal Prison Industries, Incorporated, is hereby authorized to make such expenditures, within the limits of funds and borrowing authority available, and in accord with the law, and to make such contracts and commitments, without regard to fiscal year limitations as provided by section 9104 of title 31, United States Code, as may be necessary in carrying out the program set forth in the budget for the current fiscal year for such corporation, including purchase (not to exceed five for replacement only) and hire of passenger motor vehicles.

LIMITATION ON ADMINISTRATIVE EXPENSES, FEDERAL PRISON INDUSTRIES, INCORPORATED

Not to exceed \$2,700,000 of the funds of the Federal Prison Industries, Incorporated shall be available for its administrative expenses, and for services as authorized by section 3109 of title 5, United States Code, to be computed on an accrual basis to be determined in accordance with the corporation's current prescribed accounting system, and such amounts shall be exclusive of depreciation, payment of claims, and expenditures which such accounting system requires to be capitalized or charged to cost of commodities acquired or produced, including selling and shipping expenses, and expenses in connection with acquisition, construction, operation, maintenance, improvement, protection, or disposition of facilities and other property belonging to the corporation or in which it has an interest.

STATE AND LOCAL LAW ENFORCEMENT ACTIVITIES

OFFICE ON VIOLENCE AGAINST WOMEN VIOLENCE AGAINST WOMEN PREVENTION AND PROSECUTION PROGRAMS

For grants, contracts, cooperative agreements, and other assistance for the prevention and prosecution of violence against women, as authorized by the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.) ("the 1968 Act"); the Violent Crime Control and Law Enforcement Act of 1994 (Public Law 103-322) ("the 1994 Act"); the Victims of Child Abuse Act of 1990 (Public Law 101-647) ("the 1990 Act"); the Prosecutorial Remedies and Other Tools to end the Exploitation of Children Today Act of 2003 (Public Law 108-21); the Juvenile Justice and Delinquency Prevention Act of 1974 (42 U.S.C. 5601 et seq.) ("the 1974 Act"); the Victims of Trafficking and Violence Protection Act of 2000 (Public Law 106-386) ("the 2000 Act"); and the Violence Against Women and Department of Justice Reauthorization Act of 2005 (Public Law 109-162) ("the 2005 Act"); and for related victims services, \$435,000,000, to remain available until expended: Provided, That except as otherwise provided by law, not to exceed 3 percent of funds made available under this heading may be used for expenses related to evaluation, training, and technical assistance: Provided further, That of the amount provided (which shall be by transfer, for programs administered by the Office of Justice Programs)—

(1) \$15,000,000 for the court-appointed special advocate program, as authorized by section 217 of the 1990 Act;

(2) \$2,500,000 for child abuse training programs for judicial personnel and practitioners, as authorized by section 222 of the 1990 Act;

(3) \$200,000,000 for grants to combat violence against women, as authorized by part T of the 1968 Act, of which—

(A) \$18,000,000 shall be for transitional housing assistance grants for victims of domestic violence, stalking or sexual assault as authorized by section 40299 of the 1994 Act; and

(B) \$2,000,000 shall be for the National Institute of Justice for research and evaluation of violence against women and related issues addressed by grant programs of the Office on Violence Against Women;

(4) \$60,000,000 for grants to encourage arrest policies as authorized by part U of the 1968 Act;

(5) \$15,000,000 for sexual assault victims assistance, as authorized by section 41601 of the 1994 Act;

(6) \$41,000,000 for rural domestic violence and child abuse enforcement assistance grants, as authorized by section 40295 of the 1994 Act;

(7) \$3,000,000 for training programs as authorized by section 40152 of the 1994 Act, and for related local demonstration projects;

(8) \$3,000,000 for grants to improve the stalking and domestic violence databases, as authorized by section 40602 of the 1994 Act;

(9) \$9,500,000 for grants to reduce violent crimes against women on campus, as authorized by section 304 of the 2005 Act;

(10) \$45,000,000 for legal assistance for victims, as authorized by section 1201 of the 2000 Act;

(11) \$4,250,000 for enhanced training and services to end violence against and abuse of women in later life, as authorized by section 40802 of the 1994 Act;

(12) \$14,000,000 for the safe havens for children program, as authorized by section 1301 of the 2000 Act;

(13) \$6,750,000 for education and training to end violence against and abuse of women with disabilities, as authorized by section 1402 of the 2000 Act;

(14) \$3,000,000 for an engaging men and youth in prevention program, as authorized by section 41305 of the 1994 Act;

(15) \$1,000,000 for analysis and research on violence against Indian women, as authorized by section 904 of the 2005 Act;

(16) \$1,000,000 for tracking of violence against Indian women, as authorized by section 905 of the 2005 Act;

(17) \$3,500,000 for services to advocate and respond to youth, as authorized by section 41201 of the 1994 Act;

(18) \$3,000,000 for grants to assist children and youth exposed to violence, as authorized by section 41303 of the 1994 Act;

(19) \$3,000,000 for the court training and improvements program, as authorized by section 41002 of the 1994 Act;

(20) \$500,000 for the National Resource Center on Workplace Responses to assist victims of domestic violence, as authorized by section 41501 of the 1994 Act; and

(21) \$1,000,000 for grants for televised testimony, as authorized by part N of title I of the 1968 Act.

OFFICE OF JUSTICE PROGRAMS JUSTICE ASSISTANCE

For grants, contracts, cooperative agreements, and other assistance authorized by title I of the Omnibus Crime Control and Safe Streets Act of 1968; the Missing Children's Assistance Act (42 U.S.C. 5771 et seq.); the Prosecutorial Remedies and Other Tools to end the Exploitation of Children Today Act of 2003 (Public Law 108-21); the Justice for All Act of 2004 (Public Law 108-405); the Violence Against Women and Department of Justice Reauthorization Act of 2005 (Public Law 109-162); the Second Chance Act of 2007 (Public Law 110-199); the Victims of Child Abuse Act of 1990 (Public Law 101-647); the Victims of Crime Act of 1984 (Public Law 98-473); the Adam Walsh Child Protection and Safety Act of 2006 (Public Law 109-248); the PROTECT Our Children Act of 2008 (Public Law 110-401); subtitle D of title II of the Homeland Security Act of 2002 (Public Law 107-296), which may include research and development; and other programs (including the Statewide Automated Victim Notification Program); \$215,000,000, to remain available until expended, of which:

(1) \$40,000,000 is for criminal justice statistics programs, pursuant to part C of the 1968 Act, of which \$35,000,000 is for the National Crime Victimization Survey;

(2) \$48,000,000 is for research, development, and evaluation programs;

(3) \$12,000,000 is for the Statewide Victim Notification System of the Bureau of Justice Assistance;

(4) \$45,000,000 is for the Regional Information System Sharing System, as authorized by part M of title I of the 1968 Act; and

(5) \$70,000,000 is for the Missing Children's Program.

STATE AND LOCAL LAW ENFORCEMENT ASSISTANCE

For grants, contracts, cooperative agreements, and other assistance authorized by the Violent Crime Control and Law Enforcement Act of 1994 (Public Law 103-322) ("the 1994 Act"); the Omnibus Crime Control and Safe Streets Act of 1968 ("the 1968 Act"); the Justice for All Act of 2004 (Public Law 108-405); the Victims of Child Abuse Act of 1990 (Public Law 101-647) ("the 1990 Act"); the Trafficking Victims Protection Reauthorization Act of 2005 (Public Law 109-164); the Violence Against Women and Department of Justice Reauthorization Act of 2005 (Public Law 109-162); the Adam Walsh Child Protection and Safety Act of 2006 (Public Law 109-248); the Second Chance Act of 2007 (Public Law 110-199); and the Victims of Trafficking and Violence Protection Act of 2000 (Public Law 106-386); and other programs; \$1,159,000,000, to remain available until expended as follows:

(1) \$510,000,000 for the Edward Byrne Memorial Justice Assistance Grant program as authorized by subpart 1 of part E of title I of the 1968 Act, (except that section 1001(c), and the special rules for Puerto Rico under section 505(g), of the 1968 Act, shall not apply for purposes of this Act), of which \$5,000,000 is for use by the National Institute of Justice in assisting units of local government to identify, select, develop, modernize, and purchase new technologies for use by law enforcement, \$2,000,000 is for a program to improve State and local law enforcement intelligence capabilities including anti-terrorism training and training to ensure that constitutional rights, civil liberties, civil rights, and privacy interests are protected throughout the intelligence process, \$10,000,000 is to support the Nationwide Pegasus Program in coordination with the National Sheriff's Association, for rural and non-urban law enforcement databases and connectivity to enhance information sharing technology capacity, and \$10,000,000 is for implementation of a student loan repayment assistance program pursuant to section 952 of Public Law 110-315;

(2) \$178,500,000 for discretionary grants to improve the functioning of the criminal justice system, to prevent or combat juvenile delinquency, and to assist victims of crime (other than compensation): Provided, That within the amounts appropriated, \$178,500,000 shall be used for the projects, and in the amounts specified in the table entitled "Congressionally designated projects" in the report of the Committee on Appropriations of the Senate to accompany this Act;

(3) \$40,000,000 for competitive grants to improve the functioning of the criminal justice system, to prevent or combat juvenile delinquency, and to assist victims of crime (other than compensation) of which \$8,000,000 shall be available for the SMART Office activities and \$2,000,000 shall be available for grants to States and local law enforcement agencies as authorized by section 5 of Public Law 110-344;

(4) \$2,000,000 for the purposes described in the Missing Alzheimer's Disease Patient Alert Program (section 240001 of the 1994 Act);

(5) \$15,000,000 for victim services programs for victims of trafficking, as authorized by section 107(b)(2) of Public Law 106-386 and for programs authorized under Public Law 109-164;

(6) \$40,000,000 for Drug Courts, as authorized by section 1001(25)(A) of title I of the 1968 Act;

(7) \$5,000,000 for prison rape prevention and prosecution and other programs, as authorized by the Prison Rape Elimination Act of 2003 (Public Law 108-79);

(8) \$20,000,000 for grants for Residential Substance Abuse Treatment for State Prisoners, as authorized by part S of title I of the 1968 Act;

(9) \$50,000,000 for offender re-entry programs, as authorized by the Second Chance Act of 2007 (Public Law 110-199), of which \$25,000,000 is for grants for adult and juvenile offender State, tribal and local reentry demonstration projects, \$15,000,000 is for grants for mentoring and transitional services and \$5,000,000 is for family-based substance abuse treatment;

(10) \$5,500,000 for the Capital Litigation Improvement Grant Program, as authorized by section 426 of Public Law 108-405;

(11) \$10,000,000 for mental health courts and adult and juvenile collaboration program grants, as authorized by parts V and HH of title I of the 1968 Act, and the Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act of 2008 (Public Law 110-416);

(12) \$30,000,000 for assistance to Indian tribes, of which—

(A) \$10,000,000 shall be available for grants under section 20109 of subtitle A of title II of the 1994 Act;

(B) \$10,000,000 shall be available for the Tribal Courts Initiative;

(C) \$7,000,000 shall be available for tribal alcohol and substance abuse reduction assistance grants; and

(D) \$3,000,000 shall be available for training and technical assistance and civil and criminal legal assistance as authorized by title I of Public Law 106-559;

(13) \$228,000,000 for the State Criminal Alien Assistance Program, as authorized by section 241(i)(5) of the Immigration and Nationality Act (8 U.S.C. 1231(i)(5)); and

(14) \$25,000,000 for the Border Prosecutor Initiative to reimburse State, county, parish, tribal, or municipal governments for costs associated with the prosecution of criminal cases declined by local offices of the United States Attorneys: Provided, That no less than \$20,000,000 shall be for prosecution efforts on the Southern border: Provided further, That no less than \$5,000,000 shall be for prosecution efforts on the Northern border:

Provided, That, if a unit of local government uses any of the funds made available under this heading to increase the number of law enforcement officers, the unit of local government will achieve a net gain in the number of law enforcement officers who perform nonadministrative public safety service.

WEED AND SEED PROGRAM FUND

For necessary expenses, including salaries and related expenses of the Office of Weed and Seed Strategies, \$20,000,000, to remain available until expended, as authorized by section 103 of title I of the Omnibus Crime Control and Safe Streets Act of 1968.

JUVENILE JUSTICE PROGRAMS

For grants, contracts, cooperative agreements, and other assistance authorized by the Juvenile Justice and Delinquency Prevention Act of 1974 ("the 1974 Act"), the Omnibus Crime Control and Safe Streets Act of 1968 ("the 1968 Act"), the Violence Against Women and Department of Justice Reauthorization Act of 2005 (Public Law 109-162), the Missing Children's Assistance Act (42 U.S.C. 5771 et seq.); the Prosecutorial Remedies and Other Tools to end the Exploitation of Children Today Act of 2003 (Public Law 108-21); the Victims of Child Abuse Act of 1990 (Public Law 101-647); the Adam Walsh Child Protection and Safety Act of 2006 (Public Law 109-248); the PROTECT Our Children Act of 2008 (Public

Law 110-401), and other juvenile justice programs, \$407,000,000, to remain available until expended as follows:

(1) \$75,000,000 for programs authorized by section 221 of the 1974 Act, and for training and technical assistance to assist small, non-profit organizations with the Federal grants process: Provided, That no less than \$5,000,000 shall be for the Safe Start Program, as authorized by the 1974 Act;

(2) \$82,000,000 for grants and projects, as authorized by sections 261 and 262 of the 1974 Act: Provided, That within the amounts appropriated, \$82,000,000 shall be used for the projects, and in the amounts, specified in the table entitled "Congressionally designated projects" in the report of the Committee on Appropriations of the Senate to accompany this Act;

(3) \$100,000,000 for youth mentoring grants;

(4) \$65,000,000 for delinquency prevention, as authorized by section 505 of the 1974 Act, of which, pursuant to sections 261 and 262 thereof—

(A) \$25,000,000 shall be for the Tribal Youth Program;

(B) \$10,000,000 shall be for a gang education initiative; and

(C) \$25,000,000 shall be for grants of \$360,000 to each State and \$4,840,000 shall be available for discretionary grants, for programs and activities to enforce State laws prohibiting the sale of alcoholic beverages to minors or the purchase or consumption of alcoholic beverages by minors, for prevention and reduction of consumption of alcoholic beverages by minors, and for technical assistance and training;

(5) \$25,000,000 for programs authorized by the Victims of Child Abuse Act of 1990; and

(6) \$60,000,000 for the Juvenile Accountability Block Grants program as authorized by part R of title I of the 1968 Act and Guam shall be considered a State:

Provided, That not more than 10 percent of each amount may be used for research, evaluation, and statistics activities designed to benefit the programs or activities authorized: Provided further, That not more than 2 percent of each amount may be used for training and technical assistance: Provided further, That the previous two provisos shall not apply to grants and projects authorized by sections 261 and 262 of the 1974 Act.

PUBLIC SAFETY OFFICER BENEFITS

For payments and expenses authorized under section 1001(a)(4) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796), such sums as are necessary (including amounts for administrative costs, which amounts shall be paid to the "Salaries and Expenses" account); and \$5,000,000 for payments authorized by section 1201(b) of such Act; and \$4,100,000 for educational assistance, as authorized by section 1218 of such Act, to remain available until expended.

COMMUNITY ORIENTED POLICING SERVICES

For activities authorized by the Violent Crime Control and Law Enforcement Act of 1994 (Public Law 103-322); the Omnibus Crime Control and Safe Streets Act of 1968 ("the 1968 Act"); the Violence Against Women and Department of Justice Reauthorization Act of 2005 (Public Law 109-162); subtitle D of title II of the Homeland Security Act of 2002 (Public Law 107-296), which may include research and development; and the USA PATRIOT Improvement and Reauthorization Act of 2005 (Public Law 109-177); the NICS Improvement Amendments Act of 2007 (Public Law 110-180); the Adam Walsh Child Protection and Safety Act of 2006 (Public Law 109-248) (the "Adam Walsh Act"); and the Justice for All Act of 2004 (Public Law 108-405), \$658,500,000, to remain available until expended: Provided, That

any balances made available through prior year deobligations shall only be available in accordance with section 505 of this Act. Of the amount provided (which shall be by transfer, for programs administered by the Office of Justice Programs)—

(1) \$30,000,000 for the matching grant program for law enforcement armor vests, as authorized by section 2501 of title I of the 1968 Act: Provided, That \$1,500,000 is transferred directly to the National Institute of Standards and Technology's Office of Law Enforcement Standards from the Community Oriented Policing Services Office for research, testing, and evaluation programs;

(2) \$39,500,000 for grants to entities described in section 1701 of title I of the 1968 Act, to address public safety and methamphetamine manufacturing, sale, and use in hot spots as authorized by section 754 of Public Law 109-177, and for other anti-methamphetamine-related activities: Provided, That within the amounts appropriated, \$34,500,000 shall be used for the projects, and in the amounts, specified in the table entitled "Congressionally designated projects" in the report of the Committee on Appropriations of the Senate to accompany this Act;

(3) \$187,000,000 for a law enforcement technologies and interoperable communications program, and related law enforcement and public safety equipment: Provided, That within the amounts appropriated, \$187,000,000 shall be used for the projects, and in the amounts, specified in the table entitled "Congressionally designated projects" in the report of the Committee on Appropriations of the Senate to accompany this Act;

(4) \$10,000,000 for grants to assist States and tribal governments as authorized by the NICS Improvements Amendments Act of 2007 (Public Law 110-180);

(5) \$10,000,000 for grants to upgrade criminal records, as authorized under the Crime Identification Technology Act of 1998 (42 U.S.C. 14601);

(6) \$166,000,000 for DNA related and forensic programs and activities as follows:

(A) \$151,000,000 for a DNA analysis and capacity enhancement program and for other local, State, and Federal forensic activities including the purposes of section 2 of the DNA Analysis Backlog Elimination Act of 2000 (the Debbie Smith DNA Backlog Grant Program);

(B) \$5,000,000 for the purposes described in the Kirk Bloodsworth Post-Conviction DNA Testing Program (Public Law 108-405, section 412);

(C) \$5,000,000 for Sexual Assault Forensic Exam Program Grants as authorized by Public Law 108-405, section 304; and

(D) \$5,000,000 for DNA Training and Education for Law Enforcement, Correctional Personnel, and Court Officers as authorized by Public Law 108-405, section 303;

(7) \$20,000,000 for improving tribal law enforcement, including equipment and training;

(8) \$15,000,000 for programs to reduce gun crime and gang violence;

(9) \$10,000,000 for training and technical assistance;

(10) \$20,000,000 for a national grant program the purpose of which is to assist State and local law enforcement to locate, arrest and prosecute child sexual predators and exploiters, and to enforce sex offender registration laws described in section 1701(b) of the 1968 Act, of which:

(A) \$5,000,000 for sex offender management assistance as authorized by the Adam Walsh Act and the Violent Crime Control Act of 1994 (Public Law 103-322); and

(B) \$1,000,000 for the National Sex Offender Public Registry;

(11) \$16,000,000 for expenses authorized by part AA of the 1968 Act (Secure our Schools);

(12) \$35,000,000 for Paul Coverdell Forensic Science Improvement Grants under part BB of title I of the 1968 Act; and

(13) \$100,000,000 for grants under section 1701 of title I of the 1968 Act (42 U.S.C. 3796dd) for the hiring and rehiring of additional career law enforcement officers under part Q of such title notwithstanding subsections (g) and (i) of such section and notwithstanding 42 U.S.C. 3796dd-3(c).

SALARIES AND EXPENSES

For necessary expenses, not elsewhere specified in this title, for management and administration of programs within the Office on Violence Against Women, the Office of Justice Programs and the Community Oriented Policing Services Office, \$179,000,000, of which not to exceed \$15,708,000 shall be available for the Office on Violence Against Women; not to exceed \$125,830,000 shall be available for the Office of Justice Programs; not to exceed \$37,462,000 shall be available for the Community Oriented Policing Services Office: Provided, That, notwithstanding section 109 of title I of Public Law 90-351, an additional amount, not to exceed \$21,000,000 shall be available for authorized activities of the Office of Audit, Assessment, and Management: Provided further, That the total amount available for management and administration of such programs shall not exceed \$200,000,000.

GENERAL PROVISIONS—DEPARTMENT OF JUSTICE

SEC. 201. In addition to amounts otherwise made available in this title for official reception and representation expenses, a total of not to exceed \$75,000 from funds appropriated to the Department of Justice in this title shall be available to the Attorney General for official reception and representation expenses.

SEC. 202. None of the funds appropriated by this title shall be available to pay for an abortion, except where the life of the mother would be endangered if the fetus were carried to term, or in the case of rape: Provided, That should this prohibition be declared unconstitutional by a court of competent jurisdiction, this section shall be null and void.

SEC. 203. None of the funds appropriated under this title shall be used to require any person to perform, or facilitate in any way the performance of, any abortion.

SEC. 204. Nothing in the preceding section shall remove the obligation of the Director of the Bureau of Prisons to provide escort services necessary for a female inmate to receive such service outside the Federal facility: Provided, That nothing in this section in any way diminishes the effect of section 203 intended to address the philosophical beliefs of individual employees of the Bureau of Prisons.

SEC. 205. Not to exceed 5 percent of any appropriation made available for the current fiscal year for the Department of Justice in this Act may be transferred between such appropriations, but no such appropriation, except as otherwise specifically provided, shall be increased by more than 10 percent by any such transfers: Provided, That any transfer pursuant to this section shall be treated as a reprogramming of funds under section 505 of this Act and shall not be available for obligation except in compliance with the procedures set forth in that section.

SEC. 206. The Attorney General is authorized to extend through September 30, 2011, the Personnel Management Demonstration Project transferred to the Attorney General pursuant to section 1115 of the Homeland Security Act of 2002, Public Law 107-296 (6 U.S.C. 533) without limitation on the number of employees or the positions covered.

SEC. 207. Notwithstanding any other provision of law, Public Law 102-395 section 102(b) shall extend to the Bureau of Alcohol, Tobacco, Fire-

arms and Explosives in the conduct of undercover investigative operations and shall apply without fiscal year limitation with respect to any undercover investigative operation by the Bureau of Alcohol, Tobacco, Firearms and Explosives that is necessary for the detection and prosecution of crimes against the United States.

SEC. 208. None of the funds made available to the Department of Justice in this Act may be used for the purpose of transporting an individual who is a prisoner pursuant to conviction for crime under State or Federal law and is classified as a maximum or high security prisoner, other than to a prison or other facility certified by the Federal Bureau of Prisons as appropriately secure for housing such a prisoner.

SEC. 209. (a) None of the funds appropriated by this Act may be used by Federal prisons to purchase cable television services, to rent or purchase videocassettes, videocassette recorders, or other audiovisual or electronic equipment used primarily for recreational purposes.

(b) The preceding sentence does not preclude the renting, maintenance, or purchase of audiovisual or electronic equipment for inmate training, religious, or educational programs.

SEC. 210. None of the funds made available under this title shall be obligated or expended for Sentinel, or for any other major new or enhanced information technology program having total estimated development costs in excess of \$100,000,000, unless the Deputy Attorney General and the investment review board certify to the Committees on Appropriations that the information technology program has appropriate program management and contractor oversight mechanisms in place, and that the program is compatible with the enterprise architecture of the Department of Justice.

SEC. 211. The notification thresholds and procedures set forth in section 505 of this Act shall apply to deviations from the amounts designated for specific activities in this Act and accompanying statement, and to any use of deobligated balances of funds provided under this title in previous years.

SEC. 212. None of the funds appropriated by this Act may be used to plan for, begin, continue, finish, process, or approve a public-private competition under the Office of Management and Budget Circular A-76 or any successor administrative regulation, directive, or policy for work performed by employees of the Bureau of Prisons or of Federal Prison Industries, Incorporated.

SEC. 213. Notwithstanding any other provision of law, no funds shall be available for the salary, benefits, or expenses of any United States Attorney assigned dual or additional responsibilities by the Attorney General or his designee that exempt that United States Attorney from the residency requirements of 28 U.S.C. 545.

SEC. 214. None of the funds appropriated in this or any other Act shall be obligated for the initiation of a future phase of the Federal Bureau of Investigation's Sentinel program until the Attorney General certifies to the Committees on Appropriations that existing phases currently under contract for development or fielding have completed a majority of the work for that phase under the performance measurement baseline validated by the integrated baseline review conducted in 2008: Provided, That this restriction does not apply to planning and design activities for future phases: Provided further, That the Bureau will notify the Committees on Appropriations of any significant changes to the baseline.

SEC. 215. In addition to any amounts that otherwise may be available (or authorized to be made available) by law, with respect to funds appropriated by this Act under the headings

“Justice Assistance”, “State and Local Law Enforcement Assistance”, “Weed and Seed”, “Juvenile Justice Programs”, and “Community Oriented Policing Services”—

(1) Up to 3 percent of funds made available to the Office of Justice Programs for grants or reimbursement may be used to provide training and technical assistance; and

(2) Up to 1 percent of funds made available to such Office for formula grants under such headings may be used for research or statistical purposes by the National Institute of Justice or the Bureau of Justice Statistics, pursuant to, respectively, sections 201 and 202, and sections 301 and 302 of title I of Public Law 90–351.

SEC. 216. Section 5759(e) of title 5, United States Code, is amended by striking subsection (e).

SEC. 217. (a) The Attorney General shall submit quarterly reports to the Inspector General of the Department of Justice regarding the costs and contracting procedures relating to each conference held by the Department of Justice during fiscal year 2010 for which the cost to the Government was more than \$20,000.

(b) Each report submitted under subsection (a) shall include, for each conference described in that subsection held during the applicable quarter—

(1) a description of the subject of and number of participants attending that conference;

(2) a detailed statement of the costs to the Government relating to that conference, including—

(A) the cost of any food or beverages;

(B) the cost of any audio-visual services; and

(C) a discussion of the methodology used to determine which costs relate to that conference; and

(3) a description of the contracting procedures relating to that conference, including—

(A) whether contracts were awarded on a competitive basis for that conference; and

(B) a discussion of any cost comparison conducted by the Department of Justice in evaluating potential contractors for that conference.

SEC. 218. (a) Subchapter IV of chapter 57 of title 5, United States Code, is amended by adding at the end of the following:

“§5761. Foreign language proficiency pay awards for the Federal Bureau of Investigation

“The Director of the Federal Bureau of Investigation may, under regulations prescribed by the Director, pay a cash award of up to 10 percent of basic pay to any Bureau employee who maintains proficiency in a language or languages critical to the mission or who uses one or more foreign languages in the performance of official duties.”.

(b) The analysis for chapter 57 of title 5, United States Code, is amended by adding at the end the following:

“§5761. Foreign language proficiency pay awards for the Federal Bureau of Investigation.”

SEC. 219. The Attorney General is authorized to waive the application of 42 U.S.C. 3755(d)(2)(A) with respect to grants made to units of local government pursuant to 42 U.S.C. 3755(d)(1), if such units of local government were eligible to receive such grants under the transitional rule in 42 U.S.C. 3755(d)(2)(B).

This title may be cited as the “Department of Justice Appropriations Act, 2010”.

TITLE III

SCIENCE

OFFICE OF SCIENCE AND TECHNOLOGY POLICY

For necessary expenses of the Office of Science and Technology Policy, in carrying out the purposes of the National Science and Technology Policy, Organization, and Priorities Act

of 1976 (42 U.S.C. 6601–6671), hire of passenger motor vehicles, and services as authorized by 5 U.S.C. 3109, not to exceed \$2,500 for official reception and representation expenses, and rental of conference rooms in the District of Columbia, \$6,154,000.

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

SCIENCE

For necessary expenses, not otherwise provided for, in the conduct and support of science research and development activities, including research, development, operations, support, and services; maintenance; construction of facilities including repair, rehabilitation, revitalization, and modification of facilities, construction of new facilities and additions to existing facilities, facility planning and design, and restoration, and acquisition or condemnation of real property, as authorized by law; environmental compliance and restoration; space flight, spacecraft control, and communications activities; program management; personnel and related costs, including uniforms or allowances therefor, as authorized by 5 U.S.C. 5901–5902; travel expenses; purchase and hire of passenger motor vehicles; and purchase, lease, charter, maintenance, and operation of mission and administrative aircraft, \$4,517,000,000, to remain available until September 30, 2011.

AERONAUTICS

For necessary expenses, not otherwise provided for, in the conduct and support of aeronautics research and development activities, including research, development, operations, support, and services; maintenance; construction of facilities including repair, rehabilitation, revitalization, and modification of facilities, construction of new facilities and additions to existing facilities, facility planning and design, and restoration, and acquisition or condemnation of real property, as authorized by law; environmental compliance and restoration; space flight, spacecraft control, and communications activities; program management; personnel and related costs, including uniforms or allowances therefor, as authorized by 5 U.S.C. 5901–5902; travel expenses; purchase and hire of passenger motor vehicles; and purchase, lease, charter, maintenance, and operation of mission and administrative aircraft, \$507,000,000, to remain available until September 30, 2011.

EXPLORATION

For necessary expenses, not otherwise provided for, in the conduct and support of exploration research and development activities, including research, development, operations, support, and services; maintenance; construction of facilities including repair, rehabilitation, revitalization, and modification of facilities, construction of new facilities and additions to existing facilities, facility planning and design, and restoration, and acquisition or condemnation of real property, as authorized by law; environmental compliance and restoration; space flight, spacecraft control, and communications activities; program management, personnel and related costs, including uniforms or allowances therefor, as authorized by 5 U.S.C. 5901–5902; travel expenses; purchase and hire of passenger motor vehicles; and purchase, lease, charter, maintenance, and operation of mission and administrative aircraft, \$3,940,400,000, to remain available until September 30, 2011.

SPACE OPERATIONS

For necessary expenses, not otherwise provided for, in the conduct and support of space operations research and development activities, including research, development, operations, support and services; space flight, spacecraft control and communications activities including operations, production, and services; maintenance; construction of facilities including repair, rehabilitation, revitalization and modification of facilities, construction of new facilities and additions to existing facilities, facility planning and design, and restoration, and acquisition or condemnation of real property, as authorized by law; environmental compliance and restoration; program management; personnel and related costs, including uniforms or allowances therefor, as authorized by 5 U.S.C. 5901–5902; travel expenses; purchase and hire of passenger motor vehicles; and purchase, lease, charter, maintenance, and operation of mission and administrative aircraft, \$6,161,600,000, to remain available until September 30, 2011.

For necessary expenses, not otherwise provided for, in the conduct and support of science, aeronautics, exploration, space operations and education research and development activities, including research, development, operations, support, and services; maintenance; construction of facilities including repair, rehabilitation, revitalization, and modification of facilities, construction of new facilities and additions to existing facilities, facility planning and design, and restoration, and acquisition or condemnation of real property, as authorized by law; environmental compliance and restoration; program management; personnel and related costs, including uniforms or allowances therefor, as authorized by 5 U.S.C. 5901–5902; travel expenses; purchase and hire of passenger motor vehicles; and purchase, lease, charter, maintenance, and operation of mission and administrative aircraft, \$140,100,000, to remain available until September 30, 2011.

EDUCATION

For necessary expenses, not otherwise provided for, in carrying out aerospace and aeronautical education research and development activities, including research, development, operations, support, and services; program management; personnel and related costs, uniforms or allowances therefor, as authorized by 5 U.S.C. 5901–5902; travel expenses; purchase and hire of passenger motor vehicles; and purchase, lease, charter, maintenance, and operation of mission and administrative aircraft, \$140,100,000, to remain available until September 30, 2011.

CROSS AGENCY SUPPORT

For necessary expenses, not otherwise provided for, in the conduct and support of science, aeronautics, exploration, space operations and education research and development activities, including research, development, operations, support, and services; maintenance; construction of facilities including repair, rehabilitation, revitalization, and modification of facilities, construction of new facilities and additions to existing facilities, facility planning and design, and restoration, and acquisition or condemnation of real property, as authorized by law; environmental compliance and restoration; space flight, spacecraft control, and communications activities; program management; personnel and related costs, including uniforms or allowances therefor, as authorized by 5 U.S.C. 5901–5902; travel expenses; purchase and hire of passenger motor vehicles; not to exceed \$70,000 for official reception and representation expenses; and purchase, lease, charter, maintenance, and operation of mission and administrative aircraft, \$3,383,500,000, to remain available until September 30, 2011: Provided, That within the amounts appropriated \$47,000,000 shall be used for the projects, and in the amounts, specified in the table entitled “Congressionally designated projects” in the report of the Committee on Appropriations of the Senate to accompany this Act.

OFFICE OF INSPECTOR GENERAL

For necessary expenses of the Office of Inspector General in carrying out the Inspector General Act of 1978, \$36,400,000, to remain available until September 30, 2011.

ADMINISTRATIVE PROVISIONS

Notwithstanding the limitation on the duration of availability of funds appropriated to the National Aeronautics and Space Administration for any account in this Act, except for “Office of Inspector General”, when any activity has been initiated by the incurrence of obligations for environmental compliance and restoration activities as authorized by law, such amount available for such activity shall remain available until expended.

Notwithstanding the limitation on the availability of funds appropriated to the National Aeronautics and Space Administration for any account in this Act, except for “Office of Inspector General”, the amounts appropriated for construction of facilities shall remain available until September 30, 2014.

Funds for announced prizes otherwise authorized shall remain available, without fiscal year limitation, until the prize is claimed or the offer is withdrawn.

Not to exceed 5 percent of any appropriation made available for the current fiscal year for the National Aeronautics and Space Administration in this Act may be transferred between such appropriations, but no such appropriation, except as otherwise specifically provided, shall be increased by more than 10 percent by any such transfers. Any transfer pursuant to this provision shall be treated as a reprogramming of funds under section 505 of this Act and shall not be available for obligation except in compliance with the procedures set forth in that section.

Notwithstanding any other provision of law, no funds shall be used to implement any Reduction in Force or other involuntary separations (except for cause) by the National Aeronautics and Space Administration prior to September 30, 2010.

The unexpired balances of the Science, Aeronautics, and Exploration account, for activities for which funds are provided under this Act, may be transferred to the new accounts established in this Act that provide such activity. Balances so transferred shall be merged with the funds in the newly established accounts, but shall be available under the same terms, conditions and period of time as previously appropriated.

Funding designations and minimum funding requirements contained in any other Act shall not be applicable to funds appropriated by this title for the National Aeronautics and Space Administration.

NATIONAL SCIENCE FOUNDATION
RESEARCH AND RELATED ACTIVITIES
(INCLUDING TRANSFER OF FUNDS)

For necessary expenses in carrying out the National Science Foundation Act of 1950, as amended (42 U.S.C. 1861–1875), and the Act to establish a National Medal of Science (42 U.S.C. 1880–1881); services as authorized by 5 U.S.C. 3109; maintenance and operation of aircraft and purchase of flight services for research support; acquisition of aircraft; and authorized travel; \$5,618,000,000, to remain available until September 30, 2011, of which not to exceed \$570,000,000 shall remain available until expended for polar research and operations support, and for reimbursement to other Federal agencies for operational and science support and logistical and other related activities for the United States Antarctic program: Provided, That from funds specified in the fiscal year 2010 budget request for icebreaking services, \$54,000,000 shall be transferred to the U.S. Coast Guard “Operating Expenses”: Provided further, That receipts for scientific support services and materials furnished by the National Research Centers and other National Science Foundation supported research facilities may be credited to this appropriation: Provided further, That not less than \$147,800,000 shall be available for activities authorized by section 7002(c)(2)(A)(iv) of Public Law 110–69.

MAJOR RESEARCH EQUIPMENT AND FACILITIES
CONSTRUCTION

For necessary expenses for the acquisition, construction, commissioning, and upgrading of major research equipment, facilities, and other such capital assets pursuant to the National Science Foundation Act of 1950, as amended (42 U.S.C. 1861–1875), including authorized travel, \$122,290,000, to remain available until expended.

EDUCATION AND HUMAN RESOURCES

For necessary expenses in carrying out science and engineering education and human resources programs and activities pursuant to the National Science Foundation Act of 1950, as

amended (42 U.S.C. 1861–1875), including services as authorized by 5 U.S.C. 3109, authorized travel, and rental of conference rooms in the District of Columbia, \$857,760,000, to remain available until September 30, 2011: Provided, That not less than \$55,000,000 shall be available until expended for activities authorized by section 7030 of Public Law 110–69.

AGENCY OPERATIONS AND AWARD MANAGEMENT

For agency operations and award management necessary in carrying out the National Science Foundation Act of 1950, as amended (42 U.S.C. 1861–1875); services authorized by 5 U.S.C. 3109; hire of passenger motor vehicles; not to exceed \$9,000 for official reception and representation expenses; uniforms or allowances therefor, as authorized by 5 U.S.C. 5901–5902; rental of conference rooms in the District of Columbia; and reimbursement of the Department of Homeland Security for security guard services; \$300,370,000: Provided, That contracts may be entered into under this heading in fiscal year 2010 for maintenance and operation of facilities, and for other services, to be provided during the next fiscal year.

OFFICE OF THE NATIONAL SCIENCE BOARD

For necessary expenses (including payment of salaries, authorized travel, hire of passenger motor vehicles, the rental of conference rooms in the District of Columbia, and the employment of experts and consultants under section 3109 of title 5, United States Code) involved in carrying out section 4 of the National Science Foundation Act of 1950, as amended (42 U.S.C. 1863) and Public Law 86–209 (42 U.S.C. 1880 et seq.), \$4,340,000: Provided, That not to exceed \$2,500 shall be available for official reception and representation expenses.

OFFICE OF INSPECTOR GENERAL

For necessary expenses of the Office of Inspector General as authorized by the Inspector General Act of 1978, as amended, \$14,000,000.

This title may be cited as the “Science Appropriations Act, 2010”.

TITLE IV
RELATED AGENCIES
COMMISSION ON CIVIL RIGHTS
SALARIES AND EXPENSES

For necessary expenses of the Commission on Civil Rights, including hire of passenger motor vehicles, \$9,400,000: Provided, That none of the funds appropriated in this paragraph shall be used to employ in excess of four full-time individuals under Schedule C of the Excepted Service exclusive of one special assistant for each Commissioner: Provided further, That none of the funds appropriated in this paragraph shall be used to reimburse Commissioners for more than 75 billable days, with the exception of the chairperson, who is permitted 125 billable days.

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION
SALARIES AND EXPENSES

For necessary expenses of the Equal Employment Opportunity Commission as authorized by title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the Equal Pay Act of 1963, the Americans with Disabilities Act of 1990, the Civil Rights Act of 1991, the Genetic Information Non-Discrimination Act (GINA) of 2008 (Public Law 110–23); the ADA Amendments Act of 2008 (Public Law 110–325), and the Lilly Ledbetter Fair Pay Act of 2009 (Public Law 111–2), including services as authorized by 5 U.S.C. 3109; hire of passenger motor vehicles as authorized by 31 U.S.C. 1343(b); nonmonetary awards to private citizens; and not to exceed \$30,000,000 for payments to State and local enforcement agencies for authorized services to the Commission, \$367,303,000: Provided, That the Commission is authorized to make available for official reception and rep-

resentation expenses not to exceed \$2,500 from available funds: Provided further, That the Commission may take no action to implement any workforce repositioning, restructuring, or reorganization until such time as the House and Senate Committees on Appropriations have been notified of such proposals, in accordance with the reprogramming requirements of section 505 of this Act: Provided further, That the Chair is authorized to accept and use any gift or donation to carry out the work of the Commission.

INTERNATIONAL TRADE COMMISSION

SALARIES AND EXPENSES

For necessary expenses of the International Trade Commission, including hire of passenger motor vehicles, and services as authorized by 5 U.S.C. 3109, and not to exceed \$2,500 for official reception and representation expenses, \$82,700,000, to remain available until expended.

LEGAL SERVICES CORPORATION

PAYMENT TO THE LEGAL SERVICES CORPORATION

For payment to the Legal Services Corporation to carry out the purposes of the Legal Services Corporation Act of 1974, \$400,000,000, of which \$374,600,000 is for basic field programs and required independent audits; \$4,000,000 is for the Office of Inspector General, of which such amounts as may be necessary may be used to conduct additional audits of recipients; \$17,000,000 is for management and grants oversight; \$3,400,000 is for client self-help and information technology; and \$1,000,000 is for loan repayment assistance: Provided, That the Legal Services Corporation may continue to provide locality pay to officers and employees at a rate no greater than that provided by the Federal Government to Washington, DC-based employees as authorized by 5 U.S.C. 5304, notwithstanding section 1005(d) of the Legal Services Corporation Act, 42 U.S.C. 2996(d).

ADMINISTRATIVE PROVISION—LEGAL SERVICES
CORPORATION

None of the funds appropriated in this Act to the Legal Services Corporation shall be expended for any purpose prohibited or limited by, or contrary to any of the provisions of, sections 501, 502, 503, 504, 505, and 506 of Public Law 105–119, and all funds appropriated in this Act to the Legal Services Corporation shall be subject to the same terms and conditions set forth in such sections, except that all references in sections 502 and 503 to 1997 and 1998 shall be deemed to refer instead to 2009 and 2010, respectively.

MARINE MAMMAL COMMISSION

SALARIES AND EXPENSES

For necessary expenses of the Marine Mammal Commission as authorized by title II of Public Law 92–522, \$3,250,000.

OFFICE OF THE UNITED STATES TRADE
REPRESENTATIVE

SALARIES AND EXPENSES

For necessary expenses of the Office of the United States Trade Representative, including the hire of passenger motor vehicles and the employment of experts and consultants as authorized by 5 U.S.C. 3109, \$48,326,000, of which \$1,000,000 shall remain available until expended: Provided, That not to exceed \$124,000 shall be available for official reception and representation expenses: Provided further, That negotiations shall be conducted within the World Trade Organization to recognize the right of members to distribute monies collected from antidumping and countervailing duties: Provided further, That negotiations shall be conducted within the World Trade Organization consistent with the negotiating objectives contained in the Trade Act of 2002, Public Law 107–210 to maintain strong U.S. remedies laws, correct the problem of

overreaching by World Trade Organization Panels and Appellate Body, and prevent the creation of obligation never negotiated or expressly agreed to by the United States.

STATE JUSTICE INSTITUTE

SALARIES AND EXPENSES

For necessary expenses of the State Justice Institute, as authorized by the State Justice Institute Authorization Act of 1984 (42 U.S.C. 10701 et. seq.) \$5,000,000, of which \$500,000 shall remain available until September 30, 2011: Provided, That not to exceed \$3,000 shall be available for official reception and representation expenses.

TITLE V

GENERAL PROVISIONS

SEC. 501. No part of any appropriation contained in this Act shall be used for publicity or propaganda purposes not authorized by the Congress.

SEC. 502. No part of any appropriation contained in this Act shall remain available for obligation beyond the current fiscal year unless expressly so provided herein.

SEC. 503. The expenditure of any appropriation under this Act for any consulting service through procurement contract, pursuant to 5 U.S.C. 3109, shall be limited to those contracts where such expenditures are a matter of public record and available for public inspection, except where otherwise provided under existing law, or under existing Executive order issued pursuant to existing law.

SEC. 504. If any provision of this Act or the application of such provision to any person or circumstances shall be held invalid, the remainder of the Act and the application of each provision to persons or circumstances other than those as to which it is held invalid shall not be affected thereby.

SEC. 505. (a) None of the funds provided under this Act, or provided under previous appropriations Acts to the agencies funded by this Act that remain available for obligation or expenditure in fiscal year 2009, or provided from any accounts in the Treasury of the United States derived by the collection of fees available to the agencies funded by this Act, shall be available for obligation or expenditure through the reprogramming of funds that:

(1) creates or initiates a new program, project or activity;

(2) eliminates a program, project or activity, unless the House and Senate Committees on Appropriations are notified 15 days in advance of such reprogramming of funds;

(3) increases funds or personnel by any means for any project or activity for which funds have been denied or restricted by this Act, unless the House and Senate Committees on Appropriations are notified 15 days in advance of such reprogramming of funds;

(4) relocates an office or employees, unless the House and Senate Committees on Appropriations are notified 15 days in advance of such reprogramming of funds;

(5) reorganizes or renames offices, programs or activities, unless the House and Senate Committees on Appropriations are notified 15 days in advance of such reprogramming of funds;

(6) contracts out or privatizes any functions or activities presently performed by Federal employees, unless the House and Senate Committees on Appropriations are notified 15 days in advance of such reprogramming of funds;

(7) proposes to use funds directed for a specific activity by either the House or Senate Committee on Appropriations for a different purpose, unless the House and Senate Committees on Appropriations are notified 15 days in advance of such reprogramming of funds;

(8) augments funds for existing programs, projects or activities in excess of \$500,000 or 10

percent, whichever is less, or reduces by 10 percent funding for any program, project or activity, or numbers of personnel by 10 percent as approved by Congress, unless the House and Senate Committees on Appropriations are notified 15 days in advance of such reprogramming of funds; or

(9) results from any general savings, including savings from a reduction in personnel, which would result in a change in existing programs, projects or activities as approved by Congress, unless the House and Senate Committees on Appropriations are notified 15 days in advance of such reprogramming of funds.

(b) None of the funds provided under this Act, or provided under previous appropriations Acts to the agencies funded by this Act that remain available for obligation or expenditure in fiscal year 2010, or provided from any accounts in the Treasury of the United States derived by the collection of fees available to the agencies funded by this Act, shall be available for obligation or expenditure through the reprogramming of funds after August 1, except in extraordinary circumstances, and only after the House and Senate Committees on Appropriations are notified 30 days in advance of such reprogramming of funds.

SEC. 506. Hereafter, none of the funds made available in this or any other Act may be used to implement, administer, or enforce any guidelines of the Equal Employment Opportunity Commission covering harassment based on religion, when it is made known to the Federal entity or official to which such funds are made available that such guidelines do not differ in any respect from the proposed guidelines published by the Commission on October 1, 1993 (58 Fed. Reg. 51266).

SEC. 507. If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a "Made in America" inscription, or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, the person shall be ineligible to receive any contract or subcontract made with funds made available in this Act, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

SEC. 508. The Departments of Commerce and Justice, the National Science Foundation, and the National Aeronautics and Space Administration, shall provide to the House and Senate Committees on Appropriations a quarterly accounting of the cumulative balances of any unobligated funds that were received by such agency during any previous fiscal year.

SEC. 509. Any costs incurred by a department or agency funded under this Act resulting from, or to prevent, personnel actions taken in response to funding reductions included in this Act shall be absorbed within the total budgetary resources available to such department or agency: Provided, That the authority to transfer funds between appropriations accounts as may be necessary to carry out this section is provided in addition to authorities included elsewhere in this Act: Provided further, That use of funds to carry out this section shall be treated as a reprogramming of funds under section 505 of this Act and shall not be available for obligation or expenditure except in compliance with the procedures set forth in that section.

SEC. 510. None of the funds provided by this Act shall be available to promote the sale or export of tobacco or tobacco products, or to seek the reduction or removal by any foreign country of restrictions on the marketing of tobacco or tobacco products, except for restrictions which are not applied equally to all tobacco or tobacco products of the same type.

SEC. 511. None of the funds appropriated pursuant to this Act or any other provision of law may be used for—

(1) the implementation of any tax or fee in connection with the implementation of subsection 922(t) of title 18, United States Code; and

(2) any system to implement subsection 922(t) of title 18, United States Code, that does not require and result in the destruction of any identifying information submitted by or on behalf of any person who has been determined not to be prohibited from possessing or receiving a firearm no more than 24 hours after the system advises a Federal firearms licensee that possession or receipt of a firearm by the prospective transferee would not violate subsection (g) or (n) of section 922 of title 18, United States Code, or State law.

SEC. 512. None of the funds made available in this Act may be used to pay the salaries and expenses of personnel of the Department of Justice to obligate more than \$705,000,000 during fiscal year 2010 from the fund established by section 1402 of chapter XIV of title II of Public Law 98-473 (42 U.S.C. 10601): Provided, That hereafter the availability of funds under section 1402(d)(3) to improve services shall be understood to mean availability for pay or salary, including benefits for the same.

SEC. 513. None of the funds made available to the Department of Justice in this Act may be used to discriminate against or denigrate the religious or moral beliefs of students who participate in programs for which financial assistance is provided from those funds, or of the parents or legal guardians of such students.

SEC. 514. None of the funds made available in this Act may be transferred to any department, agency, or instrumentality of the United States Government, except pursuant to a transfer made by, or transfer authority provided in, this Act or any other appropriations Act.

SEC. 515. Any funds provided in this Act used to implement E-Government Initiatives shall be subject to the procedures set forth in section 505 of this Act.

SEC. 516. (a) Tracing studies conducted by the Bureau of Alcohol, Tobacco, Firearms and Explosives are released without adequate disclaimers regarding the limitations of the data.

(b) The Bureau of Alcohol, Tobacco, Firearms and Explosives shall include in all such data releases, language similar to the following that would make clear that trace data cannot be used to draw broad conclusions about firearms-related crime:

(1) Firearm traces are designed to assist law enforcement authorities in conducting investigations by tracking the sale and possession of specific firearms. Law enforcement agencies may request firearms traces for any reason, and those reasons are not necessarily reported to the Federal Government. Not all firearms used in crime are traced and not all firearms traced are used in crime.

(2) Firearms selected for tracing are not chosen for purposes of determining which types, makes, or models of firearms are used for illicit purposes. The firearms selected do not constitute a random sample and should not be considered representative of the larger universe of all firearms used by criminals, or any subset of that universe. Firearms are normally traced to the first retail seller, and sources reported for firearms traced do not necessarily represent the sources or methods by which firearms in general are acquired for use in crime.

SEC. 517. (a) The Inspectors General of the Department of Commerce, the Department of Justice, the National Aeronautics and Space Administration, the National Science Foundation, and the Legal Services Corporation shall conduct audits, pursuant to the Inspector General Act (5 U.S.C. App.), of grants or contracts for which funds are appropriated by this Act, and

shall submit reports to Congress on the progress of such audits, which may include preliminary findings and a description of areas of particular interest, within 180 days after initiating such an audit and every 180 days thereafter until any such audit is completed.

(b) Within 60 days after the date on which an audit described in subsection (a) by an Inspector General is completed, the Secretary, Attorney General, Administrator, Director, or President, as appropriate, shall make the results of the audit available to the public on the Internet website maintained by the Department, Administration, Foundation, or Corporation, respectively. The results shall be made available in redacted form to exclude—

(1) any matter described in section 552(b) of title 5, United States Code; and

(2) sensitive personal information for any individual, the public access to which could be used to commit identity theft or for other inappropriate or unlawful purposes.

(c) A grant or contract funded by amounts appropriated by this Act may not be used for the purpose of defraying the costs of a banquet or conference that is not directly and programmatically related to the purpose for which the grant or contract was awarded, such as a banquet or conference held in connection with planning, training, assessment, review, or other routine purposes related to a project funded by the grant or contract.

(d) Any person awarded a grant or contract funded by amounts appropriated by this Act shall submit a statement to the Secretary of Commerce, the Attorney General, the Administrator, Director, or President, as appropriate, certifying that no funds derived from the grant or contract will be made available through a subcontract or in any other manner to another person who has a financial interest in the person awarded the grant or contract.

(e) The provisions of the preceding subsections of this section shall take effect 30 days after the date on which the Director of the Office of Management and Budget, in consultation with the Director of the Office of Government Ethics, determines that a uniform set of rules and requirements, substantially similar to the requirements in such subsections, consistently apply under the executive branch ethics program to all Federal departments, agencies, and entities.

SEC. 518. None of the funds appropriated or otherwise made available under this Act may be used to issue patents on claims directed to or encompassing a human organism.

SEC. 519. None of the funds made available in this Act shall be used in any way whatsoever to support or justify the use of torture by any official or contract employee of the United States Government.

SEC. 520. (a) Notwithstanding any other provision of law or treaty, none of the funds appropriated or otherwise made available under this Act or any other Act may be expended or obligated by a department, agency, or instrumentality of the United States to pay administrative expenses or to compensate an officer or employee of the United States in connection with requiring an export license for the export to Canada of components, parts, accessories or attachments for firearms listed in Category I, section 121.1 of title 22, Code of Federal Regulations (International Trafficking in Arms Regulations (ITAR), part 121, as it existed on April 1, 2005) with a total value not exceeding \$500 wholesale in any transaction, provided that the conditions of subsection (b) of this section are met by the exporting party for such articles.

(b) The foregoing exemption from obtaining an export license—

(1) does not exempt an exporter from filing any Shipper's Export Declaration or notification letter required by law, or from being otherwise

eligible under the laws of the United States to possess, ship, transport, or export the articles enumerated in subsection (a); and

(2) does not permit the export without a license of—

(A) fully automatic firearms and components and parts for such firearms, other than for end use by the Federal Government, or a Provincial or Municipal Government of Canada;

(B) barrels, cylinders, receivers (frames) or complete breech mechanisms for any firearm listed in Category I, other than for end use by the Federal Government, or a Provincial or Municipal Government of Canada; or

(C) articles for export from Canada to another foreign destination.

(c) In accordance with this section, the District Directors of Customs and postmasters shall permit the permanent or temporary export without a license of any unclassified articles specified in subsection (a) to Canada for end use in Canada or return to the United States, or temporary import of Canadian-origin items from Canada for end use in the United States or return to Canada for a Canadian citizen.

(d) The President may require export licenses under this section on a temporary basis if the President determines, upon publication first in the Federal Register, that the Government of Canada has implemented or maintained inadequate import controls for the articles specified in subsection (a), such that a significant diversion of such articles has and continues to take place for use in international terrorism or in the escalation of a conflict in another nation. The President shall terminate the requirements of a license when reasons for the temporary requirements have ceased.

SEC. 521. Notwithstanding any other provision of law, no department, agency, or instrumentality of the United States receiving appropriated funds under this Act or any other Act shall obligate or expend in any way such funds to pay administrative expenses or the compensation of any officer or employee of the United States to deny any application submitted pursuant to 22 U.S.C. 2778(b)(1)(B) and qualified pursuant to 27 CFR section 478.112 or .113, for a permit to import United States origin "curios or relics" firearms, parts, or ammunition.

SEC. 522. None of the funds made available in this Act may be used to include in any new bilateral or multilateral trade agreement the text of—

(1) paragraph 2 of article 16.7 of the United States-Singapore Free Trade Agreement;

(2) paragraph 4 of article 17.9 of the United States-Australia Free Trade Agreement; or

(3) paragraph 4 of article 15.9 of the United States-Morocco Free Trade Agreement.

SEC. 523. None of the funds made available in this Act may be used to authorize or issue a national security letter in contravention of any of the following laws authorizing the Federal Bureau of Investigation to issue national security letters: The Right to Financial Privacy Act; The Electronic Communications Privacy Act; The Fair Credit Reporting Act; The National Security Act of 1947; USA PATRIOT Act; and the laws amended by these Acts.

SEC. 524. If at any time during any quarter, the program manager of a project within the jurisdiction of the Departments of Commerce or Justice, the National Aeronautics and Space Administration, or the National Science Foundation totaling more than \$75,000,000 has reasonable cause to believe that the total program cost has increased by 10 percent, the program manager shall immediately inform the Secretary, Administrator, or Director. The Secretary, Administrator, or Director shall notify the House and Senate Committees on Appropriations within 30 days in writing of such increase, and shall include in such notice: the date on which such de-

termination was made; a statement of the reasons for such increases; the action taken and proposed to be taken to control future cost growth of the project; changes made in the performance or schedule milestones and the degree to which such changes have contributed to the increase in total program costs or procurement costs; new estimates of the total project or procurement costs; and a statement validating that the project's management structure is adequate to control total project or procurement costs.

SEC. 525. Funds appropriated by this Act, or made available by the transfer of funds in this Act, for intelligence or intelligence related activities are deemed to be specifically authorized by the Congress for purposes of section 504 of the National Security Act of 1947 (50 U.S.C. 414) during fiscal year 2010 until the enactment of the Intelligence Authorization Act for fiscal year 2010.

SEC. 526. The Departments, agencies, and commissions funded under this Act, shall establish and maintain on the homepages of their Internet websites—

(1) a direct link to the Internet websites of their Offices of Inspectors General; and

(2) a mechanism on the Offices of Inspectors General website by which individuals may anonymously report cases of waste, fraud, or abuse with respect to those Departments, agencies, and commissions.

SEC. 527. None of the funds appropriated or otherwise made available by this Act may be used to enter into a contract in an amount greater than \$5,000,000 or to award a grant in excess of such amount unless the prospective contractor or grantee certifies in writing to the agency awarding the contract or grant that, to the best of its knowledge and belief, the contractor or grantee has filed all Federal tax returns required during the three years preceding the certification, has not been convicted of a criminal offense under the Internal Revenue Code of 1986, and has not, more than 90 days prior to certification, been notified of any unpaid Federal tax assessment for which the liability remains unsatisfied, unless the assessment is the subject of an installment agreement or offer in compromise that has been approved by the Internal Revenue Service and is not in default, or the assessment is the subject of a non-frivolous administrative or judicial proceeding.

SEC. 528. None of the funds appropriated or otherwise made available in this Act may be used in a manner that is inconsistent with the principal negotiating objective of the United States with respect to trade remedy laws to preserve the ability of the United States—

(1) to enforce vigorously its trade laws, including antidumping, countervailing duty, and safeguard laws;

(2) to avoid agreements that—

(A) lessen the effectiveness of domestic and international disciplines on unfair trade, especially dumping and subsidies; or

(B) lessen the effectiveness of domestic and international safeguard provisions, in order to ensure that United States workers, agricultural producers, and firms can compete fully on fair terms and enjoy the benefits of reciprocal trade concessions; and

(3) to address and remedy market distortions that lead to dumping and subsidization, including overcapacity, cartelization, and market-access barriers.

SEC. 529. None of the funds made available in this Act may be used to purchase first class or premium airline travel in contravention of sections 301–10.122 through 301–10.124 of title 41 of the Code of Federal Regulations.

SEC. 530. None of the funds made available in this Act may be used to send or otherwise pay for the attendance of more than 50 employees from a Federal department or agency at any

single conference occurring outside the United States.

(RESCISSIONS)

SEC. 531. (a) Of the unobligated balances available to the Department of Justice from prior appropriations, the following funds are hereby rescinded, not later than September 30, 2010, from the following accounts in the specified amounts:

(1) "Legal Activities, Assets Forfeiture Fund", \$379,000,000, of which \$136,000,000 shall be permanently rescinded and returned to the general fund;

(2) "Office of Justice Programs", \$42,000,000; and

(3) "Community Oriented Policing Services", \$40,000,000.

(b) The Department of Justice shall, within 30 days of enactment of this Act, submit to the Committee on Appropriations of the House of Representatives and the Senate a report specifying the amount of each rescission made pursuant to this section.

(c) The rescissions contained in this section shall not apply to funds provided in this Act.

SEC. 532. Section 504(a) of the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act, 1996 (as contained in Public Law 104-134) is amended:

(1) in subsection (a), in the matter preceding paragraph (1), by inserting after "(1)" the following: "that uses Federal funds (or funds from any source with regard to paragraphs (14) and (15) in a manner";

(2) by striking subsection (d); and

(3) by redesignating subsections (e) and (f) as subsections (d) and (e), respectively.

SEC. 533. None of the funds made available under this Act may be distributed to the Association of Community Organizations for Reform Now (ACORN) or its subsidiaries.

REVIEW AND AUDIT OF ACORN FEDERAL FUNDING

SEC. 534. (a) REVIEW AND AUDIT.—The Comptroller General of the United States shall conduct a review and audit of Federal funds received by the Association of Community Organizations for Reform Now (referred to in this section as "ACORN") or any subsidiary or affiliate of ACORN to determine—

(1) whether any Federal funds were misused and, if so, the total amount of Federal funds involved and how such funds were misused;

(2) what steps, if any, have been taken to recover any Federal funds that were misused;

(3) what steps should be taken to prevent the misuse of any Federal funds; and

(4) whether all necessary steps have been taken to prevent the misuse of any Federal funds.

(b) REPORT.—Not later than 180 days after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the results of the audit required under subsection (a), along with recommendations for Federal agency reforms.

This Act may be cited as the "Commerce, Justice, Science, and Related Agencies Appropriations Act, 2010".

MOTION OFFERED BY MR. OBEY

The text of the motion is as follows:

MR. OBEY moves that the House concur in the Senate amendment to H.R. 2847 with the amendment printed in part B of House Report 111-380.

The SPEAKER pro tempore. The House amendment to the Senate amendment to the bill H.R. 2847 contains an emergency designation for purposes of pay-as-you-go principles.

Accordingly, the Chair must put the question of consideration under clause 10(c)(3) of rule XXI.

The question is, Will the House now consider the motion to concur in the Senate amendment with an amendment?

The question of consideration was decided in the affirmative.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore. Pursuant to House Resolution 976, the amendment printed in part B of House Report 111-380 and the motion shall be considered as read.

The text of the amendment is as follows:

House amendment to Senate amendment:

In lieu of the matter proposed to be inserted by the amendment of the Senate, insert the following:

That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the fiscal year ending September 30, 2010, and for other purposes, namely:

TITLE I—INFRASTRUCTURE AND JOBS INVESTMENT

CHAPTER 1—JUSTICE

DEPARTMENT OF JUSTICE

COMMUNITY ORIENTED POLICING SERVICES

(INCLUDING TRANSFER OF FUNDS)

For an additional amount for "Community Oriented Policing Services", for grants under section 1701 of title I of the 1968 Omnibus Crime Control and Safe Streets Act (42 U.S.C. 3796dd) for hiring and rehiring of additional career law enforcement officers under part Q of such title, notwithstanding subsection (i) of such section, \$1,179,000,000, of which \$2,950,000 shall be transferred to "State and Local Law Enforcement Activities, Salaries and Expenses" for management, administration and oversight of such grants.

CHAPTER 2—ENERGY AND WATER DEVELOPMENT

CORPS OF ENGINEERS—CIVIL WORKS

DEPARTMENT OF THE ARMY

CORPS OF ENGINEERS—CIVIL CONSTRUCTION

(INCLUDING TRANSFERS OF FUNDS)

For an additional amount for "Construction", \$715,000,000: Provided, That section 102 of Public Law 109-103 (33 U.S.C. 2221) shall not apply to funds provided in this title: Provided further, That not less than \$30,000,000 of the funds provided shall be for water-related environmental infrastructure assistance: Provided further, That up to \$30,000,000 of the funds provided under this heading may be transferred to "Mississippi Rivers and Tributaries" for authorized projects and activities: Provided further, That notwithstanding any other provision of law, funds provided under this heading shall not be cost shared with the Inland Waterways Trust Fund as authorized in Public Law 99-662: Provided further, That funds provided under this heading shall only be allocated to programs, projects or activities that heretofore received funds provided in Acts making appropriations available for Energy and Water Development and that are selected using only the following criteria in order of priority: programs, projects or activities that can be commenced quickly; programs, projects or activities that will create immediate employment; programs, projects or activities that will be executed by contract or direct hire of temporary labor; and programs, projects or activities that are located in a State with high unemployment: Provided further, That the limitation concerning total project costs in section 902 of the Water Resources Development Act of 1986 (33 U.S.C. 2280), shall not apply during fiscal years 2010 and 2011 for any

project receiving funds provided in this title: Provided further, That for projects that are being completed with funds appropriated in this paragraph that would otherwise be expired for obligation, expired funds appropriated in this paragraph may be used to pay the cost of associated supervision, inspection, overhead, engineering and design on those projects and on subsequent claims, if any: Provided further, That funds made available under this heading shall be apportioned by the Office of Management and Budget not later than 30 days after the date of enactment of this Act and allocated by the Secretary of the Army to specific programs, projects or activities not later than 45 days after the date of enactment of this Act: Provided further, That the Secretary of the Army shall submit a quarterly report to the Committees on Appropriations of the House of Representatives and the Senate detailing the allocation, obligation and expenditures of these funds, including an explanation of how each selected program, project or activity fulfills the funding criteria above, beginning not later than 45 days after the date of enactment of this Act: Provided further, That the Secretary shall have unlimited reprogramming authority for the funds provided under this heading: Provided further, That up to 0.5 percent of funds provided under this heading may be transferred to "Expenses" for the purposes of management and oversight of the programs, projects or activities funded by this paragraph.

DEPARTMENT OF THE INTERIOR

BUREAU OF RECLAMATION

WATER AND RELATED RESOURCES

(INCLUDING TRANSFERS OF FUNDS)

For an additional amount for "Water and Related Resources", \$100,000,000: Provided, That of the amount appropriated under this heading, not less than \$26,000,000 shall be used for water reclamation and reuse projects authorized under title XVI of Public Law 102-575: Provided further, That up to \$30,000,000 of the funds provided under this heading may be used for programs, projects, and activities authorized by Public Law 108-361 and up to \$10,000,000 of the funds provided under this heading may be transferred to the Department of the Interior for programs, projects, and activities authorized by titles II-V of Public Law 102-575: Provided further, That funds provided under this heading shall only be allocated to programs, projects or activities that heretofore received funds provided in Acts making appropriations available for Energy and Water Development: Provided further, That for projects that are being completed with funds appropriated in this paragraph that would otherwise be expired for obligation, expired funds appropriated in this paragraph may be used to pay the cost of associated supervision, inspection, overhead, engineering and design on those projects and on subsequent claims, if any: Provided further, That the Secretary of the Interior shall submit a quarterly report to the Committees on Appropriations of the House of Representatives and the Senate detailing the allocation, obligation and expenditures of these funds, beginning not later than 45 days after the date of enactment of this Act: Provided further, That the Secretary shall have unlimited reprogramming authority for the funds provided under this heading: Provided further, That up to 0.5 percent of funds appropriated under this heading may be transferred to "Policy and Administration" for the purposes of management and oversight of the programs, projects, or activities funded by this paragraph.

DEPARTMENT OF ENERGY
ENERGY PROGRAMS

TITLE 17 INNOVATIVE TECHNOLOGY LOAN
GUARANTEE PROGRAM

For an additional amount for “Title 17 Innovative Technology Loan Guarantee Program” for the cost of guaranteed loans authorized by section 1705 of the Energy Policy Act of 2005, \$2,000,000,000, available until expended: Provided, That the cost of such loans, including the cost of modifying such loans, shall be as defined in section 502 of the Congressional Budget Act of 1974.

GENERAL PROVISION, THIS CHAPTER

INCENTIVES FOR INNOVATIVE TECHNOLOGIES LOAN
GUARANTEE PROGRAM

SEC. 1201. (a) SPECIFIC APPROPRIATION OR CONTRIBUTION.—Section 1702 of the Energy Policy Act of 2005 (42 U.S.C. 16512) is amended—

(1) by striking subsection (b) and inserting the following:

“(b) SPECIFIC APPROPRIATION OR CONTRIBUTION.—

“(1) IN GENERAL.—No guarantee shall be made unless—

“(A) an appropriation for the cost has been made;

“(B) the Secretary has received from the borrower a payment in full for the cost of the obligation and deposited the payment into the Treasury; or

“(C) a combination of appropriations or payments from the borrower has been made sufficient to cover the cost of the obligation.

“(2) LIMITATION.—The source of payments received from a borrower under paragraph (1)(B) or (C) shall not be a loan or other debt obligation, that is made or guaranteed by the Federal Government.”; and

(2) by adding at the end the following:

“(k) CREDIT REPORT.—If, in the opinion of the Secretary, a third-party credit rating of the applicant or project is not relevant to the determination of the credit risk of a project, if the project costs are not projected to exceed \$100,000,000, and the applicant agrees to accept the credit rating assigned to the applicant by the Secretary, the Secretary may waive any otherwise applicable requirement (including any requirement described in part 609 of title 10, Code of Federal Regulations) to provide a third-party credit report.

“(l) DIRECT HIRE AUTHORITY.—

“(1) IN GENERAL.—Notwithstanding section 3304 and sections 3309 through 3318 of title 5, United States Code, the head of the loan guarantee program under this title (referred to in this subsection as the ‘Executive Director’) may, on a determination that there is a severe shortage of candidates or a severe hiring need for particular positions to carry out the functions of this title, recruit and directly appoint highly qualified critical personnel with specialized knowledge important to the function of the programs under this title into the competitive service.

“(2) EXCEPTION.—The authority granted under paragraph (1) shall not apply to positions in the excepted service or the Senior Executive Service.

“(3) REQUIREMENTS.—In exercising the authority granted under paragraph (1), the Executive Director shall ensure that any action taken by the Executive Director—

“(A) is consistent with the merit principles of section 2301 of title 5, United States Code; and

“(B) complies with the public notice requirements of section 3327 of title 5, United States Code.

“(4) SUNSET.—The authority provided under paragraph (1) shall terminate on January 1, 2011.

“(m) MULTIPLE SITES.—Notwithstanding any contrary requirement (including any provision

under part 609.12 of title 10, Code of Federal Regulations) an eligible project may be located on 2 or more non-contiguous sites in the United States.”.

(b) APPLICATIONS FOR MULTIPLE ELIGIBLE PROJECTS.—Section 1705 of the Energy Policy Act of 2005 (42 U.S.C. 16516) is amended—

(1) by redesignating subsection (e) as subsection (f); and

(2) by inserting after subsection (d) the following:

“(e) MULTIPLE APPLICATIONS.—Notwithstanding any contrary requirement (including any provision under part 609.3(a) of title 10, Code of Federal Regulations), a project applicant or sponsor of an eligible project may submit an application for more than 1 eligible project under this section.”.

(c) ENERGY EFFICIENCY LOAN GUARANTEES.—Section 1705(a) of the Energy Policy Act of 2005 (42 U.S.C. 16516(a)) is amended by adding at the end the following:

“(4) Energy efficiency projects, including projects to retrofit residential, commercial, and industrial buildings, facilities, and equipment.”.

CHAPTER 3—HOMELAND SECURITY

DEPARTMENT OF HOMELAND SECURITY

FEDERAL EMERGENCY MANAGEMENT AGENCY

FIREFIGHTER ASSISTANCE GRANTS

For an additional amount for “Firefighter Assistance Grants” for necessary expenses for programs authorized by section 34 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2229a), \$500,000,000: Provided, That notwithstanding any provision under section 34(a)(1)(A) such Act specifying that grants must be used to increase the number of firefighters in fire departments, the Secretary of Homeland Security, in making grants under section 34 of such Act for fiscal year 2010, shall grant waivers from the requirements of subsections (a)(1)(B), (c)(1), (c)(2), and (c)(4)(A) of such section: Provided further, That section 34(a)(1)(E) of such Act shall not apply with respect to funds appropriated in this or any other Act making appropriations for fiscal year 2010 for grants under section 34 of such Act: Provided further, That the Secretary of Homeland Security, in making grants under section 34 of such Act, shall ensure that funds appropriated under this or any other Act making appropriations for fiscal year 2010 are made available for the retention of firefighters and shall award grants not later than 120 days after the date of enactment of this Act: Provided further, That the Secretary may transfer any unused funds under this heading to make grants for programs authorized by section 33 of such Act (15 U.S.C. 2229) after notification to the Committees on Appropriations of the Senate and the House of Representatives.

CHAPTER 4—INTERIOR AND
ENVIRONMENT

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

MANAGEMENT OF LANDS AND RESOURCES

For an additional amount for “Management of Lands and Resources”, for activities on all Bureau of Land Management lands using term employment, \$20,000,000.

UNITED STATES FISH AND WILDLIFE SERVICE

RESOURCE MANAGEMENT

For an additional amount for “Resource Management”, for activities using term employment, \$30,000,000.

NATIONAL PARK SERVICE

OPERATION OF THE NATIONAL PARK SYSTEM

For an additional amount for “Operation of the National Park System”, for activities on all national park units using term employment, \$50,000,000.

DEPARTMENT-WIDE PROGRAMS

WILDLAND FIRE MANAGEMENT

For an additional amount for “Wildland Fire Management”, for hazardous fuels reduction and related activities including necessary inventory and monitoring, using term employment, \$20,000,000.

ENVIRONMENTAL PROTECTION AGENCY

STATE AND TRIBAL ASSISTANCE GRANTS

(INCLUDING TRANSFERS OF FUNDS)

For an additional amount for “State and Tribal Assistance Grants”, \$2,000,000,000, of which \$1,000,000,000 shall be for capitalization grants for the Clean Water State Revolving Funds under title VI of the Federal Water Pollution Control Act and \$1,000,000,000 shall be for capitalization grants under section 1452 of the Safe Drinking Water Act: Provided, That the Administrator may retain up to 1 percent of the funds appropriated herein for management and oversight purposes: Provided further, That funds appropriated herein shall not be subject to the matching or cost share requirements of sections 602(b)(2), 602(b)(3) or 202 of the Federal Water Pollution Control Act nor the matching requirements of section 1452(e) of the Safe Drinking Water Act: Provided further, That the Administrator shall reallocate funds appropriated herein for the Clean and Drinking Water State Revolving Funds (Revolving Funds) where projects are not under contract or construction within 8 months of the date of enactment of this Act: Provided further, That notwithstanding the priority rankings they would otherwise receive under each program, priority for funds appropriated herein shall be given to projects on a State priority list that are ready to proceed to construction within 12 months of the date of enactment of this Act: Provided further, That notwithstanding the requirements of section 603(d) of the Federal Water Pollution Control Act or section 1452(f) of the Safe Drinking Water Act, for the funds appropriated herein, each State shall use not less than 50 percent of the amount of its capitalization grants to provide additional subsidization to eligible recipients in the form of forgiveness of principal, negative interest loans or grants or any combination of these: Provided further, That, to the extent there are sufficient eligible project applications, not less than 20 percent of the funds appropriated herein for the Revolving Funds shall be for projects to address green infrastructure, water or energy efficiency improvements or other environmentally innovative activities: Provided further, That notwithstanding the limitation on amounts specified in section 518(c) of the Federal Water Pollution Control Act, up to 2.0 percent of the funds appropriated herein for the Clean Water State Revolving Funds may be reserved by the Administrator for tribal grants under section 518(c) of such Act: Provided further, That up to 4 percent of the funds appropriated herein for tribal set-asides under the Revolving Funds may be transferred to the Indian Health Service to support management and oversight of tribal projects: Provided further, That none of the funds appropriated herein shall be available for the purchase of land or easements as authorized by section 603(c) of the Federal Water Pollution Control Act or for activities authorized by section 1452(k) of the Safe Drinking Water Act: Provided further, That notwithstanding section 603(d)(2) of the Federal Water Pollution Control Act and section 1452(f)(2) of the Safe Drinking Water Act, funds may be used to buy, refinance, or restructure the debt obligations of eligible recipients only where such debt was incurred on or after October 1, 2009: Provided further, That section 1606 of title XVI of Public Law 111-5 shall apply to the use of the funds provided under this heading.

DEPARTMENT OF AGRICULTURE
FOREST SERVICE

STATE AND PRIVATE FORESTRY

For an additional amount for "State and Private Forestry for financial assistance to States and territories for authorized activities using term employment, \$75,000,000.

NATIONAL FOREST SYSTEM

For an additional amount for "National Forest System", for activities on the National Forest System using term employment, \$40,000,000.

WILDLAND FIRE MANAGEMENT

For an additional amount for "Wildland Fire Management", for hazardous fuels reduction and related activities using term employment, \$35,000,000.

GENERAL PROVISIONS, THIS CHAPTER

(INCLUDING TRANSFER OF FUNDS)

SEC. 1401. Funds made available to the Environmental Protection Agency by this Act for management and oversight purposes shall remain available until September 30, 2012, and may be transferred to the "Environmental Programs and Management" account as needed.

SEC. 1402. In carrying out the work for which funds in this title are being made available, the Secretary of the Interior and the Secretary of Agriculture shall utilize, to the maximum extent practicable, the Public Lands Corps, Youth Conservation Corps, Student Conservation Association, Job Corps, Corps Network members, and other related partnerships with Federal, State, local, tribal or non-profit groups that serve young adults, underserved and minority populations, veterans, and special needs individuals.

CHAPTER 5—LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES

DEPARTMENT OF LABOR

EMPLOYMENT AND TRAINING ADMINISTRATION

TRAINING AND EMPLOYMENT SERVICES

For an additional amount for "Training and Employment Services" for activities under the Workforce Investment Act of 1998 ("WIA"), \$1,250,000,000, which shall be available for obligation on the date of enactment of this Act, as follows:

(1) \$500,000,000 for grants to the States for youth activities: Provided, That such funds shall be used solely for summer employment programs for youth: Provided further, That no portion of such funds shall be reserved to carry out section 127(b)(1)(A) of the WIA: Provided further, That for purposes of section 127(b)(1)(C)(iv) of the WIA, funds available for youth activities shall be allotted as if the total amount available for youth activities in the fiscal year does not exceed \$1,000,000,000: Provided further, That the work readiness performance indicator described in section 136(b)(2)(A)(ii)(I) of the WIA shall be the only measure of performance used to assess the effectiveness of summer employment for youth provided with such funds: Provided further, That an in-school youth shall meet the requirement that eligible youth be a low-income individual under section, 101(13)(B) of the WIA if such youth has been determined to meet the eligibility requirements for free meals under the National School Lunch Act (42 U.S.C. 1751 et seq.) during the most recent school year; and

(2) \$750,000,000 for a program of competitive grants for worker training and placement in high growth and emerging industry sectors: Provided, That \$275,000,000 shall be for job training projects that prepare workers for careers in energy efficiency and renewable energy as described in section 171(e)(1)(B) of the WIA, of which \$225,000,000 shall be for Pathways Out of Poverty projects: Provided further, That awarding grants from those funds not dedicated in the

preceding proviso, the Secretary of Labor shall give priority to projects that prepare workers for careers in the health care sector.

DEPARTMENT OF EDUCATION

EDUCATION JOBS FUND

For necessary expenses for an Education Jobs Fund, \$23,000,000,000, which shall remain available for obligation through September 30, 2010 and shall be administered under the terms and conditions of sections 14001 through 14013 of title XIV, and title XV, of division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), except as follows:

(1) ALLOTMENTS TO STATES AND TERRITORIES.—Such funds shall be available only for allocations by the Secretary under subsections (a) and (d) of section 14001.

(2) RESERVATION.—With respect to funds appropriated under this heading, a State that receives an allocation may reserve not more than 5 percent, for—

(A) the administrative costs of carrying out its responsibilities with respect to those funds, provided the State reserves not more than 1 percent of its total allocation for those costs; and

(B) retaining or creating positions in the State educational agency or the State agency for higher education, and other State agency positions related to the administration or support of early childhood, elementary, secondary or postsecondary education.

(3) AWARDS TO LOCAL EDUCATIONAL AGENCIES AND PUBLIC INSTITUTIONS OF HIGHER EDUCATION.—

(A) Except as specified under paragraph (2), allocation of such funds to a State under section 14001(d) shall be used only for awards to local educational agencies and public institutions of higher education for the support of elementary, secondary, and postsecondary education. The Governor shall determine how the funds appropriated under this heading are allocated for elementary and secondary education and for public institutions of higher education. In making the determination in the preceding sentence, the Governor shall allocate funds among the categories of elementary and secondary education and public institutions of higher education generally in proportion to any reductions in State funds for such categories.

(B) Funds used to support elementary and secondary education, shall be distributed through the State's primary elementary and secondary funding formulae.

(C) Section 14002(a) and (b) shall not apply.

(4) INAPPLICABILITY OF EDUCATION REFORM ASSURANCES.—Subsection (b)(2), and paragraphs (1) through (5) of subsection (d), of section 14005 shall not apply to any application for an allocation of such funds.

(5) REQUIREMENT TO USE FUNDS TO RETAIN OR CREATE EDUCATION JOBS.—Notwithstanding sections 14003(a) and 14004(a), such funds may be used only for compensation and benefits and other expenses, such as support services, necessary to retain existing employees, for activities defined in section 101(31) of the Workforce Investment Act of 1998, and to hire new employees in order to provide early childhood, elementary, secondary, or postsecondary educational and related services or for modernization, renovation, and repair of public school facilities and facilities of institutions of higher education.

(6) PROHIBITION ON USE OF FUNDS FOR RAINY-DAY FUNDS OR DEBT RETIREMENT.—A State that receives an allocation may not use such funds, directly or indirectly, to establish, restore, or supplement a rainy-day fund, or to supplant State funds in a manner that has the effect of establishing, restoring, or supplementing a rainy-day fund; or to reduce or retire debt obligations incurred by the State, or to supplant State funds in a manner that has the effect of reducing or retiring debt obligations incurred by

the State, provided that this prohibition shall not apply to fund balances that are necessary to comply with any State requirement to maintain a balanced budget.

(7) APPLICATION CONSIDERATIONS.—If, by a date set by the Secretary, a Governor has not submitted an approvable application under section 14005(a), the Secretary may provide for the distribution of funds allocated under section 14001(d) to another entity or other entities in the State, under such terms and conditions as the Secretary may establish, provided that all terms and conditions that apply to the appropriation under this heading shall apply to such funds distributed to such entity or entities.

(8) LOCAL EDUCATIONAL AGENCY APPLICATION.—Section 442 of the General Education Provisions Act does not apply to a local educational agency that has previously submitted an application to the State under title XIV of division A of the American Recovery and Reinvestment Act of 2009. The assurances provided under that application shall continue to apply to funds awarded under this heading.

(9) MAINTENANCE OF EFFORT.—The Secretary shall not allocate funds to a State under paragraph (1) unless the Governor of the State provides an assurance to the Secretary that the State will—

(A) for fiscal year 2010—

(i) maintain State support for elementary, secondary, and public higher education (not including support for capital projects or research and development or tuition and fees paid by students), in the aggregate, at the level of such support for fiscal year 2009; or

(ii) maintain State support for elementary, secondary, and public higher education (not including support for capital projects or research and development or tuition and fees paid by students), in the aggregate, at a level no less than such support for fiscal year 2006, provided that if a State has enacted a reduction to such aggregate level of fiscal year 2010 State support for elementary, secondary, and public higher education after December 12, 2009, the State shall maintain State support for elementary, secondary, and public higher education at a percentage of the total revenues available to the State that is equal to or greater than the percentage provided for such purpose for fiscal year 2010 prior to December 12, 2009; and

(B) for fiscal year 2011—

(i) comply with subparagraph (A)(i); or

(ii) maintain State support, for elementary, secondary, and public higher education (not including support, for capital projects or research and development or tuition and fees paid by students), in the aggregate, at a percentage of the total revenues available to the State that is equal to or greater than the percentage provided for such purpose for fiscal year 2010.

STUDENT FINANCIAL ASSISTANCE

For an additional amount for "Student Financial Assistance" to carry out part C of title IV of the Higher Education Act of 1965, \$300,000,000, which, shall remain available through September 30, 2011.

RELATED AGENCIES

CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

OPERATING EXPENSES

(INCLUDING TRANSFER OF FUNDS)

For an additional amount for "Operating Expenses" to carry out the Domestic Volunteer Service Act of 1973 ("1973 Act") and the National and Community Service Act of 1990 ("1990 Act"), \$132,000,000, which shall remain available through September 30, 2011: Provided, That not less than \$90,000,000 of the funds made available in this paragraph shall be used to make additional awards to existing AmeriCorps grantees and may be used to provide adjustments to

awards under subtitle C of title I of the 1990 Act made prior to September 30, 2011 for which the Chief Executive Officer of the Corporation for National and Community Service ("CEO") determines that a waiver of the Federal share limitation is warranted under section 2521.70 of title 45 of the Code of Federal Regulations: Provided further, That up to \$30,000,000 shall be for programs under title I, part A of the 1973 Act: Provided further, That any funds provided in the previous proviso shall not be made available in connection with cost-share agreements authorized under section 192A(g)(10) of the 1990 Act: Provided further, That of the amount made available in this paragraph, not less than \$7,000,000 shall be transferred to "Salaries and Expenses" to administer the funds provided in this paragraph, including making any necessary information technology upgrades: Provided further, That the CEO shall provide to the Committees on Appropriations of the house of Representatives and the Senate a fiscal year 2010 operating plan for the funds appropriated in this paragraph prior to making any Federal obligations of such funds in fiscal year 2010, but not later than 90 days after the date of enactment of this Act, and a fiscal year 2011 operating plan for such funds in fiscal year 2011, but not later than November 1, 2010, that detail the allocation of resources and the increased number of members supported by the AmeriCorps programs: Provided further, That the CEO shall provide to the Committees on Appropriations of the House of Representatives and the Senate a report on the actual obligations, expenditures, and unobligated balances for each activity funded under this heading not later than 90 days after issuance of the operating plan, and quarterly thereafter as long as funding provided under this heading is available for obligation or expenditure.

**NATIONAL SERVICE TRUST
(INCLUDING TRANSFER OF FUNDS)**

For an additional amount for "National Service Trust" established under subtitle D of title I of the National and Community Service Act of 1990 ("1990 Act"), \$68,000,000, which shall remain available until expended: Provided, That the Corporation for National and Community Service may transfer additional funds from the amount provided within "Operating Expenses" allocated to grants under subtitle C of title I of the 1990 Act to the National Service Trust upon determination that such transfer is necessary to support the activities of national service participants and after notice is transmitted to the Committees on Appropriations of the House of Representatives and the Senate: Provided further, That the amount appropriated or transferred to the National Service Trust may be invested under section 145(b) of the 1990 Act without regard to the requirements to apportion funds under 31 U.S.C. 1513(b).

GENERAL PROVISION, THIS CHAPTER

**ISSUER ALLOWED REFUNDABLE CREDIT FOR
QUALIFIED ZONE ACADEMY BONDS AND QUALIFIED
SCHOOL CONSTRUCTION BONDS**

SEC. 1501. (a) IN GENERAL.—Section 6431 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(f) APPLICATION OF SECTION TO QUALIFIED ZONE ACADEMY BONDS AND QUALIFIED SCHOOL CONSTRUCTION BONDS—

"(1) IN GENERAL.—In the case of any specified tax credit bond—

"(A) such bond shall be treated as a qualified bond for purposes of this section,

"(B) subsection (a) shall be applied without regard to the requirement that the qualified bond be issued before January 1, 2011,

"(C) the amount of the payment determined under subsection (b) with respect to any interest

payment date under such bond shall be equal to the lesser of—

"(i) the amount of interest payable under such bond on such date, or

"(ii) the amount of interest which would have been payable under such bond on such date if such interest were determined at the applicable credit rate determined under section 54A(b)(3) with respect to such bond,

"(D) interest on any such bond shall be includible in gross income for purposes of this title, and

"(E) no credit shall be allowed under section 54A with respect to such bond.

"(2) SPECIFIED TAX CREDIT BOND.—For purposes of nets of this subsection, the term 'specified tax credit bond' means any qualified tax credit bond (as defined in section 54A(d)) if—

"(A) such bond is a qualified zone academy bond (as defined in section 54E) or a qualified school construction bond (as defined in section 54F), and

"(B) the issuer of such bond makes an irrevocable election to have this subsection apply."

**(b) TECHNICAL CORRECTIONS RELATING TO
QUALIFIED SCHOOL CONSTRUCTION BONDS.—**

(1) The second sentence of section 54F(d)(1) of such Code is amended by striking "by the State" and inserting "by the State education agency (or such other agency as is authorized under State law to make such allocation)".

(2) The second sentence of section 54F(e) of such Code is amended by striking "subsection (d)(4)" and inserting "paragraphs (2) and (4) of subsection (d)".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendment made by this section shall apply to bonds issued after December 31, 2009.

(2) TECHNICAL CORRECTIONS.—The amendments made by subsection (b) shall take effect as if included in section 1521 of the American Recovery and Reinvestment Tax Act of 2009.

**CHAPTER 6—TRANSPORTATION AND
HOUSING AND URBAN DEVELOPMENT
DEPARTMENT OF TRANSPORTATION**

FEDERAL AVIATION ADMINISTRATION

GRANTS-IN-AID FOR AIRPORTS

For an additional amount for "Grants-In-Aid for Airports", to enable the Secretary of Transportation to make grants for discretionary projects as authorized by subchapter 1 of chapter 471 and subchapter 1 of chapter 475 of title 49, United States Code, \$500,000,000: Provided, That such funds shall not be subject to apportionment formulas, special apportionment categories, or minimum percentages under chapter 471 of such title: Provided further, That the Secretary shall distribute funds provided under this heading as discretionary grants to airports using the criteria established under chapters 471 and 475 of such title, but with priority given to those projects that demonstrate to his satisfaction their ability to be completed within 2 years of enactment of this Act: Provided further, That the Secretary shall award grants under this heading within 120 days of enactment of this Act: Provided further, That the amount made available under this heading shall not be subject to any limitation on obligations for the Grants-in-Aid for Airports program set forth in any Act: Provided further, That the Federal share payable of the costs for which a grant is made under this heading shall be, at the option of the recipient, up to 100 percent: Provided further, That the amounts provided under this heading may be used for expenses the agency incurs in administering this program in addition to amounts provided for administrative expenses for the Grants-in-Aid Airport Improvement Program from any other Act.

FEDERAL HIGHWAY ADMINISTRATION

HIGHWAY INFRASTRUCTURE INVESTMENT

For an additional amount for "Highway Infrastructure Investment" for restoration, repair, construction and other activities eligible under paragraph (b) of section 133 of title 23, United States Code, and for passenger and freight rail transportation and port infrastructure projects eligible for assistance under subsection 601(a)(8) of such title, \$27,500,000,000 to remain available through September 30, 2011: Provided, That, after making the set-asides required under this heading, 50 percent of the funds made available under this heading shall be apportioned to States using the formula set forth in section 104(b)(3) of title 23, United States Code, and the remaining funds shall be apportioned to States in the same ratio as the obligation limitation for fiscal year 2008 was distributed among the States in accordance with the formula specified in section 120(a)(6) of division K of Public Law 110-161: Provided further, That funds made available under this heading shall be apportioned not later than 21 days after the date of enactment of this Act: Provided further, That in selecting projects to be carried out with funds apportioned under this heading, priority shall be given to projects that are projected for completion within a 3-year time frame, and are located in economically distressed areas as defined by section 301 of the Public Works and Economic Development Act of 1965, as amended (42 U.S.C. 3161): Provided further, That in selecting projects to be carried out with funds apportioned under this heading, States shall ensure an equitable geographic distribution of funds and an appropriate balance in addressing the needs of urban and rural communities in the State: Provided further, That 90 days following the date of such apportionment, the Secretary of Transportation shall withdraw from each State an amount equal to 50 percent of the funds awarded to that State less the amount of funding under contract, as determined by the Secretary, and the Secretary shall redistribute such amounts to other States that have had no funds withdrawn under this proviso in the manner described in section 120(c) of division K of Public Law 110-161: Provided further, That 1 year following the date of such apportionment, the Secretary shall withdraw from each recipient of funds apportioned under this heading any funds that are not under contract, as determined by the Secretary, and the Secretary shall redistribute such amounts to States that have had no funds withdrawn under this proviso in the manner described in section 120(c) of division K of Public Law 110-161: Provided further, That at the request of a State, the Secretary of Transportation may provide an extension of such 1-year period only to the extent that he feels satisfied that the State has encountered extreme conditions that create an unworkable bidding environment or other extenuating circumstances: Provided further, That before granting such an extension, the Secretary shall send a letter to the House and Senate Committees on Appropriations that provides a thorough justification for the extension: Provided further, That 3 percent of the funds apportioned to a State under this heading shall be set aside for the purposes described in subsection 133(d)(2) of title 23, United States Code (without regard to the comparison to fiscal year 2005): Provided further, That 30 percent of the funds apportioned to a State under this heading shall be suballocated within the State in the manner and for the purposes described in the first sentence of subsection 133(d)(3)(A), in subsection 133(d)(3)(B), and in subsection 133(d)(3)(D): Provided further, That such suballocation shall be conducted in every State: Provided further, That of the funds provided under this heading,

\$105,000,000 shall be for the Puerto Rico highway program authorized under section 165 of title 23, United States Code, and \$45,000,000 shall be for the territorial highway program authorized under section 215 of title 23, United States Code: Provided further, That of the funds provided under this heading, \$60,000,000 shall be for capital expenditures eligible under section 147 of title 23, United States Code (without regard to subsection (d)): Provided further, That the Secretary of Transportation shall distribute such \$60,000,000 as competitive discretionary grants to States, with priority given to those projects that demonstrate to his satisfaction their ability to be completed within 2 years of enactment of this Act: Provided further, That of the funds provided under this heading, \$550,000,000 shall be for investments in transportation at Indian reservations and Federal lands: Provided further, That of the funds identified in the preceding proviso, \$310,000,000 shall be for the Indian Reservation Roads program, \$170,000,000 shall be for the Park Roads and Parkways program, \$60,000,000 shall be for the Forest Highway Program, and \$10,000,000 shall be for the Refuge Roads program: Provided further, That for investments at Indian reservations and Federal lands, priority shall be given to capital investments, and to projects and activities that can be completed within 2 years of enactment of this Act: Provided further, That 1 year following the enactment of this Act, to ensure the prompt use of the \$550,000,000 provided for investments at Indian reservations and Federal lands, the Secretary shall have the authority to redistribute unobligated funds within the respective program for which the funds were appropriated: Provided further, That up to 4 percent of the funding provided for Indian Reservation Roads may be used by the Secretary of the Interior for program management and oversight and project-related administrative expenses: Provided further, That section 134(f)(3)(C)(ii)(I) of title 23, United States Code, shall not apply to funds provided under this heading: Provided further, That of the funds made available under this heading, \$20,000,000 shall be for highway surface transportation and technology training under section 140(b) of title 23, United States Code, and \$20,000,000 shall be for disadvantaged business enterprises bonding assistance under section 332(e) of title 49, United States Code: Provided further, That funds made available under this heading shall be administered as if apportioned under chapter 1 of title 23, United States Code, except for funds made available for investments in transportation at Indian reservations and Federal lands, and for the territorial highway program, which shall be administered in accordance with chapter 2 of title 23, United States Code, and except for funds made available for disadvantaged business enterprises bonding assistance, which shall be administered in accordance with chapter 3 of title 49, United States Code: Provided further, That the Federal share payable on account of any project or activity carried out with funds made available under this heading shall be, at the option of the recipient, up to 100 percent of the total cost thereof: Provided further, That funds made available by this paragraph shall not be obligated for the purposes authorized under section 115(b) of title 23, United States Code: Provided further, That funding provided under this heading shall be in addition to any and all funds provided for fiscal years 2010 and 2011 in any other Act for "Federal-aid Highways" and shall not affect the distribution of funds provided for "Federal-aid Highways" in any other Act: Provided further, That the amount made available under this heading shall not be subject to any limitation on obligations for Federal-aid highways or highway safety construction programs set forth in any Act: Pro-

vided further, That section 1101(b) of Public Law 109-59 shall apply to funds apportioned under this heading: Provided further, That the Administrator of the Federal Highway Administration may retain up to \$45,000,000 of the funds provided under this heading to fund the oversight by the Administrator of projects and activities carried out with funds made available to the Federal Highway Administration in this Act, of which \$5,000,000 shall be for the Office of Expedited Project Delivery in the Office of the Administrator of the Federal Highway Administration, and such funds shall be available through September 30, 2013.

FEDERAL RAILROAD ADMINISTRATION

CAPITAL GRANTS TO THE NATIONAL RAILROAD PASSENGER CORPORATION

For an additional amount for "Capital Grants to the National Railroad Passenger Corporation" to enable the Secretary of Transportation to make capital grants to The National Railroad Passenger Corporation (Amtrak) as authorized by section 101(c) of the Passenger Rail Investment and Improvement Act of 2008 (Public Law 110-432), \$800,000,000, for fleet modernization, including rehabilitation of existing and acquisition of new passenger equipment, including fuel efficient locomotives: Provided, That none of the funds provided under this heading shall be used to subsidize the operating losses of Amtrak: Provided further, That section 24305(f)(4)(B) of title 49, United States Code, shall not apply to any new equipment acquired with funds provided under this heading: Provided further, That funds provided under this heading shall be awarded not later than 60 days after the date of enactment of this Act.

FEDERAL TRANSIT ADMINISTRATION

TRANSIT CAPITAL ASSISTANCE

For an additional amount for "Transit Capital Assistance" for transit capital assistance grants authorized under section 5302(a)(1) of title 49, United States Code, \$6,150,000,000: Provided, That the Secretary of Transportation shall provide 80 percent of the funds appropriated under this heading for grants under section 5307 of title 49, United States Code, and apportion such funds in accordance with section 5336 of such title (other than subsections (i)(I) and (j)): Provided further, That the Secretary shall apportion 10 percent of the funds appropriated under this heading in accordance with section 5340 of such title: Provided further, That the Secretary shall provide 10 percent of the funds appropriated under this heading for grants under section 5311 of title 49, United States Code, and apportion such funds in accordance with such section: Provided further, That funds apportioned under this heading shall be apportioned not later than 21 days after the date of enactment of this Act: Provided further, That 90 days following the date of such apportionment, the Secretary shall withdraw from each urbanized area or State an amount equal to 50 percent of the funds apportioned to such urbanized areas or States less the amount of funding under contract, as determined by the Secretary, and the Secretary shall redistribute such amounts to other urbanized areas or States that have had no funds withdrawn under this proviso utilizing whatever method he deems appropriate to ensure that all funds redistributed under this proviso shall be

utilized promptly: Provided further, That at the request of an urbanized area or State, the Secretary of Transportation may provide an extension of such 1-year period if he feels satisfied that the urbanized area or State has encountered an unworkable bidding environment or other extenuating circumstances: Provided further, That before granting such an extension, the Secretary shall send a letter to the House and Senate Committees on Appropriations that provides a thorough justification for the extension: Provided further, That of the funds provided for section 5311 of title 49, United States Code, 2.5 percent shall be made available for section 5311(c)(1): Provided further, That of the funding provided under this heading, \$100,000,000 shall be distributed as discretionary grants to public transit agencies for capital investments that will assist in reducing the energy consumption or greenhouse gas emissions of their public transportation systems: Provided further, That for such grants on energy-related investments, priority shall be given to projects based on the total energy savings that are projected to result from the investment, and projected energy savings as a percentage of the total energy usage of the public transit agency: Provided further, That applicable chapter 53 requirements shall apply to funding provided under this heading, except that the Federal share of the costs for which any grant is made under this heading shall be, at the option of the recipient, up to 100 percent: Provided further, That the amount made available under this heading shall not be subject to any limitation on obligations for transit programs set forth in any Act: Provided further, That section 1101(b) of Public Law 109-59 shall apply to funds appropriated under this heading: Provided further, That the funds appropriated under this heading shall not be commingled with any prior year funds: Provided further, That a recipient and subrecipient of funds made available under this heading may use up to 10 percent of the amount apportioned to a State or urbanized area for the operating costs of equipment and facilities for use in public transportation or for eligible activities under section 5311(f): Provided further, That in selecting projects to be carried out with funds apportioned under this heading, priority shall be given to projects that are located in economically distressed areas as defined by section 301 of the Public Works and Economic Development Act of 1965, as amended (42 U.S.C. 3161): Provided further, That in selecting projects to be carried out with funds apportioned under this heading, States shall ensure an equitable geographic distribution of funds and an appropriate balance in addressing the needs of urban and rural communities in the State: Provided further, That notwithstanding any other provision of law, three-quarters of 1 percent of the funds provided for grants under section 5307 and section 5340, and one-half of 1 percent of the funds provided for grants under section 5311, shall be available for administrative expenses and program management oversight, and such funds shall be available through September 30, 2013.

FIXED GUIDEWAY INFRASTRUCTURE INVESTMENT

For an amount for capital expenditures authorized under section 5309(b)(2) of title 49, United States Code, \$1,750,000,000: Provided, That the Secretary of Transportation shall apportion funds under this heading pursuant to the formula set forth in section 5337 of title 49, United States Code: Provided further, That the funds appropriated under this heading shall not be commingled with any prior year funds: Provided further, That funds made available under this heading shall be apportioned not later than 21 days after the date of enactment of this Act: Provided further, That 90 days following the date of such apportionment, the Secretary shall

withdraw from each urbanized area an amount equal to 50 percent of the funds apportioned to such urbanized area less the amount of funding under contract, as determined by the Secretary, and the Secretary shall redistribute such amounts to other urbanized areas that have had no funds withdrawn under this proviso utilizing whatever method he deems appropriate to ensure that all funds redistributed under this proviso shall be utilized promptly: Provided further, That 1 year following the date of such apportionment, the Secretary shall withdraw from each urbanized area any funds that are not under contract, as determined by the Secretary, and the Secretary shall redistribute such amounts to other urbanized areas that have had no funds withdrawn under this proviso utilizing whatever method he deems appropriate to ensure that all funds redistributed under this proviso shall be utilized promptly: Provided further, That at the request of an urbanized area, the Secretary of Transportation may provide an extension of such 1-year period if he feels satisfied that the urbanized area has encountered an unworkable bidding environment or other extenuating circumstances: Provided further, That before granting such an extension, the Secretary shall send a letter to the House and Senate Committees on Appropriations that provides a thorough justification for the extension: Provided further, That applicable chapter 53 requirements shall apply except that the Federal share of the costs for which a grant is made under this heading shall be, at the option of the recipient, up to 100 percent: Provided further, That the provisions of section 1101(b) of Public Law 109-59 shall apply to funds made available under this heading: Provided further, That notwithstanding any other provision of law, up to 1 percent of the funds under this heading shall be available for administrative expenses and program management oversight and shall remain available for obligation until September 30, 2013.

CAPITAL INVESTMENT GRANTS

For an additional amount for "Capital Investment Grants", as authorized under section 5338(c)(4) of title 49, United States Code, and allocated under section 5309(m)(2)(A) of such title, to enable the Secretary of Transportation to make discretionary grants as authorized by section 5309(d) and (e) of such title, \$500,000,000, of which \$1,500,000 shall be for the Office of Expedited Project Delivery in the Office of the Administrator of the Federal Transit Administration: Provided, That such amount shall be allocated without regard to the limitation under section 5309(m)(2)(A)(i): Provided further, That in selecting projects to be funded, priority shall be given to projects that are able to award contracts within 90 days of enactment of this Act: Provided further, That the provisions of section 1101(b) of Public Law 109-59 shall apply to funds made available under this heading: Provided further, That funds appropriated under this heading shall not be commingled with any prior year funds: Provided further, That applicable chapter 53 requirements shall apply, except that notwithstanding any other provision of law, up to 1 percent of the funds provided under this heading shall be available for administrative expenses and program management oversight, and shall remain available through September 30, 2013: Provided further, That, notwithstanding any other provision of law, the provisions of section 3011(f) of Public Law 109-59 shall apply to all projects evaluated under sections 5309(d) and 5309(e) of title 49, United States Code, and funded in fiscal years 2010 and 2011 with funds made available in the Act or any other Act.

MARITIME ADMINISTRATION

MARITIME GUARANTEED LOAN (TITLE XI) PROGRAM ACCOUNT

(INCLUDING TRANSFER OF FUNDS)

For the cost of guaranteed loans, as authorized, \$100,000,000: Provided, That such costs, including the cost of modifying such loans, shall be as defined in section 502 of the Congressional Budget Act of 1974, as amended: Provided further, That the Maritime Administrator may retain, and transfer to "Maritime Administration, Operations and Training" up to 2 percent of the funds provided under this heading to carry out the guaranteed loan program.

GENERAL PROVISION, DEPARTMENT OF TRANSPORTATION

SEC. 1601. (a) MAINTENANCE OF EFFORT.—

(1) CERTIFICATION.—

(A) CERTIFICATION THROUGH SEPTEMBER 30, 2010.—The certification made by the Governor of each State under section 1201(a) of division A of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5, 123 Stat. 115, 212) shall continue in effect under this Act.

(B) CERTIFICATION THROUGH SEPTEMBER 30, 2011.—Not later than 30 days after the date enactment of this Act, for each amount that is distributed to a State or agency thereof from an appropriation in this Act for a covered program, the Governor of the State shall certify to the Secretary of Transportation that the State will maintain its effort with regard to State funding for the types of projects that are funded by the appropriation. As part of this certification, the Governor shall submit to the Secretary of Transportation a statement identifying the amount of State funds the State planned to expend from State sources as of the date of enactment of this Act for the period of October 1, 2010, through September 30, 2011, for the types of projects that are funded by the appropriation. For the period of October 1, 2010, through September 30, 2011, the Governor of a State may calculate planned expenditures from State funds in the same manner as under section 1201(a) of division A of the American Recovery and Reinvestment Act of 2009 or may calculate the amount by pro rating the amount certified under section 1201(a) of division A of the American Recovery and Reinvestment Act of 2009 to establish the amount of planned expenditures for such period.

(2) DEFINITION OF STATE FUNDS.—For purposes of the certifications required by section 1201(a) of division A of the American Recovery and Reinvestment Act of 2009 and paragraph (1)(B), State funding means State funds used for transportation purposes that are expended by the State agency that is primarily responsible for carrying out the covered program. State funding does not include State transportation funds that are expended by on at the direction of non-State governmental entities.

(b) REQUIREMENT TO MAINTAIN EFFORT.—

(1) REPORTS.—Each State shall submit to the Department of Transportation for each covered program the actual aggregate expenditures from State funds during the period of February 17, 2009, through September 30, 2011, as compared to the level of such expenditures from State funds that were planned to occur during such period as certified in accordance with subsection (a). The State shall submit the maintenance of effort reports in the same manner and in the same timeframe required by subsection (c), except the State is not required to submit a maintenance of effort report on February 17, 2013. The covered agencies shall submit the reports to Congress in accordance with subsection (c)(1).

(2) DETERMINATION OF MAINTENANCE OF EFFORT.—A State is deemed to have met its level of effort if the aggregate amount of actual expenditures of State funds reported in the February 17, 2012 report in accordance with paragraph (1)

meets or exceeds the aggregate amount of planned expenditures of State funds identified in the certification required by subsection (a).

(3) PENALTY FOR FAILURE TO MAINTAIN EFFORT.—If a State is unable to maintain the level of effort certified pursuant to subsection (a), the State will be prohibited by the Secretary of Transportation from receiving additional limitation pursuant to the redistribution of the limitation on obligations for Federal-aid highway and highway safety construction programs that occurs after August 1 for fiscal year 2012.

(c) PERIODIC REPORTS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, each grant recipient shall submit to the covered agency from which they received funding periodic reports on the use of the funds appropriated in this chapter for the Department of Transportation for covered programs. Such reports shall be collected and compiled by the covered agency and transmitted to Congress. Covered agencies may develop such reports on behalf of grant recipients to ensure the accuracy and consistency of such reports.

(2) CONTENTS OF REPORTS.—For amounts received under each covered program by a grant recipient under this chapter for the Department of Transportation, the grant recipient shall include in the periodic reports information tracking—

(A) the amount of Federal funds appropriated, allocated, obligated, and outlayed under the appropriation;

(B) the number of projects that have been put out to bid under the appropriation and the amount of Federal funds associated with such projects;

(C) the number of projects for which contracts have been awarded under the appropriation and the amount of Federal funds associated with such contracts;

(D) the number of projects for which work has begun under such contracts and the amount of Federal funds associated with such contracts;

(E) the number of projects for which work has been completed under such contracts and the amount of Federal funds associated with such contracts; and

(F) the number of direct, on-project jobs created or sustained by the Federal funds provided for projects under the appropriation and, to the extent possible, the estimated indirect jobs created or sustained in the associated supplying industries, including the number of job-years created and the total increase in employment since the date of enactment of this Act.

(3) TIMING OF REPORTS.—Each grant recipient shall submit the first of the periodic reports required under this subsection not later than 1 year after the date of enactment of the American Recovery and Reinvestment Act of 2009 and shall submit updated reports not later than 15 months, 18 months, 2 years, 3 years, and 4 years after such date of enactment.

(d) DEFINITIONS.—In this section, the following definitions apply:

(1) COVERED AGENCY.—The term "covered agency" means the Federal Aviation Administration, the Federal Highway Administration, the Federal Railroad Administration, the Federal Transit Administration, and the Maritime Administration of the Department of Transportation.

(2) COVERED PROGRAM.—The term "covered program" means funds appropriated in this Act for Grants-in-Aid for Airports to the Federal Aviation Administration; for "Highway Infrastructure Investment" to the Federal Highway Administration; for "Capital Grants to the National Railroad Passenger Corporation" to the Federal Railroad Administration; for "Transit Capital Assistance", "Fixed Guideway Infrastructure Investment", and "Capital Investment Grants" to the Federal Transit Administration;

and for "Maritime Guaranteed Loan (Title XI) Program Account" to the Maritime Administration.

(3) **GRANT RECIPIENT.**—The term "grant recipient" means a State or other recipient of assistance provided under a covered program in this Act. Such term does not include a Federal department or agency.

(e) **EXEMPTION.**—Notwithstanding any other provision of law, sections 3501–3521 of title 44 United States Code, shall not apply to the provisions of this section.

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

PUBLIC AND INDIAN HOUSING

PUBLIC HOUSING CAPITAL FUND

For an additional amount for the "Public Housing Capital Fund" to carry out capital and management activities for public housing agencies, as authorized under section 9 of the United States Housing Act of 1937 (42 U.S.C. 1437g) (in this heading referred to as the "Act"), \$1,000,000,000: Provided, That the Secretary of Housing and Urban Development shall make the funds provided under this heading available by competition for priority investments, including investments that leverage private sector funding or financing for renovations and energy conservation retrofit investments: Provided further, That the Secretary shall obligate the funds provided under this heading by such competition within 60 days of the date of the enactment of this Act: Provided further, That in using the funds provided under this heading public housing authorities shall give priority to capital projects that can award contracts based on bids within 120 days from the date that the funds are made available to the public housing authorities: Provided further, That in using such funds provided under this heading public housing agencies shall give priority consideration to the rehabilitation of vacant rental units: Provided further, That in using such funds provided under this heading public housing agencies shall prioritize capital projects that are already underway or included in the 5-year capital fund plans required by section 5A of the Act (42 U.S.C. 1437c-1(a)): Provided further, That notwithstanding any other provision of law, funds provided under this heading (1) may not be used for operating or rental assistance activities, and (2) shall not be subject to any restriction of funding to replacement housing uses: Provided further, That notwithstanding section 9(j) of the Act, public housing agencies shall obligate 50 percent of the funds provided under this heading within 180 days of the date on which such funds become available to the agency for obligation, and shall expend 100 percent of such funds within one year of the date on which such funds become available to the agency for obligation: Provided further, That if a public housing agency fails to comply with the 180-day obligation requirement under the preceding proviso, the Secretary shall recapture all funds provided under this heading awarded to the public housing agency that remain unobligated and reallocate such funds to agencies that are in compliance with such requirement: Provided further, That in administering funds appropriated or otherwise made available under this heading, the Secretary may waive or specify alternative requirements for any provision of any statute or regulation in connection with the obligation by the Secretary or the use of such funds (except for requirements related to fair housing, non-discrimination, labor standards, and the environment), upon a finding that such a waiver is necessary to expedite or facilitate the use of such funds: Provided further, That, in addition to waivers authorized under the preceding proviso, the Secretary may direct that requirements relating to the procurement of goods and services arising under State and local laws and reg-

ulations shall not apply to funds provided under this heading.

COMMUNITY PLANNING AND DEVELOPMENT HOUSING TRUST FUND

For the Housing Trust Fund established pursuant to section 1338 of the Federal Housing Enterprises Financial Safety and Soundness Act of 1992 (12 U.S.C. 4568), \$1,065,000,000, for use under such section: Provided, That of the total amount provided under this heading, \$65,000,000 shall be available to the Secretary of Housing and Urban Development only for incremental project-based voucher assistance or project-based rental assistance, to be allocated to States pursuant to the formula established under such section 1338, to be used solely in conjunction with grant funds awarded under such section 1338.

CHAPTER 7—GENERAL PROVISIONS, THIS TITLE

TARP REDUCTION

SEC. 1701. The limitation under section 115(a)(3) of the Emergency Economic Stabilization Act of 2008 (12 U.S.C. 5225(a)(3)) in effect on the (date of the enactment of this Act is decreased by \$150,000,000,000.

LIMIT ON FUNDS

SEC. 1702. All funds provided under this title shall be subject to the requirements of section 1604 of division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5).

RECOVERY ACT REPORTING REQUIREMENTS

SEC. 1703. (a) Funds made available by this title shall be subject to the reporting, transparency, and oversight requirements established by title XV of division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), on the same basis as funds made available in division A of that Act.

(b) Amounts appropriated in division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) to any Office of Inspector General or to the Recovery Accountability and Transparency Board shall also be available for the same purposes with respect to any programs, grants, projects, and activities for which funds are made available by this title.

TITLE II—SURFACE TRANSPORTATION EXTENSION

SHORT TITLE

SEC. 2001. This title may be cited as the "Surface Transportation Extension Act of 2009".

FEDERAL-AID HIGHWAYS

SEC. 2002. (a) **IN GENERAL.**—

(1) **APPLICABILITY OF PROVISIONS.**—Except as provided in this title, requirements, authorities, conditions, eligibilities, limitations, and other provisions authorized under titles I, V, and VI of SAFETEA-LU (119 Stat. 1144), the SAFETEA-LU Technical Corrections Act of 2008 (122 Stat. 1572), titles I and VI of the Intermodal Surface Transportation Efficiency Act of 1991 (105 Stat. 1914), titles I and V of the Transportation Equity Act for the 21st Century (112 Stat. 107), and title 23, United States Code (excluding chapter 4 of that title), which would otherwise expire on or cease to apply after September 30, 2009, or the date specified in section 106(3) of the Continuing Appropriations Resolution, 2010 (Public Law 111-68), are incorporated by reference and shall continue in effect through September 30, 2010.

(2) **AUTHORIZATION OF APPROPRIATIONS.**—Except as provided in subsection (b), there are authorized to be appropriated out of the Highway Trust Fund (other than the Mass Transit Account) for fiscal year 2010 an amount equal to the sum of the amounts authorized to be appropriated out of the Highway Trust Fund (other than the Mass Transit Account) for programs, projects, and activities for fiscal year 2009 under titles I, V, and VI of SAFETEA-LU (119 Stat.

1144) and title 23, United States Code (excluding administrative expenses under section 104(a) and programs, projects, and activities under chapter 4 of that title), minus \$1,394,358,419.

(3) **USE OF FUNDS.**—

(A) **FISCAL YEAR 2010.**—Except as otherwise expressly provided in this title, funds authorized to be appropriated under paragraph (2) for fiscal year 2010 shall be distributed, administered, limited, and made available for obligation in the same manner as the total amount of funds authorized to be appropriated out of the Highway Trust Fund (other than the Mass Transit Account) for fiscal year 2009 to carry out programs, projects, activities, eligibilities, and requirements under SAFETEA-LU (119 Stat. 1144), the SAFETEA-LU Technical Corrections Act of 2008 (122 Stat. 1572), titles I and VI of the Intermodal Surface Transportation Efficiency Act of 1991 (105 Stat. 1914), titles I and V of the Transportation Equity Act for the 21st Century (112 Stat. 107), and title 23, United States Code (excluding chapter 4 of that title).

(B) **CALCULATION.**—The amounts authorized to be appropriated under paragraph (2) shall be calculated without regard to any rescission or cancellation of funds or contract authority for fiscal year 2009 under SAFETEA-LU (119 Stat. 1144) or any other law.

(C) **DISTRIBUTION BETWEEN PROGRAMS.**—Funds authorized to be appropriated under paragraph (2) shall be distributed under subparagraph, (A) among programs, projects, and activities referenced in such subparagraph in the ratio that—

(i) the amount authorized to be appropriated out of the Highway Trust Fund (other than the Mass Transit Account) for such program, project, or activity for fiscal year 2009; bear to

(ii) the amount authorized to be appropriated out of the Highway Trust Fund (other than the Mass Transit Account) for all such programs, projects, and activities for fiscal year 2009.

(D) **CONTRACT AUTHORITY.**—

(i) **IN GENERAL.**—Except as provided in clause (ii), funds authorized to be appropriated under this subsection shall be available for obligation in the same manner as if such funds were apportioned under chapter 1 of title 23, United States Code, and subject to a limitation on obligations for Federal-aid highways and highway safety construction programs included in an Act making appropriations for fiscal year 2010.

(ii) **EXCEPTIONS.**—

(I) **IN GENERAL.**—A limitation on obligations described in clause (i) shall not apply to any obligation under—

(aa) section 125 of title 23, United States Code; or

(bb) section 105 of title 23, United States Code, but only in an amount equal to \$639,000,000.

(II) **SPECIAL RULES.**—Except as otherwise expressly provided by this title, any special rule that applied in fiscal year 2009 to any program, project, or activity for which funds are authorized to be appropriated under paragraph (2) shall continue to apply through September 30, 2010.

EXTENSION FLEXIBILITY FOR CERTAIN ALLOCATED PROGRAMS.—

(A) **FISCAL YEAR 2010.**—

(i) **IN GENERAL.**—Notwithstanding any other provision of law, for fiscal year 2010, the portion of the share of funds of a State under paragraph (2) determined by the amount that the State received or was authorized to receive for fiscal year 2009 to carry out sections 1307, 1702, and 1934 of SAFETEA-LU (119 Stat. 1217, 1256, and 1485) and section 144(f)(1) of title 23, United States Code, shall be—

(I) made available to the State for programs specified in section 105(a)(2) of title 23, United States Code (except the high priority projects program), and in the same proportion for each such program that—

(aa) the amount apportioned to the State for that program for fiscal year 2009; bears to

(bb) the amount apportioned to the State for fiscal year 2009 for all such programs; and

(II) administered in the same manner and with the same period of availability as such funding as administered under programs identified in clause (i), except that no funds may be used to carry out the project described in section 1307(d)(1) of SAFETEA-LU (119 Stat. 1217; 122 Stat. 1577).

(ii) TERRITORIES AND PUERTO RICO.—

(I) IN GENERAL.—Notwithstanding any other provision of law, the portion of the share of funds of a territory or Puerto Rico under paragraph (2) determined by the amount that the territory or Puerto Rico received or was authorized to receive for fiscal year 2009 to carry out section 1934 of SAFETEA-LU (119 Stat. 1485), shall be—

(aa) for a territory, made available and administered in the same manner as funding is made available and administered under section 215 of title 23, United States Code; and

(bb) for Puerto Rico, made available and administered in the same manner as funding is made available and administered under section 165 of title 23, United States Code.

(II) TERRITORY DEFINED.—In this clause, the term “territory” means any of the following territories of the United States: American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, or the United States Virgin Islands.

(B) ADDITIONAL FUNDS.—

(I) IN GENERAL.—No additional funds shall be provided for any project or activity under paragraph (3)(A) that the Secretary of Transportation determines was sufficiently funded before or during fiscal year 2009 to achieve the authorized purpose of the project or activity.

(ii) RESERVATION AND REDISTRIBUTION AMONG STATES.—

(I) IN GENERAL.—Funds made available in accordance with paragraph (3)(A) for a project or activity described in clause (i) shall be—

(aa) reserved by the Secretary of Transportation; and

(bb) apportioned among all States such that each State's share of funds so apportioned is equal to the State's share for fiscal year 2009 of funds apportioned or allocated for the programs specified in subclause (II).

(II) SPECIFIC PROGRAMS.—The programs referred to in subclause (I) are—

(aa) the programs listed in section 105(a)(2) of title 23, United States Code;

(bb) the program authorized by section 144(f)(1) of such title; and

(cc) the program authorized by section 1934 of SAFETEA-LU (119 Stat. 1485).

(iii) DISTRIBUTION AMONG PROGRAMS.—Funds apportioned to a State pursuant to clause (ii) shall be—

(I) made available to the State for programs specified in section 105(a)(2) of title 23, United States Code (except the high priority projects program), and in the same proportion for each such program that—

(aa) the amount apportioned to the State for that program for fiscal year 2009; bears to

(bb) the amount apportioned to the State for fiscal year 2009 for all such programs; and

(II) administered in the same manner and with the same period of availability as such funding is administered under programs identified in subclause (I).

(C) COMPETITIVE DISTRIBUTION OF CERTAIN DISCRETIONARY FUNDS.—

(i) PROJECTS OF NATIONAL AND REGIONAL SIGNIFICANCE.—Notwithstanding section 1301(m) of SAFETEA-LU (119 Stat. 1202), the Secretary shall allocate funds authorized to be appropriated under paragraph (2) for the projects of

national and regional significance program on the basis of a competitive selection process in accordance with sections 1301(d), 1301(e), and 1301(f) of that Act (119 Stat. 1199).

(ii) NATIONAL CORRIDOR INFRASTRUCTURE IMPROVEMENT PROGRAM.—Notwithstanding section 1302 (e) of SAFETEA-LU (119 Stat. 1205), the Secretary shall allocate funds authorized to be appropriated under paragraph (2) for the national corridor infrastructure improvement program on the basis of a competitive selection process in accordance with section 1302(b) of that Act (119 Stat. 1204).

(5) EXTENSION OF AUTHORIZATION UNDER TITLE V OF SAFETEA-LU.—

(A) IN GENERAL.—The programs authorized under paragraphs (1) through (5) of section 5101(a) of SAFETEA-LU (119 Stat. 1779) shall be continued for fiscal year 2010 at the funding levels authorized for those programs for fiscal year 2009.

(B) DISTRIBUTION OF FUNDS.—Funds for programs continued under subparagraph (A) shall be distributed to major program areas under those programs in the same proportions as funds were allocated for those program areas for fiscal year 2009, except that designations for specific activities shall not be required to be continued for fiscal year 2010.

(C) ADDITIONAL FUNDS.—

(i) IN GENERAL.—No additional funds shall be provided for any project or activity under this paragraph that the Secretary of Transportation determines was sufficiently funded before or during fiscal year 2009 to achieve the authorized purpose of the project or activity.

(ii) DISTRIBUTION.—Funds that would have been made available under subparagraph (A) for a project or activity but for the prohibition under clause (i) shall be distributed in accordance with subparagraph (B).

(b) ADMINISTRATION EXPENSES.—

(I) AUTHORIZATION OF CONTRACT AUTHORITY.—Notwithstanding other provision of this title or any other law, there is authorized to be appropriated from the Highway Trust Fund (other than the Mass Transit Account), \$420,562,000 for administrative expenses of the Federal-aid highway program for fiscal year 2010.

(2) CONTRACT AUTHORITY.—Funds authorized to be appropriated by this subsection shall be—

(A) available for obligation, and shall be administered, in the same manner as if such funds were apportioned under chapter 1 of title 23, United States Code, except that such funds shall remain available until expended; and

(B) subject to a limitation on obligations for Federal-aid highways and highway safety construction programs included in an Act making appropriations for fiscal year 2010.

(c) RECONCILIATION OF FUNDS.—The Secretary shall reduce the amount apportioned or allocated for a program, project, or activity continued under this section by any amount apportioned or allocated for such program, project, or activity pursuant to the Continuing Appropriations Resolution, 2010 (Public Law 111-68).

(d) REFERENCES.—Except as otherwise expressly provided, any reference in this section to an Act, or a provision contained in an Act, shall be considered to include the amendments made by that Act or provision.

EXTENSION OF HIGHWAY SAFETY PROGRAMS OF NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION

SEC. 2003. (a) CHAPTER 4 HIGHWAY SAFETY PROGRAMS.—Section 2001(a)(1) of SAFETEA-LU (119 Stat. 1519) is amended—

(1) by striking “and”; and

(2) by inserting after “2009” the following: “, and \$235,000,000 for fiscal year 2010”.

(b) HIGHWAY SAFETY RESEARCH AND DEVELOPMENT.—Section 2001(a)(2) of such Act (119 Stat. 1519) is amended—

(1) by striking “and”; and

(2) by inserting after “2009” the following: “, and \$105,500,000 for fiscal year 2010”.

(c) OCCUPANT PROTECTION INCENTIVE GRANTS.—

(1) EXTENSION OF PROGRAM.—Section 405 of title 23, United States Code, is amended—

(A) in subsection (a)(3) by striking “6” and inserting “7”; and

(B) in subsection (a)(4)(C) by striking “in each of the fifth and sixth fiscal years beginning after September 30, 2003,” and inserting “in each subsequent fiscal year”.

(2) AUTHORIZATION OF APPROPRIATIONS.—Section 2001(a)(3) of such Act (119 Stat. 1519) is amended—

(A) by striking “and”; and

(B) by inserting after “2009” the following: “, and \$25,000,000 for fiscal year 2010”.

(d) SAFETY BELT PERFORMANCE GRANTS.—

(1) EXTENSION OF PROGRAM.—Section 406(c)(1) of title 23, United States Code, is amended by striking “2009” and inserting “2010”.

(2) AUTHORIZATION OF APPROPRIATIONS.—Section 2001(a)(4) of such Act (119 Stat. 1519) is amended—

(A) by striking “and”; and

(B) by inserting after “2009” the following: “, and \$124,500,000 for fiscal year 2010”.

(e) STATE TRAFFIC SAFETY INFORMATION SYSTEM IMPROVEMENTS.—Section 2001(a)(5) of such Act (119 Stat. 1519) is amended—

(1) by striking “and”; and

(2) by inserting after “2009” the following: “, and \$34,500,000 for fiscal year 2010”.

(f) ALCOHOL-IMPAIRED DRIVING COUNTERMEASURES INCENTIVE GRANT PROGRAM.—

(1) EXTENSION OF PROGRAM.—Section 410 of title 23, United States Code, is amended—

(A) in subsection (a)(3)(C) by striking “in each of the fifth, sixth, seventh, and eighth fiscal years” and inserting “in each subsequent fiscal year”; and

(B) in subsection (b)(2)(C) by striking “and 2009” and inserting “, 2009, and 2010”.

(2) AUTHORIZATION OF APPROPRIATIONS.—Section 2001(a)(6) of such Act (119 Stat. 1519) is amended—

(A) by striking “and”; and

(B) by inserting after “2009” the following: “, and \$139,000,000 for fiscal year 2010”.

(g) NATIONAL DRIVER REGISTER.—Section 2001(a)(7) of such Act (119 Stat. 1520) is amended—

(1) by striking “and”; and

(2) by inserting after “2009” the following: “and \$4,000,000 for fiscal year 2010”.

(h) HIGH VISIBILITY ENFORCEMENT PROGRAM.—

(1) EXTENSION OF PROGRAM.—Section 2009(a) of such Act (23 U.S.C. 402 note; 119 Stat. 1535) is amended by striking “2009” and inserting “2010”.

(2) AUTHORIZATION OF APPROPRIATIONS.—Section 2001(a)(8) of such Act (119 Stat. 1520) is amended—

(A) by striking “and”; and

(B) by inserting after “2009” the second place it appears the following: “, and \$29,000,000 for fiscal year 2010”.

(i) MOTORCYCLIST SAFETY.—

(1) EXTENSION OF PROGRAM.—Section 2010(d)(1)(B) of such Act (23 U.S.C. 402 note; 119 Stat. 1536) is amended by striking “and fourth” and inserting “fourth, and fifth”.

(2) AUTHORIZATION OF APPROPRIATIONS.—Section 2001(a)(9) of such Act (119 Stat. 1520) is amended—

(A) by striking “and”; and

(B) by inserting after “2009” the following: “, and \$7,000,000 for fiscal year 2010”.

(j) CHILD SAFETY AND CHILD BOOSTER SEAT SAFETY INCENTIVE GRANTS.—

(1) EXTENSION OF PROGRAM.—Section 2011(c)(2) of such Act (23 U.S.C. 405 note; 119

Stat. 1538) is amended by striking “fourth fiscal year” and inserting “fourth and fifth fiscal years”.

(2) **AUTHORIZATION OF APPROPRIATIONS.**—Section 2001(a)(10) of such Act (11.9 Stat. 1520) is amended—

(A) by striking “and”; and

(B) by inserting after “2009” the following: “, and \$7,000,000 for fiscal year 2010”.

(k) **ADMINISTRATIVE EXPENSES.**—Section 2001(a)(11) of such Act (11.9 Stat. 1520) is amended—

(1) by striking “and” the last place it appears; and

(2) by inserting after “2009” the following: “, and \$18,500,000 for fiscal year 2010”.

(l) **APPLICABILITY OF TITLE 23.**—Section 2001(c) of such Act (11.9 Stat. 1520) is amended by striking “2009” and inserting “2010”.

(m) **DRUG-IMPAIRED DRIVING ENFORCEMENT.**—Section 5013(7) of such Act (23 U.S.C. 103 note; 119 Stat. 1:540) is amended by striking “2009” and inserting “2010”.

(n) **OLDER DRIVER SAFETY; LAW ENFORCEMENT TRAINING.**—Section 2017 of such Act (23 U.S.C. 402 note; 119 Stat. 1541) is amended—

(1) in subsection (a)(1) by striking “2009” and inserting “2010”; and

(2) in subsection (b)(2) by striking “2009” and inserting “2010”.

EXTENSION OF FEDERAL MOTOR CARRIER SAFETY ADMINISTRATION PROGRAMS

SEC. 2004. (a) MOTOR CARRIER SAFETY GRANTS.—Section 31104(a) of title 49, United States Code, is amended—

(1) by striking “and” at the end of paragraph (4);

(2) by striking the period at the end of paragraph (5) and inserting “; and”; and

(3) by adding at the end the following:

“(6) \$212,070,000 for fiscal year 2010.”.

(b) **ADMINISTRATIVE EXPENSES.**—Section 31104(1)(1) of title 49, United States Code is amended—

(1) by striking “and” at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting “; and”; and

(3) by adding at the end the following:

“(F) \$239,828,000 for fiscal year 2010.”.

(c) **HIGH PRIORITY ACTIVITIES.**—Section 31104(k)(2) of title 49, United States Code, is amended by striking “2009” and inserting “2010”.

(d) **GRANT PROGRAM.**—Section 4104(c) of SAFETEA-LU (119 Stat. 1715) is amended—

(1) in paragraph (1) by striking “2009” and inserting “2010”; and

(2) in paragraph (2) by striking “and 2009” and inserting “2009, and 2010”; and

(3) in paragraph (3) by striking “and 2009” and inserting “2009, and 2010”; and

(4) in paragraph (4) by striking “2009” and inserting “2010”; and

(5) in paragraph (5) by striking “2009” and inserting “2010”.

(e) **COMMERCIAL DRIVER'S LICENSE INFORMATION SYSTEM MODERNIZATION.**—Section 4123(d) of SAFETEA-LU (119 Stat. 1736) is amended—

(1) by striking “and” at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting “; and”; and

(3) by adding at the end the following:

“(5) \$8,000,000 for fiscal year 2010.”.

(f) **OUTREACH AND EDUCATION.**—Section 4127(e) of such Act (119 Stat. 1741) is amended by striking “and 2009” and inserting “2009, and 2010”.

(g) **GRANT PROGRAM FOR COMMERCIAL MOTOR VEHICLE OPERATORS.**—Section 4134(c) of such Act (119 Stat. 1744) is amended by striking “2009” and inserting “2010”.

(h) **WORKING GROUP FOR DEVELOPMENT OF PRACTICES AND PROCEDURES TO ENHANCE FED-**

ERAL-STATE RELATIONS.—Section 4213(d) of such Act (119 Stat. 1759) is amended by striking “2009” and inserting “2010”.

(i) **OFFICE OF INTERMODALISM.**—Section 5503(1) of title 49, United States Code, is amended by striking “2009” and inserting “2010”.

EXTENSION OF FEDERAL TRANSIT ASSISTANCE PROGRAMS

SEC. 2005. (a) EXTENSION OF FEDERAL TRANSIT ASSISTANCE PROGRAMS.—Except as otherwise provided in this title, requirements, authorities, conditions, eligibilities, limitations, and other provisions authorized under title III of SAFETEA-LU (119 Stat. 1544), the SAFETEA-LU Technical Corrections Act of 2008 (122 Stat. 1572), title III of the Intermodal Surface Transportation Efficiency Act of 1991 (105 Stat. 2087), title III of the Transportation Equity Act for the 21st Century (112 Stat. 338), and chapter 53 of title 49, United States Code, which would otherwise expire on or cease to apply after September 30, 2009, or the date specified in section 106(3) of the Continuing Appropriations Resolution, 2010 (Public Law 111-68), are incorporated by reference and shall continue in effect through September 30, 2010.

(b) **AUTHORIZATIONS.**—For fiscal year 2010—

(1) their shall be available from the Mass Transit Account of the Highway Trust Fund \$8,343,171,000 for each Federal transit assistance program under section 5338(b) of title 49, United States Code, to be allocated among such programs in proportion to the amounts provided for each such program in fiscal year 2009; and

(2) there is authorized to be appropriated \$2,164,581,000 for each Federal transit program under subsections (c) and (d) of section 5338 of title 49, United States Code, and for administrative expenses under subsection (e) of such section.

(c) **EXCEPTIONS.**—

(1) **PROJECTS FOR BUS AND BUS-RELATED FACILITIES AND CLEAN FUELS GRANT PROGRAM.**—The project designations contained in section 3044 of SAFETEA-LU (119 Stat. 1652) shall not apply to funds made available under subsection (b)(1).

(2) **ALLOCATIONS FOR NATIONAL RESEARCH AND TECHNOLOGY PROGRAMS.**—A program, project, or activity identified in section 3046 of SAFETEA-LU (119 Stat. 1706) that the Secretary of Transportation determines was sufficiently funded before or during fiscal year 2009 to achieve the authorized purpose of the program, project, or activity shall not be eligible for funds authorized to be appropriated under subsection (b)(2).

(d) **CONTRACT AUTHORITY.**—A grant or contract approved by the Secretary and financed with amounts made available from the Mass Transit Account of the Highway Trust Fund through September 30, 2010, to carry out sections 5305, 5307, 5308, 5309, 5310, 5311, 5316, 5317, 5320, 5335, 5339 and 5340 of title 49, United States Code, and section 3038 of the Transportation Equity Act for the 21st Century (49 U.S.C. 5310 note; 112 Stat. 392) is a contractual obligation of the Government to pay the Federal share of the cost of the project.

(e) **RECONCILIATION OF FUNDS.**—The Secretary shall reduce the amount apportioned or allocated for a program, project, or activity continued under this section by any amount apportioned or allocated for such program, project, or activity pursuant to the Continuing Appropriation Resolution, 2010 (Public Law 111-68).

(f) **REFERENCES.**—Except as otherwise expressly provided, any reference in this section to an Act, or a provision contained in an Act, shall be considered to include the amendments made by that Act or provision.

BOATING SAFETY EXTENSION

SEC. 2006. Section 4 of the Dingell-Johnson Sport Fish Restoration Act (16 U.S.C. 777c) is amended—

(1) in subsection (a) by striking “2009, and the period from October 1, 2009, and the period from October 1, 2009, through the date specified in section 106(3) of the first Continuing Appropriations Resolution for Fiscal Year 2010 enacted into law, and inserting “2010,”; and

(2) in subsection (b)(1)(A) by striking “2009 and the period from October 1, 2009, through the date specified in section 106(3) of the first Continuing Appropriations Resolution for Fiscal Year 2010 enacted into law,” and inserting “2010,”.

LEVEL OF OBLIGATION LIMITATIONS

Sec. 2007. (a) HIGHWAY CATEGORY.—Section 8003(a) of SAFETEA-LU (119 Stat. 1917) is amended—

(1) by striking “and” at the end of paragraph (4);

(2) by striking the period at the end of paragraph (5) and inserting “; and”; and

(3) by adding at the end the following:

“(6) for fiscal year 2010, \$42,469,970,178.”.

(b) **MASS TRANSIT CATEGORY.**—Section 8003(b) of SAFETEA-LU (119 Stat. 1917) is amended—

(1) by striking “and” at the end of paragraph (4);

(2) by striking the period at the end of paragraph (5) and inserting “; and”; and

(3) by inserting after paragraph (5) the following:

“(6) for fiscal year 2010, \$10,338,065,000.”.

HAZARDOUS MATERIALS RESEARCH

SEC. 2008. Section 7131(e) of SAFETEA-LU (119 Stat. 1910) is amended by striking “2009” and inserting “2010”.

EXTENSION AND EXPANSION OF EXPENDITURE AUTHORITY FROM TRUST FUNDS

SEC. 2009. (a) HIGHWAY TRUST FUND.—

(1) **HIGHWAY ACCOUNT.**—Paragraph (1) of section 9503(c) of the Internal Revenue Code of 1986 is amended—

(A) by striking “September 30, 2009 (October 1, 2009)” and inserting “September 30, 2010 (October 1, 2010),” and

(B) by striking “under” and all that follows and inserting “under the Surface Transportation Extension Act of 2009 or any other provision of law which was referred to in this paragraph before the date of the enactment of such Act (as such Act and provisions of law are in effect on the date of the enactment of such Act).”.

(2) **MASS TRANSIT ACCOUNT.**—Paragraph (3) of section 95303(e) of such Code is amended—

(A) by striking “October 1, 2009” and inserting “October 1, 2010,” and

(B) by striking “in accordance with” and all that follows and inserting “in accordance with the Surface Transportation Extension Act of 2009 or any other provision of law which was referred to in this paragraph before the date of the enactment of such Act (as such Act and provisions of law are in effect on the date of the enactment of such Act).”.

(3) **EXCEPTION TO LIMITATION ON TRANSFERS.**—Subparagraph (B) of section 9503(b)(6) of such Code is amended by striking “September 30, 2009 (October 1, 2009)” and inserting “September 30, 2010 (October 1, 2010)”.

(b) **SPORT FISH RESTORATION AND BOATING TRUST FUND.**—

(1) **IN GENERAL.**—Paragraph (2) of section 9504(b) of such Code is amended—

(A) by striking “(as in effect)” in subparagraph (A) and all that follows in such subparagraph and inserting “(as in effect on the date of the enactment of the Surface Transportation Extension Act of 2009),”.

(B) by striking “(as in effect)” in subparagraph (B) and all that follows in such subparagraph and inserting “(as in effect on the date of the enactment of the Surface Transportation Extension Act of 2009), and”, and

(C) by striking “(as in effect)” in subparagraph (C) and all that follows in such subparagraph and inserting “(as in effect on the date of

the enactment of the Surface Transportation Extension Act of 2009).”.

(2) EXCEPTION TO LIMITATION ON TRANSFERS.—Paragraph (2) of section 9504(d) of such Code is amended by striking “October 1, 2009” and inserting “October 1, 2010”.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on September 30, 2009.

DETERMINATION OF HIGHWAY TRUST FUND BALANCES

SEC. 2010. (a) RESTORATION OF CERTAIN FOREGONE INTEREST TO HIGHWAY TRUST FUND.—Subsection (f) of section 9503 of the Internal Revenue Code of 1986 (relating to determination of trust fund balances after September 30, 1998) is amended—

(1) by striking paragraph (2); and

(2) by adding at the end the following new paragraph:

“(2) RESTORATION OF FOREGONE INTEREST.—Out of money in the Treasury not otherwise appropriated, there is hereby appropriated (without fiscal year limitation)—

“(A) \$14,700,000,000 to the Highway Account (as defined in subsection (e)(5)(B)) of the Highway Trust Fund, and

“(B) \$4,800,000,000 to the Mass Transit Account of the Highway Trust Fund.”.

(b) REPEAL OF PROVISION PROHIBITING CREDITING OF INTEREST TO HIGHWAY TRUST FUND.—

(1) IN GENERAL.—Paragraph (1) of section 9503(f) of such Code is amended by striking subparagraph (B).

(2) CONFORMING AMENDMENTS.—Such paragraph, as amended by paragraph (1), is further amended—

(A) by striking “, and” at the end of subparagraph (A) and inserting a period, and

(B) by striking “1998” in the matter preceding subparagraph (A) and all that follows through “the opening balance” and inserting “1998, the opening balance”.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

REPEAL OF TRANSFERS FROM HIGHWAY TRUST FUND FOR REPAYMENTS AND CREDITS

SEC. 2011. (a) IN GENERAL.—Subsection (c) of section 9503 of the Internal Revenue Code of 1986 is amended by striking paragraph (2) and by redesignating paragraphs (3), (4), (5), and (6) as paragraphs (2), (3), (4), and (5).

(b) CONFORMING AMENDMENTS.—

(1) Section 9502(a) of such Code is amended by striking “section 9503(c)(7)” and inserting “section 9503(c)(5)”.

(2) Section 9503(b)(4)(D) of such Code is amended by striking “paragraph (4)(D) or (5)(B)” and inserting “paragraph, (3)(D) or (4)(B)”.

(3) Section 9503(c)(2) of such Code, as redesignated by subsection (a), is amended by adding at the end the following sentence: “The amounts payable from the Highway Trust Fund under the preceding sentence shall be determined by taking into account only the portion of the taxes which are deposited into the Highway Trust Fund.”.

(4) Section 9503(e)(5)(A) of such Code is amended by striking “paragraphs (2), (3), and (4)” and inserting “paragraphs (2) and (3)”.

(5) Section 9504(a) of such Code is amended by striking “section 9503(c)(4), section 9503(c)(5)” and inserting “section 9503(c)(3), section 9503(c)(4)”.

(6) Section 9504(b)(2) of such Code is amended by striking “section 9503(c)(5)” and inserting “section 9503(c)(4)”.

(7) Section 9504(e) of such Code is amended by striking “section 9503(c)(4)” and inserting “section 9503(c)(3)”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid, and

credits allowed with respect to fuel used, in calendar quarters beginning after the date of the enactment of this Act.

FEDERAL SHARE

SEC. 2012. (a) IN GENERAL.—Notwithstanding any other provision of law, the Federal share of the cost of a covered project or activity (or portion of a covered project or activity) funded with amounts obligated during the period beginning on the date of enactment of this Act and ending on September 30, 2010, shall be, at the option of the recipient, up to 100 percent.

(b) COVERED PROJECT OR ACTIVITY DEFINED.—(1) IN GENERAL.—In this section, the term “covered project or activity” means a project or activity eligible for assistance under titles I through VI of SAFETEA-LU (119 Stat. 1144), the SAFETEA-LU Technical Corrections Act of 2008 (122 Stat. 1572), titles I through VI of the Intermodal Surface Transportation Efficiency Act of 1991 (105 Stat. 1914), titles I through V of the Transportation Equity Act for the 21st Century (112 Stat. 107), title 23, United States Code, chapter 53 of title 49, United States Code, chapter 303 of title 49, United States Code, or part B of subtitle VI of title 49, United States Code.

(2) EXCLUSIONS.—Notwithstanding paragraph (1), the term does not include a project or activity funded pursuant to—

(A) section 1301 or 1302 of SAFETEA-LU (119 Stat. 1198, 1204); SAFETEA-LU (119 Stat. 1144), the SAFETEA-LU Technical Corrections Act of 2008 (122 Stat. 1572), titles I through VI of the Intermodal Surface Transportation Efficiency Act of 1991 (105 Stat. 1914), titles I through V of the Transportation Equity Act for the 21st Century (112 Stat. 107), title 23, United States Code, chapter 303 of title 49, United States Code, or part B of subtitle VI of title 49, United States Code.

(2) EXCLUSIONS.—Notwithstanding paragraph (1), the term does not include a project or activity funded pursuant to Chapter 53 of title 49, United States Code.

(A) section 1301 Or 1302 of SAFETEA-LU (119 Stat. 1198, 1204);

(B) section 5309(d) or 5309(e) of title 49, United States Code;

(C) the national infrastructure investments program in the Office of the Secretary of Transportation; or

(D) section 122 of the Department of Transportation Appropriations Act, 2010.

(c) REFERENCES.—Any reference in this section to an Act, or a provision contained in an Act, shall be considered include the amendments made by that Act or provision.

BUY AMERICA REQUIREMENTS FOR HIGHWAY AND PUBLIC TRANSPORTATION PROJECTS

SEC. 2013. (a) HIGHWAYS.—Section 313 of title 23, United States Code, is amended—

(1) by redesignating subsections (c) through (f) as subsections (e) through (h), respectively;

(2) by inserting after subsection (b) the following:

“(c) REQUIREMENTS FOR ISSUANCE OF WAIVERS.—

“(1) PUBLIC INTEREST WAIVERS.—The Secretary may issue a waiver under subsection (b)(1) only after the Secretary has considered the potential impacts of the waiver on domestic manufacturing employment.

“(2) INSUFFICIENT DOMESTIC SOURCE WAIVERS.—The Secretary may issue a waiver under subsection (b)(2) with respect to a material or product only if the Secretary publishes notice of the waiver on the Internet for a period of at least 5 business days prior to issuance of the waiver and a sufficient domestic source of the material or product does not identify itself during the period.

“(d) TRANSPARENCY OF WAIVERS.—

“(1) IN GENERAL.—When the Secretary receives a written request for a waiver under this section, the Secretary shall—

“(A) publish the request on the Internet within 5 business days of the date of receipt of the request; and

“(B) if the Secretary decides to issue a waiver based on the request, publish on the Internet, within 30 days following the date of issuance of the waiver, a detailed written justification as to why the waiver is necessary, including an identification of the amount of Federal funds associated with the waiver.

“(2) EMPLOYMENT IMPACT STATEMENT.—In issuing a waiver based on a finding under subsection (b)(1), the Secretary shall include, as part of the Secretary’s written justification for the waiver decision, a statement detailing the short- and long-term impact of the decision on domestic manufacturing employment.”; and

(3) by adding at the end the following:

“(1) APPLICATION TO BRIDGE PROJECTS.—In the case of a bridge project, the requirements of this section apply to all construction contracts carried out within the scope of the applicable decision under the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.) and carried out on the bridge from abutment to abutment (including the abutments) regardless of the funding source of the contracts if at least one contract for construction with respect to the bridge is funded with amounts made available under this title.”.

(b) PUBLIC TRANSPORTATION.—Section 5323(j) of title 49, United States Code, is amended—

(1) in paragraph (2)(C) in the matter preceding clause (i) by inserting “, but excluding a rolling stock prototype” after “equipment”;

(2) by redesignating paragraphs (3) through (9) as paragraphs (5) through (11), respectively; and

(3) by inserting after paragraph (2) the following:

“(3) REQUIREMENTS FOR ISSUANCE OF WAIVER.—

“(A) PUBLIC INTEREST WAIVERS.—The Secretary may issue a waiver under paragraph (2)(A) only after the Secretary has considered the potential impacts of the waiver on domestic manufacturing employment.

“(B) INSUFFICIENT DOMESTIC SOURCE WAIVERS.—The Secretary may issue a waiver under paragraph (2)(B) with respect to a material or product only if the Secretary publishes notice of the waiver on the Internet for a period of at least 5 business days prior to issuance of the waiver and a sufficient domestic source of the material or product does not identify itself during the period.

“(4) TRANSPARENCY OF WAIVERS.—

“(A) IN GENERAL.—When the Secretary receives a written request for a waiver under this subsection, the Secretary shall—

“(i) publish the request on the Internet within 5 business days of the date of receipt of the request; and

“(ii) if the Secretary decides to issue a waiver based on the request, publish on the Internet, within 30 days following the date of issuance of the waiver, a detailed written justification as to why the waiver is necessary, including an identification of the amount of Federal funds associated with the waiver.

“(B) EMPLOYMENT IMPACT STATEMENT.—In issuing a waiver based on a finding under paragraph (2)(A), the Secretary shall include, as part of the Secretary’s written justification of the waiver decision, a statement detailing the short- and long-term impact of the decision on domestic manufacturing employment.”.

(c) IMPLEMENTATION.—

(1) FINAL GUIDANCE.—Not later than 120 days after the date of enactment of this Act, the Secretary shall issue final guidance to carry out the amendments made by this section.

(2) EFFECTIVE DATE.—The requirements of the amendments made by subsections (a) and (b)

shall begin to apply only after issuance of final guidance by the Secretary under paragraph (1).

(d) **SEMIANNUAL REPORT.**—Not later than 6 months after the date of enactment of this Act, and semiannually thereafter through September 30, 2011, the Comptroller General shall submit to the Committee on Transportation and Infrastructure and the Committee on Education and Labor of the House of Representatives and the Committee on Environment and Public Works, the Committee on Banking, Housing, and Urban Affairs, and the Committee on Health, Education, Labor, and Pensions of the Senate a report on the number of waivers issued by the Secretary of Transportation under section 313(b) of title 23, United States Code, and section 5323(j)(2) of title 49, United States Code, the reasons relied upon for issuing the waivers, and the amount of Federal funds associated with each waiver and in total for the period examined.

TITLE III—UNEMPLOYMENT AND OTHER EMERGENCY NEEDS

CHAPTER 1—AGRICULTURE AND RURAL DEVELOPMENT

DEPARTMENT OF AGRICULTURE

GENERAL PROVISION, THIS CHAPTER

RELIEF FOR DISCRIMINATION IN A CREDIT PROGRAM OF THE DEPARTMENT OF AGRICULTURE UNDER THE EQUAL CREDIT OPPORTUNITY ACT

Sec. 3101. (a) **IN GENERAL.**—To the extent permitted by the Constitution, and notwithstanding any other period of limitations, in the case of an eligible complaint alleging discrimination in violation of the Equal Credit Opportunity Act (15 U.S.C. 1691) involving a credit program of the Department of Agriculture, a complainant may, before the end of the filing period—

(1) file a civil action under subsection (c); or
(2) request administrative review under subsection (d).

(b) **ELIGIBLE COMPLAINT.**—For purposes of this section, the term “eligible complaint” means any written complaint—

(1) that is not employment related;
(2) that was filed with the Department of Agriculture after December 31, 1997, and before the earlier of—

(A) 2 years after the date of the alleged violation of the Equal Credit Opportunity Act; and
(B) the date of the enactment of this Act; and
(3) with respect to which the complainant—

(A) was not a party to the consent decree in the case entitled “Pigford v. Glickman”, approved by the United States District Court for the District of Columbia on April 14, 1999; and
(B) has not obtained relief from the Department of Agriculture or a court of competent jurisdiction.

(c) **CIVIL ACTION.**—A civil action may be filed under this subsection if, with respect to the eligible complaint, the complainant—

(1) has not requested administrative review; or
(2) has requested administrative review, and the Secretary, with respect to each request, has either—

(A) issued a determination; or
(B) failed to issue a determination by a date that is 180 days after the date such request was made.

(d) **ADMINISTRATIVE REVIEW.**—Administrative review may be requested under this subsection as follows:

(1) **DETERMINATION ON THE MERITS.**—A complainant may request a determination on the merits if the complainant, with respect to the eligible complaint, has not filed a civil action.

(2) **HEARING ON THE RECORD.**—A complainant may request a hearing on the record if the complainant, with respect to the eligible complaint—

(A) has not filed a civil action;
(B) has requested a determination on the merits, and the Secretary has not issued such deter-

mination by the issuance deadline in subsection (f)(2)(A); and

(C) requests such hearing no later than 180 days after the issuance deadline in subsection (f)(2)(A).

(e) **INFORMAL RESOLUTION.**—Notwithstanding any other provision of this section, the Secretary may informally resolve an eligible complaint with a complainant.

(f) **SPECIAL RULES FOR ADMINISTRATIVE REVIEW.**—For purposes of this section:

(1) **REQUESTS FOR ADMINISTRATIVE REVIEW.**—A request for administrative review shall be—

(A) in writing; and
(B) filed in accordance with procedures established by the Secretary.

(2) **RESPONSIBILITY OF SECRETARY.**—If a complainant requests a determination, on the merits under subsection (d)(1), then, unless a complainant, with respect to the eligible complaint, files a civil action or requests a hearing on the record, the Secretary shall, with respect to the eligible complaint, take the following actions:

(A) **ISSUANCE OF DETERMINATION.**—The Secretary shall, not later than an issuance deadline that is 1 year after the date on which the complainant requests a determination on the merits—

(i) investigate the eligible complaint; and
(ii) issue a written determination.

(B) **NOTICE OF FAILURE TO ISSUE TIMELY DETERMINATION.**—If the Secretary does not issue a written determination by the issuance deadline in subparagraph (A), the Secretary shall promptly issue to the Complainant, in writing and by registered mail, notice—

(i) that the Secretary has not issued a timely determination; and
(ii) of the period of time during which the complainant may bring a civil action or request a hearing on the record.

(3) **FINALITY OF DETERMINATION WITH RESPECT TO HEARING ON THE RECORD.**—A determination with respect to a hearing on the record shall be final.

(4) **JUDICIAL REVIEW OF ADMINISTRATIVE DETERMINATION.**—A determination on the merits or a determination with respect to a hearing on the record shall be subject to de novo review.

(g) **FILING PERIOD.**—

(1) **IN GENERAL.**—For purposes of this section, the term “filing period” means the 2-year period beginning on the date of enactment of this Act.

(2) **TOLLING.**—The running of the filing period in paragraph (1), for the purpose of filing a civil action under subsection (c) or requesting a hearing on the record under subsection (d)(2), shall be tolled for the period that, with respect to the eligible complaint—

(A) begins on the date of a request for a determination on the merits; and

(B) ends on the date on which the Secretary issues a determination with respect to a determination on the merits or a hearing on the record.

(h) **RELIEF.**—

(1) **AMOUNT.**—Subject to paragraph (2), a complainant shall, under subsection (a), and may, under subsection (e), be awarded such relief as the complainant would be afforded under the Equal Credit Opportunity Act, including—

(A) actual damages;
(B) the costs of the action, together with a reasonable attorney’s fee; and
(C) debt relief, including—
(i) write-downs or write-offs of the principal on a loan;
(ii) write-downs or write-offs of the interest on a loan;
(iii) reduction of the interest rate on a loan;
(iv) waiver or reduction of penalties with respect to a loan; or
(v) other modification of the terms of a loan.

(2) **LIMITATIONS ON RELIEF.**—

(A) **IN GENERAL.**—The total amount awarded under this section for all claims shall not exceed \$100,000,000.

(B) **ACTUAL DAMAGES, COSTS, AND ATTORNEY’S FEES.**—The sum of the total amount awarded under paragraph (1)(A) for all claims, plus the total amount awarded under paragraph (1)(B) for all claims, shall not exceed \$40,000,000.

(C) **DEBT RELIEF.**—The total amount awarded under paragraph (1)(C) for all claims shall not exceed \$60,000,000.

(3) **EXEMPTION FROM TAXATION.**—Any award under clauses (ii), (iii), or (iv) of subparagraph (C) of paragraph (1) shall not be included in gross income for purposes of chapter 1 of the Internal Revenue Code of 1986.

(i) **FUNDING.**—

(1) There is hereby appropriated to the Secretary, for relief awarded under subsection (h)(1), \$100,000,000, to remain available until expended.

(2) Of the funds derived from interest on the cushion of credit payments including funds in the current fiscal year, as authorized by section 313 of the Rural Electrification Act of 1936, an additional \$100,000,000 shall not be obligated and an additional \$100,000,000 are rescinded.

(j) **SECRETARY.**—For purposes of this section, the term “Secretary” means the Secretary of Agriculture.

CHAPTER 2—FINANCIAL SERVICES AND GENERAL GOVERNMENT

SMALL BUSINESS ADMINISTRATION

BUSINESS LOANS PROGRAM ACCOUNT

For an additional amount for “Business Loans Program Account” for fee reductions and eliminations under section 501 of division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) and for the cost of guaranteed loans under section 502 of such division, \$354,000,000: Provided, That such cost shall be as defined in section 502 of the Congressional Budget Act of 1974: Provided further, That authority to guarantee loans under section 502 of division A of the American Recovery and Reinvestment Act of 2009 shall remain in effect through September 30, 2010, notwithstanding subsection (f) of such section.

GENERAL PROVISION, THIS CHAPTER

RESCISSIONS

SEC. 3201. The following funds are hereby rescinded from the following accounts and programs in the specified amounts:

(1) “National Telecommunications and Information Administration—Digital-to-Analog Converter Box Program” in the Department of Commerce, \$111,000,000.

(2) “Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)” of the Department of Agriculture, \$243,000,000, to be derived from unobligated balances available from amounts placed in reserve in title I of division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5; 123 Stat. 115).

CHAPTER 3—LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION

GENERAL PROVISIONS, THIS CHAPTER

ASSISTANCE FOR UNEMPLOYED WORKERS AND STRUGGLING FAMILIES

SEC. 3301. (a)(1) Section 4007 of the Supplemental Appropriations Act, 2008 (Public Law 110–252; 26 U.S.C. 3304 note) is amended—

(A) by striking “December 31, 2009” each place it appears and inserting “June 30, 2010”;
(B) in the heading for subsection (b)(2), by striking “DECEMBER 31, 2009” and inserting “JUNE 30, 2010”; and

(C) in subsection (b)(3), by striking “May 31, 2010” and inserting “November 30, 2010”.

(2) Section 2002(e) of the Assistance for Unemployed Workers and Struggling Families Act, as

contained in Public Law 111-5 (26 U.S.C. 3304 note; 123 Stat. 438), is amended—

(A) in paragraph (1)(B), by striking “January 1, 2010” and inserting “July 1, 2010”;

(B) in the heading for paragraph (2), by striking “JANUARY 1, 2010” and inserting “JULY 1, 2010”; and

(C) in paragraph (3), by striking “June 30, 2010” and inserting “December 31, 2010”.

(3) Section 2005 of the Assistance for Unemployed Workers and Struggling Families Act, as contained in Public Law 111-5 (26 U.S.C. 3304 note; 123 Stat. 444), is amended—

(A) by striking “January 1, 2010” each place it appears and inserting “July 1, 2010”; and

(B) in subsection (c), by striking “June 1, 2010” and inserting “December 1, 2010”.

(4) Section 5 of the Unemployment Compensation Extension Act of 2008 (Public Law 110-449; 26 U.S.C. 3304 note) is amended by striking “May 30, 2010” and inserting “November 30, 2010”.

(b) Section 4004(e)(1) of the Supplemental Appropriations Act, 2008 (Public Law 110-252; 26 U.S.C. 3304 note) is amended by striking “by reason of” and all that follows and inserting the following: “by reason of—

“(A) the amendments made by section 2001(a) of the Assistance for Unemployed Workers and Struggling Families Act;

“(B) the amendments made by sections 2 through 4 of the Worker, Homeownership, and Business Assistance Act of 2009; and

“(C) the amendments made by section 3301(a)(1) of the Jobs for Main Street Act, 2010; and”.

EXTENSION AND IMPROVEMENT OF PREMIUM ASSISTANCE FOR COBRA BENEFITS

SEC. 3302. (A) EXTENSION OF ELIGIBILITY PERIOD.—Subsection (a)(3)(A) of section 3001 of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) is amended by striking “December 31, 2009” and inserting “June 30, 2010”.

(b) EXTENSION OF MAXIMUM DURATION OF ASSISTANCE.—Subsection (a)(2)(A)(ii)(I) of such section is amended by striking “9 months” and inserting “15 months”.

(c) RULES RELATED TO 2009 EXTENSION.—Subsection (a) of such section is further amended by adding at the end the following:

“(16) RULES RELATED TO 2009 extension.—

“(A) ELECTION TO PAY PREMIUMS RETROACTIVELY AND MAINTAIN COBRA COVERAGE.—In the case of any premium for a period of coverage during an assistance eligible individual’s transition period, such individual shall be treated for purposes of any COBRA continuation provision as having timely paid the amount of such premium if—

“(i) such individual was covered under the COBRA continuation coverage to which such premium relates for the period of coverage immediately preceding such transition period, and

“(ii) such individual pays, not later than 60 days after the date of the enactment of this paragraph (or, if later, 30 days after the date of provision of the notification required under subparagraph (D)(ii)), the amount of such premium, after the application of paragraph (1)(A).

“(B) REFUNDS AND CREDITS FOR RETROACTIVE PREMIUM ASSISTANCE ELIGIBILITY.—IN THE CASE OF AN ASSISTANCE ELIGIBLE INDIVIDUAL WHO PAYS, WITH RESPECT TO ANY PERIOD OF COBRA CONTINUATION COVERAGE DURING SUCH INDIVIDUAL’S TRANSITION PERIOD, THE PREMIUM AMOUNT FOR SUCH COVERAGE WITHOUT REGARD TO PARAGRAPH (1)(A), RULES SIMILAR TO THE RULES OF PARAGRAPH (12)(E) SHALL APPLY.

“(C) TRANSITION PERIOD.—

“(i) IN GENERAL.—For purposes of this paragraph, the term ‘transition period’ means, with respect to any assistance eligible individual, any period of coverage if—

“(I) such period begins before the date of the enactment of this paragraph, and

“(II) paragraph (1)(A) applies to such period by reason of the amendment made by section 3302(b) of the Jobs for Main Street Act, 2010.

“(ii) CONSTRUCTION.—Any period during the period described in subclauses (I) and (II) of clause (i) for which the applicable premium has been paid pursuant to subparagraph (A) shall be treated as a period of coverage referred to in such paragraph, irrespective of any failure to timely pay the applicable premium (other than pursuant to subparagraph (A)) for such period.

“(D) NOTIFICATION.—

“(i) IN GENERAL.—In the case of an individual who was an assistance eligible individual at any time on or after October 31, 2009, or experiences a qualifying event (consisting of a reduction of hours or termination of employment) relating to COBRA continuation coverage on or after such date, the administrator of the group health plan (or other entity) involved shall provide an additional notification with information regarding the amendments made by the Jobs for Main Street Act, 2010 within 60 days after the date of the enactment of such Act or, in the case of a qualifying event occurring after such date of enactment, consistent with the timing of notifications under paragraph (7)(A).

“(ii) TO INDIVIDUALS WHO LOST ASSISTANCE.—In the case of an assistance eligible individual described in subparagraph (A)(i) who did not timely pay the premium for any period of coverage during such individual’s transition period or paid the premium for such period without regard to paragraph (1)(A), the administrator of the group health plan (or other entity) involved shall provide to such individual, within the first 60 days of such individual’s transition period, an additional notification with information regarding the amendments made by the Jobs for Main Street Act, 2010, including information on the ability under subparagraph (A) to make retroactive premium payments with respect to the transition period of the individual in order to maintain COBRA continuation coverage.

“(iii) APPLICATION OF RULES.—Rules similar to the rules of paragraph (7) shall apply with respect to notifications under this subparagraph.”.

(d) CLARIFICATIONS RELATING TO SECTION 3001 OF ARRA.—

(1) CLARIFICATION THAT ELIGIBILITY AND NOTICE IS BASED ON TIMING OF QUALIFYING EVENT.—Subsection (a) of such section is amended—

(A) in paragraph (3)(A)—

(i) by striking “at any time” and inserting “such qualified beneficiary is eligible for COBRA continuation coverage related to a qualifying event occurring”; and

(ii) by striking “, such qualified beneficiary is eligible for COBRA continuation coverage”; and

(B) in paragraph (7) (A), by striking “become entitled to elect COBRA continuation coverage and inserting “have a qualifying event relating to COBRA continuation coverage”.

(2) CLARIFICATION REGARDING RETIREE COVERAGE.—Subsection (a)(2)(A)(i) of such section is amended by inserting “coverage under a retiree health plan,” after “other than”.

(3) CLARIFICATION REGARDING COBRA CONTINUATION RESULTING FROM REDUCTIONS IN HOURS.—Subsection (a) of such section is further amended—

(A) in paragraph (3)(C), by inserting before the period at the end the following: “or consists of a reduction of hours followed by such an involuntary termination of employment during such period”; and

(B) by adding at the end the following:

“(17) SPECIAL RULES IN CASE OF INDIVIDUALS LOSING COVERAGE BECAUSE OF A REDUCTION OF HOURS.—

“(A) NEW ELECTION PERIOD.—

“(i) IN GENERAL.—For the purposes of the COBRA continuation provisions, in the case of an individual described in subparagraph (C) who did not make (or who made and discontinued) an election of COBRA continuation coverage on the basis of the reduction of hours of employment, the involuntary termination of employment of such individual after the (date of the enactment of the Jobs for Main Street Act, 2010, shall be treated as a qualifying event.

“(ii) COUNTING COBRA DURATION PERIOD FROM PREVIOUS QUALIFYING EVENT.—In any case of an individual referred to in clause (i), the period of such individual’s continuation coverage shall be determined as though the qualifying event were the reduction of hours of employment.

“(iii) CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring an individual referred to in clause (i) to make a payment for COBRA continuation coverage between the reduction of hours and the involuntary termination of employment.

“(iv) PREEXISTING CONDITIONS.—With respect to an individual referred to in clause (i) who elects COBRA continuation coverage pursuant to such clause, rules similar to the rules in paragraph (4)(C) shall apply.

“(B) NOTICES.—In the case of an individual described in subparagraph (C), the administrator of the group health plan (or other entity) involved shall provide, during the 60-day period beginning on the date of such individual’s termination of employment, an additional notification described in paragraph (7)(A), including information on the provisions of this paragraph. Rules similar to the rules of paragraph (7) shall apply with respect to such notification.

“(C) INDIVIDUALS DESCRIBED.—Individuals described in this subparagraph are individuals who are assistance eligible individuals on the basis of a qualifying event consisting of a reduction of hours occurring during the period described in paragraph (3)(A) followed by an involuntary termination of employment insofar as such termination of employment occurred after the date of the enactment of the Jobs for Main Street Act, 2010.”.

(4) CLARIFICATION OF PERIOD OF ASSISTANCE.—Subsection (a)(2)(A)(ii)(I) of such section is amended by striking “of the first month”.

(5) ENFORCEMENT.—Subsection (a)(5) of such section is amended by adding at the end the following: “In addition to civil actions that may be brought to enforce applicable provisions of such Act or other laws, the appropriate Secretary or an affected individual may bring a civil action to enforce such determinations and for appropriate relief. In addition, such Secretary may assess a penalty against a plan sponsor or health insurance issuer of not more than \$110 per day for each failure to comply with such determination of such Secretary after 10 days after the date of the plan sponsor’s or issuer’s receipt of the determination.”

(6) AMENDMENTS RELATING TO SECTION 3001 OF ARRA.—

(A) Subsection (g) of section 35 of the Internal Revenue Code of 1986 is amended by striking “section 3002(a) of the Health Insurance Assistance for the Unemployed Act of 2009” and inserting “section 3001(a) of title III of division B of the American Recovery and Reinvestment Act of 2009”.

(B) Section 139C of such Code is amended by striking “section 3002 of the Health Insurance Assistance for the Unemployed Act of 2009” and inserting “section 3001 of title III of division B of the American Recovery and Reinvestment Act of 2009”.

(C) Section 6432 of such Code is amended—

(i) in subsection (a), by striking “section 3002(a) of the Health Insurance Assistance for the Unemployed Act of 2009” and inserting “section 3001(a) of title III of division B of the American Recovery and Reinvestment Act of 2009”; and

(ii) in subsection (c)(3), by striking “section 3002(a)(1)(A) of such Act” in subsection (c)(3) and inserting “section 3001(a)(1)(A) of title III of division B of the American Recovery and Reinvestment Act of 2009”; and

(iii) by redesignating subsections (e) and (f) as subsections (f) and (g), respectively, and inserting after subsection (d) the following new subsection:

“(e) **EMPLOYER DETERMINATION OF QUALIFYING EVENT AS INVOLUNTARY TERMINATION.**—For purposes of this section, in any case in which—

“(1) based on a reasonable interpretation of section 3001(a)(3)(C) of division B of the American Recovery and Reinvestment Act of 2009 and administrative guidance thereunder, an employer determines that the qualifying event with respect to COBRA continuation coverage for an individual was involuntary termination of a covered employee’s employment, and

“(2) the employer maintains supporting documentation of the determination, including an attestation by the employer of involuntary termination with respect to the covered employee, the qualifying event for the individual shall be deemed to be involuntary termination of the covered employee’s employment.”.

(D) Subsection (a) of section 6720C of such Code is amended by striking “section 3002 (a) (2)(C) of the Health Insurance Assistance for the Unemployed Act of 2009” and inserting “section 3001(a)(2)(C) of title III of division B of the American Recovery and Reinvestment Act of 2009”.

(e) **EFFECTIVE DATE.**—The amendments made by this section shall take effect as if included in the provisions of section 3001 of division B of the American Recovery and Reinvestment Act of 2009 to which they relate, except that—

(1) the amendments made by subsections (d)(2) and (d)(3) shall apply to periods of coverage beginning after the date of the enactment of this Act; and

(2) the amendment made by subsection (d)(5) shall take effect on the date of the enactment of this Act.

EXTENSION OF RECOVERY ACT INCREASE IN FMAP

SEC. 3303. Section 5001 of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) is amended—

(1) in subsection (a)(3), by striking “first calendar quarter” and inserting “first 3 calendar quarters”;

(2) in subsection (b)(2), by inserting before the period at the end the following: “and such paragraph shall not apply to calendar quarters beginning on or after October 1, 2010”;

(3) in subsection (c)(4)(C)(ii), by striking “December 2009” and “January 2010” and inserting “June 2010” and “July 2010”, respectively;

(4) in subsection (d), by inserting “ending before October 1, 2010” after “entire fiscal years” and after “with respect to fiscal years”;

(5) in subsection (g)(1), by striking “September 30, 2011” and inserting “March 31, 2012”; and

(6) in subsection (h)(3), by striking “December 31, 2010” and inserting “June 30, 2011”.

REPEAL OF EARNED INCOME THRESHOLD FOR DETERMINING REFUNDABLE PORTION OF CHILD TAX CREDIT

SEC. 3304. (a) **IN GENERAL.**—Clause (i) of section 24(d)(1)(B) of the Internal Revenue Code of 1986 is amended to read as follows:

“(i) 15 percent of the taxpayer’s earned income (within the meaning of section 32) which is taken into account in computing taxable income, or”.

(b) **CONFORMING AMENDMENTS.**—Subsection (d) of section 24 of such Code is amended—

(1) by striking paragraph (3), and

(2) by striking paragraph (4).

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 2009.

(d) **APPLICATION OF EGTRRA SUNSET.**—The amendments made by subsection (a) and (b)(1) shall be subject to title IX of the Economic Growth and Tax Relief Reconciliation Act of 2001 in the same manner as the provision of such Act to which such amendment relates.

HHS POVERTY GUIDELINES

SEC. 3305. Notwithstanding section 673(2) of the Omnibus Budget Reconciliation Act of 1981 (42 U.S.C. 9902(2)) or any other provision of law, the poverty line for 2010 issued by the Secretary of Health and Human Services under such section 673(2) shall be not lower than the poverty line so issued on January 23, 2009 (74 Fed. Reg. 14). This section shall have no effect on such Secretary’s revision of the poverty line for 2011.

REFUNDS DISREGARDED IN THE ADMINISTRATION OF FEDERAL PROGRAMS AND FEDERALLY ASSISTED PROGRAMS

SEC. 3306. (a) **IN GENERAL.**—Subchapter A of chapter 65 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

“SEC. 6409. REFUNDS DISREGARDED IN THE ADMINISTRATION OF FEDERAL PROGRAMS AND FEDERALLY ASSISTED PROGRAMS.

“(a) **IN GENERAL.**—Notwithstanding any other provision of law, any refund (or advance payment with respect to a refundable credit) made to any individual under this title shall not be taken into account as income, and shall not be taken into account as resources for the month of receipt and the following 11 months, for purposes of determining the eligibility of such individual (or any other individual) for benefits or assistance (the amount or extent of benefits or assistance) under any Federal program or under any State or local program financed in whole or in part with Federal funds.

“(b) **TERMINATION.**—Subsection (a) shall not apply to any amount received after December 31, 2010.”.

(b) **CLERICAL AMENDMENT.**—The table of sections for such subchapter is amended by adding at the end the following new item:

“Sec. 6109. Refunds disregarded in the administration of Federal programs and Federally assisted programs.”.

(c) **EFFECTIVE DATE.**—The amendment made by this section shall apply to amounts received after December 31, 2009.

PERMANENT EXTENSION OF FEE WITHHOLDING PROCEDURES TO TITLE XVI AND TO QUALIFIED NON-ATTORNEY REPRESENTATIVES

SEC. 3307. (a) **PERMANENT EXTENSION OF ATTORNEY FEE WITHHOLDING PROCEDURES TO TITLE XVI.**—

(1) **IN GENERAL.**—Section 302 of the Social Security Protection Act of 2004 (Public Law 108–203; 118 Stat. 519) is amended—

(A) in the section heading, by striking “**TEMPORARY**”; and

(B) in subsection (c), by striking “**EFFECTIVE DATE.**—” and all that follows through “The amendments” and inserting “**EFFECTIVE DATE.**—The amendments”, and by striking paragraph (2).

(2) **CLERICAL AMENDMENT.**—The item relating to section 302 in the table of contents in section 1(b) of such Act is amended by striking “Temporary extension” and inserting “Extension”.

(b) **PERMANENT EXTENSION OF FEE WITHHOLDING PROCEDURES TO QUALIFIED NON-ATTORNEY REPRESENTATIVES.**—

(1) **IN GENERAL.**—Section 206 of the Social Security Act (42 U.S.C. 406) is amended by adding at the end the following new subsection:

“(e)(1) The Commissioner shall provide for the extension of the fee withholding procedures and assessment procedures that apply under the preceding provisions of this section to agents and other persons, other than attorneys, who represent claimants under this title before the Commissioner.

“(2) Fee-withholding procedures may be extended under paragraph (1) to any nonattorney representative only if such representative meets at least the following prerequisites:

“(A) The representative has been awarded a bachelor’s degree from an accredited institution of higher education, or has been determined by the Commissioner to have equivalent qualifications derived from training and work experience.

“(B) The representative has passed an examination, written and administered by the Commissioner, which tests knowledge of the relevant provisions of this Act and the most recent developments in agency and court decisions affecting this title and title XVI.

“(C) The representative has secured professional liability insurance, or equivalent insurance, which the Commissioner has determined to be adequate to protect claimants in the event of malpractice by the representative.

“(D) The representative has undergone a criminal background check to ensure the representative’s fitness to practice before the Commissioner.

“(E) The representative demonstrates ongoing completion of qualified courses of continuing education, including education regarding ethics and professional conduct, which are designed to enhance professional knowledge in matters related to entitlement to, or eligibility for, benefits based on disability under this title and title XVI. Such continuing education, and the instructors providing such education, shall meet such standards as the Commissioner may prescribe.

“(3)(A) The Commissioner may assess representatives reasonable fees to cover the cost to the Social Security Administration of administering the prerequisites described in paragraph (2).

“(B) Fees collected under subparagraph (A) shall be credited to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, or deposited as miscellaneous receipts in the general fund of the Treasury, based on such allocations as the Commissioner determines appropriate.

“(C) The fees authorized under this paragraph shall be collected and available for obligation only to the extent and in the amount provided in advance in appropriations Acts. Amounts so appropriated are authorized to remain available until expended for administering the prerequisites described in paragraph (2).”.

(2) CONFORMING AMENDMENTS.—

(A) Section 1631(d)(2)(A) of such Act (42 U.S.C. 1383(d)(2)(A)) is amended—

(i) in clause (iv), by striking “and” at the end;

(ii) in clause (v), by striking the period at the end and inserting “; and”; and

(iii) by adding at the end the following new clause:

“(vi) by substituting, in subsection (e)(1)—

“(I) ‘subparagraphs (B) and (C) of section 1631(d)(2)’ for ‘the preceding provisions of this section’; and

“(II) ‘title XVI’ for ‘this title’.”.

(B) Section 303(e)(2) of the Social Security Protection Act of 2004 (Public Law 108–203; 118 Stat. 523) is amended by striking “AND FINAL REPORT” in the heading and by striking the last sentence.

(3) **EFFECTIVE DATE.**—The Commissioner of Social Security shall provide for full implementation of the provisions of section 206(e) of the Social Security Act (as added by paragraph (1)) and the amendments made by paragraph (2) not later than March 1, 2010.

CHAPTER 4—GENERAL PROVISIONS, THIS TITLE

EMERGENCY DESIGNATIONS

SEC. 3401. (a) **IN GENERAL.**—Each amount in this title is designated as an emergency requirement and necessary to meet emergency needs

pursuant to sections 403 and 423(b) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010.

(b) PAYGO.—All applicable provisions in this title are designated as an emergency for purposes of pay-as-you-go principles.

TITLE IV—GENERAL PROVISIONS, THIS ACT

PERIOD OF AVAILABILITY

SEC. 4001. No part of any appropriation contained in this Act shall remain available for obligation beyond September 30, 2010, unless expressly so provided herein.

BUY AMERICA

SEC. 4002. All funds provided under this Act shall be subject to the requirements of section 1605 of division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5).

This Act may be cited as the "Jobs for Main Street Act, 2010".

The SPEAKER pro tempore. The motion shall be debatable for 1 hour equally divided and controlled by the Chair and ranking minority member of the Committee on Appropriations.

The gentleman from Wisconsin (Mr. OBEY) and the gentleman from California (Mr. LEWIS) each will control 30 minutes.

The Chair recognizes the gentleman from Wisconsin.

GENERAL LEAVE

Mr. OBEY. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on the pending legislation.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Wisconsin?

There was no objection.

Mr. OBEY. Madam Speaker, I think people understand what this legislation is—it is an effort to redirect some \$75 billion from TARP funds that in the past have been directed to help Wall Street. Instead, direct them to Main Street to try to help Americans who are struggling to hang onto their jobs, their houses, and their health care. I think the need for it is obvious, and I urge passage.

I reserve the balance of my time.

Mr. LEWIS of California. Madam Speaker, Chairman OBEY calls this legislation the Jobs for Main Street Act; I call it economic insanity. Truly, this is one of those rare occasions when I hardly know where to begin.

It is because of legislation like this and the manner in which it was produced that the public has lost faith in this Congress and why confidence in Washington is at an all-time low.

This legislation repeats the failures of the so-called "Recovery Act" by pouring another \$150 billion into programs included in the original stimulus package that have so far failed to produce real results or real jobs.

Secondly, this legislation adds an additional \$150 billion to a budget deficit that has already tripled in the last year. The Democrat majority claims that this spending is offset with funds

from the TARP program, but under present law these dollars are already dedicated to reducing our debt. The public should not be fooled; every dollar will come out of the Treasury and taxpayers will be footing the bill.

Further, this legislation is a virtual mystery to almost every single Member of the House. I think we got the basic material like at 11 o'clock last night, I think. Its contents were released just shy of midnight last night for most, and there is no way for anyone to have read or understood it completely. How much thought or Member input really went into it? I dare say very, very little.

Ironically, it was Chairman OBEY who said on December 11, 2006, We will work to restore an accountable, above-board, transparent process for funding decisions and put an end to the abuses that have harmed the credibility of the Congress. This is a demonstration project of just how serious Mr. OBEY was about that.

Let me take just a moment to outline the transparent process by which this legislation comes before us today. Chairman OBEY instructed his majority staff not to share any details or information with the minority staff about the bill. Chairman OBEY's staff sent the bill to the Rules Committee at 11 o'clock last night. It has had no hearings, no markup, and is prevented from being amended on the House floor today. Mr. Speaker, martial law in the House of Representatives is hardly change that we can believe in.

Yet another irony in today's debate is that the Democrat majority has suddenly found religion by championing so-called "PAYGO" rules. This is occurring at the very same time that they are proposing to spend another \$150 billion and even as they have voted to increase the debt limit. We pass the debt limit, spend another \$150 billion.

Not long ago, small business in America was the backbone and the lifeblood of our national economy. Today, higher taxes and excessive government regulations have small business in a stranglehold, and that's even before Congress puts its stamp of approval on government-run health care.

With all this reliance on Uncle Sam, why don't we just put everyone in the United States on the Federal Government payroll and call it a day? In essence, that's what this fatally flawed process attempts to do.

□ 1645

According to Transportation Weekly, "Even if you only count title I of the stimulus II bill as an appropriations bill, it would still be the third largest fiscal year 2010 discretionary appropriations bill—bigger than Agriculture, Commerce-Justice, Energy and Water, Financial Services, Homeland Security, Interior and Environment, legislative branch, State/foreign operations, and the THUD bill."

Imagine what Ranking Member DAVID OBEY's reaction would have been had a GOP majority moved a supplement of this size to the House floor on less than 24-hours' notice and with no committee markup? Can you imagine the screaming from the rooftops? We have seen that before.

On more than one occasion, my friend, the majority leader, has suggested that the House minority has become the so-called party of "no," but he forgot to finish the sentence. House Republicans are the party of no more spending beyond our means. We are the party of no more increases to the historic debt limit. Republicans in the House are the party of no more busting the spending cap and calling it "emergency spending."

Our country's economy will never recover as long as Congress continues making the same mistakes over and over again. Spending by this House majority is unconstrained and unsustainable. Billions and billions and billions spent on the continued expansion of government will only exacerbate our financial troubles and will bring little or no relief to those without jobs.

Through this legislation, Congress is demonstrating once again that it is both unwilling and incapable of restraining its appetite to spend. This is nothing short of a taxpayer-funded Christmas shopping spree, financed with money borrowed from the Chinese.

I appeal to my friends, the Blue Dogs, to take a stand on this legislation. If you are serious about making a statement, this is your chance. Are the Blue Dogs serious about deficit reduction? If so, then vote "no."

Madam Speaker, simply put, this is an awful bill produced through a dreadful process. I strongly urge a "no" vote.

I reserve the balance of my time.

Mr. OBEY. Madam Speaker, I thank the gentleman for his support.

I now yield 4 minutes to the distinguished gentleman from Minnesota (Mr. OBERSTAR).

Mr. OBERSTAR. I thank the distinguished Chair of the Appropriations Committee, my good friend from across the waters in Wisconsin, Mr. OBEY, and I applaud him for his extraordinary persistence and leadership in bringing to us this Jobs for Main Street Act. He has been consistent, persistent, forceful, vocal, and very laser beam-oriented on creating jobs.

Madam Speaker, in this Jobs for Main Street, \$39 billion is allocated to additional transportation and infrastructure investment to create and sustain family-wage construction jobs and, at the same time, rebuilding the Nation's highways and bridges and wastewater treatment systems.

We extend in this provision the highway and highway safety and transit

programs through September 30, 2010. There is \$27.5 billion for highways, \$8.4 billion for transit, as in the current Recovery Act. There is \$800 million for Amtrak, \$500 million for airports where an extraordinary success was achieved with nearly all of the airport projects being either completed or under contract on the job, improving our airport capacity. There is \$1 billion for the Clean Water State Revolving Loan Funds to improve wastewater treatment facilities and to build new ones where they don't exist today. There is \$715 million for the Corps of Engineers, and there is \$100 million for ship construction to help our maritime interests.

We have a highly successful record on that portion of the stimulus that comes from the Committee on Transportation and Infrastructure from which both Mr. OBEY and the distinguished Republican leader are graduates.

There are 220,000 direct jobs on over 8,000 projects. There are 630,000 direct jobs and jobs in the supply chain, supplying asphalt, cement, pipe, concrete, and culverts for this program. There is \$10 billion paid in payroll checks and \$179 million in unemployment insurance compensation checks avoided, and there is \$230 million in taxes paid to the Federal Government by those on these jobs, and there is more to come.

The results: There are 28,000 miles of highway pavement—improved, widened, expanded—underway right now. That is what we have achieved to this day, and we have more to come. There are 1,200 bridges restored, repaired, replaced, and with this addition in the Jobs for Main Street Act, we will have 56,000 miles of pavement rebuilt in the coming year. That will be 10,000 miles more than the entire Interstate Highway System just in this one bill.

That is an investment in America.

I assure my colleagues that this Committee on Transportation and Infrastructure will continue its vigorous oversight and accountability and transparency. Every month, every Member has received this report from our committee, a report with 14 categories of progress for each State under these key programs. You can track how many funds are associated with projects completed, how many projects are underway, the total job hours created and sustained, and the total payroll for hours created or sustained in every month for every State.

We are making this clear that we are accountable and that we are investing in America and that we will continue to do this under the Jobs for Main Street program.

Madam Speaker, I rise in strong support of H.R. 2847, the “Jobs for Main Street Act, 2010”.

This bill provides more than \$39 billion of additional transportation and infrastructure investment to help create and sustain family-

wage construction jobs and rebuild our Nation's infrastructure. The bill also extends the highway, highway safety, and public transit programs for the current fiscal year, through September 30, 2010.

One-half of the \$75 billion provided by H.R. 2847 is dedicated to transportation infrastructure investment, including: \$27.5 billion for highways, \$8.4 billion for transit, \$800 million for Amtrak, \$500 million for airports, and \$100 million for ship construction.

In addition, H.R. 2847 provides \$11 billion for other infrastructure investment, including \$1 billion for Clean Water State Revolving Funds and \$715 million for Corps of Engineers infrastructure investments.

Each of these investments is paid for—we use the Wall Street bailout funds to rebuild Main Street.

These investments will build upon the investments already underway pursuant to the American Recovery and Reinvestment Act of 2009 (P.L. 111–5) (Recovery Act), and will create and sustain more than 1 million good, family-wage jobs.

The transportation and infrastructure investments of the Recovery Act have already played a key role in putting Americans back to work. Federal agencies, States, and their local partners have demonstrated they can deliver transportation and infrastructure projects and create urgently needed employment in the tight timeframes set forth in the Recovery Act. This Act has already resulted in almost 7,900 highway and transit projects breaking ground as well as hundreds of thousands of workers getting off the bench and back on the job all across the Nation.

However, we have only begun to stem the tide of unemployment caused by the worst recession since the Great Depression. More than 1.7 million construction workers are out of work and the unemployment rate in construction is 19.4 percent—the highest unemployment rate of any industrial sector. In addition, the private sector construction market has collapsed. At a recent hearing of the Committee on Transportation and Infrastructure, the president of an asphalt supply company testified that, although historically his company has received one-half of its work from the private sector and one-half of its work from the public sector, 98.5 percent of his current business is public sector work.

To make matters worse, State budget crises are severely limiting States' ability to move forward with their own infrastructure programs or find matching funds for Federal transportation programs.

Although the critical investments made by the Recovery Act have stemmed the tide of unemployment in the construction industry, they have not been sufficient to completely counteract the loss of private sector and State investments.

Congress must act now to pass the “Jobs for Main Street Act, 2010”, and build upon the successes of the Recovery Act.

The Jobs Act “doubles down” on the highway and transit investments of the Recovery Act and will immediately create and sustain jobs. The Jobs Act provides almost \$36 billion for highway and transit investment and much of it can be, and will be, put to use within 90 days for ready-to-go projects.

According to a December 2009 American Association of State Highway and Transportation Officials, AASHTO, survey of State Departments of Transportation, there are 7,497 ready-to-go highway and bridge projects, totaling \$47.3 billion. Furthermore, according to a December 2009 American Public Transportation Association, APTA, survey, there are thousands of ready-to-go transit projects, totaling \$15 billion.

In addition, Congress must also act now to extend the core Federal highway, highway safety, and transit programs. The long-term authorization for these programs, SAFETEA-LU, expired on September 30, 2009. Since then, these programs have been extended on a short-term basis at a funding level that is about \$12 billion below the fiscal year 2009 authorized level. H.R. 3326, the fiscal year 2010 Defense appropriations bill, will provide an additional short-term extension of these programs, to February 28, 2010, but still at the reduced funding level.

H.R. 2847 includes the Surface Transportation Extension Act (STEA) of 2009, which extends the highway, highway safety, and transit programs through September 30, 2010, at the levels assumed in the FY 2010 budget resolution. This one-year extension will provide greater certainty for States in their transportation planning, and increase funding to nearly the FY 2009 authorized level.

STEA also includes provisions that will stabilize the Highway Trust Fund. Specifically, STEA restores to the Highway Trust Fund interest payments foregone on the Trust Fund's previous cash balances. Since 1998, the Trust Fund has been the only major Federal trust fund that does not accrue interest. The restoration of interest for this period, 1998–2009, results in transferring \$14.7 billion to the Highway Account of the Highway Trust Fund, and \$4.8 billion to the Mass Transit Account of the Highway Trust Fund.

In addition, STEA allows the Highway Trust Fund to accrue interest on all balances going forward, which will increase Trust Fund receipts by an estimated \$500 million to \$1 billion annually, in the near-term.

Finally, under STEA, the General Fund, rather than the Highway Trust Fund, will support longstanding fuel tax exemptions, such as those provided to State and local governments. Full refund payments will continue to be made from the General Fund, but the Highway Trust Fund will no longer bear the cost of these refunds. The end user will see no change in their process for obtaining a refund. This provision will increase Trust Fund revenues by about \$1.7 billion annually, for a total of \$9.8 billion over six years.

I regret that the Other Body was unable to complete action on a multi-year surface transportation bill this year. I urge the Senate to focus on the needs of the millions of Americans who are without jobs or who are in danger of losing their jobs, Americans who are struggling to provide for their families, and desperately need the jobs that would be created not only by the bill before us today, but also by a long-term authorization of surface transportation programs.

I urge my colleagues to join me in supporting H.R. 2847, the “Jobs for Main Street Act, 2010”.

Mr. LEWIS of California. Madam Speaker, I yield 2 minutes to the gentleman from Georgia, JACK KINGSTON.

Mr. KINGSTON. I thank the gentleman for yielding.

Madam Speaker, I want to say, in January, the President rushed through a massive stimulus bill of \$787 billion, which was supposed to be targeted and timely for shovel-ready projects. We had to do this to keep unemployment from going to 8 percent. Well, now it's at 10 percent. Rather than going back into the stimulus program and doing major surgery, we are adding yet another spending bill from a different account.

To begin with, the stimulus bill only had about 27 percent in public work-type projects. Most of it went to plus-up pet political projects of Congress and to create 31 brand new Federal Government programs. Even then, 12 percent of the money is all that has left town. Most of it is still in Washington, D.C.

To give you some examples, there is a Smart Grid program of \$4.5 billion. None of the funds have been spent. There is a \$2.2 billion alternative fuel program. None of those funds have been spent. There is a \$4 billion energy innovative technology loan program. Only \$2 million has been spent. There is an \$8 billion high-speed rail project of which zero funds have been spent. There is \$1 billion for the COPS grants program, and no funds from it have left Washington, D.C.

Before we go spending additional money, wouldn't it make sense to try to figure out what the logjam is?

You can go to the Web site of the stimulus program, and you can see the jobs that were created in the 99th District of the Virgin Islands or in the 42nd District of Connecticut. The only problem is there are no such districts. They are fictitious numbers. You could go to Augusta, Georgia, and look at the housing projects where 317 jobs were created. Only it really wasn't for creating jobs. It was a bonus for existing employees. Again, from the administration's Web site, \$937 million was spent on 10,000 projects from which no jobs were created. The stimulus program is not working. We need to revamp it.

Another reason we don't have jobs under this administration is because of the cap-and-trade policy.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. LEWIS of California. I yield an additional 30 seconds to the gentleman from Georgia.

Mr. KINGSTON. The cap-and-trade proposal is a scheme based on some phony numbers, not all of the numbers. Incidentally, I don't recommend Al Gore's book to anybody, but if you have time for reading today, keep that one in mind. It's going to run jobs overseas. We need to take a look at it.

Particularly, it needs to be based on real numbers, not on phony numbers.

The health care policy is an 8 percent tax on small businesses with a myriad of new rules and regulations with the possibility of lawsuits. There is the banking bill, which is just going to crunch credit all over America. This is not the right thing to do at the last minute.

Mr. OBEY. Madam Speaker, I yield 3 minutes to the distinguished gentleman from California (Mr. GEORGE MILLER), chairman of the Education and Labor Committee.

Mr. GEORGE MILLER of California. I thank the gentleman for yielding, and I thank him for all of his work on this legislation.

Madam Speaker, today, Congress has the opportunity to continue the effort to rebuild the American economy. We have made significant progress since January when more than 600,000 people were losing their jobs. Last month, it was 11,000—a dramatic improvement. In fact, in November, a year ago, it was over 700,000 people who were losing their jobs. I don't know what the figure has to be before the Republicans decide they ought to help Americans keep their jobs, to find new jobs, and to get jobs so they can support their families.

The fact is, every day, as to the Recovery Act, which they want to continue to lampoon and the rest of it, more and more economists and more and more fiscal analysts of the markets in this country are telling us that the Recovery Act is the reason that we have moved from a negative GDP to a positive GDP. It is the reason we have saved or created more than 1.6 million jobs. Those aren't our words. Those are the words of the people who are in the private sector who are talking about this market.

What are they warning us about now?

It's not just the traditional jobs. It's a question of—and this comes again from private analysts—whether or not local governments which are somewhere between \$200 billion and \$300 billion underwater because of the economy, because of the recession and because of their loss of receipts and revenues can create a wave of unemployment that will swamp the good news that is taking place and the news that we hope will get better and that we think will get better. It can overwhelm the positive job numbers that we are starting to see, and it can create that kind of problem.

It also means that, once again, we can see—and what this legislation prevents—is that wave of layoffs in teachers, in firefighters, in police, and in first responders because we know that that's about keeping our communities healthy and safe. It's about making sure that our kids do not become the victims of this economy because of the layoffs, the shorter school days, the larger classes that are taking place,

and the shorter school years. The States are going to struggle with this.

We know from the private sector, if you look around at what has taken place in this recession, that the leaders in the private sector decided, in this kind of economy, this is when you want to invest in your future. That is what we are doing. We are investing in the future of our children and of our young people going to college. We are creating additional slots so they can get into community colleges, so that they can get job training, and so that they can have teachers and decent class sizes. That is what this legislation is about.

It's about trying to create job opportunities, and it's about holding onto job opportunities for American families. It's also to make sure that their children do not lose a year of educational opportunity and so that they do not slide back from the progress that we're seeing. All across this country, as the test scores are getting better and as proficiency is getting better among fourth graders and eighth graders, that is the progress that we have made. This recession could wreck it all, and we've seen it all across the country.

Rio Vista, Texas, laid off 15 percent of its teachers. Dearborn, Michigan, just approved 200 teacher layoffs. The LA Unified School District laid off 2,000 teachers and maybe another 1,500 teachers next year.

You can stop that from happening. You can stop that from happening by voting for this legislation.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. OBEY. I yield the gentleman an additional 1 minute.

Mr. GEORGE MILLER of California. This is about our future. This is about a jobs program that is paid for. This is about taking the money that was dedicated to working on Wall Street and making sure that it works for Main Street. This is your opportunity so that you can go home and say that you did everything you could to try to maintain the positive direction that the economy is starting to indicate, but we are not there yet.

Again, if you listen to the analysts, it can be overwhelmed by the loss of jobs and by the wave of unemployment that could take place at State and local governments, and our children's educational opportunities can be overwhelmed.

Mr. OBERSTAR laid out the infrastructure piece that is so important in terms of the investment, not only in jobs, but in terms of the investment in the future of this country in highways and transit. This is about human capital. This is about whether or not we can retain first responders, teachers and whether or not we can retain the growth, economic proficiency, and achievement that our children are getting in school today.

Let's not lose that because, through no fault of their own, the recession whacked their teachers, whacked their classrooms, whacked their school districts, and then all of a sudden, those opportunities were gone. We should not let that happen. We can vote against its happening today. We can vote for a jobs bill that works on Main Street.

□ 1700

Mr. LEWIS of California. Madam Speaker, I am very pleased to recognize the gentleman from New Jersey (Mr. FRELINGHUYSEN) for 2 minutes.

Mr. FRELINGHUYSEN. I thank the gentleman for yielding.

Madam Speaker, there is no question that the American people are hurting. Since the start of this recession in 2007, 6.9 million people have lost their jobs. A third of those without jobs have been unemployed for more than 6 months. That's a post-World War II high.

Clearly Congress needs to find a way to spur private sector job creation, a bipartisan way, not one rammed through without public hearings. Madam Speaker, a famous son of New Jersey once said, and that's Yogi Berra, "It's déjà vu all over again."

Congress and the President enacted in February a trillion-dollar stimulus package with the promise that its shovel-ready spending would keep unemployment from exceeding 8 percent. While the Nation's official unemployment is 10 percent, the real unemployment and underemployment now exceed 17 percent.

Yet the majority is suggesting that we double down on spending borrowed dollars in many of the same areas touched by the first stimulus. For example, only 7 percent of the \$2 billion in the stimulus bill for the Army Corps of Engineers civil construction has been spent. Yet this bill adds another \$750 million.

Only 8 percent of the \$1 billion in the stimulus for Bureau of Reclamation water projects has been spent. This legislation includes another \$100 million.

The stimulus contained \$4 billion for Energy Innovation Loans. Just 10 percent has been spent since February. So let's make sure to approve another \$1 billion.

Of the \$36 billion the Department of Energy has been given, about \$955 million has been spent and only \$17.5 billion has been obligated.

If this isn't bad enough, where is the funding coming from? It's coming from the TARP program, Troubled Asset Relief Program. That money, when it is paid back, is supposed to go to reduce the deficit. Here we are spending.

I rise to oppose this bill. This bill needs to be opposed.

Mr. OBEY. I yield 1 minute to the distinguished gentleman from Georgia (Mr. SCOTT).

Mr. SCOTT of Georgia. Thank you very much, Mr. Chairman. I appreciate

you giving me a minute to speak on this.

This is the single most important issue facing the American people, jobs. You talk about troubled assets, what greater troubled assets do we have than jobs and homes? These are the troubled assets that the American people want us to respond to.

Throughout the length and breadth of this country, small towns, country towns, from Michigan, Ohio, throughout wherever it is, people are concerned about jobs. The misery index is high, the depression index is high. Do you know what a job means?

Here we have got \$75 billion. What better place to put it than in small businesses, into the heart and the soul of the American economy, at the middle and at the bottom where people will spend it.

Ladies and gentlemen of this Congress, this is Christmastime. Next week is Christmas. What better Christmas gift can we give the American people than this jobs bill that will put our people back to work, that will build our homes, that will help our families, that will give them hope where they need it. They deserve this Christmas present this day.

Mr. LEWIS of California. Madam Speaker, it is my honor to recognize the ranking member of the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, the gentleman from Kansas, for 3 minutes, Mr. TIAHRT.

Mr. TIAHRT. I thank the gentleman from California.

Madam Speaker, 10 months ago we stood here and told you the stimulus bill would not help the economy recover. We told you it would not work because the \$787 billion plus interest would only grow the size of government. You can't grow the economy from the government down. You have to grow it from the ground up.

By any standard, we were right. Now we have news accounts of how the money was spent, mostly on government workers writing more government regulations. Then there was the news about the pay raises for Head Start teachers and the buyouts for university professors and unemployment is double digits. It's 10 percent.

Today on the floor we have the "son of the stimulus" bill. It's another \$154 billion of failed economic policies that will only prolong the economic pain.

This bill includes another \$750 million for green jobs on top of the previous bill's \$750 million. So far, no green jobs have been created.

The "son of the stimulus" adds \$23 billion to State and local governments on top of the \$53 billion in the stimulus bill.

You can't isolate State and local governments from the recession. If you do, they will do nothing to help with the recovery. History tells us what works.

When we have the opportunity in America, new ideas come into the marketplace and the economy will grow. When the economy grows, the Federal revenue grows without raising taxes.

Here is how you create opportunity: stop spending, stop borrowing. You can't grow the economy from the government down. Freeze regulations, audit every one of them and only keep the ones where the benefit exceeds the cost.

Keep taxes low. When you do, people save. They invest; they spend. All of that's good for the economy. Lower health care costs, not by taking over with the government, but by addressing tort reform and by incorporating free market principles and then become energy independent. That alone would solve your unemployment problem.

Now, it's true that providing the opportunity for the economy to grow does not pay back the government unions for all they have done for you in the last election. Government unions should be pleased with this bill, but the American taxpayers should not. They should be angry.

For those that are unemployed workers, well, we are sorry, because this bill will not do anything for the unemployment rate. It's a failed economic policy that only pays back those who invested in the last election for the majority party.

Madam Speaker, I would ask my colleagues to vote "no" on this legislation and, instead, do something that will help the economy recover by providing opportunity for the unemployed workers.

Mr. OBEY. Madam Speaker, I yield myself 2 minutes.

Madam Speaker, when President Bush left office, we were losing over 700,000 jobs a month. We passed the economic recovery package, and we have gotten that down to about 11,000 jobs a month. That's not enough, but it's terrific progress.

I am somewhat bemused, however, by all of the comments by our friends on the minority side of the aisle denouncing the recovery package and saying that it didn't work. Not a single one of them voted for it on this House floor.

But if you check newspaper accounts around the country, you will see, for instance, that the minority leader, in a June 15 press statement, said that he was pleased that Federal officials stepped in and ordered Ohio to use all of its construction dollars for shovel-ready projects that will create much-needed jobs.

The minority whip vowed to shed partisan politics to help the economy. He met with transportation officials about how his home State of Virginia could apply for stimulus grants to build a rail line.

The minority chief deputy whip, in his own press release, outright praised

the courthouse in his district receiving funds from the recovery package to build a new courthouse. He said, "I applaud this funding for the Bakersfield Federal courthouse."

My Republican colleague from New Jersey (Mr. LANCE) announced by a press release that his district received \$13 million from the Recovery Act for local flood control projects. "This is outstanding news," he said. He even sent a letter to President Obama asking for speedy release of those recovery funds.

Another of our colleagues from Michigan on that side of the aisle issued a press release saying he was pleased to announce that his international airport would receive \$12.7 million from funds received by the Recovery Act.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. OBEY. I yield myself 1 additional minute.

Another of our colleagues on the minority side from Illinois said, "There is no question these grants will be of assistance in creating jobs."

I can go on and on and on citing Member after Member who denounced the bill on the House floor and then went home to their districts and issued grandiose press releases expressing their support for the results of the recovery package.

I have a little difficulty following that ping pong ball when it's bouncing on both sides of the table. I have a little difficulty following the folks on that side of the aisle when they decide to fall off both sides of the same horse. I wish you would make up your mind: which do we believe, your statements that you make at home or the statements and the votes you cast on this House floor?

Mr. LEWIS of California. I yield 2 minutes to the gentlewoman from Missouri, who is the ranking member on the Financial Services and General Government Subcommittee, Mrs. EMERSON.

Mrs. EMERSON. Madam Speaker, I want to say a couple of things first. Number one, I don't know if the American people realize that since 2007 this Congress has increased spending on nondefense, nonveterans discretionary spending and, including the stimulus in that, by 85 percent, 85 percent. In so doing, we still have 30 percent unemployment in the construction trades in the State of Missouri, and there is no excuse for that. This bill does very little to help that, very, very little.

As a matter of fact, some of the stimulus money that went to create new jobs in my congressional district—actually, our job training people were told that anybody who is in job training counted as a new job. Now that's disingenuous at best, and it's not fair to a person who is being counted as having a job and one is not there waiting for them when they graduate.

I really want to talk today about my concerns about the use of TARP funds to offset additional government spending. You know, when we debated this legislation, we were told the funds were going to be repaid and that in the long term the Federal Government could make money on the TARP program.

However, today we are debating whether to use TARP funds, which the administration really had no plans to spend, as an offset for yet more government spending. This is a gimmick extraordinaire.

We just debated a bill to increase the debt limit to \$12.4 trillion. Using this budget gimmick as an offset for \$75 billion in new spending is not going to reduce the debt one bit. Every economist in America says if we don't reduce the debt in this country, then our economy will go away.

It is going to ensure, this bill does, that our government debt is going to continue to grow, increasing our dependence on China, on other foreign investors and increasing the financial burden on our children and grandchildren.

Mr. OBEY. Could I inquire how much time is left on both sides.

The SPEAKER pro tempore. The gentleman from Wisconsin has 17½ minutes remaining, and the gentleman from California has 14 minutes remaining.

Mr. OBEY. I yield 3 minutes to the distinguished chairman of the Ways and Means Committee (Mr. RANGEL).

Mr. RANGEL. Chairman OBEY, let me thank you for not just saying what are we going to do about the jobs, but bringing this all together and doing something about it. One of our great Presidents, Jack Kennedy, once said that sometimes your party just asks too much of you.

I know that's what my Republican friends must feel today, because there is no question in my mind that they have just as much compassion in their heart for those jobless people as we do. They know, as we do, that those who have lost their homes, lost their dignity, lost their job, didn't do it by being Democrats or being Republicans.

I recognize that when you go in a room and make a decision to say "no," you are kind of stuck with it, so we are not naive enough to believe that I can change your mind about what you already decided, but I do hope that when you go back to your home districts, and you recognize what is happening to people who are jobless, many of whom are hopeless, many have lost their skills and many who hope soon it will not continue, have lost what it's like to believe that in this great country there is no limit to how far that you could go.

□ 1715

So maybe next year would be different. Maybe the guys in the street

will be following you around, as we find people grabbing Members of the Congress, saying, Hey, my dad needs a job, Congressman, Congresswoman, can you help?

We're trying to help. It was a big crisis and a lot of blame to go around. But collectively someone thought that TARP would work. Well, it had some successes. One thing is certain: We're not going back there. This time it's not the banks. It's not Wall Street in my area. It's now going to be Main Street, so that once again you have an opportunity to explain what are you doing in the Congress.

Well, I know it didn't go over big to say that you were bailing out banks. It certainly didn't go over in my district. How about we're trying to bail out our people. We're trying to restore the hope and confidence they had. We're trying to keep kids in school. We're trying to put food on their table. Sure, we talk about food stamps and food pantry, but we're trying to restore that dignity that make Americans so much different from other people.

In the Ways and Means Committee, where we have jurisdiction over COBRA, this is another step to have dignity. You lose your job, you lose your health care. What a terrible thing to be looking for work and you're sick and you can't even go to the doctor. Worse still, if there are sick people in your family and you don't have the insurance. Well, the Federal Government comes in not with handouts but saying can we give you a hand with your responsibility to provide health care? And that's what we've done on our committee.

We've taken unemployment benefits. You know, you can get enough checks for the length of time—

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. OBEY. I yield the gentleman an additional 1 minute.

Mr. RANGEL. Thank you, Mr. Chairman.

In any event, we got aid out there for school construction. It's not just to make certain that we have a place for our kids to learn to become the leaders of tomorrow but also that people can get bricks and mortar and rebuild those schools and renovate those schools, and that's what we're doing.

We've been able to make certain that at least the Ways and Means Committee can join in with the other committees, under the leadership of our great Speaker and DAVE OBEY, to be able to say this is not all that we want to do; this is all that we can do.

Maybe over the holidays you might be able to get back to your leadership and say, We've been faithful. But we've found out that many in our districts have lost jobs, lost their home, lost their health insurance, and really lost hope. Just saying "no" is not going to work.

Mr. LEWIS of California. Madam Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. CAMP), ranking member of the Ways and Means Committee.

Mr. CAMP. I thank the gentleman for yielding.

Albert Einstein once said, "The definition of insanity is doing the same thing over and over again and expecting different results."

Yet even though their stimulus bill hasn't created a single job and has resulted in 10 percent unemployment, House Democrats have brought to the floor today a stimulus II bill that explicitly amends, continues, or expands numerous provisions of their failed stimulus I bill.

And here's a graphic depiction of this insanity.

How does spending more on the Bureau of Reclamation create jobs now when it didn't before? How does transit capital assistance create jobs now when it didn't before? And how do more loan guarantees create jobs now when they didn't before?

This is a "son of stimulus" bill. Let's stop the insanity. Vote "no."

Mr. OBEY. Madam Speaker, I yield 3 minutes to the gentleman from Massachusetts (Mr. FRANK), the chairman of the banking committee.

Mr. FRANK of Massachusetts. Madam Speaker, the assertion that the economic recovery bill, the stimulus bill, has created no jobs is, I must say, one of the least intellectually supportable statements I have heard on this House floor, and I've been here a long time. There's an argument about how much and how little, but no competent economist denies that it helped create jobs.

Here's where we are: The fact is that the Obama recovery from the Bush recession has been going more slowly than many of us would like, but it is undeniable by every statistic it is going forward.

Now, if you listen to my Republican colleagues, you learn that the third worst day in American history was January 21, 2009. The worst day, of course, was Pearl Harbor, and then we had the terrible mass murders of 2001. But to pick a day when there were no mass deaths, what was the worst day? January 21, 2009, because according to this debate, guess what happened on January 21, 2009? The Federal budget, which was apparently in surplus, all of a sudden punched into deficit. Unemployment suddenly appeared. The war in Afghanistan, by the way, was going wonderfully until January 21, 2009. There were no bailouts until January 21, 2009. Some of you may have thought they happened in September of last year, but, no, apparently it all started on January 21, 2009.

And not only that—and I have to say I'm quoting my partner, Jim, here—it was one of the worst outbreaks of dis-

ease in American history. Mass amnesia seized the Republican Party on January 21, 2009. They forgot that the Bush recession started under President Bush in 2007, after they had controlled both the House and the Senate and the Presidency for the longest time. They forgot that the deficit had mushroomed under them. They forgot that trying to pay for two wars with five tax cuts was kind of a bad idea, and at least you shouldn't be surprised it resulted in a deficit.

So what we are now doing is trying to undo that. And adults understand that you cannot go from a terrible decline to rapid increase without passing through a transitional period. We are passing through it by every economic statistic.

Now, I agree the situation was worse than we thought, and it is getting better more slowly than we had hoped, but it is clearly getting better. And, again, if you listen to my Republican colleagues, the world began on January 21, 2009. I know some of them thought it started 4,000 years ago, and they didn't believe in evolution. I didn't think they thought it all started when Barack Obama became President.

We do try here to help. I was astounded to hear the gentleman from Michigan say it hasn't created one job. Madam Speaker, tell that to the cops and firefighters in my district who were rehired because of this. Tell that to the people now working to clean up a Superfund site in my district which was funded by this bill. This denial of reality to evade responsibility for the dilemma we are in is breathtaking.

So I want to congratulate the gentleman from Wisconsin, who has been the most consistent advocate of social fairness and economic effectiveness that we've had, for a wonderful bill.

Mr. LEWIS of California. Madam Speaker, it's my privilege to yield 2 minutes to the gentleman from Texas (Mr. HENSARLING), Chairman FRANK's great friend from the committee.

Mr. HENSARLING. I thank the gentleman for yielding.

You know, repeating failure over and over might be amusing if it wasn't for the fact that so many of our countrymen are suffering.

I heard the distinguished chairman of the Financial Services Committee share with us his history lesson, but also I might add if we look at press reports, clearly Democrats have had trouble counting jobs in America.

What we do know is that the Department of Labor says that we still have double-digit unemployment under this President and this Democratic Congress. What we know is that the Department of Labor says that since the first stimulus bill was passed, to add an extra trillion dollars of spending and debt for future generations to pick up, that 3.6 million of our fellow countrymen have lost their jobs.

The history lesson that I hope my friends on the other side of the aisle would learn is that you cannot spend your way into more jobs. You cannot borrow your way into more jobs. And you cannot bail out your way into more jobs. And, Madam Speaker, the legislation they bring before us does exactly that. It's more of the same. It is "son of stimulus."

Spend another \$150 billion of taxpayer money. How many more jobs have to be lost? It wasn't an hour ago that this body just voted for \$290 billion more of debt ceiling, borrowing the money from the Chinese, sending the bill to our children and grandchildren. How many more jobs have to be lost? Bailout funds, bailout funds for the States, bailout funds for the municipalities. How many more bailouts, how many more jobs have to be lost?

In this economy, small business, they want to create the jobs, but take away your trillion-dollar takeover of health care, take away your \$600 billion national energy tax, take away your perpetual Wall Street bailout bill, and jobs will come back to America.

Those are the policies that we need, Madam Speaker.

Mr. OBEY. Madam Speaker, I yield 2 minutes to the distinguished gentleman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Madam Speaker, I rise in support of this jobs bill.

We have seen 23 straight months of job losses. What does this mean? It means that families are under a huge stress. It means there are hungry children in the United States of America. It means a lost generation of American workers.

We owe a response to those families contending with joblessness and the financial havoc it wreaks on their lives. It is not only the moral thing to do; it is our obligation as legislators and as citizens.

I urge my colleagues to support this bill. It redirects \$75 billion of TARP funds, money that was spent on Wall Street, and it moves it toward key infrastructure investments, which will provide jobs now. It provides a foundation for long-term prosperity. It helps to stabilize our public sector workforce. It supports teachers, police officers, firefighters, and other public servants. And as important, it cuts taxes for 16 million struggling families by making the child tax credit available to working families with children.

They lost their jobs. They lost their health benefits. Their work hours were cut short. And, yes, their child tax credit was decreased. Refundable tax credits are the most fiscally stimulative policies that we can put into place. Don't listen to me. Listen to economists. And it puts money into the hands of families who are living today paycheck to paycheck, and their spending in turn leads to a strong boost in

job creation. Let's put that TARP money to work where it always belonged, in the hands of the American people.

I urge my colleagues to support this bill. We need to get America back to work.

Mr. LEWIS of California. Madam Speaker, it's my privilege to yield 2 minutes to the gentleman from Virginia (Mr. CANTOR), the Republican whip.

Mr. CANTOR. I thank the gentleman from California.

Madam Speaker, Winston Churchill once said that, "All men make mistakes, but only wise men learn from their mistakes."

Today it is apparent that Congress has not learned anything. The bill on the floor today is just another round of spending that doubles down the failure of last February's so-called stimulus plan while ballooning the deficit.

The first stimulus plan and bill failed to hold down unemployment, but it successfully increased our reliance on borrowed money. Worse, a lot of the money designated for infrastructure, those shovel-ready projects we all heard about, hasn't even gotten out of Washington yet. Why is it still here if it was designed to create jobs?

Sadly, pouring billions into the very same programs will meet a similar dismal fate. Just as bad, this legislation continues to fall hopelessly short of providing real relief to small businesses so they can resume hiring, investing, and expanding.

Now is not the time to spend an additional \$150 billion we don't have. It's time to come together to ease the burden on small businesses and to start giving them a sense of certainty so they can go about the business of creating jobs and prosperity.

Madam Speaker, I urge a "no" vote on this so-called "jobs" bill.

□ 1730

Mr. OBEY. I yield 1 minute to the distinguished gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Only the lack of clarity and poor eyesight can call this the so-called jobs bill, because if we've looked over the last year, the American Recovery and Reinvestment Act helped save 3.5 million jobs. They named Chairman Bernanke as the person of the year, but his twin was the work that was done on this floor by the Democratic leadership to invest in America. My district has a 9 percent unemployment. In Saturday's Washington Post, three parents were seen with lights out and children who are hungry. Oh, yes, this sounds like spend, spend, spend, but I tell you, if we can invest a billion dollars in infrastructure, we create 27,800 jobs, and I'm proud to invest 35 billion of those dollars in fixing the highways and the roads of America.

I am glad 150,000 Americans will now be able to get training in high professional jobs, and I am glad that we are working on a metro system that will create jobs in our district.

Vote for this bill. It's jobs, jobs, jobs. Get good glasses and you'll see that.

Mr. LEWIS of California. Madam Speaker, by way of inquiry of my chairman, aside, Mr. Chairman, from the unprecedented and secretive process by which this bill was put together and is being brought to the floor, the rule before us contained a most unusual provision to allow the chairman to submit a report explaining the legislation. It would be very helpful to all Members before we vote on over \$154 billion in spending to actually have the benefit of the chairman's explanation.

I, for one, have not only not seen this report, I didn't even know he was writing one. Therefore, I would ask the chairman, is there a copy of this report, and will you make it available now so that Members will have a chance to see it before we vote on this bill?

Mr. OBEY. Well, I find it very interesting that the gentleman has not raised this point with respect to the Defense appropriations bill. But let me simply say that the explanatory statement for this bill is very short. It is on our Web site. It was posted there this morning.

Mr. LEWIS of California. The chairman certainly might have given us the courtesy of communicating that that was his intention ahead of time. And it's very clearly stated within the report that the Members would have it available to them. Obviously, the chairman has chosen to ignore that side of the responsibility.

With that, I reserve the balance of my time.

Mr. OBEY. Might I inquire how much time is remaining on both sides?

The SPEAKER pro tempore. The gentleman from Wisconsin controls 7½ minutes, and the gentleman from California controls 8 minutes.

Mr. OBEY. I yield 1 minute to the distinguished gentleman from Pennsylvania (Mr. FATTAH).

Mr. FATTAH. Madam Speaker, I rise in support of this legislation. The Republican minority has been fairly consistent. When we focused on health care, they said, well, 85 percent of the people in the country have health care, so let's not turn things upside down, let's not sacrifice too much to try to deal with the tens of millions who don't have it; 85 percent have it.

On the jobs front, 90 percent of the people in the country have jobs. So I can see their lack of empathy for the 10 percent who don't, and they don't see a need for us to act. But as we come to this holiday season, as we look and see many of our citizens who not only have not a job at this moment, mainly because of policies enacted, this unwar-

ranted war in Iraq and fiscal policies that have had us a double-digit national debt in the trillions before Barack Obama was sworn into office, but they don't really see a need for us to do a great deal of effort here to try to put Americans back to work.

I want to thank the chairman for authoring this legislation which is bifurcated, both focused on jobs and also in helping people in a difficult moment. That's what I think America ought to be about. I rise in support of this legislation.

Mr. OBEY. Could I inquire of the gentleman how many speakers he has remaining?

Mr. LEWIS of California. We have no speakers remaining. I might make a few remarks after I hear what the chairman has to say.

Mr. OBEY. Well, I am the last speaker, and since I have the right to close, I would suggest you use your time and then we'll use ours.

Mr. LEWIS of California. Can you give me an idea how much of your time you intend to take?

Mr. OBEY. The remainder of the time.

Mr. LEWIS of California. Ten minutes?

Mr. OBEY. No, we don't have 10 minutes.

The SPEAKER pro tempore. The gentleman from Wisconsin controls 6½ remaining minutes, and the gentleman from California 8 minutes.

Mr. LEWIS of California. I think it would be very important for the Members to know, Madam Speaker, that up to this point, only about 15 percent of the first piece of this package has been spent, so Stimulus I is a long ways away from being spent. And I think we all know that the agencies are awash in money coming through the pipeline, and they wonder where it's going to go from here. It's significant to know that as we spend the people's money in this process, with very, very little information available to our Members, the majority is choosing to push another \$150 billion down that pipeline, regardless of what has been spent already.

It seems to me that one of the lessons to be learned here is that the American people are much smarter than we give them credit for. They know that just throwing money at every perceived problem out there is no way to solve such a problem. In the meantime, I will listen with interest to my chairman's closing remarks.

I yield back the balance of my time.

Mr. OBEY. Madam Speaker, we have heard three times at least now our friends on the minority side indicate that only 12 percent of the original stimulus funding has, quote, left the Treasury. That's a very slippery way to put it, because the fact is that what "left the Treasury" means is that after funds are obligated to those who will actually spend it, and after the bills

have been paid by those recipients, then the money has, indeed, left the Treasury. The real term to focus on is what has been obligated. And the fact is that for the programs in this bill, 70 percent of the funds previously appropriated to those programs have already been obligated. So much for that argument.

Example: The minority press release states, "No funds out of the \$1 billion provided for COPS has left the Treasury." The fact is, all of that funding has been awarded.

The minority press release states, "Only \$235 million out of the \$6.4 billion for EPA wastewater grants has left the Treasury." The fact is, 99 percent of that funding has already been provided to the States. So much for that straw man.

Let me, Madam Speaker, simply make this observation: we have before us a bill that determines to redirect \$75 billion, which had initially been directed to help Wall Street, and we want to, instead, redirect that money to help Main Street. So we provide \$27 billion, for instance, for highway infrastructure projects to put people back in construction. You're either for it or you're against it.

We have provided enough funding in this legislation to assist more than 670 communities address their growing backlog of water and sewer repairs and put people to work in the process. You're either for it or against it.

We've provided \$27 billion from Wall Street to Main Street to try to stabilize public service jobs. We're trying to preserve 250,000 teaching jobs over the next 2 years, for instance. You're either for doing that or you're against it.

We're trying to use \$500 million to preserve the jobs of thousands of firefighters all across the country. You are either going to help or you're not.

We are trying to provide 250,000 disadvantaged youth with summer employment opportunities. You're either going to help them or you're not.

We're trying to provide 250,000 students with additional college work study funds so they can stay in school. You're either going to help those students or you're not.

We're trying to provide funding for approximately 150,000 individuals in high-growth and emerging industry sectors where we know there are job growth possibilities. You're either going to help support that or not.

We are trying to provide unemployment insurance for 6 months rather than the 2-month extension that was in the previous bill today. You're either going to help those people or not.

We are trying to provide \$23 billion to extend the higher Federal match for payments to doctors, or we're not.

So, basically, it's about time to decide where you're coming from. An article in the New York Times today de-

scribed what happens when you lose your job. It pointed out that more than half of the Nation's unemployed workers have had to borrow money from friends or relatives since losing their jobs. They've had to cut back on doctor visits. That same article indicates that a quarter of those polled had said they'd lost their home or been threatened with foreclosure. They also noted that half of the adults surveyed admitted to feeling embarrassed or ashamed as a result of being out of work. And nearly half of the respondents said they no longer had health insurance. The question is, are you going to help those people or not?

We can argue what our economic philosophy is until the cows come home, as they say in my area, but it seems to me that the question simply is, We've got a problem; what are you going to do about it?

JOBS FOR MAIN STREET ACT, 2010

EXPLANATORY STATEMENT

THE JOBS CRISIS

A jobs bill is urgently needed because of the worst job situation since the Great Depression of the 1930s. The vast majority of fair-minded economists have concluded that the Recovery Act has had a positive effect on the job situation and they also agree that sizeable and targeted deficit spending makes sense at this time of unusually high unemployment, low inflation, and low interest rates, but not after the economy recovers.

The current recession has been especially severe in the labor market:

The unemployment rate has reached 10 percent. Almost every age and education group is experiencing higher unemployment than at any time since the 1930s.

This dismal unemployment situation is not expected to improve any time soon. The Blue Chip consensus of economic forecasters expects the unemployment rate to get worse early next year and still be 9.9 percent at the end of 2010.

The number of people unemployed has more than doubled in the last two years, from 7.2 million to 15.4 million, an increase of 8.2 million. 10.6 million more people would have a job today if employment growth had simply kept up with population growth over the last two years.

The crisis in the job-market goes beyond the increase in unemployment. The number of people working part time but seeking full-time work has doubled in two years, from 4.5 million to 9.2 million. The number of people who want a job but are too discouraged to look for work has risen by 1.4 million or 30 percent in two years.

The total number of people who are either unemployed or working part-time for economic reasons or have dropped out of the labor force but want a job has risen by 14.2 million in just two years.

Other indicators make the case for a jobs bill:

For the first time since the 1930s, manufacturing is using less than two-thirds of its capacity. So much unused capacity means that production can be very responsive to new demand without increases in prices.

With its Federal funds rate at virtually zero, the Federal Reserve's capacity to stimulate the economy is limited.

The rates on Federal government borrowing remain unusually low.

The evidence is overwhelming that the Recovery Act has made the job situation sub-

stantially better than it would have been without the Recovery Act:

The Congressional Budget Office recently estimated that, as of September, the Recovery Act had already raised employment by 600,000 to 1.6 million. All major private forecasters have made similar estimates.

The rate of job loss has declined from 700,000 a month for the three months before the Recovery Act to just 11,000 job losses last month.

A recent Wall Street Journal survey of economic forecasters found that a clear majority supported additional jobs measures, a position that they would not have taken unless they believed the first round had worked.

Continued high unemployment takes a toll on those unemployed and their families who experience the frustration of not finding work. Local communities also suffer a loss of tax base which forces cutbacks on education and other services vital to everyone in the community.

It makes sense for the Federal government to invest more in expanding training opportunities at times of high unemployment. State and local governments face pressures to cut back on all spending, including education. On the other hand, the lack of work opportunities gives many people more time to devote to education and upgrading job skills.

Faster reduction of unemployment is in the long-term interest of the Nation's economy. When people have jobs, they have money to spend that has a multiplier effect on the economy generally. In addition, prolonged unemployment causes workers' skills to erode which reduces the Nation's productive capacity.

TITLE I—INFRASTRUCTURE AND JOBS INVESTMENT

CHAPTER 1—DEPARTMENT OF JUSTICE

COMMUNITY ORIENTED POLICING SERVICES

(INCLUDING TRANSFERS OF FUNDS)

The bill provides \$1,179,000,000 for Community Oriented Policing Services grants for the hiring and rehiring of an estimated 5,500 law enforcement officers.

CHAPTER 2—ENERGY AND WATER DEVELOPMENT

CORPS OF ENGINEERS—CIVIL WORKS

DEPARTMENT OF THE ARMY

CORPS OF ENGINEERS—CIVIL

CONSTRUCTION

(INCLUDING TRANSFERS OF FUNDS)

The bill provides an additional \$715,000,000 for Construction to support an estimated 7,800 jobs. This funding will support the construction of water resource projects in areas where they can quickly create jobs. Unemployment in the construction industry in November was 19.4 percent, up from just 6.2 percent two years ago. The projects will also provide long-term economic benefits through lasting infrastructure improvements. The Corps is directed to consider the following criteria when allocating funds: programs, projects or activities that can be commenced quickly; programs, projects or activities that will create high and immediate employment; programs, projects or activities that will be executed by contract or direct hire of temporary labor; and programs, projects or activities that are located in a state with high unemployment.

DEPARTMENT OF THE INTERIOR

BUREAU OF RECLAMATION

WATER AND RELATED RESOURCES

(INCLUDING TRANSFERS OF FUNDS)

The bill provides an additional \$100,000,000 to support an estimated 1,000 jobs for the

programs of the Bureau of Reclamation. This funding will support the construction of water supply projects in areas where they can quickly create jobs in the construction industry. Unemployment in that sector was 19.4 percent in November, up from just 6.2 percent two years ago. The Bureau is directed to consider the following criteria when allocating funds: programs, projects or activities that can be commenced quickly; programs, projects or activities that will create high and immediate employment; programs, projects or activities that will be executed by contract or direct hire of temporary labor; and programs, projects or activities that are located in a state with high unemployment. Additionally, funds are provided to respond to drought in western and southwestern United States by expediting projects and activities that supplement existing water supplies such as through the title XVI program, meeting fish and wildlife needs, adding flexibility to water delivery systems, or addressing other factors to reduce conflict over limited water supplies.

DEPARTMENT OF ENERGY ENERGY PROGRAMS

TITLE 17 INNOVATIVE TECHNOLOGY LOAN GUARANTEE PROGRAM

The bill provides an additional \$2,000,000,000 for the cost of guaranteed loans authorized by section 1705 of the Energy Policy Act of 2005. This funding should support an estimated 22,000 jobs in the renewable energy sector, providing a boost to the construction industry as well as contribute to the Nation's goals for energy independence. Most renewable energy funds are spent on materials and workmanship to build and maintain the facilities, rather than on costly energy imports. Further, as we build manufacturing capability in the United States, renewable energy technologies developed and built here can be sold overseas, providing a boost to the U.S. trade deficit.

INCENTIVES FOR INNOVATIVE TECHNOLOGIES LOAN GUARANTEE PROGRAMS

Section 1201 includes a provision modifying the Energy Policy Act of 2005 authorization for the Department of Energy's Innovative Loan Guarantee Program.

CHAPTER 3—HOMELAND SECURITY FEDERAL EMERGENCY MANAGEMENT AGENCY

FIREFIGHTER ASSISTANCE GRANTS

This bill provides \$500,000,000 to retain, re-hire, and hire an estimated 2,500 firefighters across the United States and directs the Department of Homeland Security to make these awards within 120 days. The Secretary may transfer any unused funds to firefighter assistance equipment grants subject to notification.

CHAPTER 4—INTERIOR AND THE ENVIRONMENT

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

MANAGEMENT OF LANDS AND RESOURCES

The bill provides \$20,000,000 as an additional amount for "Management of Lands and Resources" to support an estimated 1,000 term jobs. These funds should be used to increase term employment for activities on all Bureau of Land Management lands including maintenance, resource management, invasive species management, and inventory and monitoring.

UNITED STATES FISH AND WILDLIFE SERVICE

RESOURCE MANAGEMENT

The bill provides \$30,000,000 as an additional amount for "Resource Management" to support an estimated 1,500 term jobs. These funds should be used to increase term employment for activities funded under this heading, including activities on all national wildlife refuges and national fish hatcheries such as maintenance, invasive species management, inventory and monitoring, and for high priority habitat restoration projects.

NATIONAL PARK SERVICE

OPERATION OF THE NATIONAL PARK SYSTEM

The bill provides \$50,000,000 as an additional amount for "Operation of the National Park System" to support an estimated 2,700 term jobs. These funds should be used to increase term employment for activities on all national park units such as maintenance, interpretive, and resource management activities including invasive species management, inventory and monitoring, restoration of historical resources, and work with the National Register of Historic Places.

DEPARTMENT-WIDE PROGRAMS

WILDLAND FIRE MANAGEMENT

The bill provides \$20,000,000 as an additional amount for "Wildland Fire Management" to support an estimated 1,000 term jobs. These funds should be used to increase term employment for activities on all Interior Department lands, particularly for hazardous fuels reduction and related activities including necessary inventory and monitoring.

ENVIRONMENTAL PROTECTION AGENCY

STATE AND TRIBAL ASSISTANCE GRANTS

(INCLUDING TRANSFERS OF FUNDS)

The bill provides \$2,000,000,000 for water and wastewater infrastructure improvements, of which \$1,000,000,000 is for the Clean Water State Revolving Fund and \$1,000,000,000 is for the Safe Drinking Water State Revolving Fund. This funding will support approximately 44,000 jobs and will assist more than 670 communities and cities construct vitally needed projects to address the ever growing backlog of sewer and water repairs and rehabilitation. The bill provides that half of the funds include additional subsidies such as principal forgiveness and grants, making it easier for more communities to have access to this program.

DEPARTMENT OF AGRICULTURE

FOREST SERVICE

STATE AND PRIVATE FORESTRY

The bill provides \$75,000,000 as an additional amount for "State and Private Forestry" to support an estimated 3,800 term jobs. These funds are for financial assistance to States and other authorized cooperators, to increase term employment for activities, including reducing wildfire hazards, forest health management, restoring and rehabilitating forests damaged by pests or invasive species, enhancing urban and community ecosystems, and providing cooperation and technical assistance. The Forest Service should not require cost share for the use of these urgently needed funds.

NATIONAL FOREST SYSTEM

The bill provides \$40,000,000 as an additional amount for "National Forest System" to support an estimated 2,000 term jobs. These funds should be used to increase term employment, including management, protection, improvement and utilization activities

on the National Forest System, and including maintenance, resource management, visitor services enhancement, forest health, habitat and watershed enhancement, invasive species management, and necessary inventory and monitoring.

WILDLAND FIRE MANAGEMENT

The bill provides \$35,000,000 as an additional amount for "Wildland Fire Management" to support an estimated 1,800 term jobs. These funds should be used to increase term employment for Forest Service authorized activities, including hazardous fuels reduction and related activities, such as necessary inventory and monitoring.

GENERAL PROVISIONS—THIS CHAPTER

Section 1401 allows funds for management and oversight provided to the Environmental Protection Agency in this Act to be available until September 30, 2012, and the funds may be transferred to the "Environmental Programs and Management" account as needed.

Section 1402 requires the Secretaries of the Interior and Agriculture to utilize, to the maximum extent practicable, the Public Lands Corps, Youth Conservation Corps, Student Conservation Association, Job Corps, Corps Network members and other related partnerships with Federal, State, local, tribal or non-profit groups that serve young adults, underserved and minority populations, veterans and special needs individuals.

CHAPTER 5—LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES

DEPARTMENT OF LABOR

EMPLOYMENT AND TRAINING ADMINISTRATION

TRAINING AND EMPLOYMENT SERVICES

The bill includes \$500,000,000 for a summer employment program for youths. According to the Bureau of Labor Statistics (BLS), the unemployment rate for teenagers (age 16-19) reached 26.7 percent in November 2009—the highest level recorded since BLS began collecting data. These funds will support summer youth employment for approximately 250,000 disadvantaged youths.

HIGH GROWTH JOBS

The bill includes \$750,000,000 for competitive grants to support job training for approximately 150,000 individuals in high growth and emerging industry sectors, particularly in the health care and green industries that are adding jobs despite difficult economic conditions. Grants for job training in green industries will focus on programs that train workers living in areas of high poverty.

DEPARTMENT OF EDUCATION

EDUCATION JOBS FUND

The bill includes \$23,000,000,000 for an Education Jobs Fund to help States cope with the most dramatic decline in State tax receipts on record—due to the worst recession in 30 years. These funds will help States to save or create an estimated 250,000 jobs over the next two years. Of the total appropriation, 95 percent of the funds will be allocated by States to school districts and public institutions of higher education to retain or create jobs providing early childhood education, elementary, secondary, or postsecondary education services or for modernization, renovation, and repair of facilities. The remaining 5 percent of funds is reserved for State education-related jobs and administration of the Education Jobs Fund.

STUDENT FINANCIAL ASSISTANCE

The bill includes \$300,000,000 to support the College Work Study program, which supports

low- and moderate-income undergraduate and graduate students who work while attending college. Together with institutional matching funds, this appropriation will support work-study jobs for approximately 250,000 financially needy students.

RELATED AGENCIES

CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

OPERATING EXPENSES

(INCLUDING TRANSFERS OF FUNDS)

The bill provides \$200,000,000 for AmeriCorps programs and the National Service Trust, which will support an additional 25,000 AmeriCorps Members. This funding will enable these individuals to serve their communities while earning an education award to further their education or pay off student loans. AmeriCorps members conduct vital services for nonprofits and communities including financial counseling, disaster response, housing support, and after school programs. The Corporation has seen an unprecedented level of interest from States, localities, and nonprofit organizations in its programs. Between November 2008 and April 2009, AmeriCorps received 76,404 online applications, up 230 percent compared to the same period in the year before.

GENERAL PROVISIONS—THIS CHAPTER

ISSUER ALLOWED REFUNDABLE CREDIT FOR QUALIFIED ZONE ACADEMY BONDS (QZABS) AND QUALIFIED SCHOOL CONSTRUCTION BONDS (QSCBs)

Section 1501 includes several provisions pertaining to QSCBs and QZABS, which finance public school construction, rehabilitation, and repair. Because the market for tax credits on QSCBs and QZABS currently is small given economic conditions, the bill would allow a State, local government, or tribal government issuing QSCBs or QZABS to elect to receive a direct payment from the Federal government equal to the amount of the tax credit that would have otherwise been payable on these bonds. The bill also includes a technical correction that clarifies that large local school districts are allowed to carry their 2009 and 2010 allocations of QSCBs into future years if they are not issued.

CHAPTER 6—TRANSPORTATION AND HOUSING AND URBAN DEVELOPMENT

DEPARTMENT OF TRANSPORTATION

FEDERAL AVIATION ADMINISTRATION

GRANTS-IN-AID FOR AIRPORTS

The bill provides \$500,000,000 for the Federal Aviation Administration to provide discretionary airport grants to repair and improve critical infrastructure at our Nation's airports. Projects funded under this Act, as well as under the American Recovery and Reinvestment Act, use the criteria established for grants under the AIP program and provide long-term economic, safety and capacity benefits to the Nation's airport system. This funding will support an estimated 5,000 jobs.

FEDERAL HIGHWAY ADMINISTRATION

HIGHWAY INFRASTRUCTURE INVESTMENT

The bill provides \$27,500,000,000 for additional highway infrastructure investment to support an estimated 299,000 jobs. Funds are distributed by formula, with a portion of the funds within each State being suballocated by population areas. Set asides are also provided for: management and oversight; Indian reservation roads; park roads and parkways; forest highways; refuge roads; ferry boats;

on-the-job training programs focused on minorities, women, and the socially and economically disadvantaged; a bonding assistance program for minority and disadvantaged businesses; Puerto Rico and the territories; and environmentally friendly transportation enhancements.

FEDERAL RAILROAD ADMINISTRATION

CAPITAL GRANTS TO THE NATIONAL RAILROAD PASSENGER CORPORATION

The bill provides \$800,000,000 for capital grants to the National Railroad Passenger Corporation (Amtrak) for fleet modernization, including the rehabilitation of existing and acquisition of new passenger equipment, including fuel efficient locomotives. The Secretary of Transportation is directed to give priority to domestically manufactured equipment, including components and sub-components used for rehabilitation. In addition, new acquisitions should be part of a larger strategy to work with domestic manufacturers to create a standardized next generation corridor equipment fleet. This funding supports an estimated 9,000 jobs.

FEDERAL TRANSIT ADMINISTRATION

TRANSIT CAPITAL ASSISTANCE

The bill provides \$6,150,000,000 for urban and rural formula grants to support an estimated 67,000 jobs. Within the total amount, 80 percent of the funds shall be provided through the Federal Transit Administration's (FTA) urbanized formula; 10 percent shall be provided through FTA's rural formula; and 10 percent shall be provided through FTA's growing states and high density formula. In addition, the bill provides 2.5 percent of the rural funds for tribal transit needs and includes \$100,000,000 for discretionary grants to public transit agencies for capital investments that will assist in reducing the energy consumption or greenhouse gas emissions of their public transit agencies.

FIXED GUIDEWAY INFRASTRUCTURE INVESTMENT

The bill provides \$1,750,000,000, to support an estimated 19,000 jobs, to be distributed through an existing authorized formula for capital projects to modernize or improve existing fixed guideway systems, including purchase and rehabilitation of rolling stock, track, equipment and facilities.

CAPITAL INVESTMENT GRANTS

The bill provides \$500,000,000, to support an estimated 5,000 jobs, to be distributed on a discretionary basis for New Starts and Small Starts projects that are already in construction or are nearly ready to begin construction.

MARITIME ADMINISTRATION

MARITIME GUARANTEED LOAN (TITLE XI)

PROGRAM ACCOUNT

(INCLUDING TRANSFER OF FUNDS)

The bill provides \$100,000,000 for the Maritime Guaranteed Loan (Title XI) program to allow vessels and shipyards to obtain long-term financing for growth and modernization projects.

GENERAL PROVISION—DEPARTMENT OF TRANSPORTATION

MAINTENANCE OF EFFORT

Section 1601 ensures continued State investment in certain identified programs for which the State receives funding in this Act and requires grant recipients to report regularly on the use of those funds.

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

PUBLIC AND INDIAN HOUSING

PUBLIC HOUSING CAPITAL FUND

The bill provides \$1,000,000,000 for the Public Housing Capital Fund for additional re-

pairs and rehabilitation of public housing, including increasing the energy efficiency of units and making critical safety repairs. The Secretary is directed to award these funds competitively to public housing agencies that submitted applications in the competition for funds conducted in fiscal year 2009. In that competition, HUD received applications totaling approximately \$3,700,000,000 for Capital Fund projects, but was only able to fund \$1,000,000,000 in awards. This funding will spur construction quickly, especially since HUD has ready-to-go applications for projects on hand. This funding will support an estimated 10,900 construction jobs.

COMMUNITY PLANNING AND DEVELOPMENT

HOUSING TRUST FUND

The bill provides \$1,000,000,000 for the National Housing Trust Fund to provide communities with funds to build, preserve, and rehabilitate rental homes that are affordable for extremely and very low income households; and \$65,000,000 for project-based vouchers to support units built by the Trust Fund. Nationwide, for every 100 extremely low income renter households, there are only 37 homes they can afford, further, capital expenditures for housing will create jobs in the construction industry. This funding will support an estimated 19,000 construction jobs.

CHAPTER 7—GENERAL PROVISION

TARP REDUCTION

Section 1701 reduces the ceiling on loans, investments and other assistance under the Troubled Asset Relief Program (TARP) by \$150,000,000.

Section 1702 provides that all funds under this title shall be subject to section 1604 of division A of the American Recovery and Reinvestment Act of 2009.

Section 1703 makes appropriations in this title subject to American Recovery and Reinvestment Act reporting and transparency requirements and Inspector General oversight.

TITLE II—SURFACE TRANSPORTATION EXTENSION

This title extends the authorization for the highway, transit, highway safety and motor carrier safety programs of the Department of Transportation until September 30, 2010. In addition, the bill includes language that provides 100 percent federal share for the transportation programs authorized in the title, repeals the provision that prohibits Highway Trust Fund balances from earning interest, and restores \$20,000,000,000 to the Highway Trust Fund.

This title also strengthens the Buy America requirements for highway and transit projects, and provides greater transparency for Buy America waivers.

TITLE III—UNEMPLOYMENT AND OTHER EMERGENCY NEEDS

CHAPTER 1—AGRICULTURE AND RURAL DEVELOPMENT

DEPARTMENT OF AGRICULTURE

GENERAL PROVISION—THIS CHAPTER

(RESCISSION)

RELIEF FOR DISCRIMINATION IN A CREDIT PROGRAM OF THE DEPARTMENT OF AGRICULTURE UNDER THE EQUAL CREDIT OPPORTUNITY ACT

Section 3101 extends the statute of limitations for claims of discrimination in USDA's credit programs that have been pending at USDA.

CHAPTER 2—FINANCIAL SERVICES AND
GENERAL GOVERNMENT
INDEPENDENT AGENCIES

SMALL BUSINESS ADMINISTRATION
BUSINESS LOANS PROGRAM ACCOUNT

The bill provides \$354,000,000 to the Small Business Administration (SBA), to continue two temporary enhancements to SBA loan guarantee programs made by the American Recovery and Reinvestment Act of 2009 and which are nearly out of funding. One of the enhancements being extended allows the SBA to guarantee 90 percent of certain small business loans, instead of the 75 percent allowed under permanent law (or 85 percent for small loans), thereby encouraging banks to make these loans by reducing the amount they have at risk and the reserves they must hold. The other reduces fees paid by lenders and borrowers. The funding provided in the bill is estimated to be sufficient to continue both items through the end of fiscal year 2010. The bill also extends the expiration date of the authorization for the 90 percent loan guarantees to September 30, 2010.

GENERAL PROVISION—THIS CHAPTER
(RESCISSION)

Section 3201 rescinds funds that will lapse at the end of fiscal year 2010.

CHAPTER 3—LABOR, HEALTH AND
HUMAN SERVICES, AND EDUCATION
GENERAL PROVISIONS—THIS CHAPTER
ASSISTANCE FOR UNEMPLOYED WORKERS AND
STRUGGLING FAMILIES

Section 3301 provides a six-month extension of expiring UI benefit provisions that were established or continued in the American Recovery and Reinvestment Act, including the Emergency Unemployment Compensation program, 100 percent Federal funding for the Extended Benefits program, and the extra \$25 weekly UI benefit.

EXTENSION AND IMPROVEMENT OF PREMIUM
ASSISTANCE FOR COBRA BENEFITS

Section 3302 extends the 65 percent COBRA health insurance subsidy from nine to 15 months for individuals who have lost their jobs. The job loss eligibility date is extended in the provision through June 30, 2010.

EXTENSION OF RECOVERY ACT INCREASE IN THE
FEDERAL MEDICAL ASSISTANCE PERCENTAGE
(FMAP)

Section 3303 extends for six months, through June 2010, the FMAP provision in the Recovery Act, which increases the Federal match for Medicaid for all State programs.

REPEAL OF EARNED INCOME THRESHOLD FOR
DETERMINING REFUNDABLE PORTION OF
CHILD TAX CREDIT

Section 3304 increases the eligibility for the refundable portion of the child tax credit. The bill would increase the eligibility for the refundable child tax credit in 2010. For 2009, the child tax credit is refundable to the extent of 15 percent of the taxpayer's earned income in excess of \$3,000. The bill would eliminate this floor for 2010.

DEPARTMENT OF HEALTH AND HUMAN
SERVICES (HHS) POVERTY GUIDELINES

Section 3305 includes a provision to freeze the HHS poverty guidelines at 2009 levels in order to prevent a reduction in eligibility for certain means-tested programs, including Medicaid, Supplemental Nutrition Assistance Program (SNAP), and child nutrition, in 2010.

REFUNDS DISREGARDED IN THE ADMINISTRATION
OF FEDERAL PROGRAMS AND FEDERALLY ASSISTED PROGRAMS

Section 3306 provides, for one year, the exclusion of tax refunds as income for the pur-

pose of assessing eligibility for means-tested programs supported by Federal funds.

Section 3307 permanently authorizes a provision to help Social Security and Supplemental Security Income disability claimants retain professional representation.

CHAPTER 4—GENERAL PROVISION—THIS
TITLE

Section 3401 provides an emergency designation and PAYGO emergency designation.

TITLE IV—GENERAL PROVISIONS—THIS
ACT

Section 4001 establishes a period of availability for funds.

Section 4002 requires Buy America requirements.

DISCLOSURE OF EARMARKS AND CONGRESSIONALLY DIRECTED SPENDING ITEMS

Pursuant to clause 9 of rule XXI of the Rules of the House of Representatives, neither the amended bill nor the explanatory statement contains any congressional earmarks, limited tax benefits, or limited tariff benefits.

With that, I would yield to the Speaker to conclude my remarks.

The SPEAKER pro tempore. The gentlewoman from California is recognized.

Mr. LEWIS of California. Madam Speaker, I certainly would not object, but I had asked the chairman about additional speakers, and clearly I would never, ever detract from our Speaker, but in the meantime, a little straightforward discussion would be helpful.

Mr. OBEY. If the gentleman would yield. Well, he doesn't have the time. I will simply take the time to say that if I had known that the Speaker had been able to come to the floor, I certainly would have told the gentleman. I simply didn't know, and I trust that he believes me.

Mr. LEWIS of California. I certainly do.

Mr. OBEY. I thank the gentleman for that clarification.

Ms. PELOSI. Madam Speaker, I thank the distinguished chairman for yielding, for his unyielding work on behalf of America's working families, and in this case today for the creation of jobs, to grow our economy and to help those who have lost their jobs through no fault of their own.

I am grateful to the distinguished ranking member, Mr. LEWIS, for his courtesy. Yes, my apology. I didn't realize the debate would go to this point. But I did want to take the opportunity to talk about jobs to our colleagues and to this Congress in general.

Just to put it in perspective, 1 year ago, in January, the job loss was 740,000 jobs for that 1 month alone. Fast forward to now, and the job loss for November is 11,000 jobs. Seven hundred forty thousand 10 months ago; 11,000 jobs this month. We don't want to lose any jobs. But we are on the road to recovery, and we are there because this Congress made some very important and difficult decisions to take us there. We are on the road to recovery because

of the leadership of President Barack Obama, who stood on the steps of the Capitol on his inauguration and asked for swift, bold action now so that we could take the country in a new direction and create jobs and grow our economy.

□ 1745

One week and 1 day from the President's inaugural address, this House of Representatives passed the Recovery Act. We were able to do so because we were ready. We had been ready with job creation packages, but we could not get the resources until we had a new President to make the investments, which took us from 740,000 jobs lost in January, in the first month of this year—the President, I am reminded, was inaugurated on January 20, toward the end of that month—and then 11,000 jobs.

I also want to call to our colleagues' attention back to the first quarter of 2009, and the GDP rate of growth was a negative. It was a minus 6.4 percent, a result of the failed economic policies of the previous administration. As of November 24, 2009, the GDP has a positive 2.8 and is growing; a swing of 9.2 percent in the GDP from negative, minus 6.4 to positive 2.8.

At the same time, I call to the attention of my colleagues that because of this new direction to grow our economy, the stock market was at a nadir. The first of 2009, we're at 7,000. We are now over 10,000, an increase of over 3,000 points in the stock market. Economists tell us that some of this change is directly related to the recovery package that we passed in January, the fiscally sound budget that we passed 100 days after the President's inauguration, which was a blueprint for the future, a statement of our national values that talked about how we could create jobs, lower taxes for the middle class—over 95 percent of the American people got a tax cut—and how we could reduce the deficit. It's all about job creation and reducing the deficit.

Three pillars of changing the economy in that budget were investments in health care, in education, and in energy to prevent climate change, to create new green jobs for the future, and to do so through science and innovation. Innovation begins in the classroom and is central to our competitiveness—innovation to reduce the cost of health care to families, to businesses, to our budget, and to our economy to make us competitive and keep us number one in the world's economy. All of this was passed by the House of Representatives: energy, climate change, education, and health care.

Then finally, this past week, we passed the regulatory reform legislation. Mr. FRANK is here, our chairman. It is the work of many people in this Congress. We passed regulatory reform to hold Wall Street accountable, to say

that the party is over, to say that we are creating jobs for Main Street, not just wealth for Wall Street. We respect the creation of wealth and what it means to an economy and how it relates to the creation of jobs, but we cannot have a creation of wealth at the exploitation of the American worker. We did pass this regulatory reform without one Republican vote to hold Wall Street accountable, without one Republican vote.

So here we are today, after this plan that started on the steps of the Capitol—the inauguration of our new President—that had deep seeds in what we had tried to do before we had a Democratic administration but what we had been working for, so we were ready. And now today we want to pass this legislation which does two things: It creates jobs and saves jobs by investments in building the infrastructure of America. It doesn't do everything we would want, but what we do in there is paid for, building the infrastructure of America.

What it also invests in is to help States, cities, and localities keep their fiscal soundness so that they don't have to lay off teachers, firefighters, police officers, and people who work to meet the health needs of people in our community. This is important not only for public safety. That is self-evident. It is not only important because we don't want to lose our teachers. It is about the education of our children and how seriously that can be undermined with the layoffs and the uncertainty in the local and State budgets.

But on top of all of that, while we're concerned about what this does to working families and how important it is for people to have their jobs—they are also consumers—to the extent that they lose their jobs, our economy loses consumers. And when our economy loses consumers, we're in big trouble, economic trouble. We cannot let that happen.

So today, we have before us that package for job creation and job retention which is fiscally sound and which is paid for by using TARP funds, the unused TARP funds which were the subject of great debate but which, I do believe, saved us, pulled us from the brink of the financial crisis we were in as our recovery package later pulled us from the brink of economic disaster.

In addition to that, we have some safety net provisions about the extension of unemployment insurance, of COBRA to meet the health needs of those who are unemployed, which all expire the end of December, and other issues that relate to the well-being of America's working families, to address the concerns of the unemployed but, in addition to that, to create jobs in a fiscally sound way.

Fiscal responsibility is very important to us. It is our responsibility to our children not to increase the deficit,

and that is why our health bill does not add one dime to the deficit; in fact, it decreases the deficit. I see Chairman RANGEL shaking his head. It is an important part of paying for that legislation. And Mr. MILLER and Mr. WAXMAN were so much an important part of that health care bill.

So here we are today with an opportunity to modestly and in a paid-for way address the issue of jobs. It's a four-letter word. Let's use that four-letter word everywhere we go—jobs, jobs, jobs.

I urge my colleagues, while some of your districts and some of your States may be doing better than other parts of the country, this is the time for us to recognize that we are a national economy and that what happens in one State has an impact on our national recovery.

I thank Chairman OBEY for his great leadership in putting this package together. I urge our colleagues to act on behalf of America's working families through the creation of jobs in a fiscally sound way, to honor our responsibility of public safety by protecting our first responders and our responsibility to our children to make sure that their education does not have a gap, because we have a budgetary gap, and understanding the role that consumers play in our economy. I hope that we will have a strong "yes" vote on this legislation.

With that, Mr. Chairman, I commend you again.

Mr. LANGEVIN. Madam Speaker, I rise in strong support of H.R. 2847, the Jobs for Main Street Act, which redirects Trouble Asset Relief Program (TARP) funds from Wall Street to Main Street, where our towns, small businesses and families need it most.

While we have seen some significant improvements since this time last year, we are still feeling the repercussions of the worst economic downturn since the Great Depression. Many older Americans are entering retirement with deflated savings, forced to dramatically adjust plans and expectations for their golden years. Millions of our constituents remain unemployed, desperately searching for jobs that simply aren't there. Rhode Island families are struggling to pay bills and mortgage payments, and in too many cases, those who used to have two salaries to rely on must now make do with only one. While we have brought the economy back from the brink, we must do more to limit job loss and create new employment opportunities.

H.R. 2847 addresses these issues by redirecting \$48 billion in unused TARP funds to highway infrastructure, school renovation grants, public transportation investments and airport improvement grants. To address our housing needs, this measure contains \$1 billion for the National Housing Trust Fund that provides communities with funds to build, preserve and rehabilitate affordable rental homes and \$1 billion for the Public Housing Capital Fund for repairs and rehabilitation of public housing.

The Jobs for Main Street Act also uses \$27 billion in TARP funds to stabilize public service

jobs, including teachers, firefighters and police officers. It funds an Education Jobs Fund to help states retain or create jobs in school districts and public higher education institutions. And it includes funding for AmeriCorps, the College Work Study program, and job training for high growth and emerging industry sectors, including those in health care and green industries.

Small businesses have borne the brunt of this economic crisis, and their inability to access credit to keep their businesses operating has clearly added to the high unemployment rate across the nation, and especially in Rhode Island. It is imperative that our small businesses have access to the tools they need to weather this economic downturn, as well as to keep and create jobs. H.R. 2847 will help by extending Recovery Act provisions that eliminated fees on SBA loans and guaranteeing these loans at 90 percent. This gives local banks and credit unions the confidence to lend to small businesses.

This measure also extends crucial American Recovery and Reinvestment Act safety net programs that provide invaluable health and social services to our nation's low-income and disabled citizens with the inclusion of \$23.5 billion in enhanced funding for state Medicaid programs. It further extends a provision to assist recently unemployed individuals and their families by helping them maintain their health coverage through a 65 percent subsidy for health insurance premiums under COBRA from nine months to 15 months and also extends unemployment benefits by six months.

This job creation package will help move our country further down the road to recovery and help our families in need during this holiday season. I urge my colleagues to support this bill.

Mr. DINGELL. Madam Speaker, I rise today to offer my unequivocal support for H.R. 2847, the Jobs for Main Street Act. As a federal representative from the state of Michigan, I can attest to the hardship facing my constituents, and others across the state, as a direct result of unemployment. This legislation will build off the progress made by the American Recovery and Reinvestment Act and create jobs quickly through projects needed by the community such as new roads, water facilities, and by protecting the jobs we have in the fields of education and law enforcement.

H.R. 2847 is legislation that will greatly help the 15th District in Michigan. There is no question that Michigan has been hit the hardest and the earliest by this economic recession, leading unemployment across the country for months, which is now almost 15 percent. Yet this does not tell the full story. Since 2000, Michigan has lost over 800,000 jobs, roughly one in every six, and in Detroit alone 45 percent of working-age adults are unemployed. Combine this with the fact that for every job opening about six people are applying, and you can see why the workers in Michigan are facing a perfect storm.

This legislation will help to calm this storm by investing in public works projects that will create new jobs, setting aside \$48 billion for rebuilding our roads and bridges, modernizing public buildings, constructing new water facilities, and building and preserving affordable rental houses. We will also help to save or

create jobs in our public schools, our police and fire departments, while training workers in growing fields such as health care and alternative energy or "green" fields.

Further, this legislation will extend emergency unemployment benefits through June 2010, and extend and expand the COBRA subsidy through June and expand the months of help from 9 months to 15 months. These changes will help the nearly one million workers exhausting their unemployment benefits by January and the hundreds of thousands of workers who have already begun rolling off the COBRA subsidy program.

It is imperative that both the House and the Senate pass H.R. 2847 quickly. This legislation is not a hand-out; rather it is an immediate injection into local economies across the country. It is funding America families will use to keep their heat on this Christmas, to pay their mortgage for the next few months, and keep their health insurance through the summer. Quite frankly this funding is a crutch until these workers can find their next job, or complete the training they need for a second career.

Madam Speaker, after spending this summer bailing out Wall Street, it is time that we help Main Street. I urge my colleagues to reiterate their support to the American families in need and vote in favor of H.R. 2847.

Mr. LINDER. Madam Speaker, I rise in opposition to this legislation, and in particular the provisions adding \$40 billion to the deficit, leading to even more tax hikes on jobs, and ultimately increasing unemployment across the Nation. Those provisions are just the latest in a series of massive expansions of Federal unemployment benefits dating back to 2008. And here we are again with yet another extension of Federal unemployment benefits, at enormous expense to taxpayers. But no matter how much Congress spends and no matter how many benefit extensions this body passes, my colleagues on the other side of the aisle can't seem to understand that Americans want paychecks, not unemployment checks. Until they drop their job-killing government health care takeover and energy and other massive tax hikes, jobs and paychecks will continue to be in far too short supply.

PROMISING MILLIONS OF NEW JOBS, DELIVERING
MILLIONS MORE UNEMPLOYED

Jobs and paychecks are definitely not what Democrats have delivered to date. They insisted their so-called 2009 stimulus bill would create 3.5 million jobs and keep unemployment from rising above 8 percent. Instead we have lost almost 3 million jobs since then as unemployment rose to 10 percent:

GRAPHIC REMOVED

These rates are more than just abstract numbers. They represent real Americans who are no longer receiving a paycheck to provide for themselves and their families—a total of 3.7 million more unemployed than the President promised if his stimulus bill became law. Those 3.7 million people could form an unemployment line stretching literally from Washington, D.C. to Chicago, Illinois. No amount of Federal spending, no White House jobs summit, and not even millions of unemployment checks can distract from that sorry record of job destruction.

The American people are not fooled, either. A current CBS/New York Times poll finds that

61 percent think the \$1 trillion 2009 stimulus bill has either had no effect or made the economy worse. Half as many, only 32 percent, think the stimulus bill has made things better.

WORST "JOBS SPEAKER" EVER

In an attempt to distract from this grim record, Democrats have taken to blaming the last President for the failure of their own stimulus plan to create jobs. On December 4, 2009, 35 months after she became Speaker and 11 months after Barack Obama became President, House Speaker NANCY PELOSI said "Bush Administration policies created a huge jobs deficit." Yet every one of the "Bush Administration" job losses she decried happened on her watch as Speaker. The facts show NANCY PELOSI is the worst Speaker in terms of job creation since official data began in 1939. More than 6 million jobs—4.5 percent of all jobs in the U.S. economy—have been destroyed since she became Speaker in 2007:

GRAPHIC REMOVED

WORST "JOBS PRESIDENT" SINCE HERBERT HOOVER

Further, and despite repeated claims from the President and various Administration officials that stimulus "is working," Barack Obama has compiled the worst jobs record since Herbert Hoover:

GRAPHIC REMOVED

PROVIDING RECORD AMOUNTS OF UNEMPLOYMENT
BENEFITS

In response to this horrific record of rising unemployment and job destruction, the Democrat leadership has only one "solution"—paying even more unemployment benefits. This latest extension comes just one month after the House considered the last expansion of unemployment benefits, which added 20 more weeks of Federal unemployment benefits, increasing total benefits to an unprecedented 99 weeks in most of the U.S.:

GRAPHIC REMOVED

The USA Today last week called this payment of 99 weeks of unemployment benefits "excessive" and "a disincentive to find work." They're right. Everyone from Presidential advisor Larry Summers to the New York Times, Washington Post, and Congressional Budget Office agree that's a concern, especially as the job market starts to recover. And we all hope it will start to recover in the coming months.

CREATING RECORD UNEMPLOYMENT BENEFIT RECEIPT

But regardless of Democrats' current "jobs" rhetoric, there is no evidence this bill will deliver jobs and paychecks—just millions more unemployment checks. Those checks will be in addition to the all-time record number of unemployment benefits currently being paid to 9.5 million Americans per week last month. The Federal extended benefits programs are now so enormous—and the 2009 stimulus law was such an utter failure at stemming the tide of job loss and long-term unemployment—that soon more Americans will collect Federal extended benefits than regular State unemployment checks for the first time ever:

GRAPHIC REMOVED

ADDING MASSIVELY TO DEFICITS AND DEBT

These unemployment checks cost a tremendous amount of money. Since "emergency" Federal unemployment benefits began in mid-2008, the Federal government has spent an astonishing \$100 billion on these programs.

That is 4 times what the Federal government spent on emergency unemployment benefits in the wake of the 2001 recession and terrorist attacks. The tidal wave of recent spending has bankrupted the Federal unemployment accounts and forced Democrats to engage in a massive and growing bailout with general revenues. The legislation before us adds to those massive totals, increasing Federal spending by \$7 billion per month, or a total of over \$40 billion more during just the next six months. All of which will add to our record deficits and debt.

Tellingly, none of these additional unemployment benefits will be paid for, despite Democrats' recent claims of fiscal responsibility. For example, last week on the House floor, senior Ways and Means Member Sander Levin of Michigan said of a bill that permanently raised taxes to pay for temporary tax relief "What we are suggesting here is fiscal responsibility. Don't dig the hole deeper and deeper. Step up and pay for it." The next day, Speaker PELOSI held a news conference at which she said: "On jobs, we hope next week that in our final appropriations bill we will be able to have a jobs piece that will create jobs in the near term to address the needs of those who are unemployed and do so in a fiscally sound way."

Yet here we are again digging that hole deeper, and doing nothing "in a fiscally sound way." None of our Democrat colleagues suggest we "step up and pay for" this new spending either. This despite the fact that, even before this measure passes, debt and unemployment have increased by a staggering 55 percent since President Obama took office just 11 months ago:

GRAPHIC REMOVED

MORE UNEMPLOYMENT AND BENEFIT SPENDING TO COME

No one seriously thinks all this spending—or the job losses—will end with this extension, either. That means at least some of the "emergency" spending in today's bill is likely to continue for years ahead. The President's economist, Dr. Christina Romer, anticipated as much this past weekend when she said "I'm not going to say the recession is over until the unemployment rate is down to normal levels." She went on to define "normal" as "where we were before the recession." How long might that take? According to a recent study by economists at Rutgers, the U.S. won't return to pre-recession employment levels until 2017. That would mean the current recession, in Dr. Romer's view, would last a decade, or as long as the Depression of the 1930s.

THE COMING WAVE OF JOB-KILLING TAX HIKES

The Federal unemployment accounts are exhausted and most Federal benefits are currently supported by general revenues—the same source of funding for welfare benefits. State unemployment benefits, in contrast, remain supported either by State payroll taxes, or Federal loans—also supported by Federal general revenues and which will also have to be repaid with future State tax hikes.

Those State tax hikes are already under way. On December 8, 2009, the bipartisan National Association of State Workforce Administrators issued a report that 35 States will increase State unemployment payroll taxes in 2010. These are direct taxes on jobs, made worse by the failure of the 2009 stimulus law

to create jobs and stem unemployment. The NASWA report notes the 2010 tax hikes range up to a stunning 600 percent. As one small businessman said simply, "This is a job killer." (A list of other recent quotes about how these tax hikes will destroy jobs is included below.)

As the above data shows, Democrat stimulus legislation has succeeded in increasing unemployment, not reducing it. Instead of creating 3.5 million new jobs, the 2009 stimulus bill has been followed by almost 3 million job losses. And now record unemployment benefit payments that followed have become their own engine of job destruction, contributing to an enormous wave of Federal borrowing and State tax hikes that will stifle job growth for years to come.

Adding to the pain, Democrat energy policies would increase the price of energy and kill millions of jobs. Democrat health policies would make health care and health insurance more expensive and kill millions more jobs. And other Democrat spending proposals in this second (or really third or fourth, depending on how one counts) stimulus bill will further drive up the debt and kill even more jobs.

We can and must do better. It's well past time for us to shelve Democrats' job-killing energy, health care, and tax hike agendas. We will then unleash America's job creation engine so laid off workers can finally get back to work. That effort should start with a vote against this legislation, and a renewed commitment to offer unemployed workers real help in finding new work, instead of just more benefit checks.

APPENDIX: RECENT QUOTES ABOUT HOW STATE UNEMPLOYMENT TAX HIKES WILL KILL JOBS FROM SEA TO SHINING SEA

California: "Tax may feed unemployment: business owners fear insurance spike," March 30, 2009:

"Thanks to the tanking economy and past benefit hikes, the state's system for providing unemployment benefits is insolvent. And the fix that state lawmakers are considering is to dramatically raise the taxes employers pay into the system. The irony: That could force companies to lay off employees. Take, for example, Steve Diels, who owns a Redondo Beach call center. Any tax increase could force him to fill out some pink slips. 'Right now, my profit margin has slipped and I'm doing everything I can to avoid laying anyone off,' said Diels, a Redondo Beach city councilman who employs 38 people at Aamcom Inc. 'But if they increase the unemployment tax, employers like me will have to lay people off and that will only make things worse with the unemployment fund.'"

Connecticut: "State may tax business to bail out broke jobless fund," December 5, 2009:

"Tony Sheridan, president of the Chamber of Commerce of Eastern Connecticut, said . . . 'It's a tough situation and there's not one single business that can stand a tax increase'."

Florida: "Creating more jobs is 'Job No. 1,'" December 10, 2009

"A good example of policy that discourages hiring is the impending radical increase in the unemployment tax in Florida, triggered by the depletion of the unemployment trust fund by record jobless claims. That increase is so steep—from \$8.40 per employee to \$100 for

the minimum tax; from \$378 to \$459 for the maximum—that it could not only discourage hiring, it could put some businesses under."

Hawaii: "Big payroll tax reset weighs on Hawaii business," December 4, 2009:

"Big Island contractor Hinchcliff Drywall Construction will see a more than six-fold increase in its payroll taxes next year, which will soar from the current \$18,500 annually to \$116,350. . . . 'I don't understand why the rates were not raised gradually over the period of two or three years—it almost seems a bit backwards,' said Michelle Danihel-Kreusling, controller of Hinchcliff Drywall, which employs 80 people. 'Practically cutting off your nose to spite your face,' she said. 'This rate hike will either require many businesses to either drastically reduce their labor force or close shop completely, both of which would increase the unemployment rate.'"

Maine: "Maine raises unemployment tax by \$54 million," December 1, 2009:

"David Clough, Maine director of the National Federation of Independent Businesses, said his members will be hit hard by the tax hike. He said it will cost jobs, either from layoffs or positions that go unfilled."

Maryland: "Rising unemployment taxes could hinder hiring," November 22, 2009:

"Employers already are squeezed by tight credit, rising health care costs, wary consumers and a higher minimum wage. Now, the surging jobless rate is imposing another cost. It's forcing higher state taxes on companies to pay for unemployment insurance claims. Some employers say the extra costs make them less likely to hire. . . . Chuck Ferrar, who owns a liquor store in Annapolis, Md., expects to pay \$9,000 in unemployment taxes next year, up from \$3,000 this year. Health care costs for his employees will rise by \$8,000, or 17.5 percent. 'When you start adding this up, it turns into real money,' he said. 'If I lose an employee through attrition, I will not replace him. You can't afford to do it.'"

Massachusetts: "Unemployment at 33-year high; insurance fund running dry," October 16, 2009:

"'This is a breathtakingly bad picture,' said Michael Widmer, president of the Massachusetts Taxpayers Foundation, a business-funded public policy group, and also a member of the advisory council that monitors the solvency of the two accounts that fund unemployment benefits. 'They're putting additional taxes on employers, and we are seeing our jobs erode,' Widmer said in an interview. 'It's devastating in terms of the state's competitiveness.'"

Michigan: "New unemployment-insurance taxes: \$63 million in 2010," September 13, 2009:

"Frank Lope, an alliance board member and chairman of Romulus-based Aztec Manufacturing Corp., said . . . 'It's going to be another impediment on businesses as they go to look at hiring people,' Lopez said. 'It's just another, so to speak, of the many nails in the coffin for continued growth of businesses in the state of Michigan.'"

Nevada: "Businesses May See Huge Tax Increase," September 23, 2009:

"Some financial experts are still concerned that a huge jump in the unemployment benefit tax will force businesses to lay off employees to pay for the increase."

North Carolina: "N.C. borrowing billions for jobless," December 1, 2009:

"Walden, the economist, said raising taxes would be a mistake as long as the economy is hurting. 'In essence, you can look at that as a tax on new employees, and we don't want to do that,' he said. The deep recession has made it impossible for North Carolina to forecast how much unemployment tax funds the state will receive from employers next year, Clegg said. 'Not to be maudlin, but I don't know who will be paying taxes in the first quarter of 2010 because I don't know what businesses will survive,' he said."

Rhode Island: "R.I. businesses to pay higher jobless taxes," November 23, 2009:

"Mark Higgins, dean of the University of Rhode Island's College of Business Administration, said the tax hike was inevitable. . . . Depending on the circumstances, the tax increase is one factor that could discourage a business from hiring next year, Higgins said. Higher unemployment tax 'just increases the cost of hiring somebody,' he said. 'It increases the cost of payroll . . . [and] of keeping [an employee] on the payroll,' he said."

Mr. VAN HOLLEN. Madam Speaker, I rise in strong support of the Jobs for Main Street Act. Now that recent initiatives aimed at stabilizing our financial system and stimulating our economy are beginning to have their intended effect, this targeted legislation is laser-focused on job creation to ensure that all Americans will have an opportunity to participate in our ongoing economic recovery.

Specifically, the Jobs for Main Street Act invests \$48 billion in our nation's highways, transit systems, school facilities, water infrastructure and housing stock. In addition to putting hundreds of thousands of Americans back to work, these funds will make needed improvements and renovations to our nation's aging infrastructure. \$27 billion is provided to hire, train and equip an estimated 820,000 teachers, police, firefighters and other public service personnel. Job-generating small businesses will get greater access to Small Business Administration (SBA) loans by eliminating fees and by providing higher guarantees to the private banks that lend to them. These measures, in addition to the small business Recovery Act initiatives that preceded them, will help generate well over \$9 billion in new small business lending.

To help Americans who are out of work or have lost their employer-provided health insurance, this legislation extends emergency unemployment and COBRA benefits through June, 2010. States will receive an extra six months of federal matching funds to help cover their Medicaid costs through June, 2011, and the families of 16 million low-income children will get a tax cut through greater access to the Child Tax Credit.

Madam Speaker, this Congress on a bipartisan basis extended support to Wall Street during a period of potentially catastrophic systemic risk and extraordinary need. It is now high time we make an equally extraordinary effort on behalf of creating jobs for Main Street so that the prosperity we are creating is broadly shared by all.

Mr. BUYER. Madam Speaker, I rise in opposition to H.R. 2847 the, "Jobs for Main Street Act of 2009."

Madam Speaker, once again members are being asked to vote on a 100-page bill, which was posted in the dead of night in the name of creating jobs that unfortunately will probably never materialize. What it will do is needlessly expand the size of the Federal Government. Madam Speaker, this is not the type of open and transparent process that the American people want or deserve.

I am especially concerned that this bill spends millions of taxpayer dollars on innumerable pork barrel programs and pet projects, but it does not spend a dime to help create jobs for veterans. Recent unemployment numbers from the U.S. Bureau of Labor Statistics show that in the month of November there were over one million unemployed veterans, and that is unacceptable.

The unemployment rate among our newest veterans, ages 18–24, remains extremely high at 20 percent. Equally disturbing is that 700,000 of the one million unemployed veterans are between the ages of 35 and 64, the years normally characterized by both highest earning power and highest financial need for important items such as paying mortgages and tuitions.

Madam Speaker, it is because of these alarming statistics that earlier this month I was joined by many members of the Committee on Veterans' Affairs in introducing H.R. 4220 the Promoting Jobs for Veterans Act of 2009. H.R. 4220 would help veterans find employment by providing funding and incentives for them to pursue employment training and education. The bill would also expand opportunities within the Federal Government for veteran-owned and service disabled veteran-owned small businesses.

It was my hope that any "jobs package" would have included provisions such as those from H.R. 4220 to help those who have defended freedom, and it is unfortunate that the heavy handed tactics being used today have effectively prevented anyone from offering an amendment to include these provisions.

Madam Speaker, I believe that veterans could serve as an important catalyst to economic recovery. Veterans are dedicated employees and engaged entrepreneurs, and this would expand job and entrepreneurial opportunities for these selfless individuals. It is my hope that early in the next session we can consider H.R. 4220 and examine other ways to improve employment opportunities for our veterans.

Mr. DeFAZIO. Madam Speaker, the U.S. economy continues to limp along mired in a jobless recovery. Wall Street banks have begun to recover thanks to a \$700 billion bailout paid for by taxpayers. Unfortunately, everyone else continues to suffer the effects of the economic collapse. Oregon's unemployment rate exceeds 11 percent and small businesses in my district can't get banks to lend to them. I have long advocated for a targeted jobs recovery program that focuses on substantial investments in our Nation's infrastructure, which will create jobs quickly and leave a long-term benefit for future generations.

I reluctantly voted for H.R. 2847, the Jobs for Main Street Act because it begins to make these investments that are both desperately needed and effective at creating jobs. There are nearly 10,000 of ready-to-go infrastructure

projects across the country that have been postponed or delayed due to decades of underinvestment and underfunding. There are 61,000 miles of the National Highway System in poor or fair condition. 152,000 bridges are structurally deficient or functionally obsolete. The Nation's largest transit agencies face a combined \$80 billion maintenance backlog to bring their rail systems to a state of good repair.

The American Recovery and Reinvestment Act, ARRA, provided a mere \$34 billion for highway and transit formula programs. Nearly 70 percent of the funding has already been put out to bid on over 9,500 infrastructure projects. The 7,900 Recovery Act infrastructure projects have created or sustained more than 210,000 direct jobs, as well as 630,000 indirect jobs in the past nine months.

As the ARRA Act infrastructure funding draws to a close, there are still over 9,000 shovel ready infrastructure projects across the country that could proceed within 120 days. The projects include 7,500 in ready-to-go highway and bridge projects; over 1,800 in ready-to-go transit, rail, port, and aviation projects; and an estimated \$21 billion worth of projects that transit agencies across the country could undertake immediately. These projects will create not just public sector construction jobs, but will procure American-made transit buses, trains, electrical equipment, computer systems and software designed by private sector, American engineers.

H.R. 2847 represents the bare minimum of what we need to do. Should the Senate redirect this effort to tax cuts or other ineffective job creation policies, I will have a very difficult time supporting a final bill.

Mr. CONYERS. Madam Speaker, I rise in support of passage of the Jobs for Main Street Act of 2010.

I believe this legislation is one of the most cost effective ways to provide cities across this country with desperately needed federal funding to help create and stabilize jobs, assist families who need their unemployment benefits extended, and to ensure that they can keep their health insurance.

Passage of the Jobs for Main Street Act of 2010 is critically important for America's working families, and unemployed individuals, given the current economic status of this country.

The Nation is experiencing extreme difficulties leading to high unemployment rates, especially in my home State of Michigan. Passage of this bill will provide real tangible relief for those who are depending on the Federal Government to help them survive in a time of financial crisis—not empty rhetoric and promises that help nobody.

The Jobs for Main Street Act of 2010 will help reduce these problems by stabilizing and creating jobs through infrastructure investments, an increase in public service jobs, and provide emergency relief for families hurt by the economy.

The bill will provide billions of dollars to create or save jobs with targeted investments for highways and transit, school renovation, hiring teachers, police, and firefighters, small business, job training and affordable housing which are essential elements in promoting economic growth.

However, passage of the Jobs for Main Street Act of 2010 is just the beginning of the process to put America back to work. We must act quickly to establish a full-employment economy, where every American who wants a job should be able to find one; and at a livable wage. This can and must be done if America is ever going to become a truly productive country.

During the depression, President Roosevelt put millions of Americans to work by creating public service jobs such as building roads, national parks, and rural electrification systems. We can do the same by creating a 21st century public works jobs program for America that can quickly employ the millions of citizens in this country who simply cannot find employment in the private sector.

The passage of this legislation will help put our Nation on the road to recovery. Therefore, I urge my colleagues to support this bill.

Mr. HOLT. Madam Speaker, I rise in support of H.R. 2847, the Jobs for Main Street Act. This legislation would provide jobs for tens of thousands of Americans, preserve thousands more jobs, and continue essential benefits to aid the unemployed without increasing the national debt.

We have taken important steps to bring our economy back from the worst economic crisis in three-quarters of a century. We've made important investments in our infrastructure, clean energy jobs, science research, and the next generation of workers.

There are clear signs that the economy is improving. Instead of shrinking by 6.4 percent a quarter, the economy has grown by 2.8 percent. Instead of losing 741,000 jobs a month, as the economy did a year ago, last month the economy shed 11,000 jobs. These are encouraging signs.

Yet, I'm not going to sit on my hands and wait for job creation. Families in New Jersey, who have lost a job or had their hours or paychecks cut, are still hurting. And we know employers have cut jobs more sharply and are more hesitant to replace them than in previous downturns.

The government can and should work together to increase employment opportunities in the short-term, mid-term, and long-term. Economists, business leaders, financial experts, among others, have argued that the Federal Government, and only the Federal Government, can inject into the economy a stimulus of sufficient size to make up for the frozen, collapsing economy. The package we are considering today will build on our previous investment, creating needed jobs and helping those who continue to be unemployed.

The Jobs for Main Street Act would redirect \$48.3 billion to put Americans to work rebuilding our Nation's crumbling roads and bridges, modernizing public buildings, and improving air and water quality. Specifically it would invest \$27.5 billion in highway infrastructure improvements, \$8.4 billion for transit improvements, and \$800 million to improve Amtrak. It is estimated that this investment will create over 750,000 new jobs. Additionally, H.R. 2847 would invest \$2.8 billion in clean water infrastructure, aquatic ecosystem restoration, and flood mitigation; creating another 50,000 jobs. It also will put contractors back to work by providing states with \$4.1 billion for school

construction, rehabilitation, and renovations. The \$270 million that this legislation would invest in improving and protecting Federal, State, and local public lands would support approximately 14,000 short-term jobs, improving service to visitors, reducing the large backlog in facilities and habitat restoration needs, and reducing hazardous fuels that lead to damaging and expensive wildfires. These investments will do more than create jobs in the short term, they will provide long term benefits to all Americans.

Over the past year, I have held a number of events focused on jobs. Two months ago, I brought 50 central Jersey small business owners to Washington to hear their concerns and help them access helpful programs. Two weeks ago, I hosted a jobs forum in central New Jersey. At both events, I heard from small business owners struggling to get the credit and loans they need. The Jobs for Main Street Act would help those small businesses by eliminating fees on Small Business Administration loans and by providing a strong guarantee for Small Business Administration loans to encourage more banks to lend to small businesses. Small businesses are the engine that drives our economy, and during rough economic times they are also the engine that drives job creation. This is one step that Congress is taking to help our small businesses, who generate jobs and develop the innovative products of the future.

I especially am pleased this bill provides funding to ensure that states can keep police officers, firefighters, teachers, and other State and local employees on the job. Without this funding, States would be forced to make the difficult decision between cutting jobs and services or increasing taxes. That is a choice that no state should have to make, especially in difficult economic times.

The Jobs for Main Street Act includes \$1.18 billion to help put more than 5,500 law enforcement officers on the beat throughout the United States, and \$500 million to retain, rehire, and hire firefighters across the United States. According to the International Association of Firefighters, nearly 6,000 firefighters have been laid off or are subject to layoffs. An additional 6,000 positions have been lost through attrition. The bill would provide \$18.9 billion to school districts and public institutions of higher education to retain or create 250,000 teaching jobs.

The recession has hit those between the ages of 16 and 25 particularly hard, and the unemployment rate is especially high for this group. The Jobs for Main Street Act would provide much needed job training and temporary public service positions to get these individuals back to work. The bill would provide \$200 million to hire an additional 25,000 AmeriCorps Members, this funding would enable those individuals to serve their communities while earning an education award to further their education or pay off student loans. With the teenage unemployment rate at its highest rate in history, 27.8 percent, this legislation would invest \$500 million to create 250,000 summer jobs for disadvantaged youth. H.R. 2847 would help up to 250,000 students stay in school by investing \$300 million in the College Work Study program, which supports low- and moderate-income under-

graduate and graduate students who work while attending college. Additionally, this legislation would provide \$750 million for competitive grants to support job training for approximately 150,000 individuals in high growth and emerging industry sectors, particularly in the health care and green industries that are adding jobs despite difficult economic conditions.

For those workers struggling to maintain their health insurance while in between jobs, this bill would extend the COBRA subsidy established in the Recovery Act, which has already benefited approximately 7 million Americans. This expanded COBRA subsidy would help workers for 15 months with their COBRA health insurance premiums and help more Americans access this benefit. Job losses also have caused State Medicaid rolls to swell. This bill temporarily would increase the Federal Government's contribution to Medicaid to ensure States are able to provide health coverage to these workers. This two-prong approach will help ensure millions of unemployed workers are able to maintain health coverage for their families.

When we talk about jobs, we are not just talking about the economy. We are talking about the dignity that comes from holding a steady job that supports your family. The Jobs for Main Street Act recognizes this, and would help our families in real ways. I urge my colleagues to support it.

Mr. ETHERIDGE. Madam Speaker, I rise in support of H.R. 2847, the Jobs for Main Street Act. Over the last year, our economy has sustained serious damage. Although recent signs are pointing to an upswing in the overall economy, millions of Americans are jobless or have seen their hours drastically cut. The national unemployment rate is 10 percent while in my State of North Carolina the figure is 11 percent statewide, and reaches as high as 13 percent in parts of my district. Action is needed to help solve this crisis.

H.R. 2847 builds on earlier actions taken by Congress to create jobs and get Americans back to work. This bill provides \$48.3 billion for highway construction, mass transit, and other infrastructure projects. Our Nation's infrastructure is in need of a serious update, and repairing our highways, renovating our schools, building new mass transit, and improving our airports and water and sewer facilities provides vitally needed jobs to Americans across the country. This bill also extends authorization for highway, transit, and safety funding, the Safe, Accountable, Flexible, Efficient Transportation Equity Act (SAFETEA-LU) through September of 2010. H.R. 2847 is a timely bill and gets funding in place for infrastructure projects that can start with the spring construction season.

I would like to thank Chairman RANGEL, and Speaker PELOSI, for their work to make Qualified School Construction Bonds more effective in this bill. I worked with Chairman RANGEL to create these bonds to put the Federal Government in partnership with local schools to meet their needs and help create jobs. Where these bonds have been issued, they are having a great impact on our economy and our communities. However, contrary to the intentions of the bill, only 15 percent of the 2009 QSCB bond allocations have been used to date. This bill allows State or local governments who

issue QSCBs or Qualified Zone Academy Bonds to choose a direct payment to cover the interest they would otherwise have to fund themselves, at no additional cost to the Federal Government since the payment is equal to the tax credit that would otherwise be received by the investor. As I have mentioned before, investing in school construction and modernization is one of the best ways to help Main Street, create jobs, and address pressing national needs. I am pleased that we were able to make this change in the bill to bring funds quickly to our local schools and communities.

H.R. 2847 also provides \$26.7 billion in aid for State and local governments. These funds are used to retain police, firefighters, teachers, and other workers who would otherwise lose their jobs due to State and local revenue shortfalls. This bill also provides assistance for those struggling the most in today's economy by extending the emergency unemployment benefits initiative for six months and the COBRA health insurance subsidy for an additional six months. H.R. 2847 includes \$26.1 billion in tax credits for other assistance initiatives like the Child Care Tax Credit and Social Security legal assistance. Finally, H.R. 2847 targets small businesses, the economic engines that create the majority of new jobs, by extending funds for the Small Business Administration to continue affordable long-term loans for new startups.

Not only does this bill create jobs and boost the economy, it does so in a fiscally responsible manner. It includes the previously House-passed PAYGO language and would be paid for in part by savings from the Troubled Asset Relief Program, TARP. It's time for Wall Street to help shoulder some of the burden on Main Street. I support strong job creation measures and I support H.R. 2847. I urge my colleagues to join me in voting for its passage.

Mr. CARSON of Indiana. Madam Speaker, as we consider this final important jobs creating measure, I would like to draw attention to one of the important pieces of the legislation: the extension of the eligibility period for COBRA benefits. Unemployment numbers continue to hover nationally at 10 percent; however, in many areas of the country these numbers are far higher. With these high numbers comes a decline in access to healthcare benefits and thus the need for this critical provision.

Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986, and it has maintained a successful program by providing a continuation of group health coverage for individuals and families that might otherwise have been terminated. And, through the economic stimulus package passed in February, a 65 percent subsidy was provided for COBRA benefits for nine months and has been a welcome relief for thousands of unemployed workers who otherwise would not have been able to afford the COBRA premiums.

Many individuals and families have already exhausted their subsidy and are trying to figure out how to maintain their health insurance coverage. The problem is especially felt by older Americans who are close to retirement age and not yet eligible for Medicare, as they

tend to use more health care services. Providing our constituents with the ability to maintain health coverage when they become unemployed is a key to ensuring these individuals do not fall through the cracks and end up without the health insurance they need. I urge passage of this important legislation.

Ms. JACKSON-LEE of Texas. Madam Speaker, I rise in support of H.R. 2487, the Jobs for Main Street Act. I salute my colleague Chairman OBEY for this bill that is the opening salvo in our effort to tackle one of the most important issues of the day facing our nation.

The bill redirects \$48.3 billion from Wall Street to help put people to work rebuilding our crumbling roads and bridges, modernizing public buildings, and cleaning our air and water. I'm happy that we gave the American people a gift with \$27.5 billion to make additional highway infrastructure investments. These projects support jobs in the short term while saving commuters time and money in the long term.

Another gift was made in the area of transit, with \$8.4 billion for public transportation investments including \$6.15 billion for urban and rural formula grants; \$500 million for capital investment grants for new or expanded fixed guideway projects; and \$1.75 billion in formula funds to address repair needs of existing subway, light rail and commuter rail systems. Public transportation saves Americans time and money, reducing carbon emissions by 37 million metric tons each year, which is timely as the world's eyes are centered on the debates in Copenhagen.

These gifts are news to the ears of my constituents. Let me share with you that in my district, which covers parts of the nation's fourth largest city, Houston, TX, our unemployment rate stands at nearly 9%. While this rate is more than a full percentage point below the national average, it should be noted that over 110,000 jobs were lost in the first 10 months of this year. Regrettably, a disproportionate share of those impacted by these job losses in my district have been African Americans and Latinos.

Yet, this "jobs disparity" is not limited to Houston; data from the Department of Labor indicates that African Americans throughout the nation today, in the era of President Obama, are still the last hired and the first fired. Specifically, the Bureau of Labor Statistics reports that the unemployment rate for African American men (20 and older) was 16.5 percent as of October of this year, and 12.4 percent for African American women at the same age level.

Historically, experts have suggested that the antidote to unemployment is education. However, Labor Department statistics appear to indicate that education, alone, does not level the playing field. In fact, higher education amongst African Americans may strangely enough even make it more difficult to obtain a job. For the first 10 months of this year, as the recession has dragged on, unemployment for least educated workers was the same for African Americans and the general population. However, in 2009, the unemployment rate for African American college graduates 25 and older has been nearly twice that of their Caucasian American male counterparts (8.4 percent com-

pared with 4.4 percent). According to a New York Times article published on December 1st, even African American college graduates with degrees from Ivy League schools such as Yale, my alma mater, are finding themselves in the ranks of the unemployed.

In addition to the racial dimension of this "jobs disparity," the recent economic downturn has focused a spotlight on a widening gap between employment rates among men and women, particularly in the African American community. It has been reported that since the nation's slowdown has been most pronounced in the manual labor sectors, men with the lowest levels of education have suffered the brunt of the unemployment crisis. CNN commentators recently described our current economic condition as a "man-cession."

According to a recent Bureau of Labor Statistics report, the unemployment rate for African American men aged 20 and older was 4.1 percent higher than the unemployment rate for African American women of the same age group, which was 12.4 percent. This gender unemployment gap among African Americans mirrors a similar gap between Caucasian and Latino Americans, thus demonstrating a nationwide trend.

Friends, we are in a battle for the hearts and souls of America, literally and figuratively. To win this battle, we must take bold action, like passing health care reform legislation in both chambers of Congress. Madam Speaker, I concur with the assessment that the health reform legislation voted out of this chamber last month in fact a "jobs bill."

As evidence of this, the Bureau of Labor Statistics reports that last month's slight dip in the unemployment rate was caused by the fact that for the third straight month, hospitals reported solid payroll additions, with 6,800 new jobs created. In the first 11 months of this year, the healthcare sector created 249,700 new jobs, an average of 22,700 new health care jobs each month, according to BLS' preliminary data. Since the start of the recession in December 2007, overall 7.9 million people in America have lost their jobs, while the healthcare sector has created 613,000 jobs.

In an article published in HealthLeaders Media, it was reported that the healthcare sector—from hospitals, to physicians' offices, to residential mental health homes, kidney dialysis centers, and blood and organ banks—grew by 21,000 payroll additions in November and 613,000 payroll additions since the start of the recession in December 2007. The home healthcare services sector reported 7,300 payroll additions in November, BLS preliminary data show.

Recognizing this Madam Speaker, I am working with health care and labor leaders to craft a jobs bill that create innovative new retraining programs in partnership with our Historically Black Colleges and Universities like Texas Southern University in my District or Howard University, here in Washington, DC. These training programs would focus on retooling workers for jobs in the growth sectors such as health, biotech, and information technology. In addition to funding for job training, I propose that we provide stipends to those who are unemployed and who participate in training programs to assist them in caring for their families. Along with this, my jobs bill

would allow unemployed workers participating in job retraining to continue receiving unemployment benefits.

As a senior member of the Judiciary Committee, I am also working with the DOJ to incorporate into my jobs legislation a measure that would assist ex-offenders who are returning to the job market with strikes against them. In addition to eliminating any barriers for ex-offenders, I am also studying how we can encourage states to suspend criminal prosecution of fathers and other parents who are delinquent in child support so long as they are making good faith efforts to find jobs in this difficult employment market.

Madam Speaker, I also propose that we task the Department of Labor to expand its definition of the unemployed to cover not only those currently receiving unemployment compensation, but also those who have run out of unemployment insurance, known as the long term unemployed. I suspect that if we had accurate data that captured the entire unemployment picture, we would see jobless figures of upwards of 25–30 percent.

In addition, Madam Speaker, I also plan to propose we offer assistance to the underemployed, including thousands of lawyers and other professionals who work as part-timers or temp workers. Many of these professionals split their time between working for others and operating their own small firms. Furthermore, it has been noted that while larger firms are enjoying the benefit of government funded bailouts, our African American law firms, accounting firms, investment banking firms and media outlets are being left out of the funds directed at stimulating Wall Street. As Comcast and NBC Universal and other firms seek government permission to merge, I intend to work with these companies to ensure that our African American businesses are included, not left out of the deal flow.

Another jobs initiative would focus on creating apprentice and internship programs managed by cities and nonprofits like the Urban League. This is a take off of a Department of Labor that was very successful in the 1970s, which helped our nation rebound from its last recession.

Madam Speaker, during the 1930s–40s, the FDR Administration developed the Work Progress Administration (WPA). The WPA created thousands of jobs and helped lift our nation from depression. I am drafting legislation that would create a WPA for the 21st Century. This concept involves providing stimulus dollars to several federal agencies such as Interior, Transportation, and HHS to fund large scale projects.

Under my legislation, the new WPA would include modern day infrastructure and other projects including making broadband wireless Internet service available for all Americans, not just in wealthier suburban and downtown districts. In addition, we should create high speed rail and environmentally friendly highways and byways.

Finally, I plan that we work with HHS and the Energy Department to build new Green Hospitals across the country. This project would ensure that our nation's healthcare facilities are themselves healthy.

Madam Speaker, many of our unemployed constituents in Houston and around the nation

are asking us a simple question: how long, how long before I can find a job? I say to them, not long . . . help is on the way. With the introduction and passage of jobs legislation offered by myself and the rest of the Congressional Black Caucus, help for the unemployed and underemployed, help for small businesses, is on the way.

I ask my colleagues to join me in supporting H.R. 2847, the Jobs for Main Street Act.

The SPEAKER pro tempore. All time for debate has expired.

CALL OF THE HOUSE

Mr. OBEY. Madam Speaker, pursuant to clause 7 of rule XX, I move a call of the House.

The SPEAKER pro tempore. The previous question being ordered, the Chair notes the absence of a quorum in accord with clause 7(c) of rule XX and chooses to entertain a motion for a call of the House pursuant to clause 7(b) of rule XX.

A call of the House was ordered.

The call was taken by electronic device, and the following Members responded to their names:

[Roll No. 990]

Abercrombie	Buyer	Dingell
Ackerman	Calvert	Doggett
Aderholt	Camp	Donnelly (IN)
Adler (NJ)	Campbell	Doyle
Akin	Cantor	Dreier
Alexander	Cao	Driehaus
Altmire	Capito	Duncan
Andrews	Capps	Edwards (MD)
Arcuri	Capuano	Edwards (TX)
Austria	Cardoza	Ehlers
Baca	Carnahan	Ellison
Bachmann	Carney	Ellsworth
Bachus	Carson (IN)	Emerson
Baird	Carter	Engel
Baldwin	Cassidy	Eshoo
Barrett (SC)	Castle	Etheridge
Barrow	Castor (FL)	Fallin
Bartlett	Chaffetz	Farr
Barton (TX)	Chandler	Fattah
Bean	Childers	Filner
Becerra	Chu	Flake
Berkley	Clarke	Fleming
Berman	Clay	Forbes
Berry	Cleaver	Fortenberry
Biggert	Clyburn	Foster
Bilbray	Coble	Fox
Bilirakis	Coffman (CO)	Franks (AZ)
Bishop (GA)	Cohen	Frelinghuysen
Bishop (NY)	Cole	Fudge
Bishop (UT)	Conaway	Galleghy
Blackburn	Connolly (VA)	Garamendi
Blumenauer	Conyers	Garrett (NJ)
Blunt	Cooper	Gerlach
Boccheri	Costa	Giffords
Boehner	Costello	Gingrey (GA)
Bonner	Courtney	Gohmert
Bono Mack	Crenshaw	Gonzalez
Boozman	Crowley	Goodlatte
Boren	Cuellar	Gordon (TN)
Boswell	Culberson	Granger
Boucher	Cummings	Graves
Boustany	Dahlkemper	Grayson
Boyd	Davis (AL)	Green, Al
Brady (PA)	Davis (CA)	Green, Gene
Brady (TX)	Davis (IL)	Griffith
Braley (IA)	Davis (KY)	Grijalva
Bright	Davis (TN)	Guthrie
Broun (GA)	Deal (GA)	Gutierrez
Brown (SC)	DeFazio	Hall (NY)
Brown, Corrine	DeGette	Hall (TX)
Brown-Waite,	Delahunt	Halvorson
Ginny	DeLauro	Hare
Buchanan	Dent	Harman
Burgess	Diaz-Balart, L.	Harper
Burton (IN)	Diaz-Balart, M.	Hastings (FL)
Butterfield	Dicks	Hastings (WA)

Heinrich	McCarthy (NY)	Royce
Heller	McCauley	Ruppersberger
Hensarling	McClintock	Rush
Herger	McCollum	Ryan (OH)
Herseth Sandlin	McCotter	Ryan (WI)
Higgins	McDermott	Salazar
Hill	McGovern	Sánchez, Linda
Himes	McHenry	T.
Hinchee	McIntyre	Sanchez, Loretta
Hinojosa	McKeon	Sarbanes
Hirono	McMahon	Scalise
Hodes	McMorris	Schakowsky
Hoekstra	Rodgers	Schauer
Holden	McNerney	Schiff
Holt	Meek (FL)	Schmidt
Honda	Meeks (NY)	Schock
Hoyer	Melancon	Schrader
Hunter	Mica	Schwartz
Inglis	Michaud	Scott (GA)
Inslee	Miller (FL)	Scott (VA)
Israel	Miller (MI)	Sensenbrenner
Issa	Miller (NC)	Serrano
Jackson (IL)	Miller, Gary	Sessions
Jackson-Lee	Miller, George	Sestak
(TX)	Minnick	Shadegg
Jenkins	Mitchell	Shea-Porter
Johnson (GA)	Mollohan	Sherman
Johnson (IL)	Moore (KS)	Shimkus
Johnson, E. B.	Moore (WI)	Shuler
Johnson, Sam	Moran (KS)	Shuster
Jones	Moran (VA)	Simpson
Jordan (OH)	Murphy (CT)	Sires
Kagen	Murphy (NY)	Skelton
Kanjorski	Murphy, Patrick	Slaughter
Kaptur	Murphy, Tim	Smith (NE)
Kennedy	Myrick	Smith (NJ)
Kildee	Nadler (NY)	Smith (TX)
Kilpatrick (MI)	Napolitano	Smith (WA)
Kilroy	Neal (MA)	Snyder
Kind	Neugebauer	Souder
King (IA)	Nunes	Space
King (NY)	Nye	Spratt
Kingston	Oberstar	Stark
Kirk	Obey	Stearns
Kirkpatrick (AZ)	Olson	Stupak
Kissell	Olver	Sullivan
Klein (FL)	Ortiz	Sutton
Kline (MN)	Owens	Tanner
Kosmas	Pallone	Taylor
Kratovil	Pascarelli	Teague
Kucinich	Pastor (AZ)	Terry
Lamborn	Paul	Thompson (CA)
Lance	Paulsen	Thompson (MS)
Langevin	Payne	Thompson (PA)
Larsen (WA)	Pence	Thornberry
Larson (CT)	Perlmutter	Tiahrt
Latham	Perrilli	Tiberi
LaTourette	Peters	Tierney
Latta	Peterson	Titus
Lee (CA)	Petri	Tonko
Lee (NY)	Pingree (ME)	Towns
Levin	Pitts	Tsongas
Lewis (CA)	Platts	Turner
Lewis (GA)	Poe (TX)	Upton
Linder	Polis (CO)	Van Hollen
Lipinski	Pomeroy	Velázquez
LoBiondo	Posey	Visclosky
Loebach	Price (GA)	Walden
Lofgren, Zoe	Price (NC)	Walz
Lowe	Putnam	Wamp
Lucas	Quigley	Wasserman
Luetkemeyer	Rahall	Schultz
Lujan	Rangel	Waters
Lummis	Rehberg	Watson
Lungren, Daniel	Reichert	Watt
E.	Reyes	Waxman
Lynch	Richardson	Weiner
Mack	Rodriguez	Welch
Maffei	Roe (TN)	Westmoreland
Maloney	Rogers (AL)	Wexler
Manzullo	Rogers (KY)	Whitfield
Marchant	Rogers (MI)	Wilson (OH)
Markey (CO)	Rohrabacher	Wilson (SC)
Markey (MA)	Rooney	Wittman
Marshall	Ros-Lehtinen	Wolf
Massa	Roskam	Woolsey
Matheson	Ross	Wu
Matsui	Rothman (NJ)	Yarmuth
McCarthy (CA)	Roybal-Allard	Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the call). Although some of the amber lights in the display over the south gallery are not operational, the other sys-

tem displays confirm that all of the Members listed in the affected column have recorded their presence.

□ 1845

The SPEAKER pro tempore. 429 Members have recorded their presence. A quorum is present.

JOBS FOR MAIN STREET ACT, 2010

The SPEAKER pro tempore. Pursuant to House Resolution 976, the previous question is ordered.

The question is on the motion offered by the gentleman from Wisconsin (Mr. OBEY).

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. LEWIS of California. Madam Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, this 15-minute vote on the motion to concur will be followed by a 5-minute vote on the motion to suspend the rules and pass H.R. 4194, if ordered.

The vote was taken by electronic device, and there were—ayes 217, noes 212, not voting 6, as follows:

[Roll No. 991]

AYES—217

Abercrombie	DeFazio	Kaptur
Ackerman	DeGette	Kennedy
Altmire	Delahunt	Kildee
Andrews	DeLauro	Kilpatrick (MI)
Baca	Dicks	Kilroy
Baird	Dingell	Kissell
Baldwin	Doggett	Klein (FL)
Barrow	Doyle	Kucinich
Becerra	Edwards (MD)	Langevin
Berkley	Ellison	Larsen (WA)
Berman	Engel	Larson (CT)
Berry	Eshoo	Lee (CA)
Bishop (GA)	Etheridge	Levin
Bishop (NY)	Farr	Lewis (GA)
Bishop (UT)	Fattah	Lipinski
Blackburn	Filner	Loebach
Blumenauer	Frank (MA)	Lofgren, Zoe
Blunt	Fudge	Lowe
Boccheri	Garamendi	Lujan
Boehner	Green, Al	Lynch
Bonner	Green, Gene	Maffei
Bono Mack	Grijalva	Maloney
Boozman	Gutierrez	Markey (MA)
Boren	Hall (NY)	Marshall
Boswell	Halvorson	Massa
Boucher	Hare	Matsui
Boustany	Harman	McCarthy (NY)
Boyd	Hastings (FL)	McCollum
Brady (PA)	Heinrich	McDermott
Brady (TX)	Higgins	McGovern
Braley (IA)	Hinchee	McIntyre
Bright	Hinojosa	McMahon
Broun (GA)	Hirono	McNerney
Brown (SC)	Holden	Meek (FL)
Brown, Corrine	Holt	Meeks (NY)
Brown-Waite,	Honda	Michaud
Ginny	Hoyer	Miller (NC)
Buchanan	Inslee	Miller, George
Burgess	Israel	Mollohan
Burton (IN)	Jackson (IL)	Moore (KS)
Butterfield	Jackson-Lee	Moore (WI)
	(TX)	Moran (VA)
	Johnson (GA)	Murphy (CT)
	Kagen	Murphy (NY)
	Kanjorski	Nadler (NY)
		Napolitano
		Neal (MA)
		Oberstar
		Obey

Olver	Sánchez, Linda	Thompson (MS)	Tiberi	Wamp	Wittman
Ortiz	T.	Tierney	Turner	Westmoreland	Wolf
Owens	Sanchez, Loretta	Titus	Upton	Whitfield	Young (AK)
Pallone	Sarbanes	Tonko	Walden	Wilson (SC)	
Pascarell	Schakowsky	Towns			
Pastor (AZ)	Schauer	Tsongas		NOT VOTING—6	
Payne	Schiff	Van Hollen	Johnson, E. B.	Murtha	Speier
Pelosi	Schwartz	Velázquez	Linder	Radanovich	Young (FL)
Perlmutter	Scott (GA)	Visclosky			
Perriello	Scott (VA)	Walz			
Pingree (ME)	Serrano	Wasserman			
Polis (CO)	Sestak	Schultz			
Price (NC)	Shea-Porter	Waters			
Rahall	Sherman	Watson			
Rangel	Shuler	Watt			
Reyes	Sires	Waxman			
Richardson	Skelton	Weiner			
Rodriguez	Slaughter	Welch			
Ross	Snyder	Wexler			
Rothman (NJ)	Spratt	Wilson (OH)			
Roybal-Allard	Stark	Woolsey			
Ruppersberger	Stupak	Wu			
Rush	Sutton	Yarmuth			
Ryan (OH)	Tanner				
Salazar	Thompson (CA)				

NOES—212

Aderholt	Fleming	McKeon
Adler (NJ)	Forbes	McMorris
Akin	Fortenberry	Rodgers
Alexander	Foster	Melancon
Arcuri	Fox	Mica
Austria	Franks (AZ)	Miller (FL)
Bachmann	Frelinghuysen	Miller (MI)
Bachus	Galleghy	Miller, Gary
Barrett (SC)	Garrett (NJ)	Minnick
Bartlett	Gerlach	Mitchell
Barton (TX)	Gingrey (GA)	Moran (KS)
Bean	Gohmert	Murphy, Patrick
Biggart	Goodlatte	Murphy, Tim
Bilbray	Granger	Myrick
Bilirakis	Graves	Neugebauer
Bishop (UT)	Griffith	Nunes
Blackburn	Guthrie	Nye
Blunt	Hall (TX)	Olson
Boehner	Harper	Paul
Bonner	Hastings (WA)	Paulsen
Bono Mack	Heller	Pence
Boozman	Hensarling	Peters
Boren	Herger	Peterson
Boustany	Herseth Sandlin	Petri
Boyd	Hill	Pitts
Brady (TX)	Himes	Platts
Bright	Hodes	Poe (TX)
Broun (GA)	Hoekstra	Pomeroy
Brown (SC)	Hunter	Posey
Brown-Waite,	Inglis	Price (GA)
Ginny	Issa	Putnam
Buchanan	Jenkins	Quigley
Burgess	Johnson (IL)	Rehberg
Burton (IN)	Johnson, Sam	Reichert
Buyer	Jones	Roche (TN)
Calvert	Jordan (OH)	Rogers (AL)
Camp	Kind	Rogers (KY)
Campbell	King (IA)	Rogers (MI)
Cantor	King (NY)	Rohrabacher
Cao	Kingston	Rooney
Capito	Kirk	Ros-Lehtinen
Carter	Kirkpatrick (AZ)	Roskam
Cassidy	Kline (MN)	Royce
Castle	Kosmas	Ryan (WI)
Chaffetz	Kratovil	Scalise
Childers	Lamborn	Schmidt
Coble	Lance	Schock
Coffman (CO)	Latham	Schrader
Cole	LaTourette	Sensenbrenner
Conaway	Latta	Sessions
Connolly (VA)	Lee (NY)	Shadegg
Crenshaw	Lewis (CA)	Shimkus
Culberson	LoBiondo	Shuster
Davis (KY)	Lucas	Simpson
Deal (GA)	Luetkemeyer	Smith (NE)
Dent	Lummis	Smith (NJ)
Diaz-Balart, L.	Lungren, Daniel	Smith (TX)
Diaz-Balart, M.	E.	Smith (WA)
Donnelly (IN)	Mack	Souder
Dreier	Manzullo	Space
Driehaus	Marchant	Stearns
Duncan	Markkey (CO)	Sullivan
Edwards (TX)	Matheson	Taylor
Ehlers	McCarthy (CA)	Teague
Ellsworth	McCauley	Terry
Emerson	McClintock	Thompson (PA)
Fallin	McCotter	Thornberry
Flake	McHenry	Tiahrt

Mr. BAIRD changed his vote from “no” to “aye.”

So the motion was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated against:

Mr. RADANOVICH. Madam Speaker, I was unable to make today's votes on the House floor due to a family illness. Had I been present I would have voted as follows:

“No” on rollcall vote No. 991, on the motion to adopt H.R. 2847, the Jobs for Main Street Act.

LAW STUDENT CLINIC PARTICIPATION ACT OF 2009

The SPEAKER pro tempore. The unfinished business is the question on suspending the rules and passing the bill, H.R. 4194.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Tennessee (Mr. COHEN) that the House suspend the rules and pass the bill, H.R. 4194.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

LOCAL COMMUNITY RADIO ACT OF 2009

The SPEAKER pro tempore. The unfinished business is the question on suspending the rules and passing the bill, H.R. 1147, as amended.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Virginia (Mr. BOUCHER) that the House suspend the rules and pass the bill, H.R. 1147, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

REAPPOINTMENT AS MEMBERS TO UNITED STATES-CHINA ECONOMIC AND SECURITY REVIEW COMMISSION

The SPEAKER pro tempore. Pursuant to section 1238(b)(3) of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (22 U.S.C. 7002),

amended by division P of the Consolidated Appropriations Resolution, 2003 (22 U.S.C. 6901), and the order of the House of January 6, 2009, the Chair announces the Speaker's reappointment of the following members on the part of the House to the United States-China Economic and Security Review Commission, effective January 1, 2010:

Ms. Carolyn Bartholomew, Washington, D.C.

Mr. Jeffrey L. Fiedler, Great Falls, VA

RESIGNATION FROM THE HOUSE OF REPRESENTATIVES

The SPEAKER pro tempore laid before the House the following resignation from the House of Representatives:

CONGRESS OF THE UNITED STATES,

December 16, 2009.

Hon. NANCY PELOSI,
*Speaker of the House of Representatives, H-232,
U.S. Capitol, Washington, DC.*

DEAR SPEAKER PELOSI: This letter is to formally notify you that on October 26, 2009 I sent a letter to Governor Charlie Crist of Florida stating that I will be resigning as the United States Representative from the 19th Congressional District of Florida at the end of the day on January 3, 2010.

I have been honored to serve in the United States House of Representatives for the past 13 years, and I will be eternally grateful to the residents of Florida's 19th Congressional District for giving me the opportunity to be their representative in Washington. When I leave Congress this January, I will serve as the president of the Center for Middle East Peace and Economic Cooperation, where I will take on the critical challenges facing the Middle East. In the coming years, Israeli, Palestinian, and Arab leaders will be faced with monumental decisions that will dramatically affect the region and the entire world for decades. I am confident that now is the best time for me to dedicate myself fully to these significant issues.

While I am deeply saddened to leave this august body, I am looking forward to continuing much of my work in Congress in a different capacity in my new role with the Center for Middle East Peace. I especially want to thank you personally, Speaker Pelosi, for your extraordinary leadership during these difficult times for our nation as well as the kindness and courtesy you have always extended to me. I have particularly admired the dignified manner and deep sense of conviction that you display as Speaker of the House. The opportunity to work with you and all our colleagues in the House has been a great privilege indeed, and I hope to continue these friendships for many years to come.

With warm regards,

ROBERT WEXLER.

HONORING MS. PATRICIA FISHER

(Mr. MEEKS of New York asked and was given permission to address the House for 1 minute.)

Mr. MEEKS of New York. Mr. Speaker, I rise today to honor a remarkable woman. Ms. Pat Fisher, who is my office manager, who is retiring next week after 33 years on the Hill.

She came into my office not too long ago and said, You know, I've been thinking about it. I served 11 years with your predecessor, Floyd Flake, and 11 years with his predecessor, Joe Addabbo, and now 11 years with you, and it's time for me to go home to my family.

And she has done it with such grace and such style. She is indeed a treasure and comes here with her father, who served in this House for 50 years. They love this place.

But let me tell you that Pat Fisher, she is a time-honored treasure who will truly be missed. She has been the gatekeeper for the Sixth Congressional District of New York for 33 years. And not only will Washington and this House miss her, but the 640,000 people who comprise the Sixth Congressional District of New York. We will miss her dearly. We wish her well and much success. Our loss will be her husband, Joe's, gain, and the rest of her family's: her daughter, her son, and her grandchild.

We wish you all the luck in the world. Thank you for your service to this great Nation and to the Sixth Congressional District.

TRIBUTE TO STAFF SERGEANT DENNIS J. HANSEN

(Mr. JORDAN of Ohio asked and was given permission to address the House for 1 minute.)

Mr. JORDAN of Ohio. Mr. Speaker, I rise today to honor the life of one of America's fallen heroes, Army Staff Sergeant Dennis J. Hansen of Scottsville, New York, and formerly of Indian Lake, Ohio.

Born in Salt Lake City, Staff Sergeant Hansen was stationed at Fort Drum, New York, and assigned to the 1st Battalion, 32nd Infantry Regiment, 10th Mountain Division. He spent more than 8 years in the Marine Corps before joining the Army.

During his military career, Dennis served deployments in Africa, Kosovo, Japan, Panama, Cuba, Iraq, Afghanistan, and the Mediterranean.

He died on December 7, 2009, as a result of injuries sustained while serving his country in Afghanistan in support of Operation Enduring Freedom. Dennis, age 31, is survived by his loving family, including his wife, Jennifer; their children; and his parents, Dwight and Bonnie.

In reading of Dennis's life and speaking with his family members, it was clear he had a positive impact on the lives of everyone around him. He was a leader, a family man, an accomplished wrestler in his youth, and a champion in every sense of the word. He bravely stood up and volunteered to serve. He gave his life in defense of his family, his community, his State, and his Nation. For this we owe him and his family a great debt of gratitude.

Dennis will be missed each and every day. But the strength of his character and the courage he demonstrated through his service will live on.

□ 1915

TRIBUTE TO THE HONORABLE ROBERT WEXLER

(Mr. COHEN asked and was given permission to address the House for 1 minute.)

Mr. COHEN. Mr. Speaker, today ends the first year of the 111th Congress, a Congress that's done much to try to preserve this country's economic security, improve its place among the nations of the world, worked against the global warming problems we have, and protect our planet.

So much of what we've accomplished has been a group effort, and one of the people that's been a part of that group is Congressman ROBERT WEXLER of Florida. I was privileged to sit next to Congressman WEXLER in the Judiciary Committee. Congressman WEXLER served 13 years in this House, and today he cast his last vote and walked off this floor.

I watched him as he walked off. I was sad to see him leave because he was an outstanding Member of Congress like so many people are here who are dedicated to making this country better, working hard, speaking his opinion to try to make this country a better place. I'm proud to have served in this Congress and to have served with ROBERT WEXLER. I'm proud to be a Member of this Congress, and I want to say to ROBERT WEXLER, you've been an outstanding Congressman, and this Congress will miss you.

OUR UNCONSCIONABLE NATIONAL DEBT

(Mr. COFFMAN of Colorado asked and was given permission to address the House for 1 minute.)

Mr. COFFMAN of Colorado. Mr. Speaker, the Democrat majority voted today to raise our national debt limit by \$290 billion. That vote we took today to raise the debt limit, rollcall vote 988, served as a terrible reminder of all of the votes we didn't take. The debt limit increase vote is the direct opposite of the votes we should have cast earlier this year—the votes to curb spending, the votes to cut pork, the votes for real economic stimulus, the votes for meaningful fiscal discipline.

Today our national debt is \$12.13 trillion. More exactly, it is \$12,134,970,556,795.04. Since January 6, 2009, the start of this 111th Congress, the national debt has increased by \$1.4 trillion. I am sadly familiar with these numbers because I began to place the amount of the national debt in the CONGRESSIONAL RECORD on a daily basis

since last month as a reminder to all of us. We need to stop this borrowing and spending. I urge all of my colleagues to embrace fiscal discipline.

JOBS ARE BEING CREATED IN OUR COMMUNITIES

(Ms. JACKSON-LEE of Texas asked and was given permission to address the House for 1 minute.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today to indicate that jobs are being created in our communities. And if anyone thinks that the loss of 109,000 jobs in my community in Harris County has not hurt families during this season, then they need to be aware of the necessity of the various people who need work.

I'm very proud that in the Defense bill that was passed, we have created jobs. We have created a number of jobs, and those jobs have been the kind of jobs that will serve the entire community: solar jobs, \$800,000; technology jobs, \$1 million; Post-Traumatic Stress Disorder Center for the Riverside General Hospital that will help our local soldiers, that is \$1 million.

All total, \$4.8 million have been secured by the 18th Congressional District to provide jobs in Houston to ensure minority research or research on health issues, to ensure green technology jobs, to put people to work.

Mr. Speaker, this is the beginning of a great day when we provide jobs for the 18th Congressional District and all of America. Merry Christmas to my constituents, as I've said, and Merry Christmas to our first family and all that they have done for America.

WHO DAT!

(Mr. CAO asked and was given permission to address the House for 1 minute.)

Mr. CAO. Mr. Speaker, the New Orleans Saints are having an historic season. Their success has provided our city so much hope that I wanted to give constituents a chance to honor them.

Today's statement is from Michael DesJardins of New Orleans. Michael writes:

"I believe! Finally. It's been 40 or so years of hope and disappointment—much more disappointment. As I bask in the glow of another victory by the Saints, I have finally let my heart believe that this could be the year. They have the spirit, the talent and the determination. They seem to like and support one another. Their success is not a product of stardom but of common effort by the whole team. They have transformed the Saints into a powerful organization that lifts up the whole community. We can all learn from them.

"Long-suffering, leading to hope, only to be dashed by the heartbreak of

defeat and disappointment. This story of the Saints' past could be the story of our city government.

"Our Sainted team has been transformed into a constellation of bright shining stars. Dare we believe that New Orleans can share in that transformation?"

Thank you, and I yield back. Who Dat!

SPECIAL ORDERS

The SPEAKER pro tempore (Mr. GARAMENDI). Under the Speaker's announced policy of January 6, 2009, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

CREDIT IS FROZEN IN THIS COUNTRY

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Ohio (Ms. KAPTUR) is recognized for 5 minutes.

Ms. KAPTUR. Mr. Speaker, the job market is bleak. A major reason is that bank credit is frozen in this country still. Business can't get loans to hire and function. The Federal Deposit Insurance Corporation reports that lending has declined for the last five consecutive quarters.

This chart amply demonstrates that. It was in the Washington Post yesterday.

Credit in the real banking sector has dried up. I'm not talking about the political TARP bailout fund banking sector being managed by Treasury. I'm talking about the impact of that on the rest of the banking system where credit is simply not being lent across this country. Businesses are clamoring to get loans, only to be rejected from coast to coast. The normal banking sector is not functioning. TARP destroyed over \$600 billion of real bank capital as the Treasury moved itself into the driver's seat of picking winners and losers. Wall Street banks literally, and the way they've been handled, have blunted real economic recovery as businesses cannot get loans to conduct their affairs, to hire new employees, to pay current employees or buy equipment because they simply don't have access to credit.

Sadly, what's happened over this period of time is our local banks and the non Big 5 banks in the country have tried to compete in this economy. The Big 5—the ones that got the TARP funds from the taxpayers—have gone from holding 30 percent of the deposits in this country to 40 percent. They're getting bigger, which means it's even harder for the other thousands of banks across this country to compete.

Our financial system started seizing up after TARP was passed when normal banks refused to lend to each other in overnight transactions, and this has

just gotten worse ever since. They lost confidence in the banking system itself.

So, where does small business go to get operating loans? The Washington Post gave us a little insight on that yesterday, and I wish to place that article in the RECORD. Some of what it says is:

"The administration's options continue to be constrained by the belief of many officials that meddling in the details of banking is counterproductive."

Well, what do they think the TARP is? It's ultimate meddling. It's total meddling. And, in fact, it prevents normal lending from being restored as banks across this country see that some banks get a special deal if they go to the Treasury and others get thrown aside or merged. A lot of those big banks have used the money to buy other banks, making our banking system much less competitive, much more concentrated.

While the White House has raised the temperature of its rhetoric in recent weeks about what's going wrong, their policy measures simply have not followed. Indeed, they extended the TARP for another year.

Now there are some activists across this country calling on the President to do much more. One of them, Reverend Jesse Jackson, left a meeting in Atlanta on Monday with ministers and others who are facing foreclosure even on their churches and homes. The Reverend Jackson, as the article reports, called on President Obama to use future Federal fair lending laws to force the banks to help struggling communities. He said, and I quote, "Banks got Federal money at zero interest, but homeowners and churches are paying pre-TARP prices for their losses. The banking system must be made accountable. The Attorney General should have been in that meeting as well." I agree with Reverend Jackson.

"The banking industry," the article says, "has reduced lending"—as this chart demonstrates—"for five consecutive quarters, even as it has regained profitability thanks to vast public aid from the people of the United States. The amount of money on loan from banks fell by about \$600 billion, or 7.2 percent, from September 2008 to September 2009, according to the Federal Deposit Insurance Corporation."

□ 1930

This is not a recipe for economic recovery, not in the real economy. This is the second time the President has convened bank executives to urge their increased lending. The first was in March. But you know what the article says, it did little to slow the slide.

There are two actions that immediately could make a difference. One deals with the President meeting with the Securities and Exchange Commission and the Financial Accounting

Standards Board and looking at mark-to-market accounting, which has destroyed over \$600 billion of capital in our financial system. Credit is frozen. The very banks we have bailed out have decreased their lending over these five quarters that I've talked about, and Treasury, who is in charge of the TARP, literally is picking winners and losers.

We need reform of mark-to-market accounting, and we need somebody in the administration to look at the Making Home Affordable program to make sure that we allow people to remain in their homes so we don't have increasing foreclosures, particularly over these winter months. The problem is that they can't see the forest because the big trees, the big five, are blocking their view of what is happening across this country.

[From the Washington Post, Dec. 15, 2009]
IN WHITE HOUSE MEETING, OBAMA CALLS ON
BANKS TO INCREASE LENDING

(By Binyamin Appelbaum and Michael A. Fletcher)

President Obama exhorted the nation's biggest banks on Monday to make "extraordinary" efforts to increase lending, even as some of those firms are racing to distance themselves from government control.

The nation's most powerful bankers sat in the Roosevelt Room at the White House and nodded as the president spoke, but some executives and industry officials said afterward that increasing lending is largely beyond their ability.

Meanwhile, Citigroup and Wells Fargo announced plans Monday to spend billions of dollars—not on lending, but to repay federal aid. Citigroup chief executive Vikram Pandit missed the White House meeting to rally investor support.

Bank executives say they itch to make profitable loans, as many as possible, but are struggling to find qualified borrowers. They also say that the administration is asking for increased lending even as it pursues financial reforms that will limit the ability of banks to make loans.

Some note that a recession caused by an orgy of lending must be solved in part through greater restraint.

Obama has come under increasing pressure to demonstrate his concern for the plight of Americans caught in a rising tide of joblessness, even as the larger economy appears headed to recovery. The White House portrayed Monday's meeting as a chance for the president to channel the anger of Americans who think federal programs intended to revive the broader economy have succeeded only in restoring Wall Street's profitability.

"America's banks received extraordinary assistance from American taxpayers to rebuild their industry," the president said after the meeting. "And now that they're back on their feet, we expect an extraordinary commitment from them to help rebuild our economy."

Obama added that he expects not just effort but "results."

Some administration officials privately conceded that borrowing always declines during recessions, and that they are struggling to find effective ways of spurring new lending. Furthermore, the administration's options continued to be constrained by the belief of many officials that meddling in the details of banking is counterproductive.

The administration also is surrendering a measure of leverage over the industry as banks repay federal aid provided under the Troubled Assets Relief Program—although officials are eager to shed the political baggage of aiding big Wall Street firms. With the announcements Monday by Citigroup and Wells Fargo that they would repay federal aid, all of the nine major banks that got money late last year will be on track to pay it back.

As a result, while the White House has raised the temperature of its rhetoric in recent weeks, policy measures have not followed.

Some activists are calling on the president to do more. Just after leaving an Atlanta meeting Monday with ministers and others, some of whom are facing foreclosure on their churches and homes, the Rev. Jesse Jackson called on Obama to use federal fair-lending laws to force the banks to help struggling communities.

"Banks got federal money at zero interest, but homeowners and churches are paying pre-TARP prices for their loans," Jackson said. "The banking system must be made accountable. The attorney general should have been in that meeting."

The Congressional Black Caucus and other Democrats, who are concerned that administration efforts to slow foreclosures have come nowhere near meeting their stated goals, have also been pressing for additional steps to help distressed homeowners.

The banking industry has reduced lending for five consecutive quarters, even as it has regained profitability thanks to vast public aid. The amount of money on loan from banks fell by about \$600 billion, or 7.2 percent, from September 2008 to September 2009, according to the Federal Deposit Insurance Corp.

The White House initially portrayed the meeting with bankers as an opportunity to discuss strategies for increasing lending. But the president set a sterner tone over the weekend, telling the CBS show "60 Minutes": "I did not run for office to be helping out a bunch of fat-cat bankers on Wall Street."

One day later, the president was more temperate, saying that he did not intend to "vilify" any company or industry and that he appreciated existing efforts to increase lending, such as reviewing rejected applications to see whether loans can be approved. The president suggested Monday that banks should review applications three and four times if necessary.

Bankers also emerged from the meeting in a conciliatory mood, saying they share the administration's goals.

"Every bank in that room talked about adding many, many small-business originators and setting very aggressive goals for small-business lending next year," said Richard Davis, chief executive of US Bancorp.

Bank of America plans to increase small-business lending by \$5 billion next year. J.P. Morgan Chase has committed to an increase of \$4 billion.

"This is simply what a bank should do," J.P. Morgan chief executive Jamie Dimon said in a statement released before the meeting.

This is the second time the president has convened bank executives to urge increased lending. The first meeting, in March, did little to slow the slide. The president said Monday that he continues to get "too many letters from small businesses who explain that they are creditworthy and banks that they've had a long-term relationship with are still having problems giving them

loans." But the White House on Monday defended the value of the rhetoric.

"I think that the bully pulpit can be a powerful thing," said press secretary Robert Gibbs.

Obama said he also discussed the need for financial reform, urging the bank executives not to lobby against proposals such as the creation of an agency to protect borrowers from lending abuses. And the president said he once again urged moderation in executive compensation.

"I made it clear that it is both in the country's interest and ultimately in the financial industry's interest to have updated rules of the road to prevent abuse and excess," Obama said afterward. "I have no intention of letting their lobbyists thwart reforms."

Bank executives, however, say that they strongly favor reform—they just differ with the administration about some of the particulars.

The guest list for the meeting included the top executives of 12 of the nation's largest banks, but there were three late scratches. Goldman Sachs's Lloyd C. Blankfein, John Mack of Morgan Stanley and Citigroup's Richard Parsons participated in the meeting by telephone because the flight all three had planned to take from New York to Washington was delayed by fog.

AMERICANS MAKE THIS COUNTRY GREAT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from North Carolina (Ms. FOXX) is recognized for 5 minutes.

Ms. FOXX. Mr. Speaker, at the close of 2009, as we look to and prepare for a new year, I'm prompted to call attention to the remarkable American people who have, once again, weathered a difficult year with dignity and toughness. Sometimes the Washington establishment forgets that the solutions to America's problems lie outside this capital city.

Yes, Americans from almost every walk of life are tightening their belts and making do with less this year, but Americans continue to be an extraordinarily resourceful people who inspire me in my work every day.

As we prepare to celebrate Christmas, entering in a new year, I hope we can all draw inspiration from the American people. We live in a Nation of innovators and hardworking entrepreneurs. Their resourcefulness is unlimited. The spirit of American opportunity lives and thrives among them.

And let's not forget the North Carolinians who, with their characteristic generosity and work ethic, illustrate the greatness at work in America, even in seasons of considerable difficulty. I look to them as a source of inspiration and hope. People like those who call North Carolina home have always been the best hope for the preservation of our tradition of individual liberty and government by and for the people, whether in good times or bad.

Mr. Speaker, Washington would do well to stop and watch, listen, and learn from everyday Americans as they

go about their lives and do the things that help make our Nation great.

May God continue to bless us all.

AMERICANS WANT THEIR COUNTRY BACK

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. POE) is recognized for 5 minutes.

Mr. POE of Texas. Mr. Speaker, as we end the month, the year, the decade, this session of Congress, some observations:

Fifteen million Americans are unemployed. We have 10 percent unemployment and higher throughout the United States.

Spending is totally out of control. The country is broke, so we borrow money from China and Japan, and it seems they own our Nation. And the taxacrats have not seen a tax bill they didn't believe in.

Domestic policy is simple: Spend money, spend money we don't have, then borrow it, and then raise taxes on the American people.

The government's financial system is also simple: If it moves, tax it; if it keeps moving, regulate it; and if it stops moving, then subsidize it. Today we raised the debt ceiling so more money can be spent as soon as we get back in January. Now we're over \$12 trillion in debt.

The House has turned our Nation's health care over to the government. You know, the government who tried to run a health care vaccine program that was a total failure, where school kids didn't get the vaccine while Wall Street fat cats did. And yet the Federal Government wants to now run America's health.

The House voted on a cap-and-trade tax bill that will add a tax on energy consumption for all Americans and punish energy consumption and encourage domestic oil producers to go somewhere else.

Congress has given more money away to foreign countries that hate us while ignoring problems at home.

Many Members of Congress have already left on planes, headed to Denmark to talk about how we must control the climate because man is the evildoer and scourge of the Earth. Of course, the Al Gore warmers have been caught this year hiding data that shows reasonable minds disagree with their theory of global warming. Plus, the warmers want to force Americans to spend millions of dollars to implement changes on their yet unproven theories.

The government, in essence, has taken over Wall Street, the financial industry, the automobile industry. You know, General Motors needs to change its name to Government Motors. The Federal Government has taken over the mortgage industry, the banks, and the salaries of some executives.

More American freedom and liberty has been stolen from us, and more assaults on the Constitution have occurred than at any time in our history. And today, the radical open border crowd has announced new legislation, arrogantly demanding amnesty for millions of illegals in this country with, also, visa preferences for those nations with the most foreigners in the United States. So much for border security.

We have a new military strategy that's implemented. It's called the surge and retreat plan. That strategy is in Afghanistan where we're going to surge and send a bunch of troops in, but yet in 18 months, according to the administration, they're coming home. No strategy like that has ever been used in military history before.

And of course Gitmo, down there in Cuba where we house terrorists, it's getting a new ZIP Code. We're moving it to the United States and putting it in Illinois. And of course the country has seen that we've prosecuted our Navy SEALs and given rides to terrorists.

What an odd year it's been. It is the arrogance of power that says government is the answer to everything. Our lives, our fortunes, and our sacred honor have been turned over to government opportunists. Reagan said that government is the problem, not the answer, and I agree with him.

But, Mr. Speaker, not all is gloom, doom, and despair. There is great hope. The American people are not fooled. People in our country now fear the government, and people are mad, and people are involved. And even though the D.C. crowd pays no attention to them, I've got news for the elites: The people are not going away in the darkness of the night. They will not give up without a fight, because the American cause is righteous, and the people's actions are just.

Government should not underestimate the American soul and the American spirit. They are a force to be reckoned with. Mr. Speaker, the people want their country back, and they will get it back. After all, the Constitution says, "We the People," not, "We, the subjects."

And that's just the way it is.

HONORING SPECIALIST MICHAEL COTE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Louisiana (Mr. CASSIDY) is recognized for 5 minutes.

Mr. CASSIDY. Mr. Speaker, this may be the last address given on the floor of the House of Representatives this year. It is fitting that it is a tribute to Michael Cote, a specialist who gave his life while fighting to defend us in Iraq.

Specialist Cote was from Denham Springs, Louisiana. After graduating from Denham Springs High School, he

met his wife, Ashlee, when the two were in basic training. They passed notes back and forth during their training and snuck off to church services to be together on weekends. Just days after basic training ended, the two soldiers were married.

Michael was serving in Iraq when their daughter, Brooke, was born in March, but he found a way to be on the phone with Ashlee during the delivery. She delivered in Baton Rouge.

Ashlee tells me that Michael liked to fish and hunt. She says he was an all-around country boy who liked to goof around but always knew when it was time to be a soldier.

Michael was serving as a crew chief when his Black Hawk helicopter went down in Balad, Iraq, in September.

On the day of his memorial service, the people of Denham Springs lined the streets to wave American flags as the procession went by. Families brought their children and grandchildren out to honor Specialist Cote, a tribute to a man friends and family in Denham Springs say they knew would grow up to be a soldier.

His mother, Carol Bass, tells me that she visits the grave daily.

Mr. Speaker, we mourn with Ashlee, Brooke, and Mrs. Bass the loss of Specialist Cote, but let us celebrate his patriotism, his dedication to country, his sacrifice on behalf of our security.

We are forever indebted to the men and women of our armed services, soldiers like Michael Cote, who put themselves in harm's way so that we may live freely and in peace.

REFLECTIONS FROM 2009

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Ms. JACKSON-LEE) is recognized for 5 minutes.

Ms. JACKSON-LEE of Texas. Mr. Speaker, in the rush of a debate in an earlier 1-minute, I was not able to capture the somberness of the moment. As our colleagues have finished their work and have, in fact, recognized the need of this Nation, I think it is important to summarize how important it is to keep our minds focused as we return back in the new year.

We know that this country is a resilient country. People are tough, and they've gotten tougher. We are blessed by the fact that we have a country of laws. We're a democratic Nation. If there is oppression in our Nation, we have a court system to seek to be redeemed. We have the amenities of life, technology, transportation, clean water. But in every country comes a time when things are not as good as they need to be, and I think we should clarify what has been done over these last couple of months.

I was here during the past two Presidential terms. When I say "two Presidential terms," the past and former

Presidents. I voted for the 1997 Budget Reconciliation Act that generated an enormous surplus and created an opportunity for millions of our children to be insured. That was 1997. We had a surplus as that previous administration, the Clinton administration, left office.

We had a tragedy on 9/11, and we had to respond to that enormous tragedy, a terrorist act, and I joined with my colleagues to respond to that by allowing our Nation to defend itself by going into Afghanistan. I did not support the detour into Iraq. However, I support the men and women, and I mourn for those families who have lost loved ones.

So what have we done over this year? We have fought for America, and that is why there was the political sacrifice. Some people say that's your job, to vote for the TARP—not willingly. We didn't want a fat-cat bill. We didn't want a bill that paid people to stuff their pockets. We wanted to ensure that businesses stayed open, that we had the opportunity for small businesses, my friends and neighbors, my constituents to get money to keep those jobs.

All right, it wasn't perfect, but the numbers don't fib. We did create jobs. We kept businesses open. The President has gone to the mat by saying to these fat cats, Look, we are in a capitalistic system. I understand that. But he's gone to them and said, You have to lend to small businesses.

□ 1945

Mr. Speaker, we have done a lot. And in doing a lot, we have provided the opportunity for the kinds of dollars coming to the districts.

So let me just say this: \$48 billion in highways, transit and other infrastructure. We are going to be able to stop the bleeding by keeping our teachers, our police, our firefighters and job training. That's \$27 billion. We are going to guarantee the loans, guarantee loans to ensure that we will have the opportunity to loan money to our small businesses. That's an important statement.

And I wanted to be sure by looking at what I have to let my constituents know of the kind of projects that come out of the Defense bill. Because someone would make the argument, why support a Defense bill? Let me tell you. I've already spoken about the first post-traumatic stress disorder center in an African American hospital for \$1 million, \$800,000 for the Center for Research on Minority Health-Prostate Cancer research project, jobs; \$800,000 for high-efficiency solar energy generation and storage, jobs; \$1.6 million for science, technology, engineering and mathematics initiative, jobs. And then \$1 million with a private collaborator that is independent of Federal dollars that will give \$1 million to one of the

poorest school districts in my community, public and private partnership, Mr. Speaker.

Let us not leave this place in shame. We came from the deep darkness of an economic recession. We have saved jobs. We are creating jobs. We are moving forward. And I want to stop reading articles about mothers who are on the front pages of our newspapers who cannot turn on the lights and cannot feed their children.

Let me wish everyone, again, as I have done, a happy holiday and say that this Congress deserves the recognition for those who have put themselves on the line to be able to help the needy. I look forward to us coming back, passing health care, and going on with the jobs effort.

REVISIONS TO THE ALLOCATIONS AND BUDGETARY AGGREGATES ESTABLISHED BY THE CONCURRENT RESOLUTIONS ON THE BUDGET FOR FISCAL YEAR 2010 AND THE PERIOD OF FISCAL YEAR 2010 THROUGH 2014

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from South Carolina (Mr. SPRATT) is recognized for 5 minutes.

Mr. SPRATT. Madam Speaker, under sections 421(a)(4) and 423(a)(1) of S. Con. Res. 13, the concurrent resolution on the budget for fiscal year 2010, I hereby submit for printing in the CONGRESSIONAL RECORD a revision to the budget aggregates and allocations for certain House committees for fiscal year 2010 and the period of fiscal years 2010 through 2014. These adjustments respond to House consideration of the House amendment to the Sen-

ate amendment to the bill H.R. 3326, Making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes. Section 1011 of the House amendment includes funding for Medicare improvements. The House amendment also designates certain funding for overseas deployments and other activities pursuant to S. Con. Res. 13. Corresponding tables are attached.

This revision represents an adjustment for the purposes of sections 302 and 311 of the Congressional Budget Act of 1974, as amended. For the purposes of the Congressional Budget Act of 1974, as amended, this revised allocation is to be considered as an allocation included in the budget resolution, pursuant to section 427(b) of S. Con. Res. 13.

Any questions may be directed to Ellen Balis or Gail Millar at 226–7200.

BUDGET AGGREGATES
[On-budget amounts, in millions of dollars]

	Fiscal Year 2009	Fiscal Year 2010	Fiscal Years 2010–2014
Current Aggregates: ¹			
Budget Authority	3,668,601	2,882,149	n.a.
Outlays	3,357,164	3,002,606	n.a.
Revenues	1,532,579	1,653,728	10,500,149
H.R. 3326 (Department of Defense Appropriations):			
Budget Authority	0	0	n.a.
Outlays	0	–1,579	n.a.
Revenues	0	0	0
Revised Aggregates:			
Budget Authority	3,668,601	2,882,149	n.a.
Outlays	3,357,164	3,001,027	n.a.
Revenues	1,532,579	1,653,728	10,500,149

n.a. = Not applicable because annual appropriations Acts for fiscal years 2011 through 2014 will not be considered until future sessions of Congress.
¹ Current aggregates do not include the disaster allowance assumed in the budget resolution, which if needed will be excluded from current level with an emergency designation (section 423(b)).

DISCRETIONARY APPROPRIATIONS—APPROPRIATIONS COMMITTEE 302(a) ALLOCATION
[In millions of dollars]

	BA	OT
Current allocation:		
Fiscal Year 2009	1,482,201	1,247,872
Fiscal Year 2010	1,219,652	1,377,618
H.R. 3326 (Department of Defense Appropriations):		
Changes for overseas deployment and other activities designations:		
Fiscal Year 2009	0	0
Fiscal Year 2010	0	–1,579
Changes for Medicare improvements:		
Fiscal Year 2009	0	0
Fiscal Year 2010	1,240	1,240
Revised allocation:		
Fiscal Year 2009	1,482,201	1,247,872
Fiscal Year 2010	1,220,892	1,377,279

DIRECT SPENDING LEGISLATION—AUTHORIZING COMMITTEE 302(a) ALLOCATIONS FOR RESOLUTION CHANGES
[Fiscal years, in millions of dollars]

House Committee	2009		2010		2010–2014 Total	
	BA	Outlays	BA	Outlays	BA	Outlays
Current allocation:						
Ways and Means	0	0	6,840	6,840	37,000	37,000
H.R. 3326 (Department of Defense Appropriations):						
Ways and Means	0	0	–1,240	–1,240	–1,030	–1,030
Revised allocation:						
Ways and Means	0	0	5,600	5,600	35,970	35,970

JOB CREATION THEORIES

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Missouri (Mr. AKIN) is recognized for 60 minutes as the designee of the minority leader.

Mr. AKIN. Mr. Speaker, it's a treat to be able to join you and my col-

leagues and fellow Americans that might possibly be tuned in. This is a bit like the last day of school. We think the voting is done for this year, and yet the work is not done. In fact, America, among other things, is suffering from a considerably high level of unemployment. And that was going to be the topic for this evening.

I want to talk a little bit about employment, spending and the different theories that people have as to how jobs are created. And there are some theories out there that don't work very well, and there are some that do work well. And history tells us the difference between the two.

I thought what I might do this evening would be to start with something which, in a way, may seem remedial. It should seem fairly basic because most Americans have plenty of common sense. And I think that it's important, though, to start at the basic level and start defining your terms as we talk about the problem of unemployment.

Now, there are certain series of things, I have identified six—there may be other ways economists might look at it differently—but there are six things that are job killers. To start with, we need to understand where jobs come from. Jobs come from businesses. What sort of businesses? Well, if you take a look at businesses that have 500 employees or less, those businesses employ about 90 percent of the Americans that have jobs in the private sector. Five hundred or less employees, those, many people would say, are small businesses.

Well, what are the things that these small businesses need in order to create these jobs, 90 percent of the jobs in America? Well, the first thing is that there are certain things that are killers of jobs. The first is economic uncertainty. Let's talk about that for just a minute. Economic uncertainty. Put yourself in charge of a business. Say you have 100 employees and you're manufacturing some product, and you just really don't know what's going to happen with the economy. And so there is a level of uncertainty. Maybe political things are going on which increase your level of uncertainty. You don't know whether or not perhaps we are going to go into some kind of economic slump.

And so what are you going to do if you are a president of a small business? Well, what you're going to do is, in the State of Missouri, they call it hunkering down. You say, I'm not going to take a lot of risks; I'm going to prepare for some sort of an economic storm, or at least be prepared that I'm not too extended. I don't want to take a lot of risk when there is economic uncertainty.

And what sort of risks might those be? The risk might be to add a wing on your building, to buy a new machine, to start a new process, to patent a new invention and decide to try to produce it and sell it on a market. All of those things create jobs. But you're not liable to take a high-risk position if there's a high level of economic uncertainty. So economic uncertainty is a job killer.

The next thing is consumption reduction. That's a fancy word for saying you got a business slowdown. People aren't buying as much stuff. Everybody is worried. People are having a hard time economically. They are not spending as much money. People aren't making investments, and so your business is going along with all the other

businesses around you, when you are in a time when there is a recession going on, it's an economic uncertainty. It's a form of economic uncertainty, I suppose, and that is you're thinking, hey, it used to be last year we had orders for 100 widgets. But this year, it looks like we are only getting orders for 50. So you're not going to be thinking about getting a machine that will make widgets more efficiently. You're not going to be thinking about making investments in adding to the building so you can increase production because you're expecting that you're going to sell less this year than you did because of the fact that there is a slowdown in the economy. So a slowdown in the economy tends to affect businesses and therefore affects jobs. Pretty much common sense, I think.

And then excessive taxation. How does that hurt jobs? Well, here is the deal. You're, again, the president of a business. Maybe you have 100 employees. And you find out, all of a sudden, that your taxes are really going up. Now, if you have a lot of taxes, that means you don't have very much choice, you're going to have to pay those taxes. What is the tax going to be paid with? Well, it's going to be paid with the money from your company, from the profits and the proceeds of the company that you have.

And, hopefully, you have 100 employees, you're paying them, you're selling product, and you're selling product for more than it costs you, and so you're making some profits, and you're pocketing those profits. But now you understand that there's going to be a whole lot of taxation coming down the pike.

So one of the things that taxation is going to do is take money away from the guy that owns the business. And when you do that, he doesn't have the money to spend on adding additions to the building or perhaps taking a risk on introducing new products or maybe even inventing some different ways of doing things. And so the taxation takes the place of investment that would normally be made in the company. When that investment is made, that usually results in hiring more people. But the hiring more people isn't going to happen if you have excessive taxation.

In fact, we have found historically that if you drive the business owners with enough taxation, you can not only stop job creation; you can stop the whole business and bring it into bankruptcy and destroy the engine that creates jobs. So excessive taxation is a big factor in killing jobs.

Another thing is insufficient liquidity. Now, that sounds like a fancy thing. There's nothing too fancy about it. The fact is that businesses need money to run on, just like the engine in your car needs oil. And what happens is the business, let's say it's a machine shop, decides that they want to

buy a new piece of equipment. That new piece of equipment is going to cost them \$5 million. Well, you have got your machinists there in your company, but you don't have any \$5 million to buy this new piece of equipment; but you figured out that if you had that piece of equipment that in a matter of 2½ or 3 years, you could pay for the whole piece of equipment just by the kinds of products that you could make on it so you can say, hey, this is a great investment. I can pay this off relatively quickly, but I don't have that million, couple million, dollars to buy this new piece of equipment.

So what do you do? Well, you're going to have to go out and get a loan. And when you take a loan, you're going to pay interest on that loan. But then you get that piece of equipment in, and it's running just beautifully for you. You get all those orders, you make these parts, and pretty soon you pay off the piece of equipment.

How did that happen? It happened because you were able to borrow money, which people call liquidity, and you can borrow money and get that tool or whatever it was. When you did it, you hired a few people to run the new piece of equipment and, of course, you created jobs.

If you do not have that liquidity, if you can't borrow money that you need, then what happens? Well, then you can't buy the new pieces of equipment. And guess what? You're killing jobs or the potential for creating jobs.

Another thing is excessive government spending. Oh, now wait a minute. Now, how can the government spending affect jobs in America? Well, it turns out that there is an effect indeed. And what it is is when the government spends a lot of money, it has to get that money from somewhere. Guess where the money comes from? The private sector. Where does the money come from? From taxes. And so as the government tries to collect more and more money to appease its appetite for spending, what happens is that affects liquidity, and it plays out as taxation. And so as the government does a whole lot of spending, you find that it tends to kill jobs.

Now, it may not appear to kill jobs in the short term. If the government does a whole lot of spending—let's just say the government decides to spend \$150 billion. We just decided to do that a few hours ago here on the floor, \$150 billion for "son of stimulus." This is stimulus Jr., mini-stimulus, \$150 billion stimulus, still real money to most people, and real money to the U.S. Government, although you wouldn't know it by the way we spend it. Today, by the way, we did a pretty good job of spending money. We spent about \$1.1 trillion today, but mini-stimulus was just \$150 billion, still a lot of money.

And that government spending, let's say you go out and hire a whole lot of

people. Well, wouldn't you create jobs, Congressman AKIN? Well, you would in a temporary sense. You could put some people on a government payroll. But what economists have found is that when you temporarily hire someone from the government, what you're doing is you're taking money out of the economy through this government spending.

In fact, what happens is for every one job you create in government, you're taking 2.2 jobs out of the private sector. So it's one of these things where it may seem like you're doing well. It's a little bit like drinking salt water. You're getting a drink, but the salt makes you even more thirsty than you were before. So it's kind of very much a losing proposition when you start to get into this excessive government spending.

And then the other thing, of course, is excessive government mandates and red tape. We have a picture here that my staffer found of some poor CEO buried in red tape, all kinds of memos, pieces of paper, and all kinds of regulations. I think that your common sense will show why this is a problem, because let's say particularly you're a small business. Well, you have a certain number of employees. Those employees, you have them working right away, making product that you can sell because you have a clean, lean and efficient process. And you don't have very many people that are management people, just a few people to try to keep an eye and organize things and get some orders in the door.

And all of a sudden, somebody from the government knocks on your door, knock knock knock, and says, hey, you didn't fill out such and such form. And somebody else knocks or calls and says, you didn't fill out this form. You didn't fill out this form. Did you do this? Have you applied for this? Did you get this? And pretty soon, you have all kinds of employees. And what do they produce? They produce paperwork. Paperwork for whom? For the government.

And so if you get more and more red tape and excessive mandates, obviously that is one of the things where you may seem like you're creating jobs; but in effect, you're making the business less efficient so it cannot grow and really put those good producing jobs on to the payroll.

□ 2000

In a sense, those are like excessive government spending because they're really government jobs that in fact tend to get rid of the actual productive private.

So all of these things, all of these conditions kill jobs. So if the Federal Government wants to create jobs—first of all, we have to understand something: The Federal Government can't create jobs. The whole concept of stim-

ulus is a false assumption. The only thing the Federal Government can do is create the conditions so the people in the private sector can create the jobs. We can create an environment that is helpful in producing jobs, but the Federal Government, when it tries to hire people, all that does is take jobs away from the private sector. So all of these things are job killers.

So let's go in a more positive light and say, well, what do you do to create jobs? Well, just the reverse of these things, and that will tend to create jobs. In fact, you might even have some trouble in a couple of areas, but you're doing very well in some other areas, and you could create some jobs.

This whole bit about the problem with unemployment in America is not really that complicated when you understand that the jobs come largely from these 500-employee and smaller size companies, and that they're created by the fact that those companies and the owner of those companies have enough money they can invest in their company and can do the new processes, innovation and the ideas that Americans are so great in doing. That's what makes the economy strong, and that's what makes jobs.

Now, we have here a cartoon. We have the President here speaking to a small businessman, and the President is saying here, Now, give me one good reason why you're not hiring? And what do we have coming into the china shop? Well, we have three big bulls: One is the health care referendum; there is cap-and-trade, or cap-and-tax; and then another is a war tax. Well, the point here in a cartoon form, obviously the bulls are not going to have a good influence on the china shop. And the President doesn't seem to get what's going on with the businessman. He's not looking too excited about a good reason for why you're not hiring with these guys coming in the door.

Now, let's take this back to what we were just talking about, health care reform. Health care reform was going to introduce probably, at a minimum, \$1 trillion worth of spending, or close to it. So what happens if the government does a whole lot of spending? Well, they're going to do a whole lot of taxing. Guess who is going to be taxed with several different types of taxes to pay for socialized medicine? Well, it was going to be the small businessman.

So now what have you done relative to our chart here when you have the Senate—and the House has already passed this \$1 trillion socialized medicine bill that has all these mandates on small business—what have you done in terms of jobs when you pass this socialized medicine? Well, first of all, you are creating economic uncertainty, because the bill hasn't passed. We don't quite know what's going to happen. So there is uncertainty. There is also the slowdown in the economy, which of

course is not helped by a tremendous level of spending and debt.

Excessive taxation. Of course the taxation in the socialized medicine bill is going to fall very heavily on these small business owners. If you take their money away and force them to provide all this health care, they're going to have an incentive, one, to get rid of employees, because they can't afford them anymore because the health care is so expensive for them. So they're going to figure out ways to get rid of employees, not hire them. And what they're going to do, because of the excessive taxation, is they're not going to be investing in new equipment. So it's going to be a job killer. That was what one of these bulls is.

And then cap-and-trade, or cap-and-tax here, bull number two. That, of course, is the large tax that was going to be part of the solution to global warming. And we're going to talk about that a little bit too, but that also had a very, very large tax associated with it. Not only did it have a very big tax to increase the cost of energy, it had a very large tax in terms of red tape. In fact, I suppose that the red tape and the amount of additional Federal authority to regulate anything in the energy area, including even how individual American citizens' houses are built—that is, building codes at the Federal level, building codes regulating how you build your house and whether it has the proper carbon footprint or green footprint all in this bill with not only the largest tax in history, but also a great deal of red tape.

These are all things that hurt jobs. And so should we be surprised that we're getting a high level of unemployment? We should not be surprised. We are breaking all the basic laws.

Here is the first stimulus bill. We were told last spring—late spring and early summer—that we needed to pass a \$787 billion stimulus bill. And what was the idea of the stimulus bill? The idea of the stimulus bill was that government is going to spend a whole lot of money, and by spending money, the economy is going to be better. Now, that entire premise is suspect. If the economy was going to be better by us spending money, we would have one of the most robust, healthy economies in the whole world. We wouldn't have any unemployment. We would be going gangbusters if Federal spending was the thing that was going to make the economy good.

But most people with a little common sense, if your family budget is in trouble, the thing you're going to do is not run down to the local store with your credit card and stack up a whole lot of debt and spend like mad—unless you're a little bit nutty or had too much to drink.

But anyway, we were told that the thing to do is we've got to pass this \$787 billion stimulus bill. And we were

told, if you don't pass it, do you know what's going to happen, America, and you, Congressmen, that are representing Americans? If you don't pass this stimulus bill, you may see unemployment go up to 8 percent if you don't pass this stimulus bill.

So this is the President's forecast of what's going to happen if we pass this stimulus bill right here. You see this is 8 percent unemployment, and he says we're going to keep it under 8 if you just get this \$787 billion into our hands to spend. Without the stimulus, he said, this is what's going to happen; if you don't pass the stimulus, it's going to do this:

First, the red line here is what has actually happened. Is this red line a surprise? No, it wasn't a surprise at all. I stood here on this floor 6 months ago with similar charts and said this stimulus isn't going to work. Is it because I'm very smart or brilliant? No, it's not at all. It's simply because I know a little bit about history. I know what will and I know what will not work.

If the Democrats had known something about history, they would have, at a minimum, learned something from a fellow Democrat. This Democrat's name was Henry Morgenthau. He was Franklin Roosevelt's Treasury Secretary, and he appeared before the House Ways and Means Committee, right here in Congress, in 1939. Now, we have some old people in Congress; not too many people probably remember Henry Morgenthau, but they could know something about history and about Franklin Delano Roosevelt. And here is what Henry Morgenthau said: After 8 years of spending money on this—it's called Keynesian economics. Henry Morgenthau was a close buddy and associate of little Lord Keynes—he was a strange little fellow, that British man—and came up with this idea that we could stimulate the economy by spending money. And so they went at it, hammer and tongs, stimulating away, spending lots of money.

At the end of 8 years, this is how well it works: Henry Morgenthau appears before the House Ways and Means Committee: We have tried spending money. We are spending more than we've ever spent before, and it does not work. That's pretty straightforward English, we've been spending money, more than we ever did before, and it doesn't work. I say, after 8 years of the administration, we have just as much unemployment as when we started, and an enormous debt to boot.

And so it's not rocket science to see that this idea of spending \$787 billion that we don't have, it's not rocket science for us to be able to stand here 6 months ago and say, hey, we hope it works, but it's not going to work. It has never worked in history before; it's a lousy solution, it's going to make the problem worse. We said all of those things. Dozens of people stood on this

floor and said those things. And it's not because they're so smart, it's just because we understand the basics of what it takes to make jobs. And the thing that kills jobs is too much government spending.

Now, I will say about the stimulus bill that we put in place, it would have made Henry Morgenthau very uncomfortable, because it wasn't even traditional, old-fashioned stimulus. Old-fashioned stimulus is like making highways or building hydroelectric plants or hard job creation. This thing was more an expansion of wealth here. It was giving money so that organizations like ACORN could apply for community organizing, and a lot of things that really were never going to create jobs in the first place, or if they were, they were government jobs. And those things, the result has been, look, we've got unemployment; by the time you get into the latter part of this year, up in excess of 10 percent, not 8 percent, but 10 percent unemployment. And that's not a big surprise.

And so today, what did we do? We passed mini-stimulus, little brother to big brother stimulus. This was only, instead of \$787 billion, \$150 billion today. And did we learn anything from our experience? No, nothing at all, apparently. I think it was Einstein who said that if you repeat the same thing over and over again expecting a different result, you may just be crazy. And that's what we have done today. We came up with a junior stimulus bill, and we passed it on this floor. And the people who voted for it were the Democrats. They were a little reluctant in voting for it because it didn't work very well the first time when they did the stimulus, and they're not so confident that it's going to work again.

So, what are we looking at in terms of Obama-Pelosi spending? Well, you've got the second half of the Wall Street bailout here, \$350 billion. Then you've got this economic stimulus thing that has not worked, that we said it wouldn't work, it doesn't work, it will never work, and yet they spent \$787 billion—well, they haven't spent it all, they're just slopping it into other government programs. And then you've got the SCHIP, and then the appropriations, another \$410 billion over there. IMF bailout—that chart is wrong, it's probably about \$110 billion.

And then the House got really excited about doing some really serious spending, and they passed this cap-and-tax, which is that global warming bill. And that was—let me see what the number on that is here, get the chart turned around—that was \$846 billion. The reason on this chart that that's a little hazy is because the Senators weren't brilliant enough to go along with this \$800 billion cap-and-tax or cap-and-trade bill. Now, this is going to extend a huge government net over the energy business, and it was probably

worse in terms of red tape and government than it was in terms of its tax.

Now, the ironic thing is that I'm an engineer. And the thing about this bill that's particularly frustrating is that it doesn't appear that there is a consistency between the stated purpose and what the bill does. Let's assume for a minute that global warming is an imminent threat, it's something that we need to spend billions of dollars on that sometimes people don't call it global warming anymore because it isn't clear that the planet is warming, and so they call it "climate change."

But anyway, the theory runs along the lines that there are these various organic kinds of pollutants, particularly CO₂, carbon dioxide, that's the bubbles in soda pop. And the theory runs that if mankind makes enough of this CO₂—which we make by burning carbon or burning coal or burning gasoline or diesel, or whatever, we make CO₂. And if we make enough of this, what happens is the CO₂ then reacts with other kinds of effects, particularly water vapor and clouds in the atmosphere, and they amplify the effect of the CO₂, and the sun warms it up, and the climate gets hot and melts down. That's the general idea.

Now, let's just assume for a moment that that were true, and that it were a bad thing for us to make CO₂—I don't believe that that's entirely true, some of that is true, but a lot of it's not. But let's just say, for instance, that we really did believe CO₂ is a big problem and we needed to spend billions of dollars.

Do we need to give the Federal Government all this regulatory authority over building codes, how you put a wing on your house and all this kind of stuff? The answer is of course it's not necessary at all. Let's say that instead what we wanted to do was to reduce the CO₂ in America, reduce the CO₂ by the amount of all of the passenger cars that drive on the highways in America. Let's say that's our objective. Just to start with, we're worried about CO₂, we want to basically make it so that it was the equivalent, from a generation of CO₂, of turning off all of the American passenger cars on our roads in America. That would be a pretty ambitious goal. If you were worried about CO₂, that would be a pretty good place to start maybe.

□ 2015

How would you possibly accomplish something like that?

Well, the fact is you could accomplish it relatively easily for much, much less money than what is here and with much less government regulation. What you would have to do would be to simply take the coal-fired plants that produce 20 percent of America's electrical output and replace them with nuclear plants. Currently, 20 percent of the electricity in America is produced

in nuclear plants. If we were to go from 20 to a little over 40 percent in nuclear generation, we would eliminate the CO₂ from effectively every passenger car in America. That is not that complicated, and the nuclear plants are pretty efficient. Over time, they would probably prove to be not much different in cost than the coal-fired plants are, but that is the question.

Is that really the objective—to get rid of CO₂ or is it that we just want more taxes and government control? I've become a little cynical because the engineering solution to this problem is not where the legislation went in the House.

Then, of course, we've got this other thing here. It's a little bit of a side-track.

The bottom line is, if you make energy cost expensive and if you tax people a whole lot for energy, what is that going to do to jobs? It's going to get rid of jobs. So everything we've been doing here—everything we are doing—is killing jobs, and we can't seem to understand why the small business can't make the jobs.

Now we go on to the government health care proposal passed here on this floor not so long ago. What is the price tag on that? Well, even with a little bit of financial hocus-pocus, it is still up there in terms of \$1 trillion. We spent \$1.1 trillion today, but some of it was for the appropriations for the defense of our country. To add to this big socialized medicine bill, to add \$1 trillion more on top of all of these other things, is going to bury our economy.

Well, now wait a minute, Congressman AKIN. Aren't you overstating your case? I mean you are a Republican, and it seems like you're bashing those Democrats for overspending. Under the Bush administration, didn't you spend too much money? Well, let's just take a look at that question.

The worst deficit of the Bush administration occurred in 2008 under the Pelosi Congress. That worst deficit was \$455 billion. Now, that was a bad deficit, \$455 billion. Maybe even a more effective number to ask is, What was that deficit as a percent of the gross domestic product of America? That's a way of looking at that number. That was about 3.1 percent, which is actually fairly common as you look back over a number of Presidents who did that kind of spending. Anyway, that was 2008 under a Pelosi Congress, Bush's worst spending—\$455 billion.

What happened this year? Under a Pelosi Congress and President Obama, instead of \$455 billion, it was \$1.4 trillion. That's more than three times more than Bush's biggest spending. I wasn't fond of his biggest spending, and people who know my voting record know I did not support some of the costly elements that were there. This year, we're three times over what we were with Bush—at \$1.4 trillion.

What does that do to our deficit as a percent of GDP? We go from 3.1 to 9.9 percent of our debt to GDP, which is, by the way, the highest level since World War II. So this track record here doesn't make a lot of sense—billions and trillions of dollars.

Well, what does this all mean? If you put it in context, what we're saying here is, this year, there was three times more spending than Bush's most aggressive spending. We're making Bush look like Ebenezer Scrooge with the level of spending this year.

What does that spending do? Of course it affects unemployment. It affects jobs because that spending has to come out of the pockets of American taxpayers. Some of those pockets—in fact, some of the deep pockets—are the people who own the businesses who can no longer do the innovation and make the improvements to create jobs. That is a very, very serious problem.

You have to say that this is a new era of irresponsibility, the national debt of the United States at \$16.17 trillion. So, in other words, have we been spending too much money? Yeah, we sure have, but this year has been a regular budget buster, and that is of serious, serious concern. Of course, in the long term, we have the concern with Medicare and Medicaid growing over time, absorbing more and more of the budget.

There is a certain level the American economy can sustain in taxes. If you raise the taxes higher, what happens is that the economy suffers so badly that you don't actually collect any more money from the government, and that overtaxing is pointed out by a guy by the name of Laffer. He had a thing called a Laffer curve. It's an interesting idea. You think, Well, look. We really want to spend all this money because it's really good to take care of global warming and to pay for everybody and to give them all free health care with a socialized health care system, and we've got to do this because this is all kinds of additional money that we're schlepping around and giving to different people. We've got the Wall Street bailout. We've got to pick winners and losers, and so we're going to be having to spend this Wall Street.

Then as people come back and pay back some of the Wall Street, now what we're going to do is turn that money around and give it to other businesses, so now the government is playing in the private business. If we'd had a President who'd fired the president of General Motors a number of years ago, that would have raised some eyebrows, indeed.

So, when we get done with all of this, the problem is that it is creating unemployment. It's a problem of jobs. It gets back to these things here, which are just awfully simple, but they're inflexible, immovable kinds of facts, and that is when you follow the policy that

we've been doing, which is, first of all, we're increasing red tape and government regulation; we're engaging in excessive government spending unlike anything that has ever happened before in our history; we have a problem—and I haven't talked about this—of insufficient liquidity. This is also a problem. We've got about a perfect storm going on for small businesses in America. Here is what has happened:

The Federal Reserve doesn't actually print money, but they call it "printed money." They've increased the liquidity in America, and they did that by a factor of 10 last year. In other words, if you look at a chart of the amount of M1 money supply, it runs along, up and down like a saw tooth, and all of a sudden, we get to last year and—boom. Excuse me. I think it was the end of last year—this year—and the thing jumps by a factor of 10. So the Federal Reserve created all of this money. Boom. It printed a whole lot of it, and that's available at a very low interest rate, and the big banks have access to that.

The question is: Does all of that liquidity get down to the small business man? Because if you could get that liquidity into the hands of the small business man and if you could knock his taxation back, all of a sudden, presto zingo, you've got the formula to get the economy back chugging and churning.

It's not the government that is going to fix the economy. It's American individuals. It's the free enterprise spirit of Americans. It's the people who love freedom, who have the ingenuity, who say there's a better way to do this. I think I could do it. I think I could build my own business, and I could make a living for my family this way. These people have the courage to take the risks, to put the equipment together, to put the systems together, to put the inventions together. America grows one dream at a time. They are the people who pull us out of recessions, and it is those people who we are hurting with excessive taxation.

As to this liquidity thing, the problem now is that the small businesses can't get their hands on money at a reasonable interest rate. Here is what happened. That liquidity that the big bank has trickles down to the little bank, and the little bank gets some of it. All of these Federal regulators are running around, and the bank is saying, Man, I am not going to loan money to any small business unless I know it's a slam dunk. They're going to pay me back because I'm already skating on a very thin edge. I've got a lot of assets that my bank owns that are not too strong, and I'm afraid they're going to shut me down and that my bank is going to go out of business, so I am not going to loan money very easily to just anybody who comes down the pike. When you do come down the pike and want to borrow money, I'll tell you

what: I'm going to charge you a pretty good interest rate on that money.

So what happens is the small business man is already intimidated because of the threats of all of these taxations that are coming along, and the economy has slowed down. He has got economic uncertainty. He has got a slowdown in the economy. He's getting excessive taxation. Now, I haven't even talked about all of the taxes he's facing.

First of all, the Bush tax cuts are expiring, so the death tax is coming back. The dividend tax, the capital gains tax, all of those are coming due because those tax things are expiring, and they're coming back, resetting at a higher rate.

So the small business man sees the death tax, capital gains, dividend taxes. Now he's seeing the other taxes we talked about, which are socialized medicine, energy taxes and cap-and-trade. What other things has he got coming? He has got these taxations coming. Now, with that, he's thinking, Oh, my goodness. I'm not too sure I really want to borrow anything.

Even if he does get the courage to borrow something because he has to, he'll go to the bank, and the bank will say, Ah. Before, I was giving you a couple percent interest on those loans. It was a 3-year, a 5-year loan for your business. Now I'm going to need to get a little more interest from you. I think about 4 or 5 or 6 percent is what I want now.

All of a sudden, the small business man, even if he qualifies and if he has a solid, strong business, it's going to be harder for him. These days, it's increasingly harder for him to get liquidity. So, aside from the taxation, excessive government spending, aside from the red tape and mandates, the economic uncertainty and the slowdown, now he's also getting hit with the problem of liquidity. This is fairly close to a perfect storm for small business. So guess what? We're not very surprised that unemployment has been going up.

Now, do we have any good news? It's always nice to have a little bit of good news somewhere. Until we fix these things or at least a number of them, you are not going to hear much about good news. People can say, Oh, the stock market is fine, and everything is going well. We've hit the bottom. Everybody looks at these things like they're cycles that repeat. It doesn't have to be a cycle. You know, FDR managed to take a recession and turn it into a Great Depression because he did the wrong things. We can follow in his footsteps, but we don't have to.

The point is we don't have to follow Keynesian economics. We don't have to do all of this tremendous level of spending and taxation. It's not necessary. It's not what the Republicans are proposing. We know it won't work, and we have learned from Morgenthau,

and we have learned from other people as well.

What is the solution? Well, actually, it's kind of interesting. One of the people who learned the solution was JFK, a Democrat. What he did was what? Well, he cut taxes. Oh, my goodness. A Democrat cutting taxes? Yeah, JFK actually did. We had a recession. He understood that businesses have to have some breathing room, so he cut taxes. Guess what? The economy improved.

Then Ronald Reagan comes along. Ronald Reagan had the same basic idea. He said, Hey, we've got a bad economy. How can we ever compete with the Soviet Union when our economy is all in trouble? So what did he do? He had a huge tax cut—two or three times what George Bush's tax cut was. Everybody called it trickle-down economics and made fun of Ronald Reagan for about a year or so until the economy turned around and took off like a horse, and it pulled us on ahead. He continued to spend money on defense. He bankrupted the Soviet Union. The Berlin Wall fell down, and the Western World was freed from the threat of an aggressive, Marxist/communist regime that was bent on taking over the free world. This is all because he understood these basic principles.

So who is it who has given us the model? JFK, Ronald Reagan, and also President Bush—the last President—all understood this principle. You've got to get off of the taxation and big government spending.

Here is the funny thing that is interesting. It was called sometimes "supply side economics." People made fun of it, but here is how it works, and you can see, in your own logic, how it would be. Let's say somebody appointed you to be king for the year and that your job was to raise money for your little government and your kingdom and that the only thing you could do was tax loaves of bread. People in your kingdom liked to eat bread. They bought loaves of bread, so you had the power to tax them on loaves of bread.

Well, you start thinking in your own mind, How would you do that? Well, you might say, first of all, Well, I could put a penny a loaf on the bread, and I could collect a certain amount of money. You could figure out how many loaves of bread are sold. At a penny apiece, you could figure out some revenue. Then you get to thinking, You know, I'll bet I could raise more money for my little kingdom if, instead, I put a \$10 tax on every loaf of bread. Then you'd think, Wow, that would be a whole lot except what would happen is people wouldn't buy as much bread, so I really wouldn't get as much tax as I first thought I would.

So, as you play with this back and forth in your mind, you come to the conclusion that there is an optimum point where, if you raise or lower the taxes, you will get less tax revenue.

Well, that's the thing that Ronald Reagan, JFK, and Bush II understood. They understood that, if you get off the taxes, the government can actually take in more money than they would have taken in if the taxes were higher. It sounds like making water run uphill, but it isn't. As you think about the loaf of bread, you think, Wait a minute. You can tax something so much that no one will buy it anymore, and you'll basically stall the economy.

□ 2030

What happened when Bush was faced with a recession when I first came to Congress in 2001, he was criticized roundly for this. After a little while—I guess it was about 2003—he got around to this, he reduced dividends, capital gains and death taxes. Now those things affect the guys that own these small businesses.

When he did that, almost immediately, what happened was government revenues went up even though the taxes, rate of taxation, went down. Well, how in the world could that be? It's this same principle. It was called the Laffer curve. It was first published, I think, by Art Laffer, an economist.

The solution to this doesn't mean that Americans have to sit around with no jobs and suffer tremendously with a lousy economy. The solution is available. The solution has been used time after time in American history. The thing that we are doing now has also been used to turn a recession into a depression.

What we have to do is stop spending too much money. It's not very complicated; the same thing you would do in your family budget. You can't say that you are fiscally responsible, criticize George Bush for creating all of these problems when his highest level of spending at 455 billion is less than one-third of what we have just spent in this year at \$1.4 trillion.

When we get the ratio of debt to gross domestic product higher than it's been since the Second World War, you know something is wrong, and it is not that complicated. This whole idea of employment and what makes jobs is very straightforward.

What I hear the Democrats frequently doing is beating on their drum. We are going to tax that old rich man. We are going to get the rich man. We are going to take his money away from him and give it all to other people.

Well, the only trouble with that is, the trouble with socialism is sooner or later you run out of other people's money. Guess who it is you are going to tax? If you say you are going to tax the rich man, some of those rich men are the guys that own these companies, the men and women, the entrepreneurs who own the companies. Many times the amount of profit that the company makes is like their profit. They plow it back into more jobs.

Now, if you tax those people out of their hides, guess what's going to happen. They don't have any money to reinvest in their company, and you kill jobs. You cannot separate the people that run the business and the jobs. They are not separable.

If you really want jobs, you have to have employers. You can't have employees with no employers.

If you tax the employers too much, then they can't have employees. It's not that very complicated. Yet what we hear constantly is all these fat cats, we are going to run the tax up on these well-to-do people.

Well, as it is today, you might be amused to know that 50 percent of Americans pay about 1 percent of the tax revenue in America. Fifty percent of Americans pay about 1 percent—I believe my numbers on that are pretty close to right. You could also say that a very, very large percent of taxes are paid by a very small percent of Americans.

Now, if you drive that too hard, what happens again is you squeeze the small business and the wheels come off the tracks. That's what we have been doing, and we have not been making the situation better.

It's not complicated. We can fix it, but we can't fix it with what we did today. Today the Democrats decided to increase the debt ceiling, another \$300 billion. They decided to spend money on the defense of our country, which I supported and voted for, but also another \$150 billion in this stimulus kind of thing which didn't work before, and we know it's not going to work again.

We are not using the right approach. We are not going back to the basics of how jobs are created. What we are doing is we are spending Americans' money. Not just our own money, not just our kids' money, our grandchildren's money at this kind of rate. We cannot afford these kinds of programs in the condition of our economy.

We can right the economy. There's things that can be done to fix it. There's a great deal that can be done with health care. Even if you believe in global warming, and it is a high priority to spend billions of dollars on it, even if you believe that, there are a whole lot of better solutions and a whole lot of government redtape and taxes.

You can move to the nuclear model, which is going to reduce CO₂ significantly. This economic stimulus, we saw how effective that was. That's the thing that we are claiming we are going to keep our unemployment below 8 percent, and here we are closer to 10.

Now, of course, the Wall Street bailout: this was a failed idea from the start. It was sold to the Congress that the entire American economy was going to collapse, that there was going to be sulfurous smoke billowing out of the earth. There are going to be hail

storms and brick bats falling from the sky if we didn't come up with \$700 million in unmarked bills, and we wanted it in a big hurry because we made a big public announcement, the stock market is watching you, Congress.

Congress obliged. I think it was a bad decision. They passed that stimulus bill. Now we have got politicians running around inside the private sector deciding on the salaries of private employees.

The recent bill that we passed here just last week gives the Federal Government the authority to regulate financial transactions and, at least in theory, could give them the power to determine the salary of a bank teller. Do we really think that that's a job that Congress and the Federal Government can do efficiently, is to determine the salary of people in private industry?

Is that what we really want our government doing? Do we trust our government to be telling us whether we can put an addition on our house and we have to prove that the carbon footprint of our house is just right to be able to allow us to put an addition on our house?

Do we need to have an energy taxed a whole lot more when the economy is in the condition it is now? Is this threat of global warming which—by the way, a whole series of emails and electronic files were released from the scientific university in England that is the center for collecting all the data on global warming, it found that these scientists had been fudging the data. What they found was, in fact, that they were very less than professional and had been doing everything they could to quash any article appearing in a journal that would question the absolute rigid science that global warming was an imminent disaster on this planet.

Well, when the evidence of the fact that the data had been doctored, that they had been intentionally trying to quash the opinions of dissenters, trying to say that it's settled science—it's nothing settled at all, what these emails revealed in East Anglia. But that was kind of dubious science all the way along.

The question is, is that as important as our dependence on foreign oil? I am not so sure that it is.

Even if it is, there's a solution to that which is replacing coal-fired, carbon-burning plants with nuclear plants. France has 80 percent nuclear generation. If we went to 40, we would, equivalent, get rid of the CO₂ from all of those passenger cars.

This is not the approach we have been taking. The whole wrong economics of what we have been doing is wrong. That's why people are feeling pain. They are feeling unemployment. That's why people can't make their mortgage payments. That's why people are having to move in with their par-

ents and all kinds of other sacrifices are being made.

That's a tragedy, because this is something that's not that complicated. It's something that—there are models that show us what we should be doing in government. The Republican Party has proposed all of the things that I am talking about in solutions, that is, in terms of health care, are we saying there isn't something that should be done? Of course there are things that should be done in health care.

If you have got a problem with the plumbing in the kitchen sink, it doesn't mean you remodel the entire kitchen. That's what the Democrats have proposed. In socialized medicine, the government could take over all of health care. You don't have to do that, but there are things that we can do to improve the situation and can build on what we have.

We have a very, very good health care system in terms of delivery. The pay-for piece of it is broken, and it's because about a third of Americans don't pay anything for their health care. No wonder that starts to create stress in the system.

There are things that we can do to improve the efficiency and the way our health care system works, but it doesn't mean scrap the whole thing and give it to the government. In each of these areas there are good proposals, ways to solve these problems.

When we are talking about jobs and employment, we have to remember what the basic principles are. The basic principles are those small businesses have to be healthy, and they are never healthy when we spend too much money, when we create too much redtape and when we tax too much and also when we don't get the right rules in terms of liquidity.

I heard on the floor here not so long ago, the Democrats saying that this entire recession is the fault of George Bush. Of course, he is the one that brought the hurricane—it's always convenient to find somebody to blame.

But what's to blame in this recession? What's to blame in terms of job losses? Well, it's these things here. Anybody who has ever run a small business, you can check these with anybody who has a friend, talk to somebody who runs a small business. Ask them: Is economic uncertainty a problem in terms of creating jobs? Oh, yes, yes. Slowdown in the economy? Yes, that makes me concerned. Excessive taxation? Oh, yes, you are going to tax me a whole lot.

We have got this thing called a death tax. The death tax, the way it works is when it goes back into effect in 2011 or 2012, let's say you have got a business, maybe it's a farm. You have got the thousand acres and Dad is running the farm. Dad dies and passes the farm on to his son.

The government says, well, your dad died so we are going to tax you. Well,

how come you are taxing? He already paid his taxes. Yes, we are going to tax him again. It's a double taxation, and we want 45 percent of the value of the farm.

The son says, well, that means I would have to sell half the land from a thousand acres and go to 500. I would have to get rid of half of my tractors and combines and other equipment. The farm really wouldn't work at 500 acres. It needs a full thousand acres. Sorry, Bub, you owe Uncle Sam the death tax.

What that does is what? It kills small business when you do that death tax. These are things that people know you just can't do this and expect to have a strong economy.

That's where we have been making some mistakes. Unfortunately this last year these mistakes have come home to roost.

You could say, well, this is Bush's mistake because he got the whole economy messed up in the first place.

Well, let's go back to that record. Let's go back to that conservative newspaper, the New York Times. On September 11, September 11, 2003, the New York Times reported, first of all, that President George Bush was worried about what was going on with Freddie and Fannie. Freddie and Fannie had apparently lost a few billion dollars, didn't know where they had put it.

That said, these financial institutions that were quasi-public, the implication was that the government would be in the bag if something went wrong with Freddie and Fannie.

He is quoted, September 11, 2003, in the New York Times saying that Congress needs to give him authority to regulate Freddie and Fannie more. In a matter of a year or two, we here in the House, it was a Republican House at that time, passed a bill to give the President authority to get into Freddie and Fannie's finances and to regulate them more because they were out of control.

The bill went to the Senate, as you can expect; but it was killed by the Democrats in a filibuster on the floor. It never saw the light of day. It was never passed.

So it was that Freddie and Fannie, failing, along with other parts of that real estate market, which was created by laws that we had made, saying that banks had to make loans to people who couldn't afford to pay them, and also this wild speculation that came from a very, very low interest rate and a lot of liquidity created by Greenspan, you put that all together and you get a bubble in the real estate market. The bubble pops and things come apart.

Now, you could try and blame that thing on Bush, but it really wouldn't be accurate to do that. He saw, at least in 2003, that we were in trouble and recognized we should do something about it.

It's easy to try to blame problems that are created by overspending and over-taxation on the Republicans, but the fact of the matter is this Congress has got 80 Democrats more than it does Republicans. This is not exactly what you call a Republican control of the Congress or the House.

Over in the Senate, the Democrats have a working 60-vote majority, so they could even break filibusters and pass what they want. They have had a year to work on this, and we can see what they have done.

We have seen what happened to their spending. We have seen all these different things they put money into. These ones that are foggy are the ones that are just done by the House. The Senate has not passed them.

We have seen what's happened to employment as a result of that excessive spending. It has not been good, and it's not been good for a reason.

We have, today, again, continued in the same policy. I think Americans are getting tired of it. I think they realize you can't blame it on someone else, that these are basic factors that people understand. It's businesses that create jobs; and if you tax the businesses too much, and if you have the wrong environment for the businesses, they are not going to be able to keep the economy going.

□ 2045

Ironically, something that suffers a great deal in a poor economy are governments. Governments depend on tax revenues for their revenues, and the States really take a beating because many of them have balanced budgets that they have to meet. So if you happen to be some poor governor in a State when you have a Congress like this that's spending money wildly and forgetting the basic principles of economics, you've got a lot of problems.

So this cartoon is as a lot of cartoons that have a certain amount of sense and humor to them. "Now give me one good reason why you're not hiring." Well, we've seen a whole lot of reasons why we're not hiring, and the trouble is that we have essentially exasperated every single one of these things, and that's why there are not jobs here.

So we're closing up here, then, on this segment on unemployment and on spending and what it is that creates it. There's nothing here that's very complicated. Like most things in life, if you understand the mechanics and how they work, they're not very difficult. We're doing some things that are wrong in terms of jobs. If we want to have jobs, we can do it. It's not the government that's going to create the jobs. It's you, my friends, the American people that will create the jobs. But we have to give you an economic environment that is conducive to creating jobs, and that does not mean a whole lot more money in spending,

such as our \$150 billion in stimulus II, "son of stimulus," if you want to call it that, the failed bill from last summer that didn't work. It does not include increasing the debt limit, as we did today, by \$300 billion. What it includes is the same basic principle that JFK, Ronald Reagan, and Bush used, which is getting the government off the backs of the people of the United States.

This is a sad situation. My father fought in World War II, and their mindset was, we're going to give of ourselves a whole lot so the next generation, our children, can have more than we did. Some of them didn't go to college, and they said we want our kids to go to college. We want to leave America a better place.

Is that the heritage of this day, that we want to leave America a worse place, that we want to leave our kids and our grandkids up to their ears in debt, having a less bright future than what we had? Can't we learn from the great generation that fought World War II that we want to leave America a better place?

I believe the American public will say we want to go back to leaving this a stronger, better, freer country than when we inherited it, and I think we will do that. But we will do that by changing these false premises and policies that are leading us down the primrose path.

I thank the Speaker for allowing me to talk on these very important questions, and I would say Merry Christmas, wonderful holidays to Americans. God bless you and goodnight.

THE IRAQ AND AFGHANISTAN WARS AND HEALTH CARE REFORM

The SPEAKER pro tempore (Mr. TONKO). Under the Speaker's announced policy of January 6, 2009, the gentleman from Florida (Mr. GRAYSON) is recognized for 60 minutes as the designee of the majority leader.

Mr. GRAYSON. Mr. Speaker, in some respects the policy regarding the wars in Iraq and Afghanistan comes down to the subject of leadership. And as I have said, leadership is sometimes simply a question of looking into the future, seeing what's inevitable, and doing what you need to do to make the future come faster. I think that's true in both the case of Iraq and the case of Afghanistan.

In the case of the Israelites in Egypt, Moses did not say to the pharaoh, Would you please let my people go starting 2 or 3 years from now? Instead what he said is "Let my people go" now.

We all know that sooner or later our troops will be withdrawn from Iraq. They will be withdrawn from Afghanistan. So the question is why not now?

Now, if you ask that question to the other side, the people who want to perpetuate these wars, the answer is always the same in one form or another.

That answer is, something bad is going to happen. But what that really means when you get down to it is that something bad might happen. Nobody knows for sure what might happen. They're speculating that something bad might happen. But you can be sure that if the war is perpetuated, something bad will happen. And that is the loss of American lives, the loss of foreign lives, the loss of our national treasure.

In the case of Iraq, \$3 trillion already and the amount grows every day. This in a country like ours with a total net worth accumulated over more than two centuries of \$50 trillion. We have taken 6 percent of what our great grandparents and our grandparents and our parents produced and left to us and everything that we've toiled to produce over the course of our lives and everything that our children have produced. We have taken 6 percent of all of that and dumped it into the sands of Mesopotamia and lost 4,000 American lives and countless Iraqi lives to boot. Now, this is what happened because we entered into this war, because we continue this war, because the war continues to this day.

We have an enemy in this war. The enemy is called al Qaeda; al Qaeda in Iraq, al Qaeda in Pakistan, wherever they might be, but that's the name they go by. But ask yourself, what could they have possibly done to inflict that on us? What could al Qaeda have done to make us lose \$3 trillion, 4,000 American lives, countless lives of other people? What could they have possibly done? They would have literally had to vaporize New England in order to inflict the same amount of economic damage on us to destroy 6 percent of our economy. It simply wasn't possible. It isn't possible. It never was possible.

And that's why the war was such a mistake to begin with. It was born in sin, it lives in sin, and in the end it will die in sin. It never should have started, and it never should be perpetuated because every day the war continues. Every single day is another day that we risk American lives, on many occasions we lose American lives, other people die, and again our national treasure is dissipated until in the end it will be gone.

As Senator KERRY once asked, famously, "How do you ask a man to be the last man to die in Vietnam?" That's a good question. How do we ask a man today to be the last man to die in Afghanistan? How do we ask an American soldier today to be the last American soldier to die in Iraq? There is no good answer to that question. There's no good answer to why we continue to perpetuate these wars knowing full well that they will end. And they'll end only one way.

Paul Simon once had a song called "50 Ways to Leave Your Lover." There actually are 50 Ways or more to start a war. That much is true.

Once the Europeans fought a war because a pirate cut off a man's ear, the War of Jenkin's Ear, and that plunged two different nations into war for years. At another time a murder was committed. A man was shot, one man, only one man. He happened to be Archduke Ferdinand, and an entire continent was plunged into war. That was the origin of World War I.

There are all sorts of ways to begin a war. There are all sorts of ways to perpetuate a war. The Hundred Years' War in Europe was fought for more than a hundred years, left two different countries, both England and France, absolutely penniless, as many wars often do, for the simple reason that it takes an awful lot of effort to build a school, almost no effort at all to blow it up. And the same thing is true of anything that you can create. So wars destroy, and very often they destroy the countries engaged in them.

In the case of America, when America starts a war, when America is involved in a war, we are so strong, we are so powerful that the only way to end a war is for us to end it. There is only one way to end the war that America is involved in, and that is for us to decide as a country enough is enough, we're done. We spend more on our defense than all other countries combined, and the result of that is that these decisions are made by us, often by the people in this room, often by the President. And it's up to us to decide when enough is enough, when enough people have died, when enough money has been lost, when the price in both blood and money is simply too high. I submit that we've reached that point in Iraq a long time ago. We reached that point in Afghanistan a long time ago.

In the case of Afghanistan, within 2 months after 9/11, we had expelled the Taliban Government from the capital. Within 3 months we had expelled al Qaeda from the country, and our enemies were no longer even in Afghanistan at that point. They were in Pakistan and they remain there today. It's not a secret. Everybody knows it. So the result of that is within 2 months or 3 months after 9/11, we had won our victory in Afghanistan, and at some later point even in Iraq I seem to remember our President standing on an aircraft carrier and behind him the giant sign "Mission Accomplished."

Yet both these wars go on and on and on for one reason, one reason only: It's because we Americans decide to perpetuate them. And we do so out of fear, out of the sense that something bad might happen, without realizing that something bad happens every single day that we are at war. So there may be 50 ways to start a war, but there's only one way to end it, and that's for us to end it and hopefully not too much longer from now.

I think the President missed an opportunity. He took office with a great

deal of goodwill on the part of not only my party, the Democratic Party, but also on the part of good people all around America who simply want better lives for themselves. Let's not squander that opportunity. We all deserve a direction that we regard as the right direction. There are too many people in this country even today who think we're going in the wrong direction. In Iraq the wrong direction is simply the same direction. The same thing is true in Afghanistan. The wrong direction is the same direction. We voted for change. We deserve change. That's just as true with these foreign wars as it is with anything else.

We know that at some point in the future these wars will be over. And with regard to what the situation will be then, we will know that George Bush started these wars and I sincerely do hope, I sincerely do hope, that Barack Obama will end them, if not right now then as soon as possible.

Then at that point the poet Percy Bysshe Shelley will tell us what the circumstances are at that point, and I yield to Percy Bysshe Shelley for a moment or two. He described those circumstances in the poem "Ozymandias." This is what those circumstances will be like when these wars are over:

"I met a traveller from an antique land

Who said: Two vast and trunkless legs of stone

Stand in the desert. Near them on the sand,

Half sunk, a shattered visage lies, whose frown

And wrinkled lip, and sneer of cold command

Tell that its sculptor well those passions read

Which yet survive, stamped on these lifeless things,

The hand that mocked them and the heart that fed.

And on the pedestal these words appear:

'My name is George W. Bush, king of kings:

Look on my works, ye Mighty, and despair!'

Nothing beside remains. Round the decay

Of that colossal wreck, boundless and bare,

The lone and level sands stretch far away."

The lone and level sands will stretch far away when these wars are over, these monuments to the mistakes of our previous President. But in the end that's what it will be, simply a statue in the desert, pointless, endless, bare.

With regard to the issue of health care, we are now waiting for the Senate to act, this House having acted quite a while ago now.

□ 2100

And I have to wonder why. Why are we waiting so long? What facts are different today on this day in December

than were any different in November, or any different in October, any different in September, August, July? What can we do today that we could not have done then? I think the sad fact is, nothing. Nothing has really changed. The fundamental facts are the same. Americans are still denied care every single day on the basis of pre-existing conditions, on the basis of reaching lifetime caps. There are still millions upon millions of Americans who have no health care coverage. There's a million, who, every year, go bankrupt because of that. And there are thousands upon thousands who die every single month for the simple reason that they have no health care coverage. That's been true, not only for this month, not only for last month, but for year upon year.

And we Democrats in the House of Representatives, we took it upon ourselves, with the political capital that you, the American people had given to us, we took it upon ourselves to make that our priority once we had done what we could to steady the shaken economy. We delivered. We did what we needed to do. And we have waited and waited and waited for the Senate to do what it needs to do.

I pointed out here on this pedestal several weeks ago that the cost of delay is death. People die every single day, 121 of them, 122, every single day because they have no health care coverage in America. And I pointed out that there are people here in this Chamber who are dead set against health care reform, even at the cost of the lives of their own constituents. I gave their names. I gave their numbers for how many people would die in each of their districts on account of our not passing health care reform. Now I think it's time to do the same for the obstructionists in the Senate, those people who think that health care reform doesn't serve their own purposes, and they are, therefore, willing to deny it to their own constituents.

This is not a case of one State opting out. This is a case of Senators, en masse, deciding, one by one, that there will be no health care reform, not just for their States, but for all America. And so what I've done is I've created another list. This is a list of States and a list of those who die in that State, one by one, on account of there being no health care coverage, not once, but year after year after year. And now I propose to provide that list to you all. You'll be able to see it at our Web site later on today.

In the State of Alabama, the number is 541 deaths each year.

In the State of Alaska, 124 deaths each year.

In the State of Arizona, 1,185 deaths each year.

In the State of Connecticut, 326 deaths each year.

In my State of Florida, an astounding 3,542 deaths each year.

In Georgia, 1,640 deaths each year.

In Idaho, 217 deaths each year.

In Indiana, 727 deaths each year.

In Iowa, 272.

In Kansas, 329.

In Kentucky, 609.

In Louisiana, 800.

In the State of Maine, 123 deaths each year.

In Mississippi, 518 deaths.

In Missouri, 714 deaths.

In Nebraska, 216 deaths.

In Nevada, 450 deaths.

In New Hampshire, 132 deaths.

In North Carolina, 1,424 deaths.

In Ohio, 1,279 deaths.

In Oklahoma, 550 deaths.

In South Carolina, 693 deaths.

In South Dakota, 88 deaths.

In Tennessee, 883 deaths.

In the State of Texas, 5,857 deaths each year for lack of health coverage.

In Utah, 342 deaths.

In Wyoming, 69 deaths.

And on it goes.

And for those Senators who have shown some reluctance or some lack of interest in health care reform, I'm going to provide your names right now to go with your States.

In Alabama, I'm talking about JEFF SESSIONS and RICHARD SHELBY; in Alaska, LISA MURKOWSKI; in Arizona, JON KYL and JOHN MCCAIN; in Connecticut, JOSEPH LIEBERMAN; in Florida, GEORGE LEMIEUX; in Georgia, SAXBY CHAMBLISS and JOHNNY ISAKSON; in Idaho, MIKE CRAPO and JAMES RISCH; in Indiana, DICK LUGAR; in Iowa, CHUCK GRASSLEY; in Kansas, SAM BROWNBACK and PAT ROBERTS; in Kentucky, JIM BUNNING and MITCH MCCONNELL; in Louisiana, DAVID VITTER; in Maine, SUSAN COLLINS and OLYMPIA SNOWE; in Mississippi, THAD COCHRAN and ROGER WICKER; in Missouri, CHRISTOPHER BOND; in Nebraska, MIKE JOHANNES and BEN NELSON; in Nevada, JOHN ENSIGN; in New Hampshire, JUDD GREGG; in North Carolina, RICHARD BARR; in Ohio, GEORGE VOINOVICH; in Oklahoma, TOM COBURN and JAMES INHOFE; in South Carolina, JIM DEMINT and LINDSEY GRAHAM; in South Dakota, JOHN THUNE; in Tennessee, LAMAR ALEXANDER and BOB CORKER; in Texas, JOHN CORNYN and KAY BAILEY HUTCHISON; in Utah, ROBERT BENNETT and ORRIN HATCH; and in Wyoming, JOHN BARRASSO and MICHAEL ENZI.

Please remember these names. These are the people who have stalled health care in this country. These are the people who have watched when, day after day, month after month, people go broke, people remain sick and people even die because they have no health care in this country. And I want to assure each one of you who has done anything to obstruct health care reform in this country that people will remember. Maybe not the people who die, but the people who love them, the people whose names I read day after day at our Web site, NamesOfTheDead.com,

and the people whose stories I told day after day. These are people who are gone, but the names, the list grows every single day until we solve this problem. And then, in the end, when we do solve this problem—and it's inevitable. Every other industrial country in the entire world has health insurance for everyone. When we do join the ranks of those countries, people are going to remember who made that happen and show kindness and love to them. People are going to remember who blocked it, and they'll show undying hatred. People are going to remember.

And you'll remember, too. You'll remember that when the time came for you to do something for your fellow man, to stop the suffering, to stop the hurt, to stop the pain and to stop the dying, you did nothing, or you didn't do enough. You're going to remember that, and you're going to know that blood is on your hands.

May God have mercy on your soul.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair would remind the Member to refrain from engaging in personalities toward the Senate or its Members. Remarks in debate may include policy criticisms, but may not descend to personalities.

VACATING 5-MINUTE SPECIAL ORDER

The SPEAKER pro tempore. Without objection, the request for a 5-minute special order speech in favor of the gentleman from Florida (Mr. GRAYSON) is hereby vacated.

There was no objection.

THE RELIGIOUS HERITAGE OF THE UNITED STATES

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Texas (Mr. GOHMERT) is recognized for 60 minutes.

Mr. GOHMERT. Mr. Speaker, it's interesting following the gentleman from Florida. In the spirit of Christmas, it sounds like accusing previously Members of Congress and now Members of the Senate of basically being responsible for deaths. I can't help but address that in this respect—ignorance is a dangerous thing, and the fact is, if you will examine, Mr. Speaker, the statistics of those, for example, you take numbers I'm familiar with of women who find a localized tumor, of breast cancer, they have a 98 percent chance of success, of complete elimination of the cancer. That's in the United States with our health care.

If we go to what the gentleman from Florida is proposing, as we see in other countries like England, it's about 20 points less. In other words, the program the gentleman from Florida is

advocating would be responsible for killing one out of five women who find those type tumors. And you can run those statistics throughout health care.

So, despite what some have said—I know not intentionally trying to misrepresent, because I know the gentleman is an honorable man. As Shakespeare said, so are they all, all honorable men. But they're wrong about the facts. And the truth is, we have numerous proposals to reform health care and to provide health care for everyone. But one of the great misrepresentations that's been made this year in this House is that so-called health care reform is about health care reform. It is not. We've heard everyone from the President to lots of people on this side of the aisle say that yes, we want to insure 30 million more people. Well, the statistics tell us if they do their program, then they are going to be millions who lose their health care insurance. And even if you wanted to insure 30 million people, well, the statistics indicate those 30 million are in approximately 10 million households, and you can insure those 10 million households for potentially less than \$10,000. So for \$100 billion, you could insure all the people that they say they need to add to the health care insurance rolls for \$100 billion. And yet the estimates are anywhere from \$1.2 trillion to \$2.5 trillion as to what they're proposing will cost.

That makes it clear that the truth is their proposals are not about health care reform. They are about government control. And consistently, when you go through the statistics of the success rates with regard to different types of cancer, if you go to the programs being advocated, then people get on lists and they die waiting on those lists. People die waiting for the treatment, the therapy, the diagnostics that require lists in a socialized medicine setting.

But I want to get away from the partisan politics and the nasty allegations that have been made in here just prior to me speaking, and back and forth throughout this year, because this may well be the last hour that we have here in the House before we recess for Christmas and before we come back next year. So, instead of getting into all this rancor, I thought it would be good to help address an area that some people have just not had education about, and that this is the appropriate place, Mr. Speaker, to make sure that the record is correct, because we have so much wonderful history in this building, in this House.

For example, I hear people really concerned around this building, around the Supreme Court, across the way, around Capitol Hill here, about someone, my goodness, praying in public. Well, we begin every day we're in session here in the House and the Senate's in session with a prayer.

□ 2115

Many are ignorant from the place in which that tradition started, where it came. You have to go back to 1787, the Constitutional Convention.

The Constitutional Convention, people may recall, began in 1787 as a result of the failure of the Articles of Confederation. And for those that know history, they would know that the revolution was won in 1783. It was the Treaty of Paris in which England finally recognized the United States' right to exist as a Nation, and George Washington did something that had never been done in the history of mankind before or since then, and that is lead a revolutionary military, win the revolution, and then resign and go home when he could be Caesar, he could be king, emperor, whatever. That was not his goal. His goal, as he said, was to do his duty to God, basically, and his country, kind of like the Scout oath.

Anyway, here they are in Philadelphia, Independence Hall, 1787. It's June. Benjamin Franklin is 80 years old. Now, many people say, Well, we know he was a deist from history. That means he believed there was a creator out there but that he believed God, the creator, created things and then stood back and let everything happen and that he never interfered. Well, those who also know history know that there were times in his life when Benjamin Franklin sowed some wild seeds, and that included some in Europe and in England. But by the time of the Constitutional Convention, there in Independence Hall in Philadelphia, 1787, Benjamin Franklin was between 2 and 3 years away from meeting his judge, meeting his maker, and he knew that. He was as brilliant as ever, as witty, an amazing man, the genius that he was, and there he sits.

There is a picture right outside the House floor depicting that area in Independence Hall where they were meeting. Now, in the beautiful painting, the windows are open. Well, the windows were covered. It may have been by blankets instead of beautiful lined curtains depicted in the scene. But for nearly 5 weeks, they went without accomplishing much of anything. Finally, the 80-year-old Ben Franklin rose and was recognized by the President of the Constitutional Convention, George Washington. And we have these words because James Madison recorded them as secretary of that convention.

These are the exact words of Benjamin Franklin, June 28, 1787, in Philadelphia during the Constitutional Congress. Benjamin Franklin said: "Mr. President, the small progress we have made after 4 or 5 weeks' close attendance and continual reasonings with each other, our different sentiments on almost every question, several of the last producing as many noes as ayes, is, methinks, a melancholy proof of the imperfection of human understanding.

We, indeed, seem to feel our own want of political wisdom, since we've been running about in search of it. We have gone back to ancient history for models of government and examined the different forms of those republics which, having been formed with the seeds of their own dissolution, now no longer exist. And we have viewed modern states all around Europe but find none of their constitutions suitable to our circumstances.

"In this situation of this assembly groping, as it were, in the dark to find political truth, and scarce able to distinguish it when presented to us, how has it happened, sir, that we have not hitherto once thought of humbly applying to the Father of lights to illuminate our understanding? In the beginning contest with Great Britain, when we were sensible of danger, we had daily prayer in this room. Our prayers, sir, were heard and they were graciously answered. All of us who were engaged in the struggle must have observed frequent instances of a superintending providence in our favor. To that kind providence we owe this happy opportunity of consulting in peace on the means of establishing our future national felicity. And have we now forgotten that powerful friend? or do we imagine that we no longer need His assistance?"

Ben Franklin goes on and says: "I have lived, sir, a long time, and the longer I live, the more convincing proofs I see of this truth—that God governs in the affairs of men. And if a sparrow cannot fall to the ground without His notice, is it probable that an empire can rise without His aid? We have been assured, sir, in the sacred writings that, 'except the Lord build the House, they labor in vain that build it.' I firmly believe this; and I also believe that without His concurring aid, we shall succeed in this political building no better than the builders of Babel. We shall be divided by our little partial local interests; our projects will be confounded, and we, ourselves, shall become a reproach and a byword down to future age. And what is worse, mankind may hereafter this unfortunate instance despair of establishing governments by human wisdom and leave it to chance, war, and conquest.

"I therefore beg leave to move that, henceforth, prayers imploring the assistance of Heaven and its blessings on our deliberations be held in this assembly every morning before we proceed to business, and that one or more of the clergy of this city be requested to officiate in that service."

His motion was seconded, and then Ben Franklin's motion was adopted unanimously. And from that day to this day, we do not begin Congress in this body without a prayer to begin.

Now, for those who say Ben Franklin obviously was a deist who didn't believe, believed a God or creator created

things but never intervened, his own words seem to defy that. He begged and implored Congress to begin with prayer every day because, as he said, "Our prayers, sir, were heard, and they were graciously answered."

So, Mr. Speaker, also, here again, in the spirit of bipartisanship, in the spirit, for me, of Christmas that has been so historically observed in this Nation, we want to just go through and make sure people understand our heritage.

Now, the great thing about our Constitution, it does allow for freedom of religion and a freedom not to worship at all. That is because they're based on the teachings of Christ and his willingness to allow all men to make their own decisions for themselves, knowing, as he did, that one day, all people will meet their maker. But let's go back to the person that found the New World, as it was called. This was Christopher Columbus.

You don't find many history books which have these kinds of quotes in it. This is Christopher Columbus in his own hand, in his own journal. He said: "It was the Lord who put it into my mind (I could feel His hand upon me) the fact that it would be possible to sail from here to the Indies. All who heard of my project rejected it with laughter, ridiculing me. There is no question that the inspiration was from the Holy Spirit, because He comforted me with the rays of marvelous inspiration from the Holy Scriptures."

Now there are those today who say the real lesson of Columbus is that it's amazing what you can do, even when you don't know where you're going, you don't know where you are when you get there, so long as you get the government to pay for it. But I would submit that there was a creator, a creator as Christopher Columbus believed, who put this into his mind to sail west and discover this area so that the greatest nation in the history of mankind could arise.

Now if you go to the Pilgrims who came across, originally from the Netherlands to England and to America by way of stopping in England, this was 1620. Part of the Pilgrims' compact, these are their words, "In the name of God, Amen . . . Having undertaken for the glory of God, and advancement of the Christian faith, and the honor of our king and country, a voyage to plant the first colony in the northern parts of Virginia, do by these presents, solemnly and mutually in the presence of God and one another, covenant and combine ourselves together in a civil body politick." That was the Pilgrims on the Mayflower, November 11, 1620.

I have had people I have met from Harvard University who are not familiar with their history and the fact that Harvard University, September 26, 1642, this was part of their code. It was part of their handbook.

Harvard University: "Let every student be plainly instructed, and ear-

nestly pressed to consider well, the main end of his life and studies is to know God and Jesus Christ, which is eternal life, John 17:3; and therefore to lay Christ in the bottom, as the only foundation of all sound knowledge and learning. And seeing the Lord only giveth the wisdom, Let every one seriously set himself by prayer in secret to seek it of him, Proverbs 2:3." That's Harvard University at its founding back around the year 1642.

In George Washington's own personal prayer book, which he read from daily, this is one of the entries in that prayer book that was in Washington's possession when he passed away: "O most glorious God and Jesus Christ, I acknowledge and confess my faults in the weak and imperfect performance of the duties of this day. I called on Thee for pardon and forgiveness of sins, but so coldly and carelessly that my prayers are come my sin and stand in need of pardon. I have heard Thy holy word, but with such deadness of spirit that I have been an unprofitable and forgetful hearer . . . Let me live according to those holy rules which Thou hast this day, according to those holy rules which Thou hast this day prescribed in Thy holy word . . . Direct me to the true object, Jesus Christ, the way, the truth and life. Bless, O Lord, all the people of this land." That's George Washington's prayer book.

Here is a quote from Thomas Jefferson, as we know, who wrote basically the Declaration of Independence at the urging of John Adams, and it was Jefferson who was the third President after John Adams. Jefferson in 1782—and for those who visit Washington, this is inscribed inside the Jefferson Memorial.

Jefferson said: "Can the liberties of a nation be thought secure when we have removed their only firm basis, a conviction in the minds of people that their liberties are the gift of God?"

Jedidiah Morse, who is called the father of the American geography, also father of Samuel Morse—folks who know history know who that is. On April 25, 1799, Jedidiah Morse said: "Whenever the pillars of Christianity shall be overthrown, our present republican forms of government, and all the blessings which flow from them, must fall with them."

James Madison, the fourth President, March 4, 1815, in his Thanksgiving Day proclamation said: "No people ought to feel greater obligations to celebrate the goodness of the Great Disposer of events and of the destiny of nations than the people of the United States. His kind providence originally conducted them to one of the best portions of the dwelling place allotted for the great family of the human race. He protected and cherished them under all the difficulties and trials to which they were exposed in their early days. Under His fostering care, their habits, their

sentiments, and their pursuits prepared them for a transition in due time to a state of independence and self-government."

□ 2130

Then John Quincy Adams, who was the son of John Adams, John Quincy Adams was the sixth President. Some think he may have been the smartest President, but there's no way to know. He was a brilliant man, the youngest diplomat ever appointed in America when he was 11 years of age. He knew all the Founders. His father, John Adams, allowed him to accompany him to so many events and things. He knew the Founders. He knew the founding.

And John Quincy Adams in 1821 on July 4 said, "The highest glory of the American Revolution was this, it connected in one indissoluble bond the principles of the civil government with the principles of Christianity, wherefrom the day of the Declaration they, the American people, were bound by the laws of God which they all, and by the laws of the Gospel which they nearly all, acknowledged as the rules of their conduct."

Noah Webster, 1833, said: "The moral principles and precepts contained in the Scriptures ought to form the basis of all our civil constitutions and laws. All the miseries and evils which men suffer from, vice, crime, ambition, injustice, oppression, slavery and war, proceed from their despising or neglecting the precepts contained in the Bible."

Alexis de Tocqueville, 1835, said: "There is no country in the world where the Christian religion retains a greater influence over the souls of men than in America; and there can be no greater proof of its utility and of its conformity to human nature than that its influence is powerfully felt over the most enlightened and free Nation of the Earth."

Again, John Quincy Adams, he was defeated in 1828 for a second term by Andrew Jackson. Then in 1830, he believed it was God's call for him to run for Congress, run for the House of Representatives, after having been President. He was elected and served for 17 years in the House of Representatives, just down the hall in Statuary Hall. It was John Quincy Adams who was retained to represent the Africans who were aboard the *Armistad* in their case before the Supreme Court. Anthony Hopkins did a wonderful job of portraying John Quincy Adams in the movie "Armistad." I think in the movie his closing argument was around 10 to 12 minutes, whereas in real life it spilled into a third day.

John Quincy Adams, 1837, after he had been in the House 6 years, he said, "Is it not that the Declaration of Independence first organized the social compact on the Foundation of the Redeemer's mission upon Earth? That it

laid the cornerstone of human government upon the first precepts of Christianity?"

And all of these people believed. People in America will be able to worship the way they choose or do not choose because the Nation was founded upon Christian precepts that allowed that freedom as no other nation in the history of mankind.

Andrew Jackson, 1845, this was just a few weeks before his death, and of course, people that know Jackson know that he was quite a rounder and he had quite a life. But, again, as he was just a few weeks before his death, he knew he was going to meet his Maker. Andrew Jackson said these words: "Sir, I am in the hands of a merciful God. I have full confidence in His goodness and mercy. The Bible is true. I have tried to conform to its spirit as near as possible. Upon that sacred volume I rest my hope for eternal salvation, through the merits and blood of our blessed Lord and Savior, Jesus Christ." That was Andrew Jackson just a few weeks before his death, May 29, 1845.

Daniel Webster, considered the greatest orator probably of all times in this country, served in the House, served in the Senate, thought perhaps he might be President one day, but he urged a compromise which cost him the election. Whether he was right or wrong, he believed if we didn't have the Compromise of 1850 then the Nation was doomed, that there would be a civil war in 1850 from which the Nation may not survive.

So he did a very selfless thing and stood up and urged the Compromise of 1850, knowing that he would lose his base. But he believed it was to save the country. Daniel Webster said in 1852: "If we and our posterity shall be true to the Christian religion, if we and they shall live always in the fear of God and shall respect His Commandments, we may have the highest hopes of the future fortunes of our country. But if we and our prosperity neglect religious instruction and authority, violate the rules of eternal justice, trifle with the injunctions of morality, and recklessly destroy the political Constitution which holds us together, no man can tell how sudden a catastrophe may overwhelm us that shall bury all our glory in profound obscurity."

Daniel Webster, 1852.

Now the Senate Judiciary Committee in 1853 stated this as a committee: "We are a Christian people, not because the law demands it, nor to gain exclusive benefits or to avoid legal disabilities, but from choice and education; and in a land thus universally Christian what is to be expected, what desired, but that we shall pay due regard to Christianity?" Senate Judiciary Committee, January 19, 1853.

Abraham Lincoln, our 16th President, February 11, 1861, said this: "Unless the

great God who assisted Washington shall be with me and aid me, I must fail; but if the same Omniscient Mind and Mighty Arm that directed and protected him shall guide and support me, I shall not fail. Let us all pray that the God of our fathers may not forsake us now." Abraham Lincoln, February 11, 1861.

We can skip over to the President's inaugural address, 1865, again, Abraham Lincoln. He said: "Both" talking about both sides of the Civil War, the North and the South. He said: "Both read the same Bible and pray to the same God, and each invokes His aid against the other. The prayers of both could not be answered. That of neither has been answered fully. The Almighty has His own purposes. 'Woe unto the world because of offenses; for if it must needs be that offenses come, but woe to that man by whom the offense cometh.'"

Lincoln, in that same inaugural address, went on and said: "If we shall suppose that American slavery is one of those offenses which"—and he knew it was an offense. He knew it to his soul that slavery was an offense and that it would be difficult for God to ever bless America as long as slavery existed. And Christian people in this country did not treat their brothers and sisters as brothers and sisters. So Lincoln goes on in that address. And you can feel the analysis that he did as he went back and forth within himself trying to figure out how a just and mighty God could allow this type of injustice.

So Lincoln goes on and he says: "If we shall suppose that American slavery is one of those offenses which, in the Providence of God, must needs come, but which, having continued through His appointed time, He now wills to remove, and that He gives to both North and South this terrible war as the woe due to those by whom the offense came, shall we discern therein any departure from those divine attributes which the believers in a living God ascribe to Him?"

"Fondly do we hope, fervently do we pray, that this mighty scourge of war may speedily pass away. Yet, if God wills that it continue until all the wealth piled by the bondsman's 250 years of unrequited toil shall be sunk, and every drop of blood drawn with the lash shall be paid by another drawn with the sword, as was said 3,000 years ago, so it must still be said 'the judgments of the Lord are true and righteous altogether.'"

Lincoln went on: "With malice toward none, with charity for all, with firmness in the right as God gives us to see the right, let us strive on to finish the work we are in, to bind up the Nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan, to do all which may achieve and cherish a just and

lasting peace among ourselves and with all Nations."

Abraham Lincoln, 1865.

Edward Everett, the Massachusetts Governor also served as U.S. Secretary of State, U.S. Senator, he spoke immediately before Lincoln's Gettysburg Address. He said this: "All the distinctive features and superiority of our Republican institutions"—and he wasn't talking about the Republican Party, he was talking about the Nation. This is considered a Republic. Senator Everett said the "superiority of our Republican institutions are derived from the teachings of Scripture."

William Seward was a U.S. Senator, a Governor of New York, Secretary of State under Lincoln. And it was interesting, Lincoln had such a diverse cabinet. Many of them didn't like each other, didn't like him, and yet he took all of that information together and made executive decisions.

William Seward said: "I know not how long a Republican Government can flourish among a great people who have not the Bible. But this I do know: that the existing government of this country never could have had existence but for the Bible. And, further, I do in my conscience believe that if at every decade of years a copy of the Bible could be found in every family in the land, its Republican institutions should be perpetuated."

1862, Andrew Johnson, he was Vice President, and he said: "Let us look forward to the time when we can take the Flag of our country and nail it below the cross, and there let it wave as it waved in the olden times, and let us gather around it and inscribe for our motto, 'Liberty and Union, one and inseparable, now and forever,' and exclaim: Christ first, our country next."

U.S. Grant, the 18th President, 1876, said this: "Hold fast to the Bible as the sheet-anchor of your liberties; write its precepts in your hearts and practice them in your lives. To the influence of this book we are indebted for all the progress made in true civilization and to this we must look as our guide in the future."

Now, Mr. Speaker, in reading these quotes, I think it is important for people to know I'm not trying to push my religion on anyone else. But I think it is imperative that we at least know where the Founders were, where the heart was of those who provided for this incredible government, the incredible Nation we have that I believe is the greatest in the history of mankind.

This was in the case of Church of the Holy Trinity v. the United States, in the opinion, February 29, 1892. The Supreme Court said: "Our laws and our institutions must necessarily be based upon and embody the teachings of the Redeemer of mankind. It is impossible that it should be otherwise and in this

sense and to this extent, our civilization and our institutions are emphatically Christian. This is a religious people. This is historically true. From the discovery of this continent to the present hour, there is a single voice making this affirmation. We find everywhere a clear recognition of the same truth. These and many other matters which might be noticed at a volume of unofficial declarations to the massive organic utterances that this is a Christian Nation." That was the Supreme Court in their opinion *Church of the Holy Trinity v. United States*, 1892.

Theodore Roosevelt, 1917, our 26th President, said: "In this actual world, a churchless community, a community where men have abandoned and scoffed at, or ignored their Christian duties, is a community on the rapid downgrade."

Warren G. Harding, our 29th President, 1920 said: "It is my conviction that the fundamental trouble with the people of the United States is that they have gotten too far away from the Almighty God."

Calvin Coolidge, our 30th President, 1923, said: "The foundations of our society and our government rest so much on the teachings of the Bible that it would be difficult to support them if faith in these teachings would cease to be practically universal in our country."

□ 2145

Franklin D. Roosevelt, October 6, 1935, said: We cannot read the history of our rise and development as a Nation without reckoning with the place the Bible has occupied in shaping the advances of the Republic. Where we have been the truest and most consistent in obeying its precepts we have attained the greatest measure of contentment and prosperity. Again, Franklin Roosevelt, 1935.

1943, President Hoover, in a joint statement with former First Ladies Mrs. Coolidge, Mrs. Roosevelt, Mrs. Taft, Mrs. Harrison and Mrs. Cleveland, gave this statement: The whole inspiration for our civilization springs from the teachings of Christ and the lessons of the prophets. To read the Bible for these fundamentals is a necessity of American life.

Harry Truman, our 33rd President, in 1952 said this: The basis of our Bill of Rights comes from the teachings we get from Exodus and St. Matthew, from Isaiah and St. Paul. I don't think we emphasize that enough these days. If we don't have a proper fundamental moral background, we will finally end up with a government which does not believe in rights for anyone but the State. Profound. That was Harry Truman, 1952.

Charles Malik, our ambassador to the United Nations from Lebanon and the president of the U.N. General Assembly in 1958, made this statement in 1958:

Whoever tries to conceive the American word without taking full account of the suffering and love and salvation of Christ is only dreaming. I know how embarrassing this matter is to politicians, bureaucrats, businessmen and cynics; but whatever these honored men think, the irrefutable truth is that the soul of America is at its best and highest, Christian. That was the U.N. ambassador and president of the U.N. General Assembly in 1958.

Now, Ronald Reagan, our 40th President, 1984, said: The frustrating thing is that those who are attacking religion claim they are doing it in the name of tolerance, freedom, and open-mindedness. Question: Isn't the real truth that they are intolerant of religion? They refuse to tolerate its importance in our lives. Ronald Reagan, 1984.

Now, I point out these quotes from our history. I could read volumes and volumes of quotes basically along the same lines, not trying to push Christian religion on anyone, but just so that people understand where we came from. It's incredible the amount of ignorance on the basis of this Nation, the foundation of this Nation.

Let me go to some of our Founders directly. Sam Adams. He was called, back at that time by those who knew and knew well, the "Father of the American Revolution." Samuel Adams was a signer of the Declaration of Independence. In the will of Samuel Adams he says this: I . . . recommend my soul to that Almighty Being who gave it, and my body I commit to the dust, relying upon the merits of Jesus Christ for a pardon of all my sins. That was the Father of the American Revolution, Samuel Adams.

In a letter written by Charles Carroll to Charles Wharton, Charles Carroll was a signer of the Declaration of Independence, one of the 56. He said: On the mercy of my Redeemer I rely for salvation and on His merits; not on the works I have done in obedience to His precepts.

William Cushing was the first Associate Justice appointed by George Washington to the Supreme Court. William Cushing in his will said: Sensible of my mortality, but being of sound mind, after recommending my soul to Almighty God through the merits of my Redeemer and my body to the Earth.

John Dickinson was also a signer of the Constitution. In his will he said: Rendering thanks to my Creator for my existence and station among His works, for my birth in a country enlightened by the Gospel and enjoying freedom, and for all His other kindnesses, to Him I resign myself, humbly confiding in His goodness and in His mercy through Jesus Christ for the events of eternity. Again, John Dickinson, signer of the Declaration of Independence.

John Hancock we know signed the Declaration larger than anyone else,

President of the Continental Congress in 1776 when the Declaration of Independence was signed and made public. In his will he said: I, John Hancock . . . being advanced in years and being of perfect mind and memory—thanks be given to God—therefore calling to mind the mortality of my body and knowing it is appointed for all men once to die (Hebrews 9:27), do make and ordain this my last will and testament . . . Principally and first of all, I give and recommend my soul into the hands of God that gave it, and my body I recommend to the Earth, nothing doubting but at the general resurrection I shall receive the same again by the mercy and power of God. Again, that was John Hancock.

Patrick Henry, the Governor of Virginia, a patriot, made that stirring speech that I gave on the radio in fifth grade, made this statement: This is all the inheritance I can give to my dear family—this was in his will—the religion of Christ can give them one which will make them rich indeed.

John Jay played such an important role in this Nation's founding and negotiations of treaties. I believe he helped negotiate the Treaty of Paris in 1783, and so many others, but he was also the first Chief Justice of the U.S. Supreme Court. In his will, Chief Justice John Jay said: Unto Him who is the author and giver of all good, I render sincere and humble thanks for His manifold and unmerited blessings, and especially for our redemption and salvation by His beloved son. He has been pleased to bless me with excellent parents, with a virtuous wife, and with worthy children. His protection has accompanied me through many eventful years, faithfully employed in the service of my country; His providence has not only conducted me to this tranquil situation, but also given me abundant reason to be contented and thankful. Blessed be His holy name. John Jay.

Daniel St. Thomas Jenifer was a signer of the Constitution. In his will he said: In the name of God, Amen. I, Daniel St. Thomas Jenifer . . . of disposing mind and memory, commend my soul to my blessed Redeemer.

Henry Knox, Revolutionary War general, extremely important to the success of the American Revolution, said in his will: First, I think it proper to express my unshaken opinion of the immortality of my soul or mind, and to dedicate and devote the same to the supreme head of the universe—to that great and tremendous Jehovah—who created the universal frame of nature, worlds, and systems in number infinite. To this awfully sublime Being do I resign my spirit with unlimited confidence of His mercy and protection.

John Langdon was a signer of the Constitution back in 1787. He also said: In the name of God, Amen. I, John Langdon, considering the uncertainty of life and that it is appointed unto all

men once to die—again, Hebrews 9:27—do make and ordain and publish this my last will and testament.

John Morton, signer of the Declaration of Independence, said in his will: With an awful reverence to the great Almighty God, Creator of all mankind, I, John Morton, being sick and weak in body but sound of mind and memory, thanks be given to Almighty God for the same, for all His mercies and favors, and considering the certainty of death and the uncertainty of the times thereof, do, for the settling of such temporal estate as it hath pleased God to bless me with in this life.

There are so many others, just one after another, vesting these same type things, signers of the Declaration of Independence, signers of the Constitution.

Jonathan Trumbull said this in his will: Principally and first of all, I bequeath my soul to God, the Creator and Giver thereof, and body to the Earth, nothing doubting but that I shall receive the same again at the General Resurrection through the power of Almighty God, believing and hoping for eternal life through the merits of my dear exalted Jesus Christ. That was Jonathan Trumble, who painted four of the paintings that are out here in our Rotunda.

One of the things that has run throughout this Nation, you go back to the Constitution, these were the Founders I've been quoting, those who were able to come together and have a Declaration of Independence, who sought, as Benjamin Franklin said, God's help in the revolution, and who sought him in the difficult, trying times after the Articles of Confederation were passed. And who they sought, as Benjamin Franklin pointed out in those great words I read, 1787, when afterwards they were finally able to come together with a constitution.

But as we know from our history, the Constitution was not afforded to all people as it should have been. They said, as these Founders I've read, that they were Christians, and yet as Christians they should have recognized that we could not expect God to bless America while we were treating our brothers and sisters by putting them in chains and bondage.

Martin Luther King came along after the Civil War. Abraham Lincoln, as I've read, made clear his beliefs in the Almighty and His grace and mercy and justice, and that's why he pushed for an end of slavery. But even still, it took Dr. Martin Luther King, Jr. and those who worked with him to bring about civil rights and an abdication of the supreme Constitution that we hold so dear to all people. It doesn't require that everyone receive equal things; it requires equal opportunity.

I would remind my friends that Martin Luther King, Jr. was an ordained Christian minister. He said in his letter

from Birmingham jail: But more basically, I am in Birmingham because injustice is here. Just as the prophets of the 8th century B.C. left their villages and carried their "thus saith the Lord" far beyond the boundaries of their home towns, and just as the Apostle Paul left his village of Tarsus and carried the Gospel of Jesus Christ to the four corners of the Greco-Roman world, so I am compelled to carry the gospel of freedom beyond my own home town. Like Paul, I must constantly respond to the Macedonian call for aid. That was in 1963. Profound words, Martin Luther King.

One of his quotes in 1963 from Birmingham jail: Whenever the early Christians entered the town, the people in power became disturbed and immediately sought to convict the Christians for being disturbers of the peace and outside agitators. But the Christians pressed on, and in the conviction that they were a colony of heaven called to obey God rather than man, small in number, they were big in commitment. They were too God-intoxicated to be astronomically intimidated. Powerful, powerful words, Martin Luther King.

Well, I think it's worth noting also, we have an original copy of the Treaty of Paris, 1783, located in the Department of State in a glass case. I didn't realize how that started until I saw that copy there, but it made sense once I saw it. In big bold letters at the top of the Treaty of Paris—this is the one that was negotiated in Paris in 1783 after surrendering at Yorktown to get England to sign onto a treaty indicating they would observe the United States' right to exist as an independent Nation.

It starts out in big block bold letters, "In the name of the most holy and undivided Trinity." When I first saw that I thought, I wonder why they would start like that. And then you realize, you're asking the nation of England to sign a treaty and pledging not to ever attack or fail to recognize its right to exist independently of England. What do you get them to swear under that is so important and so manifest that they would not dare go back on their word? Well, they decided at that time it was to start with the words, In the name of the most holy and undivided Trinity.

Those who are familiar with the War of 1812, 1814, we're up here on Jenkins Hill, where the Capitol was built, and the British proceeded across burning every public building, proceeded to the Capitol, set fire down the hall in Statuary Hall, what was then the House of Representatives, went down and set fire to the Senate Inn, and went to the White House, set fire there. The White House was terribly damaged inside.

□ 2200

The Capitol, by all rights, with the intensity of the fire and with the muni-

tions that were spread to make the fire get more hot, should have collapsed and fallen in on itself, but it didn't because a rain came and put out the fire.

By the way, the next day, there was such a huge, straight-line wind. Some thought it was tornadic, but most believed it was a straight-line wind. It was so intense that it blew their canons off their mounts. Some credit the wind with killing soldiers.

"As the British troops were preparing to leave, a conversation was noted between the British admiral and a Washington lady regarding the storm. The admiral exclaimed, 'Great God, Madam! Is this the kind of storm to which you are accustomed in this infernal country?'"

"The lady answered, 'No, sir. This is a special interposition of Providence to drive our enemies from our city.'" The weather drove them out. The American soldiers were not able to.

A little history about the White House nativity scene: It's Italian—made in Naples around the time of the United States War for Independence, the late 1700s. It has been on exhibit in the East Room of the White House during the holiday season since 1967. In 1999, a new tableau was made for the nativity scene. The design of the new display was inspired by historical Neapolitan presepios, which is the Italian term for "Christ," from the Baroque period, which incorporated architectural elements found in the 1700s.

That is a little bit about the nativity scene. There has been a lot said about that recently.

As far as the history of the White House Christmas tree, in 1889, the tradition of placing an indoor decorated tree in the White House began on Christmas morning during the Presidency of Benjamin Harrison. It was in 1895 that First Lady Frances Cleveland created a technology savvy tree when she hung electric lights on the White House tree, which was introduced into the White House in 1891.

There is just so much history with our Founding Fathers.

Franklin D. Roosevelt, December 24—obviously Christmas Eve—1934, said, "This is the second year that I have joined with you on this happy occasion. Then, as now, with millions of others, we celebrate the happy observance of Christmas."

"The year toward which we looked then with anticipation and hope has passed," Roosevelt goes on. "We have seen fulfilled many things that a year ago were only hopes. Our human life thus goes on from anticipation and hope to fulfillment. This year again, we are entitled to new hopes and new anticipations."

He goes on and he says, "Just across the street is the house he occupied 100 years ago, the house the people of the country have built for their Presidents. From its windows, I see this monument

to this man of courage." He is talking about Washington. "It is an inspiration to me as it should be to all Americans.

"And so let us make the spirit of Christmas of 1934 that of courage and unity. It is the way to greater happiness and well-being. That is, I believe, an important part of what the Maker of Christmas would have it mean.

"In this sense," Roosevelt says, "the scriptures admonish us to be strong and of good courage, to fear not, to dwell together in unity."

He said, "I wish you one and all, here and everywhere, a very, very Merry Christmas." Franklin Roosevelt.

I have a number of other speeches that he gave on Christmas. Time will not allow me to read all of those.

I will go to 1962, John F. Kennedy, when he said: "Ladies and gentlemen, Secretary Udall, members of the clergy: With the lighting of this tree, which is an old ceremony in Washington and one which has been among the most important responsibilities of a good many Presidents of the United States, we initiate, in a formal way, the Christmas season.

"We mark the festival of Christmas, which is the most sacred and hopeful day in our civilization. For nearly 2,000 years, the message of Christmas, the message of peace and goodwill towards all men, has been the guiding star of our endeavors.

"This morning, I had a meeting at the White House, which included some of our representatives from far countries in Africa and Asia. They were returning to their posts for the Christmas holidays. Talking with them afterwards, I was struck by the fact that, in the far-off continents, Muslims, Hindus, Buddhists, as well as Christians, pause from their labors on the 25th day of December to celebrate the birthday of the Prince of Peace.

"There could be no more striking proof that Christmas is truly the universal holiday of all men. It is the day when all of us dedicate our thoughts to others, when all are reminded that mercy and compassion are the enduring virtues, when all show by small deeds and large and by acts that it is more blessed to give than to receive."

He goes on to talk about the Christmas spirit.

As my time grows short here, I want to finish with a speech Ronald Reagan gave, his Christmas message in 1988.

He said: "The themes of Christmas and of coming home for the holidays have long been intertwined in song and story. There is a profound irony and lesson in this because Christmas celebrates the coming of a Savior who was born without a home.

"There was no room at the inn for the Holy Family. Weary of travel, a young Mary, close to childbirth, and her carpenter husband, Joseph, found but the rude shelter of a stable. There was born the King of Kings, the Prince

of Peace—an event on which all history would turn.

"Jesus would again be without a home, and more than once—on the flight to Egypt and during His public ministry when He said, 'The foxes have holes, and the birds of the air have nests, but the Son of man hath nowhere to lay his head.'"

Ronald Reagan goes on. "From His very infancy on, our Redeemer was reminding us that, from then on, we would never lack a home in Him. Like the shepherds to whom the angel of the Lord appeared on the first Christmas Day, we could always say, 'Let us now go even unto Bethlehem and see this thing which is come to pass, which the Lord hath made known unto us.'

"As we come home with gladness to family and friends this Christmas, let us also remember our neighbors who cannot go home themselves. Our compassion and concern this Christmas and all year long will mean much to the hospitalized, the homeless, the convalescent, the orphaned—and will surely lead us on our way to the joy and peace of Bethlehem and the Christ Child who bids us come. For it is only in finding and living the eternal meaning of the Nativity that we can be truly happy, truly at peace, truly home.

"Merry Christmas, and God bless you." Ronald Reagan.

Mr. Speaker, with that wish from Reagan, I do now hereby move that we adjourn.

BILLS AND JOINT RESOLUTIONS APPROVED BY THE PRESIDENT

The President notified the Clerk of the House that on the following dates he had approved and signed bills and joint resolutions of the following titles:

August 7, 2009:

H.R. 2245. An Act to authorize the President, in conjunction with the 40th anniversary of the historic and first lunar landing by humans in 1969, to award gold medals on behalf of the United States Congress to Neil A. Armstrong, the first human to walk on the moon; Edwin E. 'Buzz' Aldrin, Jr., the pilot of the lunar module and second person to walk on the moon; Michael Collins, the pilot of their Apollo 11 mission's command module; and, the first American to orbit the Earth, John Herschel Glenn, Jr.

H.R. 3114. An Act to authorize the Director of the United States Patent and Trademark Office to use funds made available under the Trademark Act of 1946 for patent operations in order to avoid furloughs and reductions-in-force, and for other purposes.

H.R. 3357. An Act to restore sums to the Highway Trust Fund, and for other purposes.

H.R. 3435. An Act making supplemental appropriations for fiscal year 2009 for the Consumer Assistance to Recycle and Save Program.

August 12, 2009:

H.R. 838. An Act to provide for the conveyance of a parcel of land held by the Bureau of Prisons of the Department of Justice in Miami Dade County, Florida, to facilitate the construction of a new educational facil-

ity that includes a secure parking area for the Bureau of Prisons, and for other purposes.

August 19, 2009:

H.J. Res. 44. A joint resolution recognizing the service, sacrifice, honor, and professionalism of the Noncommissioned Officers of the United States Army.

H.R. 774. An Act to designate the facility of the United States Postal Service located at 46-02 21st Street in Long Island City, New York, as the "Geraldine Ferraro Post Office Building".

H.R. 987. An Act to designate the facility of the United States Postal Service located at 601 8th Street in Freedom, Pennsylvania, as the "John Scott Challis, Jr. Post Office".

H.R. 1271. An Act to designate the facility of the United States Postal Service located at 2351 West Atlantic Boulevard in Pompano Beach, Florida, as the "Elijah Pat Larkins Post Office Building".

H.R. 1275. An Act to direct the exchange of certain land in Grand, San Juan, and Uintah Counties, Utah, and for other purposes.

H.R. 1397. An Act to designate the facility of the United States Postal Service located at 41 Purdy Avenue in Rye, New York, as the "Caroline O'Day Post Office Building".

H.R. 2090. An Act to designate the facility of the United States Postal Service located at 431 State Street in Ogdensburg, New York, as the "Frederic Remington Post Office Building".

H.R. 2162. An Act to designate the facility of the United States Postal Service located at 123 11th Avenue South in Nampa, Idaho, as the "Herbert A Littleton Postal Station".

H.R. 2325. An Act to designate the facility of the United States Postal Service located at 1300 Matamoros Street in Laredo, Texas, as the "Laredo Veterans Post Office".

H.R. 2422. An Act to designate the facility of the United States Postal Service located at 2300 Scenic Drive in Georgetown, Texas, as the "Kile G. West Post Office Building".

H.R. 2470. An Act to designate the facility of the United States Postal Service located at 19190 Cochran Boulevard FRNT in Port Charlotte, Florida, as the "Lieutenant Commander Roy H. Boehm Post Office Building".

H.R. 2938. An Act to extend the deadline for commencement of construction of a hydroelectric project.

September 18, 2009:

H.R. 3325. An Act to amend title XI of the Social Security Act to reauthorize for 1 year the Work Incentives Planning and Assistance program and the Protection and Advocacy for Beneficiaries of Social Security program.

September 30, 2009:

H.R. 1243. An Act to provide for the award of a gold medal on behalf of Congress to Arnold Palmer in recognition of his service to the Nation in promoting excellence and good sportsmanship in golf.

H.R. 3614. An Act to provide for an additional temporary extension of programs under the Small Business Act and the Small Business Investment Act of 1958, and for other purposes.

October 1, 2009:

H.R. 2918. An Act making appropriations for the Legislative Branch for the fiscal year ending September 30, 2010, and for other purposes.

H.R. 3607. An Act to amend the Internal Revenue Code of 1986 to extend the funding and expenditure authority of the Airport and Airway Trust Fund, to amend title 49, United States Code, to extend authorizations for the airport improvement program, and for other purposes.

October 9, 2009:

H.R. 2131. An Act to amend the Foreign Affairs Reform and Restructuring Act of 1998 to reauthorize the United States Advisory Commission on Public Diplomacy.

H.R. 3593. An Act to amend the United States International Broadcasting Act of 1994 to extend by one year the operation of Radio Free Asia, and for other purposes.

October 13, 2009:

H.R. 3663. An Act to amend title XVIII of the Social Security Act to delay the date on which the accreditation requirement under the Medicare Program applies to suppliers of durable medical equipment that are pharmacies.

October 19, 2009:

H.R. 1687. An Act to designate the federally occupied building located at McKinley Avenue and Third Street, SW., Canton, Ohio, as the "Ralph Regula Federal Building and United States Courthouse".

H.R. 2053. An Act to designate the United States courthouse located at 525 Magoffin Avenue in El Paso, Texas, as the "Albert Armendariz, Sr., United States Courthouse".

H.R. 2121. An Act to authorize the Administrator of General Services to convey a parcel of real property in Galveston, Texas, to the Galveston Historical Foundation.

H.R. 2498. An Act to designate the Federal building located at 844 North Rush Street in Chicago, Illinois, as the "William O. Lipinski Federal Building".

H.R. 2913. An Act to designate the United States courthouse located at 301 Simonton Street in Key West, Florida, as the "Sidney M. Aronovitz United States Courthouse".

October 21, 2009:

H.R. 2997. An Act making appropriations for Agriculture, Rural Development, Food and Drug Administration, and Related Agencies programs for the fiscal year ending September 30, 2010, and for other purposes.

October 22, 2009:

H.R. 1016. An Act to amend title 38, United States Code, to provide advance appropriations authority for certain accounts of the Department of Veterans Affairs, and for other purposes.

October 28, 2009:

H.R. 2647. An Act to authorize appropriations for fiscal year 2010 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

H.R. 2892. An Act making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2010, and for other purposes.

H.R. 3183. An Act making appropriations for energy and water development and related agencies for the fiscal year ending September 30, 2010, and for other purposes.

October 29, 2009:

H.R. 621. An Act to require the Secretary of the Treasury to mint coins in commemoration of the centennial of the establishment of the Girl Scouts of the United States of America.

October 30, 2009:

H.R. 2996. An Act making appropriations for the Department of the Interior, environment, and related agencies for the fiscal year ending September 30, 2010, and for other purposes.

November 6, 2009:

H.J. Res. 26. A joint resolution proclaiming Casimir Pulaski to be an honorary citizen of the United States posthumously.

H.R. 1209. An Act to require the Secretary of the Treasury to mint coins in recognition

and celebration of the establishment of the Medal of Honor in 1861, America's highest award for valor in action against an enemy force which can be bestowed upon an individual serving in the Armed Services of the United States, to honor the American military men and women who have been recipients of the Medal of Honor, and to promote awareness of what the Medal of Honor represents and how ordinary Americans, through courage, sacrifice, selfless service and patriotism, can challenge fate and change the course of history.

H.R. 3548. An Act to amend the Supplemental Appropriations Act, 2008 to provide for the temporary availability of certain additional emergency unemployment compensation, and for other purposes.

H.R. 3606. An Act to amend the Truth in Lending Act to make a technical correction to an amendment made by the Credit CARD Act of 2009.

November 30, 2009:

H.R. 955. An Act to designate the facility of the United States Postal Service located at 10355 Northeast Valley Road in Rollingbay, Washington, as the "John 'Bud' Hawk Post Office".

H.R. 1516. An Act to designate the facility of the United States Postal Service located at 37926 Church Street in Dade City, Florida, as the "Sergeant Marcus Mathes Post Office".

H.R. 1713. An Act to name the South Central Agricultural Research Laboratory of the Department of Agriculture in Lane, Oklahoma, and the facility of the United States Postal Service located at 310 North Perry Street in Bennington, Oklahoma, in honor of former Congressman Wesley 'Wes' Watkins.

H.R. 2004. An Act to designate the facility of the United States Postal Service located at 4282 Beach Street in Akron, Michigan, as the "Akron Veterans Memorial Post Office".

H.R. 2215. An Act to designate the facility of the United States Postal Service located at 140 Merriman Road in Garden City, Michigan, as the "John J. Shiven Post Office Building".

H.R. 2760. An Act to designate the facility of the United States Postal Service located at 1615 North Wilcox Avenue in Los Angeles, California, as the "Johnny Grant Hollywood Post Office Building".

H.R. 2972. An Act to designate the facility of the United States Postal Service located at 115 West Edward Street in Erath, Louisiana, as the "Conrad DeRouen, Jr. Post Office".

H.R. 3119. An Act to designate the facility of the United States Postal Service located at 867 Stockton Street in San Francisco, California, as the "Lim Poon Lee Post Office".

H.R. 3386. An Act to designate the facility of the United States Postal Service located at 1165 2nd Avenue in Des Moines, Iowa, as the "Iraq and Afghanistan Veterans Memorial Post Office".

H.R. 3547. An Act to designate the facility of the United States Postal Service located at 936 South 250 East in Provo, Utah, as the "Rex E. Lee Post Office Building".

December 15, 2009:

H.R. 4218. An Act to amend titles II and XVI of the Social Security Act to prohibit retroactive payments to individuals during periods for which such individuals are prisoners, fugitive felons, or probation or parole violators.

December 16, 2009:

H.R. 3288. An Act making appropriations for the Departments of Transportation, and Housing and Urban Development, and related

agencies for the fiscal year ending September 30, 2010, and for other purposes.

H.R. 4217. An Act to amend the Internal Revenue Code of 1986 to extend the funding and expenditure authority of the Airport and Airway Trust Fund, to amend title 49, United States Code, to extend authorizations for the airport improvement program, and for other purposes.

SENATE BILLS AND JOINT RESOLUTIONS APPROVED BY THE PRESIDENT

The President notified the Clerk of the House that on the following dates he had approved and signed bills and joint resolutions of the Senate of the following titles:

July 31, 2009:

S. 1513. An Act to provide for an additional temporary extension of programs under the Small Business Act and the Small Business Investment Act of 1958, and for other purposes.

August 12, 2009:

S. 1107. An Act to amend title 28, United States Code, to provide for a limited 6-month period for Federal judges to opt into the Judicial Survivors' Annuities System and begin contributing toward an annuity for their spouse and dependent children upon their death, and for other purposes.

August 19, 2009:

S.J. Res. 19. A joint resolution granting the consent and approval of Congress to amendments made by the State of Maryland, the Commonwealth of Virginia, and the District of Columbia to the Washington Metropolitan Area Transit Regulation Compact.

September 18, 2009:

S.J. Res. 9. A joint resolution providing for the appointment of France A. Cordova as a citizen regent of the Board of Regents of the Smithsonian Institution.

September 30, 2009:

S. 1677. An Act to reauthorize the Defense Production Act of 1950, and for other purposes.

October 15, 2009:

S. 1707. An Act to authorize appropriations for fiscal year 2010 through 2014 to promote and enhanced strategic partnership with Pakistan and its people, and for other purposes.

October 19, 2009:

S. 1289. An Act to improve title 18 of the United States Code.

October 26, 2009:

S. 1717. An Act to authorize major medical facility leases for the Department of Veterans Affairs for fiscal year 2010, and for other purposes.

October 30, 2009:

S. 1793. An Act to amend title XXVI of the Public Health Service Act to revise and extend the program for providing life-saving care for those with HIV/AIDS.

S. 1929. An Act to provide for an additional temporary extension of programs under the Small Business Act and the Small Business Investment Act of 1958, and for other purposes.

November 3, 2009:

S. 1818. An Act to amend the Morris K. Udall Scholarship and Excellence in National Environmental and Native American Public Policy Act of 1992 to honor the legacy of Stewart L. Udall, and for other purposes.

November 6, 2009:

S. 832. An Act to amend title 36, United States Code, to grant a Federal charter to the Military Officers Association of America, and for other purposes.

S. 1694. An Act to allow the funding for the interoperable emergency communications grant program established under the Digital Television Transition and Public Safety Act of 2005 to remain available until expended through fiscal year 2012, and for other purposes.

November 11, 2009:

S. 475. An Act to amend the Servicemembers Civil Relief Act to guarantee the equity of spouses of military personnel with regard to matters of residency, and for other purposes.

S. 509. An Act to authorize a major medical facility project at the Department of Veterans Affairs Medical Center, Walla Walla, Washington, and for other purposes.

November 30, 2009:

S. 748. An Act to redesignate the facility of the United States Postal Service located at 2777 Logan Avenue in San Diego, California, as the "Cesar E. Chavez Post Office".

S. 1211. An Act to designate the facility of the United States Postal Service located at 60 School Street, Orchard Park, New York, as the "Jack F. Kemp Post Office Building".

S. 1314. An Act to designate the facility of the United States Postal Service located at 630 Northeast Killingsworth Avenue in Portland, Oregon, as the "Dr. Martin Luther King, Jr. Post Office".

S. 1825. An Act to extend the authority for relocation expenses test programs for Federal employees, and for other purposes.

December 14, 2009:

S. 1599. An Act to amend title 38, United States Code, to include in the Federal charter of the Reserve Officers Association leadership positions newly added in its constitution and bylaws.

S. 1860. An Act to permit each current member of the Board of Directors of the Office of Compliance to serve for 3 terms.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. RADANOVICH (at the request of Mr. BOEHNER) for today on account of a family illness.

Mr. YOUNG of Florida (at the request of Mr. BOEHNER) for today after 1:30 p.m. on account of attending a family funeral.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. TONKO) to revise and extend their remarks and include extraneous material:)

Mr. CONYERS, for 5 minutes, today.

Ms. WOOLSEY, for 5 minutes, today.

Mr. POLIS, for 5 minutes, today.

Mr. DEFAZIO, for 5 minutes, today.

Mr. HOLT, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Mr. GRAYSON, for 5 minutes, today.

Mr. SPRATT, for 5 minutes, today.

(The following Members (at the request of Ms. FOXX) to revise and extend their remarks and include extraneous material:)

Mr. CASSIDY, for 5 minutes, today.

Mr. MCCOTTER, for 5 minutes, today.

Mr. ROYCE, for 5 minutes, today.

(The following Member (at her request) to revise and extend her remarks and include extraneous material:)

Ms. JACKSON-LEE of Texas, for 5 minutes, today.

SENATE ENROLLED BILL SIGNED

The Speaker announced her signature to an enrolled bill of the Senate of the following title:

S. 1472. An act to establish a section within the Criminal Division of the Department of Justice to enforce human rights laws, to make technical and conforming amendments to criminal and immigration laws pertaining to human rights violations, and for other purposes.

BILL PRESENTED TO THE PRESIDENT

Lorraine C. Miller, Clerk of the House reports that on December 16, 2009 she presented to the President of the United States, for his approval, the following bill.

H.J. Res. 62. Appointing the day for the convening of the second session of the One Hundred Eleventh Congress.

ADJOURNMENT

Mr. GOHMERT. Mr. Speaker, pursuant to section 11(b) of House Resolution 976, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 10 o'clock and 8 minutes p.m.), pursuant to section 11(b) of House Resolution 976, the House adjourned until Saturday, December 19, 2009, at 6 p.m., unless the conditions specified in section 11(c) of that resolution are met, in which case the House shall stand adjourned pursuant to House Concurrent Resolution 223.

EXPENDITURE REPORTS CONCERNING OFFICIAL FOREIGN TRAVEL

Reports concerning the foreign currencies and U.S. dollars utilized for Speaker-Authorized Official Travel during the third quarter and fourth quarter of 2009 pursuant to Public Law 95-384 are as follows:

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, DELEGATION TO JORDAN, LEBANON, PAKISTAN, AFGHANISTAN, AND NORWAY, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN NOV. 9 AND NOV. 16, 2009

Name of Member or employee	Date		Country	Per diem ¹		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²
Hon. David Price	11/10	11/11	Jordan .....	.....	369.00	.....	.....	.....	.....	.....	369.00
Hon. David Dreier	11/10	11/11	Jordan .....	.....	369.00	.....	.....	.....	.....	.....	369.00
Hon. Lois Capps	11/10	11/11	Jordan .....	.....	369.00	.....	.....	.....	.....	.....	369.00
Hon. Keith Ellison	11/10	11/11	Jordan .....	.....	369.00	.....	.....	.....	.....	.....	369.00
Hon. Mazie Hirono	11/10	11/11	Jordan .....	.....	369.00	.....	.....	.....	.....	.....	369.00
Hon. Charles Boustany	11/10	11/11	Jordan .....	.....	369.00	.....	.....	.....	.....	.....	369.00
John Lis	11/10	11/11	Jordan .....	.....	369.00	.....	.....	.....	.....	.....	369.00
Rachael Leman	11/10	11/11	Jordan .....	.....	369.00	.....	.....	.....	.....	.....	369.00
Asher Hildebrand	11/10	11/11	Jordan .....	.....	369.00	.....	.....	.....	.....	.....	369.00
Hon. David Price	11/11	11/14	Pakistan .....	.....	1,053.00	.....	.....	.....	.....	.....	1,053.00
Hon. David Dreier	11/11	11/14	Pakistan .....	.....	1,053.00	.....	.....	.....	.....	.....	1,053.00
Hon. Lois Capps	11/11	11/14	Pakistan .....	.....	1,053.00	.....	.....	.....	.....	.....	1,053.00
Hon. Keith Ellison	11/11	11/14	Pakistan .....	.....	1,053.00	.....	.....	.....	.....	.....	1,053.00
Hon. Mazie Hirono	11/11	11/14	Pakistan .....	.....	1,053.00	.....	.....	.....	.....	.....	1,053.00
Hon. Charles Boustany	11/11	11/14	Pakistan .....	.....	1,053.00	.....	.....	.....	.....	.....	1,053.00
John Lis	11/11	11/14	Pakistan .....	.....	1,053.00	.....	.....	.....	.....	.....	1,053.00
Rachael Leman	11/11	11/14	Pakistan .....	.....	1,053.00	.....	.....	.....	.....	.....	1,053.00
Asher Hildebrand	11/11	11/14	Pakistan .....	.....	1,053.00	.....	.....	.....	.....	.....	1,053.00
Hon. David Price	11/14	11/15	Afghanistan .....	.....	78.00	.....	.....	.....	.....	.....	78.00
Hon. David Dreier	11/14	11/15	Afghanistan .....	.....	78.00	.....	.....	.....	.....	.....	78.00
Hon. Lois Capps	11/14	11/15	Afghanistan .....	.....	78.00	.....	.....	.....	.....	.....	78.00
Hon. Keith Ellison	11/14	11/15	Afghanistan .....	.....	78.00	.....	.....	.....	.....	.....	78.00
Hon. Mazie Hirono	11/14	11/15	Afghanistan .....	.....	78.00	.....	.....	.....	.....	.....	78.00
Hon. Charles Boustany	11/14	11/15	Afghanistan .....	.....	78.00	.....	.....	.....	.....	.....	78.00
John Lis	11/14	11/15	Afghanistan .....	.....	78.00	.....	.....	.....	.....	.....	78.00
Rachael Leman	11/14	11/15	Afghanistan .....	.....	78.00	.....	.....	.....	.....	.....	78.00
Asher Hildebrand	11/14	11/15	Afghanistan .....	.....	78.00	.....	.....	.....	.....	.....	78.00
Hon. David Price	11/15	11/16	Norway .....	.....	453.00	.....	.....	.....	.....	.....	453.00

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, DELEGATION TO JORDAN, LEBANON, PAKISTAN, AFGHANISTAN, AND NORWAY, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN NOV. 9 AND NOV. 16, 2009—Continued

Name of Member or employee	Date		Country	Per diem ¹		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²
Hon. David Dreider	11/15	11/16	Norway		453.00						453.00
Hon. Lois Capps	11/15	11/16	Norway		453.00						453.00
Hon. Keith Ellison	11/15	11/16	Norway		453.00						453.00
Hon. Mazie Hirono	11/15	11/16	Norway		453.00						453.00
Hon. Charles Boustany	11/15	11/16	Norway		453.00						453.00
John Lis	11/15	11/16	Norway		453.00						453.00
Rachael Leman	11/15	11/16	Norway		453.00						453.00
Asher Hildebrand	11/15	11/16	Norway		453.00						453.00
Committee total											

¹ Per diem constitutes lodging and meals.² If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

HON. DAVID E. PRICE, Chairman.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, KAREN WAYLAND, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN NOV. 2 AND NOV. 8, 2009

Name of Member or employee	Date		Country	Per diem ¹		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²
Karen Wayland	11/2	11/8	Spain		1,248.00		5,972.20		698.52		7,918.72
Committee total					1,248.00		5,972.20		698.52		7,918.72

¹ Per diem constitutes lodging and meals.² If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

KAREN WAYLAND, Dec. 8, 2009.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON FINANCIAL SERVICES, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND SEPT. 30, 2009

Name of Member or employee	Date		Country	Per diem ¹		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²
Daniel McGinchee	7/16	7/29	Haiti		723.00		1,327.83				
Hon. Andre Carson	8/4	8/5	Kuwait		109.00		(³)				
	8/5	8/5	Iraq				(³)				
	8/5	8/7	United Arab Emirates	270.00			(³)				
	8/7	8/9	Germany		253.00		(³)				
Hon. Ruben Hinojosa	8/17	8/19	South Korea		798.88		(³)				
	8/19	8/20	China		291.31		(³)				
	8/20	8/22	Taiwan		661.26		(³)				
	8/22	8/24	Hong Kong		1,055.10		(³)				
Hon. Greg Meeks	8/27	8/30	Tunisia		723.00		(³)				
	8/30	9/2	Rwanda		640.00		(³)				
	9/2	9/3	Zimbabwe		317.00		(³)				
	9/3	9/4	Senegal		393.00		(³)				
Hon. Mel Watt	8/27	8/30	Tunisia		723.00		(³)				
	8/30	9/2	Rwanda		640.00		(³)				
	9/2	9/3	Zimbabwe		317.00		(³)				
	9/3	9/4	Senegal		393.00		(³)				
Stephane LeBouder	8/27	8/30	Tunisia		723.00		(³)				
	8/30	9/2	Rwanda		640.00		(³)				
	9/2	9/3	Zimbabwe		317.00		(³)				
	9/3	9/4	Senegal		393.00		(³)				
Sanders Adu	8/27	8/30	Tunisia		723.00		(³)				
	8/30	9/2	Rwanda		640.00		(³)				
	9/2	9/3	Zimbabwe		317.00		(³)				
	9/3	9/4	Senegal		393.00		(³)				
David Oxner	8/27	8/30	Tunisia		723.00		(³)				
	8/30	9/2	Rwanda		640.00		(³)				
	9/2	9/3	Zimbabwe		317.00		(³)				
	9/3	9/4	Senegal		393.00		(³)				
Eric Thompson	8/27	8/30	Tunisia		723.00		(³)				
	8/30	9/2	Rwanda		640.00		(³)				
	9/2	9/3	Zimbabwe		317.00		(³)				
	9/3	9/4	Senegal		393.00		(³)				
Hon. Paul Kanjorski	8/30	9/1	France		1,388.00		(³)				
	9/1	9/2	Belgium		523.00		(³)				
	9/2	9/7	United Kingdom		2,320.00		(³)				
Hon. Luis Gutierrez	8/30	9/1	France		1,388.00		(³)				
	9/1	9/2	Belgium		523.00		(³)				
	9/2	9/7	United Kingdom		2,320.00		(³)				
Hon. Scott Garrett	8/30	9/1	France		1,313.00		(³)				
	9/1	9/2	Belgium		523.00		(³)				
	9/2	9/7	United Kingdom		2,245.00		(³)				
Todd Harper	8/31	9/1	France		694.00		560.10				
	9/1	9/2	Belgium		480.00		(³)				
	9/2	9/7	United Kingdom		2,320.00		(³)				

¹ Per diem constitutes lodging and meals.² If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON FINANCIAL SERVICES FOR TRAVEL AUTHORIZED BY THE SPEAKER, U.S. HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN 7/1 AND 9/30, 2009

Name of Member or employee	Date		Country	Per diem ¹		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²	Foreign currency	U.S. dollar equivalent or U.S. currency ²
Kathleen Melody	8/30	9/1	France		1,388.00		(³)				
	9/1	9/2	Belgium		480.00		(³)				
	9/2	9/7	United Kingdom		2,320.00		(³)				
Karen Feather	8/30	9/1	France		1,388.00		(³)				
	9/1	9/2	Belgium		480.00		(³)				
	9/2	9/7	United Kingdom		2,320.00		(³)				
Cynthia Chetti	8/30	9/1	France		1,333.10		(³)				
	9/1	9/2	Belgium		436.80		(³)				
	9/2	9/7	United Kingdom		2,320.00		(³)				
Scott Eckel	8/30	9/1	France		1,298.00		(³)				
	9/1	9/2	Belgium		480.00		(³)				
	9/2	9/7	United Kingdom		2,170.00		(³)				
Amy Smith	8/30	9/1	France		1,300.00		(³)				
	9/1	9/2	Belgium		480.00		(³)				
	9/2	9/7	United Kingdom		2,217.00		(³)				
Hon. Gwen Moore	8/16	8/17	Liberia		536.40		(³)				
	8/17	8/19	Ghana		294.00		(³)				
	8/19	8/23	South Africa		1,806.07		(³)				
	8/23	8/24	Morocco		341.00		(³)				
Hon. Alan Grayson	6/27	6/29	Saudi Arabia		206.00		10,186.34				
	6/29	7/2	Pakistan		243.00		(³)				
Dennis Shaul	6/27	6/29	Saudi Arabia		206.00		10,186.34				
	6/29	7/2	Pakistan		286.00		(³)				
Matt Stoller	6/27	6/29	Saudi Arabia		206.00		10,186.34				
	6/29	7/02	Pakistan		286.00		(³)				
Committee total											

¹ Per diem constitutes lodging and meals.² If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.³ Military air transportation.

Hon. BARNEY FRANK, Chairman, Dec. 7, 2009.

EXECUTIVE COMMUNICATIONS,
ETC.

Under clause 2 of rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

5120. A letter from the Deputy Secretary, Department of Defense, transmitting authorization of 12 officers to wear the authorized insignia of the grade of major general, pursuant to 10 U.S.C. 777; to the Committee on Armed Services.

5121. A letter from the Secretary, Securities and Exchange Commission, transmitting the Commission's final rule — Amendments to Rules For Nationally Recognized Statistical Rating Organizations [Release No. 34-61050; File No. S7-04-09] (RIN: 3235-AK14) received November 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

5122. A letter from the Assistant General Counsel for Legislation, Regulation and Energy Efficiency, Department of Energy, transmitting the Department's "Major" final rule — Loan Guarantees for Projects That Employ Innovative Technologies (RIN: 1901-AB27) received December 9, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5123. A letter from the Secretary, Department of Health and Human Services, transmitting the annual financial report to Congress required by the Medical Device User Fee and Modernization Act of 2002 (MDUFMA), covering FY 2008; to the Committee on Energy and Commerce.

5124. A letter from the Deputy Assistant Secretary for Export Administration, Department of Commerce, transmitting the Department's final rule — Wassenaar Arrangement 2008 Plenary Agreements Implementation: Categories 1, 2, 3, 4, 5 Parts I and II, 6, 7, 8, and 9 of the Commerce Control List, Definitions, Reports [Docket No.: 0908041218-91220-01] (RIN: 0694 AE58) received December 2, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Foreign Affairs.

5125. A letter from the Secretary, Department of Veterans Affairs, transmitting the Inspector General's semiannual report to Congress for the reporting period April 1, 2009 through September 30, 2009, pursuant to 5 U.S.C. app. (Insp. Gen. Act) section 5(b); to the Committee on Oversight and Government Reform.

5126. A letter from the Secretary, Department of Education, transmitting the fifty-ninth Semiannual Report to Congress on Audit Follow-Up, covering the period April 1, 2009 through September 30, 2009, pursuant to 5 U.S.C. app. (Insp. Gen. Act) section 5(b); to the Committee on Oversight and Government Reform.

5127. A letter from the Federal Co-Chair, Appalachian Regional Commission, transmitting the Commission's semiannual report from the office of the Inspector General for the period April 1, 2009 through September 30, 2009, pursuant to Section 5(b) of the Inspector General Act of 1978; to the Committee on Oversight and Government Reform.

5128. A letter from the Chairman, Broadcasting Board of Governors, transmitting the semiannual report on the activities of the Office of Inspector General for the period from April 1, 2009 to September 30, 2009, pursuant to 5 U.S.C. app. (Insp. Gen. Act), section 5(b); to the Committee on Oversight and Government Reform.

5129. A letter from the Acting Chief Executive Officer, Corporation for National and Community Service, transmitting the Inspector General's semiannual report to Congress for the reporting period April 1, 2009 through September 30, 2009; to the Committee on Oversight and Government Reform.

5130. A letter from the Associate General Counsel for General Law, Department of Homeland Security, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5131. A letter from the Secretary, Department of Labor, transmitting the Board's

semiannual report from the office of the Inspector General for the period April 1, 2009 through September 30, 2009, pursuant to Section 5(b) of the Inspector General Act of 1978; to the Committee on Oversight and Government Reform.

5132. A letter from the Acting Director, Office of Communications and Legislative Affairs, Equal Employment Opportunity Commission, transmitting the Commission's Fiscal Year 2009 Performance and Accountability Report; to the Committee on Oversight and Government Reform.

5133. A letter from the Chairman, Federal Communications Commission, transmitting Commission's Fiscal Year 2009 Agency Financial Report; to the Committee on Oversight and Government Reform.

5134. A letter from the Senior Procurement Executive, General Services Administration, transmitting the Administration's final rule — Federal Acquisition Regulation; Federal Acquisition Circular 2005-37; Introduction [Docket: FAR 2009-0001, Sequence 8] received October 16, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Oversight and Government Reform.

5135. A letter from the Senior Procurement Executive, General Services Administration, transmitting the Administration's final rule — Federal Acquisition Regulation; FAR Case 2008-035; Registry of Disaster Response Contractors [FAC 2005-37; FAR Case 2008-035; Item I; Docket 2009-0033, Sequence 1] (RIN: 9000-AL30) received October 16, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Oversight and Government Reform.

5136. A letter from the Senior Procurement Executive, General Services Administration, transmitting the Administration's final rule — Federal Acquisition Regulation; FAR Case 2007-008, Limiting Length of Noncompetitive Contracts in "Unusual and Compelling Urgency" Circumstances [FAC 2005-37; FAR Case 2007-008; Item II; Docket 2007-0001, Sequence 14] (RIN: 9000-AK90) received October 16, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Oversight and Government Reform.

5137. A letter from the Senior Procurement Executive, General Services Administration, transmitting the Administration's final rule — Federal Acquisition Regulation; FAR Case 2008-026, GAO Access to Contractor Employees [FAC 2005-37; FAR Case 2008-026; Item III; Docket 2009-0013, Sequence 1] (RIN: 9000-AL25) received October 16, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Oversight and Government Reform.

5138. A letter from the Senior Procurement Executive, General Services Administration, transmitting the Administration's final rule — Federal Acquisition Regulation; FAR Case 2008-034, Use of Commercial Services Item Authority [FAC 2005-37; FAR Case 2008-034; Item IV; Docket 2009-0035, Sequence 1] (RIN: 9000-AL44) received October 16, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Oversight and Government Reform.

5139. A letter from the Senior Procurement Executive, General Services Administration, transmitting the Administration's final rule — Federal Acquisition Regulation; FAR Case 2008-0031, Limitations on Pass-Through Charges [FAC 2005-37; FAR Case 2008-031; Item V; Docket 2009-0034, Sequence 1] (RIN: 9000-AL27) received October 16, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Oversight and Government Reform.

5140. A letter from the Senior Procurement Executive, General Services Administration, transmitting the Administration's final rule — Federal Acquisition Regulation; FAR Case 2008-008, Award Fee Language Revision [FAC 2005-37; FAR Case 2008-008; Item VI; Docket 2009-0036, Sequence 1] (RIN: 9000-AL42) received October 16, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Oversight and Government Reform.

5141. A letter from the Senior Procurement Executive, General Services Administration, transmitting the Administration's final rule — Federal Acquisition Regulation; FAR Case 2009-003, National Response Framework [FAC 2005-37; FAR Case 2009-003; Item VII; Docket 2009-0037; Sequence 1] (RIN: 9000-AL37) received October 16, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Oversight and Government Reform.

5142. A letter from the Senior Procurement Executive, General Services Administration, transmitting the Administration's final rule — Federal Acquisition Regulation; Technical Amendments [FAC 2005-37; Item VIII; Docket 2009-0009; Sequence 5] received October 16, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Oversight and Government Reform.

5143. A letter from the Senior Procurement Executive, General Services Administration, transmitting the Administration's final rule — Federal Acquisition Regulation; Federal Acquisition Circular 2005-37; Small Entity Compliance Guide [Docket: FAR 2009-0002, Sequence 8] received October 16, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Oversight and Government Reform.

5144. A letter from the Acting Deputy Director, International Broadcasting Bureau, transmitting Federal Information Security Management Act (FISMA) Report; to the Committee on Oversight and Government Reform.

5145. A letter from the Director, Office of Government Ethics, transmitting the Office's Performance Accountability Report for Fiscal Year 2009; to the Committee on Oversight and Government Reform.

5146. A letter from the General Counsel, Pension Benefit Guaranty Corporation, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5147. A letter from the Chairman, Postal Service, transmitting the Semiannual Report of the Inspector General on the Audit, Investigative, and Security Activities of the Postal Service (SAR) for the period of April 1, 2009 through September 30, 2009, pursuant to 5 U.S.C. app. (Insp. Gen. Act), section 5(b); to the Committee on Oversight and Government Reform.

5148. A letter from the Chairman, Railroad Retirement Board, transmitting the Board's Office of Inspector General Semiannual Report for the period April 1, 2009 through September 30, 2009, pursuant to Public Law 95-452, section 5; to the Committee on Oversight and Government Reform.

5149. A letter from the Board Members, Railroad Retirement Board, transmitting the Board's Performance and Accountability Report for Fiscal Year 2009, including the Office of Inspector General's Auditor's Report; to the Committee on Oversight and Government Reform.

5150. A letter from the Chief Human Capital Officer, Small Business Administration, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5151. A letter from the Secretary, Department of the Interior, transmitting notification that the Department intends to accept a donation of two contiguous tracts of land totaling 79.97 acres within Lassen Volcanic National Park, pursuant to 16 U.S.C. 1135(a); to the Committee on Natural Resources.

5152. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Reallocation of Halibut in the Gulf of Alaska [Docket No.: 09100091344-9056-02] (RIN: 0648-XS89) received December 1, 2009; to the Committee on Natural Resources.

5153. A letter from the Deputy Assistant Administrator For Regulatory Programs, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Snapper-Grouper Fishery off the Southern Atlantic States; Amendment 15B; Reef Fish Fishery of the Gulf of Mexico [Docket No.: 080226312-91249-03] (RIN: 0648-AW12) received December 1, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

5154. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Magnuson-Stevens Act Provisions; Fisheries off West Coast States; Pacific Coast Groundfish Fishery; Biennial Specifications and Management Measures; Inseason Adjustments [Docket No.: 0809121213-9221-02] (RIN: 0648-AY30) received December 2, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

5155. A letter from the Acting Assistant Administrator for Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Northeastern United States; Modification to the Gulf of Maine/ Georges Bank Herring Midwater Trawl Gear Letter of Authorization [Docket No.: 0907281181-91369-02] (RIN: 0648-AX93) received December 1, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

5156. A letter from the Acting Assistant Administrator For Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska, Groundfish Observer Program; Correction [Docket No.: 090601946-91010-01] (RIN: 0648-AX94) received October 28, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

5157. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Airbus Model A318-111, -112, A319, A320, and A321 Series Airplanes [Docket No.: FAA-2008-1215; Directorate Identifier 2008-NM-072-AD; Amendment 39-16077; AD 2009-23-05] (RIN: 2120-AA64) November 24, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5158. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 767 Airplanes [Docket No.: FAA-2007-28281; Directorate Identifier 2006-NM-238-AD; Amendment 39-16076; AD 2009-23-04] (RIN: 2120-AA64) received November 24, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5159. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model CL-600-1A11 (CL-600), CL-600-2A12 (CL-601), CL-600-2B16 (CL-601-3A) Airplanes [Docket No.: FAA-2009-0689; Directorate Identifier 2009-NM-092-AD; Amendment 39-16081; AD 2009-23-09] (RIN: 2120-AA64) November 24, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5160. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model CL-600-2B19 (Regional Jet Series 100 & 440) Airplanes [Docket No.: FAA-2009-0310; Directorate Identifier 2009-NM-012-AD; Amendment 39-16073; AD 2009-23-02] (RIN: 2120-AA64) November 24, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5161. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Hawker Beechcraft Corporation (Type Certificate previously held by Raytheon Aircraft Company) Models 1900, 1900C, and 1900D Airplanes [Docket No.: FAA-2009-0165; Directorate Identifier 2008-CE-055-AD; Amendment 39-16075; AD 2009-23-03] (RIN: 2120-AA64) November 24, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5162. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; PIAGGIO AERO INDUSTRIES S.p.A. Model PIAGGIO P-180 Airplanes [Docket No.: FAA-2009-0699; Directorate Identifier 2009-CE-042-AD; Amendment 39-16047; AD 2009-21-08] (RIN: 2120-AA64) November 24, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5163. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Saab AB, Saab Aerosystems Model SAAB 340A (SAAB/SF340A) SAAB 340B Airplanes [Docket No.: FAA-2009-0134; Directorate Identifier 2008-NM-162-AD; Amendment 39-16079; AD 2009-23-07] (RIN: 2120-AA64) November 24, 2009, pursuant to 5 U.S.C.

801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5164. A letter from the Program Analyst, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; SOCAT Model TBM 700 Airplanes [Docket No.: FAA-2009-0557; Directorate Identifier 2009-CE-031-AD; Amendment 39-16086; AD 2009-23-12] (RIN: 2120-AA64) November 24, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5165. A letter from the Assistant Secretary, Employment and Training Administration, Department of Labor, transmitting the Department's final rule — ETA Explains Changes made to TAA Program By Globalization Adjustment Assistance Act received November 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5166. A letter from the Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting the Service's final rule — 2010 Limitations Adjusted As Provided in Section 415(d), etc. [Notice 2009-94] received November 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5167. A letter from the Chief, Publications and Regulations, Internal Revenue Service, transmitting the Service's final rule — Agreements for Payment of Tax Liabilities in Installments [TD 9473] (RIN: 1545-AU97) received November 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5168. A letter from the Chief, Publications and Regulations, Internal Revenue Service, transmitting the Service's final rule — Publication of the Tier 2 Tax Rates received November 30, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5169. A letter from the Chief, Publications and Regulations, Internal Revenue Service, transmitting the Service's final rule — Notice Requirements for Certain Pension Plan Amendments Significantly Reducing the Rate of Future Benefit Accrual [TD 9472] (RIN: 1545-BG48), pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5170. A letter from the Chairman, Commission on Civil Rights, transmitting a report entitled "Civil Rights and the Mortgage Crisis"; jointly to the Committees on the Judiciary and Financial Services.

5171. A letter from the Inspector General, Department of Health and Human Services, transmitting a report entitled "Review of Medicare Contractor Information Security Program Evaluations for Fiscal Year 2006"; jointly to the Committees on Ways and Means and Energy and Commerce.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Ms. PINGREE of Maine: Committee on Rules. House Resolution 976. Resolution providing for consideration of the Senate amendment to the bill (H.R. 3326) making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; for consideration of the joint resolution (H.J. Res. 64) making further continuing appropriations for fiscal year 2010, and for other purposes; for consid-

eration of the bill (H.R. 4314) to permit continued financing of Government operations; for consideration of the Senate amendment to the bill (H.R. 2847) making appropriations for the Departments of Commerce and Justice, and Science, and Related Agencies for the fiscal year ending September 30, 2010, and for other purposes; (Rept. 111-380). Referred to the House Calendar.

Mr. WAXMAN. Committee on Energy and Commerce. H.R. 2190. A bill to amend the Toxic Substance Control Act to phase out the use of mercury in the manufacture of chlorine and caustic soda, and for other purposes; with an amendment (Rept. 111-381). Referred to the Committee of the Whole House on the State of the Union.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions of the following titles were introduced and severally referred, as follows:

By Mr. SCOTT of Virginia (for himself, Mr. CONYERS, Mr. SMITH of Texas, Mr. NADLER of New York, Mr. DELAHUNT, Mr. COBLE, and Mr. DANIEL E. LUNGREN of California):

H.R. 4326. A bill to provide appropriate protection to attorney-client privileged communications and attorney work product; to the Committee on the Judiciary.

By Mr. SCOTT of Virginia:

H.R. 4327. A bill to amend title 18, United States Code, with respect to the good time credit toward service of sentences of imprisonment; to the Committee on the Judiciary.

By Mr. SCOTT of Virginia (for himself, Mr. CONYERS, and Mr. LEWIS of Georgia):

H.R. 4328. A bill to amend title 18, United States Code, to award credit toward the service of a sentence to prisoners who participate in designated educational, vocational, treatment, assigned work, or other developmental programs, and for other purposes; to the Committee on the Judiciary.

By Mr. WITTMAN:

H.R. 4329. A bill to require the Secretary of the Treasury to mint coins in commemoration of President James Monroe, and for other purposes; to the Committee on Financial Services.

By Mr. POLIS (for himself, Ms. BERKLEY, Mr. CAO, Ms. DEGETTE, Mr. EHLERS, Mr. HIMES, Mr. HINOJOSA, Mr. HOLT, Mr. KLEIN of Florida, Ms. KOSMAS, Mr. MURPHY of Connecticut, Mr. PATRICK J. MURPHY of Pennsylvania, Ms. NORTON, Mr. PAULSEN, Mr. PERLMUTTER, and Mr. PERRIELLO):

H.R. 4330. A bill to provide high-quality public charter school options for students by enabling such public charter schools to expand and replicate; to the Committee on Education and Labor.

By Mr. BACHUS (for himself, Mr. GUTIERREZ, and Mr. TIBERI):

H.R. 4331. A bill to amend title 31, United States Code, to establish the Office of Money Services Business Compliance within the Department of the Treasury for the purpose of assuring compliance with subchapter II of chapter 53 of such title by money services businesses and such other duties as the Secretary of the Treasury may delegate, and for other purposes; to the Committee on Financial Services.

By Mr. MCKEON:

H.R. 4332. A bill to provide to the Secretary of Interior a mechanism to cancel contracts for the sale of materials CA-20139 and CA-

22901, and for other purposes; to the Committee on Natural Resources, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. FARR (for himself, Mr. PUTNAM, Ms. RICHARDSON, Mr. BLUMENAUER, Mr. KAGEN, Mr. MICHAUD, Ms. JACKSON-LEE of Texas, Mr. HINCHHEY, Ms. MATSUI, Ms. WASSERMAN SULTZ, Mr. MORAN of Virginia, Mr. COSTA, Mr. SERRANO, Mr. COURTNEY, Ms. HIRONO, and Mrs. CAPPS):

H.R. 4333. A bill to amend the Richard B. Russell National School Lunch Act to improve the health and well-being of school children, and for other purposes; to the Committee on Education and Labor, and in addition to the Committee on Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. BRIGHT (for himself and Mr. ELLSWORTH):

H.R. 4334. A bill to provide grants for the renovation, modernization, and construction of law enforcement facilities; to the Committee on the Judiciary.

By Mr. SCOTT of Virginia:

H.R. 4335. A bill to provide for the redress of prison abuses, and for other purposes; to the Committee on the Judiciary.

By Mr. DEAL of Georgia (for himself, Mr. GINGREY of Georgia, Mr. WESTMORELAND, Mr. LINDER, and Mr. PAUL):

H.R. 4336. A bill to provide that pay for Members of Congress be reduced following any fiscal year in which there is a Federal deficit; to the Committee on House Administration, and in addition to the Committee on Oversight and Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. RANGEL (for himself, Mr. NEAL of Massachusetts, Mr. CROWLEY, and Ms. SCHWARTZ):

H.R. 4337. A bill to amend the Internal Revenue Code of 1986 to modify certain rules applicable to regulated investment companies, and for other purposes; to the Committee on Ways and Means.

By Mr. MELANCON:

H.R. 4338. A bill to amend the Omnibus Crime Control and Safe Streets Act of 1968 to provide adequate benefits for public safety officers injured or killed in the line of duty, and for other purposes; to the Committee on the Judiciary.

By Mr. SABLON:

H.R. 4339. A bill to encourage students from the Commonwealth of the Northern Mariana Islands to become civically engaged through local and Federal government fellowships; to the Committee on Natural Resources.

By Mr. DAVIS of Alabama:

H.R. 4340. A bill to require the Secretary of the Treasury to establish a revolving loan fund program for certain businesses to facilitate increased lending in the United States; to the Committee on Financial Services.

By Mr. RYAN of Ohio (for himself, Mr. KENNEDY, Mr. HINCHHEY, and Mr. ISRAEL):

H.R. 4341. A bill to amend the Federal Food, Drug, and Cosmetic Act to require a warning on the label of any food container that is composed, in whole or in part, of

bisphenol A or could release bisphenol A into food; to the Committee on Energy and Commerce.

By Mr. McCOTTER (for himself and Mr. BACHUS):

H.R. 4342. A bill to amend the Emergency Economic Stabilization Act of 2008 to terminate the Secretary of the Treasury's authority under the Troubled Asset Relief Program, and for other purposes; to the Committee on Financial Services.

By Mr. RUSH:

H.R. 4343. A bill to establish in the Department of Commerce the Minority Business Development Program to provide qualified minority businesses with technical assistance, loan guarantees, and contracting opportunities, and for other purposes; to the Committee on Financial Services, and in addition to the Committee on Oversight and Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. McCOTTER (for himself, Mr. BURTON of Indiana, and Mr. TIBERI):

H.R. 4344. A bill to prohibit the Environmental Protection Agency from obligating any amounts for the regulation of emissions of carbon dioxide; to the Committee on Energy and Commerce.

By Mr. DAVIS of Alabama (for himself, Mr. BRIGHT, Mr. ROGERS of Alabama, Mr. GRIFFITH, Mr. BONNER, Mr. BACHUS, and Mr. ADERHOLT):

H.R. 4345. A bill to establish the Alabama Black Belt National Heritage Area, and for other purposes; to the Committee on Natural Resources.

By Mr. CONYERS (for himself, Mr. DANIEL E. LUNGREN of California, Ms. JACKSON-LEE of Texas, and Mr. HASTINGS of Florida):

H.R. 4346. A bill to establish a commission to commemorate the ending of chattel slavery in the United States, and for other purposes; to the Committee on the Judiciary.

By Mr. BOREN (for himself and Mr. WALZ):

H.R. 4347. A bill to amend the Indian Self-Determination and Education Assistance Act to provide further self-governance by Indian tribes, and for other purposes; to the Committee on Natural Resources.

By Mr. WITTMAN:

H.R. 4348. A bill to amend the Internal Revenue Code of 1986 to allow a credit against income tax for expenses incurred in teleworking; to the Committee on Ways and Means.

By Mrs. NAPOLITANO (for herself, Mr. BACA, Mr. BECERRA, Ms. BERKLEY, Mr. BERMAN, Mr. BILBRAY, Mrs. BONO MACK, Mr. CALVERT, Mr. CAMPBELL, Mrs. CAPPS, Ms. CHU, Mr. COSTA, Mrs. DAVIS of California, Mr. DREIER, Mr. FRANKS of Arizona, Mr. GALLEGLY, Mr. GARAMENDI, Mr. GRIJALVA, Ms. HARMAN, Mr. HELLER, Mr. HONDA, Mr. HUNTER, Mr. ISSA, Ms. LEE of California, Mr. LEWIS of California, Ms. MATSUI, Mr. MCCARTHY of California, Mr. MCKEON, Mr. GARY G. MILLER of California, Mr. GEORGE MILLER of California, Ms. RICHARDSON, Ms. ROYBAL-ALLARD, Mr. ROYCE, Ms. LINDA T. SANCHEZ of California, Ms. LORETTA SANCHEZ of California, Mr. SHADEGG, Mr. SHERMAN, Mr. SCHIFF, Ms. TITUS, Ms. WATERS, Ms. WATSON, Mr. WAXMAN, Ms. WOOLSEY, and Mr. FLAKE):

H.R. 4349. A bill to further allocate and expand the availability of hydroelectric power

generated at Hoover Dam, and for other purposes; to the Committee on Natural Resources.

By Mr. ISSA (for himself, Mr. REYES, Mr. SKELTON, Mr. HOEKSTRA, Mr. MCKEON, and Mr. TOWNS):

H.R. 4350. A bill to amend the Immigration and Nationality Act to provide for non-immigrant status for an alien who is the parent or legal guardian of a United States citizen child if the child was born abroad and is the child of a deceased member of the Armed Forces of the United States; to the Committee on the Judiciary.

By Mr. LIPINSKI (for himself, Ms. EDWARDS of Maryland, Ms. KAPTUR, Mr. MICHAUD, Mr. MASSA, Mr. COSTELLO, Mr. GRIJALVA, Mr. STARK, Mr. BRALEY of Iowa, Mr. HARE, Mr. VISCLOSKEY, Mr. SCHAUER, Ms. SHEA-PORTER, Mr. MURPHY of Connecticut, Mr. DEFazio, Ms. SUTTON, Mr. KAGEN, and Ms. LINDA T. SANCHEZ of California):

H.R. 4351. A bill to amend the Buy American Act to increase the requirement for American-made content, to tighten the waiver provisions, and for other purposes; to the Committee on Oversight and Government Reform.

By Mr. MCCARTHY of California:

H.R. 4352. A bill to amend the Federal Water Pollution Control Act to authorize additional assistance for projects to construct publicly owned treatment works that serve small and disadvantaged communities, and for other purposes; to the Committee on Transportation and Infrastructure.

By Mr. RUSH:

H.R. 4353. A bill to require the Federal Communications Commission to authorize access by owners and operators of certain wireless microphones to a geolocation database maintained for the purpose of prohibiting the operation of unlicensed TV band devices on protected frequencies, and for other purposes; to the Committee on Energy and Commerce.

By Mrs. DAVIS of California (for herself and Mr. PLATTS):

H.R. 4354. A bill to recruit, support, and prepare principals to improve student academic achievement at high-need schools; to the Committee on Education and Labor.

By Ms. JACKSON-LEE of Texas:

H.R. 4355. A bill to authorize the Secretary of Labor to make grants to States, units of local government, and Indian tribes to carry out employment training programs; to the Committee on Education and Labor.

By Mr. ACKERMAN (for himself, Mr. LATOURETTE, Mr. GRIJALVA, Mr. ISRAEL, Mr. CASTLE, Ms. SHEA-PORTER, Mr. MOORE of Kansas, Mr. NADLER of New York, Ms. MOORE of Wisconsin, Ms. EDDIE BERNICE JOHNSON of Texas, Ms. SUTTON, Mr. MORAN of Virginia, Mr. SHULER, Mr. KING of New York, Mr. LEWIS of Georgia, Mr. SHERMAN, Ms. JACKSON-LEE of Texas, Mr. HINCHEY, Mr. JACKSON of Illinois, Mr. BLUMENAUER, Mrs. LOWEY, Ms. SCHAKOWSKY, Mr. KUCINICH, Mr. GEORGE MILLER of California, Mr. MICHAUD, Mr. CROWLEY, Mr. GERLACH, Mr. CUMMINGS, Mr. MARKEY of Massachusetts, Mr. INSLEE, Mr. DOYLE, Mr. SERRANO, and Ms. LEE of California):

H.R. 4356. A bill to amend the Humane Methods of Slaughter Act of 1958 to ensure the humane slaughter of nonambulatory cattle, and for other purposes; to the Committee on Agriculture.

By Mr. BACA (for himself and Mr. GENE GREEN of Texas):

H.R. 4357. A bill to use amounts repaid to the Treasury under the Troubled Assets Relief Program for relief to displaced and low-wage workers, and for other purposes; to the Committee on Financial Services, and in addition to the Committees on Education and Labor, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. BALDWIN:

H.R. 4358. A bill to amend the Child Care and Development Block Grant Act of 1990 to improve access to high-quality early learning and child care for low-income children and working families, and for other purposes; to the Committee on Education and Labor.

By Mr. BOOZMAN (for himself and Mr. WALZ):

H.R. 4359. A bill to amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to guarantee housing loans for the construction energy efficient dwellings, and for other purposes; to the Committee on Veterans' Affairs.

By Mr. CAMPBELL (for himself, Mr. ROHRBACHER, Mr. FILNER, Mr. MCCARTHY of California, Mr. HUNTER, Mr. DANIEL E. LUNGREN of California, Mr. RADANOVICH, Mr. CALVERT, Mr. WAXMAN, Mrs. DAVIS of California, Mr. LEWIS of California, Mr. MCKEON, Mr. MCCLINTOCK, Ms. RICHARDSON, Mr. GALLEGLY, Ms. WATSON, Mr. DREIER, Ms. ZOE LOFGREN of California, Ms. LINDA T. SANCHEZ of California, Ms. SPEIER, Mr. SHERMAN, Mr. COSTA, Mr. ISSA, Mr. NUNES, Mrs. BONO MACK, Mr. ROYCE, Mr. BACA, Ms. LORETTA SANCHEZ of California, Mr. BERMAN, Ms. CHU, Mr. MCNERNEY, Mr. HERGER, Mr. SCHIFF, Mr. CARDOZA, and Ms. HARMAN):

H.R. 4360. A bill to designate the Department of Veterans Affairs blind rehabilitation center in Long Beach, California, as the "Major Charles R. Soltes, Jr., O.D. Department of Veterans Affairs Blind Rehabilitation Center"; to the Committee on Veterans' Affairs.

By Mr. CAMPBELL:

H.R. 4361. A bill to amend the Internal Revenue Code of 1986 to eliminate contribution limitations for retirement plans and increase penalties attributable to such contributions; to the Committee on Ways and Means.

By Mr. CAO:

H.R. 4362. A bill to amend the Internal Revenue Code of 1986 to exclude from gross income remediation payments for hazardous drywall; to the Committee on Ways and Means.

By Mrs. CAPPS:

H.R. 4363. A bill to establish a regulatory system and research program for sustainable offshore aquaculture in the United States exclusive economic zone, and for other purposes; to the Committee on Natural Resources.

By Mr. COHEN:

H.R. 4364. A bill to protect first amendment rights of petition and free speech by preventing States and the United States from allowing meritless lawsuits arising from acts in furtherance of those rights, commonly called "SLAPPs", and for other purposes; to the Committee on the Judiciary.

By Mr. MARIO DIAZ-BALART of Florida:

H.R. 4365. A bill to limit the distribution of funds for campaign-related work under the

American Recovery and Reinvestment Act of 2009, to reduce the deficit, and for other purposes; to the Committee on Oversight and Government Reform.

By Mr. DONNELLY of Indiana:

H.R. 4366. A bill to amend the Internal Revenue Code of 1986 to extend the deduction for qualified motor vehicle taxes for motor homes; to the Committee on Ways and Means.

By Mr. ELLISON (for himself and Mr. DEFAZIO):

H.R. 4367. A bill to alter requirements relating to recommendations for funding by the Federal Transit Administration of fixed guideway projects, and for other purposes; to the Committee on Transportation and Infrastructure.

By Mr. ENGEL (for himself, Mr. MEEKS of New York, Mr. HONDA, Mr. SRES, Mr. MCGOVERN, and Ms. LEE of California):

H.R. 4368. A bill to authorize the establishment of a Social Investment and Economic Development for the Americas Fund to reduce poverty, expand the middle class, and foster increased economic opportunity in that region, and for other purposes; to the Committee on Foreign Affairs.

By Mr. FRANK of Massachusetts (for himself, Mr. TIERNEY, Mr. JONES, and Ms. PINGREE of Maine):

H.R. 4369. A bill to allow the United States-Canada Transboundary Resource Sharing Understanding to be considered an international agreement for the purposes of section 304(e)(4) of the Magnuson-Stevens Fishery Conservation and Management Act; to the Committee on Natural Resources.

By Mr. GONZALEZ (for himself and Ms. NORTON):

H.R. 4370. A bill to require railroad carriers to prepare and maintain a plan for notifying local emergency responders before transporting hazardous materials through their jurisdictions; to the Committee on Transportation and Infrastructure.

By Mr. GONZALEZ (for himself, Mr. ORTIZ, Mr. BOREN, Mr. GRIFFITH, Mr. THORNBERRY, Mr. MEEK of Florida, Mr. COURTNEY, Mr. GARRETT of New Jersey, Mr. ARCURI, Mr. CARNAHAN, Mr. HALL of Texas, Mr. RUPPERSBERGER, Mr. MORAN of Virginia, Mr. SCOTT of Georgia, Mr. AKIN, Mr. PITTS, Mr. CUELLAR, Mr. KAGEN, Mr. MCINTYRE, Mr. GRAYSON, Mrs. MCCARTHY of New York, Mr. BISHOP of Georgia, Mr. CUMMINGS, Mr. MASSA, Mr. BARTLETT, Mr. COHEN, Mr. PETERS, Mr. BERRY, Mr. HIMES, Ms. MCCOLLUM, Mr. BISHOP of New York, Mrs. LOWEY, Mr. MAFFEI, Mr. CLAY, Mr. MURPHY of New York, Mrs. CHRISTENSEN, Mr. KRATOVIL, Mr. ROE of Tennessee, Mr. WITTMAN, Mr. BUTTERFIELD, Mr. ISRAEL, Mr. LUETKEMEYER, Mr. RUSH, Mr. MARCHANT, Mr. HILL, Ms. WASSERMAN SCHULTZ, Mr. LINCOLN DIAZ-BALART of Florida, Ms. NORTON, Mr. LOBIONDO, Ms. KOSMAS, Mr. DENT, Mr. FALCONE, Mrs. BIGGERT, Mr. ADLER of New Jersey, Mr. GERLACH, and Mr. PAUL):

H.R. 4371. A bill to amend title XVIII of the Social Security Act to continue using 2009 Medicare practice expense relative value units for certain cardiology services; to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. GRAVES (for himself and Mr. CLEAVER):

H.R. 4372. A bill to direct the Secretary of Transportation to establish a pilot program for evaluating technologies that are likely to prevent adverse weather effects associated with freezing temperatures on bridges, improve bridge safety, extend the life of bridges, and promote energy efficiency on bridges on the National Highway System; to the Committee on Transportation and Infrastructure.

By Mr. HASTINGS of Florida (for himself, Mr. MEEK of Florida, Mr. BARROW, Ms. JACKSON-LEE of Texas, Mr. STARK, and Mrs. NAPOLITANO):

H.R. 4373. A bill to amend title XVIII of the Social Security Act to stabilize and modernize the provision of partial hospitalization services under the Medicare Program, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. HERSETH SANDLIN (for herself and Mr. HERGER):

H.R. 4374. A bill to amend the Internal Revenue Code of 1986 to extend the credit for electricity produced from biomass, to provide credit rate parity under such credit, and to exclude certain unprocessed fuels from the cellulosic biofuel producer credit; to the Committee on Ways and Means.

By Mr. HINCHEY (for himself, Mr. INSLEE, Mr. TIERNEY, Mr. DEFAZIO, Ms. KAPTUR, and Mr. McDERMOTT):

H.R. 4375. A bill to restore certain provisions of the Banking Act of 1933, commonly referred to as the "Glass-Steagall Act", and for other purposes; to the Committee on Financial Services.

By Mr. ISRAEL (for himself, Mr. FRANK of Massachusetts, Ms. BALDWIN, Mr. POLIS of Colorado, Mr. SERRANO, Mr. MORAN of Virginia, Mr. HASTINGS of Florida, Mr. GRIJALVA, Mr. TOWNS, Mr. ACKERMAN, Mr. WEINER, Mr. GUTIERREZ, Mr. HONDA, Mr. CAPUANO, Ms. SPEIER, Mr. CROWLEY, Ms. PINGREE of Maine, Mr. NADLER of New York, Ms. WATSON, Mrs. MALONEY, Mr. QUIGLEY, Mr. SABLAN, Ms. SUTTON, Mr. SHERMAN, Mrs. CAPPS, Ms. BERKLEY, Ms. LINDA T. SANCHEZ of California, Mr. PETERS, Ms. ZOE LOFGREN of California, Mr. WAXMAN, Ms. LEE of California, Ms. WASSERMAN SCHULTZ, Mr. ENGEL, Mr. OLIVER, Mr. ANDREWS, Mr. HINCHEY, Mr. LUJAN, Mr. KENNEDY, Mr. WU, Ms. CLARKE, Ms. CHU, Mr. MCGOVERN, Mr. CLAY, Mr. TONKO, and Mr. MURPHY of Connecticut):

H.R. 4376. A bill to amend the Equal Credit Opportunity Act to prohibit discrimination on account of sexual orientation or gender identity when extending credit; to the Committee on Financial Services.

By Ms. KAPTUR:

H.R. 4377. A bill to repeal certain provisions of the Gramm-Leach-Bliley Act and revive the separation between commercial banking and the securities business, in the manner provided in the Banking Act of 1933, the so-called "Glass-Steagall Act", and for other purposes; to the Committee on Financial Services.

By Mr. KISSELL:

H.R. 4378. A bill to amend the Americans with Disabilities Act to require that the same access to transportation and public ac-

commodations be afforded to certified trainers of service animals as is afforded under such Act to individuals with disabilities who use such service animals; to the Committee on Transportation and Infrastructure, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. LANGEVIN:

H.R. 4379. A bill to amend title 10, United States Code, to require contractors and subcontractors working on military construction projects to comply with licensing requirements for employees working at the project location; to the Committee on Armed Services.

By Mr. LEVIN (for himself and Mr. BRADY of Texas):

H.R. 4380. A bill to amend the Harmonized Tariff Schedule of the United States to modify temporarily certain rates of duty, and for other purposes; to the Committee on Ways and Means.

By Ms. ZOE LOFGREN of California (for herself and Mr. GEORGE MILLER of California):

H.R. 4381. A bill to reform the H-2B program, and for other purposes; to the Committee on the Judiciary, and in addition to the Committee on Education and Labor, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mrs. MALONEY:

H.R. 4382. A bill to authorize the Secretary of Housing and Urban Development to make grants to nonprofit community organizations for the development of open space on municipally owned vacant lots in urban areas; to the Committee on Financial Services.

By Mr. MARSHALL (for himself, Mr. ACKERMAN, Mr. ARCURI, Mr. BISHOP of New York, Ms. CLARKE, Mr. CROWLEY, Mr. ENGEL, Mr. HALL of New York, Mr. HIGGINS, Mr. HINCHEY, Mr. ISRAEL, Mr. KING of New York, Mr. LEE of New York, Mrs. LOWEY, Mr. MAFFEI, Mr. MASSA, Mrs. MCCARTHY of New York, Mr. McMAHON, Mrs. MALONEY, Mr. MEEKS of New York, Mr. MURPHY of New York, Mr. NADLER of New York, Mr. OWENS, Mr. RANGEL, Mr. SERRANO, Ms. SLAUGHTER, Mr. TONKO, Mr. TOWNS, Ms. VELAZQUEZ, and Mr. WEINER):

H.R. 4383. A bill to amend the Public Health Service Act and title XIX of the Social Security Act to provide for a screening and treatment program for prostate cancer in the same manner as is provided for breast and cervical cancer; to the Committee on Energy and Commerce.

By Mr. MATHESON:

H.R. 4384. A bill to establish the Utah Navajo Trust Fund Commission, and for other purposes; to the Committee on Natural Resources.

By Mr. MEEK of Florida (for himself, Ms. LINDA T. SANCHEZ of California, and Mr. CARNAHAN):

H.R. 4385. A bill to authorize the issuance of United States War Bonds to aid in funding of the operations in Iraq and Afghanistan; to the Committee on Ways and Means.

By Mr. MICHAUD (for himself, Ms. TSONGAS, Ms. HARMAN, Mr. RYAN of Ohio, and Mrs. DAVIS of California):

H.R. 4386. A bill to amend title 10, United States Code, to require emergency contraception to be available at all military health

care treatment facilities; to the Committee on Armed Services.

By Mr. MILLER of Florida:

H.R. 4387. A bill to designate the Federal building located at 100 North Palafox Street in Pensacola, Florida, as the "Winston E. Arnow Federal Building"; to the Committee on Transportation and Infrastructure.

By Mr. MURPHY of New York (for himself and Mr. CARNEY):

H.R. 4388. A bill to amend the Internal Revenue Code of 1986 to provide tax incentives for the donation of wild game meat; to the Committee on Ways and Means.

By Mr. MURPHY of New York:

H.R. 4389. A bill to amend the Internal Revenue Code of 1986 to allow a credit against income tax to taxpayers using energy derived from biomass to power domestic paper, pulp and paperboard manufacturing process facilities; to the Committee on Ways and Means.

By Mr. MURPHY of New York:

H.R. 4390. A bill to amend title XI of the Social Security Act to provide for enhanced program and provider protections under the Medicare, Medicaid, and Children's Health Insurance programs; to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. PASCRELL:

H.R. 4391. A bill to amend the Internal Revenue Code of 1986 to exclude from an employee's gross income any employer-provided supplemental instructional services assistance, and for other purposes; to the Committee on Ways and Means.

By Mr. PAYNE (for himself, Ms. WATSON, Mr. FATTAH, Mr. RUSH, Mr. LEWIS of Georgia, Ms. CLARKE, Ms. JACKSON-LEE of Texas, Ms. WOOLSEY, Ms. FUDGE, Mr. JACKSON of Illinois, Ms. LEE of California, and Mr. BISHOP of Georgia):

H.R. 4392. A bill to amend the Foreign Assistance Act of 1961 to provide assistance to expand, improve, support, and promote higher education in the countries of sub-Saharan Africa; to the Committee on Foreign Affairs.

By Mr. PETERS (for himself, Mr. EHLERS, Mr. DINGELL, Ms. DELAURO, Mr. RYAN of Ohio, Mr. MCGOVERN, Mr. BRADY of Pennsylvania, Mr. HOLDEN, Mr. COSTELLO, Ms. KAPTUR, Mr. WILSON of Ohio, Mr. STUPAK, Ms. FUDGE, Ms. MARKEY of Colorado, Ms. CORRINE BROWN of Florida, Mr. HARE, Ms. SUTTON, Mr. SCHAUER, Mr. KILDEE, Mr. CARNEY, Mr. CAMP, Mr. INSLEE, Mr. LUETKEMEYER, Mr. DENT, Mr. MILLER of North Carolina, Mr. FORTENBERRY, Mrs. MILLER of Michigan, Mr. GINGREY of Georgia, Mr. ROGERS of Michigan, Mr. COURTNEY, Mr. LIPINSKI, Mr. REYES, Mr. WELCH, Mr. FILNER, Mr. TONKO, Mr. SIMPSON, Mr. CARNAHAN, Mr. LATOURETTE, Ms. KILPATRICK of Michigan, Mr. TIM MURPHY of Pennsylvania, Mr. PLATTS, and Mr. MINNICK):

H.R. 4393. A bill to authorize the Secretary of Commerce to reduce the matching requirement for participants in the Hollings Manufacturing Extension Partnership Program; to the Committee on Science and Technology.

By Ms. PINGREE of Maine:

H.R. 4394. A bill to provide for a phased ban on decabrominated diphenylether and mixtures or products containing that chemical,

and for other purposes; to the Committee on Energy and Commerce, and in addition to the Committees on Foreign Affairs, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. PLATTS:

H.R. 4395. A bill to revise the boundaries of the Gettysburg National Military Park to include the Gettysburg Train Station, and for other purposes; to the Committee on Natural Resources.

By Mr. POMEROY:

H.R. 4396. A bill to amend the Clean Air Act to provide that greenhouse gases are not subject to the Act, and for other purposes; to the Committee on Energy and Commerce.

By Mr. SABLON:

H.R. 4397. A bill to clarify the transitional status of certain aliens not provided for in subtitle A of title VII of the Consolidated Natural Resources Act of 2008, and for other purposes; to the Committee on Natural Resources, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. SALAZAR (for himself, Ms. DEGETTE, Ms. MARKEY of Colorado, Mr. POLIS of Colorado, Mr. PERLMUTTER, Mr. LAMBORN, Mr. COFFMAN of Colorado, Mr. MINNICK, Mr. LUJÁN, Mrs. KIRKPATRICK of Arizona, and Ms. BERKLEY):

H.R. 4398. A bill to address public safety risks in western States by facilitating insect and disease infestation treatment of National Forest System land and certain adjacent land, to make permanent the good-neighbor authority for Colorado and stewardship contracting authorities available to the Forest Service, and for other purposes; to the Committee on Agriculture, and in addition to the Committee on Natural Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. SERRANO (for himself, Mr. TERRY, Mr. MAFFEI, Mr. GONZALEZ, Mr. CARNAHAN, and Mr. ISRAEL):

H.R. 4399. A bill to further the national deployment of electric drive vehicles, to strengthen and enhance the national power grid through the integration of such vehicles, and for other purposes; to the Committee on Oversight and Government Reform, and in addition to the Committees on Energy and Commerce, Transportation and Infrastructure, and Science and Technology, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. SHULER (for himself, Mr. MELANCON, Mrs. EMERSON, Mr. PAUL, Ms. FOX, Mr. POE of Texas, Mr. GONZALEZ, Mr. RYAN of Ohio, Mr. DELAHUNT, Mr. MINNICK, Mr. DINGELL, Mr. QUIGLEY, Mr. TANNER, Mr. SMITH of Texas, Mr. CARNEY, Mr. INGLIS, Ms. JENKINS, Mr. COBLE, Mr. CONAWAY, Mr. HILL, Ms. BEAN, Mr. CHILDERS, Mr. COSTA, and Mr. HARPER):

H.R. 4400. A bill to authorize States to exempt certain nonprofit housing organizations from the licensing requirements of the S.A.F.E. Mortgage Licensing Act of 2008; to the Committee on Financial Services.

By Mr. SMITH of Washington (for himself and Mr. DICKS):

H.R. 4401. A bill to amend the Act of August 9, 1955, to modify a provision relating to leases involving certain Indian tribes; to the Committee on Natural Resources.

By Mr. TONKO:

H.R. 4402. A bill to amend the Richard B. Russell National School Lunch Act to improve access to nutritious meals for young children in child care; to the Committee on Education and Labor.

By Mr. WALZ (for himself, Mr. BARTLETT, Mr. BUYER, and Mr. FILNER):

H.R. 4403. A bill to amend title 10, United States Code, to authorize space-available travel on military aircraft for unremarried surviving spouses of retired members of the uniformed services and the unremarried surviving spouses of veterans who died from a service-connected or compensable disability, and for the dependents of such spouses; to the Committee on Armed Services.

By Ms. WATERS (for herself, Ms. ROSS-LEHTINEN, Mrs. CHRISTENSEN, Mr. KILDEE, and Ms. BORDALLO):

H.R. 4404. A bill to amend the Public Health Service Act to authorize grants to provide treatment for diabetes in minority communities; to the Committee on Energy and Commerce.

By Ms. WATERS (for herself, Mr. FRANK of Massachusetts, Mr. BACHUS, Mrs. MALONEY, Mrs. BIGGERT, Mr. GUTIERREZ, Mr. PAYNE, Ms. LEE of California, Mr. CLEAVER, and Mr. WALDEN):

H.R. 4405. A bill to provide for greater responsibility in lending and expanded cancellation of debts owed to the United States and the international financial institutions by low-income countries, and for other purposes; to the Committee on Financial Services.

By Mr. WEINER:

H.R. 4406. A bill to render nationals of Israel eligible to enter the United States as nonimmigrant traders and investors; to the Committee on the Judiciary.

By Mr. YOUNG of Alaska:

H.R. 4407. A bill to establish a coordinated avalanche protection program, and for other purposes; to the Committee on Natural Resources, and in addition to the Committees on Oversight and Government Reform, and Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mrs. HALVORSON:

H.J. Res. 65. A joint resolution disapproving the rule submitted by the Federal Election Commission with respect to travel on private aircraft for Federal candidates; to the Committee on House Administration.

By Mr. MORAN of Kansas:

H.J. Res. 66. A joint resolution disapproving a rule submitted by the Administrator of the Environmental Protection Agency relating to endangerment and cause or contribute findings for greenhouse gases under section 202(a) of the Clean Air Act; to the Committee on Energy and Commerce.

By Ms. PINGREE of Maine:

H. Con. Res. 223. Concurrent resolution providing for the sine die adjournment of the first session of the One Hundred Eleventh Congress; considered and agreed to.

By Mr. POSEY (for himself, Mr. PUTNAM, Mr. LANCE, and Mr. PAUL):

H. Con. Res. 224. Concurrent resolution encouraging Federal financial regulators to establish clear and consistent guidelines for financial institutions seeking to grow or expand; to the Committee on Financial Services.

By Mr. SCHIFF (for himself and Ms. GRANGER):

H. Res. 225. Concurrent resolution supporting the goals and ideals of observing the National Slavery and Trafficking Prevention Month from January 1 through February 1 of each year to raise awareness of, and opposition to, modern slavery; to the Committee on the Judiciary.

By Mr. POE of Texas (for himself, Mr. BURTON of Indiana, Mr. CAPUANO, Mr. MANZULLO, Mr. BILIRAKIS, Mr. ROYCE, Mr. ROHRBACHER, Mr. WILSON of South Carolina, Mr. CALVERT, Mrs. MYRICK, Mr. SMITH of Texas, Mr. OLSON, Mrs. LUMMIS, Mr. BOOZMAN, Mr. LATTA, Mr. NEUGEBAUER, Mr. LEE of New York, Mr. NYE, Mr. JONES, Mr. COBLE, Mr. HALL of Texas, Ms. FALLIN, Mr. SAM JOHNSON of Texas, Ms. GRANGER, Mr. BRADY of Texas, Mr. KING of Iowa, Mr. CULBERSON, Mr. PRICE of Georgia, Mr. CARTER, Mr. CONAWAY, Mr. MCCAUL, Mr. GOMMERT, Mr. HENSARLING, Mr. GINGREY of Georgia, Mr. BARTLETT, Mr. PITTS, Mrs. SCHMIDT, Mrs. BLACKBURN, Mr. MARCHANT, Mr. SHADEGG, Mr. POSEY, Mr. AKIN, Mr. HUNTER, Mr. MCCOTTER, Mr. BARTON of Texas, and Mr. WITTMAN):

H. Res. 977. A resolution honoring Navy SEALs Petty Officer 2nd Class Matthew McCabe, Petty Officer 2nd Class Jonathan Keefe, and Petty Officer 1st Class Julio Huertas for their heroic actions in the capture of Ahmed Hashim Abed, the mastermind behind of one of the most notorious crimes against Americans in Iraq; to the Committee on Armed Services.

By Mr. HOEKSTRA:

H. Res. 978. A resolution requesting the President to transmit to the House of Representatives all documents in the possession of the President relating to the inventory and review of intelligence related to the shooting at Fort Hood, Texas, described by the President in a memorandum dated November 10, 2009; to the Committee on Intelligence (Permanent Select).

By Mr. FATTAH:

H. Res. 979. A resolution expressing the sense of the House of Representatives in support of the Common Core State Standards Initiative; to the Committee on Education and Labor.

By Mr. DENT (for himself, Mr. KING of New York, Mr. BILIRAKIS, Mr. DANIEL E. LUNGREN of California, Mr. OLSON, Mrs. MILLER of Michigan, and Mr. AUSTRIA):

H. Res. 980. A resolution of inquiry directing the Secretary of Homeland Security to transmit to the House of Representatives a copy of the Transportation Security Administration's Aviation Security Screening Management Standard Operating Procedures manual in effect on December 5, 2009, and any subsequent revisions of such manual in effect prior to the adoption of this resolution; to the Committee on Homeland Security.

By Mr. BERMAN (for himself, Ms. ROS-LEHTINEN, Mr. LEVIN, Mr. BARTLETT, Ms. KAPTUR, Mr. GERLACH, Mr. HASTINGS of Florida, and Mr. WEXLER):

H. Res. 981. A resolution supporting continued political and economic development in

Ukraine; to the Committee on Foreign Affairs.

By Ms. ROS-LEHTINEN (for herself and Mr. SHIMKUS):

H. Res. 982. A resolution expressing the sense of the House of Representatives that France and other member states of the North Atlantic Treaty Organization and the European Union should decline to sell major weapons systems or offensive military equipment to the Russian Federation; to the Committee on Foreign Affairs.

By Mr. BURGESS:

H. Res. 983. A resolution requesting the President, and directing the Secretary of Health and Human Services, to transmit to the House of Representatives copies of documents, records, and communications in their possession relating to certain agreements regarding health care reform; to the Committee on Energy and Commerce.

By Mr. MCCARTHY of California (for himself, Mr. MCKEON, Mr. DICKS, Mrs. CAPPS, Mr. MILLER of Florida, Mr. COURTNEY, Mr. SCOTT of Virginia, Mr. KIRK, and Mr. CAPUANO):

H. Res. 984. A resolution recognizing the importance and contributions of the official United States naval history museums; to the Committee on Armed Services.

By Mr. BOOZMAN:

H. Res. 985. A resolution of inquiry directing the Administrator of the Environmental Protection Agency to transmit to the House of Representatives all information in the possession of the Administrator relating to nutrient management of the Illinois River Watershed, Arkansas and Oklahoma; to the Committee on Transportation and Infrastructure.

By Mr. BRADY of Pennsylvania (for himself, Mr. ADLER of New Jersey, Mr. FATTAH, Mr. GERLACH, Ms. SCHWARTZ, Mr. KANJORSKI, Mr. NEAL of Massachusetts, Mr. PIERLUISI, Mr. WELCH, Mr. DOYLE, Mr. PATRICK J. MURPHY of Pennsylvania, Mr. PAYNE, and Ms. LINDA T. SANCHEZ of California):

H. Res. 986. A resolution supporting a national and international celebration commemorating the 250th anniversary of the United States of America's birth, to be held throughout the year 2026, focused on the Greater Philadelphia Region in the Commonwealth of Pennsylvania, the State of Delaware, and the State of New Jersey; to the Committee on Oversight and Government Reform.

By Mr. FRELINGHUYSEN:

H. Res. 987. A resolution recognizing the importance of trade to the United States economy and the importance of passing free trade agreements with Colombia, South Korea, and Panama; to the Committee on Ways and Means.

By Mr. HUNTER (for himself, Mr. CULBERSON, Mr. DANIEL E. LUNGREN of California, Mr. MCCOTTER, Mr. CHAFFETZ, Mr. PRICE of Georgia, Mr. LUTHEMEYER, Mr. ROONEY, Mr. GUTHRIE, Mr. LOBIONDO, Mr. HALL of Texas, Mr. BROUN of Georgia, Mr. SCALISE, Mr. YOUNG of Florida, Mr. FRELINGHUYSEN, Mr. SIMPSON, Mr. TIBERI, Mr. JORDAN of Ohio, Mr. SHUSTER, Mr. GINGREY of Georgia, Mr. TIM MURPHY of Pennsylvania, Mr. DAVIS of Kentucky, Mr. NUNES, Mr. KINGSTON, Mr. LEE of New York, Mr. SESSIONS, Mr. DREIER, Mr. BRIGHT, Mr. KING of Iowa, Mr. AKIN, Mr. COFFMAN of Colorado, Mr. WITTMAN, Mr. LATTA, Mr. BILBRAY, Mr. BURTON

of Indiana, Mr. CALVERT, Mr. POE of Texas, Mr. ISSA, Mr. COHEN, and Mr. NYE):

H. Res. 988. A resolution recognizing the exemplarily service, devotion to country, and selfless sacrifice of Special Warfare Operators 2nd Class Matthew McCabe and Jonathan Keefe and Special Warfare Operator 1st Class Julio Huertas in capturing Ahmed Hashim Abed, one of the most-wanted terrorists in Iraq, and pledging to continue to support members of the United States Armed Forces serving in harm's way; to the Committee on Armed Services.

By Mr. INSLEE (for himself, Mr. MARKEY of Massachusetts, Ms. BORDALLO, Mr. BAIRD, Mr. THOMPSON of California, Mr. LANGEVIN, Ms. HIRONO, Mrs. CAPPS, Mr. GEORGE MILLER of California, Ms. SHEA-PORTER, Ms. WOOLSEY, Mr. HONDA, Mr. WU, Ms. SPEIER, Mr. DELAHUNT, Mr. SMITH of Washington, Ms. MCCOLLUM, Mr. FARR, Mr. DICKS, Mrs. CHRISTENSEN, Mr. ADLER of New Jersey, and Mr. HOLT):

H. Res. 989. A resolution expressing the sense of the House of Representatives that the United States should adopt national policies and pursue international agreements to prevent ocean acidification, to study the impacts of ocean acidification, and to address the effects of ocean acidification on marine ecosystems and coastal economies; to the Committee on Natural Resources.

By Ms. MCCOLLUM (for herself, Mrs. DAVIS of California, and Mr. ROGERS of Michigan):

H. Res. 990. A resolution expressing support for designation of January 2010 as "National Mentoring Month"; to the Committee on Education and Labor.

By Mr. PERRIELLO:

H. Res. 991. A resolution commending the University of Virginia men's soccer team for winning the 2009 Division I NCAA National Championship; to the Committee on Education and Labor.

By Mr. POE of Texas (for himself and Mr. ROHRBACHER):

H. Res. 992. A resolution expressing the sense of the House that the Government of the Islamic Republic of Iran should halt the widespread and brutal repression of the peaceful reformist protestors, opposition supporters, human rights defenders, students, and journalists following the disputed Iranian presidential election of June 12, 2009; to the Committee on Foreign Affairs.

By Mr. ROONEY:

H. Res. 993. A resolution recognizing the service, professionalism, honor, and sacrifices of the Navy SEALs and their contribution to the national security of the United States, supporting the mission of the Navy SEALs, and encouraging the people of the United States to learn the history and mission of the Navy SEALs; to the Committee on Armed Services.

By Mr. WOLF:

H. Res. 994. A resolution directing the Attorney General to transmit to the House of Representatives all information in the Attorney General's possession relating to the decision to dismiss United States v. New Black Panther Party; to the Committee on the Judiciary.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 24: Mr. SARBANES, Ms. CLARKE, Mr. PERLMUTTER, Ms. HERSETH SANDLIN, Mr. BECERRA, Mr. HINOJOSA, Mr. WEINER, Mr. TOWNS, Mrs. MCCARTHY of New York, and Mr. WILSON of Ohio.

H.R. 43: Mr. DENT, Mrs. KIRKPATRICK of Arizona, and Mr. CAPUANO.

H.R. 208: Mr. BURGESS.

H.R. 211: Mr. CUELLAR and Mr. GONZALEZ.

H.R. 235: Ms. CHU.

H.R. 268: Mr. WILSON of South Carolina, Mr. JORDAN of Ohio, Mr. MORAN of Kansas, Mr. BOOZMAN, and Mr. GARY G. MILLER of California.

H.R. 272: Mr. BURTON of Indiana, Mr. CONAWAY, and Mr. SPRATT.

H.R. 391: Mrs. BIGGERT, Mr. BILIRAKIS, Mr. BONNER, Mr. BOUSTANY, Ms. GINNY BROWN-WAITE of Florida, Mr. BUCHANAN, Mr. CAMP, Mrs. CAPITO, Mr. COBLE, Mr. DEAL of Georgia, Mr. DUNCAN, Mr. FORBES, Mr. GALLEGLY, Mr. GRIFFITH, Mr. GUTHRIE, Mr. JONES, Mr. KING of New York, Mr. KINGSTON, Mr. LEWIS of California, Mr. LUCAS, Mr. MACK, Mr. MCCARTHY of California, Mr. MICA, Mrs. MILLER of Michigan, Mr. PUTNAM, Mr. REHBERG, Mr. ROSKAM, Mr. ROYCE, Mr. SMITH of Texas, Mr. STEARNS, Mr. TURNER, Mr. WALDEN, Mr. WHITFIELD, Mr. CAMPBELL, Mrs. EMERSON, Mr. FORTENBERRY, Mr. YOUNG of Florida, Mr. TIBERI, Mr. SIMPSON, Mr. LATOURETTE, Mr. PETRI, and Mrs. SCHMIDT.

H.R. 413: Ms. ROYBAL-ALLARD, Mr. ADLER of New Jersey, and Mr. JOHNSON of Georgia.

H.R. 450: Mr. UPTON.

H.R. 503: Mr. ORTIZ, Mr. QUIGLEY, Ms. VELÁZQUEZ, Mr. HARE, Mr. ADLER of New Jersey, Mr. TOWNS, and Mr. INSLEE.

H.R. 510: Mr. BOSWELL and Mr. BROUN of Georgia.

H.R. 558: Ms. WOOLSEY and Mr. BRIGHT.

H.R. 616: Mr. MOORE of Kansas.

H.R. 684: Mr. WELCH.

H.R. 690: Mr. ALEXANDER and Mrs. BIGGERT.

H.R. 734: Mr. BILBRAY, Mrs. HALVORSON, and Mr. DOGGETT.

H.R. 775: Mr. MCDERMOTT, Mr. CAO, and Mr. PITTS.

H.R. 847: Mr. REICHERT.

H.R. 855: Mr. DAVIS of Alabama.

H.R. 864: Mr. FOSTER.

H.R. 886: Mr. PETERSON and Mr. MOORE of Kansas.

H.R. 932: Mr. CAPUANO, Mr. KANJORSKI, Mr. AL GREEN of Texas, and Mr. GUTIERREZ.

H.R. 948: Mr. ELLSWORTH.

H.R. 988: Mr. TIM MURPHY of Pennsylvania, Mr. BISHOP of Georgia, Mr. PETERSON, Mr. BISHOP of Utah, Mr. SHINKUS, and Mr. CAPUANO.

H.R. 1006: Mr. HOLDEN and Mr. ANDREWS.

H.R. 1020: Mr. BRADY of Pennsylvania.

H.R. 1034: Ms. FOXX.

H.R. 1064: Ms. HERSETH SANDLIN.

H.R. 1067: Mr. MOLLOHAN and Mr. BOREN.

H.R. 1079: Mr. GRIJALVA and Mr. CONNOLLY of Virginia.

H.R. 1132: Mr. INGLIS, Mr. MANZULLO, and Mr. WALDEN.

H.R. 1188: Mr. HIMES.

H.R. 1194: Mr. MILLER of Florida, Mr. JACKSON of Illinois, Mr. WOLF, Mr. JOHNSON of Illinois, Mr. ETHERIDGE, Mr. ROGERS of Kentucky, and Mr. QUIGLEY.

H.R. 1205: Mr. WAMP and Mr. ROGERS of Kentucky.

H.R. 1230: Mrs. BONO MACK.

H.R. 1314: Mr. ABERCROMBIE.

H.R. 1326: Mr. ENGEL, Ms. LINDA T. SÁNCHEZ of California, Mr. QUIGLEY, Mr. ADLER of New Jersey, Mr. FOSTER, and Ms. MARKEY of Colorado.

H.R. 1351: Ms. ROS-LEHTINEN and Mr. MICHAUD.

H.R. 1352: Mr. HUNTER.

H.R. 1361: Ms. WOOLSEY and Ms. MCCOLLUM.

H.R. 1378: Mr. BRALEY of Iowa.

H.R. 1479: Ms. ZOE LOFGREN of California and Mr. QUIGLEY.

H.R. 1490: Mrs. NAPOLITANO.

H.R. 1526: Mr. KAGEN, Mr. NADLER of New York, Mr. OBERSTAR, Mr. POSEY, Mr. MCNERNEY, Ms. SUTTON, Mr. HINCHEY, and Mr. MARKEY of Massachusetts.

H.R. 1545: Mr. NYE.

H.R. 1549: Mr. QUIGLEY, Mr. CAPUANO, Mr. LEWIS of Georgia, Ms. WASSERMAN SCHULTZ, Mr. TOWNS, Ms. HARMAN, and Mr. ADLER of New Jersey.

H.R. 1551: Mr. ADLER of New Jersey.

H.R. 1557: Mr. HEINRICH.

H.R. 1585: Mr. JOHNSON of Illinois, Mr. UPTON, and Mr. ALEXANDER.

H.R. 1588: Mr. ALEXANDER.

H.R. 1693: Mr. QUIGLEY.

H.R. 1740: Mr. DENT.

H.R. 1778: Mr. LUJÁN, Ms. FUDGE, Mr. KAGEN, Ms. BALDWIN, Ms. HIRONO, Mr. HIGGINS, Mr. MCGOVERN, and Mr. SARBANES.

H.R. 1806: Mr. ROSS, Ms. LINDA T. SÁNCHEZ of California, Mr. SIREs, Mr. BUTTERFIELD, Mr. JOHNSON of Illinois, and Mr. SNYDER.

H.R. 1826: Mr. OWENS and Ms. CHU.

H.R. 1829: Mrs. BLACKBURN and Mr. CAPUANO.

H.R. 1836: Mr. MITCHELL.

H.R. 1844: Ms. DELAURO.

H.R. 1873: Mr. CONNOLLY of Virginia.

H.R. 1884: Mr. SMITH of New Jersey, Mr. BOOZMAN, and Ms. SPEIER.

H.R. 1924: Mr. HEINRICH.

H.R. 1925: Ms. PINGREE of Maine.

H.R. 1964: Ms. SLAUGHTER, Mr. AL GREEN of Texas, and Mr. ELLISON.

H.R. 1972: Mr. WALZ.

H.R. 1977: Mr. MORAN of Virginia.

H.R. 1998: Mr. SESSIONS.

H.R. 2000: Mr. PETERS and Ms. ESHOO.

H.R. 2001: Mr. HODES.

H.R. 2006: Ms. DELAURO.

H.R. 2135: Ms. WOOLSEY, Mr. BRIGHT, and Mrs. BIGGERT.

H.R. 2139: Mr. KAGEN, Ms. ESHOO, Mr. CLEAVER, and Mr. INSLEE.

H.R. 2142: Mr. BRIGHT, Mr. MELANCON, Mr. ARCURI, Mr. TANNER, Mr. KRATOVIL, Mr. ROSS, Mr. THOMPSON of CALIFORNIA, AND Mr. SCOTT of GEORGIA.

H.R. 2149: Mr. CARNEY.

H.R. 2153: Mr. YOUNG of Alaska.

H.R. 2156: Mr. ALTMIRE.

H.R. 2159: Mr. PASCRELL.

H.R. 2246: Ms. MATSUI.

H.R. 2256: Ms. SPEIER.

H.R. 2275: Ms. MOORE of Wisconsin, Mr. MEEK of Florida, Ms. ZOE LOFGREN of California, Ms. BERKLEY, Mr. SOUDER, Mr. BARROW, Mr. CLEAVER, and Mrs. MYRICK.

H.R. 2277: Mr. REHBERG.

H.R. 2296: Mrs. MYRICK.

H.R. 2324: Mr. PRICE of North Carolina, Mr. LANGEVIN, Mr. KING of New York, Mr. BLUMENAUER, Mr. FILNER, and Ms. ROYBAL-ALLARD.

H.R. 2377: Mrs. BIGGERT.

H.R. 2408: Mrs. NAPOLITANO.

H.R. 2413: Ms. SCHAKOWSKY and Mr. HEINRICH.

H.R. 2426: Mrs. MALONEY.

H.R. 2446: Ms. WOOLSEY, Mr. SHUSTER, and Mr. BRIGHT.

H.R. 2455: Mr. SMITH of New Jersey.

H.R. 2460: Ms. TSONGAS.

H.R. 2476: Mr. POLIS of Colorado.

H.R. 2478: Mr. WU.

H.R. 2480: Mr. TOWNS, Mr. INSLEE, Mr. MCDERMOTT, Mr. CAPUANO, Mr. QUIGLEY, Mr. ADLER of New Jersey, Mr. CLEAVER, Mr.

FATTAH, Ms. KILROY, Mr. FOSTER, Mr. MARKEY of Massachusetts, Mr. SCHRADER, and Mr. PERRIELLO.

H.R. 2502: Mrs. BONO MACK.

H.R. 2531: Mr. JOHNSON of Georgia.

H.R. 2567: Mr. POLIS of Colorado.

H.R. 2568: Ms. NORTON.

H.R. 2570: Mr. RUSH.

H.R. 2575: Mr. GONZALEZ.

H.R. 2578: Mr. DAVIS of Illinois.

H.R. 2579: Ms. WOOLSEY and Ms. ROYBAL-ALLARD.

H.R. 2584: Mr. MAFFEI.

H.R. 2600: Mr. MURPHY of New York, Mr. PERRIELLO, and Mr. SIREs.

H.R. 2613: Mr. FILNER.

H.R. 2624: Mrs. BIGGERT.

H.R. 2672: Mr. POE of Texas.

H.R. 2697: Mr. BOOZMAN.

H.R. 2698: Mr. NYE.

H.R. 2699: Mr. HILL and Mr. NYE.

H.R. 2710: Mr. CARNAHAN and Mr. YARMUTH.

H.R. 2730: Mrs. BIGGERT.

H.R. 2733: Mr. MORAN of Kansas and Mr. GARRETT of New Jersey.

H.R. 2746: Mr. PATRICK J. MURPHY of Pennsylvania and Mr. SCHAUER.

H.R. 2755: Ms. WOOLSEY.

H.R. 2766: Ms. SLAUGHTER.

H.R. 2799: Mr. MEEKS of New York.

H.R. 2807: Mr. LOBIONDO.

H.R. 2842: Mr. POE of Texas.

H.R. 2852: Mr. ARCURI.

H.R. 2855: Mr. LARSEN of Washington.

H.R. 2866: Mr. BARTLETT.

H.R. 2946: Mr. AL GREEN of Texas, Mr. GENE GREEN of Texas, and Ms. HIRONO.

H.R. 2999: Mr. MOORE of Kansas.

H.R. 3012: Mr. GARAMENDI.

H.R. 3024: Ms. WASSERMAN SCHULTZ and Mr. LATOURETTE.

H.R. 3043: Mrs. MALONEY, Ms. BORDALLO, and Ms. MOORE of Wisconsin.

H.R. 3077: Mr. MOORE of Kansas.

H.R. 3149: Mr. STARK and Mr. HINCHEY.

H.R. 3173: Ms. BALDWIN, Mr. CONYERS, Mr. SENSENBRENNER, and Mr. RYAN of Wisconsin.

H.R. 3202: Mr. STARK.

H.R. 3266: Mr. ISRAEL and Mr. MASSA.

H.R. 3339: Mr. PERLMUTTER, Mr. KIND, and Ms. MARKEY of Colorado.

H.R. 3380: Ms. SCHAKOWSKY and Mr. JONES.

H.R. 3401: Mr. CUMMINGS, Ms. HIRONO, Ms. ROYBAL-ALLARD, and Ms. VELÁZQUEZ.

H.R. 3413: Mr. HODES.

H.R. 3460: Ms. SLAUGHTER.

H.R. 3510: Mr. BLUMENAUER, Ms. SUTTON, and Ms. MATSUI.

H.R. 3519: Mr. TIAHRT and Mr. GRIFFITH.

H.R. 3554: Ms. KILPATRICK of Michigan.

H.R. 3560: Ms. WOOLSEY.

H.R. 3564: Mr. DELAHUNT, Mr. SALAZAR, Mr. BECERRA, Mr. CARDOZA, Mr. GUTIERREZ, Mrs.

NAPOLITANO, Mr. ORTIZ, Mr. PASTOR of Arizona, Mr. RODRIGUEZ, Mr. SIREs, Mr. FARR, Ms. LEE of California, Ms. CLARKE, Ms.

VELÁZQUEZ, Mr. ELLISON, Mr. REYES, Mr. BERMAN, Mr. CAPPS, Ms. CHU, Mr. HONDA, Ms. RICHARDSON, Ms. LORETTA SANCHEZ of California, Mr. SCHIFF, Ms. WATERS, Ms.

WATSON, Mr. WAXMAN, Ms. JACKSON-LEE of Texas, Mr. KUCINICH, Mr. GRAYSON, Ms. CORRINE BROWN of Florida, Mr. ABERCROMBIE, Mr. CAPUANO, Mr. DAVIS of Illinois, Mr. HASTINGS of Florida, Mr. FATTAH, Mr. HINCHEY, Ms. EDDIE BERNICE JOHNSON of Texas, Mrs.

MALONEY, Ms. KAPTUR, Ms. KILPATRICK of Michigan, Mr. LEWIS of Georgia, Mr. MCDERMOTT, Mr. PALLONE, Mr. PAYNE, Mr.

OLVER, Mr. RUSH, Ms. SCHAKOWSKY, Mr. THOMPSON of Mississippi, and Ms. MATSUI.

H.R. 3567: Mr. HIGGINS and Mr. SIREs.

H.R. 3571: Mr. MANZULLO.

H.R. 3578: Ms. WOOLSEY and Mr. WAXMAN.

H.R. 3586: Mr. GOODLATTE.
 H.R. 3589: Mrs. MYRICK, Mr. COBLE, Mrs. MALONEY, and Mr. ENGEL.
 H.R. 3613: Mr. LUETKEMEYER.
 H.R. 3654: Mr. GRAYSON.
 H.R. 3666: Mr. TERRY.
 H.R. 3668: Mrs. MILLER of Michigan, Mr. MINNICK, Mr. KENNEDY, Ms. WATERS, Mr. MATHESON, Mr. DELAHUNT, Mr. KIND, Mr. CUMMINGS, Mr. LUCAS, and Mr. ACKERMAN.
 H.R. 3705: Mr. SABLAN, Mr. FARR, Mr. MEEKS of New York, and Mr. POLIS of Colorado.
 H.R. 3710: Ms. MOORE of Wisconsin.
 H.R. 3712: Mr. EHLERS.
 H.R. 3752: Mr. LEE of New York.
 H.R. 3790: Ms. LINDA T. SANCHEZ of California, Mr. BACA, Mr. KILDEE, and Mrs. BONO MACK.
 H.R. 3800: Mr. YARMUTH.
 H.R. 3810: Mr. MOLLOHAN.
 H.R. 3836: Mr. SARBANES.
 H.R. 3838: Mr. CONNOLLY of Virginia.
 H.R. 3851: Mr. FRANK of Massachusetts.
 H.R. 3905: Mr. FORTENBERRY.
 H.R. 3907: Mr. POLIS of Colorado, Ms. TITUS, Mr. STARK, Mr. WU, Mr. GUTIERREZ, Mr. MASSA, Ms. SUTTON, Mr. LIPINSKI, Mr. SESTAK, Mr. CONYERS, and Ms. ZOE LOFGREN of California.
 H.R. 3922: Mr. WITTMAN.
 H.R. 3936: Mr. COURTNEY and Mr. PAYNE.
 H.R. 3943: Mr. KISSELL, Mr. LANGEVIN, Ms. PINGREE of Maine, Mr. MEEK of Florida, Mr. HEINRICH, Mr. JOHNSON of Georgia, Mr. SIRES, Mr. MURPHY of Connecticut, Mr. MANZULLO, Mr. PAYNE, and Mr. BOREN.
 H.R. 3952: Mr. NYE.
 H.R. 3953: Mr. PAUL.
 H.R. 3957: Ms. PINGREE of Maine and Mr. HOLT.
 H.R. 3995: Mr. CHANDLER.
 H.R. 4020: Mr. MCKEON, Mr. BISHOP of Utah, Mr. CHAFFETZ, Mr. REHBERG, and Mrs. LUMMIS.
 H.R. 4021: Mr. MORAN of Virginia and Mr. PERRIELLO.
 H.R. 4036: Mr. MEEKS of New York and Ms. JACKSON-LEE of Texas.
 H.R. 4046: Mr. LAMBORN.
 H.R. 4070: Mr. SOUDER and Mr. LUETKEMEYER.
 H.R. 4088: Mr. LEE of New York and Mr. RADANOVICH.
 H.R. 4089: Mr. WILSON of Ohio.
 H.R. 4099: Mr. MAFFEI and Ms. FUDGE.
 H.R. 4102: Mr. MCCOTTER.
 H.R. 4115: Mr. HODES and Mr. SIRES.
 H.R. 4116: Mr. STARK, Ms. SHEA-PORTER, Mr. CARSON of Indiana, Mrs. CHRISTENSEN, and Mr. JOHNSON of Georgia.
 H.R. 4123: Mr. BARROW, Mr. ABERCROMBIE, Mr. AL GREEN of Texas, and Mr. CLEAVER.
 H.R. 4127: Mr. DENT.
 H.R. 4131: Mr. GEORGE MILLER of California.
 H.R. 4138: Mr. SCHOCK and Mr. LEE of New York.
 H.R. 4144: Mr. MOLLOHAN.
 H.R. 4149: Mr. THOMPSON of California, Mr. INSLEE, and Mr. KIND.
 H.R. 4155: Mr. INSLEE, Mr. ISRAEL, Mrs. BONO MACK, Mr. WELCH, and Mr. TONKO.
 H.R. 4168: Mrs. BONO MACK.
 H.R. 4170: Mr. SHERMAN.
 H.R. 4178: Ms. JENKINS.
 H.R. 4186: Ms. JENKINS, Mr. PAUL, Mr. MINNICK, and Mr. MORAN of Kansas.

H.R. 4196: Mrs. NAPOLITANO, Mr. CARDOZA, Mrs. CAPPS, Mr. SIRES, and Ms. ROYBAL-ALLARD.
 H.R. 4199: Mr. PETERSON, Mr. HARE, and Mr. ETHERIDGE.
 H.R. 4202: Ms. NORTON and Mr. VAN HOLLEN.
 H.R. 4220: Mr. SCHOCK and Mr. MANZULLO.
 H.R. 4233: Mr. LEWIS of California, Mr. CALVERT, Mr. MCCLINTOCK, Mr. GARY G. MILLER of California, Mr. GALLEGLY, Mr. DEAL of Georgia, Mr. SIMPSON, Mr. HASTINGS of Washington, Mr. REICHERT, and Mr. WILSON of South Carolina.
 H.R. 4236: Mr. KAGEN.
 H.R. 4243: Mr. PAUL, Mr. CONAWAY, and Mr. MEEK of Florida.
 H.R. 4244: Mr. GENE GREEN of Texas.
 H.R. 4249: Mr. SHADEGG.
 H.R. 4255: Mr. AUSTRIA, Mr. MINNICK, and Mrs. BIGGERT.
 H.R. 4258: Mr. GERLACH.
 H.R. 4262: Mr. BILBRAY, Mr. FORTENBERRY, Mrs. LUMMIS, and Mr. MCCOTTER.
 H.R. 4263: Ms. SUTTON.
 H.R. 4264: Mr. STARK.
 H.R. 4267: Mr. BURGESS.
 H.R. 4268: Mr. BISHOP of Georgia.
 H.R. 4270: Mr. OLSON.
 H.R. 4277: Mr. CASSIDY.
 H.R. 4286: Ms. NORTON.
 H.R. 4290: Ms. LINDA T. SANCHEZ of California, Mr. CAPUANO, Mr. MCGOVERN, Mr. NEAL of Massachusetts, and Ms. ROYBAL-ALLARD.
 H.R. 4291: Mr. HARE, Ms. NORTON, and Ms. SUTTON.
 H.R. 4295: Mr. KAGEN.
 H.R. 4296: Mr. CROWLEY, Mr. JACKSON of Illinois, Ms. CLARKE, and Mr. MOORE of Kansas.
 H.R. 4298: Mr. PASCRELL.
 H.R. 4299: Mr. CLAY and Mr. ALEXANDER.
 H.R. 4300: Ms. FUDGE, Mr. HONDA, Mr. PERRIELLO, and Mr. MORAN of Virginia.
 H.R. 4303: Mr. MEEKS of New York.
 H.R. 4312: Mrs. MCMORRIS RODGERS, Mr. CASSIDY, and Mrs. BACHMANN.
 H.R. 4313: Mr. KILDEE.
 H.R. 4321: Mr. WEXLER.
 H.R. 4325: Mr. ELLISON and Mr. MCGOVERN.
 H.J. Res. 42: Mr. LEE of New York.
 H. Con. Res. 198: Ms. SCHAKOWSKY, Mr. JOHNSON of Georgia, Ms. SLAUGHTER, Mr. CHANDLER, and Mr. YARMUTH.
 H. Con. Res. 200: Mr. BILIRAKIS and Mr. CULBERSON.
 H. Con. Res. 205: Mr. MOORE of Kansas.
 H. Con. Res. 220: Mr. NYE, Mr. WITTMAN, and Mr. MURPHY of New York.
 H. Con. Res. 222: Mr. BACA, Mr. SERRANO, Mrs. NAPOLITANO, and Mr. SABLAN.
 H. Res. 191: Ms. LINDA T. SANCHEZ of California.
 H. Res. 278: Ms. SCHAKOWSKY.
 H. Res. 416: Mr. TOWNS.
 H. Res. 615: Mr. CALVERT.
 H. Res. 713: Mr. PENCE, Mr. KLINE of Minnesota, Mr. SHIMKUS, Mr. SHADEGG, Mrs. BLACKBURN, Mr. GINGREY of Georgia, Ms. SCHWARTZ, Mr. HEINRICH, Mr. HONDA, Mr. SIRES, Mr. POSEY, Mr. WHITFIELD, Mr. WALDEN, Mr. TERRY, Mr. NEUGEBAUER, Mr. GRIMALVA, Mr. OLSON, Mr. THORNBERRY, Mr. CULBERSON, Mr. SABLAN, Mr. BARTON of Texas, Mr. BARTLETT, and Ms. JENKINS.
 H. Res. 763: Mr. HOEKSTRA.

H. Res. 776: Mr. MICHAUD and Mr. COURTNEY.
 H. Res. 812: Mr. BACHUS.
 H. Res. 864: Mr. SPACE.
 H. Res. 887: Mr. ALEXANDER.
 H. Res. 898: Mr. KENNEDY and Mr. Lee of New York.
 H. Res. 904: Mr. MCGOVERN, Mr. FILNER, and Ms. RICHARDSON.
 H. Res. 911: Mr. PENCE and Mr. BROUN of Georgia.
 H. Res. 923: Mr. THORNBERRY and Mr. KLINE of Minnesota.
 H. Res. 925: Mr. SMITH of Washington and Mr. ROE of Tennessee.
 H. Res. 945: Mr. TIAHRT.
 H. Res. 946: Mr. OLVER.
 H. Res. 947: Mr. HONDA.
 H. Res. 949: Mrs. BIGGERT and Mr. WAMP.
 H. Res. 951: Mr. TURNER.
 H. Res. 954: Mr. GERLACH.
 H. Res. 957: Mr. BOUCHER, Ms. FOXX, Mr. SHULER, Mr. SOUDER, Mr. POSEY, Mr. ROE of Tennessee, Mrs. MCMORRIS RODGERS, Mr. JONES, Mr. BOOZMAN, Mr. ADERHOLT, Mr. LATOURETTE, Mr. MASSA, Mr. PAULSEN, Mr. RADANOVICH, Mr. BURTON of Indiana, Mr. HILL, Ms. JENKINS, Ms. GRANGER, Mr. GINGREY of Georgia, Mr. SCHOCK, Mr. BUTTERFIELD, Mr. TIM MURPHY of Pennsylvania, Mr. BILBRAY, Mr. POE of Texas, Mr. ROGERS of Michigan, Mr. MCCOTTER, Mr. SHIMKUS, Mr. BROUN of Georgia, Mr. SPRATT, Mrs. CAPITO, and Mr. MARIO DIAZ-BALART of Florida.
 H. Res. 958: Mr. CALVERT.
 H. Res. 959: Mr. KING of Iowa, Mr. CULBERSON, Mr. BURTON of Indiana, Mr. GINGREY of Georgia, Mr. BARTLETT, Mrs. LUMMIS, Mr. PITTS, Mrs. SCHMIDT, Mr. WAMP, Mr. HALL of Texas, Mr. MARCHANT, Mr. SHADEGG, Mr. POSEY, and Mr. AKIN.
 H. Res. 960: Mr. WALZ, Ms. JACKSON-LEE of Texas, and Ms. ROYBAL-ALLARD.
 H. Res. 966: Mr. SMITH of Texas, Mr. KINGSTON, Mr. SHIMKUS, Mr. JORDAN of Ohio, Mr. HERGER, Mr. KLINE of Minnesota, and Mr. LAMBORN.
 H. Res. 967: Mr. CARSON of Indiana.
 H. Res. 970: Mrs. MILLER of Michigan.
 H. Res. 975: Ms. KILPATRICK of Michigan.

DISCHARGE PETITIONS— ADDITIONS OR DELETIONS

The following Members added their names to the following discharge petition:

Petition 5 by Mrs. BLACKBURN on H.R. 391: Randy Neugebauer, Devin Nunes, Michael R. Turner, Charles W. Boustany, Jr., Lamar Smith, John L. Duncan, Jr., Joseph R. Pitts, Tom McClintock, Ken Calvert, Jerry Lewis, Elton Gallegly, Judy Biggert, Trent Franks, Kevin McCarthy, Candice S. Miller, Walter B. Jones, Gus M. Bilirakis, Jo Ann Emerson, Thomas E. Petri, Roy Blunt, John Fleming, and Don Young.

The following Member added his name to the following discharge petition:

Petition 8 by Mr. NUNES on H.R. 3105: Roy Blunt.

EXTENSIONS OF REMARKS**SENATE COMMITTEE MEETINGS**

Title IV of Senate Resolution 4, agreed to by the Senate on February 4, 1977, calls for establishment of a system for a computerized schedule of all meetings and hearings of Senate committees, subcommittees, joint committees, and committees of conference.

This title requires all such committees to notify the Office of the Senate Daily Digest—designated by the Rules Committee—of the time, place, and purpose of the meetings, when scheduled, and any cancellations or changes in the meetings as they occur.

As an additional procedure along with the computerization of this infor-

mation, the Office of the Senate Daily Digest will prepare this information for printing in the Extensions of Remarks section of the CONGRESSIONAL RECORD on Monday and Wednesday of each week.

Meetings scheduled for Thursday, December 17, 2009 may be found in the Daily Digest of today's RECORD.

● This “bullet” symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

SENATE—Thursday, December 17, 2009

The Senate met at 10 a.m. and was called to order by the Honorable KIRSTEN E. GILLIBRAND, a Senator from the State of New York.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

O God, from whom all noble desires and all good counsels do proceed, crown the deliberations of our lawmakers with spacious thinking and with sympathy for all humanity. As they face perplexing questions, quicken in them every noble impulse, transforming their work into a throne of service. Lord, shower them with Your blessings, enabling them to see and experience evidences of Your love. May their consistent communication with You radiate in their faces, be expressed in their character, and be exuded in positive joy. Sanctify this day of labor with the benediction of Your approval. We pray in Your great Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable KIRSTEN E. GILLIBRAND led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 17, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable KIRSTEN E. GILLIBRAND, a Senator from the State of New York, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mrs. GILLIBRAND thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. REID. Madam President, following leader remarks, the Senate will resume consideration of the motion to concur with respect to H.R. 3326, the Defense Appropriations Act. The first hour will be equally divided and controlled between the two leaders or their designees. The Republicans will control the first 30 minutes and the majority will control the next 30 minutes. I filed cloture on the motion to concur. That vote will occur sometime in the next 10 or 12 hours.

PASSAGE OF CRITICAL LEGISLATION

Mr. REID. Madam President, we are going to finish this health care bill before we leave for the holidays.

For nearly an entire year, we have reached out to the other side, offered Republicans a seat at the table, tried to negotiate in good faith—nearly a whole year. Now we are closer than ever to fixing a badly broken system and doing more to make sure every American can afford to live a healthier life than this country has done in decades.

The Republicans have made their point. Through obstruction manuals, admissions that they believe stalling is good for electoral politics, and gambits like the one we saw yesterday; that is, forcing the full, hours-long reading of an amendment they did not like, and then complaining when that amendment they did not like was withdrawn, they have made their point to the American people. They have made it perfectly clear they have no interest in cooperating or legislating.

But the families and businesses who are suffering, hurting, and dying every single day have no time for these kinds of games. That is why we are going to finish health care whether the other side cooperates or not.

But health care is not the only critical issue this body faces. It is not the only critical issue to this country or before this body. Right now we have to complete a bill that supports the fighting men and women of this country, whether they are in Iraq, Afghanistan, Korea, Japan—all those many bases where tens of thousands of people are stationed. It is as simple as that.

Here are some of the good things in the bill that is now before the Senate, the message from the House. It funds more than \$100 billion for operations, maintenance, and military personnel requirements for the wars in Iraq and Afghanistan. Part of that money will also support preparations to continue

withdrawal from Iraq. There is more than \$23 billion for the equipment used by our servicemembers in Iraq and Afghanistan to do their jobs and stay safe. There is more than \$150 billion to train our troops and prepare them for battle. There is more than \$30 billion for the health care of our servicemembers, their families, and their children. It also gives our brave and valiant troops a pay raise of 3.4 percent this year.

This is not a partisan issue. Yesterday, this bill passed the House 395 to 34. More than 90 percent of Democrats voted for this bill. More than 90 percent of Republicans in the House of Representatives voted for this bill. That is because they know to our fighting men and women—these brave Americans half a world away, a lot of them—who wage two wars on our behalf, it is immaterial whether the leaders who will give them all the resources they need to succeed are progressives or conservatives. Surely, our troops who are on deployment after deployment after deployment spend more time counting the days until they can see their loved ones again than they do counting the political points scored by either side. They do not care most of the time, Madam President. They just do their jobs.

The House proved as much yesterday. The Senate should do the same today. We received this bill yesterday at 2 p.m. Are we going to wait until tomorrow to pass it? This simply is not right. Let's give our troops what they need to succeed, and do it now. Then let's get back to giving all Americans what they need to stay healthy.

These two bills—these two pieces of legislation—are about life and death. Our responsibility is too great to waste time playing political games.

RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The Republican leader is recognized.

HEALTH CARE REFORM

Mr. MCCONNELL. Madam President, Senators on both sides acknowledge that the health care bill we are considering is among the most significant pieces of legislation any of us will ever consider—I think, I would argue, the most significant piece of legislation certainly in my time here. So it stands to reason we would devote significant time and attention to it.

Indeed, some would argue we should spend more time and attention on this

bill than most—if not every—previous bills we have considered.

The majority, obviously, disagrees. Why? Because this bill has become a political nightmare—a literal political nightmare to them—as evidenced by more and more public opinion polls, including the Wall Street Journal/NBC poll out this morning. They know Americans are overwhelmingly opposed to it, so they want to get it over with as quickly as possible.

Americans are already outraged at the fact that Democratic leaders took their eyes off the ball, rushing the process on a partisan line that makes the situation even worse.

Americans were told the purpose of reform was to reduce the cost of health care. Instead, Democratic leaders produced a \$2.5 trillion, 2,074-page monstrosity that vastly expands government, raises taxes, raises premiums, and wrecks Medicare. And they want to rush this bill through by Christmas? They want to rush this bill through by Christmas that does all of these destructive things. One of the most significant, far-reaching pieces of legislation in U.S. history, and they want to rush it.

Here is the most outrageous part. At the end of this rush, they want us to vote on a bill that no one outside the majority leader's conference room has seen yet. No one has seen it. That is right. The final bill we vote on is not even the one we have had on the floor of the Senate. It is the deal Democratic leaders have been trying to work out in private. That is what they intend to bring to the Senate floor and force a vote on before Christmas.

So this entire process is essentially a charade. But let's just compare the process so far with previous legislation for a little perspective.

Here is a snapshot of what we have done and where we stand on this bill.

The majority leader intends to bring this debate to a close as early as this weekend—4 days from now—on this \$2.5 trillion mistake. No American who has not been invited into the majority leader's conference room knows what will be in the bill.

The bill has been the pending business of the Senate since last November—less than 4 weeks ago—but we have actually only started the amendment process 2 weeks ago—just 2 weeks ago on the amendment process.

We have had 21 amendments and motions—less than 2 a day.

So let's look at how the Senate has dealt with previous legislation, arguably of lesser consequence than this one.

No Child Left Behind in 2001: 21 session days over 7 weeks, 44 rollcall votes, 157 amendments offered.

The 9/11 Commission/Homeland Security Act in 2002: 19 session days over 7 weeks, 20 rollcall votes, 30 amendments offered.

The Energy bill in 2002: 21 session days over 8 weeks, 36 rollcall votes, 158 amendments offered.

Now, Madam President, this is not an energy bill. This is an attempt by the majority to take over one-sixth of the U.S. economy—to vastly expand the reach and role of government into the health care decisions of every single American—and they want it to be done after one substantive amendment—one large, substantive amendment. This is absolutely inexcusable.

I think Senator SNOWE put it best on Tuesday. This is what she had to say Tuesday of this week. "Given the enormity and complexity," Senator SNOWE said, "I don't see anything magical about the Christmas deadline if this bill is going to become law in 2014."

And I think Senator SNOWE's comments on a lack of bipartisanship at the outset of this debate are also right on point. Here is what Senator SNOWE said in November of this year—late November:

I am truly disappointed we are commencing our historic debate on one of the most significant and pressing domestic issues of our time with a process that has forestalled our ability to arrive at broader agreement on some of the most crucial elements of health care reform. The bottom line is, the most consequential health care legislation in the history of our country and the reordering of \$33 trillion in health care spending over the coming decade shouldn't be determined by one vote-margin strategies—surely—

Surely—
we can and must do better.

Well, Senator SNOWE is entirely correct.

The only conceivable justification for rushing this bill is the overwhelming—overwhelming—opposition of the American people. Democrats know the longer Americans see this bill, the less they like it.

Here is the latest from Pew; it came out just yesterday. A majority—58 percent—of those who have heard a lot about the bill oppose it, while only 32 percent favor it.

There is no justification for this blind rush, except a political one, and that is not good enough for the American people, and that is not justification for forcing the Senate to vote on a bill that none of us have seen.

Americans already oppose the bill. The process is just as bad. It is completely reckless and completely irresponsible.

Madam President, I yield the floor.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 2010

The ACTING PRESIDENT pro tempore. Under the previous order, the

Senate will resume consideration of the House message with respect to H.R. 3326, which the clerk will report.

The legislative clerk read as follows:

House message to accompany H.R. 3326, a bill making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes.

Pending:

Reid motion to concur in the amendment of the House to the amendment of the Senate to the bill.

Reid motion to concur in the amendment of the House to the amendment of the Senate with amendment No. 3248 (to the House amendment to the Senate amendment), to change the enactment date.

Reid motion to refer the amendment of the House to the Committee on Appropriations, with instructions, Reid amendment No. 3249, to provide for a study.

Reid amendment No. 3252 (to Reid amendment No. 3248), to change the enactment date.

Reid amendment No. 3250 (to amendment No. 3249), of a perfecting nature.

Reid amendment No. 3251 (to amendment No. 3250), of a perfecting nature.

The ACTING PRESIDENT pro tempore. Under the previous order, Senators are permitted to speak for up to 10 minutes each, with the first hour equally divided and controlled between the two leaders or their designees, with the Republicans controlling the first half and the majority controlling the second half.

The Senator from Arizona is recognized.

Mr. MCCAIN. Madam President, I ask unanimous consent that the Senator from Tennessee lead a colloquy including the Senator from Oklahoma, the Senator from Wyoming, myself, and the Senator from Kentucky.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. ALEXANDER. Madam President, I thank the Senator from Arizona.

I was thinking as I listened to the Republican leader, I wonder if the Senator noticed the comments of the Governor of California on Monday. Governor Schwarzenegger said on "Good Morning America" that he supports the idea of overhauling health care, but: "the last thing we need," said Governor Schwarzenegger, "is another \$3 billion in spending when we already have a \$20 million deficit."

He was referring to one of the unintended consequences of this bill, which is big State costs for Medicaid being shifted to the States—unfunded mandates.

So here is Governor Schwarzenegger's advice, following up on the comments of the leader: "So I would say be very careful to the Federal Government."

This is from the Governor of California:

Before you go to bed with all this, let's rethink it. There is no rush from one second to the next. Let's take another week or two. Let's come up with the right package.

I wonder if the Senator saw it.

Mr. MCCAIN. I thank the Senator from Tennessee who also understands this issue as well as or better than anyone, having been a Governor and recognizing the problems the Governors face.

If I could step back a second, Governor Schwarzenegger is a very astute observer of the political scene in California. May I point out to my colleagues, in this morning's Wall Street Journal: "Democrats' Blues Grow Deeper in New Poll," and then: "Support for Health Overhaul Wanes."

There is some remarkable information concerning the mood and views of the American people, following on a Washington Post ABC News poll out yesterday that says 51 percent of Americans say they oppose the proposed changes to the system; 44 percent approve.

Thanks to the efforts of so many people, including our leadership, we have turned American public opinion because we have been informing them of the consequences of passage of this legislation.

Let me quote from the Wall Street Journal article:

More Americans now believe it is better to keep the current health system than to pass President Barack Obama's plan, according to a new Wall Street Journal-NBC News poll. Findings mark a shift from the fall when the overhaul enjoyed the edge over the status quo. According to the poll, 44 percent of Americans said it is better to pass no plan at all compared with 41 percent who said it is better to pass the plan.

What they are saying is: Don't do this government takeover; don't increase taxes; don't increase spending; don't increase the costs. It is a remarkable shift, thanks to informing the American people.

Could I mention a couple of other points made in this poll in the Wall Street Journal. In September, 45 percent of Americans said they wanted the plan passed; 39 percent wanted to "keep the current system." In December, in polling out today, only 41 percent of the American people want it passed, and 44 percent say keep the current system.

Then, of course, we have another interesting statistic:

Trust that the government will do what is right: 21 percent say always or most of the time; 46 percent say only some of the time; and 32 percent of the American people say almost never.

Of course, the anger and disapproval of this health care plan right now is the centerpiece of Americans' dissatisfaction of the way we do business.

Let me say finally, because my colleagues wish to speak, we don't have a bill. We don't have a bill. Here we have been debating all this time and we do not have legislation. This was one of the bills we were presented with, but we know that significant changes are being made behind closed doors. We

don't have a CBO estimate of the cost, do we? We understand they keep sending estimates over to CBO and it comes back and so they send them back, which probably is why last week the Senator from Illinois, the No. 2 ranking Democrat, said to me, I don't know what is in the bill either. I have the exact quote:

I would say to the Senator from Arizona that I am in the dark almost as much as he is, and I am in the leadership.

That is an interesting commentary.

Of course, the issue of the protection of the rights of the unborn is still unclear. That is a big issue for a lot of Americans. It is a big issue with me, and I know it is a big issue with my colleagues.

So here we are back, off of the bill itself, and apparently we are going to have some kind of vote on Christmas Eve or something such as that.

What the American people are saying now is, when they say keep the status quo, they are saying: Stop. Go back to the beginning. Sit down on a bipartisan basis and let's get this done, but let's get it done right.

Americans know that Medicare is going broke. Americans know that costs are rising too quickly, but Americans want us to do this right and not in a partisan fashion and not with a bill that costs too much, taxes too much, and deprives people of their benefits.

Mr. ALEXANDER. Madam President, I thank the Senator from Arizona for his comments. We have two physicians in the Senate, Dr. COBURN from Oklahoma and Dr. BARRASSO from Wyoming. I wonder if they would bear with me for a minute or two to reflect on something the majority leader said—minority leader said—I hope he is the majority leader before too long—and the Senator from Arizona.

The minority leader, the Republican leader, talked about a historic mistake. There has been a lot of talk around here about making history on health care. The problem is there are many different kinds of history, as the Republican leader has pointed out. It seems our friends on the other side are absolutely determined to pursue a political kamikaze mission toward a historic mistake which will be disastrous for them in the elections of 2010, but much more important, for the country.

I did a little research on historic mistakes. We have made them before in the United States. Maybe we would be wise to take Governor Schwarzenegger's advice and slow down and stop and learn from our history rather than try to top our previous historic mistakes, such as the Smoot-Hawley tariff. That sounded pretty good at the time in 1930 when the idea was to buy American, but most historians agree it was a mistake and it contributed to the Depression.

There was the Alien and Sedition Act of 1798. It sounded good at the time. We

were going to keep the foreigners in our midst—they were mostly French then—from saying bad things about the government, but it offended all of our traditions about free speech.

In 1969 Congress enacted the "millionaires' tax," they called it, to try to catch 155 Americans who weren't paying any tax. That turned out to be a historic mistake, because last year it caught 28 million American taxpayers until we had to rush to change it.

Just a couple more. There was the Catastrophic Coverage Act of 1988. That was well named, but it turned out to be a catastrophe, a congressional catastrophe. The idea was to help seniors deal with illness-related financial losses, but seniors didn't like paying for it. They surrounded the chairman of the Ways and Means Committee in Chicago and now the leader of that group is a Member of Congress.

Then there was a luxury tax on boats over \$100,000, another historic mistake, because it raised about half the taxes it was supposed to and it nearly sank the boating industry and it put 7,600 people out of jobs.

I ask my friends from Oklahoma and Wyoming—it is going to be a lot harder for Congress, if they try to fix the health care system all at once, to come back and repeal it than it was to repeal a boat tax. Do my colleagues think we ought to take the time to avoid another historic mistake?

Mr. COBURN. Well, I would answer my colleague from Tennessee. As a practicing physician, what I see as the historic mistake is we are going to allow the Federal Government to decide what care you are going to get. We are going to compromise the loyalty of your physician so that no longer is he or she going to be a 100-percent advocate for you, he or she is going to be an advocate for the government and what the government says. Because in this bill—even the one that is going to come—there are three different programs that put government bureaucracy in charge of what you can and cannot have. It doesn't consider your personal health, your past history, or your family history; they are going to say here is what you can and cannot do. That is called rationing. That is in the bill. That is coming. That is a historic mistake because it ruins the best health care system in the world in the name of trying to fix a smaller problem in terms of access, and it ignores the real problem.

The real problem is health care in this country costs too much. We all know this bill doesn't drive down costs, it increases costs. So your premiums go up, your costs go up, your care is going to go down because the government is going to tell you what you have to have.

I think that is a historic mistake and we have not addressed that. I wonder what my colleague from Wyoming thinks.

Mr. BARRASSO. Madam President, I agree completely. As a practicing physician taking care of people in Wyoming for 25 years, I have great concerns about this bill, what we know for sure is in it, which is \$500 billion of cuts in Medicare to our patients who depend on Medicare, and that is a system that we know is going broke. That is why there is a front-page story in one of the Wyoming papers: "Doctors Shortage Will Worsen." It is going to be harder on rural communities and others around the country if this goes through, and we know that because the folks who have looked at the parts of the bill we have seen have said that one-fifth of the hospitals in this country will be—if they are able to keep their doors open—operating at a significant loss 10 years from now. That is not the best future for health care in our country.

I had a telephone townhall meeting. People from all around the State of Wyoming were calling in and asking me questions, and they asked: What is in the bill? What is coming to the Senate?

We don't know yet. We haven't seen it.

They said: Well, when you find out, come home and let's have some more townhall meetings so we can have some input.

That is what we ought to do as a Senate. We ought to know what is in the bill and then let us go home and share it with our friends so they know. Because right now what the American people have seen of this bill, the 2,000-page bill, they rightly believe this will increase the cost of their own personal care.

Mr. COBURN. Madam President, if my colleague would yield, yesterday I asked the chairman of the Finance Committee to agree to a unanimous consent request that, in fact, for at least 72 hours the American people would get to see this bill; the Members of the Senate would get to see this bill; that there be a complete CBO score so we can have an understanding. He denied that request.

That comes back to transparency. The American people expect us to know exactly what we are voting on. They expect us to have read what we are voting on. His explanation was: I can't guarantee that. It presumes a certain level of perception on my part, an understanding of delving into the minds of the Senators that they could actually understand. What does understand mean? That is the kind of gibberish the American people absolutely don't want. They want us to know what we are voting on when we get ready to vote on this bill.

Mr. MCCAIN. Madam President, isn't that a violation of the commitment that was made that for 72 hours any legislation would be online, not just for us to see but for all Americans to see?

Could I ask the Senator from Kentucky, the Republican leader: Is it not the perception now that this bill is probably going to be pushed through? Through various parliamentary procedures, the majority will try to force a final vote on this legislation, no matter what, before we leave? Isn't that in contradiction to what the majority of the American people are saying, that they want us to do nothing? Is this a responsible way to govern, to have the Senate in round the clock, 24 hours, people on the floor, quorum calls and all this kind of stuff; and there would also be no amendments allowed at that time for us to at least address some of the issues of this bill that begins cutting Medicare by \$500 billion, increases taxes by \$500 billion on January 1, and in 4 years begins spending \$2.5 trillion? Is this a process the American people are reacting to in a negative fashion, obviously, by polling data?

By the way, I ask unanimous consent that the Wall Street Journal article entitled "Democrats' Blues Grow Deeper in New Poll" and "Support for Health Overhaul Wanes" be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Wall Street Journal, Dec. 17, 2009]

DEMOCRATS' BLUES GROW DEEPER IN NEW POLL

(By Peter Wallsten)

WASHINGTON.—Less than a year after Inauguration Day, support for the Democratic Party continues to slump, amid a difficult economy and a wave of public discontent, according to a new Wall Street Journal/NBC News poll.

The findings underscored how dramatically the political landscape has changed during the Obama administration's first year. In January, despite the recession and financial crisis, voters expressed optimism about the future, the new president enjoyed soaring approval ratings, and congressional leaders promised to swiftly pass his ambitious agenda.

In December's survey, for the first time, less than half of Americans approved of the job President Barack Obama was doing, marking a steeper first-year fall for this president than his recent predecessors.

Also for the first time this year, the electorate was split when asked which party it wanted to see in charge after the 2010 elections. For months, a clear plurality favored Democratic control.

The survey suggests that public discontent with Mr. Obama and his party is being driven by an unusually grim view of the country's status and future prospects.

A majority of Americans believe the U.S. is in decline. And a plurality now say the U.S. will be surpassed by China in 20 years as the top power.

Democrats' problems seem in part linked to their ambitious health-care plan, billed as the signature achievement of Mr. Obama's first year. Now, for the first time, more people said they would prefer Congress did nothing on health care than who wanted to see the overhaul enacted.

"For Democrats, the red flags are flying at full mast," said Democratic pollster Peter

Hart, who conducted the survey with Republican pollster Bill McInturff. "What we don't know for certain is: Have we reached a bottoming-out point?"

The biggest worry for Democrats is that the findings could set the stage for gains by Republican candidates in next year's elections. Support from independents for the president and his party continues to dwindle. In addition, voters intending to back Republicans expressed far more interest in the 2010 races than those planning to vote for Democrats, illustrating how disappointment on the left over attempts by party leaders to compromise on health care and other issues is damping enthusiasm among core party voters.

But public displeasure with Democrats wasn't translating directly into warmth for Republicans. Twenty-eight percent of voters expressed positive feelings about the GOP—a number that has remained constant through the Democrats' decline over the summer and fall. Only 5% said their feelings toward the Republicans were "very positive."

And in one arena, Afghanistan, Mr. Obama appeared to have some success in winning support for his planned troop surge. Liberals remain largely opposed to the strategy, but in fewer numbers compared with before Mr. Obama made his case in a speech at West Point. Overall, by 44% to 41%, a plurality believe his strategy is the right approach.

Still, the survey paints a decidedly gloomy picture for Democrats, who appear to be bearing the brunt of public unease as unemployment has risen from 7.6% to 10% since Mr. Obama took office. Just 35% of voters said they felt positively about the Democratic Party, a 14-point slide since February. Ten percent felt "very positive."

"Overall, it's just a depressing time right now," said Mike Ashmore, 23 years old, of Lansdale, Pa., an independent who supported Mr. Obama last year but now complained about the president's lack of action on jobs.

Julie Edwards, 52, an aircraft technician for Boeing Co. in Mesa, Ariz., said she voted Democratic in the past two elections but wasn't sure how she would vote next time. She wondered why Wall Street firms were bailed out when average Americans needed help. "We can bail out Wall Street, but everybody else has to suffer in spades for it," she said.

Democratic leaders, while bracing for losses next year, have argued that unlike the 1994 elections, in which Republicans gained 54 seats and took the House majority, Democrats would survive 2010 in part because they are taking steps to avoid that possibility. Republicans must gain 41 seats to take control.

House Speaker Nancy Pelosi said Wednesday that Democrats "fully intend to be in the majority" after November 2010, and she was now shifting to "campaign mode" to help candidates. Party officials are leaning on a number of longtime colleagues to fight for their seats rather than retire.

The Journal/NBC survey found Ms. Pelosi's presence on the campaign trail could do more harm than good. Fifty-two percent said they would be less likely to vote for a candidate who agreed with the speaker almost all the time, compared with 42% who felt that way about candidates siding with Republican leaders.

For Mr. Obama, who has relied on his personal popularity to retain the clout he needs to enact his legislative agenda, the survey pointed to troubling signs.

A majority for the first time disapproved of his handling of the economy. And the

public's personal affection for the president, a consistent strong suit, has begun to fray. Fifty percent now feel positive about him, six points lower than in October and an 18-point drop since his early weeks in office.

Democrats' troubles can be attributed in part to changing feelings among some core supporters. A third of voters 34 and under, a group that turned out heavily for Democrats last year, feel negative toward the Democratic Party. And just 38% of Hispanics feel positive, down sharply from 60% in February.

The survey, which was conducted Dec. 11-14, has a margin of error of 3.1 percentage points.

[From the Wall Street Journal, Dec. 17, 2009]

SUPPORT FOR HEALTH OVERHAUL WANES

(By Janet Adamy)

The public is turning against an overhaul of the health-care system, complicating Democrats' effort to pass a sweeping bill in the Senate.

More Americans now believe it is better to keep the current health system than to pass President Barack Obama's plan, according to a new Wall Street Journal/NBC News poll. The findings mark a shift from the fall, when the overhaul enjoyed a slight edge over the status quo. They could make it more difficult to get wavering lawmakers on board as the Senate prepares to vote on the measure as soon as next week. Some Democrats expect support will rebound if they can pass a bill quickly and start selling it.

According to the poll, 44% of Americans said it is better to pass no plan at all, compared with 41% of Americans who said it's better to pass the plan. In early October, 45% of respondents preferred passing a bill, while 39% preferred passing no bill. Uninsured people were among those who have grown less supportive of the plan.

In seeking support for his top domestic priority, Mr. Obama has said the status quo wasn't acceptable because insurance premiums were rising sharply and government insurance programs were headed toward insolvency. Republicans have argued that many Americans could be worse off, particularly the elderly, because the legislation contained hundreds of billions of dollars in cuts to health-care providers through Medicare. The legislation would extend health-insurance coverage to at least 30 million more Americans by widening the Medicaid federal-state insurance program for the poor and providing subsidies to lower earners to help them buy coverage.

The idea of creating a government-run health-insurance option still enjoys considerable support. Democrats dropped the idea from the Senate version of the health bill. When asked what they thought of removing the public option, 45% of respondents said that wasn't acceptable, while 42% called it acceptable.

Respondents also favored letting people buy into Medicare starting at age 55, another idea Democrats abandoned to win the support of centrists needed to pass the bill in the Senate.

Democrats "clearly have irritated their own base in a way that has dropped their enthusiasm for their own plan," said Bill McInturf, a Republican pollster who conducted the Wall Street Journal/NBC News poll with Democratic pollster Peter Hart.

In September, 81% of liberal Democrats thought the health plan was a good idea, and 6% thought it was a bad idea. In the most recent survey, 66% of liberal Democrats called it a good idea, while 13% called it a bad idea.

House Speaker Nancy Pelosi suggested the decline in support for the health legislation was due to "mischaracterization" by opponents. She predicted views would turn around when the House and Senate coalesced around a single bill and the president began selling it to the public. "It's very hard to merchandise health care until you have a bill," she said.

Mr. McCONNELL. Madam President, I say to my friend from Arizona, with reference to the issue of the process, it has been a bit of a charade—in fact, a whole charade. We have been out here for 2 weeks on the amendment process. We have had 21 votes, many of them have been side-by-sides, in order to cover the majority against the potential downside of voting to cut Medicare and voting to raise taxes.

But there is no serious effort to engage in any kind of genuine amendment process, such as the Senator from Arizona and I have been involved in here for quite a while. Then the bill, which we are actually only allowed to have about two votes a day on, is not the real bill. The real bill—we know the core of it, but there are a lot of things around the edges being slipped in and slipped out, and they want to jam the public before Christmas, as the Senator from Arizona indicated.

How arrogant is that? They think: We know better than you, we know better than the Republicans, and we know better than the public. Why don't all of you—the Republicans and the public—sit down and shut up and leave it to us and we will take care of it before Christmas.

Mr. ALEXANDER. I say to the Republican leader and the Senator from Kentucky, I believe there is another bit of history being made. This process is historic in its arrogance. This isn't very hard to understand. The proposal is to take 17 percent of our economy, affecting 300 million Americans, and nothing could be more personal, as the Republican leader has said, than our health care.

But now we don't have the bill. We do not have the bill. It is being written in secret in another room. If there is any part of this debate that went through to every single household in America, I believe it was when the Finance Committee voted down a motion—the Democrats voted down a motion that the bill should be on the Web for 72 hours so that the American people could see the text, know what it costs, and know how it affects them.

Eight Democratic Senators wrote the Democratic leader and said they want to insist that they know what the text is, and that they have the official score from the Congressional Budget Office, and that they have it for 72 hours before we move to vote.

We don't have the bill. We don't have the official score from the CBO. Seventy-two hours is three more days, and even though eight Democratic Senators and all the Republican Senators

said we want to know what it costs, know what it is, and how it affects us, they want to run it through before Christmas.

Mr. MCCAIN. May I mention to my colleague that maybe the reason why they don't want it to be online for 72 hours is because when they examined what we have—on page 324 in this bill is an \$8 billion tax on individuals who have nongovernment approved plans. On page 348 is a \$28 billion tax on businesses that cannot afford to offer insurance to their employees. On page 1979: Raises an almost \$150 billion tax on many middle-class workers using so-called Cadillac health insurance plans. Page 1997: Will cost families and individuals an additional \$5 billion by prohibiting the use of savings set aside for health care expenses through health savings accounts. Page 2010: Will make the cost of lifesaving medicine more expensive by taxing pharmaceutical research firms an additional \$22 billion. The list goes on and on, including on page 2040: Increasing Medicare payroll taxes by \$53.8 billion.

That may be a reason why it is going to be difficult for them to win passage of this after 72 hours of examining this bill.

Mr. McCONNELL. It makes this bill, in addition to all of the other problems, a job killer. With unemployment at 10 percent, there is a big tax increase on a variety of different Americans, as Senator McCain pointed out, in addition to all of its other problems—substantive problems, process problems. It is a job killer in the middle of a very difficult recession.

Mr. COBURN. I say to my colleagues that one of the things President Obama said he wanted to have was transparency. There has been no transparency in the process. That is why at least if there is not going to be transparency in the process, we ought to at least have it transparent to the American people for 72 hours. This is a quote from the chairman of the Finance Committee:

I think it is impossible to certify that any Senator will fully understand.

We are going to have a 2,000-plus page bill, and the chairman of the Finance Committee says he thinks it is going to be impossible to certify that any Senator will fully understand this bill. That is the best reason I know not to pass this bill, because if we don't understand it, you can bet the American people aren't going to understand it.

Mr. MCCAIN. When more Americans begin to understand it, they don't want it. That is thanks to the efforts made all over this country to educate the American people about what the impact of the bill will be.

Mr. BARRASSO. Following along what the Senators are saying, that is why the support of the American people for the bill is at an all-time low. It is at the lowest level of support ever.

According to this NBC poll, fewer than one out of three Americans support this bill. They don't know all that is in it, but they don't like what they see so far, because they believe, in overwhelming numbers, that the cost of their own care will go up, that this will add to the deficit, it will hurt the economy, and their health care would actually be better if we pass nothing.

So why would the American people support a bill that is going to cost them more personally and when their health care will get worse? That is not the value the American people have ever wanted.

That is what I hear from patients at home, and it is what I hear on telephone town meetings. That is what we are hearing in all of our States. This is what the American people continue to say: Do not pass this bill.

As our leader said, we do need health care reform, and Dr. COBURN certainly knows that. But it is not this reform that we need.

Mr. ALEXANDER. We come to the floor every day and point out the problems with the bill. We don't have a bill now, we can't read it, and we don't know how much it costs or how much it affects the American people. It raises taxes and premiums. It will increase the debt, because it doesn't include things such as the physicians Medicare reimbursement. It cuts Medicare by \$1 trillion over 10 years once it is fully implemented.

We point out what we think should be done. My colleagues have talked about it many times. Instead of wheeling in another 2,000-page bill, we should focus on the goal of reducing costs, and we should take several steps toward doing that. The Senator from Arizona talks about one of those things, which is reducing the number of junk lawsuits against doctors. I don't think that is in the bill, unless it is secretly being added in the back room today.

Mr. MCCAIN. Well, I don't think that is being added today. Again, I also point out that Americans are now against passage of this legislation. But in that polling data, it is very interesting, also, the majority of seniors, by much larger numbers—the actual beneficiaries of Medicare—are turning against it, and the intensity of Americans against it—which is harder to gauge in a poll—is incredible.

If the responses that our efforts are getting are anything close to indicative of the mood of the American people, and the intensity of it, it is probably as great as I have ever seen in the years that I have had the privilege of serving in the Congress of the United States.

This polling data says more Americans now believe it is better to keep the current health system than to pass President Obama's plan. That is a message being sent, and the intensity is higher than any I have ever observed in

my years of service. I thank them for that.

There is a chance that we can stop this, and we start in January. We would be willing to come back and sit down and negotiate, with the C-SPAN cameras on—as the President said or committed he would do as a candidate. We would sit down together here, at the White House, or anywhere, and we can fix this system that we all know needs fixing.

As the Senator from Oklahoma said, it is the cost that has to be addressed, not the quality.

Mr. COBURN. I want to bring up an example. We are going to see this time and time again if the bill goes through. We had the U.S. Preventive Health Task Force put out a recommendation on breast cancer screening through mammography on the basis of cost. They said it is not cost effective to screen women under 50 with mammograms, because you have to screen 1,900 before you find 1 breast cancer. On cost, they are right; but over 50, you have to screen 1,470.

So what we had was a decision made on cost, not on quality, not on patients, but based on cost. We fixed that as part of an amendment to this bill. We actually fixed that. There are three different agencies within this bill that are going to do the same thing. Every time they make a ruling based on cost, not on clinical outcomes and what is best for patients, are we going to fix it? No. We are transferring the care of the American patient to three bureaucracies within the Federal Government, and they are going to decide what you have to do. If you think about it, this week the wife of a Member of this body was diagnosed with breast cancer. She was diagnosed through a mammogram. Under that task force's recommendation, she would not have gotten that mammogram.

Mr. MCCAIN. I ask the Senator from Oklahoma, would that aspect of this bill come to light if it hadn't been for the recommendation that was made by another similarly acting policymaking body? In other words, that is what triggered the investigation of what was in this bill, which would have had exactly the same effect. So if we hadn't had that information of a recommendation by another government policymaking bureaucracy, we would not have known about this until the bill would have taken effect.

Mr. COBURN. So there is no transparency. What we do know is that we are going to have three organizations, the Medicare Advisory Commission, the Cost Comparative Effectiveness Panel, and the U.S. Preventive Health Task Force that will tell everybody in America what they are going to receive.

Mr. MCCAIN. This example wouldn't have been known if it hadn't been for the actions of the bureaucracy. Doesn't

that bring into question what else is buried in this 2,000-page piece of legislation?

Mr. COBURN. What are the unintended consequences of this that they don't know? What we do know is there are 70 new Government programs that will require over 20,000 new Federal employees, and there are 1,690 different times when the Secretary of HHS will write rules and regulations about your health care in America—the Secretary, not your doctor; your doctor isn't going to write the regulations. The Secretary of HHS is going to write the rules.

Mr. MCCAIN. Let me point out again that we don't know what the CBO estimate is, because we know the majority leader keeps bouncing proposals back and forth to CBO. That is why we haven't had CBO information now for many days. But there is the Commission for Medicare and Medicaid, which clearly points out that this legislation would increase taxes dramatically, increase costs dramatically, decrease care, and it would have the effect of forcing people not only out of the system, but even if they are in the Medicare system, they would not have physicians to provide the care, because more and more physicians would fail to treat Medicare patients.

Mr. COBURN. So we go back to the 72 hours. We are going to get a new bill, but we will not have the opportunity to amend it. We are not going to be able to read it and study it, nor are the American people. What do you think the outcome of that will be?

Mr. MCCAIN. I think we know what the outcome will be. We will either be able to reflect the feelings and intense feelings of the majority of the American people about this legislation and say let's go back to square one and all commit to a bipartisan approach to this issue or we will see jammed through on Christmas Eve legislation that will have the most far-reaching effects and devastating effects, I think, not only on our ability to provide much-needed medical care to all of our citizens, but also an impact that would be devastating on the debt and deficit, upon which we have laid an unconscionable burden already.

We have two choices—to go back to the beginning and enact many reforms we can agree on—and there are many we could agree on immediately on a bipartisan basis; as the Senator from Tennessee pointed out, there has never been a fundamental reform made in modern history that was not bipartisan—or we are going to see jammed through, over the objections of a majority of Americans, legislation that they have never seen, read, or understand.

That is the choice we have. That is what it is boiling down to. I think that, frankly, the American people should be heard, not a majority over on the other side.

Mr. BARRASSO. The American people are saying: Don't cut my Medicare, don't raise my taxes, don't make things worse than they are right now, and this bill cuts Medicare, raises taxes, and for people depending on a health care system in this country this makes things worse.

Mr. MCCAIN. By the way, could I mention, if you live long enough, all things can happen. I now find myself in complete agreement with Dr. Howard Dean, who says we should stop this bill in its tracks; we should go back to the beginning and have an overall bipartisan agreement. Dr. Dean, I am with you.

The PRESIDING OFFICER (Mr. BENNET). The Senator's time has expired.

The Senator from Pennsylvania.

Mr. SPECTER. Mr. President, I ask unanimous consent that I may speak up to 20 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SPECTER. Mr. President, I have sought recognition to comment about the Patient Protection and Affordable Care Act. It has been an extraordinary legislative process with a good bit of the calendar year 2009 taken up with very intensive work to try to pass health care reform. At the moment, there is still some doubt as to what will happen with the bill. The Congressional Budget Office has not yet submitted a report on the so-called managers' package.

There are still some concerns being expressed by some Senators. I can understand the frustration that some have had as we have moved away from a public option. I have been an advocate of a robust public option and think it ought to be part of the legislation.

The public option is what it says. It is an option. There have been efforts made to demagog the issue by saying it is a takeover by the Federal Government. It is not. The private insurance industry remains in the field, and this is one option.

As President Obama has put it, it is an option to try to keep the private insurance companies honest. We have seen, in the past several months, very large increases in premiums for small business. The reports have been that those increases in premiums have come from Wall Street pressure on the insurance companies to try to increase their profits before there is legislation. The public option would be a forceful factor dealing there.

When the objections were raised to the public option and in an effort to find 60 votes—it is difficult when you have no help at all from the Republican side of the aisle, illustrated by the performance just put on with their prepared colloquy—it is not easy to find everyone in agreement. Then there was an effort to move to expand Medicare. I think that is a fallback position that would have been very helpful.

There are some who are contending that people who are disappointed with the lack of a public option and disappointed from the retreat of expanding Medicare say we ought to start over and begin again. I can understand that frustration.

My own view, after thinking it through very carefully, is we ought to proceed and do as much as we can this year, realizing that some of the tough legislative achievements take a period of time to accomplish. But the Civil Rights Act of 1957 was necessary, although it did not go as far as people would have liked then, to get the Civil Rights Act of 1964. Again, it did not go as far as people would have liked, but we did find the Voting Rights Act of 1965. We have to find times when we have to build incrementally on these matters.

I have been in the Senate following the elections of 1980, and I have seen matters take a very substantial period of time. While it is not on the subject, we were trying to provide more than 100,000 jobs in Pennsylvania by deepening the channel. The authorization came in 1983. It took until 1992 to get the Corps of Engineers to agree on funding. Now it has \$77 million. We are still in court, but it is going to move forward. I do not expect health care legislation to take that kind of a long term, but it is a matter which does take some time.

It is my hope we will yet improve this bill. It is my hope that when the bill goes to conference, we will find a way, perhaps, even to bring back the public option in a refined sense. The public option is in the House bill.

One Republican Senator has stated opposition on the ground that there has not been time enough to review the bill. It is complicated. I think there has been time enough to review the bill. But I respect the view of the Senator on the other side of the aisle. When the bill goes to conference, that Senator will have an opportunity to review the bill further. That Senator has shown some inclination to support the bill, having voted it out of the Finance Committee.

Another Republican Senator has commented that the bill has been very greatly improved, not sufficiently for the taste of that Senator, but perhaps we will find a way to improve the bill. We still do have a bicameral legislature. We do have the House of Representatives which has the public option.

Comments were made about the fall of the expansion of Medicare on the ground it was considered in too brief a period of time, not enough time to digest it, not enough time to think through. We will have, in the month of January, some time to consider that further, and in conference we may well find we are able to improve the bill. We cannot get to conference unless we pass the bill out of the Senate.

I was asked yesterday how will I respond to my constituents if we have the bill which has had so much taken from it. I said: A more relevant question or an equally relevant question is how will I respond to my 12 million constituents in Pennsylvania if we go home with nothing. If we have 80 percent accomplished, then that is a starting achievement.

It may well be it will take the campaign in 2010. If this Congress will not pass a bill with a robust public option, it could well be a campaign issue.

I believe my colleagues on the other side of the aisle may well be misreading the American people. I believe the American people do want health reform. It does take time for the American people to understand the ramifications of it. But this may well be a campaign issue in 2010. The 112th Congress may have a different view as to how we ought to proceed.

During the month of August, when I was making the rounds of town meetings in Pennsylvania, in accordance with my habit to cover almost every county almost every year, when I got to the first town meeting, the second Tuesday in August, the first week we were in recess, I found instead of the customary 85 or 100 people, more than 1,000 people and 3 national television sound trucks—CNN, MSNBC, and FOX. There were a lot of vituperative statements. One man approached me apoplectic and said the Lord was going to stand before me. I think he got mixed up. I think he meant to say I was going to stand before the Lord. Senators are reputed to have power but not quite that much power. I think the public tenor is considerably more favorable to health care insurance today than it was then. After the 2010 election, it may be substantially more favorable.

We have to move ahead with building blocks, and we do have a chance to improve the bill in conference.

I point to the provisions of the bill as to what we have. We have very significant insurance reforms. We have eliminating discrimination based on pre-existing conditions. We have new health insurance exchanges. We have an elimination of a cap. We cover many of the uninsured, expanding to some 33 million additional people. We have substantial more small business assistance, preventive care, increased health workforce. We have improvements in the health delivery system. We have fiscal responsibility that this bill will not add to the deficit but will, in fact, reduce the deficit in the first decade by some \$120 billion and in the second decade by some \$650 billion.

We have a provision I have pressed in earlier legislation, S. 914, to provide for transformational medicine.

During my tenure as chairman of the Appropriations Subcommittee on Health and Human Services, I took the lead, with the concurrence of Senator

HARKIN, who was then in the minority, to increase NIH funding from \$12 billion to \$30 billion and then in the stimulus package to add \$10 billion more. There has been a gap on what we call transformational medicine, going from the so-called bench in the laboratory to the bedside. While I have not seen the final version of the managers' packet, I am informed that provision will be a part of the bill.

We have very important measures for preventive care, for annual exams, which will cut off many chronic illnesses which are so debilitating and so expensive.

I have pressed an amendment, which is pending, to have mandatory jail sentences for at least 6 months for someone convicted of \$100,000 or more of Medicare or Medicaid fraud. Jail sentences are a real deterrent. The experience I had as Philadelphia's DA showed me that when you have a fine, that is added onto the cost of doing business and is passed on to the consumers.

I ask unanimous consent to have printed in the RECORD a statement of the provisions which I briefly summarized which are very favorable in this bill and a statement of testimony at a Criminal Justice Subcommittee to show the value of deterrence.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

PROVISIONS IN THE PATIENT PROTECTION AND
AFFORDABLE CARE ACT
GENERAL INSURANCE REFORMS

Insurance companies will be barred from discriminating based on pre-existing conditions, health status, and gender.

New health insurance Exchanges will make coverage affordable and accessible for individuals and small businesses.

UNINSURED

With a reported 47 million people without health insurance the status quo is not acceptable. Additionally, there are millions more Americans who are underinsured, with health insurance that is inadequate to cover their needs.

In 2007, 1,206,115 Pennsylvanians under age 65 were uninsured for the entire year, which is 11.3 percent of the under 65 population.

The analysis found that the legislation would extend coverage to 33 million more Americans, bringing the percentage of Americans with health insurance to 93%.

The bill covers 10% more Americans with only a 0.7 percent increase in spending—a change of only 0.1% of GDP in 2019.

SMALL BUSINESS ASSISTANCE

In the current health insurance market small business are at a distinct disadvantage in providing health insurance to their employees. In a recent study it was found that 58 percent of small employers do not offer health insurance, with nearly 50 percent stating that they can't afford it.

The Patient Protection and Affordable Care Act address health insurance problems facing small businesses by providing more health plan choices, fairness in the marketplace and improving affordability with tax credits.

PREVENTATIVE CARE

The Patient Protection and Affordable Care Act will eliminate co-pays and

deductibles for recommended preventive care, provide individuals with the information they need to make healthy decisions, improve education on disease prevention and public health, and invest in a national prevention and public health strategy.

INCREASE HEALTH WORKFORCE

Currently, 65 million Americans live in communities where they cannot easily access a primary care provider, and an additional 16,500 practitioners are required to meet their needs. The Patient Protection and Affordable Care Act will address shortages in primary care and other areas of practice by making necessary investments in our nation's health care workforce.

IMPROVEMENTS IN THE HEALTH DELIVERY
SYSTEM

The legislation we are considering will establish an Independent Medicare Advisory Board to present Congress with proposals to reduce cost growth and improve quality for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, Board proposals will take effect unless an alternative is adopted by Congress. This type of reform is necessary to ensure the financial future of Medicare.

Preventable hospital readmissions diminish quality and efficiency in the health care system. Nearly 20 percent of Medicare patients who are discharged from the hospital are readmitted within 30 days. The Medicare Payment Advisory Commission (MedPAC) estimates that Medicare spent \$12 billion on potentially preventable hospital readmissions in 2005, which would be more than \$15 billion today.

The bill also begins the payment system reform of bundling Medicare provider payments as a lump sum fee—instead of paying a fee for each service—encourages care coordination and streamlining. It removes the incentive to generate additional services for added reimbursement.

FISCAL RESPONSIBILITY

The legislation is fully paid for and reduces the deficit in the next ten years and beyond.

The revenue provisions in the bill focus on paying for reform within the health care system.

THE COST OF INACTION

In 2000, family health insurance purchased through an employer cost \$6,438 and consumed 13 percent of median family income. In 2008, the same family health insurance cost \$12,680, a 97 percent increase over the 2000 cost, consuming approximately 21 percent of median family income. In 2016, the same insurance is projected to cost \$24,291, nearly double the 2008 cost, which will consume 45 percent of projected median family income.

Let's kind of go back to (inaudible). Can you—each one of you, starting with Mr. Perkins, talk about kind of what's the—the impact of criminal prosecutions and prison time versus civil actions and fines.

KEVIN PERKINS, Assistant Director, FBI: Yes, Senator. The—it's really a combination of both. We, obviously, are very successful in the health care fraud side, where we have civil remedies that we utilize each day in our investigations there. But again, I'm a—I'm a very strong proponent of criminal prosecutions that involve serious jail sentences for white-collar criminals. That is a huge deterrent.

I've seen it over the years, and I—I know—I know that, from my own personal experience, going and interviewing individuals who

are—who—white-collar criminals who have been—or are doing jail time, going and talking to them on various occasions—it's—it's a huge deterrent. It's—it's something that we have to have, going forward, to make this work.

KAUFMAN: Mr. Khuzami.

ROBERT KHUZAMI, Director, Securities and Exchange Commissions Division of Enforcement: (Inaudible), yes, but there's—there's no deterrent that's a substitute for jail time. I miss the cooperation tools, and I—I miss the sentencing guidelines even more. But there is a very significant role for the civil regulators as well, simply because: Because of the standard of proof of beyond a reasonable doubt and the necessity of convincing 12 jurors of the—of the guilt of someone, the criminal authorities, by definition, cannot and should not capture the whole field of wrongdoing.

And so what you'll often see is criminal authorities focused on the core wrongdoers, and we may cast a wider net—because we have a lower standard of proof—cast a wider net amongst those involved in the wrongdoing as well. And in particular, there's lots of wrongdoing that goes on that doesn't rise to the level of criminal intent, all sorts of activity across regulated broker-dealers and investment advisors and others where, if you can at least make it unprofitable—so that they have to give back the money they wrongfully got, pay a penalty, perhaps suffer time out or lose their license—that, too, has a significant impact.

KAUFMAN: Mr. Breuer.

LANNY BREUER, Assistant Attorney General: Senator, obviously, as Rob (ph) says: A comprehensive approach is essential. Civil remedies are essential. But I've had many years in the private practice, and I've had many years when I represented individuals, and I can tell you, Senator: In a white-collar case—I've been in the conference room with my clients—there is nothing—there is nothing like an individual—who feels as if he or she has been sort of the center of their community, is well-respected and has had a comfortable life—realizing that they're facing jail time. The terror in their eyes is like nothing else, and there's simply no deterrent like it.

KAUFMAN: You know, I think I know the answer to this, but I think it'd be good to be on the record, and starting with you, Mr. Breuer. Why don't—why haven't we seen more, you know, board room prosecutions?

Mr. SPECTER. Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. The Senator has 7 minutes remaining.

Mr. SPECTER. I thank the Chair.

Mr. President, there is another very important aspect, in my opinion, of the Senate enacting legislation on this bill; that is, we were sent to Washington to govern. What we have seen in the recent past has been staggering partisan politics. Partisan politics became a blood sport in Washington, DC. It is a blood sport on the floor of the Senate. It pervades the entire town.

The point from the Republican side of the aisle has been very clear; that is, to make this President Obama's Waterloo, to make this "break President Obama."

I saw the ramifications when we took up the stimulus package earlier this year. There were only three Republicans—Senator SNOWE, Senator COLLINS, and myself—who would even talk

to the Democrats. There was a determination to look ahead to the 2012 elections on the Presidency even before the ink was dry on the oath of office taken by President Obama on January 20. This was the second week of February, the week of February 6, as I recall, just a couple weeks, and already the plans were for the next election.

As I reviewed the matter, it seemed to me we were on the brink of going into a 1929 Depression. The 1929 Depression was very hard on the Specter family, living in Wichita, KS, at the time. Both of my parents were immigrants. In the mid-1930s, the family moved from Wichita to Philadelphia to live with my father's sister. That is what happened in the Depression—you moved in with relatives because there were no jobs.

I sided with supporting the stimulus package and played a key role in having that enacted. And the political consequences on a personal level are not something to be discussed on this floor at this time, but the conduct of partisanship on the stimulus package is directly relevant to what we are doing here today, and that is that we are being stonewalled.

I think it is harder for a Republican to stand up on health care reform and join the Democrats today than it was in January and in February when three of us did so. And if I were on the other side of the aisle today, I would be supporting health care reform. I would be supporting, and perhaps, if I were on the other side of the aisle today, I could bring somebody with me. I don't know. That is entirely speculative.

Without revealing any more of the confidence which went on inside of the Republican caucus, when I talk about a Republican Senator's statement that this should be the Waterloo of President Obama and this should break him, those are matters in the public record. But the pressure over there in the Republican caucus is absolutely intense, and we were sent here to govern.

In the Democratic caucus—and the Presiding Officer, the distinguished Senator from Colorado, was there on Monday evening—when my turn came to speak, I said: I have two sentences. And may the record show a smile on the face of the Presiding Officer. I said: I have two sentences. One sentence is, the bill is a great deal better than the current system, and the second sentence is, we should not let obstructionism prevent us from governing. And that is why I crossed the aisle to make the 60th vote. I was very surprised to see in the public record—been in the newspapers—that everybody stood up and applauded, and I read in one of the Hill newspapers today that you could hear the applause down the corridor. So they knew what was going on. Well, that is the role, it seems to me, of a Senator. We are facing a situation where, if defeated, it will have a

significant impact on the tenure of President Obama.

We had a meeting on Tuesday—2 days ago—in the Executive Office Building, and it was a rather remarkable setting. There was a large rectangular table, and in the center on each side—one side was President Obama, the other side was Vice President BIDEN, and almost all of the 60 Senators were present. I think Senator BYRD couldn't be there because of his ailment, but I believe everybody else was present. During the course of that session, the President expressed himself—and this has also been publicized—that if action was not taken now, it would discourage anyone from the foreseeable future—any President—from undertaking health care reform if now, with both Houses and 60 Members of the Democratic Party, you can't get it through the Senate and get it conferenced and get it enacted.

Some of those who were most vocal in favor of the public option urged those in the caucus who disagreed to reconsider their position, and I would renew that request that they reconsider their position. The people who would classify themselves as most progressive in the Democratic caucus have swallowed hard and have announced publicly that they would support this bill even though it doesn't have a robust public option, doesn't have the Medicare expansion. And that may shift yet.

It is fair and accurate to say there are more pressing problems confronting the United States today than at any time in our history, and we have to finish health care next year to move ahead to jobs. We have the issues of global warming and climate control, and we have the problems with the Mideast peace process and the difficulties in Iran and North Korea and Afghanistan. We need a strong President, and we need a Congress which has the courage to act and the tenacity and willingness to confront tough problems. We need to show the American people that it is not all gridlock here, that it is not all desperate, desolate partisan politics.

So my vote will be in favor of the bill. Although I am, frankly, disappointed and I share the frustration expressed by many people who say go back and start again, this is a significant step forward. We have a great chance to improve it in conference, and beyond that there will be another Congress. And with the analogy of civil rights legislation, we can get the public option and get greater public involvement for the benefit of the American people.

I thank the Chair, and I yield the floor.

Mr. President, in the absence of any other Senator seeking recognition, I ask unanimous consent to speak up to 3 minutes on another subject.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMERICANS HELD BY IRAN

Mr. SPECTER. Mr. President, there has been wide publicity given to three young Americans who were taken into custody by Iran and the recent reports that they are going to be tried in an Iranian court. Senator CASEY and I, in the Senate, introduced a resolution urging the Iranians to release those three young Americans—Congresswoman ALLYSON SCHWARTZ, on the House side, did so in the past—and it is my hope Iran will change its view.

I was talking to the Syrian Ambassador yesterday, who advised me that when the five British citizens were taken into custody by Iran, the Government of Great Britain made a request of the Syrian Government to use their good offices to secure the release of the five British citizens. That request was made via Syria, and they were released.

I have written to and contacted the State Department since that meeting yesterday afternoon to find out what is the status of U.S. activity because if we have not asked the Syrians for help, my view is that we should. It would be my hope that with the very difficult problems facing the United States in Iran, that Iran would relinquish the custody of those three young Americans and release them to their family and friends, especially at this time of the year.

I have been an advocate of dialog with Iran for years. I have tried to go to Iran since 1989, when the Iran-Iraq war ended. Senator SHELBY and I got to Iraq and met Saddam Hussein, but as yet we have not had an interparliamentary exchange, which I have sought for a long time with the Iranians.

It would be my hope that Iran, for humanitarian reasons, would release these people and that we would exercise our best efforts—the U.S. Government working through Syria or whatever other channel we can find—to secure their release.

Mr. President, I yield the floor, and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DURBIN. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. KIRK). Without objection, it is so ordered.

Mr. DURBIN. Mr. President, before the Senate now is an issue of funding our military, the Department of Defense appropriations bill. This is a bill that is critically important because it provides the funding our men and women in uniform now risking their lives while we meet in the safety of our businesses and offices and homes in America, it funds their needs to make

sure they will be safe to perform their missions effectively and come home. Without fail, every year this bill comes before the Senate and is a consensus bipartisan bill.

Regardless of our debates over foreign policy, we all want the men and women in uniform to know we stand behind them. As a consequence, this bill usually passes with an overwhelming number. I asked how this bill fared in the House of Representatives when it was considered yesterday. The vote was 395 to 34. There were 164 Republicans who voted yes on this bill. It was clearly an overwhelmingly positive bipartisan vote. There is no reason it would not be the same in the Senate.

But there is a problem. The problem is this: Tomorrow the funding for our troops runs out. It is the end of our continuing resolution in funding. We are not going to leave them high and dry, but we are going to leave them uncertain if we don't act decisively and quickly. Why would we do this to them?

Military families across America, as we go into the holiday season, I am sure, are saddened by the absence of their loved ones who may be in Iraq or Afghanistan, saddened by a separation from children and other loved ones they would like to avoid in their lifetime but they have offered it up for this great country. With this kind of uncertainty and sadness and emotion, why would we be uncertain when it comes to funding our troops?

Here is where we are: We offered this yesterday. We said: Let's vote for it. Let's vote for our troops and get this behind us so the Department of Defense appropriations bill was clear.

The other side of the aisle said: No. We want you to go through all of the hurdles that you have to go through under the procedures of the Senate for the most controversial bills. We want you to file a cloture motion which would put an end to a filibuster. We want you to fill the tree with amendments so that this bill isn't assaulted.

Believe me, the terminology would lose most people, including many Senators, but the bottom line is this: Instead of just doing what we know needs to be done and what should be done, Republicans have insisted we delay this process for at least 2 days.

Why? Why would we want to delay funding our troops in the middle of a war? Why would we want to say to our troops that the military pay raise they were counting on so their families can get by back home, and for those stationed in the United States, make sure that they have what they need, why would we say to them that we are going to raise a question as to whether we are going to put \$29.2 billion into the defense health program, the health program for our military members and their families?

Why would the Republicans insist on delaying a vote for \$472 million for

family advocacy programs for military families who are separated, many of whom are going through extraordinary stress because of the separation? Why would they want to delay a pay raise for the military? Why would they want to delay \$154 billion for equipment and training for our military?

I don't understand it. It would seem to me that we ought to come together by noon today and say: Let's do this. Let's not waste another minute in terms of helping our troops and showing them we stand behind them. But, no, the decision has been made on the other side of the aisle that we are going to delay this matter until tomorrow.

They say in politics, for every decision there is a real reason and a good reason. There may be some good reason they are giving on the other side of the aisle for delaying funding our troops, but the real reason is their hope that they can stop health care reform in the Senate. That is what is behind this. The lengths to which those on the other side of the aisle will go was demonstrated yesterday.

We had a defining moment when the leadership on the Senate Republican side insisted, through Senator COBURN of Oklahoma, that an 800-page amendment be read by the clerk. It is the right of a Senator to ask for that. It is an archaic right because people don't sit here hanging on every word to understand an amendment. That never happens. It didn't happen yesterday. But the clerk started reading.

Almost 2 hours into it, it was pretty clear that it would take 10 hours to finish this 800-page amendment, despite the best efforts of the clerk's office. Why did the Senate Republican leadership want to take 10 hours out of a day for something that was meaningless—the reading, word by word, line by line, page by page, of an 800-page amendment? To stop debate on health care reform.

During that period, no one could debate it. No one could amend it. The Republicans have conceded that they are finished with the debate and amendment phase of health care reform. They have decided now that the only thing they could possibly do is to delay everything the Senate can consider in the hopes that maybe we get tangled up with our desire personally to be home with our families during the holidays and would not do our duty here.

They are wrong. We are determined to do this. We are determined because health care reform for this country is so absolutely essential. The Presiding Officer has an awesome assignment, succeeding the late Senator Ted Kennedy whom he counted as a close friend and served as a member of his staff.

In our cloakroom is a cover of Time magazine where Senator Kennedy is looking out with that smile on his face saying: We are almost there. It was an

article he wrote before he died about health care reform. He, more than any person in the Senate, had the authority to speak to it. Senator KIRK told us in a meeting of our caucus the other day that it was 40 years ago when Senator Kennedy took to the floor as a young man and talked about the priority of health care reform. Forty years, when you think about it, 40 years of waiting for this moment to vote on health care reform. If he were here today—and I wish to God he were—he would be back there at that desk—that was Kennedy's spot—thundering in this Senate Chamber about this historic opportunity and how if it costs us Christmas Eve or costs us Christmas Day or even more, we cannot let down the people of this country.

I see the polls. This complicated issue of health care reform has a lot of people confused and even worried. They have heard some of the wild charges on the other side. At one point they were arguing about death panels; that ultimately the government was going to decide whether people would live or die. That was one of the cruelest distortions in this debate.

The actual issue was raised by Senator JOHNNY ISAKSON, who is a Republican of Georgia, whom I thought raised a serious and important consideration and one that all of us, though we might not want to, should reflect on. He said every person under Medicare ought to have a compensated, paid-for visit to a doctor if they want, voluntarily, to talk about end-of-life treatment. There is hardly a family in America who doesn't contemplate that possibility, doesn't have a husband say to a wife: Honey, I don't want any of that extraordinary stuff. Don't keep me on life support.

What Senator ISAKSON wanted to do was to give Medicare patients an opportunity to sit down with a doctor and say: What instruction should I leave? If this is what I believe, whom should I tell? That was a humane, thoughtful amendment. But the critics of health care reform twisted and distorted it into a death panel that was going to tell Grannie: We are going to pull the plug.

Sad. It was sad, when Senator ISAKSON offered such a good-faith amendment, to have it distorted. It is no wonder if the critics of health care reform would go to those extremes to try to defeat this bill, why other extreme things have been said about it. If you listened on the floor of the Senate over the last several weeks while we have debated health care reform and listened to the speeches from the other side of the aisle, you would believe that this bill is going to destroy Medicare. Many Republican Senators who historically did not support Medicare and wanted to privatize Medicare are now its most fervent champions. You might question their sincerity. We don't do

that in the Senate because we don't question motives of people. But I will question their accuracy.

This bill, which is over 2,000 pages, knows the future of Medicare is important to all of us. If we do nothing today, Medicare will go broke in 8 years. We would not be bringing in enough money from payroll taxes to pay the Medicare services we promised in 8 years. That is a fact. But this bill is going to change it. This bill will add 10 years of solvency to Medicare. I wish it were more, but it is a step in the right direction to say to those receiving Medicare and those about to go into Medicare: This important program will be there when you need it; 10 years of added solvency in Medicare; Medicare on sound financial footing for 10 more years because of this bill.

There is something else it does. At the end of our conference between the House and Senate on health care reform, we are going to take care of a problem in Medicare. It is a serious problem. When we passed the Medicare prescription drug program, there wasn't enough money to fund it. They created this strange situation where if you were seriously ill under Medicare and receiving medication, this Medicare Part D plan would pay for prescription drugs up to a certain limit and then stop.

In the midst of a new calendar year, some could find several months into that year that Medicare Part D was not paying for any more prescription drugs. You would be responsible personally to pay for them. After you had paid a certain amount of money, the Part D coverage would kick in again. It was known euphemistically as the doughnut hole, that gap in coverage in Medicare Part D. When this is over, this health care reform is going to fill that gap, close that doughnut hole, give to 45 million Americans under Medicare the peace of mind of knowing that their prescription drugs will be paid for and they will not find themselves exhausting savings or going without it when it comes to basic medication.

That is why this bill is important. That is why some of the things that have been said in the debate are so misleading.

There is something else this bill does which we ought to take pride in as Senators. Most civilized and developed countries in the world have a health care system that protects their people. We are the only developed country on Earth where a person can die because they don't have health insurance. We are the only one.

You might say: Senator DURBIN, aren't you getting a little carried away? Well, 45,000 people a year do. Let me give you an illustration: What if you had a \$5,000 copay on your health insurance and you didn't have \$5,000 and the doctor says: I am a little bit

worried about some of the things you tell me, Senator. I think you need a colonoscopy.

That is something I can understand because my mother had colon cancer. I am very careful about this. I have a history in my family.

But if you had a policy that said the first \$5,000 you have to pay for and went out and asked how much a colonoscopy cost, you would find in many places it is \$3,000. There have been cases—a man from Illinois wrote me. He said: I didn't have the \$3,000 so I skipped the colonoscopy.

Without health insurance, without coverage, without enough money to pay for that basic test, this individual is running the risk of developing a serious cancer that could claim his life or at least cost a fortune to take care of. That is what inadequate health insurance does to you. That is what no health insurance does to you.

At the end of the day, this bill will say, for the first time in the history of this great Nation, 94 percent of the people will have health insurance. Thirty million people today who have no health insurance will have it when it is over. Fifteen million will go into Medicaid because they are in low-income categories.

I met one of those people when I was back in my home State of Illinois. Her name is Judie. She works at a motel in Marion, IL. She is a hostess in the morning for their free continental breakfast—a sweet lady with a big smile on her face, in her early sixties.

She came up to me and said: Senator, I am not sure this health care reform is good for me.

I said: Judie, do you have health insurance?

She said: No, I've never had health insurance, and I'm a few years away from Medicare.

I said: If you don't mind telling me, how much money do you make?

She said: Well, they've cut our hours here at the motel because of the economy. I work about 30 hours a week now, and I make about \$8 an hour. And she said: There isn't a person here you're looking at, working on this motel staff, who has health insurance.

I said: So does that mean your income each year is about \$12,000?

She said: Well, I guess. It's the only job I have. I get by on it.

I cannot imagine how.

She said: I get by on it.

I checked into it, and I saw her the next morning before I checked out, and I said: Judie, under this bill we have, because you make less than \$14,000 a year as an individual, you will qualify for Medicaid. For the first time in your life, you will have health insurance under an Illinois State Medicaid Program that you won't have to pay for because you are in a low-income category.

Well, she said: That's great because I have diabetes.

Think about that: age 60, no health insurance, low income, no doctor regularly available to her.

And she said: And I've had a few lumps I would like to get checked out too.

I thought: This poor lady. She is a classic illustration of what we are talking about in this bill. She is not lazy. She is a hard-working person. She gets up every day at the crack of dawn to be there to make sure people feel right at home at that motel, and she has no health insurance.

Ninety-four percent of the people in this country will have health insurance—people like Judie, who, for the first time in her life, will have health insurance. Is that worth something? Is it worth something in America for us to take pride in the fact that we are expanding the peace of mind which some of us take for granted of having health insurance coverage?

I think it is worth a lot. I think it is important for us and the critics to step up and acknowledge they have never come forward with a single proposal to deal with that issue—not one. We have never heard from the Republican side of the aisle how they would cover 94 percent of the people in America. They have never put together a comprehensive health insurance plan. They have never talked about submitting it to the Congressional Budget Office to make sure it does as promised, as we have.

They come to the floor with criticisms of what we are trying to do. It is their right as Senators to do that. But it is also our right to ask them the basic question: Does the fact that you do not have a Republican health care reform bill mean that you like the current system, that you do not want to change it? That is one conclusion.

The other conclusion is: This is hard work. Writing a bill that does this takes a lot of time and effort, and they have not put in that hard work. So they come emptyhanded to the floor with good speeches and good graphs and good press releases, but without good amendments to take care of the basic problems.

There is one other element in this health care reform bill too. How many times have you met somebody in your family or at work or through a friend who told you about a battle they had with a health insurance company when somebody got sick in their family? I have run into it a lot. A few years back, when I was a Congressman, in Springfield, they had a unique program where the Sangamon County State Medical Society would invite Members of Congress to accompany doctors on their rounds in a hospital.

The first time I was invited to do that, I called back and said: You've got to be wrong. You don't want me walking into a patient's room where you are talking about their private health situation.

They said: No, no, we ask permission. And it is interesting, people are bored in the hospital, and they are amused by politicians. So would you please come?

So I accompanied a doctor on his rounds. He was examining a nice lady in my hometown of Springfield, IL, who was suffering from vertigo, who had come to the hospital, and as a result of an x-ray, they discovered she had a tumor—a brain tumor—that needed to be removed. She lived by herself. She was falling down at home. He wanted to operate on her on Monday. This was a Friday. He wanted to keep her in the hospital because he was afraid if she went home she might fall, hurt herself, and he wanted her ready for surgery on Monday.

But before he could say to her: Be prepared to stay over the weekend, he had to call her health insurance company. I stood next to this doctor at the nurses station in St. John's Hospital in Springfield, IL, as this doctor was arguing with a clerk at a health insurance company somewhere in a distant location about why this woman needed to stay in the hospital, and the clerk was saying: No, we are not going to pay for it. Send her home. Bring her back on Monday for the surgery.

He said: I'm not going to do that.

The clerk said: Well, we're not paying for it.

He hung up the phone and turned to me and said: She's staying in the hospital. We'll fight this out later on.

Fight it out—those battles, those fights take place every day across America.

I have told the story on the floor here about a friend of mine—a great friend of mine—whom I have known since he was a young man. He is a baseball coach at Southern Illinois University. His name is Danny Callahan. Danny has been battling cancer for years. Danny is a young guy. He has a young family and a good wife, and he is a terrific guy from a great family. He has been battling cancer—chemo, radiation, even surgery, removing part of his jaw and trying to stop this advance of cancer.

His oncologist came up with a drug that is working. It is called Avastin. This drug is experimental. It works on some cancers. It is certified to work on them. But they found it works on others in an off-label application. The oncologist wrote to the health insurance company and said: This is working. We have stopped the spread of his cancer. We want to keep using this drug. And they said: No. It costs \$12,000 a month, and we won't pay for it.

What is he going to do? You do not make a fortune as a baseball coach at Southern Illinois University. His family pitched in, borrowed some money to cover a month of treatment. He is going to have a trial in St. Louis at Barnes Hospital, connected with Washington University there. He is trying

his best to keep this going, but he is battling this insurance company that said no.

This bill gives people whom I have described a fighting chance. It gives them a chance to fight against the discriminatory, wrong decisions of health insurance companies. Is that worth anything? Is it worth it? I have yet to see an amendment from the other side of the aisle that does this.

We used to call this a Patients' Bill of Rights, and it used to be a bipartisan issue. Senator JOHN MCCAIN joined with Senator Kennedy and the two of them worked on this, saying that patients in America should have the right to fight insurance companies that turn them down because of preexisting conditions, that turn them down because the cost of care is so high, that turn them down because they have lost their job or turn them down because their child reaches the age of 24. This bill provides protections for those people.

So when people say: I heard Governor Dean—I like him; Howard is a friend of mine; former Governor of Vermont; former head of the Democratic National Committee—wrote a big article in the Washington Post this morning and said: Vote against this bill. It is not everything I want it to be.

Well, Governor Dean, it is not everything I want it to be either. But how could we in good conscience explain to 30 million Americans who would have health insurance for the first time in their life—such as Judie down in Marion, IL—“Judie, I am sorry, we won't be able to get you health insurance this time around. We couldn't get everything we wanted.” That is not a very compelling argument, from my point of view.

How do we say to people who want to have a fighting chance against insurance companies that say no—and will have the legal right to do that—“I am sorry, you are just going to have to continue to do your best fighting these clerks at health insurance companies who say no because this bill does not have everything in it that we want.”

You learn in this business of life and politics that concessions and compromise are critical parts of achieving a goal. Within the Democratic Caucus there are conservative and liberal or progressive members, and we have to find that sweet spot, that middle ground, where they come together. I think we have, and I am sorry we do not have any Republican support for this.

It is a fact, though, we have spent an entire year debating health care reform on Capitol Hill, and the sum total of Republican support for health care reform by vote comes down to two. One Republican Congressman from the State of Louisiana voted for the House bill, and one Republican Senator, Ms. SNOWE of Maine, voted for a version of

health care reform in the Senate Finance Committee. Not a single vote beyond those two in support of health care reform.

In fact, some take great pride in the fact that they are never going to vote for health care reform until it comes down exactly as they want it. We have invited them into conversation. In fact, my friend, the Senator from Iowa, who is on the floor here today, was part of a conversation with Senator BAUCUS and four other Members of the Senate that went on, I am told, for weeks, if not months, in an effort to find bipartisan, common ground, and they could not. I am sorry they did not. It would have been a better day if we had a real bipartisan effort before us. But I thank the Senator from Iowa for his genuine heartfelt efforts in trying.

But we come here today without a Republican alternative to health care reform. We come here today facing the reality that if we fail this time, we will not address health care reform, I am afraid, in my political lifetime or in the lifetime of many people following this debate. It took 16 years since President Clinton last offered an effort to try. If we wait another 16 or 20 years, I cannot imagine what is going to happen.

We know what is going to happen to health insurance premiums. Ten years ago, for a family of four, the average cost of their family health insurance premium was \$6,000 a year—\$500 a month. Pretty steep, right? The average cost today, for a family of four, for their family health insurance premium: \$12,000 a year. It has doubled in a 10-year period of time, and it is going up so fast that it will double in the next 7 or 8 years to \$24,000 a year.

Imagine working and earning \$2,000 a month just to pay for your health insurance premium. That is it. Imagine how meager that coverage is going to be because each year you know what happens. The cost goes up and coverage goes down. What will it be 10 years from now? If you talk to people who are negotiating for contracts, such as labor unions, all they talk about is health insurance. They do not talk about wage increases. They talk about health insurance. Those are the issues that break down the negotiations and end up in work stoppages and strikes, it has become that contentious and that difficult.

Are we going to accept that? Is that the best we can do in America? I do not think so. Are we going to accept a strategy which says: We are going to slow down the business of the Senate to a crawl, or stop it, as they tried yesterday, in an effort to defeat even having a vote on health care reform?

Don't we owe the people of this country, at the end of this debate, a vote on health care reform? Shouldn't it be in a timely fashion?

Shouldn't we first pass this bill that funds our troops that is sitting on the

floor here that passed the House 395 to 34? Why would we delay that funding of our troops in the midst of a war? Why don't we do that today before we break for lunch and say to our troops: "We took care of you."

I might add, in here there is a provision that extends unemployment benefits. Is there any doubt on the other side of the aisle that they will vote to extend unemployment benefits in the midst of a recession? The last vote we had was 97 to 0 on the floor of the Senate to extend unemployment benefits, and that was a few weeks back. I assume Republican Senators feel as Democratic Senators do, that in the midst of a recession, in the midst of the holiday season, we owe it to these families to try to help them out.

How could we in good conscience go home and celebrate Christmas or Hanukkah or whatever our holiday might be and say we want to be in the comfort and love of our families, to sit and have a glorious Christmas morning before the tree, and enjoy the blessings of this great Nation and the blessings of life, and then turn down the unemployed when it comes to their benefits? We could not do that in good conscience.

Why don't we do that today? Why do we wait until tomorrow? Why don't we say: Regardless of what your strategy is on health care reform, let's not shortchange the troops. Let's not leave them with any uncertainty. Let's not leave those unemployed with uncertainty as to whether they are going to get benefits they come to expect and deserve. I hope we can.

Mr. President, I ask unanimous consent to have printed in the RECORD a recent article published in the New York Times relating to the trauma of joblessness in the United States.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the New York Times, Dec. 14, 2009]
 POLL REVEALS TRAUMA OF JOBLESSNESS IN U.S.

(By Michael Luo and Megan Thee-Brenan)

More than half of the nation's unemployed workers have borrowed money from friends or relatives since losing their jobs. An equal number have cut back on doctor visits or medical treatments because they are out of work.

Almost half have suffered from depression or anxiety. About 4 in 10 parents have noticed behavioral changes in their children that they attribute to their difficulties in finding work.

Joblessness has wreaked financial and emotional havoc on the lives of many of those out of work, according to a New York Times/CBS News poll of unemployed adults, causing major life changes, mental health issues and trouble maintaining even basic necessities.

The results of the poll, which surveyed 708 unemployed adults from Dec. 5 to Dec. 10 and has a margin of sampling error of plus or minus four percentage points, help to lay bare the depth of the trauma experienced by

millions across the country who are out of work as the jobless rate hovers at 10 percent and, in particular, as the ranks of the long-term unemployed soar.

Roughly half of the respondents described the recession as a hardship that had caused fundamental changes in their lives. Generally, those who have been out of work longer reported experiencing more acute financial and emotional effects.

"I lost my job in March, and from there on, everything went downhill," said Vicky Newton, 38, of Mount Pleasant, Mich., a single mother who had been a customer-service representative in an insurance agency.

"After struggling and struggling and not being able to pay my house payments or my other bills, I finally sucked up my pride," she said in an interview after the poll was conducted. "I got food stamps just to help feed my daughter."

Over the summer, she abandoned her home in Flint, Mich., after she started receiving foreclosure notices. She now lives 90 minutes away, in a rental house owned by her father.

With unemployment driving foreclosures nationwide, a quarter of those polled said they had either lost their home or been threatened with foreclosure or eviction for not paying their mortgage or rent. About a quarter, like Ms. Newton, have received food stamps. More than half said they had cut back on both luxuries and necessities in their spending. Seven in 10 rated their family's financial situation as fairly bad or very bad.

But the impact on their lives was not limited to the difficulty in paying bills. Almost half said unemployment had led to more conflicts or arguments with family members and friends; 55 percent have suffered from insomnia.

"Everything gets touched," said Colleen Klemm, 51, of North Lake, Wis., who lost her job as a manager at a landscaping company last November. "All your relationships are touched by it. You're never your normal happy-go-lucky person. Your countenance, your self-esteem goes. You think, 'I'm not employable.'"

A quarter of those who experienced anxiety or depression said they had gone to see a mental health professional. Women were significantly more likely than men to acknowledge emotional issues.

Tammy Linville, 29, of Louisville, Ky., said she lost her job as a clerical worker for the Census Bureau a year and a half ago. She began seeing a therapist for depression every week through Medicaid but recently has not been able to go because her car broke down and she cannot afford to fix it.

Her partner works at the Ford plant in the area, but his schedule has been sporadic. They have two small children and at this point, she said, they are "saving quarters for diapers."

"Every time I think about money, I shut down because there is none," Ms. Linville said. "I get major panic attacks. I just don't know what we're going to do."

Nearly half of the adults surveyed admitted to feeling embarrassed or ashamed most of the time or sometimes as a result of being out of work. Perhaps unsurprisingly, given the traditional image of men as breadwinners, men were significantly more likely than women to report feeling ashamed most of the time.

There was a pervasive sense from the poll that the American dream had been upended for many. Nearly half of those polled said they felt in danger of falling out of their social class, with those out of work six months

or more feeling especially vulnerable. Working-class respondents felt at risk in the greatest numbers.

Nearly half of respondents said they did not have health insurance, with the vast majority citing job loss as a reason, a notable finding given the tug of war in Congress over a health care overhaul. The poll offered a glimpse of the potential ripple effect of having no coverage. More than half characterized the cost of basic medical care as a hardship.

Many in the ranks of the unemployed appear to be rethinking their career and life choices. Just over 40 percent said they had moved or considered moving to another part of the state or country where there were more jobs. More than two-thirds of respondents had considered changing their career or field, and 44 percent of those surveyed had pursued job retraining or other educational opportunities.

Joe Whitlow, 31, of Nashville, worked as a mechanic until a repair shop he was running with a friend finally petered out in August. He had contemplated going back to school before, but the potential loss in income always deterred him. Now he is enrolled at a local community college, planning to study accounting.

"When everything went bad, not that I didn't have a choice, but it made the choice easier," Mr. Whitlow said.

The poll also shed light on the formal and informal safety nets that the jobless have relied upon. More than half said they were receiving or had received unemployment benefits. But 61 percent of those receiving benefits said the amount was not enough to cover basic necessities.

Meanwhile, a fifth said they had received food from a nonprofit organization or religious institution. Among those with a working spouse, half said their spouse had taken on additional hours or another job to help make ends meet.

Even those who have stayed employed have not escaped the recession's bite. According to a New York Times/CBS News nationwide poll conducted at the same time as the poll of unemployed adults, about 3 in 10 people said that in the past year, as a result of bad economic conditions, their pay had been cut.

In terms of casting blame for the high unemployment rate, 26 percent of unemployed adults cited former President George W. Bush; 12 percent pointed the finger at banks; 8 percent highlighted jobs going overseas and the same number blamed politicians. Only 3 percent blamed President Obama.

Those out of work were split, however, on the president's handling of job creation, with 47 percent expressing approval and 44 percent disapproval.

Unemployed Americans are divided over what the future holds for the job market: 39 percent anticipate improvement, 36 percent expect it will stay the same, and 22 percent say it will get worse.

Mr. DURBIN. Mr. President, I am going to close by saying that for those who wonder if it makes any difference whether we move forward on the issue of helping the unemployed, they should read this article I have put in the RECORD. People across this country are not only worried about getting a job and taking care of their families, it has reached a point where it is dramatic. Some of them are making critical life decisions, spending their savings, with no health insurance to cover themselves or their kids.

I will ask the Republicans, who will follow me: Please, regardless of how long you want to talk today, agree with us that we should move quickly to fund our troops, send the money for those members of the military and their families to give them peace of mind we stand behind them. Do not make them part of any political delay and strategy that leaves uncertainty. Let's do it today. Let's not wait until the money runs out tomorrow.

Let's fund our unemployment benefits too. Let's give these families, who through no fault of their own are out of work, the peace of mind of knowing that as we go home for Christmas, they will at least have a Christmas which has, even if it is small, an unemployment check.

The PRESIDING OFFICER (Mr. BURRIS). The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I ask unanimous consent to speak as in morning business for 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

BIODIESEL TAX CREDIT

Mr. GRASSLEY. Mr. President, I rise on the issue of jobs and 10 percent unemployment and to tell my fellow Senators what we can do to preserve maybe 25,000 jobs in an industry that, by the end of the month, will be otherwise shut down because Congress is not taking action. The main point of my remarks is, if we don't extend the biodiesel tax credit by the end of the month, these jobs will be lost.

My point is 23,000 jobs will be lost. In fact, right now, on December 17, companies are making plans to shut down these operations by the end of the year.

Everybody knows our unemployment rate is 10 percent. Everybody knows the President has spent a great deal of time, over the last 2 or 3 weeks, talking about creating jobs and getting us out of the recession. But we have to remember that for those without work, this is not just a recession, it is a depression.

We all agree we should take whatever action is necessary to jump-start our economy and get people back to work. President Obama and Vice President BIDEN have been talking for months about the need to create green jobs. Well, green jobs, purple jobs, whatever kind of jobs, jobs are jobs. I don't object to the creation of green jobs. In fact, what I am talking about is some of these green jobs.

President Obama has held three public events in recent days to highlight his concern about the economy and the need to create jobs. Yesterday, the administration apparently announced billions more in tax credits for renewable energy and energy conservation efforts. I will bet when I look at that list I am going to support most of those because I believe a national energy policy involves capturing whatever we can of

petroleum and fossil fuels we have available for a short period of time because we are never going to get rid of them in the short term. We need conservation, and we need renewable and alternative energy. Those three things make a comprehensive energy program. Obviously, if I am for that comprehensive energy program, I am for renewable energy and alternative energy.

It seems as if nearly everyone, in fact, in the administration is touting the benefits of green jobs and a clean energy economy and I am doing that right now myself. It is astonishing, though, with all this talk about green jobs and clean energy that this Congress right now seems to be heading for the holidays while thousands of green energy workers will receive pink slips and furloughs.

On December 31 of this year, the current biodiesel tax credit will expire. The biodiesel tax credit provides a \$1-per-gallon credit for biodiesel made from soybean oil and yellow grease and animal fats. The tax credit is essential in maintaining the competitiveness of this clean-burning, domestically produced green fuel and the jobs that are connected with it.

The tax credit exists for a common-sense reason and something we have been using for a long period of time: to offset the higher cost of producing biodiesel—or I could just as well insert the word “ethanol”—compared to petroleum diesel. Without the tax credit, petroleum marketers will be unwilling to purchase the more expensive biodiesel and demand will vanish. From this standpoint of the tax credit, I hope everybody remembers that whether it is wind, ethanol, solar, biodiesel, biomass, or geothermal, it takes tax credits to get these programs off the ground. Right now, wind energy is a big industry in my State, not only from the production standpoint but from the standpoint of manufacturing of components because, in 1992, I got a wind energy tax credit passed; otherwise, we would not have wind energy and everybody touts wind energy today. It is a little bit like the very infant biodiesel industry we have. One might not think biofuels are an infant industry because ethanol has been around for 30 years, but biodiesel is about where ethanol was 30 years ago. So we want to help move this industry along so eventually it can stand on its own legs. That is the motive behind all these tax credits, to get an infant industry started and then they stand on their own.

In 2008, getting back to the jobs in this industry, biodiesel supported 51,000 green jobs. Because of the downturn in the economy and the credit crisis, the biodiesel industry has already shed 29,000 green jobs. So now what about the rest of those jobs? That is what my remarks are all about, and that is what getting the tax credit renewed before

the end of the year is all about. Because the industry is currently operating at just around 15 percent of capacity. Without an extension of the tax credit, all U.S. biodiesel production will grind to a halt. Plants will be shuttered and workers will be let go.

No one should be surprised by the upcoming expiration of this tax credit. It was extended most recently in October 2008. So we have known for 14 months; hence, nobody should be surprised that it would need to be extended by the end of this year.

The Senate has been in session nearly continuously for months. Earlier this year, Senator CANTWELL and I introduced a bill to extend the tax credit for 5 years and change it to a production tax credit. There is no excuse for inaction on this credit. The Democratic leadership is content to leave without doing the necessary work on extenders, believing they can extend the tax provisions retroactively sometime early next year. Retroactivity does work a lot of times on tax extenders that are not extended at the end of the year and extended to be made retroactive. But retroactivity in the case of the biodiesel market doesn't help bring it from grinding to a halt on January 1, 2010, because without the incentive, the biodiesel will cost much more than petroleum diesel.

While the House and Senate dither, thousands will lose their jobs, but demand for dirty, imported petroleum diesel, however, will continue. Investments in the domestic renewable fuels industry will lose value and possibly disappear—quite to the contrary of what I said in my remarks of yesterday, the President announcing various tax credits. So this one has been on the books. All it has to be is reauthorized.

It is too bad that among all the talk of green jobs and the clean energy economy, Congress is unable to pass a simple extension of an existing tax credit. Once again, the actions of the majority do not match their words. For all the talk, they will have failed all those in the biodiesel industry working today to reduce our dependence upon foreign oil if we leave without extending this critical tax credit before the end of the year.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. CORNYN. Mr. President, we have conferred with the other side of the aisle, and I think we have reached an agreement. I ask unanimous consent to be allowed to speak for up to 10 minutes, and then I believe two Senators from the other side of the aisle would like to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. CORNYN. Mr. President, it just shows we can do some things in a bipartisan way around here still, albeit small things.

We are talking about the Defense appropriations bill. I think it is important to point out that the majority leader has waited until the very last minute to bring up this very important bill, which I am sure will pass by a large majority, but it was 2 months ago that the fiscal year ended. The majority leader has now left us here 8 days before Christmas with a lot on our plate, a lot yet to do, and, of course, threatening to keep Congress here through Christmas—certainly up to Christmas. I would not say we are happy to be here, but this is a great responsibility. These are important issues, and none of us is going to shy away from dealing with these issues, albeit 8 days before Christmas.

It is also appropriate to talk about Christmas because this bill not only funds our troops, it is a Christmas tree on which Members of Congress have hung nice shiny little ornaments, provisions that have nothing to do with funding our troops and the Defense appropriations bill. As a matter of fact, this bill would actually create new entitlement spending programs—that is what some of these little shiny ornaments are—rather than fix the ones we have. It is significant. We are talking about our troops. At the same time, we are talking more generally about health care, because under Federal law TRICARE, which handles the reimbursement rates for health care for our troops and their families, is required under Federal law to follow Medicare reimbursement rates.

We know that under the underlying health care bill we will be considering up until Christmas, it looks like there are actually going to be \$500 billion in cuts to Medicare. The concern is, if access to care is jeopardized for Medicare beneficiaries, which we know it will be for at least some—particularly Medicare Advantage beneficiaries—then cuts to TRICARE reimbursement rates could follow.

We also know this bill includes a 2-month bandaid for the Medicare reimbursement rate for doctors, the so-called doc fix. This is the sustainable growth rate formula which has never worked since Congress passed it in 1997. It shows Congress makes assumptions—this one back in 1997—that we are going to cut Medicare, and in this particular instance Medicare reimbursement rates for doctors and that somehow that will not have a negative impact on people's ability to find a doctor who will see them.

I know in Travis County in Austin, TX, at last report, only 17 percent of doctors will see a new Medicare patient, and it is even worse for Medicaid, which pays less than Medicare. So we know the cuts the underlying health care bill will make to Medicare are going to have a negative impact on access to care for many of our seniors, and because TRICARE rates are linked

to Medicare rates under Federal law, they could well jeopardize our troops' and their dependents' access to care as well.

This experience we have had since 1997 under the Balanced Budget Act with the sustainable growth rate which, unless Congress acts, will actually cut reimbursement rates for doctors by 23 percent—and this bill provides a 2-month—a 2-month—fix—these assumptions have never worked. Yet this health care bill, at least the 2,074-page version—we have yet to see the Reid substitute, which will appear, I am sure, miraculously sometime around Saturday as the majority leader tries to cram this bill through before Christmas—we know it contains or will contain many other assumptions, such as this SGR formula that will prove unenforceable and will never work. Yet those will be used by the Congressional Budget Office to provide a cost estimate or score which may meet the demands of politics today but which will bear no relationship whatsoever to the ultimate costs. And the American people understand that. They understand the budget gimmicks of having a 10-year program and not implementing it until year 4 but starting the taxes to pay for it on day one. They understand that, and that is why they don't trust the Congress to be honest and transparent when it comes to spending their money—because of their unfortunate experience.

I also want to focus on other promises the President has made about health care reform which bear on the process by which health care reform and these bills are being considered—unfortunately, ways in which the Reid bill breaks those promises. This is one we have talked about before, but I think it bears repeating because the American people want us to read the bills before we vote on them. They want to be able to read the bills and to have them posted on the Internet so they can understand how this legislation will impact them and their families.

Here is what the President said:

I'm going to have all the negotiations [the health care negotiations] around a big table. We'll have negotiations televised on C-SPAN, so that people can see who is making arguments on behalf of their constituents and who is making arguments on behalf of the drug companies or the insurance companies.

I see one of our colleagues on the floor, who is a chief proponent of an amendment that had to do with drug pricing. We all know it is the worst-kept secret in Washington, DC, that the drug companies have cut a special deal behind closed doors—not around a big round table on C-SPAN but behind closed doors—and many of us don't know the exact terms of this deal. We do know that while the big drug companies may be protected, the American people are not at the table while spe-

cial interests are cutting deals that have not yet fully come to the light of day. I think this is a tragedy. There is no reason the President's promise cannot be kept, other than to try to run something by Congress and the American people before they have had a full opportunity to read it and understand what is in it.

This is exactly the kind of cynical act that breeds public skepticism about Congress and their elected representatives. We are elected by the people in our States to use our best judgment on their behalf, listen to them, and ask: What do you think about this? Tell me, as your elected representative, how do you think I should vote on these important issues? If we hide the substance of these cooked-up deals behind closed doors from the American people, no wonder the congressional approval rating is so low. Unfortunately, promises such as this which are broken by the Reid bill do nothing but breed skepticism or cynicism on behalf of the American people.

The Washington Post reported last October that the first Reid bill was written in secret and "behind closed doors." That is the 2,074-page bill we have seen stacked up on our tables. That bill, with sleight of hand, will be swept off the table and a new one will miraculously appear sometime on Saturday. That is the bill we are going to be asked to pass by Christmas—again, without anybody knowing what exactly is in it.

Of course, there is speculation among the press corps and the political class in Washington as to whether the majority leader will be able to get 60 votes on a bill. People are saying: Yes, I think he will get 60 votes. Others say: No, he is missing a few votes; he is not quite there yet. And we are talking about a bill most of us haven't even seen. How in the world can anybody tell their constituents they are for the bill or against the bill before they have had a chance to read it? It is mind-boggling. Yet we know these closed-door meetings are still going on—8 days before Christmas—to work on perhaps a new 2,000-page Reid bill.

I know some of our colleagues were irritated with our colleague from Oklahoma, who asked that the Sanders amendment be read before we actually considered it. Only in Washington, DC, would people be mad about knowing what is in a bill or an amendment before we are asked to vote on it. The American people want to know. They are being excluded, as are many of the rest of us who don't get to know what is being cooked up behind closed doors.

We know these private meetings continue. The President has had meetings with our Democratic colleagues from which Republicans have been excluded. We don't know what kinds of agreements or discussions were occurring behind those closed doors. Certainly, no C-SPAN cameras were allowed.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. CORNYN. I ask unanimous consent for 2 more minutes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. CORNYN. Mr. President, we need to have every single Senator look at what is in these bills before we are asked to vote on them.

Let me close on one last issue. The President has also said:

First, I will not sign a plan that adds one dime to our deficits—either now or in the future. Period.

Unfortunately, because of this cynical attitude of Washington and of the political class in Washington toward the public generally, 74 percent of voters said they don't believe that. Seventy-four percent of voters, including 82 percent of Independents, are saying: We don't believe the President of the United States when he says the bill will not add one dime to the deficit.

One reason they might think that is because of what this Reid bill—at least the 2,000-page variety—says. The Chief Actuary for CMS says that pledge is "unrealistic and doubtful." David Broder, one of the deans of the Washington press corps, said:

These bills, as they stand now, are budget-busters.

I don't know what it is going to take before Congress wakes up and listens to our constituents and the American people. I guess it is going to take another election in 2010 or in 2012 where the American people get to hold us accountable because in the end the American people will get the kind of Congress they want and the kind of Congress they deserve. I hope it will be the kind of Congress that embraces the transparency pledges the President has made and, in reality, lets the American people know what we are doing here and asks whether they approve.

Mr. President, I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from North Dakota is recognized.

Mr. DORGAN. Mr. President, it is interesting to listen to the discussion on the floor of the Senate. We hear a lot about what is wrong these days. For a moment, let me say that there is a lot right in this country as well.

We are in a deep economic recession. I understand that. This is the deepest recession we have seen since the Great Depression. It is a difficult circumstance. But this country has been in tough circumstances before. The American people are a resilient bunch; they pull themselves up and move forward.

I understand the angst and the concern across this country. I understand the debate in the Chamber about what is wrong. I would be the first to say I don't think either political party is a great bargain sometimes. Both of them have their faults.

I think of that Ogden Nash poem that goes like this:

He drinks because she [scolds],
He thinks she [scolds] because he drinks,
She thinks while neither will admit what's
[really] true that he's a [drunk] and she's a
shrew.

Both political parties, it seems to me, have faults, but both political parties have also contributed to the well-being of this country.

When I hear people say nothing works in America—I answered phones at the front desk yesterday for a while to hear from callers calling in about various things. I heard it on many occasions because a lot of people on the radio and on TV are saying nothing works in America and there is nothing the Federal Government has ever done that works.

The Internet—what a wonderful invention in the life of our planet. Yes, that was created by the Federal Government. Going way back, we brought electricity to America's farms and unleashed a barrage of productivity in American agriculture. When you drive around with a locator on the dashboard of your car, that is a GPS satellite—that is the government as well. The Interstate Highway System that connects America—when you drive down big roads that are connecting all of America, that is the Interstate Highway System, suggested by President Dwight D. Eisenhower. What a remarkable thing.

I also think of the story I read a while back about those two little creatures that are crawling around the planet Mars, one called Spirit and one called Opportunity. Five years ago, our country sent both of them to land on the surface of Mars. They landed 1 week apart. They are dune buggy-sized mechanical creatures on the surface of Mars. We sent them up by a rocket. They landed encased in a shroud, and they bounced and the shroud opened up and these dune buggy-sized vehicles began driving on the surface of Mars. They were expected to last 90 days. Five years later, Spirit and Opportunity have been driving on the surface of Mars collecting samples. One of them—I believe Spirit—had an arm that looked as if it was arthritic, so it was hanging at an angle, almost like a salute. The wheel broke, and so they were dragging the wheel and creating a trench. The arm reached back, and the scientist—it takes 9 minutes to send up a signal—the scientist had the arm reach back and dig into the trench so they could get better samples on the surface of Mars. These dune buggies were running on the surface of Mars. Yes, that is the Federal Government and all the contractors.

When somebody said to me that the Federal Government has never done anything right, I said: If you ever get to the Moon, just check the boot prints. They are not Chinese or Rus-

sian; they are made by an American astronaut—the one who planted the American flag there.

There is plenty wrong in this country, to be sure, but there is a lot right about this country.

About 9 years ago, at the start of this decade, our country had a budget surplus. Poor Alan Greenspan, the Chairman of the Federal Reserve Board, wasn't able to sleep. He was worried that we were going to pay down the debt too quickly. I assured him he ought to go to sleep peacefully because that is not a problem.

President Bush came to town and said: We are going to do very big tax cuts because it is estimated that we are going to have very big surpluses. I was one on the floor who said maybe we ought not do that. Let's be a little conservative. These surpluses don't exist for the next 10 years yet. They existed that year for the first time in a long time in the year 2000—a budget surplus. President Bush said: No, we are going to begin very large tax cuts right now in anticipation of these surpluses in the future. Some of us said: Be careful. The wealthiest Americans got very large tax cuts, especially.

Almost immediately, this country went into a recession, and 6 months after that, this country was hit with 9/11, an unbelievable terrorist attack. Almost immediately, we went into the country of Afghanistan to go after Osama bin Laden. Then, very quickly, we invaded Iraq. We were at war for the rest of the decade without paying for one penny of it. Not a penny was paid for those wars or the increased funding to deal with terrorist attacks.

Some of us went to the floor of the Senate and said: Let's begin to try to pay for some of this. Why should we send our men and women to war and decide we won't ask anybody to pay for it? They thought we will just have the kids and grandkids pay the cost. The President said: If you add this to the bill to pay for it, I will veto the bill. So here we are.

Then we see, at exactly the same time, regulators coming to town boasting that they were willing to be willfully blind and they would not look or see and they would not care. We had a bunch of big high fliers create unbelievably exotic financial industries, such as credit default swaps and liars loans for mortgages, and they steered this country right into a ditch while the people at the top were making a lot of money, causing economic havoc the likes of which we have not seen since the 1930s. Our revenue at the Federal Government dropped \$400 billion because of the deep recession. Expenditures for unemployment, food stamps, and so on, which are caused to go up during recessions, increased substantially, and we have very serious economic problems. There is no question about that. I can recite the problems as

well as anybody. But let's also, from time to time, recite the strength of this country. It requires leadership from all of us to put this country back on track. I am convinced we can. I am convinced we will do that. We need a little cooperation here and there. There is not much these days. But I am convinced all of us want the same thing for this great country, and perhaps we can come together even if we have different views of how to get to that common destination. I am convinced one of these days we will make some progress and put America first.

I wished to come today to talk about something that is happening half way around the world in Copenhagen. That is the issue of climate change and energy. Even as leaders around the world gather in Copenhagen to talk about climate change, I wish to talk about the energy legislation that addresses the issue of climate change. The energy legislation that was passed by the Senate Energy and Natural Resources Committee earlier this year is a real energy policy that also protects the planet by reducing greenhouse gas emissions.

We are not going to reduce greenhouse gas emissions because somebody signs a paper. We have a lot of environmental laws. Mexico is a good example. They have a lot of environmental laws on the books. They are just not enforced. Signing a paper is not going to mean much unless you have an agreement that makes sense for the planet and an agreement that is enforced and an agreement that is agreed to by virtually all the countries that are emitting a great deal of carbon.

I will tell you what will make a big difference; that is, for the Congress to pass the Senate Energy legislation, which truly does move us in the direction of addressing climate change.

That energy policy, by the way, is not some secretive policy. This past June we passed an energy bill out of the Senate Energy and Natural Resources Committee that does all the things I think we need to—or virtually all the things—address the issue of climate change and a lower carbon future. But it was not brought to the floor of the Senate or the House of Representatives because we are told energy legislation must be married or merged with climate change. I do not agree with that. We are going to have wasted a year, in my judgment, in which we could have debated the energy legislation on the floor of the Senate, and passed it into law by the signature of the President. This energy legislation maximizes the use of renewable energy, such as the building of the interstate transmission capability that would allow us to maximize renewable energy. The energy legislation would also establish a renewable electricity standard, the first one in the history of this country. The energy legislation would

also retrofit buildings to make them more energy efficient, which would increase energy savings. I also offered an amendment to this legislation, that would also give us the ability to reduce our dependence on foreign oil by opening oil and gas production in the eastern Gulf of Mexico.

All these issues are in an energy bill that passed the Senate Energy and Natural Resources Committee on a bipartisan vote. Yet the benefits to this country from those energy policies that make a lot of sense, will not be available during this year, because those who are pushing for climate change legislation here say you have to do energy and climate change together.

I say this: I hope when we turn the corner and start a new year, that an energy bill that is bipartisan—Mr. President, I had indicated I wished to take 20 minutes today. I ask consent for the 10 additional minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DORGAN. Mr. President, the legislation that exists and is ready, in my judgment, could be signed by the President and already moving this country down the road. The deliverable for the President to go to Copenhagen could have been: Look what we have done in energy policy; we have taken the significant step in the right direction. Yet we are told that energy legislation has to move with climate change legislation.

I am not opposed to a lower carbon future. I am not opposed to trying to do something on climate change legislation. I have indicated I am not supportive of the trade piece of cap and trade. I have no interest in consigning to Wall Street the opportunity to have a \$1 trillion carbon securities market that they could trade on Monday and Tuesday, and then they can tell us on Wednesday and Thursday how much we are going to pay for our energy. I have no interest in creating a carbon securities market.

There are a lot of things we can do, especially an energy policy at the front end—and I hope early next year—we will advance this country's energy security, No. 1, and advance this country's movement toward a lower carbon future.

I wish to put up a couple charts as I describe this. We must reduce our dependence on foreign energy, especially foreign oil. Seventy percent of the oil we use comes from off our shores. We sink straws in the planet and suck oil out. We suck out 85 million barrels a day, and one-fourth has to come to this country because of our appetite for oil.

You know what, when 70 percent of it comes from other countries—many that do not like us very much—that means we have an energy security problem. This Energy bill I have described, that has been out of the Energy Committee since June, and was

passed on a bipartisan vote, reduces our dependence on foreign oil, increases domestic production, establishes a renewable electricity standard, and creates a transmission super-highway. By the way, in the last 9 years, we have laid 11,000 miles of natural gas pipeline in this country—11,000 miles. Do you know how many miles we have laid of high-voltage transmission lines interstate? Mr. President, 668. On this bill, I worked on the transmission piece with Senator JEFF BINGAMAN and others and we solved the issue of transmission.

We can get about the business of building an interstate highway of transmission lines so you can produce electricity where the Sun shines and the wind blows, put it on a wire and move it to where it is needed in the load centers.

This is not rocket science. This is rather simple. We already passed a bipartisan bill out of committee to do this. Electrification and diversification of our vehicle fleet is in the bill. The legislation also enhances energy efficiency in a wide range of areas, it expands clean energy technology, and the training of an energy workforce for tomorrow.

Every one of us gets up in the morning and the first thing we do is flick a switch and all of a sudden there is light. Then many decide to plug in a coffee maker or turn on the stove, turn on the radio, turn on the television set, get in the car, put in a key, the engine turns on—all of this is because of energy, and that is before you get to work. No one even thinks about the role energy plays in our life. That is why it is important for us to understand we have a very serious energy security issue in this country. No. 2, we have a serious issue of the need to construct new kinds of energy and also to use the existing energy differently or produce energy differently and reduce carbon emissions.

I chair the committee that funds most of our energy projects. I chair the Senate Energy and Water Appropriations Subcommittee. It funds the energy and water issues, obviously. There is a lot going on, for example, that I think is so exciting that can unlock our opportunity to continue to use coal. Some say you cannot use coal. Of course, you can. Our science and our technology can clearly decarbonize the use of coal, which is our most abundant resource. Why would we not want to use coal in the future?

There are unbelievable things going on. Dr. Craig Venter, a scientist not far from here, is working on this issue: developing synthetic microbes that underground would turn coal into methane. These microbes would consume the coal and turn it into methane. Pretty interesting to me.

There is a guy in California who has an idea, a patented idea I don't know if

it works, but they insist it is the silver bullet. He takes the entire flue gas from a coal plant and he mineralizes it through some patented process he has. It does not separate CO₂. It mineralizes all of it and turns it into a product that is harder than concrete and more valuable than concrete and produces, as a result, the cost of carbon at almost near zero. Maybe that is the silver bullet. I don't know. There are dozens of examples like it that are very exciting and very interesting.

I started algae research after it had been discontinued for 15 years—single-cell pond scum, that green scum on the pond out on the farm—algae. You take the CO₂ that is released from a coal plant, feed it to an algae farm and grow algae. It increases its bulk in hours. Then you can harvest the algae and produce diesel fuel. Get rid of the CO₂ and produce a fuel. That is called value added. That is called beneficial use of carbon.

There are others now—Dr. Craig Venter is involved in this, along with Exxon—who have projects in which they create algae that excretes lipids directly. Instead of harvesting algae and destroying it for the purpose of acquiring a diesel fuel, it excretes lipids directly which, with very little manipulation, is a fuel.

One of the scientists with the Sandia National Laboratory talked about the development of a solar heat engine in which you put CO₂ on one side and water on the other and you fracture the molecules and thermochemically recombine them and you have methanol—water, CO₂, develop a fuel.

All these ideas are opportunities for us to continue to use coal and at the same time reduce our greenhouse gas emissions.

My point is, I think we ought to be doing a lot of everything with respect to producing a better energy future for this country and with respect to reducing the carbon in our future. I am not somebody who is a naysayer about climate change at all. I expect to be a part of discussions about how to reduce carbon in our future. But I do believe it will be a profound mistake if we do not advance the very policies we have the opportunity to advance in the Congress, in the Senate, the very policies that move us in the direction of reducing carbon and making us more energy secure.

To date, what we have had is all this breathlessness about you have to do a climate change bill right now and you cannot take up energy legislation until you take up climate change legislation. You know what, I do not agree.

I hope that high on the list of the agenda next year for this Congress is to say: We have a serious energy security problem and we have a serious issue with respect to carbon. Let's deal with both. If anybody believes this country can continue to have a 70-percent ad-

diction for oil from foreign countries, they are dreaming. That is not something that will be sustainable in the long term. It undermines this country's economy to have that kind of addiction to foreign oil.

So how do we address this issue and fix it? We address it with thoughtful policies inside this country—to increase efficiency, increase conservation, increase production, and increase production in the right way that protects our planet. All these things are possible.

I guess I have spoken six or eight times on the Senate floor about these issues, not that anybody is listening so much I guess. But it is all health care all the time right now. Health care is not unimportant. I happen to think among the first things on the agenda is, A, financial reform which restores confidence. That was important because a bunch of high fliers steered this country into the ditch. We have to make sure people think that will not happen again; then, second, restarting the economic engine and putting people to work—jobs; third, dealing with energy which has to do with the very security of virtually everything we do to create jobs in this country. All these are important issues.

My hope is, when the calendar turns and January comes, we will have the opportunity to grab and seize the progress that was made in the Senate Energy and Natural Resources Committee, now nearly 6 months ago, to do the right thing for this country and to do the right thing to address climate change at the same time.

I yield the floor.

The PRESIDING OFFICER. The Senator from Washington is recognized.

Mrs. MURRAY. Mr. President, I come to the floor on behalf of over 10,000 constituents from my home State of Washington who have sent me letters and e-mails over the past 6 months to tell me their stories and their struggles with our health care system.

I come to the floor on behalf of the thousands who do not have the time or who do not have the resources to write to me and ask for help but who are struggling as well.

I come to the floor on behalf of small business owners, parents, senior citizens, and people with preexisting conditions, people with insurance whose premiums are skyrocketing, and people without insurance who spend their nights praying they do not have an accident or fall ill.

These people are all worried about keeping their jobs or making a mortgage payment and for whom the cost of getting sick today or being dropped from their health care plan or opening their mail to see another premium increase is too much to bear. Those are the people who deserve a real debate and a real plan, not distortions or silly distractions, such as conversations

about how many pages are in this health care bill. What is more important than the number of pages in this health care bill is the help within those pages for businesses and families across this country.

I have watched, day after day, as our colleagues on the other side of the aisle have come down to this floor. They have made outrageous claims. They have handed out reams of paper and stacked copies of the Senate bill on top of copies of the House bill to try and turn a serious debate into a sideshow. But if my colleagues on the other side want to focus on pages, fine, let's focus on pages.

Beside me is a photo of a woman named Doreen Kelsey. In front of Doreen is a stack of papers. Those are hundreds upon hundreds of pages of forms and rejection letters and appeals and denials from her insurance company. These are pages that have taken hours and hours to fill out and that have stood between Doreen's husband and the care he desperately needed.

I met Doreen at a roundtable I hosted in August in Spokane, WA, in my State. Doreen told me she is self-employed and isn't able to purchase her own health insurance because she has a preexisting condition. Now, luckily, she and her family have health insurance coverage through her husband Tony's employer. She told me she and Tony thought their family had good insurance coverage. But when he asked for a colonoscopy, they soon discovered the lengths to which insurance companies will go to deny, to delay, and to dispute the care families such as the Kelseys assumed were included in their coverage.

Their insurance carrier told them before they would pay for this preventive care, it would have to be approved by a primary care physician. After being delayed for more than a month because of that requirement—and this whole stack of papers here—the colonoscopy ultimately confirmed their fears, and he was diagnosed with stage 4 colon cancer. With that diagnosis in hand, the Kelseys were determined to beat this terrible disease together, but rather than focusing on fighting cancer they were forced to fight their insurance company.

Doreen told me although they had faithfully paid their premiums throughout their entire working lives, now that Tony desperately needed life-saving treatment, he was in a constant struggle of paperwork with his insurance company to pay for even routine care. They weren't asking for anything new, they weren't asking for anything experimental, they were just asking for the care that a lifetime of paid premiums should have entitled them to.

The Kelseys assumed what most Americans do when they are paying for good health insurance. They assumed that while their insurance was expensive, it would be there for them when

they needed it. Well, Doreen and her family, like many other American families and businesses, have come to find out that in our current health care insurance system, stability is sometimes nothing more than an illusion.

With each procedure and each battle, the Kelseys faced a new fight—more paperwork stacked on more paperwork, another appeal and another appeal. At one point, Doreen told me she had to appeal all the way to the State insurance regulator just to get a corrected explanation of benefits form—paperwork—from her insurance company. She told me they had to borrow thousands of dollars to pay doctors while their claims were tied up in what seemed like an endless appeal process—paperwork.

The Kelseys' insurance now costs more than their mortgage, and they are constantly worried that Tony's employer will drop that coverage. But, thankfully, she told me Tony is working hard and successfully battling his cancer. In the meantime, Doreen has successfully been battling her insurance company. But this isn't how our system should work. When we pass the Senate's health care reform bill we are debating, it will not be.

Let me tell everyone—and the Kelseys—how our bill will help them. First of all, our bill ends insurance company discrimination for pre-existing conditions, so Doreen will be able to purchase insurance on her own and not have to rely on her husband's employer. Doreen would also have access to a number of different plans through an exchange that we are setting up where insurance companies, for the first time, would have to compete for her business. Our plan would inject competition into the insurance market, and we know that will lower costs and give families such as Doreen's more choices.

Our plan also makes it illegal for insurance companies to drop people when they get sick, so Doreen and Tony wouldn't have to worry about losing their coverage at the moment they need it the most. Since we know that preventive care is critical to saving lives and saving money on health care costs in the long term, our bill ensures free preventive services under all insurance plans.

Our plan invests in prevention and in public health to encourage innovations in health care that prevent illness and disease before they require more costly treatment. It would have allowed Tony to get a colonoscopy when he first needed it so he could get his treatment started sooner.

Mr. President, we also know families deserve the security and stability of knowing that if they or their loved one do get sick, they will not be forced into bankruptcy to pay for the cost. Our bill restricts the arbitrary limits that insurance companies currently place on

the amount of coverage families receive. It caps the total amount that insurance companies can make people pay out of pocket on copays and deductibles. And it eliminates the lifetime limits insurance companies can impose on coverage.

In addition to putting in place those important consumer protections that would help people such as Doreen and Tony, it will give families the stability and security they deserve and lower the cost of care so Americans such as Tony and Doreen would not have coverage that costs as much or more than their mortgage. We do that by putting in place premium rate reviews to track increases and crack down on excessive insurance company overhead costs.

When our bill passes—and I am confident it will, despite the delay and the delay and the delay that we are seeing on the other side of the aisle—insurance companies will no longer be able to hike up Doreen's premiums to pay for a bureaucracy they will then put to work battling her claims.

We also provide sliding scale premium tax credits—tax credits—for families who still can't afford coverage, which would help 450,000 people in my home State of Washington get the coverage they need.

Mr. President, the bill before us today—which some of my colleagues have sitting on their desks and they bring out here on a daily basis to show us the pages—will help families such as the Kelseys. That is what is within the pages of the bill they keep throwing at us. So I think, rather than talking about the number of pages in the bill, our colleagues on the other side of the aisle might actually want to talk about what is in the bill because right now, instead of debating the merits of bringing down costs or protecting families from losing the coverage when they get sick, our colleagues are actually spending time complaining this bill has too many pages.

I ask the Presiding Officer and my colleagues on the other side of the aisle to take a look at this photo of Doreen sitting next to hundreds and hundreds of pages of correspondence and appeals and fights with her insurance company. These are the pages we ought to be talking about. These are the pages that impact people's lives, and the Kelseys are the people we ought to be talking about.

So when my colleagues come down here and complain about the number of pages in our health reform bill—those pages that will help our families and businesses lower costs—I want them to think about the number of pages right here in front of Doreen. These are pages that have caused the Kelseys unimaginable heartache, and these are the pages that have come between them and the health care they paid for.

These are the numbers we ought to be focusing on—the 14,000 people who

are losing coverage every day. These are the numbers we ought to be focusing on—the 51 million people who have no insurance. Those are the numbers we ought to be focusing on, not the number of pages in the bill.

Mr. President, we have to end the politics, end the delay and the partisanship. We need to end this obstruction because that is what the Kelseys faced every day, delay and obstruction. They are facing it again on the floor of the Senate. It is time for us to come together on this important bill and bring our businesses and our families the insurance reform they have been asking for. I hope that is what Americans will remember at the end of the day, that the pages in this bill are going to change their lives so they don't have to fight their insurance companies again.

Mr. President, we are here today in the Senate—nobody on the floor, just me talking about what we ought to be doing, and you in the Chair, waiting. Why? Because we have a Defense appropriations bill in front of the Senate. It is a Defense appropriations bill that needs to be passed by the end of this year. It needs to be passed so we can get back on the floor and pass our health care reform bill.

Some people on the other side of the aisle have decided that delaying this Defense bill will somehow help them delay this from ever being passed—the health care bill that would help Doreen and her family. Well, Mr. President, it isn't just about making a political point. What we are doing is having our soldiers—who are serving on the ground in Iraq, in Afghanistan, around the globe and here in our country—wonder what they are going to get for Christmas—a delay from the Senate?

The bill in front of us provides a 3.4-percent military pay increase. This is an All-Volunteer Force we have out there working for us. Many of them are away from their families this Christmas. They do not want to hear that the Senate is delaying passing this important bill that will give them the security they need because of political obstruction in order to delay a health care bill.

This Defense bill is critically important. It has very important support for our military and their families. It has passed through this Senate before, and we are ready now to make the final trip to the White House, which needs to be done, by the way, by tomorrow. So I hope our colleagues will not continue to delay. I hope they will allow us to move to final passage on this bill so our men and women who are serving us in the military and around the globe know there is a Senate who is working for them.

I have heard some of them on the other side complain that some things were added to the Senate Defense bill—that also need to be done by the end of

the year, besides the Defense bill—such as making sure our families, whose benefits are running out for unemployment, or COBRA for health care insurance, get a 2-month extension. So should our Christmas present to them be: Sorry, you aren't going to get your small little help as we end this year. We want to keep that going for another 3 months during one of the worst economic times we have seen. So, of course, we put it in this bill.

Because of the obstruction on the other side, we can't get it through in a timely fashion. It has to be done by the end of this year. We are doing the right thing for our families. We are doing the right thing for our military by putting it in this bill and getting it done and to the President so we can finish our work.

Mr. President, these are all critical issues. We are all tired. We have been here day after day after day. It is time to get this done. Let me tell you why. Because Doreen and her husband are facing piles and piles of paperwork to care for her husband. They are fighting their insurance company. And all we have to do is put these bills in front of us, get them done, and provide some relief for America. I hope that is what we focus on, Mr. President. I hope we stop the deny and delay and obstruction that the Kelseys have had to fight with their insurance company. Let's move these bills and go home to our families for Christmas.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. UDALL of New Mexico). The Senator from Illinois is recognized.

Mr. BURRIS. Mr. President, I also would like to make a few comments on the issue that is pending before this body and which has been debated and debated and debated, discussed and discussed and discussed. It is time to bring it to a meaningful and final conclusion.

As I address this Chamber today, we stand on the cusp of history. For many years, we have known that the American health care system is badly broken. Now, after nearly a century of debate, after 100 years of delay and false starts, this body is on the verge of laying the issue of health reform to a rest.

This bill represents the culmination of decades of hard work. Its course has been shaped by 11 Presidents and countless Members of the House and Senate. It has taken a long and winding path to reach this point. This legislation is a product of compromise and consensus, of give and take on both sides. It is not perfect; by no means is it perfect. But here we stand.

We have come further than any Congress in history on this issue. We have worked hard to craft a measure that can accomplish the goals of reform without alienating those whose support we need to pass this bill. Without a commitment to certain ideals, this bill

would be empty and ineffective. But without a willingness to work together and achieve compromise, this bill can never become a political reality.

As responsible legislators, this is the fine line we must always walk. It is never easy. I applaud my colleagues for the fine work they have done at every step along the way. Still, not everyone is satisfied, so the work goes on. It is the genius of our Founding Fathers and the rules of this body that allow one Senator to keep debate alive so we can work, debate, write, rewrite legislation together. One Senator can do that under the rules of this body.

Some have suggested that we kill this legislation and start over. They suggest that we stop and come up with something new. They say without perfection we should give up on reform altogether.

I have spoken on the Senate floor, Mr. President. You know what my position has been. But giving up on this issue is not an option. So as my colleagues and I continue to move forward from here, I would like to make one thing very clear. After 100 years of debate, we have come too far and worked too hard to turn back now. Too many Americans are counting on us to make a decision on their behalf. They need it now. They don't need it tomorrow or next week or next month or next year or never—they need it now. Killing the bill would ignore those who look to us for help in their time of crisis. We cannot abandon them at this time. Leaving tens of millions of people without any health coverage at all is also unacceptable.

To all those who believe we should kill this bill I would say this: I understand their frustration, the impulse to say enough is enough. But our vote in this body on this bill is not the end of a path for this sweeping legislation, only a door to the next step of conference.

I have not yet seen the details of the legislation. I have not yet seen the CBO score. I have not yet seen the provisions that will earn my vote; namely, cost containment, competition, and accountability. It is only through keeping this legislation alive that we can continue our work to make this a more perfect document. I say we must continue to work on this document we have before us. We cannot kill this legislation and start over. We must keep working through this legislation, keeping it alive so we can continue—continue—to make this document what we want it to be. That is what we must do.

I yield the floor.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. KAUFMAN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. KAUFMAN. Mr. President, I speak today about the need for urgent action on the Defense appropriations bill. I shouldn't have to speak about urgent action on the Defense appropriations bill because this is the one area that is so important to the country and on which we should always operate as quickly as we can. I urge my colleagues on the other side of the aisle to stop their attempts to derail the health care bill and allow the Defense appropriations bill to move forward.

As always, I respect that my colleagues have different views. We have different views on all kinds of issues. We have all kinds of substantive differences. I am one of the people in this body who believe there are basic differences, and a lot of them are not political, they are about basic differences that separate us from being Democrats and Republicans. We can disagree on tactics and on principles, but I know my colleagues on the other side of the aisle support our troops, and the support of our troops should never be a partisan issue.

This bill funds more than \$100 billion for operations, maintenance requirements, and military personnel requirements for our armed action in Afghanistan and Iraq. It provides more than \$23 billion for equipment critical for protecting the brave men and women in uniform—and they are brave men and women and they deserve this. I know the other side of the aisle agrees with that. That is why we should move ahead on this bill. It funds more than \$150 billion for the training of our troops, critical to our success. It is incumbent upon the Congress to ensure that our troops in Afghanistan, Iraq, and throughout the world have the resources they need to be safe, secure, and effective in the war zone.

This bill has been operated and worked on by both parties. It puts our troops first, with the necessary equipment and improved benefits for the military and their families. This isn't just about our troops; this is about the brave men and women who remain at home, the families who need the benefits—again, issues I know my colleagues on the other side of the aisle agree with. They deserve our support and they deserve it now.

In addition to providing a 3.4-percent pay increase for our troops, it also improves military health care and research, including for the very important psychological health, which is especially important, given the startling rates of post-traumatic stress disorder. Everybody knows we must train and equip our troops, our men and women going into battle, but it is equally important—and everyone agrees with this, too—it is equally important to care for the troops and their families after they return home. That is what this bill does.

This bill is necessary, as it demonstrates solidarity with the troops and gratitude for the sacrifices they make on our behalf. It is an investment in our military, in our security, and in our future. That is why our House colleagues overwhelmingly agreed to it yesterday by a vote of 395 to 34 and why we must end these partisan delays to move this bill forward.

It is critical we pass the bill, and there is no good reason why our troops and military families should have to wait—especially in this holiday season—while the other side of the aisle is playing politics.

I support conducting a real debate on Afghanistan with a host of other military issues, but the current debate is not about substance, it is about politics. Our troops should come first and they deserve better. We should pass this bill without delay to give the military and their families the funding they need to do their jobs and to protect our Nation.

Thank you. I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. WEBB). The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. KAUFMAN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. KAUFMAN. Mr. President, I ask unanimous consent to speak as in morning business for 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE FRAUD

Mr. KAUFMAN. Mr. President, I rise to discuss health care fraud. Earlier this month, I introduced, along with Senators LEAHY, SPECTER, KOHL, SCHUMER, and KLOBUCHAR, an amendment that will protect our increased national investment in the health of Americans by improving fraud enforcement. Everyone believes in fraud enforcement, and this amendment does that.

It is no secret fraud represents one of the fastest growing and most costly forms of crime in America today. In no small part, our current economic crisis can be linked to financial fraud, starting with unchecked mortgage fraud generated by loan originators, through securities fraud that hastened the eventual market crash and maximized its impact on Main Street and average American investors.

In response, this body passed the Fraud Enforcement Recovery Act, FERA, which directed critical resources and tools to antifraud efforts.

FERA was passed in response to an unprecedented financial crisis, but Americans should expect Congress to do more than simply react to crises after their most destructive impacts

have already been felt. We owe it to our constituents to identify and address problems when they arise so we can prevent disaster rather than just trying to figure out how to clean up after it happens.

In undertaking comprehensive health care reform, we must be proactive in combating health care fraud and abuse.

It is hard to believe, but each year criminals drain between \$72 billion and \$220 billion—that is billion dollars—between \$72 billion and \$220 billion from private and public health care plans through fraud, increasing the costs of medical care and health insurance and undermining public trust in our health care system. We not only lose the money, we lose the trust people have for the system that the system works.

We pay these costs as taxpayers and through higher health insurance premiums. This amendment will provide needed tools to reduce those costs through effective investigation, prosecution, and punishment of health care fraud.

It is pretty clear that as we take steps to increase the number of Americans who are covered by health insurance and to improve the health care system for everyone, we must also ensure that law enforcement has the tools it needs to stop health care fraud.

The Finance and HELP Committees, as well as leadership, have worked long and hard to find ways to fight fraud and bend the cost curve down. They have done a great job. However, there is more work to be done, and this amendment is an important additional step.

This amendment makes straightforward but critical improvements to the Federal Sentencing Guidelines, to health care fraud statutes, and to forfeiture, money laundering, and obstruction statutes, all of which would strengthen prosecutors' ability to combat health care fraud.

First, this amendment directs a significant increase in the Federal Sentencing Guidelines for large-scale health care fraud offenses.

It is really kind of strange, but despite the enormous losses in many health care fraud cases, analysis from the U.S. Sentencing Commission suggests that health care fraud offenders often receive shorter sentences than other white-collar offenders in cases with similar loss amounts. So people basically feel you can do health care fraud and get away with it and you will not pay a major price. According to statements from cooperating health care fraud defendants, many criminals are drawn to health care fraud because of this low risk-to-reward ratio.

As we have an incredible expansion of health care that will go forward, with more funds, we know criminals out there think this is easy. They think: I can go out and commit fraud. It is a very complex process, but I commit the

fraud. My chances of getting caught are not that great, but even more, I have an added bonus that, if I get caught, I will not get much of a penalty.

That is why we need to ensure these offenders are punished not only commensurate with the costs they impose upon our health care system but also at a level that will offer a real deterrence. These folks believe they can engage in health care fraud and even if they get caught they will not have much of a penalty. Our amendment directs changes in the sentencing guidelines that, as a practical matter, amount to between 20 and 50 percent for health care crooks stealing over \$1 million.

In addition, the amendment updates the definition of "health care fraud offense" in the Federal Criminal Code to include violations of the antikickback statute, the Food, Drug, and Cosmetic Act, and certain provisions of ERISA.

These changes will allow the full range of law enforcement tools to be used against all health care fraud.

The amendment also provides the Department of Justice with subpoena authority for investigations conducted pursuant to the Civil Rights for Institutionalized Persons Act, also known as CRIPA.

It is hard to believe, but under current law the Department of Justice must rely upon the cooperation of the nursing homes, mental health institutions, facilities for persons with disabilities, and residential schools for children with disabilities that are the targets of CRIPA investigations. You can figure out that in most cases these targets will cooperate, but sometimes they may not. The current lack of subpoena authority puts vulnerable victims at needless risk.

Finally, the amendment corrects an apparent drafting error by providing that obstruction of criminal investigations involving administrative subpoenas under HIPPA—the Health Insurance Portability and Accountability Act of 1996—should be treated in the same manner as obstruction of criminal investigations involving grand jury subpoenas.

As we consider and debate meaningful health care reform, we must ensure criminals who engage in health care fraud, and those who think about doing so, understand two things: If they engage in health care fraud, they are going to be faced with swift prosecution by more prosecutors and more folks who enforce the law, and when they are found guilty, they will face substantial punishment.

These commonsense provisions should be a central part of health care reform. I urge my colleagues to support this amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent to speak as in morning business for up to 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE REFORM

Mrs. HUTCHISON. Mr. President, I rise today to speak about the health care bill that is pending. The Department of Defense bill is also pending. It is the business we have on the floor today. I have no doubt that at the appropriate time there will be a vote in support of funding our troops. I know that that may come on Saturday after the time for debate has run out.

I want to talk about the health care issue because it is the reason we have been here for really most of the last month—voting every Friday, Saturday, and Sunday—is to talk about the health care bill, debate the health care bill, ensure the American people know what is in this health care bill, and ensure people start looking at the effect it is going to have on their businesses and their families. I can't think of anything we have ever voted on in this body since I have been here that will affect people's lives in such a personal way.

I have tried to look at what is good in the bill, and then I look at what I don't like in the bill, and I have to say the scale is very heavily tilted toward what I don't like.

In fact, I had a tele-townhall meeting, which is a new capability we have to talk to people. It is a wonderful way to be able to reach out in your State to people who are interested in asking questions and actually call them and let them ask their question. At all times during the tele-townhall I had last night, there were over 6,000 people who were in and out of that tele-townhall meeting. I was very pleased because every single question was a real question, a real person. One man who called is on kidney dialysis treatments. He has very high drug costs and high expenses. Then we had people on Medicare asking how the cuts in Medicare would affect their treatment and their care. Then we had small businesspeople who are scared to death of having more burdens, more taxes, and more mandates on their small businesses. Some were almost screaming into the phone: But don't people realize how hard it is to make ends meet right now for small business? Don't you all realize we are trying to stay afloat while we are in one of the worst recessions of our lifetime?

Of course, I assured them I do understand that. That is why I am trying to amend this bill, trying to change it, trying to encourage my colleagues on the other side of the aisle that we should really start over and try to have a health care reform bill that does three basic things.

We want a bill that actually lowers the cost of health care. Right now, the

bill before us will increase the cost of health care. The cost of the bill that is before us today, if you start with when the bill takes effect, which is 2014, and you go 10 years out, you are looking at \$2.5 trillion in costs.

We have a debt of \$12 trillion in America right now. Those numbers are staggering. We used to be worried about \$12 billion, \$15 billion, and \$100 billion; now we are talking about trillions of dollars. We are talking about \$12 trillion in debt right now. The idea that we would put \$2.5 trillion more in this health care bill, which mandates taxes, to offset some of it, to businesses, employers, and families, is unthinkable. It is unthinkable in good times, but in the bad times we have now, it is absolutely unthinkable. Here we are now talking about this bill that will increase the debt and increase taxes and mandates.

In talking with the people of Texas, I did a little poll on the tele-townhall. I said: Register in, punch 1 for yes, 2 for no, and 3 for undecided. I asked: Do you support the bill that is before us today? If you say yes, press 1; no, press 2. Eighty-one percent instantly started registering against this bill.

I was listening to my colleague, Senator BARRASSO of Wyoming. He also had a tele-townhall meeting for Wyoming. Many Senators are doing this now. He had a couple of thousand people on the call. Ninety-three percent who registered on the poll were against this bill. My colleague from Nebraska, Senator JOHANNIS, said the polls in Nebraska are overwhelmingly against this bill.

People are listening to the debate, reading the newspapers, getting every bit of information they can, listening to the tele-townhall conference calls, they are asking their questions, and in unprecedented numbers they are registering their interest and their overwhelming rejection of this bill.

I talked about what is in this bill and what we could have. Instead of \$100 billion in new taxes, which would start next month, we could step back and say we are not going to put new taxes on businesses and families and companies before the bill even takes effect. In fact, Senator THUNE and I had a motion that was rejected on the floor. It was tabled yesterday afternoon. It would have done exactly that. Very simply, if the bill is going to pass, at least don't start the taxes until there is some program available that is as a result of the bill. It is very simple and clear. That was our motion, and it was tabled, with only 41 Senators saying yes, so we lost the motion.

It is of great concern to us that the tax increases in this bill start next month—we will have over \$100 billion in new taxes starting next month—and that the 40-percent excise tax on premium health care coverage policies takes effect in 2013 but the bill doesn't take effect until 2014.

That is the bill we are debating today, which an overwhelming number of American people are rejecting. They don't want taxes, mandates, and they don't want the government to step between them and their doctors. They want the physician-patient relationship that is the hallmark of American health care. It is what makes us different from most other countries in the world—that we don't have government standing in the way and most of our private plans don't say: No, you can't have this treatment because you are too old or you are not fit enough, or having the government say: Here is who is qualified for this procedure. That is not the health care we have known in America.

We are for health care reform that lowers the cost of health care in our country, and more people will have affordable options. There is a part of this bill that could provide that. It doesn't mean a government takeover. We don't need a government takeover. That is why you have all the taxes and mandates, because it will cost so much that taxes and mandates are the way the majority is putting forward to pay for this expensive government takeover.

Why not have the health care exchange without all the mandates so there would be a free market on the exchange with no cost that would allow people to have choices? The insurance companies would come forward and there would be high-deductible plans for people who wanted high-deductible plans, and there would be low-deductible plans that would be more expensive, but some people would prefer to have that. You could make your choices among the plans that would be put on an exchange that would be open, transparent, and competitive. You would have bigger risk pools and, therefore, lower premiums would be the result.

Talking about what Republicans wish to see in health care reform and asking the majority if we could stop going through every weekend with one vote on Friday, one vote on Saturday, one vote on Sunday so that we are not able to do anything with our families during this holiday season, instead why don't we step back and say we will come back after Christmas or whenever the majority wishes to come back and say: Let's sit down in a bipartisan way, and let's have three principles in a health care reform bill. No. 1, we would lower the cost with the exchange, bigger risk pools, lower costs. No. 2, how about tax credits for every individual or family who would buy their own policies because they don't have access through an employer or if they are going to go on this exchange that would not cost anything, they would be able to have a tax credit to buy their own health care coverage. That would increase the number of people insured in our country, much larger than we

are looking at today with a big government-run plan, which is said to increase the number of insured 31 million, but leave 24 million uninsured. We could get 31 million with the free market working.

No. 3, what about medical malpractice reform? We could take \$54 billion out of the cost of health care by having frivolous lawsuits curbed with some kind of reasonable limits on damages or attorneys fees that would allow people to get some compensation for a transgression, but not something that is going to raise the cost of premiums so high for doctors and hospitals that they have to order more medical tests and that raises the cost of health care across the board.

Those would be the principles we could support. Let's start again after Christmastime and do a rational proposal that the American people would accept.

The PRESIDING OFFICER. The Senator's time has expired.

Mrs. HUTCHISON. I yield the floor.

The PRESIDING OFFICER. The Senator from Florida.

Mr. NELSON of Florida. Mr. President, is it any wonder that people are responding negatively when asked, Do you support health care, when they have been bombarded with millions of dollars of TV advertisements that are not telling what this health care bill does?

Is it any wonder when they hear comments such as this health care bill will not save the American consuming public on their health insurance premiums? What does it do?

Can you believe that it is not going to allow insurance companies to cancel your policies?

Can you believe that it is not going to let an insurance company come up with some kind of fictitious excuse that you have had a skin rash and, therefore, you have a preexisting condition and they are not going to insure you?

Can you believe that it is going to bring in 31 million new people who are going to have health insurance who did not have health insurance before, and that all the rest of us paid for when they showed up at the emergency room?

Can you believe that this health care bill is going to bring down the cost of Medicare over the course of time and is going to save Medicare instead of Medicare running out of funds in about 6 or 7 years?

Can you believe that by creating a health insurance exchange for the private marketplace for private health insurance companies to compete for that available exchange of people who want to buy health insurance there, it is going to bring down their health insurance premiums from what they would otherwise pay?

You probably say it is hard for me to believe that because of all the negative

I have heard. But that is exactly what the experts tell us this bill is going to do. And, oh, by the way, it is going to do one more thing. Over 10 years, this bill is going to reduce the deficit by \$130 billion. Can you believe that? Not if you have been listening to all the stuff that has been thrown around about how bad the bill is. But that is the tactic. That is the tactic of "in your face," "oh, ain't it awful." It is time the real story gets out.

You know what will happen? When this bill is passed and it is finally signed into law by the President, then the real story is going to get out and people will know. In the meantime, I wish that in the Senate we could have closed the doughnut hole. The doughnut hole is the gap in coverage for Medicare recipients where they have to continue to pay premiums for Medicare but they receive no drug coverage whatsoever.

Under current law, a Medicare beneficiary will pay up to \$310 for their drugs, which is the deductible, and then they pay 25 percent of their drugs up until they have paid out a total out of their pocket of \$940. Above that, they hit the dread doughnut hole and they continue to pay premiums, but they receive no help from Medicare for their drugs all the way up to a much higher level. There are 3.5 million people who hit that dread doughnut hole.

Each year, because of the formulas, the doughnut hole grows bigger and it is compounded by higher and rising drug prices. We have seen that the pharmaceutical industry has raised their prices 9 percent. These out-of-control increases in prescription costs are hurting our folks and especially seniors on fixed incomes.

It is no secret that I wanted to fill the doughnut hole. It is not going to happen. But what is going to happen when this gets into conference with the House of Representatives—in fact, there has been a commitment by the majority leader, there has been a commitment and a statement by AARP, which has a significant interest in this legislation, there was a pledge on this floor by Senators REID, BAUCUS, and DODD to close the doughnut hole. I suspect that what has happened is, they have gotten the agreement of the pharmaceutical industry to help them close that doughnut hole once we get into the conference committee with the House of Representatives.

But first, we have to get the bill out of here. That means we have to stand up and push back all of this nonsense and misinformation that is coming about this bill.

What does it do, to recapitulate. It lowers the cost of Medicare over time. It gives a reduction of the Federal deficit. It allows insurance for people who do not have it to be available and affordable and they cannot cancel or use some flimsy excuse to cancel. It will

utilize the private marketplace in which to make this happen. This is an American story, and it is going to be an American success story.

Mr. President, I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. CORNYN. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. BEGICH). Without objection, it is so ordered.

Mr. CORNYN. Mr. President, as I contemplate the task ahead of us between now and Christmas to consider this huge change—some might say radical change—in our health care system, I am reminded of an oath that doctors take called the Hippocratic oath, which basically is, first, do no harm. In other words, you don't want to kill the patient when you are trying to cure them of cancer. You don't want to disable a patient, make their condition actually worse than trying to help them. I think it would be advisable if Congress took a Hippocratic oath, and nowhere is that more appropriate than when talking about health care.

We ought to make sure whatever we do, we don't make things worse. Yet the underlying health care bill, the Reid bill, makes things worse. I will talk about that in detail.

We all agree health care reform is needed. Some of us have different ideas about what reform should look like. We know health care premiums have more than doubled in the last 10 years for American families and that health care costs typically rise at two or three times the rate of wage growth. We also know this is all unsustainable. We can't keep doing what we are doing. Republicans and Democrats agree on the nature of the problem. The question is, What is the cure? What are we going to do to make it better? Are we, perhaps, due to inadvertence or unintended consequences, actually going to make things worse than they are now?

The Reid bill, the health care bill that will be considered along with a substitute that has been negotiated behind closed doors and which we haven't seen, the basic Reid bill would actually increase premiums by \$2,100 for American families purchasing insurance on their own.

I would like to recall the words of President Obama as he was describing his bill. He said:

I have made a solemn pledge that I will sign a universal health care bill into law by the end of my first term as president that will cover every American and cut the cost of a typical family's premium by up to \$2,500.

Yet this bill breaks President Obama's pledge because for an average American family buying their insurance on their own, it would raise their

premiums by \$2,100. According to the CBO and the Joint Committee on Taxation, all of the new taxes—the tax on health benefits, if you have so-called Cadillac plans. I had three firefighters from Texas in my office 2 days who said: Please don't let them tax our health care plans. We have negotiated those in lieu of wage increases. We accepted lower wages because we wanted a better health care plan. Now you are going to tax our health care plan. That is just not right.

We know those taxes on medical devices, on health insurance, whatever they may be—on prescription drugs—eventually will find their way back to the consumer. It is sheer fantasy to think these companies are just going to absorb those taxes and those cuts and they would not have an impact on the price to the consumer. That is why rather than bending the cost curve down, making health care more affordable, this will actually make it worse.

A new independent study by Oliver Wyman found that the Reid bill would actually increase insurance premiums for people with insurance. Again, I thought the purpose of health care reform was to bring costs down through managed care, medical homes, accountable care organizations, delivery reform, medical liability reform, parity of tax treatment, increased competition across State lines. Those are the kinds of things this bill does not do which would actually have some hope of bending the cost curve down for the average American family.

This study by Oliver Wyman found that the Reid bill would actually make people's insurance premiums go up. This study said premiums would go up by 54 percent—in my State of Texas, by 61 percent—for Americans purchasing health insurance on their own. In other words, it is not employer provided. They would have to go out in the marketplace, if you are a small business man or woman, and buy insurance or if you are an individual buying health insurance, this will make your premiums go up by 61 percent in Texas and 54 percent across the Nation. So an average family of four in Houston would see their premiums more than double to \$1,352 a month.

Is that the kind of health care reform we thought we were signing on to when we engaged in this debate? It certainly isn't what I call health reform. This is not what my constituents in Texas call health reform, to double the premiums for an average family of four in Houston. That just makes things worse. Premiums could go up 20 percent higher for small businesses struggling to provide benefits for their employees.

The worst part about this is that these kinds of so-called reforms have been tried before. They failed miserably. For example, in New Jersey and New York, both tried the kinds of mandates, community ratings, guaranteed

issue—these other things that sound a little arcane but which have had the impact of skyrocketing premiums in those States and causing insurance companies to leave the market. Rather than bearing these financial and regulatory burdens, many of them say: We are out of here—leaving people with less choice and higher premiums.

Then there is the Medicaid-Medicare cost shift. For example, Medicare pays about 80 percent of what private insurance does to a doctor or a hospital, Medicaid even less. So these providers have to make it up somewhere else. What they end up doing is charging more to people with insurance. That is what the cost shift is all about. According to one study, that cost shift means higher premiums of about \$1,800 a year for the average family. About half of that comes from Medicaid alone. Yet the Reid bill includes the biggest expansion of Medicaid since the program was created in 1965. And lest we forget, Medicaid is a joint Federal-State program. By expanding the coverage of Medicaid, we are basically imposing an unfunded mandate on the States.

In my State, a State of 24 million people, this Medicaid expansion will result in a \$20 billion unfunded mandate imposed on State taxpayers that the Federal Government is not going to help them out with, \$20 billion over 10 years.

The American people intuitively know all of this. A new Washington Post-ABC poll came out this week that found that most Americans, 53 percent, believe Washington's health care bill will actually increase their costs. Small businesses know this is true. According to a letter I received from the National Federation of Independent Business:

The Patient Protection and Affordable Care Act, which is short on savings and long on costs, is the wrong reform at the wrong time and will increase health care costs and the cost of doing business.

Why in the world would we impose additional costs on small businesses at the same time we are trying to get small businesses to create jobs to try to get our economy to come back? We know that small businesses are the engine of job creation. Now we are just going to impose more costs, more higher premiums on them. What is that going to do? That will discourage them from keeping employees they have in a tough economy and perhaps not hiring new people, when we want to do everything we can to bring down the 10 percent unemployment rate.

In Houston, TX, according to one small business owner:

The proposed health care bill is going to have a negative impact on my business because the cost of employee health insurance will go up. I don't believe what some are saying that the costs will go down. This bill does not make economic commonsense.

One thing about common sense is, as you find out the older you get, it is not

too common. This bill simply defies the explanation that some have given to it that it will actually make things better rather than worse. My constituents, small business owners, everyone understands that the pressures put on premiums and costs is going to make things worse.

Here is a chart that shows that from the time this bill is passed until 2016, we will see a huge increase in premiums for businesses and individuals as well—large businesses, small businesses, individuals. Americans know this is going to make an unsustainable status quo even worse. Yet the President and the majority—

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. CORNYN. I ask unanimous consent for an additional 2 minutes.

The PRESIDING OFFICER. In my capacity as a Senator from Alaska, I object.

Mr. CORNYN. I thank the Senator for his courtesy.

The PRESIDING OFFICER. The Senator from Texas.

Mr. CORNYN. Mr. President, I ask unanimous consent to speak for an additional 5 minutes.

The PRESIDING OFFICER. In my capacity as a Senator from Alaska, I object.

Mr. CORNYN. Mr. President, may I inquire of the Chair, is it the intent of the Presiding Officer to prevent any Senator from speaking on the floor on this important bill? I am looking around. I don't see any other Senator waiting to speak. I simply would like an explanation of the Chair's ruling.

The PRESIDING OFFICER. I release my objection.

Mr. CORNYN. Mr. President, the Congressional Budget Office has said—this, of course, is the nonpartisan office which is tasked with the job of scoring or determining the cost of these bills before us—the CBO has opined that the Reid bill will result in 90 percent of Americans seeing the same unsustainable premium increases as they currently do year after year or, in some cases, even higher. If we are going to spend \$2.5 trillion over 10 years, if we are going to cut Medicare by half a trillion dollars, if we are going to raise taxes by another half a trillion just to have no impact for 90 percent of Americans and for the others to actually see premiums go up, it strikes me that this is a solution in search of a problem.

The problem is, we know the premiums are too high, costs are too high, and we need a better answer than is being proposed by the Reid bill.

The Congressional Budget Office estimates that families who get their health care through small businesses or large employers will see their premiums go up under this bill. The new ideas we have seen offered by our friends on the other side are designed

to score political points but are not aimed at solving problems.

For example, one of our colleagues, the Senator from Arkansas, offered an amendment to cap compensation for insurance executives and argued that it would actually lower premiums somehow miraculously. We asked the Congressional Budget Office whether that would have any impact on premiums. It said the impact would be negligible. So what is the point?

We have heard a lot about repealing the antitrust exemption for health insurers. The CBO said while that may be a feel-good sort of provision, that it would actually make premiums higher and make things worse.

The CBO concluded that by enacting the legislation, it would have no significant impact on the premiums that private insurers would charge for health insurance. They also noted that to the extent insurers would become subjected to additional litigation, their costs and their premiums charged to consumers might increase.

We have also heard from some of our colleagues about their cost containment ideas, a group of Democratic Senators who offered an amendment. I think it does have some good ideas in it, but it only saves \$200 million, not an insignificant amount of money, but in a \$2.5 trillion bill?

So the bottom line is, this bill spends \$2.5 trillion to increase premiums or, at best, maintain the status quo. That is not health care reform. We should reject this bill and start over with a step-by-step approach that will actually solve the problems confronting the American people.

We should not accept, no matter what the crush is before the Christmas holidays—these last 8 days of this year—we should not accept a bill that cuts $\frac{1}{2}$ trillion from Medicare, which cuts benefits from Medicare Advantage beneficiaries—one-half million of whom live in Texas; there are 11 million total—we should not accept a bill that raises premiums for many Americans, and we should not accept a bill that puts crushing new taxes on small businesses when unemployment is at 10 percent.

I yield the floor and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. ROCKEFELLER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ROCKEFELLER. Mr. President, I rise with my colleagues, Senator LIEBERMAN and Senator WHITEHOUSE—who are on their way to the Chamber—to discuss an amendment to strengthen and improve the independent Medicare advisory board included in the underlying bill.

I firmly believe creating an independent authority to help Congress make informed decisions about reimbursing Medicare, getting away from a fee-for-service system, and making it based upon the cost which is incurred—but also the quality which now has to be required: evidence-based outcomes—that is the direction Medicare, all of health care, has to go.

These are not just cost decisions but quality decisions. I think it is critical to sustaining our program and the promise we made to millions of seniors that we would do right by them and still keep Medicare affordable, keep the trust fund solvent. It is meant to go broke in 2017. That does not help hospitals, doctors, Medicare beneficiaries, or anybody else. So we have to keep that in mind as we talk about this issue.

I applaud Leader REID for his bold leadership in including this advisory board in his underlying bill. It is a very strong step forward.

In their May report this year, the Medicare trustees determined, if we do nothing, the Medicare trust fund will basically go insolvent in 2017. In health care terms, that is like next February.

It is abundantly clear if we fail to put Medicare on a path of fiscal sustainability, this incredible program—and the security it means for seniors in my State of West Virginia and in the Presiding Officer's State of Alaska and people everywhere; and the disabled, who are, unfortunately, often forgotten—it will be in tremendous danger. We cannot allow that to happen.

So what does this amendment do? If we are serious about protecting Medicare's future, we have to be serious how we handle Medicare, how we allocate it, and use it as a reimbursement and quality tool. So this amendment includes a number of changes to do exactly that.

The most important change: This amendment eliminates a significant loophole in the underlying bill; that is, it eliminates the carve-out which was created by some for hospitals and other providers. I repeat, it eliminates the carve-out.

The carve-out now comprises about 60 percent of all Medicare. So it is a sham. It has to go or else Medicare is in deep trouble. I wish to talk about this a little bit.

We protect the board's integrity. In fact, we give the board integrity and we give them authority. Congress, right now, has the sole authority to change Medicare's cost curve. Yet as the ranks of lobbyists grow and prey upon Members of the House and Senate—it is amazing the relationship between how the cost of Medicare grows and their activities.

Let's be quite honest about it. This is not a politic thing to say, but it is the truth. Probably about 12 percent of the Congress understands health care down

to the wee depth that is needed to be able to decide on the reimbursement procedures, the quality outcomes procedures, which we use to reimburse Medicare providers. This means we have made a lot of mistakes, the cost of Medicare has gone out of control, and we provide Medicare reimbursement unevenly and unfairly. People complain when they should not; do not complain when they should.

You have to understand, Medicare is such a powerful force it drives prices and it drives policies in health care for years and years to come all across the span of health care. It is the elephant in the room.

Power represents an opportunity. Medicare's force and clout can also be harnessed in a direction to improve our health care system, improve efficiency. That is why I am adamantly opposed to the carve-out for hospitals and other providers because it weaves special-interest treatment into the very fabric of a board created to remove them from the process.

MedPAC was created by a Republican Congress in 1997. It, in theory, decides how Medicare reimbursement is going to be updated on an annual basis. The fact is, it has no power to do any such thing. That has to be changed.

Is this a significant change? Yes, it is. Is it just like people changing their lives in various ways all across America because they are facing situations which they have not faced before? People do not have work; people have anxiety over all kinds of subjects; they have anxiety over health care, and they should have anxiety over health care because, particularly if you are a senior, the Medicare trust fund is running out on us.

So the only way you can do that, in my judgment, is to get away from fee for service; that is, you provide the service, and whatever it is, I will pay you the fee. It is simple. It is what we have used. It is what has gotten us in trouble because we do not insist upon experts making these decisions and on demanding evidence-based outcomes in the way hospitals, doctors, and others are reimbursed under Medicare. Medicare is taxpayers' money. It is not a frivolous matter.

As was the intent of my original policy, it is time to change the equation and put expert evidence and advice at the forefront of health care decision-making. It is time to take the special interests out of the process and create an independent, politically insulated entity with its sole job to be to protect Medicare's long-term quality and solvency. I am sure many will come and object to that, saying we should do that in Congress, but I repeat: Is Congress qualified? Does it have the knowledge to the depth that it can

make a decision on how much providers should be reimbursed? My answer is some do, most don't and, therefore, the cost of Medicare keeps rising and the system is more endangered.

I have no doubt that a strong independent Medicare advisory board would be a powerful cornerstone for meaningful health reform in all of the right directions, but if we want the board to succeed, it needs the tools for both Medicare reform and genuine private sector cost containment.

Congress cannot do this on its own. We have proven ourselves incapable of making efficient, consistent decisions about Medicare's future, which now amounts to a crisis. We cannot continue standing in the way of progress. I urge my colleagues to join me in support of this truly transformative policy.

I simply repeat: If we are going to make it in health care, if we are going to make it in Medicare, if we are going to preserve the trust fund, we have to change the way we do business. People may not like that. People will complain about it. People will complain if we do nothing. People will complain if we do everything. People complain. That is the nature of it. That doesn't matter. What matters is that we do the right thing; that we bend the cost curve by making accurate decisions; that we are tough in our decision-making; and that is what this board—and Congress will have a chance to review it but cannot override it except by a very substantial vote—and that is what the Medicare advisory board is all about. It is the answer to Medicare's future, in this Senator's judgment.

The security this policy provides for our seniors is too important. We need to fight for them, always. We need to protect them. We need to protect the solvency of the trust fund, and we need to make sure seniors are getting the best possible care. The day has ended when people can submit a bill and say: I did this and, therefore, pay me that. That is our system now. It is the wrong system. It has gotten us into trouble. It is not good for health care, and it is very bad for the solvency of the trust fund.

I see my distinguished colleague Senator LIEBERMAN has arrived. He and I have been working on this for some time together, I am proud to say.

I thank the Chair. I say to my colleagues the full text of the amendment, No. 3240, is printed in the RECORD of Tuesday, December 15.

The PRESIDING OFFICER (Mr. FRANKEN). The Senator from Connecticut is recognized.

Mr. LIEBERMAN. I thank the Chair.

Mr. President, I am honored to stand and speak on behalf of this amendment which I have filed with Senator ROCKEFELLER and Senator WHITEHOUSE, and I thank them for their leadership.

I wish to speak for a few moments about it. It is not a noncontroversial

amendment, but I think it redeems one of the two central promises or goals of this bill. The fact is that a lot of the current health care reform debate in fact is focused on issues that are not central to two big goals that I think most of us share, which are, first, to expand the number of people who have health insurance coverage in our country; secondly, to lower the costs, because the costs continue to go up way beyond the rate of general inflation in our country, and that has a very burdensome effect on millions of individuals, families, businesses, our government—indeed, our entire economy.

This amendment focuses on the second of those two big shared goals, which is containing the increases in health care costs. It has become a mantra around here—but it is never bad to repeat a mantra—which is that national health expenditures in our country are now well over \$2 trillion. It is hard to imagine that amount of money, but let me try to get inside it.

We spend twice as much per person on health care as the average developed country in the world, but I am afraid we are not receiving as a country the best value for our health care spending. The fact is that the United States provides some of the best health care in the world, but we don't provide it to all of our people and we don't provide it efficiently. Medicare and Medicaid account for over 20 percent of the Federal budget and over 27 percent of national health expenditures. These two programs are expected to rise to equal 20 percent or one-fifth of our gross domestic product by 2050.

Here is the animating, motivating fact that brings Senator ROCKEFELLER, Senator WHITEHOUSE, and me together to file this amendment: The Medicare trust fund, which provides Medicare benefits to approximately 37 million senior Americans that they depend on, that they have depended on in a way that has helped to extend their lives as average life expectancy goes up, the Medicare trust fund is expected to be insolvent, out of money, bankrupt, by 2017—unable to pay the bills by 2017. That is 8 years from now. It is to prevent that unacceptable result that my colleagues and I come forth to file this amendment to make sure that by then—we have done a lot of things, but one of them is to make the delivery of health care more efficient, the delivery of health care to seniors through Medicare more efficient, so they can look forward with confidence to having Medicare coverage throughout the rest of their lives.

As we all know, it is not just the ones on Medicare now; the baby boomers are coming of age to get on Medicare, and that will add enormously to its responsibilities.

I would say that Senators REID, BAUCUS, DODD, and HARKIN did a superb job, a very good job, with the Patient

Protection and Affordable Care Act, the underlying bill, to reduce health care spending and particularly to do so while expanding coverage for 30 million more Americans, which is the second great goal that I believe we all share. While these numbers are encouraging, Senators Rockefeller, Whitehouse, and I think we can and should do more, and that is the cost containment numbers.

My colleagues introduced earlier this year the MedPAC Reform Act, which created an independent authority, a separate nonpartisan body, to make critical health care cost decisions or make recommendations about them. In the current Senate health care reform bill, their idea appears centrally as the independent Medicare advisory board. It will bring together a panel of experts whose mission it will be to extend the solvency of the Medicare trust fund by seeking out new efficiencies, new cost containments, and improving the quality of care delivered by Medicare in the private sector. The board will have the authority to make recommendations to the President and Congress to reduce Medicare spending in particular ways. Those recommendations will be fast tracked through Congress with strict requirements for the committees of jurisdiction to review them, report the recommendations to the full Congress, and then be subject, those recommendations, to limited floor debate, limited by the underlying legislation. If Congress does not pass the advisory board's recommendations or adopt other proposals that produce an equivalent amount of savings, the Secretary of Health and Human Services will be required to implement the board's original recommendations.

As Senator ROCKEFELLER said—this is the second time today I have said this—earlier today the Homeland Security Governmental Affairs Committee held a hearing on efforts to establish a commission to begin to turn around the exploding national debt we have. Part of the reason we do that and part of the reason this independent board outside of Congress is being created is that we haven't proven ourselves capable of controlling costs because we find it a lot easier to say yes to people, for good reasons, for humane reasons, but don't find it so easy to pay for the resulting costs of our affirmative answers to their requests.

The CBO has estimated that the advisory board in the current bill will save \$23 billion in the next 10 years. The Obama administration and dozens of respected economists have said that the creation of this board is instrumental in lowering costs and literally saving Medicare from bankruptcy. The amendment I have filed with Senators ROCKEFELLER and WHITEHOUSE, I am convinced—certainly our intention is to make this independent board stronger so it will result in larger savings and contain more costs over the long run.

There are six provisions in the amendment that I want to denote, describe briefly. First, this amendment will extend the board's authority to cover hospitals and hospices; sensitive, I know, but the board must have the authority to consider the entire breadth of Medicare expenditures in making its recommendations to Congress to maximize savings for the government, for taxpayers and, most of all, for the beneficiaries of Medicare so the program is still there to help them.

Second, our amendment makes it easier for the board to make recommendations in the years beyond 2019 than the underlying bill does so that it can continue to monitor Medicare over the longer term and ensure its long-term solvency. We want those on Medicare now, and those coming on Medicare, to be able to depend on it over the course of their lives.

Third, this amendment will raise the amount of savings the board must meet in years where Medicare growth exceeds the target growth rate set in the law, in the proposal.

Fourth, we move up the time of implementation of the board's recommendations by 2 months to minimize, frankly, the influence of interest groups who will be in the normal course of the process fighting to stop these cost-effective recommendations.

Fifth, the amendment allows the board to offer recommendations in years where the Medicare growth rate does not outpace the target growth rate. The goal of this provision is to be clear that the purpose of the board is not just to contain costs beyond a certain standard but also to search out constantly for inefficiencies, for waste, for the expenditure of Medicare dollars that is not actually benefiting Medicare recipients.

Finally, our amendment clarifies that the purpose of the board is not just to contain costs within Medicare but to look more broadly at health care spending outside of these publicly supported programs. That is very significant. It will provide an opportunity for broad savings in health care and health insurance for pretty much everybody in our country.

I am proud to join today with my friends, Senators ROCKEFELLER and WHITEHOUSE, to announce the filing of our amendment. These six provisions will make this advisory board stronger and reduce costs.

While we disagree on some aspects of health care reform, I hope we can agree across party lines that health care spending is out of control, and that we can contain it in a way that doesn't threaten access or benefits. We must preserve and extend Medicare for future generations, and we must ensure that the new private market we are creating in health care reform is one where health care quality and efficiency justifies the cost.

The PRESIDING OFFICER. The Senator has spoken for 10 minutes.

Mr. LIEBERMAN. I wonder if I could ask unanimous consent for an additional moment.

The PRESIDING OFFICER. In my capacity as a Senator from Minnesota, I object.

Mr. LIEBERMAN. Really. OK. I won't take it personally.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. MCCAIN. Mr. President, I ask unanimous consent that the Senator from Rhode Island be recognized for 10 minutes followed by the Senator from Michigan, the distinguished chairman of the Armed Services Committee who will be speaking on the bill, and that I be recognized to follow him.

The PRESIDING OFFICER. Is there objection?

Mr. LEVIN. No objection. I assume that is for 10 minutes each?

The PRESIDING OFFICER. Is that for 10 minutes each?

Mr. MCCAIN. Yes. I have been around here 20-some years. It is the first time I have ever seen a Member denied an extra minute or two to finish his remarks. I must say that I don't know what is happening here in this body, but I think it is wrong.

It is fine with me that it be 10 minutes.

I will tell you, I have never seen a Member denied an extra minute or so, as the Chair just did.

Mr. LEVIN. If the Senator will yield, I don't object to the unanimous consent request on that condition. I think the same occurred earlier this afternoon for reasons that have to do with trying to get this bill going.

Mr. MCCAIN. I haven't seen it before. I don't like it, and I think it harms the comity of the Senate not to allow a Member at least a minute. I am sure the time is urgent, but I doubt if it is that urgent.

I renew my unanimous consent that the Senator from Rhode Island be recognized for 10 minutes, the Senator from Michigan for 10 minutes, and then that I be recognized for 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Rhode Island is recognized.

Mr. WHITEHOUSE. Mr. President, I know the Senators have been waiting longer than I have. It is a personal courtesy from them to me to allow me to join Senator ROCKEFELLER and Senator LIEBERMAN as a cosponsor and have our remarks follow in series. I am grateful to both of them.

I am here to speak in support of the amendment offered by Senators ROCKEFELLER, LIEBERMAN, and myself, which would strengthen the provisions of the reform bill creating a nonpartisan group of experts to put the brakes on out-of-control medical spending.

One of the first things we can count on in terms of this amendment being one to protect Medicare beneficiaries is that the prime sponsor is Senator ROCKEFELLER, a man who has dedicated his career since long before I was here—even during his days in West Virginia—to looking out for seniors and for the disabled and, since he has been in the Senate, looking out for Medicare. That is a credential that deserves great respect with respect to this amendment.

One of the most persistent concerns in this health care debate is, of course, cost control. I have spoken many times on the floor about the overriding importance of cost containment for the future of health care and especially the need for innovative delivery system reforms, which can be driven by the way you pay providers.

Our Republican attackers complain that Democrats on the bill are just doing more of our usual taxing and spending and that we won't impose any discipline on the system. Mr. President, as somebody who has worked for years on health care delivery system reform, I can tell you that is simply not true. This bill undertakes the most comprehensive redesign of our chaotic, wasteful system ever attempted.

One leading health economist and expert in cost containment, MIT professor Jonathan Gruber, recently wrote of the Senate Democrats' efforts in this bill that he couldn't "think of a thing to try that they didn't try. They really made the best effort anyone has ever made. Everything is in here. . . . You couldn't have done better than they are doing."

Many critics talk about cost control as if it were just a matter of political will, that Congress can come here and cut costs by flipping a switch. Well, that may be true if you want to cut benefits for the elderly and disabled or if you want to throw the elderly and disabled off of coverage or if you want to pay doctors even less for treating Medicare patients. But those would be brutal, callous cuts that would create human misery and suffering. Better to tackle the waste in the system, the \$700 billion annually in excess costs found by President Obama's Council of Economic Advisers—a number that may actually be as high as over \$1 trillion every year, according to the Lewin Group and to George Bush's former Secretary of the Treasury, Paul O'Neill.

By this method, you save money by improving the quality and efficiency of care; by tackling the multiple sources of waste and inefficiency in the system; by improving quality and access to care and giving doctors, hospitals, employers, and employees all the correct financial incentives to adopt healthy, cost-saving, efficient practices. The complexity of getting those incentives right, aligned with top-flight health

care, versus the power of the interest groups that are involved, has historically paralyzed Congress.

History teaches that the significant national dialog and debate we are now having about health care is a momentary exception rather than the general rule. It is possible this debate will usher in a sustained period of focus on health reform, but the steepening fall of our health care system toward catastrophe should counsel us to protect against that congressional institutional paralysis.

This independent, nonpartisan board of experts to help control costs in a way that is smart, humane, and not all politics, is important. The independent Medicare advisory board will force Congress to act by issuing recommendations to reduce cost and increase efficiency that will automatically go into effect if Congress does what we so often do around here—nothing. If Congress can agree to different ideas, it can change the board's recommendations, but we still have to reduce Medicare costs by a minimum savings target. In other words, the board will force Congress to engage thoughtfully and for the public good on the most important fiscal and health issue our Nation faces.

Senator ROCKEFELLER's amendment strengthens this board in several important ways: It expands the circumstances in which the board's recommendations go into effect when Congress does nothing. It raises the maximum level of savings that the board's recommendations must achieve. It ensures all providers of health care services, including large hospitals, are equally responsible for bringing down Medicare costs. It empowers the board to issue recommendations for improving Medicare over the long term, even in years where spending is under control.

My colleagues on the other side of the aisle have depicted the board as a frightening, Orwellian, all-powerful dictator that will cut Medicare benefits. Hogwash. The bill specifically prohibits the board from doing anything to increase premiums, ration care, restrict benefits, or modify eligibility.

The facts no longer seem to matter to our friends on the other side. They have called this group the "rationing commission." If you look at page 1004, lines 3 and 4, it says this:

The proposal shall not include any recommendation to ration health care.

You are entitled to your own opinion—and we all have one—but not your own facts.

It is actually that kind of demagoguery about Medicare that proves the case for creating the board. Thoughtful, smart, technically expert people under congressional oversight but protected from these partisan spasms of congressional vitriol, passion, and folly will make careful and

consistent decisions for all of our benefits, without diminishing the power of the American people and their elected representatives, so that we can preserve and protect Medicare.

I urge my colleagues to support Senator ROCKEFELLER's amendment, in which Senator LIEBERMAN and I have so proudly joined him.

I yield the floor with my thanks to the Senator from Michigan for being so gracious in allowing me to join my colleagues in sequence on the bill.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Mr. LEVIN. Mr. President, I wish to speak for the few minutes we have this afternoon in support of the appropriations bill that is before us, the Defense appropriations bill.

Senator MCCAIN and I and other members of the Armed Services Committee have spent a lot of time each year authorizing important programs to support our troops, protect our troops, and support their families in a whole host of ways. Hopefully, it will authorize funds that can help us succeed in Afghanistan and Iraq. That bill is now law, and in front of us is an appropriations bill that contains most of those same provisions—not all but most of the same provisions.

It is critically important that this appropriations bill be passed. There are differences in this body and between this body and the House of Representatives about the policies that are involved in the war in Afghanistan and the war in Iraq. That is normal. That is the way it should be. We can have democratic debates inside this great democracy of ours. We don't have to agree, and we don't on many of the policies involved in these two war efforts. Where I believe this body is unanimous is that we are determined to support our troops when they are in the field regardless of whether we agree with the particular strategy they are supporting or whether we happen to have supported their mission.

It has been the tradition of the Congress, once a decision has been democratically arrived at to send troops to the field, that we support those troops. This appropriations bill has critically important provisions in it to support our troops. I believe there is unanimity and consensus in this body on those provisions. I will focus on a few of those provisions.

We have added significant funds. One example is the so-called Mine Resistant Ambush Protected Vehicles or MRAP. These are life-and-death matters we are talking about. These vehicles are a perfect example of that. The faster we can get the advanced MRAPs to the field in Afghanistan, the more we can get to the field in Afghanistan, the fewer Americans are going to be killed in Afghanistan. So we have funds in here—more than actually were requested—to send over 6,600 new MRAP

vehicles, all-terrain vehicles that can function better there than the ones we sent to Iraq. These all-terrain vehicles have been designed and developed in record time in order to get them to our troops. We should be acting in record time on this appropriations bill, and there are many reasons for that. Surely, getting more MRAPs more quickly into the field is one of those reasons.

We have an organization called the Joint IED Defeat Organization whose sole purpose and mission is to come up with the strategies and technologies to defeat these IEDs, these improvised explosive devices that are killing our troops. In order to defeat these devices or train our troops who are deployed there in how to identify and protect themselves against IEDs, we have \$1.8 billion in this appropriations bill for that organization. They have a laser mission to defeat the IEDs. We have to get this money to them.

This bill needs to be signed. The President has to sign it—and he will—so we can get these funds as quickly as possible to our troops. We need to adopt this appropriations bill.

We have pay raises and health programs in the bill. We add \$1.3 billion more than the President requested for the Defense Health Program. This covers shortfalls in private sector care, increases funds for medical research, including what is called TBI, which are the brain injuries, as well as PTSD, which has so afflicted our troops in these wars. We add additional funds for those programs. The quicker the bill is signed, the faster those funds get appropriated and spent, the better off our wounded warriors who suffer from TBI and from psychological health problems are going to be.

In Afghanistan now, one of the key issues is going to be whether we can get the Afghan troops trained quickly enough, supported quickly enough, given the equipment they need so they, hopefully earlier rather than later, can join with us, partner with us, and take responsibility for their own security. Regardless of people's differences over the policies and strategies in Afghanistan, I believe there is a consensus in this body—no matter what the vote ends up being on the bill, whether people vote for the bill or against the bill, I would think all of us believe we must quickly provide funds to train, support, and sustain the Afghan security forces. We want to fund that effort in this bill at \$6.6 billion.

Counternarcotics in Afghanistan. We all know the narcotics industry in Afghanistan is being used to support the Taliban. We want to continue efforts to train Afghan counternarcotics forces and support U.S. counternarcotics and interdiction activities in Afghanistan, so \$300 million in this bill is going to do that.

We have a fund called the Commander's Emergency Response Program or CERP. That fund has been

used to great advantage. This bill provides \$1.2 billion for that Commander's Emergency Response Program; \$1 billion of that is for that program in Afghanistan and \$200 million of the CERP program in Iraq. This represents about twice as much CERP funding for Afghanistan as we had in fiscal year 2009.

Those CERP funds are able to provide very quickly support and economic development village by village. Our commanders are able, without going through a whole lot of red tape, to make relatively small investments in things which make a difference, in terms of the security of our troops and the betterment of the lives of the Afghans. It has had a huge, positive impact in terms of the perception of the Afghan community about us, satisfying them that we are there for their benefit, not just for our benefit. We are not occupying Afghanistan. When we leave Afghanistan, we want to leave Afghanistan in better shape than we found it. The CERP funds are a major contribution to that goal.

One of the things we have authorized in the bill, which Senator MCCAIN and I and members of the Armed Services Committee have brought to this body, was adopted by this body, and signed into law, was the authorization to use those CERP funds to help reintegrate, where we can, Afghan Taliban fighters into Afghan society—those who will renounce violence against the Government of Afghanistan and make a commitment to participate in civilian life. We are able to actually have the funds that are so essential to make that program work. We do not yet have a program in place. That is being worked on as we speak. But these funds need to be available to support that program of reintegration of Afghans, those low-level Taliban people who are with the Taliban not for any ideological reason but because they get some pay from the Taliban. Not all the members of the Taliban fall into that category. But for the ones who do, this funding becomes critical.

Mr. President, I will only take a few minutes more, but I did want to highlight a few additional points that I believe my colleagues should know about.

The first area pertains to three initiatives that originated in the Defense authorization bill that relate to the continuing fight against al-Qaida and associated terrorist organizations.

The bill includes nearly all of the \$1.6 billion the administration requested for the coalition support fund, which is used to reimburse key partner nations, particularly Pakistan, for support provided to the United States in Operation Enduring Freedom and Overseas Contingency Operations.

It includes \$350 million in fiscal year 2010, the full amount authorized, for the train and equip program to build the capacity of foreign militaries to conduct counterterrorism operations

and support military or stabilization operations in which the U.S. participates. As clarified in the fiscal year 2010 NDAA, this authority can be used to build the capacity of ISAF coalition partners to prepare their training teams and special operations forces to be available for use in Afghanistan.

The bill also provides the full \$100 million authorized for the authority to transfer funds from DOD to the State Department to support State's security and stabilization assistance programs.

The other area pertains to missile defense.

The bill before us provides important funding for ballistic missile defense programs. It supports the decisions made by Secretary Gates and President Obama to restructure the missile defense program with a greater focus on regional missile defense against existing missile threats. These changes include the termination of the Multiple Kill Vehicle Program and the Kinetic Energy Interceptor Program, and cancel procurement of additional airborne laser aircraft. This defense appropriations act also supports the decision to cap deployment of the ground-based midcourse defense system at 30 operational ground-based interceptors in Alaska and California, rather than the 44 previously planned for deployment.

The bill supports funding for alternative missile defense systems in Europe, to defend against current and future Iranian ballistic missiles.

It also includes an additional \$57 million, above the budget request of \$169 million, to procure more standard Missile-3 interceptors for our Aegis ballistic missile defense system. This type of interceptor will be at the heart of the new missile defense plan for Europe. The amendment also provides the full \$1.1 billion requested for the terminal high altitude area defense, THAAD, system, which is another key element of our regional missile defense capabilities.

I believe my 10 minutes is up. I thank my good friend from Arizona, Senator MCCAIN, for allowing me to go first. The order of priority was that he go immediately after someone speaking on this side. But as always, his courtesy shines through to me, and I very much appreciate it.

I yield the floor.

THE PRESIDING OFFICER (Mrs. SHAHEEN). The Senator from Arizona is recognized.

Mr. MCCAIN. Madam President, I thank my friend from Michigan. I thank him for his leadership of the Armed Services Committee.

The train is about to leave the station on the last of the appropriations bills for 2010 and, unfortunately, nothing has changed. Everything is the same—earmarking, porkbarrel, excessive and unnecessary spending. Billions in wasteful earmarks again have found their way into this bill which could

otherwise be spent for the priorities that our men and women, our military leaders, as well as the Secretary of Defense, has asked for.

There is in this bill—here we go again: an appropriations bill loaded up with earmarks—a 523-page explanatory statement for 1,720 earmarks totaling \$4.3 billion. Let's do some simple math: \$4.3 billion in pork, \$2.5 billion in unauthorized and unrequested C-17s; \$500 million in unrequested and unwanted funding for the Joint Strike Fighter alternative engine; and a Presidential helicopter. That is \$7.3 billion that neither the military nor the Defense Department requested and does not need—\$7.3 billion.

Some people say that is not a lot of money. It is enough to keep the State of Arizona's budget requirements fulfilled for 10 months. States across America are facing great difficulties, as we know, and an additional \$7.3 billion would not be so bad.

I wish to say, again, this process of earmarking breeds corruption. That is why we have former Members of Congress in Federal prison. It was not inadequate disclosure requirements that led Duke Cunningham to violate his oath of office and take \$2.5 million in bribes in exchange for doling out \$70 million to \$80 million of the taxpayers' funds to a defense contractor. It was his ability to freely earmark taxpayer funds without question.

I wish to point out, again, the President pledged during the campaign he would work to eliminate earmarks. The President, last March, when we had an omnibus spending bill, said they would not do it anymore. In September, the President spoke in Phoenix, AZ, to the Veterans of Foreign Wars. In that speech, the President's words were quite compelling about waste and porkbarrel spending in Defense bills. In that speech, the President promised—promised—an end to "special interests and their exotic projects" and reaffirmed he was leading the charge to kill off programs such as the F-22, the second engine for the Joint Strike Fighter, and the outrageously expensive Presidential helicopter.

The President went on to say:

If a project doesn't support our troops, we will not fund it. If a system doesn't perform well, we will terminate it. And if Congress sends me a bill loaded with that kind of waste, I will veto it. We will do right by our troops and taxpayers.

Mr. President, I can tell you, the President of the United States, that meets your criteria with over \$7 billion of unnecessary, unwanted spending. Will the President veto this bill? Not a chance. Not a chance. But the American people are going to demand this obscene process stop. The American people are going to demand it be stopped, wasting \$7 billion of their tax dollars on wasteful and earmark spending. I am confident they are aware.

They are aware we are spending \$7.6 million to fund research in Montana on hypersonic wind tunnels, called MARIAH. This self-licking ice cream cone has been earmarked and unrequested since 1998. The Air Force lost interest in 2004, so the appropriators moved it to the Army. The Army has no requirement for this capability and published a report in 2005 stating their disinterest in the program. In summary, we spent \$70 million for some hypersonic wind tunnels nobody wants—\$70 million. Unless we demand and receive change, there will be more millions in it next year.

There is \$5 million going to the battleship USS *Missouri* Memorial Association; \$18.9 million for a center at the University of Massachusetts “dedicated to educating the general public, students, teachers, new Senators, and Senate staff about the role and importance of the Senate.” What does that have to do with defending this Nation? What does that have to do with providing the men and women who are risking their lives, as we speak, with the equipment they need? Madam President, \$18.9 million to educate the public about the importance of the Senate? Give me a break.

There is \$9.5 million going to the University of Hawaii for a program called the Panoramic Survey Telescope and Raid Response System. The list goes on and on. The Air Force is paying for this, and the Air Force will not be allowed to be getting much in return, since it will only be allowed to use the telescope 5 percent of the time. In other words, in dollar figures, the Air Force pays \$10 million to the university and receives \$500,000 in return.

What is more, the Air Force has not, in the 9-year life of this earmark, requested a single dollar for this program. Since 2001, the Air Force has been forced to spend more than \$75 million of its budget allocation on a program it does not want.

I ask unanimous consent to have printed in the RECORD these other porkbarrel earmark programs, such as \$1.2 million for the American Museum of Natural History Infectious Disease Research.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

\$7.6 million to fund research in Montana on hypersonic wind tunnels, called MARIAH. This self-licking ice cream cone has been with us, earmarked and unrequested, since 1998. The Air Force, leader in hypersonic testing and technology, lost interest in 2004, so appropriators moved the program to the Army. The Army has no official requirement for this capability and published a report in 2005 stating their disinterest in the program. To date, the Army has no plans to fund the MARIAH wind tunnel effort, as they have stated in their budget documents. But that hasn't kept Congress from pouring more than \$70 million into it, with no discernable return. One group has made out particularly well in the deal, however. Of course, I'm re-

ferring to lobbyists, including Gage LLC, whose CEO, coincidentally, had been a senior staffer to an appropriator from Montana.

\$5 million to the battleship USS *Missouri* Memorial Association. This is a private organization which owns and operates this battleship as a museum in Pearl Harbor. I am aware that the Association plans to put the *Missouri* in dry-dock and refurbish it, and also aware that it was not part of the donation agreement that the Defense Department would pay for required maintenance.

\$20 million for the National WWII Museum in New Orleans, to help pay for the construction of new facilities as part of a \$300 million expansion. This privately funded museum opened in 2000 and, through the help of the Louisiana delegation, has already received \$13 million in Department of Defense funds tacked into previous appropriations bills. This earmark has no benefit to the United States military and will be paid at the expense of equipment and training for our troops, something few WWII veterans would support.

\$14.8 million for five different earmarks pertaining to nano-tube research. Of the 1,720 earmarks in this bill, hundreds are for high-tech research or devices. I ask my colleagues whether they are capable of weighing the merits of specific technologies that they fund in this bill. The answer is they are not.

\$18.9 million for a center at the University of Massachusetts “dedicated to educating the general public, students, teachers, new Senators, and Senate staff about the role and importance of the Senate.” This center was neither requested in the President's budget nor authorized by Congress.

\$9.5 million to the University of Hawaii for a program called the Panoramic Survey Telescope and Raid Response System (Pan-STARRS). On the surface, this program seems like a reasonable need for the Air Force as a part of its Space Situational Awareness efforts. Unfortunately, the Air Force won't be getting much return on this investment, since it will only be allowed to use the telescope 5 percent of the time. In dollar figures, the Air Force pays \$10 million to the University and receives \$500,000 in return. What's more, the Air Force has not, in the nine-year life of this earmark, requested a single dollar for this program. So, since 2001, the Air Force has been forced to spend more than \$75 million of its budget allocation on a program it doesn't want—but might be able to use—only to be denied use 95% of the time.

\$500,000 for the Brown Tree Snake Program.

\$1.8 million to renovate and upgrade the Historical Fort Hamilton Community Club in the New York City area.

\$1.6 million to study human genetics at the Maine Institute for Human Genetics and Health in Brewer, Maine.

\$3.5 million for a Micro-algae Biofuel Project in Hawaii.

\$5 million for the Presidio Heritage Center, a museum, in San Francisco.

\$1.6 million for the Center for Space Entrepreneurship.

\$2 million for National Initiatives for Applications of Multifunctional Materials.

\$1.6 million for a Virtual Business Accelerator for the Silicon Prairie.

\$7.8 million to develop key technologies needed for long term operations in “near space” conditions for the Orion High Altitude Long Endurance Risk Reduction Effort, Aurora Flight Sciences in Columbus, Mississippi.

\$2.4 million for Fusion Goggle System.

\$800,000 for “Advanced Tactical Laser Flashlight” in Wyandotte, MI.

\$2 million for Cedars-Sinai Medical Center's Operating Room of the Future, Los Angeles, California.

\$4.8 million for New Vaccines to Fight Respiratory Disease and Central Nervous Disorders at the Iowa State University.

\$720,000 to survey epidemiologic health for the University of Iowa.

\$3 million for the New Jersey Technology Center.

\$1.2 million for American Museum of Natural History Infectious Disease Research.

\$1.6 million for Army Plant Vaccine Development Program.

\$1.4 million for Flight/Hangar Deck Cleaner.

\$4 million for the Hampton University Proton Cancer Treatment Initiative.

\$10 million for the Hawaii Technology Development Venture.

\$3.9 million for Intelligent Decision Exploration.

\$12 million for Laser Phalanx.

\$2.4 million for Marine Mammal Awareness Alert and Response Systems.

\$2 million for a Marine Mammal Detection System.

\$2.3 million for Marine Species.

\$1.2 million for the Maritime Directed Energy Test and Evaluation Center.

\$3.2 million for a National Functional Genomics Center Collaborating Site.

\$2.4 million for NAVAIR High Fidelity Oceanographic Library.

\$2 million for Non Traditional Ballistic Fiber and Fabric Weaving Application for Force Protection.

\$4 million for Smart Instrument Development for the Magdalena Ridge Observatory.

\$2 million for underwater imaging and Communications Using Lasers.

\$800,000 for Unmanned Undersea Vehicle Submerged Long Range Positioning.

\$2.4 million for an Unmanned Vehicle Sensor Optimization Technologies Program.

\$8 million to study oceans at the Center for Excellence for Research in Ocean Sciences.

\$2 million for an Advanced Laboratory for Information Integration in Hawaii.

\$2 million for PaintShield for Protecting People from Microbial Threats.

\$3.2 million for Playas Training and Research Center.

\$1.2 million for Progressive Research for Sustainable Manufacturing.

\$1.6 million for Protective Self-Decontaminating Surfaces.

\$1.5 million for the Institute for the “Advancement of Bloodless Medicine” for the Englewood Hospital in Englewood, New Jersey.

\$1.2 million for the Model for Green Laboratories and Clean Rooms Project.

\$1.6 million for the Maine Center for Toxicology and Environmental Health at the University of Southern Maine in Portland, Maine.

\$6 million to study the molecular signatures in tumors for the National Functional Genomics Center.

\$1.6 million for Multi-Dose Closed Loop pH Monitoring System for Platelets at Blood Cell Storage Inc., Seattle, Washington.

\$4.8 million for the National Oncogenomics and Molecular Imaging Center in Detroit, Michigan.

\$800,000 for the Natural Gas Firetube Boiler Demonstration, Rock Island Arsenal, Illinois.

\$5.8 million for the Rock Island Arsenal Roof Replacement, Rock Island, Illinois.

\$800,000 for Near Infrared Spectroscopy Military Personnel Assessment at the University Community Hospital, Tampa, Florida.

\$4.2 million for the Nicholson Center for Surgical Advancement Medical Robotics and Simulation in Central Florida.

Mr. McCAIN. Madam President, the list goes on and on: \$2 million for the Cedars-Sinai Medical Center's operating room of the future in Los Angeles, CA. That is the second earmark I have seen. The other one is for irritable bowel syndrome. Now we have the operating room of the future. Remarkable.

There is \$2.3 million for marine species; \$2 million for a marine mammal detection system. There is a threat. Also, \$2.4 million for marine mammal awareness alert and response system. The list goes on and on.

I know my time is near to expire.

Here we are with a deficit of \$1.4 trillion for this year, a debt of over \$12 trillion, unemployment at 10 percent, 900,000 families lost their homes in 2008, and we are spending over \$7 billion on earmarks, porkbarrel projects the Department of Defense neither needed nor wants, and there are programs not fully funded because of this that are vital to defending the lives of the men and women who are serving in the military.

Again, this appropriations bill is a disgrace.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KERRY. Madam President, I rise to speak on something else, but I will say very quickly, I have listened to colleagues on the other side of the aisle lamenting where we are today. It has been 11 months since a new President was inaugurated and, obviously, everybody understands this is not a mess he created. The last 8 years of the stewardship of this country, where there was never one appropriations bill vetoed in that entire time, is an extraordinary story of public negligence and even malfeasance.

We are where we are. We are creating jobs. The economy is turning around. We had the least loss in the last 11 months. We are beginning to see those changes. We will ultimately have the strength in our economy to deal with this deficit.

TRIBUTE TO DAVID MCKEAN

Madam President, I rise for a different reason right now. It is a bitter-sweet privilege for me to speak about my friend and my counselor, David McKean, staff director of the Foreign Relations Committee, who is leaving the Senate at the end of this month to become the chief executive officer of the John F. Kennedy Library Foundation.

I have enjoyed the benefit of David's advice for almost 20 years now. He will be sorely missed. My only consolation is, this son of Massachusetts will again be able to vote for me.

He has been a part of my life in the Senate since 1987, when I was a fresh-

man and he was a younger and idealistic legislative assistant. Over the years, I have drawn significantly on his knowledge and his skills. He leaves the Senate now to continue in public life, but he leaves it a little bit older but still idealistic and young at heart.

When he came to our office, he had already made a mark. He had graduated magna cum laude from Harvard College and received a law degree from Duke University and a master's degree from the Fletcher School of Law and Diplomacy. He also taught English at the Waterford Kamhlaba School in Swaziland, Africa. But he was a crusading soul deeply interested in public policy, with a zeal for investigations and an instinct to hold Washington accountable. He was looking for a place to put all those interests to work in the Senate, and he found it.

But he also found something more, I might add—much more—that summer of 1987. There was a young Kellogg fellow from the University of Pennsylvania working in my office at that time. Her name was Kathleen Kaye. She was extraordinarily smart and committed. David did not fail to notice those qualities and a lot more. Their marriage and their three wonderful children, who I am pleased to say are with us right now, Shaw, Christian, and Kaye, are a tribute and more to the relationship they share.

David has devoted his career to public service. After 5 years of working in my office, he moved across the Capitol as chief of staff to another member of the Massachusetts delegation, Representative Joe Kennedy. He later became special counsel at the Commodity Futures Trading Commission before returning home to the Senate as deputy chief counsel at the Governmental Affairs Committee and staff director of the Permanent Subcommittee on Investigations.

I failed to mention that before going to the Permanent Subcommittee, he worked with my staff early in his career in helping to develop one of the great investigative efforts in the Senate in recent memory, which was the BCCI investigation. That wound up on the cover of Time magazine and was a seminal report—one of the best reports I have seen in the 26 years I have been here.

In 1999, I was lucky to entice him to come back to my office as chief of staff. It turned out to be his longest tenure in any of those public jobs so far. Earlier this year, when I became chairman of the Foreign Relations Committee, he became the staff director.

David is the ultimate team builder and a magnet for great talent, so he would be the first to tell you that his success did not come single-handedly. But it is clear David played the essential role in turning 2009 into a stellar year for the committee and for its new

chairman. Under his guidance, we conducted 125 hearings on topics ranging from Afghanistan to Zimbabwe. We secured passage of the Enhanced Partnership with Pakistan Act, and we won approval of legislation bringing far-reaching reform to our foreign assistance program. He has worked tirelessly with the committee members and the White House over the past year, and our record is a testament to his determination and skill. I think our committee has succeeded in going through the nominations of more people and passing them more rapidly to the floor than any other in the Senate, and I congratulate him for that effort.

Somehow, during his career of service, he has found time to indulge in his passion for history and scholarship. He is the author of a highly acclaimed biography of Tommy Corcoran, the ultimate Washington insider. He also wrote a biography of Clark Clifford, which was a New York Times "notable book of the year," and he is the co-author of "The Great Decision," which skillfully, and perhaps surprisingly, transformed the story behind the Supreme Court's landmark *Marbury v. Madison* case into what the Washington Post called "a political thriller."

As those of you in this body know, we are—all of us—really only as capable or competent as our staff. Over the years, I have depended on David McKean at every stage. He has been the consummate adviser—trustworthy, loyal, unafraid of speaking up when I was about to veer off in the wrong direction—which, clearly, was very seldom indeed. Never was he more valuable to me than in the immediate aftermath of the 2004 Presidential election. Forty-eight hours after an election night—and early morning and early afternoon—that didn't end up the way that I had hoped it might, I returned to the Senate for a vote. Back to work. I don't remember what the vote was about, but I do remember that David was there with a plan to get us through the day and the next 2 years. I will miss that wisdom and guidance.

Our loss is the Kennedy Library's gain. In some ways, I think something like the Kennedy Library is the perfect place for this man who is at heart a scholar and an intellectual. But the Kennedy Library is particularly well-suited to David because it is a place Jackie Kennedy hoped would help turn history into advocacy and activism, and I have no doubt David's vision and experience will help to ensure that the legacy of President Kennedy endures to inspire future generations.

Madam President, I want to close by simply saying that my colleagues and I are grateful for David's distinguished service. I will personally miss him very much. I wish him, Kathleen, and their children my very best as they return home to Massachusetts to start this

next special chapter in David's career in public service.

I yield the floor, and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Ms. STABENOW. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Ms. STABENOW. Madam President, I ask unanimous consent that at 5:30 p.m. today, the majority leader be recognized to make a motion to recess until 12:01 a.m.

Mr. SESSIONS. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. SESSIONS. Reserving the right to object, if I might, if the Senator would propose her request again.

Ms. STABENOW. Madam President, I ask unanimous consent that at 5:30 p.m. today, the majority leader be recognized to make a motion to recess until 12:01 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

Ms. STABENOW. Madam President, I rise to speak about the position we find ourselves in as we come to the end of the year. Despite the incredible successes we have had with the recovery act and equal pay and the Children's Health Insurance Program and so many other areas where we have been focused and working hard to make a difference, every step of the way, as with the current bill, we have been faced with stalling tactics, objections, and filibusters. Now with the very important Department of Defense funding bill, we are in a filibuster again. I had to make the motion I offered because we will have to come in at 1 o'clock in the morning and have a vote to stop a filibuster. That is what this is all about, filibustering a bill that has a pay raise in it for our troops, that has help for military families, that has the funding for the next year—we are in the middle of two wars—essential funding that is needed to support our military. As our Presiding Officer knows, having been a leader on this as well, we also have placed into this bill provisions that are incredibly important for families, extending unemployment insurance for families across the country who find themselves in a situation not of their making where their job has gone away or they have been laid off because the company can't continue to employ them, maybe because of rising health care costs, which is certainly part of the equation. People are finding themselves in a situation where due to nothing they have done other than be a good citizen, care for their kids and follow the rules, they are without employment. We have this year extended unemployment insurance—and I am so

grateful that President Obama has been willing to do this, has helped to lead this in the recovery act and then again as we ended a filibuster, a month-long filibuster in October, brought that to an end in November to extend unemployment insurance. We find ourselves again, because of the unemployment situation, even though we see it getting a little bit better, with a long way to go. We are moving in the right direction, but we have a long way to go. This bill would extend for 2 months unemployment insurance that is critical for families. It would also extend help with health insurance. We are debating the larger health reform bill to create a way for families to be able to afford insurance and for us to bring down costs over the long run for businesses and for families.

This bill in front of us that is being filibustered by the Republicans would extend help for health care, for health insurance, for COBRA payments—a program put in place that made a lot of sense. If you lose your job, you could pay on your own to continue the coverage. But it is incredibly expensive.

So recognizing that, and recognizing how tough it is when you lose your job and you are in a situation—it is either savings or unemployment insurance or both—and you are trying to make the mortgage payment and care for the kids and put food on the table and pay the electric bill and all of the other things, and then to add a several hundred or several thousand dollar payment for COBRA on top of that has not been realistic for families. So we have placed a 65-percent subsidy, to help families get through this tough time, for health insurance. We also have assistance for food for families who, right now, again, have never had to ask for help before in their lives but now have a situation where they cannot put adequate food on the table for their children.

This bill is very important, and what we have in front of us, unfortunately, is another filibuster, another objection—like we have seen all year—to stop us from moving forward to fund our military, to support our troops with a pay raise, to help military families, and then to do a number of other things that are critical to do in the short run until we get into the new year and are able to focus more broadly on these things.

As the Presiding Officer knows, this is not the first time this has happened. We have had from the party of no 98 different objections this year. This is a record, a world's record I think: 98 different times that we have seen them objecting, filibustering, having stalling tactics to moving forward on things that ought to be bipartisan.

These are not Democratic issues when somebody has lost their job or when a small business needs help or needs health insurance they can afford

or when a family finds themselves in a situation where they need to be able to have help to continue their health insurance or put food on the table. This is not a Democratic idea or a Republican idea, this is American.

We have Democrats, Republicans, Independents, people who do not have a party, people who are not active politically, people who vote, people who do not vote. They are losing their jobs. They expect us to get it. They expect us to have a sense of urgency around here.

The troops who are serving us right now, who are in tougher times than we will ever face, are not saying what matters is whether you are Democrat or Republican as to whether we fund the troops and fund the Department of Defense and give them a pay raise they have earned and need or to help their families. They are saying: Come on. Come together. Solve problems. Get things done.

But yet, over and over—and we find ourselves tonight where we are going to be stopping a filibuster at 1 o'clock in the morning on a bill to fund the Department of Defense, on a bill that would help families get through the holiday season, keep a roof over their head, pay their heating bills, and keep food on the table.

To dramatize this even more, it is stunning to think about the fact that out of the 40 weeks we have been in session this year—40 weeks—for 36 of those weeks, we have had filibusters or stalling tactics, objections to amendments or objections to bills being put on the floor. That means only 4 weeks out of the entire year we have been in a situation where the Republicans have not been saying no, have not been stalling on things that are incredibly important.

Even with all of this, by any objective measure, there has been more accomplished this year than in any other time since the Great Depression. We need to be accomplishing more and faster because people have a tremendous sense of urgency about what is happening in their lives right now. So we need to be acting. Think of what we could have gotten done. We have all the things that have gotten done and have been addressed. Think about what we could have gotten done if we did not have 36 weeks of filibusters that we had to deal with and objections we had to deal with.

I hope, as we are going through this new year, there will be a sense that it is time to get things together here and work for the common good and put people back to work and tackle their health care costs and make sure people can afford to have health insurance.

Let me close by sharing a story from Annette from Lake Orion, MI. She says:

After a successful 21-year journalism career, I was laid off in May when my newspaper closed. I will turn 60 in October and am

a 12-year survivor of breast cancer. My husband, who is 62, is on my health insurance.

Thankfully, the federal government is helping [us] pay for our COBRA, which would be more than \$800 a month.

Senator, we're not pleading poverty. But it's easy to see the dilemma of many Americans in our shoes: Risk going without health insurance, you risk bankruptcy if someone gets sick. Pay the current price, and watch your life savings, which were supposed to support you in [your] old age, dwindle down.

Don't listen to those screaming to maintain the status quo; it doesn't work for too many Americans.

We have story after story where people are facing an early retirement—not by choice—dipping into retirement savings to try to keep their health care going. Young people, old people need us to act now, and I am urging Congress to act now.

The PRESIDING OFFICER. The Senator's time has expired.

Ms. STABENOW. I thank the Chair.

The PRESIDING OFFICER. The Senator from Alabama.

Mr. SESSIONS. Madam President, it is very distressing that Senator STABENOW could not finish her remarks and that other Senators such as Senator WHITEHOUSE and Senator LEVIN and Senator LIEBERMAN have been shorted of time. Why? Because, for some reason, the majority leader feels we should not go past 5:30 tonight.

This is a defense bill, and it is important. We need to be talking about the good things that are in it and the things that have been added to it that are not so good. I do not think working a few extra hours is going to hurt anybody.

I hear colleagues complain that they cannot work a weekend, they cannot work up to Christmas, they cannot work at night. Well, what about our men and women who are serving in Iraq and Afghanistan 7 days a week, 12 hours a day, Christmas and holidays? They are away from their families so I do not have any sympathy for any Member of the Senate who feels this is too hard for them. Also, I do not appreciate the fact that we are shut off from debate tonight to be able to talk about this issue that is before us. I see no reason for that to have to occur.

I object to the health care bill. The American people object to the health care bill—sixty-one percent say no. But we are supposed to now agree and go along with the majority? And if we do not, we are some sort of obstructionists? I do not think so. I believe I am representing my constituency. I believe I am representing the best interests of the United States of America. I do not believe this health care bill is part of that.

With regard to the armed services bill—I am a member of the Armed Services Committee, and I have been a Member for 12 years; I have been to Iraq six times and Afghanistan six times—I believe it is great we can give our soldiers a pay raise and support

them. A lot of things in the bill are good. There are some that are cut too much, but there are a lot of things that are good, and I wish to vote for the bill. But this defense bill has \$18 billion in unrelated spending items attached it: increased unemployment, COBRA, food stamps, and loan subsidies for businesses.

Two things strike me about this. First, these new expenditures are not paid for. They are not within the budget. They are above the budget. What does that mean? Well, the budget itself has us in deficit. So if it is not paid for in the budget resolution, every penny of this \$18 billion goes straight to the debt of the United States of America. We need to stop this.

Second, why did they put this kind of spending on the defense bill? Because they want to come down here and say: Anybody who is not willing to go along with this scheme to pad \$18 billion straight to the debt of the United States of America—anybody who objects does not love our soldiers.

That is wrong, and people are getting tired of that. This is how the debt of this country is surging out of control. This Congress is irresponsible in our spending. We have increased the debt the likes of which this Nation has never seen, and we are spending as if it is going out of style.

I would point out one matter here about the interest we pay on the debt. In 2008, the annual deficit was \$450 billion—at that time, the largest ever. This past year, the deficit for the fiscal year ending September 30 was \$1,400 billion, \$1.4 trillion. This puts us on the map, according to the Congressional Budget Office, to double the entire debt of America in 5 years, and triple it in 10. Unbelievable.

This is a kind of gimmick—attaching unpaid for, nonbudgeted items to the defense bill, then trying to force it through, so we cannot do anything about it. They snicker, I am sure, in their self-confident way that: We got 'em. If they object to the bill, we will say they don't love our soldiers, they don't support America's defense.

I am getting tired of it. I think the American people are getting tired of it. I saw a poll where the most popular party in America today is the tea party—more than Republicans or Democrats.

Somebody said: Well, \$18 billion, Sessions, that is not too much money. But it is done on bill after bill. This is not the only bill that has these kinds of gimmicks in it. Let me show you. I figured this out one day. I put together a chart here a little bit hastily: Baseline Increases: A Destructive Pattern.

When we increase funding in these bills above the budgeted amount and increase the debt, people like to think: Well, it is just \$18 billion. That is not much.

Look how that works when you do it over a period of ten years. So let's say

next year, we go over \$18 billion. This adds another \$18 billion to the national debt. Well, that is not so much. But wait, it is a lot. The State of Alabama's general fund budget is \$2 billion. Do not tell me \$18 billion in one bill, on top of this defense bill, is not a lot of money. It is a huge amount of money.

But it does not work that way. This \$18 billion tends to go into the baseline, so the next year, when they talk about increasing the budget, they pad it by another \$18 billion. It is not just \$18 billion the next year, you see. It is \$18 billion on top of what was pumped into the baseline the year before, and that totals out to \$36 billion. Then the next year, it is \$36 billion, plus \$18 billion more. And the next year, it is \$54 billion, plus \$18 billion more. The next year it is \$72 billion, plus \$18 billion. The next year, it is \$90 billion, plus \$18 billion. And the next years, it is \$108 billion, \$126 billion, \$144 billion, and \$162 billion if you pad the budget. And this bill is just 1 of 13 accounts: Defense. We have 13 different spending bills. How much is that? It is \$900 billion in additional deficits, just because of our inability, our unwillingness, to stay by the numbers that we voted on as our budget limit.

The budget itself, as presented by the President and passed by the Democratic majority, put us on a road to having \$1.4 trillion in deficit last year, and it looks as though this year we are going to have another \$1.4 trillion deficit. But just this one little gimmick, if it is replicated each year, can add almost \$1 trillion more to the debt of America over ten years. That is why we are concerned about it.

By the way, when we talk about the scheme that puts us on the road, according to the Congressional Budget Office, to tripling the debt of America by 2019, that does not include the health care bill. The health care bill has not passed. This outlook only includes the things that are in law now. So how much more would those figures be if the debt goes up?

I will point to one last thing about the overall financial status of this country: the interest we pay on that debt. This chart shows it.

Last year, this Nation paid \$170 billion in interest on the borrowings we have as a nation. In that 1 year it was \$170 billion. That is a lot of money. As I said, not counting the State education budget, for all the other matters of our State of 4.6 million people—which is almost one-fiftieth of the Nation's population, an average-sized State—our general fund is \$2 billion. However, \$170 billion is how much we paid in interest last year. According to the Congressional Budget Office, those numbers will increase to where in 2019, as a result of surging debt, \$799 billion will be added to our debt because of interest we must pay; \$799 billion just in

that 1 year. That is more than the whole defense budget. That is more than the whole U.S. discretionary budget from not too long ago. That is a huge amount of money. It is going to crowd out spending for schools, for highways, for health care, and for other projects.

I am very upset about it. We cannot continue. The President has said this is an unsustainable course. Every economist we talk to says it is an unsustainable course.

But how do we get there? We get there by taking a Defense bill and tacking on \$18 billion worth of unfunded spending. Every penny of that gets added to the debt.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. SESSIONS. I thank the Chair.

I urge my colleagues to send this bill back and reform it so we can have a clean Defense bill. We need to take these unpaid matters out and make sure they are paid for.

I thank the Chair and yield the floor.

Mr. JOHNSON. Madam President, I rise today to recognize this incredible opportunity to dramatically improve the health of our Nation. Americans face out-of-control health care costs, great inequalities in access to care, eroding benefits, and the ever-increasing threat of losing their health insurance. While it is no easy task to fix a system that is both very complex and very troubled, we cannot fail to act.

I wish today to highlight the challenges faced by approximately 12 million Americans who buy health insurance in the individual market. Many farming and ranching families in South Dakota are forced to purchase from this market, where they all too often wind up underinsured with coverage that costs too much and provides too little.

South Dakotans have contacted me directly to report health insurance discrimination that results in increased premiums, refusal of coverage for necessary treatments, and denial of coverage. I have even heard complaints from people who work in the insurance industry, like Pam from Sioux Falls, SD. She shared with me the serious barriers people encounter when looking for health insurance on the individual market. "There are huge loopholes in the individual market. People who are not healthy cannot get insurance. We turn people away every day and they want to buy health insurance."

Insurance companies increase their profits by selling to individuals who will pay premiums but rarely use their benefits, and by avoiding individuals who have health issues. This cherry-picking leaves millions of Americans without access to affordable health insurance coverage. And when families go without health insurance, they receive less preventive care and often must undergo more costly medical

treatment when illness progresses undetected. This uncompensated care for the uninsured drives health care costs up for all of us.

Those who buy insurance on the individual market pay top dollar for very limited coverage. They will benefit immensely from health reform. The Patient Protection and Affordable Care Act will increase the insurance options in the individual market and address injurious insurance industry practices that limit access to care. Immediately after enactment, a new program will be created to provide affordable coverage to Americans with preexisting conditions until insurance industry reforms are fully implemented. The legislation will also form health insurance exchanges in every State through which those limited to the individual market will have access to affordable and meaningful coverage. The exchange will provide easy-to-understand information on various health insurance plans, help people find the right coverage to meet their needs, and provide tax credits to significantly reduce the cost of purchasing that coverage.

Pam says, "People who want to buy individual insurance should be able to, regardless of their health status." I couldn't agree more. The Patient Protection and Affordable Care Act will ensure that no American is denied coverage because of their medical history, and it will provide the security of meaningful, affordable health care coverage for all.

Mr. JOHNSON. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. REID. First of all, Madam President, I apologize to everyone. I indicated to both the majority and the minority that we would be here at 5:30, but I had some things that came up, and I simply could not be here.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009—MOTION TO PROCEED

CLOTURE MOTION

Mr. REID. Madam President, I move to proceed to Calendar No. 175, H.R. 3590. I have a cloture motion that is at the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the motion to proceed to Calendar No. 175, H.R. 3590, the legislative vehicle for the Patient Protection and Affordable Care Act.

Harry Reid, Christopher J. Dodd, Mark Udall, Patrick J. Leahy, Daniel K.

Akaka, Richard J. Durbin, Sherrod Brown, Jeanne Shaheen, John F. Kerry, Jack Reed, Tom Harkin, Sheldon Whitehouse, Kirsten E. Gillibrand, Jeff Merkley, Joseph I. Lieberman, Barbara Boxer, Debbie Stabenow.

Mr. REID. I now withdraw that motion.

NEED FOR JUSTICE IN NEPAL

Mr. LEAHY. Mr. President, I want to speak briefly about a matter that is of concern to the Congress and the Department of State, involving a heinous crime that occurred in Nepal and the need for justice.

Many people are familiar with the brutal murder of Maina Sunuwar in February 2004. At the young age of 15, she was arrested by Nepali soldiers and severely tortured to death at, of all places, the Birendra Peace Operations Training Center. After her murder, the army made it look as though she had been shot while trying to escape, and then buried her body at the center.

According to a United Nations report, in September 2005, after intense public and international pressure, three army officers were brought before a court martial and sentenced to a mere 6 months imprisonment for failing to follow proper procedures when disposing of Maina's body. In spite of many requests, the Nepal army refused to disclose the nature of the charges that led to this sentence, or provide copies of any documents relating to the court of inquiry or court martial. It also refused to cooperate with police investigations.

It is shocking that one of the officers accused in her murder, Major Niranjan Basnet, was permitted to participate in a United Nations peacekeeping mission in Chad. This speaks volumes about the inadequacy of vetting procedures of military personnel for such missions, which is a separate subject that I intend to take up with officials at the Department of State and United Nations.

To his credit, Prime Minister Madhav Kumar Nepal had Major Basnet returned from Chad, following the issuance of an arrest warrant and in response to public calls for his arrest. However, when he arrived back at the Katmandu airport the army took him under its control and apparently, despite initial promises and requests from the police and orders from the Prime Minister, has still not handed him over to the police.

This case represents a critical juncture for Nepal. In large measure, and as others have pointed out, Maina's death will decide whether a civilian, democratic government and the rule of law will determine Nepal's future, or it will remain dominated by the interests of the Nepal army.

Just a few days ago, President Obama signed into law the Consolidated Appropriations Act, 2010, which

includes a prohibition on assistance to the Nepal army unless it, among other things, is cooperating fully with investigations and prosecutions by civilian judicial authorities of violations of internationally recognized human rights. This provision applies squarely to Maina's case.

I urge the new Chief of the Army Staff, General Chhatraman Gurung, to seize this opportunity to demonstrate that the army is reforming, that it recognizes in a democracy its members are answerable to the civilian courts, and that it will no longer perpetuate the impunity that has undermined the rule of law in Nepal for far too long.

PAROLE GUIDELINES

Mr. LEAHY. Mr. President, I have long questioned the policy of detaining asylum seekers who present genuine claims for protection under our laws. Asylum seekers who express a fear of return to their country, and who can establish their identity and show that they are neither a flight risk nor a threat to the community, should be allowed to pursue a claim for relief in the United States free from custody. Yesterday, U.S. Immigration and Customs Enforcement, ICE, announced new guidelines for release of asylum seekers that override an unduly harsh policy implemented in 2007 by the Bush administration and that are a welcome step toward compliance with our obligations under the Refugee Convention.

Under current law, an asylum seeker who arrives at a port of entry and asks for refugee protection is given a brief interview to ascertain whether he or she has a credible fear of persecution in their home country. If the asylum seeker passes that interview, they are detained, pending a hearing on their claim before an immigration judge. That hearing may take place weeks or months after the asylum seeker arrives in the United States. Unless the asylum seeker can convince the Department of Homeland Security that they should be released, that asylum seeker can spend those weeks or months in immigration detention. This policy is an affront to our ideals as a nation that aspires to be a beacon of light to persecuted refugees.

In 1997, the Immigration and Naturalization Service developed guidelines to determine whether asylum seekers should be released from custody in "parole" status while their asylum claims were adjudicated. To obtain parole, asylum seekers were required to establish their identity, and show that they were neither a flight risk nor a threat to the community. These guidelines were properly calibrated to deter fraud in the asylum system and threats to our national security. They also ensured that those who met the criteria for parole should be released. The 1997 parole guidelines were imperfectly im-

plemented, but the policy contained in them was reasonable and appropriate.

For reasons that were never adequately explained, under the prior administration, ICE issued new parole guidelines that raised the bar for asylum seekers. In addition to the 1997 requirements, under the Bush policy, an asylum seeker had to demonstrate other factors, such as a serious medical condition, pregnancy, status as a minor, or that his or her release was in the "public interest." The term "public interest" was not defined in the 2007 guidelines and it is not clear how a detained asylum seeker could have met such a vague standard. Members of Congress and the bipartisan U.S. Commission on International Religious Freedom questioned the need for such a restrictive policy, especially when many asylum seekers have no criminal record and pose no risk to Americans.

The new parole policy generally hews to the 1997 parole guidelines, but contains an important improvement. Again, asylum seekers will be eligible for parole if they demonstrate a credible fear of return to their country of origin, establish identity, and show that they are neither a flight risk nor a threat to the community. For the first time, however, the government will conduct a parole review of each case in which the asylum seeker establishes a credible fear of return. Under both the 1997 and 2007 policies, an asylum seeker had to request a parole determination in writing. Many asylum seekers arrive on our shores with genuine claims for protection, but no English language skills and no legal counsel. For these asylum seekers, navigating our complex immigration system presents an enormous hurdle. It is a challenge for them to even comprehend that they may seek parole from detention. Therefore, an automatic parole review will assist many bona fide refugees in winning release from custody. Our commitment to fair and humane treatment of refugees demands no less. This new policy will also save taxpayer dollars spent to detain immigrants, including asylum seekers who are otherwise eligible for parole, at an average of \$100 per person, per day.

In 1996, when our asylum laws were rewritten to restrict access to protection for many who requested protection upon arrival, I fought hard to preserve our role as a nation that welcomes refugees. I offered an amendment to restore basic due process protections to the summary exclusion and expedited removal provisions proposed for asylum seekers. Former Senator Michael DeWine of Ohio cosponsored the amendment, which prevailed by only one vote. Since that time, I have worked to strengthen access to due process for asylum seekers and ensure that our government complies with its international treaty obligations under the Refugee Convention.

I commend President Obama and Secretary Napolitano for engaging in a serious review of our asylum policies and taking steps to bring us closer to full compliance with international law. With the thirtieth anniversary of the Refugee Act of 1980 approaching, I will continue to press for both legislative and administrative changes to the law that will protect refugees and asylum seekers from harm and provide them with safety and security in America.

RECOGNIZING THE BOY SCOUTS OF AMERICA

Mr. BROWNBACK. Mr. President, I rise today to honor one of the most distinguished and recognized organizations for young people in the United States, the Boy Scouts of America. Specifically, I want to recognize its tremendous efforts to uphold the principle of service to others.

Today, the Boy Scouts of America is the largest youth service organization with nearly 3 million members. Its teachings of citizenship, character development, and self-reliance are those which all Americans should strive to emulate in their daily lives. The programs give participants the opportunity to engage in a wide range of outdoor activities, education programs, and career-oriented programs in partnership with many community organizations. Boy Scouts of America celebrates 100 years of service on February 8, 2010, with the theme "Celebrating the Adventure, Continuing the Journey." This motto will serve its members as they continue teaching the necessary skills to many more generations to come.

I want to recognize the efforts of the Jayhawk Area Council in northeast Kansas. These members are planning for the next 100 years of Scouting through their "Building Tomorrow's Leaders" project. This is just one of many projects that will honor the spirit of service in communities of Scouts across the Nation.

Boy Scouts of America recognizes that young leaders are developed over time, and has expanded its programs to help young men and women up to 20 years of age through Venturing Crews, Explorer Posts, and the Learning for Life groups. These programs have been shown to be meaningful and to improve a Scout's likelihood for success as an adult and enhance the quality of life in the community where he resides. Boy Scouts of America has kept up with the evolving and changing needs of our Nation, by adding programs in areas such as environmental ethics and responsibility. President Dwight Eisenhower recognized the contributions of the Boy Scouts 56 years ago when he praised the organization, as it "yearly enriches our Nation, and contributes generously to the economic, physical and spiritual resources of the country."

Mr. President, the Boy Scouts of America have helped shape young people of America for the past 100 years. This achievement is one to be celebrated, and I hope many of my colleges will join me in wishing this organization the best for the next 100 years.

JOHN BRADEMAs CENTER FOR THE STUDY OF CONGRESS REPORT

Mr. KERRY. Mr. President, from the Marshall Plan to tsunami relief, America's arsenal has always been most powerful when we have marshaled not just the force of our arms but the power of our ideals. It is no secret that for 8 recent years, the United States seemed to have broken with some of our best tradition and time-honored values—and it set back our security to be so isolated in the world. I have said many times that even the most powerful Nation needs some friends on this planet. Now, 1 year into President Obama's administration, the time is right for a robust public diplomacy to advance our interests in the world and to enhance our national security. That is the conclusion of a new report from New York University's John Brademas Center for the Study of Congress.

The center, well known to the Senate for its research and recommendations for new perspectives on public policies, recommends in its report that international arts and cultural exchanges be incorporated more fully into the planning strategies of U.S. policymakers.

Mr. President, this is a timely and important study. I recommend it to the Senate and ask that it be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MOVING FORWARD: A RENEWED ROLE FOR AMERICAN ARTS AND ARTISTS IN THE GLOBAL AGE

The 2008 election of Barack Obama as the 44th President of the United States has offered an historic opportunity for the renewal of faith in the American political system and restoration of America's image around the world. In January 2009, the John Brademas Center of the NYU Wagner convened a group of experts to explore the public policy implications for American arts and culture of a renewed focus on U. S. public diplomacy and issued a call for an expansion of international arts and cultural exchanges in the service of this new direction. The following report is the result of their expert opinions and deliberations.

The mission of the John Brademas Center for the Study of Congress is to increase the understanding of Congress—its role in making policy and its powers, processes, and responsibilities. The Center's nonpartisan work reaches scholars, students, public servants, policy makers and the general public. The Center conducts research, sponsors student internships, organizes academic conferences and public symposia, and hosts policy addresses by Members of Congress. As a part of the New York University's Robert F. Wagner Graduate School of Public Service, the Center strives to help the next genera-

tion of public service leaders develop a deeper understanding of how and why Congress makes decisions. It is named for its founder, NYU President Emeritus John Brademas, who served in the U.S. House of Representatives for 22 years (1959–81).

The Robert F. Wagner Graduate School of Public Service of New York University is a leadership school of public policy, urban planning and non-profit management whose faculty members are widely recognized for reframing the way people understand and act on issues of public importance, and whose graduates are bold, well-prepared change makers who expertly navigate real-world complexity and produce results that matter.

This report has been prepared and edited by Michael F. DiNiscia and Thomas M. McIntyre of the John Brademas Center and Professor Ruth Ann Stewart of the Robert F. Wagner Graduate School, New York University.

EXECUTIVE SUMMARY

Over the past decade, studies have shown that public opinion in other countries—particularly in the Islamic world—has taken an increasingly unfavorable view of the government and foreign policy of the United States. Yet international opinion about the values and culture of the United States, as distinct from government policies, has remained more positive according to the most recent surveys conducted by the non-partisan Pew Global Attitudes Project even in Middle Eastern countries. The inclination to view the fundamental ideals of American society as positive provides a valuable opening for policymakers to utilize the arts and culture both to advance America's international interests and enhance the cultural experience of its citizens and their understanding of America's place in a rapidly changing world.

To these ends, this report recommends that international arts and cultural exchanges be integrated into the planning strategies of U.S. policymakers as a key element of public diplomacy. History has proven that a robust public diplomacy is essential to U.S. national security and the promotion of American interests around the globe. The arts community has observed firsthand the value of international artistic exchanges in promoting moderation and tolerance among widely diverse religious and cultural groups.

Recognizing the fiscal constraints imposed by the current economic downturn, the report advises policymakers and the arts community to first focus on new and better ways to utilize arts and cultural exchange initiatives that are currently underway in both the private and governmental sectors.

As responsibility for America's public diplomacy initiatives is shared among the White House, National Security Council, Department of State, Congress, National Endowment for the Arts (NEA), National Endowment for the Humanities (NEH), Institute of Museum and Library Services, and other Federal agencies, this report offers specific suggestions and recommendations for fostering greater interagency cooperation in the integration of arts and cultural exchanges into their respective strategies.

At the same time, American arts groups feel a responsibility for promoting an understanding of the vibrancy of arts and culture in our country that both animates our democracy and nourishes international exchanges and America's image. Thus, the report recommends a national conversation on the arts generally and their centrality to the quality of American life both home and abroad.

A NATIONAL CONVENING ON CULTURAL DIPLOMACY

We recommend that a National Convening on Cultural Diplomacy be held in Washington, DC to bring together policymakers and leaders in the arts community. Such a meeting would be a way of directly engaging artists, at a time of domestic and international difficulty, in the efforts to tell anew America's story and expand and to deepen our country's understanding of foreign societies and the value of cultural diplomacy to the security and quality of American life.

The Convening would attempt to engage the relevant agencies of the Federal Government to make arts and cultural exchanges a strategic part of U.S. public diplomacy. While the meeting could be best organized by one or more nonprofit organizations working in this field, it would benefit greatly from the support and collaboration of the U.S. Department of State as the lead Federal agency promoting international exchanges.

We believe that the meeting would be greatly enhanced by the inclusion of representatives from other countries who are leaders of international cultural initiatives.

We believe such a meeting, drawing together policy makers, artists, scholars and representatives of professional service organizations, foundations, and other nonprofit as well as for-profit groups involved in the arts, would provide an agenda for Congress and the Administration to build on current resources and programs to expand international arts and cultural exchanges—in both directions—in the service of America's national security and quality of life.

BUILDING DEEPER AND BROADER EXCHANGES

We believe it is critical that international arts and cultural exchanges be two-way, person-to-person endeavors in order to promote the human connection and that such connections be sustained over time and not just episodic events, as too often has been the case. As an example, we recommend that visual arts presentations include an educational component and performing arts master classes to strengthen the value of these face-to-face interactions.

We believe that given the appropriate level of funding and commitment long term, cultural diplomacy programs can demonstrate—using evidence-based evaluation—their success and effectiveness in promoting the best aspects of America's culture and democracy.

American culture is rich in its diversity and demographic make-up. Through the recruitment and exchange of outstanding representatives of all of America's many cultures, we can demonstrate the multicultural nature of American society at its best, presenting a vision of openness and freedom of expression to societies where such opportunities are often lacking. Similarly, we urge a public diplomacy policy that welcomes the cultures of others to our shores.

We believe that cultural exchanges must not only be two-way but also sensitive to local needs, practices, and aspirations in selecting the type of American art to promote in a given country or region. The Internet has opened up to the world the rich variety of art and artists the U.S. has to offer and we should seek to meet those expectations and interests including for popular culture and the nonconventional.

It would seem that a priority for arts and cultural exchanges would be with countries with which the United States has limited official relations as well as with countries where there is a low level of travel or interaction at the citizen level.

We think cultural exchanges that focus on restoration and preservation projects are especially productive as would be the exchange

of experts in the areas of performing arts administration, museum policies and techniques, etc. Technical assistance exchanges have a long history of helping other countries to celebrate their heritage and promote tolerance between nations while at the same time giving Americans opportunities to learn about other cultures.

In the past, cultural exchanges organized by the Federal Government have on occasion raised suspicions that artists had compromised their artistic integrity. We believe in the importance of government at all levels—federal, state and local—working with nonprofits and NGOs both at home and in foreign countries to avoid the appearance that cultural exchanges are contrived solely to serve U.S. foreign policy interests rather than the intended purpose of furthering mutual understanding. To that end, we urge that the international exchange process not be centralized in or overly coordinated at the national level but instead structured to draw in artists and arts groups directly at all levels.

RESEARCH

Policymakers need credible evidence to help them determine the merits and value of expanding international exchange programs. We believe that a National Convening on Cultural Diplomacy would provide the appropriate forum for assembling a body of expert testimony and current and directed research that would facilitate a clear and focused examination of potential outcomes.

We believe it would be beneficial to such deliberations if a comprehensive inventory and review were undertaken of current programs by federal, state, and local governments and private groups in the international arts and cultural exchange area.

We recommend that a State Dept Working Group on Cultural Diplomacy be charged with responsibility for coordinating the effort to collect, examine and evaluate relevant reports and data generated by both government and civil society organizations as supplemented and supported by the Congressional Research Service, private foundations, and scholarly research efforts sponsored by the National Endowment for the Arts (NEA), National Endowment for the Humanities (NEH), and Institute of Museum and Library Services (IMLS).

We believe that a particularly productive part of the research process would be the opportunity to document actual experiences and impacts of both past and on-going cultural exchanges, especially the person-to-person encounters that have well established track records for generating significant and measurable goodwill toward the United States.

We believe that verification of such successes would not only help substantiate the case for international art and cultural exchanges as an important part of public diplomacy but would also enable us to identify and evaluate best practices in the field.

It is our hope that private foundations would support the research process and, working in collaboration with the arts community, help to determine a series of metrics for not only evaluating international programs but the adequacy as well of resources and work opportunities for the American artists and institutions who would fuel such efforts.

We recommend that the State Department be encouraged to be an active participant in the ongoing efforts by such international organizations as UNESCO and World Monuments Fund to map the world's cultural infrastructure toward the protection of impor-

tant art objects, artistic forms, sites, and institutions located in disaster and conflict areas. The U.S. Defense Dept and Federal Emergency Management Agency might also be considered as a source of funding and assistance for such undertakings.

TECHNOLOGY & TECHNICAL ASSISTANCE

In recognition of the borderless nature of the Internet we urge that the latest and most advanced electronic social networking technology be utilized in cultural diplomacy programs.

We believe that stronger cultural exchanges would result from government moving beyond the older idea of technology as broadcasting medium to harness the new and most advanced social networking technologies that not only distribute message and art but also encourage civic engagement and social connectivity.

Given the effectiveness of the American public/private model, a National Convening on Cultural Diplomacy would explore opportunities to recommend to Government ways of working in association with private nonprofit and for-profit cultural organizations with popular social networking sites in order to expand the range of possibilities for sharing and exchanging cultural experiences.

We believe that the pairing of technology and culture would be especially efficacious through the dissemination of hardware and software (e.g., cell phones, wi-fi systems, low-cost computers, hand-crank radios, etc.) to more remote areas of the globe where cultural understanding and exchanges are especially needed.

We also recommend cultural exchanges involving scholars and experts in such specialties as performing arts management, conservation and preservation, museology, and curation, especially those with expertise in newer forms of media and technology. For example, we urge the expansion and integration into public diplomacy efforts of the Cultural Preservation Fund which currently sends conservators abroad to provide technical assistance and run education projects,

PUBLIC/PRIVATE PARTNERSHIP

We believe that the Government should encourage and promote two-way international exchanges, acting in a convening role to bring together private organizers and private funders, as the cost should not be fully assumed by American taxpayers.

We urge the State Department to consider ways in which it might utilize its administrative capacity and area expertise to explore possibilities for working with foundations and U.S. corporations to increase grants for international exchanges, as well as to investigate the potential of coordinated activity with the many arts and media industries engaged in the international marketplace of culture.

At the same time, we recognize the importance of members of the arts community keeping informed about policy changes and shifts in the national agenda. We believe that over time and in evolving ways, cultural exchanges could render service in partnership with government (as well as foundations and corporations) that would continue to enhance America's public diplomacy process.

We believe that through the export of a wide diversity of American arts and artists, and the import (and ready admission through the passage of the Arts Require Timely Service Act [H.R. 1785 and S. 1409]) of a broadly representative group of foreign arts and artists, America's best foreign and domestic cultural interests would be served.

LEADERSHIP AT THE FEDERAL LEVEL

We believe that the effectiveness of American public diplomacy would be advanced by the integration of cultural diplomacy into the policy-making process of the White House and the State Department.

We propose that a National Convening on Cultural Diplomacy incorporate into its agenda an examination of the recent call by various nongovernmental study groups concerned with Federal support of the arts generally for the creation of a full time White House post specifically charged with promoting the arts and culture as part of the Domestic Policy Council. Arts and cultural professionals agree that without a strong and healthy cultural sector at home (frequently characterized as cultural vibrancy), the U.S. would not have the rich pool of diverse talents in place and available when selecting art and artists to represent the nation at its best internationally.

We further recommend that a National Convening on Cultural Diplomacy be given the opportunity to propose the creation by the President of a position on the National Security Council (NSC) to oversee public diplomacy, including the coordination of relevant arts and cultural exchange efforts with the Domestic Policy Council, State Department, and the Federal cultural agencies.

We further recommend the National Convening agenda include a proposal for the creation of a Standing Committee to advise the Secretary of State on ways in which the State Department could begin to renew its diplomatic strength and expertise in the area of culture. Committee members would be persons in the arts world involved in both informal and formal international exchanges.

We would also recommend that a Special Envoy for Culture be appointed by the State Department to work on building relationships and partnerships with foreign governments and international bodies such as UNESCO, International Council of Museums, World Heritage Alliance, et al.

EXPANDING FEDERAL PROGRAMS

We believe that it is both timely and desirable to urge the creation of a new direction for public diplomacy through the expansion of Federal cultural programming.

We believe that key to this new direction is an expansion of the budgetary capacity of the State Department to increase the number of cultural affairs officers stationed at embassies and consulates and their capabilities for carrying out cultural programming as the ones most informed about what exchanges would be best coupled with which country.

We recommend that, in addition to increasing its personnel numbers, the State Department further enhance its ability to attract good people by creating parity in career advancement and status between cultural affairs officers and political officers.

We believe that the State Department would benefit as well from the creation of a Cultural Diplomacy Fellowship Program that would increase the flow of personnel through the cultural diplomacy system; rotate outside cultural experts through the Department; and enable State Department employees to go for further training at cultural institutions in the U.S. and abroad for fixed periods of time.

Additional recommendations that have been proposed for consideration by a National Convening on Cultural Policy include:

A publicity campaign coordinated by the State Dept., NEA, NEH, and IMLS to alert more U.S. and foreign artists and cultural institutions about the opportunities available for international cultural exchanges, including Fulbright fellowships.

Ways for the United States Agency for International Development (USAID) to support cultural programs that are consistent with their development goals (i.e., cultural preservation projects and arts and crafts programs).

Ways for the Peace Corps and AmeriCorps to develop cultural projects and recruit artists into both organizations.

Ways for the Commerce Department to promote cultural tourism that would direct Americans to cultural programs abroad and market cultural activities in the U.S. to foreign tourists.

Increase funding for arts and cultural exchanges in departments other than State and the Federal cultural agencies (e.g., Defense Department, Commerce Department, etc.) to encourage the sending of artists and technical assistance to localities deemed to be less developed and comfortable.

CONGRESSIONAL ACTION

We encourage the relevant committees in Congress, in particular the House and Senate Foreign Affairs Committees, to hold a series of public hearings on the proposals coming out of the National Convening on Cultural Diplomacy.

We believe that congressional hearings are key to the development of new and expanded legislation and programs in support of two-way cultural exchanges, for all the reasons and recommendations outlined above.

We offer the Arts and Artifacts Indemnity Act of 1975 for consideration by the Congress in its deliberations as a legislative model of the time proven success of international cooperation and cultural exchange.

We recommend the inclusion in such hearings of a broad representation of knowledgeable parties, especially representatives of state and local arts and humanities councils and agencies and of professional service organizations.

Finally, we again urge the reintroduction and passage by Congress of the Arts Require Timely Service Act [H.R. 1785 and S. 1409] as an essential component of cultural exchange and the enrichment and diversity of the cultural experience of the American public.

ADDITIONAL STATEMENTS

REMEMBERING SOL PRICE

• Mrs. BOXER. Mr. President, I am honored to remember Sol Price, who passed away on December 14, 2009, at the age of 93. Sol was a man of vision in business, charity, and community. I will remember his great accomplishments, but I will also remember him as a wonderful man and a dear friend.

A trendsetter in retail, Sol Price founded FedMart and the Price Club, which subsequently sparked the wholesale warehouse industry. He envisioned providing consumers with products at low prices while providing good wages and working conditions for his employees. When FedMart opened its first store in San Antonio, TX, in 1957, Sol Price paid double the minimum wage. He also succeeded getting a mortgage company to drop its requirement on separate restroom facilities for "Colored" and "Whites."

Sol Price was a leader in philanthropy and education. In 1991, after the

death of his grandson Aaron, he established the Price Fellows program for young people in San Diego County, with a mission to enrich their lives and encourage stewardship for their community. The 3-year program for high school students teaches them about business, cultural institutions, and government; it also encourages lasting relationship across different ethnic, religious, and economic backgrounds. This program has created a new generation of local leaders in government, business, and civic life.

In 2000, Sol and his wife Helen set up the San Diego Revitalization Corporation, which was later renamed Price Charities. The end goal is to improve the lives of the urban poor. Among his many commitments, Sol worked to revitalize City Heights, a neighborhood in the city of San Diego that was a poor, high-crime but diverse community. In partnership with the city of San Diego, he built low-income housing and commercial space for community organizations and attracted businesses that would not otherwise have located in City Heights.

Sol was a member of the board of trustees for the Urban Institute in Washington, DC, the board of directors for the Center on Budget and Policy Priorities, the Consumer Affairs Advisory Committee of the U.S. Securities and Exchange Commission, and the San Diego Financial Review Panel.

Born in the Bronx, NY, Sol Price grew up in San Diego. He graduated from San Diego State University in 1934 and earned a law degree in 1938 from the University of Southern California.

Sol will be dearly missed. There is no doubt that his spirit will live on, carried along by the people he helped, the neighborhoods he transformed, and the entrepreneurial path he blazed.

He is survived by two sons, Robert and Larry, five grandchildren, and four great-grandchildren. My heart goes out to the family during this time of grief. They are in our thoughts and in our prayers.●

REMEMBERING ORVAL ALLEN KELSO

• Mr. CRAPO. Mr. President, today I wish to ask my colleagues to join me in recognizing the accomplishments of Mr. Orval Allen Kelso.

Today, deeply engaged in a war on terror, thousands of American civilians are working and serving in harm's way. Like the brave men and women serving in uniform, these patriotic citizens risk their lives every day in an effort to rebuild a stronger future for the people of Iraq. However, they are not alone. American civilian contractors have been operating in combat theatres since as early as World War II, and I am here today to tell you about one of those.

Hailing from Emmett, ID, Orval Allen Kelso arrived on Wake Island in the North Pacific in June 1941, working as a powerplant operator for Morrison Knudsen. Mr. Kelso worked as a powerplant operator until December 1941, when he was captured and taken as a POW to Camp 18, Sesabo, Japan. While a POW at Camp 18, Orval helped build the Soto Dam that provides water to Sesabo city today. He, among several hundred civilian POWs, built this dam with hardly the right tools to work with, malnutrition, improper clothing, and daily physical and emotional abuse by their captors. Orval later died in Camp 18 on April 8, 1943, just days after his birthday. In 1949, his only child, Walter Richard "Dick" Kelso, reclaimed his father's remains, and brought him back to rest on U.S. soil at the National Memorial Cemetery of the Pacific in Honolulu, HI. I also note that although Mr. Kelson was a civilian during the time I have discussed, after his death, the Department of the Navy awarded him an E4 military status.

It is fitting that we honor Mr. Kelso for his sacrifice and also be reminded of the many others who were taken prisoner or who paid the ultimate sacrifice working in harm's way. We often forget about the nonmilitary Americans who gave their all for the freedoms we cherish in our great Nation. Let us help remedy that today by recognizing Mr. Kelso and the civilian POWs taken during World War II. They are an exemplary example of the selflessness displayed by Americans in an effort to bring peace and freedom to millions, and we thank them for their sacrifice.●

TRIBUTE TO RICHARD R. JENNINGS

• Mr. KERRY. Mr. President, I wish to congratulate Richard R. Jennings of Wilmington, MA, for the honor he received from the Smithsonian Institution at the American History Museum earlier this year. Mr. Jennings was recognized for his long service with the Railway Mail Service. The 85-year-old Mr. Jennings is one of the last survivors of one of the most important innovations in the history of mail service in the United States.

Mr. Jennings was honored as part of a postal service exhibit at the American History Museum last summer. In addition to the recognition he received, the Smithsonian also recorded Mr. Jennings's memories of his years as part of the Boston-to-Albany and the Boston-to-New York "mail by rail" routes—part of a network that was so important to U.S. mail service before the airlines took over much of the service.

The Railway Mail Service began in the mid-19th century but grew in importance as the railroads became dominant in transportation until the mid-

20th century. "Mail by rail" was quite successful—dramatically increasing the speed of delivery of mail, especially over long distances.

Mr. Jennings and his fellow Railway Mail Service clerks were considered the elite of the Postal Service's employees. And for good reason. Their jobs were exhausting and dangerous. They were required to sort 600 pieces of mail an hour in a speeding train that could wreck—and occasionally did. The potential for danger certainly added pressure to an already difficult job.

In addition to changing our postal system, the Railway Mail Service was the source of an expression well known in the United States. Empty mail sacks and sacks filled with damaged, misaddressed or otherwise unsortable mail were referred to as "bums." And before the trains would leave the stations along their routes, rail clerks would often shout "throw the bums out."

Mr. Jennings served this country in important ways, not only as a postman in the "mail by rail" network but also as a sergeant with the U.S. Army Medical Corps in Italy and North Africa during World War II. There, as much as with the "mail by rail" service, Mr. Jennings helped to "throw the bums out."

Mr. Jennings deserves our thanks for his unique and great service to our country. I congratulate him and his family and I share their pride in him and his important role in the history of our country's Postal Service.●

TRIBUTE TO DICK AND CHRISTINE MOODY

● Mr. KERRY. Mr. President, anyone who has served in our Armed Forces or who has had a loved one in uniform understands just how difficult the holiday season can be—separated from husbands, wives, fathers, mothers, daughters, and sons. It can be the loneliest time of the year. Dick and Christine Moody understand that better than most, and since 2003 they have worked tirelessly to make the holidays a little cheerier for the men and women who keep America safe. They have done it with Operation Troop Support, the organization they founded 6 years ago as a way to say thank to those serving in the military.

Since its founding, Operation Troop Support has sent more than 25,000 care packages to men and women in the military abroad. These packages are sent throughout the year, but during the holidays extra care is taken to see that the season is a little brighter for the troops. And it is for that reason that during this holiday season, I would like to recognize and commend Dick and Christine Moody for their efforts—efforts that have earned them national recognition and the accolades of the National Military Family Association,

the Employer Support to the Guard and Reserve, ESGR, and numerous State and local officials.

I also want to recognize the hundreds of volunteers who have contributed their time, energy and money to Operation Troop Support. The support the North Shore community has given the organization has been inspiring. Volunteers have spent countless hours boxing the care packages, and they have donated thousands of dollars to ship the packages to ensure that each soldier, marine, airman and sailor receives something during the holiday season.

I had the opportunity to meet with many of the Operation Troop Support volunteers while attending a St. Patrick's Day luncheon hosted by the organization last year. During the luncheon, I spoke with a soldier, Thomas Lanzoni, who had recently returned from Iraq. Inspired by the volunteers of Operation Troop Support, Sergeant Lanzoni walked across the Commonwealth of Massachusetts to raise money and awareness for the Moodys's organization.

Dick and Christine Moody understand the special burden placed on military families. Dick spent 23 years in the Air Force and retired as a lieutenant colonel. Additionally, the Moodys have a son and a daughter who have served abroad in the Air Force. The military has long been a part of their life. Consequently, Operation Troop Support not only supports the troops in the field but also hosts family support group meetings for the loved ones of servicemembers deployed or about to be deployed overseas.

I salute the Moodys and Operation Troop Support for their service and dedication to our country. Their gestures of gratitude have reached thousands of servicemembers, reminding each of them that we support them and their families while they are deployed and when they return.●

2009 NATIONAL BOARD CERTIFIED RHODE ISLAND TEACHERS

● Mr. REED. Mr. President, I commend the announcement yesterday that 44 Rhode Island teachers and nearly 9,000 teachers nationwide achieved National Board for Professional Teaching Standards certification this year.

The single most effective step we can take to raise student achievement and turn around struggling schools is to ensure that we improve the quality of our teachers. For years I have worked to improve what the Federal Government does to help train and develop teachers. Indeed, I have worked with National Board on nearly every piece of teacher quality legislation I have introduced in the Senate. The National Board has been instrumental in identifying effective teaching practices and infusing those practices throughout our Nations

schools. Their certification process is rigorous and includes multiple components that regularly assess and improve a teacher's ability to improve student learning. Since 1994, 82,000 teachers have been National Board certified, including 383 Rhode Island teachers.

Last week, the National Board announced an expansion of their certification process to include principals and other school leaders, recognizing the research that effective leadership is second only to classroom instruction among factors that influence student outcomes. I was pleased that this important expansion was made possible through Federal funding provided through the fiscal year 2009 Labor, Health, and Education appropriations bill.

I congratulate the Rhode Island teachers and teachers nationwide on their significant accomplishment and dedication to their professional development, and I look forward to continuing to work with the National Board to ensure that our children have the most effective teachers, principals, and school leaders.

I ask that the names of the Rhode Island teachers who achieved National Board certification this year be included in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

2009 RHODE ISLAND NATIONAL BOARD CERTIFIED TEACHERS

Rhonda Asprinio, Michelle Beaulieu, Karen Bessette, Catherine Boutin, Dawn Brooder, Alison Burke, Jaclyn Cambio, David Clegg, Leila Connolly, Suzanne Costa, Lilly Coustan, Cheryl Degnan, Stephanie Desmarais, Amy Devault, Jonathan Dune, Kerri Gendice, Michael Gendice, Andrea Hainey-Turcotte, Carolyn Higgins, Michaela Holmes, James Hovey, and David Kearsley.

Denise Ledoux, Jeanne Maggiasco, Treva Mcelroy, Karen Mchenry, Maryelizabeth Melillo, Bonnie Morency-Lima, Lisa Narcisi, Kerry Perschau, Margaret Pouliot, Mary Roberts, Elizabeth Ruest, Lynn Rzemien-Plotkin, Marilyn Salisbury, Elyse Scherza, Denise Sherman, Nicole Tetreault, Jennifer Theroux, Julee Thomas, Christa Thompson, Jennifer Walker, Lynn Warila, and Amy Weigand.●

TRIBUTE TO ANDREW SAMWICK

● Mrs. SHAHEEN. Mr. President, today I congratulate Professor Andrew Samwick for being recognized for his dedication to and his excellence in teaching. Professor Samwick is the winner of the 2009 New Hampshire Professor of the Year Award, one of the most prestigious awards for undergraduate teaching. Honorees are recognized for their influence in the lives and careers of their students.

Mr. Samwick has taught at Dartmouth College since 1994 and is a professor of economics and the director of the Nelson A. Rockefeller Center for Public Policy and Social Sciences. He

is a well-known expert on the economics of retirement and social security reform, and has testified several times before Congress and has served as chief economist on the staff of the President's Council of Economic Advisors. He is also a research associate at the National Bureau of Economic Research where he cochairs the Social Security Working Group.

Professor Samwick graduated *summa cum laude* from Harvard College and received a Ph.D. in economics from the Massachusetts Institute of Technology. He has won numerous prizes, grants, and fellowships for his work. His articles frequently appear in prestigious economics and finance journals and he often provides commentary and opinion for national public radio and national newspapers.

The U.S. Professors of the Year program acknowledges the most exceptional undergraduate instructors in the country—those who stand out in their teaching and positive influence on the lives and careers of their students. It is important that we recognize the critical work and contribution that our talented professors make in educating the next generation of young people. I am extremely proud that Professor Samwick has been honored by this prestigious distinction.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mrs. Neiman, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

ENROLLED BILL SIGNED

At 10:03 a.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the Speaker has signed the following enrolled bill:

S. 1472. An act to establish a section within the Criminal Division of the Department of Justice to enforce human rights laws, to make technical and conforming amendments to criminal and immigration laws pertaining to human rights violations, and for other purposes.

The enrolled bill was subsequently signed by the President *pro tempore* (Mr. BYRD).

At 10:38 a.m., a message from the House of Representatives, delivered by

Mrs. Cole, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 1147. An act to implement the recommendations of the Federal Communications Commission report to the Congress regarding low-power FM service.

H.R. 3714. An act to amend the Foreign Assistance Act of 1961 to include in the Annual Country Reports on Human Rights Practices information about freedom of the press in foreign countries, and for other purposes.

H.R. 4194. An act to amend title 18, United States Code, to exempt qualifying law school students participating in legal clinics or externships from the application of the conflict of interest rules under section 205 of such title.

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 3714. An act to amend the Foreign Assistance Act of 1961 to include in the Annual Country Reports on Human Rights Practices information about freedom of the press in foreign countries, and for other purposes; to the Committee on Foreign Relations.

H.R. 4194. An act to amend title 18, United States Code, to exempt qualifying law school students participating in legal clinics or externships from the application of the conflict of interest rules under section 205 of such title; to the Committee on the Judiciary.

ENROLLED BILL PRESENTED

The Secretary of the Senate reported that on today, December 17, 2009, she had presented to the President of the United States the following enrolled bill:

S. 1472. An act to establish a section within the Criminal Division of the Department of Justice to enforce human rights laws, to make technical and conforming amendments to criminal and immigration laws pertaining to human rights violations, and for other purposes.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. LEAHY, from the Committee on the Judiciary:

Report to accompany S. 1490, a bill to prevent and mitigate identity theft, to ensure privacy, to provide notice of security breaches, and to enhance criminal penalties, law enforcement assistance, and other protections against security breaches, fraudulent access, and misuse of personally identifiable information (Rept. No. 111—110).

By Mr. LIEBERMAN, from the Committee on Homeland Security and Governmental Affairs, with an amendment in the nature of a substitute:

H.R. 730. A bill to strengthen efforts in the Department of Homeland Security to develop nuclear forensics capabilities to permit attribution of the source of nuclear material, and for other purposes.

By Mr. LIEBERMAN, from the Committee on Homeland Security and Governmental Affairs, without amendment:

H.R. 1817. A bill to designate the facility of the United States Postal Service located at 116 North West Street in Somerville, Tennessee, as the "John S. Wilder Post Office Building".

By Mr. LIEBERMAN, from the Committee on Homeland Security and Governmental Affairs, with amendments:

H.R. 2711. A bill to amend title 5, United States Code, to provide for the transportation of the dependents, remains, and effects of certain Federal employees who die while performing official duties or as a result of the performance of official duties.

By Mr. LIEBERMAN, from the Committee on Homeland Security and Governmental Affairs, without amendment:

H.R. 2877. A bill to designate the facility of the United States Postal Service located at 76 Brookside Avenue in Chester, New York, as the "1st Lieutenant Louis Allen Post Office".

H.R. 3072. A bill to designate the facility of the United States Postal Service located at 9810 Halls Ferry Road in St. Louis, Missouri, as the "Coach Jodie Bailey Post Office Building".

H.R. 3319. A bill to designate the facility of the United States Postal Service located at 440 South Gulling Street in Portola, California, as the "Army Specialist Jeremiah Paul McCleery Post Office Building".

H.R. 3539. A bill to designate the facility of the United States Postal Service located at 427 Harrison Avenue in Harrison, New Jersey, as the "Patricia D. McGinty-Juhl Post Office Building".

H.R. 3667. A bill to designate the facility of the United States Postal Service located at 16555 Springs Street in White Springs, Florida, as the "Clyde L. Hillhouse Post Office Building".

H.R. 3767. A bill to designate the facility of the United States Postal Service located at 170 North Main Street in Smithfield, Utah, as the "W. Hazen Hillyard Post Office Building".

H.R. 3788. A bill to designate the facility of the United States Postal Service located at 3900 Darrow Road in Stow, Ohio, as the "Corporal Joseph A. Tomci Post Office Building".

By Mr. LEAHY, from the Committee on the Judiciary, with an amendment in the nature of a substitute:

S. 678. A bill to reauthorize and improve the Juvenile Justice and Delinquency Prevention Act of 1974, and for other purposes.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of nominations were submitted:

By Mr. DODD for the Committee on Banking, Housing, and Urban Affairs.

*Eric L. Hirschhorn, of Maryland, to be Under Secretary of Commerce for Export Administration.

*Ben S. Bernanke, of New Jersey, to be Chairman of the Board of Governors of the Federal Reserve System for a term of four years.

*Marisa Lago, of New York, to be an Assistant Secretary of the Treasury.

*Steven L. Jacques, of Kansas, to be an Assistant Secretary of Housing and Urban Development.

By Mr. ROCKEFELLER for the Committee on Commerce, Science, and Transportation.

*Julie Simone Brill, of Vermont, to be a Federal Trade Commissioner for the term of seven years from September 26, 2009.

*Edith Ramirez, of California, to be a Federal Trade Commissioner for the term of seven years from September 26, 2008.

*Nicole Yvette Lamb-Hale, of Michigan, to be an Assistant Secretary of Commerce.

*Michael A. Khouri, of Kentucky, to be a Federal Maritime Commissioner for a term expiring June 30, 2011.

*David L. Strickland, of Georgia, to be Administrator of the National Highway Traffic Safety Administration.

*Coast Guard nomination of Rear Adm. (1h) Steven E. Day, to be Rear Admiral.

Mr. ROCKEFELLER. Mr. President, for the Committee on Commerce, Science, and Transportation I report favorably the following nomination lists which were printed in the RECORDS on the dates indicated, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar that these nominations lie at the Secretary's desk for the information of Senators.

The PRESIDING OFFICER. Without objection, it is so ordered.

*Coast Guard nomination of Andrew G. Liske, to be Captain.

*Coast Guard nomination of Robert A. Moomaw, to be Lieutenant.

*National Oceanic and Atmospheric Administration nominations beginning with Keith E. Tucker and ending with Jason P.R. Wilson, which nominations were received by the Senate and appeared in the CONGRESSIONAL RECORD on December 9, 2009.

By Mr. LEAHY for the Committee on the Judiciary.

Mark Anthony Martinez, of Nebraska, to be United States Marshal for the District of Nebraska for the term of four years.

Michael W. Cotter, of Montana, to be United States Attorney for the District of Montana for the term of four years.

Barbara L. McQuade, of Michigan, to be United States Attorney for the Eastern District of Michigan for the term of four years.

James L. Santelle, of Wisconsin, to be United States Attorney for the Eastern District of Wisconsin for the term of four years.

Christopher A. Crofts, of Wyoming, to be United States Attorney for the District of Wyoming for the term of four years.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

(Nominations without an asterisk were reported with the recommendation that they be confirmed.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. WYDEN:

S. 2895. A bill to restore forest landscapes, protect old growth forests, and manage national forests in the eastside forests of the State of Oregon, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. FRANKEN (for himself, Mr. HATCH, Mr. BENNET, Mr. BROWN, and Mr. CARPER):

S. 2896. A bill to recruit, support, and prepare principals to improve student academic

achievement at high-need schools; to the Committee on Health, Education, Labor, and Pensions.

By Mr. BENNET:

S. 2897. A bill to establish incentives to increase the energy efficiency of federally assisted housing; to the Committee on Banking, Housing, and Urban Affairs.

By Ms. LANDRIEU (for herself and Mr. ALEXANDER):

S. 2898. A bill to provide for child safety, care, and education continuity in the event of a presidentially declared disaster; to the Committee on Health, Education, Labor, and Pensions.

By Mrs. FEINSTEIN (for herself and Mr. MERKLEY):

S. 2899. A bill to amend the American Recovery and Reinvestment Act of 2009 and the Internal Revenue Code of 1986 to provide incentives for the development of solar energy; to the Committee on Finance.

By Mrs. GILLIBRAND:

S. 2900. A bill to establish a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined cycle and simple cycle power generation systems; to the Committee on Energy and Natural Resources.

By Ms. COLLINS (for herself, Mrs. MCCASKILL, and Mr. BENNETT):

S. 2901. A bill to improve the acquisition workforce through the establishment of an acquisition management fellows program, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

By Ms. COLLINS (for herself, Mrs. MCCASKILL, and Mr. BENNETT):

S. 2902. A bill to improve the Federal Acquisition Institute; to the Committee on Homeland Security and Governmental Affairs.

By Mr. BURR (for himself and Mr. ENZI):

S. 2903. A bill to amend the Child Care and Development Block Grant Act of 1990 to require criminal background check for child care providers; to the Committee on Health, Education, Labor, and Pensions.

By Mr. FRANKEN (for himself, Ms. SNOWE, Mr. KERRY, Mr. LAUTENBERG, Mr. FEINGOLD, Mr. MENENDEZ, Mr. DURBIN, Mrs. GILLIBRAND, Mrs. FEINSTEIN, Mrs. BOXER, Mrs. MCCASKILL, Mr. HARKIN, and Mr. SCHUMER):

S. 2904. A bill to amend title 10, United States Code, to require emergency contraception to be available at all military health care treatment facilities; to the Committee on Armed Services.

By Mr. INOUE:

S. 2905. A bill to amend the Internal Revenue Code of 1986 to repeal the reduction in the deductible portion of expenses for business meals and entertainment; to the Committee on Finance.

By Mr. FEINGOLD (for himself, Mr. MCCAIN, and Mr. LIEBERMAN):

S.J. Res. 23. A joint resolution disapproving the rule submitted by the Federal Election Commission with respect to travel on private aircraft by Federal candidates; to the Committee on Rules and Administration.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mrs. HAGAN (for herself and Mr. BURR):

S. Res. 377. A resolution congratulating the University of North Carolina Tar Heels for winning the 2009 National Collegiate Athletic Association Field Hockey National Championship; to the Committee on the Judiciary.

By Mrs. HAGAN (for herself and Mr. BURR):

S. Res. 378. A resolution congratulating the University of North Carolina Tar Heels for winning the 2009 National Collegiate Athletic Association Women's Soccer National Championship; to the Committee on the Judiciary.

By Mrs. GILLIBRAND:

S. Res. 379. A resolution to express the sense of the Senate regarding the protection of intellectual property rights for clean energy and environmental technology; to the Committee on Foreign Relations.

ADDITIONAL COSPONSORS

S. 604

At the request of Mr. SANDERS, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 604, a bill to amend title 31, United States Code, to reform the manner in which the Board of Governors of the Federal Reserve System is audited by the Comptroller General of the United States and the manner in which such audits are reported, and for other purposes.

S. 619

At the request of Mrs. FEINSTEIN, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. 619, a bill to amend the Federal Food, Drug, and Cosmetic Act to preserve the effectiveness of medically important antibiotics used in the treatment of human and animal diseases.

S. 841

At the request of Mr. KERRY, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 841, a bill to direct the Secretary of Transportation to study and establish a motor vehicle safety standard that provides for a means of alerting blind and other pedestrians of motor vehicle operation.

S. 1067

At the request of Mr. FEINGOLD, the name of the Senator from Hawaii (Mr. INOUE) was added as a cosponsor of S. 1067, a bill to support stabilization and lasting peace in northern Uganda and areas affected by the Lord's Resistance Army through development of a regional strategy to support multilateral efforts to successfully protect civilians and eliminate the threat posed by the Lord's Resistance Army and to authorize funds for humanitarian relief and reconstruction, reconciliation, and transitional justice, and for other purposes.

S. 1183

At the request of Mr. DURBIN, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 1183, a bill to authorize the Secretary of Agriculture to provide assistance to the Government of Haiti to end

within 5 years the deforestation in Haiti and restore within 30 years the extent of tropical forest cover in existence in Haiti in 1990, and for other purposes.

S. 1197

At the request of Mr. VOINOVICH, the name of the Senator from Vermont (Mr. SANDERS) was added as a cosponsor of S. 1197, a bill to establish a grant program for automated external defibrillators in elementary and secondary schools.

S. 1255

At the request of Mr. SCHUMER, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 1255, a bill to amend the Magnuson—Stevens Fishery Conservation and Management Act to extend the authorized time period for rebuilding of certain overfished fisheries, and for other purposes.

S. 1345

At the request of Mr. REED, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 1345, a bill to aid and support pediatric involvement in reading and education.

S. 1492

At the request of Ms. MIKULSKI, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. 1492, a bill to amend the Public Health Service Act to fund breakthroughs in Alzheimer's disease research while providing more help to caregivers and increasing public education about prevention.

S. 1589

At the request of Ms. CANTWELL, the name of the Senator from Nebraska (Mr. JOHANNES) was added as a cosponsor of S. 1589, a bill to amend the Internal Revenue Code of 1986 to modify the incentives for the production of biodiesel.

S. 1739

At the request of Mr. DODD, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 1739, a bill to promote freedom of the press around the world.

S. 1938

At the request of Mr. NELSON of Florida, his name was added as a cosponsor of S. 1938, a bill to establish a program to reduce injuries and deaths caused by cellphone use and texting while driving.

S. 2831

At the request of Mr. REED, the name of the Senator from Ohio (Mr. BROWN) was added as a cosponsor of S. 2831, a bill to provide for additional emergency unemployment compensation and to keep Americans working, and for other purposes.

S. 2833

At the request of Mr. REED, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 2833, a bill to provide adjusted Fed-

eral medical assistance percentage rates during a transitional assistance period.

S. 2853

At the request of Mr. GREGG, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 2853, a bill to establish a Bipartisan Task Force for Responsible Fiscal Action, to assure the long-term fiscal stability and economic security of the Federal Government of the United States, and to expand future prosperity growth for all Americans.

S. 2854

At the request of Mr. KOHL, the names of the Senator from Michigan (Ms. STABENOW) and the Senator from Missouri (Mrs. McCASKILL) were added as cosponsors of S. 2854, a bill to amend the Internal Revenue Code of 1986 to extend and modify the credit for new qualified hybrid motor vehicles, and for other purposes.

S. 2874

At the request of Ms. LANDRIEU, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 2874, a bill to designate the facility of the United States Postal Service located at 2000 Louisiana Avenue in New Orleans, Louisiana, as the "Ray Rondono, Sr. Post Office Building".

S. 2886

At the request of Ms. CANTWELL, the names of the Senator from Vermont (Mr. SANDERS) and the Senator from California (Mrs. BOXER) were added as cosponsors of S. 2886, a bill to prohibit certain affiliations (between commercial banking and investment banking companies), and for other purposes.

S. RES. 316

At the request of Mr. MENENDEZ, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. Res. 316, a resolution calling upon the President to ensure that the foreign policy of the United States reflects appropriate understanding and sensitivity concerning issues related to human rights, ethnic cleansing, and genocide documented in the United States record relating to the Armenian Genocide, and for other purposes.

AMENDMENT NO. 2790

At the request of Mr. CASEY, the name of the Senator from Illinois (Mr. BURRIS) was added as a cosponsor of amendment No. 2790 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2845

At the request of Mr. SANDERS, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of amendment No. 2845 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in

the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2846

At the request of Mr. SANDERS, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of amendment No. 2846 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2847

At the request of Mr. SANDERS, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of amendment No. 2847 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2848

At the request of Mr. SANDERS, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of amendment No. 2848 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2849

At the request of Mr. SANDERS, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of amendment No. 2849 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2871

At the request of Mr. BROWN, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of amendment No. 2871 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2883

At the request of Ms. STABENOW, the name of the Senator from North Carolina (Mrs. HAGAN) was added as a cosponsor of amendment No. 2883 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2909

At the request of Mr. NELSON of Florida, the names of the Senator from Oregon (Mr. WYDEN) and the Senator

from New Jersey (Mr. LAUTENBERG) were added as cosponsors of amendment No. 2909 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2978

At the request of Mr. BEGICH, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of amendment No. 2978 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2995

At the request of Mr. SCHUMER, the name of the Senator from Ohio (Mr. BROWN) was added as a cosponsor of amendment No. 2995 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3037

At the request of Mr. JOHNSON, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of amendment No. 3037 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3076

At the request of Mr. DURBIN, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of amendment No. 3076 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3088

At the request of Ms. COLLINS, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of amendment No. 3088 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3112

At the request of Ms. CANTWELL, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of amendment No. 3112 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to mod-

ify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3114

At the request of Mr. GRASSLEY, the names of the Senator from Montana (Mr. BAUCUS) and the Senator from Arkansas (Mrs. LINCOLN) were added as cosponsors of amendment No. 3114 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3117

At the request of Mr. WYDEN, the names of the Senator from Louisiana (Ms. LANDRIEU) and the Senator from Illinois (Mr. BURRIS) were added as cosponsors of amendment No. 3117 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3136

At the request of Mr. UDALL of New Mexico, the names of the Senator from Oregon (Mr. MERKLEY) and the Senator from Virginia (Mr. WARNER) were added as cosponsors of amendment No. 3136 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3170

At the request of Mr. PRYOR, the name of the Senator from Ohio (Mr. BROWN) was added as a cosponsor of amendment No. 3170 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3173

At the request of Mr. MERKLEY, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of amendment No. 3173 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3185

At the request of Mr. BROWN, the names of the Senator from Massachusetts (Mr. KERRY), the Senator from Michigan (Ms. STABENOW), the Senator from Massachusetts (Mr. KIRK) and the Senator from Illinois (Mr. DURBIN) were added as cosponsors of amend-

ment No. 3185 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3203

At the request of Mr. BAYH, the name of the Senator from North Carolina (Mrs. HAGAN) was added as a cosponsor of amendment No. 3203 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3228

At the request of Ms. LANDRIEU, the name of the Senator from Hawaii (Mr. INOUE) was added as a cosponsor of amendment No. 3228 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3240

At the request of Mr. ROCKEFELLER, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of amendment No. 3240 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. WYDEN:

S. 2895. A bill to restore forest landscapes, protect old growth forests, and manage national forests in the eastside forests of the State of Oregon, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. WYDEN. Mr. President, I rise today to introduce critical forest legislation for my home State of Oregon.

For too many decades, Oregon has been at war with itself over the fate of one of our most abundant—and most threatened—resources, our forests.

Nowhere has the negative impact of this battle been greater than in Oregon's eastside forests.

Over-logging and disastrous fire suppression policies of the past gave way over time to excessive litigation and gridlock.

With each passing month, our inability to take action, our inability to address the needs of Oregon's declining forests means that they are growing more at risk of preventable fire and disease.

With each passing month and each attempted timber sale and threatened lawsuit, the relationship between the

environmental community and the timber industry has grown increasingly bitter.

Each side in these disputes has thoroughly armed itself politically enough to survive, but never enough to succeed.

The end result is that today, across Oregon's Federal forest landscape, we have around 9.5 million acres of choked, at-risk forest in desperate need of management, and millions of acres of old growth, species habitat, and watersheds face an uncertain future.

Unless something fundamental changes, that number and that peril will grow, not shrink, in coming years.

Today, good and decent people on both sides of these difficult issues have come together with me to craft legislation that will bring peace, jobs, and a healthier tomorrow to 8.3 million acres of Federal forest in eastern and central Oregon.

Today, for the first time in memory, timber executives are standing shoulder-to-shoulder with leaders of the Oregon environmental community to take shared responsibility for saving our endangered forests.

These folks have been a part of negotiations with my office for over 8 months, and have made difficult concessions in order to save our threatened Eastside forests.

Today in eastern Oregon we are down to only a small handful of surviving mills. Without far greater certainty of supply and an immediate increase in merchantable timber, more mills will close.

If that happens our Eastside forests will pay the price.

Without mills to process saw logs and other merchantable material from forest restoration projects, there will be no restoration of our Eastside forests.

The folks my office worked with to come to an agreement set aside their differences and found common ground that will prevent that from happening.

The legislation that we are rolling out today, the Oregon Eastside Forests Restoration, Old Growth Protection and Jobs Act of 2009, will provide an immediate supply of logs in the short term to jump-start restoration efforts and keep our timber mills alive.

Job One must be saving our remaining forest management infrastructure in central and eastern Oregon while preserving our old growth and watersheds.

Over the long term—in 3 years from its passage to be precise—this legislation will also provide the long-term certainty required to restore each of the six Eastside national forests, protect our most sensitive environmental assets, and restore countless jobs to rural communities.

I want to make clear that the road ahead is likely to see some challenges. Our coalition will be tested. But I have great faith that the decent people who

helped to put this bill together will honor the components of this agreement and will fight to preserve its many elements as we move through the process.

I also want to point out that none of our efforts will succeed unless Oregon Federal forests are also adequately funded to properly manage and restore these valuable Federal assets.

Together, we have entered a partnership that goes beyond the four corners of this legislation. Together, as a team, we will fight for the funding to put our people back to work and restore the health of our forests.

Together, we have demonstrated something that I think my colleagues here in the Senate will appreciate: working together on a difficult issue is not only possible, it yields far greater results than working apart.

Later today, and tomorrow, I will be sitting down with key members of the Obama administration and the timber industry so that the administration can better understand the peril and opportunity in Oregon's Eastside forests. This is a united front that has not been witnessed by a White House since the onset of the timber wars.

It is my hope we will learn to work together, we will develop real trust, and that we will use these new experiences to tackle the difficult issues that await us on the west side of the Cascades.

I also want to single out a few individuals who have endured thousands, of hours of difficult work and negotiations to reach this point: John Shelk, president of Ochoco Lumber; Andy Kerr; the American Forest Resource Council, represented by Heath Heikkila and Tom Partin, who spearheaded negotiations.

I also want to recognize others that joined me earlier today to rollout this legislation Tim Lillebo with Oregon Wild; Tom Insko with Boise Cascade; Mary Scurlock, with Pacific Rivers Council; Randi Spivak, with the National Center for Conservation Science and Policy; Ben Bendick with the Nature Conservancy; and Bob Irvin with Defenders of Wildlife.

I also want to recognize back in the State, their colleagues that could not join me earlier today; Rick Brown with Defenders of Wildlife, Joseph Vaile of Klamath Siskiyou Wildlands Center, Steve Pedry with Oregon Wild, and Michael Powelson with the Nature Conservancy, as well as the other members and mill owners of AFRC.

I want to thank my staff, Michele Miranda, Mary Gautreaux, and Josh Kardon, who gave their nights and weekends to get us to this point.

I am proud to introduce this legislation today, and I am going to keep working with all the folks in my State who are willing to talk in good faith about restoring our eastside forests.

By Mrs. FEINSTEIN (for herself and Mr. MERKLEY):

S. 2899. A bill to amend the American Recovery and Reinvestment Act of 2009 and the Internal Revenue Code of 1986 to provide incentives for the development of solar energy; to the Committee on Finance.

Mrs. FEINSTEIN. Mr. President, I rise to introduce the Renewable Energy Incentive Act of 2009, which is cosponsored by Senator JEFF MERKLEY.

This act would extend, expand, and improve existing tax incentives and grant programs for renewable energy, especially for solar energy.

Provisions of this act are widely supported by public power utilities, environmental groups, renewable energy companies, renewable energy industry associations, and labor unions.

These include, for example: the American Public Power Association; the Solar Energy Industries Association; the Los Angeles Department of Water and Power; the Northern California Power Agency; the Southern California Public Power Agency; the Large Public Power Council, LPPC; solar companies including Brightsource, Solyndra, Tesseract Solar, and Stirling Energy Systems and many others.

First, the bill would allow renewable energy companies to claim grants from the Treasury department, in lieu of renewable energy tax credits, through 2012 instead of 2010.

Second, it would permit public power utilities to claim these same Treasury Grants.

Third, it expands the solar investment tax credit to include manufacturing equipment and solar water heaters for commercial and community pools.

Finally, it establishes a new tax credit for solar companies who consolidate and develop disturbed private land instead of developing our more pristine public lands.

The most significant provision in this bill would extend the Treasury Grants Program established in the stimulus by two years, allowing renewable energy developers to continue claiming these grants.

Section 1603 of the American Recovery and Reinvestment Act established "payments in lieu of tax credits for specified energy property" in order to support renewable energy development.

The program allows renewable energy developers to take grants, or payments, from the Treasury department instead of claiming tax credits in order to help build projects that require a great deal of capital upfront.

The provision has reduced the impact of the financial crisis on renewable energy development.

Before the grants program was established, most renewable energy developers had to partner with profitable banks, or "tax equity partners," in order to take advantage of renewable energy tax incentives.

These big financial institutions would apply tax credits against their large profits, taking a cut for themselves along the way.

But in 2008, when financial sector profits sank, the \$8 billion "tax equity" market largely evaporated.

Renewable energy development ground to a halt because developers could not find tax equity partners.

Major players in the space, such as AIG and Lehman Brothers, disappeared. The banks that still had profits began demanding a much higher cut.

That's when Congress stepped in.

The stimulus created the Treasury Grants, which allow developers to claim their tax benefits directly, instead of partnering with profitable banks.

The U.S. wind industry installed 1,649 megawatts of new capacity in the third quarter of this year alone, a boost from the previous two quarters and in excess of 2008 levels. Experts credit the Treasury grants program.

Solar is also getting back on track. For instance, SunEdison used a Treasury grant in lieu of tax credits to accelerate construction of an 18 megawatt photovoltaic array—one of the largest in the U.S.

The firm's CEO told the press: "That could not have been done without this program."

The Treasury program is also allowing renewable energy developers to attract significantly more debt backing for projects than would otherwise be possible, according to recent statements by the managing director of energy investments at J.P. Morgan Capital.

But the grants program is set to expire in 2010, far before most utility scale solar projects will begin construction or financial analysts predict tax equity markets will recover.

If the grant program is not extended, bank profits will again become the limiting factor on renewable energy development in the U.S., and that makes no sense.

That is why I propose to extend the program two years.

This legislation would also level the playing field between public power and for-profit companies by allowing public power utilities to receive Treasury Grants for renewable energy projects.

Public power utilities serve 45 million American consumers, but they are currently prohibited from receiving grants for their renewable energy development.

The basis for this prohibition is that public power utilities are tax exempt, non-profit corporations owned by local governments, who therefore have not been able to claim tax credits directly on their income tax returns.

But excluding public power from the grants program does not make sense.

Congress created the Treasury grants program specifically to assist firms

that lacked the ability to claim the full benefits of renewable energy tax incentives.

If we are going to allow for-profit companies to claim these direct grants, why would we exclude our non-profit public power utilities?

So leveling the playing field for public power is fair.

This provision is also necessary to protect our local community utility companies who want to deploy renewable energy.

The federal grants make building renewable energy projects cost effective for rate payers.

Because public power utilities lack access to these grants, they are now frequently establishing complex financial arrangements with private developers in order to build renewable energy projects that qualify for federal help.

This is in direct conflict with public power's historic, proven business model as a vertically integrated, non-profit.

It requires our cities and towns to negotiate unnecessarily complex deals with Wall Street.

Let me give you an example.

Turlock Irrigation District, TID, a public power utility in my state, decided to build a 137 megawatt wind farm in 2007.

They wanted to build and own.

But to make it cost effective, Turlock signed a contract to buy the power, but a tax equity partner would "own" the project and receive the benefit of the federal production tax credit.

The contract was extremely complex and costly, requiring the participation of an investment bank to find a tax equity partner, an equity group to be the tax equity partner, legal counsel for the equity group, experts to provide risk advice and engineering advice to the equity group; bond counsel to provide renewable asset specialists; an operator to run the plant for the equity group; and an asset manager, to advise the equity group on the performance of the operator.

After 2 years and millions of dollars spent trying to finalize this deal, Turlock learned that the supposedly profitable equity partner, American International Group, AIG, wasn't profitable at all.

AIG backed out and the entire deal collapsed.

After much analysis, Turlock Irrigation District decided to own and operate the wind farm, giving up on receiving any Federal support.

Larry Weis, the General Manager, explained in a letter to me:

The bottom line is that TID made a business decision to forego working with a private developer to develop a project, because the complexity of the deal and the dollars spent to arrange it meant that much of the value of the tax credit would go to the equity partners and not pass through to our consumers. Given the facts and the absence

of a comparable incentive for consumer-owned utilities, TID made the best choice it could under the circumstances, even though it means our customers will pay more.

This legislation is necessary to prevent other public power utilities from being forced to make this difficult, unnecessary choice.

Public power utilities deserve access to renewable energy incentives comparable to those awarded to the private sector, and this legislation will assure that happens.

This legislation also expands the solar investment tax credit to include manufacturing equipment and solar water heaters for commercial and community pools.

The bill would allow equipment that makes solar panels to qualify for the 30 percent solar investment tax credit.

Solar panel manufacturing is moving offshore, to Germany and Asia, where support is considerable.

This financial incentive could jumpstart solar manufacturing in this country, and could lead to thousands of new jobs, such as those being created at Solyndra's new factory in Fremont, CA. Or those proposed by Applied Materials at their proposed facility near Los Angeles.

The bill would allow commercial pool solar hot water heaters to qualify for the solar tax credit.

Approximately 189,000 commercial pools nationwide—at hotels/motels, health clubs, and schools—use fossil fuel or electricity to heat an estimated 27 billion gallons of water.

If the heating systems were replaced with solar hot water systems, there would be 1.23 million metric tonnes of carbon dioxide emissions avoided annually.

That is the equivalent of taking 237,000 cars off the road.

In California, which has 26 percent of all commercial pools in the U.S., this provision could significantly reduce pollution.

Finally, the legislation would establish a new tax credit for the purchase, consolidation, and use of multiple, 100 acre or less blocks of high solarity, disturbed private lands for solar development.

Solar developers have focused development proposals on pristine public land because it is very difficult, costly, and time intensive to consolidate large blocks of disturbed private land from many different owners.

This tax credit will financially reward those firms that are willing to go through the trouble of land consolidation, thereby making the increased burden of private lands development more appealing.

Over the last few years, the renewable energy industry has grown dramatically.

Last year the U.S. added more new capacity to produce renewable electricity than it did to produce electricity from natural gas.

A great deal of this growth can be attributed to our renewable energy tax policies.

This legislation, I believe, would continue this growth into the future.

By Ms. COLLINS (for herself, Mrs. MCCASKILL, and Mr. BENNETT):

S. 2901. A bill to improve the acquisition workforce through the establishment of an acquisition workforce fellows program, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

Ms. COLLINS. Mr. President, along with Senators MCCASKILL and BENNETT, I rise to introduce two bills that would lay a strong foundation to improve the Federal acquisition system.

The first bill, the Acquisition Workforce Improvement Act of 2009, would create a federal acquisition management fellows program to develop a new generation of acquisition leaders with government-wide perspective, skills, and experience.

The second bill, the Federal Acquisition Institute Improvement Act of 2009, would institute much-needed organizational clarity to enable the Federal Acquisition Institute, FAI, to fulfill its mission of facilitating career development and strategic human capital management for the federal acquisition workforce.

The federal acquisition system is under tremendous stress. Between fiscal years 2000 and 2008, acquisition spending by the Federal Government expanded by 163 percent, from \$205 billion to \$539 billion. The rising costs of military operations, natural disasters, homeland security precautions, and other vital programs will drive those expenditures to even higher levels in the years ahead.

This prodigious level of purchasing creates abundant opportunities for fraud, waste, and abuse. We have seen far too many outrageous failures in government contracting, such as unusable trailers for hurricane victims, shoddy construction of schools and clinics in Afghanistan, or the installation of showers in Iraq for our troops that pose electric-shock hazards. These and other failures demand strong steps to protect taxpayer dollars and deliver better acquisition outcomes.

As a long-time advocate for stronger competition, accountability, and transparency in government contracting, I recognize and appreciate the steps the administration has taken recently to improve Federal contracting. Many of these initiatives originated from legislation I co-authored with Senator LIEBERMAN during the last Congress.

But no matter how many laws we pass or OMB guidance documents are issued, the effectiveness of our Federal acquisition system depends on a vital human component—the acquisition workforce.

While contract spending has risen dramatically, the number of acquisition professionals who help plan, award, and oversee these contracts has been stagnant. With roughly half of the current acquisition workforce eligible to retire over the next decade, the difficulties of strengthening that workforce will become increasingly acute. A well-trained and well-resourced acquisition workforce is critical to keeping pace with increased Federal spending and much more complex procurements of services and goods.

The two pieces of legislation I am introducing today would help to address these important long-term problems that we must solve to make our acquisition system healthy again.

First, the Acquisition Workforce Improvement Act of 2009 would create a centrally-managed Government-wide Acquisition Management Fellows Program that combines both a Master's degree-level academic curriculum and on-the-job training in multiple federal agencies. By partnering with leading universities that have specialized government acquisition programs, the government can attract top-caliber students who are interested in pursuing both academic advancement and public service.

Compared to the several existing agency-specific intern programs, this government-wide program would provide a unique and much-needed skill set that we currently do not have in sufficient number, that is, acquisition professionals with multi-agency and multi-disciplinary training who can understand and manage government-wide acquisition needs and perspectives.

Considering that interagency acquisition now accounts for approximately 40 percent of the entire contract spending and that GAO has designated the management of interagency contracting a high-risk area since 2005, it is without question that we need to develop future acquisition leaders who can understand government-wide needs and perspectives.

Specifically, the program would include the following: one academic year of full-time, on-campus training followed by 2 years of on-the-job and part-time training toward a Masters or equivalent graduate degree in related fields; and a curriculum that would include rotational assignments at three or more executive agencies covering, among other issues, acquisition planning, cost-estimating, formation and post-award administration of “high risk” contract types, and interagency contracts.

Upon graduation, participants will have completed all required non-agency-specific training courses necessary for a basic contracting officer warrant.

In addition, participants would be required to enter into a service commitment appropriate in length to ensure

the Federal Government receives a proper return on its investment. The service commitment would be no less than one year for each year in the program, and would require reimbursement of funds for those who do not successfully complete the program or do not fulfill the minimum service requirements.

It is also important to note that this program would be less expensive than its current alternative. Typically, existing agency career intern programs like those run by DHS or GSA hire interns at GS-5, -7, or -9 level, which pays between \$33,000 and \$66,000, for Washington, DC area. These interns also receive benefits and free training during this internship period.

The proposed program would not pay salaries during the training, but unlike the other programs, would award a graduate degree. Based on market research, this alternative money-saving arrangement would be able to attract top-notch candidates with both public and academic interests.

Second, the Federal Acquisition Institute Improvement Act of 2009 would strengthen the Federal Acquisition Institute, FAI, whose key responsibilities are to promote career development and strategic human capital management for the entire civilian acquisition workforce.

In part due to the lack of organizational clarity and the disproportionate funding compared to its counterpart in the Department of Defense, the FAI has remained largely underutilized.

The proposed legislation would establish a clear line of responsibility and accountability for the Institute by requiring that the Federal Acquisition Institute, through its Board of Directors, directly reports to the Office of Federal Procurement Policy; the director of FAI be appointed by the OFPP Administrator and report directly to the Associate Administrator for Acquisition Workforce at OFPP.

All existing civilian agency training programs fall under the purview of FAI. This would ensure consistent training standards necessary to develop uniform core competencies; and the OFPP Administrator would be required to report annually to Congressional committees of jurisdiction projected budget needs and expense plans of FAI to fulfill its statutory mandate.

With respect to its core government-wide functions, FAI would be required to provide and keep current government-wide training standards and certification requirements including—ensuring effective agency implementation of government-wide training and certification standards; analyzing the curriculum to ascertain if all certification competencies are covered or if adjustments are necessary; developing career path information for certified professionals to encourage retention in

government positions; and coordinating with the Office of Personnel Management for human capital efforts.

The administration has identified acquisition workforce development as a pillar for improving acquisition practices and contract performance. While I fully agree with this goal, we need specific and concrete action to solve this problem. It is also important to remember that it took the better part of two decades for the acquisition workforce to reach its current state and that it will likely take a similar amount of time to rebuild.

My legislation would prompt the sustained effort necessary to rebuild the acquisition workforce. While this will take time and investment, I am confident this is a wise investment that will yield substantial returns. Just think about it, if our better-trained acquisition professionals can prevent one failed procurement, it can save the taxpayer hundreds of millions of dollars. If they can avoid overpaying one percent of our contract spending, it will save the taxpayer more than 5 billion each year. The numbers speak for themselves.

The Acquisition Workforce Improvement Act and the Federal Acquisition Institute Improvement Act are critically needed and both enjoy bipartisan support. I encourage my colleagues to support them.

By Mr. FRANKEN (for himself, Ms. SNOWE, Mr. KERRY, Mr. LAUTENBERG, Mr. FEINGOLD, Mr. MENENDEZ, Mr. DURBIN, Mrs. GILLIBRAND, Mrs. FEINSTEIN, Mrs. BOXER, Mrs. McCASKILL, Mr. HARKIN, and Mr. SCHUMER);

S. 2904. A bill to amend title 10, United States Code, to require emergency contraception to be available at all military health care treatment facilities; to the Committee on Armed Services.

Mr. FRANKEN. Mr. President, the Compassionate Care for Servicewomen Act, which I am introducing today with my friend and colleague, Senator SNOWE, is a straightforward but vital piece of legislation. It would ensure that servicewomen in our military have reliable and timely access to emergency contraception when they need it.

Emergency contraception, or Plan B as it is more commonly known under its brand name, is Food and Drug Administration-approved medication that prevents pregnancy. It is safe and, if taken shortly after pregnancy, highly effective. Since 2006, the FDA has approved it for over-the-counter sale. Currently, women 17 years old and older may purchase emergency contraception over the counter, while those younger require a prescription.

Emergency contraception is widely available at pharmacies throughout the U.S.

The problem this legislation is meant to address is that there's no guarantee that emergency contraception be available to our servicewomen in the military. The military health care system includes what is called a basic core formulary, which lists the medications that must be stocked at all Department of Defense medical facilities, including those overseas. Emergency contraception is not currently on the basic core formulary.

Consequently, emergency contraception is not systematically and reliably available at all medical military facilities. It is allowed to be stocked at such facilities, so it is available in some places. In that regard, the bill that Senator SNOWE and I are introducing today is not a dramatic departure from existing practice.

But there is no guarantee that a servicewoman will have access to it. Immediate accessibility is especially important in the case of emergency contraception because it is only effective if taken within a short window of time. Once a pregnancy is established, it doesn't work.

There is no good reason why servicewomen shouldn't have the same access to emergency contraception that civilians here in the U.S. have.

That is just what this legislation would do. It would guarantee that all military health care treatment facilities stock emergency contraception by placing that medication on the basic core formulary.

All servicewomen should be able to have access to emergency contraception in order to prevent unwanted pregnancy. The fact that more than 2,900 sexual assaults were reported last year in the military only heightens the need to ensure emergency contraception is always available.

This is legislation that has been endorsed by a wide range of organizations both in Minnesota and nationally.

I hope that my colleagues will join me in supporting this commonsense legislation. I thank Senator SNOWE for joining me in introducing this bill, and I thank all my colleagues who have signed on as cosponsors.

Mr. President, I ask unanimous consent that the text of the bill and a list of supporters be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 2904

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Compassionate Care for Servicewomen Act".

SEC. 2. REQUIREMENT TO MAKE AVAILABLE EMERGENCY CONTRACEPTION AT ALL MILITARY HEALTH CARE TREATMENT FACILITIES.

Section 1074g(a) of title 10, United States Code, is amended by adding at the end the following new paragraph:

"(9)(A) Emergency contraception in drug form shall be included on the basic core formulary of the uniform formulary, notwithstanding any provision of law or regulation requiring that only drugs ordered or prescribed by a physician (or other authorized provider) may be included in the uniform formulary. Emergency contraception in other than drug form may also be included on the basic core formulary, notwithstanding any such provision.

"(B) Nothing in subparagraph (A) may be construed to require emergency contraception to be covered under the pharmacy benefits program.

"(C) Notwithstanding paragraph (4), prior authorization shall not be required for emergency contraception. Nothing in the preceding sentence may be construed as waiving any provision of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or any other provision of law administered by the Food and Drug Administration, including rules and orders of such Administration in effect at any time under such Act or other provisions of law.

"(D) In this paragraph, the term 'emergency contraception' means a drug, drug regimen, or device that is—

"(i) approved by the Food and Drug Administration to prevent pregnancy; and

"(ii) used postcoitally."

MINNESOTA AND NATIONAL ORGANIZATIONS THAT HAVE ENDORSED THE COMPASSIONATE CARE FOR SERVICEWOMEN ACT

MINNESOTA

NARAL Pro-Choice Minnesota
Minnesota Nurses Association
Minnesota Medical Association
Planned Parenthood Minnesota, North Dakota, South Dakota
Minnesota Indian Women's Sexual Assault Coalition
Minnesota Coalition Against Sexual Assault
Sexual Violence Center
Minnesota National Organization for Women
Pro Choice Resources
Midwest Health Center for Women
Religious Coalition for Reproductive Rights

NATIONAL

NARAL Pro-Choice America
SWAN: Servicewomen's Action Network
National Council of Women's Organizations (NCWO)
National Partnership for Women and Families
Women's Research & Education Institute (WREI)
American Association of University Women
National Coalition against Domestic Violence
American Civil Liberties Union
American College of Obstetricians and Gynecologists
American Association of University Women
American Society for Reproductive Medicine
Center for Reproductive Rights
National Council of Jewish Women
National Family Planning & Reproductive Health Association (NFPFRA)
National Organization for Women
National Partnership for Women & Families
Planned Parenthood Federation of America
Population Connection

Religious Coalition for Reproductive Choice
 Reproductive Health Technologies Project
 Speaking Out Against Rape (SOAR)
 National Women's Law Center
 National Research Center for Women and Families

By Mr. INOUE:

S. 2905. A bill to amend the Internal Revenue Code of 1986 to repeal the reduction in the deductible portion of expenses for business meals and entertainment; to the Committee on Finance.

Mr. INOUE. Mr. President, today I rise to introduce legislation to repeal the current 50 percent tax deduction for business meals and entertainment expenses, and to restore the tax deduction to 80 percent for all taxpayers. In 1986, the Congress reduced the allowable tax deduction for business meals and entertainment from 100 percent to 80 percent. In 1993, the Congress again reduced the deduction to 50 percent. Restoration of this deduction is essential to the livelihood of small and independent businesses as well as the food service, travel, tourism, and entertainment industries throughout the United States. These industries are being eco-

nomically harmed as a result of the 50 percent tax deduction.

At a time when the nation is getting back on a stronger economic footing, the legislation is particularly critical especially for the small businesses and self-employed individuals that depend so heavily on the business meal to conduct business. Small companies often use restaurants as "conference space" to conduct meetings or close deals. Meals are their best, and sometimes only, marketing tool. Certainly, an increase in the meal and entertainment deduction would have a significant impact on a small businesses bottom line. In addition, the effects on the overall economy would be significant.

Accompanying my statement is the National Restaurant Association's, NRA, State-by-State chart reflecting the estimated economic impact of increasing the business meal deductibility from 50 percent to 80 percent. The NRA estimates that an increase to 80 percent would increase business meal sales by \$6 billion and create an \$18 billion increase to the overall economy.

I urge my colleagues to join me in cosponsoring this important legislation.

Mr. President, I ask unanimous consent that the text of the bill and a State-by-State chart be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 2905

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. REPEAL OF REDUCTION IN BUSINESS MEALS AND ENTERTAINMENT TAX DEDUCTION.

(a) IN GENERAL.—Section 274(n)(1) of the Internal Revenue Code of 1986 (relating to only 50 percent of meal and entertainment expenses allowed as deduction) is amended by striking "50 percent" and inserting "80 percent".

(b) CONFORMING AMENDMENT.—Section 274(n) of the Internal Revenue Code of 1986 is amended by striking paragraph (3).

(c) CLERICAL AMENDMENT.—The heading for section 274(n) of the Internal Revenue Code of 1986 is amended by striking "ONLY 50 PERCENT" and inserting "PORTION".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2009.

ESTIMATED IMPACT OF INCREASING BUSINESS MEAL DEDUCTIBILITY FROM 50% TO 80%

State	Increase in Business Meal Spending 50% to 80% Deductibility (in millions)	Total Economic Impact in the State (in millions)	Total Employment Impact in the State (number of jobs created)
Alabama	\$77	\$155	\$2,464
Alaska	17	29	401
Arizona	118	235	3,125
Arkansas	43	87	1,451
California	767	1,797	20,868
Colorado	114	264	3,328
Connecticut	71	133	1,624
Delaware	19	35	402
District of Columbia	31	43	254
Florida	368	745	9,746
Georgia	193	446	5,642
Hawaii	44	86	1,154
Idaho	24	47	799
Illinois	256	610	7,207
Indiana	117	241	3,712
Iowa	47	95	1,544
Kansas	46	92	1,314
Kentucky	78	158	2,266
Louisiana	81	158	2,374
Maine	24	46	709
Maryland	113	235	2,750
Massachusetts	161	324	3,884
Michigan	171	341	5,272
Minnesota	105	240	3,270
Mississippi	41	78	1,340
Missouri	115	256	3,512
Montana	20	39	682
Nebraska	31	64	1,048
Nevada	71	127	1,703
New Hampshire	29	53	653
New Jersey	170	367	4,139
New Mexico	37	66	1,079
New York	379	751	8,855
North Carolina	176	371	5,435
North Dakota	11	20	333
Ohio	217	466	6,978
Oklahoma	60	127	2,016
Oregon	82	169	2,274
Pennsylvania	212	478	6,311
Rhode Island	24	45	598
South Carolina	87	179	2,689
South Dakota	14	27	458
Tennessee	121	272	3,531
Texas	477	1,164	14,109
Utah	41	92	1,375
Vermont	11	19	288
Virginia	157	331	4,155
Washington	129	279	3,419
West Virginia	28	47	830
Wisconsin	100	210	3,399
Wyoming	10	16	293

Source: National Restaurant Association estimates, 2009.

By Mr. FEINGOLD (for himself, Mr. MCCAIN, and Mr. LIEBERMAN):

S.J. Res. 23. A joint resolution disapproving the rule submitted by the Federal Election Commission with respect to travel on private aircraft by Federal candidates; to the Committee on Rules and Administration.

Mr. FEINGOLD. Mr. President, the very first bill debated on the floor of the Senate after the 2006 elections was S. 1, the Honest Leadership and Open Government Act of 2007, HLOGA. About 9 months later, President Bush signed that bill into law as Public Law Number 110-81. It was the most sweeping ethics reform legislation since Watergate, and it passed both houses of Congress by a wide margin—the final votes were 411-8 in the House and 83-14 in the Senate.

The new law contained, among many other provisions, significant reforms to the lobbying disclosure laws, a tough new prohibition on gifts from lobbyists, improvements to the revolving door rules, and new restrictions on privately funded fact-finding trips. It also contained new rules on personal, official, and campaign travel on non-commercial aircraft, often known as “corporate jets.” Prior to HLOGA, members who flew on corporate jets, often accompanied by corporate lobbyists, were required to reimburse the owner of the aircraft only the amount that they would have paid to fly first class between the origin and destination of the flight. HLOGA provided that Senators and presidential candidates would have to reimburse such travel at the charter rate. House members were prohibited from flying on non-commercial aircraft altogether.

Because Senators travel in different capacities, HLOGA addressed the issue in separate sections. Section 544(c) of the bill amended the Senate Rules XXXV and XXXVIII to address official and personal travel by Senators. The House had already amended its rules at the very beginning of the year. Section 601 dealt with campaign travel for both House and Senate candidates by amending the Federal Election Campaign Act, “FECA”.

Both the House and the Senate have been living under these new rules for over two years. No House member has flown on a corporate jet, as far as we know. Senators, whether they were traveling in personal, official, or campaign capacity, and regardless of who was paying for the trip, have flown on them only if they were prepared to pay the charter rate for these trips. Presidential candidates in the last campaign abided by the new rules as well.

Because HLOGA made amendments to the FECA on this issue, the FEC started a rulemaking shortly after its enactment to implement the new provision. But at the end of 2007, just as the agency was poised to put new regu-

lations in place, the terms of several recess-appointed Commissioners expired. A stalemate ensued that left the agency without a quorum to do business until the summer of 2008. Once a full slate of Commissioners was in place, the agency deadlocked on issuing final regulations. The three new Republican commissioners refused to sign off on the rules that the Commission had been prepared to adopt in December 2007. The deadlock was resolved only a few weeks ago, when a Democratic Commissioner reluctantly agreed to go along with modifications that the Republicans proposed. See Statement of Chairman Steven T. Walther, Campaign Travel Regulations, Nov. 19, 2009. The new rule was published in the Federal Register on December 7, 2009. Federal Election Commission, Notice 2009-27, Campaign Travel, 74 Fed. Reg. 63951, Dec. 7, 2009.

I will put this as simply as I can. The new FEC rule relating to travel on non-commercial aircraft is an outrage. Rather than respecting the intent of Congress in HLOGA to address all travel on corporate jets by members of Congress and presidential candidates, the FEC has carved a loophole in the statute for travel by candidates on behalf of someone other than their own campaigns. No one in the House or the Senate contemplated this exception when the bill was passed. No one discussed it. No one considered it. The FEC just made it up. Now we in Congress have no choice but to take action to correct it if the FEC refuses to do so.

We cannot let a lawless agency undermine our effort to police ourselves, to end a practice that exposed Congress to public criticism and even ridicule. Some Senators and House members may have agreed to kick the corporate jet habit reluctantly, but they have learned to live with it. There is no need for the loophole the FEC has opened. It is contrary to the statutory language and to the legislative history. It must be closed.

So today, I will introduce, along with my colleagues from Arizona, Connecticut, and New York, Senators MCCAIN, LIEBERMAN, and SCHUMER, all of whom played a key role in the enactment of HLOGA, a resolution of disapproval under the Congressional Review Act. This resolution, if passed by the House and signed by the President, will send the FEC back to the drawing board. After a rebuke of this kind, one can only hope that the Commission will craft a regulation that does not so completely ignore the letter and spirit of the provision we passed in HLOGA.

Let me take a minute to explain what the FEC has done and what it must do to correct its error. The new regulation takes the position that the key fact in determining what rate must be paid for a corporate jet flight is not who is flying, but who is paying

for the flight. The explanation and justification, “E&J”, adopted by the commission states:

[W]hen a presidential, vice-presidential, or Senate candidate, or a representative of the candidate, is traveling on behalf of another political committee (such as a political party committee or Senate leadership PAC, rather than on behalf of the candidate's own authorized committee, the reimbursement for that travel is the responsibility of the political committee on whose behalf the travel occurs. If the political committee is other than an authorized committee or House candidate's leadership PAC, then the appropriate reimbursement rate for that political committee is set forth in new 11 CFR 100.93(c)(3), discussed below. In such cases, the presidential, vice-presidential, or Senate candidate or candidate's representative, is treated the same as any other person traveling on behalf of the political committee.

74 Fed. Reg. at 63955. That rate for such a trip, under an FEC regulation promulgated in 2003, is the first class rate unless regularly scheduled commercial air service is not available between the origin and the destination of the flight. The E&J also reiterates that leadership PACs of Senators and Presidential candidates can continue to pay the first class rate, even for the candidates themselves.

In addition, although House leadership PACs are prohibited from taking advantage of this loophole, the E&J makes clear that House candidates can do so if they are traveling on behalf of a political party committee or a Senate or presidential candidate, even though they are otherwise completely prohibited from traveling on a corporate jet. The loophole seems to apply to House members even if they are traveling on behalf of a corporate PAC.

In a recent article in the Capitol Hill newspaper Roll Call, FEC Commissioner Matthew Peterson attempted to explain the FEC's decision. He argues that the loophole is compelled by the statutory language, which is structured to prohibit an expenditure for any flight by a Senate candidate or the candidate's authorized committee unless the charter rate is paid for that flight. This interpretation ignores specific language in section 601 that requires payment of the charter rate by “the candidate, the authorized committee, or other political committee” and the lack of any language in the statute or the legislative history suggesting that Congress meant to leave open a way for Senators to travel on corporate jets without paying the charter rate.

Moreover, it ignores the clear intent of the two provisions of HLOGA concerning travel on private aircraft—to prohibit all corporate jet flights by Senators unless the charter rate is paid. There are literally more than a dozen statements by supporters of the bill that make this intent clear. The FEC chose to ignore the clear purpose of the bill in favor of a strained interpretation of the statutory language

that flies in the face of that purpose. That is unacceptable. The FEC's duty is to implement the statute as Congress intended it. Its job is to give guidance to candidates and others who want to follow the law, not to provide a roadmap for evading it.

For the convenience of my colleagues, my staff has collected statements from the floor debate on HLOGA that show beyond any doubt that the corporate jet provisions were intended to apply to all travel on corporate jets by Senators without regard to who is reimbursing the jet owner. One Senator said the following:

I understand that for many Members, these jets are an issue of convenience. They allow us to get home to our constituents, to our families, and to the events that are often necessary for our jobs. But in November, the American people told us very clearly they are tired of the influence special interest wields over the legislative process. The vast majority of Americans can't afford to buy cheap rides on corporate jets. They don't get to sit with us on 3-hour flights and talk about the heating bills they can't pay, or the health care costs that keep rising, or the taxes they can't afford, or their concerns about college tuition. They can't buy our attention, and they shouldn't have to. And the corporation lobbyists shouldn't be able to either. That is why we need to end this corporate jet perk if we are to pass real, meaningful ethics reform.

Cong. Rec. at S263, Jan. 9, 2007. The speaker of those words, which make plain that the intent of the provision was to completely eliminate subsidized travel on corporate jets, was then-Senator Barack Obama. This strongly suggests that the President of the United States will sign the resolution of disapproval once we pass it.

Notwithstanding my strong feelings about the part of the FEC rule I have just discussed, significant portions of the rule are unexceptional. The intent of this resolution of disapproval under the Congressional Review Act is solely to reverse the FEC's decision to open a loophole in the requirements for corporate jet travel by members of Congress and their staffs. So we do not intend to disable the FEC from putting out a new regulation, only from including a gaping loophole in it.

I note this because the Congressional Review Act only allows Congress to disapprove, and therefore make ineffective, an entire regulation. It states that the agency may not promulgate a rule that is "substantially the same" as the old one without new congressional authorization. I want to be clear that the loophole created by the FEC's recent rule is so significant that a rule that is otherwise identical to the entire campaign travel regulation, but that does not contain the loophole that this resolution is designed to disapprove, should not be considered to be "substantially the same" as the previous rule, even though other portions of that rule may be re-promulgated unchanged.

The Congressional Review Act has only once been successfully used to overturn an agency regulation. Thus, there is little experience to fall back on to determine the consequences for future agency action of a successful disapproval resolution. Morton Rosenberg, a long time analyst at the Congressional Research Service, includes the following useful analysis in his 2008 assessment of the CRA:

A review of the CRA's statutory scheme and structure, the contemporaneous congressional explanation of the legislative intent with respect to the provisions in question, the lessons learned from the experience of the March 2001 disapproval of the OSHA ergonomics rule, and the application of pertinent case law and statutory construction principles suggests that (1) It is doubtful that Congress intended that all disapproved rules would require statutory reauthorization before further agency action could take place. For example, it appears that Congress anticipated further rulemaking, without new authorization, where the statute in question established a deadline for promulgating implementing rules in a particular area. In such instances, the CRA extends the deadline for promulgation for one year from the date of disapproval. (2) A close reading of the statute, together with its contemporaneous congressional explication, arguably provides workable standards for agencies to reform disapproved regulations that are likely to be taken into account by reviewing courts. Those standards would require a reviewing court to assess both the nature of the rule-making authority vested in the agency that promulgated the disapproved rule and the specificity with which the Congress identified the objectionable portions of a rule during the floor debates on disapproval. An important factor in a judicial assessment may be the CRA's recognition of the continued efficacy of statutory deadlines for promulgating specified rules by extending such deadlines for one year after disapproval.

Congressional Research Service, Congressional Review of Agency Rule-making: An Update and Assessment of The Congressional Review Act after a Decade, RL30116, May 8, 2008, at 30. Rosenberg notes that the fact that Congress specifically provided in the CRA for a one year extension of any statutory deadline for a rule that has been overturned by the CRA shows that Congress did not intend to disable an agency from issuing regulations on the same topic. Indeed, a Joint Explanatory Statement by the principal sponsors of the CRA in the House and Senate states the following:

The authors intend the debate on any resolution of disapproval to focus on the law that authorized the rule and make the congressional intent clear regarding the agency's options or lack thereof after enactment of a joint resolution of disapproval. It will be the agency's responsibility in the first instance when promulgating the rule to determine the range of discretion afforded under the original law and whether the law authorizes the agency to issue a substantially different rule. Then, the agency must give effect to the resolution of disapproval.

Joint Explanatory Statement of House and Senate Sponsors, 142 Cong. Rec. E 571, at E 577, daily ed. April 19,

1996; 142 Cong. Rec. S 3683, at S 3686 daily ed. April 18, 1996. It is the intent of this resolution of disapproval to invalidate the loophole that the FEC created in the E&J, but not to disable the FEC from issuing a new rule that properly implements Congress's intent in passing HLOGA.

My displeasure with the actions of the FEC over the past 7 years is well known. The agency has repeatedly failed to properly implement provisions of the Bipartisan Campaign Reform Act, BCRA, leading to its regulations being overturned by the courts numerous times. Indeed, because of the agency's dismal record in the courts, some important BCRA regulations are still not in place 7½ years after BCRA's enactment. But the FEC's recent action on corporate jets may be its worst yet. Congress passed HLOGA with wide bipartisan support and clear intent. Because of the FEC's failure to issue rules promptly, members of Congress have been living under the terms of the statute alone with no misunderstanding of what it means. And yet, over two years after its enactment, the FEC has now created an unnecessary and wholly unjustified loophole in the statute. Congress must act to correct this egregious mistake.

I urge my colleagues to support this resolution of disapproval.

Mr. President, I ask unanimous consent that a collection of quotations concerning corporate jet provisions of HLOGA be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SELECTED STATEMENTS CONCERNING TRAVEL ON CORPORATE JETS FROM 2007 DEBATE ON HLOGA

Sen. Reid, 1/4/2007

Another critical aspect requiring reform is the ability of a Member to travel on a corporate jet and only pay the rate of a first class plane ticket. This bill requires Senators and their employees who use corporate or charter aircraft to pay the fair market value for that travel. While I appreciate that such a change is not popular with some of my colleagues, the time has come to fundamentally change the way we do things in this town. Much of the public views our ability to travel on corporate jets, often accompanied by lobbyists, while only reimbursing the first-class rate, as a huge loophole in the current gift rules. And they are right—it is. I have no doubt that the average American would love to fly around the country on very comfortable corporate-owned aircraft and only be charged the cost of a first-class ticket. It is a pretty good deal we have got going here. We need to face the fact that the time has come to end this Congressional perk. [Cong. Rec. S186]

Sen. Obama, 1/9/2007

The second area in which we need to go further is corporate jets. Myself and Senator Feingold introduced a comprehensive ethics bill that, among other things, would close the loopholes that allow for subsidized travel on corporate jets. Today, I am very pleased to see the majority leader has offered an amendment that would serve the same purpose. I fully support him in his effort.

Let me point out that I fully understand the appeal of corporate jets. Like many of my colleagues, I traveled a good deal recently from Illinois to Washington, from Chicago to downstate, from fundraisers to political events for candidates all across the country. I realize finding a commercial flight that gets you home in time to tuck in the kids at the end of a long day can be extremely difficult. This is simply an unfortunate reality that goes along with our jobs.

Yet we have to realize these corporate jets don't simply provide a welcome convenience for us; they provide undue access for the lobbyists and corporations that offer them. These companies don't just fly us around out of the goodness of their hearts. Most of the time we have lobbyists riding along with us so they can make their company's case for a particular bill or a particular vote.

It would be one thing if Congressmen and Senators paid the full rate for these flights, but we don't. We get a discount—a big discount. Right now a flight on a corporate jet usually costs us the equivalent of a first-class ticket on a commercial airplane. But if we paid the real price, the full charter rate would cost us thousands upon thousands of dollars more.

In a recent USA Today story about use of corporate jets, it was reported that over the course of 3 days in November 2005, BellSouth's jet carried six Senators and their wives to various Republican and Democratic fundraising events in the Southeast. If they had paid the full charter rate, it would have cost the Democratic and Republican campaign committees more than \$40,000. But because of the corporate jet perk, it only cost a little more than \$8,000.

There is going to be a lot of talk in the coming days about how important it is to ban free meals and fancy gifts, and I couldn't agree more, but if we are going to go ahead and call a \$50 lunch unethical, I can't see why we wouldn't do the same for the \$32,000 that BellSouth is offering in the form of airplane discounts. That is why I applaud Senator Reid on his amendment to require Members to pay the full charter rate for the use of corporate jets.

As I said, I understand that for many Members, these jets are an issue of convenience. They allow us to get home to our constituents, to our families, and to the events that are often necessary for our jobs. But in November, the American people told us very clearly they are tired of the influence special interest wields over the legislative process. The vast majority of Americans can't afford to buy cheap rides on corporate jets. They don't get to sit with us on 3-hour flights and talk about the heating bills they can't pay, or the health care costs that keep rising, or the taxes they can't afford, or their concerns about college tuition. They can't buy our attention, and they shouldn't have to. And the corporation lobbyists shouldn't be able to either. That is why we need to end this corporate jet perk if we are to pass real, meaningful ethics reform. [Cong. Rec. S263-4]

Sen. Feingold, 1/9/2007

When I introduced my lobbying reform bill back in July 2005, it included a provision addressing the abuse of Members flying on corporate jets. At that time, I have to say, it seemed like a fantasy that we would actually pass such a provision. I heard complaint after complaint about it, that we shouldn't do it.

Slowly but surely, many people have come around to where the public is: Corporate jet travel is a real abuse. Sure, it is convenient, but it is based on a fiction—that the fair

market value of such a trip is just the cost of a first class ticket. And when that fiction is applied to political travel, it creates a loophole in the ban on corporate contributions that we have had in this country for over a century. Any legislation on corporate jets must include campaign trips as well as official travel because one thing is for certain—the lobbyist for the company that provides the jet is likely to be on the flight, whether it is taking you to see a factory back home or a fundraiser for your campaign.

Our bill does that. It covers all of the possible uses of corporate jets, and amends all of the Senate rules needed to put in place a strong reform, and the Federal election laws as well. From now on, if you want to fly on a corporate jet, you will have to pay the charter rate. And these flights shouldn't be an opportunity for the lobbyist or CEO of the company that owns the jet to have several hours alone with a Senator. Our bill prohibits that as well. This is what the American people have been calling for. There are no loopholes or ambiguities here. Politicians flying on private planes for cheap will be a thing of the past if we can get this provision into the bill. Senator Reid's amendment includes a tough corporate jet provision. I am pleased to support that portion of the amendment. This is a big deal, and I commend the majority leader for taking this step. [Cong. Rec. S267]

Sen. Lieberman, 1/10/2007

I am also very pleased that the majority leader has included in this amendment that I referred to an additional amendment, a strong provision on the use of corporate jets. This is a controversial, difficult matter. It is an issue that Senators McCain, Feingold, Obama, and I wanted to pursue last year when we took this up essentially in its predecessor form, but we were unable to do so once cloture was reached on the bill because the amendment was determined to be non-germane.

Under current law this is the reality. When a Member of Congress or a candidate for Federal office uses a private plane instead of flying on a commercial airline, the ethics rules, as well as the Federal Election Commission rules, require a payment to the owner of the plane equivalent to a first-class commercial ticket. The current rules undervalue flights on noncommercial jets and provide, in effect, a way for corporations and individuals to give benefits to Members beyond the limits provided for in our campaign finance laws. The Reid amendment would eliminate that loophole by requiring that the reimbursement be based on the comparable charter rate for a plane. [Cong. Rec. S320]

Sen. Sanders, 1/16/2007

Members of Congress do not need free lunches from lobbyists. Members of Congress do not need free tickets to ball games. And they do not need huge discounts for flights on corporate jets. Congress does need transparency in earmarks and holds, and we do need a new policy regarding the revolving door by which a Member one year is writing a piece of legislation and the next year finds himself or herself working for the company that benefited from the legislation he or she wrote. In other words, we need to pass the strongest ethics reform bill possible. But in passing this legislation, we need to understand this is not the end of our work but, rather, it is just the beginning, and much more needs to be done. [Cong. Rec. S553]

Sen. Reid, 1/16/2007

Let me say a word about corporate jets. The State of Nevada is very large areawise.

The cities of Las Vegas and Reno are separated by about 450 miles. There is good travel between those two cities. But to get around the rest of the State is not easy. When you travel from Las Vegas to Reno, I again say it is easy. But then let's say you want to go to Elko. By Nevada standards, it is a pretty large city. Going on a commercial airplane, it is very, very, very difficult, and to go to Ely is next to impossible. These two cities, both important in their own right, have required on a number of occasions calling upon people you know who have an airplane to take us up there.

Under the old rules, you could pay first-class travel. An example of that is Senator Ensign and I, last August, had to go to Ely. It was extremely important. We were working on a piece of legislation that has since passed. We wanted to sit down in person and talk to the people in Ely about what we were doing.

For us to get there was very difficult. The time factor was significant. To drive up and back is 2 days, 1 day up, 1 day back. It was complicated by the fact that Senator Ensign had a longstanding engagement in Reno. To go from Ely to Reno—it is hard to get there. If you drive very fast, you can make it in 6 hours. So I called a friend of mine, Mike Ensign, Senator Ensign's father. This good man has done very well in the business world. He is a man with limited education but a great mind. He started out working in somewhat menial jobs in the gaming industry. He worked his way up. He became a dealer, a pit boss, a shift boss, and then Mike Ensign moved into the corporate world and became an executive and then ultimately started buying hotel properties himself and has done very well. He is the principal officer and owner of Mandalay Bay, a huge company. It is the second largest hotel-casino operator in the country. I called him and I said: Mike, with one of your airplanes, can you fly me and your son to Ely?

He is a wonderful man, just the greatest guy. He said: Sure, I will be happy to do that. And he did that. He is an example of the type of people we have called upon for these airplanes.

I tell this story. I have used these airplanes a lot because I live in Nevada and because of other duties I have here. The reason I tell the Mike Ensign story is because Mike Ensign doesn't want anything from me. There isn't a thing in the world I can give this man. He is famous, he is rich, he has a wonderful family. I can't do anything to help Mike Ensign. He did this because he is my friend.

Most every—I should not say most. For every airplane I fly on, of course I don't have the relationship with them that I have with Mike Ensign, but I want everyone who has allowed me to use their airplanes to know I am not in any way denigrating them. They have done this out of the goodness of their heart. I have never had anyone say: I will give you an airplane ride if you give me something, or, I have a piece of legislation pending, will you help me with that? That has never happened. I want all these people to know that I am certainly not in any way disparaging these good people who have allowed me and others to fly on their airplanes.

What I am saying, though, is that in this world in which we live, because of all the corruption that has taken place in the last few years here in America, that you not only have to do away with what is wrong but what appears to be wrong. I am confident I have never been influenced by anyone who

provided me with the courtesy of a private airplane, but I have come to the realization that this practice presents a major perception problem. It is a major perception problem because the American people have the right to insist that we do what seems right as well as what is right. Does it appear it is OK? For us to fly around in these airplanes doesn't appear to be the right thing, no matter how good-hearted these people are, just like Mike Ensign. So because a perception isn't right, this amendment is pending, and it means Senators should pay the full fare when they fly on someone's private airplane. [Cong. Rec. S548-9]

Sen. Levin, 1/25/2007

Strong travel restrictions are also an essential component of this bill. The new rules will ensure that Members traveling on corporate jets would have to reimburse at the charter rate, not as is now the case merely at the level of a first class commercial ticket. [Cong. Rec. S1185]

Sen. Reid, 6/26/2007

The American people responded at the polls last November with a clear message that they wanted a new direction, and we, the Democrats, responded by passing the most sweeping ethics and lobbying reform in a generation. We did it with the help of the minority. I do not say that lightly. But let's see what is in this bill. Let's review it for a bit to find out what this bill does.

It prohibits lobbyists and entities that hire lobbyists from giving gifts to lawmakers and their staffs. It prevents corporations and other entities that hire lobbyists from paying for trips for Members or staffs. And it prohibits lobbyists from participating in or paying for any such trips. It requires Senators to pay fair market value prices for charter flights, which put an end to the abuses of corporate travel.

Many people in this Chamber flew in corporate jets and paid first-class airfare. That did not corrupt any Members of Congress, but it was corrupting. It didn't look right, and therefore it is important it be stopped. And I hope it stopped. We need legislation to make sure it is stopped. [Cong. Rec. S8400]

Sen. Klobuchar, 7/31/2007

This ethics bill, as many outside groups have stated, is the most sweeping ethics reform we have seen since Watergate. It is about banning gifts and free meals. It is about not allowing people to take advantage of corporate jets. It is about bringing transparency to the earmark process. [Cong. Rec. S10401]

Sen. Obama, 8/2/2007

In January, I came back with Senator Feingold, and we set a high bar for reform. I am pleased to report that the bill before us today comes very close to what we proposed. By passing this bill, we will ban gifts and meals and end subsidized travel on corporate jets; we will close the revolving door between Pennsylvania Avenue and K Street; and we will make sure the American people can see all the pet projects lawmakers are trying to pass before they are actually voted on. [Cong. Rec. S10692]

Sen. Levin, 8/2/2007

Strong travel restrictions are also an essential component of this bill. The new rules will ensure that Members traveling on corporate jets would have to pay for them at the charter rate, not at the current level of a first class commercial ticket, which is but a fraction of the cost. [Cong. Rec. S10703]

Sen. Feinstein, 8/2/2007

Section 544 includes a separate provision relating to flights on private jets. This provi-

sion requires Senators to pay full market value—defined as charter rates—for flights on private jets, with an exception for jets owned by immediate family members (or non-public corporations in which the Senator or an immediate family member has an ownership interest).

In general, the changes made by section 544 go into effect 60 days after enactment, or the date that the Select Committee on Ethics issues the required guidelines under the rule, whichever is later. Until the new rules take effect, the existing rules for travel will remain in place. In light of the transition to the new rule relating to reimbursement for flights on private jets and the lack of experience in many offices in determining "charter rates," the Select Committee on Ethics may treat reimbursement at current rates as reimbursement at charter rates for a transition period not to exceed 60 days.

Section 601 amends the Federal Election Campaign Act to require that candidates, other than those running for a seat in the House of Representatives, pay the fair market value of airfare when using non-commercial jets to travel. Fair market value is to be determined by dividing the fair market value of the charter fare of the aircraft, by the number of candidates on the flight. This provision exempts aircraft owned or leased by candidates or candidates' immediate family members (or non-public corporations in which the Senator or his or her immediate family member has an ownership interest). The bill prohibits candidates for the House of Representatives from any campaign use of privately-owned, non-chartered jets.

Many candidates are not accustomed to determining charter rates. The FEC may, during a transition period of no more than 60 days, deem reimbursement at current rates to be charter rates while committees determine how to calculate charter rates. [Cong. Rec. S10713]

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 377—CONGRATULATING THE UNIVERSITY OF NORTH CAROLINA TAR HEELS FOR WINNING THE 2009 NATIONAL COLLEGIATE ATHLETIC ASSOCIATION FIELD HOCKEY NATIONAL CHAMPIONSHIP—

Mrs. HAGAN (for herself and Mr. BURR) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 377

Whereas on November 22, 2009, the University of North Carolina defeated the University of Maryland by a score of 3-2 to win the 2009 National Collegiate Athletic Association (NCAA) Field Hockey National Championship;

Whereas the University of North Carolina Tar Heels finished the season with an overall record of 20-2, and an Atlantic Coast Conference (ACC) regular season record of 4-1;

Whereas the University of North Carolina's Ilse Davids, Katelyn Falgowski, Danielle Forword, Jackie Kintzer, and Kelsey Kolojejchick were named to the 2009 All-ACC first team;

Whereas Kelsey Kolojejchick was named the ACC Rookie of the Year;

Whereas the Tar Heels entered the NCAA tournament ranked third, behind the only 2

teams to which they had lost during the regular season, the University of Virginia and the University of Maryland;

Whereas the Tar Heels defeated the University of Virginia by a score of 3-2 in the national semi-final game;

Whereas the defending national champion and top-ranked University of Maryland entered the NCAA championship game with an undefeated 23-0 record;

Whereas the University of North Carolina kept the University of Maryland scoreless during the first period, despite being outshot 8-1;

Whereas senior captain Danielle Forword lifted the Tar Heels to victory in the championship game on a game-winning goal with 11.7 seconds remaining;

Whereas the Tar Heels overcame a previous 4-1 loss during the regular season to the University of Maryland;

Whereas the University of North Carolina's Ilse Davids, Katelyn Falgowski, Danielle Forword, and Jackie Kintzer were named to the 2009 NCAA All-Tournament Team;

Whereas the University of North Carolina's Katelyn Falgowski, Jackie Kintzer, and Kelsey Kolojejchick were named first team All-Americans by the National Field Hockey Coaches Association;

Whereas Kelsey Kolojejchick became the first Tar Heel freshman to earn first-team All-America honors;

Whereas the University of North Carolina's Ilse Davids and Danielle Forword were named second team All-Americans, with Melanie Brill named to the third team;

Whereas 31 North Carolina players have earned first-team All-America honors on 43 occasions;

Whereas Coach Karen Shelton was named as the South Region Coach of the Year by the National Field Hockey Coaches Association; and,

Whereas the University of North Carolina made its 26th NCAA Tournament appearance and won the school's sixth NCAA field hockey championship; Now, therefore, be it

Resolved, That the Senate—

(1) congratulates the University of North Carolina on winning the 2009 National Collegiate Athletic Association Field Hockey National Championship;

(2) recognizes the achievement of the players, coaches, and students, as well as their dedication to excellence that helped propel the field hockey team to win the championship; and

(3) respectfully requests the Secretary of the Senate to transmit an enrolled copy of this resolution to—

(A) the chancellor of the University of North Carolina, H. Holden Thorp;

(B) the athletic director of the University of North Carolina, Dick Baddour; and

(C) the head coach of the University of North Carolina field hockey team, Karen Shelton.

SENATE RESOLUTION 378—CONGRATULATING THE UNIVERSITY OF NORTH CAROLINA TAR HEELS FOR WINNING THE 2009 NATIONAL COLLEGIATE ATHLETIC ASSOCIATION WOMEN'S SOCCER NATIONAL CHAMPIONSHIP—

Mrs. HAGAN (for herself and Mr. BURR) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 378

Whereas on December 6, 2009, the University of North Carolina defeated Stanford University by a score of 1-0 to win the 2009 National Collegiate Athletic Association (NCAA) Women's Soccer National Championship;

Whereas the Tar Heels finished the regular season third in the Atlantic Coast Conference (ACC) with a conference record of 7-3-0 and an overall record of 14-3-1;

Whereas the University of North Carolina's Whitney Engen was named ACC Defensive Player of the Year;

Whereas the University of North Carolina's Whitney Engen, Ashlyn Harris, and Tobin Heath were named to the 2009 All-ACC first team;

Whereas the University of North Carolina's Ali Hawkins and Jessica McDonald were named to the 2009 All-ACC second team;

Whereas the third-seeded Tar Heels won the 2009 ACC Women's Soccer Championship with a 3-0 victory over Florida State University, winning the 20th/ ACC Tournament Championship in the school's history;

Whereas the University of North Carolina's Casey Nogueira was named the Most Valuable Player of the 2009 ACC Championship;

Whereas the University of North Carolina's Casey Nogueira, Ashlyn Harris, Kristi Eveland, Whitney Engen, and Tobin Heath were each named to the 2009 ACC Women's Soccer All-Tournament Team;

Whereas Stanford University entered the National Championship game with an undefeated 25-0 record;

Whereas the University of North Carolina's Jessica McDonald scored the decisive goal in the third minute of the National Championship game on an assist from Casey Nogueira and Tobin Heath;

Whereas the Tar Heels withstood a furious second-half Stanford rally, with the University of North Carolina's goalkeeper Ashlyn Harris providing a key save to preserve the Tar Heels' victory;

Whereas Casey Nogueira was named the Most Valuable Player on Offense in the NCAA Women's College Cup for the second successive year;

Whereas Whitney Engen was named the Most Valuable Player on Defense in the NCAA Women's College Cup;

Whereas the University of North Carolina's Tobin Heath and Whitney Engen were named to the National Soccer Coaches Association of America All-America first team;

Whereas the University of North Carolina's 9 seniors completed their collegiate careers as the winningest senior class in the country, having won 3 National Championships and 4 ACC Tournament Championships with a combined overall record of 94-9-4;

Whereas the University of North Carolina's NCAA Tournament record stands at 106-7-1, and the University has won 93.4 percent of its NCAA Tournament competitions;

Whereas the University of North Carolina has participated in 23 of 28 NCAA Tournament Championship games played to date; and

Whereas the University of North Carolina has won 20 of the 28 NCAA Women's Soccer National Championships: Now, therefore, be it

Resolved, That the Senate—

(1) congratulates the University of North Carolina for winning the 2009 National Collegiate Athletic Association Women's Soccer National Championship;

(2) recognizes the achievement of the players, coaches, students, and staff of the University of North Carolina, whose persever-

ance and dedication to excellence helped propel the women's soccer team to win the championship; and

(3) respectfully requests the Secretary of the Senate to transmit an enrolled copy of this resolution to—

(A) the chancellor of the University of North Carolina, H. Holden Thorp;

(B) the athletic director of the University of North Carolina, Dick Baddour; and

(C) the head coach of the University of North Carolina women's soccer team, Anson Dorrance.

SENATE RESOLUTION 379—TO EXPRESS THE SENSE OF THE SENATE REGARDING THE PROTECTION OF INTELLECTUAL PROPERTY RIGHTS FOR CLEAN ENERGY AND ENVIRONMENTAL TECHNOLOGY

Mrs. GILLIBRAND submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 379

Whereas the development and deployment of innovative clean energy and environmental technology is critical to addressing global climate change;

Whereas intellectual property rights are a key driver of investment and research and development in, and facilitate global deployment of, clean energy and environmental technology;

Whereas efforts to weaken intellectual property rights for clean technology would undermine the environmental objectives of climate change negotiations by reducing incentives for investment, innovation, and clean energy and environmental technology deployment required to meet those objectives;

Whereas weakened intellectual property right protections relating to clean energy and environmental technology could pose a substantial competitive risk to United States businesses and United States workers and inhibit the creation of new green jobs and the transition to a green economy for the 21st century; and

Whereas climate action presents a significant opportunity for international cooperation on clean technology development and deployment, with substantial environmental and economic benefits for all countries.

Now, therefore, be it

Resolved, That it is the sense of the Senate that the President of the United States should pursue opportunities for international cooperation in technology deployment, and should act to ensure that any treaty or other accord resulting from negotiations of the United Nations Framework Convention on Climate Change, done at New York on May 9, 1992 (or a successor agreement) does not weaken or undermine international legal rules and obligations in effect as of the date of enactment of this Act relating to the protection and enforcement of intellectual property rights for energy and environmental technology, including—

(1) wind, solar, biomass, geothermal, hydro, landfill gas, natural gas, marine, trash combustion, fuel cell, hydrogen, micro-turbine, nuclear, clean coal, electric battery, alternative fuel, alternative refueling infrastructure, advanced vehicle, electric grid, and energy efficiency-related technologies; and

(2) any other technologies covered by such an agreement.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3259. Mr. UDALL, of Colorado submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 3260. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3261. Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3262. Mr. WHITEHOUSE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3263. Mr. BAUCUS (for himself, Ms. SNOWE, Mr. CARPER, Mrs. LINCOLN, and Mr. BENNET) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3264. Mr. WYDEN (for himself, Mr. BROWN, Mr. SPECTER, Mr. KOHL, and Ms. COLLINS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 3259. Mr. UDALL of Colorado submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 396, between lines 8 and 9, insert the following:

SEC. 1. STATE COURT INNOVATION PROJECT.

(a) GRANT.—

(1) IN GENERAL.—

(A) GRANT PROGRAM.—The Attorney General shall develop and implement a competitive grant program to improve the efficiency and lessen the costs and burdens of medical malpractice civil litigation for plaintiffs and defendants.

(B) ELEMENTS OF PROGRAM.—The grant program under subparagraph (A) shall be designed—

(i) to give State courts a mechanism for improving court rules and procedures, allowing parties to go to trial in more cost-effective ways and reducing the complexity and cost of litigation; and

(ii) to fund research and objective measurement, evaluation, and reporting of outcomes to identify innovative ways of promoting the resolution of medical malpractice cases in court or tried by jury in a more cost-effective and timely manner pursuant to clause (i).

(C) **ELIGIBLE ENTITY.**—To be eligible to receive a grant under subparagraph (A), an entity shall—

(i) be a nonprofit State court improvement organization that was incorporated or in existence before December 31, 2009, and which is experienced in developing State court improvement programs; and

(ii) submit to the Attorney General an application at such time, in such manner, and containing such information as the Attorney General may require.

(2) **USE OF FUNDS.**—A grant recipient under paragraph (1) shall use amounts awarded under the grant to conduct research and evaluations, develop rules and procedures designed to improve the efficiency and lessen the costs of medical malpractice litigation for plaintiffs and defendants, and to award subgrants to eligible entities to carry out activities—

(A) to conduct pilot projects;

(B) to increase the operating efficiency of State courts with respect to medical malpractice litigation;

(C) to conduct research to seek innovative ways to resolve medical malpractice litigation in State courts in a more cost-effective and timely manner; and

(D) to measure and report on outcomes with respect to activities funded under the subgrant.

(3) **ELIGIBLE SUBGRANT ENTITY.**—To be eligible to receive a subgrant under paragraph (2), an entity shall—

(A)(i) be a State or local governmental entity in a jurisdiction that permits jury trials for civil medical malpractice actions; or

(ii) be an academic institution; and

(B) submit an application at such time, in such manner, and containing such information as required by the recipient of the grant under paragraph (1), in accordance with any rules established by the Attorney General.

(4) **REPORTING.**—Not later than 2 years after receiving grant funds under this subsection, each grant recipient under paragraph (1) shall submit to the Attorney General a report that describes the activities conducted by the recipient under this section, including the activities of any subgrantees of such grant recipient under paragraph (2).

(b) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated \$10,000,000 to carry out this section.

SA 3260. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 522, between lines 2 and 3, insert the following:

SEC. 2603. PAYMENT FOR ILLEGAL UNAPPROVED DRUGS.

(a) **FINDINGS.**—Congress finds that each year, the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et

seq.) pays millions of dollars in reimbursement for covered outpatient drugs that are not approved by the Food and Drug Administration under a new drug application under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)) or an abbreviated new drug application under section 505(j) of such Act, or that such drug is not subject such section 505 or section 512 due to the application of section 201(p) of such Act (21 U.S.C. 321(p)).

(b) **LISTING OF DRUGS AND DEVICES.**—Section 510 of the Food, Drug and Cosmetic Act (21 U.S.C. 360) is amended—

(1) in subsection (j)(1)(B)—

(A) in clause (i), by inserting “in the case of a drug, the authority under this Act that does not require such drug to be subject to section 505 and section 512,” after “labeling for such drug or device;” and

(B) in clause (ii), by inserting “, in the case of a drug, the authority under this Act that does not require such drug to be subject to section 505 and section 512,” after “for such drug or device;” and

(2) in subsection (f)—

(A) by striking “(f) The Secretary” and inserting the following:

“(f) **INSPECTION BY PUBLIC OF REGISTRATION.**—

“(1) **IN GENERAL.**—The Secretary”; and

(B) by adding at the end the following:

“(2) **LIST OF DRUGS THAT ARE NOT APPROVED UNDER SECTION 505 OR 512.**—Not later than January 1, 2011, the Secretary shall make available to the public on the Internet website of the Food and Drug Administration a list that includes, for each drug described in subsection (j)(1)(B)—

“(A) the drug;

“(B) the person who listed such drug; and

“(C) the authority under this Act that does not require such drug to be subject to section 505 and section 512, as provided by such person in such list.”.

(c) **PAYMENT FOR COVERED OUTPATIENT DRUGS.**—Section 1927 of the Social Security Act (42 U.S.C. 1396r-8) is amended by inserting at the end the following:

“(1) **CONDITION.**—Beginning January 1, 2011, no State shall make any payment under this section for any covered outpatient drug unless such State first verifies with the Food and Drug Administration that such covered outpatient drug has been approved by the Food and Drug Administration under a new drug application under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)) or an abbreviated new drug application under section 505(j) of such Act, or that such drug is not subject such section 505 or section 512 due to the application of section 201(p) of such Act (21 U.S.C. 321(p)). The Secretary shall have the authority to prescribe regulations to create an information sharing protocol to allow States to verify that a covered outpatient drug has been approved by the Food and Drug Administration.”.

SA 3261. Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 722, after line 20, insert the following:

SEC. 3016. CULTURE OF SAFETY HOSPITAL ACCOUNTABILITY STUDY AND DEMONSTRATION PROGRAM.

(a) **STUDY.**—

(1) **IN GENERAL.**—The Secretary shall conduct a study that—

(A) examines existing activities and programs in hospitals for quality assurance, patient safety, and performance improvement and provides an analysis regarding best practices with respect to such activities and programs; and

(B) identifies best practices that should be replicated in hospitals to improve patient safety and quality of care, consistent with the provisions included under the quality assessment and performance improvement program, as required under the conditions of participation for hospitals under Medicare.

(2) **REPORT.**—Not later than 2 years after the date of enactment of this Act, the Secretary shall prepare a report containing the results of the study conducted under paragraph (1). Such report shall be made available on the Internet website of the Centers for Medicare & Medicaid Services.

(b) **DEMONSTRATION PROGRAM.**—

(1) **IN GENERAL.**—The Secretary shall establish the Culture of Safety Hospital Accountability demonstration program to provide support for establishing partnerships and other cooperative approaches between hospitals, State health care agencies, and the Department of Health and Human Services to promote and implement the best practices identified under subsection (a), with the goal of improving the safety and quality of care provided to Medicare beneficiaries and enhance compliance with the conditions of participation for hospitals under Medicare.

(2) **DURATION.**—The demonstration program shall operate during a period of 3 years, beginning not later than 12 months after completion of the report described in subsection (a)(2).

(3) **SCOPE.**—

(A) **STATES.**—The Secretary shall select not less than 4 States, but not more than 6 States, to participate in the demonstration program.

(B) **HOSPITALS.**—The Secretary shall select not more than 24 hospitals, within the States selected under subparagraph (A), to participate in the demonstration program. The hospitals selected under this subparagraph shall satisfy criteria, as developed by the Secretary, indicating a need for substantial improvement in quality of care and patient safety.

(4) **APPLICATION.**—A State or hospital that desires to participate in the demonstration program shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(5) **IMPLEMENTATION.**—

(A) **TECHNICAL ASSISTANCE.**—The Secretary shall provide participating hospitals with technical assistance in implementation of the best practices identified through the study under subsection (a).

(B) **HOSPITAL SURVEYORS.**—For each State participating in the demonstration program, the Secretary shall provide training to State surveyors that is designed to—

(i) enhance knowledge of the disciplines of patient safety, quality assessment, and performance improvement;

(ii) increase skill in evaluating compliance with quality assessment and performance improvement programs required under the conditions of participation for hospitals under Medicare; and

(iii) focus investigations of complaints regarding hospital care on the hospital's quality assessment and performance improvement program.

(6) **EVALUATION.**—For each State and hospital participating in the demonstration program, the Secretary shall evaluate the following:

(A) The level of implementation of the best practices identified under subsection (a) by the participating hospitals and whether adoption of such practices—

(i) improved quality and patient safety (including an analysis of changes in quality measures and other indicators of outcome and performance); and

(ii) resulted in a decrease in the seriousness or number of citations for deficiencies under the conditions of participation for hospitals under Medicare.

(B) The training provided to State surveyors and whether such training resulted in enhanced proficiency in evaluations of hospital quality assessment and performance improvement programs.

(7) **REPORT.**—Not later than 12 months after completion of the demonstration project, the Secretary shall submit to Congress a report containing an evaluation of the demonstration program, including—

(A) the findings of the evaluation under paragraph (6); and

(B) recommendations—

(i) in regard to whether the best practices identified under the demonstration program should be adopted by other hospitals, and how the Secretary can best promote adoption of such best practices;

(ii) in regard to whether the training for State surveyors developed under the demonstration program should be provided to all State surveyors; and

(iii) for such legislation and administrative action as the Secretary determines appropriate.

(8) **WAIVER AUTHORITY.**—The Secretary may waive such requirements under titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program.

(c) **FUNDING.**—For purposes of carrying out this section, the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) of \$25,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2010 through 2017. Amounts transferred under the preceding sentence shall remain available until expended.

(d) **ALTERNATIVE REMEDIES.**—Section 1866(b) of the Social Security Act (42 U.S.C. 1395cc(b)) is amended by adding at the end the following new paragraph:

“(5)(A) The Secretary is authorized to promulgate regulations that establish enforcement remedies that are in addition to, or in lieu of, termination of an agreement under this section for hospitals or critical access hospitals for violations of health and safety requirements under this title. Such remedies may include directed plans of correction that are designed to—

“(i) ensure compliance with requirements under this title (including conditions of participation for hospitals or critical access hospitals);

“(ii) prevent recurrence of non-compliance with such requirements; and

“(iii) improve the internal structures and processes within the hospital or critical access hospital for provision of continuous quality and safety enhancement.

“(B) The regulations described under subparagraph (A) may be promulgated by the Secretary before, during, or after the evaluation described under section 3016(b)(6) of the Patient Protection and Affordable Care Act.”.

(e) **NON-APPLICATION OF PAPERWORK REDUCTION ACT.**—Chapter 35 of title 44, United States Code (commonly referred to as the ‘Paperwork Reduction Act of 1995’) shall not apply to this section.

(f) **DEFINITIONS.**—In this section:

(1) **DEMONSTRATION PROGRAM.**—The term “demonstration program” means the Culture of Safety Hospital Accountability demonstration program conducted under this section.

(2) **HOSPITAL.**—The term “hospital” means—

(A) an institution described under section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)); or

(B) a critical access hospital (as described under section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1))).

(3) **MEDICARE.**—The term “Medicare” means the program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(4) **SECRETARY.**—The term “Secretary” means the Secretary of Health and Human Services.

SA 3262. Mr. WHITEHOUSE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 796, between lines 5 and 6, insert the following:

SEC. 3028. VOLUNTARY ACCELERATED SHARED SAVINGS PROGRAM.

(a) **ESTABLISHMENT.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall establish the Voluntary Accelerated Shared Savings Program (referred to in this section as the “shared savings program”) under which health care providers that voluntarily report on quality measures, adopt quality-improving protocols or strategies, and achieve quality benchmarks are eligible for a shared savings payment.

(2) **DURATION.**—The shared savings program shall be conducted during the following periods:

(A) The hospital readmission reduction program, as described under subsection (d), shall—

(i) begin on such date as determined appropriate by the Secretary for implementation of the program, but not later than 6 months after the date of enactment of this Act; and

(ii) end not later than October 1, 2012.

(B) The hospital-acquired conditions reduction program, as described under subsection (e), shall—

(i) begin on such date as determined appropriate by the Secretary for implementation of the program, but not later than 6 months after the date of enactment of this Act; and

(ii) shall end not later than October 1, 2015.

(b) **ELIGIBILITY; PARTICIPATION REQUIREMENTS.**—

(1) **ELIGIBILITY.**—A hospital described in section 1866(q)(5)(C) of the Social Security

Act, as added by section 3025, shall be eligible to participate in the shared savings program.

(2) **APPLICATION.**—A provider seeking to participate in the shared savings program shall submit an application to the Secretary, in such manner and containing such information as the Secretary may require, that includes a detailed description of the methods through which the provider expects to—

(A) reduce readmissions or hospital-acquired condition rates, as applicable;

(B) reduce costs; and

(C) integrate and coordinate such quality improvement efforts with post-acute providers.

(3) **PARTICIPATION REQUIREMENTS.**—A participating provider shall be required to—

(A) report on quality measures (as determined by the Secretary under subsection (c));

(B) satisfy applicable benchmarks for such quality measures; and

(C) demonstrate savings (as described in subsection (f)).

(c) **QUALITY AND OTHER REPORTING REQUIREMENTS.**—

(1) **IN GENERAL.**—The Secretary shall determine appropriate measures to assess the quality of care furnished by participating providers, such as measures of—

(A) clinical processes and outcomes;

(B) patient and, where practicable, caregiver experience of care; and

(C) utilization rates.

(2) **INCORPORATION OF MEASURES.**—For purposes of the measures described under paragraph (1), the Secretary may incorporate measures established—

(A) under sections 1848(k) and 1886(b) of the Social Security Act; and

(B) pursuant to any provision of this Act or amendment made by this Act.

(3) **REPORTING REQUIREMENT.**—A participating provider shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the participating provider to report in order to evaluate the quality of care furnished by such provider.

(4) **QUALITY PERFORMANCE STANDARDS.**—The Secretary shall establish quality performance standards to assess the quality of care furnished by participating providers. The Secretary shall seek to improve the quality of care furnished by participating providers over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

(d) **HOSPITAL READMISSION REDUCTION PROGRAM.**—

(1) **HOSPITAL READMISSIONS RATE MEASURES.**—For purposes of establishing measures under subsection (c) for the hospital readmission reduction program, the Secretary shall include measures for readmission rates established under 1886(b) of the Social Security Act (42 U.S.C. 1395ww(b)).

(2) **BENCHMARK.**—The Secretary shall establish a benchmark for reduction in the readmission rate for a hospital that is adjusted for geographic area, patient population characteristics, and such other factors as determined appropriate by the Secretary. The Secretary may establish a higher benchmark for hospitals with an annual readmission rate that is above the mean nationwide readmission rate.

(3) **SHARED SAVINGS REQUIREMENTS.**—A participating provider shall be eligible for a shared savings payment under subsection (f) if such provider—

(A) achieves the applicable benchmark established by the Secretary under paragraph (2); and

(B) has an annual readmission rate that is below the risk adjusted expected readmissions rate as determined under section 1886(q)(4)(C)(i)(II) of the Social Security Act (as added by section 3025).

(4) **COMMUNITY-BASED ORGANIZATIONS.**—The Secretary may permit a community-based organization, as described in section 3026(b)(1)(B), to receive shared savings payments under the hospital readmission reduction program if such an organization—

(A) satisfies the requirements described under section 3026; and

(B) is associated with a subsection (d) hospital (as described in section 3026(b)(1)(A)) that would be eligible for a shared savings payment under this section.

(e) **HOSPITAL-ACQUIRED CONDITIONS REDUCTION PROGRAM.**—

(1) **HOSPITAL-ACQUIRED CONDITIONS RATE MEASURES.**—For purposes of establishing measures under subsection (c) for the hospital-acquired conditions program, the Secretary shall establish measures that accurately determine rates of hospital-acquired conditions (as defined in section 1886(p) of the Social Security Act, as added by section 3008).

(2) **REDUCTION IN HOSPITAL-ACQUIRED CONDITIONS BENCHMARK.**—The Secretary shall establish a benchmark for reduction in the hospital-acquired conditions rate for a participating provider that is adjusted for geographic area, patient population characteristics, and such other factors as determined appropriate by the Secretary. The Secretary may establish a higher benchmark for hospitals with an annual hospital-acquired conditions rate that is above the mean nationwide hospital-acquired conditions rate.

(3) **SHARED SAVINGS REQUIREMENTS.**—A participating provider shall be eligible for a shared savings payment under subsection (f) if such provider achieves the applicable benchmark established by the Secretary under paragraph (2).

(f) **SHARED SAVINGS PAYMENTS.**—

(1) **IN GENERAL.**—Under the shared savings program, payments shall continue to be made to participating providers under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating provider is eligible to receive payment for shared savings under paragraph (3) if—

(A) the provider meets quality performance standards established by the Secretary under subsection (c); and

(B) the provider meets the requirement under paragraph (2)(A).

(2) **SAVINGS REQUIREMENT AND BENCHMARK.**—

(A) **DETERMINING SAVINGS.**—Subject to subparagraph (C), in each year of the period under subsection (a)(2), a participating provider shall be eligible to receive payment for shared savings under paragraph (3) only if the estimated average per capita Medicare expenditures for such provider for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under subparagraph (B).

(B) **ESTABLISH AND UPDATE BENCHMARK.**—The Secretary shall estimate a benchmark for each period under subsection (a)(2) for each participating provider using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries served by the provider. Such benchmark shall be adjusted for beneficiary characteristics and

such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary.

(C) **HIGHER BENCHMARK.**—For purposes of subparagraph (A), the Secretary may require a greater percentage in savings below the benchmark established under subparagraph (B) for a participating provider with an annual readmission or hospital-acquired conditions rate, as applicable, that is above the mean nationwide rate (as described in subsections (e)(2) and (f)(2)).

(3) **PAYMENTS FOR SHARED SAVINGS.**—Subject to performance with respect to the quality performance standards established by the Secretary under subsection (c), if a participating provider meets the requirements under paragraphs (1) and (2), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, for the provider and such benchmark for the provider may be paid to the provider as shared savings and the remainder of such difference shall be retained by the Medicare program under title XVIII of the Social Security Act. The Secretary shall establish limits on the total amount of shared savings that may be paid to a participating provider under this paragraph.

(g) **EARLY PARTICIPATION IN MEDICARE SHARED SAVINGS PROGRAM AND NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.**—

(1) **IN GENERAL.**—For purposes of section 1866D of the Social Security Act (as added by section 3023) and section 1899 of such Act (as added by section 3022), the Secretary may establish a program to provide for early participation payments under such sections to eligible providers or groups of providers.

(2) **ELIGIBILITY.**—

(A) **IN GENERAL.**—Providers eligible for the early participation program under this subsection shall include—

(i) providers described under section 1866D(a)(2)(G) of the Social Security Act; and

(ii) providers that meet the requirements in section 1899(b) of such Act.

(B) **WAIVER OF REQUIREMENTS.**—Subject to subparagraph (C), for purposes of the early participation program under this subsection, the Secretary may waive—

(i) any requirements under section 1899 of the Social Security Act, except that the Secretary shall not waive—

(I) the requirements under subsection (b) of such section (with the exception of subparagraphs (B) and (D) of subsection (b)(2)); or

(II) the provisions under subsection (d) of such section.

(ii) any requirements under section 1866D of the Social Security Act, provided that the proposal submitted by the provider (as described under subparagraph (C)) adequately provides for—

(I) a plan for quality improvement that is consistent with subsection (c)(4) of such section; and

(II) a valid payment methodology that is consistent with subsection (c)(3) of such section.

(C) **APPLICATION.**—Providers seeking to participate in the early participation program under this section shall submit a proposal, in such manner and containing such information as the Secretary may require, that includes, for purposes of determining applicable payments under this section, a methodology for calculation of savings or determination of bundled payments.

(3) **MEDICARE SHARED SAVINGS PROGRAM.**—For purposes of section 1899 of the Social Security Act, a provider seeking to participate in the early participation program under this section shall, as part of the proposal described under paragraph (2)(C), provide a detailed plan for quality improvement that is consistent with the goals described under subsections (a) and (b)(3) of section 1899 of the Social Security Act.

(4) **NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.**—For purposes of section 1866D of the Social Security Act, a provider seeking to participate in the early participation program under this section shall, as part of the proposal described under paragraph (2)(C), provide a detailed plan in regard to the methods by which such provider will satisfy the objectives described under subsection (a)(1) of section 1866D of the Social Security Act, which shall include—

(A) a bundled payment methodology;

(B) methods by which quality of care will be improved; and

(C) a description of the conditions and services that are to be covered through the bundled payment.

(5) **APPLICABLE PERIOD.**—Any payments made to providers pursuant to early participation program under this section shall cease upon establishment of the programs described under sections 1866D and 1899 of the Social Security Act, except to the extent that providers are determined to be eligible for, and continue to participate in, the programs established under such sections.

SA 3263. Mr. BAUCUS (for himself, Ms. SNOWE, Mr. CARPER, Mrs. LINCOLN, and Mr. BENNET) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE —ALTERNATIVE TO MEDICAL TORT LITIGATION

SEC. —01. SHORT TITLE.

This title may be cited as the “Fair and Reliable Medical Justice Act”.

SEC. —02. PURPOSES.

The purposes of this title are—

(1) to restore fairness and reliability to the medical justice system by fostering alternatives to current medical tort litigation that promote disclosure of health care errors and provide prompt, fair, and reasonable compensation to patients who are injured by health care errors;

(2) to promote patient safety through disclosure of health care errors; and

(3) to support and assist States in developing such alternatives.

SEC. —03. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by this Act, is further amended by adding at the end the following:

"SEC. 399V-2. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

"(a) IN GENERAL.—The Secretary is authorized to award demonstration grants to States for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. In awarding such grants, the Secretary shall ensure the diversity of the alternatives so funded.

"(b) DURATION.—The Secretary may award grants under subsection (a) for a period not to exceed 5 years.

"(c) CONDITIONS FOR DEMONSTRATION GRANTS.—

"(1) REQUIREMENTS.—Each State desiring a grant under subsection (a) shall develop an alternative to current tort litigation that—

"(A) allows for the resolution of disputes over injuries allegedly caused by health care providers or health care organizations; and

"(B) promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes resolved under subparagraph (A) by organizations that engage in efforts to improve patient safety and the quality of health care.

"(2) ALTERNATIVE TO CURRENT TORT LITIGATION.—Each State desiring a grant under subsection (a) shall demonstrate how the proposed alternative described in paragraph (1)(A)—

"(A) makes the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes;

"(B) encourages the efficient resolution of disputes;

"(C) encourages the disclosure of health care errors;

"(D) enhances patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events;

"(E) improves access to liability insurance;

"(F) fully informs patients about the differences in the alternative and current tort litigation;

"(G) provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative;

"(H) would not conflict with State law at the time of the application in a way that would prohibit the adoption of an alternative to current tort litigation; and

"(I) would not limit or curtail a patient's existing legal rights, ability to file a claim in or access a State's legal system, or otherwise abrogate a patient's ability to file a medical malpractice claim.

"(3) SOURCES OF COMPENSATION.—Each State desiring a grant under subsection (a) shall identify the sources from and methods by which compensation would be paid for claims resolved under the proposed alternative to current tort litigation, which may include public or private funding sources, or a combination of such sources. Funding methods shall to the extent practicable provide financial incentives for activities that improve patient safety.

"(4) SCOPE.—

"(A) IN GENERAL.—Each State desiring a grant under subsection (a) shall establish a scope of jurisdiction (such as Statewide, designated geographic region, a designated area of health care practice, or a designated group of health care providers or health care organizations) for the proposed alternative to current tort litigation that is sufficient to evaluate the effects of the alternative. No

scope of jurisdiction shall be established under this paragraph that is based on a health care payer or patient population.

"(B) NOTIFICATION OF PATIENTS.—A State shall demonstrate how patients would be notified that they are receiving health care services that fall within such scope, and the process by which they may opt out of or voluntarily withdraw from participating in the alternative. The decision of the patient whether to participate or continue participating in the alternative process shall be made at any time and shall not be limited in any way.

"(5) PREFERENCE IN AWARDING DEMONSTRATION GRANTS.—In awarding grants under subsection (a), the Secretary shall give preference to States—

"(A) that have developed the proposed alternative through substantive consultation with relevant stakeholders, including patient advocates, health care providers and health care organizations, attorneys with expertise in representing patients and health care providers, medical malpractice insurers, and patient safety experts;

"(B) that make proposals that are likely to enhance patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events; and

"(C) that make proposals that are likely to improve access to liability insurance.

"(d) APPLICATION.—

"(1) IN GENERAL.—Each State desiring a grant under subsection (a) shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

"(2) REVIEW PANEL.—

"(A) IN GENERAL.—In reviewing applications under paragraph (1), the Secretary shall consult with a review panel composed of relevant experts appointed by the Comptroller General.

"(B) COMPOSITION.—

"(i) NOMINATIONS.—The Comptroller General shall solicit nominations from the public for individuals to serve on the review panel.

"(ii) APPOINTMENT.—The Comptroller General shall appoint, at least 9 but not more than 13, highly qualified and knowledgeable individuals to serve on the review panel and shall ensure that the following entities receive fair representation on such panel:

"(I) Patient advocates.

"(II) Health care providers and health care organizations.

"(III) Attorneys with expertise in representing patients and health care providers.

"(IV) Medical malpractice insurers.

"(V) State officials.

"(VI) Patient safety experts.

"(C) CHAIRPERSON.—The Comptroller General, or an individual within the Government Accountability Office designated by the Comptroller General, shall be the chairperson of the review panel.

"(D) AVAILABILITY OF INFORMATION.—The Comptroller General shall make available to the review panel such information, personnel, and administrative services and assistance as the review panel may reasonably require to carry out its duties.

"(E) INFORMATION FROM AGENCIES.—The review panel may request directly from any department or agency of the United States any information that such panel considers necessary to carry out its duties. To the extent consistent with applicable laws and regulations, the head of such department or agency shall furnish the requested information to the review panel.

"(e) REPORTS.—

"(1) BY STATE.—Each State receiving a grant under subsection (a) shall submit to the Secretary an annual report evaluating the effectiveness of activities funded with grants awarded under such subsection. Such report shall, at a minimum, include the impact of the activities funded on patient safety and on the availability and price of medical liability insurance.

"(2) BY SECRETARY.—The Secretary shall submit to Congress an annual compendium of the reports submitted under paragraph (1) and an analysis of the activities funded under subsection (a) that examines any differences that result from such activities in terms of the quality of care, number and nature of medical errors, medical resources used, length of time for dispute resolution, and the availability and price of liability insurance.

"(f) TECHNICAL ASSISTANCE.—

"(1) IN GENERAL.—The Secretary shall provide technical assistance to the States applying for or awarded grants under subsection (a).

"(2) REQUIREMENTS.—Technical assistance under paragraph (1) shall include—

"(A) guidance on non-economic damages, including the consideration of individual facts and circumstances in determining appropriate payment, guidance on identifying avoidable injuries, and guidance on disclosure to patients of health care errors and adverse events; and

"(B) the development, in consultation with States, of common definitions, formats, and data collection infrastructure for States receiving grants under this section to use in reporting to facilitate aggregation and analysis of data both within and between States.

"(3) USE OF COMMON DEFINITIONS, FORMATS, AND DATA COLLECTION INFRASTRUCTURE.—States not receiving grants under this section may also use the common definitions, formats, and data collection infrastructure developed under paragraph (2)(B).

"(g) EVALUATION.—

"(1) IN GENERAL.—The Secretary, in consultation with the review panel established under subsection (d)(2), shall enter into a contract with an appropriate research organization to conduct an overall evaluation of the effectiveness of grants awarded under subsection (a) and to annually prepare and submit a report to Congress. Such an evaluation shall begin not later than 18 months following the date of implementation of the first program funded by a grant under subsection (a).

"(2) CONTENTS.—The evaluation under paragraph (1) shall include—

"(A) an analysis of the effects of the grants awarded under subsection (a) with regard to the measures described in paragraph (3);

"(B) for each State, an analysis of the extent to which the alternative developed under subsection (c)(1) is effective in meeting the elements described in subsection (c)(2);

"(C) a comparison among the States receiving grants under subsection (a) of the effectiveness of the various alternatives developed by such States under subsection (c)(1);

"(D) a comparison, considering the measures described in paragraph (3), of States receiving grants approved under subsection (a) and similar States not receiving such grants; and

"(E) a comparison, with regard to the measures described in paragraph (3), of—

"(i) States receiving grants under subsection (a);

"(ii) States that enacted, prior to the date of enactment of the Patient Protection and

Affordable Care Act, any cap on non-economic damages; and

“(iii) States that have enacted, prior to the date of enactment of the Patient Protection and Affordable Care Act, a requirement that the complainant obtain an opinion regarding the merit of the claim, although the substance of such opinion may have no bearing on whether the complainant may proceed with a case.

“(3) MEASURES.—The evaluations under paragraph (2) shall analyze and make comparisons on the basis of—

“(A) the nature and number of disputes over injuries allegedly caused by health care providers or health care organizations;

“(B) the nature and number of claims in which tort litigation was pursued despite the existence of an alternative under subsection (a);

“(C) the disposition of disputes and claims, including the length of time and estimated costs to all parties;

“(D) the medical liability environment;

“(E) health care quality;

“(F) patient safety in terms of detecting, analyzing, and helping to reduce medical errors and adverse events;

“(G) patient and health care provider and organization satisfaction with the alternative under subsection (a) and with the medical liability environment; and

“(H) impact on utilization of medical services, appropriately adjusted for risk.

“(4) FUNDING.—The Secretary shall reserve 5 percent of the amount appropriated in each fiscal year under subsection (k) to carry out this subsection.

“(h) MEDPAC AND MACPAC REPORTS.—

“(1) MEDPAC.—The Medicare Payment Advisory Commission shall conduct an independent review of the alternatives to current tort litigation that are implemented under grants under subsection (a) to determine the impact of such alternatives on the Medicare program under title XVIII of the Social Security Act, and its beneficiaries.

“(2) MACPAC.—The Medicaid and CHIP Payment and Access Commission shall conduct an independent review of the alternatives to current tort litigation that are implemented under grants under subsection (a) to determine the impact of such alternatives on the Medicaid or CHIP programs under titles XIX and XXI of the Social Security Act, and their beneficiaries.

“(3) REPORTS.—Not later than December 31, 2016, the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission shall each submit to Congress a report that includes the findings and recommendations of each respective Commission based on independent reviews conducted under paragraphs (1) and (2), including an analysis of the impact of the alternatives reviewed on the efficiency and effectiveness of the respective programs.

“(i) OPTION TO PROVIDE FOR INITIAL PLANNING GRANTS.—Of the funds appropriated pursuant to subsection (k), the Secretary may use a portion not to exceed \$500,000 per State to provide planning grants to such States for the development of demonstration project applications meeting the criteria described in subsection (c). In selecting States to receive such planning grants, the Secretary shall give preference to those States in which State law at the time of the application would not prohibit the adoption of an alternative to current tort litigation.

“(j) DEFINITIONS.—In this section:

“(1) HEALTH CARE SERVICES.—The term ‘health care services’ means any services provided by a health care provider, or by any

individual working under the supervision of a health care provider, that relate to—

“(A) the diagnosis, prevention, or treatment of any human disease or impairment; or

“(B) the assessment of the health of human beings.

“(2) HEALTH CARE ORGANIZATION.—The term ‘health care organization’ means any individual or entity which is obligated to provide, pay for, or administer health benefits under any health plan.

“(3) HEALTH CARE PROVIDER.—The term ‘health care provider’ means any individual or entity—

“(A) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or

“(B) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

“(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, such sums as may be necessary to carry out this section for each of fiscal years 2011 through 2015.

“(1) CURRENT STATE EFFORTS TO ESTABLISH ALTERNATIVE TO TORT LITIGATION.—Nothing in this section shall be construed to limit any prior, current, or future efforts of any State to establish any alternative to tort litigation.

“(m) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as limiting states’ authority over or responsibility for their state justice systems.”.

SA 3264. Mr. WYDEN (for himself, Mr. BROWN, Mr. SPECTER, Mr. KOHL, and Ms. COLLINS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 999, between lines 16 and 17, insert the following:

SEC. 3402. LIMITATION ON HOSPICE SPENDING.

Section 1814(i)(1)(C) of the Social Security Act, as amended by sections 3132 and 3401, is further amended—

(1) in each of clauses (ii)(VII) and (iii), by striking “clause (iv)” and inserting “clauses (iv) and (v)”;

(2) in clause (iv)—

(A) in subclause (II)—

(i) by striking “subject to clause (v),”; and

(ii) by striking “.05 percentage point” and inserting “.25 percentage point”; and

(B) by striking the flush sentence following subclause (II); and

(3) by striking clause (v) and inserting the following new clauses:

“(v) After determining the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, with respect to fiscal years 2014 through 2019, if the Secretary determines there is excess hospice spending (as defined in clause (vi)) for the fiscal year, the Secretary shall reduce such percentage by the amount of such excess hospice spending. The application of this clause may not result in the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, being less than 0.0 for a fiscal year.

“(vi) For purposes of clause (v), the term ‘excess hospice spending’ means—

“(I) for fiscal year 2014, the excess (expressed as a percentage) of—

“(aa) the aggregate amount of payments for hospice care under this title for fiscal year 2011; over

“(bb) the aggregate amount of such payments for fiscal year 2010 increased by the medical care component of the Consumer Price Index for fiscal year 2011, plus 3.0 percentage points; and

“(II) for fiscal year 2015 through 2019, the excess (expressed as a percentage) between—

“(aa) the aggregate amounts of such payments for the fiscal year 3 years prior to the fiscal year involved; over

“(bb) the aggregate amount of such payments for the fiscal year 4 years prior to the fiscal year involved increased by the medical care component of the Consumer Price Index for the fiscal year 3 years prior to the fiscal year involved, plus 3.0 percentage points.”.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on December 17, 2009, at 9:30 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet during the session of the Senate on December 17, 2009, in room 253 of the Russell Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on December 17, 2009, at 10 a.m., to conduct a hearing entitled “Safeguarding the American Dream: Prospectus for Our Economic Future and Proposals to Secure It.”

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON INDIAN AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to meet during the session of the Senate on December 17, 2009, at 2:15 p.m., in room 628 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on December 17, 2009, at 10 a.m., in SD-226 of the Dirksen Senate Office

Building, to conduct an executive business meeting.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON SMALL BUSINESS AND
ENTREPRENEURSHIP

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Small Business and Entrepreneurship be authorized to meet during the session of the Senate on December 17, 2009, at 1:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

AD HOC SUBCOMMITTEE ON CONTRACTING
OVERSIGHT

Mr. DURBIN. Mr. President, I ask unanimous consent that the Ad Hoc Subcommittee on Contracting Oversight of the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on December 17, 2009, at 2 p.m., to conduct a hearing entitled, "Afghanistan Contracts: An Overview."

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. DURBIN. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on December 17, 2009, at 2:30 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON CONSUMER PROTECTION,
PRODUCT SAFETY, AND INSURANCE

Mr. DURBIN. Mr. President, I ask unanimous consent that the Subcommittee on Consumer Protection, Product Safety, and Insurance of the Committee on Commerce, Science, and Transportation be authorized to meet during the session of the Senate on December 17, 2009, at 2:30 p.m., in room 253 of the Russell Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON PUBLIC LANDS AND FORESTS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Subcommittee on Public Lands and Forests be authorized to meet during the session of the Senate to conduct a hearing on December 17, 2009, at 2:30 p.m., in room SD-366 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGES OF THE FLOOR

Mr. LEVIN. Mr. President, first, on behalf of Senator DODD, I ask unanimous consent that a military fellow in his office, CPT Joslyn Hemler, be granted floor privileges during the consideration of the 2010 Department of Defense appropriations bill.

The PRESIDING OFFICER. Without objection, it is so ordered.

RECESS UNTIL 12:01 A.M.
TOMORROW

Mr. REID. Mr. President, I now move to recess until 12:01 a.m.

Mr. MCCONNELL. Parliamentary inquiry.

The PRESIDING OFFICER (Mr. DURBIN). The Republican leader.

Mr. MCCONNELL. Before we proceed to the vote, I would like to make a parliamentary inquiry: I believe it is the case that a simple motion to recess or adjourn is not amendable; is that correct?

The PRESIDING OFFICER. The Republican leader is correct.

Mr. MCCONNELL. Further inquiry. I also believe that a motion to recess or adjourn to a time certain is amendable with time changes.

The PRESIDING OFFICER. The Republican leader is correct.

Mr. MCCONNELL. I will not offer an amendment to change the time to convene later, but so everybody will know, with regard to their own personal schedules, this vote could occur at any time tomorrow. It wouldn't have to be at 1 a.m. The majority leader has the discretion to do that. We are, of course, prepared to talk around the clock and happy to have a vote at 1 o'clock. I just want everybody to understand it is my understanding that the majority leader does have the ability to set the vote later than 1 a.m.

The PRESIDING OFFICER. The majority leader.

Mr. REID. I ask for the yeas and nays on my motion.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) is necessarily absent.

Mr. KYL. The following Senators are necessarily absent: the Senator from Wyoming (Mr. ENZI) and the Senator from Georgia (Mr. CHAMBLISS).

The PRESIDING OFFICER (Mr. BEGICH). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 59, nays 38, as follows:

[Rollcall Vote No. 380 Leg.]

YEAS—59

Akaka	Conrad	Kerry
Baucus	Dodd	Kirk
Bayh	Dorgan	Klobuchar
Begich	Durbin	Kohl
Bennet	Feingold	Landrieu
Bingaman	Feinstein	Lautenberg
Boxer	Franken	Leahy
Brown	Gillibrand	Levin
Burris	Hagan	Lieberman
Cantwell	Harkin	Lincoln
Cardin	Inouye	McCaskill
Carper	Johnson	Menendez
Casey	Kaufman	Merkley

Mikulski
Murray
Nelson (NE)
Nelson (FL)
Pryor
Reed
Reid

Rockefeller
Sanders
Schumer
Shaheen
Specter
Stabenow
Tester

Udall (CO)
Udall (NM)
Warner
Webb
Whitehouse
Wyden

NAYS—38

Alexander
Barrasso
Bennett
Bond
Brownback
Bunning
Burr
Coburn
Cochran
Collins
Corker
Cornyn
Crapo

DeMint
Ensign
Graham
Grassley
Gregg
Hatch
Hutchison
Inhofe
Isakson
Johanns
Kyl
LeMieux
Lugar

McCain
McConnell
Murkowski
Risch
Roberts
Sessions
Shelby
Snowe
Thune
Vitter
Voinovich
Wicker

NOT VOTING—3

Byrd

Chambliss

Enzi

The motion was agreed to.

The PRESIDING OFFICER. The Senate stands in recess until 12:01, a.m., Friday, December 18, 2009.

Thereupon, the Senate, at 6:52 p.m., recessed until Friday, December 18, 2009, at 12:01 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF TRANSPORTATION

DAVID T. MATSUDA, OF THE DISTRICT OF COLUMBIA, TO BE ADMINISTRATOR OF THE MARITIME ADMINISTRATION, VICE SEAN T. CONNAUGHTON, RESIGNED.

NATIONAL COUNCIL ON DISABILITY

GARY BLUMENTHAL, OF MASSACHUSETTS, TO BE A MEMBER OF THE NATIONAL COUNCIL ON DISABILITY FOR A TERM EXPIRING SEPTEMBER 17, 2010, VICE ANNE RADER, TERM EXPIRED.

CHESTER ALONZO FINN, OF NEW YORK, TO BE A MEMBER OF THE NATIONAL COUNCIL ON DISABILITY FOR A TERM EXPIRING SEPTEMBER 17, 2012, VICE KATHLEEN MARTINEZ, TERM EXPIRED.

SARA A. GELSER, OF OREGON, TO BE A MEMBER OF THE NATIONAL COUNCIL ON DISABILITY FOR A TERM EXPIRING SEPTEMBER 17, 2011, VICE PATRICIA POUND, TERM EXPIRED.

ARI NE'EMAN, OF MARYLAND, TO BE A MEMBER OF THE NATIONAL COUNCIL ON DISABILITY FOR A TERM EXPIRING SEPTEMBER 17, 2012, VICE ROBERT DAVILA, TERM EXPIRED.

DONGWOO JOSEPH PAK, OF CALIFORNIA, TO BE A MEMBER OF THE NATIONAL COUNCIL ON DISABILITY FOR A TERM EXPIRING SEPTEMBER 17, 2012, VICE TONY J. WILLIAMS, TERM EXPIRED.

CAROL JEAN REYNOLDS, OF COLORADO, TO BE A MEMBER OF THE NATIONAL COUNCIL ON DISABILITY FOR A TERM EXPIRING SEPTEMBER 17, 2010, VICE LISA MATTHEISS, TERM EXPIRED.

FERNANDO TORRES-GILL, OF CALIFORNIA, TO BE A MEMBER OF THE NATIONAL COUNCIL ON DISABILITY FOR A TERM EXPIRING SEPTEMBER 17, 2011, VICE GRAHAM HILL, TERM EXPIRED.

JONATHAN M. YOUNG, OF MARYLAND, TO BE A MEMBER OF THE NATIONAL COUNCIL ON DISABILITY FOR A TERM EXPIRING SEPTEMBER 17, 2012, VICE KATHERINE O. MCCARY, TERM EXPIRED.

BARRY GOLDWATER SCHOLARSHIP &
EXCELLENCE IN EDUCATION FOUNDATION

GWENDOLYN E. BOYD, OF MARYLAND, TO BE A MEMBER OF THE BOARD OF TRUSTEES OF THE BARRY GOLDWATER SCHOLARSHIP AND EXCELLENCE IN EDUCATION FOUNDATION FOR A TERM EXPIRING AUGUST 11, 2014, VICE DONALD J. SUTHERLAND, TERM EXPIRED.

PEGGY GOLDWATER-CLAY, OF CALIFORNIA, TO BE A MEMBER OF THE BOARD OF TRUSTEES OF THE BARRY GOLDWATER SCHOLARSHIP AND EXCELLENCE IN EDUCATION FOUNDATION FOR A TERM EXPIRING JUNE 5, 2012, (REAPPOINTMENT)

SMALL BUSINESS ADMINISTRATION

MARIE COLLINS JOHNS, OF THE DISTRICT OF COLUMBIA, TO BE DEPUTY ADMINISTRATOR OF THE SMALL BUSINESS ADMINISTRATION, VICE JOVITA CARRANZA, RESIGNED.

EXTENSIONS OF REMARKS

HONORING ROSE KAUFMAN

HON. NANCY PELOSI

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Ms. PELOSI. Madam Speaker, I rise today to honor the life of an extraordinary wife, mother, grandmother, and artist, Rose Kaufman.

The Pelosi family was blessed to be forever joined to the Kaufman family when our daughter Christine married Rose and Phil's son, Peter. Their wedding brought us all closer together and made us a single family and dear friends.

Rose was a beautiful person inside and out. I enjoyed listening to her warm, witty insights about people and her career in the arts. She was an actor and a screenwriter; a creative force and an active member of the San Francisco community. She was full of passion and spirit, brimming with ideas, committed to artistic excellence and the rich culture of our City and our nation.

Her remarkable story brought her together with Philip, her husband of 51 years. They shared a love of film and art in all forms. They collaborated on screenplays and build a warm, welcoming home for friends and family. Their partnership began as filmmakers, as professional peers; it transformed into a love story—one that stretched from their work on Phil's first film through her courageous battle with cancer in recent years.

The memories of Rose Kaufman will be ones of joy, happiness, optimism and creativity. Our whole family mourns Rose's passing, and will be reminded of her fun-loving spirit in the laughter of Octavio and Isabella. We will long remember her warmth, her vibrant personality, her commitment to those she loved, and her enduring contributions to those who loved her.

PERSONAL EXPLANATION

HON. DAVID G. REICHERT

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. REICHERT. Madam Speaker, as indicated in the Leave of Absence request granted by the House of Representatives, I was not in attendance for votes on Tuesday, December 8, 2009, so that I could support my constituents, the law enforcement community, and the residents of the Pacific northwest at a memorial service to mourn the tragic loss of four Lakewood Police officers.

Were I in attendance, I would have voted in favor of the Motion to Instruct Conferees on H.R. 3288, rollcall Vote No. 931; H. Con. Res. 199, rollcall Vote No. 932; H. Con. Res. 206,

rollcall Vote No. 933; H. Res. 940, rollcall Vote No. 934; H. Res. 845, rollcall Vote No. 935; H.R. 2278, rollcall Vote No. 936; H. Res. 915, rollcall Vote No. 937; and H. Res. 907, rollcall Vote No. 938.

HONORING THE 65TH ANNIVERSARY OF THE BATTLE OF THE BULGE

HON. JOE SESTAK

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SESTAK. Madam Speaker, December 16, 2009 marks the 65th Anniversary of the Battle of the Bulge. On this day 65 years ago, German forces launched the Ardennes Offensive against American and Allied Forces in Belgium, Luxembourg, and Germany. The Battle of the Bulge, which lasted 40 days, represents one of the greatest displays of valor, honor, and perseverance in American military history. It also marked the beginning of the end of World War II.

One week into this historic battle, commanding officer General Anthony McAuliffe was approached by Colonel Harper with a note from Germany's command asking for an "honorable surrender" by American forces. When General McAuliffe was read the note, he laughed and exclaimed, "Us surrender? Aw, nuts!" He then realized that a reply was in order, and began to ask his staff what he should say. Lieutenant General Harry Kinnard spoke up, saying "That first remark of yours would be hard to beat." "What do you mean?" asked McAuliffe. "Sir, you said 'Nuts'." replied the Lieutenant General. And that was the answer that McAuliffe gave back to the Germans; Nuts.

Surrender was never an option for our boys. Despite being outnumbered and outgunned at the onset of the battle, the Allied Forces refused to yield. Even when they were forced to retreat to Bastogne in the face of an overwhelming German force, the objective remained the same: stop Hitler's army, whatever it takes.

According to the Department of Defense, American forces suffered almost 90,000 casualties during the battle, including 19,000 killed, 47,500 wounded and 23,000 missing. It is our duty to honor those lost in battle, and to acknowledge the sacrifice they made—the ultimate sacrifice—in defense of our freedom and security. These men were not expecting combat. In fact, the area they were defending had been considered a "quiet sector". As the German Forces advanced, neither they nor their officers were aware of the impending attack. Hitler's army confronted them with half a million troops, 1,800 tanks, and thousands of guns, yet our men prevailed.

In this way, the Battle of the Bulge serves as both a legacy and a precedent. Its legacy

is that of the largest land battle in our Army's history and the turning point of World War II. Its precedent is the model it provides, even today, for our men and women in combat. During my 31 years of service in the Navy, I witnessed acts of extraordinary bravery and resolve among the men and women under my command. As a Vice Admiral, I was honored to serve with the finest sailors that our country has to offer and witness these men and women perform their duties with the same purpose and spirit that led the Allied Forces to victory 65 years ago.

This past August, I was honored with the opportunity to welcome the 83rd Infantry Division of World War II to my District. Many of these men served in the Battle of the Bulge, and it was with tremendous gratitude and respect that I addressed them, shared my own experiences as a Veteran, and fielded questions. As the son of a Navy Captain who served in the War, I have an understanding of the sacrifices these men made to serve their country, including the years they spent away from home and family. I cannot begin to express how grateful I am to these men and the deep appreciation for all they have done to defend the democratic principles of this nation.

It is with humility and a strong sense of obligation that I ask us to recognize the Allied Forces' victory at the Battle of the Bulge in late January, 1945 and the men who made that victory possible.

RECOGNIZING THE CAREER OF PHIL URBAN

HON. PATRICK J. TIBERI

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. TIBERI. Madam Speaker, I am extremely pleased to honor the work of Phil Urban, on the occasion of his retirement as President and CEO from Grange Insurance.

Our nation has always been blessed by the many individuals, who through their innovation and drive led a successful business that impacted a community and its people. Motivated by an unceasing spirit, these entrepreneurs built this great country through their work and accomplishments. Today, the tremendous strength of America and individual communities like Central Ohio are still sustained through the passion and vitality of these dedicated people. Therefore, those who contribute to this heritage deserve to be honored for their service.

As president and chief executive officer, Phil Urban directed Grange Insurance to the heights of its industry, becoming a standout-provider in a crowded market. Phil's unparalleled focus on his craft and drive to succeed helped lead Grange to numerous industry awards and unprecedented profits. Yet, profits

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

cannot solely capture Phil's legacy in our community. Since announcing his retirement earlier this year, Phil has been inundated with an outpouring of affection and praise by his peers and the entire Grange family, all of which can surely attest to the impact he made in his position. The respect he showed for his over 1,500 Central Ohio employees is well-known and is a part of why Grange has become a company emulated and respected by many. Additionally, the weight Phil placed on corporate responsibility led Grange to give millions of dollars back to greater Columbus, leaving a legacy for Phil that will stand for years to come.

Through such distinction and service to his company and to Columbus, Phil stands as a pillar of our community. I am very pleased to thank him for all he has done for Central Ohio.

I offer my congratulations to Phil Urban for a career spent in service. I hope the spirit he daily brings forth in his life and work continues to inspire his friends and co-workers for years to come.

CELEBRATING THE 191ST ANNIVERSARY OF THE STATE OF ILLINOIS

HON. DEBORAH L. HALVORSON

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mrs. HALVORSON. Madam Speaker, today I rise to recognize a great day in American history. On December 3, 1818 Illinois joined the United States of America. This month marks the 191st anniversary of this event. I join over 12 million Illinoisans in celebrating our great state's inclusion in the Union.

For nearly two centuries, Illinois has occupied an important position within our country. From Illinois, great, transformative leaders have risen to national prominence. In 1830, our 16th President, Abraham Lincoln, moved to Illinois where he practiced law in Springfield and served in our state legislature and the U.S. House of Representatives before winning the presidency in 1860. It was in Illinois where Lincoln and foe, Senator Stephen Douglas, debated the issue of slavery, the first of which was in Ottawa. Lincoln proclaimed that, "A house divided against itself cannot stand." It was Illinois that answered Lincoln's call by being the first state to ratify the Thirteenth Amendment to the Constitution, abolishing slavery. Today, we are proud to have another Illinoisan following Lincoln's legacy in the White House, our 44th President Barack Obama, with whom I served in Springfield and who served our great state in the U.S. Senate.

Illinois is home to a wide array of historic sites testifying to its important role in our nation's history. From Chicago's Museum of Science and Industry, a physical remnant of the 1893 World's Fair, to the Cahokia Mounds, a pre-Columbian settlement in the southern part of the state, Illinois bears many of our nation's historical riches.

In addition, Illinois serves as one of the leaders in our nation's economy. Illinois is at the forefront of agriculture. It is the number two producer of corn, number one producer of

soybeans in the United States, and a major producer of pork. Illinois is one of our nation's leading transportation hubs, which contribute greatly to our local economy. My district is home to the largest intermodal in the country, which provides thousands of local jobs. Many large corporations call Illinois home, such as State Farm Insurance of Bloomington, which is a major employer in Illinois' 11th Congressional District. Many motion pictures have been filmed in Illinois including the classic film *Blues Brothers*.

Within Illinois, communities from large urban cities to small rural villages come together to form the fabric of the fifth most populous state in the nation. In my own 11th District, I am proud to serve communities ranging from Peotone, in the near Chicago, to smaller communities, such as Streator and Princeton. In my district and across the state, farmers and urban professionals, teachers and firefighters all compose the diverse body of Americans known as Illinoisans. I am proud to join them today in celebrating our great state.

LEE DERROUGH

HON. SAM GRAVES

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. GRAVES. Madam Speaker, it is with great pride and pleasure that I rise today to recognize the outstanding service and leadership of Lee Derrough, on the occasion of his retirement as CEO of Hunt Midwest Enterprises Inc.

Lee is a 1967 journalism graduate of the University of Kansas. Lee faithfully served forty-two years with the Hunt Organization. He began his career as a public relations assistant for the Kansas City Chiefs. Lee then became the Marketing Director for Worlds of Fun, before becoming General Manager of the park in 1974. It was also Lee's idea to develop Oceans of Fun, which, with Worlds of Fun, became the largest tourist attraction for Kansas City, providing hundreds of jobs and opportunities for young people throughout the metropolitan community. Many of the people who worked for Lee have gone on to be major contributors to our community in their roles as lawyers, judges, doctors, teachers and business associates.

Under Lee's leadership, he grew and developed more than 6,000 acres of surface commercial and residential real estate for Hunt Midwest Real Estate Development, Inc. He also served on the Boards of Directors for the Greater Kansas City Chamber Commerce, the Kansas City Chiefs Football Club, the Civic Council of Kansas City, the Clay County EDC, the Missouri Transportation Alliance. Lee also served as the Chairman of the Board for the Economic Development Corporation of Kansas City and the Convention and Visitors Bureau of Greater Kansas City.

Madam Speaker, I ask my colleagues to join with me in commending Lee Derrough for his dedicated service to the people of Kansas City, Missouri and the Hunt Midwest Organization. I know Lee's colleagues, family and friends join with me in thanking him for his

commitment to others and wishing him happiness and good health in his retirement.

PERSONAL EXPLANATION

HON. JIM GERLACH

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. GERLACH. Madam Speaker, unfortunately, on Monday, December 14, 2009, I missed two recorded votes on the House floor. Had I been present, I would have voted YEA on rollcall 969 and YEA on rollcall 970.

WES BANNISTER RECOGNITION

HON. DANA ROHRABACHER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. ROHRABACHER. Madam Speaker, I would like to bring to the attention of my colleagues the following press release, which tells the story of Wes Bannister, who succumbed to cancer earlier this month. As the first Vice President of the Orange County Water District, he advised me on water issues for many years, and gave me his personal direction. He was a leader in the community and the state, and he will be missed. I know firsthand that his contributions will be enjoyed by Orange Countians for generations to come.

WATER INDUSTRY LOSES A GREAT LEADER

THE ORANGE COUNTY WATER DISTRICT BOARD AND STAFF MOURNS THE UNTIMELY LOSS OF FIRST VICE PRESIDENT, DIRECTOR WES BANNISTER

FOUNTAIN VALLEY, CA (Dec. 11, 2009).—In the late hours of December 10, 2009, the water world and Orange County lost an important trailblazer and public servant, Wesley "Wes" Mastin Bannister lost his battle with cancer. Wes Bannister was elected to the Orange County Water District (OCWD) Board of Directors in 1991 representing Division 6, which includes Fountain Valley, Huntington Beach and parts of Westminster. He was re-elected to four consecutive four-year terms in 1996, 2001, 2004 and 2008. He was elected in 2007 and 2008 by his fellow board members to serve as the District's 1st Vice President.

"The Board and staff of the Orange County Water District have lost an incredible leader who lived and breathed water," stated OCWD Board President Stephen R. Sheldon. "Those who had the privilege of working with Wes know that he had the tenacity to get to the core of critical issues and drive and inspire others to do what was right and economically sound. He stood true to his principles and convictions, like no other person. We are truly sorry for his family's great loss."

During his tenure as a Board Member, the District celebrated many important achievements including the building and operation of the Groundwater Replenishment (GWR) System, the largest water purification project of its kind in the world, and a state-of-the-art Advanced Water Quality Assurance Laboratory.

In addition to serving on the OCWD Board, in 1993 Director Bannister was appointed Director to the Metropolitan Water District of Southern California (MWD) representing the

Municipal Water District of Orange County. In 2004, Director Bannister was elected as Chair of the MWD Board of Directors, for which he served until October 31, 2006.

"Wes was a principled leader and committed advocate for Orange County and its water interests who also worked faithfully to address the water challenges facing the entire southern California region," said Wayne Clark, President of the Municipal Water District of Orange County (MWDOC). "We were honored to have had Wes represent MWDOC as one of our appointed representatives to the Metropolitan Water District of Southern California and we are going to miss our good friend."

Director Bannister devoted over 23 years to serving the communities of Orange County. He served on the Huntington Beach City Council from 1986 to 1990, including as Mayor in 1989. "I had the distinct honor of serving with Wes on the City Council", stated Assemblyman Jim Silva (R-Huntington Beach). "If it weren't for his encouragement and support, I would not be serving in the Assembly today. Wes was invaluable to me and many of my colleagues when it came to solving state water issues. He was a mentor and a true friend who genuinely cared about the people in his community and gave of his time and energy to making a difference."

Director Bannister was also the Republican nominee for California Insurance Commissioner in 1990 and was nominated to the Electoral College by President Bush in that same year. He also served on the West Orange County Board from 1986 to 1990 and on the Orange County Sanitation District Board of Directors, District 11, from 1988 to 1990.

In 1986, Director Bannister was appointed by the Governor to the California FAIR Plan Board of Governors and continued to serve on this Board until his untimely death. Since 1993, Director Bannister had represented OCWD on the Board of Directors of the Association of California Water Agencies Joint Powers Insurance Authority (ACWA-JPIA). While serving, the Board elected him to the Governing Committee and to serve two years as its Vice President. Following his two-year term, the Board elected him President in 2005 for a three-year term.

Active in local affairs, Director Bannister served on the boards of the Boys and Girls Club and YMCA, as Charter President of the Huntington Beach Sunrise Rotary Club and as an advisor to the Huntington Beach Search and Rescue Post 536.

Director Bannister was born in Houston, Texas in 1936. He and his wife Elizabeth (Betty) Ann Rogers Bannister were married at Fort Sill in Oklahoma in 1959 where he was stationed and recently celebrated their 50th wedding anniversary. Director Bannister and his wife Betty have lived in Huntington Beach since 1969. Together, the Bannisters welcomed three children Catherine (Cathy) Ann, Alice (Lisa) Elizabeth and Douglas (Doug) Mastin.

In addition to devoting much of his time to serving the communities of Orange County, Director Bannister founded Bannister and Associates Insurance Agency in 1974, from which he retired in 2003. The family business continues to flourish under the leadership of his two surviving children Alice (Lisa) Elizabeth Bannister and Douglas (Doug) Mastin Bannister. Director Bannister is also survived by two grandchildren Kaitlyn Michelle and Brent Douglas.

RECOGNIZING AND COMMENDING THE 200TH ANNIVERSARY OF BIBLICA

HON. DOUG LAMBORN

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. LAMBORN. Madam Speaker, I rise today to recognize and commend Biblica for the contributions they have made to our country and join with them in the celebration of their 200th anniversary.

On December 4, 1809, a small group of concerned citizens met in lower Manhattan to discuss how to make the Bible available to the residents of the city and formed the New York Bible Society, beginning an organization that has been woven into the fabric of United States culture for 200 years.

The New York Bible Society provided Scripture for members of the United States Armed Forces in each conflict, foreign and domestic, since the War of 1812, and in partnership with the United States military chaplaincy, distributed more than 1,000,000 Bibles to members of the Armed Forces looking for courage, guidance, and comfort.

When the gates of Ellis Island opened in 1890, the New York Bible Society greeted new immigrants with a copy of Scripture in their native language, and over the 60 years that followed, provided an average of 160,000 copies of Scripture each year to immigrants.

In 1962, John Glenn lifted off into space with a Bible he received from the New York Bible Society. In 1968, the New York Bible Society sponsored the Committee on Bible Translation, a group responsible for creating the New International Version, which is now the most widely distributed, contemporary English version in the world, with more than 300,000,000 copies in circulation.

The New York Bible Society moved to Colorado Springs, Colorado in 1988 and became the International Bible Society.

Following the 9/11 terrorist attacks, the International Bible Society distributed more than 800,000 copies of Scripture to those seeking hope and comfort during one of the darkest moments in United States history. The International Bible Society also provided Scripture to disaster survivors worldwide, including victims of Hurricane Katrina and the 2004 Indian Ocean tsunami.

The International Bible Society merged with Living Bibles International and Send the Light and today operates as Biblica.

Biblica is one of the largest distributors of Bibles and biblical resources in the world, operates in 54 countries, and has translated the Bible into more than 100 languages. Biblica is the leading provider of Bible translations on the Internet, providing the Bible in 29 languages to more than 100,000,000 Internet users annually.

It is an honor to recognize Biblica as an integral part of our nation's history and I commend them for the contributions they have made to the United States and around the world.

HONORING THE LIFE OF MARY MADELEINE SEGAL HALL

HON. RALPH M. HALL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. HALL of Texas. Madam Speaker, I rise today to honor the life of Mary Madeleine Segal Hall, a remarkable woman and personal friend who passed away on October 6, 2009 at the age of 85.

Mary was born on July 18, 1924 in Jefferson, Texas to Margaret Manning and Maurice Segal. She graduated from Jefferson High School in 1940 and went on to attend the College of Marshall, now East Texas Baptist University, where she met her future husband of 48 years, the late Sam B. Hall, Jr., a former member of the U.S. House of Representatives and my good friend.

Throughout her 85 years, Mary was a dedicated member of the community. Her civic commitment was evidenced by the many community organizations in which she was involved. She was a charter member of Marshall Symphony League, served on the Boards of Marshall Symphony Society and the Starr Home, active in Belle Maison, Club 25 and on the advisory board of Historical Commission Advisory Council. During her husband's Congressional years, she was active in the Congressional Wives Club, Texas Breakfast Club, and Texas State Society. She loved her life in Washington where she would give tours of the White House on a regular basis. In 1977, she and her husband were named the first recipients of the J. Wesley Smith Award given annually by East Texas Baptist University for outstanding achievements.

Mary was a devoted Christian and served as a member of Eastern Hills Church of Christ in Marshall. She is survived by three daughters and sons-in-law, Becky and W.F. Palmer, Amanda and Tom Wynn, and Sandra and Don Bodenhamer; five grandchildren, and five great-grandchildren. She was a very loving, wonderful mother, grandmother, and great-grandmother; she was someone you wanted to emulate. Mary was a wonderful wife to her husband and wherever he was, she loved being there.

Madam Speaker, it gives me great pleasure to honor the life, accomplishments, and memory of Mrs. Mary Madeleine Segal Hall. Her contributions will be greatly missed but her kindness and service will not be forgotten.

INTRODUCTION OF THE UNITED STATES WAR BONDS ACT OF 2009

HON. KENDRICK B. MEEK

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. MEEK of Florida. Madam Speaker, I rise today to introduce before the House of Representatives, the War Bonds Act of 2009. War bonds are a cost-effective way to reduce our dependence on foreign creditors and create an outlet for Americans to express their patriotism and support for our servicemembers as

well as the security mission for which they are deployed.

To be sure, thousands of Americans have made tremendous sacrifices over the course of this war. Members of the military, their families, and their friends have gone above and beyond the call of duty, and we must never take their service for granted. Many of us have begun shopping for our friends and families this holiday season, while a relatively small group of families are preparing to send their loved ones off to battle.

We have an opportunity to bridge that disconnection. We have an opportunity to open our wallets and provide gifts, big or small, to our troops. These funds will go toward more than war machinery, but to clothing, feeding, securing, and providing medical services for our service men and women abroad. It will allow them the means to make quick work of their mission and to return home safely to their families. The War Bonds Act of 2009 will allow Americans to show their support for the troops even if they are wary about the war itself.

We also need to responsibly finance the increase in troop levels rather than continuing deficit spending for the mission. Each soldier, sailor, airman, and marine that we send abroad costs \$1 million per deployment. A 34,000 person troop increase could raise our Afghanistan tab by some \$40 billion per year, affecting our ability to invest domestically and to rebuild our military from the wear of the Iraq war. In past wars, Congress has raised taxes to fund most of our fighting, but since 9/11 the war bills have been piling up. Our engagements in the Middle East have been financed primarily by debt, money borrowed from foreign countries. In fact, nearly \$3.5 trillion—46 percent of U.S. debt—is held by foreign investors.

War bonds allow us to borrow from ourselves, rather than other countries. United States savings bonds are considered some of the safest investments in the world. They are available in predetermined denominations and mature over a period of time while accruing interest. After a number of years, the owner of the bond can collect the face value cost of the bond plus interest. All U.S. savings bonds are backed by the full faith and credit of the United States Government.

The legislation I am introducing today will allow American citizens to do our part without being required to do so through taxation. The legislation will authorize the Treasury to issue and market war bonds to the American people to help finance the wars in Afghanistan and Iraq.

I believe that we need shared sacrifice and fiscal discipline in financing the war effort. Where we have sacrificed our future with billions of dollars of deficit spending on the war, we can begin bringing down that deficit with much smaller individual sacrifices now.

The U.S. War Bonds Act of 2009 finds a precedent in World War II savings bonds. From May 1, 1941, through December 1945, the War Finance Division and its predecessors were responsible for the sale of nearly \$186 billion worth of government securities. Of this, more than \$54 billion was in the form of war savings bonds.

I believe that the same patriotism is alive and well today, and that as a Nation and a

people we have not lost the will to make collective sacrifices for the greater good. The men and women in the U.S. military are fighting year-round in faraway places, with their sacrifices and those of their families beyond comprehension. I believe that in that same spirit, Americans will be able to use war bonds to offer a token of respect, admiration, and support for those in uniform who show the same for us every day of their lives.

A BILL TO DIRECT THE PRESIDENT TO TRANSMIT TO CONGRESS A REPORT ON ANTI-AMERICAN INCITEMENT TO VIOLENCE IN THE MIDDLE EAST

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. KUCINICH. Madam Speaker, H.R. 2278 condemns the use by groups designated as Foreign Terrorist Organizations in the Middle East of television programs to incite anti-American violence.

I do not condone the use of television programming to promote anti-American sentiment in the Middle East; I strongly object to it. Similarly, I strongly condemn ongoing policies that seek to punish civilian populations in an effort to undermine political leadership in their respective countries. However, if we want to stop anti-American incitement in the Middle East, we must end our military occupation of Iraq and Afghanistan, we must put an end to the drone attacks in Pakistan and we must end the blockade of Gaza.

Our continued occupation fuels the insurgency in Iraq and the Taliban in Afghanistan. Just this week, over 100 people have been killed and almost 200 wounded in a series of bombings in Baghdad, resulting in one of the deadliest attacks in Iraq this year. President Obama accepted his Nobel Peace Prize as over 16,000 American troops were readying for deployment as part of our military escalation in Afghanistan.

More unmanned drone attacks in Pakistan have been authorized by President Obama during his first three months in office than President Bush ordered during his entire presidency. Predator drones have killed hundreds of innocent civilians and have spurred significant anti-American sentiment. The recent revelations that the C.I.A. is running the predator drone program show that we are deploying an extraordinary use of lethal force in a country we are not at war with.

On the eve of the one-year anniversary of Operation Cast Lead, the people of Gaza continue to suffer immeasurably under the U.S. imposed blockade, living in tents next to the remains of their homes. Not one house has been rebuilt and not one pane of glass has been allowed in. Ninety-five percent of the drinking water is unfit for human consumption as the man-made humanitarian crisis continues. The United States and our closest ally, Israel, have a responsibility to uphold international humanitarian and international human rights law, both of which are violated by this blockade.

A resolution condemning television programming by designated Foreign Terrorist Organizations does not make our condemnation of terrorist acts more clear. Furthermore, this resolution does nothing to bring the United States and our friends in the Middle East closer to peace and stability. Anti-American sentiment in the Middle East can only be solved through diplomatic means and through the consistent application of peaceful solutions that ensure the security and basic human rights of all people.

HONORING THE LIFE OF JAMES ROBERT PAXTON

HON. RALPH M. HALL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. HALL of Texas. Madam Speaker, I rise today to honor the life of James Robert Paxton, a veteran, civic servant, and personal friend who passed away August 2, 2009 at the age of 86.

"Jim Bob," as he was known to his friends and family, was born September 15, 1923. The youngest child of Eugene Stratton Paxton and Ella Clark Paxton, "Jim Bob" grew up in Elkhart, Texas before attending Baylor University. Deciding to put his education on hold, "Jim Bob" enlisted in the United States Navy as an officer where he taught airplane recognition in World War II. His service in the U.S. Navy took him many places, including his arrival on the Japanese island of Nagasaki to help liberate American and Allied prisoners the day after the atom bomb was dropped.

After World War II, "Jim Bob" returned to Baylor University to complete his undergraduate degree before attending law school at Southern Methodist University in Dallas, Texas. Mr. Paxton then served two terms in the Texas Legislature, where he met and fell in love with his wife, Doris, whom he married in 1954. The couple moved to Palestine where they lived and raised their family, and where Mr. Paxton practiced law for more than fifty years. Among his many outstanding achievements, "Jim Bob" was appointed by Governor Dolph Brisco to serve on the Texas Parks and Wildlife Commission.

As evident through his military and civic service, Mr. Paxton was not only a leader in his home as a loving husband and father, but a leader in his community and country. He was known as a man of faith, who lived his life in devotion to God, and he will be missed by those who knew him.

He is survived by his wife of 55 years, Doris Lee Hall Paxton, their five daughters, and numerous grandchildren, nieces, nephews, and friends. Madam Speaker, I ask those here today to join me in remembrance of this great American, James Robert Paxton.

HONORING U.S. MARINE CORPS
VETERAN JOHN D. DAY

HON. ERIC J.J. MASSA

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. MASSA. Madam Speaker, I rise today to laud the lifelong achievements, patriotism and honorable milita service to our country by U.S. Marine Corps veteran John D. Day of Hornell, New York. It is a distinct honor to submit his name before the United States House of Representatives for his numerous contributions to the 29th Congressional District and a grateful Nation.

A graduate of Hornell High School, John went on to study Criminal Justice at Finger Lakes Community College and Corning Community College where he balanced his academic studies with his participation on the collegiate baseball teams. After completing his studies, John heeded the call of duty and enlisted with the U.S. Marine Corps where he served until his honorable discharge in 2000, after 4 years of service.

John then embarked on a career path of public service as a member of various, local police departments where he achieved the rank of Sergeant while simultaneously working towards the completion of his associates degree.

As a training officer, John was credited with designing and implementing numerous programs to better train officers and to improve job performance. Tragically, while en route to work at the Bath VA Police Department on October 27, 2008, John was killed when his vehicle was hit by a drunk driver.

Since the accident, John was posthumously promoted to Lieutenant and was honored in April as the United States Department of Veteran Affairs Police Officer of the Year at the Annual Law Enforcement Banquet. John was also cited by the VA National Central Office for his perfect record maintaining and completing all training records. In addition, the last two classes at the Federal Police Officer Academy at Little Rock, Arkansas, dedicated their graduation and hard work to the way John performed his duties at work and the professionalism he demonstrated.

On behalf of the United States House of Representatives, it is my honor to recognize Officer John D. Day's contributions to his country and community.

GRATITUDE FOR THE SERVICE OF
KAREN WILKINSON

HON. JOHN CONYERS, JR.

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. CONYERS. Madam Speaker, the Judiciary Committee's Crime, Terrorism, and Homeland Security Subcommittee Chairman ROBERT C. "BOBBY" SCOTT and I would like to take this opportunity to thank Karen Wilkinson for her work with the Committee for the past 2 years.

Karen came to us as a detailee from the Administrative Office of the United States

Courts. At the end of December, Karen will return to Phoenix, Arizona to continue her work as an Assistant Federal Public Defender representing indigent clients in federal criminal cases, where she worked for eight years before coming to the Committee. Prior to that, she clerked for the U.S. District Court for Arizona and then joined the law firm of Brown & Bain. Karen graduated magna cum laude from Arizona State University Law School, received a Masters in Business Administration from NOVA University and her Bachelor of Science degree from the University of Michigan.

Karen's accomplishments during her tenure with the Committee include a number of bills that are very important to improving our country's criminal justice system. During the 111th Congress, she was responsible for guiding several legislative measures to approval on the floor of the House of Representatives, including: H.R. 448, the Elder Abuse Victims Act of 2009; H.R. 632, the National Silver Alert Act of 2009; H.R. 748, CAMPUS Safety Act of 2009; H.R. 908, the Missing Alzheimer's Disease Patient Alert Program Reauthorization Act of 2009; H.R. 1333, which amends chapter 40 of title 18 of the United States Code to exempt the transportation, shipment, receipt, or importation of explosive materials for delivery to a federally recognized Indian tribes; H.R. 1727, the Managing Arson Through Criminal History, MATCH, Act; H.R. 1933, a Child is Missing Alert and Recovery Center Act; S. 1289, the Foreign Evidence Request Efficiency Act of 2009, and H.R. 2661, the Court Security Enhancement Act of 2009.

In addition, she is shepherding several very important bills pending before the Judiciary Committee, such as: H.R. 503, the Prevention of Equine Cruelty Act of 2009; H.R. 3327, the Ramos-Compean Justice Act of 2009; H.R. 2289, the Juvenile Justice Accountability and Improvement Act of 2009; H.R. 2095, the Restitution for the Exonerated Act; H.R. 1149, the Child Protection Reauthorization Act of 2009 and H.R. 1422, the Adam Walsh Child Protection and Safety Reauthorization Act of 2009. Karen is also developing the Literacy Education and Rehabilitation Act, LERA, and the Department of Justice Reauthorization Act, legislation that would require a criminal defense representative to be appointed to the United States Sentencing Commission, as well as bills that would correct the firearm recidivist sentencing guidelines and the computation of good time credit in federal prison system.

We would like to thank the Administrative Office of Courts and the Federal Public Defender's Office of Phoenix for their generosity in allowing such a dedicated, responsible, and committed person to become such an integral part of our team. We are deeply grateful to Karen for her service, professionalism, and friendship during the past 2 years. She possesses that rare balance of humility, warmth, wit, and passion without a trace of ego, and she will be sorely missed. We wish her the best of luck and give her our thanks.

PAYING TRIBUTE TO THE LIFE OF
JACK GAINES THAXTON

HON. RALPH M. HALL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. HALL of Texas. Madam Speaker, I rise today to pay tribute to the life of Jack Gaines Thaxton who passed away August 7, 2009 at the age of 90. A lifelong Texan, Mr. Thaxton was born April 23, 1919 in Kaufman, Texas to Estelle Gaines Thaxton and John W. Thaxton. He spent his childhood and adolescent years in Rockwall, Texas, graduating from high school in 1937. Even in his early years, he demonstrated character qualities which would be associated with his name throughout his life. He dedicated himself to many activities in school including football, which he excelled in, baseball, and tennis, also taking pride in his perfect attendance record.

Upon graduating, Mr. Thaxton worked for three years as assistant manager for the Boyer Drug Company in Rockwall before volunteering for service in the Texas National Guard, later serving with the 112th Calvary. During World War II, he campaigned in the Pacific Theater and in the liberation of the Southern Philippines and Luzon. After contracting malaria and hepatitis, Mr. Thaxton spent several months recovering in an Army hospital before being released in 1945. Mr. Thaxton received several decorations, including five bronze stars for meritorious service.

After he returned to Texas, Mr. Thaxton enrolled at the University of Texas in Austin, Texas, where he earned a Bachelor Degree in Business Administration in 1949. Shortly after graduating, he married Marguerite Ruth Davis and the couple moved to Corpus Christi where he worked for H.E.B Grocery Company for thirty years. Marguerite passed away after twenty-two years of marriage, and Mr. Thaxton later remarried to Marjorie N. Thaxton.

Mr. Thaxton decided to combine his passion for sports and education when he established a golf scholarship at his alma mater, Rockwall High School, the proceeds of which help students further their academic goals.

He was a faithful member of the First United Methodist Church, a Mason, and later a member of the Al Amin Shrine Temple. He is survived by his son, James Eric Thaxton and his wife Carol Arnold Thaxton, along with three grandchildren.

Madam Speaker, I ask those present today to join me in honoring the life of this American veteran and dedicated American citizen, Mr. Jack Gaines Thaxton.

IN MEMORY OF WILLIAM POPE
"BILLY" LANGDALE, SR.

HON. SANFORD D. BISHOP, JR.

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. BISHOP of Georgia. Madam Speaker, I rise today to honor the memory of William Pope "Billy" Langdale, Sr., a man I was proud

to call my friend and constituent. An accomplished public servant who was devoted to his community, state, country, his family, and friends, Billy passed away on December 12, 2009, at the age of 88.

Billy lived his entire life in Valdosta in Lowndes County, Georgia. He graduated from Valdosta High School in 1938 where he was a proud member of the Valdosta Wildcat football team. He went on to attend the University of Georgia, where he played football for the Bulldogs before enlisting in the United States Marine Corps in 1942. He served in the Marines for 10 years and was awarded a Bronze Star before retiring at the rank of Lieutenant Colonel.

His public career began in 1960, when he was elected as chairman to the Lowndes County Board of Commissioners, where he served for 16 years. He then served as Chairman of the Georgia Department of Transportation board for 2 years before becoming the Second Congressional District representative on the DOT board, a post he held for more than 25 years. He was instrumental in numerous local transportation projects, from highway improvements to the six-laning of Interstate 75.

Billy fittingly received many accolades for his public service, including being named as one of Georgia Trend magazine's "100 Most Influential Georgians" as well as South Georgia Business magazine's list of the "Most Influential South Georgians." A highway in my district is named the "Billy Langdale Highway" in his honor. Upon his retirement in 2008, both the Georgia State Senate and the Georgia House of Representatives passed resolutions thanking Billy for his many years of service to the state.

Madam Speaker, the State of Georgia, especially the Second Congressional District, and our Nation have been truly blessed to have benefited from the tremendous leadership of Billy Langdale. He will be remembered for the compassion he spread continuously throughout his life, his great humor, his never ending modesty, his intense desire to help others, and his unwavering love for his family.

A TRIBUTE TO BOB HEFT

HON. DAVE CAMP

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. CAMP. Madam Speaker, I rise today to pay tribute to and remember the life of an outstanding individual, Mr. Robert G. Heft of Saginaw, MI, who I am sad to report passed away this week.

Mr. Heft, who liked to be called simply "Bob," was a man whose innovation and patriotism created a legacy that reaches even into outer space.

Bob was the man behind a true representation of patriotism, the symbol of our Nation that flies proudly today above this very building, across the country, around the world, and yes, is even on the moon.

Using his mother's sewing machine and a hot iron, Bob created the first fifty-star flag as an assignment for school. His teacher origi-

nally gave him a B minus, so they made a deal: if Bob's design was accepted by Congress, he would change the grade to an A.

So Bob sent his prototype to his Governor and Congressman.

Then, one morning in 1958, Bob received a very special phone call. On the other end of the line was President Dwight D. Eisenhower, personally calling the high schooler to tell him that Bob's version of the American Flag was picked by the President to replace the 48-star flag as the official design for our recently-expanded Nation. Bob's flag was chosen from more than 190,000 entries submitted.

Bob was there with the President on July 4, 1960, when the flag was flown for the first time. What began as a history project later became the longest-serving flag in American History, an American icon, and the true face of freedom. Bob's work is an inspiration to our students that each morning recite the pledge of allegiance to the flag of the United States of America.

And yes, it was his flag that just a few years later was launched and planted on the Moon, a perpetual reminder that our citizens' innovative talents know no bounds.

Bob's service to our Nation did not end there though. He was a longtime Professor at Northwest State Community College in Archbold, Ohio. After his retirement, Bob served as mayor of Napoleon, Ohio for 14 years, becoming the longest serving mayor in the town's history. During this time, Bob also became a popular motivational speaker, going to schools and veterans' groups all over the country to tell his unique stories. The many that met him said that Bob emanated a true warmth and love for his country.

I wish to extend my sincere thanks to Bob Heft, a true patriot throughout his life. I also wish to extend my deepest condolences to his family and friends. Though most citizens may have never met him, all have been touched by the symbol of American freedom that he created, and has become part of the integral fabric of this country.

EARMARK DECLARATION

HON. ZACH WAMP

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. WAMP. Madam Speaker, as a leader on earmark reform, I am committed to protecting taxpayers' money and providing greater transparency and a fully accountable process. H.R. 3326, Department of Defense and Related Agencies Appropriations Act, 2010 contains the following funding:

Requesting Member: Rep. ZACH WAMP

Account: Research, Development, Test And Evaluation, Army—Medical Technology
Legal Name Requesting Entity: Department of Orthopedic Surgery, University of Tennessee College of Medicine Chattanooga

Address: 975 East Third Street Chattanooga, TN 37403

Description of Request: The University of Tennessee College of Medicine Chattanooga requested funding for its work with artificial bone implants and grafts for American sol-

diers, airmen, sailors and marines who have lost limbs in combat. This research will greatly enhance the lives of injured service members giving them more independence and allow them to live more productive and fulfilling lives. The University of Tennessee College of Medicine Chattanooga receives \$1,000,000 for this project.

Distribution of funding:

Yearly Staffing—37%

Consultative Services—9%

Scientific Material—54%

Requesting Member: Rep. ZACH WAMP

Account: Other Procurement, Army—Training Devices, Nonsystem

Legal Name Requesting Entity: Tennessee Army National Guard

Address: Houston Barracks, 3041 Sidco Drive Nashville, TN 37204

Description of Request: The Tennessee Army National Guard requested funding to purchase and maintain Combined Arms Virtual Trainers to better prepare service members for deployments to Iraq and Afghanistan. This equipment replicates virtual battlefields and allows Army National Guard soldiers to train as they will fight. Allowing Combined Arms Training within a virtual environment will save lives on the real battlefield. The Tennessee Army National Guard receives \$5,000,000 for this equipment.

Distribution of funding: Equipment, Software, & Maintenance—100%

HONORING THE LIFE OF EDWARD ALLEN POPE

HON. RALPH M. HALL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. HALL of Texas. Madam Speaker, I rise today to honor the life and accomplishments of Edward Allen Pope of Amarillo and life-long resident of Dallas, who died at the age of 85 on October 29, 2009.

Ed was born October 31, 1923 to Gertrude Milam and Edward G. Pope. After graduating from Crozier Tech High School in 1942, he joined the U.S. Navy and earned the rank of Lieutenant Commander. He served during World War II and the Korean Conflict as a naval aviator. He received The China Service Medal, the National Defense Service Medal and the Naval Reserve Medal. After Naval retirement, he became an electrician for Ling, Oliver and O'Dwyer, working there until his retirement in 1989.

In December 1947, he married Virginia Shelly, and they would have celebrated 62 years together this year as man and wife. He was a great "in-law", loving Virginia's family as his own. Ed was a family man—a great father of strong faith and conviction. He was a faithful member of Christ Church in Dallas, serving on their Vestry as Junior Warden for 35 years. He loved unconditionally and he loved a good time. His rule in life was "the more the merrier" and he was the leader and planner for hunting, skiing and boating excursions and many family outings. He was an inquisitive, generous, tender-hearted, gentle man loved by all who knew him.

Ed is survived by his wife, Virginia; a brother, Norman Pope of Austin; a daughter, Janace Pope Ponder of Amarillo and her husband, David; his daughter-in-law Debby Pope; his grandchildren, Paige Garmon, Abby Mitchell, Carmen Juckett and Courtney Pope; and great grandchildren, Michael Clouse, Peyton Garmon, Madison Garmon, Shelby Garmon, Kaylee Mitchell and Jacob Juckett; as well as nieces, nephews and many close friends and other family members. He was preceded in death by his parents and his son, Joseph Pope. Madam Speaker, I ask those present today to join me in honoring the life of this great American, Edward Allen Pope.

INTRODUCTION OF THE RESOLUTION OF INQUIRY

HON. FRANK R. WOLF

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. WOLF. Madam Speaker, I rise today to introduce a Resolution of Inquiry directing the Attorney General to transmit to the House all information relating to the decision to dismiss an important voter intimidation case, *United States v. New Black Panther Party*. The case sought to enforce Voting Rights Act statutes against members of the New Black Panther Party that threatened Philadelphia voters—both verbally and physically—last year.

This case was inexplicably dismissed earlier this year—over the ardent objections of the career attorneys overseeing the case as well as the department's own appeal office.

I regret that Congress must resort to oversight resolutions as a means to receive information about the dismissal of this case, but the Congress and the American people have a right to know why this case was not prosecuted.

As ranking Republican member of the House Commerce-Justice-Science Appropriations Subcommittee that funds the Justice Department, I take oversight of the department very seriously.

I also strongly support voting rights protections. In 1981, I was the only member—Republican or Democrat—of the Virginia delegation in the House to vote for the Voting Rights Act and was harshly criticized by the editorial page of the *Richmond Times-Dispatch*, and when I supported its reauthorization in 2006, I was criticized again by editorial pages.

Time and again over the last year, the department has stonewalled any effort to learn about the decision to dismiss this case.

I have written Attorney General Holder on six occasions asking for an explanation for the dismissal of this case. To date, I have received no response from him.

I wrote the DOJ Inspector General to request a review of this decision. He deferred to the Office of Professional Responsibility—which reports directly to the Attorney General.

I have written the Office of Professional Responsibility seeking information on its investigation. The Office has refused to share any information.

In fact, the only response I have received—from a legislative affairs staffer—was woefully incomplete and—in places—inaccurate.

Two months ago, I met with House Judiciary Chairman CONYERS to ask for his assistance in obtaining this information, but he has yet to take any action. This is a shameful failure to provide necessary congressional oversight.

It is not only Congress that is being stonewalled by the Attorney General. The U.S. Commission on Civil Rights has repeatedly sought this same information, in fulfillment of its statutory responsibility to ensure the enforcement of civil rights law.

After being similarly rebuffed, the commission filed subpoenas with the department for this information as well as to interview the career attorneys that handled the case.

However, we understand that the Attorney General has instructed his department to ignore these subpoenas. The nation's chief law enforcement officer is forcing these career attorneys to choose between complying with the law and complying with the Attorney General's obstruction.

At least one of the attorneys has been compelled to obtain private counsel.

I urge the House Judiciary Committee to report this resolution out favorably and to demand that the Attorney General answer the questions surrounding this case.

The career attorneys and Appellate Division within the department sought to demonstrate the Federal Government's commitment to protecting voting rights by vigorously prosecuting any individual or group that seeks to undermine this right.

This House must not turn a blind eye to the Attorney General's obstruction. He has an obligation to answer the legitimate questions of the House and the Civil Rights Commission.

It is imperative that we protect the right of all Americans to vote—the sacrosanct and inalienable right of any democracy.

I submit for the record a copy of the resolution that I am introducing.

RESOLUTION

Directing the Attorney General to transmit to the House of Representatives all information in the Attorney General's possession relating to the decision to dismiss *United States v. New Black Panther Party*.

Resolved, That the Attorney General is directed to transmit to the House of Representatives, not later than 14 days after the date of adoption of this resolution, copies of any document, memo, or correspondence of the Department of Justice with regard to *United States v. New Black Panther Party*, or any portion of any such document, memo, or correspondence that refers or relates to—

(1) any department communications with regard to the case between November 5, 2008 and November 15, 2009;

(2) any communication with the defendants or the defendants' attorneys between November 5, 2008 and November 15, 2009;

(3) any communication with third-party organizations or individuals between November 5, 2008 and November 15, 2009; or

(4) any evidence with regard to the dismissal of the case.

HONORING THE LIFE OF EDDIE M. BROOKS

HON. RALPH M. HALL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. HALL of Texas. Madam Speaker, I rise today in honor of the life of Mr. Eddie Brooks, a loving husband and father, veteran of the Korean War, and an American hero, who passed away August 18, 2009 at the age of 90.

Hailing from Hope, Arkansas, Mr. Brooks committed twenty years of his life in service to the United States Army, serving with the Army Medical Service, Medical Detachment, and 555th Field Artillery Battalion in the Korean War. Mr. Brooks was sent into combat in Korea with no training, but rose to the occasion, demonstrating bravery in how he handled himself and defended his comrades.

Early on in his deployment, his unit was trapped in a river bed where they were exposed to extensive shooting and grenades. Mr. Brooks was injured when one grenade got under his feet, seriously wounding one leg. Corporal Eddie M. Brooks refused evacuation, continuing to treat other wounded soldiers and assisting in their removal from the area. The United States Army Headquarters 25th Infantry Division stated, "When the unit began displacement because of increased hostile action, he drove a 2½ ton truck loaded with critical supplies to safety. Corporal Brooks' gallant and selfless devotion to duty reflects the greatest credit upon himself and the Army Medical Service." When asked about his received honors, Mr. Brooks always expressed his feeling that he was undeserving but appreciative, believing that others had sacrificed more than him.

For his military service, Mr. Brooks was awarded the Purple Heart, Silver Star, Germany Occupation Medal, United Nations Medal, Good Conduct Medal, National Defense Medal, and the Korean Service Medal.

At home, Mr. Brooks was the devoted husband to his wife of 58 years, Joyce, and the father of four daughters, Brenda, who passed away in 2005 due to illness, Debra, Charlotte, and Angela. Held in high esteem by all who knew him, he left behind a legacy of honor, service, and love. Madam Speaker, I ask those here today to join me in paying tribute to this great American hero, Mr. Eddie M. Brooks.

HONORING FRANK "PONCHO" ROBERTS

HON. KEVIN BRADY

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. BRADY of Texas. Madam Speaker, I rise today to honor Frank "Poncho" Roberts, a dedicated husband, father, and community servant on the occasion of his graduation from Sam Houston State University in Huntsville, Texas. Mr. Roberts graduates with a bachelor of fine arts degree in theatre.

Poncho Roberts was born to Frank and Daisy Roberts on February 19, 1932, in Madisonville, Texas. He spent part of his childhood in Huntsville, but later moved to Houston and graduated from Austin High School in 1949. After graduation, he worked for the Southwestern Bell Telephone Company. He spent most of his career working for the company at NASA as a craftsman and supervisor. Poncho fondly recounts his days working as a contractor for the space agency having seen some of its earliest missions from Gemini to Apollo.

Upon retirement in 1986, Poncho and his wife, Sugar, moved back to Huntsville to be close to their children. With a heart for serving others and a joyful, outgoing personality, Poncho was called on to help with various community service projects. He was the driving force behind the effort to build the Huntsville Aquatic Center, which has given the youth of Huntsville a place to swim and has allowed for the development of the Huntsville Lakers Swim Team.

Poncho has volunteered many hours of his time to work with the Huntsville-Walker County Chamber of Commerce working at the Sam Houston Statue and Visitors Center. He is a member of the Huntsville Rotary Club and leads the "I Like Me!" program that distributes books to children to promote literary and character building. Poncho is also a deacon at University Heights Baptist Church in Huntsville.

Poncho is well known for the penchant he has for the fine arts, especially theatre, and he has been a part of many plays performed by the Huntsville Community Theatre.

Of all his accomplishments, Poncho is most proud of being a loving husband and father. Poncho and Sugar have been married for 58 years. They have raised two children, a son, Frank Jr., and a daughter, Debbie. They have eight grandchildren and two great-grandchildren with another on the way.

Madam Speaker, Poncho Roberts has dedicated his life to being a family man and to serving his community. He is proof that education is a lifelong endeavor. It is such an honor to represent good people like Poncho in the U.S. House of Representatives. I urge you to join me in congratulating him on his graduation. That's Togetherness, One More Time.

EARMARK DECLARATION

HON. MICHAEL N. CASTLE

OF DELAWARE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. CASTLE. Madam Speaker, pursuant to the Republican Leadership standards on earmarks, I am submitting the following information regarding funding benefitting the State of Delaware included in H.R. 3326, the Fiscal Year 2010 Defense Appropriations Act.

Name of Intended Recipient: Delaware National Guard

Location: First Regiment Rd, Wilmington, DE 19808

Requesting Member: Congressman MICHAEL N. CASTLE

Account: DRUGS

Name of Project: Delaware National Guard Counterdrug Task Force

Project Description: The Act includes \$300,000 to provide counterdrug support to federal, state, and local law enforcement agencies and to Community Based Organizations requesting Drug Demand Reduction Assistance. Funding will provide unique military support and resources to our police agencies which enable the police to concentrate more police resources to other priorities in their department. Increased funding from federal appropriations will permit the Delaware National Guard to provide support to open requests from the FBI, Delaware State Police, and local authorities. It will also enable the Delaware Guard to expand its Drug Education Program.

Name of Intended Recipient: WL Gore & Associates

Location: 555 Paper Mill Rd., Newark, DE 19711

Requesting Member: Congressman MICHAEL N. CASTLE

Account: OM, DW

Name of Project: Special Operations Forces Modular Glove System

Project Description: The Act includes \$4,780,000 to accelerate the fielding of the Modular Glove System for U.S. Special Operations Forces (SOF). This is a five piece system that provides the war fighter the necessary protection across a wide range of climactic conditions. Developed to be compatible with the SOF's Protective Combat Uniform designed for frigid conditions, this SOF Modular Glove System provides cold weather protection to -50 degrees as well as waterproof protection in wet conditions. The Special Operations Command has an established requirement for a Modular Glove System to better meet the real-world mission needs of its SOF in a broad range of deployed environments. This funding would accelerate the fielding by about one year to ensure all U.S. SOF forces in theater have access to this high technology, readiness enhancing system.

Name of Intended Recipient: University of Delaware

Location: Hulihan Hall, Newark, DE 19716

Requesting Member: Congressman MICHAEL N. CASTLE

Account: RDTE, A

Name of Project: Composite Applied Research and Technology for FCS and Tactical Vehicle Survivability

Project Description: The Act includes \$3,200,000 to rapidly advance the Technology Readiness Level of existing and promising new ultra-lightweight composite structures and armor for combat and light, medium and heavy tactical vehicle applications. Using heavy materials such as steel and aluminum will continue to result in vehicles that are too heavy to transport and will overload vehicles—which reduces life, increases maintenance costs and requires more frequent vehicle replacement. The project is addressing the critical needs of the U.S. Army to protect our soldiers and provide them with the best equipment to carry out their missions. Lightweight composite vehicle structures and armor increase mobility and mission payloads while increasing soldier protection against direct fire, improvised explosive devices and explosively formed penetrators.

Name of Intended Recipient: INVISTA S.à r.l.

Location: 2801 Centerville Road, Wilmington, DE 19808

Requesting Member: Congressman MICHAEL N. CASTLE

Account: RDTE, A

Name of Project: Improved Thermal Resistant Nylon for Enhanced Durability and Thermal Protection in Combat Uniforms

Project Description: The Act includes \$3,200,000 to increase the safety and protection of U.S. soldiers with improved flame resistant, durable, and lower cost materials for the U.S. Army combat uniforms. These improvements will meet an urgent need due to the threat of Improvised Explosive Devices (IED). This project will fund and accelerate research, development, testing, and evaluation for nylon fiber development, fiber formulation, fabric scale up and performance blend specification for U.S. Army combat uniforms.

Name of Intended Recipient: ILC Dover LP

Location: One Moonwalker Road, Frederica, DE 19946-2080

Requesting Member: Congressman MICHAEL N. CASTLE

Account: RDTE, DW

Name of Project: Joint Services Aircrew Mask Don/Off Inflight Upgrade

Project Description: The Act includes \$2,400,000 for research, development, testing, and evaluation of a Joint Services Aircrew Mask, which will provide above the neck Chemical, Biological, and Anti-G protection to DoD aircrew personnel. The mask is a hood that goes over the wearer's head and seals at the neck. This project will enhance our military's mission capability while minimizing performance degradation in chemical and biological contaminated scenarios.

Name of Intended Recipient: Piasecki Aircraft Corporation

Location: 2nd Street West, Essington, PA 19029

Requesting Member: Congressman MICHAEL N. CASTLE

Account: RDTE, N

Name of Project: X-49A Envelope Expansion Modifications

Project Description: The Act includes \$3,600,000 to conduct flight demonstrations at New Castle County Airport in Delaware on the Vectored Thrust Ducted Propeller (VTDP) Compound Helicopter technology's potential to increase rotorcraft speed, range, and survivability. These funds will cover the cost of design, fabrication, assembly, instrumentation and check out of propulsion and control system modifications that will enable flight beyond the current operating limits of the baseline conventional helicopter. Many current US combat and humanitarian operations require rotorcraft capabilities well beyond those of existing fleet helicopters.

Name of Intended Recipient: ANP Technologies, Inc.

Location: 824 Interchange Blvd., Newark, DE 19711

Requesting Member: Congressman MICHAEL N. CASTLE

Account: RDTE, DW

Name of Project: NIDS Handheld Common Identifier for Biological Agents

Project Description: The Act includes \$2,400,000 for research, development, testing,

and evaluation to develop a handheld device for detection of a variety of biological warfare agent related bacteria and viruses. According to the Report of the Commission on the Prevention of Weapons of Mass Destruction Proliferation and Terrorism (released in December 2008), a biological attack is more likely to be used by terrorists than any other weapons of mass destruction in the near future. The proposed handheld common identifier for biological agents will allow war fighters to perform rapid, on-site biological agent tests during threat situations.

Name of Intended Recipient: University of Delaware

Location: Hullahen Hall, University of Delaware, Newark, DE 19716

Requesting Member: Congressman MICHAEL N. CASTLE

Account: RDTE, N

Name of Project: Advanced Composite Maritime Manufacturing

Project Description: The Act includes \$1,600,000 to research and develop design, engineering and manufacturing technologies for U.S. Navy ship structures based on advanced lightweight composite materials. The objective of this project is to keep Navy, SOCOM (Special Operations Command), and Coast Guard craft at the forefront of technology, and help insure superiority of the US military in the water over current and future adversaries. The application of these materials and technologies will provide ship structures that are optimally engineered, and manufactured using state-of-the-art methods to provide the highest performance at the lowest cost.

Name of Intended Recipient: University of Delaware

Location: Hullahen Hall, University of Delaware, Newark, DE 19716

Requesting Member: Congressman MICHAEL N. CASTLE

Account: RDTE, N

Name of Project: Millimeter Wave Imaging

Project Description: The Act includes \$1,360,000 for research, development, testing, and evaluation to develop real-time millimeter-wave imaging to allow U.S. soldiers to see in harsh conditions, including dust, fog, sand, and clouds. Millimeter wave imaging systems are able to image through smoke, fog, marine layer, blowing dust and sand, and fabric. The technology development is supported by the Office of Naval Research with the intent to deploy systems on military helicopters landing in harsh environments such as the "brownout" conditions faced when landing in the deserts of places such as Afghanistan and Iraq. It will also improve situational awareness of Naval vessels, particularly when close to the shore or at ports.

Name of Intended Recipient: University of Delaware

Location: Hullahen Hall, University of Delaware, Newark, DE 19716

Requesting Member: Congressman MICHAEL N. CASTLE

Account: RDTE, A

Name of Project: Cybersecurity in Tactical Environments

Project Description: The Act includes \$800,000 for research, development, testing and evaluation to detect vulnerabilities and intrusions in the U.S. Army's battlefield networks.

The U.S. Army uses mobile computer networks to both communicate between soldiers, and between soldiers and their weapons systems. This concept is called network centric warfare, and the security and availability of this network is critical to combat operations. The project will focus on detection of data exfiltration in tactical networks, intrusion detection in mobile ad-hoc networks, detection of malicious hardware and software components, and detecting security threats in commercial off the shelf (COTS) wireless networking equipment.

Name of Intended Recipient: Fraunhofer USA Center for Molecular Biotechnology

Location: 9 Innovation Way, Suite 200, Newark, DE 19711

Requesting Member: Congressman MICHAEL N. CASTLE

Account: RDTE, DW

Name of Project: Army Plant Vaccine Development Program

Project Description: The Act includes \$1,600,000 for research, development, testing, and evaluation to deliver a combined multivalent one-shot vaccine to protect the U.S. Armed Forces and civilian communities against plague and anthrax. This quick response ability can assist communities around the world with mass therapeutic treatment or for mass vaccination in the event of bioterrorist attack or natural disease outbreak such as an avian influenza.

Name of Intended Recipient: Delaware National Guard

Location: First Regiment Road, Wilmington, DE 19805

Requesting Member: Congressman MICHAEL N. CASTLE

Account: OP, A

Name of Project: Phoenix Quad-Band Satellite Receiver for the Delaware National Guard

Project Description: The Act includes \$3,200,000 for a mobile communications terminal to provide the Delaware National Guard with improved high data rate exchanges between various satellites and ground communications systems in secure and non-secure digital formats.

GRATITUDE FOR THE SERVICE OF GEORGE C. ELLIOTT

HON. JOHN CONYERS, JR.

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. CONYERS. Madam Speaker, I rise today to honor George C. Elliott for his two years of dedicated service to the Committee on the Judiciary. As a detailee from the United States Patent and Trademark Office (USPTO), George spent a year with the Committee in 2007 and was gracious enough to come back for another year when I requested him again in 2009. George will be returning to the USPTO at the end of 2009, where he will resume his duties as a Director.

George came to work for the Committee to support Congress' efforts to pass patent reform legislation. George's knowledge and experience in patent law proved invaluable to

this endeavor. In the 110th Congress, George's tireless work in advising and crafting policy options contributed greatly to passage of the House of Representative's patent reform legislation, H.R. 1908. His dedication to this task continued in the 111th Congress, where he has played an equally important role in advancing patent reform legislation.

In addition to patent reform, George has worked on a variety of other intellectual property policy and legislative matters, including patent settlements, technology transfer, gene patents, and USPTO appropriations. George's expertise, work ethic, and friendly nature have earned him the respect and admiration of his colleagues. He has become a fixture of the Committee's staff and a valued member of the Committee's intellectual property team.

We were privileged to have this opportunity to work with George and we wish him all the best in his future endeavors.

HONORING THE CAREER OF DON LINDSEY

HON. RALPH M. HALL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. HALL of Texas. Madam Speaker, the Boy Scouts of America, which will celebrate its 100th Anniversary on February 8, 2010, has contributed to our communities through their leadership and dedication over the past 100 years, creating a better environment for our families to live, work and play. I rise today to pay tribute to one individual in particular, Mr. Don Lindsey, who began his scouting career in 1957. As an Eagle Scout, Mr. Lindsey took over a newly formed group as a Scoutmaster, a position he held for 31 years, and was directly involved in the making of 144 Eagle Scouts from this troop. He has served as a Boy Scout Chairman twice, and is directly responsible for \$4.4 million in facility renovations and new additions to Clements Scout Ranch over the last four years, with another \$6 million slotted for use.

Along with his service to the Boy Scouts of America over the past 52 years, Mr. Lindsey has been involved in service to his community and country in many other forms. He served as mayor of Terrell, Texas for ten years, County Fire Marshall for eight years, and retired from 35 years of military service as an Army Command Sergeant Major. In his church, Mr. Lindsey has served as an elder, deacon, and board member. He currently serves as a Council Committee Member and Summer Camp Director for Circle Ten Council. His contributions to his community have been recognized through the many awards and decorations he has received, including the Whitney Young Award; God and Service Award; Citizen of the Year for Terrell, Texas; Silver Beaver; and the George Meany Award.

Mr. Lindsey is a man who lives by example through his service to God, country, and through his role as a Scout, which has garnered him respect by all those who come in contact with him. Madam Speaker, I ask those present today to join me in recognizing a true servant to our country, Mr. Don Lindsey.

RECOGNIZING KYLE FOSS AND
MICHAEL HAWKEN

HON. HOWARD P. "BUCK" McKEON
OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. McKEON. Madam Speaker, I rise today to recognize two incredible young men, Kyle Foss and Michael Hawken. Both Kyle and Michael have achieved three prestigious honors: the Eagle Scout Award, the Venturing Silver Medal, and the Venturing Ranger Award. Nationally, less than one in ten thousand Boy Scouts earn all three of these honors, and they are the first young men in the history of California's 25th Congressional District to earn these prestigious honors.

The hard work and dedication of Kyle and Michael will pay dividends throughout their lives. The Boy Scouts teach boys and young men the value of hard work, commitment, community service, and morality. Kyle and Michael have been shaped by this outstanding organization and will continue to build on the strength of the program.

Kyle and Michael have proven to be young men of great character. They have learned what it means to be responsible citizens and have committed themselves to improving the communities in which they live. In a fast-paced and rapidly changing world, Kyle and Michael have anchored themselves in the most consistent fundamentals of America. I admire their spirit and enthusiasm to go above and beyond their duties in all that they do. I thank these young men for their service to our community, our state, our nation, and congratulate them on their remarkable achievements.

WALTONVILLE COAL
GASIFICATION PLANT

HON. JOHN SHIMKUS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SHIMKUS. Madam Speaker, I rise today to express my opposition to the encroachment of federal authority into matters of the state and the continued appeasement of environmental special interests over the well-being of the American people.

Several weeks ago, the Illinois Environmental Protection Agency permitted the construction of a new coal gasification plant near Waltonville, IL. An appeal was filed to prevent construction with the U.S. EPA based on their "finding that carbon dioxide and other greenhouse gases represent a significant threat to public health and welfare."

Burdensome regulations levied on unsubstantiated science will destroy jobs. Coal gasification, the production of coal gas to convert into liquid gasoline, is a real solution to rising energy prices and it creates jobs here in the United States.

Taking drastic precautionary steps like those suggested by the EPA will have profound consequences on workers in Southern Illinois and all people throughout the country. Government action to reduce greenhouse gas emissions is

not without a heavy cost. It is irresponsible for a group of unelected bureaucrats at the EPA to make significant policy decisions that will restrain and prevent job creation based on unproven science. The EPA's response to their endangerment findings will more certainly endanger the economic well-being of Americans than fulfill the Obama Administration's promise of reducing carbon emissions or lowering global temperature.

HONORING THE ACCOMPLISHMENTS OF MALIA CALI

HON. STEVE SCALISE

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SCALISE. Madam Speaker, I rise today to honor Malia Cali, the 2009 High School Heisman Award winner. Malia is a senior at St. Thomas Aquinas High School in Hammond, Louisiana, and is only the second winner in the history of the award from the State of Louisiana. She is a three-year All State selection in track and field, cross-country and soccer. Off the field, Malia founded "Cleats for Kids," a non-profit organization that collects used cleats and distributes them to children in Nicaragua. As if her impressive athletic and community service achievements weren't enough, Malia also has the No. 1 academic ranking in her senior class.

The High School Heisman has been awarded to one male and one female student each year since 1994. The High School Heisman recognizes the Nation's most esteemed high school senior men and women for excellence in academics, athletics and community service. Malia's success both on and off the field is a testament to what can be accomplished with hard work, dedication, and a commitment to others.

It's easy to see why Malia Cali was selected over nearly 55,000 other entrants in this competition. Malia is truly deserving of this prestigious award. Her successes and achievements shine brightly on the State of Louisiana, and I am proud to highlight the accomplishments of Malia Cali here today.

STATEMENT ON H.R. 4173, THE
WALL STREET REFORM AND
CONSUMER PROTECTION ACT OF
2009

HON. MELISSA L. BEAN

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Ms. BEAN. Madam Speaker, as the principal author of the compromise provision regarding the preemption of State consumer financial laws under the National Bank Act and the Home Owners Loan Act that was included in the manager's amendment on page 139 to 150, I wanted to take this opportunity to explain to my colleagues my intention in drafting the language.

The compromise language made improvements in several areas to allow national banks

and Federal savings associations, which are institutions that operate under a national charter to comply with a uniform national standard where appropriate. I would like to further explain four components of the compromise specifically for the House. Those components include (1) limiting the scope of new preemption procedures to State consumer financial laws, so as not to affect preemption for other State laws; (2) the ability for categories of State consumer financial law to be preempted; (3) modifications of the preemption standard to more accurately reflect the Supreme Court Case of *Barnett Bank v. Nelson*, which established the preemption standard currently applied to national banks and Federal savings associations; and (4) the degree of deference afforded to the Office of the Comptroller of the Currency and Office of Thrift Supervision by the courts.

First, under the compromise, the changes to preemption procedures under the National Bank Act for national banks and the Home Owners Loan Act for Federal savings associations are exclusively limited to State consumer financial laws. During the drafting of the compromise, I removed a sentence, previously suggested by the Committee that said national banks are to generally comply with State law. I removed this sentence because I wanted to make clear that the changes in the Act do not alter the preemption standards and precedents that apply to those State laws which are not State consumer financial laws. Narrowing the scope to just State consumer financial law is consistent with the initial scope of Subtitle D of H.R. 3126, The Consumer Financial Protection Act, when it was introduced in July 2009.

Second, the compromise language included language that allows for categories of State consumer financial law to be preempted. This means that if the Comptroller of the Currency (the regulator of national banks) or the Director of the Office of Thrift Supervision (the regulator of Federal savings associations) determines a State consumer financial law in a particular state should be preempted because it "prevents, significantly interferes with, or materially impairs" the abilities of a national bank or Federal savings association, then that specific determination can be applied to other States' consumer financial laws with equivalent terms. For example, if one state seeks to require additional disclosure requirements for credit cards that the Comptroller of the Currency determines "prevents, significantly interferes with, or materially impairs" the ability of a national bank to engage in the business of banking, that determination can be applied to another state's credit card disclosure laws if those laws have equivalent terms.

Third, a critical portion of the compromise was drafting a preemption standard that embodied existing precedent. The preemption standard that was reported out of the Financial Services Committee stated that a State law could be preempted if it "prevents or significantly interferes with" the ability of a national bank (or a Federal savings association) to engage in the business of banking. "Prevents or significantly interferes with" has been often mentioned as the shorthand citation of the preemption standard established by the Supreme Court in 1996 in *Barnett Bank v. Nelson*. However, as I and many others have

noted, the Supreme Court ruling was not limited to those two terms as the only circumstance in which preemption of State laws is appropriate. In fact, they expanded on those words by saying that a State law should be preempted not only when it "prevents or significantly interferes with," but also "stands as an obstacle to the accomplishment of the purposes," "encroach(es) on," "destroy(s) or hamper(s)," or "impair(s)."

Since the Barnett case describes a number of situations in which State law is preempted, in addition to the "prevents or significantly interferes with" standard, I was concerned that limiting the underlying text to the shorthand expression of "prevents or significantly interferes with" could be construed as narrowing the Constitutional standard. I therefore added the words "materially impairs," so that there would be no question that the preemption standard is the same as the standard described in Barnett, and that State consumer financial law may be preempted if it violates any of the well established Constitutional benchmarks for preemption. I chose the word "materially" because if the impairment is not material—meaning it would only have a negligible effect on the bank—it should not be subject to preemption under current law.

When making preemption determinations on State consumer financial laws, the Comptroller of the Currency for national banks, Director of the Office of Thrift Supervision for Federal savings associations, or the Court must find that Federal law applicable to national banks and Federal savings associations, including regulations and similar issuances, deals with the subject or activity that the State consumer financial law is seeking to regulate. A good example is the detailed disclosure requirements set by Federal law and Federal regulators, developed after substantial consumer testing, that apply to certain types of consumer financial products.

Finally, the compromise language is intended to clarify that when a court is reviewing an OCC determination concerning the proper interpretation of the National Bank Act or other Federal law that the OCC is charged with administering, the court is to apply the traditional deference accorded to an agency, often referred to as "Chevron" deference. The same clarification applies when a court is reviewing an OTS determination regarding the proper interpretation of the Home Owners Loan Act or other Federal law that the OTS administers. Further, while the underlying legislation directed the courts to apply a different type of deference to OCC or OTS preemption determinations, the compromise amendment makes clear that the Chevron deference standard applies to all OCC and OTS interpretations of Federal law, the National Bank Act, and the Home Owners Loan Act, including those made in the context of a preemption determination.

Madam Speaker, I thank you for the opportunity to further explain the preemption compromise I drafted in the manager's amendment.

I yield back the balance of my time.

IN CELEBRATION OF THE WORK OF RONALD EUGENE KIRK

HON. DAVID SCOTT

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SCOTT of Georgia. Madam Speaker I rise today to honor a dedicated member of my staff, Mr. Ronald Kirk, who has dedicated his life to government service. Born on November 2, 1944, in New York City to William Henry Kirk and Marjorie Smith Kirk, Ronald Eugene Kirk, the fourth of five children, was born and raised in Harlem and is a product of the New York City Public School system. Ron's passion for community involvement and neighborhood empowerment was evident from the start of his life. After receiving a bachelor's in business administration from Pace University and a master's in business management from Manhattan College, Ron began his lifelong involvement in community service.

Early on, Ron became politically active and cut his teeth with such community based organizations as the Community Planning Board #10 in Manhattan, the Community Corporation/Harlem Youth in Action, Model Cities and several political organizations established in the Harlem community. He was twice elected Democratic District Leader in the 70th Assembly District of New York. Ron served as foundation director of the City University of New York and as a confidential secretary to a New York Supreme Court Judge. During his time in New York, Ron received numerous accolades and commendations from such notable individuals as Representative CHARLIE RANGEL, former Mayor David Dinkins, Former New York Secretaries of State Basil Patterson and Percy Sutton. His efforts have been recognized by organizations such as the Sickle Cell Foundation, the Catholic Youth Organization, and the New York City Department for the Aging.

Upon moving to Atlanta, Ron served as a dedicated host for the 1996 Olympics held in Atlanta, Georgia, and worked for the David Scott for Congress campaign in 2002. For the past 8 years he has served admirably as my senior Immigration/Department of State Specialist and Constituent Services Representative.

Ron is a dedicated family man, having been married to the lovely Emma for 38 years, has two beautiful children, Kwesi and Amina, and three wonderful grandsons, Nikai, James and Malachai. Ron is actively involved in community outreach and the Red Oak Methodist Church in Stockbridge, Georgia.

It is with a heavy heart that I and my staff say goodbye to Ron as he retires from my Congressional staff. I am extremely proud of the accomplishments Ron has made throughout his life and for his outstanding work in my office. As this chapter of Ron's life closes and he begins his new chapter, it is a blessing to know that Ron's ability to be a social catalyst touched the lives of many in the 13th District of Georgia and the Nation. Ron, I wish you every success for the future and thank you for your outstanding work effort, passion for change, and your ability to look at the impossible and ask, "why not?"

God bless Ron Kirk.

RECOGNIZING THE 75TH WEDDING ANNIVERSARY OF MARVIN AND MARY LOU COHRON

HON. JEFF MILLER

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. MILLER of Florida. Madam Speaker, I rise today to recognize Marvin and Mary Lou Cohron on the occasion of their 75th wedding anniversary. Their 75 years of marriage is a testament to all American families, and I am proud to honor the Cohrons.

Marvin and Mary Lou first met at Excel Junior High School in Monroe County, Alabama, around 1932. Both were the children of farming families and spent much of their free time going to church services and social functions. On a Sunday evening, December 23, 1934, Marvin drove Mary Lou and some of her family to the home of the Justice of the Peace where the two were married. Marvin was 16 and Mary Lou was 15.

After their marriage, Marvin and Mary Lou tried their hand at farming. After 3 years of marriage, Marvin had saved enough money from the sale of collard greens they had grown to buy Mary Lou a wedding band. Marvin moved to Pensacola, Florida, in 1939 and started work at the Pensacola City Bus Company while Mary Lou continued working at Vanity Fair in Alabama until she was able to join her husband in Pensacola. In 1943, Marvin was drafted into the United States Navy where he served honorably in World War II. He then went to school on the G.I. Bill to learn refrigeration maintenance and repair. In 1950, Marvin began work at Navy Point stores before going into business for himself in 1958. He opened Cohron's Air Conditioning/Refrigeration Sales and Service and Mary Lou worked as the bookkeeper and secretary for the office. In 1986, the Cohrons retired. They now spend their days enjoying fishing, camping, and ballroom dancing. They belong to several seniors' dance clubs and Mary Lou belongs to the Red Hat Society.

Madam Speaker, on behalf of the United States Congress, I am privileged to recognize the 75th wedding anniversary of Marvin and Mary Lou Cohron. Their family has been an invaluable part of our community for over seventy years. My wife Vicki and I wish Marvin and Mary Lou, their 5 daughters, 10 grandchildren, 12 great-grandchildren, and great-great grandchild all the best.

HONORING JUDGE DRAYER

HON. JIM GERLACH

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. GERLACH. Madam Speaker, I rise today to honor the Honorable Calvin S. Drayer Jr. who is retiring after faithfully serving the people of Montgomery County, Pennsylvania, as a Common Pleas Court Judge since 1998.

Before joining the Montgomery County Court, Judge Drayer had a distinguished legal career that spanned nearly 30 years. He was a founding partner in the Norristown-based firm of Wilson, Drayer, Morrow and Broderick where he concentrated on estates and trust law.

Despite his demanding career and heavy caseload, Judge Drayer has always been generous with his time and talent outside the courtroom. He is a Fellow of the American College of Trusts and Estate Counsel and a member of both the Supreme Court Orphans' Court Procedural Rules Committee and the Pennsylvania Joint State Government Commission Advisory Committee on Descendents' Estates. Judge Drayer also was an organizer of the probate and Tax Section of the Montgomery County Bar Association and an adjunct professor in the graduate tax program at the Villanova University School of Law.

Madam Speaker, I ask that my colleagues join me today in recognizing the outstanding service and extraordinary career of the Honorable Calvin S. Drayer Jr. and all who dedicate their careers to the pursuit of justice.

A TRIBUTE TO FLOYD HAYS ELLIS

HON. BRETT GUTHRIE

OF KENTUCKY

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. GUTHRIE. Madam Speaker, I rise today to honor the memory of a truly remarkable Kentuckian, Floyd Hays Ellis. Over the course of his long and storied life as a farmer, soldier, businessman and state senator, Bowling Green's favorite son embodied the values of the "Greatest Generation" to which he belonged.

Generous in the extreme, Ellis was just as thoughtful a legislator as he was a friend and father. Known for his winning smile and dry sense of humor, he proved to be a canny businessman, as well. He served for 20 years as the president and CEO of the Warren Rural Electric Cooperative Corp., in addition to chairing the boards of Citizens First Bank, Trans Financial Bank Corp., Commonwealth Health Corp. and the Kentucky Association of Electric Cooperatives.

Though many people who enjoy his level of success often sacrifice their private lives for the sake of their profession, Floyd never put his work before family and friends. To the contrary, Floyd's natural sociability and devotion to his loved ones was perhaps his most remarkable trait.

Sadly, on Saturday, December 12, 2009, Floyd Hays Ellis passed away in the company of his long-time group of friends and confidants; and while Kentucky may never again see one of its finest sons, the evidence of his legacy will be visible in the countless lives that he touched.

HISTORICAL PERSPECTIVE OF THE ONEIDA TRIBE OF INDIANS OF WISCONSIN

HON. STEVE KAGEN

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. KAGEN. Madam Speaker, the Oneida Tribe of Indians of Wisconsin is sovereign government with a long and proud history of self-government. We are a federally recognized treaty tribe of the United States. We have faced threats and continue to face threats to our homelands. The Oneida have persevered in the face of adversity for centuries, and we proudly and passionately continue to protect and preserve our homelands.

The Oneidas, along with the Mohawk, Seneca, Cayuga and Onondaga comprised the original Five Nations of the Iroquois Confederacy that dates back to the 1500s, which later became the Six Nations when the Tuscarora joined in the 1700s. The Iroquois held millions of acres of land in what is now the State of New York, which entered statehood in 1776.

During the Revolutionary War, the Oneida and the Tuscarora supported the colonies and served in General George Washington's army. For this service, our lands were to be protected forever, a promise reflected in the 1794 Treaty of Canandaigua between the Oneida and United States.

The 1784 Treaty of Fort Stanwix was the first treaty between the Oneida and United States that established peace between the Iroquois Confederacy and the colonial states, which operated under the Articles of Confederation at the time. This treaty of peace established the government-to-government relationship between the Oneida Tribe and the United States that continues to exist today.

Through the 1785 Treaty of Fort Herkimer and the 1788 Treaty of Fort Schuyler with the State of New York, the Oneida lost more than 5 million acres of their ancestral homelands to the State of New York.

In 1789, the States ratified the United States Constitution, which declared treaties of the United States to be the law of the land. The United States adopted the Non-Intercourse Act of 1793, which prohibited the purchase of any Indian land by any person or entity without the Federal Government's approval.

In spite of the Non-Intercourse Act, the State of New York continued to enter into a series of land transactions between 1795 and 1846 with the Oneida in direct violation of Federal law. These land transactions continued to deplete the Oneida land holdings in New York until only 32 acres remained in Oneida possession by the 1820s.

During the 1820s, Oneidas relocated to what would become the State of Wisconsin to establish new homelands. The Oneidas purchased 5 million acres of land from the Winnebago and Menominee Tribes for the purpose of preserving sovereignty as a self-governing sovereign nation. This band of Oneidas became recognized as the Oneida Tribe of Indians of Wisconsin, who entered their final treaty with the United States in 1838, 10 years before Wisconsin entered statehood.

The Treaty of 1838 between the Oneida Tribe of Indians of Wisconsin and the United States established the present day Oneida Reservation boundaries located in northeast Wisconsin and comprised of 65,430 acres. To the present day, the Oneida Reservation has not been diminished or disestablished by an Act of Congress and our reservation boundaries as established by treaty continue to exist under the full force and effect of Federal law and the United States Constitution.

The Dawes Allotment Act of 1887 enacted by Congress was the next challenge of maintaining our homelands. Our lands were divided into individual parcels that resulted in a significant loss of tribal land ownership because our members did not understand the English language and did not understand land taxation. Consequently, tribal land ownership was reduced to a few thousand acres within the Oneida Reservation boundaries.

The Dawes Allotment Act and the loss of tribal land ownership were ended when Congress passed the Indian Reorganization Act of 1934, IRA. The Federal policy of the IRA was to recognize and strengthen the authority and autonomy of tribal governments, and implicit in the recognition of tribal authority is a tribe's right of self-government. The IRA provided the foundation for adopting a tribal constitution that would govern tribal members.

In 1936, the Oneida membership adopted the Oneida Constitution that established an elected governing body for the Oneida membership. Upon adoption of the Oneida Constitution, the United States Federal Government purchased 1,270 acres of land within the Oneida Reservation and placed that land into trust for the benefit of the Oneida Tribe.

Since passage of the IRA, the Oneida Tribe has taken the initiative to actively acquire ownership of land within the Oneida Reservation boundaries, and to provide for its membership through governmental programs and services that meet the needs of the people. More importantly, the Oneida Tribe has strengthened its authority by the adoption, implementation and enforcement of tribal laws. The Oneida Tribe preserves its sovereignty by exercising the inherent right of self-government over our lands and members within the Oneida Reservation boundaries.

Among the most significant of our continuing initiatives is the Oneida Land Claim and the resolution of that claim. The Oneida Land Claim is the oldest and largest land claim in the United States. Oneida has twice prevailed before the Federal courts, most recently in 1985 when the United States Supreme Court recognized the Oneida's rightful claim against the State of New York for its violations of Federal law more than 200 years ago.

The Oneida Tribe entered into treaties with the United States that are recognized as the law of the land under the United States Constitution. Federal law, United States Supreme Court decisions and Federal Indian policy recognize the treaty obligations of the Federal Government to the federally-recognized tribes of the United States. The Oneida treaties also established the government-to-government relationship between the Oneida Tribe and the United States, and form the basis for the Federal trust responsibility that is also recognized by Federal law, United States Supreme Court decisions and Federal Indian policy.

The Oneida Land Claim is deeply intertwined with the history of the United States. We have strived to resolve this claim through continued negotiation and mediation and will continue to do so as a means to protect and preserve our Tribal homelands. The Oneida will continue to act in an honorable manner to resolve the land claim that allows the United States, under the Federal trust responsibility owed to the Oneida Tribe by virtue of our treaties with the United States, to right the wrongs of the past that continue to exist today.

EARMARK DECLARATION

HON. GREGG HARPER

OF MISSISSIPPI

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. HARPER. Madam Speaker, pursuant to the Republican Leadership standards on earmarks, I am submitting the following information regarding earmarks I received as part of H.R. 3326—Department of Defense Appropriations Act, 2010.

Requesting Member: Congressman GREGG HARPER

Bill Number: H.R. 3326

Project Name: Regional Counter-Drug Training Academy—Meridian

Project Amount: \$2,800,000

Account: Operating Forces Drug Interdiction and Counter-Drug Activities, Defense

Recipient and Address: MS National Guard, Naval Air Station, 219 Fuller Road, Meridian, Mississippi

Description of Request: The National Guard Bureau identified a Fiscal Year 2009 unfunded requirement of \$24.2M for Counterdrug (CD) Schools. With appropriate funding, CD schools will be better positioned to provide counter narcotics-based training programs critical to domestic law enforcement against narcoterrorism. The RCTA Meridian budget has shown little growth since FY2000, yet the costs associated with training law enforcement officers have increased by approximately 20 percent.

Requesting Member: Congressman GREGG HARPER

Bill Number: H.R. 3326

Project Name: On-Board Hybrid Power Unit (OBHPU)

Project Amount: \$1,040,000

Account: Research, Development, Test, and Evaluation, Army

Recipient and Address: Diversified Technology, 476 Highland Colony Parkway, Ridgeland, MS 39157

Description of Request: 2010 funding will ensure the completion of, field-testing, development, integration plan and a training program for the production version of the OBHPU 10 KW system. The Space and Missile Defense Command (SMDC) supports the OBHPU program to provide on-board electric power to deployed radar and missile systems, and is applicable in many other fields.

Requesting Member: Congressman GREGG HARPER

Bill Number: H.R. 3326

Project Name: Simulation Based Reliability and Safety (SimBRS) Program

Project Amount: \$4,900,000

Account: Army, Combat Vehicle and Automotive Advanced Technology

Recipient and Address: Mississippi State University, P.O. Box 6301, Mississippi State, MS 39762.

Description of Request: SimBRS engages in synergized research and development experimentally validated cradle-to-grave modeling and simulation capabilities to optimize reliability in vehicular components and systems with consideration of uncertainties in input loads, manufacturing, operations and maintenance, and material properties to decrease weight and cost, and yet increase the performance, durability, and safety of the warfighter. This initiative is a follow-on effort to ongoing Mississippi State University simulation based reliability systems research.

Requesting Member: Congressman GREGG HARPER

Bill Number: H.R. 3326

Project Name: VePro—Health Usage Monitoring and Vehicle Prognostics

Project Amount: \$2,880,000

Account: Army, Combat Vehicle and Automotive Advanced Technology

Recipient and Address: nCode International, 200 Research Blvd., Starkville, MS 39759

Description of Request: Better understanding of operational usage severity is critical for vehicle designs to reliably meet needs at minimum cost and weight. VePro will save billions of dollars spent annually on maintaining U.S. Army equipment, improve readiness and reduce danger to soldiers from unexpected vehicle failures. The next stage is to evolve these into scalable, robust cost effective pre-production Vehicle Health Management Systems (VHMS)—technology configuration, manufacturing, assembly and testing for pre-production systems.

Requesting Member: Congressman GREGG HARPER

Bill Number: H.R. 3326

Project Name: F-15C AESA Classified Demo

Project Amount: \$8,000,000

Account: Air Force, F-15E Squadrons

Recipient and Address: Raytheon, Forest Consolidated Manufacturing Center, 19859 Highway 80, Forest, MS 39074

Description of Request: Funding will be used for the final year of a 3-year development effort to demonstrate APG-63(V)3 Active Electronically Scanned Array (AESA) classified capability with a Radar Common Data Link (RCDL). ANG and USAF F-15s are the backbone of forces assigned to perform a significant portion of the Nation's Homeland Defense mission, protecting the United States from attack by an airborne threat. FY10 funding will complete the third and final phase of the 3-year RCDL demonstration program.

Requesting Member: Congressman GREGG HARPER

Bill Number: H.R. 3326

Project Name: Silicon Carbide Electronics Material Producibility Initiative

Project Amount: \$2,400,000

Account: Air Force, Advanced Materials for Weapon Systems

Recipient and Address: II-VI Wide Band Gap Materials Group, 201 Research Blvd., Starkville, MS 39759

Description of Request: Funding will be used to develop technology, and establish pro-

duction capability, along with evaluation and testing of SiC materials and integrated circuits for use in high power, high frequency DoD weapons systems and platforms. Future mission requirements dictate a range of current and next-generation U.S. Military systems requiring critical high frequency and high power components with dramatically enhanced capabilities which are unattainable with current technology.

Requesting Member: Congressman GREGG HARPER

Bill Number: H.R. 3326

Project Name: Advanced, Long Endurance Unattended Ground Sensor Technologies

Project Amount: \$3,920,000

Account: Defense-Wide, Special Operations Intelligence Systems Development

Recipient and Address: Mississippi State University, P.O. Box 6301, Mississippi State, MS 39762

Description of Request: A significant challenge in modern military operations is the ability to achieve and maintain real-time battlefield situational awareness. Achieving battlefield situational awareness requires the ability to robustly and persistently monitor the movements of the adversary in near real-time across a wide range of operational environments including foliage, mountainous, and urban terrain. This initiative is a follow-on effort to ongoing Mississippi State University Unattended Ground Sensor (UGS) research and development in support of the U.S. Special Operations Command (USSOCOM).

EARMARK DECLARATION

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SMITH of New Jersey. Madam Speaker, pursuant to the Republican Leadership standards on earmarks, I am submitting the following information regarding earmarks I received as part of the FY 10 Department of Defense Appropriations Act.

Requesting Member: Representative CHRISTOPHER H. SMITH

Bill Number: H.R. 3326

Project name: Re-establishing Ties: The Road from Warrior to the Community

Account: OM, ARNG

Legal Name of Requesting Entity: New Jersey Department of Military and Veterans Affairs

Address of Requesting Entity: 101 Eggert Crossing Road, Lawrenceville, NJ 08648

Description of Request: This funding would be used to help successfully transition returning soldiers back in civilian life through the NJ National Guard's multi-tiered, reintegration program to address the needs of the returning combat veteran. This program includes: PTSD and TBI Screening; Suicide Prevention Efforts; Small Business Restart Assistance; and Counseling Services, among other benefits.

CELEBRATING THE 50TH ANNIVERSARY OF THE GARFIELD RIDGE CHAMBER OF COMMERCE

HON. DANIEL LIPINSKI

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. LIPINSKI. Madam Speaker, I rise today to honor the Garfield Ridge Chamber of Commerce as it celebrates 50 years of service to the community.

Founded in 1959, the Garfield Ridge Chamber has grown to 100 members who work tirelessly to fully embody its motto, "The Neighborhood that Cares and Shares."

The chamber takes great pride in being an active member of the community, participating each year in the Patriot Day Parade and Annual Pumpkin Parade, providing Christmas decorations along a major thoroughfare in the neighborhood, delivering a business directory to 17,500 homes in the area, and recognizing a police officer, firefighter, and teacher of the year at its annual dinner dance.

The chamber's largest event, in which it takes special pride, is the "Snack with Santa," at which children are provided with a gift from Santa, snacks, and a puppet show. This year marks the 26th anniversary of the event, which is extremely popular, attracting over 1,300 attendees.

Throughout the year, chamber members show their commitment to the organization and its role in the community at monthly gatherings featuring speakers who keep business owners informed of new developments and innovations.

Through its dedication to service, the Garfield Ridge Chamber of Commerce has contributed immensely to the larger community. As a proud native of Garfield Ridge, I sincerely offer the chamber's many dedicated members my heartfelt congratulations on the occasion of its 50th anniversary.

A PROCLAMATION HONORING
SHERRI LAWRENCE FOR HER
CERTIFICATION BY THE NA-
TIONAL BOARD FOR PROFES-
SIONAL TEACHING STANDARDS

HON. ZACHARY T. SPACE

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SPACE. Madam Speaker, Whereas, Sherri Lawrence has been granted certification by the National Board for Professional Teaching Standards; and

Whereas, Sherri Lawrence has sufficiently demonstrated adherence and dedication to the five core propositions of teaching set by the National Board for Professional Teaching Standards; and

Whereas, due to her hard work and dedication to her profession, Sherri Lawrence was able to achieve this esteemed honor; and

Whereas, we recognize the values and lessons teachers impart to our children; and

Whereas, the creative ingenuity that Sherri Lawrence has demonstrated while educating her students; now, therefore, be it

Resolved, that along with Ohio's 18th Congressional District, I congratulate Sherri Lawrence for her certification by the National Board for Professional Teaching Standards.

THE LOSS OF JACK PEEL

HON. KATHY CASTOR

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Ms. CASTOR of Florida. Madam Speaker, I rise today in honor of a brave American veteran and a great Floridian, Jack Peel, who passed away on November 29, 2009.

Mr. Peel was a native Floridian, born in Chipley, and a graduate of Chipley High School. He served his country for four years in the Navy where he made lifelong friends with his fellow sailors. He then joined the Air Force where he remained for the next 26 years and retired as master sergeant.

After retirement from the military, Mr. Peel and his beloved wife Lynette made their home in Bay Crest Park in Hillsborough County, Tampa. There he dedicated his time to public service. He served as president of the Bay Crest Park Civic Association, an active member of the Town N Country Alliance, a Catholic Church community volunteer and advocate. Jack Peel had a talent for persuading his neighbors, policymakers, and the Hillsborough Board of County Commissioners to beautify and enhance Bay Crest and Town N Country. He and Lynette and the outstanding Town N Country community activists worked diligently to improve our community. For his dedication to service, the Civic Association completed Peel Park in December 2009 in honor of Mr. Peel.

Madam Speaker, Jack Peel will be greatly missed. For all who love our community, be inspired by Jack Peel's dedication and service.

BUENOS AIRES NATIONAL
WILDLIFE REFUGE

HON. RAÚL M. GRIJALVA

OF ARIZONA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. GRIJALVA. Madam Speaker, I rise today to pay tribute to all the staff at the Buenos Aires National Wildlife Refuge. The Refuge consists of a beautiful 118,000 acres of mountains, riparian zones, and grasslands in the Southern Arizona desert and contains majestic areas such as Brown Canyon, Arivaca Cienega and the Baboquivari Mountains.

The Buenos Aires National Wildlife Refuge is a sanctuary for many different types of wildlife including the Pima pineapple cactus, the pygmy-owl and the endangered masked bobwhite quail. Additionally, 325 bird species, 53 species of reptiles and amphibians, 58 mammal species, including mule deer, white-tailed deer, pronghorn, javelina, and mountain lions all call the Refuge home. Without the protection of the Refuge, many of these species would disappear and be lost to us forever. The Refuge is also a vital part of the community

and offers guided tours, hiking, camping, horseback riding, mountain biking, excellent birding, and plenty of beautiful picnic areas. The Refuge even offers wonderful educational opportunities through volunteer projects and nature workshops.

The men and women employed at the Refuge work tirelessly to preserve this beautiful area. Through their efforts, the Refuge has successfully reintroduced the endangered bobwhite quail and the pronghorn deer into the wild and ensures their continued protection. These people are truly the guardians of an environmental treasure and view their task as a privilege, not just a job.

In addition to the wonderful staff at the Refuge, an exemplary group of volunteers known as the Friends of the Buenos Aires National Refuge dedicate their time to the community education conservation, and preservation of this wonderful land. This nonprofit group gives selflessly to promote the goals of the Refuge and with the help of the Refuge staff; they recently held the 1st Annual Grasslands Fair to celebrate this beloved land.

The Buenos Aires National Wildlife Refuge, its staff, and the volunteers who dedicate their time are all truly valued players in the protection of America's wild lands. Being a member of the House Committee on Natural Resources and having seen our community grow to over a million people, during my lifetime, I know the importance of protecting areas like the Buenos Aires National Wildlife Refuge. It gives me great joy to see such wonderful people giving of themselves to preserve and protect this spectacular region of southern Arizona.

A PROCLAMATION HONORING
MICHELE MANISKAS FOR HER
CERTIFICATION BY THE NA-
TIONAL BOARD FOR PROFES-
SIONAL TEACHING STANDARDS

HON. ZACHARY T. SPACE

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SPACE. Madam Speaker, Whereas, Michele Maniskas has been granted certification by the National Board for Professional Teaching Standards; and

Whereas, Michele Maniskas has sufficiently demonstrated adherence and dedication to the five core propositions of teaching set by the National Board for Professional Teaching Standards; and

Whereas, due to her hard work and dedication to her profession, Michele Maniskas was able to achieve this esteemed honor; and

Whereas, we recognize the values and lessons teachers impart to our children; and

Whereas, the creative ingenuity that Michele Maniskas has demonstrated while educating her students; now, therefore, be it

Resolved, that along with Ohio's 18th Congressional District, I congratulate Michele Maniskas for her certification by the National Board for Professional Teaching Standards.

**CELEBRATING METRO GOLD LINE
CONSTRUCTION AUTHORITY'S 10
YEARS OF SERVICE**

HON. ADAM B. SCHIFF

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SCHIFF. Madam Speaker, I rise today to congratulate the Metro Gold Line Foothill Extension Construction Authority as it celebrates ten years of service and commitment to the community. Since the Construction Authority was established by the California State Legislature to design and construct the Pasadena Metro Gold Line, it has completed 13.7 miles of light rail, which averages 24,000 daily weekday boardings.

One decade ago, the Los Angeles County Metropolitan Transportation Authority, faced with serious budgetary problems, delayed the construction of the light-rail line to Pasadena. Senate Bill 1847 was introduced to create the Construction Authority and finish the work that had already been started on the new rail line. The newly created Construction Authority was not only able to complete the project on time but was also able to build it under budget.

Today, the Metro Gold Line Foothill Extension Construction Authority is continuing its work in connecting downtown Los Angeles to the San Gabriel Valley and beyond. Funding has been secured to extend the line to the city of Azusa and plans are in place to continue the Gold Line to Montclair and Ontario International Airport. The success of the Gold Line is a testament of the collaborate efforts between the staff of the Construction Authority and the elected officials, civic leaders, and residents of the surrounding communities.

The Gold Line not only provides a reliable and efficient source of transportation to residents of the greater Los Angeles region, it also alleviates traffic and is a part of our fight to reduce pollution. The congestion on the Gold Line corridor highways has continued to increase as the Inland Empire grows in population. As we work to find solutions to solve our traffic congestion dilemma, extending the Gold Line into our eastern cities is clearly part of the answer.

It is with great pleasure that I congratulate the Metro Gold Line Foothill Extension Construction Authority on its ten years of success. I am proud of the role I have played in helping the Gold Line become the pride of the San Gabriel Valley and I wish it continued success!

THE BELLEVUE WOLVERINES

HON. DAVID G. REICHERT

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. REICHERT. Madam Speaker, I rise today to applaud a phenomenal high school football program in my District—the 8th of Washington—for winning another State Championship—their seventh in nine years.

The Bellevue Wolverines have an illustrious history of football success in the State of Washington, and they continued the trend on

Saturday, December 5, defeating the Liberty Patriots, 23–17, to secure another 3A title. Head Coach Butch Goncharoff and his assistants provide some of the best coaching and vision in the country and the program—well known for their great on-the-field success—often makes positive impacts in the community as well.

I congratulate every member of the roster for their continued and storied success on the field. I thank coach Goncharoff, his assistants, Athletic Director Brian Hercules and Principal David Wellington for creating an environment that allows student-athletes to thrive on the field, in the classroom and in their community. Once again, congratulations and I wish the Wolverines all possible success in the future.

**A PROCLAMATION HONORING LISA
ABELE FOR HER CERTIFICATION
BY THE NATIONAL BOARD FOR
PROFESSIONAL TEACHING
STANDARDS**

HON. ZACHARY T. SPACE

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SPACE. Madam Speaker,

Whereas, Lisa Abele has been granted certification by the National Board for Professional Teaching Standards; and

Whereas, Lisa Abele has sufficiently demonstrated adherence and dedication to the five core propositions of teaching set by the National Board for Professional Teaching Standards; and

Whereas, due to her hard work and dedication to her profession, Lisa Abele was able to achieve this esteemed honor; and

Whereas, we recognize the values and lessons teachers impart to our children; and

Whereas, the creative ingenuity that Lisa Abele has demonstrated while educating her students; now, therefore, be it

Resolved, that along with Ohio's 18th Congressional District, I congratulate Lisa Abele for her certification by the National Board for Professional Teaching Standards.

EARMARK DECLARATION

HON. HAROLD ROGERS

OF KENTUCKY

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. ROGERS of Kentucky. Madam Speaker, pursuant to the House Republican standards on congressionally-directed funding, I am submitting the following information regarding funding included in H.R. 3326—Department of Defense Appropriations Act, 2010.

Requesting Member: Congressman HAROLD ROGERS

Bill Number: H.R. 3326

Account: PA,A

Legal Name of Requesting Entity: Blue Grass Army Depot

Address of Requesting Entity: 431 Battle Field Memorial Road, Richmond, KY 40475

Description of Request: The funding of \$3.92 million will be used for the Blue Grass

Army Depot Superficial Water Oxidation-Conventional Demilitarization. These funds will provide the Army with a state-of-the-art environmentally friendly means of processing the problematic energetic wastes generated at the Blue Grass Army Depot.

**HONORING THE LIFE OF FORMER
CALIFORNIA ASSEMBLYMAN NAO
TAKASUGI**

HON. MICHAEL M. HONDA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. HONDA. Madam Speaker, today I honor the life and achievements of my dear friend, former California State Assemblymember Nao Takasugi. Nao dedicated his life to public service with humility, integrity, and commitment to the American ideals of equality and justice.

Nao was a 19-year-old student at the University of California, Los Angeles, when he and his family were incarcerated in an internment camp for Japanese Americans during World War II.

His family was forced to sell most of their possessions, but was able to keep the family store, the Asahi Market in downtown Oxnard, which they had owned since 1907.

The Takasugi family was able to save the store during their imprisonment by entrusting the family business to a Mexican American employee, Ignacio Carmona. When the Takasugi family returned to Oxnard in 1945, Mr. Carmona returned the business back to the Takasugis, after faithfully carrying on the business for three years.

In 1943, Nao was among approximately 4,000 Japanese American college students who were released from the internment camps and allowed to attend college on the East Coast. Nao earned his business administration degree at Temple University in Philadelphia and a master's in business administration from the Wharton School at the University of Pennsylvania in 1946. When he returned to Oxnard, he ran his family's Asahi Market.

His family's imprisonment inspired him to commit his life to strengthening our democracy in public service, and did not cause deep embitterment. As Oxnard City Councilman, Mayor, and then California State Assemblyman, he ably represented all of his diverse constituents, crossing racial and ethnic divides, and building bridges across party lines.

At the age of 87, Nao died of complications from a stroke on November 19, 2009. He is survived by his wife of 57 years, Judy, and their five children, Scott, Russell, Ron, Tricia and Lea.

I was truly saddened by the loss of my dear friend Nao Takasugi. He was a gentle soul, and never let his kind demeanor get in the way of his strong beliefs about justice and civil rights. When he spoke, people listened as he was always true to his convictions and sense of honor. I will miss him dearly and will always reflect on his life as a metric of how I should conduct my own.

**"THIS CHRISTMAS," IN HONOR OF
ALL OUR ARMED FORCES AND
THEIR FAMILIES THIS CHRIST-
MAS SEASON**

HON. KENDRICK B. MEEK

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. MEEK of Florida. Madam Speaker, I rise today with a poetic tribute in honor of our Magnificent Armed Forces and their Splendid Families this Christmas and holiday season. And for all of the ones who are so separated by the miles, so very far across the shores. Our hearts, especially go out to all of those families who have lost their greatest loves of all, in the defense of our nation. And to all of those recovering from the grave wounds of war we pray for their speedy recovery. Bless them all! I ask that this poem penned by Albert Caswell be placed in the RECORD in honor of them as follows:

THIS CHRISTMAS . . .

As the snow falls to the ground. . . .
And all of our children dance, with songs of
joy so all around. . . .
With stockings hung by the chimneys with
care. . . .
With all of those hopes and dreams, of Santa
there. . . .
With Christmas dinners and fires all aglow,
as before this family a feast lies so. . . .
A child is born, for all to know!
But, remember . . . remember . . . remember
all of those. . . .
Those families! Those Patriots of Peace, all
them, all of these. . . .
The ones, who this Christmas will not to-
gether be. . . .
Who upon battlefields of honor fight!
So far away from our Country 'Tis of Thee,
this night. . . .
Men and Women of such honor bright, who
for all of us. . . . so carry that fight. . . .
Who live with such heartache and death, as
on each new day their honor blesses
. . . .
As they bless us all, with all their gifts of
selflessness. . . .
And all of those ones, whose greatest of all
loves. . . . now so lie in soft quiet
graves. . . .
Precious Daughters and Sons, Husbands and
Wives. . . .
Fathers and Mothers, Sisters and Brothers
who so gave. . . .
Who so gave That Last Full Measure. . . . did
they!
Whose loved ones pain, can not be healed by
time, nor so divided. . . .
Who on this Christmas morning, sit with
tears in eyes. . . .
With one less place set at the dinner table
this year. . . . as they cry. . . .
And all of those who have come home, with-
out arms and legs. . . .
Blessing us with their fine gifts of courage
displayed!
Making us all so see, just how magnificent
and inspiring a heart can be!
And all of those with loved ones, who are so
far across the shores. . . .
As each new day but brings such great worry
. . . . sure. . . .
But, waiting. . . . but waiting for, that knock
on the door. . . .
That phone call, that they now not so pray
for. . . .
Quiet Heroes, one and all!

Watching them from Heaven, The Angel's
tear drops fall. . . .
Lord God, Lord God. . . . Bless Them. . . .
Bless Them All!
For So Many, So Few Have But Paid The
Cost!
So bore the burden, so carry that cross! That
cross of war!
This Christmas, as you hold your families
tight. . . .
And seem so fine, and so very right. . . .
And you see those smiles, of your children
very bright. . . .
Give thanks, Give praise. . . . as upon your
knees fall and pray. . . .
For all of those families, who've sacrificed
. . . . and blessings of freedom they
gave!
This Christmas. . . .

**TRIBUTE TO JANICE AND
BENJAMIN REZNIK**

HON. HOWARD L. BERMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. BERMAN. Madam Speaker, I rise today to congratulate my good friends Janice and Benjamin Reznik on the occasion of their Parnas Award honor from the Masorti Foundation for Conservative Judaism in Israel 14th Annual Los Angeles Celebration.

Before becoming the Founding President of Jewish World Watch, Janice Kamenir-Reznik led an active career in the field of law. A graduate of UCLA law school, Janice spent years building a distinguished career in the legal field and then, recognizing her passion for community service work, turned to that avocation. Under her able leadership, Jewish World Watch—founded jointly with Rabbi Harold Schulweis—has become one of the leading advocacy groups in the fight against the genocide in Darfur and other global human rights abuses.

Janice served as the director of the Commission on Soviet Jewry for the Los Angeles Jewish Federation, and during her years in practice was President of California Women Lawyers, the statewide women's bar. She was a founder and president of California Women's Law Center, a public interest organization advocating for the rights of women and girls. She has testified before the House Judiciary Committee.

In addition to the numerous legal positions held by Janice over the years, she also served in many Jewish community leadership roles. I commend her for her invaluable contributions in serving on the following boards: Los Angeles Hebrew High School, Valley Beth Shalom, Los Angeles Hillel Council, UCLA Hillel, and the Jewish Federation Council.

Ben Reznik boasts a stellar professional and philanthropic record. Widely respected for his tenacious legal acumen, Ben has been described as "the most litigious attorney in Los Angeles" by his peers. He has been a key leader and activist in the community, devoting himself to a wide variety of organizations and causes. Currently, he is chairman of the Government, Land Use, Environment and Energy Department at the law firm of Jeffer Magels Butler & Marmaro LLP, JMBM, and leads 25

lawyers who comprise that department. Ben has also argued before the Supreme Court and has represented many prominent companies including the Mitsubishi Corporation and The Clarett Group.

Ben and Janice have three children, Yoni, Devi and Sami. They live in Encino where, through years of community activism and professional success, they have helped numerous people and are shining examples of what the Jewish tradition calls tikkun olam.

Madam Speaker and distinguished colleagues, I ask you to join me in congratulating Janice and Ben Reznik for their impressive career and dedication to the community and to congratulate them on receiving this honor.

**PAYING TRIBUTE TO THE
HEALTHCARE WORKERS UNION
1199 SEIU AS THEY MARK THEIR
50TH ANNIVERSARY**

HON. CHARLES B. RANGEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. RANGEL. Madam Speaker, this year marks the 50th Anniversary of 1199 SEIU as a healthcare workers union. For the union, the last 50 years have been challenging ones. Through its efforts, much has changed for the better, and they have been a large part of that change. In the words of founder and former president Leon Davis, it is a history of "tough struggles and pioneering advances, decent wages, and working conditions instead of poverty, respect on the job instead of contempt, security instead of fear, and hope instead of despair."

The 1199 changed history in 1959 when a drugstore union made up of pharmacists joined the Civil Rights Movement and set out to organize 30,000 predominantly Black and Latino workers in New York City's voluntary hospitals. The union succeeded in signing their first collective bargaining agreement with Montefiore Medical Center that year. Today, the union is 350,000 healthcare workers strong, in hospitals, nursing homes, and homecare agencies throughout New York, New Jersey, Massachusetts, Maryland, and Washington, DC. And they continue to grow despite these difficult times.

Aside from raising labor standards and restoring dignity to their members, 1199 has been a leading force for social and economic justice for all. It is why Dr. Martin Luther King, Jr., called 1199 his "favorite union." And it is why they were the only labor union Malcolm X chose to speak before. The union was once the headquarters for Cesar Chavez's national grape and lettuce boycotts, as well as the headquarters for Nelson Mandela's visit to New York when he was released from prison. In all its years of activism in electoral politics, the union's greatest crowning achievement was in 2008, when it dispatched thousands of members—many of them for several months—to help elect Barack Obama as our nation's first African-American president.

For all its achievements over the many years of service, including being champions of worker rights, I applaud 1199 on its 50th anniversary and have pledged to its president,

George Gresham, that the union can continue to count on my strong support in the many years ahead.

So Madam Speaker, I ask that you and my distinguished colleagues join me in celebrating the 50th anniversary of 1199 United Healthcare Workers East of the Service Employees International Union. As 1199 looks back at its historic accomplishments over the last 50 years, let's join it in looking forward to the next 50 years, meeting the challenges that lie ahead with the same spirit, determination, and strength that has shaped who it continues to be today.

A PROCLAMATION HONORING CYNTHIA RUCKER FOR HER CERTIFICATION BY THE NATIONAL BOARD FOR PROFESSIONAL TEACHING STANDARDS

HON. ZACHARY T. SPACE

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SPACE. Madam Speaker,

Whereas, Cynthia Rucker has been granted certification by the National Board for Professional Teaching Standards; and

Whereas, Cynthia Rucker has sufficiently demonstrated adherence and dedication to the five core propositions of teaching set by the National Board for Professional Teaching Standards; and

Whereas, due to her hard work and dedication to her profession, Cynthia Rucker was able to achieve this esteemed honor; and

Whereas, we recognize the values and lessons teachers impart to our children; and

Whereas, the creative ingenuity that Cynthia Rucker has demonstrated while educating her students; now, therefore, be it

Resolved, that along with Ohio's 18th Congressional District, I congratulate Cynthia Rucker for her certification by the National Board for Professional Teaching Standards.

IN MEMORY OF DAVID STONE

HON. JANE HARMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Ms. HARMAN. Madam Speaker, the post-9/11 world has posed many challenges—especially to the old way of doing business. Someone who stepped up and used his military training and experience to transform airport security was David Stone. David died unexpectedly earlier last month, at age 57, and I rise to commemorate my friend and his exceptional career.

Admiral Stone was selected as the first federal security director at LAX—the top terror target on the West Coast—shortly after 9/11. He proved more than equal to the task. Working under immense pressure and close public scrutiny, Stone established strict new federal airport security standards, secured nearly \$1 billion in federal funding for security upgrades and positioned LAX to become a test site for

new security technologies that are now used around the world.

The Bush administration noticed and Stone was asked to apply his talents at the national level. As the Nation's third TSA administrator, he was charged with overseeing security at not just one airport—but all of them, in addition to ports, railroads, and pipelines. In just 2 years, he shaped the role of the TSA for years to come.

When Stone left the TSA it marked a culmination of more than three decades of national service. He was a decorated soldier, a graduate of the U.S. Naval Academy who rose to rank of Rear Admiral. During his 28-year military career he commanded warships, vessel fleets, NATO naval forces, and an aircraft carrier battle group. For his valor he received three Legions of Merit, five Meritorious Service medals, and three Navy Commendation medals.

A lovely memory is how David spoke to high school seniors in my district who were applying to the military academies. He was so excited about them—and recalled his own journey decades earlier. David Stone also shared this excitement and talent with a grateful nation. He is fondly remembered.

RESPONDING TO THE GOVERNMENT OF AUSTRALIA'S APOLOGY FOR THE MISTREATMENT OF CHILD MIGRANTS AND CHILDREN IN INSTITUTIONAL CARE UNDER STATE SUPERVISION

HON. ALCEE L. HASTINGS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. HASTINGS of Florida. Madam Speaker, I rise today to recognize the apology offered by the Government of Australia for the mistreatment of child migrants and children in institutional care under state supervision.

In an effort to populate its empire, the British Government assisted private organizations with settling people in many of its overseas dominions. Between 1922 and 1967 over 7,000 children were sent to Australia and placed in the care of residential institutions. Many of these children were separated from their families and never told the truth about their loved ones. They became part of the half a million Australian children who were placed in institutional or foster care during this period who would later be called the "Forgotten Australians". As wards of the state, the Forgotten Australians suffered from appalling physical, emotional and sexual abuse. They were subjected to harsh, often brutal discipline and labor programs, and referred to by number instead of by name.

For years, their story has been lost—unheard and unacknowledged by the wider community. The aftermath of this government-condoned suffering left deep emotional and psychological scars on countless individuals and their families, and many resorted to crime, drug and alcohol abuse and suicide.

On November 16, 2009, Prime Minister Kevin Rudd formally apologized to the Forgotten Australians on behalf of the Australian

government and the Parliament of Australia and took an important step in national healing. This apology was accompanied by a commitment to properly record and share the experiences of the Forgotten Australians with future generations and support victims as they attempt to discover their familial backgrounds and reunite with loved ones.

This statement came nearly 2 years after another historic apology that Prime Minister Rudd gave on behalf of the Australian Government to the Indigenous people of Australia and the Stolen Generation. The willingness of the Australian government to address past wrongs and present inequalities shows its dedication to national healing, growth and reconciliation.

Madam Speaker, I commend the Australian Government for acknowledging its past transgressions and for its commitment to the sacred duty of protecting its children, families and communities in the years to come.

EARMARK DECLARATION

HON. MICHAEL K. SIMPSON

OF IDAHO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SIMPSON. Madam Speaker, in accordance with the policies and standards put forth by the House Appropriations Committee and the GOP leadership, I would like to list the congressionally-directed projects I have requested in my home State of Idaho that are contained in the Conference Report accompanying H.R. 3326, the FY2010 House Defense Appropriations Bill.

Project Name: 3-D Technology for Advanced Sensor Systems

Amount Received: \$2,000,000

Account: Electronics Technology Account in the Department of Defense RDT&E

Recipient: Boise State University

Recipient's Street Address: 1910 University Drive, Boise, Idaho 83725

Description: The 3-D packaging approach offers the promise of a dramatic decrease in the system weight and volume, together with increased system performance. This project will provide funding to continue to develop 3-D processing techniques on silicon and LTCC platforms. These include technologies for die and wafer-scale bonding and 3-D interconnects. These techniques will be applied to create 3-D integration and packaging solutions applicable to a general category of high performance sensor systems. The military has a need for new three-dimensional (3-D) packaging of electronic systems, particularly sensor systems for portable (i.e., on-soldier) applications. 3-D integration and packaging of sensors will result in smaller electronics with expanded capability, allowing the soldier in the field to be more effective.

Project Name: Accelerator-Driven Non-Destructive Testing

Amount Received: \$2,000,000

Account: Support Systems Development Account in the Air Force RDT&E

Recipient: Idaho State University

Recipient's Street Address: 921 South 8th Avenue, Stop 8007, Pocatello, Idaho 83209

Description: The Idaho Accelerator Center (IAC) will develop a research, education and commercialization program that takes non-destructive testing techniques developed at the IAC and advances their development. The penetrating and non-destructive techniques that are under development include new techniques in positron annihilation spectroscopy with accelerator-based gammabeams, the use of mono-chromatic x-ray beams and the use of photon activation (via photonuclear reactions) for trace element analysis of materials and manufacturing processes. The development of practical non-destructive testing (NDT) techniques will help the U.S. Air Force reduce aircraft downtime necessary for inspection and enhance turn-around times by more quickly identifying needed repairs through spectroscopy and the use of x-ray. The development of practical NDT techniques will be of immense value to the armed forces in four critical areas: quicker return of aircraft to the line by reducing the tear-downs necessary for inspection; non-destructively addressing the enormous 'aging fleet' problem of the U.S.A.F. and the private sector; better economics by replacing parts on an on condition inspections basis instead of a 'life limited' basis; and the ability to successfully apply NDT techniques to composite materials. Currently, no commercialized NDT technique works on composite materials.

Project Name: Domestic Manufacturing of 45nm Electronics (DOME)

Amount Received: \$3,200,000

Account: Advanced Spacecraft Technology Account in the Air Force RDT&E

Recipient: American Semiconductor, Inc

Recipient's Street Address: 3100 South Vista Avenue, Suite 230, Boise, Idaho 83705

Description: Funding for this program will deploy a new foundry capability to address the most critical electronics sourcing issue faced for secure supply of advanced DoD integrated circuits in 2012 and beyond. DOME is an AFRL-sponsored initiative to implement a 45nm state-of-the-art wafer fabrication capability to meet current and future system requirements for fabrication of specialized integrated circuits in a broadly available foundry capacity to serve DOD. Microelectronics capability for defense applications requires advancement of technology for each generation of new defense system. Defense system requirements are often highly specialized and include capability beyond that of standard commercial devices due to their unique operational environments. An advanced and sustainable defense microelectronics supply solution is required that can provide parts in low volume at reasonable costs and be fabricated on-shore to meet security requirements. This advanced process technology enables higher speed, lower power electronics that are of vital importance to the military and intelligence communities. The DOME program will deliver the capability to manufacture semiconductors at the most advanced technology node currently in production, 45nm, at an American run on-shore facility optimized for DoD/IC business.

Project Name: Hybrid Energy Systems Design and Testing

Amount Received: \$2,000,000

Account: Military Engineering Advanced Technology Account in the Army RDT&F

Recipient: Idaho National Laboratory

Recipient's Street Address: 2525 Fremont Avenue, Idaho Falls, Idaho 83415

Description: The Hybrid Energy Systems Development and Testing Program will provide the Army transformational technologies that advance Army leadership in global energy security and carbon reduction. Hybrid energy concepts provided through this program could allow the Army to simultaneously address energy supply (electrical grid and fuel supply) security and surety, environmental (CO₂) footprint reduction, and provide national economic benefits. This project will leverage unique assets at the INL, such as its Hybrid Testing Lab, engineering-scale energy system beds, supercomputing capabilities, and hybrid systems design teams, and nuclear technology designs, to develop, validate, and assess hybrid and other advanced energy system concepts. This program will provide a foundation for Army leadership in clean, smart, secure energy for future defense and non-defense applications.

Project Name: Integrated Passive Electronic Components

Amount Received: \$1,360,000

Account: Advanced Spacecraft Technology in the Air Force RDT&E

Recipient: University of Idaho

Recipient's Street Address: 820 Idaho Ave., Morrill Hall 109, Moscow, ID 83844

Description: Spacecraft are critical for coordinating modern military operations, particularly for intelligence gathering, battle-space communications, resource deployment (e.g. Global Positioning System), and targeting. More accurate and timely information enables more effective deployment, but requires enhanced sensing, communications and computing, which require more power. Limited energy sources and cooling capacity aboard spacecraft restrict increased processing capability. Power consumption has become a limiting factor in the performance electronic and computing technologies. Microchip designers have addressed rising power consumption by reducing the voltage levels of the power delivered to the chips, with excellent results. However, this creates a new problem of how to deliver clean low-voltage power to the chips. This research will develop the technologies to enable low-voltage power regulation to be integrated onto the same piece of silicon that holds the computing circuits, thus making ultra-low-power microelectronics practical. The key to this technology is integrated passive components. In addition, this research will produce a new range of component options for analog circuit designers, enabling greater ability to program and increasing flexibility of on-board electronic systems.

Project Name: Material, Design, Fabrication Solutions for Advanced SEAL Delivery System external structural components

Amount Received: \$2,000,000

Account: Operations Advanced Seal Delivery System (ASDS) Development in the Department of Defense Research, Development, Test and Evaluation (RDT&E)

Recipient: Premier Technology Inc.

Recipient's Street Address: 1858 West Bridge Street, Blackfoot, Idaho 83221.

Description: Premier Technology Inc. will work with the Idaho National Lab, Navy PEO

Submarine (PMS 399), U.S. Special Operations Command, Naval Special Warfare Command and the Navy Office of Naval Research to provide material, design and fabrication solutions for ASDS external structural components allowing those components to withstand severe hydrodynamic, hydrostatic and shock loading while maintaining significant resistance to corrosion in situations where the ASDS is attached to the submerged host submarine operating at high speeds. Candidate components include the host submarine pylon assembly, ASDS lower hatch (buttress threads) and ASDS shaft line components. The goal of this project is to assist the U.S. Navy in bringing ASDS to its fullest operational capability by addressing challenges that it faces in key material issues.

Project Name: Radiation Hardened Cryogenic Read Out Integrated Circuits

Amount Received: \$1,600,000

Account: Defense Production Act Purchases in Department of Defense Procurement

Recipient: ON Semiconductor, Inc.

Recipient's Street Address: 2300 Buckskin Road, Pocatello, Idaho 83201

Description: Readout integrated circuits (ROIC) are the foundation of thermal imaging systems. These systems have forever changed modern warfare and surveillance. The United States Air Force and the Missile Defense Agency have been investigating ways to improve manufacturing capabilities and improve cryogenic and radiation performance of these circuits. The thermal imagers of the future will operate in harsh environmental conditions for longer periods of time and will have increased resolution (through increased pixel count) than the detectors of today. Maintaining a domestic source of this technology, as well as working to enhance the manufacturing capabilities of this critical technology, are as equally important as increasing the yield. The DPA Tide III Readout Integrated Circuit (ROIC) program will continue the improvement efforts to develop technology that includes a larger stitched die, smaller feature size (< 0.35um), improved yields, and reduced cycle times will enable a domestic U.S. source for ROIC manufacturing to meet our national defense needs.

I appreciate the opportunity to provide a list of congressionally-directed projects in the Conference Report accompanying the FY2010 Defense Appropriations bill on behalf of Idaho and provide an explanation of my support for them.

A PROCLAMATION HONORING
ERICA RHEA FOR HER CERTIFICATION BY THE NATIONAL
BOARD FOR PROFESSIONAL
TEACHING STANDARDS

HON. ZACHARY T. SPACE

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SPACE. Madam Speaker,

Whereas, Erica Rhea has been granted certification by the National Board for Professional Teaching Standards; and

Whereas, Erica Rhea has sufficiently demonstrated adherence and dedication to the five

core propositions of teaching set by the National Board for Professional Teaching Standards; and

Whereas, due to her hard work and dedication to her profession, Erica Rhea was able to achieve this esteemed honor; and

Whereas, we recognize the values and lessons teachers impart to our children; and

Whereas, the creative ingenuity that Erica Rhea has demonstrated while educating her students; now, therefore, be it

Resolved, that along with Ohio's 18th Congressional District, I congratulate Erica Rhea for her certification by the National Board for Professional Teaching Standards.

EARMARK DECLARATION

HON. JO ANN EMERSON

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mrs. EMERSON. Madam Speaker, pursuant to the House Republican standards on earmarks, I am submitting the following information in regards to H.R. 3326, the Fiscal Year 2010 Department of Defense Appropriations Bill.

Requesting Member: Rep. JO ANN EMERSON
Bill Number: H.R. 3326

Account: RDTE, A

Requesting Entity: Missouri University of Science and Technology

Address of Requesting Entity: 1870 Miner Circle, Rolla, Missouri 65409

Description of Request: Provide an earmark of \$2,400,000 to research materials that will lead to advances in the storage and generation of power. To maintain a strong national defense, our Nation must develop new devices from innovative polymer-based materials that have lower-power requirements, greater strength, lighter weight, higher sensitivity, and robustness to operate under extreme conditions. The research will provide materials that will lead to important advances in the generation and storage of power. The power generation systems would have advantages for military use over current systems in terms of weight, flexibility, and functionality.

Requesting Member: Rep. JO ANN EMERSON
Bill Number: H.R. 3326

Account: RDTE, A

Requesting Entity: Missouri University of Science and Technology

Address of Requesting Entity: 1870 Miner Circle, Rolla, Missouri 65409

Description of Request: Provide an earmark of \$2,400,000 to complete a project to develop high performance alloy materials and advanced manufacturing of steel castings for new lightweight and robotic weapon systems. This program would enhance defense component capabilities at a reduced cost. The program would also augment war fighter capability by increasing the mobility and reliability of weapons systems.

Requesting Member: Rep. JO ANN EMERSON
Bill Number: H.R. 3326

Account: RDTE, A

Requesting Entity: Missouri University of Science and Technology

Address of Requesting Entity: 1870 Miner Circle, Rolla, Missouri 65409

Description of Request: Provide an earmark of \$4,800,000 to develop new, low-cost, sensors and an integrating network methodology for geospatial localization and tracking of explosive related threats and precursor materials using spatially distributed, multimodal sensors. This effort is consistent with the U.S. Army goals of assured mobility and force protection.

Requesting Member: Rep. JO ANN EMERSON
Bill Number: H.R. 3326

Account: RDTE, AF

Requesting Entity: Missouri University of Science and Technology

Address of Requesting Entity: 1870 Miner Circle, Rolla, Missouri 65409

Description of Request: Provide an earmark of \$2,400,000 to develop fiber reinforced ultra-high temperature materials for hypersonic flight vehicles. Ultra-high temperature materials are imperative for the leading and trailing edges, and control surfaces, of future hypersonic vehicles. The proposed project would greatly advance the material selection and design capability for military systems projected to operate in the extreme environments associated with hypersonic flight. Success of this project would enable the United States to uphold its position of world leadership in these critical technology areas.

HONORING WILLIAM H. BEARDSLEY

HON. MICHAEL H. MICHAUD

OF MAINE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. MICHAUD. Madam Speaker, I rise today to recognize the accomplishments of William H. Beardsley.

William Beardsley served for the past 22 years as president of Husson University in Bangor, Maine. When Mr. Beardsley took over, the University was threatened by eminent bankruptcy, but because of William's strong leadership, the University today is financially solid and continues to educate the future leaders of Maine and the United States.

Under his guidance, enrollment at Husson tripled, the campus doubled in size and degree offerings multiplied, including the establishment of a new law school. Mr. Beardsley's strong, pragmatic leadership has created a thriving academic center with a promising future indeed.

Prior to his service at Husson University, Mr. Beardsley worked with the University of Vermont, Green Mountain Power Corp., Bangor Hydro Electric Co., Alaska Pacific University, the state of Alaska and Bar Harbor Banking & Trust Co. Humble, down to earth, engaging, eloquent and a visionary entrepreneur, Mr. Beardsley is a husband and father of three with a doctorate from Johns Hopkins University.

As the faculty and staff of Husson University prepare to continue educating its students without Mr. Beardsley, they are left in charge of an academic institution dedicated to providing quality private education with tuition costs comparable to many public universities. The low tuition and high level of financial aid at Husson University is one of Mr. Beardsley's most important legacies.

Madam Speaker, please join me in honoring William H. Beardsley for his life of dedication and service to his community and the education of Maine's students.

EARMARK DECLARATION

HON. JOHN J. DUNCAN, JR.

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. DUNCAN. Madam Speaker, consistent with House Republican Earmark Standards, I am submitting the following earmark disclosure information for project requests that I made and which were included within H.R. 3326, the "Department of Defense Appropriations Act, FY2010."

Requesting Member: Congressman JOHN DUNCAN

Account: RDTE—Air Force

Project Amount: \$1,600,000

Legal Name of Requesting Entity: University of Tennessee, 328 Ferris Hall, 1508 Middle Drive, Knoxville, Tennessee 37996

Description of Request: The funding will be used for design, testing, and evaluation of systems needed for the harvesting and storage of green energy. The need for the nation to design, implement, and test systems and processes capable of producing renewable energy at a large scale is vital for the U.S. military and the Nation as a whole.

A PROCLAMATION HONORING KELLY LAW FOR HER CERTIFICATION BY THE NATIONAL BOARD FOR PROFESSIONAL TEACHING STANDARDS

HON. ZACHARY T. SPACE

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SPACE. Madam Speaker,

Whereas, Kelly Law has been granted certification by the National Board for Professional Teaching Standards; and

Whereas, Kelly Law has sufficiently demonstrated adherence and dedication to the five core propositions of teaching set by the National Board for Professional Teaching Standards; and

Whereas, due to her hard work and dedication to her profession, Kelly Law was able to achieve this esteemed honor; and

Whereas, we recognize the values and lessons teachers impart to our children; and

Whereas, the creative ingenuity that Kelly Law has demonstrated while educating her students; now, therefore, be it

Resolved, that along with Ohio's 18th Congressional District, I congratulate Kelly Law for her certification by the National Board for Professional Teaching Standards.

EXPRESSING CONDOLENCES AND
CELEBRATING THE LIFE OF
HENRY S. MILLER, JR.

HON. EDDIE BERNICE JOHNSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Ms. EDDIE BERNICE JOHNSON of Texas. Madam Speaker, I rise today in honor of Henry S. Miller, Jr. who passed away on Saturday, December 5, 2009.

Mr. Miller was an icon in the Dallas community who created a real estate empire with over 1,300 employees and 41 offices. After joining the business his father founded, Miller steered Henry S. Miller Co. to success by pioneering the concept of specialization of services. Essentially, Miller championed the idea of creating specialists in commercial real estate fields like industrial, retail, and multifamily. By doing this, he created a real estate culture that encouraged employees to be incredibly knowledgeable in specific areas, allowing the company to move forward quickly and effectively in those fields.

Throughout his career and life, Mr. Miller was regarded as an honest and humble man, and maintained these traits in an industry where it is easy to devolve into something much different. Known throughout the community as a businessman of integrity and knowledge, he was a pioneer in the Dallas real estate industry and helped to develop it into the powerhouse that it is today.

Madam Speaker, I ask my fellow colleagues to join me in honoring this great man who truly was ahead of his time.

RECOGNIZING THE MANY YEARS
OF SERVICE OF JIM PITCOCK

HON. JOHN BOOZMAN

OF ARKANSAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. BOOZMAN. Madam Speaker, I rise today to pay tribute to a fine Arkansan who, on December 11, 2009, ended a 51-year career in television, radio and politics.

Jim Pitcock's career in Arkansas radio, television and politics began in his hometown of Fort Smith in 1958 as a part-time camera operator at KFSA television. He would attend junior college during the day, then work at the television station during the evening newscasts.

A short time later he was offered a job at KCCL Radio in Paris, Arkansas where he received his first chance to do "on-air" work as a disc jockey. He traded in school for the job and spent the next two years driving back and forth to Paris while continuing his work at the television station in the evening.

In 1960, Jim began work as a full-time disc jockey at KFSA Radio in Fort Smith.

In 1963, KAAV, the "Mighty 1090" in Little Rock offered Pitcock a job in the Capitol City where he assumed the identity of "Ron Owens—The Midnight Satellite."

Almost a year to the day later, Jim Pitcock was hired by KATV Television where he

began a 32-year career as the station's News Director. At one point, Pitcock served as the longest-tenured news director in the country. He traveled from Moscow to Vietnam bringing Arkansans news in international significance with a local perspective. Pitcock also oversaw the station's coverage of then-Governor Bill Clinton's rise to the White House in 1991 earning the station a Regional Emmy Award from the National Academy of Television Arts and Sciences.

During his tenure Pitcock won numerous Associated Press Broadcaster's Association awards and led the station's news department atop the ratings for more than a decade.

Jim Pitcock has been honored with a number of other awards for his work as an Arkansas broadcast journalism pioneer including: The Arkansas Society of Professional Journalist's "Silver Microphone" Award for lifetime achievement and the University of Arkansas Department of Journalism's "Ernie Deane Award" for his contribution to broadcast journalism in the state.

Pitcock also served for a time as Congressman Bill Alexander's Field Director in Arkansas, worked with former Arkansas Attorney General MARK PRYOR and finished his career as an aide to United States Senator MARK PRYOR.

One of seven siblings, Jim Pitcock and all three of his brothers worked in the broadcast journalism field during their careers. Oldest brother Bill Pitcock (deceased) served as evening news anchor for KOTV News in Oklahoma City, Bob Gregory Pitcock worked as a correspondent for CBS News Washington and youngest brother Jerry Pitcock worked at KATV in Little Rock and the Arkansas Educational Television Network in Conway, Arkansas.

Jim has four grown children and six grandchildren.

A PROCLAMATION HONORING KIMBERLY BRUGGER FOR HER CERTIFICATION BY THE NATIONAL BOARD FOR PROFESSIONAL TEACHING STANDARDS

HON. ZACHARY T. SPACE

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SPACE. Madam Speaker,

Whereas, Kimberly Brugger has been granted certification by the National Board for Professional Teaching Standards; and

Whereas, Kimberly Brugger has sufficiently demonstrated adherence and dedication to the five core propositions of teaching set by the National Board for Professional Teaching Standards; and

Whereas, due to her hard work and dedication to her profession, Kimberly Brugger was able to achieve this esteemed honor; and

Whereas, we recognize the values and lessons teachers impart to our children; and

Whereas, the creative ingenuity that Kimberly Brugger has demonstrated while educating her students; now, therefore, be it

Resolved, that along with Ohio's 18th Congressional district, I congratulate Kimberly

Brugger for her certification by the National Board for Professional Teaching Standards.

EARMARK DECLARATION

HON. ROBERT B. ADERHOLT

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. ADERHOLT. Madam Speaker, pursuant to the Republican Leadership standards on earmarks, I am submitting the following information regarding earmarks I received as part of H.R. 3326—the Department of Defense Appropriations Act, 2010.

Request as named in the report: Electrically Charged Mesh Defense Net Troop Protection System

Requesting Member: ADERHOLT
Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010

Account or Provision: RDT&E—Army
Legal Name of Requesting Entity: Victory Solutions, Inc.

Address of Requesting Entity: 4900 Corporate Drive, Suite A, Huntsville, AL 35805.

Description of Request: \$7,500,000. The funding would be used for "D-NET" a Defense Net Troop Protection System designed to intercept and negate the serious insurgent and terrorist threat tactics employing Rocket Propelled Grenades (RPG), mortars, and small rocket munitions encountered by U.S. Combat Forces. This product could help save warfighters' lives in hostile territories such as Afghanistan and Iraq through an innovative and low-cost system of defending vehicles against enemy attacks by further testing and prototype development of a system which has passed all tests so far and gotten favorable government program manager review, and which was developed with input from troops in the field. The spending plan for this Phase II of the program, to total \$7,500,000, is: Prototype Production and Field Test & Evaluation Program for integration and operational development. Further develop the D-Net technology based on Phase I R&D Tests to a Technology Readiness Level (TRL) worthy of deploying a limited quantity of "Field Prototypes" to Theatre for field and operations test and evaluation.

FY2010 Task A: D-Net "Field Prototypes" (\$3.5M). Deliver to Army Logistics: 100 "Field Prototypes" of the D-Net Static Troop Protection System for Theatre Deployment on military asset vehicle for field testing (Procurement of Prototypes delivered to Military. Develop, Build, Assemble, Kit Packaging within military requirements like HAZMAT etc, Deliver and Ship to War Zone to fill purchase for Field Test Program) (\$3.5M, or \$35K/unit).

Task B: Field Test Program, data collection and refinement (\$1.075M). Send science and engineering teams to Theatre for collection of field data from Field Prototypes deployed (Data collection material \$125K, OCONUS Labor \$425K), interact with operating community for feedback, return to lab and refine the technology for better performance and utility (Re-engineer labor \$225K). Requires OCONUS travel (\$300K).

Task C: Threat Characterization (\$350K). Analyze and Perform trade Studies on Threat

variants commonly engaged in Theatre scenarios. Engineering and analysis labor (\$350K).

Task D: Net Optimization & Continued R&D (\$1.3M); Range Test Net Materials (\$250K); Government Provided Range Test Facilities & Government Provided Threats for Tests (\$500K); Parametric Studies/ Validation Labor/ Salaries Engineering (\$250K) and Manufacturing labor (\$250K), Travel (\$50K).

Task E: Continue Launcher Development (\$870K). Ground and Aerial Launcher Design and Development R&D and Fabrication Material (\$320K); Testing (\$150K); Labor for Engineering, Integration and Manufacturing for Platform Depot Requirements (\$400K).

Task F: Integration to Systems & Platforms (\$405K). Design and Integration Trade Studies, COTS Sensor Integration Analysis and Labor (\$250K); Material (\$75K), Travel to Platform Project Offices (\$80K).

Request as named in the report: Marine Corps MK 1077 Flatracks

Requesting Member: ADERHOLT

Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010

Account or Provision: RDT&E—Army

Legal Name of Requesting Entity: SUMMA Technology, Inc.

Address of Requesting Entity: headquartered at 140 Sparkman Drive, Huntsville, AL 35805. The manufacturing facility is in Cullman, Alabama.

Description of Request: \$3,000,000. The funding would be used for the MK1077 Flatrack. This is a revolutionary material handling system that provides the Marines with expedited logistical support while achieving significant manpower and equipment reductions. These racks and the containers they work with can be used to transport ammunition or other supplies in and out of areas quickly, thus greatly reducing the warfighter's exposure to danger. This is a continuation of a multi-year procurement program, and the recipient company has a proven record of meeting the strict, structural requirements for this item. The USMC has a requirement for 3,500 MK1077 Flatrack units of which 1,000 units have been acquired to date. \$3,000,000 will provide approximately 347 additional units, bringing the inventory up to 1,347.

Request as named in the report: Waterside Wide Area Tactical Coverage and Homing

Requesting Member: ADERHOLT

Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010

Account or Provision: RDT&E—Army

Legal Name of Requesting Entity: Miltec Corporation

Address of Requesting Entity: Miltec Corporation, located at 21232 Hwy 431, Guntersville, AL 35976

Description of Request: \$4,000,000. The funding would be used for development and integration of systems for the final test and demonstration of the WaterWATCH affordable underwater monitoring capability. Most waterfront facilities are unprotected due to cost considerations. Finalization of this product would make available a security system which installations at military bases and other critical infrastructure locations (such as nuclear power plants near waterways) could afford. WaterWATCH integrates many currently avail-

able components through the development of new software and the testing of these systems. Approximately \$60,000 would be needed for travel, approximately \$150,000 for hardware, and the rest for labor (software development and testing).

Request as named in the report: Protective Self-Decontaminating Surfaces

Requesting Member: ADERHOLT

Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010

Account or Provision: RDT&E—Defense-Wide

Legal Name of Requesting Entity: Ventana Research Corp. (VRC) & Kappler, Inc., and Kappler, Inc.

Address of Requesting Entity: VRC at 2702 South 4th Avenue, South Tucson, AZ 85713-4816; and Kappler at 115 Grimes Drive, Guntersville, AL 35976-9364

Description of Request: \$2,000,000. The funding would be used for Prototype field validation tests of VRC-Kappler Chemical Biohazard Protective systems, lab tests of bacterial infections, diseases and contaminated human remains pouches (CHRP's); to field and live test nerve gas and radiological agents (in order to design the suit to withstand such an attack by a hostile nation). Present decontamination processes are labor intensive and require lengthy downtimes. Field-tested prototypes of this fabric demonstrate cost-effective Chemical Biohazard protection for military personnel and civilian populations. Applications could be military, for homeland security, or for dangerous medical and rescue operations. The spending plan is Personnel: \$620,000; Materials: \$80,000; Equipment: \$120,000; travel: \$25,000; Govt Agency partnerships: Oversight and testing work: DTRA/CBT: \$90,000; AFRL/Tyndall AFB: \$250,000; USA NSRDEC: \$90,000; Preproduction, Live Agents Tests, \$825,000

Request as named in the report: Scenario Generation for IAMD Evaluation (SGIE)

Requesting Member: ADERHOLT

Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010

Account or Provision: RDT&E—Defense-Army

Legal Name of Requesting Entity: QinetiQ North America Systems Engineering Group

Address of Requesting Entity: AMSRD-AMR-BA Bldg. 6263, Redstone Arsenal, AL 35898

Description of Request: \$4,200,000 for Scenario Generation for IAMD Evaluation (SGIE) in fiscal year 2010. The entity to receive funding for this project is QinetiQ North America Systems Engineering Group, located at 890 Explorer Boulevard, Huntsville, AL 35806. The funding would be used for 54 ground test cases identified in the IAMD TEMP and 7 flight test cases derived from ground test matrix. A scenario for each test case is required to capture the design specification as it is intended to perform in a battlefield situation. Taxpayer Justification: This program will contribute to the work of establishing an Integrated Air & Missile Defense System protect against air breathing missile and cruise missile threats. This work will provide a network centric system to integrate a mix of sensors and shooters through a common IAMD battle command system.

Request as named in the report: Enhanced—Rapid Tactical Integration for Fielding of Systems Initiative (E-RTIFS)

Requesting Member: ADERHOLT

Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010

Account or Provision: RDT&E—Defense-Army

Legal Name of Requesting Entity: PeopleTec, Inc.

Address of Requesting Entity: 4901-D Corporate Drive, Huntsville, AL 35805

Description of Request: \$3,900,000 for Enhanced Rapid Tactical Integration for Fielding of Systems (ERTIFS) in fiscal year 2010. The entity to receive funding for this project is PeopleTec, Doug Scalf, Linda Maynor, located at PeopleTec, Inc. 4901-D Corporate Drive, Huntsville, AL 35805. The funding would be used to support early SoS testing to ensure that interoperability issues are corrected before software is released for formal AIC testing. The ABCS-BA will leverage and evolve ERTIFS to support four types of required Interoperability Tests: (1) Individual System, (2) System of Systems (e.g. Software Blocking), (3) Backwards Compatibility—Interoperability and (4) Regression Testing. Taxpayer Justification: The early identification of these issues will limit cost and schedule overruns on Aviation/Missile Systems prior to expensive hardware tests.

Request as named in the report: Swarms Defense Systems

Requesting Member: ADERHOLT

Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010

Account or Provision: RDT&E—Defense-Army

Legal Name of Requesting Entity: Southeast Systems Technology

Address of Requesting Entity: 4090 South Memorial Parkway M/S 3427B, Huntsville, AL 35802

Description of Request: \$3,000,000 funding for SWARMS DEFENSE SYSTEMS in fiscal year 2010. The entity to receive funding for this project is Computer Science Corporation, located at 4090 S. Memorial Parkway M/S 3427B, Huntsville, Alabama 35801. The funding would be used to close the gap between current and future Air Defense Systems dealing with enemy mortars, rockets, UAV's, and cruise missiles. Future threats exceed all requirements of current system and future AD plans. Taxpayer Justification: Swarms Defense is designed to protect soldiers and critical assets against enemy fire, especially high volume small munitions such as mortars, rockets, UAV's, cruise missiles, developing the critical technologies required to close the gap in current asset protection plans.

Request as named in the report: Tactical UAV, Heavy Fuel Engine

Requesting Member: ADERHOLT

Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010

Account or Provision: RDT&E—Defense-Army

Legal Name of Requesting Entity: Science and Engineering Services

Address of Requesting Entity: 4015 Pulaski Pike, NW., Huntsville, AL 35810

Description of Request: \$2,000,000 for the Tactical UAV, Heavy Fuel Engine in fiscal year

2010. The entity to receive funding for this project is Science and Engineering Services, Inc., located at 4015 Pulaski Pike, Huntsville, AL 35810. The funding would be used for development of lightweight military fuel engine for UAVs. Scope includes building engines to perform platform integration and flight test for use in a military environment. Funding supports design and implementation of the process to military standards. Taxpayer Justification: Shadow UAS is ideal for providing direct information to commanders increasing awareness. Heavy fuel technology allows an engine to burn any fuel, diesel, JP5, JP8, gasoline, producing low emission, can be economically manufactured, and maintained

Request as named in the report: Army Responsive Tactical Space System Exerciser (ARTSSE)

Requesting Member: ADERHOLT
 Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010
 Account or Provision: RDT&E—Defense-Army

Legal Name of Requesting Entity: J2 Technologies Inc.

Address of Requesting Entity: 4801 University Square, Suite 31, Huntsville, AL 35816

Description of Request: \$3,000,000 for Army Responsive Tactical Space System Exerciser (ARTSSE) in fiscal year 2010. The entity to receive funding for this project is J2 Technologies Inc., located at 4801 University Square, Suite 31, Huntsville, AL 35816–1815. The funding would be used to provide the hardware-in-the-loop test capability designed to address the need to define performance requirements, evaluate and execute Operationally Responsive Space programs thus ensuring the warfighter's continued access to space. Taxpayer Justification: Army Responsive Tactical Space System Exerciser (ARTSSE) provides technologies critical to maintaining access to space. ARTSSE supports an unfunded Army need to provide a responsive surge for space based communication, surveillance, and reconnaissance, especially when a change in circumstances brought about by foreign-owned assets requires a response from the U.S. systems within hours or a few days in order to maintain protection of U.S. personnel and assets.

Request as named in the report: Autonomous Cargo Acquisition for Rotorcraft Unmanned Aerial Vehicles

Requesting Member: ADERHOLT
 Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010
 Account or Provision: RDT&E—Defense-Army

Legal Name of Requesting Entity: Advanced Optical Systems, Inc.

Address of Requesting Entity: 6767 Old Madison Pike, Suite 410, Huntsville, AL 35806

Description of Request: \$1,600,000 for Autonomous Cargo Acquisition for Rotorcraft Unmanned Aerial Vehicles in fiscal year 2010. The entity to receive funding for this project is Advanced Optical Systems, Inc., located at 6767 Old Madison Pike, Suite 410, Huntsville, Alabama 35805. The funding would be used to demonstrate fully unmanned cargo pickup and delivery under operational conditions. The work will leverage current developments for manned systems, and will cooperate with

TRADOC and logistics personnel at Ft. Rucker and Ft. Lee. Taxpayer Justification: The Army needs to leverage rotorcraft unmanned aerial systems to provide unmanned pickup and delivery for logistics supply and weapons placement. Unmanned cargo operations would reduce both aircrew losses and costs.

Request as named in the report: On-Board Vehicle Power (OBVP)

Requesting Member: ADERHOLT
 Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010

Account or Provision: RDT&E—Defense-Army

Legal Name of Requesting Entity: DRS Training and Energy Management

Address of Requesting Entity: 110 Wynn Drive, Huntsville, AL 35805

Description of Request: \$3,100,000 for On-Board Vehicle Power (OBVP) in fiscal year 2010. The entity to receive funding for this project is DRS Training and Energy Management, located at 110 Wynn Drive, Huntsville, AL 35805. The funding would be used for OBVP provides electric power for vehicles and mission electronics. OBVP fits the space inside the bell housing of vehicle transmissions. The system is capable of producing 30–70 kW. Increased power is needed for IED detection and weapon systems. Taxpayer Justification: Growth in energy requirements on the battlefield has created a critical need to accelerate this program to production readiness. The system can deliver mobile/exportable electric power from the vehicle engine for electric power gap requirements.

Request as named in the report: Extremely Large, Domestic Expendable and Reusable Structures (ELDEERS)

Requesting Member: ADERHOLT
 Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010

Account or Provision: Dpa Defense Production Act Purchases

Legal Name of Requesting Entity: ATK Aerospace Structures

Address of Requesting Entity: 751 County Road 989, Building 1000, Iuka, MS 38852

Description of Request: \$9,800,000 For Current domestic large-scale, composites production capacity is constrained by processing limitations associated with the large diameter of the items being manufactured. At the same time, the Air Force is making future plans to utilize structures with diameters in excess of nine meters. The current domestic industrial production capacity does not support this scale of extremely large composite launch structures. The ELDEERS Title III program was initiated in FY2009 with \$8.0 million to scale-up domestic composites manufacturing and processing capacity and support facilities to meet this critical emerging need in military space access. The three-phase program includes evaluation, modification and qualification of current automated production equipment and facilities, and the acquisition of necessary industrial capacity and processing capabilities. In general, Title III activities serve to lower defense acquisition and life-cycle costs and to increase defense system readiness and performance through the use of higher quality, lower cost, and technologically superior materials and technologies. The ELDEERS Program will increase the capacity for increasingly large-

er composite structures, including development and acquisition of higher performing composite processing equipment.

Request as named in the report: Adaptive Robotics Technology for Space, Air and Missiles [ART-SAM]

Requesting Member: ADERHOLT
 Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010

Account or Provision: RDT&E—Defense-Army

Legal Name of Requesting Entity: Calhoun Community College

Address of Requesting Entity: 6250 Hwy. 31 North Decatur Campus, Tanner, AL 35671

Description of Request: \$4,200,000 for Adaptive Robotics Technology for Space, Air and Missiles [ART-SAM] in fiscal year 2010. The entity to receive funding for this project is Calhoun Community College, located at 6250 U.S. Highway 31 North, Tanner, AL 35671. The funding would be used for a joint venture with leadership from the U.S. Army Space and Missile Defense Command (SMDC) and Alabama Industrial Development Training (AIDT), and will establish national robotics research and development capability at Calhoun Community College to leverage government, industry, and academia partnerships and their respective investments. Additionally, funds will be used to procure instrumentation, components and test fixtures to provide a hands-on laboratory for experiments and process testing in an unmanned environment. Taxpayer Justification: The ART-SAM project, once operational, will develop robotics technologies, systems and products for a variety of SMDC projects, programs, and core mission needs. It will serve as an economic development catalyst for robotic research and development, training, operations and manufacturing. It will also support workforce development initiatives throughout the state.

Request as named in the report: Protective Self-Decontaminating Surfaces

Requesting Member: ADERHOLT
 Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010

Account or Provision: RDT&E—DW

Legal Name of Requesting Entity: Ventana Research Corp. (VRC)

Address of Requesting Entity: 139 Barnes Drive, Suite 2, Tyndall AFB, FL

Description of Request: \$1,600,000 for ACD&P project of self-decontaminating surfaces for long-lasting personnel (e.g. clothing) & shelter (e.g. hospitals) protection from Chem/Bio (& nerve gas) attacks. Light-activated decontaminating material produces singlet oxygen, a mild oxidant, to destroy CB agents. Demonstrated the material traps & stores excess singlet oxygen during periods of sun & artificial light. Stored singlet oxygen is released to provide indoor & outdoor protection of 8+ hours during no light & dark periods. Further, no protection loss demonstrated in intense Arizona sunlight 39+ hours during 100+ degrees days. Completed FY07 Individual Protection (IP) ATD milestones. Started FY08 IP ACD&P phase & initiated nerve gas protection ATD for ACD&P in FY10 and will continue ACD&P effort in FY09. Technology: Sun or artificial light activates the decontaminating material to produce singlet oxygen, a mild, short-lived oxidant that effectively destroys chemical/nerve & biological agents. This long-lasting & durable capability for around-the-clock

protection using sun or artificial light is the heart of the invention. Our FY10 request is prompted by the need for including nerve gas and nuclear decontamination capability. This will involve added-on tasks to the program in terms additional test and evaluation efforts. Nerve gas protection effort will address chemistry efforts and tests, nuclear protection disposable, absorbent materials.

Progress: (1) Mustard gas stimulant treated fabric tests demonstrated self-decontamination capability after exposure of 39 days to the intense AZ summer sun; (2) Kappler Provent fabric treated with VRC Decon Dye Coating demonstrated standard industrial practice can be used for first-article production of garments for breathability, field laundering, & durability testing; (3) VRC Decon Dye Coating showed no adverse effect upon Provent fabric's breathability, an essential Joint Service Lightweight Integrated Suit Technology (JSLIST) Ensemble requirement; (4) Airtight seam-bonding process demonstrated with Provent Fabric dyed with VRC Dye Coating enables standard protective suit manufacturing procedures eliminating protective coating application after suit completion, a more costly approach; (5) NMR & UV-Visible Spectroscopy showed Ventana Decon Dye Coating efficiently traps visible light-generated singlet oxygen in repeated release & oxidation a mustard gas & VX stimulant to decontaminated product in darkness; (6) UV-Visible Spectroscopy demonstrated to be a more cost-effective QA tool than conventional NMR inspection; (7) Live tests will be performed at the Defense Science & Technology Laboratory (distl), Proton Down, UK, during the week of April 27, 2009, additional tests are planned for 2Q09 & 3Q09. Samples have been provided to Dr. Stephen Lee, Chief Scientist, Ofc. Director U.S. Army Research Office, for coordination & ITAR, export/import matters & permits.

The requested FY10 program under JPM-CBD's leadership addresses: (1) Perform ATDs on VRC Decon Dye coatings to add nerve gas & radiological agent (disposable garments & coatings) protection; (2) Conduct operational validity tests (ACD&P) of preselected Light-Activated CBNR Protective systems; (3) Continue pre-production of protection systems at Kappler & Ventana for several ACD&Ps of representative JLIST materials, components & suits & upgrade facilities to full production status.

Request as named in the report: Remote Monitoring and Troubleshooting (RMAT) Project

Requesting Member: ADERHOLT
Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010
Account or Provision: OP.N

Legal Name of Requesting Entity: Intergraph
Address of Requesting Entity: 170 Graphics Drive, Madison, AL 35758

Description of Request: \$2,320,000 for RMAT will integrate with shipboard local control and monitoring systems by networking them together and providing secure shore-based remote monitoring of those systems in real time. Through the use of sensors, networks, and software-based controllers, RMAT will provide the means for monitoring and troubleshooting various shipboard systems that are vital to ship operations, and allow engi-

neers from various shore-based locations to collaborate in a real-time secure environment. RMAT will enable faster response times and mitigation of damage caused by engineering casualties, blast, fire, flooding, and equipment malfunction. Implementation of RMAT will increase the level of sensor data fusion, situational awareness, and survivability of the ship, as well as its ability to successfully complete its mission. The change from analog systems and manual data collection will save thousands of man-hours every year. Without funding for this effort, a need will exist to continue maintenance of obsolete hardware-based control panels and large redundant watch-standing and damage control repair parties that rely on slow, outdated, and error producing control systems and information management techniques.

Request as named in the report: Transitioning Stretch Broken Carbon Fiber to Production Programs

Requesting Member: ADERHOLT
Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010
Account or Provision: RDT&E—Defense-Army

Legal Name of Requesting Entity: Hexcel Corporation

Address of Requesting Entity: 3300 Mallard Fox Drive, Decatur, AL 35609

Description of Request: \$3,200,000 for composite structure on existing military aircraft has saved weight and reduced O&M costs. However, a solution to the high cost and unrealized weight benefits of these structures is badly needed. Studies done in conjunction with the major aircraft manufacturers show that while composite material properties predict a weight savings of about 50% is achievable, only about 10–20% is being realized in today's designs. The problem is that the composite materials that are currently available in the marketplace cannot be formed into the complex geometries necessary to realize the true weight savings available. This results in pressure at the design stage to reduce the complexity of parts so they are more fabrication friendly. If the designer holds firm on the part complexity, automated fabrication techniques are often ruled out due to the challenges of forming complex geometries with these processes. The end result is added weight and cost to the structure. Stretch Broken Carbon Fiber (SBCF) technology affords more weight reduction opportunities than any other solution under evaluation by the DoD. SBCF product forms offer a pseudo plasticity akin to metals that makes the forming of complex geometries much easier. These products can be used in all of the automated composite processes currently being used by fabricators including fiber and tape placement and engineered textile approaches for fabricating net shape preforms used in resin infusion processes. The focus of this program will be two-fold. First, funding will be allocated to various composite part fabricators to develop robust processes to mold full size prototype parts with SBCF product forms. Second, funding will be allocated to generate a Mil-HdBk-17 approved database. Both tasks are necessary to take this technology into production.

Request as named in the report: Cooperative International Neuromuscular Research Group

Requesting Member: ADERHOLT
Bill Number: H.R. 3326—the Department of Defense Appropriations Act, 2010
Account or Provision: RDT&E—Defense-Army

Legal Name of Requesting Entity: Children's National Medical Center

Address of Requesting Entity: 111 Michigan Avenue, NW., Washington, DC 20010

Description of Request: \$3,280,000 for funds will be used for ongoing research and testing using molecular patches, to see if the same improvements experienced by dogs in clinical trials can be extended to humans with muscle damage. The funds will be used for ongoing research and testing using molecular patches, to see if the same improvements experienced by dogs in clinical trials can be extended to humans with muscle damage. This research benefits both warfighters (in terms of combating the effects of biological warfare attacks), and also potentially the civilian population who suffer from similar muscle tissue deterioration.

PRINCIPIA COLLEGE SOLAR CAR

HON. JOHN SHIMKUS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SHIMKUS. Madam Speaker, I rise today to honor the achievements of the Principia College Solar Team at this year's Global Green Solar Challenge.

Thirty-two teams from around the world traveled to Darwin, Australia for a 3000 kilometer race across the Australian outback in solar powered cars. Only nine teams were able to finish the grueling challenge, included among them was this outstanding group from Elsah, Illinois. Principia's Ra7 finished seventh in the world in this year's race and third among American entries.

While other teams spent millions from corporate sponsorships, the Principia team spent less than \$180,000. The winner, Tokai University of Japan, was sponsored by Sharp Electronics, a leader in solar engineering. This year's runner-up was sponsored by the European Space Agency. When the race was over, Principia earned the Safety Award from race officials, their fourth overall and first in international competition.

I want to congratulate John Broere (Director of Engineering Science), Joe Ritter (Assistant Dean of Academics) and the members of the Principia College Solar Team on their outstanding achievement. Their efforts have done much in accelerating this exciting field of scientific exploration.

IN RECOGNITION OF DOROTHY BRYANT

HON. IKE SKELTON

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SKELTON. Madam Speaker, let me take this means to recognize Dorothy Bryant

from my hometown of Lexington, Missouri. Mrs. Bryant will be retiring at the end of this year after thirty years of dedicated service to the Lafayette County Sheriffs Department.

Mrs. Bryant began working for the Sheriffs Department on January 21, 1980, and since then has worked for five different Sheriffs of Lafayette County. She has worked for the current Sheriff, Kerrick Alumbaugh, for nine of her thirty years. A loyal and dedicated employee, Mrs. Bryant has worked tirelessly to serve the residents of Lafayette County.

Madam Speaker, Dorothy Bryant has helped keep the people of Lafayette County safe for the past three decades. I trust that my fellow members of the House will join me in wishing her the very best in her well-earned retirement.

HONORING LARRY KELLNER,
CHAIRMAN AND CHIEF EXECUTIVE
OFFICER OF CONTINENTAL
AIRLINES INC.

HON. JOHN ABNEY CULBERSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. CULBERSON. Madam Speaker, I rise today to honor Larry Kellner, chairman and chief executive officer of Continental Airlines Inc, the world's 5th largest airline. In May 2001, Larry Kellner was elected president of the airline and to the Board of Directors, and in March 2003, he was named president and chief operating officer. In December 2004, Mr. Kellner became chairman and chief executive officer, where he has promoted international growth at Continental Airlines and has fostered the company's unique culture, putting emphasis on strong internal communication and giving employees the tools to provide outstanding customer service.

Throughout Mr. Kellner's 14-year career at Continental, the company has won more awards for customer satisfaction than any other airline. In 2009, *FORTUNE* magazine ranked Continental the No. 1 airline on their annual airline industry list of "Most Admired Global Companies" for the 6th consecutive year. Continental Airlines also employs 41,000 system-wide and nearly 12,000 in Houston, Texas.

Prior to joining Continental, Mr. Kellner was executive vice president and chief financial officer of American Savings Bank, owned by The Robert M. Bass Group. Prior to that, he was executive vice president and chief financial officer of The Koll Company, a private real estate investment and construction firm.

Kellner graduated magna cum laude with a bachelor of science in business administration from the University of South Carolina, where he served as Student Body President. In addition, the University of South Carolina presented him with the Distinguished Alumni Award in 1998.

Mr. Kellner is active in numerous community and civic organizations. He currently serves on the board of directors for Marriott International and the Air Transport Association. On the civic front, he is a member of the board of directors for the Methodist Hospital, YMCA of Greater

Houston, the Greater Houston Partnership, the Spring Branch Education Foundation, and Central Houston, Inc., and is a member of the Boy Scouts of America National Executive Board. Mr. Kellner also serves on the advisory boards of the March of Dimes and Teach for America, and is on the development board of the University of Texas Health Science Center at Houston. He resides in Houston with his wife, Susan, and their four children.

After more than 14 years at Continental Airlines and 5 years as its CEO, Mr. Kellner will leave the company at the end of 2009 and will head Emerald Creek Group, LLC, a new private investment firm based in Houston.

Congratulations to Larry Kellner for his many achievements throughout his career at Continental Airlines and the best of luck in his future endeavors.

SHILOH MISSIONARY BAPTIST
CHURCH 100TH ANNIVERSARY

HON. JOHN SHIMKUS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SHIMKUS. Madam Speaker, I rise today to honor Shiloh Missionary Baptist Church of Mount Vernon, Illinois for reaching the centennial milestone.

Shiloh Missionary Baptist Church opened in 1909 on Vaught Avenue in Mount Vernon and held services at the location throughout 1960's. After being sold, the congregation was unable to find a new location. Being unwilling to dissolve their tight-knit congregation, the Shiloh Missionary Baptist family held services at a member's home for years before acquiring property on Conger Avenue in Mount Vernon.

In spite of adversity, including a disastrous fire in 1999, Shiloh Missionary Baptist Church has held true to its mission in the community and has become a part of Mount Vernon. Its congregation continues its outreach ministry to troubled youths and many others in the community.

I want to join with the members of this House in congratulating Reverend Lawrence James and the men and women of Shiloh Missionary Baptist Church on celebrating one hundred years of good works, to thank them for all they do for our community and to wish them another hundred years of success.

FREEDOM CAPTIVATES THE
HUMAN SPIRIT

HON. FRANK R. WOLF

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. WOLF. Madam Speaker, last week I spoke at a moving exhibit at the Heritage Foundation which featured a collection of 50 paintings by Ukrainian artist and gulag survivor Nikolai Getman.

Mr. Getman spent eight years in a Siberian gulag. Following his harrowing experience he secretly undertook to chronicle his time in the

Soviet forced labor system because he said he was "convinced that it was my duty to leave behind a testimony to the fate of the millions of prisoners who died and who should not be forgotten."

These 50 paintings are the fruit of 40 years of work on the part of Nikolai. They are a powerful testimony of one's man's triumph over totalitarianism. They ought not be relegated to the annals of history. While the Soviet Union no longer exists, those who seek to suppress freedom, be they in North Korea, China or Egypt, are still with us.

I submit my remarks from the Heritage Foundation event:

"Experience and the record had convinced me that communism is a form of totalitarianism, that its triumph means slavery to men wherever they fall under its sway, and spiritual night to the human mind and soul."

These words were spoken by famed Communist party member, Soviet spy and ultimate defector, Whitaker Chambers.

In testimony before the House Un-American Activities Committee, Chambers said that in spite of what he knew to be true of communism, he believed he was "leaving the winning side for the losing side" but that was "better to die on the losing side than to live under communism."

Of course we know that Chambers' fear proved to be untrue. That communism, as Ronald Reagan predicted, was destined for the "ash heap of history." That the gulags of that era, depicted before us tonight, were destined to be relics of the past.

Ronald Reagan modeled how to confront repressive regimes like the Soviet Union. He spoke truth to power. He boldly pressed the Soviets to respect the fundamental human rights of their own people. He raised the cases of dissidents by name.

He did this because of a fundamental belief that the U.S. constitution was a "covenant we have made not only with ourselves, but with all of mankind"

Reagan once said, "Coersion, after all, merely captures man. Freedom captivates him."

Indeed freedom captivates the human spirit and ultimately triumphs over tyranny whatever form it takes.

RECOGNIZING WINIFRED "WINN"
BUNDY

HON. GABRIELLE GIFFORDS

OF ARIZONA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Ms. GIFFORDS. Madam Speaker, I rise today to recognize Winifred "Winn" Bundy, who has been named a 2009 Arizona Culturekeeper for her commitment and dedication to upholding the traditions, rituals and culture of my State.

For thirty-five years, Winn has operated the Singing Wind Bookshop near Benson, Arizona. Time magazine called Singing Wind "one of the warmest bookshops on Earth" and a national travel writer said it was "the most unique book-buying experience of my life."

Winn did not start out planning to run a book store. In 1956, she earned a degree in

history and English from the University of Arizona. That year she and her husband bought the Singing Wind, a working cattle ranch.

Winn's love of literature led her to start selling books from the living room of her ranch home. Winn soon developed a reputation for featuring a rich selection of regional authors and topics that draw readers from around the world. Since then, Winn's ranch house has become a must-visit destination for lovers of Southwestern literature who come from far and wide by car and tour bus. Winn now has 150,000 titles in stock on everything from Indian rock art to ghost towns to the Jewish Western experience.

Since 1974, Winn has helped hundreds of Southwestern writers get their start. She specializes in small press books that do not appear in big chain stores and connects authors with publishers to get their works in print.

Winn also cultivates the love of literature and the humanities through the many community activities she sponsors. From its inception, Singing Wind has offered a bookmobile, school programs, book discussions, author readings and writers' festivals.

Earlier this year, Winn received the Juliana Yoder Friend of the Humanities Award from the Arizona Humanities Council. On December 20, 2009 she will be named an Arizona Culturekeeper, an award presented by the Westin Kierland Resort & Spa, in conjunction with the Sharlot Hall Museum, the Arizona Historical Society and Marshall Trimble, Arizona's official state historian.

I am proud of the work that Winn has done to preserve Arizona's culture and to bring literature to a wide audience. She is truly a deserving recipient of the Culturekeeper Award and I join with the award committee in commending her for all that she has done for the people of Arizona and for readers across the country and around the world.

VFW POST 2055 75TH ANNIVERSARY

HON. JOHN SHIMKUS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SHIMKUS. Madam Speaker, I rise today to honor the men and women of the Veterans of Foreign Wars Post 2055 in Centralia, Illinois, as they celebrate their 75th anniversary on December 18.

Post 2055 began in a renovated church in 1934 and was followed a year later by the chartering of the local VFW Ladies Auxiliary. The post has grown from its original membership of 56 to a high of more than 600 members.

The men and women of the Centralia VFW post have continued to serve their community and our nation long after their terms of active duty military service have ended. Post 2055 members assemble and send care packages to service men and women in Iraq and Afghanistan.

Members of VFW Post 2055 are dedicated to serving their community. They regularly volunteer at the local Veterans Administration hospital, teach firearms safety courses and participate in cancer research fundraisers.

I would like to thank the men and women of VFW Post 2055 in Centralia, Illinois, for their service to our nation, their continued support of America's soldiers and their dedication to their community.

TO COMMEMORATE THE ESTABLISHMENT OF THE NORTH AMERICAN HEADQUARTERS OF NUMONYX

HON. DANIEL E. LUNGREN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. DANIEL E. LUNGREN of California. Madam Speaker, tomorrow in my district—in Folsom, California—Numonyx will establish its North American headquarters. Numonyx is a leading semiconductor technology firm that specializes in memory products.

Approximately 450 members of the Numonyx global workforce will be located in nearly 100,000 square feet of building space on its new campus. The campus will house product research and development, business management, testing labs, validation labs, sales, marketing, and more.

Folsom was chosen as the new home for Numonyx due to its business-friendly environment, highly skilled and educated workforce as well as being a family-oriented community. Numonyx will play an important role in the ongoing growth of the workforce, economy and technical skill within the greater Sacramento region.

Beyond the obvious business, employment, and economic benefits, Numonyx's impact reaches the community at large with "Numonyx in Your Neighborhood" campaigns. These campaigns assist in meeting the needs of individuals and charitable organizations within the Sacramento region.

I am pleased that this leading-edge and high impact company has chosen California's 3rd district as its home.

THE TALKING WATER GARDENS PROJECT IN OREGON IS AN EXCELLENT USE OF RECOVERY ACT FUNDS

HON. PETER A. DeFAZIO

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. DeFAZIO. Madam Speaker, I rise today to draw attention to an example of Recovery Act funds that have been invested wisely. The "Talking Water Gardens" is a high-priority wastewater treatment project in Albany and Millersburg, Oregon that received Recovery Act funds from the Clean Water State Revolving Loan Fund. Those funds will be used to construct 39 acres of treatment wetlands and reuse the treated water to improve riparian habitat. Unfortunately, a report by two members of the Senate entitled, "Stimulus Checkup: A closer look at 100 projects funded by the American Recovery and Reinvestment Act," inaccurately and unfairly criticized this

project. Had the two Senators who authored the report called these two Oregon cities to inquire about the project they would have learned that the Talking Water Gardens is a shining example of how Recovery Act funds can be used to improve our aging infrastructure, mitigate environmental damage, and create good-paying jobs. The project also illustrates how a successful public-private partnership can work. I respectfully submit this letter from the City of Albany, which further explains the inaccuracies in the "Stimulus Checkup" report on this important project.

CITY OF ALBANY,

Albany, OR, December 14, 2009.

Hon. PETER DeFAZIO,
Rayburn House Office Building,
Washington, DC.

DEAR CONGRESSMAN DeFAZIO: On December 10, 2009, we learned that Senator John McCain and Senator Tom Coburn named "Talking Water Gardens," our wastewater treatment and water reuse project, in a report that questions the validity of 100 projects funded by the American Recovery and Reinvestment Act. This project is an important, necessary, and high-priority wastewater treatment project for the State of Oregon that received funding through the State Clean Water Revolving Loan Fund program. This project provides sustainable benefits for the community, the economy, and the environment. We offer this letter in rebuttal to the "Stimulus Checkup" report dated December 2009.

No one from Senator McCain or Senator Coburn's offices have ever contacted the City of Albany or the City of Millersburg regarding the project. The information sources referenced in the report were never verified with us for accuracy. It appears that our project was singled out simply because of the whimsical name, "Talking Water Gardens." The project will construct roughly 39 acres of treatment wetlands and reuse the water to improve the riparian habitat on land that is the blighted site of two defunct lumber mills adjacent to the old oxbow of the Willamette River. This land has significant elevation differences, so the treated wastewater from the Albany-Millersburg Water Reclamation Facility and the ATI Wah Chang treatment facility will enter the project at elevations above the wetlands, creating several waterfalls that will aerate the water. Waterfalls are often referred to as "talking waters" and the name was chosen with children and the Native American Kalapuya/Willamette River heritage in mind.

The conclusions of the McCain-Coburn report are inaccurate and misleading:

(1) The report states that a non-competitive contract was issued for the construction. This is false. In accordance with the Oregon Revised Statutes, the cities employed a construction manager/general contractor (CM/GC) procurement method that is allowed and, in fact, encouraged by the State to lower public project costs. The process followed a Request for Proposal and interview process that included evaluation of both cost and non-cost elements. Of six proposals received, the selected contractor represented the best qualified and least costly.

(2) The report fails to mention that the Willamette River, one of the 14 American Heritage rivers, has new thermal load restrictions placed upon treatment plants to protect and recover threatened and endangered salmon fish species as well as other water quality regulations.

(3) The report fails to mention that the wastewater treatment plant serving the cities of Albany and Millersburg and ATI Wah

Chang must construct additional wastewater treatment capital facilities to comply with the regulations.

(4) The report failed to note that the project is a unique industrial/municipal partnership, between the cities of Albany, Millersburg, and ATI Wah Chang with the industrial partner contributing its share of capital.

(5) The report failed to note that this project provides a secure and environmentally-sound wastewater treatment solution for ATI Wah Chang, a major local employer and significant rare metals industry in the United States. This project protects the jobs at this industry that would have been put at risk had a cost-effective treatment solution not been found.

(6) The report fails to mention that the project is the least-cost alternative that requires the smallest ratepayer increases to comply with the regulations.

(7) The report fails to mention that this project received an Honor Award from the American Academy of Environmental Engineers for Excellence in Environmental Engineering.

(8) The report failed to say that the project will provide employment for an estimated 100 people in diverse sectors: electricians, mechanics, pipe layers, and excavators; surveyors, engineers and construction managers; raw material and equipment suppliers for the pipe, pumps, rock, concrete, asphalt, wiring, steel and other materials; landscapers and nurseries. These jobs are needed in Linn County, where 15.1% unemployment far exceeds the U.S. (10.2%) and Oregon (11.3%) seasonally adjusted rates as reported in the December 2009 Benton/Linn Labor Trends Report for October.

Talking Water Gardens is a shining example of how to balance the needs of the environment with the needs of cities and American industries to preserve jobs in these tough economic times. Many, many people have worked hard to make this project happen and singling it out for criticism without verified foundation is shameful at a time when we all need to be working together.

Sincerely,

SHARON KONOPA,
Mayor.

JUNIOR SERVICE CLUB 75TH BIRTHDAY

HON. JOHN SHIMKUS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SHIMKUS. Madam Speaker, I rise today to join in the celebration of the 75th anniversary of an important community organization in Collinsville, Illinois.

The Junior Service Club has worked for three quarters of a century to better the lives of the children in the community. The group's volunteers have worked tirelessly to provide fun activities for the community's youth. Over the decades, they ensured the children had a good meal during the holidays and have taught them the value of service to one's neighbors.

The club's fundraising efforts have gone to benefit hospitals, fire victims, community parks, senior programs and scholarships for graduates of Collinsville High School. Today, the club consists of about 50 members. Many

of the volunteers are teachers who represent the third generation of their family to belong to the Junior Service Club.

I want to join with the members of this House in congratulating the members of the Collinsville Junior Service Club on celebrating their 75th anniversary and thank them for their service. I want to wish them another 75 years of continued success.

PERSONAL EXPLANATION

HON. MARY JO KILROY

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Ms. KILROY. Madam Speaker, on the legislative day of Tuesday, December 15, 2009, I was unable to cast a vote on rollcall vote 971. Had I been present, I would have voted "yea" on rollcall vote 971.

THE RETIREMENT OF CHIEF CHARLES A. TEALE, SR., FROM THE HARTFORD FIRE DEPARTMENT

HON. JOHN B. LARSON

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. LARSON of Connecticut. Madam Speaker, I rise today to honor Fire Chief Charles A. Teale, Sr., of the Hartford Fire Department who is retiring after serving 27 years—9 of those as its chief.

In his years of service, Chief Teale has gained a reputation as a fair, no-nonsense administrator who helped to restore order and stability to the Hartford Fire Department. Under his watch, the Hartford Fire Department maintained its Class 1 status, a designation shared by only 41 of 38,000 departments across the country. Among Teale's many accomplishments is his emphasis on attaining high educational and professional standards. Due to the department's educational outreach, the number of structure fires in Hartford decreased from 366 in 2001 to just 80 in 2008.

In one of his proudest accomplishments, Teale showed a dedication to the community he served that extended far beyond his duties as fire chief. He worked as co-chairman of a committee that raised \$125,000 to create a memorial to the 168 people who died in the Hartford circus fire of July 6, 1944. Motivated by the conviction that a memorial had to be created before the generation that remembered one of Connecticut's worst disasters passed on, Teale dedicated the beautiful memorial in 2005, on the 61st anniversary of the fire.

Chief Teale's own story is truly remarkable. He dropped out of school at age 14, but returned and excelled, thanks to the mentoring of legendary Hartford educator Walter "Doc" Hurley. He went on to earn multiple advanced degrees, including a master's in public administration from the University of Hartford. Chief Teale's passion for learning is everlasting, and after retirement he plans to pursue a doctorate

in psychology, which will help him empower Hartford's young men to make smart choices as they enter adulthood, just as Doc Hurley influenced him.

The residents of Hartford and Connecticut's First Congressional District are indebted to Chief Teale for his extensive efforts to serve the Greater Hartford community. His dedication to Hartford and its history, as well as his ability to lead, have made him not just an outstanding fire chief but an exceptional ambassador for the city. His fire boots will be hard to fill, but we wish him well on his admirable goals of returning to school and serving as a mentor to the young men in Hartford.

JUDGE DOROTHY SPOMER

HON. JOHN SHIMKUS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SHIMKUS. Madam Speaker, I rise today to honor Judge Dorothy Spomer, who broke barriers as she served on the bench in Southern Illinois. Judge Spomer was recently honored at Southern Illinois University Carbondale's Inspiring Women Gala.

Judge Spomer graduated from the University of Illinois College of Law in 1943, at the age of 22. Throughout her historic career, she set an example for other young women as the first female judge in Alexander County, the first female circuit judge in the First Judicial Circuit and the first woman to sit on the appellate court in the Fifth District.

A dedicated public servant, Judge Spomer came out of retirement in 1977, when Illinois Supreme Court Justice Joseph Goldenhersch called on her to serve on the appellate court in Mount Vernon.

Judge Spomer's example inspired her son, Judge Stephen Spomer, to carry on the proud family tradition of public service as he presides over the same Fifth District Appellate Court.

I would like to join Southern Illinois University Carbondale, as they honor her at their Inspiring Women Gala, in thanking Judge Dorothy Spomer for her lifelong service to Southern Illinois.

HONORING LIAM McLAUGHLIN

HON. ELIOT L. ENGEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. ENGEL. Madam Speaker, Liam McLaughlin is leaving the Yonkers City Council after serving four terms, representing the Fourth District since 1999. He served as Majority Leader of the City Council and is leaving as the Minority Leader and Chair of the Budget Committee and the Environmental Policy & Protection Committee.

He also served on the Education Committee, the Real Estate & Economic Development Committee, the Municipal Operations Committee, the Intergovernmental Relations Committee, the Rules Committee, and the Legislation and Codes Committee.

He graduated from Fordham University in 1989, majoring in accounting, and worked for the major accounting firm of Ernst & Young before taking his law degree from the New York Law School.

As a council member Liam worked with the mayor and fellow council members on a bipartisan basis for the betterment of his district and the City of Yonkers as a whole. He strove to hold down taxes, to create jobs, to improve the city's parks and playgrounds, increase senior citizen programs and implement a city-wide beautification program. He encouraged 'smart development' to make Yonkers attractive to new businesses which brought many new jobs to the city.

Aside from his representation on the council, he is a Board Member of the Aisling Irish Community Center, a Board Member and President of Tara Circle, a member of the Ancient Order of Hibernians, the Westchester Friendly Sons of St. Patrick, and a member of the New York State Bar Association.

I congratulate Liam for all of his good work and diligence in representing not only his district and its families, but the City of Yonkers as a whole. I was privileged to be able to work with him in helping Yonkers and know first hand that Yonkers is enormously better for having him. I know his family will be happier now that he will not have as many meetings to attend but the City of Yonkers will sorely miss his leadership and dedication. I wish him the best in all his endeavors and am looking forward to his return to office.

ST. MARY'S GOOD SAMARITAN HOSPITAL CENTENNIAL

HON. JOHN SHIMKUS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SHIMKUS. Madam Speaker, I rise today to honor a century of service from an institution of healing in Centralia, Illinois.

St. Mary's Hospital opened on Thanksgiving Day in 1909 and has been serving the Centralia area since. As the city grew, the Poor Handmaids of Jesus Christ and the Felician Sisters worked to meet the medical needs of the growing population. In 1958, the hospital moved to a new 117-bed facility on Pleasant Avenue, where it went through 3 expansions 1969 to 1981.

In 1996, St. Mary's Hospital merged with Good Samaritan Regional Health Center in nearby Mt. Vernon. With the merger, they entered the 21st Century at the forefront of medical care. Over the last 100 years, the people at St. Mary's have not forgotten their core mission and have served our community with a level of devotion that is second to none.

I want to join with the members of this House and the residents of South Central Illinois in congratulating St. Mary's Good Samaritan Hospital on celebrating its centennial. I want to thank them for their healing ministry and to wish them continued success for the next hundred years.

RICHARD ALGER FLORIDA AGRICULTURE'S MAN OF THE YEAR

HON. ILEANA ROS-LEHTINEN

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Ms. ROS-LEHTINEN. Madam Speaker, I rise today to give my heartfelt congratulations to Richard Alger on his recent induction into the Florida Agricultural Hall of Fame.

Being named to the Florida Agricultural Hall of Fame is a high honor, because it is the closest thing we have in South Florida to being named agriculture's man of the year.

With his very strong educational background, gregarious personality and true compassion for our community, Richard has been a strong voice for farming for over four decades.

Richard made his mark through his assistance to minority farmers in our area, as a board member of Farm Credit of South Florida; a generous contributor to the Farm Share program; and for working with the University of Florida on agricultural research.

I am pleased to join the Greater Homestead/Florida City Chamber, Jolayne, his family, including 17 grandkids, friends and neighbors in their celebration of his countless contributions.

HONORING TOM MCROBERTS

HON. COLLIN C. PETERSON

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. PETERSON. Madam Speaker, I rise today to honor the accomplishments of Tom McRoberts on the occasion of his retirement from the University of Minnesota, Morris (UMM). During his career of over 34 years with the University, Tom has served several communities as an administrator, mentor, and innovative educator. These titles are unable to capture the full measure of Tom's contribution to the University, local community, the state of Minnesota.

Tom is tireless in his efforts to expand learning opportunities. His ingenuity has never been bound by his official titles of Director of Continuing Education and Regional Programs, Director of the Center for Small Towns, Director of the Center for International Programs, and the other positions he's held over the years. Tom has served as a mentor and academic advisor to numerous students who have gone on to obtain internships and jobs in the public service arena and win prestigious national scholarships. He has been instrumental in developing programs to connect the University to the local community and to open the world for exploration by the students he has so faithfully served, including establishing the UMM Center for International Programs and creating the UMM Summer Scholars program for gifted high school juniors from around the region, soon to be in its twenty-sixth year.

Over the years, Tom has been recognized for his remarkable contributions with a number of honors, including the all-University John

Tate Award for Excellence in Undergraduate Advising, the UMM Academic Staff Award, the College of Continuing Education Deans Award for Individual Achievement, and the University of Minnesota Presidents Award for Outstanding Service.

This impressive record of service doesn't begin to describe the man. As his colleagues and students note, Tom is modest, compassionate, and blessed with a good sense of humor. One close colleague has described Tom as a specialist in making things happen without claiming credit. He accepts assignments others won't take. He sees opportunities to do good and he takes them and when these aren't obvious, he creates them. Tom has truly made walking the extra mile a way of life, achieving a legacy of accomplishments that will pay dividends for generations to come.

Madam Speaker, I wish to extend my congratulations and appreciation to Tom McRoberts for the extraordinary career at the University of Minnesota Morris.

SPRINGFIELD SENATORS—CROSS COUNTRY STATE CHAMPIONS

HON. JOHN SHIMKUS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SHIMKUS. Madam Speaker, I rise today to honor the achievements of an outstanding group of student-athletes from Springfield, Illinois.

The Springfield Senators girls cross country team took the state championship at this year's Illinois High School Association state finals November 7 at Detweiller Park in Peoria. Springfield High finished with a score of 124, six better than the runners-up from Yorkville. The Senators were led by Kirby Hale, who had the fourth-best overall time for the tournament, finishing in 17:51.

I want to congratulate Coach Dan Devlin, Assistant Coach Trae Cotner and the members of the 2009 Springfield Senators state champion cross country team: Kirby Hale, Madie Alexander, Maggie Cornelius, Christy Rolf, Jessica Larson, Leora Reyhan, Sarah Ward, Giuliana Bailey, Christina Kropid, Julia McClure, Erin Shultz and Lauren Smith. They have represented themselves, their school and our community in a first-rate fashion. I want to join with my colleagues in this House in wishing them continued success in their future academic and athletic endeavors.

EARMARK DECLARATION

HON. DON YOUNG

OF ALASKA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. YOUNG of Alaska. Madam Speaker, pursuant to the Republican Leadership standards on earmarks, I am submitting the following information regarding earmarks I received as part of H.R. 3326, the Departments of Defense Appropriations Act, 2010.

Project Name: Synthetic Liquid Fuels
Bill Number: H.R. 3326

Legal Name and address of entity receiving earmark: Eielson Air Force Base, Alaska

Description of how the money will be spent and why the use of federal taxpayer funding is justified: This project will supply the U.S. Air Force and other military branches a secure supply of synthetic fuels to operate fighters, bombers and other aircraft and military equipment. It will help the Air Force to achieve its stated goal of certifying its fleet of aircraft on a synthetic fuel blend and purchasing 50 percent of its fuels in the form of a synthetic fuel blend by 2016.

Appropriated Amount: \$2,400,000

Detailed Finance Plan: Research and Development, \$2,400,000

Project Name: AutoScan Under-Vehicle Inspection System

Bill Number: H.R. 3326

Legal Name and address of entity receiving earmark: Kachemak Research Development, Inc., 59584 East End Road, Homer, Alaska 99603

Description of how the money will be spent and why the use of federal taxpayer funding is justified: Kachemak Research Development, Inc. is a woman owned, HUBZone, 8(a) entity. AutoScan, an under vehicle inspection system developed by KRD, is a stationary system that captures the entire undercarriage image of vehicles, ranging in size from passenger vehicles to semi-trucks. Because of the unique capabilities of AutoScan, vehicles do not need to maintain a constant speed as they travel across the system. Funding will be used for product enhancement and beta testing of AutoScan generation 2 and 3 architecture. As part of the inspection protocol at every military base, CONUS and OCONUS, the undercarriage of every delivery vehicle must be inspected. Standard inspection protocols have been comprised of a mirror-mounted stick or search pits. AutoScan makes it possible for inspection personnel to maintain a safe stand-off distance. Additionally, it stores images for later comparison and analysis if needed. And it provides one, complete, clear image of any vehicle's under-side in real-time and capabilities that no similar system is able to provide.

Appropriated Amount: \$2,400,000

Detailed Finance Plan: Research and Development, and Testing, \$2,400,000

Project Name: Electromagnetic Interference Hardened Expandable Rigid Wall Shelter

Bill Number: H.R. 3326

Legal Name and address of entity receiving earmark: Alkan Shelter, LLC, 1701 South Cushman Street, Fairbanks, Alaska 99701

Description of how the money will be spent and why the use of federal taxpayer funding is justified: The U.S. Marine Corps has a requirement to develop an EMI hardened, expandable composite rigid wall shelter, which currently does not exist. The USMC Electronic Maintenance Shelter Program, Calibration Laboratory Program, and the Communication Maintenance Shelter Program are several funded programs with an immediate need. Sufficient funding is not available for an EMI hardened, expandable rigid wall composite shelter development program. Alkan Shelter, LLC, a small business located in a HUBZone in Fairbanks, AK, proposes a three-phase de-

velopment and test program for an expandable, composite EMI hardened shelter for the U.S. Marine Corps. First phase is to study the feasibility of EMI hardening to 60-80dB attenuation for the entire expandable shelter or hardening one wing of the shelter. The second phase is to manufacture the EMI hardened composite expandable shelter prototype. The third phase will be to perform EMI and environmental testing to ensure requirements are met. The Marine Corps now uses 1980's technology rigid wall shelters that have aluminum skins and a paper honeycomb core. These shelters are: poorly insulated, have a limited roof and floor load, do not have ballistic protection, the roof cannot be sandbagged, are highly subject to corrosion and can only be stacked six-high on ocean going container ships. Additionally, the U.S. military does not have an EMI hardened expandable rigid wall shelter. Alkan's new carbon fiber hybrid composite expandable shelter will provide a technologically superior structure that will correct the deficiencies of old 1980's technology. Combining high tech carbon fiber composites with EMI protection will provide the USMC and the U.S. military with a lightweight, expandable, rugged, thermally efficient, and safer working environment for carrying out their sensitive electronics and calibration repair and maintenance missions.

Appropriated Amount: \$800,000

Detailed Finance Plan: Research and Development, \$800,000

HONORING THE MEMORY OF DR. STEVEN KARL TEPLICK

HON. JO BONNER

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. BONNER. Madam Speaker, Southwest Alabama recently lost a dedicated medical professor and highly regarded academic physician. Dr. Steven Karl Teplick passed away on December 8, 2009, at the age of 68.

Dr. Teplick was Chairman of the Department of Radiology at the University of South Alabama's College of Medicine for nearly 15 years. He was known for his devotion to the teaching and training of medical professionals as well as leading the University's transition to digital cancer diagnostic technology.

Dr. Teplick was a graduate of the University of Vermont, and of Hahnemann Medical College in Pennsylvania. He completed his residency in Radiology and a fellowship in Neuroradiology at Boston City Hospital. Dr. Teplick served his country for three years as a major in the U.S. Army Medical Corps before returning as a faculty member at Hahnemann. Afterwards, he became Vice Chairman of the Department of Radiology at the University of Arkansas, before coming to South Alabama.

A member of numerous medical committees and organizations, Dr. Teplick was most notably a fellow in the American College of Radiology, president of the Alabama Academy of Radiology and a founding member of the International Society of Biliary Radiology.

Dr. Teplick was a lover of nature and enjoyed farming and his horses and beloved

pets. He is survived by his wife of 40 years, Carol; two children, Jennifer and Joanna; and four grandchildren.

As we pause to reflect upon the many contributions of Dr. Teplick to our community, we also extend our thoughts and prayers to his family for their loss.

EARMARK DECLARATION

HON. JOHN J. DUNCAN, JR.

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. DUNCAN. Madam Speaker, consistent with House Republican Earmark Standards, I am submitting the following earmark disclosure information for project requests that I made and which were included within H.R. 3326, the "Department of Defense Appropriations Act, FY2010."

Requesting Member: Congressman JOHN J. DUNCAN, Jr.

Account: RDTE—Defensewide

Project Amount: \$2,000,000

Legal Name of Requesting Entity: Lentix, 800 South Gay Street, Suite 1625, Knoxville, Tennessee 37929

Description of Request: The funding will be used for the development of a very high resolution benchmarking vision system for long-range surveillance with focus on SOCOM and Navy tracking needs.

EARMARK DECLARATION

HON. DON YOUNG

OF ALASKA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. YOUNG of Alaska. Madam Speaker, pursuant to the Republican Leadership standards on earmarks, I am submitting the following information regarding earmarks I received as part of H.R. 3288, the Departments of Transportation, HUD, and Related Agencies Appropriations Act, 2010.

Project Name: Sexual Assault Response Team Center

Bill Number: H.R. 3288

Legal Name and address of entity receiving earmark: Sexual Assault Response Team (SART) Center, Municipality of Anchorage, P.O. Box 196650, Anchorage, Alaska 99519

Description of how the money will be spent and why the use of federal taxpayer funding is justified: Funding will be used for the continued development and operations of the Municipality of Anchorage Sexual Assault Response Team (SART) Center. This project will support victims through care while participating in investigation and prosecution and help in prosecution of sexual assault cases through professional evidence collection, documentation, preservation and processing.

Appropriated Amount: \$400,000

Detailed Finance Plan: Development and Operations \$400,000

HONORING JANET M. RODERICK

HON. MICHAEL H. MICHAUD

OF MAINE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. MICHAUD. Madam Speaker, I rise today to recognize the accomplishments of Janet M. Roderick of Rome, Maine.

Janet Roderick has been a longtime proponent of the small business community that drives Maine's economy, and her hard work has helped numerous individuals and small businesses throughout Maine.

Janet has been a Maine Small Business Development Center (Maine SBDC) certified business counselor since 2006 at the Maine SBDC service center at Coastal Enterprises, Inc. On December 21, 2009, Janet will be acknowledged as the 2009 Maine State Star. This honor recognizes her exemplary service on behalf of the small business community in Maine, particularly in Kennebec and Somerset counties in central Maine.

The State Star award is presented each year by the national Association of Small Business Development Centers and recognizes an outstanding SBDC employee from each state. The 2009 award is based on Janet's efforts in 2008 when she worked with 148 small businesses, provided 1,070 hours of one-on-one counseling, and helped to launch 20 new businesses in central Maine. Her efforts led to the creation of 37 new jobs and the retention of 21 jobs. Through her efforts, her clients were able to access capital totaling over \$4 million.

Janet has long been involved in helping small businesses, and she has been especially active with women-owned businesses and nonprofits. A certified public accountant, Janet was previously a counselor for 11 years with the Women's Business Center at Coastal Enterprises, Inc. in Augusta. Later, she was an accounting supervisor with an Augusta-based accounting firm, where she specialized in small and women-owned businesses and nonprofit organizations.

Janet was the SBA 1993 Accountant Advocate of the Year and the SBA 2002 Women's Business Advocate of the Year and this further recognition is well deserved. The State of Maine and its small business community owe a debt of gratitude to Janet M. Roderick for her commitment to the success of small business. I applaud Janet's work and extend congratulations to her as the 2009 State Star.

Madam Speaker, please join me in honoring Janet M. Roderick for her life of dedication and service to her community and the growth of Maine's small businesses.

EARMARK DECLARATION

HON. DON YOUNG

OF ALASKA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. YOUNG of Alaska. Madam Speaker, pursuant to the Republican leadership standards on earmarks, I am submitting the following information regarding earmarks I received as part of H.R. 3288, the Transpor-

tation, Housing and Urban Development Appropriations bill.

Project Name: Port of Bristol Bay Expansion
Bill Number: H.R. 3288

Agency: Department of Housing and Urban Development

Legal name and address of entity receiving earmark: Bristol Bay Borough, 1 Main Street, Naknek, AK, 99633

Description of how the money will be spent and why the use of federal taxpayer funding is justified: Shovel ready dock expansion where the largest run of sockeye salmon is processed and shipped. This project is the economic engine for the low-income area of Bristol Bay. These funds will go toward constructing a sheet pile dock and addition to the 27 year old structure.

Appropriated Amount: \$1,000,000

Detailed Finance Plan: Construction \$1,000,000

THE NATIONAL EMANCIPATION
COMMEMORATION ACT OF 2009**HON. JOHN CONYERS, JR.**

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. CONYERS. Madam Speaker, I am pleased to introduce, on behalf of myself and my colleagues DAN LUNGREN of California, SHEILA JACKSON-LEE of Texas, and ALCEE HASTINGS of Florida, the National Emancipation Commemoration Act of 2009. This legislation will establish an 18-member National Emancipation Commemoration Commission to provide for an appropriate national observance of the 150th anniversaries of the Emancipation Proclamation in 2013, the Thirteenth Amendment to the Constitution in 2015, and related events, and to conduct a study exploring why modern slavery continues to exist in the United States and elsewhere.

Our Nation's history is unfortunately intertwined with the story of slavery and the slave trade. For hundreds of years, men, women and children were captured and taken from Africa and enslaved in the American colonies. Yet alongside the history of slavery in the United States, we also remember the stories of those who fought against the abhorrent practice—some with the pen, and some with the sword. The work and lives of historical figures like Frederick Douglass, Sojourner Truth, and Harriet Tubman are familiar to our classrooms and history books. Other abolitionists are less well-known, such as Levi and Catherine Coffin, a Quaker couple in Indiana who helped over 3,000 slaves escape to freedom.

The struggle for freedom for all Americans reached a new height on January 1, 1863, when President Abraham Lincoln issued the Emancipation Proclamation. With it, he declared "that all persons held as slaves" within the States rebelling against the Union "are, and henceforward shall be free." As the Union Army advanced on the Confederate territory, thousands of slaves gained their freedom each day. Shortly after the war ended, the Thirteenth Amendment to the Constitution was adopted, prohibiting slavery and involuntary servitude throughout the United States.

Despite these milestones, slavery has not yet been relegated to the pages of history. An estimated 27 million people are still in servitude worldwide—including an estimated 50,000 or more people enslaved in the United States.

The National Emancipation Commemoration Commission's work is two-fold. It will advise the Attorney General on making grants available to government and non-profit entities for activities and programs related to the commemoration. These activities may include the publication of scholarly research, production of a commemorative stamp or coin, and the development of informational displays and programs at National Parks and historic sites related to slavery, the Underground Railroad, and the Emancipation throughout the United States.

The Commission created by this bill is also tasked with connecting the commemoration of Emancipation with the problem of modern slavery in the United States and around the world. The Thirteenth Amendment to the Constitution is a living promise of freedom that places a duty on all of us to prevent involuntary servitude. In support of that duty, the Commission will conduct a study addressing why slavery in all its forms still exists, analyzing the persistence of modern slavery in the United States from 1865 to the present, and make recommendations to address issues and concerns highlighted by the study.

For as long as there have been slaves in this country, there have been justice-minded individuals and groups dedicated to the abolition of slavery. It is appropriate that we commemorate their work and the 150th anniversaries of the Emancipation Proclamation and the Thirteenth Amendment, and in so doing, renew our commitment to ending modern slavery in the United States and around the world.

INTRODUCTION OF THE OUT-
PATIENT MENTAL HEALTH MOD-
ERNIZATION ACT OF 2009**HON. ALCEE L. HASTINGS**

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. HASTINGS of Florida. Madam Speaker, I rise to introduce the Outpatient Mental Health Modernization Act of 2009, which will support a high quality and cost-savings approach to long-term care mental health services.

Five million Medicare beneficiaries have mental disorders other than mental retardation and 1.3 million of these individuals are under the age of 65. Medicare Partial Hospitalization Programs (PHPs) provide a structured and clinically intensive alternative to hospitalization for patients who otherwise might require sustained inpatient psychiatric hospitalization. PHP psychiatric patients typically receive four to six hours of treatment per day, five to six days a week in hospital-based settings and community mental health centers.

The severity the patient's illness often prevents the individual from obtaining or seeking transportation to the PHP facility, or from accessing high quality food. Additionally, some

psychiatric medications that are prescribed to the patient cannot be safely administered without food. These patients often live in group-supervised settings due to difficulties in maintaining family relationships and their financial instability.

Currently, Medicare does not cover the costs of nutritional planning, meals or transportation for patients who receive psychiatric treatment in a PHP setting. Therefore, PHP facilities are responsible for the cost of providing food and transportation. This aggravates financial burdens that many PHPs and countless other community organizations are experiencing in these difficult economic times.

The Outpatient Mental Health Modernization Act of 2009 requires Medicare to reimburse PHPs for providing transportation and food and nutritional services. The bill also establishes a Behavioral Health Advisory Committee in which a diverse group of behavioral health stakeholders would examine and provide recommendations on how to address the persisting challenges of access, stigma, quality and operability in the mental health delivery system. The Outpatient Mental Health Modernization Act of 2009 is a house companion to S. 1522, a bill that was introduced by Senator DAVID VITTER (R-LA) on July 28, 2009.

Madam Speaker, PHPs are a cost effective alternative that can prevent mentally ill individuals from facing expensive inpatient care, incarceration, or institutionalization. The growing use and role of mental health PHPs in our health care system requires that we amend the law to assist PHPs in delivering the services, care and support to those who are living with severe and chronic mental illness. I urge my colleagues to support the bi-partisan Outpatient Mental Health Modernization Act of 2009, which help sustain an important treatment option in long-term care service network.

EARMARK DECLARATION

HON. DON YOUNG

OF ALASKA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. YOUNG of Alaska. Madam Speaker, pursuant to the Republican leadership standards on earmarks, I am submitting the following information regarding earmarks I received as part of H.R. 3288, the Departments of Transportation, HUD, and Related Agencies Appropriations Act, 2010.

Project Name: Arctic Utilidors (Phase 11) at Eielson Air Force Base, Alaska

Bill Number: H.R. 3288

Legal Name and address of entity receiving earmark: Eielson Air Force Base, Alaska 99702

Description of how the money will be spent and why the use of federal taxpayer funding is justified: This project (which would be another increment in a highly successful, multi-year funding effort) will repair large sections of the utilidor that are in extreme need. The utilidors and related piping were constructed and installed in the 1950s and were they to fail during the winter season, when temperatures are commonly -40F and lower, the base could suffer catastrophic results in as quickly as four hours.

Appropriated Amount: \$9,900,000

Detailed Finance Plan: Repairs \$9,900,000

Project Name: Install Edge Lights, Taxiway Golf at Eielson Air Force Base, Alaska

Bill Number: H.R. 3288

Legal Name and address of entity receiving earmark: Eielson Air Force Base, Alaska 99702

Description of how the money will be spent and why the use of federal taxpayer funding is justified: Provides for new taxiway edge lights along a major aircraft access point to the base runway. Project includes installing 12,000 lineal feet of underground wiring and lighting fixtures. There will also be new asphalt shoulders installed after the lighting is completed.

Appropriated Amount: \$3,450,000

Detailed Finance Plan: Installation \$3,450,000

IN HONOR OF COLONEL JOHN ROBERT MCCARNAN

HON. MICHAEL N. CASTLE

OF DELAWARE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. CASTLE. Madam Speaker, it is with great pleasure that I rise today to recognize the career of Colonel John Robert McCarnan, retiring Chief Executive Officer of the Delaware River and Bay Authority Police Department (DRBA-PD). Colonel McCarnan, through exemplary commitment and service, has protected the people of our great state for more than 40 years, and he has proven to be a tough and formidable leader in a profession that requires exceptional skill and dedication.

Colonel McCarnan's tenure as CEO of DRBA-PD began in July of 1993. Since that time, he has led the DRBA-PD to new heights, working hard to establish high standards and promote professionalism, integrity, and customer service-oriented policing. DRBA-PD is known as a professional and progressive police organization, and this is a direct result of John's diligence and talent. Police officers serve such an important function in our society, and to be as effective as possible, they must have dedicated and organized leaders. John has been this and more to DRBA-PD and he leaves behind him big shoes to fill for those that will follow.

A genuine Delawarean through and through, John earned his Bachelor of Science in Criminal Justice from Wilmington University and later his Juris Doctor Degree from Widener University's School of Law. John began his law enforcement career as a patrol officer with the Wilmington Bureau of Police, later moving to the New Castle County Police Department, where he served for 20 years. John worked faithfully and diligently during his years with New Castle County, serving eight of them as Chief of Police. After his retirement from the New Castle County Police Department, John lent his skills to the Delaware State Government, first as Deputy Attorney General and later as Executive Director of the Division of Alcoholic Beverage Control. Some of John's professional affiliations include: both the Delaware and American Bar Associations; the District of Columbia and the Pennsylvania Bar;

the U.S. District Courts for Delaware and Pennsylvania; and Life Member, and former Chairman, of the Delaware Police Chief's Council.

John is a dedicated man who has had a very successful career, filled with achievements both impressive and numerous. But John is more than that; he is a loving husband to his wife, Sharen, he is a devoted father and grandfather to his children, Barbara and Darren, his daughter-in-law, Dana, and his grandson, Robbie, and he is a concerned citizen, serving as an Executive Board Member of the Delaware Safety Council. John also served 6 years as a member of the Delaware Army National Guard. I can attest to John's outstanding achievements and his fine character, and today, as he begins a new chapter in his life, I stand to honor and recognize the service he has rendered to both the individual citizens and the collective communities of Delaware. The Delaware River and Bay Authority Police Department's mission is to protect and serve Delaware and New Jersey, and Colonel John McCarnan has been doing exactly that for the past 16 years. I thank him for his service and wish him the best on this momentous occasion.

CALLING FOR A DRAMATIC INCREASE IN ASSISTANCE FOR DEVELOPING COUNTRIES IN FINAL LEGISLATION ON GLOBAL WARMING TO HELP THEM ADJUST TO THE CONSEQUENCES OF CLIMATE CHANGE

HON. ENI F. H. FALEOMAVAEGA

OF AMERICAN SAMOA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. FALEOMAVAEGA. Madam Speaker, I rise today to urge my colleagues to support a doubling of assistance by developed countries for developing nations in helping them adjust to the impacts of global warming. Increased commitments are essential if we are to achieve a successful international climate change agreement, one that will prevent the most devastating effects of global warming.

Ironically, the poorest and most vulnerable countries are the ones that will suffer the most from rising sea levels, severe weather events and other consequences of climate change—despite the fact that those nations have contributed only negligibly to the problem. U.S. leadership is vital if we are to prod other developed countries to step up to the plate and provide appropriate levels of assistance. And in the aftermath of House passage of the Waxman-Markey cap-and-trade legislation earlier this year, the Senate must now act.

That is why my colleagues—Rep. RAÚL GRIJALVA, Rep. EMANUEL CLEAVER, Rep. MAXINE WATERS, Rep. PETE STARK, Rep. DENNIS MOORE, Del. DONNA CHRISTENSEN and Rep. MICHAEL HONDA—sent a letter today to Sen. JOHN KERRY, the Chairman of the Foreign Relations Committee and leader on climate change legislation in the Senate, urging him to double assistance for developing countries in legislation the Senator is currently drafting. As our letter states, “the amount of funding developed countries are currently promising to developed countries is grossly insufficient to

meet the need. . . . Given the magnitude of the problem developing countries face, and given the responsibility of developed countries for the majority of historic greenhouse gas emissions, we believe that U.S. climate change legislation should double the emissions allowances currently dedicated in the House bill to international adaptation and mitigation in developing countries."

Madam Speaker, for the RECORD, I include a full copy of the letter to Senator KERRY.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, December 15, 2009.

Hon. JOHN F. KERRY,
Chairman, Senate Committee on Foreign Relations,
Dirksen Senate Office Building,
Washington, DC.

DEAR MR. CHAIRMAN: We want to commend you for your valuable contributions toward enacting climate change legislation. We particularly appreciate your introduction of S. 2835, which focuses on the countries most vulnerable to the impacts of global warming. We sincerely hope that with that measure as well as the recent pledges by China and India to curb their emissions relative to economic growth, and President Obama's support for mobilizing developed countries to contribute \$10 billion a year by 2012 and implementing longer-term mechanisms to assist developing countries with adaptation and mitigation, Copenhagen makes substantial progress toward completion of a binding agreement to limit climate change.

The bill you are working on with the Senators Graham and Lieberman offers a crucial opportunity to advance that agreement. We urge you to include an adequate commitment of resources for the nations and peoples most vulnerable to the consequences of global warming in that legislation.

The needs of developing countries are manifest. As noted by the recent World Development Report 2010, even if average global temperatures rise only 2 degrees Celsius above pre-industrial levels, "Between 100 million and 400 million more people could be at risk of hunger. And 1 billion to 2 billion more people may no longer have enough water to meet their needs. . . . It is estimated that developing countries will bear most of the costs of the damages—some 75–80 percent." As the Stern Review made clear, even if greenhouse emissions ceased today, the world would still face at least two decades of increasing global temperatures.

In the very near future, higher temperatures will lead to economic and political instability, refugee crises and conflicts over ever-scarcer natural resources in developing nations, all of which will have direct, negative implications for developing and developed countries alike. That is why the United Nations negotiating blocs of Least Developed Countries and the Alliance of Small Island States (AOSIS)—which together represent 80 countries least responsible for climate change but most severely affected by it—have recently called for a minimum 45 percent reduction of greenhouse gas emissions below 1990 levels by 2020. They are further requesting that there be no more than a 1.5 global temperature rise from pre-industrial levels, and that atmospheric greenhouse gas concentrations return to below 350 parts per million of carbon dioxide equivalent.

As AOSIS has pointed out, "Serious adverse impacts are already being felt by island states at the current 0.8°C of warming, including coastal erosion, flooding, coral bleaching and more frequent and intense extreme

weather events. The U.N.'s lead agency on refugees has already warned that some particularly low-lying island states are 'very likely to become entirely uninhabitable'."

Estimates vary on the level of funding needed by the developing world to lessen the destabilizing impacts of climate change that will likely occur regardless of the adoption of an international agreement. However, the UN's latest Human Development Report estimates that additional adaptation finance needs alone will amount to \$86 billion annually by 2015. And last week in Copenhagen, Yvo de Boer, Executive Secretary of the United Nations Framework Convention on Climate Change, said that developed countries should expect to contribute \$100 billion annually to developing nations.

Yet the amount of funding developed countries are currently promising to developed countries is grossly insufficient to meet the need. The United States must demonstrate leadership if the developed world is to meet its obligation to provide appropriate sums. The Congressional Research Service's calculation of the funding produced by H.R. 2454 for developing countries—based on the current percentage of emissions allowances dedicated to international adaptation and international clean technology deployment and the allowance prices used in the EPA/IGEM Model—suggests that less than \$1 billion per year would be available in 2012, rising to less than \$1.6 billion by 2020.

Given the magnitude of the problem developing countries face, and given the responsibility of developed countries for the majority of historic greenhouse gas emissions, we believe that U.S. climate change legislation should double the emissions allowances currently dedicated in the House bill to international adaptation and mitigation in developing countries.

While such enhanced allocations would amount to substantial sums of money, we believe they will more than pay for themselves over time when compared to American commitments of troops and resources that would likely be required to address adverse impacts in developing countries affecting vital U.S. interests. As retired Marine Corps General Anthony Zinni, former commander of U.S. Central Command, has noted, "We will pay now to reduce greenhouse gas emissions. . . . or we will pay the price later."

Again, we applaud your efforts at addressing the enormous challenge of climate change. As legislation moves toward passage in the Senate, we sincerely hope that it provides increased commitments to the countries and peoples most vulnerable to the consequences of global warming.

Sincerely,

ENI F.H. FALEOMAVAEGA,
Member of Congress.

RAÚL M. GRIJALVA,
Member of Congress.

EMANUEL CLEAVER,
Member of Congress.

MAXINE WATERS,
Member of Congress.

PETE STARK,
Member of Congress.

DENNIS MOORE,
Member of Congress.

DONNA M. CHRISTENSEN,
Member of Congress.

MICHAEL M. HONDA,
Member of Congress.

CONGRATULATING RAPIDES REGIONAL MEDICAL CENTER

HON. RODNEY ALEXANDER

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. ALEXANDER. Madam Speaker, today I stand before you proud to announce that the Rapides Regional Medical Center has been named one of the nation's 100 Top Hospitals for cardiovascular care. Moreover, this hospital, located in Alexandria, Louisiana, is the only hospital in Louisiana to make Thomson Reuters' 2009 list.

As a premier teaching hospital, Rapides Regional Medical Center cultivates a community of care. The annual study examines the performance of 971 hospitals by analyzing clinical outcomes for patients diagnosed with heart failure and heart attacks, and for those who received coronary bypass surgery or interventions such as angioplasties.

As noted by the Thompson Reuters Company, "results show these top performers not only provided exceptional inpatient care, but also had significantly better post-discharge outcomes, including lower readmission rates for heart failure and heart attack patients as well as lower 30-day mortality rates for heart attack patients. This means that patients treated in hospitals with balanced high performance in cardiovascular care are more likely to have better results 30 days after discharge."

At a time when our healthcare system is under constant scrutiny by citizens and public servants alike, the team at Rapides Regional Medical Center provides hope and reassurance that in fact, the United States, and Louisiana, offer exceptional care.

I join those whose lives have been touched by Rapides Regional Medical Center in saying congratulations and thank you for the dedication to excellence by each employee and doctor on staff.

IN RECOGNITION OF THE PHOEBUS HIGH SCHOOL FOOTBALL TEAM

HON. ROBERT C. "BOBBY" SCOTT

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SCOTT of Virginia. Madam Speaker, I am honored to rise on behalf of myself, Congressman ROB WITTMAN and Congressman GLENN NYE to call attention to a group of young students from Hampton, Virginia, who have once again distinguished themselves, their school, their community and the Commonwealth of Virginia.

For the second consecutive year, the Phoebus High School Phantoms football team had a remarkable season. On December 12, the Phoebus High School Phantoms won their fifth state football championship this decade, defeating Stone Bridge High School of Ashburn 15–10, at Scott Stadium in Charlottesville, Virginia.

Taking over from coach Bill Dee, new head coach Stan Sexton led the Phantoms another 15–0 season. Their winning streak now stands at 30 wins. No other Group AAA school has won back-to-back championships since Phoebus did it in 2001 and 2002; now Phoebus has done it again. This has truly been Phoebus' decade in football, having won five state championships this decade with a record of 120–12 (.909). No other AAA school has won more than 102 games. This latest championship is just another accolade for the City of Hampton's youngest school, founded in 1975.

Phoebus High's legacy of excellence is not limited to just the field of athletics. Under the Direction of Principal Robert Johnson, the Phoebus faculty seeks to inspire students to strive for excellence and achievement in the classroom, in their extracurricular activities and in their communities. Phoebus has two innovative programs that expand the learning experience outside of the traditional classroom. Phoebus hosts the Hampton School Division's Center for High Technology. This magnet career academy includes classes in pre-engineering, design and 2 drafting, and Cisco network administration, preparing students for college classes and jobs in the technology sector. Phoebus is also home to the Blue Phantom Inn. This student-run restaurant gives students an opportunity to develop their culinary arts skills, and was nationally recognized in Southern Living magazine.

The Phantom's excellence in football is also characteristic of the quality of athletics in the Peninsula District of Virginia. Phoebus High School's championship this year marked the 11th time in the last fifteen years that a Peninsula District team has won a state title in football. To quote from our hometown newspaper, the Daily Press, "High school football on the Peninsula is championship football."

We would like to extend our enthusiastic congratulations to Coach Stan Sexton, his coaching staff and all of the players on the Phoebus High School Phantoms, the 2008 and 2009 Group AAA Division 5 Virginia High School League state football champions.

ON THE RETIREMENT OF DAVE LAUGHTER

HON. BART GORDON

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. GORDON of Tennessee. Madam Speaker, I rise today to recognize the service of a valued staff member of the House Committee on Science and Technology, David Laughter, on his retirement.

Dave has served as Financial Administrator for the Committee since 2001. He has been on the Hill since 1994, working for the House Committee on Ways and Means and Congressman DAN BURTON of Indiana. Before coming to the Hill, he served as the Deputy Administrator for Management and Policy Support for the United States Department of Agriculture, USD; Rural Electrification Administration, REA; and as the Vice President/General Manager for an OEM manufacturer supplying large sheet metal stamping dies and special

machinery to domestic and transplant auto assembly plants in North America.

Dave received his B.A. in Economics from Hillsdale College in Michigan. He is from Dayton, and, as a native Ohioan, he has a special place in his heart for the Bengals, the Reds, and Skyline Chili.

Madam Speaker, Dave is the first person new employees meet on their first day, and the last person they see when they are leaving on their last day. Dave handles all the Committee staff benefits and payroll, he maintains our budget to ensure we're on track, and he makes sure that all our bills get paid. Dave has provided a steady hand on the Committee's financial tiller for these past 8 years, and I want him to know how much I appreciate his hard work.

I know Dave has wrestled with this decision, and while I don't expect him to turn into a "Nature Boy," I'm sure he's looking forward to having a little more time to pursue his other hobbies and interests.

I know that all of the Science and Technology Committee's members and staff wish him well. He'll have more time to spend with his lovely wife, Marsha, his children, Carrie, David, and Brittany, his grandchildren Peter and Meredith, and his other family and friends. We hope Dave enjoys a relaxing retirement filled with fishing, grilling, and listening to classic rock.

Dave, thank you again for your years of service.

HONORING WILLIAM H. CASSIDY

HON. MICHAEL H. MICHAUD

OF MAINE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. MICHAUD. Madam Speaker, I rise today to recognize the accomplishments of William H. Cassidy of Calais, Maine.

A native of Calais, Bill has dedicated himself to public education for the past 36 years, serving as president of Washington County Community College since 2003. Under his strong leadership, the college added new academic programs, undertook significant capital improvements and formed new partnerships with many other universities and colleges in Maine and New Brunswick, Canada.

He has previously served in a number of senior administrative posts within the Maine Community College System as an associate commissioner within the Maine Department of Education, director of the Waterville Regional Vocational Center, and a teacher at the middle, high school, and college levels.

An accomplished academic, Bill holds credentials from Northern Maine Technical College, the University of Maine at Machias, Husson College, the University of Maine and Nova Southeastern University. Bill has been recognized for his achievements and leadership in collaborative international education, receiving the Lady Dunn Award of Excellence by the St. Andrews Campus of the New Brunswick Community College. Most importantly, Bill has left a lasting mark at Washington County Community College with his emphasis on volunteerism and the role of the college in the life of the local community.

Madam Speaker, please join me in honoring William H. Cassidy for his life-long dedication and service to his community and the education of Maine's students.

IN HONOR OF MR. MARVIN N. SCHOENHALS

HON. MICHAEL N. CASTLE

OF DELAWARE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. CASTLE. Madam Speaker, it is with great pleasure that I rise today to pay tribute to Mr. Marvin N. Schoenhals, former Chairman of the Wilmington Savings Fund Society (WSFS). Mr. Schoenhals, through his leadership, hard work and dedication, has accomplished a great deal for the state of Delaware, and I am honored to recognize him for his achievements, both personal and professional.

Skip joined WSFS in 1990 as President and Chief Executive Officer of both WSFS Financial Corporation and its principal subsidiary, Wilmington Savings Fund Society, located in Wilmington, Delaware. He was named Chairman in 1992 and served in this capacity until November 1, 2009, when Skip assumed the role of non-employee director. Skip's nearly 20 years as WSFS Chairman are marked by many noteworthy accomplishments; during his tenure, Skip led the \$3.6 billion financial services company to world class service levels and significantly increased shareholder value.

But Skip's impact on others is not limited solely to his professional career. He is a role model for others and is actively involved in his community, lending his knowledge and expertise to worthy causes and organizations. Skip is Chairman of Vision 2015, a coalition of Delaware leaders working towards making Delaware's public education the best in the world. He serves on, and from 2003 to 2004 was Chairman of, the Board of Directors of the Delaware State Chamber of Commerce and is also a member of the Delaware Business Roundtable, Chairman of its Education Committee, and a Trustee, and former Chairman, of the Delaware Public Policy Institute.

A cause very dear to Skip's heart is the Sunday Breakfast Mission, our state's largest shelter and rehabilitation facility. Each fall, WSFS partners with the Sunday Breakfast Mission to sponsor the Great Thanksgiving Food Drive, and, as Chairman of the Mission, Skip spearheads the effort, working diligently on behalf of his fellow Delawareans. With Skip's direct involvement in this initiative, the drive has experienced exponential growth, collecting a total of 37 tons of food for 2008. In 2009, Skip was awarded the Delaware State Chamber's Josiah Marvel Cup. This distinguished award is given annually in recognition of outstanding contributions made to the state, community and society; I applaud the Chamber's selection of Skip for this recognition and can say without hesitation that the honor which has been bestowed upon him is one he most truly deserves.

Skip's career in the financial industry has been nothing short of exemplary, and anyone that knows Skip knows that he is, and no doubt will remain, very active in his many professional, business, community, and advisory

organizations. Moreover, Skip is truly a great guy—dedicated to his wife, Linda, and to his church. Today, I commend Mr. Marvin N. Schoenhals for the service which he has rendered our state as not only Chairman of WSFS, but as a caring and devoted member of our society. In recognition of his tireless dedication and immeasurable contributions, I thank Skip and offer my best wishes on this momentous occasion.

CAPTAIN BOB BERNAZAL

HON. TED POE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. POE of Texas. Madam Speaker, in July of 2008, a courageous mission was undertaken to rescue 15 hostages who were being held by the Revolutionary Armed Forces of Colombia, known as FARC. Three of these hostages were American civilians. The operation was code named, Operation Willing Spirit, a perfect description of the valor demonstrated by all of the rescuers involved. Captain Bob Bernazal, a Kingwood, Texas native, was especially vital to the success of the operation in his role as the Information Operations Integration Strategy Division chief of the 612th Air Operations Center.

Captain Bernazal's ability and dedication was clearly shown through his comprehensive planning of Operation Willing Spirit. The nine-year Air Force veteran has proved a fine example of the aptitude of our Armed Forces by ensuring mission success.

He is praised by his superiors as an outstanding Information Operations expert, and is recognized for the development and implementation of a plan for utilizing IO duty officers. We are fortunate to have great men like Capt. Bob Bernazal at our side to outwit our enemies and protect our nation.

It is with great pride and admiration that the Second District of Texas is able to commend Captain Bernazal as the Air Force-level Outstanding Information Operations Active Duty Company Grade Officer of the Year. This Kingwood, Texas native is truly deserving of this award as well as the respect of our nation. We thank him for his service. He is a great Texan and a true hero.

RECOGNIZING JUDGE CHARLES FOLEY

HON. ROBERT J. WITTMAN

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. WITTMAN. Madam Speaker, I rise today to recognize Judge Charles Foley on the occasion of his retirement from the bench of the General District Court. Since 1986, Judge Foley has faithfully served the 20th Judicial District which includes the counties of Fauquier, Rappahannock and Loudoun in Virginia.

Judge Foley was born in Richmond, Virginia and in 1968 he married Ms. Janice Foley, with

whom he has two children, Page and James. Judge Foley graduated from the University of Richmond in 1968 with a Bachelor of Science in Business Administration.

In 1971, Judge Foley received his Juris Doctor from the T.C. Williams School of Law at the University of Richmond where he was the President of Phi Delta Theta legal fraternity. From there he moved into private practice until 1974 when he was elected Commonwealth's Attorney for Fauquier County Virginia.

Judge Foley served as a Commonwealth Attorney for 12 years until 1986 when he was appointed to the General District Court for the 20th Judicial District where he has served for the past 23 years.

All of his life, Judge Foley has been a positive influence on his community and his profession. In addition to being a founding member of the Young Lawyers Conference of the Virginia State Bar, he coached Youth baseball, basketball and soccer for 15 years. He also served as a board member, and later, as President of the Board of Directors of Fauquier Hospital, Inc. He has been a member of the American Judges Association as well as the Warrenton Fauquier Jaycees.

I continue to be impressed by Judge Foley's selfless contributions to his community in an effort to enrich those lives around him. I urge my colleagues to join me in congratulating Judge Charles Foley on his retirement from 36 years of public service.

PERSONAL EXPLANATION

HON. RICK LARSEN

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. LARSEN of Washington. Madam Speaker, I request that for rollcall vote #963, the Marshall Amendment to H.R. 4173, I inadvertently voted "no" but I intended to vote "aye."

IN RECOGNITION OF THE VILLAGE OF TINLEY PARK, IL

HON. DEBORAH L. HALVORSON

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mrs. HALVORSON. Madam Speaker, today I rise to recognize the Village of Tinley Park in Illinois, which was recently named "America's Best Place to Raise Your Kids" by Business Week Magazine. The village was recognized primarily for its top-rated schools, low crime, beautiful parks, affordable housing, and easy access to jobs.

Founded in 1892, Tinley Park rests just a Metra ride from the city of Chicago, and a short drive from Illinois' vast farmlands. Established on the Rock Island Railroad, Tinley Park grew over the years through both agricultural industries, including a grain elevator and a windmill, and manufacturing plants, including a soft-drink bottling plant. The population grew slowly prior to World War II; however, it grew rapidly after the war, doubling every decade from 1950 to 1980.

In recent years Tinley Park has grown in recognition, with all three main high schools ranking among the top 100 in the state. Students of Andrew High School help at neighborhood shelters, libraries, and nursing homes through a requirement they complete 24 hours of community service. This requirement keeps the students closely tied to their community and, as a result, only three percent of the student body of 2,400 move away during high school, compared with the state average of 14 percent. Tinley Park is also home to many exceptional citizens, including Olympic swimmer Christine Magnuson and former Major League Baseball player Kevin Sefcik.

TRIBUTE TO THE CINCINNATI URSULINE ACADEMY GIRLS VOLLEYBALL TEAM

HON. JEAN SCHMIDT

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mrs. SCHMIDT. Madam Speaker, I rise today to congratulate the Cincinnati Ursuline Academy Girls Volleyball Team on winning the Division I Ohio High School Athletic Association State Championship. This is Ursuline's fourth state championship in volleyball. Ursuline Academy also won state titles in 1975, 1993, and 2002.

After a heartbreaking loss in last year's state championship game the young women of Ursuline entered the new season determined as ever to make the sacrifices needed to win this year's title.

At Wright State University's Nutter Center the Lions prevailed in the championship game over an undefeated Dublin Coffman in four sets. Impressively, Ursuline never trailed the match until the third set. The Lions were led by senior Jade Henderson of Loveland with 18 kills and by senior Dani Reinert of Symmes Township with 48 assists.

Under the direction of Head Coach Jeni Case, Ursuline finished the season with a perfect record of 29-0. Additionally, the Lions captured the Girls' Greater Cincinnati League Championship for the second straight season.

Madam Speaker, please join me in congratulating Ursuline Academy on yet another State Championship. Go Lions.

CONGRATULATING THE JOLIET ARSENAL DEVELOPMENT AUTHORITY FOR BEING NAMED THE 2009 BASE REDEVELOPMENT COMMUNITY OF THE YEAR

HON. DEBORAH L. HALVORSON

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mrs. HALVORSON. Madam Speaker, today I rise to recognize the Joliet Arsenal Development Authority (JADA) for being named the 2009 Base Redevelopment Community of the Year by the Association of Defense Communities. I join the Association of Defense Communities in honoring JADA for bringing permanent jobs and revenue to the community in an environmentally friendly manner.

JADA was created in 1995, after Congress passed legislation allowing the former Army munitions facility in Joliet, IL, to be redeveloped with a transfer of ownership. The site has been developed into the largest intermodal facility in the Nation. An intermodal involves the transportation of freight in a container or vehicle, using multiple modes of transportation without any handling of the freight itself when changing modes. The development of the 3,000-acre site has already created 2,000 permanent jobs with approximately \$150 million in annual wages. A portion of the site will be devoted to a state-of-the-art facility engineering training facility for the development of a range of engineering skills. There remains enormous potential to create many additional high-paying manufacturing and engineering jobs at this site.

Throughout the process of this redevelopment, special attention has been devoted to mitigating the environmental impacts of ammunition waste on the site. A dozen public and private agencies worked to clean up the site and provide quality groundwater and soil. They finished this important work last year, three years ahead of schedule.

Will County and the Joliet area have greatly benefited from the efforts of the Joliet Arsenal Development Authority. It comes as no surprise JADA is being recognized on the national stage as a leader in redevelopment.

HONORING PAMELA THOMPSON

HON. MICHAEL H. MICHAUD

OF MAINE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. MICHAUD. Madam Speaker, I rise today to recognize the accomplishments of Pamela Thompson.

Pamela has been selected to receive the Presidential Awards for Excellence in Mathematics & Science Teaching. This prestigious award distinguishes Pamela as one of the best elementary school science teachers in the nation.

Pamela has been hailed for her enthusiasm, knowledge and ability to instill a love of learning in her students over her 27 dedicated years of teaching the students of Madison, as well as her contributions to Maine's overall education system.

An exceptional science teacher, Pamela constantly seeks methods to enrich her students' grasp of complex ideas. She is commended for deepening her own understanding of science, learning and applying the best instructions and strategies available. Most importantly, Pamela listens intently to the needs of her students and shares her awareness with colleagues.

Pamela is also credited with leading Maine School Administrative District 59's success in obtaining and implementing two consecutive science grants from the Maine Mathematics and Science Alliance. She has served on the Leadership Design Team since its inception in 2004, spearheading the integration of formative assessment probes, new science literature and science notebooks in a program that provides science kits to kindergarten through fifth

grade classes. She piloted the new strategies developed under the grants and shared her successes with the K-12 Science Design Team, which led to the creation of a professional development plan for the entire district science staff.

Madam Speaker, please join me in honoring Pamela Thompson for her life-long dedication and service to her community and the education of Maine's students.

HONORING THE BOURBON COUNTY HIGH SCHOOL BAND FOR WINNING CLASS A CHAMPION IN THE BANDS OF AMERICA NATIONAL COMPETITION

HON. BEN CHANDLER

OF KENTUCKY

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. CHANDLER. Madam Speaker, I rise today to recognize the accomplishments of a special group of students in my congressional district. In November, the Bourbon County High School Marching Colonels became Class A champion at the prestigious Bands of America Grand Nationals competition for the second year in a row, placing first out of 91 marching bands from across the nation. I am proud to be able to address the accomplishments of such a talented group of students who are more than deserving of our recognition.

The Bourbon County High School Band, led by directors Eric and Nadine Hale and Kevin Akers, has enjoyed great success recently. In addition to their national championship—a prize considered to be the most prestigious award a marching band can win—they won the Class AAA title at the Kentucky Music Educators' Association championship just one week earlier. At the national championship, the 80-member band had the honor of performing for 25,000 people at Lucas Oil Stadium in Indianapolis. Winning one championship would be quite an accomplishment for any band, but that the Bourbon County Band has now won back-to-back national titles shows just how talented this group of young men and women is.

Madam Speaker, the Bourbon County Marching Colonels' unprecedented success is truly deserving of praise and recognition. I believe that educating our young adults in music and the arts is important in continuing to foster our great American culture, and it is with great pride that I rise today to acknowledge the successes of these extremely talented and accomplished young men and women.

EARMARK DECLARATION

HON. JOHN J. DUNCAN, JR.

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. DUNCAN. Madam Speaker, consistent with House Republican Earmark Standards, I am submitting the following earmark disclosure information for project requests that I

made and which were included within H.R. 3326, the "Department of Defense Appropriations Act, FY2010."

Requesting Member: Congressman JOHN DUNCAN

Account: OP—Army

Project Amount: \$5,000,000

Legal Name of Requesting Entity: TN Army National Guard, Houston Barracks, 3041 Sidco Drive, Nashville, Tennessee 37204

Description of Request: The funding would be used to allow Army National Guard trainers (both fielded and yet-to-be procured) to network together on a Combined Arms virtual battlefield.

TRIBUTE TO MR. JAMES B. FARR

HON. HOWARD L. BERMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. BERMAN. Madam Speaker, on December 31, 2009, the House of Representatives will lose one of its most senior and valuable staff members—Mr. James B. Farr. Jim will be retiring after 38 years of service in the House of Representatives, during which time he served on the Committee on the Judiciary and, most recently, the Committee on Foreign Affairs, where he is the Financial Clerk.

Thirty nine years ago, as a young man from southern Maryland, Jim decided to leave the tobacco farm founded by his grandfather and seek a job on Capitol Hill. This was quite an adventure for a country boy who had grown up tilling the land. Proudly, the farm is still in the family, but no longer grows tobacco.

Following his graduation from Prince George's Community College with a degree in personnel and business management, Jim headed for Washington, D.C., where he landed on the doorstep of Congressman Emanuel Celler from Brooklyn and Queens, New York, the longtime former Chairman of the House Judiciary Committee. Jim was hired by Mrs. Dick, the Staff Director of the Committee, and began working as a clerk in the publications office where he sorted mail, answered the phones, referred bills and assisted in hearing preparation. It was shortly after his arrival on the Hill that he met his future wife, Christine Lynn Wills, who had moved to the Washington, D.C., area from West Virginia. Christine Lynn and Jim have been married for 31 years and have two lovely daughters—Michelle and Jennifer.

Jim's career on the Hill also progressed. In February 1973, he became the Judiciary Committee's publications clerk, where he was responsible for maintaining the Committee's documents. Three years later, Jim was promoted to be the Committee's financial clerk where, under the guidance of the Committee Chairman, he prepared, maintained and oversaw the Committee's budget. Jim was so talented, and his services so highly prized, that he was retained by Chairmen Peter Rodino, Jack Brooks and Henry Hyde. In 2001, when the late Rep. Hyde became Chairman of what was then known as the House International Relations Committee, he asked Jim to move with him and serve as financial clerk for

that Committee. There, Jim once again became an indispensable figure, helping to ensure the smooth functioning of the Committee and easing the transition to the late Chairman Tom Lantos and, subsequently, to me.

Mr. Farr has served the Congress under both Democratic and Republican leadership with great distinction and integrity. His service epitomizes the finest qualities of government service. We are all grateful for that service and for the example he has provided to generations of new committee staff whom he has mentored. He will now retire and spend more time with his family and more time on the farm, where third and fourth generations of the Farr family now reside. Thankfully, despite his years of dedicated and impressive service, Jim wears his years easily, and we wish him much good will as he pursues his favorite hobbies of boating, fishing, and hunting.

Good luck and thank you Jim from a grateful House of Representatives.

EARMARK DECLARATION

HON. DON YOUNG

OF ALASKA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. YOUNG of Alaska. Madam Speaker, pursuant to the Republican Leadership standards on earmarks, I am submitting the following information regarding earmarks I received as part of H.R. 3288, the Departments of Transportation, HUD, and Related Agencies Appropriations Act, 2010.

Project Name: Maniilaq Association in Kotzebue, AK, for establishing a cancer treatment center

Bill Number: H.R. 3288

Legal Name and address of entity receiving earmark: Maniilaq Association, P.O. Box 256, Kotzebue, AK 99752

Description of how the money will be spent and why the use of federal taxpayer funding is justified: There are high rates of cancer among AK Natives and a cancer center located in rural Alaska would allow for screenings, early detection and local treatment.

Appropriated Amount: \$500,000

Detailed Finance Plan: Equipment \$500,000

Project Name: Denali Commission in Anchorage, AK, to support health projects and economic development activities for the arctic region

Bill Number: H.R. 3288

Legal Name and address of entity receiving earmark: Denali Commission, 510 L Street, Suite 410, Anchorage, AK 99501

Description of how the money will be spent and why the use of federal taxpayer funding is justified: The funding would be used to support health projects and economic development activities for the arctic region under the Denali Commission Act of 1998.

Appropriated Amount: \$10,000,000

Detailed Finance Plan: Programming \$10,000,000

THIS HANUKKAH—IN HONOR OF ALL OUR ARMED FORCES AND THEIR FAMILIES THIS HANUKKAH

HON. KENDRICK B. MEEK

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. MEEK of Florida. Madam Speaker, I rise today with a poetic tribute in honor of our magnificent Armed Forces and their splendid families this Hanukkah, and holiday season. And for all of the ones who are so separated by the miles so very far across the shores. Our hearts, especially go out to all of those families who have lost their greatest loves of all, in the defense of our Nation. And to all of those recovering from the grave wounds of war we pray for their speedy recovery. Bless them all! I ask that this poem penned by Albert Caswell be placed in the RECORD in honor of them as follows:

THIS HANUKKAH

This Hanukkah . . .
As the family gathers round . . .
All in This Festival of Lights to be found . . .

All in this time of remembrance, as described in the Talmud of long . . . long ago . . .

With eights days of light and remembrance, of events so miraculous so . . .

As the children dance with songs of joy, and the love of your family grows . . .

Reciting Hallel prayer, and the games, as the Dreidels spin there so . . .

We should also remember, this other miracle of all of those . . .

THE MIRACLE OF OUR ARMED FORCES, SELFLESSNESS SO!

Of All Those families! Those Patriots of Peace, of all of these . . .

The ones, who will not together be . . .
Who upon battlefields of honor fight . . .

So far away from our Country Tis of Thee, on this night . . .

Men and Women of honor bright, who for all of us so carry on that fight . . .

Who live with such heartache and death, as on each new day our lives they bless . . .

And all of those ones, whose greatest of all loves . . . now lie in soft quiet graves . . .

Precious Daughters and Sons, Husbands and Wives . . .

Brother and Sisters, Fathers and Mothers who gave . . .

The greatest of gifts, That Last Full Measure . . . as did they!

Whose loved ones pain, can not be healed by time . . . nor so divided this day . . .

As on this joist holiday season, they sit with tears in eyes do they . . .

With one less place at the dinner table set . . . with all of this grieving so yet!

And all of those who have come home, without arms and legs . . .

Inspiring us with their courage they!
Blessing us all, but with all those fine gifts of selflessness conveyed!

Making us all so see, just how magnificent and inspiring a heart can be!

And all of those who have loved ones, far across the shores . . .

As each new day, but brings to them such great worry so for sure . . .

But, waiting . . . but waiting for, that dreaded knock on the door . . .

That phone call, that they so now pray not for . . .

Quiet Heroes, one and all!
Watching them from Heaven, The Angel's tear drops fall . . .

Lord God, Lord God . . . Bless Them . . . Bless Them All!

For So Many, So Few Have But Paid The Cost!

So bore the burden, so carry that cross! That cross of war!

This Hanukkah, as you hold your families tight . . . and all seems so very right . . .

As you see all those smiles on your children's faces, as these sacred nights races . . .

Give thanks, Give praise . . . as upon your knees you pray . . .

For all of those families, whose sacrifice . . . the blessings of freedom, they gave!

On This Hanukkah, in this The Kindling . . . as each new candle you light . . .

Eight days of prayer and gratitude, in this joist Festival of Lights . . .

A time for families to celebrate, to remember how miracles can burn so bright . . .

Remembering too, our Armed Forces miracles of sacrifice . . .

This Hanukkah!

THE SKYLINE SPARTANS

HON. DAVID G. REICHERT

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. REICHERT. Madam Speaker, today I rise in recognition of a high school football program located in my District—the 8th of Washington—that won the 4A State title on Saturday, December 5, their third in a row.

The Skyline Spartans (12–2), located in Sammamish, Washington—and competing in the KingCo 4A League, Crest Division—defeated the Ferris Saxons, 45–21 at the Tacoma Dome to win the 2009 State 4A Championship. The win marked the third straight State title win for Skyline. I offer my congratulations to the entire team and team captains Anthony De Matteo, Cooper Pelluer, Jake Heaps, Jase Butorac and Tommy Aarts.

I also want to thank head coach Mat Taylor and his assistant coaches, Steve Chmiel, Tom Collins, Jeff Johnson, Bruce Hasson, Kyle Snell, Ryan Thorsen, Brett VanVoorhis and Evan Flay for providing wonderful examples for their players and dedicating many hours to the teaching and training of a group of talented young athletes. Our communities and our young people are better off with the influence you provide. Thank you for your service.

Congratulations and thanks also go out to Principal Lisa Hechtman, Athletic Director Kevin Rohrich and all the teachers at Skyline. Enjoy another football championship and know that your community, your students and your student-athletes all appreciate your efforts and sacrifices. Go Spartans!

IN HONOR OF MS. KAREN NESBIT

HON. PAUL RYAN

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. RYAN of Wisconsin. Madam Speaker, I would like to take this opportunity to recognize and congratulate Ms. Karen Nesbit of Franklin, Wisconsin. Ms. Nesbit was recently awarded the 2008 Presidential Award for Excellence in Mathematics and Science Teaching. The Presidential Award for Excellence in Mathematics and Science Teaching Program recognizes outstanding teachers across the country for their contributions to the academic and personal development of students in science and mathematics.

Ms. Nesbit has been an educator for 23 years. She has taught in the Franklin Public School District since 1990, and currently teaches first grade at Pleasant View Elementary School. The education of our youth is very important to the continued success of our communities and our country. It is through the dedication of teachers such as Ms. Nesbit that students are well-equipped with the knowledge and skills they need for their future.

On behalf of those I represent in the 1st District of Wisconsin, I extend my gratitude and congratulations to Ms. Karen Nesbit.

FIRST FLIGHT OF THE 787
DREAMLINER**HON. JAY INSLEE**

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. INSLEE. Madam Speaker, I want to recognize the Boeing Co. on their first flight of the 787 Dreamliner. This successful flight marks an important milestone in the development of the 787 Dreamliner, and represents the collective efforts and hard work of everyone at the Boeing Company, particularly the dedicated Boeing employees who live in my district. The 787 Dreamliner is airplane that is not only much more efficient than any other airplane on the market, but also represents a new generation of technologically advanced commercial airplanes that will change the future of commercial aviation.

SPIRIT OF TOURISM AWARDS

HON. NICK J. RAHALL II

OF WEST VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. RAHALL. Madam Speaker, I rise today to offer congratulations to several of West Virginia's most dedicated and hardworking individuals. On December 1, 2009, several individuals were honored for their role in enhancing tourism to Greenbrier County when the Greenbrier County Convention and Visitors Bureau (CVB) presented their fourth annual Spirit of Tourism Awards.

The Greenbrier County CVB presented four awards to honor people who have made a dif-

ference in the local economy through enhancing local tourism. The Spirit of Tourism Awards recognize residents that have made a significant impact on the tourism industry in the areas of tourism development, volunteerism, securing a convention or meeting to the area, and excelling at partnering with the Greenbrier County CVB.

This year's Greenbrier Award recipient was awarded to Jim Justice for his hard work and dedication since his purchase of 'The Greenbrier' earlier this year. Mr. Justice has made significant developments since then with the development of a new restaurant, Prime 44, The Tavern Casino, and the announcement of the new PGA Tour 'The Greenbrier Classic'. Mr. Justice has worked hard to improve 'The Greenbrier' all the while increasing tourism to the county and state.

Russell Williams and Annamarie Visclosky were this year's recipients of the Greenbrier County Ambassador Award, which honors those who have assisted the tourism community by going above and beyond the call of duty. Mr. Williams and Ms. Visclosky have spearheaded a number of impressive activities in the community, including the Lewisburg Chocolate Festival, Carnegie Hall's Taste of Our Towns, and the Rhythm and Blues Festival.

The State Fair of West Virginia was named as this year's recipient of the Hometown Hero Award, which recognizes an individual or group that has gone above the call of duty in securing conferences or meetings in Greenbrier County. Board Member Kathryn Tuckwiller accepted the award on behalf of the State Fair of West Virginia.

The Friend of Tourism Award is chosen by the Convention and Visitors Bureau to recognize an individual or group that has excelled in promoting tourism in partnership with the Bureau. This year's winner was Brier Properties which was recognized for their significant hotel development in the area and their outstanding willingness to partner with the Greenbrier County CVB in marketing initiatives.

Madam Speaker, I ask that my distinguished colleagues join me in congratulating the winners of this year's Spirit of Tourism Awards who have contributed in unique ways to the growth and development of the economy in the Third Congressional District of West Virginia—a district that I am very proud to represent here in Washington, DC.

HONORING A.C. REYNOLDS HIGH
SCHOOL FOR THEIR VICTORY AT
THE NORTH CAROLINA STATE
FOOTBALL CHAMPIONSHIP**HON. HEATH SHULER**

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SHULER. Madam Speaker, I rise today to honor the recent accomplishments of the A.C. Reynolds High School football team, the Rockets.

On Saturday, December 12, the Rockets won the North Carolina 4-A State Football Championship against Hartnett Central High School, with a score of 14-13. They finished

the season with a record of fourteen wins and only two losses. A.C. Reynolds is the first high school in the history of Buncombe County to win three State High School Football Championships in 1999, 2002 and 2009.

I especially wish to congratulate A.C. Reynolds Head Football Coach, Shane Laws. I know from experience that teams do not rise to this level of success without a strong coach. It takes a great leader to instill the determination and work ethic that lead to victories on the football field.

The A.C. Reynolds Rockets Football team is known throughout the mountain area for their strong defense. This season's championship and stellar defensive play only continue that legacy. These young men have well represented the mountains of Western North Carolina throughout their drive to this year's State Football Championship. It is my privilege to recognize their accomplishments today in this chamber.

Madam Speaker, I ask my colleagues to join me in expressing our congratulations to this group of young men and their coaches for their accomplishments on the football field this season.

REINTRODUCTION OF THE REVI-
TALIZING CITIES THROUGH
PARKS ENHANCEMENT (RECIPE)
ACT**HON. CAROLYN B. MALONEY**

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mrs. MALONEY. Madam Speaker, I strongly believe that open spaces and community parks are a critical part of urban infrastructure. That's why today I am reintroducing the Revitalizing Cities Through Parks Enhancement (RECIPE) Act, that would establish a \$10 million grant program for qualified, non-profit, community groups, allowing them to lease municipally owned vacant lots and transform these areas into parks. Parks and gardens created with the grants will not only provide safe places to gather, but will increase property values as well. The grants will be available from the Secretary of Housing and Urban Development to groups who have met standards of financial security, and who have histories of serving their communities. To further ensure that these grants are used to make lasting positive changes, land improved and made into open community space under this legislation must be available for use as open space from the local government for at least seven years.

CONGRATULATING THE SOUTH
JOHNSTON HIGH SCHOOL 2009
VARSITY FOOTBALL TEAM**HON. BOB ETHERIDGE**

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. ETHERIDGE. Madam Speaker, I rise today to congratulate the South Johnston High

School Trojans football team in Four Oaks, North Carolina for a historic season and trip to the 3-AA North

Carolina High School Athletic Association State Championship football game this past Saturday, December 12, 2009 at Kenan Stadium in Chapel Hill. South Johnston finished the season with an impressive record of 14 and 2 and were the 2009 Conference and 3-AA Regional Champions. This is the third conference title for South Johnston, the first ever appearance in the third round of Regionals and the school's first trip to the State Finals.

I am extremely proud of the dedication, determination, sportsmanship, and discipline of this talented football team. The members of the 2009 team are to be commended for their drive and perseverance. They include Dee Williams, Brandon Bussiere, Willie Jefferson, Brandon Beasley, Dan Atkins, Alex Barbour, Vivek Patel, Justin Sanders, Jim Abdalla, Anthony Crumity, Shawn Williams, Blake Ingram, Shaun Write, Josh Barbour, Matt McClendon, Rohelio Morales, Mitch McLamb, Marcus Faison, Aaron Anderson, Unek Lloyd, Matt Stanley, RonJonek Gill, Dan Stanley, John Jefferies, Javonte Burns, Woody Thornton, Johntavious Chrisp, Jon Farmer, Tyler Benson, Devon Smith, Pat Dunigan, Stacy Thornton, Mike Purvis, Erasto Simmons, Jovonte Cox, Trevor Beasley, Adam Hockaday, and Tyvon Small.

South Johnston Head Coach Joe Salas and his great team of assistant coaches worked tirelessly behind the scenes and are the architects of the behind the team's success.

I am proud to have the honor of representing this outstanding high school and I ask my colleagues to join me today in honoring these fine young athletes.

TERRORISTS BELONG AT GITMO, NOT A NEIGHBORHOOD JAIL

HON. LAMAR SMITH

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SMITH of Texas. Madam Speaker, the Obama Administration has announced its plan to transfer 75 Guantanamo Bay detainees to the United States.

The Administration claims that transferring these detainees from Guantanamo Bay will somehow lessen al Qaeda's desire to attack America. But a change in location of detainees is not going to reduce terrorists' hatred of America.

However, the transfer of any Gitmo detainee to the U.S. will give them additional constitutional rights, making it harder for prosecutors to obtain convictions.

The Administration claims that it can detain these terrorists indefinitely. But many agree this is an impossible goal. Civil liberties groups were quick to point out that indefinite detention inside the United States without a trial is little more than a change in zipcode.

It is clear to all but those in the Administration that this decision will likely result in the almost immediate challenge to detention as soon as these terrorists arrive in Illinois.

The Guantanamo Bay facility in Cuba, not a prison in America's heartland is the right place for terrorists.

225TH ANNIVERSARY OF TRENTON'S TIME AS CAPITAL OF THE UNITED STATES

HON. RUSH D. HOLT

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. HOLT. Madam Speaker, I rise to commemorate the 225th anniversary of the city of Trenton's tenure as the capital of the United States.

Students of American history are familiar with the Compromise of 1790. James Madison and Thomas Jefferson won permanent residence for Congress on the Potomac in exchange for the Federal Government's assumption of State debts from the Revolution—a priority of Alexander Hamilton. What followed was the Residence Act, which established what we now know as the District of Columbia.

What is less understood is the capital's journey through eight other towns, the abandoned proposals and the near-misses before Congress settled here on the Potomac. During the Revolutionary War, Congress moved frequently to avoid British troops—meeting famously in Philadelphia then in Baltimore, York, and Lancaster. Upon ratification of the Articles of Confederation, Congress returned to Independence Hall only to be removed abruptly in the summer of 1783.

That June, approximately 500 mutinous Pennsylvania militiamen demanding back pay from their service during the Revolution, encircled Independence Hall and refused to let Members of Congress leave the building unless their demands were met. Uncertain of their safety and the integrity of Congress, the delegates fled across the Delaware to Princeton, New Jersey.

In Princeton, Congress redoubled its efforts to select a permanent seat of government. To settle regional animosity, Congress agreed on two permanent capitals on the Delaware and Potomac, while designating Annapolis and Trenton as interim capitals.

On November 1, 1784, Congress convened in Trenton. Travel-weary legislators reluctantly trickled into Trenton—then a town of roughly 500 people—and it began official business at the French Arms Tavern on the corner of Warren and State Streets.

When Congress finally reached a quorum on November 29 it considered matters of foreign affairs and finance, appointing ministers to Britain and France and selecting commissioners to the Board of Treasury.

The highlight of Trenton's time as the capital was a visit by the Marquis de Lafayette. During his visit he petitioned Congress to take official leave to France and addressed a joint session of the New Jersey State Legislature. In honor of Lafayette, one of George Washington's most trusted generals, Congress drafted a letter to the King of France praising Lafayette's service and passed a resolution commending Lafayette for his bravery during the siege of Yorktown.

As the session concluded before Christmas, Congress scrapped the plan for two capitals and took up a resolution to establish a permanent capital in Trenton. Unfortunately for Tren-

ton, debate stalled, and on Christmas Eve Congress agreed to meet in New York City after the New Year.

The rest as they say is history. The bustling, city life of New York was more appealing to Members of Congress than the calm of small-town Trenton. They quickly forgot their plans and continued to meet in New York until 1790.

Still, Congress's brief visit to Trenton offers a fascinating glimpse into the early history of the United States and should remind us that the remarkable Capitol building in which we conduct the people's business should not be taken for granted.

I commend the Crossroads of the American Revolution National Heritage Area, the Trenton Historical Society, and the other organizations that make up Trenton 1784—The Nation's Capital Committee, for their excellent work, schedule event and lectures and preparing exhibits and online resources to bring to life this fascinating yet fleeting moment in American history. Trenton was then and is today a town with great appeal.

IN RECOGNITION OF PATRICK W. HENNING'S OUTSTANDING CAREER OF PUBLIC SERVICE

HON. GEORGE MILLER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. GEORGE MILLER of California. Madam Speaker, I rise to offer the following statement, in recognition of Patrick W. Henning upon his retirement, on behalf of myself and the following members of the California congressional delegation: Representatives PETE STARK, HOWARD BERMAN, SAM FARR, LYNN WOOLSEY, ZOE LOFGREN, ANNA ESHOO, HENRY WAXMAN, DORIS MATSUI, JERRY MCNERNEY, JIM COSTA, BARBARA LEE, GRACE NAPOLITANO, LAURA RICHARDSON, BRAD SHERMAN, MIKE HONDA, LINDA SANCHEZ, JOE BACA, and other colleagues.

We rise in honor of Patrick Henning, upon his retirement from public service as the director of California's Employment Development Department, EDD. With nearly 40 years of experience in the field of labor, Mr. Henning brought to his office a deep and unmatched commitment to strengthening California's workforce.

Throughout his career, Mr. Henning has worked to improve the lives of California's workers—from his early days as a union organizer to his appointment to one of the state's largest Departments.

Prior to joining the Employment Development Department, Mr. Henning served the California Legislature for 17 years as a key labor policy consultant—first in the Assembly, and then in the Senate's Labor and Industrial Relations Committee headed by now-Secretary of Labor Hilda Solis. In the early 1980s, Mr. Henning served as California Labor Commissioner, and later as a member of the Agricultural Labor Relations Board. As a union representative in Southern California in the 1970s, Mr. Henning helped hundreds of workers bargain for improved wages, benefits, and working conditions.

Other major achievements include his tenure as chair of the state Developmental Disabilities Area Board for Los Angeles County. He also served several years in the United States Marine Corps Reserve.

Without a doubt, California's working families have benefited from Mr. Henning's lifelong contributions to the labor field. We would like to thank Mr. Henning for everything he has achieved for California's workers, and we give him our very warmest wishes for many happy years of retirement.

**HONORING BALBINA "BARBIE"
HERNANDEZ**

HON. CHARLES A. GONZALEZ

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. GONZALEZ. Madam Speaker, on December 11, 2009, San Antonio lost a great public servant when Balbina "Barbie" Hernandez passed away at the age of 62. I ask my colleagues to join me in honoring Barbie Hernandez as we celebrate her life, which was highlighted by decades of community service, philanthropy, and leadership.

Balbina Hernandez was born on November 2 and was named after her paternal grandmother. She was nicknamed "Barbie" in high school and was by known by this name the rest of her life.

She was an active member of her community, serving countless organizations and served the City of San Antonio for 18 years, which included being part of then Mayor Henry Cisneros' administration. As a single parent, Barbie passionately worked to be a role model for young women and boldly carried a red purse to remind people of the disparity in pay between men and women. Also, as a proud Vok, Barbie was dedicated to Lanier High School and worked to make a difference for the students attending her alma mater.

After working tirelessly to earn her bachelor's degree from the University of the Incarnate Word she set out to work for the Mexican American & Hispanic Physicians Association, MAHPA, as Executive Director. At MAHPA, Barbie took great joy in working to make college and medical school a reality for so many kids.

The City of San Antonio and the State of Texas feel a little emptier now, but we have all lived richer, better lives because of the life of Balbina "Barbie" Hernandez. Her life may have ended, but her contributions will live on and generations shall enjoy the fruits of her labor.

**STOP ANY TARP EXTENSION ACT
OF 2009**

HON. BRAD SHERMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SHERMAN. Madam Speaker, I have co-sponsored the Stop Any TARP Extension Act of 2009. The position of the Treasury Depart-

ment—that it is free to reuse any repaid TARP funds—is entirely contrary to the law. Due to the Department's unwillingness to adhere to the statutory language of the Emergency Economic Stabilization Act of 2008, it is necessary to terminate that Act.

My office has inquired with the Treasury Department as to whether it possesses any legal opinion justifying the recycling of funds repaid by the banks. It should be noted that the Department has hundreds of lawyers and rarely does anything without a legal opinion, certainly not anything involving hundreds of billions of dollars. The Treasury Department refused to provide any legal opinion to Congress, implying that this is a case where he cannot find even one Department lawyer to reach the conclusion the Department would prefer.

Terminating TARP today will immediately return more than \$300 billion to the general treasury. This will give us the fiscal capacity to take the actions necessary to fight the great recession and get Americans back to work. I voted to enact the American Recovery and Reinvestment Act of 2009 in February and would be willing to support well designed job-creation programs again today.

A disadvantage of keeping TARP alive is that the administration may select job-creating programs based upon whether they somehow fit a contrived and expanded interpretation of the TARP statute, rather than whether they constitute the best job creation strategy. Once the TARP funds are returned to the treasury, Congress should immediately consider job-creating and recession-fighting bills.

THE SCHOOL PRINCIPAL RECRUITMENT AND TRAINING ACT OF 2009

HON. SUSAN A. DAVIS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mrs. DAVIS of California. Madam Speaker, research shows that school leadership can be one of the most positive and effective factors in improving student learning. In fact, a strong school principal is often the principle reason behind a successful, well-functioning school that attracts and maintains quality instructors. In high-need schools, strong school leadership is especially crucial.

When the No Child Left Behind Act is reauthorized, the federal government will look to provide additional resources to help high-need schools improve student achievement. With a strong and inspirational principal at the helm, a high-need school will be more likely to achieve success.

Representative TODD RUSSELL PLATTS and I are introducing the School Principal Recruitment and Training Act of 2009 to put the nation on the right track toward creating a new generation of effective school leaders. The legislation provides competitive grants to recruit and train high-caliber aspiring and current principals to lead high-need schools and stay in their positions.

As part of the training, principals will be mentored by other successful school leaders, and they will receive on-going education even

after their placement. The legislation includes a data and reporting component so successful outcomes can be disseminated and replicated at other high-need schools.

Madam Speaker, I urge consideration of this legislation as we continue the effort to improve education in the United States and close the Achievement Gap.

**RECOGNIZING THE IMPORTANCE
OF TRADE TO THE UNITED
STATES ECONOMY AND THE IM-
PORTANCE OF PASSING FREE
TRADE AGREEMENTS WITH CO-
LOMBIA, SOUTH KOREA, AND
PANAMA**

HON. RODNEY P. FRELINGHUYSEN

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. FRELINGHUYSEN. Madam Speaker, the Department of Labor has recently announced that unemployment across the country remained at double-digits and many states have followed with their own bleak statements of jobs being eliminated and families struggling.

These continued job losses demonstrate the need to approve and implement three free trade agreements—Colombia, South Korea and Panama—that can and will "save and create" high value private sector jobs for Americans.

Since 2005, 64 trade pacts have taken effect across the globe. The U.S. is a party to only five—with Australia, Bahrain, Morocco, Oman and Peru. During the same time frame, Japan has signed nine and the European Union (EU), which already has liberalized trade practices among its 27 member states, has signed eight.

And yet, pending free trade agreements with Colombia, Panama and South Korea that will tear down barriers to our products languish in the United States Congress. Unfortunately, there has not been a debate in Congress on the ratification of these agreements.

When visiting South Korea in November, the President indicated that the U.S. would move forward on the pending U.S.-South Korea free trade agreement (KORUS FTA). This is a pact, signed over two years ago, which will virtually eliminate remaining tariffs between our two economies. It also takes aim at non-tariff barriers such as Seoul's burdensome safety standards that many U.S. businesses have been unable to meet and, thus, gain access to the growing Korean market.

As the U.S. stalls, the EU is moving to fill the void. It is actively negotiating with South Korea, using many of the same principles and goals that our trade officials used years ago. In fact, there are credible estimates that the U.S. will lose 345,000 jobs if it fails to implement the KORUS FTA!

Likewise, it has been nearly 1,100 days since President Bush sent a final U.S.-Colombia free trade agreement to Congress for implementation. In the meantime, the Canadians have completed their own deal with Colombia which will ultimately disadvantage our manufacturers and our farmers.

So, as Congress places us firmly on the sidelines, Canada, the EU, China and other commercial competitors are taking the field and our business.

This is not some dry, theoretical debate for my home state of New Jersey. Our businesses, large and small, and their workers, have a great deal riding on these agreements and others yet to be reached. They will create jobs here in America, in general, and in New Jersey, specifically.

For example, the Port of New Jersey and New York is a major international gateway for our region. Today, \$80 billion in commerce flows through the Port each year. Total exports from New Jersey have increased by \$8.1 billion over the past five years.

In fact, the latest data has shown that 130,500 jobs in New Jersey depend on trade. Of these, 50,500 are manufacturing jobs. Indeed, approximately one of every six manufacturing jobs in New Jersey is directly connected to trade. In addition, small businesses, America's job creators, would be among the major beneficiaries of U.S. initiatives to reduce foreign barriers to our exports.

Understandably, there is a high level of job-related anxiety in America today. This apprehension is fueling the rise of protectionism. The President and the Congressional leadership apparently now believe that defeating or delaying these trade agreements will somehow shield American jobs. To the contrary, discarding these pending trade agreements will deny American businesses the opportunity to create or grow high quality private sector jobs here at home and cede these markets to our allies and adversaries!

Madam Speaker, there is no doubt that Beijing, Ottawa, Tokyo and our EU friends understand the importance of trade. Our economy and, most importantly, our workers, are paying an incredibly high price for enacting these trade agreements. I urge the adoption of this resolution and the immediate ratification of the Colombia, Panama and South Korean free trade agreements.

RECOGNIZING THE SERVICE OF JAMES J. CORNELL, INSPECTOR GENERAL OF THE U.S. HOUSE OF REPRESENTATIVES

HON. ROBERT A. BRADY

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. BRADY of Pennsylvania. Madam Speaker, on behalf of myself and Congressman DANIEL E. LUNGREN of California, I want to call to the attention of my colleagues a letter we recently sent to the Speaker regarding the retirement of Mr. James J. Cornell from the post of Inspector General of the House of Representatives. I enclose the letter here for your consideration.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON HOUSE ADMINISTRATION,
Washington, DC, December 16, 2009.

Hon. NANCY PELOSI,
Speaker, House of Representatives, The Capitol,
Washington, DC.

DEAR MADAM SPEAKER: The Inspector General of the House of Representatives, Mr.

James J. Cornell, will be retiring on January 2, 2010, after a long and distinguished career in service to the United States. His exemplary career spans 31 years, including nearly six years with the House. Jim is a perfect example of the exceptional public servants who labor in the fields, absent the fanfare, but without whom this institution would not function. Jim's commitment to excellence will be missed, but his legacy as Inspector General of the House of Representatives will have an enduring, positive impact on the institution.

One of the objectives of the Office of Inspector General is to produce value-added reviews and analyses which have improved House financial management, administrative processes, workplace safety and security—be it physical, informational or technological. Jim's creation of an advisory services division has expanded the types of value-added services provided by the Office of Inspector General.

Further, Jim's efforts to train House Officers' staff on process improvement and to provide mentoring and project support, have allowed numerous House management staff to detect process inefficiencies and find ways to eliminate them. None of this would have been possible without Jim's strong commitment to training, transparency, and accountability. Jim's hard work and tenacity for thorough analyses have been vital to ensuring the success of the House's administrative and financial operations.

Jim's non-partisan collaboration with House Leadership and the Committee on House Administration has provided a solid foundation for the continued work of the Office of Inspector General. Due to Jim's leadership, we have great confidence that the Office will continue to ensure strong internal controls on the financial and administrative functions, will promote policies and procedures to improve efficiency and reduce the risk of asset loss, and will streamline processes and ensure that House operations remain in compliance with applicable rules, laws, and regulations.

Although Jim will be missed by his colleagues, we share the excitement for his new challenge and opportunity. As Jim opens a Christian school in an under-served area in New Jersey, we know that he will make a positive impact on the lives of many children. Jim can take great pride and satisfaction in the positive and important accomplishments made throughout his career. We wish Jim and his wife Joanne a joyful and exciting retirement, and we know that all Members of the House join us in thanking Jim Cornell for his years of distinguished service.

Sincerely,

ROBERT A. BRADY,
Chairman.
DANIEL E. LUNGREN,
Ranking Minority
Member.

NATIONAL MEDIA SPELL 'SCANDAL' WITHOUT THE 'D'

HON. LAMAR SMITH

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. SMITH of Texas. Madam Speaker, the national media spell 'scandal' without the 'D.'

Recently, the mayor of Baltimore was convicted of embezzlement.

On December 2, ABC's "Good Morning America" and CBS's "The Early Show" both briefly reported the Mayor's conviction.

Both failed to mention that she is a Democrat.

The Baltimore Sun and The Washington Post both failed to identify the Mayor as a Democrat in articles at the beginning of the trial.

The media also were guilty of selective omission in their coverage of scandals involving the Democratic former governors of Illinois and New York, as well as the Democratic former mayor of Detroit, among others.

On the contrary, when a former mayor in Georgia was arrested earlier this year, the Atlanta Journal-Constitution was quick to point out that he is a Republican.

The national media should treat both sides the same, not show favoritism based on party affiliation.

CONGRATULATING THE HARNETT CENTRAL HIGH SCHOOL 2009 VARSITY FOOTBALL TEAM

HON. BOB ETHERIDGE

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 16, 2009

Mr. ETHERIDGE. Madam Speaker, I rise today to congratulate the Harnett Central High School Trojans football team in Angier, North Carolina, for their historic season and trip to the North Carolina High School Athletic Association State Championship football game this past Saturday, December 12, 2009 at Carter Finley Stadium in Raleigh. Saturday marked the first time any Harnett County school has made it to the state championship game since school district consolidation in the 1970s. Harnett Central also made history this year by finishing the season with a 15 and 1 record, a record made more impressive because this is the first year the team has played in the 4-A conference.

I am extremely proud of the dedication, determination, sportsmanship, and discipline of this talented football team and its coaches, and they are to be commended for their drive and perseverance. The 2009 team members include Anthony Johnson, A.J. Hayes, Jarrod Spears, Mike Murray, Jeremy Wells, Logan Klauka, Ocean Stroud, Torin Walker, Tate Wheelin, Brian Taylor, Jevon Morris, Nick Corbin, Brian Baker, Lemonte Taylor, Dalan Snow, Jacob Hyde, Shag Long, Kendrick Rodgers, Rico Currie, Michael Vahue, Todd Hodges, Donavon General, Dylan Kinton, Joseph Diniz, Ethan Gardner, Eric Upchurch, Jared Crumpler, Travis Jones, Alan Swan, Landon Ellington, Zack Avrette, Carlos Salas, Quincy Wells-Johnson, Alvin McLean, Frank Vetere, Wesely Smith, Johnathon Hill, Caleb Baker, Max Ramirez, Abiye Fubara, Jordan Keith, Tim McClain, Darius Forte, and Brandon McLean.

Head Coach Marc Morris and his great team of assistant coaches, including Wayne Stewart, Bill Wyrick, Travis Gaster, Clayton Williams, Joseph Capps, Kenny Jones, Scott Riley, Rodney Ellis, worked tirelessly behind the scenes all season and are backbone of the team's success.

December 17, 2009

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I am proud to have the honor of representing this outstanding high school and I ask my colleagues to join me today in honoring these fine young athletes.

SENATE—Friday, December 18, 2009*(Legislative day of Thursday, December 17, 2009)*

The Senate met at 12:03 a.m., on the expiration of the recess, and was called to order by the Honorable AL FRANKEN, a Senator from the State of Minnesota.

PRAYER

The PRESIDING OFFICER. Our guest Chaplain, Senator John Barrasso, of Wyoming, will lead the Senate in prayer.

The guest Chaplain offered the following prayer:

Please join me in prayer.

Almighty God, we praise You for the constancy and consistency of Your faithfulness in blessing and guiding the Senate of the United States through the years of our Nation's history. We turn to You again today and know that You will be faithful to give the women and men of this Senate exactly what is needed in each hour, each challenge, each decision. Give us light when our vision is dim, courage when we need to be bold, decisiveness when it would be easy to equivocate, and hope when others are tempted to be discouraged. So we commit ourselves to be Your faithful servants, examples of patriotism to our people, and crusaders for Your best for our Nation.

In Your Holy Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable AL FRANKEN led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 18, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable AL FRANKEN, a Senator from the State of Minnesota, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. FRANKEN thereupon assumed the chair as Acting President pro tempore.

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 2010—Resumed

Pending:

Reid motion to concur in the amendment of the House to the amendment of the Senate to the bill.

Reid motion to concur in the amendment of the House to the amendment of the Senate with amendment No. 3248 (to the House amendment to the Senate amendment), to change the enactment date.

Reid motion to refer the amendment of the House to the Committee on Appropriations, with instructions, Reid amendment No. 3249, to provide for a study.

Reid amendment No. 3252 (to Reid amendment No. 3248), to change the enactment date.

Reid amendment No. 3250 (to amendment No. 3249), of a perfecting nature.

Reid amendment No. 3251 (to amendment No. 3250), of a perfecting nature.

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

Mr. REID. Mr. President, I ask unanimous consent that the time until 1 a.m. be equally divided and controlled between the leaders or their designees, that Senators be permitted to speak for up to 10 minutes each, that the mandatory quorum be waived, and that the majority leader be recognized for the last 10 minutes and the 10 minutes prior to that the Republican leader be recognized, if he chooses to speak.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The Senator from Illinois.

Mr. DURBIN. Mr. President, those who are following the business of the Senate may be surprised to find us in session a little after midnight. This is a decision made by the Senate just a few hours ago, to postpone the continuation of our session into a new day. The purpose is parliamentary, so that a motion which we have filed can be voted on. It is an important motion. It is a cloture motion. We often have them. It is a motion that closes debate on the floor and moves us forward to the consideration of a measure.

There are very few measures the Senate would consider any more important than the one on which we are about to vote. In about an hour or less, we will be voting on the Defense appropriations bill.

This is a bill which is critically important to our Nation's defense and security, as Secretary Gates reminded us today in a letter to the Senate. It is also a bill that is important to the men and women in uniform, those who are

in harm's way overseas literally risking their lives while we meet in the safety of this Senate Chamber.

The bill contains a 3.4-percent pay raise for our military, richly deserved, for the men and women who serve us. It also will be a pay raise appreciated by their families, many of whom wait patiently for the return of their loved one. There is money in this, as well, for military families, to make sure that not only the servicemembers but their spouses and children have health care. It is a very basic requirement of life and one we want to provide for all of our men and women in uniform and their families.

There is certainly an allotment and allocation here for equipment, which our men and women in uniform will need to perform their missions and come home safely. Readiness and training—it covers a wide range of important expenditures for our national security.

There is no more important bill when it comes to the safety of our troops and for our endorsement and support of what they are giving for our country.

In addition to that, there are provisions added by the House which are critically important at this moment in our history. We extend for several months the unemployment benefits for the millions of Americans who have lost their jobs during this recession. Although we see things getting a little better in the economy, there are still a lot of people suffering because of unemployment. They have not only lost their jobs, many have expended their savings. They have lost their health insurance. They may lose their homes. They are struggling. This bill extends for a short period of time those unemployment benefits and some help to pay for health insurance.

It is also a bill that provides for food stamps. I wish this Nation did not need food stamps, but we need them desperately. One out of six people in the State of Michigan is on food stamps because of the state of their economy, and many States with high unemployment rates are near that. The food stamps provide literally the basics and necessities of life for these families.

You would think, as I describe this bill, that it would pass in the Senate by the same overwhelming margin it just passed in the House 2 days ago. In the House, the vote was, if I recall correctly, in the range of 393 to 35 or something close to that. It was an overwhelming bipartisan vote. Mr. President, 164 Republican Congressmen

voted for it, and it is understandable why. It was a vote of confidence in our men and women in uniform. It was a vote of support for them. And it was a vote of compassion and caring for all the people suffering in this great recession.

Yet we may find—I hope it is not true—we may find that in just a few moments this will become a strictly partisan vote. I hope that does not happen. It should not. It was not a partisan issue in the House of Representatives. But many have said on the other side of the aisle that they will not vote to support our troops with this appropriation, nor provide money for the unemployed. I do not question their patriotism or their commitment to our men and women in uniform. They are doing it because of a political or procedural approach they want to use to try to stop or slow down health care reform. I think they picked the wrong bill for it. I think we have had a healthy debate, a vigorous debate, and we are likely to have that debate continue for the next several days. But why are we putting the men and women in uniform in the middle of this debate? They did not ask for that. They asked to serve our country, to be respected for that service, and to have some help so they come home safely. That is what this bill does.

I hope at 1 a.m., in just a few minutes from now, those on the other side of the aisle will reconsider their opposition to the Department of Defense appropriations bill. If there was ever a time when we should stand together in solidarity for those who defend our country, it is now. And I hope many on the Republican side of the aisle will join us in that effort, in a bipartisan effort, in a show of support for these men and women in uniform.

There is plenty of time for debate, but there is also a time for debate to end. There comes a moment, after we have tried our best and engaged in debate and amendments, when a vote should be taken and the Senate should decide.

We are dragging this series of votes out on health care reform I think to a degree which is unnecessary. At some point, and some point soon, we should take the vote and see if there are literally 60 votes in the Senate for health care reform. Having done our best on our side of the aisle to argue the case, those on the other side have argued against it, and now the people of America should have the last word through their elected Senators.

I urge my colleagues on the other side of the aisle, who tried yesterday to stop the proceedings or at least slow them down by requiring the reading of an amendment and are trying now through the attempt to postpone this vote on the Department of Defense appropriations bill, to accept the verdict of the Senate. There should reach a

point when we should do that. And we should do it in a timely fashion. Denying Members of the Senate on both sides of the aisle an opportunity to be home with their families—not to mention our poor staff, people around here who work night and day to support our efforts—denying them a chance to be home with their families in one last, perhaps, vain effort to stop a vote on health care reform really does not speak as well of this institution as it should.

I hope those on the other side of the aisle will have reached a conclusion, after 2 days in trying to stop this process, that it is better for us to have a record vote. If they believe this bill is so bad, they have a chance to vote against it. Those of us who support it will be on record for it. Then let the American people decide. Let them decide in the next election or let them decide in response to us.

But I hope that come 1 o'clock this morning, when we vote on the Department of Defense appropriations bill, we will have a solid bipartisan vote in support of our men and women in uniform. They deserve no less.

I yield the floor.

The ACTING PRESIDENT pro tempore. Who yields time?

The Senator from Texas.

Mrs. HUTCHISON. Mr. President, I know we are going to eventually vote on the DOD—the Department of Defense—appropriations bill. And it may pass tonight and cloture may be invoked. If it is not, it will be in 30 hours. So I think the bill that is before us is not what is driving, actually, the timing of the vote, at 12:15 in the morning on Friday morning. I think what is driving it is health care, and I believe all of us are going to support—or most of us are going to support—the Department of Defense appropriations bill when the time is right.

But I think it is very important that we have the opportunity to talk about the health care bill that is the underlying bill that will be the next piece of legislation that is considered. I hope people are looking at the underlying bill we have before us, because it is so important for the quality of every family, every person in this country, that we have a health care system that is affordable, available, and is the quality health care we have known in our country for all of these years.

I think what concerns so many of us is that we are concerned that if we have health care reform, instead of providing more access to more people to have the quality health care we all want every American to have, we are going to lose the choices and the patient-doctor relationships if we have a health care takeover that increases costs. The underlying bill is actually going to start taxing every drug people take, every piece of medical equipment they buy, and insurance companies are

going to have to raise their prices to accommodate the taxes that are in the bill.

The bill starts the taxes 2 weeks from today. Two weeks from today, the taxes on this health care bill start. The health care bill itself doesn't start for 4 years. So I think the people of America are saying: What am I hearing? What am I hearing? That taxes start next year, but there is no health program that will give me some kind of new option for 4 years.

It doesn't seem like the way we have had policy made in our country before, where you would be taxed for 4 years before there would ever be a program that you could sign up for. So I think that is what we are going to be dealing with in the next few days.

I think the people of America are very concerned about the bill and the explanations of the bill that we hear. It could be that this bill has changed. We don't know because we haven't seen a new bill come forward, but we have heard that a new bill is being written. So we don't know for sure what it says. But the bill that was introduced and that we have been debating for 3 weeks now has tax increases of about $\frac{1}{2}$ trillion over a 10-year period, tax increases, mandates, employer business expenses, individual mandates for every person to have to have health care coverage or pay a fine. It could be \$750 per person, the fine; it could go up from there. Every employer is going to have to offer a specified type of health care coverage or they are going to have a mandate that will require fines as well.

I think the American people have been watching this debate and are trying to listen to what is in this bill, and what I am getting in my office is more questions. I have had teletown meetings and people are calling in with questions. They are legitimate questions. When they hear that there are so many taxes and mandates and then the government is going to start saying what would be covered in any kind of plan, people are becoming very concerned.

I think that what happened a few weeks ago—the task force that came out and changed the guidelines for mammograms in this country for women—we have all been told for so many years that early detection is what has saved lives. In fact, that is true; we know early detection has saved lives. So women have been encouraged to get mammograms starting at the age of 40 and, at the age of 40, they start having mammograms on an annual basis. But a few weeks ago a task force, a task force that is a part of the bill that would have the government single-payer system, that task force began to change the guidelines. The guidelines were then that you don't need to have a mammogram under the age of 50. So you don't need

mammograms at the age of 40, you start at 50, and then it is every other year. Well, that concerned women all over our country. This task force that made this recommendation is the same task force that is going to be making the recommendations about what kind of health care coverage there will be in the underlying bill that is before us. So it begins to look as though there is going to be a government task force saying what will be covered in a government plan and that it is no longer women who are 40 and above, it is now women who are 50 and above. So those women between 40 and 50 are not going to have that same kind of access.

I think it is a concern that people are saying: Well, if it is going to happen on mammograms, what else is it going to happen on? What else is going to be taken away from me by a government task force instead of my doctor and me making that decision?

There are many questions about what is in this bill, many questions about what this means to my doctor-patient relationship. I think people around the country wish for us to say: Let's stop here. Let's do this in a way that people know how it is going to affect them, how it is going to affect their families. People want to know more about this bill before, all of a sudden, just before Christmas, we have a health care reform bill and it has taxes, it has more mandates on business in a very tough economic climate, and it has taxes that start actually next year, and it has $\$ \frac{1}{2}$ trillion worth of cuts in Medicare over a 10-year period— $\$ \frac{1}{2}$ trillion in cuts in Medicare. That is \$500 billion in Medicare cuts.

People from Texas were asking me: What does that mean? It means you are going to have severe cuts in Medicare Advantage, and there are hundreds of thousands of Texans who have Medicare Advantage and like Medicare Advantage. But that is going to be severely curtailed in this bill.

The payments to hospitals, the underpayments to hospitals for Medicare patients, has always been brought back up so that hospitals could break even, but that is not the case in this bill because those payments are going to be cut. So the underpayment to hospitals is going to be a part of this bill.

That is going to hurt our rural hospitals. We are very concerned about the rural hospitals that are already having a hard time. Their costs are higher and they have a harder time making ends meet, so we are worried about the quality of care people are going to get, particularly in our rural areas with these cuts to Medicare. There will be cuts to home health care. There will be cuts to hospice, nursing homes, long-term care. These are the cuts in Medicare that are not going to shore up Medicare; they are going to a new program at the expense of Medicare coverage, Medicare treatment for Medicare patients.

So here we are. It is 12:25. We are going to be voting in about 30 minutes, at 1 o'clock in the morning. It seems as though it is time for us to say that the American people are very concerned about this bill, and wouldn't it be better to start all over and have a bipartisan effort where Republicans and Democrats can sit down together and lay out the principles we want in health care reform: principles such as lower costs; principles such as making sure more people have access to coverage with bigger pools to lower the cost of premiums.

I think my time is up, and I will certainly yield the floor to those who are wishing to speak. I hope we can start over. It is more important to do this right than to do it fast.

Thank you, Mr. President. I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Michigan is recognized.

MR. LEVIN. Mr. President, many who are filibustering this Defense appropriations bill tonight are filibustering because they want to delay health care. They want to delay the health care reform legislation from being voted on so the bill that provides the funding to support our men and women in uniform who are serving on the front lines, often under arduous and dangerous circumstances to protect our Nation, is being filibustered to keep the Senate from acting on another unrelated piece of legislation. This is not only unbelievable, it is unconscionable.

A 3.4-percent pay raise for the troops is being filibustered. Additional funding for needed medical research in traumatic brain injuries and posttraumatic stress syndrome, and to improve the care, the medical care for our wounded warriors is being filibustered tonight. Funding to provide over 6,000 MRAP vehicles—those are the Mine Resistant Ambush Protected vehicles that are so desperately needed by our troops in Afghanistan—is being filibustered tonight.

There is \$1.8 billion for what is called the joint IED organization, which has one purpose, one mission, and that is to develop and deploy technologies to protect our troops from the deadly Improvised Explosive Devices that have maimed and killed so many, is being filibustered here tonight.

There is \$470 million for family advocacy programs and full funding for family support and yellow ribbon programs to provide support to military families, including quality childcare, job training for spouses, expanded counseling and outreach to families experiencing the separation and the strain and the stress of war is being filibustered here tonight.

What in the world kind of message does a filibuster such as this send to our troops? Our troops deserve the full support—and they should know they

have the full support—of the Congress when they are in the field carrying out the democratically arrived at policies and decisions of our government.

Instead, what they are getting tonight is a Republican filibuster. Those who are filibustering this Defense bill because they think they are aiming at health care reform are tragically off target. They are hitting our troops and their families. How in the name of heaven should the well-being of our troops be sacrificed for 1 hour when they are sacrificing so much for us day after day?

There are those who are going to argue that the end they seek—the delay of the health care reform bill—justifies the means they are using: holding hostage the critical funding to support our troops and their families. I couldn't disagree more. The lesson our troops are going to take from the filibusters tonight is that those who are filibustering this bill think a short-term political objective is more important than a prompt vote of support and confidence for our military members and their families.

Just yesterday, the ranking member, the ranking Republican member of the Appropriations Committee, said the following about this appropriations bill:

This Defense appropriations bill ought to be passed and it ought to be passed as soon as possible in recognition of our respect for servicemembers and their families.

Our respect for our troops and the sacrifice they and their families make for our country every day is exactly why this filibuster should be defeated tonight.

Those who are filibustering this bill because they want to delay a vote on health care legislation should end that filibuster out of respect for our troops and their families—out of respect for our troops and their families—and for the sacrifices they make for this country every day. The Senate should defeat this filibuster tonight.

The stakes are huge, Mr. President. They were set forth in a letter we received from the Secretary of Defense. This is what the Secretary of Defense is telling us:

I am writing to advise you of my serious concern over the prospect that fiscal year 2010 appropriations authority for the Department of Defense could expire by Friday, December 18, 2009.

That is today. He goes on:

Should we face this unfortunate situation, it would result in a serious disruption in the worldwide activities of the Department of Defense and limit our ability to pay our workforce, including military forces.

I am going to repeat this. This is what our Secretary of Defense is saying. He is not someone who shoots from the hip. Our Secretary of Defense is one of the most serious-minded, careful Secretaries of any agency that I have ever known. The Secretary of Defense

said the following. I will repeat it because I want everybody to know what the stakes are tonight if we don't defeat this filibuster:

Should we face this unfortunate situation, it would result in a serious disruption in the worldwide activities of the Department of Defense and limit our ability to pay our workforce, including military forces.

He concludes:

It is inconceivable to me that such a situation would be permitted to occur with U.S. forces actively deployed in combat. Accordingly, I strongly urge the Congress to do what is necessary to ensure the Department has the needed resources to fully and appropriately continue its vital national mission.

It is signed by Robert Gates. I hope everybody, before they decide whether to continue this filibuster, will read this letter from Secretary Gates and think about what the message is to our troops and their families if an unrelated issue as important as that issue is allowed to interfere with us appropriating the necessary funds for the men and women who put on the uniform of this Nation, who take that risk for us.

Let's remember that as we vote tonight and understand what the stakes are if this filibuster succeeds.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Arizona is recognized.

Mr. KYL. Mr. President, I find it rather curious that our colleague, my friend from Michigan, is accusing Republicans of filibustering this Defense appropriations bill. Republicans don't control the Senate or the House. The House just passed this bill Wednesday. Now, it could have been passed in October or September or July or perhaps it could have been passed in November.

Republicans didn't control the timing of this legislation. We have not been holding up the Defense appropriations bill. We always vote for the Defense appropriations bill. Everyone supports that. No, the majority controls the timing. The House finally got around—a week before Christmas or 10 days—to passing the bill, and they sent it here. The Senate took it up Thursday—yesterday.

Republicans are filibustering the bill? The majority leader brought it up yesterday. We are having the vote on it tonight. There is only one reason there are 60 votes required, and that is that the majority leader scheduled the vote at 1 a.m. in the morning for purposes that we all understand have to do with the health care legislation, and Republicans figured it was probably a good idea that we all be here and vote and, therefore, the majority could produce the 60 votes, which it has, there being 60 members of the majority. I suspect when we vote on this piece of legislation, virtually all of us in this body will support it. There is no question about that.

I find it odd that we are accused of filibustering. Have you heard any Re-

publicans giving speeches about this? I think of Jimmy Stewart, in that great movie talking for 24 hours straight, or whatever it was, and Senator HUTCHISON from Texas just gave about a 5-minute speech primarily talking about health care. Republicans haven't been speaking this bill to death, talking the bill to death. As I said, it was just offered yesterday.

Mr. DURBIN. Will the Senator yield for a question?

Mr. KYL. Let me complete my thought. We are voting on Friday morning, and so I think if anybody is staying up late enough to watch this, they might think it is rather odd. They haven't heard anybody talking this bill to death, filibustering.

Why haven't the Democrats been able to bring this most important bill to the Senate for a vote until a week before Christmas, when the fiscal year began October 1? Don't blame Republicans for the fact that this bill comes before us a week before Christmas and, therefore, we have to act on it at this point in time. Republicans had nothing to do with that timing. I will now yield.

Mr. DURBIN. I say to my friend from Arizona, the whip, what a great relief it is for him to say that. I will make a unanimous consent that we pass this, and we won't have to wait for the roll-call at 1 a.m., and Members can go home to their families. Will the Senator from Arizona join me in the unanimous consent request that we immediately take up, consider, and pass this important Department of Defense bill?

Mr. KYL. With all due respect, I will decline that kind invitation, given the fact that the majority leader saw fit to call us here to vote at 1 a.m. Everybody is probably on their way in, and they would appreciate the chance to do that and not be denied that opportunity.

Mr. LEVIN. If the Senator will yield for another question, I wonder if my good friend is aware of the statement of the ranking Republican on the Appropriations Committee, when he said that—the Senator from Arizona says we have not been talking, referring to Republicans, about the Defense appropriations bill at all. Is he aware of the statement of the ranking Republican on the Appropriations Committee, who said yesterday that this bill “ought to be passed as soon as possible, in recognition of our respect for the service-members and their families?”

I wonder if the Senator is aware of that statement, and “as soon as possible” is tonight, not tomorrow or the next day.

Mr. KYL. I am aware of it because the Senator from Michigan read it a moment ago. I talked to the Senator from Mississippi earlier today. There is nobody more committed to the troops than the Senator from Mississippi, who is concerned that we get this done. I talked to Secretary Gates about it

today. There is no question the Defense Department needs to be funded, and there is a point in time in which the funding runs out, and it needs to be funded. That is not the Republicans' fault. The majority leader could have brought this up. And the House is controlled by Democrats. Republicans didn't delay this bill until a week before Christmas. If there is a concern about tonight, all you have to do is pass a continuing resolution for 24 hours or 48 hours. There is no question that the troops will be funded or the Defense Department will be funded. Nobody believes that is an issue.

The point is, don't blame Republicans for being here at almost 1 a.m. in the morning a week before Christmas. We don't control the timing of the legislation. We are not the reason the bill isn't ready until right now or it wasn't brought up until now. We certainly haven't been talking it to death.

The ACTING PRESIDENT pro tempore. The remainder of the Republicans' time is reserved for the minority leader.

Mr. KYL. I thank the Chair.

The ACTING PRESIDENT pro tempore. The Senator from Wyoming is recognized.

Mr. BARRASSO. Mr. President, I want to speak about the troops because I spent Thanksgiving with the troops, the troops from Wyoming, our National Guard—

Mr. REID. Mr. President, parliamentary inquiry.

The ACTING PRESIDENT pro tempore. There is a parliamentary inquiry from the leader.

Mr. REID. Under whose time is the Senator from Wyoming speaking?

The ACTING PRESIDENT pro tempore. The time for the Republican leader to close the argument is all the time remaining for the Republican side.

Mr. MCCONNELL. Mr. President, I yield 6 minutes to the Senator from Wyoming.

The ACTING PRESIDENT pro tempore. The Senator from Wyoming is recognized.

Mr. BARRASSO. Mr. President, listening to the debate and discussion tonight, I spent Thanksgiving with the troops from Wyoming who are serving our Nation overseas in Kuwait and in Iraq. These 700 men and women, driving in and out of Iraq on dangerous missions, have driven over 1 million miles. I went to three different bases in Kuwait to spend Thanksgiving with the troops, to pray with them, and tell them how the people of Wyoming are supportive of their efforts, tell them all of us at home are trying to do all we can to make sure their families know how much we care and that we want to do anything we can in our communities to help the families.

I held three townhall meetings on Thanksgiving day at different military bases in Kuwait. In those meetings, listening to the troops, they said they

had what they needed in terms of the military supplies. But they said their biggest concern was jobs; what was going to happen to them when they got home. Would there be jobs in the energy field? Would they still be available? Do the people in Washington and in the Senate realize we have 10 percent unemployment in this country? They want to go back to their jobs. Do those people realize they are debating health care and that we have an economic crisis that the Senate ought to be focused on now? Do they realize all the discussions on health care are going to drive up the cost of care and cut Medicare and increase premiums for people and raise taxes? Do we care what is going to happen to our families? And we want to know about jobs.

They know, as many of them are small business people, that the National Federation of Independent Business estimates that if we pass this health care bill, it will cost our Nation 1.6 million jobs by 2013. That is what the men and women in the field, on Thanksgiving Day, from Wyoming, who are part of our communities, our brothers, sisters, and the firefighters, policemen in our communities and the teachers in our schools—that is their concern. That was the No. 1 concern in the military that I heard about in three different townhall meetings that day.

They want us to focus on the economy. They said: I want to make sure a job is there when I get back. I want to make sure health care is not going to be made worse by what will happen in this Senate between now and the end of the year. And don't cut Medicare for my parents or raise my taxes, and don't make things worse for me.

I heard from the men and women in the field that they have the same concerns the other American people have, which is the rating on the health care bill which is at an all-time low. Only 32 percent, one in three Americans support what the Senate is trying to jam through before the holidays with the health care bill. They have great concerns because they believe their own costs are going to go up and quality will go down and the cost of care for the Nation will increase if we proceed with the health care bill.

The other question they asked, of course, is, What is in the bill? Have you seen the bill? Have you read the bill? I had with me at these townhall meetings the first 400 pages of the bill so they could look at that, and we went through some of it. As I was working my way through—and this was at the Thanksgiving recess—they were astonished. Even as of today, when I had a townhall meeting by phone two nights ago, the people of Wyoming said: Do you know what is in the bill right now? I had to say no.

Mr. WICKER. Will the Senator yield?

Mr. BARRASSO. Yes.

Mr. WICKER. Isn't the Senator from Wyoming saying that the troops he

spoke to, and the troops we are going to fund in the next day or so with this legislation, want a strong country to come back to, and they would be happy if we were standing firm today, this weekend, to prevent the ever-increasing deficits, to prevent this country from being burdened with larger and larger debt, to protect the programs that they will come back to, and to make sure Medicare is not cut even further?

Isn't the Senator saying these troops expect us to be standing for the financial strength of this country so they can have the same America to come back to that they volunteered to fight for?

Mr. BARRASSO. Mr. President, that is exactly what I am saying. My colleague from Mississippi is so right. That is what the men and women from Wyoming who are serving right now in Iraq and Kuwait want. They want to come home to the same country they left, the place where they have jobs, where they have opportunities for their children, where they are focused on growth, economic development, opportunities for the children, for the next generation.

They are very concerned about the debt. They are very concerned about the amount of spending going on by this Congress. They are very concerned. As one said, the debt is the threat. It is astonishing to be with our men and women in the field, with their guns and with their ammunition, and what they want to talk about is the national debt in the United States right now as a result of the extensive amounts of spending that are going on in this country. They are saying do not make things worse. What is going to happen to our kids? Senator, aren't we still borrowing more and more money from China? Why are we doing that? How much money do we owe to the Chinese people? That is what I heard from Kuwait on Thanksgiving.

Mr. WHITEHOUSE. Will the Senator yield for a question?

Mr. BARRASSO. Mr. President, how much time do I have remaining?

The ACTING PRESIDENT pro tempore. The Senator has used the time yielded to him.

Mr. BARRASSO. I thank the Chair.

Mr. McCONNELL. Mr. President, how much time remains on this side?

The ACTING PRESIDENT pro tempore. There is 3 minutes 8 seconds remaining.

Mr. McCONNELL. Mr. President, regretfully, due to the schedule that the majority has set, we are going to be unable to finish the Defense bill before the current funding authority expires midnight on Friday. As we all know, the President will be out of the country. The House of Representatives, anticipating this problem, sent over a continuing resolution that would take care of the operations of this remain-

ing portion of government unfunded through December 31.

With the President out of the country, of course, this would have to be flown over to him to be signed. With the country at war and troops in the field, it would be the height of irresponsibility to let funding for the Defense Department lapse. That is why, of course, the House of Representatives sent us this continuing resolution.

I have indicated to the majority that I would propound a consent agreement that we take up and pass this continuing resolution, and I will do that at this time.

I ask unanimous consent that the Senate proceed to the immediate consideration of H.J. Res. 64, that the motion to proceed be agreed to, the joint resolution be read a third time and passed, and the motion to reconsider be laid upon the table.

The ACTING PRESIDENT pro tempore. Is there objection?

Mr. REID. Reserving the right to object, I hope the American people have the opportunity to see this, even though it is in the middle of the night. On the west coast it is 3 hours earlier, so there will be a lot of people watching.

They are doing everything they can to stall, divert, and distract. And now they are using the troops. It is difficult to comprehend the illogic of my friends, the Republicans. We have a simple issue here.

There was a unanimous consent request by my friend, the assistant leader, a few minutes ago that said if you support the troops, let's pass this bill, and that was objected to. So I object to the unanimous consent request of my friend. I will say this: Don't worry about the President being gone. The President will be back tonight. OK?

Mr. McCONNELL. Mr. President, I believe I have some time.

The PRESIDING OFFICER. Yes, 42 seconds.

Mr. McCONNELL. Mr. President, the reason we are in this snarl is because my good friend, the majority leader, has this issue all tangled up with the debt ceiling extension and a health care bill that there is this rush to pass before Christmas, a 2,100-page bill and no one has seen the final version yet. All of these things are all tangled up together.

Our advice would be to quit trying to pass this health care bill before Christmas that has an artificial deadline to pass something that most of us have not seen. Let's do the necessary business of the government and do what Senator SNOWE has recommended continuously, which is that we pass the bill on a bipartisan basis with a broad coalition of support.

I believe my time may have expired.

The ACTING PRESIDENT pro tempore. The Senator's time has expired.

The majority leader.

Mr. REID. I yield 3 minutes to my friend from Illinois.

Mr. DURBIN. Mr. President, it is difficult to reconcile the statements made by the Republican whip and the Republican leader. The Republican whip says we are not stopping the Defense bill. The Republican leader says because of actions that have been taken here, this bill cannot pass.

I made a unanimous consent request to end this debate immediately and pass this appropriations bill and fund our troops, which I think both Republican leaders have said they want to do. But, unfortunately, the Republican whip objected to it.

We know why we are here. We are here because, as Senator LEVIN of Michigan, the chairman of the Armed Services Committee, said, there is a Republican filibuster against the funding bill for our troops. There will be an opportunity in a few moments for Members on both sides of the aisle to vote, and I hope all of the Senators of both parties will vote—a vote of confidence in support for our men and women in uniform by voting for this cloture motion, and then I will renew my unanimous consent request that we pass that bill immediately.

So there will be no questions, we will have had a rollcall vote, the Senate expressed its sentiment, and we move forward. I do not think there is any reason for us to delay this another minute. The fact we are here early in the morning may be part of a strategy I hope the Republicans have abandoned.

It is time to stand behind our troops and not abandon them during the course of war.

The ACTING PRESIDENT pro tempore. The majority leader.

Mr. REID. Mr. President, “We should not cause uncertainty or hardship for our Armed Forces.” The senior Senator from Mississippi, a Republican, said that.

“Playing politics with the critical funding that our troops need now is political theater of the worst kind.” The junior Senator from Texas, a Republican, said that.

“Our obligation to those troops must transcend politics.” The junior Senator from Arizona, the Republican whip, said that.

“Every day we don’t fund our troops is a day their ability to fight this war is weakened.” The senior Senator from Kentucky, the Republican leader, said that.

And yet not a single one of these Republican Senators, not a single one of the 40 Republicans in this body, has committed to renewing our commitment to our troops before the funding expires later today.

We are voting at this rare late hour, but not even the darkness outside can conceal the game being played inside this Senate Chamber. We are here in

the middle of the night, but the reason is as clear as day. Senate Republicans so desperately want to turn their backs on Americans who are suffering and dying for want of decent health care—45,000 a year, 750,000 bankruptcies, 14,000 losing their insurance every day—that they are turning their backs on America’s troops at wartime.

Rarely has the Senate seen such a sad statement. Rarely have I seen such brazen irresponsibility, and rarely have our Nation’s citizens received such little regard from their leaders.

Our sons and daughters are fighting tonight and every night in the deserts of Iraq and in the bitter cold mountains and valleys in Afghanistan on our behalf. The least we can do is make sure they have the training and equipment they need to succeed—the least we can do.

Our Nation’s bravest spend month after month half a world away from their families and children. The least we can do is make sure those military families and children who have already sacrificed so much can get the health care they need.

Our Nation’s most selfless men and women volunteer for duty. We have an all-volunteer Army. Every single one stepped forward to serve. They volunteered. The least we can do is to give them the well-deserved pay raise they need.

I received a letter, as has been announced here a few hours ago. The letter that Senator DURBIN and the senior Senator from Michigan talked about is a letter addressed to me. He let me know he has no patience for the partisan games being played and no time for the precious hours that are being wasted. He expressed, in his words, serious concern that this Senate might cause “a serious disruption in our military efforts around the world.” But Secretary Gates added this:

It is inconceivable to me that such a situation would be permitted to occur with United States forces actively deployed in combat.

I agree. I couldn’t agree more. I am going to vote for this bill in support of every single one of those servicemembers, including the hundreds of Nevadans who at this very moment fight for our Nation in other nations around the world.

I will vote yes because I support the 432 men and women from the 221st Armored Cavalry from Las Vegas and the 102 men and women from the 152nd Air Guard in Reno, both of which serve in Afghanistan. There are other Nevadans serving around the world.

Those on the other side of the aisle have stubbornly said they will not. The Senate Republican leadership has shamelessly turned the funding of our military into a purely partisan exercise. They can make all the excuses they want. We are here at 1 o’clock in the morning because of the Repub-

licans. We could have voted for this bill 2 days ago. I even had some Republican Senators tell me, regretfully and regrettably—they have admitted this to me personally, they have told me plainly that while they want to support our troops, they fear retribution from their own leaders. Retribution from their own leaders.

We know Senators on this side of the aisle have made commitments to vote for this. That is not exactly what John Kennedy, who was not only President of the United States but a war hero who served in this very body, would call a profile in courage.

I am confident not a single one of our troops could care less whether the leaders who give them what they need to succeed are progressives or conservatives. I am certain these men and women on deployment after deployment spend more time counting the days until they see their loved ones again than they do counting the political points scored on either side.

My vote in support of these soldiers, sailors, marines, and airmen has nothing to do with the party with which I am affiliated and everything to do with the country for which I took an oath to support and defend.

Although it is shortly after midnight here in Washington, DC, our Nation’s Capital, it is late morning on the battlefields of Iraq and Afghanistan. When the Sun rises over this city, this great city of Washington, a few hours from now, you will be able to see out those windows on the west side of this Capitol and see past the great monuments of Washington and Lincoln, and you will be able to see the Potomac River and see the skyline break for the great lawn of Arlington. Within that consecrated ground, in neat rows that rise and fall with the rolling hills, lie the remains of men and women, boys and girls who fought and fell for our flag.

Their headstones are simple, and from a distance they are identical. No matter how closely you look at the words and symbols etched in those solemn marble gravestones, you will never be able to discern whether that warrior beneath was a Democrat, an Independent, or a Republican. We cannot tell for whom he voted in the last election of his life or what she thought of this policy or that policy. That is not by accident. That is not an oversight.

While the demarcations of left and right, of red and blue seem so important to the daily lives as air and water to some of us, those stones are eternal reminders of such triviality. Dedication to this Nation above all else—“All For Our Country,” which is Nevada’s motto, should guide us now. On this hill, on this side of the river, in this early morning hour, we can stand a little more of selflessness we too often keep at a distance on the sacred ground we call Arlington.

I ask unanimous consent that the vote begin.

CLOTURE MOTION

The ACTING PRESIDENT pro tempore. Under the previous order, pursuant to rule XXII, the Chair lays before the Senate the pending cloture motion, which the clerk will state.

The assistant legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the motion to concur in the House amendment to the Senate amendment to H.R. 3326, the Department of Defense Appropriations Act for Fiscal Year 2010.

Daniel K. Inouye, Harry Reid, Max Baucus, Patrick J. Leahy, Sheldon Whitehouse, Carl Levin, Patty Murray, Mark Begich, Maria Cantwell, Mark L. Pryor, Jack Reed, Edward E. Kaufman, Al Franken, Tom Harkin, Jim Webb, Paul G. Kirk, Jr., Michael F. Bennet.

The ACTING PRESIDENT pro tempore. By unanimous consent, the mandatory quorum call has been waived.

The question is, Is it the sense of the Senate that debate on the motion to concur in the amendment of the House to the amendment of the Senate to H.R. 3326, shall be brought to a close?

The yeas and nays are mandatory under the rule.

The clerk will call the roll.

Mr. KYL. The following Senators are necessarily absent: the Senator from Georgia (Mr. CHAMBLISS), the Senator from Missouri (Mr. BOND), the Senator from Kentucky (Mr. BUNNING), and the Senator from Texas (Mr. CORNYN).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted "nay," and the Senator from Texas (Mr. CORNYN) would have voted "nay."

The ACTING PRESIDENT pro tempore. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 63, nays 33, as follows:

[Rollcall Vote No. 381 Leg.]

YEAS—63

Akaka	Franken	Mikulski
Baucus	Gillibrand	Murray
Bayh	Hagan	Nelson (NE)
Begich	Harkin	Nelson (FL)
Bennet	Hutchison	Pryor
Bingaman	Inouye	Reed
Boxer	Johnson	Reid
Brown	Kaufman	Rockefeller
Burr	Kerry	Sanders
Byrd	Kirk	Schumer
Cantwell	Klobuchar	Shaheen
Cardin	Kohl	Snowe
Carper	Landrieu	Specter
Casey	Lautenberg	Stabenow
Collins	Leahy	Tester
Conrad	Levin	Udall (CO)
Dodd	Lieberman	Udall (NM)
Dorgan	Lincoln	Warner
Durbin	McCaskill	Webb
Feingold	Menendez	Whitehouse
Feinstein	Merkley	Wyden

NAYS—33

Alexander	Bennett	Burr
Barrasso	Brownback	Coburn

Cochran	Hatch	Murkowski
Corker	Inhofe	Risch
Crapo	Isakson	Roberts
DeMint	Johanns	Sessions
Ensign	Kyl	Shelby
Enzi	LeMieux	Thune
Graham	Lugar	Vitter
Grassley	McCain	Voinovich
Gregg	McConnell	Wicker

NOT VOTING—4

Bond	Chambliss
Bunning	Cornyn

The ACTING PRESIDENT pro tempore. On this vote, the yeas are 63, the nays are 33. Three-fifths of the Senators duly chosen and sworn having voted in the affirmative, the motion is agreed to.

The motion to refer falls.

The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, in light of the vote and the fact that cloture has been invoked on the motion to concur, I ask unanimous consent that the motion to concur in the House amendment to the Senate amendment with an amendment be withdrawn, all postcloture time be yielded back, and the motion to concur in the House amendment to the Senate amendment to H.R. 3326 be agreed to, and the motion to reconsider be laid upon the table.

The ACTING PRESIDENT pro tempore. Is there objection?

Mr. McCONNELL. I object.

The ACTING PRESIDENT pro tempore. Objection is heard. The majority leader is recognized.

Mr. REID. For the information of all Senators, unless we can work something out with the minority, the next vote will occur very early on Saturday morning, around 7:30 or so that morning. There could be several votes. We will work with the minority to find out, in fact, if they want these other votes. I hope we can make that determination tomorrow. We have some people for whom that would be very convenient, if they knew it would be a simple majority vote or whether we need 60 votes on some of the issues that might be raised. We have one Member, of course, who has to walk very early, a long ways, and others who will be terribly inconvenienced.

But unless we hear from our friends on the other side of the aisle, the vote will occur at 7:30 or so Saturday morning. That is tomorrow.

I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DURBIN. I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

MORNING BUSINESS

Mr. DURBIN. I ask unanimous consent that the Senate proceed to a pe-

riod of morning business, with Senators permitted to speak for up to 10 minutes each.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

MEASURE READ THE FIRST TIME

Mr. DURBIN. Mr. President, I understand H.R. 4314 has been received from the House and is at the desk.

The ACTING PRESIDENT pro tempore. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 4314) to permit continued financing of Government operations.

Mr. DURBIN. I ask for its second reading and object to my own request.

The ACTING PRESIDENT pro tempore. Objection is heard.

Mr. DURBIN. I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. DURBIN. I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

ORDERS FOR FRIDAY, DECEMBER 18, 2009

Mr. DURBIN. Mr. President, I ask unanimous consent that when the Senate completes its business, it adjourn until 11 a.m., Friday, December 18; that the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of the House message with respect to H.R. 3326, the Department of Defense appropriations bill, postcloture, with Senators permitted to speak therein for up to 10 minutes each; that following any leader remarks, the time until 12 o'clock be equally divided between the two leaders or their designees, and with the time from 12 o'clock until 4 p.m. equally divided and controlled in 30-minute alternating blocks of time, with the Republicans controlling the first block and the majority controlling the next block.

Further, I ask that the time until 4 p.m. count postcloture.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

SCHEDULE

Mr. DURBIN. Mr. President, this morning cloture was invoked on the House message with respect to the Defense appropriations bill. If all postcloture time is used, the Senate

will proceed to vote on the motion to concur at approximately 7:30 a.m. Saturday.

ADJOURNMENT UNTIL 11 A.M.
TODAY

ask unanimous consent that it adjourn under the previous order.

Mr. DURBIN. If there is no further business to come before the Senate, I

There being no objection, the Senate, at 1:47 a.m., adjourned until Friday, December 18, 2009, at 11 a.m.

SENATE—Friday, December 18, 2009

The Senate met at 11 a.m. and was called to order by the Honorable MARK R. WARNER, a Senator from the Commonwealth of Virginia.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, the leadership time is reserved.

**DEPARTMENT OF DEFENSE
APPROPRIATIONS ACT, 2010**

The PRESIDING OFFICER. Under the previous order, the Senate will resume consideration of the House message with respect to H.R. 3326, which the clerk will report.

The assistant legislative clerk read as follows:

House message to accompany H.R. 3326, a bill making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes.

Pending:

Reid motion to concur in the amendment of the House to the amendment of the Senate to the bill.

Reid motion to concur in the amendment of the House to the amendment of the Senate with amendment No. 3248 (to the House amendment to the Senate amendment), to change the enactment date.

Reid amendment No. 3252 (to Reid amendment No. 3248), to change the enactment date.

The PRESIDING OFFICER. Under the previous order, the time until 12 noon shall be equally divided and controlled between the two leaders or their designees, with Senators permitted to speak for up to 10 minutes each.

RECOGNITION OF THE ACTING MAJORITY LEADER

The PRESIDING OFFICER. The Senator from Illinois is recognized.

SCHEDULE

Mr. DURBIN. Mr. President, following leader remarks, the Senate will resume the House message with respect to H.R. 3326, the Department of Defense Appropriations Act. The time until 12 o'clock, as the Chair has mentioned, will be equally divided and controlled between the two leaders or their designees, and I have been designated by the majority leader. The time from 12 until 4 p.m. will be equally divided and controlled in 30-minute alternating blocks of time, with the Republicans controlling the first block and the majority controlling the next block.

If we are required to use all 30 hours of postcloture debate time, the vote on the motion to concur with respect to the Defense bill will occur around 7:30 a.m. tomorrow morning. Senators are

encouraged to plan accordingly in light of an anticipated winter storm expected to hit the Washington, DC area and Virginia tonight and tomorrow morning.

MEASURE PLACED ON THE CALENDAR—H.R. 4314

Mr. President, I understand that H.R. 4314 is at the desk and due for a second reading.

The PRESIDING OFFICER. The clerk will read the title of the bill for the second time.

The assistant legislative clerk read as follows:

A bill (H.R. 4314) to permit continued financing of Government operation.

Mr. DURBIN. Mr. President, I now object to any further proceedings at this time.

The PRESIDING OFFICER. Objection is heard.

The bill will be placed on the calendar.

The Senator from Illinois.

Mr. DURBIN. Mr. President, pursuant to the unanimous consent agreement, we now have time equally divided for the next 60 minutes between the Republican side and the Democratic side.

I see the Senator from Indiana is on the Senate floor, and certainly, if he is prepared to speak and could give me an indication of the time he will use to speak, I would appreciate it.

Mr. LUGAR. Mr. President, in response to the distinguished Senator, I would like to speak for 10 minutes, perhaps 12 minutes.

Mr. DURBIN. Well, I would say, in response to my friend from Indiana, that 30 minutes of the 1 hour between now and noon but for leader time—and I see your leader has taken the floor—is given to the minority, and I will yield to the Senator from Indiana, unless the minority leader is prepared to speak at this point.

I yield to the Senator from Indiana.

Mr. LUGAR. I thank the distinguished Senator.

The PRESIDING OFFICER. The Senator from Indiana.

Mr. LUGAR. Mr. President, as we debate the Defense appropriations bill, I want to take the opportunity to update my colleagues on the activities of the Nunn-Lugar Cooperative Threat Reduction Program that is funded in this bill. I am very pleased that the Defense appropriations bill contains \$424.1 million for the Nunn-Lugar program this year. This amount of funding will ensure the continuation of current Nunn-Lugar projects and will permit Nunn-Lugar to take on new tasks in new countries, principally in the area of biological threat reduction.

Eighteen years ago, Senator Sam Nunn and I, along with a bipartisan group of legislators, in the last hours of that 1991 session, determined that our government had to address the proliferation threats posed by the dissolution of the Soviet Union. In the waning days of the 1991 congressional year, we passed legislation establishing the Nunn-Lugar Cooperative Threat Reduction Program, which devotes American technical expertise and money for joint efforts to safeguard and destroy materials and weapons of mass destruction. Since that time, the program has amassed an impressive list of accomplishments in the former Soviet Union, and it has been expanded to address weapons of mass destruction contingencies around the globe.

I have devoted much time and effort to overseeing and accelerating the Nunn-Lugar program. Uncounted individuals of great dedication serving on the ground in the former Soviet Union and in our government have made this program work. We have shared many productive adventures in locations and circumstances that few Americans have ever experienced. From snowy runaways at former Soviet bomber bases to biological weapons labs in Georgia; from the chemical weapon destruction facility in Siberia to submarine bases on the Kola Peninsula; from former nuclear weapons test sites in Kazakhstan to the mountains of Albania, it has been my privilege to support the talented professionals of the Defense Department and other agencies in reducing threats facing our country. I continue to be impressed by their commitment to the mission and their ingenuity in finding creative solutions to seemingly impossible tasks.

Much of this work has been done outside the public eye. This is not to say that nonproliferation activities have lacked public support. Congressional votes have consistently backed funding for Nunn-Lugar and other nonproliferation projects. But few Members of Congress or American citizens fully understand the contributions that threat reduction programs have made to the United States and global security.

During my conversations with Hoo-siers and others around the country, I do my best to explain what is happening on the ground in Russia and many other locations. I put out monthly press releases describing exactly how many weapons were destroyed in the previous month. My office displays a large representation of the Nunn-Lugar scorecard and numerous photos and artifacts from my visits to weapon elimination sites. But, understandably,

threat reduction programs rarely make headlines. We are engaged in an endeavor in which notoriety is likely to come if something goes wrong—if materials or weapons of mass destruction are not contained in some instance. This makes for an exceptionally painstaking standard that must be met day in and day out.

As of this month, the Nunn-Lugar program has dismantled 7,514 nuclear warheads, destroyed 768 intercontinental ballistic missiles, eliminated 498 ICBM sites, eliminated 155 bombers, destroyed 651 submarine launched ballistic missiles, dismantled 32 nuclear submarines, and destroyed 960 metric tons of chemical weapons.

Together, the United States and Russia have eliminated more nuclear weapons than the combined arsenals of the United Kingdom, France, and China. In addition, American and Russian experts have worked together to remove nuclear material from vulnerable locations around the world and to secure it in Russia. In 2008, the last of the nuclear warhead storage facilities identified under the Bratislava Agreement received safety and security upgrades. In May 2009, the chemical weapons destruction facility at Shchuchye began its important work of destroying 2 million chemical munitions.

I would point out, Mr. President, that in the case of each one of these shells, a hole is drilled in the bottom of the shell. The nerve gas is carefully extracted, bituminized, and placed in the ground, we hope, forever.

Despite these successes, some question why we should continue our work in Russia given recent strains in the United States-Russian relationship. I believe that both the United States and Russia must accept the fact that we need each other. Kremlin rhetoric will swing from one end of the strategic spectrum to the other. Projects will be on and then off. Our frustration level sometimes will be high. But we must not lose patience or miss the possibilities of cooperative threat reduction. We should recall that the Nunn-Lugar program was created to safeguard U.S. national security interests, and those interests exist regardless of the state of our relationship with Russia. It is also vital that we understand the verification utility of the Nunn-Lugar program, which provides for American technicians on the ground in Russia, systematically destroying Russian weaponry. The cooperative links established by such activity and the confidence-building value inherent in our on-site presence are assets of incalculable value.

Beyond Russia, it is vital that we break new ground in safeguarding and destroying weapons of mass destruction. I have never considered the Nunn-Lugar Act to be merely a program, or a funding source, or a set of agreements. Rather, it is an engine of non-

proliferation cooperation and expertise that can be applied around the world. And it is a concept through which we, as leaders, are responsible for the welfare of our children and grandchildren, as we attempt to take control of the global threat.

The United States must send the clear message that we are willing to go anywhere to prevent the proliferation of weapons of mass destruction. New opportunities for partnership must be pursued creatively and relentlessly. Some may say that we cannot forge cooperative nonproliferation programs with the most troublesome nations. But the Nunn-Lugar program has demonstrated that the threat of weapons of mass destruction can lead to extraordinary outcomes based on mutual interest. No one would have predicted in the 1980s that Americans and Russians would be working together to destroy weapons in the former Soviet Union. Taking the long view, a satisfactory level of accountability, transparency, and safety must be established in every nation with a weapons of mass destruction program.

This year, Congress enhanced our government's ability to pursue this goal by including language from the Nunn-Lugar Cooperative Threat Reduction Improvement Act of 2009 in the 2010 Defense authorization bill. These provisions give the Nunn-Lugar program additional flexibility to meet unexpected threats in locations around the world in which certain laws would bar the use of such funds. They provide the Defense Department with the authority to spend up to 10 percent of annual Nunn-Lugar program funds notwithstanding any other law to meet urgent proliferation threats. The Defense authorization bill also included important authority that allows the Secretary of Defense to accept contributions from foreign governments, international organizations, multinational entities, and other entities for activities carried out under the Nunn-Lugar program.

The Nunn-Lugar program has made tremendous progress on the destruction and dismantlement of massive Soviet weapons systems and the facilities that developed them. But in the future, the program will be asked to address much more complex and diverse security threats in a large number of countries.

I believe the proliferation of weapons of mass destruction remains the No. 1 national security threat facing the United States and the international community. Over the years, I have described international cooperation in addressing threats posed by weapons of mass destruction as a "window of opportunity." We never know how long that window will remain open. We must eliminate those conditions that restrict us or delay our ability to act. The United States has the technical ex-

pertise and the diplomatic standing to dramatically benefit international security. American leaders must ensure that we have the political will and the resources to implement programs devoted to these ends. The funds in this bill are vital to these efforts, and I thank the Appropriations Committee for its thoughtful attention to this issue.

Mr. President, I yield the floor.

RECOGNITION OF THE MINORITY LEADER

The PRESIDING OFFICER. The Republican leader is recognized.

HEALTH CARE REFORM

Mr. MCCONNELL. Mr. President, the majority leader has signaled that he will finally unveil the most significant piece of domestic legislation in modern history sometime on Saturday—and force a vote in the middle of the night about 36 hours later. This is truly outrageous.

This will be a bill that none of my constituents have seen, that none of the majority leader's constituents have seen, that none of you have seen, and that nobody outside the Capitol has seen.

You can fit into a phone booth the number of people who have seen this bill that will affect the lives of every single American in the most profound ways.

Every American should have an opportunity to know what their Senators are being asked to vote on before anyone can see it. I doubt if anyone in this Chamber could come down here and defend the secrecy surrounding this bill.

Earlier this week, the President said:

I think it is important for every single Member of the Senate to take a careful look at what is in this bill.

Unfortunately, there is no bill to read. Let me repeat: There is literally no bill to inspect. Even Senator DURBIN, my good friend from Illinois who is here on the floor, the second in command on the Democratic side, admits he hasn't seen the details of the bill.

The only thing we know for sure about this bill is that it will raise taxes, raise premiums, and slash Medicare. That much we know for sure. The Medicare cuts will be nearly \$½ trillion to pay for a vast expansion of government into health care that an overwhelming majority of Americans we now know oppose.

That is what is at the heart of this bill no one has seen yet. So we may not know all the details, but we already know this bill can't be fixed, and we know Americans are outraged by what has happened in this debate. A bill that was supposed to lower costs and lower taxes and lower premiums will actually raise all three, making existing problems not better but worse. It is not too late to start over and deliver the reform Americans want—the step-by-step reforms we know would actually lower health care costs.

The majority knows this bill is a colossal legislative blunder. That is why

they are rushing it through. That is why the only argument they are left with is a call to history. Well, history will be made either way, and this much is clear: Passing this bill in this way would be an historic mistake that those who support it will come to regret.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, this is the bill that is before the Senate. It is 2,074 pages. It has been on the Internet now for 3 weeks in its entirety. You cannot only read it on the Democratic Senate Web site, you can read it on the Republican Senate Web site. So one might ask: Well, where is the Republican comprehensive health care reform bill? It is not to be found—not on the floor of the Senate, not on the Web site—because it doesn't exist.

After 1 year of debate about America's health care system, the Republicans in the Senate have failed to produce any legislation that has gone through the scrutiny this legislation has faced in terms of its impact on America, its impact on our budget. They are emptyhanded. What they bring to us on the floor of the Senate are speeches, press releases, charts, and graphs, and an occasional criticism. I say "occasional" because for 19 days on the Senate floor we have debated this measure—comprehensive health care reform—and let's take a look at the RECORD after 19 days of debate on the floor of the Senate.

The Republicans in the Senate—there are 40 of them—have offered four amendments to the bill in 19 days. Four amendments. Oh, and they have offered six motions to take the bill off the floor and send it back to committee. They have looked at this—and you heard the minority leader and his criticism of this measure—and found four things they are willing to bring before the Senate to change. It doesn't strike me that this is a good-faith effort to try to bring us to closure in a bipartisan way. Instead, what we hear from the Republican side of the aisle in addition to only four specific amendments over 19 days is: We haven't had enough time to offer amendments. Nineteen days, four amendments.

I guess some of us are reaching advanced stages in life and in age and maybe we don't have the energy we once did, but I honestly believe that even the Senate could come up with one amendment a day on health care reform, but the Republicans have come up with four over 19 days. It tells us one of two things: Either this is hard work and they are not up to it or they like the current system of health care; and if they do, I would like them to defend the current system of health care. I would like for them to try to explain in their States what I have found in my State. Instead of soaring rhetoric and

abstractions, let's get down to specifics.

This is a gentleman who lives in Evanston, IL, named David Buckley. Evanston is a great town just north of Chicago. I enjoy going up there and I have a lot of friends there. David had insurance when he needed it, but it ended up costing him his financial health. He is a freelance videographer. He was paying \$4,500 a year for health insurance when he was diagnosed with cancer at the age of 48. David Buckley had a prompt surgery followed by chemotherapy and radiation. He managed to rid his body of cancer. But that battle ended and another battle began.

David's insurance company agreed to cover his cancer treatment but only after 3 solid months of investigations of his application for health insurance to determine whether they could find in that application a preexisting condition which would eliminate any responsibility to pay for David's bills. They couldn't. After covering his cancer treatment costs, they did the next thing that insurance companies do: They raised his premiums, and they didn't just raise them a little bit. In the year following his cancer diagnosis, David's insurance rates went up 80 percent, and that was just the beginning. Within 7 years, David was paying \$28,000 a year in premiums. He had gone from roughly \$400 a month to more than \$2,000 a month in 7 years. He had a \$2,500 deductible, not to mention out-of-pocket expenses. He is self-employed, makes a decent living—about \$70,000 a year—but imagine taking \$2,000 out of your paycheck every month just for health insurance. He tried.

Incidentally, 12 days after his surgery, David, who is not lazy by any measure, flew into a war zone to shoot video. He was still wearing a chemo pump when he arrived for work. He pushes himself to pay his bills, but it has been a losing battle. What started as a \$5,000 debt in the year 2000 grew to a \$70,000 debt by 2003 and a large portion of it came from medical bills. David said:

I thought the point of having insurance was to keep you out of bankruptcy, not put you in it.

It is a valid point. Insurance is meant to be a promise of protection, but for too many people it isn't enough. For David, the high costs and ballooning debt led him to drop his health insurance last year. Think about that. He battled cancer and won, and you know once you have been through that life experience, you are always vigilant. You need the best care to make certain that anything that recurs is caught early, but David had to walk away from health insurance coverage because he couldn't afford it. He decided it was health care or saving for retirement or meeting the costs of living. He is in his late 50s and he is worried

about the years when he won't be able to work.

Health reform is going to help people like David—people who have insurance but still find themselves vulnerable to financial ruin. It will stop insurance companies from running the rates up sky high when you get sick. For those with employer-sponsored, large-group coverage, it will provide access to a broader insurance pool where costs will be pooled and spread.

Health reform will hold insurance companies to annual caps on how much they can charge for out-of-pocket expenses.

Think about the battle this man went through and won over cancer and then went to battle with his health insurance company. It is not unusual. It happens every day. This bill, which has been criticized by those on the other side of the aisle, will give David and others like him a fighting chance.

Let me tell my colleagues about another person. This is an interesting story. Valerie, this beautiful young woman, is from Arlington Heights, IL. She is a student, a doctoral student studying biochemistry at Cambridge University in England. When she was 4 years old, Valerie was diagnosed with type 1 diabetes. She decided early in life that she wasn't going to let her diabetes stop her career ambition. She couldn't become an artist or an entrepreneur; she knew she needed a stable job because she always needed to have health care. She had diabetes. Now, at 24, this brilliant young scientist, this doctoral candidate, worries that her diabetes and what she calls the "broken, insecure U.S. health system" will keep her from returning to the United States from England and using her skills to help her home country.

To control her disease, Valerie needs a lot of medical service, including regular doctor visits and insulin shots. For most of her life, her medical care was paid for by her parents, but those of us who raise children know what happens next. Most health care plans we have for our families cut off our kids at age 24, and that is Valerie's age. However, Valerie is going to school in England. If you listen to some of the criticisms on the floor here about England and Canada and other nations that approach health care differently, you might have an impression in your mind about what that means to be living in a country such as that.

Valerie, because she is a student at Cambridge in England, receives free health care through England's national health service that she says is as good or better than anything she had in the United States. In addition to free doctor visits, insulin, and syringes, her care includes regular contact with a dietitian and an endocrinologist, also free of charge.

These medical professionals have encouraged Valerie to take a more active

role in managing her own disease and she is in better health now than she has been for years. Eventually she hopes to open her own laboratory where she can use her great education and skills to continue research in mitochondrial biology and develop treatments and cures for disease. Valerie worries about whether she will be able to do that if she came back to the United States, and here is what she said:

As long as the same broken, insecure health system remains in place, I see little incentive to come home to the United States with my talents and experience.

We can't afford to lose talented scientists such as Valerie who one day might find a cure for a disease such as Parkinson's. We are the only industrialized Nation in the world where people can die for lack of health insurance, and that is a fact: 45,000 a year. They can't get the care they need to stay healthy and they lose their lives. If we don't change this system, if we don't reform it, we stand to lose talented people and we also stand to lose valuable lives.

The last person I want my colleagues to see is a friend of mine, Dale Mizeur. Dale lives in Blue Mound, IL. The Mizeur family is well-known in my part of the world. I think I have met them all, and they are a big family. Over the years, I have visited with them in their homes and in their home towns. Blue Mound is a little town south of Decatur, IL, 1,100 people. Everybody knows one another. They are all neighbors and friends. Most of them go to church together and have their community picnics; a great small town in Midwestern America. There are a lot of farmers there. There are retired factory workers from the Caterpillar plants up in Decatur and a lot of folks who like living in a small town. This used to be a thriving area. It has struggled with changes in manufacturing and changes in our economy, but it is a close-knit community.

Dale Mizeur lives there. He was born in Owaneco 61 years ago. He was a hard worker at a Cat plant up in Decatur for 32 years. He decided to retire 11 years ago. Based on a simple calculation, he was told he would have a modest pension and his health care costs would be covered in his union contract.

In the time since he retired, his expectations haven't been met. A difficult economy and new contract negotiations up in Decatur have resulted in the erosion of Dale's union health care coverage. As a result, he now has to spend more of his pension on filling the gaps in his reduced health care coverage. His monthly premiums have skyrocketed from nothing when he first retired to almost \$400 a month, and that is 20 percent of his pension check. In addition to these premiums, the quality of his coverage has gone down. What was once a generous health

care plan has such high out-of-pocket costs that Dale questions whether he can afford to stay with it.

He is like most Americans; he doesn't worry about his health until he needs to do something about it. During the early years of his retirement when his insurance coverage was rock solid, he considered himself healthy and never saw the need to use it. But we all get a little older, our bodies aren't what they used to be, and things have changed for Dale. A few weeks ago he noticed some pain in his chest, some dizziness that was too noticeable to ignore. He saw his doctor who told him to go to the emergency room. He fretted about what this was going to cost him, but he went anyway. Thankfully, Dale is physically OK, but economically and emotionally is another story.

Last week, Dale received his bill from the ER. His own personal out-of-pocket expense: \$600. He now has to figure out how he is going to pay that bill out of his pension. What other expenses will he have to delay? What about the mortgage and utility bills? He has to worry about the costs he will endure next time.

Dale and his wife live on a fixed income. As I said, he is 61 years old. The money that comes in each month is accounted for and there isn't a lot of wiggle room.

He is contemplating coming out of retirement after 11 years, primarily because he can't make ends meet and because of medical expenses. This isn't a very good economy for a 61-year-old retired factory worker to look for a job. He is one of the many early retirees who have found that health care costs threaten their financial stability. The unlucky ones lost their health care coverage completely, perhaps because their employer has gone bankrupt. Even those such as Dale, who still has coverage, are finding themselves in a much more precarious situation than they expected.

I tell these stories because they are real-life stories of people I have either met or come to know because they have contacted our office. I listened to the minority leader come and say: Stop the presses, stop the debate, stop moving forward in this effort to have real health care reform in America. The minority leader, from Kentucky, said we need to start over.

We have been starting over on health care for decades. We have never reached the finish line because there are always obstacles in our path. Right now, the obstacle is bringing this matter to a vote. Why were we in session at 1 a.m. this morning casting a vote? Because the Republican side of the aisle is determined that, regardless of the issue, they are going to stop us from bringing this matter to a debate and vote. They don't want us to have a vote on this. They don't want us to make a decision. They don't want to be on the record.

That is unfortunate. The bill they have chosen to filibuster—the one before us in the Senate—is a bill that should have no controversy whatsoever. It is a bill to fund our troops. It is the Department of Defense appropriations bill. Can you imagine, in the midst of a war, when the bravest men and women in our Nation are risking their lives at war, the Republicans are filibustering the bill to pay their salaries, the bill to pay for the equipment they need to stay safe, the bill to pay for the medical care of these soldiers, sailors, airmen, marines, and their families. It is unthinkable.

This is a bill that passed over in the House of Representatives overwhelmingly. I think the number was 394 to 35, and 164 Republicans voted for it because we want to stand behind our troops.

Last night, only 3 Republican Senators out of 40 would step up and say we should go forward on this bill—only 3. The rest of them, led by the minority leader and the minority whip, said we will stop this bill if this is the only way we can stop the health care debate. Why did they pick this bill of all bills—a bill where we should be standing in solidarity behind our troops, and we now have split into partisan camps.

There is nothing partisan about standing behind our troops. That vote early in the morning, unfortunately, was very partisan. There is also a provision in the bill that deals with the unemployed in America.

We want to go home. I want to go home. I called my wife this morning. I have been here 3 straight weeks now, and it looks like there is another week to follow before the holidays and Christmas. I don't like this. You give up a lot in this job. There are certain pieces of my family life I hold dear, and this is one of them—to be back home for Christmas, not just at the last minute but to be there, and it doesn't look like we will be able to do that. The Republicans decided they will use every political and parliamentary device possible to delay this vote. So we will do nothing today because we are running the clock out under the procedures of the Senate, and then we will meet at 7:30 tomorrow morning and have several votes on this Department of Defense appropriations bill, which should have been passed instantly when we received it from the House of Representatives. Then we will start the clock running again to move toward a vote on health care reform.

Why? Let's be honest. We ought to bring this matter up for a vote and see if we, in fact, have 60 votes on this side of the aisle. I hope we do. We are working on it. The reason I am here and the majority leader is not is because he is working, at this very moment, to bring those 60 votes together. Instead, the Republicans have said they are going to do everything possible, including

asking Members to stay here Christmas Eve and Christmas Day, in order to stop this vote on health care reform. That is unfortunate.

Let me tell you the bottom line of what this bill does for America. This bill is not perfect, and no bill we ever consider is. This bill, first, is the biggest deficit reduction ever introduced on the Senate floor. If we bring down health care costs, it not only will help families and businesses but even our Federal Government. As we bring down the increase in the cost in health care, Medicare for seniors will cost less to the government. The same thing is true of Medicaid, the health insurance program for the poor and disabled.

First and foremost, CBO tells us this bill, at a time when we have great national debt, will actually bring down America's debt \$130 billion in the first 10 years and \$650 billion more in the next 10 years. So it is a fiscally responsible bill. That is what President Obama challenged us to do: If you are going to pass health care reform, don't do it at the expense of the next generation. Pay for it.

We do. We more than pay for it. We also reduce the cost of government in the process. The second thing the bill does is start to bring down health care costs. It does it in a variety of different ways. I wish it were bringing it down faster. I commend the Presiding Officer, the Senator from Virginia, Mr. WARNER, who joined with a group of freshman Democrats, and they introduced cost-containment amendments to the bill—to be part of the managers' amendment—which have been heralded by the major business and manufacturing groups in America—a thoughtful amendment that addresses the core issue of how to bring down health care costs. They rolled up their sleeves and went to work and made an amendment.

You cannot say the same, I am afraid, for the other side of the aisle. Their amendments have not been as constructive as the one I just described. They have tried to stop this bill rather than improve it. Senator WARNER of Virginia and his freshman colleagues have taken a more constructive and positive approach.

Bringing down costs of health insurance and making it more affordable is job one for this health care reform. But it does something else. This bill extends the coverage of health insurance in America. Currently, there are 50 million Americans who don't have health insurance. They are people who have lost their jobs. They are folks who work for small businesses and cannot afford health insurance. They are people who have tried their best, but they can't get health insurance. There are 50 million of them. Imagine, if you will, going to sleep tonight, if you are a father or mother with a sick child, and you have no health insurance. Imagine, for one frightening moment, waking

tomorrow morning to face a diagnosis from a doctor of a serious illness or to be involved in an accident that requires medical care and having no health insurance. One out of every six Americans—50 million—have no health insurance.

This bill will change that. Thirty million Americans will be covered with health insurance who currently don't have coverage, and 15 million in the lower income categories—the working poor and lower income folks—will go into Medicaid at the State level; 15 million will go into private health insurance. At the end of the day, with this bill, 94 percent of Americans will have health insurance. That has never happened in our history—ever; 94 percent will have the piece of mind of having health insurance.

There is something else this bill does. It goes back to my illustration. It says to the health insurance companies it is over; the way you have been mistreating the people who pay your premiums is going to come to an end. We are not going to allow you to “fly-speck” applications for health insurance to find a preexisting condition. We are going to make sure those with preexisting conditions have a real opportunity for health insurance coverage and will not be denied when they need coverage. We are going to also make sure that when you get sick, the health insurance company cannot cut and run, as so many do. We are going to extend that coverage for young people through ages 24 and 25. This is all good and positive. It will mean the Patients' Bill of Rights, which former and late Senator Kennedy and even Senator MCCAIN worked for, will be part of the law of America.

There are critics of this health insurance plan, for sure. We saw them come out at townhall meetings and protests and so forth. Some don't want to change the system; they like the system. They fear government or whatever it may be. Their motive is to stop this. There are also critics who say this bill doesn't go far enough. It doesn't go as far as I would like to go. I think there ought to be a public option. We ought to have a not-for-profit plan that competes with private plans. The realities of the Senate don't make it possible to do that in this bill at this time.

When the Republican leader comes to the floor and says so many people oppose it—some oppose it because they may want to do nothing; others don't think it does enough—that is the nature of this process. I have been around long enough to know you can't satisfy everybody. Is it better if this bill passes or not? I think the answer is overwhelmingly it is.

Howard Dean is my friend and a former Governor. He said he would vote against this. I say to Dr. Howard Dean: Don't you believe 30 million Americans with health insurance are worth the ef-

fort? I think you do. I think most people do. We can do better, and we will work to improve the bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Indiana is recognized.

Mr. LUGAR. Mr. President, how much time remains on this side?

The PRESIDING OFFICER. There is 16 minutes remaining on the Republican side and 3½ minutes on the Democratic side.

Mr. LUGAR. Mr. President, the bill before us contains more than \$128 billion for operations in Afghanistan and Iraq. Since the President's announcement 2 weeks ago that he would be ordering tens of thousands of additional U.S. troops to Afghanistan, the Congress has held numerous hearings examining the military strategy to be employed, political issues in the region, and the dispensation of funding for the war.

As we consider our course in Afghanistan, we should evaluate options according to how well they contribute to U.S. national security. The ultimate purpose of committing tens of thousands of new troops and tens of billions of additional dollars to the war effort in Afghanistan must be to enhance U.S. security and our vital national interests in the region.

Sometimes during long wars, specific tactical objectives can become ends in themselves, disconnected from the broader strategic context or an accounting of finite resources. Congressional oversight of the funds in this bill is part of that accounting. We need to get the most value for our defense dollar in Afghanistan, as well as Iraq. This is especially true at a time when our Armed Forces have been strained by many years of high deployment rates, our capacity for new government debt is limited, and our Nation has not fully emerged from a severe recession. As we think through the implications of the defense spending bill before us, we need to be cognizant that even if the President's Afghanistan plan achieves the very best stabilization scenario, allowing for U.S. withdrawals on the schedule he contemplates, we may be responsible for most of the Afghanistan defense and police budgets indefinitely.

Much of the debate in Congress has focused on the President's stated intention to begin withdrawing some U.S. troops by July 2011. Some Members have voiced the concern that such a date undercuts impressions of U.S. resolve and gives the Taliban and al-Qaida a target beyond which they can wait us out. Other Members, with a very different view of the war, worry that the July 2011 date is so flexible that it offers no assurance at all that troops will be withdrawn. This is a legitimate item for debate, but I am doubtful that success or failure hinges on this point nearly as much as it does on the counterinsurgency strategy employed by allied troops, the viability of

the Afghan security forces, and most importantly, how the United States engages with Pakistan.

I have confidence that the addition of tens of thousands of U.S. and allied troops, under the direction of Generals Petraeus and McChrystal will improve the security situation on the ground in Afghanistan. More uncertain is whether the training mission will succeed sufficiently to allow U.S. forces to disengage from combat duties in a reasonable time period. The most salient question, however, is whether improvements on the ground in Afghanistan will mean much if Taliban and al-Qaida sanctuaries in Pakistan remain or if instability within Pakistan intensifies.

As hearings in the Foreign Relations Committee have underscored, the potential global impact of instability in a nuclear armed Pakistan dwarfs anything that is likely to happen in Afghanistan. The future direction of governance in Pakistan will have consequences for nonproliferation efforts, global economic stability, our relationships with India and China, and security in both the Middle East and South Asia regions, among other major issues. The President and his team must justify their plan not only on the basis of how it will affect Afghanistan, but also on how it will impact our efforts to promote a much stronger alliance with Pakistan that embraces vital common objectives.

Secretaries Clinton and Gates and Admiral Mullen acknowledged the importance of Pakistan in the President's calculation. They underscored that the administration is executing a regional strategy. I am encouraged by press reports that have described the intense diplomatic efforts with the Pakistani government aimed at securing much greater cooperation.

But we should remain cognizant that the focus of policy tends to follow resources. By that measure, Afghanistan will still be at the core of our regional effort.

The President has said that the United States did not choose this war, and he is correct. But with these troop deployments to Afghanistan, we are choosing the battlefield where we will concentrate most of our available military resources. The Afghanistan battlefield has the inherent disadvantage of sitting astride a border with Pakistan that is a porous line for the militants, but a strategic obstacle for coalition forces. As long as this border provides the enemy with an avenue of retreat for resupply and sanctuary, our prospects for destroying or incapacitating the insurgency are negligible.

The risk is that we will expend tens of billions of dollars fighting in Afghanistan, while Taliban and al-Qaida leaders become increasingly secure in Pakistan, where the long-term strategic stakes are even higher. If they are able to sit safely across the border

directing a hit-and-run war against us in Afghanistan, plotting catastrophic terrorist attacks abroad, and working to destabilize Pakistan from within, our strategic goals in the region will be threatened despite progress on the ground in Afghanistan.

Some reports indicate that Taliban leaders, aware of the threat from U.S. operated Predator drones, are moving out of remote areas into crowded Pakistani cities, including Karachi. If such reports are true, the United States will have even fewer options in pursuing Taliban and al-Qaida leaders in Pakistan, absent the active help of Pakistani authorities. Specifically, will Pakistan work with us to eliminate the leadership of Osama bin Laden and other major al-Qaida officials?

In addition to improving the cooperation of the Pakistani authorities, the United States and our allies will have to become more creative in how we engage with the Afghan and Pakistani people. We should understand that as a matter of survival, people in dangerous areas on both sides of the border will tend to side with whoever is seen as having the best chance of winning. We should also recognize that tribal loyalties, most notably Pashtun loyalties, are at odds with a strong central government and with acquiescence to external military power. As Seth Jones of the Rand Corporation has observed: "The objective should be to do what Afghanistan's most effective historical governments have done: help Pashtun tribes, sub-tribes, and clans provide security and justice in their areas and manage the process." Meaningful progress in Afghanistan is likely to require tolerance, or even encouragement, of tribal administration in many areas, as well as convincing tribal leaders that opposing the Taliban is in their interest.

In these circumstances, we should explore how cell phones and other communication technologies can be used more effectively, both as an avenue for public diplomacy to the Afghan people and as a means for gathering intelligence from them. Already, seven million cell phones are in Afghanistan—one for every four inhabitants. The Taliban's reported priority on destroying communications towers underscores their understanding of the threat posed by these technologies. For example, cell phones could be used by sympathetic Afghans to produce real-time intelligence, including photographs of IEDs being prepared or calls alerting coalition troops to movements of the Taliban. Phones eliminate the need for informants to take the risks of visiting a police station in person or of conversing openly with U.S. troops. Similarly, expanding the use of credit card transactions could prove revolutionary in addressing some vexing problems in a country that lacks an effective banking system. They can pro-

vide a way to reduce corruption, improve accounting within the Afghan government and security forces, and relieve soldiers from the need to go AWOL to deliver pay safely to their families.

I want to recognize that the President has been confronted with extremely difficult choices in Afghanistan and Pakistan. He and his team have worked through the problem carefully and deliberately to reach their conclusions. There are no options available that are guaranteed to succeed. Every conceivable course, from complete withdrawal to maintaining the status quo to the plan outlined by the President, to an unrestrained and unlimited counterinsurgency campaign has its own set of risks and costs for the United States. The President deserves credit for accepting ownership of this difficult problem as we go forward. In this situation, the advocacy of the President and his national security team must continue to be as broad-minded and thorough as his policy review appeared to be.

Within months, the President is likely to ask Congress for additional funds for Afghanistan, beyond what is contained in this bill. In the meantime, the administration must be prepared to answer many questions about its strategy as the American people study the potential consequences of the President's decision.

THE PRESIDING OFFICER. The Senator from Arizona.

MR. MCCAIN. Mr. President, my friend, the Senator from Illinois, whom I see back on the floor—for the record, the Senator from Illinois and I entered the House together longer ago than we would like to mention, particularly for those who favor term limits. We have had our philosophical disagreements, but I have appreciated his leadership. I have appreciated his honest approach to the issues. We obviously have significant disagreements. Those disagreements have been respectful, and I look forward, during the next whatever period of time until we dispense with the issue of health care reform and the issue of DOD appropriations, to discussing this issue with him.

The Senator from Illinois has been saying that the Republicans are holding up funding for our troops by not conceding to an immediate vote on the Defense appropriations bill after the House sent it to the Senate. I understand that, and I understand his zeal to get onto other issues, which is the job of the majority, to get legislation passed, but I would like to point out the real facts.

The real facts about the Defense appropriations bill are that the House passed its version on July 30, last July 30. The Senate passed its version on October 6. By my calculation, that is well over 2 months ago. All they had to do then, of course, was go to conference

and report it out to the floor of the Senate—something that could have been done in 24, 48 hours. Instead, over 2 months has gone by and the Democratic leadership in both the House and Senate held captive this bill for the troops. Why would they do that? Because they knew that at the end of the year, they would stuff in unrelated must-pass legislation which has nothing to do with the Department of Defense or the men and women in the military, they would have to put that in so they could get it passed. We have a number of additional pieces of legislation stuffed into the bill which the Democratic leadership knew had to be passed.

I say in all due respect to my friend and colleague from Illinois—he and I, as I mentioned, have been around here the same amount of time—the fact is, after the House and Senate both passed their bills over 2 months ago, they could have brought it to the floor and we could have debated it and, of course, passed it into law.

So now we have the Secretary of Defense calling around to people saying: We have to pass this immediately. Where was the Secretary of Defense, whom I admire and respect, on October 7, 2009, after the Senate passed its bill? Where was he then urging Members to not harm the men and women who are serving in the military?

I will get from my staff the bills that are stuffed into this bill which have nothing to do with our Nation's defense and have everything to do with the agenda of the Democratic majority. I want to say again to my friend from Illinois, I understand that. I understand why they are doing what they are doing. But I don't understand why they are blaming us when after 2 months the bill has not been passed.

Let me just add, there is a portion of the bill called division B, "Other Matters." Only in the Senate could we call it "Other Matters." Let me tell you what they have larded onto the Defense bill.

Food stamps. Food stamps are very necessary. Is anybody going to be against food stamps? Of course not. It extends appropriations for the Supplemental Nutrition Assistance Program in the USDA. Food stamps administration, \$400 million in emergency funds through September 30, 2011.

Satellite Home Viewer Act extension. Perhaps the Senator from Illinois, my friend, can tell me what the Satellite Home Viewer Act extension has to do with defending our Nation. I know it has a lot to do with the ability of millions of Americans to watch NFL football, but I do not think it has a lot to do with defense spending.

PATRIOT Act extension. Section 1004 provides a clean 2-month extension until February 28, 2010, of the three PATRIOT Act provisions expiring at the end of this calendar year. That has

to do with investigation of business records and also roving wiretaps. Is there anyone who did not know the PATRIOT Act was going to expire? Was the Senator from Illinois unaware that we needed to extend the PATRIOT Act? Most people believe we do. We still have extremist organizations that want to attack the United States of America.

Flood insurance extension. It extends the Flood Insurance Program through February 28, 2010.

Small business extension. There is \$125 million for the Small Business Administration to continue offering reduced-fee and higher cap loan guarantees under the American Recovery and Reinvestment Act. It extends the higher limits through February 28, 2010. It further designates such amounts as emergency spending; i.e., it is not included in the budget. But that is an argument for another day.

The point is, again, small businesses are vital. Small businesses are what have been ignored. Small business is the reason the stimulus package has failed. It has done a great job for Wall Street—boy, these bonuses, \$16 billion, \$18 billion, are going to be distributed. They are going to have a Merry Christmas up on Wall Street at Goldman and Morgan and all those places. It is going to be great, thanks to the TARP and the stimulus package. But what is it on Main Street where we have 10-percent unemployment?

Of course we need to help small businesses. They have not done much so far, I tell you that. I will take you to my State and take you all over this country outside of Manhattan, and they will tell you small businesses are hurting very badly. We could not do that before. We had to put it on the Defense appropriations bill.

We also have payment for a North Carolina construction project. Here is something that really has a lot to do with defending the Nation. It provides a \$12.8 million appropriation for a construction project in North Carolina, of which—note designation of the State—of which \$4 million will be obligated immediately and the rest will be available 120 days after the signing of an agreement between the Federal Government and several local authorities. This is paid for through rescission funds previously appropriated for this project. I don't know what the project is, I say to my colleagues, but I am not sure we are in dire need.

In addition, highways extension. Section 1008 extends the authority for the highway trust fund to make and receive payments through February 28. It also provides \$33.4 million for administrative expenses, paid for out of the earlier rescission from the highway trust fund. I am one who believes we need to make sure the highway trust fund is funded and we move forward with the highways. Again, what does

that have to do with defending this Nation? Not a lot.

Unemployment insurance extension. Here we are again. It extends the authority of expiring Federal unemployment insurance programs and benefits through February 28, 2010, continuing the current availability of up to 99 weeks of total unemployment. Of course, we have to extend unemployment. Unemployment, except up on Wall Street, is at 10 percent. In my home State of Arizona, real unemployment is 17 percent.

In addition to that, I guess the conferees were beaver away by adding earmarks, and plenty of them—in fact, 1,720 earmarks, totaling \$4.3 billion; \$2.5 billion in unauthorized and unrequested C-17s. No one outside of those who are contractors believes we need to spend \$2.5 billion on unauthorized C-17s which cost \$2.5 billion; \$500 million in unrequested and unwanted funding for the Joint Strike Fighter alternative engine and Presidential helicopter. That is \$7.3 billion. There is \$18 billion in new non-offset funding for food stamps, unemployment assistance, COBRA benefits, physician payments, the so-called doc fix, and small business lending. By designating the funding as an "emergency," none of it is paid for. It is just another \$18 billion of debt that will be laid on our children and grandchildren and our national debt in 2010.

I guess some Americans wonder why we are going to have a debt for this year of \$1.5 trillion—trillion, "t," trillion. Someone said to me—several times it has been said to me—we hope the President never learns what comes after a trillion.

Here we are with another \$18 billion of funny money. Here we are with a bill passed by the Senate 2 months 10 days ago and passed by the House months before that. Clearly, one can only assume—let me put it this way: One would question, if the Senate passed its version on October 6 and the House passed its version on July 30, then why would we wait until December 16 to bring it to the floor of the Senate? One might conjecture that they did not bring it to the floor of the Senate because they knew it was going to have to be passed by the Congress of the United States. Of course, we are going to pass it. So this is the best opportunity to add these programs and projects that would never otherwise be passed. So here we are with legislation to take care of the men and women in the military and our national security needs and we have loaded it up with \$7.3 billion in pork and \$18 billion in new offset funding, which is not paid for. So then my friend and colleague from Illinois comes to the floor and says: Republicans are holding up the passage of this bill, even though—even though—the Senate passed this bill on October 6.

Mr. DURBIN. Would the Senator yield for a question?

Mr. MCCAIN. I would be more than happy to engage in a colloquy with my friend from Illinois, if he requests to do so or just has a question—either way.

Mr. DURBIN. I have a question. When we were here at 1 a.m., bleary-eyed and voting, there were two unanimous consent requests made to pass the Department of Defense appropriations bill immediately. Does the Senator from Arizona remember the objections to passing the bill immediately so we could get the money to the troops came from his side of the aisle when we tried to pass this bill?

Mr. MCCAIN. I do recall that, I say to my friend, and I also recall I was only allowed 10 minutes—10 minutes—to talk about this bill and the 1,720 earmarks such as the telescope in Hawaii and—I have a list here somewhere. But I was allowed 10 minutes, and I need a long time to talk about this.

If the Democratic majority, which is their right, wants to wait until December 17 and then jam it through in the middle of the night, that is their right to try it. But we need to talk more about why the American people are angry. Here we have a bill to defend the Nation—to defend the Nation—and \$18.9 million for a center at the University of Massachusetts “dedicated to educating the general public, students, teachers, new Senators, and Senate staff about the role and importance of the Senate.”

I hope this organization, this center at the University of Massachusetts, will somehow come into being, perhaps, but not by taking it out of money for Defense. If there is ever a time the American people need to understand the role and importance of the Senate—given our approval rating is about 4 percent, and I haven’t met any of them—I understand why someone would want to have a center to teach new Senators and Senate staff about the role and importance of the Senate. But \$18.9 million, when people are not being able to stay in their homes, when they are unemployed, when they can’t feed their families, when unemployment is 17 percent? Sure, let’s add it on to the Defense appropriations bill. That is the way to do it.

Here are some more: \$500,000 for my old favorite—the old Brown Tree Snake Program. I totaled up the millions that have been spent on the old Brown Tree Snake Program. Of course, Historical Fort Hamilton Community Club, that needs \$1.8 million. The old Historical Fort Hamilton Community Club, I am sure it is a nice place to visit.

I am sure it is great to have \$1.6 million to study human genetics at the Maine Institute for Human Genetics and Health in Brewer, ME; \$3.5 million for a microalgae biofuel project in Hawaii; \$5 million for the Presidio Heritage Center, a museum, in San Fran-

cisco; \$1.6 million for the Center for Space Entrepreneurship. I think that would match with the \$2.9 million we appropriated on the previous bill to study surgery in outer space.

I am telling you, the Trekkies are happy about these appropriations bills. Here are more: the \$1.6 million for a Virtual Business Accelerator for the Silicon Prairie; \$7.8 million to develop key technologies needed for the long-term operations in near-space conditions. So we have surgery in outer space and key technologies needed for near-space conditions for the Orion High Altitude Long Endurance Risk Reduction Effort, the Aurora Flight Sciences in Columbus, MI; \$2.4 million for Fusion Goggle System; \$800,000 for Advanced Tactical Laser Flashlight in Wyandotte, MI; \$10 million for the Hawaii Technology Development Venture.

My friends, this is kind of a classic example. I see my friend and colleague on the floor, Senator COBURN, a man of courage and integrity and one who I think has led, in many ways, this fight. But here is an earmark in this bill—it has never been authorized, never had a hearing—\$10 million for the Hawaii Technology Development Venture. What could that be? What could that be? Did we ever have a hearing? Did we ever have a depiction of this? Did we ever have it? No. It is included by the appropriators.

A few more: \$3.9 million for Intelligent Decision Exploration. If there is ever a place that needed that, it must be, in my view, the Congress. So \$3.9 million for Intelligent Decision Exploration. I think, frankly, the results of that exploration would be rather bleak. How about \$2.3 million for marine species; \$2.4 million for NAVAIR High Fidelity Oceanographic Library.

The list goes on and on and on. Oh, here is Hawaii again—strange how Hawaii pops up—\$2 million for Advanced Laboratory for Information Integration, naturally, in Hawaii; \$1.2 million for the Model for Green Laboratories and Clean Rooms Project.

Now, again, I wish to point out, as my colleague from Oklahoma has, these may be very worthwhile projects. They may be projects that maybe will help America. Maybe spending our Defense appropriations—\$5.8 million of it—for the Rock Island Arsenal Roof Replacement in Rock Island, IL, is something that is badly needed. Maybe the \$800,000 for the Natural Gas Firetube Boiler Demonstration at the Rock Island Arsenal is also very necessary. But how are we to know? How are we to know?

So the Senator from Illinois and the Democratic leader have come to the floor and are saying: The Republicans are blocking passage of vitally needed funding for the men and women in the military who are defending our Nation as we speak. My response is: Where were you for the last 2 months after

the Senate passed this bill? The Senate and the House could have had a conference and we could have had this bill long ago.

The fact is, it has been loaded up with food stamps, the Satellite Home Viewer Act extension, the PATRIOT Act extension, flood insurance extension, small business extension, payment for construction projects, highways extension, unemployment insurance, COBRA extension, the old doc fix—the old doc fix that we do year to year, which is another chapter in profiles of courage on the part of the Congress—poverty adjustment freeze, rescission of DTV funds, and it goes on and on. What does all that have to do with Defense? What does that have to do with defending this Nation? What does that have to do with giving the men and women, who are serving in our armed services today in harm’s way, the best equipment, the best training, and the best support we can provide to them?

I see my colleague from Oklahoma on the floor and so I yield the floor at this time.

The PRESIDING OFFICER (Mr. KAUFMAN). The Senator from Oklahoma is recognized.

Mr. COBURN. I thank Senator MCCAIN. I think America looks at us and says: Here it is, a week before Christmas, and we are debating the Defense appropriations bill, but it is interesting to note that the first appropriations bill that passed out of the Congress was the bill to fund us.

We put us first. We didn’t put our troops first. We didn’t put the Department of Defense first. We have had no inflation this year, and what did we do? We gave ourselves a 5.8-percent increase. The first appropriations bill to be passed and signed by the President. We put us first.

So here we find ourselves a week before Christmas debating the Defense bill, while we are in the midst of two wars, and there is an increase of only 4 percent. Yet we have all these people who say they are for Defense. We pass a bill that increases our own expenses by 5.8 percent and then we tell the Defense Department: You can’t do that. You can’t have what we have.

The fact is, it is easy to return 15 percent of everything you take in up here, in what you are allotted. I have done it, on average, every year I have been here. My employees are well paid. They work hard, but they are well paid. So we gave ourselves a 5.8-percent increase, but this Defense Department bill, in the middle of two wars, has a 4-percent increase.

That is not the worst of it because the average of all the increases right now is almost 11 percent on all the rest of the bills and here they are. That doesn’t include any of the spending for each of these agencies—which averaged around 30 percent of their budget—that

they got in the stimulus bill. Here we go: We give ourselves a 5.8-percent increase; Homeland Security, 7.2 percent; T-HUD, 23 percent; Interior, 16 percent; State and Foreign Ops, 33 percent. We did ours first to make sure we got us covered.

All of this is very ironic to me, based on the fact that out of every dollar we spend this year, 43 cents of it is borrowed. Of every dollar the Federal Government spends, 43 cents out of that dollar is borrowed. We are borrowing \$4.2 billion a day. That is not every business day, that is every day of the week. There is \$350 billion to \$380 billion worth of waste in the Federal Government. Yet not one place in any of these bills do we eliminate duplicative services; not one place in any of these bills did we eliminate fraud; not one place in any of these bills did we cut the value of earmarks—though the number is down, only slightly, but the total dollar is up.

We made no attempt to do what every family in America is doing today; that is, to prioritize. Next year, it is going to be 45 cents of every dollar the Federal Government spends we are going to borrow. Why is that important? It is important because the people making the decisions to borrow the money are not the ones who will have to pay it back. We are going to transfer that. We are going to violate the tradition and heritage of our country because we are going to transfer a markedly lower standard of living to our children.

I met this little girl. She is from Maryland. Her name is Madelyn. If you divide the total debt by the total population—just the debt we owe now—and that is truly Enron accounting because it doesn't count the internal debt we owe or money we borrowed from Medicare, money we borrowed from Social Security, and other transfer funds—it equals \$38,375. That is what it was when this picture was taken. It is well over \$39,000 for every man, woman, and child, and that is just on external debt. The only thing she owns is a dollhouse.

The real tragedy is, when Madelyn is 45, everybody her age and younger will be responsible for \$1.19 million worth of debt and over \$70,000 worth of interest per year before they pay any other taxes, before they buy themselves a home or an automobile or before they send their kids to school. They will be \$1.19 million in debt, plus combined unfunded liabilities.

This is the U.S. debt clock. It sits in the doorway of my office in the Russell Building. I had it out in the hall, but the Rules Committee would not allow people to look at that. I don't know whether they didn't want them to see it or it truly doesn't fit with protocol. Now I have a door open in my office and I have this on the live computer screen and it changes every day.

It is pretty interesting. This was as of November 21. So, November 21 to De-

cember 18, that is 27 days, we have borrowed another \$100 billion since we took this picture off the Internet. We are at \$12.118 trillion. Calendar year to date, the Federal Government had spent \$3.285 trillion. The debt per citizen on the 21st was \$39,000 and, per taxpayer, it was \$110,000. Our deficit as of November 1, for the calendar year, was \$1.409 trillion—all of it borrowed.

The private debt in the country is \$16 trillion. That is our private debt. That is what all of us owe on our own stuff. The mortgage debt is \$14 trillion.

If you look at the second screen that is outside my office, what you see is the total cost of the bailout so far—\$11 trillion. We only have personal savings of \$643 billion. Our savings per adult is less than \$3,000. How do you take that \$3,000 against the \$39,000 and make any sense out of it?

The final screen shows the personal individual debt, the credit card debt, and the payment debt. It also shows our GDP. We are good as a nation. Our workers are good. We produce \$91,000 worth of product per person every year. That is going to decline because of what the Federal Government is doing.

There was a guy once named Cicero and he warned of some things that were happening in one of the best known and most successful republics in the world. It happened to be Rome. Here is what he said. "The budget should be balanced." I think 90 percent of America would agree with that:

The Treasury should be refilled, the public debt should be reduced, the arrogance of officialdom should be tempered and controlled, and the assistance to foreign lands should be curtailed lest Rome become bankrupt. People must again learn to work, instead of living on public assistance.

They didn't listen to Cicero, much like the Senate is not listening to the citizens of this country and we are growing a Federal Government we cannot afford, outside the bounds of what this document, the U.S. Constitution, says is our legitimate role. If you go to it and look at article I, section 8, you see the enumerated powers and you go look at the 10th amendment and ask: How in the world is the Federal Government involved in all these things?

We have before us a bill to fund our troops and fighting two wars. Other than one other appropriations bill, we gave it the smallest increase.

By the way, in this bill is \$18 billion of what we call emergency so we do not have to play inside the budget. We automatically transferred another \$18 billion to Madelyn and her generation.

How do we get out of this? What do we do? We actually, in Congress, should be following the lead of the families in this country. What are families doing? Families are sitting down and making priorities. They are saying what are the things we must do? What are the things we want to do? What are the things we would like to do? Most of the

"What are the things we would like to do?" are going out of the window for American families today. A large portion of the things families want to do is going out the window so they can maintain the things they must do. It is called making hard choices.

When you see that the Congress took care of itself before it took care of anybody else, it describes the problem in Washington. We are absolutely clueless as to what the average American is going through. We could have all the words on this Senate floor said that we want to say, but our actions speak far louder than any words we could ever say. What are our actions? Our actions are to steal the future and prosperity of our children. It is not a very noble cause.

We are here this week not because of the Defense Department bill. We are not here the week before Christmas because of this bill. We are here the week before Christmas because somebody has set an artificial deadline that we must pass a health care bill, any health care bill, so we can say we passed a health care bill. That is why we are here. When we look at health care in our country, we recognize that we have significant problems in making sure everybody has access to care. We know what the problem is on access to care because we know per capita we spend almost twice as much as anybody else in the world on health care. The problem plaguing access to care—and as a practicing physician for over 25 years—is cost.

We have some bill coming sometime that will not be available for 72 hours for everybody in the country to read, that by the time you add the 2,074 pages to the couple of hundred pages we are going to add on, nobody is going to understand exactly what they are voting on. But we are going to vote on it because we said we would. We are going to impact one-sixth of our economy and we are going to destroy the best of our health care system in the name of fixing some of the problems in our system.

We are totally disconnected with America, the America I know. There was a guy who said—I will paraphrase the statement:

Freedom is a precious thing. It is not ours by inheritance alone. It must be fought for and defended by each and every successive generation.

What is that freedom he is talking about and who was he talking to? He was talking to the American people. He wasn't talking to our troops. The freedom he was talking about was the liberty that comes when free people come together under a democratic Republic with a limited Federal Government to make the best choices they can make for themselves and their families, and the freedom to do just that. That person was Ronald Reagan.

I got an e-mail from a constituent of mine. I can't use the exact words because they are not appropriate for the Senate floor. But he kind of paraphrased that statement and then he said: Every now and then somebody comes along and pees it all away. He said: Son, don't let it be you.

Our freedom is being taken away in this country—not intentionally but unintentionally. Because as the Federal Government grows and expands, your opportunity to make choices for yourself and your family become limited. We have a health care bill that is going to spend \$2.5 trillion over the next 10 years. It is going to cause premiums to rise, it is going to cause quality of care to go down, it is going to cause us to lose 1.6 million more jobs, and it is going to involve the Government between the patient and the caregiver. That bill will create 70 new government programs, 15,000 to 20,000 new Federal employees. It will create three panels that will ration care in this country directly. And it will in fact take Americans'—not just Americans on Medicare or Medicaid—Americans' freedom to make the best decision for them and their family as regard to their health care and stuff it in a box.

That is because we are going to tell you what you can have, what you can buy. We are going to totally disregard the art of medicine and we are going to practice cookbook medicine in this country.

A week ago we reversed the U.S. Preventive Services Task Force recommendation on breast cancer screening. We are going to have to do that hundreds of times every year under the bill that is being proposed right now because all of that is based on cost estimates. It was based on 1 out of every 1,970 women they find a breast cancer in between 40 and 50; but what people didn't say is 1 out of 1,400 women between 50 and 60 they find a cancer. So on a cost basis they are right; on a clinical basis they are not.

The majority whip earlier today said the Republicans didn't have any ideas on health care. The fact is we do have ideas on health care. What we know from a Thomson Reuters study that came out in April of this year is that there is \$700 billion in our system today that is not helping anybody get well and isn't preventing anybody from getting sick. If we want to truly cut the cost of health care, what ought to be required reading for every Senator in this body is the Thomson Reuters report. Because they can go through the fraud and abuse—19 percent of everything we spend. Unwarranted use—that includes me as a doctor doing tests I should not be doing. That includes defensive medicine, administrative inefficiencies, provider inefficiency and errors, avoidable care and lack of care coordination—duplication.

We have not attacked the disease of runaway health care costs in this coun-

try. What we have attacked is the symptoms. You do not cure people by treating their symptoms. You cure people by finding out what their disease is and curing the disease and treating the disease.

We are accused of being the party of "no." I want to tell my colleagues and the American public, "no" is a wonderful word. When your child is misbehaving, you say "no." When your adolescent child is making bad judgments, you say "no." When somebody is stealing something from somebody else, i.e. liberty, you say "no." When you are stealing the future, in terms of opportunity, we should say "no." When you are creating a government-centric health care system rather than a patient-centric health care system, "no" is a great word.

We have heard all about why we do not have any ideas. We had two mark-ups. The ideas we offered were rejected.

I see Senator WYDEN on the floor. He has a wonderful health care bill. It is somewhat different than the one I introduced but it is a great bill. It does not fall into any of the traps the bill that is on the floor today falls into. It also addresses many of the problems that are outlined in the Thomson Reuters study on health care in America.

Saying "no" at the right time saves lives. Saying "no" at the right time saves money. Saying "no" at the proper time preserves our future. Saying "no" when no is the best answer is the correct, right thing to do.

We have a government we cannot afford.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. COBURN. I ask unanimous consent for 30 seconds.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. COBURN. We have a government we cannot afford. We are borrowing money to buy things we do not need. We earmarked \$18 billion worth of projects this year. Some were good and some were terrible.

We eliminated no duplication in any agencies. We got rid of none of the fraud. We did nothing about efficiency, and we did nothing about creating priorities. I agree with my Democratic colleagues that health care should be a priority. When we had the leadership, we didn't do anything with it, and we should have. But mark my words, this is a turning point in America if we pass this health care bill. It is a turning point from which we will not recover.

I yield the floor.

The PRESIDING OFFICER. The majority whip.

Mr. DURBIN. Mr. President, it is my understanding the Democratic side has 30 minutes now.

The PRESIDING OFFICER. The Senator is correct.

Mr. DURBIN. I see the Senator from Oregon is here. If I could have a few

minutes to respond and then turn the floor over to him for as much time as he would need—I thank the Senator from Oregon.

First, a history lesson. Sometimes facts are tenuous, difficult, sticky things you can't get rid of. Let's look at the facts. When William Jefferson Clinton left the Presidency, America's budget was in surplus. For the first time in 30 years, we were generating more revenue than we were spending. We were adding life and longevity to the Social Security system, to Medicare, and many others. We did this with a prosperous, booming economy, one of the most prosperous we had seen in modern history. We created new jobs, new businesses, new home opportunities. When William Jefferson Clinton left office, we had a national debt of \$5 trillion.

In came the Republicans, billing themselves as fiscal conservatives. They were going to do it better, get government off our backs, reduce spending, and show us how they could manage. They took a \$5 trillion national debt, and over the next 8 years more than doubled it. In other words, when George W. Bush left office, America had more debt, twice as much, as was the case when he took office.

How did we reach a point where our debt mushroomed and more than doubled in 8 years? Because these fiscally conservative, flinty-eyed, stymie-hard Republicans engaged in a war they wouldn't pay for. Some of the Senators who just spoke this morning voted for us to go to war and not pay for it and just add it to the debt.

Secondly, President Bush did something no President had ever done in history. It was counterintuitive. It made no sense, but he did it. What was it? He cut taxes in the midst of a war. It has never been done because you can't explain it. You have the ordinary expenses of government that still continue, and now you have a new expensive war. And instead of doing what Franklin Roosevelt did in World War II, saying we are going to sell bonds, we will do our best to pay for this war, they said just the opposite: We will go into debt even deeper to not pay for the war. That is what they did. They went into debt by cutting taxes on the wealthiest Americans.

Unpaid for wars, tax cuts in the midst of wars for the wealthiest people, and then to add insult to injury, they passed the Medicare prescription Part D Program—a needed program, for sure—and didn't pay for it, adding hundreds of billions of dollars to the debt too. So at the end of 8 years, George W. Bush, who inherited a surplus from Bill Clinton, gave us twice the national debt, gave us the largest annual deficit we had ever seen, and left the economy in shambles.

Witness the recession we are currently in just starting to inch away

from. That was the record of the fiscally conservative, let's-get-tough-on-debt Republicans for 8 years, and many of those years they controlled Congress. All of those years the President had a veto pen.

When I come to the Senate floor and hear my Republican colleagues relate how they have a better vision of America—and their vision is in many respects a good one, to reduce debt for future generations—the record speaks for itself. They failed.

Now comes President Obama, and he says to Congress: We have to get the economy moving again. Some Republicans are criticizing him saying it is a mistake for us to put money into our economy. The President said we have to put people back to work, give working families a tax cut, create jobs building highways and infrastructure, do the things that help small businesses expand their payrolls. It costs money for sure, and I know we are in debt, but if we don't get that engine of the economy churning and moving forward, then we will never get out of this hole and more suffering will be the lot of the American people.

Not a single Republican would support that, not one. We didn't get one Republican vote for that in the House of Representatives. Over here, we had three—the two Senators from Maine and the Senator from Pennsylvania who has since crossed the aisle and joined the Democratic party. That was the reality. As a party, the Republicans opposed stimulating the economy in the midst of the deepest recession.

Now comes health care. President Obama says to us: Before you pass this health care bill, there is one basic rule—do not add to the deficit. Find a way to reduce health care costs for individuals, families, and businesses. Do not add to the deficit. The Congressional Budget Office took a look at this bill—it took a year to prepare it—and said it is the biggest deficit cutter in the history of the United States because over 10 years, this bill alone will save the Federal Government \$130 billion and over the next 10 years, \$650 billion. If we continue without changing the current health care system, it will mean more debt for everyone, higher premiums, higher costs, and more deficit. That is the fiscal choice we face.

I hear Senator MCCAIN, who is my friend—I respect him. We served the same period of time together in the House and Senate, and we disagree on a whole lot of things. But I like him. I think he likes me a little bit some days—come to the floor and say: Do you know what is wrong with this Department of Defense appropriations bill? In his words, the Democrats have “larded it up.” They have larded on things.

What is the lard in this bill? The extension of unemployment benefits for

millions of Americans out of work. Last time I came to the floor of the Senate it passed 97 to nothing—not exactly a hotly controversial issue. Sadly, it took us 1 whole month to get to a vote. Then it passed 97 to nothing.

We larded it up with food stamps. In the State of Michigan, one out of six people is on food stamps. Food stamps in this economy are a lifeline for people to feed their children when they are out of work and don't know where the next meal is coming from. Is that the kind of squandering of taxpayers' dollars that we often hear from Senator MCCAIN. I don't think so. He is not a hardhearted man. He wants to feed children. He wants food stamps.

How about COBRA? COBRA is an acronym for a program that allows people to pay for health insurance. One of the first casualties when you lose your job is your health insurance. We want people to keep that health insurance. We help them pay the premiums. That is in here. I don't think we are larding it up when we include that.

The extension of the PATRIOT Act for a few months. Of course, if we are going to be vigilant against enemies, we want to extend it. We can debate what should be in it, but an extension of the PATRIOT Act is going to mean that America will be safer. The alternative is unacceptable.

Money for the Small Business Administration—that is where jobs are created. If we don't give money in loans to small businesses, we will see people losing their businesses and cutting back on employment. This is just fundamental. There is no credible, respectable, mainline economist who argues that the way to get out of a recession is to cut spending at the Federal level. Exactly the opposite is true. You have to help people with the safety net. You have to try to create a catalyst for more job creation. That means spending money.

I don't think this is lard and earmarks and porkbarrel. We are talking about the basic necessities of life. The Department of Defense appropriations should not be filibustered as the Republicans are currently doing.

Before I hand the floor over to the Senator from Oregon, I salute him. He has given more hard thought as an individual Senator than almost anyone in this Chamber about what to do with the system. The Senator's premise in health care is the right premise—more competition, more choice. We may disagree on some concepts. That is what we are here for. But I want to salute the Senator from Oregon and tell him this underlying health care bill is going to do things for America that need to be done. It is going to start—not as much as we would like—to bring down the increase in costs and provide affordability for families and businesses. It will extend the reach of health insurance to 94 percent of the

American people. It is amazing. It is historic. It is going to create a Patients' Bill of Rights which gives every family in America the legal tools to fight back when the health insurance company says no to their doctor and no to what they or their families need. It has a lot of positive things in it.

I want to salute Senator WYDEN, as well as Senator BERNIE SANDERS of Vermont, for one particular provision in the bill. We don't have the details yet, but we believe this will result in the most dramatic expansion of health care clinics across America. Those of us who represent communities such as Chicago and even downstate Illinois know these clinics are the first line of defense for medicine. Men and women can walk through the front door and find primary care and have their needs taken care of even if they are poor. Some of the most dedicated, hard-working professionals in medicine are in those clinics.

I have walked into many in Chicago, such as the Alivo Clinic where my friend Carmen Velasquez is the director. I have said: Carmen, if I were sick or my wife were sick, I would feel confident walking in the front door of your clinic. You have the best people on Earth who are doing dramatic things.

I ask unanimous consent there be printed in the RECORD an article from the Chicago Sun Times that talks about the terrible health care disparities in the United States, particularly between African Americans and White Americans.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Sun Times, Dec. 18, 2009]

HEALTH GAP KILLS 3,200 BLACK CHICAGOANS EVERY YEAR

(By Monifa Thomas)

The wide racial gap in health is growing in Chicago, a major new study has found.

Already lagging far behind whites on most key measures of health, blacks in Chicago have fallen even further behind in 11 of 15 areas reviewed by Chicago's Sinai Urban Health Institute between 1990 and 2005—including infant mortality, heart-disease deaths and diabetes.

There's a stark, human cost in that: In all, the researchers estimated that the toll of the black-white health disparity is an additional 3,200 deaths of African Americans in Chicago every year.

It isn't that blacks' health is declining. In fact, overall, the health of both African Americans and whites in Chicago and across the United States has improved on most of the measures studied between 1990 and 2005. But whites showed gains at a sharply higher rate, resulting in a wider gap, according to the Sinai institute, which is part of Chicago's Sinai Health System and which works to find “approaches that improve the health of urban communities.”

Nationally, the racial gap in health between blacks and whites in the United States has remained fairly constant over the same 15-year period, according to the new analysis, which was abased largely on communicable disease reports and birth and death

records and was published online Thursday in the American Journal of Public Health.

In Chicago, areas where the divide between blacks and whites in Chicago worsened significantly included: the death rates from heart disease and breast cancer, rates of prenatal care during the first trimester of pregnancy and the number of cases of tuberculosis.

The death rate from all causes for black Chicagoans was 36 percent higher than whites in 1990. By 2005, the difference had grown to 42 percent. In contrast, at the national level the racial gap in death rates shrank, going from 35 percent to 29 percent.

The researchers attributed the growing racial gap largely to whites' greater ability to benefit from health care advances because of "racism and poverty."

"What's happening is that, as advances become available for these different diseases, white people are able to gain access to advances, and black people are not," said Steven Whitman, director of the Sinai Urban Health Institute. "It's absolutely essential to understand the underlying structural issues that are causing these disparities: those are racism and poverty."

Whitman said the segregated nature of Chicago puts minorities at a disadvantage for accessing high-quality health care. He also noted that blacks in Chicago often live in poorer neighborhoods with underperforming schools, fewer parks and recreation areas and more "food deserts"—areas that don't have supermarkets and the array of healthy foods they carry.

What isn't clear and needs to be studied, according to Whitman, is whether the disparities seen in Chicago are worse than in other cities.

Romana Hasnain-Wynia, director of the Center for Healthcare Equity at Northwestern University's Feinberg School of Medicine, said the racial health gap isn't helped by "one size fits all" public health messages aimed at lowering death rates from heart disease, cancer and other illnesses.

"We have to be targeted in our interventions," said Hasnain-Wynia, who was not involved in the study.

James Randell recently was diagnosed with heart disease at Mount Sinai Hospital after coming in with chest pain. The Chicago man said he was troubled—but not surprised—to learn that African Americans aren't seeing the same level of improvement in their health as whites. His layman's take? It's the result of a lack of health literacy among minorities.

"A lot of us, we don't know what we should be doing to be healthy," said Randell, 47. "If I had taken better care of myself, I wouldn't be here."

The gap between blacks and whites in Chicago on a number of health indicators has increased between 1990 and 2005. Here are a few areas where the divide has grown significantly:

Heart-disease deaths: 1990: 8 percent difference (meaning deaths for blacks were 8 percent higher than whites). 2005: 24 percent.

Female breast-cancer deaths: 1990: 20 percent difference. 2005: 99 percent.

No prenatal care during the first trimester: 1990: 119 percent difference. 2005: 199 percent.

Tuberculosis cases: 1990: 310 percent difference. 2005: 497 percent difference.

Mr. DURBIN. In heart disease deaths in 1990, there was an 8-percent difference between African Americans and White Americans. Today it is 24 percent. Female breast cancer deaths, there was a 20-percent difference be-

tween African Americans and White Americans in 1990. Today there is a 99-percent difference. Prenatal care during the first trimester, there was a 119-percent difference in 1990. Today it is 199 percent; tuberculosis, 310 percent difference in 1990, 497 percent today.

These gross health care disparities are the result of the lack of primary care in the neighborhoods and towns of America. Senator WYDEN and Senator SANDERS, thank you for leading the fight to expand that.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. WYDEN. Mr. President, before he leaves the floor, I commend the distinguished Senator from Illinois for his statement and want to make sure the body recognizes that it has been Senator SANDERS who has championed this cause relentlessly, making the case that, dollar for dollar, there is no better investment in American health care than these community health centers. I was going to spend my time talking about the opportunities for Democrats and Republicans to continue to team up on this health reform issue. I think it is worth noting that Senator SANDERS, who has championed this effort in this bill, is actually picking up on work that a number of the most influential Republicans in this country have been interested in for years.

President George W. Bush was a great champion of community health centers. BERNIE SANDERS, now in this bill, is making sure we get a very significant increase so that there will be many new clinics across the country.

There are opportunities for Democrats and Republicans to work together. I will talk about a way we can create a new marketplace in American health care through health care exchanges and get more value for the health care dollar. This is an opportunity for Democrats and Republicans to team up, much like with community health centers. I thank my colleague.

I know because of our work together on health legislation the Senator shares my view that we can continue this effort to bring the Senate together on both sides around key principles of health reform. I want to do that again this morning by focusing on one of the most transformational and least understood parts of the health care debate; that is, the question of health insurance exchanges. My guess is across the country people are still trying to figure out what in the world these are and whether this is yet some other kind of health care lingo. It is fair to say, in basic English, these exchanges will be like farmers markets. This will be an opportunity for people to go to one place and to do what they can't do in the dysfunctional American health care system today; that is, actually shop and be in a position to compare

various kinds of products and services. When you invest wisely, you can put the savings in your pocket. The reality is, that has not been possible in our country ever since the middle of the 1940s. During the 1940s, when there were wage and price controls, judgments were made about the delivery of American health care. The decision to tie insurance to someone's job made sense back then, when people went to work somewhere and stayed put for 30 years until their employer gave them a big retirement party and a gold watch.

But today's economy is very different. On average, people change their jobs 11 times by the time they are 40. We need to make sure that no longer is the consumer insulated from the health care system, no longer are most consumers incapable of being rewarded when they shop wisely. People understand that they lose out in terms of their wages if health care costs continue to rise as a result of inefficiency. So these health insurance exchanges are the key to making health care markets work, in effect, for the first time since the middle of the last century.

In the merged bill, Senator REID, in my view, has laid an important foundation. There are three fundamental principles in Senator REID's merged bill. Of course, we are going to continue to work on this. When the managers' package and this bill get out of the Senate, we are going to be working on this for quite some time. We are going to work on this long after 24/7 cable TV has moved on to other topics.

But in Senator REID's merged bill, there are three important features of the exchange. The first is, it is going to be possible for consumers to make apples-to-apples comparisons of various health care plans. Consumers will be able to see that one plan will cost them \$20 in copays for a physician visit, but perhaps another plan will cost them \$30. It will be much like you can do in a store, a Costco, a grocery store, where consumers look at products on a shelf, look at the price, look at the various offerings, and choose the best product for themselves.

The second feature in the merged bill that Democrats and Republicans alike should appreciate is that it will be possible to keep low-quality plans out of the new marketplaces. This is especially important at the outset. I learned this back in the days when I was codirector of the Oregon Gray Panthers, the senior citizens group. One of the things the country learned in the early days of Medicare is a lot of the policies that were sold to supplement Medicare were just junk. They were not worth the paper they were written on, and people would buy 10, 12, 15 policies, literally wasting money they could have used for food and fuel and paying the rent. It took us until the mid-1990s to drain the swamp, and finally we were able to do it, standardize

those packages, stop the ripoff of older people with products that literally were not worth the paper they were written on.

The consumer protection provisions Senator REID has put in the merged bill, as it relates to exchanges, are going to keep low-quality plans out. This is going to offer customers the peace of mind of knowing that when they look at the plans, they can be certain they will have to meet minimum consumer protection standards. This is an important message to send in a new marketplace, and it will be an opportunity to have a very different start than we saw with Medicare, during those early days, when seniors were sold these policies to supplement their Medicare, private insurance policies that were a lot of junk.

Finally, under the merged bill, you are going to be able to see the value you are getting for your health care dollar, in an important respect, through what are called loss ratios that insurance companies will have to make public. What this means, of course, is consumers want to know that when they put out a dollar for premiums, they will get a significant portion of that dollar back in actual benefits and services. With the exchange, it is going to be possible to finally get this kind of loss information in one place and make it public.

So what I would like to do is talk about the steps from here and particularly build on principles the President talked to us about earlier this year in terms of ideas that bring Democrats and Republicans together; that is, more choice and more competition in the health care marketplace. What we are pointing to is the day when every consumer in America can say to their insurance company: I am giving you an ultimatum. You treat me right or I am taking my business elsewhere. That is what we are pointing to.

Here are some of the steps it is going to take in the days ahead to build to that future.

First, you have to have a big enough pool of people as soon as you can so as to maximize their clout in the marketplace. You have to make sure the exchanges are open to more than just folks who have been uninsured. If you open it just to folks who are uninsured, who have not seen a doctor, who have had chronic illnesses, who have not been able to get the preventive care they need, you have coming to the exchanges folks who are sicker and, of course, they are more expensive in terms of getting them good health care, and it is harder to hold down costs.

Once you have a big enough pool, where the risk is spread across a large group of people who have a wide range of health risks, you will be in a better position to force the insurance companies to compete and drive down costs for everybody.

In effect, in the days ahead, we will be in a position to put in place a cycle in the health care marketplace that will get more value for the American consumer. More and more people will come to the exchanges because the premiums are lower. More insurers will come into the exchange because they see that is the place you have to go in order to get business. Then you have what amounts to the beginnings of a revolution in the health care marketplace: get as many healthy people into the exchange; make it impossible for insurance companies to find loopholes and use slick marketing campaigns to cherry-pick just the youngest and healthiest; force them to compete on the basis of price, benefit, and quality and then you are on your way to taking a dysfunctional American health care system and getting the choice and competition that will finally pay off for the American consumer.

There are some additional interim steps I wish to mention briefly. The majority leader, Senator REID, and Chairman BAUCUS and I have come to an agreement that will also provide the opportunity to get more choice and more competition into the health care marketplace. What we have agreed to is, folks who spend more than 8 percent of their income on health care but are not eligible for subsidies—in effect, folks with what is called the hardship waiver—they would be able to get a voucher from their employer and go into the marketplace. With that kind of approach, which would be tax free to them, our estimate is that it will be less than one-third as expensive, in terms of getting health care for those folks, as the alternative—the system of subsidies. Again, we get more people covered in a more affordable way, building on these time-honored principles of choice and competition.

Finally, Senator COLLINS, Senator BAYH, and I have a proposal, a proposal that has been endorsed by the National Federation of Independent Business, that would say that employers that are in the exchange can voluntarily say they want to give their workers more choices. In effect, it would say to those small employers in the exchange: You and your workers will have a choice to have a choice. No employer is required to do anything. But should they want to concentrate on making their widgets rather than being in the health insurance business, they would have the opportunity to do it.

What they would give their worker would be tax free to the employer, tax free to the worker. Once again, you bring the principles of choice and competition into the health care marketplace and move us closer to that day when the consumer can give the insurance company the ultimatum I have envisioned; which is: Treat me right or I go elsewhere.

I close by saying, in my view, the majority leader has laid the foundation

for a new health care marketplace. I certainly would like to do more. As the distinguished Presiding Officer knows, as cosponsor of our bipartisan Healthy Americans Act, I would like to do more, and I would like to do it faster. But make no mistake about it, this is laying a foundation to create a new marketplace in American health care, where that concept has been foreign.

To let people make apples-to-apples comparisons, keep crummy products out of the exchange, make sure people can get information about loss ratios, that is a real foundation. Then we seek to go further. We have had the counsel of some of the country's leading thinkers about American health care.

Let's get more healthy people into the exchanges. Let's make sure we have these big pools. Let's make sure the insurers cannot try to steer the marketplace because we know they are going to try, in ingenious ways through advertising and market promotion strategies, to still find the best risks. Let's build on what Senator REID has laid out with respect to the exchanges in the days ahead.

We are going to be at this a long time. You are not going to fix a dysfunctional health care marketplace in a matter of weeks. We are going to be at this the rest of this week, next week, well into 2010. I have been part of this debate since I was codirector of the Oregon Gray Panthers, going back 30 years now.

I continue to believe there is an opportunity for Democrats and Republicans to work together. Our party has been right on the issue of coverage. You cannot fix this unless all Americans have good, quality, affordable coverage because otherwise there will be too much cost shifting. But as I have said to my colleagues on the other side of the aisle—I see Senator BUNNING, and he and I have worked together on the Finance Committee—our colleagues on the other side of the aisle make important points with respect to choice, with respect to markets, with respect to competition. This is an area we can work on together.

There is nothing partisan, in my view, about creating a new health care marketplace through these exchanges. This bill lays a foundation, and there will be opportunities for Democrats and Republicans to build on that foundation in the days ahead.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. BUNNING. Mr. President, what is the current order of business?

The PRESIDING OFFICER. The Republicans control 29 minutes at this point.

Mr. BUNNING. Twenty-nine minutes?

The PRESIDING OFFICER. Yes.

Mr. BUNNING. The order of the day would be the Defense appropriations bill?

The PRESIDING OFFICER. The Senator is correct.

Mr. BUNNING. Thank you very much.

Mr. President, I rise to talk about the 2010 Department of Defense appropriations bill. There are several parts of this legislation I would like to discuss. But first of all, I would like to talk about the process the majority has used for this bill.

This past weekend, we passed an omnibus bill that jammed together six different appropriations bills. I had high hopes that this year we would not have to resort to an Omnibus appropriations bill. We have done it in the past. I was hoping this year we would not. I hoped we could go through regular order and give each bill the time and attention it deserves. In fact, I think we could have done that if we were not spending so much time on the floor with this monstrous health care bill. We have had a lot of floor time but not much action on health care. However, earlier this week, we passed a bill containing all the remaining appropriations bills, except the one for funding the Department of Defense.

Why was this done? Why was this bill left for last? It was done because this bill was used as a political football. The majority felt that because this bill contains important funding for our troops, they could attach unrelated provisions to it and then insinuate that anyone who has concerns about these provisions and tries to slow down the bill to look at them is jeopardizing our fighting men and women. In fact, some Members of the majority have made those claims this week.

My question to them is, why didn't the majority include the appropriations for the Department of Defense in the omnibus we just passed? The funding for our troops could have been signed by the President and made into law by now. However, the majority wanted to use this funding as a political hammer. This is not right, and the American people should know what is really going on here. Our troops deserve better.

I wish to talk about some of the provisions contained in this bill, beginning with the detention facility at Guantanamo Bay.

The bill before us does provide that no detainees from Guantanamo may be released into the United States. It also does not provide funding for the closure of the Guantanamo detainee facility. These are good provisions, but they are not good enough. This bill does not prevent sending these prisoners to the United States for trial and housing them in our own backyards. It would be much improved if it contained a complete ban on moving them to the United States.

On January 22, 2009, President Barack Obama signed an Executive order to close the detention center at

Guantanamo Bay. I am against the shutting down of that facility. It is absolutely irresponsible to order this closure and not have a plan in place to address what the United States will do with all the detainees held there. Under no circumstances should they be brought to the United States. The terrorists housed at Guantanamo Bay are the worst of the worst. I have personally visited these facilities and met with the brave men and women who guard these detainees. As long as the terrorists remain housed at Guantanamo, they cannot harm us or any of our allies. However, the administration has seen fit to push ahead on sending Guantanamo detainees to the United States. In fact, we learned they now plan to send some of the most dangerous terrorists in the world to Illinois. President Obama could not bring the Olympics to Illinois, but it looks as though he will bring terrorists there instead. The plan appears to be to use a currently empty supermax facility in northwestern Illinois to hold Guantanamo detainees.

I think bringing these terrorists to the United States is a terrible idea. First of all, there are serious legal problems associated with bringing these terrorists to our soil. The Supreme Court has noted that it is "well established that certain constitutional protections available to persons inside the United States are unavailable to aliens outside of our geographic borders."

The nonpartisan Congressional Research Service said that "noncitizens held in the United States may be entitled to more protection under the Constitution than those detained abroad." This means they could be afforded extra rights which are available to American citizens. They could include protection under the fifth amendment due process clause, which would cover how they are confined, or they also may raise claims regarding religious practices.

Furthermore, while the Obama administration may not have the intention to release any detainees, their wishes could be overruled by a civilian judge. Guantanamo detainees who are cleared for release have, in fact, petitioned the court to be released into the United States. Last year, a Federal judge even approved such a request before being overruled by an appellate judge. The reason the higher court cited for overturning the ruling was that the government could not be forced to accept someone into the United States from outside the country. If we start bringing detainees to the United States, this legal safeguard will be removed.

Throughout the debate on whether closing Guantanamo is good policy, supporters of the idea have consistently maintained that the facilities serve as a lightning rod for anti-U.S.

sentiment and that it is used as a recruiting tool for terrorists. I don't buy that argument. I would argue that the greatest recruiting tool for these terrorists is the United States itself and our way of life with democracy and freedom of religion. What if it was found that the Statue of Liberty was being used as a symbol to incite attacks on our country? Would we tear it down? Of course not. The United States has suffered many terrorist attacks prior to the opening of the Guantanamo Bay facility, including the horrific events of September 11, 2001. If we close this facility, then those who hate us will simply find another tool of motivation for their followers.

The bottom line is that the Guantanamo Bay detention facility works and we are putting ourselves at a disadvantage by not using it. I wish this bill had taken a stronger position on making sure this facility is not abandoned.

As everyone here knows, this bill also provides further funding for the wars in Iraq and Afghanistan. I was glad to see that the President finally announced a plan for Afghanistan earlier this month. We waited far too long for this decision. I was very concerned that this wait was unnecessary and was putting the lives of our servicemembers at risk. I am glad he finally heeded the call of our commanders on the ground for more troops. In fact, I agree with the bulk of his strategy for waging the war in Afghanistan.

However, I strongly disagree with him on one particular issue. I have serious concerns about the administration's decision to set a timetable for troop withdrawal. I could not disagree more with the announcement that U.S. troops will begin leaving Afghanistan in July of 2011.

What makes this situation even more confusing is that the announcement also claimed that any withdrawal will take conditions on the ground into account. This is puzzling and it is a contradiction. What will the administration do if conditions on the ground dictate that no troops be removed from Afghanistan? Will it proceed with a withdrawal anyway? I don't want to keep any of our brave men and women in Afghanistan any longer than absolutely necessary, but we have work to do. Leaving before it is done is unacceptable.

By announcing an arbitrary deadline for our forces to come home, possibly before the job is done, the President is telling our enemies how long they will have to hold out and wait until we leave. They will bunker down and emerge after we are gone. It is unimaginable what the horrible consequence of this would be. I was glad to see this strategy rejected in Iraq, and it is no less foolish to apply it to the war in Afghanistan. I fear we could be setting our efforts up for defeat and putting our fighting men and women in

further danger, and I am deeply troubled by this.

While I strongly oppose President Obama's notion for a timeline for withdrawing from Afghanistan, I do support his call for a surge of troops to stabilize the country. We learned a great deal from our counterinsurgency strategy implemented by GEN David Petraeus and Ambassador Ryan Crocker in Iraq. He knew that if the U.S. forces spent most of their time only in a small protected area such as the Green Zone in Baghdad, then little would be accomplished.

The surge in Iraq was successful not only because there were simply more troops in Iraq; it was what they did that mattered. By simply going out into insurgent areas and being more visible, this gave reassurance to the local populations that Americans were still around, but it did not stop there. Previously, coalition forces would clear an area but then retreat. This time, they were there to stay.

Our soldiers became involved with the local communities, assisting with infrastructure and even doing things such as helping to set up farm cooperatives. The strategy evolved from only clear, to clear, hold, and build. Soon, our forces had the trust of the locals. The citizens of Iraq began to help with the stabilization and rebuilding of their country. They began to cooperate with our military efforts and help us fight insurgents. Before, they were scared and powerless. Now they were safe and had the ability to make their lives better. These conditions have made it very difficult for our enemies to operate. It is now time to apply these lessons to Afghanistan. It is time to clear, hold, and build there.

It is unfortunate but true that the Afghan Government suffers from a deplorable level of corruption. However, it will not do us any good to refuse to help until things get better. This is because they won't get better without our help. The citizens in Afghanistan by and large do not trust their government, and this creates an atmosphere that is very helpful to our enemies. When our forces move into communities, they create stability and undermine insurgent forces and corruption.

Use of the proper strategy can help improve the government, as we have seen in Iraq. However, if it is not improved, then the people will never trust it and it will not protect them. They will have no choice but to comply with the wishes of the insurgents. Eventually, the government will slide into chaos and the Taliban and al-Qaida will return to power. We cannot let this happen. A return to Afghanistan's previous status as an unhindered launching pad for global terrorist plots is totally unacceptable. We know all too well what the consequences of this are. However, it could possibly get even worse than that.

We have seen the difficulties Pakistan has had in fighting the Taliban on its own soil. Currently, U.S. and NATO forces are fighting and hopefully soon beating the Taliban and al-Qaida in Afghanistan. If we were to leave before finishing the job, the result could be disastrous for Pakistan. A Taliban-controlled Afghanistan would be a sanctuary and staging point for the radical Islamist terrorists to attack from. Pakistan is a nuclear power, and its fall to these groups would be utterly catastrophic.

Victory in Afghanistan is essential.

We learned a lot from the Bush administration's revised strategy for Iraq that put that war on a path to success. It would be a shame if we did not apply those hard-learned lessons to the current conflict in Afghanistan.

As I mentioned at the beginning of my remarks, this is a large bill—larger than it had to be. The use of this Defense appropriations measure as a political football is why it is so big. I think it is a shame that the majority chose to legislate in this manner.

We did not need to do it this way. It is probably too late in this process for us to fix this mash-up of different bills and give all of these issues the individual attention that they deserve. However, hopefully, next year will be different. Hopefully, the majority will not try to once again politicize the bill that is supposed to be about funding our military. Hopefully, they will not hold this bill back and wait until the last minute like they did this year. It is the responsibility of the majority to set the schedule of the Senate.

We will see this time next year if they are still devoted to playing politics with the funding of our troops. I sincerely hope they are not.

I yield the floor.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Ms. MURKOWSKI. How much time remains on our side?

The PRESIDING OFFICER. There is 10½ minutes remaining.

Ms. MURKOWSKI. Mr. President, I rise to speak today on H.R. 3326, the Defense appropriations bill for fiscal year 2010. I appreciate all of the hard work that goes into the formulation of this bill and commend the leaders of the Defense Appropriations Subcommittee, Mr. INOUE and Mr. COCHRAN, on an outstanding product.

It is a product that does justice to the men and women who wear the uniform of the United States in defense of peace and liberty. It is a product that does right by our military families who we must never forget also serve.

I would like to take a few moments to share some comments about what this bill means for the fighting men and women in my State of Alaska. Alaska is home to about 21,000 men and women who serve on active duty. Add to that number approximately 4,700

members of the National Guard and Reserves.

The bill that is before us supports the soldiers of Fort Richardson, Fort Wainwright and Fort Greely; the airmen of Elmendorf Air Force Base, Eielson Air Force Base, Clear Air Force Station, and 18 radar sites in remote, rural areas of the State; the Marine detachment hosted by Elmendorf Air Force Base; and Naval Special Warfare Center Detachment in Kodiak.

It supports units big and small. Units like the 4th Airborne Brigade Combat Team, of the 25th Infantry Division based at Fort Richardson near Anchorage which number in the thousands of troops.

The 4th Airborne Brigade Combat Team is known as "the Spartans." This Spartan Brigade will be spending Christmas in Afghanistan.

Also in Afghanistan this Christmas are 11 members of the Alaska Air National Guard 176th Wing who left Anchorage on November 5 after serving an early Christmas.

We wish you well this Christmas. We are thinking about your families and we collectively pray for your safe return.

Mr. President, I mentioned Christmas. We know that we are upon the holiday season, although in this Chamber it certainly doesn't feel that way. There is no sense of giving and sharing and the general cooperation and cheeriness that comes—at least in my family—with the holiday season.

I think we have to also, as we approach the holidays, think about what is going on throughout the country as we face an economic recession. Families are choosing to do differently this year. They are squeezing back on their family budgets, and they are making some different choices—some hard choices. I think it is fair to say that folks are probably looking at us in Congress and saying: We wish they would be doing more of the same, making some of these hard choices when it comes to spending.

To put it into context in terms of what we have seen in Congress this past week or so, last Sunday—less than a week ago—we passed a \$1 trillion-plus spending bill. These were six different appropriations bills, and three of those six bills were not subject to Senate amendment and debate. We went above and beyond the regular order and produced an omnibus package. Again, it was a package in excess of \$1 trillion in spending or about a 12-percent increase over the previous year.

Shortly before that, about a week prior to the action on the omnibus, the EPA, the Environmental Protection Agency, issued an endangerment finding. This endangerment finding—for those who are following this issue, I think many recognize that the potential cost to this country, the financial burden that could be placed on this

country if we advance through the regulatory process, as opposed to the legislative process, these regulatory burdens, I think it is clear the costs and impact to this country and our Nation's economy are truly dangerous.

When we talk about an endangerment finding coming out of EPA, it is just that—it endangers our economy, it endangers jobs, and it endangers the competitiveness of those of us in this country.

Again, people are looking at this and saying: What is going on in Washington, DC? Don't they realize we need to be working to save and create jobs? We need to do positive things that will help us as a nation and our economy, not those things that legislatively, or through regulation, would hurt us.

Now we are in the midst of trying to move through a health care bill in the final days before Christmas—a \$2.5 trillion reform package that, at this point in time, we are not quite sure what is in it. But when it is revealed, it is possible we will have about 36 hours to review it, to understand it, and to appreciate the implications for us in our States and the impact to our economy.

Again, one of the aspects we do know about this is that the framework we are operating off of is one that will increase taxes on small businesses and individuals in this country. It will cause cuts to Medicare at a level that is incomprehensible, almost $\$1\frac{1}{2}$ trillion. For all that we can tell, it is going to increase premiums.

Alaskans are looking at this package and saying: This isn't the reform we thought the Congress was going to be giving us.

Following on the track of the spending, we are going to be discussing increasing the debt limit. Again, people in the rest of the country are wondering: What is going on in Washington, DC. What is in the water that is causing them to spend at levels that are almost uncontrollable?

Our reality is that you and I are not going to be facing the financial consequences in the outyears so much as our children. During the holiday season—I have kids, and I still try to keep their presents secret. So I have a tendency to rat-hole them away, hide them.

The one thing we cannot hide from our children this Christmas is the fact that what they will be receiving is an incredible debt. That is not a "gift" that we can afford to give our children. When it comes to the discussion about the health care bill and the consequences of it, there have been a great number of journalists who have been opining and commenting. We certainly have kept the press busy with this.

There was an article on the opinion page in the Washington Post a couple days ago by Michael Gerson. He made a statement that I would like to read. He states:

The entire Democratic health reform effort is foundering, as its deep bow enters the

shallow channel of fiscal reality. And that splash you hear is the sound of various groups being thrown from the ship to lighten the load. Instead of beginning with affordable, realistic objectives, President Obama and the Democratic Congress set the goal of guaranteed, comprehensive coverage for everyone. This requires a lot more money in the system, which must come from someone.

Then I go to an article in this morning's Hill magazine. For this one, the headline is "Senate Plan to Tax Health Plan is Bad Policy." It starts off:

Millions of working Americans will pay thousands of dollars more in taxes under the Senate proposal that taxes healthcare benefits to finance reform.

According to the Congressional Budget Office, this excise tax will affect one in five Americans.

Millions more will have their health benefits cut and see their costs go up. This is the opposite of healthcare reform.

You might think that was an article that I might have written or that some of my Republican colleagues wrote. Actually, this article was penned by Jim Hoffa, who is the Teamsters' general president, and Mr. Larry Cohen, the president of Communication Workers of America.

Mr. President, my point in saying this is that as people understand more and more about what is contained within this health care legislation, they are coming to understand the impact to them and to their families. They are quite anxious because they know that as the years go out, the costs don't go down, the costs only go up.

We are concerned in Alaska about access to care. I have stood on this floor many times and talked about how, in Alaska, we simply do not have the Medicare providers that we need to see the people in my State, particularly in our largest communities. We just learned that one of the medical clinics in Anchorage has made an announcement. They issued a letter to their patients saying that Northwest Medical had four practicing physicians who were seeing Medicare patients earlier this month, and three of the four physicians opted out of Medicare, resulting in 550 Medicare beneficiaries being without a physician.

What is happening is that they are calling us for a doctor's appointment. The problem is that we can't get them in anywhere either. We have one facility in Anchorage where they are taking new Medicare-eligible individuals. When we did a count—the institute of economic research did a count as to how many providers in Anchorage, AK, were taking new Medicare individuals. It was 13. We heard from a provider just last week that she is opting out. These three make a total of four. This is simply not sustainable.

For us as a Senate and as a Congress to be moving forward in the name of health care reform, any provision that will further jeopardize access for the people of Alaska or the people of rural

America or all over this country, that we would do anything that would jeopardize their access is foolish. It makes no sense.

We must stop this reform effort. We must do our job in Congress to provide the people of my State, and all of our States, real health care reform that reduces the cost, provides for access, and does right by the American people.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Ohio is recognized.

Mr. BROWN. Mr. President, as we near Christmas, our troops are overseas, away from their families during this holiday season, facing dangers most of us cannot even contemplate. Many in this Chamber have long supported the wars in Iraq and Afghanistan, but the loudest supporters of war today are leading the charge in trying to block the Defense appropriations bill.

It is irresponsible, plain and simple, to play politics with the funding of our troops. It is a disservice to them. It is a disservice to their families. It is a disservice to our great country.

We do not agree on health care reform. I understand that. I get that. But to hold up the funding for our troops, I do not get that. This bill funds our overseas military operations and provides our troops with a hard-earned pay raise. It includes funds for joint IED Defeat Fund, Mine Resistant Ambush Protected Vehicles, so-called MRAPs. It provides equipment for our National Guard and Reserve.

The tired politics of delay and distraction offered by my Republican friends does a disservice to our troops, to their families, and to the Nation.

It does a disservice to the millions of Americans also who would benefit from the provisions of the Defense appropriations bill that would extend the COBRA Premium Assistance Program.

This month, thousands of Americans—hundreds in the Miami Valley were hit so hard, where in the Dayton area they were hit so hard from DHL to General Motors to NCR to the suppliers for those companies, hundreds and hundreds in the Mahoning Valley, where people in the Washington Post read about Warren, OH, what happened to people there with this terrible recession.

It is a disservice to hundreds all over my State who saw a 65-percent spike in their monthly health insurance premium. That is because the 9-month COBRA subsidy—one of the things we did right earlier this year. The government has never stepped in to do that to help people in tough times with their health insurance. The 9-month COBRA subsidy started phasing out in December.

COBRA provides a much needed health insurance option to those Americans out of work. It allows workers to stay on their previous employer's

health plan for 18 months, but it could be prohibitively expensive. That is why I introduced a bill 11 months ago—the Coverage Continuity Act—to provide a health insurance subsidy to laid-off workers. They simply cannot afford COBRA without it.

Remember, COBRA is the health insurance program where if you lose your job, you can keep your same health insurance. You continue to pay your own premium, but you have to pay the employer contribution. If you have lost your job, it is pretty hard to do that, putting it mildly.

This, for the first time, gives a very generous subsidy so people can keep their insurance. A version of that proposal I introduced in January was included in the stimulus. It provided a 65-percent subsidy toward the price of a COBRA premium for recently laid-off workers.

Now that subsidy has expired for some. It is about to expire for many more. Nearly 16 million Americans are out of work still and 14,000 lose their health insurance every day.

When I hear my friends on the other side of the aisle say: You have to slow down on health reform, we don't want to do this too fast, they need to go back to their States. I hope they get some time off at Christmas. I hope, after they spend time with their family, they go out and start talking to people getting hurt by this recession. They are not hard to find. They are in every neighborhood in every community in every State—people who lost jobs and are losing their health insurance.

In Ohio—from Toledo to Millard to Mansfield to Ravenna, Gallipolis—350 Ohioans every day lose their insurance. Across this country, 1,000 people a week die because they do not have health insurance. Mr. President, 1,000 people a week die because they do not have health insurance. Yet too many people in this institution, too many people think we have to wait.

They need to know, when you think about 1,000 people dying every week without health insurance in this country, they need to understand a woman with breast cancer is 40 percent more likely to die if she does not have insurance than a woman who has breast cancer with insurance. If that is not reason enough for them to get on board and stop their delay tactics and quit saying: Let's slow down; let's slow down, it clearly has not worked. That is why the COBRA extension is so important. The extension is similar to one included in S. 2730, the COBRA Subsidy Extension and Enhancement Act, which I introduced with Senator BOB CASEY in November.

The bill before us will ensure Americans receive the COBRA subsidy for 15 months, not 9. It means that most workers who first started receiving the subsidy last March when it started will

continue to receive it until May of next year.

It extends the day on which you can be laid off and still be eligible for the subsidy. Under current law, only those who lose their job in the next 2 weeks will be eligible. We need to extend that eligibility window at least to February of next year. This will help Americans, such as Don Hall from Castalia, OH. Castalia is a community west of where I live near Sandusky, OH, in the north-west part of the State.

Don was laid off from an auto supplier in October of last year. As severance, the company gave him 6 months of paid COBRA coverage and then he became eligible for the premium assistance program we included in the stimulus.

However, his ninth and final subsidy payment came through in November. He is still out of work. Earlier this month, on December 1, he and his wife were charged \$763 for their coverage, up \$500 from the month before. He was paying about \$250. Now he is paying \$763. Don is also fighting to save his house from foreclosure. He has cut back as much as he can, but he doesn't want to stop paying for a cell phone because that is his only way for potential employers to contact him. He has had six job interviews in the last 13 months. None have panned out because there are not enough jobs in Castalia, Sandusky, Toledo, and Lorain.

Don worked hard and played by the rules. Similar to so many American men and women, he is experiencing hard times and needs some help. They on the other side of the aisle say: Let's slow down; we have to slow down.

For Don, slowing down means the loss of his house. It means he is more likely to get sick and ruined financially because they want to slow down.

Don's story is not unique. Take Tim Wolfrum from Milford, OH. His COBRA subsidy is scheduled to expire at the end of December, at which point he will owe \$417 a month. That is nearly as much as he receives in unemployment benefits.

When Tim started shopping around in the individual market knowing he would be forced out of COBRA, everything he found either had exorbitant premiums or bare-bones coverage. That is because Tim suffered a heart attack 2 years ago and suffers from a digestive disease. These preexisting conditions made him a liability for private insurance companies.

Tim is confident he can find a job once the economy picks up. But in the meantime, he needs the COBRA subsidy.

Carol Williams from Dayton, OH, is in a similar bind. She is 63 years old and was employed at R.J. Reynolds for 18 years before being laid off in October of last year. She started receiving the COBRA subsidy in March but was responsible for the entire premium this month.

Remember, COBRA is what you were paying when you were employed. If you lose your job, you continue to pay COBRA to keep your insurance and you also have to pay your employer's contribution. Almost nobody can do that after they have lost their job for very long. That is why the subsidy we put in the stimulus package back in February and that is why the subsidy we want to put in this Defense appropriations bill is so darn important to so many Americans.

Because Carol remains unemployed and suffers from minor thyroid problems and high blood pressure, her insurance options are limited.

She decided to pay the full COBRA premium in December, with the hope that Congress will act to extend the subsidy. Here is her calculation: While they delay, while they say: Let's slow down, on the other side of the aisle, Carol says: My premium went up several hundred dollars. If I cancel, I will never have insurance. If I dig deep and do not heat my house as warm, do not eat as well for the next few weeks, I will pay more and hope Congress passes this so she can get that better rate again.

That is what delay says; delay for their little political reasons and the little political games and tricks the other side of the aisle is playing, such as they did at 1 o'clock this morning, puts Carol Williams in a position where she has to make those hard decisions. I wish some of my friends on the other side of the aisle would meet the Carol Williams of the world. I wish for 1 day we could walk in the shoes of the Carol Williams of the world and see the kind of horrible decisions they have to make because they want to play their political games.

Let's not let Carol down and Don and Tim down. Let us in this Chamber hear their cries. I hope they hear the cries of thousands of people in Helena, Kalispell, Wilmington, Dover, and all over this country. It is too important for us to fail.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I thank my friend from Ohio for his statement, for two reasons. It is very much on target and, second, a couple towns in my state of Montana have the same problems that some of the towns in his State of Ohio have. We are all in this together. So many people and so many towns all across the country need health care coverage or are denied coverage because some insurance company has said they have some preexisting condition.

I thank my friend for his statement.

The Defense appropriations bill before us provides essential support for American troops fighting for our freedom abroad. The bill before us also continues crucial safety net programs

for American families, for those families struggling with tough economic times here at home.

What our colleague and former majority leader, ROBERT C. BYRD, said in 1988 remains true:

Without economic security, we cannot have national security.

Millions of jobless Americans struggle for economic security every day. Even people with jobs are seeing their paychecks stretched.

For every six unemployed workers, there is only one job opening—only one for every six unemployed. We need to continue to work to help create jobs. We also need to address the challenges that unemployed Americans are facing right now. This bill takes action to help Americans who are seeking jobs.

Without this bill, the three unemployment insurance provisions established or continued by the Recovery Act that we passed at the beginning of the year will expire in 2 weeks. If we don't pass this legislation, unemployed Americans will not be able to apply for new unemployment insurance benefits after December 31, and those who are currently receiving benefits will lose this vital help.

The loss of these benefits will be devastating to many Americans, including a young father in my home State of Montana from whom I heard recently. He was working hard to support his family at a carwash in northwestern Montana. Then he was laid off. Since then, he has simply been unable to find work.

His work situation only adds to his concerns because he recently lost a child to sudden infant death syndrome, and his wife is now pregnant with another child. They are living in a house 20 miles out of town. They heat their house entirely by burning wood because that is all they can afford on his unemployment benefits.

Without this bill, his benefits would run out in 2 weeks, and his family would be left in the cold while he struggles to try to find work.

This bill would extend emergency unemployment compensation for 2 months. That program provides additional weeks of unemployment benefits for out-of-work Americans, such as my western Montana constituent, during this period of high unemployment.

The bill would also provide 2 additional months of extended unemployment benefits. Those benefits provide targeted assistance to areas of our country that have been affected by particularly high unemployment rates.

The bill includes a 2-month extension of the Federal Additional Compensation Program. That program increases all unemployment benefits by \$25 a week. Together, these provisions will protect unemployment benefits for roughly 2 million Americans. Those are people who would lose unemployment benefits if we do not pass this bill.

These extensions would provide much needed economic security for Americans who are struggling to find work in these uncertain times.

I do not think enough of us realize the depths of angst people suffered when they are out of work and trying to find work and when potentially their unemployment benefits, which help a little bit, might not be extended.

In addition to the critical unemployment insurance extensions in this bill, this package also includes an extension of what people call COBRA. What is that? That is assistance that helps unemployed Americans and their families to maintain their health care coverage.

When workers lose their jobs, they lose more than just their paychecks. Unfortunately, they also lose their ability to afford health insurance coverage as well.

To address this problem, the Recovery Act we passed earlier this year provided assistance to help their families to pay for health insurance while looking for a new job.

Fortunately, in most cases, workers who lose their jobs have the right to keep their employer health care coverage for up to 18 months under the COBRA program. It is called that after the name of the Consolidated Omnibus Budget Reconciliation Act that set up the program. That is why it is called COBRA. To be eligible for COBRA health benefits, workers typically had to pay all the premium costs, plus an additional 2 percent for administrative costs.

Can you believe that? People laid off have to pay all the costs, plus an additional 2 percent. That is a penalty. It is not a gift. It is not assistance. It is a penalty.

Paying the full premium, plus administrative costs, is simply more than most families can afford when out of work. It is just plain wrong that we even had that in the law in the first place.

Fortunately, this provision, the COBRA provision in the Recovery Act, provides relief to struggling workers. And what did it do? It made a change. That provision covered up to 65 percent of health premium costs for up to 9 months for unemployed Americans. Previously, it was zero percent, and now it is 65 percent of health premium costs for up to 9 months for those who are unemployed.

This premium subsidy has made a real difference in helping unemployed workers and their families maintain health insurance. Roughly 7 million Americans have benefited from this assistance. The bill before us today would extend that for another 6 months for those who remain unemployed. In addition, the legislation would offer similar assistance to people who lose their jobs between now and the end of February.

This assistance is the right prescription for families in these tough eco-

nomic times. For many Americans who have lost their health coverage because they have lost their jobs, this benefit provides critical help to ensure they can get their health care when they are in need.

This bill also protects access to health care for seniors and military families. The legislation would ensure that doctors will not suffer a reduction in payments for their services. The bill would reverse planned cuts to physician payments under what is called the sustainable growth rate, otherwise known as the SGR. Blocking cuts to doctors' payments would keep health care available to seniors in Medicare, and it would help keep health care available to military families insured by the TRICARE program. Without this provision, Medicare and TRICARE providers would see a 21-percent cut in their payments. That could make it difficult, obviously, to continue to participate in the program. Doctors say they can't do it. They are not going to participate.

I am committed to finding a permanent solution to the flawed payment formula that has caused this cut. In the meantime, this bill would make sure our physicians in Medicare and TRICARE will not face deep, unfair cuts. This bill would help ensure they can continue to care for our seniors and military families—another reason this legislation is so important. Not only does it help fund our troops, but all these other benefits are here, those I am outlining, which make a big difference and mean so much to so many people, basically people who are out of work in these tough economic times.

The bill also includes a provision to protect access to critical safety-net programs for low-income families who would otherwise lose those benefits in already tough economic times.

This legislation would hold the poverty level constant at the 2009 level. That would prevent a decrease in the year 2010, because prices went down this last year. This legislation would thus keep struggling families, who are right at the poverty line, from dropping off of critical safety-net programs. To keep up with the rising cost of living, the Federal poverty level is adjusted for inflation each year. Because of the great recession this year, prices actually went down. There was what is commonly called deflation instead of inflation. As a result of this deflation, the Federal poverty level could actually be lower in 2010 than it was in 2009. That means American families right at the poverty line, who rely on programs such as Medicaid, home heating assistance, and food stamps, could actually lose their access to these vital services even though they did not have any additional income. This legislation would allow families who qualify for safety-net provisions today to stay on those

critical programs if their circumstances don't change. These families cannot afford to bear any additional hardship in this recession, and this provision would ensure they do not lose the vital services they need to keep them afloat.

This bill also extends vital funding for the repair and maintenance of our roads and our bridges. This would save hundreds of thousands of highway jobs. These are jobs that pay well and jobs that cannot be shipped overseas. This provision provides a 2-month extension of Federal highway funding—not very much but 2 months is better than no extension, and that will allow important repairs to America's roads and bridges to continue so we can, next year, pass a meaningful highway program, a multiyear program, hopefully 4 or 5 or 6 years.

Without this provision, this 2-month extension, the Federal Highway Administration and construction projects across the Nation will be forced to shut down, taking thousands of jobs along with them. The safety of our Nation's roads and bridges is vital. And at a time when unemployment is already more than Americans can bear, we cannot afford to lose hundreds of thousands of good highway jobs. These provisions make sure we don't.

Economists have seen some signs that the economy is starting to recover, but many American families, unfortunately, continue to struggle. This legislation will provide vital support and services that the economy and American families need to get through these tough times. Working together, we are going to get this economy back on track. Passing this bill is part of the answer. Passing this bill is important for both our national safety and our economic security. I urge my colleagues to support this vital legislation.

Mr. President, I yield the floor, and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BOND. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BOND. Mr. President, earlier this month President Obama renewed his commitment to the counterinsurgency on a "clear, hold, and build" strategy for Afghanistan. As I have said several times before on this floor, I believe this strategy will allow our troops to return with success and put Afghanistan on the road to stability. But, as I have also said, when you go into a war, when you launch a major effort such as this involving tens of thousands of Americans who will be putting their lives on the line, we must go in with an attitude of success. We are going in to suc-

ceed. Let's be clear about that. We must succeed in Afghanistan unless we are to face the kinds of risks we faced on 9/11.

Harking back to the early 2000s when the Taliban ruled Afghanistan. Their friends from al-Qaida came into Afghanistan and used it as a ground for recruiting, training, issuing command and control, and preparing for attacks. From that part of Afghanistan came the directions and the leadership for the tragic attacks on 9/11.

As President Obama has said many times over, fighting in Afghanistan is the war of necessity. It is one we cannot fail to win because we have seen what happens when Afghanistan falls into Taliban hands.

I happen to disagree with him because Iraq was the next featured spot for al-Qaida, Osama bin Laden, and Ayman al-Zawahiri to go. We had that from the Clinton administration. Their intelligence chief, Security Chief Clark, said that when we drive Osama bin Laden out of Afghanistan, he will boogie to Baghdad. That is what all of the information we saw in the intelligence committee indicated. They wanted to make Iraq—Baghdad—at the confluence of the Euphrates and Tigris Rivers, headquarters for their operations. They call it the Caliphate.

We went in and cleaned out Saddam Hussein, who was a vicious, murderous tyrant. We didn't find any weapons of mass destruction. People said we didn't need to go in. However, in the intelligence community, we found out that, No. 1, the intelligence was off base. They made assumptions they should not have.

But we also sent in the Iraq Survey Group, headed by David Kay, who went in to look at the conditions in Iraq and found out what those conditions were prior to our going into Iraq to clean out Saddam Hussein. The conclusion Mr. Kay and his very skilled team came to was that Iraq was a far more dangerous place even than we knew. There were terrorist groups running around in there.

Abu Mus'ab al-Zarqawi, who later became famous for beheading Westerners he captured, on television, for the edification of his twisted viewers, had a group called Ansar al-Islam. That group later morphed into al-Qaida and became al-Qaida in Iraq.

Fortunately, very good intelligence work and the administration of a shot from a listening pod on an Air National Guard F-16—and I am proud to have been a sponsor of earmarks to put listening pods on Air National Guard aircraft—wiped out Abu Mus'ab al-Zarqawi.

At the same time he was running around, he was looking for weapons of mass destruction. There is no question that Iraq had used weapons of mass destruction before. He had used them against the Kurds, his own people. He

had the facilities to produce them. He had the scientists to produce them. He had the recipes to produce them and what we call a just-in-time inventory system. He could have started up chemical or biological weapons of mass destruction, had he not been taken out, and turned them over to terrorist groups.

In Iraq, we successfully took out Saddam Hussein. Then we tried to prevail with a counterterrorism strategy. That is where you send in some of our elite forces and you take out the leaders of al-Qaida. Then you go back to your base. The problem we found was that once we left, al-Qaida would come back.

Insurgency is different from a regular war. They would come back in. If anybody cooperated with the American forces, they would kill them or torture them first and kill them or even torture their families in front of them and then kill them. So we knew things were not going right.

President Bush chose, with Secretary Gates—he and Secretary Gates chose GEN David Petraeus, who was a real scholar. He happened to have gone to the same college I went to, but he was a real scholar. He had developed a counterinsurgency strategy that he believed was the only way to deal with insurgency, so they instituted the "clear, hold, and build" approach in Iraq. They would send in the troops and clear out al-Qaida. Then they would embed or lock down with the Iraqi forces there. That way, they could maintain the security of the area. People would not dare come back in with American and Iraqi troops there.

My son happened to see both sides of that. He was there in 2005, in the ground intel operation in Fallujah. They found that the locals were not interested in working with the Americans. We now know why. They were very fearful for their lives if they did.

The second time he went, he went in with the 2/6 Marines, who drove al-Qaida out of Al Anbar Province. His scout snipers were assigned to capture his old stomping ground in Fallujah. They did it, and the difference was dramatic.

By that time, General Petraeus had set up the Sunni citizens watch, working with the Iraqi Government. They had the Sunni police. When they went in, they immediately started recruiting young Sunni men to serve in the police force in Fallujah. They offered people who had injuries medical help. They offered assistance for those who needed reparations, who had damage. They got that done.

Within a month, my son said, the marines were not all needed, they were not active, because when somebody brought in an IED, an improvised explosive device, or an AQI—al-Qaida in Iraq—person came in, the Sunni citizens watch would turn it over to the

Sunni police and they would take care of it.

That is why we have made the progress, despite what some on this floor said—that the war is lost; we can't win it; we ought to withdraw. The counterinsurgency strategy worked.

When we moved into Afghanistan, we found that in the years since we had driven the Taliban out, we turned the task of keeping Afghanistan stable and secure over to NATO. NATO forces, regrettably, were not adequate. They employed a counterterrorism “fire and fall back” strategy, or even less. Some rode around in armored vehicles during the daytime and went back and had tea in the late evening. The Taliban owned the evening.

So when GEN Stan McChrystal went there, he was assigned by President Obama to carry out his strategy. The President outlined a very clear strategy, which was, we need a counterinsurgency strategy, clear, hold, and build—what I refer to as “smart power.” You need military force, but you need economic development assistance, whether it be medical or governance assistance. You need to help people develop a better life. He tasked General Petraeus to do that.

General Petraeus outlined a strategy—he outlined it in August; we first saw it then—and he outlined a good strategy. He said he needed 40,000 troops. Since the President has said he is going to send 30,000, he has cut back on the objectives. He believes that will work.

We are now getting the troops there. It is going to take time to get the troops there. I wish we had started 3 months earlier because we had been losing ground until we got the additional troops in. But he started getting the troops there.

I believe we can provide stability and security in Afghanistan. Are we building a nation? No. But we are building stability and security. Before you can have a nation, before you can even have a working economy, you have to have security. You have to make sure the insurgents, the Taliban or occasionally their friends from al-Qaida, do not come back in and take over the area and destroy your crops.

Previously, the Taliban had cut down all the pomegranates. Afghanistan was the breadbasket for that part of the world. They had destroyed agriculture so that only their colleagues in the drug trade could control the land. That is where a significant amount of the money for funding the Taliban has been coming from, poppy production and the drugs it produces.

That process is ongoing. But we have found some test markets where that has worked. I was told by then-General Eikenberry in January 2006, and echoed by President Karzai, that they needed extensive agents from America to help them rebuild their agriculture. I tried

for 2 years. With the help of my colleagues on the Appropriations Committee, we twice appropriated \$5 million to the Department of State to get the USAID to send in extension agents. With \$10 million, absolutely zero people went, as far as we know. So in 2007, I worked with the Missouri National Guard, good friends of mine. They sent a survey team over and said: We can help. In early 2008, they sent a 50-member agricultural development team to Nangarhar Province, Jalalabad. It was the No. 2 poppy producing province in the nation, but they had an excellent Governor. They wanted to work. So the Guard team went in. These were trained soldiers and armed airmen and women who knew how to fight in a battle. But they also had agricultural backgrounds in their day jobs, in civilian employment. They were farmers, agronomists, soil specialists, foresters, food processors, veterinarians. They went in and helped the farmers of that province rebuild their agriculture.

By the end of the growing season in 2008, President Karzai said they had made a tremendous difference. He said it was one of the great successes. Ten more National Guard teams are going. In December of last year, when I was there, before I went out to Nangarhar, President Karzai served us a wonderful dinner including broccoli from Nangarhar. I found that not only did they have security but poppy production in Nangarhar went from being second highest in the Nation to almost zero. We now have our third Missouri National Guard team over there. They are planning on going 7 more years, because they want to continue that partnership. Guard units across the Nation are lining up to partner with other provinces.

This is a great model. Unfortunately, it is not enough to have Guard forces there. We have to have a national security budget that includes the civilian side, the economic and development side, the agricultural side, the educational side along with the military force. That is one of the things I am worried about. We have to make sure that we get the “build” side of clear, hold and build, of smart power working in Afghanistan. We cannot expect them to maintain their security if they don't have a way of earning a good livelihood. Make no mistake, they are earning a better livelihood with legitimate crops than they were with poppies. They are not bowing down to the drug lords or to the Taliban. Most of all, producing flowers for drugs was against their religion so they are happier. But we need to do a lot more of that.

I think the first and most significant part in doing that was sending the 30,000 more of our trained military volunteers deploying to Afghanistan. The bill before the Senate today is critical to ensuring these troops have the equipment, training, and resources

needed to execute their mission. You can't send that many more troops there without giving them resources. This bill is essential for giving the resources.

I especially thank the majority of the House and Senate for not loading this critical troop bill up with poison pills. I know there was some discussion—it must have been tempting—to use legislation to pass unrelated and controversial proposals. I have always voted for and continue to support funds our troops need. If we had seen on this bill things to add, for example, another expensive, doomed-to-fail stimulus bill, I would have had to vote no. We have seen that the majority's \$1 trillion stimulus bill, passed late last winter, has failed to produce the jobs promised and the budget which doubles the debt in 5 years and triples it in 10. It puts our children and grandchildren's financial future at hock. I didn't want to see that on legislation to appropriate the funds that our troops needed. I am delighted they didn't.

I offer a very special thank you to my good friend Chairman DAN INOUE who heads our Appropriations Committee. He is a true American hero, and I have the utmost admiration for him and greatly commend him for the manner in which he is leading the Appropriations Committee. He tirelessly works to ensure that America's priorities in defense are put in the right place. I issue my strongest thanks to him and our distinguished Republican leader THAD COCHRAN. One of the things I think they did, which was absolutely necessary, was to add the most reliable, heavily used workhorses in the Air Force inventory, the C-17 cargo aircraft, to the bill. This is the modern transport plane used to move our warfighters into battle. It gives them the equipment and supplies to execute their mission. With the President's recent announcement of an additional 30,000 troops, there is going to be more need for them. It is only growing. Secretary Gates has said we must prepare for the fights we are in today. It is no secret that the C-17 is in the middle of the fights, getting equipment and troops to and from Iraq to Afghanistan today. It is a combat-tested aircraft, essential to the fight we are in.

The CRS said it was designed to fly 1,000 hours per year over 30 years. But overseas we have seen it flying 2,400 hours a year. The logistics are particularly responsive to the kind of delivery the C-17 can make. Some people say: We have enough C-17s and C-5s. I agree with General Schwartz who stated “too much iron is not enough.” The C-5As, which must be retired and now can be retired, only have a 50-percent readiness level, a per-hour operating cost of \$29,000, and 40 maintenance man-hours per 1 hour of flight. It is time to retire them and replace them with the C-17.

Dr. Ashton Carter hit the nail on the head. I commend him for his vision. He said:

I feel industrial base issues are completely legitimate because having the best defense industrial technology base in the world is not a birthright. It's something we have to earn again and again.

As America's only large airlift production line, if we were to end C-17 production, it would risk our Nation's long-term opportunity to produce the aircraft we need. It will also keep the scientists, engineers, designers, and dedicated workers who can turn out the future aircraft we need.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

Mrs. HUTCHISON. Mr. President, I was listening to the remarks of the Senator from Missouri about his football team. I couldn't possibly follow that without mentioning my beloved Texas Longhorns who are going to play for the national BCS championship.

Mr. BOND. I am on the Senator's side.

Mrs. HUTCHISON. I appreciate the Senator from Missouri saying that he supports fully the Longhorns as the Big 12 champions. It is always good for the conference, of which the University of Missouri is a great member, that we win the national championship which I have all confidence that my beloved Longhorns will do.

Moving right along to the other important issues of today, I certainly am serious when I start talking about the issue that is before us today. I see the distinguished chairman of the Appropriations Committee sitting on the floor. The winner of the Congressional Medal of Honor, the only Member of our body who has that great distinction, and well deserved, Senator DAN INOUE is one of the great leaders who fought in World War II, was a hero, was given the Congressional Medal of Honor, our Nation's highest military honor that can be bestowed. He has led our committee in such a commendable way.

Senator INOUE has always assured that we have the support for our troops. I have served with Senator INOUE and Senator COCHRAN, our ranking member, and Senator Ted Stevens before him. I can tell you that all of these Senators have led our Defense Appropriations Committee. They have led it by assuring that our troops always have what they need, whether they are in the field of battle, which has been the case for part of our terms here, or whether they are not in the field of battle which has also been the case for much of our terms here. But it happens that our troops are on the field of battle today. That is why I have supported this appropriations bill, supported it as a member of the Defense Appropriations Subcommittee and certainly am assured that we have

the appropriations that give our troops who are in harm's way today the support they need.

I was in Iraq this year. I was in Afghanistan and Iraq last year visiting with those who are doing the work that keeps us free, that allows us to speak on this floor, that allow us to have Christmas holidays with our families. There is not a better experience in my entire time in public life than to get to visit with our troops on the field when they are in harm's way. I have been to Bosnia when we were in Bosnia, Kosovo, then Iraq, Afghanistan, Kuwait, where we have so many troops who are supporting our troops in Iraq, and also now supporting our troops with the equipment transfers into Afghanistan.

Those troops are not going to be with their families this Christmas. We will pass this bill. We will support our troops. We will follow in the great tradition of the Senate. This will be a very bipartisan vote.

HEALTH CARE REFORM

I also wish to mention that the major issue we must face before we finish in the Christmas holidays and then hopefully go on into next year is the health care reform bill that is before us. This is of great concern to me because I don't think we ought to rush the health care reform bill. Health care affects every family, every person in our country. It is a quality-of-life issue. America has had the great tradition and now expectation that we will have the best health care in the world, that we will have a doctor-patient relationship that determines what treatment is best and what is needed, and the patient then makes the final decision.

I very much fear this government takeover of health care is going to put government in between the doctor and the patient. This is a bill that, for the next 10 years, is going to transform our health care system with \$½ trillion in new taxes, new mandates, which can only run up the cost of health care. For those who have coverage, it will be more expensive. For those who do not have coverage, I fear the alternatives are not going to be much better.

I think we have alternatives that can work; I just do not think this one is it. What would work? What will Republicans support? Republicans have a plan with three basic principles. No. 1, we want to bring the cost of health care down so there could be more affordable access for more people in our country. That means we have medical malpractice reform to curb frivolous lawsuits. It means we have the ability to have risk pools that are bigger so premiums are lower.

That means small business health plans. It means that we allow small businesses, without a bunch of bureaucratic nonsense, to come together, form bigger risk pools, and give lower cost options to employers to give to

their employees. That is what every employer in this country wants. They do not want mandates. They do not want taxes. They do not want sticks. They want carrots; and that is, alternatives that are affordable for them.

Last, but not least, why not give every individual who buys their own health care a tax credit that helps them buy their own health care at an affordable cost? I am supporting a bill. It is the DeMint-Hutchison bill that would have a \$5,000 tax credit available for people who have to buy their own health care coverage because they do not have employer options. That would take away the burden that is so heavy on families today.

So we have alternatives. We can do this right. We can do it right if we will take the time to do it right.

The bill that is going to be voted on, surely within the next 3 or 4 days, is actually a bill we have not seen. We have a bill before us. We have been debating it for 3 weeks. But there is another bill that supposedly is the consensus bill that is being written behind closed doors that we have not even seen, and we are going to be asked to vote on it in a 2- or 3-day period. We do not know how long it is, so we do not know how much time we are going to have to read it. But we know we cannot mess around with health care in this country and pass something that may not be right, that may not cover all the bases, that may have hidden things in it we cannot prepare for.

We need the time to do it right. The Republicans are offering a hand to the other side and saying: Let's do this in a bipartisan way. I stated the Republican principles. We can do health care reform with those principles. Maybe the Democrats have certain principles they could lay out, where we could come together and have something that would not be a government health care takeover, that would not be \$½ trillion in Medicare cuts, that would not add \$2.5 trillion to the debt of our country, which is about to sink in debt, and that would not have taxes and mandates and burdens on small business at a time when we want small business to hire people. We want small business to grow and help our economy thrive. But it cannot with more taxes and burdens.

We know we can do better.

The PRESIDING OFFICER (Mr. BURRIS). The time for the Republicans has expired.

Mrs. HUTCHISON. Thank you, Mr. President. I hope we will go back to the drawing boards and create a bill that America will be proud of and that we will see the American people support.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. INOUE. Mr. President, first, I wish to thank the Senator from Texas for her very generous remarks.

The measure before us represents the culmination of the work of the Appropriations Committee for the year. But in many respects, it is our committee's most important responsibility.

What could be more important today, 1 week before Christmas, than demonstrating support for our men and women in uniform, whose sacrifices and dedication to the people of this country are unmatched.

If I may be a bit personal at this point, I have spent several Christmases away from home in my youth when I was serving in Italy and France during World War II. I have seen the anguish of wives without their husbands on Christmas Eve. I have seen the tears of mothers when they received the news of the death of their son. I have seen the blood. I have seen the misery.

As has been noted by others, this measure before us provides the essentials for the Department of Defense. That is the least we can do for our men and women. Yes, the amount involved is tremendous, \$636 billion. The amounts in this measure will go to pay the troops, support their families, provide care for the wounded, and equip our forces. Funding of \$128 billion is included in this total to give our men and women in harm's way the resources they need—the guns, the bullets, the bulletproof vests, helmets, and such.

I know there are some who oppose the wars in Afghanistan and Iraq. I should like to remind my colleagues that I too voted against sending forces to Iraq. Yes, I did—1 of 23 of us here. Nonetheless, when the majority of both Houses voted to engage in that conflict, regardless of my personal view on the wars in which our Nation is involved, I have always supported the funding required to ensure that those who have responded to our Nation's call are provided all the equipment and resources they require to carry out their missions. That is the least we can do. While others may disagree, I will flatly state that it is unconscionable not to support them.

This is a good bill. It is a good measure. Some will criticize the relatively small amounts which are allocated to items requested by Members of Congress. Some will question the overall level of resources for defense and, as noted earlier, there are some who oppose funding the war.

But, despite the few loud voices who raise objections to this bill, I am certain the majority of my colleagues support this measure because this is a good bill which provides essential funding to provide for the common defense.

I think we should remind ourselves that at midnight tonight the continuing resolution providing stopgap funding will expire. Tomorrow morning, if it is not clear that the Congress will pass this measure, the Department of Defense will begin to take steps to

shut down some of their functions worldwide. And I can assure you, it will be costly, it will be inefficient, and totally unnecessary.

The Senate has already voted overwhelmingly to cut off further debate on this measure. It is clear there is broad-based support. There is no reason to wait any longer.

As we sit here 1 week from Christmas, we are engaged in an extremely partisan debate in a highly charged atmosphere over our Nation's health care system. Both sides of the aisle feel passionately about this issue. I do not fault my colleagues who oppose that measure. But this defense bill is too important to be caught up in partisan politics. This bill was drafted in a bipartisan agreement, and I think we should recall that it was reported out of the Appropriations Committee by a vote of 30 to 0, unanimously. In both bodies of this Congress, the respective versions of the bill were supported overwhelmingly.

The compromise measure we are working on at this moment passed the House of Representatives by a 398-to-24 vote. That is almost unanimous, unheard of. So I plead with my colleagues, let's not force a wasteful shutdown of the Defense Department. Let's not continue the delay which has stalled action on this bill. And, above all, let's not raise doubts in the minds of our military men and women worldwide, who would follow our actions, and make them question us: Do we support them? Instead, let's come together in the bipartisan spirit in which this bill was created and crafted and vote to pass it today.

As in ancient times, it was said: Peace on Earth, good will to all men.

Mr. President, I would like to submit a short list of technical corrections to the Disclosure of Congressionally Directed Spending Items report that is attached to the explanatory statement for H.R. 3326, the Department of Defense Appropriations Act for fiscal year 2010. The following corrections are necessary to provide the most accurate description of congressionally directed spending items in this bill.

Senators BINGAMAN and UDALL of New Mexico should be removed from the list of sponsors for the Advance Propulsion Non-Tactical Vehicle in Research, Development, Test and Evaluation, Air Force.

Senator REED should be added in support of the Standoff Sensors, Detection of Explosives and Explosive Devices—IEDs—in Research, Development, Test and Evaluation, Army.

Senator SCHUMER should be added in support of the WMD Civil Support Team for New York in National Guard Personnel, Army.

Senators CRAPO and RISCH should be added in support of the Radiation Hardened Cryogenic Read Out Integrated Circuits in the Defense Production Act account.

I yield the floor, Mr. President.

The PRESIDING OFFICER. The Senator from Delaware is recognized.

Mr. KAUFMAN. Mr. President, I thank you for your help in this, as always. I say to the Presiding Officer, you are a great colleague, and I appreciate it.

Mr. President, I ask unanimous consent to speak as in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

BROADCAST STATIONS

Mr. KAUFMAN. Mr. President, I want to take a few minutes today to speak about television and to alert my colleagues to a troubling situation.

Recently, the only VHF television station licensed in Delaware canceled the one nightly public affairs program which covered Delaware issues, closed its local studio, and moved almost all of its employees out of Delaware.

That station—WHYY-TV—did this even though the community it is supposed to serve first, that should be its primary focus, is Wilmington, DE. This is offensive and it is wrong. These and other actions led the city of Wilmington, last week, to challenge the license renewal of WHYY. I understand and commend the city's complaint, and I hope it will bring about better service to Delawareans.

Frankly, I think WHYY was emboldened to make these changes by the weakened oversight of the regulatory agency charged with making sure broadcast stations serve the public interest: the Federal Communications Commission. If this sort of snub to the community of license proceeds with no repercussions, we could be seeing less and less local service from stations all across the country.

If the requirement to serve the public interest has no meaning, if the broadcast station provides its community of license with nothing more than what we can get from a national cable, satellite, or Internet channel, then the public is getting a bad deal for giving away spectrum at no charge.

At the core of the FCC's licensing policies—right from the beginning—is a principle that every community of appreciable size needs and deserves its own station. As a nation, we have licensed broadcast stations to cities all across America. In America, we do not have nationwide broadcast channels. You get that on cable channels such as HBO or Discovery, either through cable or through DISH. TV channels are local. These stations that are granted free use of public airwaves are required to be responsive to local needs. Each has a duty to determine the programming appropriate for its viewing community and then make its programming decisions based on those needs. That is the deal. You get the spectrum, you take care of the local needs. Broadcasters are, for all intents and purposes, temporary trustees of the public

airwaves. For that privilege, they must serve their own communities.

It is exactly because broadcasters must address local issues and needs that the FCC required cable companies to carry local broadcast channels. For the same reason, satellite carriers have been restricted in their ability to bring distant network signals into homes that should be receiving their local stations. That all makes sense. Yet unless the FCC steps up and makes it clear to broadcasters that their duty to serve the public interest is real and includes making program decisions that are responsive to their communities of license, I fear the public is going to lose out and local needs will go unmet.

As long as stations think they can get away with doing less, they will be tempted to do less. If there are no consequences to ignoring their obligations, they will take shortcuts and our communities will be the worse off for it. If that happens, our historic allocation of channels all across the country designed to ensure community-oriented service will become a sham.

I call these concerns to the attention of my colleagues today because this is what is happening in my own hometown of Wilmington, DE. We have one VHF station in Delaware. It is Channel 12, WHYY-TV. Its city of license is Wilmington, DE, and it is a public television station.

WHYY-TV is not always on Channel 12. In fact, it started out on a UHF channel in Philadelphia. But in the 1960s, when a commercial station operating on Channel 12 ran into problems, WHYY beat out the competition for the VHF license. It was no secret that WHYY made this move not because it wanted to relocate from Philadelphia to Wilmington but because it wanted to move from a UHF channel to a stronger VHF channel with greater viewership. However, this move nonetheless was tied to a promise that the station's primary duty was to serve the interests and needs of the people of Wilmington, DE, its new city of license. Unfortunately, it has been a near constant struggle for our community to get the attention it was promised.

When its license was first granted, WHYY agreed to present 16.5 hours per week of Delaware-oriented programming. Let me repeat that. They promised and agreed to present 16½ hours per week of Delaware-oriented programming. By the time its license came up for renewal in 1978, it was providing less than 3½ hours per week. As renewal of its license was challenged, WHYY added some additional Wilmington-oriented programming. Nonetheless, the FCC conditioned the grant of its license on demonstrating a commitment to local programs broadcast from Wilmington rather than Philadelphia.

WHYY was again chastised for failing to serve Wilmington during its 1983 li-

cense renewal proceeding. The criticism touched on such issues as the location of its main studio; its station log, staff, and management; the production of nonnetwork programming; and the amount of locally produced programming focused on Delaware. The FCC ordered WHYY to base personnel in Wilmington capable of addressing the many failures.

With the diminishing of FCC oversight of broadcasters' responsiveness to local needs, WHYY service to Wilmington diminished as well. Its main studio has long been in Philadelphia, and the Web site for both the Corporation for Public Broadcasting and the Public Broadcasting Service list it as a Philadelphia station. This is even though its license was based on being in Wilmington, DE. In June of this year, WHYY announced it was closing and putting up for sale its studio in Wilmington, closing its news bureau in Dover, and eliminating most of the 16 employment positions in Delaware. In short, it is virtually leaving our State and its city of license.

WHYY's programming decisions also mock its community of license. Gone is the daily afternoon report that focused on issues of interest to those living in and around Wilmington. Today, Delaware's only VHF station has committed to producing merely a single, 30-minute weekly—weekly—program focused on our State. The program is scheduled to air at 10 p.m. on Fridays and to be rebroadcast over the weekend.

If you look at the listings of locally produced programs that are touted on WHYY's Web page, you would be hard-pressed to find programs focused on Wilmington.

WHYY has the audacity to rationalize its cut in local programs by saying it will provide more Delaware-focused stories in its Philadelphia licensed FM radio station and online. So they get a broadcasting license and the programming is going to be on their radio station in Philadelphia and online. You don't have to be a genius to see this is not an acceptable substitute. This plan leaves entirely unserved those who look at television for information about the local community. Reporting through other media is not the same as reporting on television, and to do so WHYY does not need a TV license.

The people of my State feel short-changed and they should, and they are, especially because WHYY operates a noncommercial educational television station that receives support from tax revenues as well as individual and corporate donations. The public expects the licensee will be responsible and attentive to the obligations it holds to its community of license. There is no doubt WHYY has failed in this regard.

Those of us who live in Delaware understand we are situated in one of

those areas of the country where airwaves are crowded. Also, television channel assignments to major cities in adjacent States have left little room in the spectrum for allocations to communities in our State. I know other States face the same problem.

The television stations to which Delawareans tune their sets predominantly broadcast out of Philadelphia, Pennsylvania, and Salisbury, MD. These out-of-State stations, however, owe only a secondary obligation to address the needs of their Delaware viewers.

Broadcasting in this country is coming to a significant transition, but the promise that comes with digital transmission should mean States such as Delaware and communities such as Wilmington will receive more attention to the local needs and interests, not less. That was the promise of digitalization. That was the promise of high-def TV. That was the promise of broadband. The allocation of a channel to a particular community must bring with it some special duty or else it has no meaning at all.

The FCC needs to reassert its role to insist that the licensees—companies that get free use—that is free use—of the public's airwaves take their responsibilities to serve the public interests seriously. If they do not, we will see more stations such as WHYY take advantage of lax policies. We will have more citizens in more communities left with little or no local programming. The complaint filed by the city of Wilmington last week against WHYY's license provides the FCC with a perfect opportunity to give real meaning to a broadcaster's obligation to its community of license.

I strongly encourage the FCC to use this chance and act decisively to protect the public interests.

Mr. President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. ISAKSON. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. REED). Without objection, it is so ordered.

Mr. President, I rise today to support the DOD appropriations bill before us and to take a few minutes to talk about a couple of the provisions in the bill that are important to Georgia but, in particular, I think, also point out something important for us to recognize as Members of the Senate.

In this appropriation is an appropriation to the Office of Economic Assistance for \$40 million. That money is appropriated to be competitively granted back to communities for various economic difficulties they have suffered. One of those communities is Hinesville,

GA, in Liberty County, the home of Fort Stewart. Fort Stewart is the base through which most of our troops who serve today in Afghanistan and Iraq pass and many are trained. It is an outstanding facility in a town with a population of about 29,000. It is a rural county near the coast and near the great Port of Savannah where almost all of the materiel and equipment is shipped from the United States to the theater in the Middle East.

A few years ago, it was announced by the DOD that we would add three new brigade combat teams in the United States of America, and Fort Stewart would be the host of one of those new brigade combat teams. Immediately, the community has done what it has always done. It invested tens of millions of dollars in infrastructure, road improvements, community improvements, and it incentivized the private sector through the banks and the developing community to build the housing necessary to house the dependents and families of those new troops who would come and be a part of that brigade combat team. So the construction work began over 2 years ago. Moneys were borrowed, developments were begun.

A little earlier this year, it was announced quickly and summarily that the Department of Defense was dropping back those three brigade combat teams and that none of the three would be created or deployed. Unfortunately for the community of Liberty County and for the private developers and the banking system there, they cannot get a do-over. They have already borrowed the money. They have already deployed the capital. They already made the investment.

Worst of all, the announcement came at a time when we are in great economic turmoil anyway, where our banking centers are under great stress. As I know everybody is aware, of all the States in the United States, the State of Georgia has had the most banks closed by the FDIC during the last 18 months. To have these assets become nonaccruing assets because the military changed its mind and the decision puts all of the banks that participated in that in a difficult situation.

I rise to thank the committee and Chairman INOUE and Ranking Member COCHRAN and all the members of the House committee, especially Congressman JACK KINGSTON from Savannah, for adding this \$40 million to the Office of Economic Assistance. It will be a help, but it also should be a warning. Whenever we announce to communities in our States an expansion of our military in that State, and we call upon them to provide the money, the infrastructure, and manpower as their cost to support those troops, if we pull the plug, we change our mind, unfortunately, they don't get a do-over. It is

important for us to live up to the responsibilities we have to see to it that, to the maximum extent possible, those communities are made whole.

In the months ahead, I will continue to work on behalf of Liberty County and the people of Hinesville, GA, who have made this investment to see to it we do everything we can to have the deployments necessary to make up the difference, and where that is not possible, to see to it that funds are available to hopefully mitigate some of the damage.

The beginning of that starts with passage of this bill today or tomorrow morning. It will pass this \$40 million program for the Office of Economic Assistance, so that Hinesville in Liberty County, and other communities damaged by the decision made to withdraw the brigade combat teams, will have a chance to be made whole.

TRIBUTE TO BILL BOLLING

Mr. ISAKSON. Mr. President, it is Christmas. We are all here in Washington working. Our troops are working for us around the world, in Afghanistan and in Iraq. There are a lot of other soldiers who have been working very hard this past year, the soldiers who support the Feed the Hungry programs and the community food banks all over the United States of America.

In Atlanta, GA, our State, there has been an award sponsored by Atlanta Gas Light for many years, called the "Shining Light award." The award is that a gas light is installed somewhere in Atlanta to pay tribute to an individual who has made a historic contribution to the community and for the betterment of mankind—people such as former President Jimmy Carter, such as Ambassador Andrew Young, such as the founder and the gem of our State, S. Truett Cathy, the founder of Chick-Fil-A.

This year, the award has been named and will be given to Bill Bolling. Bill Bolling runs the Atlanta Community Food Bank. Bill Bolling, this year, will oversee the distribution of 20 million pounds of food to 800 nonprofit agencies to feed citizens of our State. It is his 29th year in building the Atlanta Community Food Bank into one of the finest facilities in our country.

Bill Bolling is an unselfish, untiring, honorable man of our community, who unselfishly gives of his time to see to it that others in pain and in hunger have food, support, and nourishment.

In this Christmas season of 2009, on the floor of the Senate, I pay tribute to Bill Bolling for his unselfish contribution to our State and to those less fortunate. But, equally, I do the same for those around the country who, in this difficult time of recession and this wonderful time of holiday, see to it that those who have little have food and those who have hunger have some nourishment, and see to it that America is what it always has been: a giving

and compassionate country on behalf of its people.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. ROBERTS. Mr. President, the bill pending is, of course, appropriations for our national security, our defense. But within this bill is legislation containing a doctor fix—meaning to prevent any further cuts in reimbursements to our Nation's doctors. They now only get reimbursed up to about 80 percent. I think it is very important to do that—to do something for doctors. But it is equally important to prevent something that would be very disastrous to doctors and the entire health care delivery system of our country.

In that vein, there are a lot of things in the bill that I object to: the \$2.5 trillion cost, the 24 million people still left uninsured, the $\frac{1}{2}$ trillion cut to Medicare, with another $\frac{1}{2}$ trillion in job-killing tax increases, the stunning assault on liberty, and the Orwellian policies making health insurance even more expensive—any one of these things would make me vote no on this ill-conceived and dangerous legislation. We don't even know what the last iteration, the manager's amendment, of the effort will look like. We don't even know what the cost of that will be.

There is another issue that has troubled me the most, and that is the issue of rationing. I don't think this issue has sunk in with the American people, and especially within the media.

I want everyone to understand this bill aims to control the government's spending by rationing your access to health care. That is not "scaremongering" or a scare tactic. Facts are stubborn things.

In this bill, there are at least four government entities, and we are going to call them the "rationers" over here to my right on the chart who will stand between you and your doctor. These four entities are represented by the four walls on this chart behind me standing between you and perhaps your wife and the doctor. These folks are obviously somewhat elderly, and that is the big issue in regard to rationing, which I will talk about in just a minute.

Let's talk about the first one, the Patient-Centered Outcomes Research Institute. The acronym is PCORI. You haven't heard of that before, but it is the Patient-Centered Outcomes Research Institute. This one here, that is the first wall between this couple, or you, and your doctor. The Obama-Reid bill establishes the Patient-Centered Outcomes Research Institute to conduct something called comparative effectiveness research, or CER. Rest assured, every health care provider in the country knows what CER is. I am not sure the public understands it. I am not sure those in the media yet fully

understand it. It is research that compares two or more options for the same condition to see which one works best.

That sounds like a great idea, and it is a pretty good idea. But unfortunately, when CER is conducted by a government under pressure to meet a budget, it can be manipulated in some very sinister ways. That has been demonstrated by the United Kingdom's CER institute. Let's look at that as an example. It is the National Institute for Health and Clinical Excellence, the acronym being NICE—but it hasn't been very nice.

NICE is notorious for delaying or outright denying access to health care treatments based on comparative effectiveness research that takes into account the cost of the treatment and the Government's appraisal of the worth of the patient's life or comfort.

Some of the more shocking CER decisions handed down by NICE include restricting drugs to save seniors' vision from macular degeneration until the patient is blind in one eye; denying access to breakthrough treatments for aggressive brain tumors; and refusing to allow Alzheimer's therapy until the patient deteriorates. That is unbelievable, but that happens.

This Patient-Centered Outcomes Research Institute will be the American version of NICE, using CER to save the government money by rationing health care. We tried very hard in the HELP Committee to insert one word, "prohibit," that CER could not be used in any way for cost containment. It should be used for patient care, and we tried to put in the word "prohibit." It was talked about for 2 or 3 days, and then in a very partisan decision, "prohibit" became a thing of the past.

I have offered several amendments, along with my friend and colleague, Senator KYL, a real leader on trying to alert the Senate all about CER and the dangerous path it might be taking. Senator COBURN also talked about this, and he had an excellent article in the Wall Street Journal 2 days ago. Senator ENZI, the ranking member, also serves on the Finance Committee and has been involved with this effort. These amendments were to protect American patients from NICE-style rationing. Unfortunately, they have all been voted down on party-line votes. It is not that we haven't tried.

Let's get to rationer No. 2, the independent Medicare advisory board, right here, the second wall between you and your doctor.

The Obama-Reid bill establishes a new independent Medicare advisory board. It is to be an unelected body of 15 so-called experts who will decide Medicare payment policy behind closed doors with no congressional input. When they make this decision on reimbursement to all of the health care providers, and then all of the health care providers, some of which their national

organizations have chosen to go along with this bill, when they wake up to the fact that they are not protected, they will come to the Congress, and some will say we cannot do anything about it because, obviously, the Medicare advisory board will make that kind of decision.

That is a complete abrogation of our responsibilities, one way or the other, in terms of cutting reimbursements in the appropriate way to save money, or to make sure the reimbursements don't close down a particular vital part of our health care delivery system.

Although this bill says this anonymous board "shall not include any recommendation to ration health care," what else would you call denying coverage for Medicare patients based on cost? That is what it will do—deny payment for knee replacements or heart surgery or breakthrough drugs—all to achieve an arbitrary government spending target. I don't know what you call that, but I call that rationing.

Also, notice that this board will necessarily ration access to health care based on age and disability, of all things, since its payment policies will only affect the elderly and disabled who receive Medicare. What will be a patient's recourse if Medicare refuses to pay for an innovative new therapy that could save or prolong their life?

These are the reasons the Wall Street Journal dubbed this board the "Rationing Commission."

Let's go to No. 3. This is another rationer, the CMS Innovation Center. The Centers for Medicare and Medicaid Services, or CMS, currently administers the Medicare Program on which 43 million Americans rely. That is almost 15 percent of the population.

Listen up: CMS already rations care. It is not authorized to do so, but it does. It does so indirectly through payment policies that curtail the use of virtual colonoscopies, certain wound-healing devices, and asthma drugs.

Medicare already has a higher claims denial rate than most private insurance companies. Let me repeat that. Medicare already has a higher claims denial rate than most private insurance companies—something you are not going to hear my friends on the other side admitting, not when it is so convenient to simply demonize the big bad insurance companies. In fact, the courts recently had to intervene to prevent CMS from rationing a relatively expensive asthma drug in Medicare because rationing is now against the law. However, the Reid bill establishes a new CMS Innovation Center which will be, for the first time, granting CMS broad authority to decide which treatments to ration.

Last one, the last rationer—it is like the four horsemen—the U.S. Preventive Services Task Force. They got a lot of headlines recently, and I will go into that in just a moment. It is yet

another panel of appointed experts—we have four panels here, none of them elected or accountable. This particular task force will make recommendations on what preventive services patients should receive. Currently, the task force recommendations are optional. But the Reid bill bestows this unelected, unaccountable body with substantial new powers to determine insurance benefit requirements in Medicare, Medicaid, and even the private market.

The task force has already revealed the types of recommendations it will be making. Just recently, it decided to reverse its longstanding recommendation that women get regular routine mammograms to detect breast cancers starting at age 40. One really has to wonder if the task force's abrupt about-face—and it was abrupt—has anything to do with the fact that the Federal Government's financial responsibility for these screenings and for the health care needs they would potentially reveal would be greatly expanded if this health care reform bill passes.

In the words of one prominent Harvard professor:

Tens of thousands of lives are being saved by this screening, and these idiots want to do away with it. It's crazy—unethical really.

The outcry from oncologists, the American Cancer Society, the American College of Radiology, and breast cancer survivors and families all across the country has forced Secretary of Health and Human Services Kathleen Sebelius to backpedal, to do a backstroke real quick from the task force's recommendations, saying that they do not affect government payment policy. But this bill relies on the task force's recommendations some 14 times throughout the legislation to set benefits, to determine copayments, to make grant awards, et cetera—all policy decisions. So contrary to Secretary Sebelius's assertion, if this bill passes, the recommendations of the task force will become government policy. Not only that, they would be forced onto private insurers as well.

I know some may ask: Senator, why so cynical? Why not trust that these tools will be used only for good, to advance medical science and patient care? To those folks, I answer by showing this chart. This is my favorite chart, Dr. Ezekiel Emanuel's "Complete Lives System." It sounds like something you would be hearing somebody selling over a Del Rio radio station. It is Dr. Ezekiel Emanuel's "Complete Lives System."

As many of you know, Dr. Emanuel is the brother of White House Chief of Staff Rahm Emanuel. He is a bioethicist and one of those special advisers to the President. I am sure he is very intelligent, very smart. Maybe he should be the rationing czar.

Dr. Emanuel has published some very disturbing ideas on how to ration care

which can be summed up by this “brave new world, humpback whale” graph behind me. Dr. Emanuel’s “Complete Lives System” basically works off the premise that the older you are—listen to this—the older you are, the more you have lived, and therefore the less you deserve health care. Let me repeat that. The older you are, the more you have lived, and therefore the less you deserve health care.

You know something, the average age of my colleagues in this body is 62 years old—just something to think about.

President Obama has clearly been listening to Dr. Emanuel’s counsel. Remember his observation in an interview this summer that, as patients get closer to the end of their life—from the President no less—“maybe you’re better off not having the surgery, but taking the shots and the painkiller” instead.

Telling someone they cannot have a knee replacement because they are too old—how old is too old? Who should be making that decision? The doctor and the patient or any one of these four task forces, more especially this “Complete Lives System” as a blueprint?

The Wall Street Journal reported on the age rationing that occurs in Canada’s government-run health care system. Apparently in that country, 57 is too old for hip surgery. Luckily, many of those so-called old geezers can drive south and find care right here in the United States. I am not sure where they will go after this bill passes, however.

The White House may complain that I am taking Dr. Emanuel’s musings out of context. My response to that is this: This is the context. This is how the government will contain costs. This is the blueprint right here, the “Complete Lives System.” This is what we are going to be basing decisions on in terms of reimbursement, not between a doctor and patient.

All of the rationing policies in this bill must be viewed through the prism of Dr. Emanuel’s ideas, of this chart, and consequently this is the goal—to save the government money by rationing care. That is what the President means all the time when he says we are going to squeeze money out of the health care delivery system by basing that rationing on something like a pseudoscientific graph such as this. At least in the United Kingdom they are honest about it. These are the tools of rationing. These tools will restrict your ability and your family member’s ability to get a knee replacement or a breakthrough cancer drug or treatment for Alzheimer’s or a mammogram.

The four rationers—if we are not able to stop this, you are going to see the destruction of the American health care system, the best health care system in the world.

They are among the main reasons I will vote no on this bill.

Mr. President, I yield back the remainder of my time.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. KYL. Mr. President, first, I compliment my colleague from Kansas. He and I have been working on this problem of delay and denial of care, the problem of rationing of care specifically as it comes about through the comparative effectiveness research that is in this legislation, for a long time. I appreciate what he has said today.

Given the amount of time, if I am not able to get a little bit more time over there, I am going to speak off the cuff, commenting on a couple of things he said.

I am concerned about the cost of this legislation. I am concerned about the cuts in Medicare. I am concerned about the taxes. I am concerned about the fact that premiums go up, not down, under the legislation. I am concerned about all sorts of things that are in this government takeover of health care in our country. But nothing concerns me more than the problem raised by my colleague from Kansas because, in my view, nothing is more important to all of us all over the country than the health of our families and ourselves, except, perhaps, our freedom.

In many respects, this legislation takes that away by denying us the ability to work with a physician, a family physician who can help decide what is best for us and then provide that kind of treatment to us. When that is taken away from us in the name of cost cutting for the Federal Government, yes, we are bending the cost curve down all right and we are also hurting the quality of health care for all Americans from now on. That is what bothers me most about this legislation.

I wonder why, if my colleagues on the other side of the aisle are so certain rationing is not going to occur, they have defeated over and over again the amendments my colleague from Kansas and I have proposed that very simply say: You will not use cost-effectiveness research to deny coverage. It is very simple. They say: The language already covers it. I don’t think so. But if it is your view that we should not ration care, then let’s just say it. No, they don’t want to do it. I think the reason they don’t want to do it is very clear—because throughout this legislation there are numerous ways in which rationing will occur, and it has to occur under their scheme of things because it is the only way to accommodate the promises that have been made relative to the amount of money they have to pay for it.

In some countries, they basically set a budget and say—I will pick a number out of the air—\$50 billion this year to spend on health care. It is kind of like we deal with Indian health care in our

country. It is said on Indian reservations that you better get sick early in the year because when they run out of money, that is it. Your appointment will be next January. Get in line.

We don’t want the kind of care Great Britain, Canada, and some other countries have where the quality of your care depends upon how much money they have available to treat you. At first, it is done subtly. They simply don’t inform you of things that might otherwise be available, so you don’t even know the treatments are available. Then they begin delay. It takes long and longer to get an appointment with the doctor. Then, finally, it is actual denial of care. They simply don’t make various treatments available, various pharmaceutical products available to you, and so on.

I was going to mention one of the experiences in Great Britain where they finally figured out how to get the delay down to 4½ months and are really proud of that.

The National Health Service in Great Britain launched what they called an End Waiting, Change Lives campaign. The campaign’s goal was to reduce patients’ waiting time from 18 weeks from referral to treatment—18 weeks. And that is supposed to be a good thing? That is not what Americans want. They know what starts with delay in getting an appointment eventually results in denial of care.

But probably the most pernicious thing is what my colleague was talking about with comparative effectiveness research where panels of experts decide what kind of treatments work best and which ones are most cost-effective for most people most of the time. The difference between that and a physician treating a patient is the physician knows each one of his or her patients.

He knows their needs, and they are not all average. They are not all the general rule. Some require special circumstances.

Mr. President, let me just conclude by reading from what one of our colleagues, Senator TOM COBURN, wrote in the Wall Street Journal. As everyone knows, he is a physician. He wrote:

The most fundamental flaw of the Reid bill is best captured by the story of one of my patients I’ll call Sheila. When Sheila came to me at the age of 33 with a lump in her breast, traditional tests like a mammogram under the standard of care indicated she had a cyst and nothing more. Because I knew her medical history, I wasn’t convinced. I aspirated the cyst and discovered she had a highly malignant form of breast cancer. Sheila fought a heroic battle against breast cancer and enjoyed 12 good years with her family before succumbing to the disease. If I had been practicing under the Reid bill, the government would have likely told me I couldn’t have done the test that discovered Sheila’s cancer because it wasn’t approved under CER [comparative effectiveness research]. Under the Reid bill, Sheila may have lived another year instead of 12, and her daughters would have missed a decade with their mom. The

bottom line is that under the Reid bill the majority of America's patients might be fine. But some will be like Sheila—patients whose lives hang in the balance and require the care of a doctor who understands the science and the art of medicine and can make decisions without government interference.

Mr. President, I rue the day that government stands in between a patient and a physician, when the physician says: I don't care what the research says the average patient needs or generally what is indicated or what costs too much. I know what this patient needs, and unless she gets it, she is going to die. At that point, if our government has inserted itself between the patient and physician and says: We are sorry, it can't be done, then our freedom will have been taken away, the quality of our health care will have been taken away, and we will have succumbed to a government so powerful that it literally has life-and-death control over us and our families.

That is fundamentally wrong, and we cannot allow that to happen by adopting the legislation that is before us now.

Mr. ROBERTS. Would my friend and colleague yield for just a moment?

Mr. KYL. I would be happy to yield, but I think I only have about 30 seconds left.

Mr. ROBERTS. I promise to be brief. I thought about saying this, but I think the example Senator COBURN wrote about in the Wall Street Journal about Sheila made me decide to speak of it.

I had a very close friend, a member of the British Parliament, who thought he had broken his wrist. He had a lot of pain. It took quite a while to get in to see a doctor for a broken wrist. He finally did, and it was put in a cast. Then he kept feeling bad and thought maybe it was set wrong. Finally, he got back in and never left the hospital. He died within about 2 or 3 days. He had bone cancer.

That, to me, was incredible that in Great Britain, this could happen. It was just inconceivable to me. You have to sort of equate it to what this bill would do and what other people would experience, very similar to that and the situation Sheila found herself in as well.

So I thank the Senator for yielding.

Mr. KYL. Mr. President, I believe my time has expired.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, for those who are keeping score and following the Senate, you may wonder what we are doing. We are in the middle of a filibuster, which is an attempt to stop legislation from moving forward. It is a filibuster inspired by the Republican side of the aisle. The bill they are filibustering and trying to delay is the Department of Defense appropriations bill. This is the bill that funds our

military. It is the bill that funds our soldiers, sailors, airmen, and marines who are at war in Iraq and Afghanistan.

This is a bill that, almost without fail, passes overwhelmingly with a bipartisan majority in the Senate and the House each year. It has passed the House of Representatives with a substantial vote of about 394 to 35, with 164 Republicans voting for it over there. There was no controversy associated with it. Yet when it came to the Senate, the Senate Republicans announced they were going to filibuster the Defense appropriations bill.

Why? Do they disagree with any of the contents? I have yet to hear—aside from Senator MCCAIN and Senator COBURN, who went through two or three provisions in the bill they disagreed with—anyone say we shouldn't fund our military. We certainly should. Now some have come to the Senate floor and argued the reason we are in this predicament is because the Democrats, who are in control, have waited too long to bring this bill to the floor. But that statement fails to acknowledge the reality of what this calendar year has meant because day after day and week after week, month after month, with very few exceptions, the role and strategy of the minority—the Republicans—in the Senate has been to slow down and stop the consideration of important legislation.

Mr. ROBERTS. Mr. President, would my friend and colleague yield?

Mr. DURBIN. Pardon me?

Mr. ROBERTS. Would my friend and colleague yield?

Mr. DURBIN. Only for a question.

Mr. ROBERTS. Only for a question.

Mr. DURBIN. I will be happy to yield for a question.

Mr. ROBERTS. I just want to assure him—in the form of a question—if he were asking me, am I filibustering, that is not the case. The problem was, as I see it—and I am asking the distinguished Senator whom I have known for a long time and whom I respect—what would he think about the response—this is the question—where we have only had seven amendments that have been allowed on this bill? I have one on the Medicare advisory board. We have the one on CER here—rationing—and I had another one in regard to a tax matter—about four amendments—all of which have been considered in the Finance Committee.

All were defeated by a party-line vote, so I knew where it was headed, but I thought it certainly deserved some debate and some consideration on the Senate floor. To all of a sudden limit a bill of this size—the health care bill, not the Defense bill—to seven amendments seems to be very untoward and showing a lack of comity in regard to a bill of this size.

The defense bill has the doc fix in it, and so, as such, I think you can pivot

into the problems doctors face and at least have an opportunity to talk about it. But this is the first time I have had 10 or 15 minutes to talk about anything about health care. It is not that I would choose to do it when we are considering a Defense appropriations bill. I have served on the Armed Services Committee, the Intel Committee, as the Senator knows. There is no person stronger for our warriors and our men and women in uniform, and they will get their money.

This bill is going to pass. That is not the issue. The issue is we haven't had enough time, and I would ask the Senator to comment on my comments and tell me if I am wrong.

Mr. DURBIN. I would say in response to the Senator from Kansas, he has a grievance with the consideration of this bill—the health care reform bill—a 2,000-page bill, which I will address in a moment. But I would say to the Senator from Kansas that we are considering this bill—the Department of Defense appropriations bill. And because of a grievance over the consideration of this bill, the Republicans are filibustering the Department of Defense appropriations bill. They are trying to slow down as much as possible the passage of the Department of Defense appropriations bill.

Many of us think that is unfair, particularly when we have our best and bravest young men and women at war, that we would somehow make the bill funding their effort and funding the things they need to protect themselves the center of a political debate over another bill. And it is a filibuster. Twice last night on this floor, early this morning—I should say in the early hours of the morning—I made a unanimous consent request that on a bipartisan basis we fund our troops. I offered it on the floor and twice it was objected to—the last time by the Republican leader and the Republican whip in the well of the Senate. They had a chance to pass this bill.

Now, the funding for our troops runs out at midnight tonight. We are going to come in at 7:30 tomorrow morning because the Republicans insist on this delay, and we are actually going to fund the troops. I really believe when push comes to shove, we will. I hope we do. I will be voting for it, and I hope the Republicans will join me. So I don't understand why the Republicans are holding the Department of Defense appropriations bill for our troops hostage to their anger or frustration over health care reform.

Then let me address health care reform. I would say to the Senator from Kansas, we have been on this bill for 19 days. Do you know how many substantive amendments have been offered by the Republican side to this bill in 19 days? Four—not even one a day. And six amendments—or I should say motions—were made to this bill to send it

back to committee and start over. So if the Senator has substantive amendments—and others do—the obvious question is, Where have they been? Nineteen days, four amendments.

It appears to me that when a decision was made several days ago on the Republican side to order the reading of an 800-page amendment, it was very clear that this had nothing to do with debate and voting on amendments. It was all about slowing things down and stopping them, and they tried and couldn't on the reading of this bill. Now they are trying, as best they can, when it comes to an unrelated bill.

You know, there comes a point when, I would say to the Senator from Kansas, there has to be a vote. I mean, we are here to vote. Let's get on with it. We either win or lose. You either win or lose, and we have to go forward. I know you don't support this from what you have said. I do. I may prevail; you may prevail. But at some point, don't we owe it to the American people to take a vote? Unfortunately, this delaying tactic that has been going on is just postponing what I think we are here to do, and it is doing it at a time of year when I have to tell you—and I always say, at least they told me when I ran for the House, if you don't like this job, you know, don't run for it. And if you get this job, don't complain about it.

Well, I am not going to complain, but I do have to tell you, most of the Members of this Senate would like to be home with their families for Christmas, and we may not be.

Mr. ROBERTS. Will the Senator yield to allow me to answer the Senator's question?

Mr. DURBIN. I will yield for a question, otherwise I would be yielding the floor. But I will certainly yield to the Senator from Kansas for a question.

Mr. ROBERTS. You could go for it, yield the floor, and see what happens.

I think the question the Senator asked of me—and I will defer it back to him in the form of a question was, Was I taking part in the filibuster? The only reason I am here to talk about rationing—and I had that rationing amendment ready, along with the Medicare advisory board, along with several others, is because we have not had the time or opportunity to offer them. Why are we rushing and not allowing time to consider amendments?

Consequently, I have four amendments sitting on my desk waiting to at least talk about them, as opposed to bringing them up. I don't think that is filibustering. I think I am taking advantage of whatever time we have to at least talk about these amendments, certainly on the health care bill.

On the Defense appropriations bill, it is very unfortunate this situation has developed, but I want to assure the Senator, and my good friend, that I am not here trying to hold up anything.

One other thing—is it not true there is a bill out there but nobody has seen it? More especially, the managers' amendment, which will be combined with what came over from the House, and we do not have a score. So whatever you have there, if that is the bill, I would sure like to get it up on the Web or something so we can take a look at it and also have the score.

We keep talking about the bill. I would ask the Senator: Is that the bill? Is that the final bill with the score?

Mr. DURBIN. I would say to the Senator from Kansas that it is not the final bill. There will be a managers' amendment offered tomorrow, and it will be considerably smaller than this. It will have specifics in it that have been reviewed by the Congressional Budget Office. That is underway. It will be introduced, I hope, tomorrow morning, and it will be up for consideration for a procedural vote early Monday morning, and then the remainder of the week, as long as the Republicans want us to stay.

It is your decision whether we will be here for Christmas, and we are prepared to stay, if necessary, to get it done, if that is what it takes.

But it is true there is a managers' amendment coming. It is also true the Congressional Budget Office—maybe one of the most powerful agencies of the Federal Government—can literally stop the Congress in its tracks while the people who work there pour through these bills and try to make some estimate as to whether they are going to add to the deficit; whether they will, in fact, reduce health care costs.

The good news for all of us is they took a look at our bill—the Democratic health care reform bill—and concluded it would, in fact, reduce the deficit \$130 billion over the next 10 years and \$650 billion beyond that.

It is also true this is the only bill that has been brought before us—the Democratic bill—which would expand the coverage of health insurance to 94 percent of Americans.

There has been a lot of talk about rationing in other countries. Senator KYL of Arizona speaks about England and Canada and rationing and waiting in line and how unfair it is—and there is a fundamental unfairness to waiting in line when a doctor says you need some medical treatment. But keep in mind there is rationing in America. Fifty million Americans have no health insurance. That is rationing. Many Americans have health insurance policies that are not worth anything. That is rationing.

We know more and more people are filing for bankruptcy in America because of medical bills because they do not have the out-of-pocket money for medical care they need in America, and that is rationing. In the developed world, which America certainly leads,

we are the only Nation on Earth where a person can die for lack of health insurance, and that is rationing and that is our current system.

Some say these reforms are too complex—2,000 pages. I defy anyone to take 2,000 pages and write down and describe the current health care system in America. They cannot. It is much more arcane, complex, and bewildering than this bill itself.

Also, I think this bill, it is critically important to note, is going to give people an opportunity to fight the health insurance companies who consistently turn down the requests of doctors and patients for care, saying they are not covered by the policy or the person failed to disclose everything they should in their application for health insurance.

We take them on. It is about time we did. These health insurance companies make a fortune. Their CEOs are paid a fortune, and they have created a situation which rations care to Americans today. I have seen it firsthand. I know friends who are going through it, people right in my office. And anyone who is listening to their constituents back home knows this is true.

There is also one other element I will mention before yielding the floor to the Senator from Minnesota. We will dramatically expand the Community Health Care Clinics in America with this bill. If you are aware—and you should be—of these clinics in your community, you know these are the clinics with the medical professionals, doctors, nurses, dentists, radiologists, who provide basic primary care to people who are not wealthy. They provide care at a fraction of the cost to people going into a hospital or emergency room for a fever or a child with an earache, and they do it well. They do it in Chicago, do it in Springfield, and do it all over my State—and we will expand it. You will see after this bill passes a dramatic change in primary care in America, more and more primary care physicians' costs being brought down with quality care at a local level.

We need more of it. This bill does it, and there is nothing coming from the other side that even matches it. I am prepared at this point to yield the floor to the Senator from Minnesota for the remainder of the time until 4 o'clock.

Mr. ROBERTS. I have one other question to ask of the Senator.

The PRESIDING OFFICER. The Senator from Minnesota has the floor.

Mr. FRANKEN. I will yield to the Senator from Kansas for a question.

Mr. ROBERTS. OK. "You again?" Just a personal aside.

When we get through with the Defense appropriations bill, which will be soon, and that issue will be settled—and I am not going to talk about it anymore with the exception that this is the only time I have had to speak to several amendments I feel very strongly about. But as I say, I don't know

whether four is the accurate number being substantive. I think the three amendments I have on my desk are substantive.

I would say to the Senator, when we take up health care again, would the Senator give me some assurances that I can offer these three amendments? One would be the Medicare advisory board; one would be to cut out the cuts in regard to the hospitals, \$1.5 billion to Kansas alone; and then what we are talking about are the four rationing task forces and boards that we had when I was making my speech.

If I could have some assurance I could offer those—

The PRESIDING OFFICER. The Senator from Minnesota has the floor. If he has yielded for a question, the Senator from Kansas will propound a question.

Mr. ROBERTS. That is the question, if he could give me some assurance that those would be considered? That would be fine. But that has not happened, which is why we are in the situation we are. I am done.

Mr. FRANKEN. Thank you, Mr. President.

Mr. DURBIN. If the Senator from Minnesota will yield for a kind of question?

Mr. FRANKEN. Certainly.

Mr. DURBIN. I would like to ask the Senator from Minnesota if he is aware of the fact that we have been debating health care reform for 19 days on the floor of the Senate, and in that period of time there have been four amendments offered by the Republican side of the aisle to change the bill and six motions to commit the bill back to committee, stop the debate on the floor, and that is the sum total of all of the effort on the Republican side to date? We do not choose the amendments, the leadership chooses it on the Republican side of the aisle.

I ask the Senator from Minnesota, is he aware of that?

Mr. FRANKEN. I am now. I was aware of the general shape of things, which is the sort of dearth of substantive amendments offered and the delay—yes. That I am aware of. Thank you.

Mr. President, I ask unanimous consent to speak for 10 minutes as in morning business.

The PRESIDING OFFICER. Is there objection?

Mr. ROBERTS. Reserving the right to object, and I will not object to my good friend, but I can't let this stand when the distinguished Senator from Illinois says there are only four amendments, and I have on my desk amendments I have tried to—

The PRESIDING OFFICER. Does the Senator from Kansas have an objection?

Mr. ROBERTS. I am reserving my right to object. Under my reservation, I point out to my distinguished friend,

I would like to invite him to my office so he could see these amendments that this leadership has not allowed us the time to consider. I do not think that is right. I had to set the record straight.

The PRESIDING OFFICER. The Senator from Minnesota.

THE SCHOOL PRINCIPAL RECRUITMENT AND TRAINING ACT

Mr. FRANKEN. Mr. President, the American dream, and its promise of prosperity, has long been predicated on the simple idea that opportunity is a right, and not a privilege, and that every individual should be afforded a level playing field on which to set out into the world.

To fulfill this promise to our children, we must close the school achievement gap that is leaving so many of our low-income and minority children behind.

Closing the school achievement gap is one of the defining civil rights issues of our time. It is a cause that challenges our society to uphold its time-honored commitment to equal access and opportunity for all.

Yet reversing decades of educational inequality is no easy task. We cannot expect our schools to go it alone. We also need to improve social services in low-income communities to help students address the numerous challenges they face outside the classroom that make it difficult for them to learn. At the same time, we cannot absolve schools of their responsibility to improve considerably. There are exemplary schools scattered across the country that are proving every day that while they cannot solve all of their students' problems, they can push them to increasingly higher levels of achievement under the most trying of circumstances.

Our task now is to learn from these schools. While No Child Left Behind shined a light on the inequality of our educational system, it has done little thus far to address the problem. As we approach the reauthorization of No Child Left Behind, it's critical that we look to the schools that are beating the odds, and determine how to replicate their success.

One of the most common features of successful schools in low-income and high-minority communities is the presence of an effective school principal. This should come as no surprise; it is a matter of common sense to expect a successful school, or any successful organization, to have a strong leader. Moreover, research underscores the importance of school leadership. In fact, research shows that school leadership is second only to teacher quality in its impact on student learning.

Yet despite the importance of school leadership, the Federal Government has not devoted adequate attention and resources to improving the quality of principals in high-need schools, which serve high proportions of low-income and minority students.

Senator HATCH and I intend to change this. Having seen the extraordinary impact of effective school principals in Minnesota and Utah, we believe that improving principal quality is essential to turning around high-need schools.

That is why we have introduced the School Principal Recruitment and Training Act. The bill will create a pipeline of effective principals for high-need schools by providing high-quality programs with funding to recruit and train principals to take on the challenge of leading those schools.

One principal who has made a particular impression on me is Principal Andrew Collins at Dayton's Bluff Elementary School in Saint Paul, MN. The Dayton's Bluff School is diverse and poor. Nearly all its students are eligible for free and reduced price lunch. One-third of its students are English language learners.

Dayton's Bluff used to be one of the worst performing schools in Minnesota. Only 6 percent of its third graders and only 4 percent of its fifth graders were proficient in reading and math.

But that was Dayton's Bluff 10 years ago. In 2001, the school was restructured. Today, Principal Collins is in his fifth year of leading the school, and under his leadership, student achievement is increasing at a truly amazing pace. Proficiency on State math tests at Dayton's Bluff has increased from 49 percent 3 years ago—10 points below the State average—to 71 percent, or 8 points above the State average. African-American students at the school have performed more than 20 percentage points above African-American students statewide on both math and reading tests.

It is the same school, the same neighborhood, and the same kids. Yet the school is achieving vastly different results. The success of the school is a testament to the hard work of Principal Collins and his staff. Principal Collins has led the school's transformation by working closely with teachers to help them improve their instruction and their use of formative assessments and student data. He has also supported the growth of his teachers by giving them time to collaborate with each other on improving their instructional practices.

Principal Collins is, unfortunately, the exception to the rule. Many districts report shortages of qualified principals willing to lead schools that are particularly in need of a strong guiding hand. We need to recruit and prepare more principals like Principal Collins in order to improve student achievement, and close the achievement gap. We can't afford not to make this a priority.

When schools are not performing adequately, we hold principals accountable. But it doesn't make sense to place underprepared principals in

schools facing great challenges—and then be surprised when these schools experience high principal turnover rates and continue to struggle with student achievement.

We need to provide principals with more intensive and hands-on training than most of them currently receive so they will be ready to tackle the challenges of leading high-need schools. They need to be ready to lead and inspire staff, create a positive atmosphere for students, engage families, and use data to drive a continuous process of improvement. The School Principal Recruitment and Training Act would provide principals with the high-quality and intensive training they need to address these challenges.

We are fortunate to have principals in some schools who have put in long hours as school leaders, constantly striving to improve their schools for the sake of their students. We owe it to our children to provide the resources necessary to recruit, train, and support more principals of this caliber so every school, and particularly those in greatest need, can benefit from effective leadership.

Senator HATCH and I will continue to work in the coming months to ensure that we invest in principal recruitment, training, and retention so that our schools have the leadership they need to do right by our students. We view this investment as key to closing the achievement gap, and, in the process, delivering on America's promise of opportunity for all.

The PRESIDING OFFICER. The Senator from Utah.

Mr. BENNETT. Mr. President, may I inquire as to what the status of the time allotment is?

The PRESIDING OFFICER. The minority now has 30 minutes.

Mr. BENNETT. I thank the Chair.

I rise to discuss the Defense appropriations bill. We think of that in terms of funding the troops and taking care of challenges overseas, but there is an aspect to this bill I wish to focus on. In this bill, in addition to appropriations for the Defense Department, there is what has come to be known around here as the doc fix. That is, every year we face a situation with respect to physician reimbursements for Medicare. Every year the law that is before us cuts the level of reimbursements for Medicare to the doctors. Every year the doctors come back to the Congress and say: We can't survive this. We can't live with this. We have to have some more reimbursement. The cuts that are in the law can't be allowed to continue.

Every year we come along and say: All right, we will fix that but just for this year. Every year we say: All right, we will give you the full amount of reimbursement that you feel you are entitled to and, thereby, postpone the amount of cuts in your reimbursement

that are in the law. This has happened so often that it now has a generic name. Every time it happens it is called the doc fix. This year the doc fix is included in the appropriations bill for the Defense Department.

The reason it is appropriate for us to be talking about the impact of the doc fix at this particular time is because of the impact of the doc fix on the health care bill which is what we will return to when we are through with the Defense appropriations bill. Given the fact that the doc fix is in the Defense appropriations bill, I think it appropriate that I talk about the underlying problem for a moment. When you get to the health care bill and try to figure out how it is going to be paid for, this multitrillion dollar bill, you find that one of the main ways it is going to be paid for is by cutting the reimbursement to doctors and hospitals under Medicare. Indeed, I believe the amount that will be cut is up to $\$1\frac{1}{2}$ trillion. The reason I say I believe that is the amount is because we have not seen the actual language of the bill we will be asked to vote on probably on Christmas Eve. The bill has been drafted. The managers package has been drafted. It has been referred to CBO for a score. But it has not been shared with any of the Members of the Senate. We are guessing as to what it will be.

But there has been enough said and enough written about it that I think the guess of a $\$1\frac{1}{2}$ trillion cut in appropriations to physicians and hospitals is a legitimate number.

All right. We have never seen a cut of this magnitude before. We have had much smaller cuts that have come along, and every time we have dealt with those cuts by passing a doc fix.

Now what we are seeing here is the passage in the Defense appropriations bill of yet another doc fix. What that means is, we know, based on precedent, that the Congress will never allow the \$500 billion cut that is in the underlying health care bill to actually take place. If it is not going to take place, why is it in the bill? The answer to that is something I have a hard time explaining to my constituents, because they don't understand the ins and outs of the scoring situation by the CBO. But I will do my best to help make it clear.

The Congressional Budget Office is called upon to score each bill separately. So if you have a bill with respect to defense, they score that bill, and they do not talk about the impact of that on the overall budget. They say: These are the numbers. If you have a bill that deals with Interior, they score that bill. If you have a bill that deals with Transportation, they score that bill. Each bill is scored separately as a single entity.

Let's talk about the health care bill. The health care bill is going to increase costs dramatically. When it in-

creases cost dramatically, in order to keep President Obama's pledge that it will not add one dime to the Federal deficit, there has to be something in that bill that cuts the cost. So we assume, based on previous versions, what will be put in the managers' amendment is a \$500 billion cut in Medicare reimbursements. Now you begin to balance the dollars within that bill. Because if we have \$500 billion more in spending but we are going to take \$500 billion out of Medicare, then the two balance each other, and you can say, as the computers at CBO do say: This bill is in balance and will not increase the deficit.

All right. But if you take the \$500 billion that has been cut from Medicare reimbursement and pass a fix, if you will, for that \$500 billion in another bill, it doesn't get scored against this bill. That is what we are doing with respect to the Defense appropriations bill. We are taking the Defense appropriations bill and passing a bill that would pay doctors under Medicare, would take care of the shortfall under Medicare, but would not be scored against the health care bill.

I don't know of any business that dares to keep its books that way. I don't know of any business that could possibly survive that would say: All right, we are going to calculate only in this one area the cost of the product against the sales of the product and say the two balance each other in such a fashion that this is a logical thing to do. But at the same time in a separate situation, we are going to say we are going to borrow X amount of money to pay for the shortfall in this product, and we are going to pretend that the borrowing of the money separately somehow doesn't affect the accounting with respect to the product. Nobody keeps books that way. Indeed, if a private entity were to try to keep its books that way, it would not only go out of business but possibly its owners or managers would end up going to jail. You cannot do that kind of sleight of hand in a private enterprise, but we do it all the time with respect to the government.

The attempt was made, if you will recall, for us to do the doc fix prior to the time when we got to health care. The Senate turned it down. The Senate said: No, we are not going to engage in those kinds of smoke and mirrors with respect to the budget. We turned that down. As I was driving home that night and I had the radio on and listened to people talk about today in Congress, this is what I heard. They said two items with respect to today's activity. No. 1, it talked about the progress of the health care bill in the Senate. And then, No. 2, it said the House just passed a \$200 billion doc fix to take care of the shortfall in reimbursements to doctors with respect to Medicare. Again, the computers at the Congressional Budget Office can't link these

two events. But they were clearly linked in the comments and the report made on the radio, and they are clearly linked in the deficit.

So the House is saying: We understand that we are not going to keep the pledges we are making in the health care bill, and we are going to appropriate \$200 billion for the sole purpose of breaking the pledge that will be made in the health care bill. But because they are done in two separate pieces of legislation, we hope no one will notice. We hope the American people won't find out that this is the kind of bait and switch we are going through with respect to this bill. We are finding an example of this in the bill before us, the Defense appropriations bill. It has a doc fix in it to take care of the situation as far as the computers are concerned, but it will not take care of the situation as far as the deficit is concerned.

This is not the only piece of smoke and mirrors that we have in the underlying legislation. Going along with it is another item that I find absolutely incredible. I have run a business. I have kept books. I have paid taxes. I have dealt with the government as they have come in to audit. I know that no one in a business could ever get by with the thing that is proposed in the managers' amendment, we think—we haven't seen the amendment—along with the doc fix that I have been describing.

Let me try to put it in this form. Let's assume that you are the manager of a company and the sales manager comes to you and says: We have a new product. It is going to be a hot new product. It is going to be fabulous in terms of its return for the company.

You say: Great, love that. Good news. How does it work?

Well, we are going to manufacture this new widget and it will cost us X. But the revenue from it is going to be Y and that is much more than X so we will make all that money.

You say: All right. How much does each widget cost?

Well, each widget costs more than we are going to sell it for.

OK, how in the world are you going to make so much money when you have a widget that costs more to make than you can sell it for?

He says: Easy. This is the way we are going to do it. We are going to lay out a 10-year program of sales, and we are going to sell this widget for that entire 10 years. But we are only going to deliver the widgets for 6 years. So we have 10 years of revenue and only 6 years of cost. So we have 4 years of pure revenue and no cost whatsoever.

At that point, I am sure you would say: Let's get ourselves a new sales manager. Let's get ourselves somebody who understands that the world doesn't work that way. You cannot balance your books by charging for 10 years and

then only delivering for 6. But that is what the underlying health care bill does. It says the taxes to pay for this health care plan will start in 2010. Indeed, it will start within a week or two after the passage of the bill, if we pass the bill on Christmas Eve. But the expenditures under this plan to make things available for all of these people who have been telling us we need health care reform now, that we cannot wait, we have to have it today. I have seen the placards raised. I have seen the protests. We have to have it now.

We say: All right. One thing you will get now are the taxes and the increases in premiums on people who already have health care. But you won't get any of the other benefits out of the bill for 4 years. We have to do it that way in order to make the books balance.

You have the doc fix, which the underlying bill we are debating, the Defense appropriations bill, makes clear is not going to happen as part of the way you pay for the health care. And then you have the 10-year revenue, 6-year expense kind of scheme to pay for a good portion of the rest of it.

So what is going to happen between now and 2014 when the bill finally kicks in? You are going to have three open seasons—for those who understand the language of the health insurance business—three open seasons in which people will look at their level of premiums and say: Wait a minute, how come my premiums are going up when nothing additional is being done with respect to health care reform? The answer will be: Your premiums are going up so the money can be charged by the computers as compensation for the new benefits that will kick in, in 2014.

If you are so impudent as to ask: Well, is the money that is going to come from the increased taxes and the increased premiums being put in a trust fund somewhere to be held solely for the purpose of paying for the increased health insurance benefits? The answer, of course, will be no. The money that is coming from the increased taxes and from the increased premiums will all go against the current deficit. It will all go to deal with the money we are talking about with the stimulus package. It will all go for other governmental purposes. There will not be a time of it saved to deal with health care. That is not the way the government keeps its books. The money comes in. It goes into general funds. It gets spent, and it gets spent immediately.

Oh, so that means in 2014, when the expenses of this bill kick in, there will not be a dime that will have been accumulated to help pay for that? That is true, as far as cash flow is concerned. But it is not true as far as the CBO score is concerned, and that is all we care about. All we care about is what the CBO computers tell us about scoring this bill.

One of the frustrations I have had coming to the Senate from a business background—having run a business, having understood the challenges of running a business—is the way the government keeps its books. I cannot think of a more devastating demonstration of how misleading the government accounting system is than the bill we will get to when we are through with the bill we are debating today. As I said at the beginning, one of the primary examples of that dishonesty is contained in the Defense appropriations bill, as it has this year's version of the doc fix.

Let me move to a related subject because, as I say, this bill talks about the doc fix. The doc fix is connected to the way we try to deal with entitlements. Let me step a step beyond the specifics of this bill for just a moment and describe what we are dealing with, with the entitlements.

First, I need to explain what an entitlement is. I have had constituents come to me and say: I hear all this conversation about Federal entitlements, and I don't understand. What is an entitlement?

Simply put, an entitlement is a payment to which the individual is entitled, whether the government has the money or not. It is not the same thing as the government appropriating money and saying: Now we are going to give it to you or now we are going to buy this or now we are going to pay that bill.

An entitlement means you are entitled to this money ahead of everything else. You are entitled to this money whether we have it or not. If we do not have the tax revenue that would give us the cash to pay you this entitlement, we have the legal obligation to go out and borrow the money and pay you the entitlement.

Entitlements—or as they are known in the appropriations world: Mandatory spending—now comprise more than two-thirds of all Federal expenditures. Let me repeat that because I get gasps of disbelief when I say this to my constituents back home. Entitlement spending—money the government is required by law to pay whether it has it or not—now comprises more than two-thirds of the entire Federal expenditures. The largest portion of the entitlement spending we deal with is in—you guessed it—health care.

If we allow the health care costs to continue to go up, as they have been going up, this is what we are looking at. We will be unable, by virtue of our tax base, to pay this entitlement spending. It will all be borrowed. The consequences to the national debt will be as follows. This is from the Congressional Budget Office. This is not an outside analysis. This is from within the own group we turn to in the Congress to tell us what is going to happen financially.

At the end of 2008, the publicly held debt of the United States was \$5.8 trillion. There were many who were very critical of the Congress and President Bush for allowing the debt to get to \$5.8 trillion.

If there is no diminution of the rate of increase of entitlement spending, if it goes as it has been going, if we take no steps to turn the cost curve down, what will it be in 10 years—not a long period of time in the Nation's history. It was \$5.8 trillion at the end of 2008. What will it be in 2019? The Congressional Budget Office says it will have grown from \$5.8 trillion to \$17.1 trillion. It will triple in a 10-year period if we do not do something about entitlements.

So what are we talking about with respect to the health care proposal? We are talking about creating a new entitlement. We are talking about not turning the cost curve down in the entitlements we have already; we are talking about creating a new one and adding it on top.

The best way to dramatize this, is to look at the 2010 budget, where we are right now, the 2010 budget on which we are drawing up appropriations bills. We passed that budget. I did not vote for it, but it was passed. Here are the details of the budget that was passed for 2010. It projected Federal revenues in 2010 at \$2.2 trillion. It seems like a lot of money. It should be enough to cover all our bills. Then you go to the next line, and it says: Mandatory spending—those are the entitlements—\$2.2 trillion.

That meant that in 2010, every single dime that came into the Federal Treasury was already committed to go out to an entitlement and not subject to the appropriations process in the Congress.

That meant that everything we appropriated money for in the Congress—the Embassies overseas, the military, the war in Afghanistan, AID activities, transportation, the national parks, education—everything else you can think of that the government does was paid for by borrowed money. Mr. President, \$2.2 trillion in and \$2.2 trillion out for entitlements meant that the additional \$1.4 trillion, that actually grew to \$1.7 trillion, that we spent had to be borrowed, added to the national debt.

That is why the Congressional Budget Office says we are currently on track to go from a national debt, when President Bush stepped down, of \$5.8 trillion to—10 years from now—a national debt of \$17.1 trillion.

I see my colleague from Texas has come to the floor, and I will be happy to allow him to take the rest of the time. It is up to him as to whether he wishes to enter into this.

The PRESIDING OFFICER. The Senator from Texas.

Mr. CORNYN. Mr. President, I would like to pose, through the Chair, a question to my colleague from Utah.

Is the Senator aware that on October 6, eight of our colleagues on the other side of the aisle wrote a letter to the majority leader asking that when a bill is introduced, the so-called substitute—that presumably is going to be revealed tomorrow morning—that eight of our Democratic colleagues asked that that legislation be posted for a full 72 hours, along with a score or cost estimate of the Congressional Budget Office, before they would be required to vote on it?

Mr. BENNETT. I say to the Senator from Texas, I was aware of the letter. I was not aware there were that many Democratic signers to it.

Mr. CORNYN. I would say to my colleague from Utah, Senator LINCOLN, Senator LANDRIEU, Senator MCCASKILL, Senator PRYOR, Senator BAYH, Senator LIEBERMAN, Senator NELSON, and Senator WEBB were all signatories on that letter.

I know at different points of the debate we have had some discussion. I think Senator DORGAN from North Dakota, who sponsored the amendment that would deal with drug prices, had expressed some concerns—I know, certainly, the Senator from Arizona, Mr. MCCAIN, has expressed some concerns about drug price issues and what kind of deals had been basically cut on the side that Members of the Senate are not necessarily privy to.

I would ask my colleague, is he aware the Obama administration has now been sued for the visitor list at the White House—which they have claimed privilege to—has been sued because they have withheld the names of the individuals who have come to the White House, some of whom may have been involved in negotiating these side deals we are not privy to? Was the Senator aware of that?

Mr. BENNETT. I say to the Senator from Texas, I was not aware of the lawsuit, and I appreciate his calling it to my attention.

Mr. CORNYN. Well, I would, finally, ask the Senator from Utah, you have heard, along with me and others, Senators say they are for the bill. But it is amazing how few people have actually seen it. Presumably, it will be revealed to us and the rest of the world tomorrow morning. Presumably, amendments will not be allowed on that bill. The majority leader can take procedures to block any amendments to the bill but we will then be put on a fast track, presumably, for passage—at least that is the intention of the majority leader—by Christmas Eve. Is that the Senator's understanding of the process we are looking forward to starting tomorrow morning?

Mr. BENNETT. It is my understanding that is the process, but I am not looking forward to it. I had hoped

to spend Christmas Eve with my family. In my family, the tradition is, we have the extended family get together on Christmas Eve. My house in Utah is being decorated on the assumption there will be anywhere from 60 to 70 people there to celebrate Christmas Eve. Regrettably, I will not be one of them.

But I say to the Senator from Texas, I will be here doing whatever I can to see to it that this bill does, in fact, not pass on Christmas Eve, for all the reasons we have been talking about. I think the best Christmas present we can give to the people of America, and particularly to their children and grandchildren, would be to defeat this bill and see to it there is not another new entitlement created that will cause the national debt to go up even more extravagantly than it is currently projected to do.

Mr. CORNYN. Mr. President, I ask unanimous consent that the two documents I referred to earlier be printed in the RECORD at the end of this colloquy.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. CORNYN. I would finally ask my distinguished colleague from Utah—he was alluding to this earlier—is he aware of any reason why this bill—much of the benefits of which will not kick in until 2014—why there is such an urgency to pass this bill before Christmas?

Mr. BENNETT. That has been the greatest logical disconnect of this entire debate. Because, as I said, I have seen the protest signs that are raised: We want health care reform now. I have seen the people come to the offices and pound on the doors and say: We have to get reform now. I have heard our friends on the other side of the aisle give examples of people who do not have health care coverage and say: They must get this coverage now. By the way, we have crafted a bill that will not do anything for them for 4 years.

If the thing is 4 years away, we can certainly wait until January to allow people to read the bill and offer some amendments.

Mr. CORNYN. I thank the Senator. I said that was my last question; this one really will be: Is the Senator aware of late-breaking news to the effect that not only Howard Dean, the former chairman of the Democratic National Committee, but several liberal pundits, including Keith Olbermann, and that now even moveon.org and the AFL-CIO have all come out in opposition to this bill? Is the Senator aware of the opposition not only on the right but apparently now on the left? We know the mainstream opposition of the American people as a result of the polling we have seen. Was the Senator aware of those developments?

Mr. BENNETT. I have been aware of that opposition. My own sense is that

in the end, that opposition will melt in the face of those who are trying to rush this bill through in the hope that by next November, the American people will have forgotten the details. I do not believe the American people will have forgotten the details of the bill by next November because even though the bill will not be in force in terms of benefits, it will be in force in terms of increased premiums and increased taxes.

Mr. CORNYN. I thank my colleague.

Mr. BENNETT. Mr. President, I believe the time for the minority has expired.

The PRESIDING OFFICER. The Senator from Utah is correct.

EXHIBIT 1

U.S. SENATE,
Washington, DC, October 6, 2009.

Hon. HARRY REID,
Senate Majority Leader,
Washington, DC.

DEAR LEADER REID: As you know, Americans across our country have been actively engaged in the debate on health care reform. Whether or not our constituents agree with the direction of the debate, many are frustrated and lacking accurate information on the emerging proposals in Congress. Without a doubt, reforming health care in America is one of the most monumental and far-reaching undertakings considered by this body in decades. We believe the American public's participation in this process is critical to our overall success of creating a bill that lowers health care costs and offers access to quality and affordable health care for all Americans.

Every step of the process needs to be transparent, and information regarding the bill needs to be readily available to our constituents before the Senate starts to vote on legislation that will affect the lives of every American. The legislative text and complete budget scores from the Congressional Budget Office (CBO) of the health care legislation considered on the Senate floor should be made available on a website the public can access for at least 72 hours prior to the first vote to proceed to the legislation. Likewise, the legislative text and complete CBO scores of the health care legislation as amended should be made available to the public for 72 hours prior to the vote on final passage of the bill in the Senate. Further, the legislative text of all amendments filed and offered for debate on the Senate floor should be posted on a public website prior to beginning debate on the amendment on the Senate floor. Lastly, upon a final agreement between the House of Representatives and the Senate, a formal conference report detailing the agreement and complete CBO scores of the agreement should be made available to the public for 72 hours prior to the vote on final passage of the conference report in the Senate.

By publicly posting the legislation and its CBO scores 72 hours before it is brought to a vote in the Senate and by publishing the text of amendments before they are debated, our constituents will have the opportunity to evaluate these policies and communicate their concerns or their message of support to their Members of Congress. As their democratically-elected representatives in Washington, DC, it is our duty to listen to their concerns and to provide them with the chance to respond to proposals that will impact their lives. At a time when trust in Congress and the U.S. government is unprecedentedly low, we can begin to rebuild

the American people's faith in their federal government through transparency and by actively inviting Americans to participate in the legislative process.

We respectfully request that you agree to these principles before moving forward with floor debate of this legislation. We appreciate your serious consideration and look forward to working with you on health care reform legislation in the weeks ahead.

Sincerely,

BLANCHE L. LINCOLN.
MARY L. LANDRIEU.
CLAIRE MCCASKILL.
MARK L. PRYOR.
EVAN BAYH.
JOSEPH I. LIEBERMAN.
BEN NELSON.
JIM WEBB.

OBAMA IS SUED FOR WHITE HOUSE VISITOR LIST

(By Bill Dedman)

The nonprofit conservative group Judicial Watch has sued the U.S. Secret Service after the Obama administration again denied a request for copies of the list of visitors to the White House.

The records are being sought by journalists and public interest groups to help determine who is influencing White House policy on health care, the economy and a host of other issues.

Under the Obama policy, most of the names of visitors from Inauguration Day in January through the end of September will never be released. After the Secret Service and the White House denied a request for those records, Judicial Watch filed suit on Monday in federal court in Washington.

Like the Bush administration before it, the Obama White House argues that the visitor records belong to the White House, not the Secret Service. White House records are not subject to the Freedom of Information Act, as agency records would be. Federal Judge Royce C. Lamberth ruled twice during the Bush administration that White House visitor logs belong to the Secret Service, which creates and maintains them, and must be released.

To settle lawsuits against the Bush and Obama administrations, filed by the liberal group Citizens for Responsibility and Ethics in Washington, or CREW, the Obama administration has released the names of hundreds of visitors, out of the hundreds of thousands who have been to the White House for meetings, events or tours. The administration has promised to release more of the names of visitors for the period from October onward. The first wave of records is due near the end of this year.

Even for the names it has released, the White House has not provided a city or affiliation, such as a company name or organization represented, making it difficult or impossible to tell whether a person named on the list is a well-known person with that name. And some names are not being released at all, including potential Supreme Court nominees, personal guests of the first family and certain security officials.

The White House has set up a Web page where members of the public can request the release of names of visitors, but that system gives results only for the names of visitors that the public can guess. If the public can't guess who may have visited the White House between January and September, it can't find out the names.

In addition, although the White House system requires requesters to submit their e-mail address, requests are not acknowledged

by the White House, and no reply is sent to the requesters. The names sought, if they correspond to actual visitors, just show up in the next batch of names released by the White House. So far, each release of names by the White House has happened on the evening before a holiday, the classic Washington tactic for burying uncomfortable news.

NEGOTIATIONS WITH WHITE HOUSE

Judicial Watch, in a press release, described being invited to the White House to discuss its request. It met on Oct. 27 with Norman L. Eisen, special counsel to the president, who happens to be a founder of CREW, which had dropped its own lawsuits on this issue.

"During the meeting, the Obama White House officials asked Judicial Watch to scale back its request and expressed hope that Judicial Watch would publicly praise the Obama administration's commitment to transparency," Judicial Watch said. "However, the White House refused to abandon its legally indefensible line of reasoning that White House visitor logs are not subject to FOIA law."

"If the Obama administration is serious about transparency, they will agree to the release of these records under the Freedom of Information Act," said Judicial Watch President Tom Fitton.

White House officials did not reply Wednesday to a request for comment on the Judicial Watch lawsuit.

REQUEST BY MSNBC.COM ALSO DENIED

A similar request by msnbc.com was rejected by the Secret Service, which referred us to the White House, which also denied the request. The Secret Service denied an administrative appeal of msnbc.com's request on Monday.

The White House now says that national security is a reason not to release the records for January through September, an issue not raised by the Bush or Obama administrations in their previous legal filings on this issue.

"The inherited visitor entrance system was not structured to identify sensitive records," Eisen wrote to msnbc.com. "As a result, we cannot make a broad retroactive release of White House visitor records without raising profound national security concerns. For example, the release of certain sensitive national security records encompassed in your request could assist foreign intelligence agencies to identify and target U.S. government officials working on sensitive national security issues."

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. CASEY. Mr. President, I ask unanimous consent that we continue with alternating blocks of time until 6 p.m.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. CASEY. Mr. President, I rise at this late afternoon hour to talk about what has transpired over the last 24 hours. As the Presiding Officer knows, we had a vote at 1 a.m. this morning. To say that is unusual is an understatement; to have the Senate voting at that hour is most unusual. What that vote symbolized—what happened here pursuant to that vote was I think an exercise in Washington game playing.

We have now a health care bill that the American people have been debating for months—the bill in front of the Senate right now, a bill we have been debating intensively over the last couple of weeks, and we want to get to a vote on it. In order to prevent a vote on health care, the Republican side of the aisle decided they would use any tactic necessary to stop the bill, so they came out in full force at 1 a.m. and voted against the Department of Defense Appropriations Act for 2010.

It is hard to understand why. I can understand opposition to a health care bill, and we can debate that, but it is hard to understand why any political party—even one that is intent on killing a health care bill—would use the Department of Defense Appropriations Act to do that, but that is what they did. It is another example of what makes people angry about what happens or doesn't happen in Washington.

We have seen over the last couple of months a real debate about what our policy will be in Afghanistan. We have had a debate for years about what has been happening in Iraq, in those two conflicts, and what our fighting men and women are doing around the world serving their country. We know now that there are more than 34,000—almost 35,000—Americans deployed in Afghanistan.

When I consider my home State of Pennsylvania, when you look at the number of Pennsylvanians overseas—Afghanistan, Iraq, as well as other places around the world where they are serving, where they are deployed—10,430 Pennsylvanians are serving around the world. There are 6,431 active duty and 3,999 Guard and Reserve Pennsylvanians. Many other States could point to similar numbers. So we have tens of thousands of Americans serving around the world, especially those who are serving in Afghanistan and in Iraq right now, and yet we have the Senate, on the Republican side of the aisle, using a Defense appropriations bill to slow down the health care debate and to stop the bill. It is beyond insulting to the American people that they would use this tactic.

What is the bill all about? Well, I won't go through all of it, but here is what the Department of Defense Appropriations Act entails. First of all, military personnel: Funding for more than 2.2 million Americans who are serving our country. More than 1.4 million are active duty and over 844,000 for the Reserve component.

Military pay: The bill provides for a 3.4-percent military pay increase above the requested amount.

Operations and maintenance, readiness and training: The bill includes \$154 billion for Defense operations and maintenance.

Procurement, research, development, testing and evaluation, a whole series of expenditures that our fighting men

and women need to have in place to help them around the world, and a whole list of vehicles and other equipment that are paid for by this bill.

It goes on from there, a long, important list of what our fighting men and women need. What they don't need is a group of Washington, DC politicians using the Defense appropriations bill to play a game on health care. If the Republicans want to slow down health care or stop it, they have every right to do that, and they have every right to use lots and lots of tactics and procedures. What they should never do—there may not be a rule against this per se, but one would think as Americans who are supposed to be supporting our fighting men and women in Afghanistan and in Iraq and other places around the world, one would think they would draw the line and not cross the line of using the Defense Appropriations Act to enforce their will as it relates to health care.

What our fighting men and women expect of us is they expect us to give them the resources they need to fight those battles and not to play petty, insulting political games in the midst of that, but that is what we have had. We had Republican Senators come down to this floor at 1 o'clock in the morning last night and vote one after another after another against moving the Department of Defense Appropriations Act forward.

I will note that in the midst of all that, the Secretary of Defense, Secretary Gates, who we know served several Republican Presidents—he served now former President Bush and President Reagan and served under the first President Bush as well—recently wrote that delay of this bill, delay of the Department of Defense Appropriations Act, would result in a “serious disruption” in the military's ability to pay troops. The Secretary of Defense continued:

It is inconceivable to me that such a situation would be permitted to occur with U.S. forces actively deployed in combat.

I couldn't say it better myself. It is inconceivable. We know political parties fight and both parties have battled and they carry it too far once in a while, but I don't know of an example where a political party, in order to stop a domestic bill that deals with domestic issues—in this case health care—to stop that from moving forward would use the Department of Defense appropriations bill as its vehicle.

As it stands now, we know the vehicle that keeps our government moving and paying for government programs—the so-called CR, which is an acronym for continuing resolution—which, to get out of the Washington-speak for a moment, means the way we are paying for government to operate over a limited period of time, we know that resolution, the funding in that resolution as it relates to Pentagon operations

runs out at midnight. I recognize there is some flexibility that will allow operations to move forward, but it is outrageous and insulting when a political party feels the need to unreasonably delay funding for the troops because they want to put something in the way of having health care move forward. There are lots of ways to obstruct. There are lots of ways to slow things down.

Under the Senate rules, the minority party—in this case the Republicans in the Senate—have rights to do that. But one would think when we have people on the battlefield they would draw the line at this, but they haven't. They have crossed this line, and I think the American people know what is going on here. It is a game. It is a big Washington game. The only problem here, the fundamental problem here is that it is in direct conflict with our obligation to make sure that we move legislation as it relates to our military as fast as we can. This isn't something that people have been working on for a couple of days. There have been hearings that are the undergirding or the foundation of this appropriations act. There have been debates about what the spending increases should be. All of that took place over many months, and now we want to move a Defense Appropriations Act forward, and what are the Republicans doing? They are using that vehicle to stop the health care bill.

So, even as I said before, to say it is insulting or outrageous doesn't begin to capture it, but I think the American people know what we are talking about. They understand a game when they see it, and they are seeing it with this shell game that has been played over the last couple of hours.

We are going to continue to make sure that we do everything possible to move this legislation forward, and then, after we get this legislation moved forward, then we are going to get back to health care and pass a health care bill before Christmas.

With that, I yield the floor.

I note the absence of a quorum.

THE PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. BENNETT. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

THE PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BENNETT. Mr. President, I understand there is a member of the Democratic Caucus who is headed to the floor. I will immediately cease speaking as soon as he or she arrives. I simply wish to make a few comments with respect to statements made with respect to the schedule. The question was asked by my colleague from Texas: Why would people want to rush this bill through when the effective date is not until 2014?

The other question was: Why would someone want to delay the vote? I think the answer to both questions is the same. The American people are looking at this bill. Admittedly, they are not looking at the specific bill, because no one knows what it is. It is still, for the umpteenth time, being rewritten. They are looking at the general outline of the bill, and the more they see, the more they don't like it.

Every poll that comes out shows increasingly decreasing support for the bill and increasingly opposition to the bill. The gap between these two positions is growing wider and wider. This is quite remarkable, because when we began the debate in the Spring, support for the idea of health care reform, and particularly for some of the specifics, was very high, and disapproval was very low. We have seen, over time, those two lines cross. Now opposition to the bill is, according to some polls, as high as 60 percent or more, and support for the bill has dropped.

I can understand that those who want the bill passed want to rush the process as fast as possible, because they don't want any more erosion in popular support. Those who want the bill stopped want to stretch the process out so that the polls can have their impact on Members of this body. It should not, therefore, come as a surprise to anybody that the procedures will be handled in the way they are—with the one group saying, let's get it done quickly before people find out more about it, and the other group saying let's slow it up as much as we can while people find out more about it.

I think that is the answer to the questions that have been raised here with respect to the procedure.

I see other Senators may well be coming. Until they arrive, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Ms. COLLINS. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

The time currently is all located to the Democratic side. The Senator must ask unanimous consent to do so at this time.

Ms. COLLINS. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Ms. COLLINS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Ms. COLLINS. Mr. President, I ask unanimous consent that, notwithstanding the fact that there are few re-

maining moments on the other side of the aisle, I be permitted to proceed.

The PRESIDING OFFICER. Without objection, it is so ordered.

Ms. COLLINS. Mr. President, let me emphasize that it was cleared with my colleagues on the other side of the aisle.

I rise today in support of the fiscal year 2010 National Defense Appropriations Act. Let me begin by thanking the committee's distinguished chairman, Senator INOUE, and the ranking member, Senator COCHRAN, for their leadership in crafting this bill and for their strong commitment to our Nation's Armed Forces.

I am very proud of the work that the State of Maine does that contributes to our national defense. The appropriations bill provides vital resources that our troops need and recognizes the enormous contributions made by the State of Maine to our national security. From the Portsmouth Naval Shipyard in Kittery, to the Pratt & Whitney Plant in North Berwick, to the Bath Iron Works shipbuilders to the University of Maine's engineers, to the Maine Military Authority in Aroostook County, Mainers all over our great State are leading the way to a stronger national defense.

This legislation will provide funding for essential training, equipment, and support to our troops as they bravely and skillfully engage in national security efforts at home and abroad. This is a critical time in our nation's history and the Committee has, once again, demonstrated its strong support of our soldiers, airmen, sailors, and marines.

This legislation also will fund critical force protection and health care initiatives for our troops, while continuing development of important technologies and acquisition programs to counter existing and emerging threats.

The legislation before us includes a strong commitment to strengthening Navy shipbuilding. Our nation needs a strong and modern naval fleet allowing us to project power globally and to respond to threats. This bill authorizes \$1 billion in funding for construction of the third DDG-1000, a priority of mine. The Pentagon's decision to have Bath Iron Works, BIW, build all three of the DDG-1000s demonstrates well-deserved confidence in BIW and will help ensure a stable work load for the shipyard and more stable production costs for the Navy.

In addition, this legislation authorizes \$2.2 billion for continued DDG-51 procurement and nearly \$150 million for the DDG-51 modernization program. The lessons and technology developed in the design of the DDG-1000 can be incorporated into the DDG-51 program to reduce crew size and to improve capabilities.

The legislation fully funds the F-35 Joint Strike Fighter request for both

the Navy and the Air Force. This aircraft, powered by the superb engines made by Pratt & Whitney, will enable our servicemen and women to continue to maintain our air superiority.

At the request of Senator SNOWE and myself, the Committee provides an additional \$20 million for Humvee maintenance to be performed at Maine Military Authority's, MMA, Army National Guard Readiness Sustainment Site, RSMS, located in Limestone, ME. For nearly 13 years, the Army National Guard has relied on Maine Military Authority to provide a dependable service to our Nation's war fighters. The dedicated and talented professionals at MMA have demonstrated their value to the Army and to the Nation and consistently have performed Humvee refurbishment at a lower cost than the Army's own depots. This funding would help to ensure that MMA's valued workforce and high quality product remain a national asset supporting the defense of our country.

The bill also provides \$250 million for cancer research through the Defense Health Programs with \$150 for the Breast Cancer Research Program, \$80 million for Prostate Cancer Research program, and nearly \$20 million for the Ovarian Cancer Research Program. I believe that there is simply no investment that promises greater returns for America than its investment in biomedical research. These research programs at the Department of Defense are important to our nation's efforts to treat and prevent these devastating diseases that also affect our veterans and servicemembers.

The bill provides \$307 million to address the Tricare private sector shortfall in fiscal year 2010 as identified by the Department of Defense. I know Tricare funding is vital to so many Maine veterans. We must continue to support robust funding for this important program and limit increases in Tricare premiums and copayments.

I strongly support the additional \$15.6 million to strengthen the Office of the Inspector General in order to keep pace with the growth in the size of the defense budget and the number of defense contractors. More vigorous oversight of defense contracts to prevent waste, fraud, and abuse of taxpayer dollars will complement the procurement reforms we approved earlier this year.

This bill also includes funding for other defense-related projects that would benefit Maine and our national security.

Funding is provided, for example, to Saco Defense in Saco, Maine, to enable the company to continue manufacturing weapons that are vital to the Armed Forces.

In addition, at my urging, the legislation appropriates \$5.28 million for the University of Maine. This funding would support the development of LGX

High Temperature Acoustic Wave Sensors and allow the University of Maine to continue to investigate fundamental sensor materials and design concepts as well as demonstrate functional prototypes of acoustic wave sensors that will be tested under extreme temperature environments. The funding for the University will also provide for woody biomass conversion to JP-8 fuel, which will provide affordable alternative sources for military aviation fuel.

Mr. President, I want to comment further on the health care bill currently before the Senate. I have talked about my concerns previously regarding the impact on premiums, my belief that the bill will actually cause many middle-income Americans to pay more for health insurance. I have also talked about my concerns about the impact on our small businesses.

I want to talk about a couple of other issues that are particularly important to the State of Maine. The first is the impact of the nearly \$500 billion in Medicare cuts on Maine's home health, hospital, and other health care providers, including our nursing homes.

I am concerned that the bill before us is financed, in large measure, through these enormous cuts in the Medicare Program—a program that already has long-term financing problems. According to the CMS Actuary, these proposed deep cuts will threaten Medicare's fiscal stability and push one in five hospitals, nursing homes, and home health care providers into the red. Many of these providers, I fear, would simply stop taking Medicare patients, which would jeopardize care for millions of seniors.

I want to make clear that I do believe there are savings that can be found in the Medicare Program. For example, far too much is lost each year to fraudulent claims. That is an area where we need to crack down. As we put in place the health care reforms that have widespread support on both sides of the aisle, we could also achieve real breakthroughs that would improve the quality of care while lowering costs. But that is not what we are talking about in the underlying bill. Instead, we are talking about essentially across-the-board cuts, deep cuts, cuts that are going to hurt some of the most vulnerable people in our country—our seniors and our disabled citizens.

This became even more clear to me as a result of a conversation I had this past week with Peter Chalke, the CEO of Central Maine Health Care. He runs not only the tertiary hospital in Lewiston, ME, but also rural hospitals in western Maine, in Rumford and in Bridgton, as well as a smaller hospital in Brunswick, ME. So you can see from that description, if you are familiar with the State of Maine, that the hospital network he covers makes a huge difference in the lives of so many

Mainers. Here is what he told me. He first pointed out that Maine is one of the oldest States in the country. So we have a substantial Medicare population.

Despite being recognized nationally for providing high-quality care, Maine's hospitals currently receive the second lowest Medicare reimbursement in the country relative to their costs. There is no fat to cut in the reimbursements of hospitals in the State of Maine. They have very high quality, some of the highest quality in the Nation, according to health care experts, and according to Medicare itself. Yet they get the second lowest reimbursements.

The CEO of this hospital network put it bluntly to me. He said passage of this bill in its current form would be disastrous for the State of Maine. He said the bill would saddle Maine's hospitals with some \$800 million in Medicare cuts over the next decade, with very little upside benefit from expanded coverage since about 90 percent of Maine residents are covered by some type of insurance policy today.

We also have a large Medicaid population in our State, which led him to another concern. Mr. Chalke told me that a further expansion of the Medicaid Program is simply not sustainable, since Maine has repeatedly demonstrated its inability to pay for the current Medicaid Program.

In Maine, that program is known as MaineCare. It pays Central Maine Health Care just 60 percent of its allowable costs. Moreover, MaineCare will owe Central Maine Health Care more than \$50 million by the end of the year.

The failure on the part of Medicare and Medicaid to pay their full share, to pay the amount that it actually costs to provide the care, simply results in cost shifting to private payers. In Maine, this cost shifting means that individuals who have private insurance cover 130 percent or more of hospital costs. That should not be a surprise to us. If both Medicare and Medicaid are not paying at a sufficient level to truly cover the cost of care, what happens? The cost gets shifted to private insured patients. This big gap is one reason Maine's insurance rates are the fourth highest in the Nation.

This is an untenable situation. The CEO told me that if Congress passes this bill, Maine's hospitals and physicians will be forced to expand cost shifting, further increasing the pressures on private insurance markets, further making that cost an extraordinary burden on middle-income families.

Medicare, which is so critically important to our Nation's seniors, should not be used as a piggy bank for new spending programs when the revenues are needed to shore up the current program. I know my colleague from Tennessee has been talking about that

issue for a long time. I joined him in a letter that said if there are savings to be found in Medicare, let's use those savings to shore up Medicare. We all know that Medicare is not financially sustainable. So what are we doing? We are cutting nearly \$500 billion out of a program that does not have sufficient funds to deal with the influx of the baby boom generation, much less with the costs it is now incurring. It is fiscally irresponsible to raid Medicare to pay for a new entitlement program.

Mr. McCONNELL. Will the Senator from Maine yield for a question?

Ms. COLLINS. I will be happy to yield.

Mr. McCONNELL. I think I heard some of our colleagues say these Draconian Medicare cuts would actually lead to the closure of some rural hospitals. I am wondering if the Senator from Maine thinks that may even be possible given the magnitude of these Medicare cuts we are hearing complaints about all across America.

Ms. COLLINS. Mr. President, the minority leader brings up a very good point. I know the Republican leader is familiar with the analysis that was done by Medicare's own Actuary that says that one out of five hospitals—and these are likely to be the small rural hospitals that are so important in our States—would be so jeopardized by these cuts that they may not survive. Another thing that will happen is that physicians are going to start turning away Medicare patients.

Mr. McCONNELL. I ask my friend from Maine, isn't that beginning to happen in some States already before we even take this additional step?

Ms. COLLINS. It is. My friend from Kentucky is exactly right. In my State, there are already severe shortages of primary care physicians, particularly in the more rural areas of the State—the northern, eastern, and western parts of the State. Their practices are full to start with. What we are asking them to do is to keep accepting new Medicare patients whose reimbursements will not cover the cost of their care. That is why in many States you see physicians limiting how many Medicare patients they will take. I know how painful that is for our physicians. After all, they became physicians to care for people. They want to ensure people have the care they need. But there is a limit to what they can do.

I share the concerns of the Senator from Kentucky that the result of this bill will be to jeopardize the very existence of rural hospitals, small nursing homes, home health care providers, which, in my State, are absolutely critical. After all, I know my colleagues from Tennessee and Kentucky have had the same experience I have had of talking to seniors who are getting home health care. They are so happy to receive health care in the privacy and

the comfort and security of their own homes rather than being forced into a hospital setting or a nursing home. Yet the bill before us singles out the Medicare home health benefit for a disproportionate share of the cuts. It proposes that home health care and hospice care—hospice care, Mr. President—would be slashed by \$42 billion over the next 10 years. That makes no sense whatsoever. That's \$42 billion in cuts for home health care and \$8 billion on top of that for hospice care.

A home health care director in my State, a nurse whom I know well, really summed it up well. First, she described the impact on Visiting Nurses of Aroostook, the county I am from in northern Maine. It had total revenues of \$1.9 million last year. It estimates that it will lose \$313,000 in the first year of the House bill, if that were to pass, and \$237,000 under the Senate bill.

According to the director of this agency, cuts of this magnitude would cause this home health agency to consider shrinking the area served or discontinuing some services. They cannot afford to cover such a geographically huge area as Aroostook County with that kind of cut.

Here is another thing I want to share with my colleagues, because this is what this debate is really all about. What she told me is the following: It is going to be hard for our staff—and our staff is scared—but it is our patients who will pay the price if Congress makes these cuts in home care.

That is what concerns me. It is not just the impact on our rural hospitals, our dedicated physicians, our struggling nursing homes, and our valiant home health agencies. It is their patients. It is the vulnerable senior citizen who lives on a rural Maine road who may lose access to home health care. It is families who want to live in rural communities but cannot if there is not a hospital nearby. It is a nursing home that closes, forcing families to move a loved one far away from the home. Those are the real-life consequences of slashing Medicare.

I hope we will reconsider the cuts in this bill. It is so disappointing that the Senate has repeatedly rejected attempts to try to mitigate those cuts.

There are so many other problems with this bill.

I see the Republican time is about to expire. I hope as we proceed that we can also talk about the impact of the 4-year gap between when all the new taxes under this bill go into effect and when the subsidies are proposed to go into effect. \$73 billion in new taxes and fees will go into effect by 2014, and some of those new taxes start in 2 weeks—2 weeks—if, in fact, this bill is passed. And I hope it will not be. For example, the bill taxes pharmaceuticals and medical devices. The bill taxes health insurance. Next year, the bill imposes a penalty for health sav-

ings accounts, which makes no sense to me. We want people to be able to save money to help cover their deductibles.

Next year, the bill proposes to restrict flexible spending accounts—again, this makes no sense to me.

The \$73 billion in new taxes and fees imposed by the bill over the next four years are going to be passed on to consumers, without a doubt. CBO says that and the Joint Committee on Taxation says that. But when do the subsidies go into effect to mitigate this upward pressure on premiums? Not until 2014. I do not see how imposing these new taxes now—before the exchanges are set up that the chief benefits of the bill are supposed to become available—makes health care more affordable.

Mr. President, the health care legislation that the Senate is currently considering would have enormous consequences for our economy and our society. It would affect every single American and 17 percent of our economy. There are many reforms that have strong, bipartisan support, that could have been the basis of our efforts here in the Senate. It has therefore been disappointing that this process has been so divisive and partisan. While I continue to believe that our health care system is in need of fundamental reform, the bill before us takes us in the wrong direction and will do more harm than good. In keeping with the Hippocratic oath of “first of all, do no harm,” I plan to oppose this legislation.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Minnesota is recognized.

Ms. KLOBUCHAR. Mr. President, I ask unanimous consent to speak as in morning business for 5 minutes.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Ms. KLOBUCHAR. Mr. President, I come to the floor today to voice my support for the Department of Defense appropriations bill we are currently considering and my disappointment that some of my colleagues have chosen to hold up this important legislation for reasons completely unrelated to anything to do with this bill.

We have been debating health care in this Senate for months, and in the coming days we will continue to debate health care. There are many honest disagreements about the best ways to reform our Nation's health care system. They deserve discussion.

I will say, hearing my colleague from Maine speak, that I am concerned about Medicare as well. I am concerned because Medicare is going in the red in 2017 if we don't do anything about it. I look at my mom, who is 82 years old, who wants to make sure she stays on Medicare. I look at friends who are in their fifties and who want to make sure

they get Medicare when they are 65. We need to make sure we put in place those cost reforms that are going to give us the high-quality kind of care we have in Minnesota.

But what I want to talk about today is the Defense appropriations bill. Whatever disagreements we may have on health care, they have absolutely nothing to do with the Defense spending bill. Funding for our troops in Iraq, Afghanistan, and around the world, as well as for defense health and other critical programs should not be dragged into this debate. We should be able to separate the two issues and pass this Defense bill swiftly and overwhelmingly.

Senator INOUE and several of my other colleagues have already discussed the importance of this bill's funding provisions to our ongoing operations in Iraq, Afghanistan, and to our Nation's overall defense. I would like to spend a few minutes on the importance of this bill to my home State of Minnesota and where the Acting President pro tempore also resides.

There are currently over 1,300 members of the Minnesota National Guard deployed in Iraq. These deploying members are with the 34th Infantry Division, the famous Red Bulls—the longest serving unit in Iraq. They assumed command of all U.S. forces in Iraq's southern quadrant in May of this year, taking over from the New York-based 10th Mountain Division. This means these Minnesota National Guard soldiers have command responsibilities for 9 of Iraq's 18 provinces. For the last 7 months, they have overseen the continuing transfer of security responsibility to Iraqi forces, which will ultimately enable the responsible withdrawal of U.S. forces from Iraq. In order for these Minnesota National Guard soldiers to successfully complete their mission and return home to their families early next year, as scheduled, we need to provide them the funding included in this bill.

I know all of my colleagues share my belief that we have a responsibility to the brave men and women we send overseas to provide them with the resources they need to carry out their mission. And there is simply no reason for delay.

In addition to providing our troops with what they need when they are overseas, we also have the responsibility to take care of them when they return home.

As the Chair knows, in Minnesota, we are proud to have created the Beyond the Yellow Ribbon reintegration program. This groundbreaking initiative, pioneered by the Minnesota National Guard, helps soldiers make the transition from their life as a soldier to civilian life through counseling and other services.

Due to its overwhelming success in Minnesota, this program now serves as

a model for the national Yellow Ribbon program that I have worked with my colleagues to authorize and fund in recent Defense bills. The bill on the floor right now includes funding that will continue the Minnesota Yellow Ribbon program, as well as funding for similar reintegration programs in States across the Nation.

These are soldiers who don't have a base to come home to. They come home to small towns all over the country. The idea here is to bring them in to meet with their commanders again, to see if they have a job, to see if they have the right health care, to see if they have their education benefits set. That is the idea with Beyond the Yellow Ribbon.

When the 1,300 Minnesota National Guard soldiers return home early next year, they and their families need the funding in place in this bill in order to resume civilian life. Any delay makes it harder for commanders to have the necessary resources in place.

When our brave soldiers signed up to fight for us, there wasn't a waiting line. When they come home to the United States of America, there shouldn't be a waiting line. When they need health care, when they need their education or they need a job, there shouldn't be a waiting line. When they signed up to fight, there wasn't a delay, and there shouldn't be a delay in Washington, DC, when it comes to funding for our troops.

I urge my colleagues on the other side of the aisle to support this bill and get this voted on as soon as possible—in fact, immediately.

I yield the floor.

The ACTING PRESIDENT pro tempore, The Senator from Tennessee.

Mr. CORKER. Mr. President, I agree with my friend and colleague from Minnesota, there shouldn't be a delay in funding our troops. I do find odd the urgency of the bill that has come to us a week before Christmas, something we passed out of here months ago.

I know that history has shown and certainly the Members who are part of the Republican side of the aisle have shown constantly that we care deeply about our troops and want to make sure they are funded. But the fact that this bill has come up at this time just demonstrates the tremendous hypocrisy with regard to what is happening as this sausage is being made in the majority leader's office on this health care bill.

The reason I speak to that is this is must-pass legislation. The Senator from Minnesota—as we all do—wants to see this passed. And all of us know this will pass. But I want to point out that in this bill, there is \$1.2 billion in money to go to physicians so that their pay will not be cut.

What this bill does is just point out again the tremendous fallacies of the process taking place beyond the ulti-

mate passage of this bill, and that is the health care bill we have been discussing now for months and months. The fact is, we are taking \$464 billion out of Medicare if this bill passes and we are using that money to leverage a whole new entitlement program. The fact is, we are not dealing with the physician pay cuts, which we all know are looming. We all know there is \$250 billion worth of cuts that will take place in physician pay over the next 10 years. We know this bill does not deal with that. Yet, somehow or other, on this Defense appropriations bill, we are dealing with that for a few months because everybody in the world who can wake up and put one foot in front of the other knows that right after this health care bill passes, in the name of being budget neutral—again, using all the gimmicks the Senator from Maine just talked about a minute ago; using 6 years' worth of cost and 10 years' worth of revenue; taking money from an insolvent program to create another program that will become insolvent over time—what it doesn't deal with is the SGR and the doc fix.

So what will happen is the majority leader, the chairman of the Finance Committee will come forth with a bill—right after this passes, I am sure, ironically—and pass another \$250 billion or try to pass another \$250 billion piece of legislation, unpaid for, just so that we can say—so that you can say—so that they can say that, in fact, a piece of health care legislation passed that was budget neutral.

Mr. President, I have to tell you, I came from a world where we focused more on results, and the process really wasn't much a part of it. But in this body, with 100 Senators and 435 House Members on the other side of the building, process matters some. It matters because it really keeps each of us feeling, hopefully, if we have the right process, that there is integrity in what is happening.

I think between the way this body and my friends on the other side of the aisle have used the CBO office and 6 years' worth of cost and 10 years' worth of revenues and all this to make it look as if this bill is budget neutral, yet knowing we haven't dealt with this very important aspect, it points to one part of this process. The fact that in the morning the majority leader is going to lay down about a 300-page amendment—one I haven't seen yet—that a few people working in close quarters developed—and I don't know if the Acting President pro tempore has seen this piece of legislation—and then he will file cloture on an amendment with 300 pages worth of changes, which I understand are going to be fairly important changes, without our having the ability to amend this legislation, to me, is pretty incredible. This is an important piece of legislation. It is going to affect every American in this country.

I was talking with some of my colleagues earlier today—and I know the Senator from South Dakota has been very concerned about the provisions of this bill—and Senator THUNE pointed out the other day, as the Senator from Maine did, about the taxes that start in 2 weeks and the benefits starting in 4 years, mostly. I know there are some benefits that start on the front end. But what my friends on the other side of the aisle were saying is that once this bill passes, that is just the beginning. There will have to be multiple changes over the next 4 years to actually cause this bill to work. This points to the fact that this is about a political victory.

I guess I would ask my friend from South Dakota, if we were going to pass a landmark piece of legislation and do so in a way that would stand the test of time, wouldn't you think we would vote on more than seven amendments? Wouldn't you think we would actually debate the bill in a real way and try to work out these difficulties in advance?

Again, just a few hours ago, my friends were telling me we are just going to try to pass this thing, then we are going to try to fix it over the next 4 years before all these problems hit Americans throughout our country, because what we are really doing on the front end is just collecting a lot of money. That is what we are doing to make this budget neutral. And then the real changes to the health care system take effect over time. We know we have problems, but we will fix those down the road. That is not exactly a process that I think passes muster with most people back home.

Mr. THUNE. Mr. President, would the Senator yield?

Mr. CORKER. I would love to hear from the Senator from South Dakota as to what he thinks about this type of process.

Mr. THUNE. If I might, through the Chair, Mr. President, ask a question of the Senator from Tennessee, if he will yield, because he is absolutely right. This is being rushed. This is a massive reordering and restructuring of one-sixth of our economy, which we are going to be expected to vote upon in just a few days, on a managers' amendment which will be the so-called latest deal struck behind closed doors, as the Senator mentioned. We are going to be expected to vote upon that without having seen it today. In fact, I don't think any of our colleagues on the other side, or very few of them, have seen it, nor have the American people.

I have listened as the other side has gotten up here today with all these statements of outrage and that it is insulting, it is unconscionable that this side would be holding up funding for the troops, and what strikes me about that is the deadline for passing the appropriations bills is September 30. I think that feigned outrage is all about

a bigger, grand sort of cynical plan at work here to try to push this health care bill through.

But would the Senator from Tennessee be able to answer a question regarding this. The Defense appropriations bill passed the House last summer. It passed the Senate in October, I think October 6. So we are talking 8, 9, 10 weeks ago now. Clearly, the Democratic majority's clock management is either very bad or this was part of some big, grand plan to push this thing to the very end and to jam this thing through, to try to set it up so that the health care bill could be passed right before the Christmas holiday without the American people having had an opportunity to see it, and the Defense appropriations bill, which carries a bunch of other unrelated items, would pass as well.

Does it seem a little odd and coincidental to the Senator from Tennessee that you would be debating the Defense appropriations bill right now when it could have been done weeks ago, if not months ago? In fact, these bills are supposed to be done by September 30, which is the end of the fiscal year.

Mr. CORKER. I do think it is odd. As my colleague knows, I think the two of us—all three of us on the Senate floor on our side of the aisle signed a letter to the Appropriations Committee and to the leader of the Senate asking that these be taken up one at a time so we would be finished with this work by the time the fiscal year ended. So it is ironic.

Let me tell you the purpose, in my opinion. I certainly do not know all the inner workings of what is happening on this floor in the Senate. But this is sort of a filibuster. In other words, there is a segment where we discuss this must-pass piece of legislation, where some things can be added in that have not been dealt with that are unrelated—unrelated to defense but also 1,720 earmarks, many of which are mighty suspect. But this is a filibuster, in my opinion, where during this period of time we can be drafting, or the majority leader can be drafting what I would call the “bad actors amendment.”

What I mean by that is, if you have had opposition to the health care bill, which is the real issue we are going to be dealing with over the next few days, if you have had some trouble with the bill, then you can go in and get some niceties.

For instance, I am sure if I decided I was going to support this bill, the health care bill—which I am not—I am sure there are all kinds of things that might spring up in Tennessee as a part of this health care legislation to make it so that the bill was more suitable, if you will, to the people of Tennessee and to me myself. My guess is this managers' amendment is going to be quite interesting to read. I look for-

ward to seeing the details because my guess is it not only will fix technical issues, but my guess is it will also fix some wants and needs of some people who might otherwise have difficulty supporting this legislation. So, yes, I think this Defense appropriations bill—give it a little time for this to germinate. We will have a chance to see that tomorrow for the first time when cloture is filed on it—as I understand, no debate, no amendments. I think it is a shame the Senate has gotten to the point where this is the type of process that is in place.

I understand my time may be up. If not, I would love to yield to the Senator from South Dakota.

The PRESIDING OFFICER. The time for the Republicans has expired.

The Senator from Pennsylvania is recognized.

Mr. SPECTER. Mr. President, I have sought recognition to comment briefly on the proceedings in the Senate in the last few days. I call upon my fellow Senators to reconsider the tactics which are being used to defeat the pending legislation. This body prides itself on being the world's greatest deliberative body. But that designation has been destroyed with what has occurred in the last several days.

We have seen a filibuster on the Defense appropriations bill. We are at war, and we have 68,000 young men and women in Afghanistan today who are giving life and limb for this country. We are debating whether they ought to be funded. I have heard the question raised by those in the military: Doesn't the Congress support the troops?

The impact on morale is potentially devastating when the Senate is not moving ahead to provide the funding, the money to support their efforts. I have no hesitancy in extolling their virtues at the highest level of patriotism. I wouldn't want to make any comment about a corollary negative, as to what is going on in this body. But it is hardly in the spirit of patriotism that we are asking these young men and women to be in harm's way and to give life and limb.

We have seen procedures involved on the reading of the amendments.

Rule 15 does provide for reading: Amendments shall be reduced to writing, read, copies deposited on the desks of the majority leader and the minority leader before being debated.

Those are the purposes involved. But there is no intent in the rules of the Senate to have hours spent reading an amendment for dilatory purposes. The intent of the rule and the spirit of the rule is to inform people but not to have this body paralyzed by this kind of conduct.

We have passed the point of civility. We have passed the point of decency in the way this body is being conducted. I call upon my colleagues to reconsider these tactics and to try to move ahead

and do the people's business. The American people are perplexed, mystified—it is hard to find words strong enough on what the public reaction is. The public opinion polls show that approval ratings are plummeting—plummeting. People have no confidence on what is happening in this body, no understanding as to what is going on, and they see partisan political gridlock of the worst sort in the time since my election in 1980, and from my conversations with those who have been in this body a good bit longer and from my own study of the history of the Senate.

I urge my fellow Senators to reconsider these kinds of tactics and to try to get on with the people's business because that is why we are here.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KERRY. Mr. President, I thank the Senator from Pennsylvania for his comments. I associate myself with them and appreciate what he just said.

We find ourselves in a remarkable situation, where, frankly, there is an extraordinary amount of distortion and fakery taking place on the floor of the Senate. There is a great strategy of deception which the Republicans have engaged in and in which they continue to engage, claiming they are being left out of the process; claiming we ought to go back and start over; claiming they haven't been included; claiming they do not know what is going on. We are where we are today after a year and a half of effort in this initiative specifically—years and years beyond that if you want to go back to Teddy Roosevelt and Harry Truman and every President since then.

But right now we have a specific effort going. We began in the Finance Committee a year and a half ago, the summer of a year ago, where we assembled over at the Library of Congress, and we had an entire day during which time we had Republicans and Democrats. We listened as a committee to experts from across the country about how to do health care.

Subsequent to that we began hearings, constant hearings. And then at the beginning of this year, 11 months ago, we began what we hoped would be a bipartisan process. No chairman in the 25 years I have been here and working here has ever reached out as much as I watched Chairman MAX BAUCUS reach out in an effort to try to get a bipartisan effort. How many Senators from the other side came to the table? For the entire summer, 3 months were taken up with the so-called Gang of 6, 6 Senators—3 Republicans and 3 Democrats.

Unfortunately, several of the Republicans have already walked away because they didn't like something that 60 Members of the Senate might want to do. So they walked away. The Senator from Utah is one. He was part of

those early negotiations. Then he said: I am not going to do this.

In the end, the Senator from Colorado, Senator ENZI, and Senator GRASSLEY, the Senator from Iowa, walked away. And Senator SNOWE, to her credit, has stayed at the table, worked hard with people, and continues to try to have a dialog about what it might need or not need. But somehow they come here with the notion that they have a right to dictate what is in the bill that 60 Senators might think otherwise about, and because they just cannot get their way on the big picture, they are even willing to try to block the funding for the troops in Afghanistan and Iraq. That is just stunning to me.

I learned full well firsthand what it is like to be fighting in a war when people back home are not supporting it. I vowed when I came back that would never be a mistake we might make again. We might disagree with the war, but we would never confuse the war with the warriors, the people fighting it.

In fact, these folks don't care, the folks on the other side. They are willing to just hold it hostage, do anything they can—not just to defeat health care because they don't like it because it is different philosophically from how they would approach it.

Incidentally, they opposed Medicare. I hope America hears this. This is the party over here that opposed Medicare when it was put in. They opposed Medicaid. They do not believe in that. They run around talking about the ills and dangers of a government program for health care. Which of them has brought an amendment to the floor ever or a bill to the floor to say: Stop Medicare, end it? They never do that.

It is a government program. How many of them want to take away veterans health care, a government program? They never do that. But they come to the floor and they jumbo mumbo the words around on the floor and confuse America and make everybody believe this bill is somehow what it is not. These are tried and true tactics. In a lot of places you call it demagoguery.

They have come here relying on crude but effective emotionally laden buzz words, tried and tested in focus groups, funded with millions of dollars. Where do the millions of dollars come from? They come from the people who want the status quo. Fourteen thousand people a day in America lose their health insurance. Where is their plan to put those 14,000 people back on the rolls? They don't have one. But we do; we do. That is what we are here to do.

There is so much good in this bill. Is it perfect? Of course it is not perfect. I will talk about that in a minute. But it is extraordinary to me that the folks who oppose it philosophically—they are never going to change. They keep

talking about let's go back and start over. Going back and starting over to them means let's write the bill the way we want it even though there are only 40 of us and literally to hell with the rest of you 60 who represent the majority of the country. That is their idea of going back to the beginning.

It is not going back to the beginning and coming up with a constructive way to approach it because they had that chance. All year long they had that chance. All they want to do is beat President Barack Obama. That is their theory.

I was here in 1994. Unfortunately it has some potency out there. You make the institution look bad, make the entire Congress look bad, and then the voters will say: O, my God, who is running it? Oh, it is those guys. We better go to the other guys now. Just make it look bad because people will not discern who is really responsible.

Let me be very clear. We are trying to move this forward. We have tried and tried, again and again, to reach out in a bipartisan way which requires compromise. Some people have come to the Senate in modern times with a new definition of compromise. Their definition is "do it my way," not meet you halfway, not give in to what a majority might believe they have a right to say is a fundamental bedrock principle of the way they want to approach a particular piece of legislation.

Here we are with some of our folks now on our side of the fence actually being emboldened by the comments they hear that distort the bill on the other side, to say: Oh, you guys better throw it in. Don't vote for it.

Yesterday we heard a person I admire and like and have become a good friend of, Howard Dean, who worked his heart out in 2004 to try to win, and then worked his heart out in 2008 to help elect this President.

Yesterday he wrote something which, incidentally, had some errors in fact about what was included and not included in the bill. But he said yesterday:

Let's kill the bill and start over.

As another person whose work I greatly admire because I think he holds things accountable, Keith Olbermann said Wednesday night:

This is not health, this is not care, this is certainly not reform.

I respectfully—and I mean that—respectfully disagree with both of them. I don't think they fully evaluated what is in this bill and what it accomplishes for America, nor fully evaluated the realities of what it would mean if you said kill it and start over. There is no President who is going to step up in the next few years if we don't make progress. There is no Senator who is going to invest in a process after this, if we don't make this reform work now.

If you follow that kind of advice and give up now because this bill isn't ev-

erything you want it to be individually, then the very reforms people have spent their life working for, reforms that the Democratic Party has been proposing for decades that are in this bill, many of us ran on them and said: This is why we want to come to Washington to accomplish this—they would be destroyed. That would be it. It would be gone. What a mistake that would be.

The fact is, there are things I wanted that are not in this bill. I am a passionate supporter of a public option. Do you know what our public option was in this bill? Our public option, ultimately, in this bill required the people who take part in it to carry the option with their premiums, not very different from a regular plan, except that it wasn't for profit. It had no public money to support it, and it wouldn't allow public money to come in and bail it out. It had to abide by the actuarial values and rules of the marketplace, the way private insurance companies do. But it just wouldn't have shareholders and a for-profit structure. It could drive competition in order to have those companies that we all know have not stepped up when it comes to making sure that they are there for the patients. Why? Because if you are for profit and you are one of these insurance companies answerable to Wall Street and your shareholders, your principal concern is to drive that profit. So what do they do? They hold onto the money until the last minute because they get the float in the market. As long as the money is in your coffers, then you are working the interest on it or you have it to use for your company. If you pay out at the last moment, you make more money. If you pay less than you have to pay, you make more money. If you cut people off, which they would do all the time, you make more money. If you tell people who bought their insurance, who thought they had the insurance: Sorry, we don't have that insurance for you because of a little clause down here that you didn't read, too bad for you, but you don't have the insurance, even though you have stage 4 cancer and you have two kids and you are a divorced parent, too bad for you, you don't have insurance. They do that because then they make more money. These are real stories. You can find thousands of them across America. How else do you lose 14,000 people a day who lose the insurance they thought they had or wanted?

This wasn't easy for Franklin Roosevelt when he tried to do it. It wasn't easy for Harry Truman when he tried to do it. It wasn't easy for Bill Clinton when he tried to do it. Some of us were here and tried with him. We understand how difficult it is. But you don't sound retreat. You don't ignore history and say: We are going to be better off by giving in to 40 people who are trying to destroy a Presidency and simply

can't stand the fact that there are 60 votes here and there is a President who has an agenda to fix things. So the best thing they can do is try and stand and stop it.

Some of our progressive friends have said because it doesn't have the public option, we ought to do that. Even though it doesn't have a public option, the bill encourages the creation of more not-for-profit insurers, which I will say a little more about in a minute, that have the ability to drive costs and increase competition. We don't have that today. Is that not worth fighting for on the Senate floor and putting into this bill?

Again, my friend, Howard Dean, wrote in the Washington Post that real health care reform needed this public option to "give all Americans a meaningful choice of coverage."

I happen to know this because he and I spent some time combating each other for the Presidency. In 1993, Howard Dean said of Medicare:

One of the worst Federal programs ever and a living advertisement for why the Federal Government should never administer a national health care program.

That shift of opinion on something as important as this leaves me asking whether they have analyzed, all these folks, the level of reform in this bill.

We need to step back and see the forest for the trees of what this legislation does. I believe this legislation, even though it doesn't have the public option I want—and there are a lot of other things it doesn't do that could make the bill more effective—I believe when you take the totality of this bill and measure it against the problems we have in America today in delivery of health care and you look at the ways in which this bill increases coverage for seniors, provides lower cost drugs for seniors, expands the number of people who will be able to afford health care, helps to promote any number of individual reforms, almost every single idea that is worth considering that has been put forward by any think tank or any group in America is in this legislation in an effort to do what we call bending the cost curve—a terrible phrase, a Washington phrase.

It just means lower the cost increase in health care. Bring it down so it is reasonable with respect to what people can afford in relation to the rate of increase of inflation and other costs in our lives.

The Senate bill that is attracting all this trumped up, completely inapplicable but effective politics of destruction, this Senate bill, in fact, provides a provision that will allow the States to establish health care coverage for people between 133 percent and 200 percent of poverty. It allows States, not the Federal Government telling them what to do, no government from Washington, as everybody is trying to pretend this does, it doesn't tell the

States what to do, but it allows the States to contract directly with plans that provide insurance. It allows those States to have the authority. This is States rights. This is the party that always talked about States rights. We are empowering Governors, we are empowering States individually to have the right to negotiate the premiums, the cost sharing, and the benefits for their citizens.

Something else the Senate bill does. It provides \$6 billion in startup funding under the Consumer Operated and Oriented Plan, CO-OP program. This money fosters the creation of a new nonprofit member-run health insurance that offers coverage in the individual and small group markets. Those are the markets where the costs have gone up most rapidly and where Americans have the hardest time surviving.

I just came back from Boston. A fellow came up to me, an unemployed pilot, at the airport and talked to me about the \$1,100 a month he pays for his family premium and how it was killing them. It goes up 20 percent a year. It is the market that is squeezing most Americans out. We lower those costs. We dampen down that increase, and we make it more affordable for people who are at the lowest end of the income scale, who deserve to buy insurance, deserve to have insurance. We make it more accessible to them and affordable for them.

The press has reported that one of the options being considered in the managers' amendment is the creation of the Office of Personnel Management-administered plan. That is a plan administered by the Federal Government that would offer individuals an option to get a national nonprofit plan. I would say to Keith Olbermann and Howard Dean, take a look at this. Look at the OPM-managed and co-op-managed plans that actually provide a not-for-profit option at the Federal level.

When I ran for President, I proposed allowing everyone to have access to the same health care coverage offered to Federal employees and to Members of Congress. Ask any American, do you think you should have access to the same health insurance that the Members of Congress give themselves? They will say yes. That is exactly what we do. We give Americans the option of participating in a plan administered by the same entity that administers the health insurance for Members of Congress. I think leveraging the role of OPM to encourage creation of a national nonprofit plan is a key way to lower health care costs and to roll more Americans into plans that devote a higher premium portion of dollars to medical dollars.

Some of our progressive friends have also said we ought to kill this bill because it has an age-rated premium. They want us to kill this bill because it has an age-rated premium. I don't like

age-rated premiums. It would be wonderful to get rid of them altogether. An age-rated premium is a premium, let's say for a lot of young people, because young people are healthier. When an insurance company looks at the young person, they say the odds of that young person having high blood pressure, any number of other diseases that seniors tend to have more because they are older, is less, therefore, we ought to charge those people less and we are going to charge the seniors a whole bunch more because they are much more likely to be a lot sicker, and it costs the system more. That does make sense to some degree. But the whole theory of insurance is to spread the risk of being sick among everybody.

Those young people are going to be old people one day—not a bad idea that they are going to be able to pay an affordable premium for good health care when they are older too. So maybe there is a sharing across the board. That is how you do your home insurance. That is how you do car insurance. It is spread across the entire population of users and risks that are within those user fields. Although there is some allocation, even in automobile insurance, we all understand, for age ratings and the likelihood that if you are young and a new driver, you may have an accident, more prone, and we have some deferential there, as we do in this bill.

People who are criticizing this bill ought to stop and take a look at what it does. Insurance companies are going to be prohibited from denying coverage or charging more because of a pre-existing condition. How many people in America complain: I can't get insurance. They turned me down because, once upon a time, I had this or I had cancer 4 years ago, but now I am cured but they won't give me insurance because they think it may come back and I am going to be sick later on. That is what insurance is for. But companies have been allowed to say no. This bill will prohibit companies from denying insurance to people because they have a preexisting condition.

I introduced the Women's Health Insurance Fairness Act, which prevents insurers in the individual market from charging women higher premiums than men. That is what has been happening all this time. I am happy to say that in this legislation, in our bill, we prohibit discrimination in those premium increases for women. Insurance companies will also be prohibited from dropping coverage once someone becomes seriously ill, and they are going to be required to renew your coverage each year. Why would Americans across the board not say: Wow, you guys are going to protect me so I can't be kicked off. You are going to guarantee that I can buy it, even though I had a preexisting condition. That sounds pretty reasonable to me.

Our colleagues don't come to the floor and talk about that. They just use a lot of scare tactics, pretending they don't know what is in the bill. They know what is in this bill because we did it in the HELP Committee, and we did it in the Finance Committee, and we have been doing it for 11 months. So insurance companies are going to be prohibited from providing a lifetime cap or an unreasonable annual limit on coverage. That sounds pretty reasonable to me.

Now, I also wish the bill would include an age rating so that insurance could not charge older Americans more. I hope older Americans are listening to this carefully because the fact is, the Senate bill imposes a 3-to-1 limit on age rating, i.e. the rating charged seniors is restricted to three times the level of premium that is charged to a young person.

A lot of people are going to react: Oh my God, you mean I am going to pay three times more than a young person? That doesn't sound fair to me. Guess what. When it began in the bill, it was 5 to 1. Under current state, premiums can be 25 to 1. There are States that charge 25 to 1, 20 to 1, 15 to 1. That is the way it is today. That is what seniors face today without this bill.

Guess what. In this bill, in the Finance Committee, we knocked it down from 5 to 1 to 4 to 1, and then, in the merged bill, we knocked it down to 3 to 1. In the House bill, it is 2 to 1. I ask a simple question: Is 3 to 1 or 2 to 1 better than 25 to 1 or 20 to 1? That is what is in this bill. This limits the age rating disparity in America. I offered an amendment to try to limit it to 2 to 1, but we were not able to carry that in the committee. Republicans spoke out against imposing a cap age rated premiums.

Charging older Americans nearly three times as much for health insurance is by no means ideal. I know that. But, boy, when you look around the country, the majority of States have no rating structure in the individual market at all, and there is a huge rate disparity, as I described, in the small group market. So you have no rating restraints. So we get down, at least, to 3 to 1. The House is at 2 to 1. Today, in most places in America, there are no restraints, nothing—zero—for the individual market, and there are high rating bands, as I said, of 20, 25 percent for the small group market.

Let me give you an example for Kentucky. We have a couple Senators from Kentucky on the Republican side. The rate bands in the small group market in Kentucky are as high as 25 to 1. I guess that is OK with them because they do not want this bill.

In Utah, the rate bands in the small group market can be as high as 34 to 1. I guess that is OK with them.

As I said, the 3 to 1 is too high, but, boy, is it a vast improvement over current law.

Some of our friends have said we should kill this bill because the exchanges are not strong enough. Well, I have been working on the exchanges with about 70 different groups in America ranging from seniors' representatives, union representatives, small business, and other representatives, all of whom are concerned about the exchanges being strong. I am pleased to say those who claim the exchanges in this Senate bill are not strong enough have not read the bill. You do not have to get past the first 200 pages in this bill to see how the exchanges have been strengthened.

In the Finance Committee, I offered an amendment to allow State exchanges to engage in prudent, selective purchasing of insurance. Under my proposal, exchanges would negotiate with plans for lower bids, encourage plans to form select networks, and exclude plans that did not offer good cost and good value.

The Senate bill we are looking at now provides exchanges with strong authority to certify whether a plan can participate in the exchange based on a number of criteria, including whether the plans meet certain marketing requirements, whether it has broad provider networks, whether they deliver quality benefits for the price. They can literally negotiate for all of those things. You do not have that today. You just have plans, and you have no control over what is in them.

So we actually create an exchange that can negotiate down the prices. And they have the power to approve the participation of plans if they are determined to be in the best interests of qualified individuals and qualified employers in the State.

I have advocated for these provisions because of a simple reason. In Massachusetts today we have this ability. We do this, and it has driven down the premiums. In Massachusetts, we have something called the Connector. In fact, the exchange that is in this bill is significantly based on the Connector in Massachusetts. In that, the Connector has the ability to negotiate contracts for what is called Commonwealth Care, and it has placed pressure on the carriers to reduce the rates overall. We have had this in place for 3 years now. The average premium increases have been only 4.7 percent compared to 8 percent average premium increases for private insurance.

The language in the Senate bill is modeled after the strength of the exchanges in Massachusetts, and I believe it will ensure that taxpayer dollars are spent in a smart way. That is what this does. It guarantees you can go negotiate for lower premiums, so you are driving down the cost to the taxpayers.

This bill also will ensure that all Americans have access to quality, affordable health care and will create the transformation within the health care

system necessary to contain costs. The Congressional Budget Office has determined that it is fully paid for—fully paid for—and it is going to provide coverage to more than 94 percent of all Americans. Even as it does that, it stays under the \$900 billion limit President Obama established. It reduces the costs of health care in America, and it reduces the deficit over the next 10 years and beyond.

I cannot think of how few the times were over the course of 25 years where we had a piece of legislation that accomplished a social goal that managed to simultaneously lower the deficit. That is an enormous accomplishment.

This bill includes immediate changes to the way health insurance companies do business to protect consumers from discriminatory practices, and it provides Americans with better preventive coverage—something we do not do enough of in America. We spend an amazing amount of time in our health care system just responding to symptoms, addressing disease, hospitalizing people with expensive procedures. A classic example of that is diabetes because we do not screen people. Because a lot of Americans do not have coverage, they do not get screened at an early stage. Therefore, when they are discovered to have diabetes, it becomes a far more acute treatment as a consequence of having gone all those years without the discovery. So you wind up with expensive alternatives, such as the amputation of limbs, dialysis, instead of having treated them earlier with oral intake of a pill or other treatments, diet, and other kinds of things that ultimately would save billions.

Well, this bill tries to encourage the embrace of better coverage for prevention and wellness. It empowers people in America. It does not say, in Washington: You have to do this or that. It is not command and control. It puts information at the disposal of Americans, so every American can decide what they want, where they want to go get it, who will treat them. That fundamental principle of American health care is absolutely, totally preserved and sacrosanct in this bill. Every American can choose their own doctor, choose their own plan. No one is told to go do this or go do that.

Uninsured Americans with a pre-existing condition can have access to an immediate insurance program and help them avoid medical bankruptcy. One of the huge bankruptcy causes in America is health care. How many seniors have had the situation where they have had to spend down by selling their homes, selling—if they are lucky enough to have any stocks—whatever assets they have, sell the family farm, sell the small business because they are very ill and they do not have the money, the kids do not have the money? But they hope to leave that

money to their kids. They hope to leave something to their children. Instead, we just wipe it out because we do not provide a lot of those folks with the insurance they deserve.

The new health insurance exchanges will make coverage affordable and accessible for individuals and small businesses. Premium tax credits and cost-sharing assistance is going to help people who need assistance. Insurance companies are going to be barred from discriminating based on preexisting conditions, health status, and gender.

The bill also improves the quality and efficiency of health care itself. As the Presiding Officer knows, we are strengthening the Medicare Program for America's seniors. I cannot believe the distortion that has been taking place over the course of these last weeks, months. Time and again, someone on the other side of the aisle will come to the floor and say this is attacking Medicare or this is going to tax the benefits.

Well, we believe—we, the party that created Medicare; we, the party that expanded Medicare; we, the party that has lifted a huge percentage of Americans out of poverty over the last 50, 60 years through Medicare—that it is a sacred trust, and we are going to keep it. This bill helps, in fact, to extend the life of Medicare. The cost of inaction is unacceptable for seniors and the Medicare Program that serves them. In fact, the Medicare hospital trust fund, as we know, is expected to go broke in over 7 years. This bill makes Medicare stronger. It makes it more sustainable. It extends the solvency by 9 years.

Medicare currently reimburses health care providers on the basis of the volume of care they provide rather than the value of the care they provide. For each test, scan, or procedure conducted, Medicare provides a separate payment. So we do that regardless of whether that was necessary or whether it had anything to do with the outcome for that particular patient. That does not make a lot of sense. We do not pay people to build our home the wrong way, or to build something we did not ask for and charge us more, or a whole bunch of other kinds of examples. But Medicare is doing that.

I think Americans deserve to get something better out of their taxpayer dollar. This bill includes a number of proposals to move away from what we call the “*a la carte*” Medicare fee-for-service system so that we begin to pay for quality and value, and that reduces costs to America's seniors.

This bill promotes, as I said, preventive care and improves the public health to help Americans live healthier lives and to help restrain the growth of health care costs over time. It, importantly, eliminates copays and deductibles for recommended preventive care, and it provides individuals with information they need to be able

to make good decisions about their health care and improves education on disease prevention, public health, and invests in a national prevention and public health strategy. It does all of that. All of those things just put to shame the idea of just scrapping this legislation.

Currently, 65 million Americans live in communities where they cannot access a primary care provider. An additional 16,500 practitioners are required to meet their needs. If you scrap this, that number is going to go up, and the number of millions—65 million today—of Americans who do not have access to a primary care provider is going to go up.

This bill addresses the shortages in primary care in other areas of practice by making necessary investments in the Nation's health care workforce.

Specifically, this bill will invest in the National Health Service Corps, scholarship and loan repayment programs. It will expand the health care workforce. The bill includes incentives for primary care practitioners and for providers to serve underserved areas.

Don't listen to me on the transformational changes. Listen to a fellow by the name of Jon Gruber, who is a very respected and renowned economist from MIT, and here is what he writes:

The United States stands on the verge of the most significant change to our health care system since the 1965 introduction of Medicare. The bill that was passed by the House and the parallel bill before the Senate would cover most uninsured Americans, saving thousands of lives each year and putting an end to our status as the only developed country that places so many of its citizens at risk for medical bankruptcy. Moreover, the bill would accomplish this while reducing the Federal deficit over the next decade and beyond. They would reform insurance markets, lower administrative costs, increase people's insurance choices, and provide “insurance for the insured” by disallowing medical underwriting and the exclusion of preexisting conditions. The Senate bill in particular would move us closer to taming the uncontrolled increase in health care spending that threatens to bankrupt our society.

That is what this bill does. That is what the Republicans are opposing.

These aren't minor things. These are things we have been striving to accomplish here for decades. I see colleagues who were here with me back when we struggled with the Clinton administration's effort on health care and every one of us would have been more than happy back then to have accepted—right then and there, we would have accepted what we have here today. I will tell you something: We would have had Republicans, such as Senator John Chafee, and I think Bob Packwood and others at that time, who would have tried to get a compromise passed, not totally dissimilar from the direction we are moving in here, and it was totally rejected by the Clinton administration.

So now is the time to examine what we have promised our people and decide where we stand. We know where the other side stands when they say “let's begin over,” pretending to America there is some place to begin over here. They have engaged in fear-mongering and deliberate misinformation. Those have been the core of the arguments they have used, fundamentally, to stop the success of President Obama.

They are also continuing now, obviously, to use procedural tactics, chewing up the Senate's time. The week before Christmas: Boy, let's see if we can back this right up and make it look as bad as possible and try to make the Congress look as bad as possible; make them fold. So they use this idea, and they are willing to block the funding for our troops so we can go on with this delay. We could have voted today, but they have said no.

There is no reason to do this. I think there is a snow storm coming to Washington. I suspect they are hoping the snow will prevent some Senator from getting here and then they won't be able to vote, because normal decency would have said, Hey, why don't we convenience everybody and have the vote before the snowstorm, but no. So they link it to blocking the money for the troops. I hate to think what some of those troops think is going on here. It is embarrassing.

We have heard repeatedly from Republicans that our health care reform bill is going to drive insurance premiums sky high for families. That is what they say, but the Congressional Budget Office says the opposite. It says that the 134 million Americans who get their insurance through their employer would end up paying 3 percent less for their premiums if we passed the reform measure before us. In addition, the CBO says the subsidies included in the measure would result in a 59-percent reduction in costs for nearly 18 million Americans who purchase their own insurance—a 59-percent reduction for a lot of Americans out there who buy their insurance individually. You don't think they want a 59-percent reduction? And despite the fact that the CBO says there is a 59-percent reduction, they continually come out here and tell people otherwise. Because one of the things we have learned in American politics is that if you throw the mud out there, throw the lie out there, throw the distortion out there enough, enough people will hear it and they won't know the difference.

Health care reform has dramatically reduced the premiums in Massachusetts. Premiums fell by 40 percent. We are not here conjecturing as to what is going to happen. This isn't some pie-in-the-sky theory that if we do this, here is what is going to happen. We have done it. In Massachusetts, we are insuring over 97 percent of all of our citizens, the highest level of insurance in

the United States of America. Guess what. The number of companies participating in the program has gone up since it was passed, and they like it. The premiums fell by 40 percent, from \$8,537 at the end of 2006 to \$5,143 in mid 2009, while the rest of the Nation saw a 14-percent increase. So in Massachusetts, premiums go down for the individual market by 40 percent; the rest of the Nation they go up 14 percent. What do you think most Americans would rather have, the 40-percent reduction or the 14-percent increase? Our bill gives Americans the opportunity to experience the same success we have enjoyed in Massachusetts.

We have also heard repeatedly from Republicans that this bill will add billions of dollars to the Federal budget deficit, despite the fact that the CBO analysis concludes that the bill is not going to add one dime to the Federal deficit—not one dime. From the very beginning of this debate, our colleagues on the other side of the aisle have tried to make the case that seniors' Medicare benefits—benefits—are jeopardized by our reform measure. Well, it is patently false, but we keep hearing it. It gets repeated again and again no matter how many times it has been shown to be false. The bill before us, in fact, does exactly the opposite. It actually adds benefits for seniors.

For example, there are new screening benefits. The bill shrinks the so-called doughnut hole in the Medicare prescription drug benefit. When we passed the prescription drug benefit, millions of seniors had a large gap in coverage. In 2009 seniors will experience a \$3,454 coverage gap. Even though they must continue to pay their monthly premium, they will receive no assistance with their drugs costs between \$2700 and \$6,154. That is a lot of money out of pocket for seniors. Well, we have reached an agreement where now that will be closed, and no longer will those seniors be out of pocket for the costs of drugs in the middle of that bracket.

In addition, the nonpartisan National Committee to Preserve Social Security and Medicare sent a letter to every Senator a few days ago. The Republicans and Democrats alike got this letter, but it hasn't stopped them from continuing to make the argument, but here is what the argument says: Not a single penny in the Senate bill will come out of the pockets of beneficiaries in the traditional Medicare Program. In fact, the letter adds that our reforms: "will positively impact millions of Medicare beneficiaries by slowing the rate of increases and out-of-pocket costs and improving benefits, and it will extend the solvency of the Medicare trust fund by 5 years."

To me, and to I think all of my colleagues here on our side of the aisle, that is a win-win for seniors, and it is a win-win for the Medicare Program.

Since sending that letter, the CMS actuary released a report saying that

the solvency of the Medicare trust fund would be extended by 9 years as a result of the Senate bill. So it has been interesting to watch Republicans speak about protecting Medicare, as I said earlier, a program that their party has opposed since the very beginning. While claiming to be trying to protect Medicare, they have simultaneously warned us many times about the evils of a government-run program. Again, I would ask, if they are so opposed to a government-run program, why don't they come to the floor with an amendment or a proposal to do away with Medicare? They won't, of course, because Medicare prevents millions of seniors from falling into poverty due to health care costs.

They also always promote the idea that competition is good for the marketplace, yet they adamantly oppose adding an option that could help provide some of that competition. President Obama said it clearly, that a public plan would help keep the private plans honest. I couldn't agree more.

Like some of our friends, some of our progressive friends, the Republicans have argued again and again about starting over. Let me remind my colleagues about one of the greatest legislators of the Senate's attitude about that, and one of the greatest champions of health care. Ted Kennedy fought for health care from the day he came here. One of his early speeches on the Senate floor was about health care. He often said that the biggest political mistake that he personally made in the 46 years he legislated was turning down a health care deal with Richard Nixon in 1971 that for the first time would have required all companies to provide a health plan for their employees, with Federal subsidies for low-income workers. That is how far the Republican Party has drifted from one of their own Presidents who, most people would agree, despite what happened in terms of what cost him the presidency, that he was a strong and capable President with respect to social policy in America.

The fact is that for the first time, all companies would have been required to cover their employees. That is the plan Richard Nixon offered Ted Kennedy and Ted Kennedy made the mistake of turning it down. He backed away from that deal under heavy pressure from fellow Democrats who wanted to hold out for a single-payer system once the party recaptured the White House in the wake of the Watergate scandal.

Well, 38 years have passed and single payer is still out of reach; not even on the table. Some people want to give up what we have available to us here and repeat that greatest mistake.

The lesson Teddy learned is this: that when it comes to historic breakthroughs in America, especially in social policies, you make the best deal you can and then immediately start pushing for ways to improve the deal.

Let me share a quick story with my colleagues. We all remember how Ted Kennedy on the floor of the Senate kept pushing and pushing to raise the minimum wage, which hadn't been raised in years. Finally, he pushed so hard that Robert Dole, who was then the majority leader and who was then running for President, decided he couldn't run for President while Ted Kennedy was pushing that hard, tying up the Senate, to get the legislation passed. It might raise people just a little bit; it wouldn't even get them up to par. Robert Dole resigned from the Senate to go run for President. He said, Ted Kennedy doesn't run the world, but he did.

Trent Lott came in. Senator Lott from Mississippi became the majority leader. He vowed the same thing. He said: This isn't going to happen. Within months, within months, Senator Kennedy was doing the same thing again, pushing for the rise in the minimum wage. Senator Lott acceded to him. We got the minimum wage passed. And at a rally where he was celebrating the rise of the minimum wage, which was then not even up to par, he was in the victory moment and he turned to Congressman GEORGE MILLER and he said: I am introducing a bill to raise the minimum wage. GEORGE MILLER said, What do you mean? We haven't even let the dust settle. He said, We have to move on this.

That is what is going to happen with this bill. We all know there are things we are going to have to watch, there are things we are going to have to do, things we are going to have to improve, things that aren't in it that we want to get in it. But to pass up the opportunity for all of the things I have talked about and listed would be an enormous—an enormous—mistake.

Since 1965, when Medicare and Medicaid were created, they have involved and improved over the years.

When Medicare first passed, it didn't cover individuals with disabilities or individuals with end-stage renal disease. Now it does. Similarly, Medicaid evolved to allow States to cover additional services such as home- and community-based care. Now, both Medicare and Medicaid are indispensable elements of the social contract of the United States.

Our march to this point has been too long and too slow—almost a century, in fact. It began in 1912 when Teddy Roosevelt ran for President promising government protection against, as he put it, "the hazards of sickness." There have been fits and starts ever since—through the shouting and distortions and big interests clinging to the status quo, and we cannot allow that to continue any longer.

We know the legislative process is a long one. But 97 years is way too long for America to finally join the other major industrialized nations in guaranteeing health care for all of our people.

That we are here today, with an opportunity to take a giant step, shows not only what a challenge this undertaking has been, but it shows what hard work, skill, and dedication a lot of Senators have shown trying to get us here.

I particularly applaud the effort of Senator REID, who personally has sacrificed the effort to help move this, and the entire leadership, including Senator BAUCUS, chairman of the Finance Committee, and Senator DODD, of the HELP Committee, who was carrying that load for Senator Kennedy. TOM HARKIN is now doing that job, and he and BARBARA MIKULSKI and JEFF BINGAMAN were central to shaping what is coming to the floor.

Hundreds of Republican amendments were accepted during that process. Senator BAUCUS considered hundreds of amendments on the Republican side. The bill is not perfect. Tell me what bill is. All of us would like to change it here and there, but none of us can credibly claim we didn't get a chance to have input to this bill.

Make no mistake, this legislation, with cooperation and bipartisanship, can make history and improve the lives of Americans for decades to come, and that is important to this country and to our economy. It can help change who we are as a country. Ninety-four percent of Americans will have health care. Just think of that. If we do nothing, things are only going to get worse—more expense, more bankruptcies, and more people without coverage.

I can't help but think how often we have private conversations around here at the Prayer Breakfast, at the National Prayer Breakfast, at the Senate Prayer Breakfast, and in private conversations about what the duties and obligations are of good adherence to most of the organized religions of the world and certainly most of the philosophies of the world. They all embrace a component of the Golden Rule. You can go to any Scripture and you can read about one person's human responsibility to another human. These kinds of opportunities to live up to those guidelines, these values, don't come very often. Many of us here saw that pass in 1993. We learned a lot of tough lessons then.

I say to my progressive friends in this country, after that, we did a little better with the Children's Health Insurance Program, and we did better with portability and little pieces here and there. But still the system is out of whack and gets more expensive, and still more Americans lose their health insurance. Still, we wind up with institutionalized unfairness.

I remind my colleagues of when Ted Kennedy worked on the Children's Health Insurance Program. Do you know who the minority cosponsor was? It was ORRIN HATCH. He said that passing it was the mark of a compas-

sionate, caring Congress. We still have millions of kids who are not covered by health insurance.

Compassion can be the mark of this Congress, if we act with respect, courage, and with cooperation. I don't think we can stop now. I don't think there is any object but to get this job done after all these years.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Jersey is recognized.

Mr. MENENDEZ. Mr. President, my distinguished colleague from Massachusetts has been talking about the urgency and the importance of this legislation, and he has done so masterfully. We have been debating health care for weeks. We have been debating it for months if you think about the markup that took place in the HELP Committee, as well as in the Senate Finance Committee. We have been debating it even more if you consider the times of negotiation that took place between a group of six Members of the Senate—three Democrats and three Republicans—in search of a bipartisan effort. So all of this talk that this is a rush to judgment doesn't square itself with the facts.

But there is another bill that is pending before the Senate, a bill that should have passed without any difficulty.

Mr. President, the tactics of delay and obstruction we have seen on this floor for the last few weeks on the part of the minority have now reached critical mass. We are fighting two wars. It is nice to be home. It is nice to be home for the holidays. It is nice to be here in the comfort of the Senate. It is nice to be able to see your family. But we are fighting two wars abroad. We have work to do for the American people, and these continued unnecessary delays from the Republican side of the aisle are now impacting our military men and women on the ground in Iraq and Afghanistan. These delays come at a time when we are seeing greater success in Iraq, a time when we are more focused on wiping out al-Qaida along the Afghanistan-Pakistan border.

Our colleagues on the other side of the aisle are engaged not in governing, not in the bipartisanship they claim to embrace, but in pure politics—a political game that does not threaten the majority, does not benefit the minority; what it does is threaten the health, safety, and in some cases the lives of military men and women in harm's way.

Never have so few been asked to sacrifice so much on behalf of their country. Never have a relatively small group of Americans in uniform, in harm's way, been asked to sacrifice so much, with multiple tours of duty, while the rest of America enjoys security at home because of their sacrifice. You would think that our friends on the other side of the aisle would want

to join expeditiously to make sure that their pay, their health care, and the equipment they need would be there as quickly as possible.

Our friends on the other side of the aisle have determined that their only strategy is to bring the work of the Senate to a halt—to diminish the effectiveness of the Senate they serve in an effort to diminish the majority. It is a shame, but our Republican colleagues have come to their view as a political tactic, the road to electoral victory next year in the midterm elections of 2010 and then preparing themselves already for the Presidential election of 2012, wanting this President to fail and this Congress to fail. If you looked at it as a political tactic, you might say, well, as a political tactic it might make sense for them.

It is a horrid political tactic because it is not about this President failing. It is not about this Congress failing. It is about the failure for the country in one of its most precarious moments.

This President inherited the worst economy since the Great Depression, and I don't think people understand how close to the abyss we were from facing a real depression once again in our history. Financial institutions were collapsing, and we cared but not for the sake of them as big institutions but what they would have meant to the economy as a whole. There was a free-fall in the housing market and the reality of two wars raging abroad, which he inherited, in Iraq and Afghanistan. There is a nuclear North Korea and nuclear-thirsty Iran, an energy policy that sends \$1 trillion to countries that are despotic and wish us ill. Ultimately, we give them the money to act out on their despotism. This is what this President inherited.

Instead of working with him, our colleagues on the other side of the aisle have determined that the politics of failure will lead them to electoral victory, and that is more important than the future of the country. They have come to the floor of the Senate to say no to everything—first, health care, and now to providing for our troops in harm's way. They have come armed with an arsenal of parliamentary maneuvers—not to govern or do what is best for the American people, not to do what is best for the Senate, but to do what is politically expedient for them.

Diminishing the Senate's ability to pass the Defense appropriations as well as health care reform in order to score political points—and then call it victory—is an insult to the American people. It flies in the face of what our Founders intended of a true representative democracy—not to tear down the institutions of government and bring them to a halt but to make them work for the people.

Sam Rayburn once said:

A jackass can kick a barn door down, but it takes a carpenter to build one.

My friends on the other side of the aisle seem intent on kicking the barn door down. In my view, that is not victory. Doing nothing, delaying, obfuscating, saying no, no to everything, blocking the ability of this Chamber to fulfill its duty to the people is no victory.

Saying no to funding our troops serving bravely overseas in Iraq and Afghanistan is hardly victory. Delaying it is hardly victory. Saying no to funding medical care for our military men and women and their families is not a victory; it is shameful delay of needed care. Saying no to \$120 million for traumatic brain injury and psychological health research at a time when so many of our troops are coming home from Iraq and Afghanistan with such injuries is by no means a victory. Saying no to necessary funding to train and equip Afghan security forces so they can stand up for their own country and get our people out is contrary to the President's surge policy, which our friends on the other side publicly supported.

Imagine if the tables were turned and it were the Democrats delaying funding for mine resistant vehicles to protect our troops in Iraq and Afghanistan. What would our friends on the other side say then? Imagine if it were this side of the aisle delaying passage of \$636 billion for the military, including \$128 billion in funding for contingency operations in Iraq and Afghanistan. Imagine if it were this side of the aisle delaying \$154 billion to increase readiness and training of our troops. Imagine if it were this side of the aisle delaying funding for Bradley Fighting Vehicles, Stryker Combat Vehicles, and three E-2D Hawkeye aircraft. Imagine if it were this side of the aisle delaying all of this critical equipment. Imagine if Democrats were standing in the way of funding military health care for service men and women and their children. This is all included in the Defense appropriations bill. But that is what our Republican friends on the other side are doing. Imagine if the Democrats were holding up needed assistance in health coverage for Americans who lost their jobs and are unemployed in this economy at this time of the year. That is included in the bill as well. But that is what our friends on the other side are doing. What would our colleagues on the other side say of our patriotism if we on this side were delaying funding for our troops?

Patriotism doesn't shift with the political tides. It is not something used to advance a political agenda because if it is, it is not patriotism.

We can disagree on the issues. We can disagree on substance. We can hold opposing views. That is what happens in a democracy. But there is no victory in diminishing the functions of government, the responsibilities of government, the duties of this Chamber for

calculated political gain. There is no victory in holding up extending desperately needed unemployment benefits included in this bill. There is no victory in blocking the extension of COBRA health insurance subsidies in this bill for people who have lost their job, their health care, and may be in danger of losing everything—everything—they have worked for, especially at this time of the year.

As I think about this time of the year, it is not a stretch to look at the delaying tactics of our friends on the other side of the aisle on this legislation and think of that famous Christmas movie, "A Christmas Carol," and think of Ebenezer Scrooge who, when asked for a contribution to those who were in need, replied: What, are there no poor houses?

Our colleagues on the other side are holding so tightly to their tactics that they are forgetting the very democratic values they profess so fiercely to protect.

I urge my colleagues on the other side to see victory not in delay and obstruction but in doing what is right for the American people. Do what is right for our military men and women who will spend this holiday season in Iraq and Afghanistan in harm's way.

I say if the tables were turned, my colleagues on the other side would come to this floor, wave the flag, proclaim themselves the only true patriots and vilify this side of the aisle as un-American, unpatriotic, undemocratic.

The fact is, we are all patriots, and as patriots, though, we have a job to do. That job is to make sure our men and women have everything they need, even when we disagree as to whether it is an appropriate engagement. Once they are engaged, it is our responsibility to ensure they are appropriately taken care of.

The tactics of delay for political advantage can never—never—be accepted. I urge my colleagues: Do not play politics with the Defense appropriations that includes funding necessary to protect our men and women in uniform. Let's not play politics at the expense of unemployed Americans in need in this economy at this time of the year. It is not time for those debates. Those debates should be behind us. And it is not time for the political tactics that, in essence, put people at risk.

There are many other ways to try to achieve political victory. You can do it with the power of your ideas, but you certainly do not have to do it by a political tactic that puts the country in jeopardy, that puts our men and women in jeopardy, that at the end of the day says we would rather see failure than success so we can win an election. That is not acceptable.

I yield the floor.

Mr. JOHNSON. Mr. President, I rise today to recognize the momentum pro-

pellung us forward in the health care reform debate.

Today, one-sixth of our economy is consumed by health care. In the absence of reform, the Congressional Budget Office projects total health care spending to consume an ever greater share of our economy, up to 30 percent by 2035. What should we expect in return for the staggering amount of money our nation spends on health? Shouldn't one-sixth of our economy buy us health care for every American? I believe that it can. Not only will the Senate health care reform proposal extend access to health insurance to 30 million Americans, but it will reduce health spending in the long run. This is vital to the future of our economy and our continued competitiveness in the international community.

We may be at the global forefront of medical innovation, but we remain the only industrialized nation to not guarantee each of its citizens access to basic health care. Americans are being priced out of our private health care market at alarming rates. Health care premiums have risen 98 percent since 2000 and continue to rise four times faster than wages. In South Dakota, where incomes are lower than in most other States, families making \$50,000 per year can expect to pay on average 10 percent of their income for a policy on the individual market. And this share will only grow if we fail to reform the system.

Families and small businesses are faltering under the weight of increasing health care costs and medical bankruptcies. A 2005 study linking medical bills to bankruptcy found that even brief lapses in coverage, such as during a job change, expose individuals to significant risk. I have heard from far too many South Dakotans forced into bankruptcy due to a health emergency. I would like to share one of those specific stories with my colleagues. Mary had just started a job when she was diagnosed with breast cancer. Her new policy required a 3-month waiting period before coverage began, but cancer treatment could not be postponed. She frequently traveled over 50 miles to the nearest facility for radiation, chemotherapy and follow-up appointments, but often went without necessary care because she could not afford it. Her brief lapse in coverage left her with thousands of dollars in out-of-pocket medical bills and, after 2 years of garnished wages, she was ultimately forced into bankruptcy.

Her problems didn't end there. The aggressive radiation and chemotherapy treatment for her breast cancer has caused her other health problems. She now requires dental care to address her weakened tooth enamel, but can't afford to pay out-of-pocket and doesn't qualify for low-income public programs. At one point, this woman was securely employed and carried health

insurance, but misfortune left her in financial ruin and with poor health. Like millions of underinsured Americans, she discovered the inadequacies of our health care system the moment she needed it most.

Most insured Americans have a false sense of security and don't realize that many health insurance policies prove inadequate in the face of serious illness. The Patient Protection and Affordable Care Act holds health insurance companies accountable, creates competition and provides assistance to those who need help buying insurance. As the end of the year approaches, we stand on the brink of passing historic legislation. Never before have we been this close to reforming our health care system in such a positive way. I urge my colleagues to seize this opportunity to provide all American with the security of health insurance through all of life's transitions.

Mr. INHOFE. Mr. President, we may be quickly approaching the end of this health care debate in the Senate. It has been a partisan event. Republican amendments have consistently failed roughly along party lines. However, I don't want to overlook some of my Democratic colleagues who have voted with us on a number of the Republican offered amendments. However, I want to focus my remarks on the half a trillion dollar increase in taxes this health care bill imposes on individuals, families, and businesses. I would also like to focus my remarks on one of the 471 amendments filed to this bill highlighting the new taxes on assistive medical devices under this bill.

President Obama repeatedly promised during his campaign that no one making under \$250,000 per year would see their taxes increase. However, the Democrats plan to spend \$2.5 trillion in new healthcare promises at a time when the country can't afford the promises we have already made and we have a record 1-year budget deficit of \$1.4 trillion. This health care reform bill, currently under consideration in the Senate, raises revenues to a large extent on the backs of middle class Americans despite Obama's pledge—his firm pledge—that this would not happen.

Reading through the legislation, I am struck by the myriad of ways this bill raises taxes on American citizens, from job-creating small businesses to middle class families. I count about a dozen of them, adding up to about \$500 billion in tax increases over the next few years. Half a trillion dollars in new taxes. So everyone should get ready to pay a higher health care bill and a higher tax bill should this measure become law. I mentioned the tax increases in this legislation last week, but I believe it bears repeating and I plan to specifically point out a tax increase in this bill I find particularly objectionable.

First let me remind the Senate and the American people that when the bill

is fully enacted, the nonpartisan Joint Committee on Taxation, JCT, found that, on average, individuals making over \$50,000 and families making over \$75,000 would see their taxes go up in this bill. Let me repeat that: if you make over \$50,000 as an individual or \$75,000 as a family, your taxes are going up under this bill. Indeed, according to the JCT 42 million middle class families and individuals, those making less than \$200,000, on average will pay higher taxes in this bill.

If you have health insurance, you get taxed. According to the nonpartisan Congressional Budget Office, new excise taxes applied to health insurance providers will end up taxing the beneficiaries. This tax also has the effect of increasing premiums as well. So you are double taxed on this deal. That is if you do have health insurance.

If you don't have health insurance, you get taxed. Under the bill, you get taxed if you don't carry health insurance as a penalty. Where does this burden fall? You guessed it, middle class Americans. CBO has said that half of the Americans affected by this provision make between \$22,800 and \$68,400—for a family of four.

If you take prescription drugs, you get taxed. According to JCT and CBO, new taxes in this bill applied to the provision of prescription drugs will end up raising the cost of those drugs. Taxed again.

So those are some examples of what you can do to pay higher taxes under this bill: have health insurance, don't have it, take prescription drugs. All of these activities are taxed mercilessly under this legislation. There is yet another tax provision that I find extremely detrimental and objectionable. If you happen to need a medical device, you get taxed. Section 9009 imposes a new \$2 billion a year tax on assistive devices which includes items like pacemakers, ventilators, prosthetics, hearing aids, glucose monitors for diabetics, and incubators for premature babies. It has no regard for the age or status of the individual requiring the device. It's totally indiscriminate. I have filed an amendment that will exempt assistive devices for individuals with disabilities from this tax. It is amendment No. 3053.

Let's look at some of the individuals impacted by this \$2 billion a year tax.

My son-in-law, Brad Swan, installs pacemakers and defibrillators. One morning last week, at 1 a.m., he was called to an emergency involving an 8-year-old boy with no heartbeat. He was born with congenital heart disease, had a pacemaker put in, and was healthy that morning. My older sister, Marilyn, faced a similar situation 9 years ago and is alive and healthy today. Additionally, Dr. Stanley DeFehr, a cardiologist in my hometown of Tulsa, explained to me that “the decision of who needs a pacemaker could be com-

plicated, particularly the decisions to put in a pacemaker on someone we might consider quite elderly. But it's a false economy to deny putting one in because of their risk of falling and breaking a hip or shoulder. In the case where they fall, the costs become quite high. The cost of a pacemaker (\$5,000, lasting 10 years) pales in comparison to the cost of a stroke or multiple fractures.”

Let's look at the impact this tax will have on our servicemen and women.

We all remember when Congress passed the Wounded Warriors Act as part of the Fiscal Year 2008 National Defense Reauthorization Act, which required the Department of Defense and Veterans Administration to jointly develop a comprehensive policy on improvements to care for our servicemembers. The bill created three Centers of Excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of traumatic brain injury, post-traumatic stress disorder, PTSD, and eye injuries.

The very next year, I successfully amended the Wounded Warriors Act in the Fiscal Year 2009 National Defense Reauthorization Act to expand the Center of Excellence care network in the Wounded Warriors Act to include amputations and traumatic extremity injuries. Eighty-two percent of injuries from the global war on terror involve the extremities, and are often severe, including multiple injuries to the arms, legs, head and neck.

In fact, Congress has found, “Extremity injuries are the number one battlefield injury. Dynamic research and treatment is necessary to provide servicemembers the greatest ability to recover from injuries sustained on the battlefield.” When limbs cannot be saved, often these injuries are treated with the use of state of the art prosthetic devices enabling our service men and women in some part to regain the use of arms or legs lost from combat injuries.

I have long supported the innovations in prosthetics and assistive devices for our Nation's service men and women. Today, there are nearly 2 million Americans with limb loss. Prosthetic technologies developed for military medicine are almost universally dual-use, meaning the technology can be applied for civilian use as well. Much of this research is being done at the University of Oklahoma and by Oklahoma companies such as Hanger Prosthetics, Martin Bionics, and Sabolich Prosthetics. Oklahoma has a long, proud history of excellence in prosthetic care. For the past twenty-five years, persons who have lost limbs have traveled to Oklahoma from around the world to receive the finest in prosthetic care. Only this past October, I visited the Oklahoma City-based company, OrthoCare Innovations,

which is developing a robotic prosthetic alignment system which builds on its prosthetic innovations.

The Democrat health bill includes a tax on all assistive devices. In fact, to add insult to injury, the Democrat health bill contemplates the detrimental effect the bill may have on our veterans. Section 9011 calls for a study on the impact of this tax on our veterans after the fact. However, a study after the damage is done is too little, too late. This is simply irresponsible and damaging for those veterans who need these devices.

The Democrat agenda and this bill clearly include more taxes on Americans. The new taxes may be hidden but they are there. It is disingenuous. It is costly. This bill is expected to cost \$2.5 trillion on top of our already exploding debt. This bill is exactly what America does not need, and that is why Americans oppose it. It is common sense.

Mr. ENZI. Mr. President, I rise to express my concerns about the Fiscal Year 2010 Defense Appropriations Act which is currently pending before the Senate. I was one of the seven Members of the Senate to vote against our version of this bill in October and I regret that I must vote against it once again. This time it was also held to a time when they thought Christmas would force fast action even on things that don't belong on a defense bill that should have been last October.

Congress has gotten into a bad habit of using our military funding bills as "must pass" legislation to get approval for other unrelated items. This year, the items are a number of extensions on legislation we were not able to finish as part of our regular business. The majority leadership wouldn't allow us to work together to get our job done so some are using a troop bill as cover. There are 13 sections attached to this bill that have nothing to do with our troops.

Now folks might wonder why Congress attaches unrelated items to military bills. Because doing what is right is a difficult stand to take and say no to military funding. The majority party is hoping that enough Senators will want to avoid voting against military funding and be willing to take the bad or the unknown with the good.

We are also now considering this defense bill not as a conference report that has gone through our regular process, but as a message between the House and Senate in order to avoid normal Senate procedures. The Senate has our rules and procedures for a reason. Our procedures are designed to allow Senators the opportunity to fully consider what legislation does and does not do. When Senate leaders avoid Senate rules and procedures, they dodge their responsibility to those who elect us.

I want to make very clear my strong support for the members of our Armed

Forces and the vital work they are doing around the world every day. My State of Wyoming currently has about 900 soldiers deployed with our National Guard in Iraq and Kuwait our largest deployment ever.

I have the greatest admiration for all of them for their commitment to preserving our freedoms and maintaining our national security. They are all true heroes and they are the ones who are doing the heavy lifting and making great sacrifices in our country's name so that we might continue to be the land of the free and the home of the brave.

I am extremely disappointed that our troops must continue to pay the price for political posturing in a must-pass military funding bill loaded with unrelated and unquestioned provisions. Do our troops at home and deployed need the funding for the programs in this legislation? Do they deserve better from their elected congressional representation than being used as cover to enact unrelated legislation? The answer is yes.

Mr. LEVIN. Mr. President, I support the Department of Defense Appropriations Act for 2010.

This legislation provides the funding our men and women in uniform need to continue their efforts on behalf of our Nation. The \$128.3 billion included in this bill to fund operations in Iraq and Afghanistan is an important statement of support for the troops who are serving so bravely so far from home.

This bill also includes important measures that will help Michigan and other states weather the economic strain they now face.

Most important of these are provisions that will extend unemployment benefits and Federal assistance to offset the costs of health insurance for those who have lost their jobs. Existing unemployment benefits are expected to expire at the end of this year. I am pleased that under this bill, benefits will be extended to February 28, 2010, making many Michiganders and other Americans eligible for expanded benefits that provide more support, and for a longer duration. This is crucial assistance to families coping with the devastation of job loss.

In addition, the bill extends from nine to 15 months the American Recovery and Reinvestment Act's assistance to workers who have involuntarily lost their jobs to pay for health coverage under COBRA. That assistance pays up to 65 percent of workers' COBRA premiums. Under current law, workers who lose their jobs after December 31 would not be eligible for this assistance, but the bill extends that deadline to February 28, 2010, ensuring that thousands of Americans will not have to deal with the loss of health care at the same time they face the loss of a job.

The legislation also would continue improvements in Small Business Ad-

ministration loan programs, improvements enacted in the American Recovery and Reinvestment Act to make SBA loan guarantee programs more attractive to borrowers and lenders. Through February 28, 2010, the SBA would be able to continue offering guarantees up to 90 percent of loan amounts, and to continue waiving or reducing loan fees. Access to capital is among the biggest factors keeping companies from hiring, and continuing these measures is an important step toward boosting employment.

This bill also includes provisions to ensure that the Supplemental Nutrition Assistance Program, SNAP, has the funding required to meet increasing demand, and to provide States with funding to process the growing number of applications for the program more quickly. And it will maintain 2009 poverty guidelines for Health and Human Services programs through February 28, 2010, preventing a loss of eligibility for many recipients of means-tested programs, including Medicaid, SNAP and child nutrition programs. These provisions will prevent the opening of holes in our social safety net just as Americans are most in need of support.

These provisions are much needed to help blunt the impact of recession on America's workers as we work toward a brighter economic future.

MORNING BUSINESS

Mr. MENENDEZ. Mr. President, I ask unanimous consent that the Senate proceed to a period for the transaction of morning business, with Senators permitted to speak for up to 10 minutes each.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

CONGRATULATING THE NORTHWEST MISSOURI STATE UNIVERSITY FOOTBALL TEAM

Mr. President, I commend and congratulate the Northwest Missouri State University Football team on their most recent victory in the NCAA Division II Championship this past weekend. Their journey to this game and their performance in it testifies to their dedication and perseverance.

The Bearcat football team has seen much success and disappointment over the past four seasons. Having reached the championship contest the previous 4 years only to fall short in the title game, the Bearcats, led by Coach Mel Tjeerdsma, would not be denied victory in this fifth straight championship contest.

By a score of 30-23 over the Grand Valley State Lakers, a formidable opponent, the Northwest Missouri State Bearcats wiped away their heartbreak from the past with their win.

The victory comes on the 10th anniversary of their last national championship, and once again brings great

pride to their football program, students, faculty, their home city of Maryville, and the entire State of Missouri. The NWMSU Bearcats have now won three national championships since 1998, proving to be one of the best programs in Division II football.

It is with great pleasure that I congratulate Coach Tjeerdsma and his entire coaching staff, current students, faculty and alumni, and most all the football players who never gave up—especially the senior class who have gone through the challenges of the past 4 years. They proved that with hard work and dedication any goal is attainable.

Congratulations to the Northwest Missouri State University Bearcats on their third Division II football National Championship. We look forward to more good things to come from this university and this football program.

COPENHAGEN CONFERENCE ON CLIMATE CHANGE

Mr. LEAHY. Mr. President, I want to speak briefly as the Copenhagen conference on climate change approaches its final hours.

Earlier this week, Secretary of State Clinton announced on behalf of the United States the intention to work with other governments to raise \$100 billion in long-term financing by 2020 to help developing countries address global climate change. This is an important commitment and an essential part of any comprehensive approach to global warming. If the United States is to play a leading role in addressing climate change, we must provide not only strong policies and resources here at home in our factories and on our farms, but also help poor countries adapt to rising sea levels and temperatures which affect agricultural productivity, and to reduce their own emissions of the greenhouse gases that affect every American as well as billions of others across the globe.

The United States has been historically the major emitter of CO₂, and we clearly have a responsibility to help address this global problem. Those who suggest otherwise ignore history. But this is a win-win situation: By exporting U.S. clean energy technology and expertise, we will also generate jobs here at home, help other countries reduce their emissions in a transparent, verifiable and accountable manner, and help to avoid the worst effects of global warming.

Other nations, particularly China and India, are also major contributors to global warming. The administration is right to insist that they be part of the solution and agree to verifiable limits on their own greenhouse gas emissions. It is encouraging that China is already a major investor in renewable energy technology, but at the same time is building coal-fired powerplants at an alarming rate.

For the past 8 years, the policy of the Bush administration was to ignore this problem. In fact it was worse than that, as the last administration actively sought to discredit the scientific evidence and oppose any efforts both here and abroad to address global warming with anything more than lip-service.

Fortunately, times have changed. We have a President and a Congress that are committed to developing a strategy to invest in clean energy, energy efficiency and new high-tech infrastructure that will bring us to long-sought goals: energy independence, good jobs for our citizens, and a healthy planet for our children and grandchildren. The recently passed fiscal year 2010 Department of State, Foreign Operations, and Related Programs Appropriations Act provides more than \$1.2 billion for climate change and environment programs overseas. This is a significant increase over last year. From exports of renewable energy technology to programs to protect tropical forests, these funds will play a part in our bilateral and multilateral efforts to work collectively with other countries.

This and Secretary Clinton's announcement are important steps, but the relentless burning of fossil fuels and destruction of the world's remaining forests call for nothing less than unprecedented commitments to reverse these trends. There is already speculation that Copenhagen will fall far short of what is needed. I am hopeful that before the conference concludes the Obama administration will demonstrate further that the U.S. is going to do what is necessary so future generations will not look back and ask why we failed when faced with this great challenge.

HONORING OUR ARMED FORCES

PRIVATE FIRST CLASS JAICIAE L. PAULEY

Mr. BAYH. Mr. President, I rise today with a heavy heart to honor the life of PFC Jaiciae L. Pauley. Jaiciae was 29 years old when he lost his life on December 11, 2009, in Kirkuk, Iraq. He was assigned to the 1st Battalion, 30th Infantry Regiment, 2nd Brigade Combat Team, 3rd Infantry Division, Fort Stewart, GA. Jaiciae died supporting Operation Iraqi Freedom.

Today, I join Jaiciae's family and friends in mourning his death. Jaiciae will forever be remembered as a loving son and a friend to many. Jaiciae is survived by his parents, Mr. Roger D. Pauley of Muncie, IN; his mother, Ms. Caitlin Ramshaw of Fort Pierce, FL; and a community of his family and friends.

Jaiciae was an ambulance aide and driver. He joined the Army in 2008, and this was his first deployment.

While we struggle to express our sorrow over this loss, we can take pride in Jaiciae's service as a soldier and in his

life as a son and friend. Today and always, he will be remembered by family, friends and fellow Hoosiers as an American hero, and we cherish the memory of his service and his life.

As I search for words to do justice to this fallen soldier, I recall President Abraham Lincoln's words as he addressed the families of soldiers who died at Gettysburg: "We cannot dedicate, we cannot consecrate, we cannot hallow this ground. The brave men, living and dead, who struggled here, have consecrated it, far above our poor power to add or detract. The world will little note nor long remember what we say here, but it can never forget what they did here." This statement is just as true today as it was nearly 150 years ago, as we search for some measure of solace in knowing that Jaiciae's sacrifice and memory will outlive the record of the words spoken here.

It is my sad duty to enter the name of Jaiciae L. Pauley in the RECORD of the U.S. Senate for his service to this country and to freedom, democracy and peace. I pray that Jaiciae's family can find comfort in the words of the prophet Isaiah, who said, "He will swallow up death in victory; and the Lord God will wipe away tears from off all faces."

May God grant strength and peace to those who mourn, and may God be with all of you, as I know He is with Jaiciae.

MESSAGE FROM THE HOUSE

At 12:58 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House agrees to the amendment of the Senate to the bill (H.R. 2847) making appropriations for the Departments of Commerce and Justice, and Science, and Related Agencies for the fiscal year ending September 30, 2010, and for other purposes, with an amendment, in which it requests the concurrence of the Senate.

The message also announced that pursuant to section 1238(b)(3) of the Floyd D. Spence National Defense Authorization Act of Fiscal Year 2001 (22 U.S.C. 7002), amended by division P of the Consolidated Appropriations Resolution, 2003 (22 U.S.C. 6901), and the order of the House of January 6, 2009, the Speaker reappoints to the United States-China Economic and Security Review Commission the following private citizens: Ms. Carolyn Bartholomew of Washington, DC, and Mr. Jeffrey L. Fiedler of Great Falls, Virginia.

MEASURES PLACED ON THE CALENDAR

The following bill was read the second time, and placed on the calendar:

H.R. 4314. An act to permit continued financing of Government operations.

MEASURES READ THE FIRST TIME

The following bill was read the first time:

H.R. 4314. An act to permit continued financing of Government operations.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC-4098. A communication from the Chief of Research and Analysis, Food and Nutrition Services, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "School Food Safety Program Based on Hazard Analysis and Critical Control Point Principles" (RIN0584-AD65) received in the Office of the President of the Senate on December 16, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4099. A communication from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "Importation of Swine Hides and Skins, Bird Trophies, and Ruminant Hides and Skins" (Docket No. APHIS-2006-0113) received in the Office of the President of the Senate on December 16, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4100. A communication from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "Importation of Cooked Pork Skins" (Docket No. APHIS-2008-0032) received in the Office of the President of the Senate on December 16, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4101. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Tribenuron methyl; Pesticide Tolerances" (FRL No. 8797-9) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4102. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Rimsulfuron; Pesticide Tolerances" (FRL No. 8796-9) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4103. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Quinclorac; Pesticide Tolerances" (FRL No. 8800-7) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4104. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Prosulfuron; Pesticide Tolerances" (FRL No. 8800-8) received in the Office of the

President of the Senate on December 15, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4105. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Prometryn; Pesticide Tolerances" (FRL No. 8801-8) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4106. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Mesotrione; Pesticide Tolerances" (FRL No. 8799-1) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4107. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Glyphosate; Pesticide Tolerances" (FRL No. 8408-1) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4108. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Fluoxastrobin; Pesticide Tolerances" (FRL No. 8803-4) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4109. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Fenarimol; Pesticide Tolerances" (FRL No. 8793-5) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4110. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Endothall; Pesticide Tolerances" (FRL No. 8804-8) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4111. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Dinotefuran; Pesticide Tolerances" (FRL No. 8803-1) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4112. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Chlorimuron Ethyl; Pesticide Tolerances" (FRL No. 8798-1) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4113. A communication from the Director of the Regulatory Management Division,

Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Bifenazate; Pesticide Tolerances" (FRL No. 8804-1) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4114. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "2,6-Diisopropyl-naphthalene (2,6-DIPN); Time-Limited Pesticide Tolerances" (FRL No. 8798-5) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4115. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "2-propenoic acid, butyl ester; polymer with ethenylbenzene, methyl 2-methyl-2-propenoate and 2-propenoic acid; Tolerance Exemption" (FRL No. 8800-6) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-4116. A communication from the Assistant Secretary, Bureau of Political-Military Affairs, Department of State, transmitting, pursuant to law, an addendum to a certification, transmittal number: DDTC 131-09, of the proposed sale or export of defense articles, including technical data, and defense services to a Middle East country regarding any possible affects such a sale might have relating to Israel's Qualitative Military Edge over military threats to Israel; to the Committee on Armed Services.

EC-4117. A communication from the Director of Defense Procurement and Acquisition Policy, Department of Defense, transmitting, pursuant to law, the report of a rule entitled "Defense Federal Acquisition Regulation Supplement; Foreign Participation in Acquisitions in Support of Operations in Afghanistan" (DFARS Case 2009-D012) received in the Office of the President of the Senate on December 16, 2009; to the Committee on Armed Services.

EC-4118. A communication from the Director of Defense Procurement and Acquisition Policy, Department of Defense, transmitting, pursuant to law, the report of a rule entitled "Defense Federal Acquisition Regulation Supplement; Statutory Waiver for Commercially Available Off-the-Shelf Items" (DFARS Case 2008-D009) received in the Office of the President of the Senate on December 16, 2009; to the Committee on Armed Services.

EC-4119. A communication from the Director of Defense Procurement and Acquisition Policy, Department of Defense, transmitting, pursuant to law, the report of a rule entitled "Defense Federal Acquisition Regulation Supplement; Technical Data and Computer Software Requirements for Major Weapon Systems" (DFARS Case 2006-D055) received in the Office of the President of the Senate on December 16, 2009; to the Committee on Armed Services.

EC-4120. A communication from the Director of Defense Procurement and Acquisition Policy, Department of Defense, transmitting, pursuant to law, the report of a rule entitled "Defense Federal Acquisition Regulation Supplement; Allowability of Costs to Lease Government Equipment for Display or Demonstration" (DFARS Case 2007-D004) received in the Office of the President of the

Senate on December 16, 2009; to the Committee on Armed Services.

EC-4121. A communication from the Assistant General Counsel for Legislation, Regulation and Energy Efficiency, Department of Energy, transmitting, pursuant to law, the report of a rule entitled "Inflation Adjustment of Civil Monetary Penalties" (RIN1990-AA32) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-4122. A communication from the Deputy Secretary, Division of Corporation Finance, Securities and Exchange Commission, transmitting, pursuant to law, the report of a rule entitled "Extension for Filing Accommodation for Static Pool Information in Filings With Respect to Asset-Backed Securities" (RIN3235-AK44) received in the Office of the President of the Senate on December 16, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-4123. A communication from the Attorney-Advisor, Departmental Offices, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Terrorism Risk Insurance Program; Cap on Annual Liability" (RIN1505-AB92) received in the Office of the President of the Senate on December 16, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-4124. A communication from the Attorney-Advisor, Departmental Offices, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Terrorism Risk Insurance Program; Recoupment Provisions" (RIN1505-AB10) received in the Office of the President of the Senate on December 16, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-4125. A communication from the Secretary of the Treasury, transmitting, pursuant to law, a six-month periodic report relative to the national emergency with respect to Belarus; to the Committee on Banking, Housing, and Urban Affairs.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. HARKIN, from the Committee on Health, Education, Labor, and Pensions, with an amendment in the nature of a substitute:

S. 510. A bill to amend the Federal Food, Drug, and Cosmetic Act with respect to the safety of the food supply.

By Mr. KERRY, from the Committee on Foreign Relations, with an amendment in the nature of a substitute:

S. 1739. A bill to promote freedom of the press around the world.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Ms. CANTWELL (for herself and Mrs. MURRAY):

S. 2906. A bill to amend the Act of August 9, 1955, to modify a provision relating to leases involving certain Indian tribes; to the Committee on Indian Affairs.

By Ms. MURKOWSKI (for herself, Mr. BEGICH, and Mr. UDALL of Colorado):

S. 2907. A bill to establish a coordinated avalanche protection program, and for other

purposes; to the Committee on Energy and Natural Resources.

By Mr. KOHL (for himself, Mr. CORKER, and Mr. FEINGOLD):

S. 2908. A bill to amend the Energy Policy and Conservation Act to require the Secretary of Energy to publish a final rule that establishes a uniform efficiency descriptor and accompanying test methods for covered water heaters, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. SANDERS (for himself, Mr. LEAHY, Mr. BROWN, and Mr. MENENDEZ):

S. 2909. A bill to provide State programs to encourage employee ownership and participation in business decisionmaking throughout the United States, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. SANDERS:

S. 2910. A bill to increase wages and benefits of blue collar workers by strengthening labor provisions in the H-2B program, to provide for labor recruiter accountability, and for other purposes; to the Committee on the Judiciary.

By Mr. SESSIONS (for himself, Mr. BUNNING, Mr. VITTER, Mr. LEMIEUX, Mr. ENZI, Mr. CORNYN, Mr. BARRASSO, and Mr. HATCH):

S. 2911. A bill to reduce the deficit by establishing 5-year discretionary spending caps and strengthened Pay-As-You-Go procedures; to the Committee on the Budget.

By Mr. NELSON of Florida:

S. 2912. A bill to require lenders of loans with Federal guarantees or Federal insurance to consent to mandatory mediation; to the Committee on Banking, Housing, and Urban Affairs.

By Ms. COLLINS (for herself and Mr. CARPER):

S. 2913. A bill to establish a national mercury monitoring program, and for other purposes; to the Committee on Environment and Public Works.

By Mr. SANDERS (for himself, Mr. LEAHY, Mr. BROWN, and Mr. MENENDEZ):

S. 2914. A bill to provide for the establishment of the United States Employee Ownership Bank, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. CORKER (for himself, Mr. ALEXANDER, Mr. CRAPO, and Mr. VITTER):

S. 2915. A bill to provide that employment-related arbitration agreements shall not be enforceable with respect to any claim related to a tort arising out of rape; to the Committee on Health, Education, Labor, and Pensions.

By Mr. BUNNING:

S. 2916. A bill to provide that Internal Revenue Service Notice 2010-2 shall have no force and effect and to amend the Internal Revenue Code of 1986 to restrict the authority of the Secretary of the Treasury to prescribe regulations under section 382 of such Code; to the Committee on Finance.

By Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. NELSON of Nebraska, Ms. LANDRIEU, Mr. BOND, Mr. LUGAR, Mr. BROWNBACK, Mr. ROBERTS, Mr. HATCH, and Mr. CRAPO):

S. 2917. A bill to amend the Internal Revenue Code of 1986 to modify the penalty for failure to disclose certain reportable transactions and the penalty for submitting a bad check to the Internal Revenue Service, to modify certain rules relating to Federal ven-

dors, and for other purposes; to the Committee on Finance.

By Mr. CORNYN (for himself, Mr. ALEXANDER, Mr. BARRASSO, Mr. BENNETT, Mr. BOND, Mr. BROWNBACK, Mr. BURR, Mr. CHAMBLISS, Mr. COBURN, Mr. COCHRAN, Ms. COLLINS, Mr. CORKER, Mr. CRAPO, Mr. DEMINT, Mr. ENSIGN, Mr. ENZI, Mr. GRAHAM, Mr. GRASSLEY, Mr. GREGG, Mr. INHOFE, Mr. ISAKSON, Mr. KYL, Mr. LEMIEUX, Mr. LUGAR, Mr. MCCAIN, Mr. MCCONNELL, Ms. MURKOWSKI, Mr. RISCH, Mr. ROBERTS, Mr. SESSIONS, Mr. THUNE, Mr. VITTER, and Mr. WICKER):

S.J. Res. 24. A joint resolution providing for congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by the Department of Labor relating to financial disclosure and transparency by labor union management; to the Committee on Health, Education, Labor, and Pensions.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. MCCAIN (for himself, Mr. KERRY, Mrs. LINCOLN, Mr. INOUE, Mr. BEGICH, Mr. FEINGOLD, Mr. SPECTER, Mr. GRASSLEY, Mr. BURR, Ms. COLLINS, Ms. MURKOWSKI, and Mr. COCHRAN):

S. Res. 380. A resolution designating January 2010 as "National Mentoring Month"; to the Committee on the Judiciary.

By Mrs. MURRAY (for herself and Ms. COLLINS):

S. Res. 381. A resolution designating the week of February 1 through February 5, 2010, as "National School Counseling Week"; to the Committee on the Judiciary.

ADDITIONAL COSPONSORS

S. 144

At the request of Mr. KERRY, the names of the Senator from Virginia (Mr. WARNER) and the Senator from California (Mrs. BOXER) were added as cosponsors of S. 144, a bill to amend the Internal Revenue Code of 1986 to remove cell phones from listed property under section 280F.

S. 416

At the request of Mrs. FEINSTEIN, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 416, a bill to limit the use of cluster munitions.

S. 538

At the request of Mr. SPECTER, his name was added as a cosponsor of S. 538, a bill to increase the recruitment and retention of school counselors, school social workers, and school psychologists by low-income local educational agencies.

S. 634

At the request of Mr. SPECTER, his name was added as a cosponsor of S. 634, a bill to amend the Elementary and Secondary Education Act of 1965 to improve standards for physical education.

S. 663

At the request of Mr. NELSON of Nebraska, the names of the Senator from Montana (Mr. TESTER) and the Senator from Missouri (Mr. BOND) were added as cosponsors of S. 663, a bill to amend title 38, United States Code, to direct the Secretary of Veterans Affairs to establish the Merchant Mariner Equity Compensation Fund to provide benefits to certain individuals who served in the United States merchant marine (including the Army Transport Service and the Naval Transport Service) during World War II.

S. 818

At the request of Mr. SPECTER, his name was added as a cosponsor of S. 818, a bill to reauthorize the Enhancing Education Through Technology Act of 2001, and for other purposes.

S. 941

At the request of Mr. CRAPO, the name of the Senator from North Carolina (Mr. BURR) was added as a cosponsor of S. 941, a bill to reform the Bureau of Alcohol, Tobacco, Firearms, and Explosives, modernize firearm laws and regulations, protect the community from criminals, and for other purposes.

S. 1029

At the request of Mr. SPECTER, his name was added as a cosponsor of S. 1029, a bill to create a new incentive fund that will encourage States to adopt the 21st Century Skills Framework.

S. 1052

At the request of Mr. SPECTER, his name was added as a cosponsor of S. 1052, a bill to amend the small, rural school achievement program and the rural and low-income school program under part B of title VI of the Elementary and Secondary Education Act of 1965.

S. 1129

At the request of Mr. SPECTER, his name was added as a cosponsor of S. 1129, a bill to authorize the Secretary of Education to award grants to local educational agencies to improve college enrollment.

S. 1137

At the request of Mr. SPECTER, his name was added as a cosponsor of S. 1137, a bill to amend the Elementary and Secondary Education Act of 1965 to establish a Volunteer Teacher Advisory Committee.

S. 1431

At the request of Mr. NELSON of Florida, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 1431, a bill to amend the Help America Vote Act of 2002 to require a voter-verified permanent paper ballot under title III of such Act, and for other purposes.

S. 1646

At the request of Mr. REED, the name of the Senator from Vermont (Mr.

SANDERS) was added as a cosponsor of S. 1646, a bill to keep Americans working by strengthening and expanding short-time compensation programs that provide employers with an alternative to layoffs.

S. 1652

At the request of Mr. SPECTER, his name was added as a cosponsor of S. 1652, a bill to amend part B of the Individuals with Disabilities Education Act to provide full Federal funding of such part.

S. 2847

At the request of Mr. WHITEHOUSE, the name of the Senator from Ohio (Mr. BROWN) was added as a cosponsor of S. 2847, a bill to regulate the volume of audio on commercials.

S. 2869

At the request of Ms. LANDRIEU, the name of the Senator from Maryland (Mr. CARDIN) was added as a cosponsor of S. 2869, a bill to increase loan limits for small business concerns, to provide for low interest refinancing for small business concerns, and for other purposes.

S. 2886

At the request of Ms. CANTWELL, the name of the Senator from Delaware (Mr. KAUFMAN) was added as a cosponsor of S. 2886, a bill to prohibit certain affiliations (between commercial banking and investment banking companies), and for other purposes.

AMENDMENT NO. 2909

At the request of Mr. NELSON of Florida, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of amendment No. 2909 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2941

At the request of Mr. SPECTER, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of amendment No. 2941 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2976

At the request of Mr. VITTER, his name was added as a cosponsor of amendment No. 2976 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3046

At the request of Mr. KERRY, the name of the Senator from Nebraska

(Mr. NELSON) was added as a cosponsor of amendment No. 3046 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3185

At the request of Mr. BROWN, the names of the Senator from North Carolina (Mrs. HAGAN) and the Senator from New Jersey (Mr. MENENDEZ) were added as cosponsors of amendment No. 3185 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3256

At the request of Mr. BENNET, the names of the Senator from North Carolina (Mrs. HAGAN) and the Senator from Virginia (Mr. WARNER) were added as cosponsors of amendment No. 3256 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Ms. MURKOWSKI (for herself, Mr. BEGICH, and Mr. UDALL of Colorado):

S. 2907. A bill to establish a coordinated avalanche protection program, and for other purposes; to the Committee on Energy and Natural Resources.

Ms. MURKOWSKI. Mr. President, I rise today to reintroduce in the Senate legislation that will help to reduce the Nation's yearly death toll caused by snow and ice avalanches.

As a member of the Congressional Hazards Caucus, I am introducing legislation, the Federal Land Avalanche Protection Act of 2009 to tackle the impacts of one of our Nation's natural hazards, avalanches. I am introducing this bill jointly with Senators MARK BEGICH and MARK UDALL. It is identical to a measure introduced earlier this week in the House of Representatives by Alaska's Congressman DON YOUNG, who was its prime sponsor when first introduced in May 2008 late in the 110th Congress.

The goal of the bill is to better protect people in avalanche zones nationwide and to reduce the growing potential for avalanches to damage properties, as more and more building takes place on mountainsides and in valleys threatened by potential avalanches. Avalanches are a continuing problem in this country. Last year 49 avalanches in 10 States and Canada caused

54 fatalities in North America, 28 in America. The fall-winter-spring of 2008–2009, however, was not unusual.

In the 2007–2008 season, 36 Americans lost their lives as a result of avalanches. Another 16 Canadians died that season in 43 reported avalanches. In the 2002–03 season, 58 people in North America died as a result of 55 reported avalanches. For the past decade 38 people have died on average each year in North America from avalanches. Most occur in the western States of Colorado, Montana, Idaho, Wyoming, Utah, Alaska, California, Oregon, Washington, but deaths certainly have occurred in eastern States such as Vermont and New Hampshire, as well.

Many think that avalanches are just a problem for backcountry skiers, hikers, or snowboarders. But as urbanization spreads the dangers caused by snow and ice buildups on steep slopes will grow and affect more urban populations, and especially more motorists traveling through mountain passes and along valley roads. So far this season, just in the past 2 months, 11 skiers and 1 ice climber have been caught in avalanches in Montana, Utah, and Colorado. Fortunately only one death has so far resulted. But this Nation needs to devote additional resources to warning and battling the impacts of avalanches because there are things that we know how to do to improve forecasts, increase warnings, and take advance actions to reduce the build up of snow loads on steep slopes, thus lessening the danger of larger, deadly avalanches when snow packs release.

The bill I introduce today directs the Secretary of Agriculture, acting through the Chief of the U.S. Forest Service, to establish an avalanche protection program to: identify the potential for avalanches on Federal lands and inform the public about the probability of avalanches and their potential adverse effects; carry out ongoing research to improve avalanche forecasting; and reduce the risks of avalanches and mitigate their effects.

The bill requires the Secretary to coordinate the program to ensure protection for recreational users of public land under the Secretary of the Interior's jurisdiction, using resources of the Forest Service's National Avalanche Center; to establish an advisory committee to assist in program development and implementation; and with the Secretary of Transportation and the Secretary of the Army, to establish a central depository for weapons, ammunition, and parts for avalanche control purposes.

The measure also authorizes the Secretary to make grants to carry out projects and activities to assist in the prevention, forecasting, detection, and mitigation of avalanches; maintain essential transportation, utilities, and communications; assist avalanche artillery users to ensure the availability

of adequate supplies of artillery and explosives required for avalanche control in specified areas; and assist research and development activities for alternatives to minimize reliance on military weapons for avalanche control.

It directs the Secretary to give priority to projects carried out in avalanche zones with a high frequency or severity of avalanches or in which deaths, injuries, or damage to public facilities and communities have occurred. It requires the Administrator of the General Services Administration to transfer specified property suitable for avalanche control purposes to a user of surplus ordnance.

When first introduced last year for public and professional consideration and comment the measure was strongly supported by Federal avalanche officials.

Just in my home State of Alaska avalanches are a concern not just in the backcountry at Hatcher Pass, north of Palmer, or for heli-skiing enthusiasts near Thompson Pass outside of Valdez or Johnson Pass on the Kenai Peninsula, but in urban areas, such as the capital city of Juneau, or for motorists who daily drive the Seward Highway from Girdwood to Anchorage or through Turnagain Pass. While Alaska's three fatalities last year occurred in Thompson and Johnson Pass among recreational skiers, the future is that we need to do more on Federal lands, and we need to do more to assist states to lessen the severity of avalanche dangers on State and private lands.

This bill would take logically, fiscally prudent steps, to doing just that. I urge members to support its passage and modest funding for implementation next year.

By Mr. KOHL (for himself, Mr. CORKER, and Mr. FEINGOLD):

S. 2908. A bill to amend the Energy Policy and Conservation Act to require the Secretary of Energy to publish a final rule that establishes a uniform efficiency descriptor and accompanying test methods for covered water heaters, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. KOHL. Mr. President, I rise today to introduce a bill with Senator CORKER that would establish a uniform energy efficiency descriptor for all water heaters and improve the testing methods by which that descriptor is determined. Currently, water heaters are lumped into two categories under two federal statutes, based on arbitrary gallon capacity and energy input ratings. "Smaller" water heaters are covered by the National Appliance Energy Conservation Act, NAECA, and must be rated using an energy factor or EF rating. "Larger" water heaters are within the scope of the Energy Policy Act,

EPACT, and must be rated using a thermal efficiency or TE rating. Not only do the testing methods differ, but a manufacturer is forbidden to place an EF rating on a TE-sized unit, and vice-versa.

The difference between energy factor and thermal efficiency was based on the assumption that smaller units are exclusively for residential uses while larger units are exclusively for commercial purposes, so the competing rating methods would not cause any confusion or adverse effects. Due to advances in manufacturing technology over the past 15 years, the assumptions underlying the earlier dividing line are no longer accurate. In fact, both larger and smaller units made by leading U.S. manufacturers are used in residences without regard to which Federal law applies. Yet, Federal legislation continues to be written by taking this distinction into account.

This legislation would direct the Department of Energy, DOE, to work with industry stakeholders to develop a uniform energy efficiency descriptor that applies to all sizes of water heaters. It also would develop a test method to accurately determine that descriptor for all types of water heaters, including new, efficient, advanced technologies, like heat pump water heaters, hybrids, and others, that are not correctly rated under today's test methods.

This bill, which has the support of the Air-Conditioning, Heating, and Refrigeration Institute, AHRI, and the American Council for an Energy-Efficient Economy, ACEEE, brings the DOE and affected industries together to focus on this effort. It is my hope that the water heating manufacturing community can develop and implement the new test method and descriptor that will eliminate confusion and enable consumers and business owners to make informed purchasing decisions on water heaters.

By Ms. COLLINS (for herself and Mr. CARPER):

S. 2913. A bill to establish a national mercury monitoring program, and for other purposes; to the Committee on Environment and Public Works.

Ms. COLLINS. Mr. President, today, along with my colleague from Delaware, Senator CARPER, I am introducing the Comprehensive National Mercury Monitoring Act. This bill will ensure the Environmental Protection Agency has accurate information about the extent of mercury pollution in our nation as it works to enforce regulations about this toxic chemical.

Mercury is a dangerous substance that can cause serious neuron-developmental harm, especially to children and pregnant women. Scientists at the Environmental Protection Agency, EPA, estimate that some 630,000 infants are born each year with blood mercury levels higher than what is considered safe.

Mercury is hazardous not only to people, but also to wildlife. As of 2006, States issued 533 new fish advisories bringing the nationwide total advisories to 3,851. These advisories cover 38 percent of the Nation's total lake acreage and 26 percent of the Nation's total river miles. Almost 65 percent of the U.S. coastline, except Alaska, is under advisory, including 92 percent of the Atlantic coast and 100 percent of the Gulf coast.

Each new scientific study seems to find higher levels of mercury in more ecosystems and in more species than we had previously thought. We must have more comprehensive information and we must have it soon; otherwise, we risk making misguided policy decisions.

For example, in 2005 the Environmental Protection Agency issued a new mercury regulation based on computer measurements that were not peer-reviewed and that were not verified with actual measurements. The effect of the regulation was to allow power plants to continue spewing unlimited amounts of mercury into our air until the year 2018. Many experts, including the EPA Inspector General, sharply criticized the science underlying that new regulation and recommended that EPA develop and implement a mercury monitoring plan. That was a major reason why I am introducing the Comprehensive National Mercury Monitoring Act.

Specifically, my mercury bill would establish mercury monitoring sites across the nation in order to measure mercury levels in the air, rain, soil, lakes and streams, as well as in plants and animals; authorize about \$30 million annually for fiscal years 2011 through 2013 for the Environmental Protection Agency, United States Geological Survey, United States Fish and Wildlife Service, the National Oceanic and Atmospheric Administration, and the National Park Service to perform scientific mercury measurements; and create a "Mercury Monitoring Advisory Committee" to advise the Administrator of the EPA in choosing the monitoring sites.

We must establish a more robust national mercury monitoring network to provide EPA the data it needs to make decisions that protect the people and environment of Maine and the entire Nation.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2913

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Comprehensive National Mercury Monitoring Act".

SEC. 2. FINDINGS.

Congress finds that

(1)(A) mercury is a potent neurotoxin of significant ecological and public health concern;

(B) exposure to mercury occurs largely by consumption of contaminated fish;

(C) children and women of childbearing age who consume large quantities of fish are at high risk of adverse effects;

(D) it is estimated that more than 630,000 children born each year in the United States are exposed to levels of mercury in the womb that are high enough to impair neurological development; and

(E) the Centers for Disease Control and Prevention have found that 8 percent of women in the United States of childbearing age have blood mercury levels in excess of values determined to be safe by the Environmental Protection Agency;

(2)(A) as of 2006, 3,080 fish consumption advisories due to mercury contamination have been issued for 48 States, including 23 statewide advisories for freshwater and 12 statewide advisories for coastal waters;

(B) that is a 26 percent increase over the number of advisories issued in 2004;

(C) those advisories represent more than 22,000 square miles of lakes and 882,000 miles of rivers;

(D) however, fish and shellfish are an important source of dietary protein, and a healthy fishing resource is important to the economy of the United States; and

(E) the extent of fish consumption advisories underscores the extensive human and ecological health risk posed by mercury pollution;

(3)(A) in many locations, the primary route for mercury input to aquatic ecosystems is atmospheric emissions, transport, and deposition;

(B) the cycling of mercury in the environment and resulting accumulation in biota are not fully understood; and

(C) computer models and other assessment tools provide varying effectiveness in predicting mercury concentrations in fish, and no broad-scale data sets exist to test model predictions;

(4)(A) on September 14 through 17, 2003, the Environmental Protection Agency cosponsored a Society of Environmental Toxicology and Chemistry workshop involving more than 30 international experts to formulate a system to quantify and document mercury changes in the various environment fields resulting from anticipated reductions in mercury emissions in the United States; and

(B) the resulting plan proposes a holistic, multimedia, long-term mercury monitoring program that is documented in 2 sources—

(i) on January 1, 2005, the article entitled "Monitoring the Response to Changing Mercury Deposition" was published in the journal *Environmental Science and Technology*; and

(ii) in 2008, the book entitled "Ecosystem Responses to Mercury Contamination: Indicators of Change" was published by CRC Press;

(5) as of the date of enactment of this Act, many regulations limiting mercury emissions from different sources have gone into effect or will be implemented, but ongoing monitoring programs are not adequately measuring the environmental benefits and effectiveness of mercury emission controls;

(6) on May 15, 2006, the Office of Inspector General of the Environmental Protection Agency issued a report entitled, "Monitoring Needed to Assess Impact of EPA's Clean Air Mercury Rule (CAMR) on Potential Hotspots", Report No. 2006-P-0025, which states, in part—

(A) "Without field data from an improved monitoring network, EPA's ability to advance mercury science will be limited and 'utility-attributable hotspots' that pose health risks may occur and go undetected"; and

(B) "We recommend that the EPA develop and implement a mercury monitoring plan to assess the impact of CAMR, if adopted, on mercury deposition and fish tissue and evaluate and refine mercury estimation tools and models";

(7)(A) on January 1, 2007, the articles entitled "Biological Mercury Hotspots in the Northeastern U.S. and Southeastern Canada" and "Contamination in Remote Forest and Aquatic Ecosystems in the Northeastern U.S.: Sources, Transformations and Management Options" were published in the journal *BioScience*; and

(B) the authors of the articles—

(i) identified 5 biological mercury hotspots and 9 areas of concern in the northeastern United States and southeastern Canada associated primarily with atmospheric mercury emissions and deposition;

(ii) located an area of particularly high mercury deposition adjacent to a coal-fired utility in southern New Hampshire; and

(iii) concluded that local impacts from mercury emissions should be closely monitored in order to assess the impact of Federal and State policies; and

(8)(A) building on previous efforts in 2003, on May 5 through 7, 2008, the Environmental Protection Agency coconvened a workshop with experts from the United States Geological Survey, the National Oceanic and Atmospheric Administration, the United States Fish and Wildlife Service, the National Park Service, State and tribal agencies, the Biodiversity Research Institute, the National Atmospheric Deposition Program, industry, and other institutions;

(B) more than 50 workshop scientists participated and agreed on a goal and major design elements for a national mercury monitoring program, including a national distribution of approximately 20 intensive sites to understand the sources, consequences, and trends in United States mercury pollution;

(C) the consortium found that "policy makers, scientists and the public need a comprehensive and integrated mercury monitoring network to accurately quantify regional and national changes in atmospheric deposition, ecosystem contamination, and bioaccumulation of mercury in fish and wildlife in response to changes in mercury emissions."; and

(D) the workshop findings are published in a report of the Environmental Protection Agency (430-K-09-001).

SEC. 3. DEFINITIONS.

In this Act:

(1) ADMINISTRATOR.—The term "Administrator" means the Administrator of the Environmental Protection Agency.

(2) ADVISORY COMMITTEE.—The term "Advisory Committee" means the Mercury Monitoring Advisory Committee established under section 5.

(3) ANCILLARY MEASURE.—The term "ancillary measure" means a measure that is used to understand the impact and interpret results of measurements under the program.

(4) ECOREGION.—The term "ecoregion" means a large area of land and water that contains a geographically distinct assemblage of natural communities, including similar land forms, climate, ecological processes, and vegetation.

(5) **MERCURY EXPORT.**—The term “mercury export” means mercury flux from a watershed to the corresponding water body, or from 1 water body to another water body (such as a lake to a river), generally expressed as mass per unit of time.

(6) **MERCURY FLUX.**—The term “mercury flux” means the rate of transfer of mercury between ecosystem components (such as between water and air), or between portions of ecosystem components, expressed in terms of mass per unit of time or mass per unit of area per time.

(7) **PROGRAM.**—The term “program” means the national mercury monitoring program established under section 4.

(8) **SURFACE SEDIMENT.**—The term “surface sediment” means sediment in the uppermost 2 centimeters of a lakebed or riverbed.

SEC. 4. MONITORING PROGRAM.

(a) ESTABLISHMENT.—

(1) **IN GENERAL.**—The Administrator, in consultation with the Director of the United States Fish and Wildlife Service, the Director of the United States Geological Survey, the Director of the National Park Service, the Administrator of the National Oceanic and Atmospheric Administration, and the heads of other appropriate Federal agencies, shall establish a national mercury monitoring program.

(2) **PURPOSE.**—The purpose of the program is to track—

(A) long-term trends in atmospheric mercury concentrations and deposition; and

(B) mercury levels in watersheds, surface waters, and fish and wildlife in terrestrial, freshwater, and coastal ecosystems in response to changing mercury emissions over time.

(3) MONITORING SITES.—

(A) **IN GENERAL.**—In carrying out paragraph (1), not later than 1 year after the date of enactment of this Act and in coordination with the Advisory Committee, the Administrator, after consultation with the heads of Federal agencies described in paragraph (1) and considering the requirement for reports under section 6, shall select multiple monitoring sites representing multiple ecoregions of the United States.

(B) **LOCATIONS.**—Locations of monitoring sites shall include national parks, wildlife refuges, National Estuarine Research Reserve units, and other sensitive ecological areas that include long-term protection and in which substantive changes are expected from reductions in domestic mercury emissions.

(C) **COLOCATION.**—If practicable, monitoring sites shall be colocated with sites from other long-term environmental monitoring programs.

(4) **MONITORING PROTOCOLS.**—Not later than 1 year after the date of enactment of this Act, the Administrator, in coordination with the Advisory Committee, shall establish and publish standardized measurement protocols for the program under this Act.

(5) **DATA COLLECTION AND DISTRIBUTION.**—Not later than 1 year after the date of enactment of this Act, the Administrator, in coordination with the Advisory Committee, shall establish a centralized database for existing and newly collected environmental mercury data that can be freely accessed once data assurance and quality standards established by the Administrator are met.

(b) AIR AND WATERSHEDS.—

(1) **IN GENERAL.**—The program shall monitor long-term changes in mercury levels and important ancillary measures in the air at locations selected under subsection (a)(3).

(2) **MEASUREMENTS.**—The Administrator, in consultation with the Director of the United

States Fish and Wildlife Service, the Director of the United States Geological Survey, the Director of the National Park Service, the Administrator of the National Oceanic and Atmospheric Administration, and the heads of other appropriate Federal agencies, shall determine appropriate measurements, including—

(A) the measurement and recording of wet and estimation of dry mercury deposition, mercury flux, and mercury export;

(B) the measurement and recording of the level of mercury reemitted from aquatic and terrestrial environments into the atmosphere; and

(C) the measurement of sulfur species and ancillary measurements at a portion of locations selected under subsection (a)(3) to fully understand the cycling of mercury through the ecosystem.

(c) **WATER AND SOIL CHEMISTRY.**—The program shall monitor long-term changes in mercury and methyl mercury levels and important ancillary measures in the water and soil or sediments at locations selected under subsection (a)(3) that the Administrator, in primary consultation with the Director of the United States Geological Survey, determines to be appropriate, including—

(1) extraction and analysis of soil and sediment cores;

(2) measurement and recording of total mercury and methyl mercury concentration, and percent methyl mercury in surface sediments;

(3) measurement and recording of total mercury and methyl mercury concentration in surface water; and

(4) measurement and recording of total mercury and methyl mercury concentrations throughout the water column and sediments.

(d) **AQUATIC AND TERRESTRIAL ORGANISMS.**—The program shall monitor long-term changes in mercury and methyl mercury levels and important ancillary measures in the aquatic and terrestrial organisms at locations selected under subsection (a)(3) that the Administrator, in primary consultation with the Director of the United States Fish and Wildlife Service and the Administrator of the National Oceanic and Atmospheric Administration, determines to be appropriate, including—

(1) measurement and recording of total mercury and methyl mercury concentrations in—

(A) zooplankton and other invertebrates;

(B) yearling fish; and

(C) commercially, recreationally, or conservation relevant fish; and

(2) measurement and recording of total mercury concentrations in—

(A) selected insect- and fish-eating birds; and

(B) measurement and recording of total mercury concentrations in selected insect- and fish-eating mammals.

SEC. 5. ADVISORY COMMITTEE.

(a) **ESTABLISHMENT.**—There shall be established a scientific advisory committee, to be known as the “Mercury Monitoring Advisory Committee”, to advise the Administrator and Federal agencies described in section 4(a)(1), on the establishment, site selection, measurement and recording protocols, and operation of the program.

(b) **MEMBERSHIP.**—The Advisory Committee shall consist of scientists who are not employees of the Federal Government, including—

(1) 3 scientists appointed by the Administrator;

(2) 2 scientists appointed by the Director of the United States Fish and Wildlife Service;

(3) 2 scientists appointed by the Director of the United States Geological Survey;

(4) 2 scientists appointed by the Director of the National Park Service; and

(5) 2 scientists appointed by the Administrator of the National Oceanic and Atmospheric Administration.

SEC. 6. REPORTS AND PUBLIC DISCLOSURE.

(a) **REPORTS.**—Not later than 2 years after the date of enactment of this Act and every 2 years thereafter, the Administrator shall submit to Congress a report on the program, including trend data.

(b) **ASSESSMENT.**—At least once every 4 years, the report required under subsection (a) shall include an assessment of the reduction in mercury deposition rates that are required to be achieved in order to prevent adverse human and ecological effects.

(c) **AVAILABILITY OF DATA.**—The Administrator shall make all data obtained under this Act available to the public through a dedicated website and on written request.

SEC. 7. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this Act—

(1) for fiscal year 2011 to—

(A) the Environmental Protection Agency \$15,000,000;

(B) the United States Fish and Wildlife Service \$9,000,000;

(C) the United States Geological Survey \$5,000,000;

(D) the National Oceanic and Atmospheric Administration \$4,000,000; and

(E) the National Park Service \$4,000,000;

(2) for fiscal year 2012 to—

(A) the Environmental Protection Agency \$12,000,000;

(B) the United States Fish and Wildlife Service \$7,000,000;

(C) the United States Geological Survey \$4,000,000;

(D) the National Oceanic and Atmospheric Administration \$3,000,000; and

(E) the National Park Service \$3,000,000;

(3) for fiscal year 2013 to—

(A) the Environmental Protection Agency \$12,000,000;

(B) the United States Fish and Wildlife Service \$7,000,000;

(C) the United States Geological Survey \$4,000,000;

(D) the National Oceanic and Atmospheric Administration \$3,000,000; and

(E) the National Park Service \$3,000,000; and

(4) such sums as are necessary for each of fiscal years 2014 through 2016 to—

(A) the Environmental Protection Agency;

(B) the United States Fish and Wildlife Service;

(C) the United States Geological Survey;

(D) the National Oceanic and Atmospheric Administration; and

(E) the National Park Service.

By Mr. BUNNING:

S. 2916. A bill to provide that Internal Revenue Service Notice 2010-2 shall have no force and effect and to amend the Internal Revenue Code of 1986 to restrict the authority of the Secretary of the Treasury to prescribe regulations under section 382 of such Code; to the Committee on Finance.

Mr. BUNNING. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2916

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. LIMITATION ON REGULATORY AUTHORITY RELATING TO LIMITATION ON LOSSES FOLLOWING OWNERSHIP CHANGE.

(a) REPEAL OF NOTICE 2010-2.—Internal Revenue Service Notice 2010-2 shall have no force and effect.

(b) MODIFICATION OF REGULATORY AUTHORITY UNDER SECTION 382.—Section 382(m) of the Internal Revenue Code of 1986 is amended by adding at the end the following flush sentence:

“Notwithstanding the preceding sentence or any other provision of law, the Secretary may not prescribe any regulation after December 18, 2009, which provides an exemption or special rule under this section which is restricted to dispositions of instruments acquired by the Secretary unless such exemption or special rule is specifically authorized by Congress.”.

(c) NO INFERENCE.—Nothing in subsection (a) or in the amendment made by subsection (b) shall be construed to create any inference with respect to the authority of the Secretary of the Treasury on or before December 18, 2009, to provide exceptions to the application of the rules of section 382 of the Internal Revenue Code of 1986 with respect to certain classes of taxpayers.

By Mr. CORNYN (for himself, Mr. ALEXANDER, Mr. BARRASSO, Mr. BENNETT, Mr. BOND, Mr. BROWNBACK, Mr. BURR, Mr. CHAMBLISS, Mr. COBURN, Mr. COCHRAN, Ms. COLLINS, Mr. CORKER, Mr. CRAPO, Mr. DEMINT, Mr. ENSIGN, Mr. ENZI, Mr. GRAHAM, Mr. GRASSLEY, Mr. GREGG, Mr. INHOFE, Mr. ISAKSON, Mr. KYL, Mr. LEMIEUX, Mr. LUGAR, Mr. MCCAIN, Mr. MCCONNELL, Ms. MURKOWSKI, Mr. RISCH, Mr. ROBERTS, Mr. SESSIONS, Mr. THUNE, Mr. VITTER, and Mr. WICKER):

S.J. Res. 24. A joint resolution providing for congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by the Department of Labor relating to financial disclosure and transparency by labor union management; to the Committee on Health, Education, Labor, and Pensions.

Mr. CORNYN. Mr. President, the U.S. Department of Labor's Office of Labor-Management Standards, OLMS, is responsible for ensuring that labor unions follow basic standards of fiscal responsibility. OLMS collects annual financial disclosure reports, LM-2, from labor organizations with annual receipts of \$250,000 or more. Union members who work hard to pay their dues deserve to know how their money has been spent. So, these annual financial disclosure reports provide rank-and-file members with an essential tool for exercising union democracy: information about important financial decisions made by their union leadership. Consequently, it is vital that OLMS have the necessary tools to monitor

union compliance with the law as well as to deter corruption. Yet, on average, over ONE third of all unions fail to comply with existing requirements to file annual financial disclosure reports on time.

In fact, between 2001 and 2008, OLMS reported that its investigations yielded a total of 1,004 indictments with 929 convictions and court-ordered restitution of more than \$93 million dollars. For example, according to statistics reported by the Office of Management and Budget, OMB, the OLMS audits turned up criminal violations in about 11.5 percent of audits and nearly 8 percent of unions showed some fraudulent activity in 2008 alone. Between January 1 and October 19, 2009, OLMS reported obtaining indictments, convictions and sentences in embezzlement cases that total nearly \$3 million in theft from union funds.

In order to provide a better method for collecting information about union finances, the Department of Labor proposed modifying the LM-2 form. After a lengthy rulemaking process, the Department issued a final rule on January 21, 2009, which required additional information about the receipt and disbursement of labor organization funds, and established standards and procedures for revoking, where appropriate, a labor organization's simplified filing privilege. But politics got in the way of transparency and good government. And on October 13, 2009, the Department announced a final decision to rescind these regulations.

This is outrageous. No one is talking about protecting rank-and-file members' ability to hold their leadership accountable. Instead, the Secretary of Labor has bowed to pressure and complaints from labor unions. The unions argued that requiring labor organizations with reported annual receipts over \$250,000 to file more detailed disclosure reports was unnecessarily burdensome and imposed additional administrative costs on their organizations.

Rigorous disclosure requirements promote union transparency and accountability of union leaders to their rank-and-file members. The annual financial reports ensure that workers' dues are used legitimately and can also help workers and oversight investigators detect fraudulent or criminal activity. Bringing corrupt union officials to justice and recovering millions of dollars in hard-earned dues would not be possible if unions were not required to file annual financial disclosure reports.

For this reason, I am introducing a Congressional Review Act resolution disapproving the Department of Labor's October 13 decision to rescind the LM-2 rule. My resolution, which is cosponsored by 17 of my colleagues, would have the effect of reinstating the original LM-2 rule published in Janu-

ary 2009 and would ensure that OLMS continues to protect the rights of rank-and-file union members against corrupt union leaders.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 380—DESIGNATING JANUARY 2010 AS “NATIONAL MENTORING MONTH”

Mr. MCCAIN (for himself, Mr. KERRY, Mrs. LINCOLN, Mr. INOUE, Mr. BEGICH, Mr. FEINGOLD, Mr. SPECTER, Mr. GRASSLEY, Mr. BURR, Ms. COLLINS, Ms. MURKOWSKI, and Mr. COCHRAN) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 380

Whereas mentoring is a longstanding tradition in which a dependable, caring adult provides guidance, support, and encouragement to facilitate a young person's social, emotional, and cognitive development;

Whereas continued research on mentoring shows that formal, high-quality mentoring focused on developing the competence and character of the mentee promotes positive outcomes, such as improved academic achievement, self-esteem, social skills, and career development;

Whereas further research on mentoring provides strong evidence that mentoring successfully reduces substance use and abuse, academic failure, and delinquency;

Whereas mentoring, in addition to preparing young people for school, work, and life, is extremely rewarding for those serving as mentors;

Whereas more than 4,700 mentoring programs in communities of all sizes across the United States focus on building strong, effective relationships between mentors and mentees;

Whereas approximately 3,000,000 young people in the United States are in solid mentoring relationships due to the remarkable vigor, creativity, and resourcefulness of the thousands of mentoring programs in communities throughout the Nation;

Whereas in spite of the progress made to increase mentoring, the United States has a serious “mentoring gap”, with nearly 15,000,000 young people in need of mentors;

Whereas mentoring partnerships between the public and private sectors bring State and local leaders together to support mentoring programs by preventing duplication of efforts, offering training in industry best practices, and making the most of limited resources to benefit young people in the United States;

Whereas the designation of January 2010 as “National Mentoring Month” will help call attention to the critical role mentors play in helping young people realize their potential;

Whereas a month-long celebration of mentoring will encourage more individuals and organizations, including schools, businesses, nonprofit organizations, faith institutions, and foundations, to become engaged in mentoring across the United States; and

Whereas National Mentoring Month will, most significantly, build awareness of mentoring and encourage more people to become mentors and help close the mentoring gap in the United States: Now, therefore, be it

Resolved, That the Senate—

(1) designates the month of January 2010 as “National Mentoring Month”;

(2) recognizes with gratitude the contributions of the millions of caring adults and students who are already volunteering as mentors and encourages more adults and students to volunteer as mentors; and

(3) encourages the people of the United States to observe National Mentoring Month with appropriate ceremonies and activities that promote awareness of, and volunteer involvement with, youth mentoring.

Mr. McCAIN. Mr. President, I am pleased today to join many of my colleagues in introducing a resolution designating January 2010 as National Mentoring Month.

We all agree that young people need a supportive environment based on structured and trusting relationships with adults. The world is more complicated for children today than it ever was when I was growing up. Mentors can help young people through the difficult periods, help them see the difference between right and wrong, alleviate their doubts and concerns, and answer their questions frankly. Mentors can dramatically impact a young person's life by providing the support and encouragement that children need in order to grow into responsible, caring adults.

This resolution recognizes the value of volunteering time to make a difference in the life of a child. A growing body of research has shown that high-quality programs can make all the difference and help students in need achieve the type of future they might never have thought possible. Children with mentors are shown to improve in school performance and attendance. Also, they are more self-confident, have good social skills, and above all else, they are motivated to reach their full potential. Unfortunately, a severe shortage of volunteers has left over 15 million young people without mentors.

National Mentoring Month highlights the needs and goals of mentoring in this country and honors the contributions of the many volunteers across the country that are currently connecting with youth in such programs. Next month, non-profit organizations, schools, businesses, faith communities, and Government agencies—led by the National Mentoring Partnership and the Harvard School of Public Health—will join together to encourage adults to serve as mentors for our young people. Programs must be expanded to recruit more volunteers to help fill the mentoring gap. Mentoring has successfully helped many children in this country and we must work together to expand such valuable programs. I urge the Senate to approve this resolution.

SENATE RESOLUTION 381—DESIGNATING THE WEEK OF FEBRUARY 1 THROUGH FEBRUARY 5, 2010, AS “NATIONAL SCHOOL COUNSELING WEEK”

Mrs. MURRAY (for herself and Ms. COLLINS) submitted the following reso-

lution; which was referred to the Committee on the Judiciary:

S. RES. 381

Whereas the American School Counselor Association has declared the week of February 1 through February 5, 2010, as “National School Counseling Week”;

Whereas the Senate has recognized the importance of school counseling through the inclusion of elementary and secondary school counseling programs in the reauthorization of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.);

Whereas school counselors have long advocated that the education system of the United States must leave no child behind and must provide opportunities for every student;

Whereas personal and social growth results in increased academic achievement;

Whereas school counselors help develop well-rounded students by guiding the students through their academic, personal, social, and career development;

Whereas school counselors have been instrumental in helping students, teachers, and parents deal with the trauma that was inflicted upon them by hurricanes Katrina, Rita, and Wilma, and other recent natural disasters;

Whereas students face a myriad of challenges every day, including peer pressure, depression, the deployment of family members to serve in conflicts overseas, and school violence;

Whereas school counselors are usually the only professionals in a school building who are trained in both education and mental health matters;

Whereas the roles and responsibilities of school counselors are often misunderstood, and the school counselor position is often among the first to be eliminated in order to meet budgetary constraints;

Whereas the national average ratio of students to school counselors of 475-to-1 is almost twice the 250-to-1 ratio recommended by the American School Counselor Association, the American Counseling Association, the American Medical Association, the American Psychological Association, and other organizations; and

Whereas the celebration of National School Counseling Week would increase awareness of the important and necessary role school counselors play in the lives of students in the United States: Now, therefore, be it

Resolved, That the Senate—

(1) designates the week of February 1 through February 5, 2010, as “National School Counseling Week”; and

(2) encourages the people of the United States to observe the week with appropriate ceremonies and activities that promote awareness of the role school counselors perform in the school and the community at large in preparing students for fulfilling lives as contributing members of society.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3265. Mr. VITTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 3266. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3267. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3268. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3269. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3270. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3271. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3272. Mr. LEMIEUX submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3273. Mrs. SHAHEEN (for herself, Mr. BENNET, and Ms. COLLINS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3274. Mr. MERKLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3275. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 3265. Mr. VITTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 179, line 5, add at the end the following: “Of the amount appropriated under this subsection, there shall be made available \$100,000,000 for each of fiscal years 2010 through 2019 to carry out section 4101 (and the amendments made by such section),

\$1,000,000,000 for each of fiscal years 2010 through 2013 for the National Cancer Institute (in addition to amounts otherwise appropriated to such Institute), and \$120,000,000 for each of fiscal years 2010 through 2019 for the Maternal and Child Health Services Block Grant program under title V of the Social Security Act.”.

SA 3266. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1798, between lines 21 and 22, insert the following:

SEC. 6608. REQUIRED INVESTIGATION OF OUTLIERS.

Section 1862 of the Social Security Act (42 U.S.C. 1395y), as amended by section 6402(h), is amended by adding at the end the following new subsection:

“(p) **REQUIRED INVESTIGATION OF OUTLIERS.**—The Secretary shall conduct an investigation (in consultation with the Inspector General of the Department of Health and Human Services) or other appropriate review of a provider of services or supplier if the Secretary determines that the provider of services or supplier is an outlier in terms of utilization or payment under this title over a period of not less than 2 years.”.

SA 3267. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1783, between lines 2 and 3, insert the following:

SEC. 6412. REQUIRING INDIVIDUALS OR ENTITIES THAT PARTICIPATE IN OR CONDUCT ACTIVITIES UNDER FEDERAL HEALTH CARE PROGRAMS TO COMPLY WITH CERTAIN CONGRESSIONAL REQUESTS.

(a) **IN GENERAL.**—Section 1128J of the Social Security Act, as added by section 6402, is amended by adding at the end the following new subsection:

“(f) **COMPLIANCE WITH CERTAIN REQUESTS BY INDIVIDUALS AND ENTITIES THAT PARTICIPATE IN OR CONDUCT ACTIVITIES UNDER FEDERAL HEALTH CARE PROGRAMS.**—

“(1) **IN GENERAL.**—Any individual or entity that participates in or conducts activities under a Federal health care program (as defined in section 1128B(f)) shall, as a condition of such participation or such conduct, comply (at a time and in a manner specified by the Chairman or ranking member) with any request submitted by the Chairman or the ranking member of a relevant committee of Congress to the individual or entity for the following:

- “(A) Documents.
- “(B) Information.

“(C) Interviews.

“(2) **RELEVANT COMMITTEE OF CONGRESS DEFINED.**—In this subsection, the term ‘relevant committee of Congress’ means the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.”.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on the date that is 2 years after the date of enactment of this Act.

SA 3268. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1798, between lines 21 and 22, insert the following:

SEC. 6608. MEDICAL ID THEFT INFORMATION SHARING PROGRAM AND CLEARINGHOUSE.

(a) **ESTABLISHMENT.**—Not later than 24 months after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the “Secretary”), acting through the Administrator of the Centers for Medicare & Medicaid Services and in coordination with the Chairman of the Federal Trade Commission, shall establish an information sharing program regarding beneficiary medical ID theft under the programs under titles XVIII, XIX, and XXI of the Social Security Act (in this section referred to as the “program”).

(b) **CONTENTS OF PROGRAM.**—The program shall include—

- (1) the establishment of methods to identify and detect relevant warning signs of medical ID theft; and
- (2) the establishment of appropriate responses to such warning signs that would mitigate and prevent beneficiary medical ID theft; and
- (3) the development of a detailed plan to update the program as appropriate, taking into consideration such warning signs and appropriate responses.

(c) **ESTABLISHMENT OF CLEARINGHOUSE.**—The Secretary, in coordination with the Chairman of the Federal Trade Commission, shall establish a clearinghouse at the Centers for Medicare & Medicaid Services that collects reports of ID theft against beneficiaries under the programs under titles XVIII, XIX, and XXI of the Social Security Act from the Federal Trade Commission and other sources determined appropriate by the Secretary. Such clearinghouse shall be used to fight medical ID theft against beneficiaries and to prevent the improper payment of claims under such programs.

SA 3269. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1740, strike lines 1 through 16, and insert the following:

“(o) **SUSPENSION AUTHORITY.**—

“(1) **IN GENERAL.**—The Secretary shall suspend payment to a provider of services or supplier under this title pending an investigation of credible allegations of fraud against the provider of services or supplier, unless the Secretary finds good cause not to suspend such payment.

“(2) **CONSULTATION.**—The Secretary shall consult with the Inspector General of the Department of Health and Human Services in determining whether there is a credible allegation of fraud against a provider of services or supplier.”.

SA 3270. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1798, between lines 21 and 22, insert the following:

SEC. 6608. PERMISSIVE EXCLUSION AUTHORITY.

Clauses (i) and (ii) of section 1128(b)(15)(A) of the Social Security Act (42 U.S.C. 1320a-7(b)(15)(A)) are amended to read as follows:

“(i) who has or had a direct or indirect ownership or control interest in the sanctioned entity and who knew or should have known (as defined in section 1128A(i)(7)) of the action constituting the basis for the conviction or exclusion described in subparagraph (B); or

“(ii) who is or was an officer or managing employee (as defined in section 1126(b)) of such an entity at the time of the action constituting the basis for the conviction or exclusion so described.”.

SA 3271. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1783, between lines 2 and 3, insert the following:

SEC. 6412. REQUIREMENTS FOR THE TRANSMISSION OF MANAGEMENT IMPLICATION REPORTS BY THE HHS OIG.

Section 1128J of the Social Security Act, as added by section 6402, is amended by adding at the end the following new subsection:

“(f) **TRANSMISSION OF MANAGEMENT IMPLICATION REPORTS BY THE HHS OIG.**—

“(1) **CONGRESSIONAL NOTIFICATION.**—Not later than 30 days after the transmission by the Inspector General of the Department of Health and Human Services to another agency of the Department of Health and Human Services of a management implication report, the Inspector General shall notify the relevant committees of Congress of such transmission.

“(2) **SECRETARIAL RESPONSE.**—The Secretary shall respond to a management implication report transmitted under paragraph

(1) not later than 90 days after such transmission.

“(3) RELEVANT COMMITTEES OF CONGRESS DEFINED.—In this subsection, the term ‘relevant committees of Congress’ means the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.”.

SA 3272. Mr. LEMIEUX submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1798, between lines 21 and 22, insert the following:

SEC. 6608. OTHER MISCELLANEOUS PROVISIONS.

(a) INCREASED CIVIL MONEY PENALTIES AND CRIMINAL FINES AND SENTENCES FOR MEDICARE FRAUD AND ABUSE.—

(1) INCREASED CIVIL PENALTIES AND CRIMINAL FINES.—

(A) INCREASED CIVIL MONEY PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a-7a) is amended—

(i) in subsection (a), in the flush matter following paragraph (7)—

(I) by striking “\$10,000” each place it appears and inserting “\$20,000”;

(II) by striking “\$15,000” and inserting “\$30,000”; and

(III) by striking “\$50,000” and inserting “\$100,000”; and

(ii) in subsection (b)—

(I) in paragraph (1), in the flush matter following subparagraph (B), by striking “\$2,000” and inserting “\$4,000”;

(II) in paragraph (2), by striking “\$2,000” and inserting “\$4,000”; and

(III) in paragraph (3)(A)(i), by striking “\$5,000” and inserting “\$10,000”.

(B) INCREASED CRIMINAL FINES.—Section 1128B of the Social Security Act (42 U.S.C. 1320a-7b) is amended—

(i) in subsection (a), in the flush matter following paragraph (6)—

(I) by striking “\$25,000” and inserting “\$100,000”; and

(II) by striking “\$10,000” and inserting “\$20,000”;

(ii) in subsection (b)—

(I) in paragraph (1), in the flush matter following subparagraph (B), by striking “\$25,000” and inserting “\$100,000”; and

(II) in paragraph (2), in the flush matter following subparagraph (B), by striking “\$25,000” and inserting “\$100,000”;

(iii) in subsection (c), by striking “\$25,000” and inserting “\$100,000”;

(iv) in subsection (d), in the second flush matter following subparagraph (B), by striking “\$25,000” and inserting “\$100,000”; and

(v) in subsection (e), by striking “\$2,000” and inserting “\$4,000”.

(C) EFFECTIVE DATE.—The amendments made by this subsection shall apply to civil money penalties and fines imposed for actions taken on or after the date of enactment of this Act.

(2) INCREASED SENTENCES FOR FELONIES INVOLVING MEDICARE FRAUD AND ABUSE.—

(A) FALSE STATEMENTS AND REPRESENTATIONS.—Section 1128B(a) of the Social Security Act (42 U.S.C. 1320a-7b(a)) is amended, in clause (i) of the flush matter following para-

graph (6), by striking “not more than 5 years” and inserting “not more than 10 years”.

(B) ANTI-KICKBACK.—Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a-7b(b)) is amended—

(i) in paragraph (1), in the flush matter following subparagraph (B), by striking “not more than 5 years” and inserting “not more than 10 years”; and

(ii) in paragraph (2), in the flush matter following subparagraph (B), by striking “not more than 5 years” and inserting “not more than 10 years”.

(C) FALSE STATEMENT OR REPRESENTATION WITH RESPECT TO CONDITIONS OR OPERATIONS OF FACILITIES.—Section 1128B(c) of the Social Security Act (42 U.S.C. 1320a-7b(c)) is amended by striking “not more than 5 years” and inserting “not more than 10 years”.

(D) EXCESS CHARGES.—Section 1128B(d) of the Social Security Act (42 U.S.C. 1320a-7b(d)) is amended, in the second flush matter following subparagraph (B), by striking “not more than 5 years” and inserting “not more than 10 years”.

(E) MINIMUM SENTENCE.—Section 1128B of the Social Security Act (42 U.S.C. 1320a-7b) is amended by adding at the end thereof the following:

“(g) Notwithstanding any other provision of this section, the minimum period of imprisonment for a conviction under this section relating to Medicare fraud and abuse (if such imprisonment is otherwise provided for under this section) shall be 1 year and 1 day.”.

(F) EFFECTIVE DATE.—The amendments made by this subsection shall apply to criminal penalties imposed for actions taken on or after the date of enactment of this Act.

(b) CONSUMER RIGHT-TO-KNOW.—At the end of title I, insert the following:

“SEC. 1563. CONSUMER RIGHT TO KNOW.

“(a) DEVELOPMENT OF INFORMATION SYSTEM.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall develop a system for the collection of quality and pricing information related to the provision of health care services. Through the use of such information, the Secretary shall, to the extent practicable—

“(1) determine the lowest, median, average, and highest charged amount and reimbursed amount for each outpatient and inpatient health care procedure conducted at each facility in the United States;

“(2) provide comparisons of such prices with respect to procedures in similar facilities in the same county, city, State and on a national basis; and

“(3) develop quality of care data, including data on consumer satisfaction, coordination and continuity of care, infrastructure, the results of accreditation, Medicare-related information, and other survey information, and combine such data with price information to enable consumers to make informed choices.

“(b) USE OF EXISTING SOURCES.—To the extent that the information required under subsection (a) is being collected by the Centers for Medicare & Medicaid Services, States, State medical societies, or private sector entities, the Secretary, to the extent practicable, utilize such information to carry out such subsection.

“(c) AVAILABILITY OF INFORMATION.—The Secretary, either directly or through contract, shall make the information and data collected and developed under this section available on an Internet website. Such information and data shall be displayed by payer

(such as Medicare, Medicaid, health insurance plans, employer-based health plans, and other types of health care coverage).”.

(c) PRODUCTIVITY AWARD PROGRAM.—After section 3027, insert the following:

“SEC. 3028. PRODUCTIVITY AWARD PROGRAM.

“Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall establish a Productivity Award Program to recognize employees, work units, and contractors of the Centers for Medicare & Medicaid whose work significantly and measurably increases productivity and promotes innovation to improve the delivery of services and achieving savings for taxpayers. The amount of any such award shall be equal to 10 percent of the amount of the estimated saving to the Federal Government as a result of the action resulting in the award (as determined by the Secretary), but not to exceed \$50,000.”.

SA 3273. Mrs. SHAHEEN (for herself, Mr. BENNET, and Ms. COLLINS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 796, between lines 5 and 6, insert the following:

SEC. 3028. IMPROVEMENTS TO COMMUNITY-BASED CARE TRANSITIONS PROGRAM.

Section 3026 is amended—

(1) in subsection (a), by inserting “evidence-based” before “care transition services”;

(2) in subsection (b)—

(A) in paragraph (1), in the matter preceding subparagraph (A), by striking “The term” and inserting “Subject to paragraph (7), the term”; and

(B) by adding at the end the following new paragraph:

“(7) LIMITATION.—The term ‘eligible entity’ includes a subsection (d) hospital described in paragraph (1)(A) or a community-based organization described in paragraph (1)(B) only if the provider of services or organization demonstrates to the Secretary relevant training and experience in the delivery of care transition services, including for individuals providing such services under the program.”;

(3) in subsection (c)—

(A) in paragraph (1)—

(i) by redesignating subparagraph (B) as subparagraph (C);

(ii) by inserting after subparagraph (A) the following new subparagraph:

“(B) EVALUATION.—

“(i) IN GENERAL.—The Secretary shall conduct an evaluation of the program, and shall take such evaluation into account in determining whether to expand the program under subparagraph (C).

“(ii) DETERMINATION OF CRITERIA.—The Secretary shall determine the criteria used under such evaluation, taking into account hospital readmission rates and the experiences of primary caregivers and high-risk Medicare beneficiaries under the program, including the quality of care transition interventions and health outcomes.”;

(iii) in subparagraph (C), as redesignated by subparagraph (A), by striking “that such

expansion" and all that follows through the period at the end and inserting "that such expansion would—

"(i) reduce spending under title XVIII of the Social Security Act without reducing quality of care;

"(ii) improve quality of care and reduce such spending; or

"(iii) improve quality of care without increasing such spending."; and

(iv) by adding at the end the following new subparagraph:

"(D) REQUIRED ELEMENTS OF PROGRAM DURING EXPANSION PERIOD.—If the Secretary expands the program under subparagraph (C), the following shall apply with respect to such expansion:

"(i) EVIDENCE-BASED SERVICES.—The Secretary shall require the use of only evidence-based care transition services during such expansion.

"(ii) EXPANSION OF ELIGIBLE ENTITIES.—The Secretary shall expand the type of providers of services or organizations that may qualify as eligible entities for the provision of care transition services under subsection (b)(1), such as a home health agency, primary health care practice, or a Federally qualified health center. Any provider of services or organization that so qualifies under the preceding sentence shall be required to demonstrate to the Secretary relevant training and experience in the delivery of evidence-based care transition services, including for individuals providing such services under the program.";

(B) in paragraph (2)(B)—

(i) in the matter preceding clause (i), by striking " , which may include the following:" and inserting " . Each care transition intervention proposed shall include, at a minimum, the following:";

(ii) in clause (i)—

(I) by inserting "(and, as appropriate, the primary caregiver of the beneficiary)" after "high-risk Medicare beneficiary";

(II) by striking "not later than 24 hours"; and

(III) by inserting " , with a recommendation that such services should be initiated not less than 24 hours prior to such discharge and, whenever possible, earlier in the stay at the eligible entity" before the period at the end; and

(iii) by adding at the end the following new clauses:

"(vi) Providing care transition services to the high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) under the care transition intervention after admission and prior to the discharge of the beneficiary from the eligible entity and for a period of up to 90 days after such discharge.

"(vii) Providing at least some of the care transition services provided to the high-risk Medicare beneficiary under the care transition intervention in-person."; and

(C) in paragraph (3)—

(i) in subparagraph (A), by striking "or" at the end;

(ii) in subparagraph (B), by striking the period at the end and inserting " ; or"; and

(iii) by adding at the end the following new subparagraph:

"(C) support inpatient and ambulatory health care providers in improving the safety and quality of care, with a governing body that is not comprised of a majority of any type of provider or profession.";

(4) by redesignating subsection (f) as subsection (g); and

(5) by inserting after subsection (e) the following new subsection:

"(f) PROVISION OF DE-IDENTIFIED DATA TO PROVIDERS OF SERVICES AND SUPPLIERS.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, subject to paragraph (3), an eligible entity participating in the program may make available to providers of services and suppliers participating in a care transition intervention under the program de-identified data with respect to high-risk Medicare beneficiaries.

"(2) DATA.—Data made available under paragraph (1) shall identify services provided by providers of services and suppliers to high-risk Medicare beneficiaries, for the purposes of—

"(A) improving the safety, quality, and effectiveness of care transition services provided to those beneficiaries under the program; and

"(B) measuring the safety, quality, and effectiveness of such services provided by a provider of services or supplier to the safety, quality, and effectiveness of such services provided by another provider of services or supplier.

"(3) PRIVACY STANDARDS.—Nothing in this subsection shall be construed to limit, alter, or affect the requirements imposed by the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996."

SA 3274. Mr. MERKLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 144, between lines 23 and 24, insert the following:

(3) STANDARDS FOR OFFERING PLANS THROUGH EXCHANGE.—In carrying out its responsibilities under paragraph (1)(B), an Exchange may—

(A) set standards under which health plans may be offered through the Exchange, including the authority to negotiate bids; and

(B) enforce such standards, including by refusing to certify a health plan as a qualified health plan that may be offered through the Exchange.

SA 3275. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

SEC. 3115. ACCREDITATION REQUIREMENT FOR ROTARY WING AIR AMBULANCE SERVICES.

Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by this Act, is amended by adding at the end the following new subsection:

"(p) ESTABLISHMENT OF ROTARY WING AIR AMBULANCE ACCREDITATION PROCESS.—

"(1) IN GENERAL.—

"(A) ESTABLISHMENT OF PROCESS.—The Secretary, in consultation with the Secretary of Transportation (acting through the Administrator of the Federal Aviation Administration), shall establish a process for the accreditation of suppliers and providers of rotary wing air ambulance services reimbursed under the fee schedule established under subsection (1).

"(B) REQUIREMENT.—On or after January 1, 2012, payment may only be made to a supplier or provider of rotary wing air ambulance services (whether provided directly or under arrangement with a provider under this part) under the fee schedule established under subsection (1) if such supplier or provider is accredited by an organization designated by the Secretary pursuant to the process described in paragraph (2).

"(2) ACCREDITATION ORGANIZATIONS.—

"(A) DESIGNATION.—Not later than June 30, 2011, the Secretary shall designate organizations to accredit suppliers and providers of rotary wing air ambulance services under the process established under paragraph (1).

"(B) FACTORS FOR DESIGNATION.—The Secretary shall consider the following factors in designating accreditation organizations under subparagraph (A):

"(i) The ability of the organization to provide timely reviews of applications.

"(ii) Whether the organization uses random site visits, site audits, or other strategies for ensuring adherence to the criteria developed under paragraphs (3), (4), and (5).

"(iii) The ability of the organization to take into account the capacities of and special circumstances applicable to suppliers and providers of rural air ambulance services (as defined in subsection (1)(4)(C)).

"(iv) The ability of the organization to take into account the capacities of and special circumstances applicable to suppliers and providers of air ambulance services that are owned and operated by units of State or local government, including those that utilize a single aircraft for both air ambulance services and public safety purposes.

"(v) Whether the organization has established reasonable fees to be charged to suppliers and providers applying for accreditation.

"(vi) With respect to application of the criteria developed under paragraphs (3), (4), and (5), whether the organization has applicable experience in the accreditation of suppliers and providers.

"(vii) Whether the organization has developed an accreditation program that is adequate and appropriate to the goal of ensuring high caliber rotary wing air ambulance services.

"(viii) Such additional factors as are specified by the Secretary (acting through the Administrator of the Centers for Medicare & Medicaid Services) with respect to quality, medical services, and emergency medical services integration considerations under paragraph (3)(A)(i).

"(ix) Such additional aviation safety-related factors as are developed by the Administrator of the Federal Aviation Administration under paragraph (4)(A).

"(x) The ability of the organization to effectively enforce the criteria developed under paragraphs (3), (4), and (5).

"(xi) Such other factors as the Secretary determines appropriate.

"(C) REVIEW AND MODIFICATION OF LIST OF ACCREDITATION ORGANIZATIONS.—The Secretary, in consultation with the Secretary of Transportation (acting through the Administrator of the Federal Aviation Administration) shall review on a regular basis the list

of organizations designated under subparagraph (A) with reference to the factors described in subparagraph (B) and, as a result of such review, may modify the list of organizations so designated by adding or removing organizations from such list.

“(3) DEVELOPMENT OF QUALITY, MEDICAL SERVICES, AND EMS INTEGRATION-RELATED DESIGNATION FACTORS AND ACCREDITATION CRITERIA.—

“(A) DEVELOPMENT OF DESIGNATION FACTORS AND ACCREDITATION CRITERIA BY ADMINISTRATOR OF CMS.—Not later than January 1, 2011, subject to subparagraphs (B) and (C), the Secretary (acting through the Administrator of the Centers for Medicare & Medicaid Services) shall—

“(i) develop and transmit to the Secretary the additional quality, medical services, and integration with State emergency medical services systems related factors considered under paragraph (2)(B)(viii) in designating accreditation organizations under paragraph (2)(A); and

“(ii) develop and provide to the Secretary high-caliber quality, medical services, and emergency medical services integration criteria that accreditation organizations designated under paragraph (2)(A) shall utilize in the accreditation process established under paragraph (1).

“(B) CONSULTATION WITH FEDERAL AVIATION ADMINISTRATION.—The Secretary (acting through the Administrator of the Centers for Medicare & Medicaid Services) shall consult with the Administrator of the Federal Aviation Administration in the development of the factors and criteria under clauses (i) and (ii), respectively, of subparagraph (A).

“(C) SCOPE OF QUALITY, MEDICAL SERVICES, AND EMS INTEGRATION-RELATED CRITERIA.—

“(i) CONSIDERATIONS.—In developing the criteria under subparagraph (A)(ii), the Secretary (acting through the Administrator of the Centers for Medicare & Medicaid Services) shall consider National Transportation Safety Board Recommendations A-09-102 through A-09-103 and A-09-106 through A-09-107.

“(ii) CRITERIA.—Such criteria shall address—

“(I) the presence and qualifications of medical personnel on board the air ambulance;

“(II) real-time coordination between suppliers and providers and 911 systems and integration with State emergency medical systems;

“(III) medical oversight of paramedics, flight nurses, or other medical personnel on board air ambulances;

“(IV) quality assurance;

“(V) design of the air ambulance medical bay for the provision of patient care;

“(VI) minimum medically related service requirements;

“(VII) medical equipment and supplies on board the air ambulance;

“(VIII) the need to obtain licensure of the air ambulance by the State within which it is based, consistent with paragraph (8)(C); and

“(IX) such other matters as the Secretary (acting through the Administrator of the Centers for Medicare & Medicaid Services) determines appropriate.

“(4) DEVELOPMENT OF AVIATION SAFETY-RELATED DESIGNATION FACTORS AND ACCREDITATION CRITERIA BY ADMINISTRATOR OF THE FAA.—

“(A) DEVELOPMENT OF DESIGNATION FACTORS AND ACCREDITATION CRITERIA.—Not later than January 1, 2011, subject to subparagraphs (B) and (C), the Administrator of the Federal Aviation Administration shall—

“(i) develop and transmit to the Secretary the additional aviation safety-related factors to be used under paragraph (2)(B)(ix) in designating accreditation organizations under paragraph (2)(A); and

“(ii) develop and provide to the Secretary aviation safety-related criteria that accreditation organizations designated under paragraph (2)(A) shall utilize in the accreditation process established under paragraph (1).

“(B) SOLE AUTHORITY OF FAA OVER DEVELOPMENT OF AVIATION SAFETY-RELATED DESIGNATION FACTORS AND ACCREDITATION CRITERIA.—The Administrator of the Federal Aviation Administration shall have sole authority over the development of designation factors and accreditation criteria under subparagraph (A).

“(C) SCOPE OF AVIATION SAFETY-RELATED CRITERIA.—

“(i) IN GENERAL.—The criteria developed by the Administrator of the Federal Aviation Administration under subparagraph (A) shall comprise minimum safety requirements for suppliers and providers of rotary wing air ambulance services to address aviation safety considerations particular to the transportation of patients between health care facilities and from emergency response locations for purposes of medical care and treatment that augment the operating standards under part 135 of title 14, Code of Federal Regulations and other statutory and regulatory requirements pertaining to aviation safety of helicopter aircraft used for emergency medical service.

“(ii) CRITERIA.—Such criteria shall consist of—

“(I) those criteria that the Administrator of the Federal Aviation Administration adopts based upon consideration of any National Transportation Safety Board Recommendations regarding the use of helicopter aircraft for emergency medical service that are not otherwise required by statute or regulation; and

“(II) such other matters as the Administrator of the Federal Aviation Administration determines appropriate.

“(5) REQUIREMENTS FOR CRITERIA DEVELOPMENT PROCESS.—

“(A) CONSIDERATION OF IMPACTS ON PATIENT AND RURAL ACCESS AND GOVERNMENT OWNED AND OPERATED SERVICE PROVIDERS; REQUIREMENT FOR STAKEHOLDER PARTICIPATION.—In developing accreditation criteria under paragraphs (3) and (4), the Secretary (acting through the Administrator of the Centers for Medicare & Medicaid Services) and the Administrator of the Federal Aviation Administration, respectively, shall—

“(i) ensure that such criteria avoid adversely impacting beneficiaries under this title and other patient access to medically necessary and reasonable rotary wing air ambulance services, particularly in rural areas;

“(ii) expressly consider—

“(I) the particular needs and circumstances of suppliers and providers of rural air ambulance services (as defined in subsection (1)(14)(C));

“(II) the particular needs and circumstances of those suppliers and providers of air ambulance services that are owned and operated by units of State or local government (including those that utilize a single aircraft for both air ambulance services and public safety purposes);

“(III) the extent to which any such criteria is economically feasible to ensure continued access to rotary wing air ambulance services, particularly in rural areas;

“(IV) the extent to which any such criteria is technically feasible, taking into account

the ability of existing aircraft to comply with any such standards, as well as the market availability and future development of equipment and products that can be installed on or carried aboard existing rotary wing aircraft; and

“(V) the incorporation of any such criteria during appropriate implementation timeframes with the goal of transitioning toward higher caliber criteria for beneficiaries under this title over a reasonable period of time and in a manner that does not impede access to rotary wing air ambulance services, particularly in rural areas; and

“(iii) ensure that the process of developing such criteria is undertaken through a transparent process that provides for input from various stakeholders, including organizations representing physicians and other medical professionals, State, or local governments that own and operate air ambulance services, organizations representing air medical suppliers or providers, patient organizations, State emergency medical services, public health officials, and any other stakeholders determined appropriate by the Secretary (acting through the Administrator of the Centers for Medicare & Medicaid Services) or the Administrator of the Federal Aviation Administration, respectively.

“(B) REGULAR UPDATING OF CRITERIA.—The Secretary (acting through the Administrator of the Centers for Medicare & Medicaid Services) and the Administrator of the Federal Aviation Administration shall ensure that the criteria developed under paragraphs (3) and (4), respectively, are reviewed not less than frequently than every 2 years and updated as appropriate to reflect consideration of new medical and aviation standards, technologies, and equipment.

“(6) INCORPORATION OF ACCREDITATION CRITERIA.—

“(A) IN GENERAL.—The Secretary shall combine the criteria developed by the Secretary (acting through the Administrator of the Centers for Medicare & Medicaid Services) under paragraph (3) and the criteria developed by the Administrator of the Federal Aviation Administration under paragraph (4) into a single set of final criteria and ensure that accreditation organizations designated under paragraph (2)(A) apply such set of final criteria as substantive requirements in the accreditation process established under paragraph (1).

“(B) REVIEW.—The Secretary shall review such set of final criteria to ensure that, taken as a whole, such criteria are consistent with the requirements of clauses (i) and (ii) of paragraph (5)(A). If the Secretary determines that such set of final criteria is not consistent with such requirements, the Secretary shall request that the Secretary (acting through the Administrator of the Centers for Medicare & Medicaid Services) and the Administrator of the Federal Aviation Administration modify such criteria in accordance with the process described in paragraphs (3), (4), and (5).

“(7) GRANDFATHER PROTECTION FOR AIRCRAFT PRESENTLY PROVIDING ROTARY WING AIR AMBULANCE SERVICES.—

“(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall exempt any rotary wing air ambulance listed on a currently valid operating certificate with A021 air ambulance operations specifications pursuant to parts 119 and 135 of title 14, Code of Federal Regulations or any air ambulance for which a contractual obligation to purchase such air ambulance had been entered into prior to the date of enactment of the Patient Protection and Affordable Care Act, from

compliance with any accreditation criteria developed under paragraphs (3), (4), and (5) or incorporated under paragraph (6), if, as determined by the Administrator of the Federal Aviation Administration in consultation with the Secretary (acting through the Administrator of the Centers for Medicare & Medicaid Services), compliance with such criteria would require the replacement of such aircraft or impose an undue economic burden on a supplier or provider of rotary wing air ambulance services with respect to compliance costs.

“(B) LIMITATION.—The exemption authority under subparagraph (A) shall not apply to any new or used aircraft purchased after the date of enactment of the Patient Protection and Affordable Care Act (including aircraft purchased as a replacement for an existing aircraft) unless the supplier or provider was under contractual obligation to purchase such air ambulance prior to such date of enactment.

“(8) RELATIONSHIP TO OTHER LAWS AND AUTHORITIES.—Nothing in this section shall—

“(A) limit the authority of the Federal Aviation Administration over civil aviation or infringe upon any regulations or guidance respecting civil aviation safety;

“(B) affect the provisions of or requirements under section 41713(b) of title 49, United States Code; or

“(C) affect the authority of States to license providers of air ambulance services or medical personnel aboard such air ambulances, except to the extent otherwise prohibited by law, including such section 41713(b).”.

EXPANDING VETERAN ELIGIBILITY FOR REIMBURSEMENT

Mr. MENENDEZ. Mr. President, I ask unanimous consent that the Veterans' Affairs Committee be discharged from further consideration of H.R. 1377 and the Senate proceed to its immediate consideration.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The clerk will report the bill by title.
The bill clerk read as follows:

A bill (H.R. 1377) to amend title 38, United States Code, to expand veteran eligibility for reimbursements by the Secretary of Veterans Affairs for emergency treatment furnished in a non-Department facility, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. AKAKA. Mr. President, today I urge our colleagues to pass legislation that would rightfully correct a deficiency in the law governing emergency health care treatment for veterans.

H.R. 1377, which passed the House in March of this year, would expand veteran eligibility for reimbursement for emergency treatment furnished in a non-Department facility. H.R. 1377 is a companion bill to provisions contained in S. 1963, the Caregiver and Veterans Omnibus Health Services Act of 2009, which passed the Senate just a few weeks ago.

Under current law, originally enacted on November 30, 1999, a veteran who is enrolled in VA's health care system

can be reimbursed for emergency treatment received at a non-VA hospital. However, the statute only permits such VA reimbursement if the veteran has no other outside health insurance, no matter how limited that other coverage might be. This means that a veteran who has any insurance is not entitled to reimbursement from VA for emergency medical treatment received at a non-VA facility. This holds true even if the veteran's insurance policy does not cover the full amount owed.

In discussing the importance of this legislation, I mention one particular story that came to the committee's attention. A disabled Vietnam veteran from Illinois was in a serious motorcycle accident which led to emergency medical bills totaling over \$100,000. This veteran had state mandated motorcycle insurance, but it only covered \$10,000 in expenses. Because under current law veterans are personally responsible for any difference between whatever coverage they have and the costs of their emergency care, VA was prohibited from paying for this veteran's care.

H.R. 1377 would modify current law so that a veteran who has outside insurance would be eligible for reimbursement in the event that the outside insurance does not cover the full amount of the emergency care. VA would be authorized to cover the difference between the amount the veteran's insurance will pay and the total cost of care. In essence, VA would become the payer of last resort in such cases. This would keep the veteran from being burdened by medical fees with no insurance with which to pay them. Additionally, this bill would also allow the Secretary of Veterans Affairs to retroactively apply this law to emergency treatment received between the effective date of the current law and the date of enactment of the legislation, thereby ensuring assistance to as many veterans as possible.

Mr. President, I urge passage of H.R. 1377 to rightfully fill this hole in veterans' health care.

Mr. MENENDEZ. Mr. President, I ask unanimous consent that the bill be read a third time and passed, the motion to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to the bill be printed in the RECORD.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The bill (H.R. 1377) was ordered to a third reading, was read the third time, and passed.

RECOGNIZING EFFORTS TO PROVIDE GAME MEAT TO FEED THE HUNGRY

Mr. MENENDEZ. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 230, S. Res. 374.

The ACTING PRESIDENT pro tempore. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 374) recognizing the cooperative efforts of hunters, sportsmen's associations, meat processors, hunger relief organizations, and State wildlife, health, and food safety agencies to establish programs that provide game meat to feed the hungry.

There being no objection, the Senate proceeded to consider the resolution.

Mr. MENENDEZ. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to the resolution be printed in the RECORD.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The resolution (S. Res. 374) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 374

Whereas almost every State has a program in which hunters may donate game meat to feed the hungry;

Whereas hunters, sportsmen's associations, meat processors, community hunger organizations, and State wildlife, health, and food safety agencies work together successfully to operate such programs whereby hunters feed the hungry; and

Whereas such programs have brought hundreds of thousands of pounds of game meat to homeless shelters, soup kitchens, and food banks: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes the cooperative efforts of hunters, sportsmen's associations, meat processors, hunger relief organizations, and State wildlife, health and food safety agencies to establish programs that provide game meat to feed the hungry across the United States; and

(2) recognizes the contributions of such programs to efforts to decrease hunger and feed individuals in need.

EXPRESSING SYMPATHY FOR CIVILIANS KILLED IN THE PHILIPPINES

Mr. MENENDEZ. Mr. President, I ask unanimous consent that the Foreign Relations Committee be discharged from further consideration of H. Con. Res. 218 and the Senate proceed to its immediate consideration.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered. The clerk will report the concurrent resolution by title.

The bill clerk read as follows:

A concurrent resolution (H. Con. Res. 218) expressing sympathy for the 57 civilians who were killed in the southern Philippines on November 23, 2009.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mr. MENENDEZ. Mr. President, I ask unanimous consent that the concurrent resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to the concurrent resolution be printed in the RECORD.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The concurrent resolution (H. Con. Res. 218) was agreed to.

The preamble was agreed to.

ORDERS FOR SATURDAY,
DECEMBER 19, 2009

Mr. MENENDEZ. Mr. President, I ask unanimous consent that when the Senate completes its business today, it ad-

journal until 6:45 a.m., Saturday, December 19; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of the House message with respect to H.R. 3326, the Department of Defense Appropriations Act, with the time until 7:20 a.m. equally divided and controlled between the two leaders or their designees, with the final 10 minutes reserved for the two leaders, with the majority leader controlling the final 5 minutes. Finally, I ask that the time during the adjournment and any period of morning business count postcloture.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

PROGRAM

Mr. MENENDEZ. Mr. President, Senators should expect multiple votes to begin at approximately 7:20 a.m. tomorrow.

ADJOURNMENT UNTIL 6:45 A.M.
TOMORROW

Mr. MENENDEZ. If there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the previous order.

There being no objection, the Senate, at 6:52 p.m., adjourned until Saturday, December 19, 2009, at 6:45 a.m.

HOUSE OF REPRESENTATIVES—Saturday, December 19, 2009

The House met at noon and was called to order by the Speaker pro tempore (Ms. EDWARDS of Maryland).

DESIGNATION OF THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

WASHINGTON, DC,
December 19, 2009.

I hereby appoint the Honorable DONNA F. EDWARDS to act as Speaker pro tempore on this day.

NANCY PELOSI,
Speaker of the House of Representatives.

COMMUNICATION FROM THE SERGEANT AT ARMS OF THE HOUSE

The SPEAKER pro tempore laid before the House the following communication from the Sergeant at Arms of the House of Representatives:

OFFICE OF THE SERGEANT AT ARMS,
HOUSE OF REPRESENTATIVES,
Washington, DC, December 18, 2009.

Hon. NANCY PELOSI,
The Speaker,
Washington, DC.

DEAR MADAM SPEAKER, As you are aware, the time previously appointed for the next meeting of the House is 6 p.m. on Saturday, December 19, 2009. This is to notify you, pursuant to clause 12(c) of rule I, of an imminent impairment of the place of reconvening at that time. The impairment is due to the weather.

Respectfully,

WILSON LIVINGOOD,
Sergeant at Arms.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Under clause 12(c) of rule I, the Speaker established this time for reconvening and notified Members accordingly.

PRAYER

The Reverend Gene Hemrick, Washington Theological Union, Washington, D.C., offered the following prayer:

Lord, during this holy season which prompts us to especially lift our thoughts to You, may You bless this Congress with Your wisdom and the peace and justice it creates when we turn to You.

We further pray that in this inclement weather You give its Members safe passage home to be with their loved ones and to experience the joy this creates. Amen.

PLEDGE OF ALLEGIANCE

The SPEAKER pro tempore. The Chair will lead the House in the Pledge of Allegiance.

The SPEAKER pro tempore led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER pro tempore laid before the House the following communication from the Clerk of the House of Representatives:

OFFICE OF THE CLERK,
HOUSE OF REPRESENTATIVES,
Washington, DC, December 19, 2009.

Hon. NANCY PELOSI,
The Speaker,
Washington, DC.

DEAR MADAM SPEAKER: Pursuant to the permission granted in Clause 2(h) of Rule II of the Rules of the U.S. House of Representatives, the Clerk received the following message from the Secretary of the Senate on December 19, 2009, at 10:00 a.m.

That the Senate concurs in the amendment of the House to the amendment of the Senate to the bill H.R. 3326.

That the Senate passed without amendment H.R. 1377.

That the Senate agreed to without amendment H. Con. Res. 218.

That the Senate agreed to without amendment H.J. Res. 64.

With best wishes, I am
Sincerely,

LORRAINE C. MILLER,
Clerk of the House.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(c) of rule I, the House shall stand in recess until approximately 11:30 a.m. on Wednesday, December 23, 2009.

Accordingly (at 12 o'clock and 3 minutes p.m.), the House stood in recess.

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. MORAN of Virginia) at 11 o'clock and 30 minutes a.m.

THE JOURNAL

The SPEAKER pro tempore. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER pro tempore laid before the House the following communication from the Clerk of the House of Representatives:

HOUSE OF REPRESENTATIVES,
Washington, DC, December 22, 2009.

Hon. NANCY PELOSI,
The Speaker, The Capitol, House of Representatives,
Washington, DC.

DEAR MADAM SPEAKER: Pursuant to the permission granted in Clause 2(h) of Rule II of the Rules of the U.S. House of Representatives, the Clerk received the following message from the Secretary of the Senate on December 22, 2009, at 9:45 a.m.:

That the Senate passed without amendment H.R. 2877.

That the Senate passed without amendment H.R. 3072.

That the Senate passed without amendment H.R. 3319.

That the Senate passed without amendment H.R. 3539.

That the Senate passed without amendment H.R. 3667.

That the Senate passed without amendment H.R. 3767.

That the Senate passed without amendment H.R. 3788.

That the Senate passed without amendment H.R. 1817.

With best wishes, I am

Sincerely,

LORRAINE C. MILLER,
Clerk of the House.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER pro tempore laid before the House the following communication from the Clerk of the House of Representatives:

HOUSE OF REPRESENTATIVES,
Washington, DC, December 22, 2009.

Hon. NANCY PELOSI,
The Speaker, The Capitol, House of Representatives,
Washington, DC.

DEAR MADAM SPEAKER: Pursuant to the permission granted in Clause 2(h) of Rule II of the Rules of the U.S. House of Representatives, the Clerk received the following message from the Secretary of the Senate on December 22, 2009, at 9:17 a.m.:

That the Senate passed without amendment H.R. 4282.

That the Senate agreed to without amendment H. Con. Res. 206.

Appointments: United States-China Inter-parliamentary Group (2).

With best wishes, I am

Sincerely,

LORRAINE C. MILLER,
Clerk of the House.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 4 of rule I, the following enrolled bill and joint resolution were signed on Saturday, December 19, 2009:

□ This symbol represents the time of day during the House proceedings, e.g., □ 1407 is 2:07 p.m.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

By the Speaker:

H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes;

and by Speaker pro tempore VAN HOLLEN:

H.J. Res. 64, making further continuing appropriations for fiscal year 2010, and for other purposes.

ENROLLED BILLS SIGNED

Lorraine C. Miller, Clerk of the House, reported and found truly enrolled a bill of the House of the following title, which was thereupon signed by the Speaker on Saturday, December 19, 2009:

H.R. 3326. An act making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes.

Lorraine C. Miller, Clerk of the House, further reported and found truly enrolled a joint resolution of the House of the following title, which was thereupon signed by the Speaker pro tempore, Mr. VAN HOLLEN, on Saturday, December 19, 2009:

H.J. Res. 64. Joint resolution making further continuing appropriations for fiscal year 2010, and for other purposes.

ADJOURNMENT

The SPEAKER pro tempore. Pursuant to section 11(b) of House Resolution 976, the House shall stand adjourned until noon today unless the conditions specified in section 11(c) of that resolution have been met, in which case the House shall stand adjourned sine die pursuant to House Concurrent Resolution 223.

Accordingly (at 11 o'clock and 33 minutes a.m.), the House adjourned until today, Wednesday, December 23, 2009, at noon.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of Rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

5172. A communication from the President of the United States, transmitting an supplemental consolidated report, consistent with the War Powers Resolution, to help ensure that the Congress is kept fully informed on U.S. military activities in support of the war on terror and Kosovo, pursuant to Public Law 93-148; (H. Doc. No. 111-79); to the Committee on Foreign Affairs and ordered to be printed.

5173. A letter from the Acting Executive Secretary, U.S. Agency For International Development, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5174. A letter from the Acting Executive Secretary, U.S. Agency for International Development, transmitting a report pursuant

to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5175. A letter from the Acting Executive Secretary, U.S. Agency for International Development, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5176. A letter from the Acting Executive Secretary, U.S. Agency for International Development, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5177. A letter from the Acting Executive Secretary, U.S. Agency for International Development, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5178. A letter from the Acting Executive Secretary, U.S. Agency for International Development, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5179. A letter from the Acting Executive Secretary, U.S. Agency for International Development, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5180. A letter from the Acting Executive Secretary, U.S. Agency for International Development, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5181. A letter from the Acting Executive Secretary, U.S. Agency for International Development, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5182. A letter from the Acting Executive Secretary, U.S. Agency for International Development, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5183. A letter from the Acting Executive Secretary, U.S. Agency for International Development, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5184. A letter from the Acting Executive Secretary, U.S. Agency for International Development, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5185. A letter from the Acting Executive Secretary, U.S. Agency for International Development, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5186. A letter from the Acting Executive Secretary, U.S. Agency for International Development, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5187. A letter from the Acting Executive Secretary, U.S. Agency for International Development, transmitting a report pursuant to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

5188. A letter from the Acting Executive Secretary, U.S. Agency for International Development, transmitting a report pursuant

to the Federal Vacancies Reform Act of 1998; to the Committee on Oversight and Government Reform.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

[Omitted from the Record of December 16, 2009]

Mr. CONYERS: Committee on the Judiciary. H.R. 3845. A bill to extend and modify authorities needed to combat terrorism and protect civil liberties, and for other purposes; with an amendment (Rept. 111-382 Pt. 1). Ordered to be printed.

[The following actions occurred on December 17, 2009]

Mr. SKELTON: Committee on Armed Services. House Resolution 924. Resolution directing the Secretary of Defense to transmit to the House of Representatives copies of any document, record, memo, correspondence, or other communication of the Department of Defense, or any portion of such communication, that refers or relates to the trial or detention of Khalid Sheikh Mohamed, Walid Muhammad Salih Mubarek Bin 'Attash, Ramzi Binalshibh, Ali Abdul Aziz Ali, or Mustafa Ahmed Adam al Hawsawi, with an amendment (Rept. 111-383). Referred to the House Calendar.

Mr. REYES: Permanent Select Committee on Intelligence. House Resolution 923. Resolution requesting the President to transmit to the House of Representatives all documents in the possession of the President relating to the effects on foreign intelligence collection of the transfer of detainees held at Naval Station, Guantanamo Bay, Cuba, into the United States, with an amendment (Rept. 111-384). Referred to the House Calendar.

[Filed on December 23 (legislative day of December 19), 2009]

Mrs. MALONEY: The 2009 Joint Economic Report (Rept. 111-388). Referred to the Committee of the Whole House on the State of the Union.

DISCHARGE OF COMMITTEE

Pursuant to clause 2 of rule XIII the Committees on Financial Services and the Judiciary discharged from further consideration, H.R. 977 referred to the Committee of the Whole House on the State of the Union and ordered to be printed.

Pursuant to clause 2 of rule XIII the Committee on Financial Services discharged from further consideration, H.R. 2646 referred to the Committee of the Whole House on the State of the Union, and ordered to be printed.

REPORTED BILL SEQUENTIALLY REFERRED

Under clause 2 of rule XII, bills and reports were delivered to the Clerk for printing, and bills referred as follows:

Mr. PETERSON: Committee on Agriculture. H.R. 977. A bill to amend the Commodity Exchange Act to bring greater transparency and accountability to commodity markets, and for other purposes, with an amendment, Rept. 111-385, Pt. 1; Referred to

the Committee on Judiciary for a period ending not later than December 19, 2009, for consideration of such provisions of the bill and amendment as fall within the jurisdiction of that committee pursuant to clause 1(k), rule X.

Mr. OBERSTAR: Committee on Transportation and Infrastructure. H.R. 3376. A bill to amend title 46, United States Code, to ensure the traditional right of self-defense of United States mariners against acts of piracy, and for other purposes, Rept. 111-386, Part 1; Referred to the Committees on Judiciary, and Homeland Security for a period ending not later than March 25, 2010, for consideration of such provisions of the bill as fall within the jurisdiction of those committees pursuant to clause 1(k) and 1(i) respectively, rule X.

Mr. TOWNS: Committee on Oversight and Government Reform. H.R. 2646. A bill to amend title 31, United States Code, to enhance the oversight authorities of the Comptroller General, and for other purposes, with an amendment, Rept. 111-387, Part 1; Referred to the Committee on Financial Services for a period ending not later than December 19, 2009, for consideration of such provisions of the bill and amendment as fall within the jurisdiction of that committee pursuant to clause 1(g), rule X.

TIME LIMITATION OF REFERRED BILL PURSUANT TO RULE XII

Pursuant to clause 2 of rule XII the following action was taken by the Speaker:

[Omitted from the Record of December 16, 2009]

H.R. 3845. Referral to the Committees on Intelligence (Permanent Select) and Financial Services extended for a period ending not later than January 29, 2010.

[The following action occurred on December 19, 2009]

H.R. 3376. Referral to the Committees on the Judiciary and Homeland Security extended for a period ending not later than March 25, 2010.

PUBLIC BILLS AND RESOLUTIONS

Under the clause 2 of rule XII, public bills and resolutions of the following titles were introduced and severally referred, as follows:

By Mr. GOHMERT (for himself, Mr. AKIN, Mrs. BACHMANN, Mr. BARTLETT, Mrs. BLACKBURN, Mr. BROWN of South Carolina, Mr. BURTON of Indiana, Ms. FALLIN, Mr. FLEMING, Ms. FOXX, Mr. GARRETT of New Jersey, Mr. GINGREY of Georgia, Mr. HENSARLING, Mr.

ISSA, Mr. SAM JOHNSON of Texas, Mr. KING of Iowa, Mr. KINGSTON, Mr. LAMBORN, Mr. MCCLINTOCK, Mr. PITTS, Mr. SCALISE, and Mr. SHAD-EGG):

H.R. 4408. A bill to amend the Balanced Budget and Emergency Deficit Control Act of 1985 to eliminate automatic increases for inflation from CBO baseline projections for discretionary appropriations, and for other purposes; to the Committee on the Budget.

By Mr. GENE GREEN of Texas (for himself and Mr. SARBANES):

H.R. 4409. A bill to amend the Public Health Service Act to authorize a program for the training of medical residents in community-based settings; to the Committee on Energy and Commerce.

By Mr. PETERSON (for himself and Mr. CONAWAY):

H.R. 4410. A bill to amend title 31, United States Code, to require that a vacancy in the position of Comptroller General be filled only by an individual who is a licensed certified public accountant and who meets other qualification requirements; to the Committee on Oversight and Government Reform.

By Mr. ROSKAM (for himself, Ms. BERKLEY, Mr. CANTOR, Mr. BRADY of Texas, and Mr. BOUSTANY):

H.R. 4411. A bill to amend the Internal Revenue Code of 1986 to make permanent accelerated depreciation of natural gas distribution property and to clarify to which property such treatment applies; to the Committee on Ways and Means.

By Mr. WELCH:

H.R. 4412. A bill to amend the Internal Revenue Code of 1986 to impose a 50 percent tax on bonuses paid by TARP recipients; referred to the Committee on Ways and Means, and in addition to the Committee on Small Business, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. BOOZMAN:

H. Res. 995. A resolution of inquiry requesting the President to transmit to the House of Representatives all information in the possession of the Administrator of the Environmental Protection Agency relating to nutrient management of the Illinois River Watershed, Arkansas and Oklahoma; to the Committee on Transportation and Infrastructure.

By Ms. FUDGE (for herself, Ms. GRANGER, Mr. BISHOP of Georgia, Mr. BLUMENAUER, Mrs. BONO MACK, Ms. BORDALLO, Mr. CASTLE, Ms. CASTOR of Florida, Mrs. CHRISTENSEN, Mr. CONYERS, Ms. DEGETTE, Mr. AL GREEN of Texas, Mr. GRIJALVA, Mr. HARE, Ms. NORTON, Ms. JACKSON-LEE

of Texas, Mr. KENNEDY, Mr. KIND, Mr. KIRK, Mr. KUCINICH, Mr. MASSA, Mrs. MCCARTHY of New York, Mr. MCGOVERN, Mr. MORAN of Virginia, Mr. ORTIZ, Mr. PAYNE, Mr. PLATTS, Ms. RICHARDSON, Ms. LORETTA SANCHEZ of California, Mr. SCHIFF, Mr. SESTAK, Mr. SIRES, and Mr. ALEXANDER):

H. Res. 996. A resolution expressing support for designation of September as National Childhood Obesity Awareness Month; to the Committee on Energy and Commerce.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 13: Ms. WOOLSEY, Mr. TONKO, and Mr. PLATTS.

H.R. 197: Mr. TEAGUE.

H.R. 211: Mr. DAVIS of Alabama and Mr. GARAMENDI.

H.R. 1166: Mr. QUIGLEY.

H.R. 1549: Mr. HIMES, Ms. BERKLEY, and Mr. COURTNEY.

H.R. 1597: Mr. MCCAUL, Mr. MORAN of Kansas, Mr. COBLE, Mr. PATRICK J. MURPHY of Pennsylvania, and Mr. TAYLOR.

H.R. 1955: Mr. MASSA.

H.R. 2296: Mr. TEAGUE.

H.R. 2377: Mr. TONKO and Mr. PLATTS.

H.R. 2450: Mr. STARK and Ms. LINDA T. SANCHEZ of California.

H.R. 2579: Mr. TONKO and Mr. PLATTS.

H.R. 2624: Mr. PLATTS.

H.R. 2730: Mr. TONKO and Mr. PLATTS.

H.R. 2866: Mr. SCHIFF.

H.R. 2900: Mr. INGLIS.

H.R. 3019: Mrs. CHRISTENSEN.

H.R. 3077: Ms. CLARKE.

H.R. 3430: Mr. GENE GREEN of Texas.

H.R. 3578: Mr. TONKO.

H.R. 3589: Mr. MURPHY of Connecticut and Mr. PRICE of North Carolina.

H.R. 3692: Ms. PINGREE of Maine.

H.R. 3778: Mr. PETERS.

H.R. 4180: Mr. FARR.

H.R. 4243: Ms. JACKSON-LEE of Texas.

H.R. 4255: Mr. RODRIGUEZ, Mr. CHILDERS, Mr. LOBIONDO, Mr. KIND, Mr. PATRICK J. MURPHY of Pennsylvania, Ms. PINGREE of Maine, Mr. MICHAUD, Mr. HILL, Mr. HALL of New York, Ms. KOSMAS, Mr. FOSTER, Mrs. DAHLKEMPER, Mr. JOHNSON of Illinois, Ms. TSONGAS, and Mr. SMITH of Washington.

H.R. 4256: Mr. LARSON of Connecticut.

H.R. 4291: Mr. McDERMOTT, Ms. SCHA-KOWSKY, and Mr. LYNCH.

H.R. 4312: Mr. HOEKSTRA.

H.R. 4357: Mr. PIERLUISI.

H.R. 4400: Mr. CASTLE and Mr. RAHALL.

H. Res. 444: Mr. LIPINSKI.

H. Res. 988: Mr. WOLF and Mr. BOEHNER.

SENATE—Saturday, December 19, 2009

The Senate met at 6:45 a.m. and was called to order by the Honorable ROBERT P. CASEY, Jr., a Senator from the Commonwealth of Pennsylvania.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Almighty God, remove from our hearts any destructive fear of the future, whether of the life that now is or the life that is to come. Today, abide with our lawmakers, giving them wisdom to allow Your Spirit to have access to their hearts. Deepen their joy during this sacred season when we remember Your journey to our world to save us from sin. Remind them that they cannot begin to manage life as You intend it to be unless they look to You for guidance and power. Renew their trust in You as the Sovereign of our Nation and the generous Benefactor of the blessings that come to our land.

We pray in Your mighty Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable ROBERT P. CASEY, Jr., led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 19, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable ROBERT P. CASEY, Jr., a Senator from the Commonwealth of Pennsylvania, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. CASEY thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. REID. Mr. President, following leader remarks, if any, the Senate will resume the House message with respect to H.R. 3326, the Department of Defense Appropriations Act.

The time until 7:20 a.m. will be equally divided and controlled between the two leaders or their designees, with the final 10 minutes reserved for the two leaders, with the majority leader controlling the final 5 minutes. At approximately 7:20 a.m. the Senate will proceed to a series of votes with respect to the Defense appropriations bill.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 2010

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of the House message with respect to H.R. 3326, which the clerk will report.

The legislative clerk read as follows:

House message to accompany H.R. 3326, a bill making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes.

Pending:

Reid motion to concur in the amendment of the House to the amendment of the Senate to the bill.

Reid motion to concur in the amendment of the House to the amendment of the Senate with amendment No. 3248 (to the House amendment to the Senate amendment), to change the enactment date.

Reid amendment No. 3252 (to Reid amendment No. 3248), to change the enactment date.

The ACTING PRESIDENT pro tempore. Under the previous order, the time until 7:20 a.m. shall be equally divided and controlled between the two leaders or their designees, with the final 10 minutes reserved for the two leaders, and with the final 5 minutes controlled by the majority leader.

The majority leader is recognized.

Mr. REID. Mr. President, it is my understanding the time until 7:10 is equally divided and controlled; is that right?

The ACTING PRESIDENT pro tempore. The Senator is correct.

Mr. REID. Mr. President, I designate the majority whip, the Senator from Illinois, DICK DURBIN, to have control of that 10 minutes on our side.

The ACTING PRESIDENT pro tempore. Who yields time?

The Senator from Tennessee.

Mr. ALEXANDER. Mr. President, how much time do we have on this side?

The ACTING PRESIDENT pro tempore. Ten minutes.

Mr. ALEXANDER. Mr. President, please let me know when 1 minute remains.

Mr. President, we are here on this early Saturday morning, as we lead up to Christmas Day, to finish work on the Defense appropriations bill. But the country knows the focus of our attention, the reason we are here, is because of the health care debate. We are in our 20th consecutive day of considering health care, and we still do not have a final bill. In other words, we do not yet know what we are voting on, how much it costs, or how it affects the American people.

On October 6, 2009, eight Democratic Senators wrote the majority leader a letter which expressed the view also of all 40 Republican Senators, and it said what ought to be obvious: that when debating even a minor bill, but certainly a major bill of this magnitude, the "public's participation in this process"—so the letter went—"is critical to our overall success of creating a bill that lowers health care costs and offers access to quality and affordable health care for all Americans."

The letter from the eight Democratic Senators continues:

Every step of the process needs to be transparent, and information regarding the bill needs to be readily available to our constituents before the Senate starts to vote on legislation that will affect the lives of every American.

The letter continues:

The legislative text and complete budget scores from the Congressional Budget Office of the health care legislation considered on the Senate floor should be made available on a website the public can access for at least 72 hours prior to the first vote to proceed to the legislation. Likewise, the legislative text and complete CBO scores of the health care legislation as amended should be made available to the public for 72 hours prior to the vote on final passage of the bill in the Senate. Further, the legislative text of all amendments filed and offered for debate on the Senate floor should be posted on a public website prior to beginning debate on the amendment on the Senate floor. Lastly, upon a final agreement between the House of Representatives and the Senate, a formal conference report detailing the agreement and complete CBO scores of the agreement should be made available to the public for 72 hours prior to the vote on final passage of the conference report in the Senate.

Mr. President, that is wise advice from Senator LINCOLN, Senator BAYH, Senator LANDRIEU, Senator LIEBERMAN, Senator MCCASKILL, Senator NELSON,

Senator PRYOR, and Senator WEBB. What they are saying is, before we vote on a health care bill that affects nearly every 1 of all 300 million Americans we ought to have 72 hours to read the bill and know what it costs. We know the current version, when fully implemented, will spend \$2.5 trillion, which the Chief Actuary of the government says insofar as we know it will increase the cost of health care rather than reduce it. We know that the version we have seen so far will take \$1 trillion out of Medicare when the bill is fully implemented and not use it to strengthen Medicare—which is becoming insolvent in the years 2015 to 2017, according to the trustees of Medicare—but instead would spend that money on some other program. We know it would—as David Brooks in a New York Times column said yesterday—create a huge tax, \$1.42 trillion in the second decade of its operation to help pay for this, which the Director of the Congressional Budget Office has said would inevitably be passed along to consumers and cause premium costs to go up, not down. And we know it would expand Medicaid, the other large government program we already have for low-income Americans, sending a bill of \$25 billion to the States that has been roundly denounced by almost every Governor in the country, Democratic and Republican.

Because at a time when the States are struggling more than they have since the Great Depression with their own budgets, when they cannot print money, when they have to balance their budgets, we are expanding health care and sending them a huge bill to help pay for it. This inevitably will force States to raise taxes, raise college tuition; and, in my State, the Governor is considering releasing up to 4,000 nonviolent offenders from the prisons as a result of some of the budgetary pressures that are on him.

So that is what we do know about the bill. But we do not have the final version of the bill. Yet it is said we should vote on this by Christmas when, in fact, most of the provisions of the bill do not take effect until 2014. That is 4 years from now. Only a few provisions start right away. Mr. President, \$73 billion in taxes start right away. Medicare cuts start right away. Mandates start right away. A few benefits start right away.

But, basically, the thrust of this massive legislation that affects 17 percent of our economy does not take effect for 4 years. So if we do not have the bill, and if most of the legislation does not take effect for 4 more years, then why are we spending this time staying up all night, rushing to enact the bill by Christmas?

I believe it is because the majority knows the longer the public sees the bill, the more they know about it, the less they will like it, and they want to

try to pass it before people know what is in it. Otherwise, we would already have the bill. Otherwise, we would be taking the time we took with the farm bill, with the Education bill, with the Energy bill, with other major legislation that takes 5, 6, 8, 10 weeks. Otherwise, we would have worked across party lines and had many different kinds of views. So this is a rush.

There has been a lot of talk about making history on health care. The problem is, there are different kinds of history. In this case, the Democratic majority seems to be determined to pursue a political kamikaze mission toward an historic mistake. If it succeeds, the results will be disastrous for the Democrats in 2010, I would predict. But, unfortunately, it will be a bigger disaster for our country.

Now, this will not be Congress's first historic mistake. The Smoot-Hawley tariff of 1930 "to buy American" sounded pretty good. It sounded like a good way to protect jobs by keeping foreign products out. But historians agree it was an historic mistake, setting off retaliatory waves, tariffs, and making the Great Depression worse.

The Alien and Sedition Acts of 1798 sounded good too. The idea was, let's protect the country from enemies within our midst, mostly French then. But that turned out to be an historic mistake encouraging more protests and offending our traditions of free speech.

In 1969, the Congress found 155 Americans who were not paying taxes and said: Let's have a millionaires tax. That sounded good too. It turned out to be another historic mistake. Last year, it caught 28 million Americans before we rushed to patch it, to fix it for a year.

More recently, there was the Catastrophic Coverage Act of 1988 to help seniors deal with financial losses. The trouble is, seniors resented paying for it, and angry crowds surrounded the chairman of the House Ways and Means Committee in his home district. Congress repealed that mistake, and the leader of those angry seniors is now a Congresswoman from Illinois.

Then there was the luxury tax on boats in 1991. That sounded good: We are going to get all those people who have boats that cost more than \$100,000. The trouble was, it raised about half the revenue projected, and it nearly sank the boat industry, putting 7,600 people out of work. A change in Congress repealed that one too. Rather than make history of this sort, Congress should learn from history. We should take Governor Schwarzenegger's advice this week.

He suggested:

So I would say, be very careful to the federal overment before you go to bed with all this. Let's rethink it. There's no rush from one second to the next. Let's take another week or two and come up with the right package.

The Governor, of course, was concerned about the Medicaid expansion

costs in his State—\$3 billion for California. He said:

[The] last thing we need is another \$3 billion of [state] spending when we already have a \$20 billion deficit.

So why the rush? We do not have the bill. We have plenty of time to deal with this. Most of it does not take effect for 4 more years. And what if in trying to fix everything all at once we get it wrong—will Congress be rushing back to fix health care again? Because if Congress makes another historic mistake, it will not be nearly as easy to fix as repealing a boat tax.

I thank the Acting President pro tempore, and I yield the floor.

The ACTING PRESIDENT pro tempore. The assistant majority leader is recognized.

Mr. DURBIN. Mr. President, we met before 7 a.m. on this Saturday morning, and I am reminded of the famous quote:

Neither snow nor rain nor heat nor gloom of night stays these couriers from the swift completion of their appointed rounds.

A snowstorm has struck Washington, DC. Yet 100 Members of the Senate will be called on in less than half an hour to be on the floor of the Senate to vote at this early morning hour. And for any who are hale and hearty and up watching or following this debate, the obvious question is, why? Why is the Senate in? What is it doing?

Well, we are in because the Republican Senators are filibustering the Department of Defense appropriations bill. This is the money for our troops, for our military, for their families, for their health care, for their equipment, for their paychecks. It is a bill which usually passes with a few patriotic speeches and little controversy. Yet the Republicans have held us now. This is the third day on the floor because they are filibustering the Department of Defense appropriations bill.

You might ask yourself: What is happening? Has the Republican Party turned on America's military? I do not think so. I think, in fact, they support America's military. But they are willing to use them and use their spending bill as part of their parliamentary procedure.

We know what this is all about. It is about delaying the business of the Senate and not just health care. They want to delay everything in the Senate. That is their strategy. That is what they have to offer to the American people. Not ideas, not alternatives, not solutions, but delay.

I suppose they think that is a winning way. The Senator from Tennessee just predicted in the next election the American people will rally behind this strategy of theirs of doing nothing, of failing to respond to the challenges facing America. I see it otherwise. I have this simple analysis of why I am here. The people of Illinois sent me here to try to do a good job for them

and make some good judgments on the Senate floor, but basically to help improve their lives. If you do nothing, if you deny, if you filibuster, if that is all you do, you don't have much to show for it at the end of the day.

The record is pretty clear. We have been debating health care reform for more than 2 weeks, about 19 or 20 days of debate, on a 2,000-page bill. The Senator from Tennessee complains: Well, we just don't know what is in this bill. This bill has been posted on the Republican Senate Web site for more than 2 weeks. I think they know what is in it.

Do you know how many amendments they came up with to change the language of this bill in the span of 20 days? How many bright, creative Republican ideas came up to change this bill in 20 days? Four, four amendments in 20 days. The combined wisdom of the Republican Senate caucus came up with four amendments to this bill of 2,000 pages in 20 days and six different motions to send the bill back to committee and stop talking about it.

Now the Senator tells us: We just need more time.

You have had time. You have had plenty of time. You have had time to offer your substitute. We have been waiting on the Republicans to come forward, if they think America's health care system could be improved, with their ideas. The Senator from Oklahoma, Mr. COBURN, has said he has a plan. He never offered it. I don't know if he tried to offer it, if the Republican leadership turned him down. He never offered it.

Senator GRASSLEY from Iowa said on the Senate floor: We have a plan.

Where is this secret plan? Where is the Republican plan for reforming health care? Carefully hidden, secreted away in a cloakroom? Is it under a snowdrift in a parking lot? What have you done with your plan? You don't have one. If you go to the Republican Senate Web site and look for health care reform, you will find it. You will find the Democratic bill because, frankly, they have nothing to offer.

Now comes the Senator from Tennessee and he says stop what we are doing. Let's stop right now. Our plan is to slow down, filibuster the Defense appropriations bill, and then slow down everything that comes after it in the hope that we will stop and do nothing. He argues that is good for the American people. Let me tell my colleagues what the Senator from Tennessee will risk for the American people if he has his way.

We know immediately—immediately—the doughnut hole in the Medicare prescription Part D for seniors is going to be filled across America. What it means is seniors who have a gap in insurance coverage for prescription drugs will have that filled. Eight million seniors in 2007 hit that doughnut hole because they had med-

ical bills more expensive than what Medicare covered. We are going to fill that doughnut hole. By 2010, seniors across America, immediately, will see the benefit.

The Senator from Tennessee says: This bill will destroy Medicare. Not quite true. In fact, the Congressional Budget Office says this bill will put Medicare on sound footing. Medicare untouched will go broke in about 8 years. Medicare, because of this bill, will have another 10 years of sound financial footing—exactly the opposite of what has been stated on the floor of the Senate.

How many parents get worried because their kids are in college and they are on their family health care plan and they are about to graduate and they wonder if they are going to have health insurance. Well, in most places across America, most policies, by age 24 your dependent child is no longer covered by your family plan. Immediately, with the passage of this bill, we are going to extend coverage, providing immediate help for 13 million to 14 million young Americans no longer in college and not covered by their own employment insurance, not eligible for their parents' coverage. They are going to have coverage under this plan.

Only 6 months after the enactment of this bill, insurers will be required to permit children to stay on family policies until age 26, in the year 2010. So when the Senator from Tennessee says nothing happens until 2014 except collecting taxes, he is mistaken. That happens. It happens immediately.

Free prevention services are going to be available as well—prevention services that will help a lot of people avoid serious illness. Today, many Americans pay 20 percent of the cost of many preventive services. Millions have no access to them at all. The Senate bill will require coverage of prevention and wellness benefits. For seniors, the Senate bill is going to provide free annual wellness checkups, immediately.

There is insurance reform as well. The Senator from Tennessee keeps overlooking this, and he shouldn't. One of the biggest ripoffs for American consumers are health insurance companies that turn you down because of pre-existing conditions and a variety of other reasons they find not to cover you. This Senate bill will give Americans the opportunity to focus on healthy living, will put patients first. It will eliminate abuses by insurance companies. It immediately bans rescissions, the practice where health insurance companies cancel your policy. Six months after enactment in 2010, insurers are prohibited from imposing lifetime limits on benefits. These are immediate benefits.

We know what the Republican playbook is because they gave it to us—maybe not intentionally. But early on, 8 months ago, the Republican strate-

gist Frank Luntz sent out a memo before the bill was even written and said: Here is how we can defeat health care reform. That suggests to me there was never a good-faith effort at the top in the Republican Party to even consider health care reform. Frank Luntz went through all the things to defeat health care reform even before the bill was introduced, talking about rationing and denial and talking about government programs and so forth and so on—buzz words. Then, the current inspiration of the Republican National Party, Michael Steele, the Republican National Committee chairman, a man I am sure the Senator from Tennessee holds in the highest esteem, recently shared with us the following in a memo. Chairman Steele wrote:

I urge everyone to spend every bit of capital and energy you have to stop this health care reform. The Democrats have accused us of trying to delay, stall, slow down, and stop this bill. They are right.

Chairman Steele says, his words: "Delay, stall, slow down, and stop." And for 8 months that has been the Republican strategy.

Unfortunately, that strategy now applies to the Department of Defense appropriations bill which we will vote on this morning. One hundred Senators will trek through the snow and come in early this morning to vote on a bill which we should all support unanimously. They will try parliamentary efforts to stop the bill, derail the bill, even though the continuing resolution expired last night.

The ACTING PRESIDENT pro tempore. The Senator's time has expired.

Mr. DURBIN. I hope we can gather enough bipartisan support for our troops this morning, have a cup of coffee, and go home to our families soon to celebrate the holiday season.

I reserve the remainder of my time and yield the floor.

Mr. REID. Mr. President, I ask unanimous consent that 5 of the 10 minutes I have been reserved for the Senator from Illinois.

Mr. President, I withdraw that request.

The ACTING PRESIDENT pro tempore. The Senator from Texas is recognized.

Mrs. HUTCHISON. Mr. President, I will be using some of the leader's time, and if the leader decides to step in, all he has to do is signal.

I wish to, first of all, say how much I appreciate the leader, Senator MCCONNELL, the Republican leader for the heroic efforts he has made in the last few weeks to try to assure that the American people know what is in the bill that will be put before us very soon. Now, I say put before us very soon because we don't know what the substitute bill is that has been worked on for the last few days. We haven't seen it yet. I think that brings up an important point.

I am hoping the distinguished majority leader, who is also on the floor, will allow America, as well as Senators certainly, to see the managers' amendment which includes all of the changes in the bill that is before us before we are forced to vote on this monumental piece of legislation.

When I am talking to my constituents back home, my friends, the people who just come up to me on an airplane, they say: What are you doing? Why is this being rushed through when it is one-sixth of our economy, when it is quality of life for every American, when we are talking about jobs in the private sector that will be sacrificed for a big government takeover, more government jobs, fewer private sector jobs. People are saying: What are you doing?

When I was talking about the taxes that are going to take effect in 2 weeks, before the bill takes effect 4 years from now, people were surprised. Even very informed people who read all the major newspapers, they said: What? The taxes are going to take effect 4 years before the bill takes effect? I mean, what are you all doing? Has Congress ever done that before?

I couldn't remember a time when Congress would pass taxes for 4 years, purporting to put together a new program, and then all of a sudden, after 4 years, the program would start but the taxes have accumulated, and it is going to be \$75 billion that will have accumulated before any implementation of the bill that is before us.

So I have heard the criticism on the floor that Republicans are trying to slow this down, that they are trying to stop this bill. It is very important that this health care bill be slowed down so that not only the Senate but the people of America can look at this and determine how it affects them personally, so they can look at what the proposed options are going to be. They can look at the taxes. They can look at the mandates. They can look at the small business requirements that could actually cost jobs.

Now, one might say: Well, if it costs a few jobs, maybe there is a greater good. We are in the toughest recession we have been in since the 1940s, since World War II. We are in the toughest recession we have been in, and here we are maybe stopping job increases or maybe adding to the unemployment figures which are the highest in 40 years in our country.

So I know the American people are saying: Why? Why push this through? Why push it through so fast when we are talking about maybe losing jobs in an economic downturn, when people are already hurting. Even the people who are employed are afraid that maybe they are going to be laid off because times seem to be getting tougher out there. We hear that the buying season, the Christmas season, is not going

as well as retailers have come to expect to try to make their yearly requirements to make their profits.

What does that mean? If we do not make those profits, then people are not buying and people are not going to be hired and maybe people are going to be laid off.

I do not think this is the time to be talking about losing jobs, something that is going to increase the burden and the mandate and the taxes on our business.

Mr. AKAKA. Mr. President, I strongly support the Defense appropriations conference report for 2010, H.R. 3326. This bill provides funding for our troops in Afghanistan, Iraq, and elsewhere. I thank the chairman and ranking member of the Senate Appropriations Committee, Senators INOUE and COCHRAN, as well as other committee members, for their efforts to develop this vital legislation.

This bill keeps our commitments to our troops and military families. The bill provides a 3.4-percent military pay raise, \$29.2 billion for the Defense Health Program, including \$120 million for traumatic brain injury and psychological health research. The measure also includes \$472 million for family advocacy programs which include quality childcare, job training for spouses, and expanded counseling for families experiencing stress due to deployments.

In order for our military to continue to perform at its best, we must continue to provide ample funds for training and readiness accounts. This bill provides \$154 billion to increase the readiness and training of our troops. Funding is being adjusted to ensure that we are training for the conflicts of today and those in the future.

Continuing our strong support for our troops in Iraq and Afghanistan, the bill includes over \$23 billion for equipment to be used in the region. This includes \$6.3 billion to complete procurement of over 6,600 Mine Resistant Ambush Protected, MRAP, all-terrain vehicles to protect our troops; \$1.1 billion for High Mobility Multi-Purpose Wheeled Vehicles, HMMWVs; and \$950 million for the National Guard and Reserve equipment accounts.

I am also pleased that this bill includes just under \$200 million for defense projects in the State of Hawaii including many of the projects which I requested. This includes a standoff improvised explosive device, IED, detection program, a virtual combat training program, and an anti-corrosion effort to extend the life of weapons systems. These are examples of programs in which innovators in Hawaii produce systems and products which will enhance military capabilities.

In addition to doing right by our troops, this bill also includes measures that will help other segments of our country.

Small business represents a vital part of our economy, but many small

business owners are having difficulties securing loans in today's economic climate. This bill includes a measure which will allow the Small Business Administration, SBA, to extend enhancements to its loan guarantee program which will free up capital by making loans more attractive.

The bill also includes an extension of unemployment insurance benefits. As many of our citizens continue to navigate a difficult labor market, it is vital that we continue to provide benefits for the unemployed.

In addition, this bill includes an extension for COBRA subsidies. It extends from 9 to 15 months the 65-percent COBRA health insurance subsidy for individuals who have lost their jobs. This vital program will help those who have lost jobs keep their health insurance.

These are just some of the projects and programs this important bill will fund for the 2010 fiscal year. I appreciate the hard work of Chairman INOUE, Ranking Member COCHRAN, and the rest of the Appropriations Committee for bringing this conference report before us, and I urge my colleagues to support it.

Mr. FEINGOLD. Mr. President, I strongly oppose this fiscally irresponsible and misguided bill. While the bill includes many good provisions, it will also fund a massive troop surge in Afghanistan that will overburden our troops and will likely hurt, not help, our efforts to eliminate the global threat posed by al-Qaida and its affiliates. And it is stuffed with earmarks and wasteful spending, such as \$2.5 billion for 10 C-17s that the Defense Department does not want and \$130 million for a Presidential helicopter program that has been cancelled.

While I will vote against the Defense appropriations bill, I am not going to be part of a partisan and cynical effort to delay passage of the Defense bill in order to block the Senate from considering health care reform. That is why I voted to end debate on the Defense appropriations bill, so the Senate could conduct a final vote on that bill and return to debating and voting on health care reform legislation.

The ACTING PRESIDENT pro tempore. The minority time has expired.

Mrs. HUTCHISON. I hope we can have a bill that will be bipartisan that we can all support.

The ACTING PRESIDENT pro tempore. The majority leader.

Mr. REID. Mr. President, my understanding is there is 5 minutes remaining.

The ACTING PRESIDENT pro tempore. That is correct.

Mr. REID. Mr. President, I direct this question to my distinguished colleague, Senator MCCONNELL, who is on the floor. Is my distinguished friend going to use any of his leader time this morning?

Mr. McCONNELL. No.

Mr. REID. To my friend from Texas, whom I care about a great deal—she is a member of the Appropriations Committee. I am disappointed she spent all morning not talking about the bill before us; namely, the bill that is going to fund our troops. That is why she is here. It is just after 7 in the morning in Washington. It is just after 4 a.m. in Nevada. Those watching around the United States may be wondering why we are voting at this rare hour, early on a Saturday morning, in what is shaping up to be the worst snowstorm in Washington's history.

The reason is very simple. We have work to do. We are going to support the troops, to make sure they have all the resources they need. I am confident my Republican colleagues will join with us in that regard.

I also say to my friend from Texas and others, it is as if they are in some other universe. First of all, we offered a unanimous consent request as soon as these proceedings started dealing with health care. I said:

I ask unanimous consent that no amendment be in order to the Reid substitute amendment . . . unless the text . . . of the amendment is posted on the home page of the official Senate Web site of the Member of the Senate who is sponsoring the amendment prior to the amendment being called up for consideration by the Senate and the amendment is filed at the desk. Further, that this unanimous consent request be in effect for the duration of the consideration of [this bill].

That is pretty direct. Offer an amendment and people should be able to see it. Guess what. The Republicans objected to that. Here is exactly what the senior Senator from Wyoming said:

In light of some of the trust problems and transparency problems we have, while this appears to lead to greater transparency . . . I object.

Something that creates transparency, they object because it does not create transparency.

Let me just say, we are going to finish this Defense bill. We are going to move on, at the appropriate time, and vote on the so-called managers' package, which will save lives—along with the other bill that is now before the Senate on health care—save money, and save Medicare. There are immediate deliverables.

I don't know what in the world the Senator from Texas was talking about. Something that is picked up on talk radio? I don't know. But it is not anything that deals with reality. We are going to do away with preexisting disabilities. The letters we receive from around the country, what insurance companies do is incredible. We will insure 31 million new people—pretty good, 31 million. Thousands of primary care physicians will be created and thousands of community health centers, which we should have been doing a long time ago.

I can remember, as a new Senator, that seat right there in the back of the Chamber was held by the famous Pat Moynihan. We were, at that time, dealing with homelessness. That was the issue of the day. He turned around to me, a new Senator, and said: This is ridiculous. The reason there are so many homeless is because we did not do our job. When the insane asylums, the mental institutions were emptied, because we had medicine that would take care of these people in institutions, part of the deal was we would have community health centers to have them come and get their medication, have them taken care of. We didn't do that, and that is why we have so many homeless people. This bill is going to alleviate most of that.

We have something in this legislation called the CLASS Act, which will offer for the first time in the history of this country for people who are working to plan ahead in case they become disabled. It is fully paid for. CBO said, in the far future, decades and decades into the future, it is paid for. I did not use a penny of that money for the bill that is before the Senate.

Again, I say to my friends on the other side of the aisle, I am sorry this has been such a method of just saying no to everything—everything, everything. It is too bad we didn't have a little more help. We received none. We hope they will join with us, the minority, as did the Republicans in the House of Representatives, and support the troops, 395 to 34. Out of 435 Members, only 34 voted against that bill. Democrats and Republicans—overwhelming majorities—over 90 percent of Democrats and Republicans in that House supported that bill. That is what we need to do in a show of good faith for the men and women fighting around the world.

For example, in Afghanistan, I read the morning news from Nevada. The Nevada National Guard, in the mountains of Afghanistan, had a vicious fire-fight lasting more than a day, chasing these evil people through villages. Many of them were killed. One Nevadan was wounded. That is what this legislation before this body is about.

I hope we can do what needs to be done.

Mr. President, I move to table the motion to concur in the House amendment to the Senate amendment with amendments, and I ask for the yeas and nays.

The ACTING PRESIDENT pro tempore. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from Connecticut (Mr. LIEBERMAN), is necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from New Hampshire, Mr. GREGG.

The ACTING PRESIDENT pro tempore. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 63, nays 35, as follows:

[Rollcall Vote No. 382 Leg.]

YEAS—63

Akaka	Feingold	Mikulski
Baucus	Feinstein	Murray
Bayh	Franken	Nelson (NE)
Begich	Gillibrand	Nelson (FL)
Bennet	Hagan	Pryor
Bingaman	Harkin	Reed
Bond	Inouye	Reid
Boxer	Johnson	Rockefeller
Brown	Kaufman	Sanders
Burris	Kerry	Schumer
Byrd	Kirk	Shaheen
Cantwell	Klobuchar	Snowe
Cardin	Kohl	Specter
Carper	Landrieu	Stabenow
Casey	Lautenberg	Tester
Cochran	Leahy	Udall (CO)
Collins	Levin	Udall (NM)
Conrad	Lincoln	Warner
Dodd	McCaskill	Webb
Dorgan	Menendez	Whitehouse
Durbin	Merkley	Wyden

NAYS—35

Alexander	Ensign	McCain
Barrasso	Enzi	McConnell
Bennett	Graham	Murkowski
Brownback	Grassley	Risch
Bunning	Hatch	Roberts
Burr	Hutchison	Sessions
Chambliss	Inhofe	Shelby
Coburn	Isakson	Thune
Corker	Johanns	Vitter
Cornyn	Kyl	Voinovich
Crapo	LeMieux	Wicker
DeMint	Lugar	

NOT VOTING—2

Gregg Lieberman

The motion was agreed to.

The ACTING PRESIDENT pro tempore. The Senator from Oklahoma is recognized.

Mr. COBURN. Mr. President, the pending motion to concur to the House amendment would cause an aggregate level of outlays for fiscal year 2010, as set out in the most recently agreed to concurrent resolution on the budget, S. Con. Res. 13, to be exceeded.

Therefore, I raise a point of order under section 311(a)(2) of the Congressional Budget Act of 1974.

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

Mr. REID. Mr. President, pursuant to section 904 of the Congressional Budget Act of 1974, I move to waive all applicable sections of the Budget Act for purposes of the pending motion, and I ask for the yeas and nays.

The ACTING PRESIDENT pro tempore. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from Connecticut (Mr. LIEBERMAN) is necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from New Hampshire, Mr. GREGG.

The yeas and nays resulted—yeas 63, nays 35, as follows:

[Rollcall Vote No. 383 Leg.]

YEAS—63

Akaka	Feingold	Mikulski
Baucus	Feinstein	Murray
Bayh	Franken	Nelson (NE)
Begich	Gillibrand	Nelson (FL)
Bennet	Hagan	Pryor
Bingaman	Harkin	Reed
Bond	Inouye	Reid
Boxer	Johnson	Rockefeller
Brown	Kaufman	Sanders
Burr	Kerry	Schumer
Byrd	Kirk	Shaheen
Cantwell	Klobuchar	Snowe
Cardin	Kohl	Specter
Carper	Landrieu	Stabenow
Casey	Lautenberg	Tester
Cochran	Leahy	Udall (CO)
Collins	Levin	Udall (NM)
Conrad	Lincoln	Warner
Dodd	McCaskill	Webb
Dorgan	Menendez	Whitehouse
Durbin	Merkley	Wyden

NAYS—35

Alexander	Ensign	McCain
Barrasso	Enzi	McConnell
Bennett	Graham	Murkowski
Brownback	Grassley	Risch
Bunning	Hatch	Roberts
Burr	Hutchison	Sessions
Chambliss	Inhofe	Shelby
Coburn	Isakson	Thune
Corker	Johanns	Vitter
Cornyn	Kyl	Voinovich
Crapo	LeMieux	Wicker
DeMint	Lugar	

NOT VOTING—2

Gregg Lieberman

The PRESIDING OFFICER (Mrs. MCCASKILL). On this vote the yeas are 63, the nays are 35. Three-fifths of the Senators duly chosen and sworn having voted in the affirmative, the motion is agreed to.

The question is on agreeing to the motion to concur in the House amendment to the Senate amendment.

Mr. REID. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from Connecticut (Mr. LIEBERMAN) is necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from New Hampshire, Mr. GREGG.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 88, nays 10, as follows:

[Rollcall Vote No. 384 Leg.]

YEAS—88

Akaka	Brown	Cochran
Alexander	Brownback	Collins
Baucus	Bunning	Conrad
Bayh	Burr	Corker
Begich	Byrd	Cornyn
Bennet	Cantwell	Crapo
Bennett	Cardin	Dodd
Bingaman	Carper	Dorgan
Bond	Casey	Durbin
Boxer	Chambliss	Ensign

Feinstein	Lautenberg	Rockefeller
Franken	Leahy	Sanders
Gillibrand	LeMieux	Schumer
Graham	Levin	Shaheen
Grassley	Lincoln	Shelby
Hagan	Lugar	Snowe
Harkin	McCaskill	Specter
Hatch	McConnell	Stabenow
Hutchison	Menendez	Tester
Inhofe	Merkley	Udall (CO)
Inouye	Mikulski	Udall (NM)
Isakson	Murkowski	Vitter
Johnson	Murray	Voinovich
Kaufman	Nelson (NE)	Warner
Kerry	Nelson (FL)	Webb
Kirk	Pryor	Whitehouse
Klobuchar	Reed	Wicker
Kohl	Reid	Wyden
Kyl	Risch	
Landrieu	Roberts	

NAYS—10

Barrasso	Enzi	Sessions
Burr	Feingold	Thune
Coburn	Johanns	
DeMint	McCain	

NOT VOTING—2

Gregg Lieberman

The motion was agreed to.

VOTE EXPLANATION

Mr. LIEBERMAN. Madam President, I regret that I was unable to be present to vote for the final passage of H.R. 3326, the Department of Defense Appropriations Act for Fiscal Year 2010, but had I been present, I would have supported it.

This Act will provide \$636.3 billion in funding for the Department of Defense, including nearly \$125 billion in funds that will directly support the men and women fighting at the frontlines of this Nation's wars. I am honored to serve on the Senate Armed Services Committee, which drafted the law authorizing these funds, and thank my colleagues on the Senate Appropriations Committee, led by Chairman DANIEL INOUE, for their hard work guiding this bill to its final approval.

This bill will do much to both protect our service members overseas and improve their lives at home. It will provide \$6.3 billion to procure additional mine resistant ambush protected, MRAP, vehicles and more than 6,600 MRAP all-terrain vehicles, MRAP-ATVs, which will save countless lives in Iraq and Afghanistan. For our service members and their families, it will also provide a 3.4-percent pay raise, additional funding for the Defense Health Program, and \$120 million to support research for traumatic brain injury and psychological health research.

I am particularly proud of the critical role that Connecticut plays in supporting our Nation's defense, a role that this act reaffirms. Connecticut workers are essential to building critical equipment and systems that account for nearly 15 percent of the \$104.4 billion in procurement funds provided in this bill. These include the Virginia class submarine, the Blackhawk family of utility helicopters, the engines that power the F-35 Joint Strike Fighter, the powerful radar on the Joint STARS aircraft, and even the Colt carbine that our soldiers carry at the frontlines of

battle. There truly is a Connecticut worker supporting every member of the U.S. Armed Forces.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. REID. Could we have order?

The PRESIDING OFFICER. The majority leader.

Mr. REID. First of all, to the Senate: This is a good, strong message we have sent to our men and women in uniform around the world as 88 Senators voted. It was a little bit of a struggle to get here, but we got here, and I am so grateful we were able to do that.

MAKING FURTHER CONTINUING APPROPRIATIONS FOR FISCAL YEAR 2010

Mr. REID. Madam President, we are going to do the continuing resolution now until the 23rd. The reason for that is this Defense bill will take a little time to enroll. We want to make sure there are no gaps in having full funding for Secretary Gates.

I ask unanimous consent that the Senate proceed to the immediate consideration of H.J. Res. 64, the continuing resolution received from the House and that is at the desk; that the joint resolution be read three times and passed, and a motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The joint resolution (H.J. Res. 64) was ordered to a third reading, was read the third time, and passed.

SERVICEMEMBERS HOME OWNER-SHIP TAX ACT OF 2009—Resumed

The PRESIDING OFFICER. The clerk will report the pending business.

The legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid Amendment No. 2786, in the nature of a substitute.

AMENDMENT NO. 3276 TO AMENDMENT NO. 2786

Mr. REID. Madam President, I ask unanimous consent that the amendment be considered read.

Mr. MCCONNELL. I object.

The PRESIDING OFFICER. The majority leader.

Mr. REID. It is my understanding that the amendment needs to be reported at this time.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Nevada (Mr. REID), for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN, proposes an amendment numbered 3276 to amendment No. 2786.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The majority leader.

Mr. REID. Madam President, before offering the amendment, the so-called managers' amendment, I have spoken to my Republican counterpart.

I ask unanimous consent that a Democratic Senator on my side be allowed to speak for up to 9 minutes prior to my offering the amendment.

Mr. McCONNELL. Madam President, I object.

The PRESIDING OFFICER. Objection is heard.

Mr. McCONNELL addressed the Chair.

Mr. REID. I have not given up the floor, Madam President.

Mr. McCONNELL. Madam President, I have a parliamentary inquiry.

The PRESIDING OFFICER. The minority leader is recognized for a parliamentary inquiry.

Mr. McCONNELL. What is the pending business?

The PRESIDING OFFICER. The amendment No. 3276 that has been presented.

Mr. McCONNELL. Is it necessary to report the last amendment?

Mr. REID. The amendment, I think, has been reported.

The PRESIDING OFFICER. The amendment has been reported.

Mr. REID. I still have the floor; is that right?

Mr. McCONNELL addressed the Chair.

The PRESIDING OFFICER. The regular order is the reading of the amendment unless consent is granted that that not occur.

Mr. REID. Madam President, first of all, it is my understanding—Madam President, I understand the amendment has to be read. This is the so-called managers' amendment that is at the desk.

I ask unanimous consent that—if the minority wants this amendment read, it is going to take a little bit of time to do that, and I understand that. But I ask unanimous consent, as I did, that Senator NELSON of Nebraska be allowed to speak for up to 9 minutes.

Mr. McCONNELL. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. REID. Madam President, it is my understanding that the Senator from Nebraska told me before coming here he had a question he wanted to ask; is that right?

Mr. NELSON of Nebraska. The Senator is correct.

Mr. McCONNELL. The regular order is the reading of the amendment, I understand.

The PRESIDING OFFICER. The regular order is the reading of the amendment.

The clerk will read the amendment.

The legislative clerk continued with the reading of the amendment.

Mr. UDALL of New Mexico. Mr. President, I ask unanimous consent

that the reading of the amendment be dispensed with.

The PRESIDING OFFICER (Mr. BURRIS). Is there objection?

Mr. ENSIGN. Objection.

The PRESIDING OFFICER. Objection is heard.

The clerk will continue.

The assistant legislative clerk continued with the reading of the amendment.

Mrs. BOXER. Mr. President, I ask unanimous consent that this amendment be considered as read.

The PRESIDING OFFICER (Mr. DURBIN). Is there objection?

Mr. SESSIONS. I object.

The PRESIDING OFFICER. Objection is heard. The clerk will continue.

The Assistant Parliamentarian (Leigh Hildebrand) continued with the reading of the amendment.

Mr. UDALL of New Mexico. Mr. President, I ask unanimous consent to dispense with the reading of the amendment.

Mr. SESSIONS. I object.

The PRESIDING OFFICER (Mr. ROCKEFELLER). Objection is heard. The clerk will continue.

The Assistant Secretary continued with the reading of the amendment.

(The text of the amendment is printed in today's RECORD under "Text of Amendments.")

The PRESIDING OFFICER (Mr. BENNET). The majority leader is recognized.

CLOTURE MOTIONS

Mr. REID. Mr. President, I have three cloture motions at the desk.

The PRESIDING OFFICER. The cloture motions having been presented under rule XXII, the Chair directs the clerk to read the motions.

The legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the Reid amendment No. 3276 to the Reid substitute amendment No. 2786, to H.R. 3590, the Service Members Home Ownership Tax Act of 2009.

Christopher J. Dodd, Richard Durbin, Max Baucus, Paul G. Kirk, Jr., Claire McCaskill, Jon Tester, Maria Cantwell, Barbara A. Mikulski, Mark Udall, Arlen Specter, Sherrod Brown, Mark Begich, Sheldon Whitehouse, Bill Nelson, Roland W. Burris, Kirsten E. Gillibrand, Ron Wyden.

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the Reid substitute amendment No. 2786 to H.R. 3590, the Service Members Home Ownership Tax Act of 2009.

Christopher J. Dodd, Richard Durbin, Paul G. Kirk, Jr., Max Baucus, Claire McCaskill, Jon Tester, Maria Cantwell, Barbara A. Mikulski, Mark Udall, Sherrod Brown, Arlen Specter, Bill Nelson, Mark Begich, Sheldon Whitehouse, Roland W. Burris, Kirsten E. Gillibrand, Ron Wyden.

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on H.R. 3590, the Service Members Home Ownership Tax Act of 2009.

Christopher J. Dodd, Richard Durbin, Mark Begich, Paul G. Kirk, Jr., Sheldon Whitehouse, Roland W. Burris, Max Baucus, Sherrod Brown, Claire McCaskill, Jon Tester, Barbara A. Mikulski, Bill Nelson, Maria Cantwell, Mark Udall, Arlen Specter, Kirsten E. Gillibrand, Ron Wyden.

The PRESIDING OFFICER. The majority leader is recognized.

AMENDMENT NO. 3276

Mr. REID. Mr. President, I ask for the yeas and nays on my amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3277 TO AMENDMENT NO. 3276

Mr. REID. Mr. President, I have a second-degree amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID] proposes an amendment numbered 3277 to amendment No. 3276.

The amendment is as follows:

At the end of the amendment, add the following:

The provisions of this Act shall become effective 5 days after enactment.

AMENDMENT NO. 3278

Mr. REID. Mr. President, I have an amendment to the language proposed to be stricken.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID] proposes an amendment numbered 3278 to the language proposed to be stricken by amendment No. 2786.

The amendment is as follows:

At the end of the language proposed to be stricken, insert the following:

This section shall become effective 4 days after enactment.

Mr. REID. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? The appears to be a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3279 TO AMENDMENT NO. 3278

Mr. REID. Mr. President, I have a second-degree amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID] proposes an amendment numbered 3279 to amendment No. 3278.

The amendment is as follows:

In the amendment, strike "4" and insert "3".

MOTION TO COMMIT WITH AMENDMENT NO. 3280

Mr. REID. Mr. President, I have at the desk a motion to commit the bill with instructions.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID] moves to commit the bill to the Finance Committee with instructions to report back with the following amendment numbered 3280.

The amendment is as follows:

At the end, insert the following:

The provisions of this Act shall become effective 2 days after the enactment.

Mr. REID. Mr. President, I now ask for the yeas and nays on that motion.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3281

Mr. REID. Mr. President, I have an amendment to those instructions.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID] proposes an amendment numbered 3281 to the instructions of the motion to commit.

The amendment is as follows:

Strike "2 days" and insert "1 day".

Mr. REID. Mr. President, I ask for the yeas and nays on that amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

AMENDMENT NO. 3282 TO AMENDMENT NO. 3281

Mr. REID. Mr. President, I have a second-degree amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada (Mr. REID) proposes an amendment numbered 3282 to amendment No. 3281.

The amendment is as follows:

Strike "1 day" and insert "immediately"

Mr. REID. Mr. President, I ask unanimous consent that the mandatory quorums be waived.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. COBURN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

Mr. REID. Mr. President, reserving the right to object.

The PRESIDING OFFICER. Is there objection?

Mr. REID. I object.

The PRESIDING OFFICER. Objection is heard.

The legislative clerk continued with the call of the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The majority leader is recognized.

Mr. REID. Mr. President, I have spoken to my friend, the Senator from Oklahoma, and he thinks this is appropriate. He wants to speak, and we have known that for some time. So I ask the following unanimous consent request: I ask unanimous consent that at the conclusion of 10 minutes for Senator STABENOW and 10 minutes for Senator DURBIN, Senator COBURN be recognized; that at the conclusion of his remarks—and he said he will probably take a couple of hours—the Senate then stand adjourned, after he completes his remarks, until 1 p.m. tomorrow, Sunday, December 20; that on Sunday, following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, and the time for the two leaders be reserved for their use later in the day, and that the Senate resume consideration of H.R. 3590, and that the time until 1:30 p.m. be equally divided and controlled between the two leaders; that beginning at 1:30 p.m. and until 11:30 p.m., Sunday, there be alternating hour blocks of time, with Republicans controlling the first hour block; that at 11:30 p.m., Sunday, the Senate then recess until 12:01 a.m., Monday, December 21; that following the prayer and pledge, the time until 1 a.m. be equally divided and controlled between the two leaders or their designees, with the majority leader controlling the final 10 minutes prior to 1 a.m., and the Republican leader controlling the 10 minutes immediately prior to that; that at 1 a.m. the Senate proceed to vote on the motion to invoke cloture on the Reid and others managers' amendment; and that today the debate of Senators DURBIN, STABENOW, and COBURN be for debate only; and that also for Sunday the same thing. I did not mention that before.

The PRESIDING OFFICER. Is there objection?

Mr. COBURN. Mr. President, reserving the right to object, and I do not intend to object, but I want to make a parliamentary inquiry prior to us doing that. And the inquiry is this: Based on the second-degree amendments just filed by the majority leader, as well as the elimination of their language, is it, in fact, the effect that no other amendments will be allowed on this bill?

The PRESIDING OFFICER. There are no available amendment slots at this time.

Mr. COBURN. Further in my parliamentary inquiry, if there were amendments available, could they be filed on this bill?

Mr. REID. I am sorry, I could not hear my friend.

Mr. COBURN. If, in fact, amendments were available, could amendments be filed to this bill and made pending?

I will restate my inquiry to the Chair. Is it, in fact, a fact that because of the filling of the tree by the majority leader, the opportunity to amend the bill before us will be limited?

The PRESIDING OFFICER. The Senator is correct.

Mr. COBURN. Thank you.

I do not object.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. REID. Mr. President, this may surprise everyone, but the day after tomorrow is the shortest day of the year, December 21. We start longer days after that.

The PRESIDING OFFICER. The Republican leader is recognized.

Mr. MCCONNELL. Mr. President, I just want to take this opportunity to thank the clerks. I know it has been a challenging experience to have to read for the last 7 or 8 hours, but I just wanted to thank them for their good work and good spirits in the holiday season; and for those who substituted during the process, I hope you will extend to them our thanks as well.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. REID. Mr. President, it is very nice of the Republican leader to recognize them. I join in his remarks, and not only the reading, but the long, long hours they have had to bear over the last several weeks.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I do not see the Senator from Michigan on the Senate floor. I hope she will not be upset if I go first. I had spoken to her earlier about a 10-minute statement, and she is to have a 10-minute statement, as well, relative to this managers' amendment.

We just spent the last 7½ or 8 hours having the clerks dutifully read this 383-page amendment. During that period of time, many of us have had a chance to read it ourselves. We have had staff explain it to us, and for those who are wondering what has happened, we can tell them the following.

Originally, we offered this bill—2,074 pages—on health care reform. It was offered by Senator REID, after a merger of the bills created by the Health, Education, Labor, and Pensions Committee as well as the Finance Committee. Then an effort was made to perfect this bill and address some other provisions that were not included. That effort was underway for a lengthy period of time because the Congressional Budget Office had to look at each suggestion to see whether it had an impact on the cost of the bill or the goal of the bill, which is to make health insurance more affordable.

Finally, the Congressional Budget Office has given its report—not in its entirety—but at least its preliminary report, and the news is very encouraging. Many of my colleagues come to the floor—the Senator from Oklahoma, who will speak after Senator STABENOW and I—and talked about our Nation's deficit. It is appropriate that issue be raised and taken seriously.

But I hope the Senator from Oklahoma and others who raise that issue will acknowledge something; this health care reform bill, as amended, is the greatest deficit reduction bill in the history of the United States. We have now been told by the Congressional Budget Office this bill will not only reduce our deficit over the next 10 years by over \$130 billion, but in the following 10 years, their new calculation is it will reduce the deficit of the United States up to \$1.3 trillion. How does it achieve this? It achieves this by achieving the goal of this bill: to bring down the increase in costs in health care.

The Congressional Budget Office tells us—and this is an independent group that looks at these things—we are achieving our goal to start bringing down the cost of health care in America. For those who will come to the floor and make speeches about our deficit and debt, please give credit where it is due. This bill will do more to reduce the deficit than anything ever proposed in Congress.

The second thing I wish to say is the basics of this bill remain. At the end of the day, 94 percent of the people in America will have health insurance, the highest percentage insured in our history. Thirty-one million uninsured Americans will have health insurance because of this legislation.

In addition to bringing down the costs of medical care and health insurance, in addition to extending the protection of insurance to over 30 million Americans currently uninsured, this bill will also provide protections to individuals against discrimination by health insurance companies. The new amendment which has been introduced today goes even further than the original bill. I think it will be a source of great consolation to many families across America to know this new amendment will say, in a very brief period of time, that every child under the age of 18 will be entitled to health insurance regardless of preexisting conditions. That is an amazing statement. It is an incredible statement. It says we are going to move forward quickly on this protection of the bill to eliminate the discrimination against people because of preexisting conditions and we will start with those under the age of 18 and do it in short order. That, to me, is a dramatic change.

Then, it says health insurance companies are now going to have to assert that the premiums collected are actu-

ally used to pay medical expenses. We will require of them that the medical loss ratio of certain companies be 80 percent and others up to 85 percent, which means the money collected in premiums—that money, up to 85 percent—has to be spent on actual medical expenses. That reduces the amount of money for these health insurance companies to spend on advertising, on salaries, on bonuses, on clerical help to deny claims. It says: Focus the money on helping people or rebate the money to those who pay the premiums.

In addition to that, this bill is going to make certain, with this new amendment, that patient health insurers have to abide by patient protections; for example, that protect an individual's right to choose their own doctor; also, ensuring access to needed care and guaranteeing an opportunity to appeal any denial of coverage. This bill, with its new amendment, is going to offer alternatives that aren't available today. I look at all these things in the bill, and I think of the profound impact some of them will have.

One of the provisions in this bill is going to dramatically expand community health centers across America. Senator BERNIE SANDERS of Vermont has been credited with being the leader on this, and he should be. He has done an extraordinary job. What a legacy he will leave and this bill will create: 10,000 more clinics and health care centers across America providing primary care in towns large and small. Rural and underserved communities will have opportunities tomorrow they don't have today because of this.

In addition to these things, this bill expands the small business health care affordability tax credit. I am not going to go into depth on this because Senator STABENOW from Michigan has been our leader on that, and she will tell you how. To the critics on the other side of the aisle who say this bill raises taxes and doesn't help people: Wait until you hear from Senator STABENOW what this bill does for small businesses. It expands tax credits to small businesses so they can provide health insurance to their employees. What a breakthrough this will be for many businesses that can't afford to do it today.

We also have provisions in here to engage in more direct efforts to try to find ways to reduce medical malpractice and the lawsuits that follow. It is an aggressive effort to find ways to protect victims of medical malpractice and yet reduce any lawsuits which should not be filed to the lowest possible number.

This bill increases access to workplace wellness programs, something all of us believe is the way of the future.

Let me also tell my colleagues that this bill has a provision in it which I have included, and I thank the leadership for accepting, on congenital heart

research. This is near and dear to me and my family. The problem we have run into is many children born with congenital heart defects end up living into adulthood without the necessary surveillance to determine what is the best practice to keep them alive and healthy and comfortable. This is a very tiny part of this bill, but it is so important to so many families that we will finally have surveillance of these patients around America with congenital heart defects and find those therapies that work best, those surgeries that will succeed. It will bring peace of mind to a lot of families to know we are going to make this extra special effort with a birth defect which affects literally hundreds of thousands of Americans.

I think this bill has been improved by this amendment. I know the Senator from Oklahoma is going to speak about the issue of amendments. I wish to say for the record that this is the 20th day since we brought this bill to the floor. In the 20 days the Senate has been considering this bill, the Republican side of the aisle has offered four amendments to change the bill—four amendments in 20 days. They offered another six motions to send the bill back to committee and stop the deliberation on the Senate floor but only four substantive amendments. We have been promised over and over there would be a substitute amendment which is even better than ours. It has never been introduced by the Republican side of the aisle. It certainly has never been cleared with the Congressional Budget Office. If they had a better idea, where has it been for 20 days? The amendments which they offered, many of them, related directly to the Medicare Advantage Program.

I think they offered at least two of their four amendments to protect that program. It is a private health insurance program, heavily subsidized by the Federal Government and one that, frankly, is wasting dollars that should be spent to help people and expand their care under Medicare. They have tried, time and again, on behalf of these health insurance companies to continue the subsidy, but we know it is wasteful and we know there is a better expenditure.

So I would say to those who would complain now while here, we are almost out of time to offer amendments, where have you been? For 20 days, for almost 3 weeks, where have you been? Where have your amendments been? You had your chance. Your leadership could have brought them to the floor but, instead, we had six motions to commit—take the bill off the floor—instead of amendments that dealt with the basic substance of the bill.

I think we have a good bill, and I think we have reached the point where we should vote, have an up-or-down vote. The Senate has considered this

for a year. We have no Republican alternative that has been cleared by the Congressional Budget Office that indicated it is a viable alternative, and now we should bring the one bill before us that can make a difference in America: make health care more affordable, expand its coverage to 94 percent of our people, give our families and individuals across America a chance to bargain effectively with health insurance companies that say no. That, to me, is a good bill.

The bill that has just been read on the floor has been posted on the Internet now for more than 4 hours. Go to Senate Democrats, take a look, you will find it, and when you do, you will find the original bill and this amendment. All of America will get a chance to read this bill in its entirety today, tomorrow, and Monday, before the vote is going to be taken as to whether we are going to proceed with this managers' amendment, 72 hours before there is a vote on Tuesday morning, so America will have a chance, as it should, because it is a critically important issue.

The last thing I wish to do—Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. The Senator has consumed 10 minutes.

Mr. DURBIN. I ask unanimous consent for 1 minute.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. DURBIN. Mr. President, I ask unanimous consent to have printed in the CONGRESSIONAL RECORD an article written by Victoria Reggie Kennedy, which will be published tomorrow in the Washington Post Sunday edition. It is entitled, "The moment Ted Kennedy would not want to lose."

There are many things said here which we can expect, but the one paragraph I wish to read into the RECORD is as follows, from the wife of Senator Ted Kennedy:

Still, Ted knew that accomplishing reform would be difficult. If it were easy, he told me, it would have been done a long time ago. He predicted that as the Senate got closer to a vote, compromises would be necessary, coalitions would falter and many ardent supporters of reform would want to walk away. He hoped that they wouldn't do so. He knew from experience, he told me, that this kind of opportunity to enact health care reform wouldn't arise again for a generation.

This bill has been called many things. It is officially titled the "Patient Protection and Affordable Care Act." I am going to refer to it as "Kennedy Care" because Ted Kennedy, throughout his public career, cared deeply about this health care issue.

Our time is here, and in his name and in his memory, we need to pass this historic legislation.

I yield the floor.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE MOMENT TED KENNEDY WOULD NOT WANT TO LOSE

(By Victoria Reggie Kennedy)

The Washington Post—Sunday, December 20, 2009; A19—My late husband, Ted Kennedy, was passionate about health-care reform. It was the cause of his life. He believed that health care for all our citizens was a fundamental right, not a privilege, and that this year the stars—and competing interests—were finally aligned to allow our nation to move forward with fundamental reform. He believed that health-care reform was essential to the financial stability of our nation's working families and of our economy as a whole.

Still, Ted knew that accomplishing reform would be difficult. If it were easy, he told me, it would have been done a long time ago. He predicted that as the Senate got closer to a vote, compromises would be necessary, coalitions would falter and many ardent supporters of reform would want to walk away. He hoped that they wouldn't do so. He knew from experience, he told me, that this kind of opportunity to enact health-care reform wouldn't arise again for a generation.

In the early 1970s, Ted worked with the Nixon administration to find consensus on health-care reform. Those efforts broke down in part because the compromise wasn't ideologically pure enough for some constituency groups. More than 20 years passed before there was another real opportunity for reform, years during which human suffering only increased. Even with the committed leadership of then-President Bill Clinton and his wife, reform was thwarted in the 1990s. As Ted wrote in his memoir, he was deeply disappointed that the Clinton health-care bill did not come to a vote in the full Senate. He believed that senators should have gone on the record, up or down.

Ted often said that we can't let the perfect be the enemy of the good. He also said that it was better to get half a loaf than no loaf at all, especially with so many lives at stake. That's why, even as he never stopped fighting for comprehensive health-care reform, he also championed incremental but effective reforms such as a Patients' Bill of Rights, the Children's Health Insurance Program and COBRA continuation of health coverage.

The bill before the Senate, while imperfect, would achieve many of the goals Ted fought for during the 40 years he championed access to quality, affordable health care for all Americans. If this bill passes:

Insurance protections like the ones Ted fought for his entire life would become law.

Thirty million Americans who do not have coverage would finally be able to afford it. Ninety-four percent of Americans would be insured. Americans would finally be able to live without fear that a single illness could send them into financial ruin.

Insurance companies would no longer be able to deny people the coverage they need because of a preexisting illness or condition. They would not be able to drop coverage when people get sick. And there would be a limit on how much they can force Americans to pay out of their own pockets when they do get sick.

Small-business owners would no longer have to fear being forced to lay off workers or shut their doors because of exorbitant insurance rates. Medicare would be strengthened for the millions of seniors who count on it.

And by eliminating waste and inefficiency in our health-care system, this bill would bring down the deficit over time.

Health care would finally be a right, and not a privilege, for the citizens of this country. While my husband believed in a robust public option as an effective way to lower costs and increase competition, he also believed in not losing sight of the forest for the trees. As long as he wasn't compromising his principles or values, he looked for a way forward.

As President Obama noted to Congress this fall, for Ted, health-care reform was not a matter of ideology or politics. It was not about left or right, Democrat or Republican. It was a passion born from the experience of his own life, the experience of our family and the experiences of the millions of Americans across this country who considered him their senator, too.

The bill before Congress will finally deliver on the urgent needs of all Americans. It would make their lives better and do so much good for this country. That, in the end, must be the test of reform. That was always the test for Ted Kennedy. He's not here to urge us not to let this chance slip through our fingers. So I humbly ask his colleagues to finish the work of his life, the work of generations, to allow the vote to go forward and to pass health-care reform now. As Ted always said, when it's finally done, the people will wonder what took so long.

The PRESIDING OFFICER. The Senator from Michigan is recognized for 10 minutes.

Ms. STABENOW. Mr. President, I wish to thank our distinguished assistant majority leader for being on the floor, for his passion, for his commitment to the issue of health care, affordable health care for every American. I thank him always for his comments.

The bottom line for all of us is, this legislation is about saving lives, saving money, and saving Medicare. I would also say it is about saving jobs.

That is certainly a big focus for me, coming from the State of Michigan. The reality is that this year 45,000 people lost their lives because they couldn't find affordable health insurance. Forty-five thousand families during the holidays will have one less person sharing dinner and exchanging gifts. We can do better than that in this great country. This morning, 14,000 people got up with health insurance and they will go to bed tonight without it and that happens every day, every day, every day. We can do better, and this bill does better than that.

As Senator DURBIN indicated, in addition to other provisions in the bill, this amendment would dramatically expand community health centers across the country where people can have the opportunity to go into the neighborhood community health center, see a doctor, see a nurse, and get the care they need—incredibly important.

This bill saves money. It saves money at every level. This bill has over \$400 billion in tax cuts for small businesses and families in it. I am very pleased and proud to have been part of an effort with other colleagues, including the chair of the Small Business Committee, MARY LANDRIEU, and the

distinguished Senator from Arkansas, BLANCHE LINCOLN, and other colleagues to strengthen the provisions for small business that are in this amendment. It is very important.

The 35-percent tax credit for small businesses with up to 25 employees will start next year. So right out of the gate, that is something that will be available for small businesses. We also expand on the provisions that would add to the benefits for that particular tax cut. Going forward, the whole point of creating an insurance pool that small businesses can buy into and self-employed individuals can buy into and people without insurance is because, right now, big businesses already provide insurance, for the most part, and they get a good deal because they have enough employees to negotiate a better rate. So health insurance reform, in terms of new coverage, is very much about small businesses.

Most of the people who don't have health insurance work. They don't qualify for Medicaid for low-income individuals. They are not in a big business that has health insurance.

They are working for a small business or maybe they are working one part-time job, two part-time jobs, or three part-time jobs without insurance or maybe they had a job and then lost their job and, like many people in my great State, lost their job on day one and lost their insurance on day two. This is very much tied to small business and filling the gap.

Of the people who have insurance now, about 60 percent of the public will keep what they have. They will benefit from the insurance reforms, so they are getting what they are paying for, and people with preexisting conditions will be able to find insurance that they cannot find today. Those who have public plans, such as Medicare, will be able to continue with a strengthened plan. I want to talk about that in a minute.

For that 15 to 20 percent today who cannot find affordable insurance, that is what this health reform is all about—to make sure small businesses and individuals working out of their homes, their garages—the next entrepreneur, the next Bill Gates down the road—have the opportunity to find affordable insurance through a large group pool. That is what this is very much about.

I am very pleased to say we have increased the amount of tax cuts for small businesses and tax cuts overall in this bill to help people afford to buy health insurance.

Also, as a part of saving money, we are for taxpayers saving dollars and reducing the deficit over the first 10 years, the second 10 years, and beyond. The Congressional Budget Office now says that during the first 10 years, we will decrease the deficit by \$131 billion, not the huge increases that are being talked about on the other side of the

aisle, and in the second 10 years, we are looking at up to \$1.3 trillion in reduced deficits.

For my large businesses that compete internationally, where we do not have a level playing field right now, in many ways because of health care costs, we are going to be able to bring those costs down. It is absolutely critical for us if we are going to stay competitive and be able to create good-paying middle-class jobs in this country.

We also know we have to stop the insurance company abuses that are occurring today, whether it is dropping people when they get sick because of a technicality, blocking people from getting care, putting on artificial caps, lifetime caps that stop people from getting coverage, or whether they are spending way too much on administrative costs and on profits rather than putting it into medical care. We address all of those issues in this bill, and this amendment strengthens that as well.

We are very much about saving Medicare. We stop overpayments to for-profit insurance companies and put that money back into closing what has been a gap in prescription drug coverage. We add preventive care with no out-of-pocket costs for seniors, and we lengthen the life of the Medicare trust fund.

I have to take just a moment because we have reached a milestone in all of the delaying tactics that have gone on this year, much of it focused on stopping us from passing health care reform that benefits Americans.

We have now reached 101 different Republican objections to moving our country forward as of today. The party of no has blocked us from moving forward 101 times. People oftentimes say: What does that mean? How can they do that?

The rules of the Senate are such that each Member has the ability to object to something going forward. Most of the time, we operate in a way where people agree and we do not object. But if someone objects and you are trying to get something done, you have to go through motions and time clocks and things that become very difficult for people who are following this to understand.

The reality is, if there is an objection, our leader has to do what he has done today. He files a motion to get past a filibuster, we have to wait 2 days, then we vote on stopping the filibuster, then we wait 30 hours, and then we vote on whatever it is—the amendment, the bill, whatever it is we are trying to do. After that, we then move on to the next step. There is an objection again, as there has been on health care, the leader has to file a motion to stop the filibuster, wait 2 days, vote to stop the filibuster, wait 30 hours, and then vote on whatever it is. This goes on and on.

We have seen historic numbers—what I view as an abuse of the process—his-

toric numbers in order to block us not just from health care reform but from funding the troops with the Department of Defense, extending unemployment insurance for unemployed Americans—I can go on and on.

At every step of what we have tried to do this year—and we have done some historic things—every step of the way, we have had to maneuver through an unprecedented effort to block and stall and say no. Mr. President, 101 times now this has happened.

Despite that, we have accomplished many very important things. We are not done. I am not going to be done until we make sure everybody who wants to work has a good job in this country, and we are all focused on that. We have a tremendous amount to do together to tackle the debt, to make sure we are supporting efforts for good-paying jobs to be created. But this health reform is a critical part of that because it does, in fact, affect costs in this country. It saves lives. We should care about that.

In this amendment, we add additional funds for prenatal care and to support families who want to adopt children with a refundable tax credit. We put in place other items to support women who are pregnant to make sure they have the health care they need so they and their babies can be healthy moving forward.

This saves lives, saves money, saves Medicare. It is the right thing to do, and it is time to get it done. Now is the time to get this done.

THE PRESIDING OFFICER. The Senator's time has expired.

The Senator from Oklahoma.

Mr. COBURN. Mr. President, I am going to spend a few minutes talking this afternoon. I apologize in advance because the staff is going to stay here, but this is an issue so big, this country has never faced it before. So the inconvenience for us to be here in the Senate Chamber is going to be very well worth it to the American people.

We just heard the assistant majority leader and the Senator from Michigan explain how great what is getting ready to happen is, and I want to tell you, there is a different perspective coming from a country doctor from Oklahoma who has practiced under Medicare and Medicaid for a number of years.

What we heard was, and it is important to the American people listening to this—I am going to go through what the Federal Government has been doing for the last 3 or 4 years, if you want to stay tuned for a civics lesson about the tremendous amount of incompetency and waste in this Federal Government.

We just heard the assistant majority leader talking about amendments. What he did not tell the American people is that the majority required unanimous consent for us to get an amendment and they limited us to 10 amendments over the last 2 weeks. They

strung it out so we could not get our amendments up.

The other point I wish to make is that we now have a new amendment—the one offered by the majority leader—to this bill, which we have no opportunity to amend. It is one-sixth of the bill, but there is no opportunity to amend it. So now we have a \$2.5 trillion bill that has had 10 substantive amendments offered to it. The American people should not trust that process.

We heard the Senator from Michigan just say it saves lives. I want to tell you, as a practicing physician, this bill is not going to save lives. It is going to cost lives because we are going to allow the Federal Government to determine what treatment you can get, when you can get that treatment, and who is going to give it to you. That is the ultimate result of this bill. Over the next few days, we will be explaining and showing why that is the case.

The Washington-speak of “it saves Medicare,” a program that is bankrupt now, that has an infinite \$85 trillion unfunded liability—we are going to cut \$1 trillion out of it over the next full first 10 years of this program. And the American people are supposed to expect this is going to save Medicare? It is not going to come anywhere close. And save money? The assistant majority leader quoted the CBO. Let me read to you what he did not quote:

It is unlikely that key cost containment provisions that are in this bill will remain intact.

That is what CBO said today. You did not hear that statement from the assistant majority leader.

Here is the other thing:

It reduces payments to physicians by 21 percent starting in 2011.

Do you really think we are going to reduce payments to physicians 21 percent in Medicare in 2011? One of the first bills we will see on this floor come January will be \$250 billion that will be stolen from our kids to adjust the sustainable growth rate formula for Medicare. It will not be paid for, and that is one of the reasons this thing looks for—that is why the CBO said: Wait a minute, before you claim this thing is so good, recognize that you are not accounting for \$250 billion you are going to call an emergency and not pay for it.

Here is the third thing he did not mention:

An unaccountable, unelected board of bureaucrats must make arbitrary budget cuts to ensure the cost containments in this bill.

We are saying we are going to have cost containment, but we are going to pin that on three different programs, boards, and panels in this bill that are not going to cause you to save lives. It certainly might save us money, but it certainly is not going to increase the quality of care and it certainly is not going to save Medicare.

Here is the other thing he did not mention:

CBO cannot predict that the quality of care will not decline.

That is what they are saying.

It is unclear whether such a reduction in growth rate can be achieved and, if so, whether it would be accomplished through greater efficiencies in the delivery of health care or would reduce access to care or diminish the quality of care.

That is from the CBO.

Here is the other thing the assistant majority leader did not mention:

The long-term budgetary impact could be quite different if key provisions of the legislation were ultimately changed or not fully implemented.

The U.S. Preventive Services Task Force recommended a change in breast cancer screening. They did it based on cost. We reversed it. I will bet a dollar against a nickel that the next three or four they recommend, we will not do, either, which are counted on in CBO's score for us to do. So the numbers on this do not make any sense.

CBO says this will reduce the deficit, but people who understand the CBO from the inside out admit even their best estimates are professional guesses with lots of uncertainty.

I ask unanimous consent to have printed in the RECORD the comments of Donald Marron, Alice Rivlin, and Phil Ellis.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

WILL THE REID HEALTH BILL REALLY REDUCE THE DEFICIT?

(Claim: CBO says this bill will reduce the deficit)

PEOPLE WHO UNDERSTAND CBO FROM THE INSIDE OUT ADMIT THAT EVEN THEIR BEST ESTIMATES ARE PROFESSIONAL GUESSES WITH LOTS OF UNCERTAINTY

Donald Marron, former Acting Director of CBO, said that “the Congressional budget process demands specific estimates of how much proposed legislation will cost, so that’s what CBO produces. But reality is much more complex, and the actual costs will undoubtedly be more or less. That uncertainty can be frustrating, but it’s unavoidable.”

Alice Rivlin, CBO's founding director in 1975, said that “Everyone in the process—especially the CBO—knows that it is very, very difficult to make these estimates and that they’re no more than very educated guesses . . .”

Phi Ellis, head of CBO's health insurance modeling unit, admitted this in an October Washington Post article, saying: “We’re always putting out these estimates: This is going to cost \$1.042 trillion exactly. But you sort of want to add, you know, ‘Your mileage may vary.’”

The Washington Post ran a front page story in October with the headline: “In health debate, those numbers are just numbers,” saying that “the CBO's price tags are educated guesses, but guesses nonetheless.”

EXAMINE WASHINGTON'S RECORD OF ESTIMATING THE COST OF HEALTH PROGRAMS

Washington has just run a \$1.4 trillion budget deficit for fiscal 2009, even as we are told a massive, new health-care government program will reduce deficits by raising and spending about a trillion dollars over 10 years.

To believe that fantastic claim, you have to ignore everything we know about Washington and the history of government health-care programs.

Some argue that more federal control or “competition” will restrain costs and make health care more affordable. The problem with this argument is that it ignores history.

LOOK AT THE RECORD OF CONGRESSIONAL FORECASTERS IN PREDICTING COSTS

Start with Medicaid, the joint state-federal program for the poor. The House Ways and Means Committee estimated that its first-year costs would be \$238 million. Instead it hit more than \$1 billion, and costs have kept climbing.

Medicaid now costs 37 times more than it did when it was launched—after adjusting for inflation.

Its current cost is over \$250 billion, up 25% or \$50 billion in fiscal 2009 alone, and that's before the health-care bill covers millions of new beneficiaries.

MEDICARE HAS A SIMILAR RECORD. IN 1965, CONGRESSIONAL BUDGETERS SAID THAT IT WOULD COST \$12 BILLION IN 1990. ITS ACTUAL COST THAT YEAR WAS \$90 BILLION

The Medicare hospitalization program alone was supposed to cost \$9 billion but wound up costing \$67 billion. These aren't small forecasting errors. The rate of increase in Medicare spending has outpaced overall inflation in nearly every year (up 9.8% in 2009), so a program that began at \$4 billion now costs \$428 billion.

The Medicare program for renal disease was originally estimated in 1973 to cover 11,000 participants. Today it covers 395,000, at a cost of \$22 billion.

The 1988 Medicare home-care benefit was supposed to cost \$4 billion by 1993, but the actual cost was \$10 billion, because many more people participated than expected. This is nearly always the case with government programs because their entitlement nature—accepting everyone who meets the age or income limits—means there's no fixed annual budget.

ONE OF THE FEW HEALTH-CARE ENTITLEMENTS THAT HAS COME IN WELL BELOW THE ORIGINAL ESTIMATE IS THE 2003 MEDICARE PRESCRIPTION DRUG BILL

Those costs are now about one-third below the original projections, according to the Medicare actuaries. Part of the reason is lower than expected participation by seniors and savings from generic drugs.

But as White House budget director Peter Orszag told Congress when he ran the Congressional Budget Office, the “primary cause” of these cost savings is that “the pricing is coming in better than anticipated, and that is likely a reflection of the competition that's occurring in the private market.”

The Centers for Medicare and Medicaid Services agrees, stating that “the drug plans competing for Medicare beneficiaries have been able to establish greater than expected savings from aggressive price negotiation.” It adds that when given choices, “beneficiaries have overwhelmingly selected less costly drug plans.”

THE RECORD IS CLEAR: GOVERNMENT COST ESTIMATES ARE EDUCATED GUESSES AND NOT COMPLETELY RELIABLE BECAUSE OF CONGRESSIONAL SPENDING. OUR COUNTRY NEEDS REAL HEALTH REFORM, TO LOWER COST AND INCREASE CHOICES, NOT INCREASED FEDERAL CONTROL

Yet today, Democrats in Congress still fight against private-competition, instead

preferring government intervention and price controls—through a Medicaid expansion, a Medicare board of bureaucrats, federal mandates and regulation of all health insurance, and

This is all headed in the wrong direction. The Majority wants to increase the role of the federal government in health care and prevent private health plans from really competing.

Congress can hold insurers accountable and cover pre-existing conditions without increasing federal control of health care. The government does not have a good record with programs.

The government already controls too much of health care. Uncle Sam is directly or indirectly financially directing nearly two thirds of all health care. Roughly one out of 3 Americans is already on Medicaid and Medicare—programs which are going bankrupt.

The lesson here is that spending on nearly all federal benefit programs grows relentlessly once they are established. This history won't stop Democrats bent on pushing for a massive new tax hike and cuts to seniors on Medicare to raise money for new handouts.

Every Member who votes for the Democrats' plans is guaranteeing larger deficits and higher taxes far into the future. And that is a future we cannot afford.

Mr. COBURN. Mr. President, let's look at Washington's estimate of the cost of health care. We have just run a \$1.4 trillion deficit this last year. It is going to be bigger next year. It is going to be bigger. And we are going to have a brandnew health care system where we are going to start collecting taxes with some very minor changes in the health care system.

We are going to have the CLASS Act that is going to collect \$72 billion over the next 12 or 13 years, but we are not going to reduce the deficit because we refuse to make the hard choices to do so.

Mr. President, I ask unanimous consent to have printed in the RECORD CBO's key caveats on the pricetag of the Reid amendment.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CBO'S KEY CAVEATS ON PRICE TAG OF REID AMENDMENT

UNLIKELY THAT KEY COST CONTAINMENT PROVISIONS REMAIN ENACTED

"These longer-term calculations assume that the provisions are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation. For example, the sustainable growth rate (SGR) mechanism governing Medicare's payments to physicians has frequently been modified (either through legislation or administrative action) to avoid reductions in those payments, and legislation to do so again is currently under consideration in the Congress."

REDUCES MEDICARE PAYMENT TO PHYSICIANS BY 21 PERCENT IN 2011

"The legislation would maintain and put into effect a number of procedures that might be difficult to sustain over a long period of time. Under current law and under the proposal, payment rates for physicians' services in Medicare would be reduced by about 21 percent in 2010 and then decline further in subsequent years."

UNACCOUNTABLE, UNELECTED BOARD OF BUREAUCRATS MUST MAKE ARBITRARY BUDGET CUTS TO ENSURE COST CONTAINMENT

"At the same time, the legislation includes a number of provisions that would constrain payment rates for other providers of Medicare services. In particular, increases in payment rates for many providers would be held below the rate of inflation (in expectation of ongoing productivity improvements in the delivery of health care). The projected longer-term savings for the legislation also assume that the Independent Payment Advisory Board is fairly effective in reducing costs beyond the reductions that would be achieved by other aspects of the legislation. Based on the extrapolation described above, CBO expects that Medicare spending under the legislation would increase at an average annual rate of roughly 6 percent during the next two decades—well below the roughly 8 percent annual growth rate of the past two decades (excluding the effect of establishing the Medicare prescription drug benefit)."

BUT CBO CANNOT PREDICT THAT QUALITY OF CARE WILL NOT DECLINE

"It is unclear whether such a reduction in the growth rate could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or would reduce access to care or diminish the quality of care."

ONE CHANGE COULD BLOW UP THE DEFICIT NEUTRALITY AND COSTS

"The long-term budgetary impact could be quite different if key provisions of the legislation were ultimately changed or not fully implemented. If those changes arose from future legislation, CBO would estimate their costs when that legislation was being considered by the Congress."

Mr. COBURN. Mr. President, the other statement the assistant majority leader made was that no bill was offered that they would not allow to be scored. There are four comprehensive bills out there that they have not allowed to be scored.

Tomorrow afternoon, on this same floor, RICHARD BURR and I will go through the Patients' Choice Act which saves billions, saves the States trillions, covers exactly the same number of people or more, gives everybody freedom of choice and gets the government out of health care, requires competition, requires coverage of pre-existing illness, accomplishes everything we say we want to accomplish in this bill.

So now we are getting ready to turn over \$2.5 trillion more of health care to the Federal Government. What kind of job have we done? Let's look at it for a second.

Here is what we have done this year: 43 cents out of every dollar we spent in the Federal Government we borrowed against our children. It is going to be 45 cents next year. As we spend our taxpayers' money—and, oh, by the way, I recall that the Senator from Michigan stated that we are going to improve people's lives. We are going to improve everybody's lives except the generation that follows us and their children. We are going to damage their lives.

So 43 cents of every dollar that the Federal Government spends, we are borrowing. How have we been doing? The claim is Medicare isn't broke. Anybody with a high school accounting class knows it is broke. The reason we know it is broke—and it is not only broke fiscally, it is broke in terms of methodology—is because it is a Ponzi scheme. We have robbed the money. We have promised benefits for years and never raised the taxes to pay for them. We now manage 60 percent of the health care in the country.

Medicare is broke, the State Medicaid Programs are broke, the census is broke. We heard this week that Fannie and Freddie aren't going to require just \$400 billion—that is a government-run mortgage insurance company that the Congress created—it is going to require \$800 billion, almost \$1 trillion to get us out of that. Social Security, we know, is going to be broke. It is fiscally unsustainable. The U.S. Post Office business model is broke; cash for clunkers; the highway trust fund is broke. We can't even get the \$8 billion we need to continue to run it. We have done a great job managing that. Now we are going to put another 20 percent of health care in this country under the auspices of the very people who run the broke programs that have created \$1.4 trillion worth of deficits.

What is the meaning of that? How does it affect you? Well, right now, every child, every person, every grandparent in this country owes directly \$39,000 in Federal debt, and that doesn't count everything they owe. That just counts what is external debt. That doesn't count internal debt, which is another \$39,000. What do we know with regard to Madelyn here? She says: I am already \$38,375 in debt—and, by the way, that was in October; it is over \$39,000 now—and I only own a dollhouse.

What we know is, this Federal Government spent \$33,880 per household this last fiscal year, the highest total in history. The Federal Government collected \$18,000 in taxes, and the remaining \$15,000 we borrowed, mostly from the Chinese. Over 40 percent of everything we are doing, we can't fund. The inefficiencies of the programs we have created—but with no oversight and we won't manage—we continue to allow to fail.

It is good for us to learn from our Founders. I will quote Thomas Jefferson:

My reading of history convinces me that most bad government results from too much government.

Creating \$2.5 trillion in new health care programs and damaging the health care programs we have today isn't going to save lives, it isn't going to improve health care, and it certainly isn't going to save money. Nobody can name one thing the Federal Government does that saves money.

Nobody can—that saves money. So I thought I would spend this afternoon kind of going through the last 4 years of oversight so people could actually get an opportunity to see some of the examples.

It is interesting that in the last 12 days of Christmas, here is what the Congress will have done: On Sunday, December 13, we spent \$445 billion on an omnibus package; on Saturday, December 19, we spent \$626 billion on fiscal 2010 DOD, plus billions in pork; and on December 24, we are going to create a health care program that is going to consume \$2.5 trillion over a 10-year period—or truly \$250 billion per year—and run it through the government.

So in the 12 days of Christmas, the Senate is on pace to spend \$1.942 trillion—in the 12 days leading up to Christmas. We are on pace to spend \$6.7 billion an hour in the 12 days before Christmas. Then, before you know it, we will have to raise the debt limit by \$190 billion. Then we are going to have to come back and raise the debt limit another \$1.8 trillion because, statutorily, we can't borrow money we don't have, and we will not make the hard choices to cut wasteful spending. So what we are going to do is we are going to borrow it against our children's future.

I have never voted for a debt increase. I have no intention of ever voting for one in the future. I have every intention to try to stop any debt increase we might vote on because the only thing that will cause us to make the hard priority choices in this country is not having the ability to borrow money from our children and our grandchildren.

If you go to the Web sites of Members—and you can go to cuburn.senate.gov—or any other Member site—and look at oversight reports—I thought I would go through a few of them so the American people can see where the waste is in the Federal Government. I am going to spend the time to talk about it because it is ludicrous what we have done and what we continue to do.

Here is the Justice Department. We put out a report this last year showing \$10 billion worth of waste a year in the Justice Department. That is \$100 billion every 10 years. Here is a synopsis. Here is the report we put out. Nobody in Congress read it, other than my staff and a few other Members who are concerned about our spending:

There were \$500 million in grants allowed to recipients who were not legally capable of receiving them; \$1.6 billion in unspent, unobligated funds. They are the only Federal agency that has unobligated funds that is allowed to keep them, and we have no management over it.

We have this debate on earmarks—that we ought to be directing—but we will not do anything about allowing

the Department of Justice to save the money at the end of the year that they don't spend and then spend it any way they want. We will not even do an oversight hearing on it.

Here is \$312 million on conferences for the Department of Justice—\$312 million for conferences. In 2007 alone, they lost 125,476 hours to employees who were supposed to be there that didn't check out, weren't on paid leave, weren't on sick leave, weren't taking unpaid time off, we paid them, and they didn't show up for work. Here is \$529.7 million, 1,500 special projects that were earmarked from DOJ funding.

What is an earmark? An earmark is something that benefits somebody politically and benefits somebody parochially and 98 percent of them are never competitively bid. What they are is they are the corruption of this Congress. Yet here we see \$529.7 million worth of earmarks through the Justice Department.

I will not go into the details, but if you want to go to our Web site, you can see this report and you can see how \$10 billion of your money was wasted in the Justice Department.

How about the Centers for Disease Control and Prevention? A 115-page report detailing the waste and mismanagement at the CDC and wasting billions of dollars in taxpayer money. We have offered amendments to clean up this stuff. They never pass because Members of Congress don't want to make the hard choices. They do not want to offend anybody.

They had \$45 million in conferences just last year, \$1.7 million for a Hollywood liaison program, where we pay tax dollars to tell Hollywood studios how to get it right in terms of how they portray things. That is a wonderful use of our tax dollars, when we are borrowing \$1.4 trillion a year.

Again, a 115-page report outlining instance after instance of waste that the Congress will not do anything about with regard to the CDC.

Here is a special little one that the American people, I know, will love. We are spending hundreds of millions of dollars a year putting sand back on beaches that nature says shouldn't be there. So the people who live in States on beaches share the tax dollars of people who don't rather than pay for it themselves because most of these are earmarked. The lobbying method of choice to get a beach replenished is to get an earmark. So hundreds of millions of dollars every year go out of here to put sand back that we put back 2 years ago, but because of the natural occurrence, it normally washes away.

That is not a Federal responsibility. We are confused about our responsibility. But we are so enamored of the power to look good at home, we send taxpayer money home that is not a priority so we can get reelected.

Here is a report on highway transportation waste: \$78 billion has been obligated over the last 5 years for purposes other than the construction and maintenance of highways and bridges. Let me say that, again: Over the last 5 years, \$78 billion from the Transportation Department has been spent on things other than highways and bridges and transportation, and we wonder why the highway trust fund is belly up and broke.

This is all detailed. You can go to our Web site and find all the details of the stupid stuff, the low-priority stuff, the things that don't matter in the context of the problems we have and the situation we find ourselves in today of borrowing this kind of money against our children's future.

Then we had a nice little Christmas gift last year—"The Worst Waste of 2008." We will be coming up with "The Worst Waste of 2009." There was \$2.4 million for a 3D space theater in Indiana—an earmark—so people in Colorado, I would remind the President pro tempore, got to pay for that. I know that has to be a priority. At a time when our country is struggling with 10 percent unemployment and a \$1.4 trillion deficit, we are doing that kind of stuff. How about \$2.8 million for a visitor center for a hatchery in Missouri? They have the hatchery, but we spent \$2.8 million to create a visitor center in the worst economic times we have ever seen.

How about \$100,000 for studying Chinese video game habits? That has to be a priority for our country. We have to know what the habits are of the Chinese population in terms of playing video games. A \$298,000 earmark to develop a potato for high-end restaurants or \$82 million in SBA loans to liquor stores. That is wonderfully good for our society. Here is \$13 million for an art museum in Iraq—not for us, for them. We are going to spend \$13 million for that. Then we spent \$784,000 for training classes for casino workers in Kansas.

That is a high-quality project. You know, if you have casinos in Kansas maybe you ought to train your own workers rather than take the money from Colorado and Oklahoma to do that.

If you would like to see that, this is a wonderful little—it has Santa Claus on the front, cheery—fits with our time.

Then we put out two stimulus reports. We have a burr under the saddle for some people but, you know, dadgummit, if we are going to spend \$787 billion, and the inspector general says of that \$787 billion at least \$50 billion is going to get wasted—let me say that again: at least \$50 billion is going to get wasted; that is the expectation from Washington—then we ought to be talking about where it is getting wasted and who is benefiting from it. The

fact is that the vast majority of the funds that have gone out from the stimulus project so far have not been competitively bid, so the well-connected—those people who give campaign contributions—are the ones who are getting the contracts. Those who are most connected with people who are appropriators get the contracts. They do not have to competitively bid it, it is a gift.

The first stimulus report outlined \$5.5 billion. Remember, we have only sent \$200 billion out the door on the stimulus, and we have already listed \$12 billion in two stimulus reports of pure waste or at least nonpriority items.

How about guard rails for a road over a nonexistent lake in my home State, \$1 million? So we have one boondoggle in our State where the Corp of Engineers builds a lake where no water ever comes—never has come and never will come—and then we are going to spend \$1 million on the road rather than close the road around a nonexistent lake—but that is the kind of priority we have?

We are going to spend \$10 million to renovate a train station that has not been used in 30 years and call this a priority rather than fix bridges that are crumbling in this country. Or how about the town of Union, NY, given a grant to spend money it did not request for a homeless problem it does not have, according to local officials? Or give a Nevada nonprofit a contract to do weatherization after it had been previously fired by the government for not doing good quality work? But we give the same money back to the same people? I wonder if there was any political connection. That is the first stimulus report.

In the second one we sent out \$350 million to get a broadband map that we could have bought for \$35 million, but we spend 10 times what it was worth to get that done. How are we doing? Do you think we are doing a good job? Do you think we have our eye on the ball? Do we have a priority? Are we spending the American people's money wisely? No, because the Senate refuses to do significant oversight on spending. There is a reason for it because, when you oversight it, you expose the connectedness of the well-connected to Congress. So we do not want to do that.

Then we talk about the census. The census is going to cost at least double what it did 10 years ago.

Where do we find ourselves? We find ourselves with a government we cannot afford and there is not any other way you can describe that. If we were borrowing \$1.4 trillion last year, and we are going to borrow \$1.5 trillion this year, and the Senate has refused every attempt through the amendment process to cut spending in any area, every attempt—they may pass it when we have the bill, but when it comes out of

conference it is always gone. So they want to look good, and then they can deny they knew it was taken out when they vote for the conference report.

So not once in the last 5 years have we passed an amendment that has stuck, that reduced the spending in this country on waste and junk, like I just outlined.

On January 1, 2009, the national debt was \$10.6 trillion. It now stands at \$12.1 trillion. That is not President Obama's fault. Do not confuse this with a partisan attack. My attack is on the Senate and on the Congress and the irresponsible behavior of Members of Congress who say they want to do one thing and then in the dark do something totally different. Our debt is rising \$4.2 billion a day. In January 2009 the unemployment rate was 7.6 percent. Today it is 10 percent. That is not President Obama's fault either. That is our fault. It is the fault of the Members of Congress because in fact we created Fannie Mae and Freddie Mac. We allowed it, we failed to do the oversight. When we had an opportunity to fix it we got it struck down because of the well-connectedness of the financially influential people associated with that program.

What it means is that we lost 12,210 jobs every day since January 1, and we saw an uptick in that this last week.

That debt, as I show in the picture of Madelyn, is \$39,000 per citizen. But it is important to think long term, which is my own criticism of my colleagues in the Senate. We think about the next election. We don't think long term. We think: How does this look for the next election?

What the next election is going to show us is that we are going to be \$14 trillion in debt; that every young person who is 25 years of age or younger in this country, they and their children when they are 45—that is 20 years from now—will each be responsible for debt and unfunded liabilities of \$1,119,000.

Let me say that again. Twenty years from now everybody in this country who is 45 years of age or younger will be responsible for \$1,119,000 worth of debt and unfunded liabilities. Those are unfunded liabilities they will get no benefit from. Those are for the people who came before them. So they will be paying about \$70,000 per year per individual just to fund the interest on the debt obligation that we are creating for them because we refuse to eliminate the silliness. We refuse to make priorities. We refuse to make the tough choices that may make somebody uncomfortable with us because we are thinking about the next election rather than the next generation.

While individuals, families all across this country are worried about having a job next year, Congress is busy trying to keep their jobs by passing out earmarks; by trying not to offend the well-connected and well-heeled in this Nation.

We have talked a lot about earmarks in the last year. Earmarks went down 6 percent this year in total number. They went down to 12,099 earmarks. Divide that by 100 Senators and see what you get. But the cost of them went up.

In the last 11 months, Congress has passed trillions of dollars in new spending on everything from a multibillion-dollar lands omnibus package stuffed with 100 parochial bills benefiting only a few and endangering the property rights of Americans across the country, to a stimulus bill meant to generate economic growth and create jobs, the vast majority of which hired more government workers and transfer statements to States rather than created true economic activity.

We bailed out the auto industry, we loaned hundreds of billions of dollars to private companies, we passed another omnibus spending bill just this past weekend with a price tag of \$500 billion, including \$3.7 billion in additional earmarks. Now we hear we are doing another stimulus, another jobs package.

Where are we going to get the money? Where does the House say we are going to get the money? We are going to take the money from TARP that had not been borrowed yet, so we are going to borrow the money for another stimulus package against our children and grandchildren.

The Congressional Budget Office had this to say about our fiscal situation, and we have had the Congressional Budget Office quoted:

Over the long term, beyond the 10-year baseline projection, the budget remains on an unsustainable path. Unless changes are made to current policies, the nation will face a growing demand for budgetary resources caused by rising health care costs—

Not lowering health care costs, contrary to what we have heard in this body—

rising health care costs and the aging of the population. Continued large deficits and the resulting increases in Federal debt over time would reduce long-term economic growth by lowering the national saving and investment rates. Unless revenues were increased correspondingly—

And remember what we are talking about: significant, steep, severe tax increases on the American public—annual deficits would climb and the Federal debt would grow, significantly posing a threat to the economy. Alternatively, if taxes were raised to finance the rise in spending, tax rates would have to reach levels never seen in the United States—

Never. We have had it up as high as 90 percent, I remind my colleagues—

some combination of significant changes in benefit programs, rationing, and other spending and tax policies will be necessary in order to attain long-term fiscal balance.

We actually find our deficit situation endangering our national security now because so much of the value of the dollar is now dependent upon what China does because we have not been

good stewards of the American people's money.

If we want to reduce government spending, Congress has to start somewhere, even if it is just eliminating waste. I am going to go through \$350 billion worth of waste that occurs every year in the Federal Government—\$350 billion. I will not go through every bit of it to allow the clerk and the Presiding Officer and the staff to go home, but I am going to go through enough of it so people get a flavor of where the waste is.

The cover of Newsweek's December 7 issue entitled: "Steep Debt, Slow Growth, and High Spending Kill Empires—And America Could Be Next" warns that our current fiscal situation is putting our country at risk and calling into question our position of power in the global economy.

This is how an empire declines. It begins with a debt explosion. It ends with inexorable reduction in the Army, Navy and Air Force. . . .

What did we just pass? A 4-percent increase for the military and an average 11 percent increase for every other branch of the Federal Government. We are already starting to see it. We actually increased our own budgets 6 percent, but what did we do to our military? What they are predicting in Newsweek we are already doing. We are destroying the ability to defend ourselves because, financially, we are not secure because we do not have the courage to make the hard choices in Washington.

Government has grown to such an enormous size it is almost impossible to fully grasp just how huge the Federal operation has become. The 2008–2009 U.S. Government Manual now is nearly 700 pages long and provides details on 15 executive branch agencies and nearly 60 independent establishments and government corporations—60. We have 60 government corporations.

The Government Accountability Office found that 13 different Federal agencies spent nearly \$3 billion from 2004 to 2007 to fund 207 Federal Government programs to encourage students to enter the fields of math and science.

Let me read that again:

Thirteen different Federal agencies spent nearly \$3 billion . . . to fund 207 Federal programs to encourage students to enter the fields of math and science.

Why wouldn't we just have one? Why do we have 207 programs run from 13 different agencies to encourage people to go into math and science? That is the idiocy of what we are doing.

Another example, the GAO report said with \$30 billion, the Federal Government "funds more than 44 job training programs, administered by 9 different Federal training agencies across the Federal bureaucracy."—\$30 billion, 44 programs by 9 different agencies. The right hand doesn't have any idea

what the left hand is doing. Why not one agency? Why not all job training programs in one agency? We do not have the courage to change that?

How about Federal domestic assistance? Fourteen departments within the Federal Government, forty-nine Federal agencies operating exchanges for study-abroad programs.

Let me say that again. We have 14 different departments within the Federal Government, and 49 independent agencies operating study-abroad programs.

Why not one? And why not ask the question, Is that a role for the Federal Government rather than the State government? Yet despite the decades of government spending hundreds of billions of dollars on programs that address every possible issue from homelessness to job training to obesity to education and everything in between, all these problems are actually worse—they still exist and they continue to worsen.

This calls into question if mortgaging our children's future and endangering the country to spend money we simply do not have on programs that are working is truly an effective way to address the changes we face as a Nation. We have to address these issues.

The reason I am spending time on our fiscal nature is because the thing that got us in trouble in health care, the thing that causes our problem in health care is the lack of any Federal restraint. Now we are going to move one-sixth of our economy under the purview of the Federal Government. Let me outline quickly \$387.7 billion worth of waste that could be cut from the Federal Government: The general government in total, \$150 billion; Department of Agriculture, \$9 billion; Department of Commerce, \$5.9 billion; Department of Defense, \$36.6 billion; Department of Education, we could cut \$6 billion, nobody would ever notice the difference; Department of Energy, \$2.2 billion; Department of Health and Human Services, we could cut \$1.8 billion and nobody would ever notice the difference. Medicare, by all sorts of studies now, we know that at least there is \$100 billion worth of fraud in Medicare. We know that. The bill we are so proud of that our colleagues are going to pass without significant amendments on our part goes after \$2 billion of that over 10 years. So they are going to go after two-tenths of 1 percent of the fraud and say they have done something rather than go after the fraud. Medicaid, we could cut \$48 billion from it in waste, duplication, and fraud; Indian Health Service, the inefficiency in the AIDS program; Department of Homeland Security, \$1.5 billion; Department of Housing and Urban Development, \$4.8 billion; Department of the Interior, \$2 billion; the Corps of Engineers, \$1 billion; Department of Justice, at a minimum \$1.6 bil-

lion. We have this report that outlines \$10 billion of waste. They have \$1.6 billion left over at the end of almost every year. They are the only agency that gets to keep their unexpended balances. We have no control over how they spend it. We haven't changed that. We have offered amendments to change it. They have been rejected. We have offered amendments to have that money come back to the Treasury. They have been rejected. Department of Labor, \$12.4 billion worth of waste; Department of State, \$2.5 billion; Department of Transportation, \$4.3 billion; Department of Veterans Affairs, \$1.3 billion. That comes to \$387.7 billion a year which tomorrow would markedly improve the value of the dollar and could markedly change the long-term curve that we are going to have.

Here is what it is. People need to pay attention to this. Every year we don't get rid of the \$387.7 billion and continue to waste it speeds this curve up. Because this chart, which shows where we are now, shows the debt held by the public as a percent of GDP versus where it is going. So if you have a child today who is 1 or 2 years old or you are like Madelyn, the little girl who is 3, where is she going to be in 40 years? Forty years from now puts her at 2050. That means 300 percent of her GDP will be held by the public. What happens when we do that? No growth. Look at the lost decade of Japan. What is the implication for that? The implication is opportunity gets stolen. It is paramount that we change how we operate in the Senate and we start thinking long term. It is not a partisan issue. What it is is a careerism issue and a parochialism issue.

If we care about what our oath is to this little book, the oath that every one of us took to uphold and defend the Constitution, and if we care about what the future holds, we should be worried about this. Because quite frankly, right here the interest on the debt will become \$1 trillion a year, and that is irreversible. That will happen. By 2020, the interest on the U.S. debt will be at least \$1 trillion a year. That is 10 years from now. We are going to be borrowing money and adding to the debt to pay the interest on the debt. That is called bankruptcy. That is why the Chinese are so worried about what we are doing and the fact that we are not effectively managing our government. At the end of World War II, with all the debt we had, we were only at 109 percent of our GDP; in 2080, if we don't change what we are doing, 600 percent of our GDP.

Translate that into what that means for somebody's individual life. That means my grandchildren and their children will never be able to buy a home. They will never own a home. They won't send their kids to college to advance their education. They may not even be able to buy transportation for

themselves. The reason it is important is because it is counter to the heritage we have. We are the first generation in this country, in its whole history, to leave the next generation worse off. Nobody seems to be worried about it. Nobody is willing to sacrifice their position in Washington to make the hard choices to fix what is wrong with the country. That doesn't mean I don't want to fix health care. I do. I have seen the experience, in 25 years of practicing medicine, of what government-run health care does to health care. And with all these other systems that are broke and all these different agencies that are broke and all this duplication and we won't fix it, what makes you think we will fix it this time?

There is a rumble in America. I said that on the floor the first time 4½ years ago. It is growing. It is getting big. For the first time in America, independents poll higher than either Democrats or Republicans. There is a reason for it. They can't stand us. We refuse to make the hard choices they send us here to make. Consequently, they are discouraged. There is a crisis of confidence in America about a government that is supposed to be serving them instead of them serving the government.

As this rumble builds, we should make no mistake about what the long-term consequences are, as many of us won't be here because Americans have had enough. If the average American knew what was in this book, the things we have allowed to happen and continue to allow to happen, they should fire every one of us today. There should be a recall election for every one of us. Because no matter where you are on the political spectrum, none of us has done enough to fix what is wrong. None of us has lessened the risk that will happen to our children. None of us has changed the curve of government dominance over liberty. Until we start doing that, that rumble is going to grow.

The only way that rumble calms down is when we start taking the oath to the Constitution and recognizing the enumerated powers and having respect for the tenth amendment that says specifically, everything that is not specifically mentioned in here as a role for the Federal Government is explicitly reserved to people and their States. All you have to do is look at the health care bill that is going to pass Christmas Eve. We are taking a valuable freedom away in that bill. We are taking away a right. We are going to say if you are an American citizen, you have to buy something. That is a big leap on the commerce clause that we have never had before. It is going to get challenged constitutionally. There is no question. But we are stealing liberty with that one little section called an individual mandate; you have to buy something in this country.

What should be our goal in the sunset years of our lives, after serving in this body, is that we should have preserved or increased freedom for people, not lessened it. Whether it is under Republican domination or Democratic domination, liberty has shrunk. As the government grows, liberty declines.

Another one of Thomas Jefferson's sayings:

Compelling a man to subsidize with his taxes the propagation of ideas which he disbelieves and abhors is sinful and tyrannical.

That last word is an important word in America. They see tyranny. You are going to tell me I have to buy a health insurance policy. What if I have \$250,000 in the bank and I don't want to buy a health insurance policy; you are going to tell me I have to buy it? I have to buy it? That is tyranny. There is no freedom in that. There is no freedom to make an economic choice. There is no freedom to be responsible and accountable. We have said the government will know best.

I will put some information on my Web site so that the Federal Government doesn't have to spend money. If we quit publishing this every day—it is available on line—we could save \$6.5 million a year. Nobody reads them. Everybody looks at them on the computer. We could save \$6.5 million a year if we quit doing this. But we won't quit doing it. It is \$6.5 million peed down the drain every year for something that goes and gets recycled. But we won't do it. We won't do it. Those are the little examples. If you take 100 \$6.5 million programs, you get \$650 million worth of savings. There is thousands of \$6.5 million programs we could all get together and eliminate. But we don't do it. I will make this available on my Web site.

I had my staff use data from the Office of Personnel Management, the Office of Management and Budget, take data from those two areas compiled by the Congressional Research Service. Here is what I came up with in terms of Federal employees. It is pretty revealing. We now have in the Postal Service 762,000 employees; in the Department of Defense, civilians, 677,000 employees; in all the rest of the remainder of the Federal agencies we have 1.247 million employees. The direct compensation, the direct pay cost per person in the Postal Service is \$55,614 a year. The Department of Defense civilian is \$70,201. The remainder of the Federal agencies is \$81,271. That is the direct pay. The benefits, however, at the Postal Service are \$24,743 a year. Department of Defense civilian, not our soldiers, not our military, is \$18,796 a year. And the remaining of the Federal agencies is \$31,754 a year.

So the total per capita compensation for active Federal employees right now is \$113,000 a year—2½ times what it is in the private sector across this country.

So the next time somebody comes to me and says: We need to increase the wages of Federal employees, I am going to lay down and stop it until we create the opportunity our children deserve to have that was given to us. We have wonderful Federal employees, but that is part of the things on which we have to start making a decision. We cannot continue to increase, increase, increase when we are borrowing all the money that we use to increase.

With that, I yield to the Senator from South Dakota.

The PRESIDING OFFICER (Mr. UDALL of Colorado). The Senator from South Dakota is recognized.

Mr. THUNE. Before the Senator from Oklahoma leaves—and I understand the staff needs to get out of here, and the weather is not cooperating in Washington today—I am interested in his discussion and the points he was making about the liabilities we continue to rack up and how that is going to impact future generations.

I wonder if the Senator from Oklahoma might respond to a question with regard to the current debate. Because it strikes me, in light of all the spending and borrowing the country is doing, the concerns it is now creating about not only the economy in the near term but also the impact this could have on our country's strength in the long term, the way some of our creditors, the people who actually buy our debt, are viewing the debate about health care—in fact, when the President was in Asia recently, the discussion with the Chinese was more about, their interest was about what is going to happen with health care in this country, not because they cared about whether there was a public option in the bill, not because they cared about whether it was universal coverage, but because they were interested in what it was going to do to the debt, what it was going to do to the deficit. They were worried about their investments.

I think it is fair to say having this last fiscal year rack up a \$1.5 trillion deficit—and looking to be somewhere in that ballpark again this year—that we cannot sustain over time this pace we are on of borrowing, spending, and continuing just to mortgage the future of future generations, and that bears on the debate we are having today. Because under the best case scenario, this health care expansion, when it is fully implemented, is going to be a \$2.5 trillion expansion. And the managers' amendment, which was laid down today, actually increases the cost.

I do not know if the Senator from Oklahoma has—I am sure he has looked at this, but it was \$848 billion, and now it is \$871 billion. That is their first 10-year number, which I suspect means the fully implemented number, the \$2.5 trillion number—

Mr. COBURN. It is \$2.73 trillion.

Mr. THUNE.—is equally larger. The tax increases went up as well. The

taxes that were in the original bill were \$493 billion. It is now \$518 billion. The Medicare payroll tax, which was going to be a half a point increase is now nine-tenths of a point. That, of course, impacts the Medicare trust fund, for which this will be the first time I think that a payroll tax will be levied that does not go to the trust fund; it actually goes to create a new entitlement program.

But I just wonder what the Senator from Oklahoma thinks about how the health care debate and the spending that is going to be associated with that is going to impact the scenario he was describing, the fiscal condition of our country as we head into the future, and whether we will be able to really keep the cost at the \$2.5 trillion, and whether the tax and the Medicare cuts—which the CMS Actuary says it is unlikely, on a permanent basis, that those cuts will be sustainable—how does this thing get paid for? It seems to me it gets paid for by putting more on the debt, by putting more on future generations.

I am interested in the reaction of the Senator from Oklahoma to that.

Mr. COBURN. I think it gets paid for by rationing health care to Americans. That is how I think it gets paid for. You have three different programs within this bill, three different panels that are going to mandate what I as a physician can do with my patients. Once it gets applied, there is not going to be an exception to it. For 80 percent of Americans that is going to be fine. The real key is to ratchet it down by rationing care.

What do we know? We know \$1 out of every \$3 that is spent on health care today does not help anybody. Do we fix that in this bill? No. We know that \$1 out of every \$3 does not prevent anybody from getting sick and does not treat anybody's illness. Did we fix that in this bill? No. We did not do anything about it.

I will tell the Senator from South Dakota, the tenet of medicine is you do not treat symptoms. You find the disease and you treat the disease. The bill we have before us is a bill that treats the symptoms. It does not attack the disease. Because that \$600 billion a year, at a minimum, that does not help anybody get well and does not prevent them from getting sick—if we just took half of it, we could cover everybody who is not covered in this country today. We could cover everybody and not spend a penny more on health care. But we have not attacked the disease. We are treating symptoms. We are not working to solve the real problems underlying health care.

The problem in America for health care is access to services. The access limitation is because of cost. If you cut costs 15 percent tomorrow, you would increase the same number of people who are increased in the bill in terms

of availability. If you had real transparency in the insurance industry, where people could see and actually compete and buy all across this country what they wanted, and we hammered the insurance industry in terms of transparency of outcomes—the same for doctors—you would cut the cost even further. In other words, you put the patient in charge. We have a government-in-charge bill that we are going to be voting on instead of the patients.

So we are treating symptoms. We are not treating the disease. We are treating those who are screaming the loudest, but we are not fixing the problem. We are just making the problem worse and bigger.

Mr. THUNE. If the Senator from Oklahoma would yield for another question, does the CMS Actuary and the Congressional Budget Office conclude, when it is all said and done, that the overall cost of health care goes up, not down? It seems to me, at least, that as to the points the Senator mentioned, if we were sincere about reforming health care in this country, what most small businesses, what most individuals, what most families want to see is health care costs going down. This actually bends the cost curve up, according to the CMS Actuary, with a \$234 billion increase in health care costs over 10 years.

According to the Congressional Budget Office, it is a \$160 billion increase in health care over 10 years. So there is a slight difference in terms of their analyses, but both conclude that health care costs will go up. The amount we spend on health care as a part of our total economy in this country—

Mr. COBURN. Will rise to 21 percent.

Mr. THUNE.—will be 21 percent. It is currently about 17 percent or in that ballpark. So it seems to me, at least, we have done very little—

Mr. COBURN. You are not fixing the disease.

Mr. THUNE. If anything, to address that problem.

So I simply would ask the Senator from Oklahoma, some of the things the Senator talks about in terms of actually attacking the disease could be the basis upon which we could put together a consensus bill around here that actually does reform health care in a way that drives down the cost rather than raise it and does not rely on all these tax increases, does not rely on the \$1 trillion in Medicare cuts, which the CMS Actuary says are unlikely to be substained on a permanent basis, therefore, again putting more and more of the burden of the cost of this new expansion on future generations.

I just see this as a very dangerous path to be on when you are running \$1.5 trillion deficits, when you have an economy in recession, and unemployment is about 10 percent. We are talking about tax increases that are going

to be passed on in the form of higher premiums for most Americans.

To be fair, there will be some Americans who will benefit. Most will not. Most will see their premiums go up. We are going to see Medicare cuts. The program will be cut, but not to reform it or make it more sustainable or extend its life but, rather, to create a new entitlement program.

How can we move forward with legislation such as this and call it reform? Wouldn't it be fair to suggest that if our colleagues on the other side were serious about reforming health care, they would sit down with us in a way that is constructive that would actually represent the common ground we could find and not write these bills, as they have, behind closed doors and then spring it on us today on a Saturday morning, and try to push this thing through to passage before Thursday of next week or Friday on Christmas Day?

Mr. COBURN. The Senator has asked a lot of questions. There is an organization that is based out in Oklahoma. It is called Safeway. Safeway has 200,000 employees. They have had a zero percent increase in their health care costs in the last 5 years, doing the things that we talk about in the Patients' Choice Act: using market forces, getting patient participation.

What have they found out? Their workers are healthier. Their absenteeism rate has gone down. They have lost cumulatively thousands and thousands of pounds. Their work product is better and their company is healthier because they are not spending more.

What has happened to their wages? Their wages are going up. One of the statistics most people do not understand is that for every 3.5 percent rise in health care costs, you lose 2.5 percent in real wages. In other words, if health care costs would stay flat, you would get a 2.5-percent increase. If they go up 3.5 percent, you are going to lose that 2.5 percent. If they go up 7 percent, you are going to lose 5 percent. So controlling the costs, when we have a third of it wasted anyway, should be our goal, and that is not where we are headed.

So the disappointment is not that we do not need to fix health care. We do. The disappointment is that—which I think I have outlined here today—the government is highly inefficient at everything it does, and effective only on a limited basis on the things we do fund, and then we are going to move another 20 percent of health care under the control of an organization that has proven itself ineffective at what it does.

That is insanity. The direction of the bill is one that treats the symptoms so we will feel better for a while, but we still die. If we practiced medicine that way, we would be run out of town on a rail. You do not treat symptoms.

Symptoms cover up worsening disease. You treat the real disease, and the real disease is lack of transparency, lack of accountability, lack of reform, lack of tort reform, and lack of a competitive nature, both in the health insurance industry as well as in providers like myself.

Make me compete based on quality and price, and make sure my patients can see it, so that a consumer can make a real choice. If we were to do that—which this bill does none of that—if we were to do that, American consumers could get a much better deal.

I thank the Senator.

Mr. THUNE. Mr. President, if I might say, the Senator from Oklahoma has put forward a comprehensive approach to health care reform. It has been argued here many times on the floor that Republicans do not have their own ideas. We have argued throughout the course of this debate that we ought to be approaching this not in sort of a radical overhaul of an expansion of the Federal Government's role in our health care delivery system, which this legislation would do, but, rather, look at ways we can provide more competition and create a more robust private sector health care delivery system. Instead, this approach relies heavily on growing the government footprint with regard to health care, as is evidenced by the \$2.5 trillion cost of the legislation.

But the Senator from Oklahoma and our colleague from North Carolina have come up with a comprehensive solution, which is very, in my view, bold and does represent true reform that moves us away from the system we have today, which has demonstrated, as the Senator from Oklahoma has pointed out, that it continues to increase in cost and continues to probably—I think it will be argued—deliver less in terms of quality and makes the failures in the current system even bigger and worse, without doing anything to address the fundamental underlying problem or disease.

So I would say that inasmuch as the Senator from Oklahoma has a comprehensive solution, we also support what I would call more step-by-step approaches. One, of course, is interstate competition, allowing people to buy insurance across States lines. One would allow pooling, allowing small businesses to join a larger group, thereby getting the benefit of group purchasing power.

As the Senator from Oklahoma mentioned, medical malpractice reform is something we all believe needs to be done. The Congressional Budget Office, by the way, has said all these various solutions bend the cost curve down, not up. But those are all things we could be doing to improve upon the system we have today.

Frankly, I think we need to have a fair debate of the proposal of the Sen-

ator from Oklahoma, which is a comprehensive approach, which does take us away from the employer-based system, which empowers individuals through the form of tax credits to buy their own health insurance to make them more informed consumers. We always talk about a consumer-driven model. That is exactly the approach that his legislation and his reform proposal would employ.

So I would like to see us have an opportunity to debate that. We are not going to get that chance, I do not think, because it sounds as if the amendment tree has been filled. The bill that is before us now with the managers' amendment will prevent other alternatives, other amendments from being offered. That is unfortunate because I think the direction we are headed is a train wreck, as has been described by many, because it leads to more spending, more taxing, Medicare cuts, and I would argue, in the end, more borrowing, frankly, does little to solve the underlying problems that exist in our health care system today.

Mr. COBURN. Would the Senator yield for a moment?

Mr. THUNE. I am happy to yield.

Mr. COBURN. There is one area I needed to cover that I didn't, and I will do so rather quickly.

Since 1977, this country has said we are not going to take Federal taxpayer dollars to pay for abortions. That is a divisive issue. The only way we change that issue is to change people's hearts in this country. So we are going to have to all agree to disagree on abortion in this country, and it is about a 50-50 split. What is about a 70-30 split is that the vast majority of Americans don't think their tax dollars, whether they are pro-choice or not, should be used to pay for somebody else's abortion.

What we saw come through the Senate this morning is something that every significant pro-life group in this country, including the Catholic Bishops, including Right to Life, including this doctor who has delivered thousands of babies and understands the issues of life, is going to abhor. What we have done is ultimately eliminate the Hyde amendment, and come next September 30, throughout the Federal Government as well as in this bill, the Federal Government is now going to allow taxpayer dollars to be used to pay for abortion.

Congressman STUPAK, who is a friend of mine, who made sure the House did not allow that to happen, has recently been quoted today saying this is absolutely unacceptable, and it should be. We should not be using Federal funds for that procedure to end the life of an unborn human being.

With that, I yield the floor and yield back my time.

Mr. THUNE. I appreciate that. I appreciate and share the Senator's view

with regard to the changes or proposal that was unveiled this morning and how it treats the issue of abortion.

As was noted, the House of Representatives and Congressman STUPAK came up with a clear, unequivocal policy position that extends the policy, essentially, that has been in place now for the past 30 years in this country regarding the use of taxpayer funds for abortions. The language that supposedly was negotiated between the Senator from Nebraska and the Democratic majority does not follow through or maintain that policy and, in fact, opens the door to allowing Federal funding to be used for abortions.

Irrespective of which side you come down on, on this issue, there has been widespread and broad American support for a very long time. I think it is something both Republicans and Democrats have agreed upon, and we should not deviate from that. The American people have made it very plain that they believe—60 to 70 percent, in most surveys—the Federal Government should not be using taxpayer funds to finance abortions. The funding is clearly in the Senate version that now has been negotiated. As the Senator from Oklahoma mentioned, the opposition comes from the Catholic Bishops, the opposition comes from the National Right to Life. It is very clear that this provision that is now included in the managers' amendment does not maintain the long-held policy we have had in this country supported by so many Americans that we not use taxpayer funds for abortions. So that, too, is something this bill falls short on, along with all of the other many things I have mentioned.

I think we are going to have many opportunities over the course of the next several days to continue to discuss this issue. We just received the managers' amendment this morning, and I think it is important, as the debate over the managers' amendment begins and we have some votes that are going to be coming up in the next few days, that we continue to talk about why this is the wrong approach for America, why it is the wrong approach for health care, why it is the wrong approach for our economy, and why it is the wrong approach for jobs. We can do so much better by the American people. This needs to be done in a step-by-step way. It needs to be done right. This legislation takes us in the wrong direction for the future of this country.

Mr. President, I yield the floor.

MESSAGE FROM THE HOUSE

ENROLLED BILL AND JOINT RESOLUTION SIGNED

At 10:53 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks,

announced that the Speaker has signed the following enrolled bill and joint resolution:

H.R. 3326. An act making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes.

H.J. Res. 64. Joint resolution making further continuing appropriations for fiscal year 2010, and for other purposes.

The enrolled bill and joint resolution were subsequently signed by the Acting President pro tempore (Mr. CASEY).

ADDITIONAL COSPONSORS

S. 565

At the request of Mr. DURBIN, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of S. 565, a bill to amend title XVIII of the Social Security Act to provide continued entitlement to coverage for immunosuppressive drugs furnished to beneficiaries under the Medicare Program that have received a kidney transplant and whose entitlement to coverage would otherwise expire, and for other purposes.

AMENDMENT NO. 3065

At the request of Mr. CARDIN, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of amendment No. 3065 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3076

At the request of Mr. DURBIN, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of amendment No. 3076 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3077

At the request of Mr. DURBIN, the name of the Senator from Illinois (Mr. BURRIS) was added as a cosponsor of amendment No. 3077 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3276. Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit

in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

SA 3277. Mr. REID proposed an amendment to amendment SA 3276 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra.

SA 3278. Mr. REID proposed an amendment to the bill H.R. 3590, supra.

SA 3279. Mr. REID proposed an amendment to amendment SA 3278 proposed by Mr. REID to the bill H.R. 3590, supra.

SA 3280. Mr. REID proposed an amendment to the bill H.R. 3590, supra.

SA 3281. Mr. REID proposed an amendment to amendment SA 3280 proposed by Mr. REID to the bill H.R. 3590, supra.

SA 3282. Mr. REID proposed an amendment to amendment SA 3281 proposed by Mr. REID to the amendment SA 3280 proposed by Mr. REID to the bill H.R. 3590, supra.

SA 3283. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 3276. Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, strike lines 22 through 25, and insert the following:

(f) **EFFECTIVE DATE.**—The amendments made by subsections (a) through (d) of this section shall apply to amounts paid or incurred after December 31, 2008, in taxable years beginning after such date.

TITLE X—STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Provisions Relating to Title I

SEC. 10101. AMENDMENTS TO SUBTITLE A.

(a) Section 2711 of the Public Health Service Act, as added by section 1001(5) of this Act, is amended to read as follows:

“SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.

“(a) **PROHIBITION.**—

“(1) **IN GENERAL.**—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—

“(A) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

“(B) except as provided in paragraph (2), annual limits on the dollar value of benefits for any participant or beneficiary.

“(2) **ANNUAL LIMITS PRIOR TO 2014.**—With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or bene-

ficiary with respect to the scope of benefits that are essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, as determined by the Secretary. In defining the term ‘restricted annual limit’ for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.

“(b) **PER BENEFICIARY LIMITS.**—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, to the extent that such limits are otherwise permitted under Federal or State law.”.

(b) Section 2715(a) of the Public Health Service Act, as added by section 1001(5) of this Act, is amended by striking “and providing to enrollees” and inserting “and providing to applicants, enrollees, and policyholders or certificate holders”.

(c) Subpart II of part A of title XXVII of the Public Health Service Act, as added by section 1001(5), is amended by inserting after section 2715, the following:

“SEC. 2715A. PROVISION OF ADDITIONAL INFORMATION.

“A group health plan and a health insurance issuer offering group or individual health insurance coverage shall comply with the provisions of section 1311(e)(3) of the Patient Protection and Affordable Care Act, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public.”.

(d) Section 2716 of the Public Health Service Act, as added by section 1001(5) of this Act, is amended to read as follows:

“SEC. 2716. PROHIBITION ON DISCRIMINATION IN FAVOR OF HIGHLY COMPENSATED INDIVIDUALS.

“(a) **IN GENERAL.**—A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(h)(2) of the Internal Revenue Code of 1986 (relating to prohibition on discrimination in favor of highly compensated individuals).

“(b) **RULES AND DEFINITIONS.**—For purposes of this section—

“(1) **CERTAIN RULES TO APPLY.**—Rules similar to the rules contained in paragraphs (3), (4), and (8) of section 105(h) of such Code shall apply.

“(2) **HIGHLY COMPENSATED INDIVIDUAL.**—The term ‘highly compensated individual’ has the meaning given such term by section 105(h)(5) of such Code.”.

(e) Section 2717 of the Public Health Service Act, as added by section 1001(5) of this Act, is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b), the following:

“(c) **PROTECTION OF SECOND AMENDMENT GUN RIGHTS.—**

“(1) **WELLNESS AND PREVENTION PROGRAMS.**—A wellness and health promotion activity implemented under subsection (a)(1)(D) may not require the disclosure or collection of any information relating to—

“(A) the presence or storage of a lawfully-possessed firearm or ammunition in the residence or on the property of an individual; or

“(B) the lawful use, possession, or storage of a firearm or ammunition by an individual.

“(2) **LIMITATION ON DATA COLLECTION.**—None of the authorities provided to the Secretary

under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used for the collection of any information relating to—

“(A) the lawful ownership or possession of a firearm or ammunition;

“(B) the lawful use of a firearm or ammunition; or

“(C) the lawful storage of a firearm or ammunition.

“(3) LIMITATION ON DATABASES OR DATA BANKS.—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used to maintain records of individual ownership or possession of a firearm or ammunition.

“(4) LIMITATION ON DETERMINATION OF PREMIUM RATES OR ELIGIBILITY FOR HEALTH INSURANCE.—A premium rate may not be increased, health insurance coverage may not be denied, and a discount, rebate, or reward offered for participation in a wellness program may not be reduced or withheld under any health benefit plan issued pursuant to or in accordance with the Patient Protection and Affordable Care Act or an amendment made by that Act on the basis of, or on reliance upon—

“(A) the lawful ownership or possession of a firearm or ammunition; or

“(B) the lawful use or storage of a firearm or ammunition.

“(5) LIMITATION ON DATA COLLECTION REQUIREMENTS FOR INDIVIDUALS.—No individual shall be required to disclose any information under any data collection activity authorized under the Patient Protection and Affordable Care Act or an amendment made by that Act relating to—

“(A) the lawful ownership or possession of a firearm or ammunition; or

“(B) the lawful use, possession, or storage of a firearm or ammunition.”

(f) Section 2718 of the Public Health Service Act, as added by section 1001(5), is amended to read as follows:

“SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

“(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

“(1) on reimbursement for clinical services provided to enrollees under such coverage;

“(2) for activities that improve health care quality; and

“(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

“(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

“(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—

“(A) REQUIREMENT.—Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health in-

surance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

“(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

“(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.

“(B) REBATE AMOUNT.—

“(i) CALCULATION OF AMOUNT.—The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—

“(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and

“(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

“(ii) CALCULATION BASED ON AVERAGE RATIO.—Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

“(2) CONSIDERATION IN SETTING PERCENTAGES.—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

“(3) ENFORCEMENT.—The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

“(c) DEFINITIONS.—Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

“(d) ADJUSTMENTS.—The Secretary may adjust the rates described in subsection (b) if

the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

“(e) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.”

(g) Section 2719 of the Public Health Service Act, as added by section 1001(4) of this Act, is amended to read as follows:

“SEC. 2719. APPEALS PROCESS.

“(a) INTERNAL CLAIMS APPEALS.—

“(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

“(A) have in effect an internal claims appeal process;

“(B) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes; and

“(C) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

“(2) ESTABLISHED PROCESSES.—To comply with paragraph (1)—

“(A) a group health plan and a health insurance issuer offering group health coverage shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503-1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70256), and shall update such process in accordance with any standards established by the Secretary of Labor for such plans and issuers; and

“(B) a health insurance issuer offering individual health coverage, and any other issuer not subject to subparagraph (A), shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures set forth under applicable law (as in existence on the date of enactment of this section), and shall update such process in accordance with any standards established by the Secretary of Health and Human Services for such issuers.

“(b) EXTERNAL REVIEW.—A group health plan and a health insurance issuer offering group or individual health insurance coverage—

“(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or

“(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—

“(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or

“(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).

“(c) SECRETARY AUTHORITY.—The Secretary may deem the external review process of a group health plan or health insurance issuer, in operation as of the date of enactment of this section, to be in compliance with the applicable process established under subsection (b), as determined appropriate by the Secretary.”.

(h) Subpart II of part A of title XVIII of the Public Health Service Act, as added by section 1001(5) of this Act, is amended by inserting after section 2719 the following:

“SEC. 2719A. PATIENT PROTECTIONS.

“(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

“(b) COVERAGE OF EMERGENCY SERVICES.—

“(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B)).

“(A) without the need for any prior authorization determination;

“(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

“(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

“(i) by a nonparticipating health care provider with or without prior authorization; or

“(ii) (I) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

“(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

“(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of this Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

“(2) DEFINITIONS.—In this subsection:

“(A) EMERGENCY MEDICAL CONDITION.—The term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowl-

edge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

“(B) EMERGENCY SERVICES.—The term ‘emergency services’ means, with respect to an emergency medical condition—

“(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

“(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

“(C) STABILIZE.—The term ‘to stabilize’, with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

“(c) ACCESS TO PEDIATRIC CARE.—

“(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer in the group or individual market, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider if such provider participates in the network of the plan or issuer.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

“(d) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

“(1) GENERAL RIGHTS.—

“(A) DIRECT ACCESS.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan’s or issuer’s policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

“(B) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorizing of the primary care provider.

“(2) APPLICATION OF PARAGRAPH.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in this paragraph is a group health plan or coverage that—

“(A) provides coverage for obstetric or gynecologic care; and

“(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

“(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to—

“(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

“(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.”.

(i) Section 2794 of the Public Health Service Act, as added by section 1003 of this Act, is amended—

(1) in subsection (c)(1)—

(A) in subparagraph (A), by striking “and” at the end;

(B) in subparagraph (B), by striking the period and inserting “; and”; and

(C) by adding at the end the following:

“(C) in establishing centers (consistent with subsection (d)) at academic or other nonprofit institutions to collect medical reimbursement information from health insurance issuers, to analyze and organize such information, and to make such information available to such issuers, health care providers, health researchers, health care policy makers, and the general public.”; and

(2) by adding at the end the following:

“(d) MEDICAL REIMBURSEMENT DATA CENTERS.—

“(1) FUNCTIONS.—A center established under subsection (c)(1)(C) shall—

“(A) develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates;

“(B) use the best available statistical methods and data processing technology to develop such fee schedules and other database tools;

“(C) regularly update such fee schedules and other database tools to reflect changes in charges for medical services;

“(D) make health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services; and

“(E) regularly publish information concerning the statistical methodologies used by the center to analyze health charge data and make such data available to researchers and policy makers.

“(2) CONFLICTS OF INTEREST.—A center established under subsection (c)(1)(C) shall adopt by-laws that ensures that the center (and all members of the governing board of the center) is independent and free from all conflicts of interest. Such by-laws shall ensure that the center is not controlled or influenced by, and does not have any corporate relation to, any individual or entity that may make or receive payments for health care services based on the center’s analysis of health care costs.

“(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to permit a center established under subsection (c)(1)(C) to compel health insurance issuers to provide data to the center.”.

SEC. 10102. AMENDMENTS TO SUBTITLE B.

(a) Section 1102(a)(2)(B) of this Act is amended—

(1) in the matter preceding clause (i), by striking “group health benefits plan” and inserting “group benefits plan providing health benefits”; and

(2) in clause (i)(I), by inserting “or any agency or instrumentality of any of the foregoing” before the closed parenthetical.

(b) Section 1103(a) of this Act is amended—
(1) in paragraph (1), by inserting “, or small business in,” after “residents of any”; and

(2) by striking paragraph (2) and inserting the following:

“(2) CONNECTING TO AFFORDABLE COVERAGE.—An Internet website established under paragraph (1) shall, to the extent practicable, provide ways for residents of, and small businesses in, any State to receive information on at least the following coverage options:

“(A) Health insurance coverage offered by health insurance issuers, other than coverage that provides reimbursement only for the treatment or mitigation of—

“(i) a single disease or condition; or

“(ii) an unreasonably limited set of diseases or conditions (as determined by the Secretary).

“(B) Medicaid coverage under title XIX of the Social Security Act.

“(C) Coverage under title XXI of the Social Security Act.

“(D) A State health benefits high risk pool, to the extent that such high risk pool is offered in such State; and

“(E) Coverage under a high risk pool under section 1101.

“(F) Coverage within the small group market for small businesses and their employees, including reinsurance for early retirees under section 1102, tax credits available under section 45R of the Internal Revenue Code of 1986 (as added by section 1421), and other information specifically for small businesses regarding affordable health care options.”

SEC. 10103. AMENDMENTS TO SUBTITLE C.

(a) Section 2701(a)(5) of the Public Health Service Act, as added by section 1201(4) of this Act, is amended by inserting “(other than self-insured group health plans offered in such market)” after “such market”.

(b) Section 2708 of the Public Health Service Act, as added by section 1201(4) of this Act, is amended by striking “or individual”.

(c) Subpart I of part A of title XXVII of the Public Health Service Act, as added by section 1201(4) of this Act, is amended by inserting after section 2708, the following:

“SEC. 2709. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

“(a) COVERAGE.—

“(1) IN GENERAL.—If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage to a qualified individual, then such plan or issuer—

“(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

“(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

“(C) may not discriminate against the individual on the basis of the individual’s participation in such trial.

“(2) ROUTINE PATIENT COSTS.—

“(A) INCLUSION.—For purposes of paragraph (1)(B), subject to subparagraph (B), routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.

“(B) EXCLUSION.—For purposes of paragraph (1)(B), routine patient costs does not include—

“(i) the investigational item, device, or service, itself;

“(ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

“(iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

“(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

“(4) USE OF OUT-OF-NETWORK.—Notwithstanding paragraph (3), paragraph (1) shall apply to a qualified individual participating in an approved clinical trial that is conducted outside the State in which the qualified individual resides.

“(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ‘qualified individual’ means an individual who is a participant or beneficiary in a health plan or with coverage described in subsection (a)(1) and who meets the following conditions:

“(1) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.

“(2) Either—

“(A) the referring health care professional is a participating health care provider and has concluded that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

“(B) the participant or beneficiary provides medical and scientific information establishing that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

“(c) LIMITATIONS ON COVERAGE.—This section shall not be construed to require a group health plan, or a health insurance issuer offering group or individual health insurance coverage, to provide benefits for routine patient care services provided outside of the plan’s (or coverage’s) health care provider network unless out-of-network benefits are otherwise provided under the plan (or coverage).

“(d) APPROVED CLINICAL TRIAL DEFINED.—

“(1) IN GENERAL.—In this section, the term ‘approved clinical trial’ means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

“(A) FEDERALLY FUNDED TRIALS.—The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

“(i) The National Institutes of Health.

“(ii) The Centers for Disease Control and Prevention.

“(iii) The Agency for Health Care Research and Quality.

“(iv) The Centers for Medicare & Medicaid Services.

“(v) cooperative group or center of any of the entities described in clauses (i) through

(iv) or the Department of Defense or the Department of Veterans Affairs.

“(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

“(vii) Any of the following if the conditions described in paragraph (2) are met:

“(I) The Department of Veterans Affairs.

“(II) The Department of Defense.

“(III) The Department of Energy.

“(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

“(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

“(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

“(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

“(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

“(e) LIFE-THREATENING CONDITION DEFINED.—In this section, the term ‘life-threatening condition’ means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

“(f) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan’s or issuer’s coverage with respect to clinical trials.

“(g) APPLICATION TO FEHBP.—Notwithstanding any provision of chapter 89 of title 5, United States Code, this section shall apply to health plans offered under the program under such chapter.

“(h) PREEMPTION.—Notwithstanding any other provision of this Act, nothing in this section shall preempt State laws that require a clinical trials policy for State regulated health insurance plans that is in addition to the policy required under this section.”

(d) Section 1251(a) of this Act is amended—
(1) in paragraph (2), by striking “With” and inserting “Except as provided in paragraph (3), with”; and

(2) by adding at the end the following:

“(3) APPLICATION OF CERTAIN PROVISIONS.—The provisions of sections 2715 and 2718 of the Public Health Service Act (as added by subtitle A) shall apply to grandfathered health plans for plan years beginning on or after the date of enactment of this Act.”

(e) Section 1253 of this Act is amended insert before the period the following: “, except that—

“(1) section 1251 shall take effect on the date of enactment of this Act; and

“(2) the provisions of section 2704 of the Public Health Service Act (as amended by section 1201), as they apply to enrollees who are under 19 years of age, shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act.”

(f) Subtitle C of title I of this Act is amended—

(1) by redesignating section 1253 as section 1255; and

(2) by inserting after section 1252, the following:

"SEC. 1253. ANNUAL REPORT ON SELF-INSURED PLANS.

"Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary of Labor shall prepare an aggregate annual report, using data collected from the Annual Return/Report of Employee Benefit Plan (Department of Labor Form 5500), that shall include general information on self-insured group health plans (including plan type, number of participants, benefits offered, funding arrangements, and benefit arrangements) as well as data from the financial filings of self-insured employers (including information on assets, liabilities, contributions, investments, and expenses). The Secretary shall submit such reports to the appropriate committees of Congress.

"SEC. 1254. STUDY OF LARGE GROUP MARKET.

"(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study of the fully-insured and self-insured group health plan markets to—

"(1) compare the characteristics of employers (including industry, size, and other characteristics as determined appropriate by the Secretary), health plan benefits, financial solvency, capital reserve levels, and the risks of becoming insolvent; and

"(2) determine the extent to which new insurance market reforms are likely to cause adverse selection in the large group market or to encourage small and midsize employers to self-insure.

"(b) COLLECTION OF INFORMATION.—In conducting the study under subsection (a), the Secretary, in coordination with the Secretary of Labor, shall collect information and analyze—

"(1) the extent to which self-insured group health plans can offer less costly coverage and, if so, whether lower costs are due to more efficient plan administration and lower overhead or to the denial of claims and the offering very limited benefit packages;

"(2) claim denial rates, plan benefit fluctuations (to evaluate the extent that plans scale back health benefits during economic downturns), and the impact of the limited recourse options on consumers; and

"(3) any potential conflict of interest as it relates to the health care needs of self-insured enrollees and self-insured employer's financial contribution or profit margin, and the impact of such conflict on administration of the health plan.

"(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a report concerning the results of the study conducted under subsection (a)."

SEC. 10104. AMENDMENTS TO SUBTITLE D.

(a) Section 1301(a) of this Act is amended by striking paragraph (2) and inserting the following:

"(2) INCLUSION OF CO-OP PLANS AND MULTI-STATE QUALIFIED HEALTH PLANS.—Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 1322, and a multi-State plan under section 1334, unless specifically provided for otherwise.

"(3) TREATMENT OF QUALIFIED DIRECT PRIMARY CARE MEDICAL HOME PLANS.—The Secretary of Health and Human Services shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are

coordinated with the entity offering the qualified health plan.

"(4) VARIATION BASED ON RATING AREA.—A qualified health plan, including a multi-State qualified health plan, may as appropriate vary premiums by rating area (as defined in section 2701(a)(2) of the Public Health Service Act)."

(b) Section 1302 of this Act is amended—

(1) in subsection (d)(2)(B), by striking "may issue" and inserting "shall issue"; and

(2) by adding at the end the following:

"(g) PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.—If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service."

(c) Section 1303 of this Act is amended to read as follows:

"SEC. 1303. SPECIAL RULES.

"(a) STATE OPT-OUT OF ABORTION COVERAGE.—

"(1) IN GENERAL.—A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition.

"(2) TERMINATION OF OPT OUT.—A State may repeal a law described in paragraph (1) and provide for the offering of such services through the Exchange.

"(b) SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.—

"(1) VOLUNTARY CHOICE OF COVERAGE OF ABORTION SERVICES.—

"(A) IN GENERAL.—Notwithstanding any other provision of this title (or any amendment made by this title)—

"(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(i) or (B)(ii) as part of its essential health benefits for any plan year; and

"(ii) subject to subsection (a), the issuer of a qualified health plan shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year.

"(B) ABORTION SERVICES.—

"(i) ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

"(ii) ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

"(2) PROHIBITION ON THE USE OF FEDERAL FUNDS.—

"(A) IN GENERAL.—If a qualified health plan provides coverage of services described in paragraph (1)(B)(i), the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services:

"(i) The credit under section 36B of the Internal Revenue Code of 1986 (and the amount

(if any) of the advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).

"(ii) Any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act (and the amount (if any) of the advance payment of the reduction under section 1412 of the Patient Protection and Affordable Care Act).

"(B) ESTABLISHMENT OF ALLOCATION ACCOUNTS.—In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall—

"(i) collect from each enrollee in the plan (without regard to the enrollee's age, sex, or family status) a separate payment for each of the following:

"(I) an amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the plan of services other than services described in paragraph (1)(B)(i) (after reduction for credits and cost-sharing reductions described in subparagraph (A)); and

"(II) an amount equal to the actuarial value of the coverage of services described in paragraph (1)(B)(i), and

"(ii) shall deposit all such separate payments into separate allocation accounts as provided in subparagraph (C).

In the case of an enrollee whose premium for coverage under the plan is paid through employee payroll deposit, the separate payments required under this subparagraph shall each be paid by a separate deposit.

"(C) SEGREGATION OF FUNDS.—

"(i) IN GENERAL.—The issuer of a plan to which subparagraph (A) applies shall establish allocation accounts described in clause (ii) for enrollees receiving amounts described in subparagraph (A).

"(ii) ALLOCATION ACCOUNTS.—The issuer of a plan to which subparagraph (A) applies shall deposit—

"(I) all payments described in subparagraph (B)(i)(I) into a separate account that consists solely of such payments and that is used exclusively to pay for services other than services described in paragraph (1)(B)(i); and

"(II) all payments described in subparagraph (B)(i)(II) into a separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (1)(B)(i).

"(D) ACTUARIAL VALUE.—

"(i) IN GENERAL.—The issuer of a qualified health plan shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under the qualified health plan of the services described in paragraph (1)(B)(i).

"(ii) CONSIDERATIONS.—In making such estimate, the issuer—

"(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

"(II) shall estimate such costs as if such coverage were included for the entire population covered; and

"(III) may not estimate such a cost at less than \$1 per enrollee, per month.

"(E) ENSURING COMPLIANCE WITH SEGREGATION REQUIREMENTS.—

"(i) IN GENERAL.—Subject to clause (ii), State health insurance commissioners shall ensure that health plans comply with the segregation requirements in this subsection through the segregation of plan funds in accordance with applicable provisions of generally accepted accounting requirements,

circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office.

“(ii) CLARIFICATION.—Nothing in clause (1) shall prohibit the right of an individual or health plan to appeal such action in courts of competent jurisdiction.

“(3) RULES RELATING TO NOTICE.—

“(A) NOTICE.—A qualified health plan that provides for coverage of the services described in paragraph (1)(B)(i) shall provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage.

“(B) RULES RELATING TO PAYMENTS.—The notice described in subparagraph (A), any advertising used by the issuer with respect to the plan, any information provided by the Exchange, and any other information specified by the Secretary shall provide information only with respect to the total amount of the combined payments for services described in paragraph (1)(B)(i) and other services covered by the plan.

“(4) NO DISCRIMINATION ON BASIS OF PROVISION OF ABORTION.—No qualified health plan offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions

“(C) APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.—

“(1) NO PREEMPTION OF STATE LAWS REGARDING ABORTION.—Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

“(2) NO EFFECT ON FEDERAL LAWS REGARDING ABORTION.—

“(A) IN GENERAL.—Nothing in this Act shall be construed to have any effect on Federal laws regarding—

“(i) conscience protection;

“(ii) willingness or refusal to provide abortion; and

“(iii) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

“(3) NO EFFECT ON FEDERAL CIVIL RIGHTS LAW.—Nothing in this subsection shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964.

“(d) APPLICATION OF EMERGENCY SERVICES LAWS.—Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as ‘EMTALA’).”

(d) Section 1304 of this Act is amended by adding at the end the following:

“(e) EDUCATED HEALTH CARE CONSUMERS.—The term ‘educated health care consumer’ means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters.”

(e) Section 1311(d) of this Act is amended—

(1) in paragraph (3)(B), by striking clause (i) and inserting the following:

“(ii) STATE MUST ASSUME COST.—A State shall make payments—

“(I) to an individual enrolled in a qualified health plan offered in such State; or

“(II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled;

to defray the cost of any additional benefits described in clause (1).”; and

(2) in paragraph (6)(A), by inserting “educated” before “health care”.

(f) Section 1311(e) of this Act is amended—

(1) in paragraph (2), by striking “may” in the second sentence and inserting “shall”; and

(2) by adding at the end the following:

“(3) TRANSPARENCY IN COVERAGE.—

“(A) IN GENERAL.—The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, accurate and timely disclosure of the following information:

“(i) Claims payment policies and practices.

“(ii) Periodic financial disclosures.

“(iii) Data on enrollment.

“(iv) Data on disenrollment.

“(v) Data on the number of claims that are denied.

“(vi) Data on rating practices.

“(vii) Information on cost-sharing and payments with respect to any out-of-network coverage.

“(viii) Information on enrollee and participant rights under this title.

“(ix) Other information as determined appropriate by the Secretary.

“(B) USE OF PLAIN LANGUAGE.—The information required to be submitted under subparagraph (A) shall be provided in plain language. The term ‘plain language’ means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

“(C) COST SHARING TRANSPARENCY.—The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual’s plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an Internet website and such other means for individuals without access to the Internet.

“(D) GROUP HEALTH PLANS.—The Secretary of Labor shall update and harmonize the Secretary’s rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Secretary under subparagraph (A).”

(g) Section 1311(g)(1) of this Act is amended—

(1) in subparagraph (C), by striking “; and” and inserting a semicolon;

(2) in subparagraph (D), by striking the period and inserting “; and”; and

(3) by adding at the end the following:

“(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.”

(h) Section 1311(i)(2)(B) of this Act is amended by striking “small business devel-

opment centers” and inserting “resource partners of the Small Business Administration”.

(i) Section 1312 of this Act is amended—

(1) in subsection (a)(1), by inserting “and for which such individual is eligible” before the period;

(2) in subsection (e)—

(A) in paragraph (1), by inserting “and employers” after “enroll individuals”; and

(B) by striking the flush sentence at the end; and

(3) in subsection (f)(1)(A)(ii), by striking the parenthetical.

(j)(1) Subparagraph (B) of section 1313(a)(6) of this Act is hereby deemed null, void, and of no effect.

(2) Section 3730(e) of title 31, United States Code, is amended by striking paragraph (4) and inserting the following:

“(4)(A) The court shall dismiss an action or claim under this section, unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed—

“(i) in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party;

“(ii) in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or

“(iii) from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

“(B) For purposes of this paragraph, “original source” means an individual who either (1) prior to a public disclosure under subsection (e)(4)(a), has voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or (2) who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing an action under this section.”

(k) Section 1313(b) of this Act is amended—

(1) in paragraph (3), by striking “and” at the end;

(2) by redesignating paragraph (4) as paragraph (5); and

(3) by inserting after paragraph (3) the following:

“(4) a survey of the cost and affordability of health care insurance provided under the Exchanges for owners and employees of small business concerns (as defined under section 3 of the Small Business Act (15 U.S.C. 632)), including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges; and”

(1) Section 1322(b) of this Act is amended—

(1) by redesignating paragraph (3) as paragraph (4); and

(2) by inserting after paragraph (2), the following:

“(3) REPAYMENT OF LOANS AND GRANTS.—Not later than July 1, 2013, and prior to awarding loans and grants under the CO-OP program, the Secretary shall promulgate regulations with respect to the repayment of such loans and grants in a manner that is consistent with State solvency regulations and other similar State laws that may apply. In promulgating such regulations, the Secretary shall provide that such loans shall be repaid within 5 years and such grants shall be repaid within 15 years, taking into consideration any appropriate State reserve requirements, solvency regulations, and requisite surplus note arrangements that must be constructed in a State to provide for such

repayment prior to awarding such loans and grants.”.

(m) Part III of subtitle D of title I of this Act is amended by striking section 1323.

(n) Section 1324(a) of this Act is amended by striking “, a community health” and all that follows through “1333(b)” and inserting “, or a multi-State qualified health plan under section 1334”.

(o) Section 1331 of this Act is amended—

(1) in subsection (d)(3)(A)(i), by striking “85” and inserting “95”; and

(2) in subsection (e)(1)(B), by inserting before the semicolon the following: “, or, in the case of an alien lawfully present in the United States, whose income is not greater than 133 percent of the poverty line for the size of the family involved but who is not eligible for the Medicaid program under title XIX of the Social Security Act by reason of such alien status”.

(p) Section 1333 of this Act is amended by striking subsection (b).

(q) Part IV of subtitle D of title I of this Act is amended by adding at the end the following:

“SEC. 1334. MULTI-STATE PLANS.

“(a) OVERSIGHT BY THE OFFICE OF PERSONNEL MANAGEMENT.—

“(1) IN GENERAL.—The Director of the Office of Personnel Management (referred to in this section as the ‘Director’) shall enter into contracts with health insurance issuers (which may include a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark), without regard to section 5 of title 41, United States Code, or other statutes requiring competitive bidding, to offer at least 2 multi-State qualified health plans through each Exchange in each State. Such plans shall provide individual, or in the case of small employers, group coverage.

“(2) TERMS.—Each contract entered into under paragraph (1) shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party. In entering into such contracts, the Director shall ensure that health benefits coverage is provided in accordance with the types of coverage provided for under section 2701(a)(1)(A)(i) of the Public Health Service Act.

“(3) NON-PROFIT ENTITIES.—In entering into contracts under paragraph (1), the Director shall ensure that at least one contract is entered into with a non-profit entity.

“(4) ADMINISTRATION.—The Director shall implement this subsection in a manner similar to the manner in which the Director implements the contracting provisions with respect to carriers under the Federal employees health benefit program under chapter 89 of title 5, United States Code, including (through negotiating with each multi-state plan)—

“(A) a medical loss ratio;

“(B) a profit margin;

“(C) the premiums to be charged; and

“(D) such other terms and conditions of coverage as are in the interests of enrollees in such plans.

“(5) AUTHORITY TO PROTECT CONSUMERS.—The Director may prohibit the offering of any multi-State health plan that does not meet the terms and conditions defined by the Director with respect to the elements described in subparagraphs (A) through (D) of paragraph (4).

“(6) ASSURED AVAILABILITY OF VARIED COVERAGE.—In entering into contracts under this subsection, the Director shall ensure

that with respect to multi-State qualified health plans offered in an Exchange, there is at least one such plan that does not provide coverage of services described in section 1303(b)(1)(B)(i).

“(7) WITHDRAWAL.—Approval of a contract under this subsection may be withdrawn by the Director only after notice and opportunity for hearing to the issuer concerned without regard to subchapter II of chapter 5 and chapter 7 of title 5, United States Code.

“(b) ELIGIBILITY.—A health insurance issuer shall be eligible to enter into a contract under subsection (a)(1) if such issuer—

“(1) agrees to offer a multi-State qualified health plan that meets the requirements of subsection (c) in each Exchange in each State;

“(2) is licensed in each State and is subject to all requirements of State law not inconsistent with this section, including the standards and requirements that a State imposes that do not prevent the application of a requirement of part A of title XXVII of the Public Health Service Act or a requirement of this title;

“(3) otherwise complies with the minimum standards prescribed for carriers offering health benefits plans under section 8902(e) of title 5, United States Code, to the extent that such standards do not conflict with a provision of this title; and

“(4) meets such other requirements as determined appropriate by the Director, in consultation with the Secretary.

“(c) REQUIREMENTS FOR MULTI-STATE QUALIFIED HEALTH PLAN.—

“(1) IN GENERAL.—A multi-State qualified health plan meets the requirements of this subsection if, in the determination of the Director—

“(A) the plan offers a benefits package that is uniform in each State and consists of the essential benefits described in section 1302;

“(B) the plan meets all requirements of this title with respect to a qualified health plan, including requirements relating to the offering of the bronze, silver, and gold levels of coverage and catastrophic coverage in each State Exchange;

“(C) except as provided in paragraph (5), the issuer provides for determinations of premiums for coverage under the plan on the basis of the rating requirements of part A of title XXVII of the Public Health Service Act; and

“(D) the issuer offers the plan in all geographic regions, and in all States that have adopted adjusted community rating before the date of enactment of this Act.

“(2) STATES MAY OFFER ADDITIONAL BENEFITS.—Nothing in paragraph (1)(A) shall preclude a State from requiring that benefits in addition to the essential health benefits required under such paragraph be provided to enrollees of a multi-State qualified health plan offered in such State.

“(3) CREDITS.—

“(A) IN GENERAL.—An individual enrolled in a multi-State qualified health plan under this section shall be eligible for credits under section 36B of the Internal Revenue Code of 1986 and cost sharing assistance under section 1402 in the same manner as an individual who is enrolled in a qualified health plan.

“(B) NO ADDITIONAL FEDERAL COST.—A requirement by a State under paragraph (2) that benefits in addition to the essential health benefits required under paragraph (1)(A) be provided to enrollees of a multi-State qualified health plan shall not affect the amount of a premium tax credit provided under section 36B of the Internal Revenue Code of 1986 with respect to such plan.

“(4) STATE MUST ASSUME COST.—A State shall make payments—

“(A) to an individual enrolled in a multi-State qualified health plan offered in such State; or

“(B) on behalf of an individual described in subparagraph (A) directly to the multi-State qualified health plan in which such individual is enrolled; to defray the cost of any additional benefits described in paragraph (2).

“(5) APPLICATION OF CERTAIN STATE RATING REQUIREMENTS.—With respect to a multi-State qualified health plan that is offered in a State with age rating requirements that are lower than 3:1, the State may require that Exchanges operating in such State only permit the offering of such multi-State qualified health plans if such plans comply with the State’s more protective age rating requirements.

“(d) PLANS DEEMED TO BE CERTIFIED.—A multi-State qualified health plan that is offered under a contract under subsection (a) shall be deemed to be certified by an Exchange for purposes of section 1311(d)(4)(A).

“(e) PHASE-IN.—Notwithstanding paragraphs (1) and (2) of subsection (b), the Director shall enter into a contract with a health insurance issuer for the offering of a multi-State qualified health plan under subsection (a) if—

“(1) with respect to the first year for which the issuer offers such plan, such issuer offers the plan in at least 60 percent of the States;

“(2) with respect to the second such year, such issuer offers the plan in at least 70 percent of the States;

“(3) with respect to the third such year, such issuer offers the plan in at least 85 percent of the States; and

“(4) with respect to each subsequent year, such issuer offers the plan in all States.

“(f) APPLICABILITY.—The requirements under chapter 89 of title 5, United States Code, applicable to health benefits plans under such chapter shall apply to multi-State qualified health plans provided for under this section to the extent that such requirements do not conflict with a provision of this title.

“(g) CONTINUED SUPPORT FOR FEHBP.—

“(1) MAINTENANCE OF EFFORT.—Nothing in this section shall be construed to permit the Director to allocate fewer financial or personnel resources to the functions of the Office of Personnel Management related to the administration of the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.

“(2) SEPARATE RISK POOL.—Enrollees in multi-State qualified health plans under this section shall be treated as a separate risk pool apart from enrollees in the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.

“(3) AUTHORITY TO ESTABLISH SEPARATE ENTITIES.—The Director may establish such separate units or offices within the Office of Personnel Management as the Director determines to be appropriate to ensure that the administration of multi-State qualified health plans under this section does not interfere with the effective administration of the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.

“(4) EFFECTIVE OVERSIGHT.—The Director may appoint such additional personnel as may be necessary to enable the Director to carry out activities under this section.

“(5) ASSURANCE OF SEPARATE PROGRAM.—In carrying out this section, the Director shall ensure that the program under this section

is separate from the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code. Premiums paid for coverage under a multi-State qualified health plan under this section shall not be considered to be Federal funds for any purposes.

“(6) FEHBP PLANS NOT REQUIRED TO PARTICIPATE.—Nothing in this section shall require that a carrier offering coverage under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code, also offer a multi-State qualified health plan under this section.

“(h) ADVISORY BOARD.—The Director shall establish an advisory board to provide recommendations on the activities described in this section. A significant percentage of the members of such board shall be comprised of enrollees in a multi-State qualified health plan, or representatives of such enrollees.

“(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary to carry out this section.”.

(r) Section 1341 of this Act is amended—

(1) in the section heading, by striking “AND SMALL GROUP MARKETS” and inserting “MARKET”;

(2) in subsection (b)(2)(B), by striking “paragraph (1)(A)” and inserting “paragraph (1)(B)”;

(3) in subsection (c)(1)(A), by striking “and small group markets” and inserting “market”.

SEC. 10105. AMENDMENTS TO SUBTITLE E.

(a) Section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986, as added by section 1401(a) of this Act, is amended by striking “is in excess of” and inserting “equals or exceeds”.

(b) Section 36B(c)(1)(A) of the Internal Revenue Code of 1986, as added by section 1401(a) of this Act, is amended by inserting “equals or” before “exceeds”.

(c) Section 36B(c)(2)(C)(iv) of the Internal Revenue Code of 1986, as added by section 1401(a) of this Act, is amended by striking “subsection (b)(3)(A)(ii)” and inserting “subsection (b)(3)(A)(iii)”.

(d) Section 1401(d) of this Act is amended by adding at the end the following:

“(3) Section 6211(b)(4)(A) of the Internal Revenue Code of 1986 is amended by inserting ‘36B,’ after ‘36A.’”.

(e)(1) Subparagraph (B) of section 45R(d)(3) of the Internal Revenue Code of 1986, as added by section 1421(a) of this Act, is amended to read as follows:

“(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B) and subsection (c)(2)—

“(i) 2010, 2011, 2012, AND 2013.—The dollar amount in effect under this paragraph for taxable years beginning in 2010, 2011, 2012, or 2013 is \$25,000.

“(ii) SUBSEQUENT YEARS.—In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be equal to \$25,000, multiplied by the cost-of-living adjustment under section 1(f)(3) for the calendar year, determined by substituting ‘calendar year 2012’ for ‘calendar year 1992’ in subparagraph (B) thereof.”.

(2) Subsection (g) of section 45R of the Internal Revenue Code of 1986, as added by section 1421(a) of this Act, is amended by striking “2011” both places it appears and inserting “2010, 2011”.

(3) Section 280C(h) of the Internal Revenue Code of 1986, as added by section 1421(d)(1) of this Act, is amended by striking “2011” and inserting “2010, 2011”.

(4) Section 1421(f) of this Act is amended by striking “2010” both places it appears and inserting “2009”.

(5) The amendments made by this subsection shall take effect as if included in the enactment of section 1421 of this Act.

(f) Part I of subtitle E of title I of this Act is amended by adding at the end of subpart B, the following:

“SEC. 1416. STUDY OF GEOGRAPHIC VARIATION IN APPLICATION OF FPL.

“(a) IN GENERAL.—The Secretary shall conduct a study to examine the feasibility and implication of adjusting the application of the Federal poverty level under this subtitle (and the amendments made by this subtitle) for different geographic areas so as to reflect the variations in cost-of-living among different areas within the United States. If the Secretary determines that an adjustment is feasible, the study should include a methodology to make such an adjustment. Not later than January 1, 2013, the Secretary shall submit to Congress a report on such study and shall include such recommendations as the Secretary determines appropriate.

“(b) INCLUSION OF TERRITORIES.—

“(1) IN GENERAL.—The Secretary shall ensure that the study under subsection (a) covers the territories of the United States and that special attention is paid to the disparity that exists among poverty levels and the cost of living in such territories and to the impact of such disparity on efforts to expand health coverage and ensure health care.

“(2) TERRITORIES DEFINED.—In this subsection, the term ‘territories of the United States’ includes the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and any other territory or possession of the United States.”.

SEC. 10106. AMENDMENTS TO SUBTITLE F.

(a) Section 1501(a)(2) of this Act is amended to read as follows:

“(2) EFFECTS ON THE NATIONAL ECONOMY AND INTERSTATE COMMERCE.—The effects described in this paragraph are the following:

“(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

“(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from \$2,500,000,000,000, or 17.6 percent of the economy, in 2009 to \$4,700,000,000,000 in 2019. Private health insurance spending is projected to be \$854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

“(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

“(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has

strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

“(E) The economy loses up to \$207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

“(F) The cost of providing uncompensated care to the uninsured was \$43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over \$1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

“(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

“(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

“(I) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

“(J) Administrative costs for private health insurance, which were \$90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.”.

(b)(1) Section 5000A(b)(1) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended to read as follows:

“(1) IN GENERAL.—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).”.

(2) Paragraphs (1) and (2) of section 5000A(c) of the Internal Revenue Code of 1986, as so added, are amended to read as follows:

“(1) IN GENERAL.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

“(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

“(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

“(2) MONTHLY PENALTY AMOUNTS.—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/2 of the greater of the following amounts:

“(A) FLAT DOLLAR AMOUNT.—An amount equal to the lesser of—

“(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

“(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

“(B) PERCENTAGE OF INCOME.—An amount equal to the following percentage of the taxpayer's household income for the taxable year:

“(i) 0.5 percent for taxable years beginning in 2014.

“(ii) 1.0 percent for taxable years beginning in 2015.

“(iii) 2.0 percent for taxable years beginning after 2015.”

(3) Section 5000A(c)(3) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended by striking “\$350” and inserting “\$495”.

(c) Section 5000A(d)(2)(A) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended to read as follows:

“(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—

“(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

“(ii) an adherent of established tenets or teachings of such sect or division as described in such section.”

(d) Section 5000A(e)(1)(C) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended to read as follows:

“(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to required contribution of the employee.”

(e) Section 4980H(b) of the Internal Revenue Code of 1986, as added by section 1513(a) of this Act, is amended to read as follows:

“(b) LARGE EMPLOYERS WITH WAITING PERIODS EXCEEDING 60 DAYS.—

“(1) IN GENERAL.—In the case of any applicable large employer which requires an extended waiting period to enroll in any minimum essential coverage under an employer-sponsored plan (as defined in section 5000A(f)(2)), there is hereby imposed on the employer an assessable payment of \$600 for each full-time employee of the employer to whom the extended waiting period applies.

“(2) EXTENDED WAITING PERIOD.—The term ‘extended waiting period’ means any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) which exceeds 60 days.”

(f)(1) Subparagraph (A) of section 4980H(d)(4) of the Internal Revenue Code of 1986, as added by section 1513(a) of this Act, is amended by inserting “, with respect to any month,” after “means”.

(2) Section 4980H(d)(2) of the Internal Revenue Code of 1986, as added by section 1513(a) of this Act, is amended by adding at the end the following:

“(D) APPLICATION TO CONSTRUCTION INDUSTRY EMPLOYERS.—In the case of any employer the substantial annual gross receipts of which are attributable to the construction industry—

“(i) subparagraph (A) shall be applied by substituting ‘who employed an average of at least 5 full-time employees on business days during the preceding calendar year and whose annual payroll expenses exceed \$250,000 for such preceding calendar year’ for ‘who employed an average of at least 50 full-time employees on business days during the preceding calendar year’, and

“(ii) subparagraph (B) shall be applied by substituting ‘5’ for ‘50’.”

(3) The amendment made by paragraph (2) shall apply to months beginning after December 31, 2013.

(g) Section 6056(b) of the Internal Revenue Code of 1986, as added by section 1514(a) of the Act, is amended by adding at the end the following new flush sentence:

“The Secretary shall have the authority to review the accuracy of the information provided under this subsection, including the applicable large employer's share under paragraph (2)(C)(iv).”

SEC. 10107. AMENDMENTS TO SUBTITLE G.

(a) Section 1562 of this Act is amended, in the amendment made by subsection (a)(2)(B)(iii), by striking “subpart 1” and inserting “subparts I and II”; and

(b) Subtitle G of title I of this Act is amended—

(1) by redesignating section 1562 (as amended) as section 1563; and

(2) by inserting after section 1561 the following:

“SEC. 1562. GAO STUDY REGARDING THE RATE OF DENIAL OF COVERAGE AND ENROLLMENT BY HEALTH INSURANCE ISSUERS AND GROUP HEALTH PLANS.

“(a) IN GENERAL.—The Comptroller General of the United States (referred to in this section as the ‘Comptroller General’) shall conduct a study of the incidence of denials of coverage for medical services and denials of applications to enroll in health insurance plans, as described in subsection (b), by group health plans and health insurance issuers.

“(b) DATA.—

“(1) IN GENERAL.—In conducting the study described in subsection (a), the Comptroller General shall consider samples of data concerning the following:

“(A)(i) denials of coverage for medical services to a plan enrollees, by the types of services for which such coverage was denied; and

“(ii) the reasons such coverage was denied; and

“(B)(i) incidents in which group health plans and health insurance issuers deny the application of an individual to enroll in a health insurance plan offered by such group health plan or issuer; and

“(ii) the reasons such applications are denied.

“(2) SCOPE OF DATA.—

“(A) FAVORABLY RESOLVED DISPUTES.—The data that the Comptroller General considers under paragraph (1) shall include data concerning denials of coverage for medical services and denials of applications for enrollment in a plan by a group health plan or health insurance issuer, where such group health plan or health insurance issuer later approves such coverage or application.

“(B) ALL HEALTH PLANS.—The study under this section shall consider data from varied group health plans and health insurance plans offered by health insurance issuers, including qualified health plans and health plans that are not qualified health plans.

“(c) REPORT.—Not later than one year after the date of enactment of this Act, the Comptroller General shall submit to the Secretaries of Health and Human Services and Labor a report describing the results of the study conducted under this section.

“(d) PUBLICATION OF REPORT.—The Secretaries of Health and Human Services and Labor shall make the report described in subsection (c) available to the public on an Internet website.

“SEC. 1563. SMALL BUSINESS PROCUREMENT.

“Part 19 of the Federal Acquisition Regulation, section 15 of the Small Business Act (15 U.S.C. 644), and any other applicable laws or regulations establishing procurement requirements relating to small business concerns (as defined in section 3 of the Small Business Act (15 U.S.C. 632)) may not be waived with respect to any contract awarded under any program or other authority under this Act or an amendment made by this Act.”

SEC. 10108. FREE CHOICE VOUCHERS.

(a) IN GENERAL.—An offering employer shall provide free choice vouchers to each qualified employee of such employer.

(b) OFFERING EMPLOYER.—For purposes of this section, the term “offering employer” means any employer who—

(1) offers minimum essential coverage to its employees consisting of coverage through an eligible employer-sponsored plan; and

(2) pays any portion of the costs of such plan.

(c) QUALIFIED EMPLOYEE.—For purposes of this section—

(1) IN GENERAL.—The term “qualified employee” means, with respect to any plan year of an offering employer, any employee—

(A) whose required contribution (as determined under section 5000A(e)(1)(B)) for minimum essential coverage through an eligible employer-sponsored plan—

(i) exceeds 8 percent of such employee's household income for the taxable year described in section 1412(b)(1)(B) which ends with or within in the plan year; and

(ii) does not exceed 9.8 percent of such employee's household income for such taxable year;

(B) whose household income for such taxable year is not greater than 400 percent of the poverty line for a family of the size involved; and

(C) who does not participate in a health plan offered by the offering employer.

(2) INDEXING.—In the case of any calendar year beginning after 2014, the Secretary shall

adjust the 8 percent under paragraph (1)(A)(i) and 9.8 percent under paragraph (1)(A)(ii) for the calendar year to reflect the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(d) FREE CHOICE VOUCHER.—

(1) AMOUNT.—

(A) IN GENERAL.—The amount of any free choice voucher provided under subsection (a) shall be equal to the monthly portion of the cost of the eligible employer-sponsored plan which would have been paid by the employer if the employee were covered under the plan with respect to which the employer pays the largest portion of the cost of the plan. Such amount shall be equal to the amount the employer would pay for an employee with self-only coverage unless such employee elects family coverage (in which case such amount shall be the amount the employer would pay for family coverage).

(B) DETERMINATION OF COST.—The cost of any health plan shall be determined under the rules similar to the rules of section 2204 of the Public Health Service Act, except that such amount shall be adjusted for age and category of enrollment in accordance with regulations established by the Secretary.

(2) USE OF VOUCHERS.—An Exchange shall credit the amount of any free choice voucher provided under subsection (a) to the monthly premium of any qualified health plan in the Exchange in which the qualified employee is enrolled and the offering employer shall pay any amounts so credited to the Exchange.

(3) PAYMENT OF EXCESS AMOUNTS.—If the amount of the free choice voucher exceeds the amount of the premium of the qualified health plan in which the qualified employee is enrolled for such month, such excess shall be paid to the employee.

(e) OTHER DEFINITIONS.—Any term used in this section which is also used in section 5000A of the Internal Revenue Code of 1986 shall have the meaning given such term under such section 5000A.

(f) EXCLUSION FROM INCOME FOR EMPLOYEE.—

(1) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 139C the following new section:

“SEC. 139D. FREE CHOICE VOUCHERS.

“Gross income shall not include the amount of any free choice voucher provided by an employer under section 10108 of the Patient Protection and Affordable Care Act to the extent that the amount of such voucher does not exceed the amount paid for a qualified health plan (as defined in section 1301 of such Act) by the taxpayer.”.

(2) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of such Code is amended by inserting after the item relating to section 139C the following new item:

“Sec. 139D. Free choice vouchers.”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to vouchers provided after December 31, 2013.

(g) DEDUCTION ALLOWED TO EMPLOYER.—

(1) IN GENERAL.—Section 162(a) of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: “For purposes of paragraph (1), the amount of a free choice voucher provided under section 10108 of the Patient Protection and Affordable Care Act shall be treated as an amount for compensation for personal services actually rendered.”.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to vouchers provided after December 31, 2013.

(h) VOUCHER TAKEN INTO ACCOUNT IN DETERMINING PREMIUM CREDIT.—

(1) IN GENERAL.—Subsection (c)(2) of section 36B of the Internal Revenue Code of 1986, as added by section 1401, is amended by adding at the end the following new subparagraph:

“(D) EXCEPTION FOR INDIVIDUAL RECEIVING FREE CHOICE VOUCHERS.—The term ‘coverage month’ shall not include any month in which such individual has a free choice voucher provided under section 10108 of the Patient Protection and Affordable Care Act.”.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 2013.

(i) COORDINATION WITH EMPLOYER RESPONSIBILITIES.—

(1) SHARED RESPONSIBILITY PENALTY.—

(A) IN GENERAL.—Subsection (c) of section 4980H of the Internal Revenue Code of 1986, as added by section 1513, is amended by adding at the end the following new paragraph:

“(3) SPECIAL RULES FOR EMPLOYERS PROVIDING FREE CHOICE VOUCHERS.—No assessable payment shall be imposed under paragraph (1) for any month with respect to any employee to whom the employer provides a free choice voucher under section 10108 of the Patient Protection and Affordable Care Act for such month.”.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to months beginning after December 31, 2013.

(2) NOTIFICATION REQUIREMENT.—Section 18B(a)(3) of the Fair Labor Standards Act of 1938, as added by section 1512, is amended—

(A) by inserting “and the employer does not offer a free choice voucher” after “Exchange”; and

(B) by striking “will lose” and inserting “may lose”.

(j) EMPLOYER REPORTING.—

(1) IN GENERAL.—Subsection (a) of section 6056 of the Internal Revenue Code of 1986, as added by section 1514, is amended by inserting “and every offering employer” before “shall”.

(2) OFFERING EMPLOYERS.—Subsection (f) of section 6056 of such Code, as added by section 1514, is amended to read as follows:

“(f) DEFINITIONS.—For purposes of this section—

“(1) OFFERING EMPLOYER.—

“(A) IN GENERAL.—The term ‘offering employer’ means any offering employer (as defined in section 10108(b) of the Patient Protection and Affordable Care Act) if the required contribution (within the meaning of section 5000A(e)(1)(B)(i)) of any employee exceeds 8 percent of the wages (as defined in section 3121(a)) paid to such employee by such employer.

“(B) INDEXING.—In the case of any calendar year beginning after 2014, the 8 percent under subparagraph (A) shall be adjusted for the calendar year to reflect the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

“(2) OTHER DEFINITIONS.—Any term used in this section which is also used in section 4980H shall have the meaning given such term by section 4980H.”.

(3) CONFORMING AMENDMENTS.—

(A) The heading of section 6056 of such Code, as added by section 1514, is amended by striking “LARGE” and inserting “CERTAIN”.

(B) Section 6056(b)(2)(C) of such Code is amended—

(i) by inserting “in the case of an applicable large employer,” before “the length” in clause (i);

(ii) by striking “and” at the end of clause (iii);

(iii) by striking “applicable large employer” in clause (iv) and inserting “employer”;

(iv) by inserting “and” at the end of clause (iv); and

(v) by inserting at the end the following new clause:

“(v) in the case of an offering employer, the option for which the employer pays the largest portion of the cost of the plan and the portion of the cost paid by the employer in each of the enrollment categories under such option.”.

(C) Section 6056(d)(2) of such Code is amended by inserting “or offering employer” after “applicable large employer”.

(D) Section 6056(e) of such Code is amended by inserting “or offering employer” after “applicable large employer”.

(E) Section 6724(d)(1)(B)(xxv) of such Code, as added by section 1514, is amended by striking “large” and inserting “certain”.

(F) Section 6724(d)(2)(HH) of such Code, as added by section 1514, is amended by striking “large” and inserting “certain”.

(G) The table of sections for subpart D of part III of subchapter A of chapter 1 of such Code, as amended by section 1514, is amended by striking “Large employers” in the item relating to section 6056 and inserting “Certain employers”.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to periods beginning after December 31, 2013.

SEC. 10109. DEVELOPMENT OF STANDARDS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.

(a) ADDITIONAL TRANSACTION STANDARDS AND OPERATING RULES.—

(1) DEVELOPMENT OF ADDITIONAL TRANSACTION STANDARDS AND OPERATING RULES.—Section 1173(a) of the Social Security Act (42 U.S.C. 1320d-2(a)), as amended by section 1104(b)(2), is amended—

(A) in paragraph (1)(B), by inserting before the period the following: “, and subject to the requirements under paragraph (5)”; and

(B) by adding at the end the following new paragraph:

“(5) CONSIDERATION OF STANDARDIZATION OF ACTIVITIES AND ITEMS.—

“(A) IN GENERAL.—For purposes of carrying out paragraph (1)(B), the Secretary shall solicit, not later than January 1, 2012, and not less than every 3 years thereafter, input from entities described in subparagraph (B) on—

“(i) whether there could be greater uniformity in financial and administrative activities and items, as determined appropriate by the Secretary; and

“(ii) whether such activities should be considered financial and administrative transactions (as described in paragraph (1)(B)) for which the adoption of standards and operating rules would improve the operation of the health care system and reduce administrative costs.

“(B) SOLICITATION OF INPUT.—For purposes of subparagraph (A), the Secretary shall seek input from—

“(i) the National Committee on Vital and Health Statistics, the Health Information Technology Policy Committee, and the Health Information Technology Standards Committee; and

“(ii) standard setting organizations and stakeholders, as determined appropriate by the Secretary.”.

(b) ACTIVITIES AND ITEMS FOR INITIAL CONSIDERATION.—For purposes of section 1173(a)(5) of the Social Security Act, as added by subsection (a), the Secretary of Health and Human Services (in this section referred

to as the “Secretary”) shall, not later than January 1, 2012, seek input on activities and items relating to the following areas:

(1) Whether the application process, including the use of a uniform application form, for enrollment of health care providers by health plans could be made electronic and standardized.

(2) Whether standards and operating rules described in section 1173 of the Social Security Act should apply to the health care transactions of automobile insurance, worker’s compensation, and other programs or persons not described in section 1172(a) of such Act (42 U.S.C. 1320d–1(a)).

(3) Whether standardized forms could apply to financial audits required by health plans, Federal and State agencies (including State auditors, the Office of the Inspector General of the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services), and other relevant entities as determined appropriate by the Secretary.

(4) Whether there could be greater transparency and consistency of methodologies and processes used to establish claim edits used by health plans (as described in section 1171(5) of the Social Security Act (42 U.S.C. 1320d(5))).

(5) Whether health plans should be required to publish their timelines of payment rules.

(c) ICD CODING CROSSWALKS.—

(1) ICD-9 TO ICD-10 CROSSWALK.—The Secretary shall task the ICD-9-CM Coordination and Maintenance Committee to convene a meeting, not later than January 1, 2011, to receive input from appropriate stakeholders (including health plans, health care providers, and clinicians) regarding the crosswalk between the Ninth and Tenth Revisions of the International Classification of Diseases (ICD-9 and ICD-10, respectively) that is posted on the website of the Centers for Medicare & Medicaid Services, and make recommendations about appropriate revisions to such crosswalk.

(2) REVISION OF CROSSWALK.—For purposes of the crosswalk described in paragraph (1), the Secretary shall make appropriate revisions and post any such revised crosswalk on the website of the Centers for Medicare & Medicaid Services.

(3) USE OF REVISED CROSSWALK.—For purposes of paragraph (2), any revised crosswalk shall be treated as a code set for which a standard has been adopted by the Secretary for purposes of section 1173(c)(1)(B) of the Social Security Act (42 U.S.C. 1320d–2(c)(1)(B)).

(4) SUBSEQUENT CROSSWALKS.—For subsequent revisions of the International Classification of Diseases that are adopted by the Secretary as a standard code set under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)), the Secretary shall, after consultation with the appropriate stakeholders, post on the website of the Centers for Medicare & Medicaid Services a crosswalk between the previous and subsequent version of the International Classification of Diseases not later than the date of implementation of such subsequent revision.

**Subtitle B—Provisions Relating to Title II
PART I—MEDICAID AND CHIP**

SEC. 10201. AMENDMENTS TO THE SOCIAL SECURITY ACT AND TITLE II OF THIS ACT.

(a)(1) Section 1902(a)(10)(A)(i)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IX)), as added by section 2004(a), is amended to read as follows:

“(IX) who—

“(aa) are under 26 years of age;

“(bb) are not described in or enrolled under any of subclauses (I) through (VII) of this

clause or are described in any of such subclauses but have income that exceeds the level of income applicable under the State plan for eligibility to enroll for medical assistance under such subclause;

“(cc) were in foster care under the responsibility of the State on the date of attaining 18 years of age or such higher age as the State has elected under section 475(8)(B)(iii); and

“(dd) were enrolled in the State plan under this title or under a waiver of the plan while in such foster care;”.

(2) Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)), as amended by section 2001(a)(5)(A), is amended in the matter following subparagraph (G), by striking “and (XV)” and inserting “(XV)”, and by inserting “and (XVI) if an individual is described in subclause (IX) of subparagraph (A)(i) and is also described in subclause (VIII) of that subparagraph, the medical assistance shall be made available to the individual through subclause (IX) instead of through subclause (VIII)” before the semicolon.

(3) Section 2004(d) of this Act is amended by striking “2019” and inserting “2014”.

(b) Section 1902(k)(2) of the Social Security Act (42 U.S.C. 1396a(k)(2)), as added by section 2001(a)(4)(A), is amended by striking “January 1, 2011” and inserting “April 1, 2010”.

(c) Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3), 2001(a)(5)(C), 2006, and 4107(a)(2), is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by inserting in clause (xiv), “or 1902(a)(10)(A)(i)(IX)” before the comma;

(2) in subsection (b), in the first sentence, by inserting “, (z),” before “and (aa)”;

(3) in subsection (y)—

(A) in paragraph (1)(B)(ii)(II), in the first sentence, by inserting “includes inpatient hospital services,” after “100 percent of the poverty line, that”; and

(B) in paragraph (2)(A), by striking “on the date of enactment of the Patient Protection and Affordable Care Act” and inserting “as of December 1, 2009”;

(4) by inserting after subsection (y) the following:

“(z) **EQUITABLE SUPPORT FOR CERTAIN STATES.**—

“(1)(A) During the period that begins on January 1, 2014, and ends on September 30, 2019, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to a fiscal year occurring during that period shall be increased by 2.2 percentage points for any State described in subparagraph (B) for amounts expended for medical assistance for individuals who are not newly eligible (as defined in subsection (y)(2)) individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).

“(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

“(i) is an expansion State described in subsection (y)(1)(B)(ii)(II);

“(ii) the Secretary determines will not receive any payments under this title on the basis of an increased Federal medical assistance percentage under subsection (y) for expenditures for medical assistance for newly eligible individuals (as so defined); and

“(iii) has not been approved by the Secretary to divert a portion of the DSH allotment for a State to the costs of providing medical assistance or other health benefits

coverage under a waiver that is in effect on July 2009.

“(2)(A) During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to all or any portion of a fiscal year occurring during that period shall be increased by .5 percentage point for a State described in subparagraph (B) for amounts expended for medical assistance under the State plan under this title or under a waiver of that plan during that period.

“(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

“(i) is described in clauses (i) and (ii) of paragraph (1)(B); and

“(ii) is the State with the highest percentage of its population insured during 2008, based on the Current Population Survey.

“(3) Notwithstanding subsection (b) and paragraphs (1) and (2) of this subsection, the Federal medical assistance percentage otherwise determined under subsection (b) with respect to all or any portion of a fiscal year that begins on or after January 1, 2017, for the State of Nebraska, with respect to amounts expended for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be determined as provided for under subsection (y)(1)(A) (notwithstanding the period provided for in such paragraph).

“(4) The increase in the Federal medical assistance percentage for a State under paragraphs (1), (2), or (3) shall apply only for purposes of this title and shall not apply with respect to—

“(A) disproportionate share hospital payments described in section 1923;

“(B) payments under title IV;

“(C) payments under title XXI; and

“(D) payments under this title that are based on the enhanced FMAP described in section 2105(b).”;

(5) in subsection (aa), is amended by striking “without regard to this subsection and subsection (y)” and inserting “without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act” each place it appears;

(6) by adding after subsection (bb), the following:

“(cc) **REQUIREMENT FOR CERTAIN STATES.**—Notwithstanding subsections (y), (z), and (aa), in the case of a State that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures required under the State plan under section 1902(a)(2), the State shall not be eligible for an increase in its Federal medical assistance percentage under such subsections if it requires that political subdivisions pay a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1923, than the respective percentages that would have been required by the State under the State plan under this title, State law, or both, as in effect on December 31, 2009, and without regard to any such increase. Voluntary contributions by a political subdivision to the non-Federal share of expenditures under the State plan under this title or to the non-Federal share of payments under section 1923, shall not be considered to be required contributions for purposes of this subsection. The treatment of voluntary contributions, and the treatment of contributions required by a State under the State plan under this

title, or State law, as provided by this subsection, shall also apply to the increases in the Federal medical assistance percentage under section 5001 of the American Recovery and Reinvestment Act of 2009.”.

(d) Section 1108(g)(4)(B) of the Social Security Act (42 U.S.C. 1308(g)(4)(B)), as added by section 2005(b), is amended by striking “income eligibility level in effect for that population under title XIX or under a waiver” and inserting “the highest income eligibility level in effect for parents under the commonwealth’s or territory’s State plan under title XIX or under a waiver of the plan”.

(e)(1) Section 1923(f) of the Social Security Act (42 U.S.C. 1396r-4(f)), as amended by section 2551, is amended—

(A) in paragraph (6)—

(i) by striking the paragraph heading and inserting the following: “ALLOTMENT ADJUSTMENTS”; and

(ii) in subparagraph (B), by adding at the end the following:

“(iii) ALLOTMENT FOR 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012, FISCAL YEAR 2013, AND SUCCEEDING FISCAL YEARS.—Notwithstanding the table set forth in paragraph (2) or paragraph (7):

“(I) 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012.—The DSH allotment for Hawaii for the 2d, 3rd, and 4th quarters of fiscal year 2012 shall be \$7,500,000.

“(II) TREATMENT AS A LOW-DSH STATE FOR FISCAL YEAR 2013 AND SUCCEEDING FISCAL YEARS.—With respect to fiscal year 2013, and each fiscal year thereafter, the DSH allotment for Hawaii shall be increased in the same manner as allotments for low DSH States are increased for such fiscal year under clause (iii) of paragraph (5)(B).

“(III) CERTAIN HOSPITAL PAYMENTS.—The Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST section 1115 Demonstration Project except to the extent that such limitation is necessary to ensure that a hospital does not receive payments in excess of the amounts described in subsection (g), or as necessary to ensure that such payments under the waiver and such payments pursuant to the allotment provided in this clause do not, in the aggregate in any year, exceed the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project.”; and

(B) in paragraph (7)—

(i) in subparagraph (A), in the matter preceding clause (i), by striking “subparagraph (E)” and inserting “subparagraphs (E) and (G)”;

(ii) in subparagraph (B)—

(I) in clause (i), by striking subclauses (I) and (II), and inserting the following:

“(I) if the State is a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 25 percent;

“(II) if the State is a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 17.5 percent;

“(III) if the State is not a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allot-

ments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 50 percent; and

“(IV) if the State is not a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 35 percent.”;

(II) in clause (ii), by striking subclauses (I) and (II), and inserting the following:

“(I) if the State is a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 27.5 percent;

“(II) if the State is a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 20 percent;

“(III) if the State is not a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 55 percent; and

“(IV) if the State is not a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 40 percent.”;

(III) in subparagraph (E), by striking “35 percent” and inserting “50 percent”; and

(IV) by adding at the end the following:

“(G) NONAPPLICATION.—The preceding provisions of this paragraph shall not apply to the DSH allotment determined for the State of Hawaii for a fiscal year under paragraph (6).”.

(f) Section 2551 of this Act is amended by striking subsection (b).

(g) Section 2105(d)(3)(B) of the Social Security Act (42 U.S.C. 1397ee(d)(3)(B)), as added by section 2101(b)(1), is amended by adding at the end the following: “For purposes of eligibility for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 and reduced cost-sharing under section 1402 of the Patient Protection and Affordable Care Act, children described in the preceding sentence shall be deemed to be ineligible for coverage under the State child health plan.”.

(h) Clause (i) of subparagraph (C) of section 513(b)(2) of the Social Security Act, as added by section 2953 of this Act, is amended to read as follows:

“(i) Healthy relationships, including marriage and family interactions.”.

(i) Section 1115 of the Social Security Act (42 U.S.C. 1315) is amended by inserting after subsection (c) the following:

“(d)(1) An application or renewal of any experimental, pilot, or demonstration project undertaken under subsection (a) to promote the objectives of title XIX or XXI in a State that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to a State program under title XIX or XXI (in this subsection referred to as a ‘demonstration project’) shall be considered by the Secretary in accordance with the regulations required to be promulgated under paragraph (2).

“(2) Not later than 180 days after the date of enactment of this subsection, the Secretary shall promulgate regulations relating to applications for, and renewals of, a demonstration project that provide for—

“(A) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

“(B) requirements relating to—

“(i) the goals of the program to be implemented or renewed under the demonstration project;

“(ii) the expected State and Federal costs and coverage projections of the demonstration project; and

“(iii) the specific plans of the State to ensure that the demonstration project will be in compliance with title XIX or XXI;

“(C) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input;

“(D) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the demonstration project; and

“(E) a process for the periodic evaluation by the Secretary of the demonstration project.

“(3) The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for demonstration projects under this section.”.

(j) Subtitle F of title III of this Act is amended by adding at the end the following: **“SEC. 3512. GAO STUDY AND REPORT ON CAUSES OF ACTION.**

“(a) STUDY.—

“(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of whether the development, recognition, or implementation of any guideline or other standards under a provision described in paragraph (2) would result in the establishment of a new cause of action or claim.

“(2) PROVISIONS DESCRIBED.—The provisions described in this paragraph include the following:

“(A) Section 2701 (adult health quality measures).

“(B) Section 2702 (payment adjustments for health care acquired conditions).

“(C) Section 3001 (Hospital Value-Based Purchase Program).

“(D) Section 3002 (improvements to the Physician Quality Reporting Initiative).

“(E) Section 3003 (improvements to the Physician Feedback Program).

“(F) Section 3007 (value based payment modifier under physician fee schedule).

“(G) Section 3008 (payment adjustment for conditions acquired in hospitals).

“(H) Section 3013 (quality measure development).

“(I) Section 3014 (quality measurement).

“(J) Section 3021 (Establishment of Center for Medicare and Medicaid Innovation).

“(K) Section 3025 (hospital readmission reduction program).

“(L) Section 3501 (health care delivery system research, quality improvement).

“(M) Section 4003 (Task Force on Clinical and Preventive Services).

“(N) Section 4301 (research to optimize delivery of public health services).

“(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General of the United States shall submit to the appropriate committees of Congress, a report containing the findings made by the Comptroller General under the study under subsection (a).”.

SEC. 10202. INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES.

(a) **STATE BALANCING INCENTIVE PAYMENTS PROGRAM.**—Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), in the case of a balancing incentive payment State, as defined in subsection (b), that meets the conditions described in subsection (c), during the balancing incentive period, the Federal medical assistance percentage determined for the State under section 1905(b) of such Act and, if applicable, increased under subsection (z) or (aa) shall be increased by the applicable percentage points determined under subsection (d) with respect to eligible medical assistance expenditures described in subsection (e).

(b) **BALANCING INCENTIVE PAYMENT STATE.**—A balancing incentive payment State is a State—

(1) in which less than 50 percent of the total expenditures for medical assistance under the State Medicaid program for a fiscal year for long-term services and supports (as defined by the Secretary under subsection (f)(1)) are for non-institutionally-based long-term services and supports described in subsection (f)(1)(B);

(2) that submits an application and meets the conditions described in subsection (c); and

(3) that is selected by the Secretary to participate in the State balancing incentive payment program established under this section.

(c) **CONDITIONS.**—The conditions described in this subsection are the following:

(1) **APPLICATION.**—The State submits an application to the Secretary that includes, in addition to such other information as the Secretary shall require—

(A) a proposed budget that details the State's plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program during the balancing incentive period and achieve the target spending percentage applicable to the State under paragraph (2), including through structural changes to how the State furnishes such assistance, such as through the establishment of a “no wrong door - single entry point system”, optional presumptive eligibility, case management services, and the use of core standardized assessment instruments, and that includes a description of the new or expanded offerings of such services that the State will provide and the projected costs of such services; and

(B) in the case of a State that proposes to expand the provision of home and community-based services under its State Medicaid program through a State plan amendment under section 1915(i) of the Social Security Act, at the option of the State, an election to increase the income eligibility for such services from 150 percent of the poverty line to such higher percentage as the State may establish for such purpose, not to exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1)

of the Social Security Act (42 U.S.C. 1382(b)(1)).

(2) **TARGET SPENDING PERCENTAGES.**—

(A) In the case of a balancing incentive payment State in which less than 25 percent of the total expenditures for long-term services and supports under the State Medicaid program for fiscal year 2009 are for home and community-based services, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 25 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.

(B) In the case of any other balancing incentive payment State, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 50 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.

(3) **MAINTENANCE OF ELIGIBILITY REQUIREMENTS.**—The State does not apply eligibility standards, methodologies, or procedures for determining eligibility for medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program that are more restrictive than the eligibility standards, methodologies, or procedures in effect for such purposes on December 31, 2010.

(4) **USE OF ADDITIONAL FUNDS.**—The State agrees to use the additional Federal funds paid to the State as a result of this section only for purposes of providing new or expanded offerings of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program.

(5) **STRUCTURAL CHANGES.**—The State agrees to make, not later than the end of the 6-month period that begins on the date the State submits an application under this section, the following changes:

(A) **“NO WRONG DOOR - SINGLE ENTRY POINT SYSTEM”.**—Development of a statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that shall provide information regarding the availability of such services, how to apply for such services, referral services for services and supports otherwise available in the community, and determinations of financial and functional eligibility for such services and supports, or assistance with assessment processes for financial and functional eligibility.

(B) **CONFLICT-FREE CASE MANAGEMENT SERVICES.**—Conflict-free case management services to develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary's caregivers) in directing the provision of services and supports for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary's needs and achieve intended outcomes.

(C) **CORE STANDARDIZED ASSESSMENT INSTRUMENTS.**—Development of core standardized assessment instruments for determining eligibility for non-institutionally-based long-term services and supports described in subsection (f)(1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs.

(6) **DATA COLLECTION.**—The State agrees to collect from providers of services and

through such other means as the State determines appropriate the following data:

(A) **SERVICES DATA.**—Services data from providers of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) on a per-beneficiary basis and in accordance with such standardized coding procedures as the State shall establish in consultation with the Secretary.

(B) **QUALITY DATA.**—Quality data on a selected set of core quality measures agreed upon by the Secretary and the State that are linked to population-specific outcomes measures and accessible to providers.

(C) **OUTCOMES MEASURES.**—Outcomes measures data on a selected set of core population-specific outcomes measures agreed upon by the Secretary and the State that are accessible to providers and include—

(i) measures of beneficiary and family caregiver experience with providers;

(ii) measures of beneficiary and family caregiver satisfaction with services; and

(iii) measures for achieving desired outcomes appropriate to a specific beneficiary, including employment, participation in community life, health stability, and prevention of loss in function.

(d) **APPLICABLE PERCENTAGE POINTS INCREASE IN FMAP.**—The applicable percentage points increase is—

(1) in the case of a balancing incentive payment State subject to the target spending percentage described in subsection (c)(2)(A), 5 percentage points; and

(2) in the case of any other balancing incentive payment State, 2 percentage points.

(e) **ELIGIBLE MEDICAL ASSISTANCE EXPENDITURES.**—

(1) **IN GENERAL.**—Subject to paragraph (2), medical assistance described in this subsection is medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) that is provided by a balancing incentive payment State under its State Medicaid program during the balancing incentive payment period.

(2) **LIMITATION ON PAYMENTS.**—In no case may the aggregate amount of payments made by the Secretary to balancing incentive payment States under this section during the balancing incentive period exceed \$3,000,000,000.

(f) **DEFINITIONS.**—In this section:

(1) **LONG-TERM SERVICES AND SUPPORTS DEFINED.**—The term “long-term services and supports” has the meaning given that term by Secretary and may include any of the following (as defined for purposes of State Medicaid programs):

(A) **INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.**—Services provided in an institution, including the following:

(i) Nursing facility services.

(ii) Services in an intermediate care facility for the mentally retarded described in subsection (a)(15) of section 1905 of such Act.

(B) **NON-INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.**—Services not provided in an institution, including the following:

(i) Home and community-based services provided under subsection (c), (d), or (i) of section 1915 of such Act or under a waiver under section 1115 of such Act.

(ii) Home health care services.

(iii) Personal care services.

(iv) Services described in subsection (a)(26) of section 1905 of such Act (relating to PACE program services).

(v) Self-directed personal assistance services described in section 1915(j) of such Act.

(2) **BALANCING INCENTIVE PERIOD.**—The term “balancing incentive period” means the period that begins on October 1, 2011, and ends on September 30, 2015.

(3) **POVERTY LINE.**—The term “poverty line” has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

(4) **STATE MEDICAID PROGRAM.**—The term “State Medicaid program” means the State program for medical assistance provided under a State plan under title XIX of the Social Security Act and under any waiver approved with respect to such State plan.

SEC. 10203. EXTENSION OF FUNDING FOR CHIP THROUGH FISCAL YEAR 2015 AND OTHER CHIP-RELATED PROVISIONS.

(a) Section 1311(c)(1) of this Act is amended by striking “and” at the end of subparagraph (G), by striking the period at the end of subparagraph (H) and inserting “; and”, and by adding at the end the following:

“(I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act.”.

(b) Effective as if included in the enactment of the Children’s Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3):

(1) Section 1906(e)(2) of the Social Security Act (42 U.S.C. 1396e(e)(2)) is amended by striking “means” and all that follows through the period and inserting “has the meaning given that term in section 2105(c)(3)(A).”.

(2)(A) Section 1906A(a) of the Social Security Act (42 U.S.C. 1396e–1(a)), is amended by inserting before the period the following: “and the offering of such a subsidy is cost-effective, as defined for purposes of section 2105(c)(3)(A).”.

(B) This Act shall be applied without regard to subparagraph (A) of section 2003(a)(1) of this Act and that subparagraph and the amendment made by that subparagraph are hereby deemed null, void, and of no effect.

(3) Section 2105(c)(10) of the Social Security Act (42 U.S.C. 1397ee(c)(10)) is amended—

(A) in subparagraph (A), in the first sentence, by inserting before the period the following: “if the offering of such a subsidy is cost-effective, as defined for purposes of paragraph (3)(A)”;

(B) by striking subparagraph (M); and

(C) by redesignating subparagraph (N) as subparagraph (M).

(4) Section 2105(c)(3)(A) of the Social Security Act (42 U.S.C. 1397ee(c)(3)(A)) is amended—

(A) in the matter preceding clause (i), by striking “to” and inserting “to—”; and

(B) in clause (ii), by striking the period and inserting a semicolon.

(c) Section 2105 of the Social Security Act (42 U.S.C. 1397ee), as amended by section 2101, is amended—

(1) in subsection (b), in the second sentence, by striking “2013” and inserting “2015”; and

(2) in subsection (d)(3)—

(A) in subparagraph (A)—

(i) in the first sentence, by inserting “as a condition of receiving payments under section 1903(a),” after “2019,”;

(ii) in clause (i), by striking “or” at the end;

(iii) by redesignating clause (ii) as clause (iii); and

(iv) by inserting after clause (i), the following:

“(ii) after September 30, 2015, enrolling children eligible to be targeted low-income

children under the State child health plan in a qualified health plan that has been certified by the Secretary under subparagraph (C); or”;

(B) in subparagraph (B), by striking “provided coverage” and inserting “screened for eligibility for medical assistance under the State plan under title XIX or a waiver of that plan and, if found eligible, enrolled in such plan or a waiver. In the case of such children who, as a result of such screening, are determined to not be eligible for medical assistance under the State plan or a waiver under title XIX, the State shall establish procedures to ensure that the children are enrolled in a qualified health plan that has been certified by the Secretary under subparagraph (C) and is offered”; and

(C) by adding at the end the following:

“(C) **CERTIFICATION OF COMPARABILITY OF PEDIATRIC COVERAGE OFFERED BY QUALIFIED HEALTH PLANS.**—With respect to each State, the Secretary, not later than April 1, 2015, shall review the benefits offered for children and the cost-sharing imposed with respect to such benefits by qualified health plans offered through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act and shall certify those plans that offer benefits for children and impose cost-sharing with respect to such benefits that the Secretary determines are at least comparable to the benefits offered and cost-sharing protections provided under the State child health plan.”.

(d)(1) Section 2104(a) of such Act (42 U.S.C. 1397dd(a)) is amended—

(A) in paragraph (15), by striking “and” at the end; and

(B) by striking paragraph (16) and inserting the following:

“(16) for fiscal year 2013, \$17,406,000,000;

“(17) for fiscal year 2014, \$19,147,000,000; and

“(18) for fiscal year 2015, for purposes of making 2 semi-annual allotments—

“(A) \$2,850,000,000 for the period beginning on October 1, 2014, and ending on March 31, 2015, and

“(B) \$2,850,000,000 for the period beginning on April 1, 2015, and ending on September 30, 2015.”.

(2)(A) Section 2104(m) of such Act (42 U.S.C. 1397dd(m)), as amended by section 2102(a)(1), is amended—

(i) in the subsection heading, by striking “2013” and inserting “2015”; and

(ii) in paragraph (2)—

(I) in the paragraph heading, by striking “2012” and inserting “2014”; and

(II) by adding at the end the following:

“(B) **FISCAL YEARS 2013 AND 2014.**—Subject to paragraphs (4) and (6), from the amount made available under paragraphs (16) and (17) of subsection (a) for fiscal years 2013 and 2014, respectively, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for each such fiscal year as follows:

“(i) **REBASING IN FISCAL YEAR 2013.**—For fiscal year 2013, the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2012 (including payments made to the State under subsection (n) for fiscal year 2012 as well as amounts redistributed to the State in fiscal year 2012), multiplied by the allotment increase factor under paragraph (5) for fiscal year 2013.

“(ii) **GROWTH FACTOR UPDATE FOR FISCAL YEAR 2014.**—For fiscal year 2014, the allotment of the State is equal to the sum of—

“(I) the amount of the State allotment under clause (i) for fiscal year 2013; and

“(II) the amount of any payments made to the State under subsection (n) for fiscal year 2013,

multiplied by the allotment increase factor under paragraph (5) for fiscal year 2014.”;

(iii) in paragraph (3)—

(I) in the paragraph heading, by striking “2013” and inserting “2015”; and

(II) in subparagraphs (A) and (B), by striking “paragraph (16)” each place it appears and inserting “paragraph (18)”;

(III) in subparagraph (C)—

(aa) by striking “2012” each place it appears and inserting “2014”; and

(bb) by striking “2013” and inserting “2015”; and

(IV) in subparagraph (D)—

(aa) in clause (i)(I), by striking “subsection (a)(16)(A)” and inserting “subsection (a)(18)(A)”; and

(bb) in clause (ii)(II), by striking “subsection (a)(16)(B)” and inserting “subsection (a)(18)(B)”;

(iv) in paragraph (4), by striking “2013” and inserting “2015”; and

(v) in paragraph (6)—

(I) in subparagraph (A), by striking “2013” and inserting “2015”; and

(II) in the flush language after and below subparagraph (B)(ii), by striking “or fiscal year 2012” and inserting “, fiscal year 2012, or fiscal year 2014”; and

(vi) in paragraph (8)—

(I) in the paragraph heading, by striking “2013” and inserting “2015”; and

(II) by striking “2013” and inserting “2015”.

(B) Section 2104(n) of such Act (42 U.S.C. 1397dd(n)) is amended—

(i) in paragraph (2)—

(I) in subparagraph (A)(ii)—

(aa) by striking “2012” and inserting “2014”; and

(bb) by striking “2013” and inserting “2015”; and

(II) in subparagraph (B)—

(aa) by striking “2012” and inserting “2014”; and

(bb) by striking “2013” and inserting “2015”; and

(ii) in paragraph (3)(A), by striking “or a semi-annual allotment period for fiscal year 2013” and inserting “fiscal year 2013, fiscal year 2014, or a semi-annual allotment period for fiscal year 2015”.

(C) Section 2105(g)(4) of such Act (42 U.S.C. 1397ee(g)(4)) is amended—

(i) in the paragraph heading, by striking “2013” and inserting “2015”; and

(ii) in subparagraph (A), by striking “2013” and inserting “2015”.

(D) Section 2110(b) of such Act (42 U.S.C. 1397jj(b)) is amended—

(i) in paragraph (2)(B), by inserting “except as provided in paragraph (6),” before “a child”; and

(ii) by adding at the end the following new paragraph:

“(6) **EXCEPTIONS TO EXCLUSION OF CHILDREN OF EMPLOYEES OF A PUBLIC AGENCY IN THE STATE.**—

“(A) **IN GENERAL.**—A child shall not be considered to be described in paragraph (2)(B) if—

“(i) the public agency that employs a member of the child’s family to which such paragraph applies satisfies subparagraph (B); or

“(ii) subparagraph (C) applies to such child.

“(B) **MAINTENANCE OF EFFORT WITH RESPECT TO PER PERSON AGENCY CONTRIBUTION FOR FAMILY COVERAGE.**—For purposes of subparagraph (A)(i), a public agency satisfies this

subparagraph if the amount of annual agency expenditures made on behalf of each employee enrolled in health coverage paid for by the agency that includes dependent coverage for the most recent State fiscal year is not less than the amount of such expenditures made by the agency for the 1997 State fiscal year, increased by the percentage increase in the medical care expenditure category of the Consumer Price Index for All-Urban Consumers (all items: U.S. City Average) for such preceding fiscal year.

“(C) **HARDSHIP EXCEPTION.**—For purposes of subparagraph (A)(ii), this subparagraph applies to a child if the State determines, on a case-by-case basis, that the annual aggregate amount of premiums and cost-sharing imposed for coverage of the family of the child would exceed 5 percent of such family’s income for the year involved.”.

(E) Section 2113 of such Act (42 U.S.C. 1397mm) is amended—

(i) in subsection (a)(1), by striking “2013” and inserting “2015”; and

(ii) in subsection (g), by striking “\$100,000,000 for the period of fiscal years 2009 through 2013” and inserting “\$140,000,000 for the period of fiscal years 2009 through 2015”.

(F) Section 108 of Public Law 111-3 is amended by striking “\$11,706,000,000” and all that follows through the second sentence and inserting “\$15,361,000,000 to accompany the allotment made for the period beginning on October 1, 2014, and ending on March 31, 2015, under section 2104(a)(18)(A) of the Social Security Act (42 U.S.C. 1397dd(a)(18)(A)), to remain available until expended. Such amount shall be used to provide allotments to States under paragraph (3) of section 2104(m) of the Social Security Act (42 U.S.C. 1397dd(m)) for the first 6 months of fiscal year 2015 in the same manner as allotments are provided under subsection (a)(18)(A) of such section 2104 and subject to the same terms and conditions as apply to the allotments provided from such subsection (a)(18)(A).”.

PART II—SUPPORT FOR PREGNANT AND PARENTING TEENS AND WOMEN

SEC. 10211. DEFINITIONS.

In this part:

(1) **ACCOMPANIMENT.**—The term “accompaniment” means assisting, representing, and accompanying a woman in seeking judicial relief for child support, child custody, restraining orders, and restitution for harm to persons and property, and in filing criminal charges, and may include the payment of court costs and reasonable attorney and witness fees associated therewith.

(2) **ELIGIBLE INSTITUTION OF HIGHER EDUCATION.**—The term “eligible institution of higher education” means an institution of higher education (as such term is defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001)) that has established and operates, or agrees to establish and operate upon the receipt of a grant under this part, a pregnant and parenting student services office.

(3) **COMMUNITY SERVICE CENTER.**—The term “community service center” means a nonprofit organization that provides social services to residents of a specific geographical area via direct service or by contract with a local governmental agency.

(4) **HIGH SCHOOL.**—The term “high school” means any public or private school that operates grades 10 through 12, inclusive, grades 9 through 12, inclusive or grades 7 through 12, inclusive.

(5) **INTERVENTION SERVICES.**—The term “intervention services” means, with respect to domestic violence, sexual violence, sexual assault, or stalking, 24-hour telephone hot-

line services for police protection and referral to shelters.

(6) **SECRETARY.**—The term “Secretary” means the Secretary of Health and Human Services.

(7) **STATE.**—The term “State” includes the District of Columbia, any commonwealth, possession, or other territory of the United States, and any Indian tribe or reservation.

(8) **SUPPORTIVE SOCIAL SERVICES.**—The term “supportive social services” means transitional and permanent housing, vocational counseling, and individual and group counseling aimed at preventing domestic violence, sexual violence, sexual assault, or stalking.

(9) **VIOLENCE.**—The term “violence” means actual violence and the risk or threat of violence.

SEC. 10212. ESTABLISHMENT OF PREGNANCY ASSISTANCE FUND.

(a) **IN GENERAL.**—The Secretary, in collaboration and coordination with the Secretary of Education (as appropriate), shall establish a Pregnancy Assistance Fund to be administered by the Secretary, for the purpose of awarding competitive grants to States to assist pregnant and parenting teens and women.

(b) **USE OF FUND.**—A State may apply for a grant under subsection (a) to carry out any activities provided for in section 10213.

(c) **APPLICATIONS.**—To be eligible to receive a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the purposes for which the grant is being requested and the designation of a State agency for receipt and administration of funding received under this part.

SEC. 10213. PERMISSIBLE USES OF FUND.

(a) **IN GENERAL.**—A State shall use amounts received under a grant under section 10212 for the purposes described in this section to assist pregnant and parenting teens and women.

(b) **INSTITUTIONS OF HIGHER EDUCATION.**—

(1) **IN GENERAL.**—A State may use amounts received under a grant under section 10212 to make funding available to eligible institutions of higher education to enable the eligible institutions to establish, maintain, or operate pregnant and parenting student services. Such funding shall be used to supplement, not supplant, existing funding for such services.

(2) **APPLICATION.**—An eligible institution of higher education that desires to receive funding under this subsection shall submit an application to the designated State agency at such time, in such manner, and containing such information as the State agency may require.

(3) **MATCHING REQUIREMENT.**—An eligible institution of higher education that receives funding under this subsection shall contribute to the conduct of the pregnant and parenting student services office supported by the funding an amount from non-Federal funds equal to 25 percent of the amount of the funding provided. The non-Federal share may be in cash or in-kind, fairly evaluated, including services, facilities, supplies, or equipment.

(4) **USE OF FUNDS FOR ASSISTING PREGNANT AND PARENTING COLLEGE STUDENTS.**—An eligible institution of higher education that receives funding under this subsection shall use such funds to establish, maintain or operate pregnant and parenting student services and may use such funding for the following programs and activities:

(A) Conduct a needs assessment on campus and within the local community—

(i) to assess pregnancy and parenting resources, located on the campus or within the local community, that are available to meet the needs described in subparagraph (B); and

(ii) to set goals for—

(I) improving such resources for pregnant, parenting, and prospective parenting students; and

(II) improving access to such resources.

(B) Annually assess the performance of the eligible institution in meeting the following needs of students enrolled in the eligible institution who are pregnant or are parents:

(i) The inclusion of maternity coverage and the availability of riders for additional family members in student health care.

(ii) Family housing.

(iii) Child care.

(iv) Flexible or alternative academic scheduling, such as telecommuting programs, to enable pregnant or parenting students to continue their education or stay in school.

(v) Education to improve parenting skills for mothers and fathers and to strengthen marriages.

(vi) Maternity and baby clothing, baby food (including formula), baby furniture, and similar items to assist parents and prospective parents in meeting the material needs of their children.

(vii) Post-partum counseling.

(C) Identify public and private service providers, located on the campus of the eligible institution or within the local community, that are qualified to meet the needs described in subparagraph (B), and establishes programs with qualified providers to meet such needs.

(D) Assist pregnant and parenting students, fathers or spouses in locating and obtaining services that meet the needs described in subparagraph (B).

(E) If appropriate, provide referrals for prenatal care and delivery, infant or foster care, or adoption, to a student who requests such information. An office shall make such referrals only to service providers that serve the following types of individuals:

(i) Parents.

(ii) Prospective parents awaiting adoption.

(iii) Women who are pregnant and plan on parenting or placing the child for adoption.

(iv) Parenting or prospective parenting couples.

(5) **REPORTING.**—

(A) **ANNUAL REPORT BY INSTITUTIONS.**—

(i) **IN GENERAL.**—For each fiscal year that an eligible institution of higher education receives funds under this subsection, the eligible institution shall prepare and submit to the State, by the date determined by the State, a report that—

(I) itemizes the pregnant and parenting student services office’s expenditures for the fiscal year;

(II) contains a review and evaluation of the performance of the office in fulfilling the requirements of this section, using the specific performance criteria or standards established under subparagraph (B)(i); and

(III) describes the achievement of the office in meeting the needs listed in paragraph (4)(B) of the students served by the eligible institution, and the frequency of use of the office by such students.

(ii) **PERFORMANCE CRITERIA.**—Not later than 180 days before the date the annual report described in clause (i) is submitted, the State—

(I) shall identify the specific performance criteria or standards that shall be used to prepare the report; and

(II) may establish the form or format of the report.

(B) **REPORT BY STATE.**—The State shall annually prepare and submit a report on the findings under this subsection, including the number of eligible institutions of higher education that were awarded funds and the number of students served by each pregnant and parenting student services office receiving funds under this section, to the Secretary.

(C) **SUPPORT FOR PREGNANT AND PARENTING TEENS.**—A State may use amounts received under a grant under section 10212 to make funding available to eligible high schools and community service centers to establish, maintain or operate pregnant and parenting services in the same general manner and in accordance with all conditions and requirements described in subsection (b), except that paragraph (3) of such subsection shall not apply for purposes of this subsection.

(D) **IMPROVING SERVICES FOR PREGNANT WOMEN WHO ARE VICTIMS OF DOMESTIC VIOLENCE, SEXUAL VIOLENCE, SEXUAL ASSAULT, AND STALKING.**—

(1) **IN GENERAL.**—A State may use amounts received under a grant under section 10212 to make funding available to its State Attorney General to assist Statewide offices in providing—

(A) intervention services, accompaniment, and supportive social services for eligible pregnant women who are victims of domestic violence, sexual violence, sexual assault, or stalking.

(B) technical assistance and training (as described in subsection (c)) relating to violence against eligible pregnant women to be made available to the following:

(i) Federal, State, tribal, territorial, and local governments, law enforcement agencies, and courts.

(ii) Professionals working in legal, social service, and health care settings.

(iii) Nonprofit organizations.

(iv) Faith-based organizations.

(2) **ELIGIBILITY.**—To be eligible for a grant under paragraph (1), a State Attorney General shall submit an application to the designated State agency at such time, in such manner, and containing such information, as specified by the State.

(3) **TECHNICAL ASSISTANCE AND TRAINING DESCRIBED.**—For purposes of paragraph (1)(B), technical assistance and training is—

(A) the identification of eligible pregnant women experiencing domestic violence, sexual violence, sexual assault, or stalking;

(B) the assessment of the immediate and short-term safety of such a pregnant woman, the evaluation of the impact of the violence or stalking on the pregnant woman's health, and the assistance of the pregnant woman in developing a plan aimed at preventing further domestic violence, sexual violence, sexual assault, or stalking, as appropriate;

(C) the maintenance of complete medical or forensic records that include the documentation of any examination, treatment given, and referrals made, recording the location and nature of the pregnant woman's injuries, and the establishment of mechanisms to ensure the privacy and confidentiality of those medical records; and

(D) the identification and referral of the pregnant woman to appropriate public and private nonprofit entities that provide intervention services, accompaniment, and supportive social services.

(4) **ELIGIBLE PREGNANT WOMAN.**—In this subsection, the term "eligible pregnant woman" means any woman who is pregnant on the date on which such woman becomes a victim of domestic violence, sexual violence,

sexual assault, or stalking or who was pregnant during the one-year period before such date.

(E) **PUBLIC AWARENESS AND EDUCATION.**—A State may use amounts received under a grant under section 10212 to make funding available to increase public awareness and education concerning any services available to pregnant and parenting teens and women under this part, or any other resources available to pregnant and parenting women in keeping with the intent and purposes of this part. The State shall be responsible for setting guidelines or limits as to how much of funding may be utilized for public awareness and education in any funding award.

SEC. 10214. APPROPRIATIONS.

There is authorized to be appropriated, and there are appropriated, \$25,000,000 for each of fiscal years 2010 through 2019, to carry out this part.

PART III—INDIAN HEALTH CARE IMPROVEMENT

SEC. 10221. INDIAN HEALTH CARE IMPROVEMENT.

(A) **IN GENERAL.**—Except as provided in subsection (b), S. 1790 entitled "A bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes," as reported by the Committee on Indian Affairs of the Senate in December 2009, is enacted into law.

(B) **AMENDMENTS.**—

(1) Section 119 of the Indian Health Care Improvement Act (as amended by section 111 of the bill referred to in subsection (a)) is amended—

(A) in subsection (d)—

(i) in paragraph (2), by striking "In establishing" and inserting "Subject to paragraphs (3) and (4), in establishing"; and

(ii) by adding at the end the following:

"(3) **ELECTION OF INDIAN TRIBE OR TRIBAL ORGANIZATION.**—

"(A) **IN GENERAL.**—Subparagraph (B) of paragraph (2) shall not apply in the case of an election made by an Indian tribe or tribal organization located in a State (other than Alaska) in which the use of dental health aide therapist services or midlevel dental health provider services is authorized under State law to supply such services in accordance with State law.

"(B) **ACTION BY SECRETARY.**—On an election by an Indian tribe or tribal organization under subparagraph (A), the Secretary, acting through the Service, shall facilitate implementation of the services elected.

"(4) **VACANCIES.**—The Secretary shall not fill any vacancy for a certified dentist in a program operated by the Service with a dental health aide therapist.";

(B) by adding at the end the following:

"(e) **EFFECT OF SECTION.**—Nothing in this section shall restrict the ability of the Service, an Indian tribe, or a tribal organization to participate in any program or to provide any service authorized by any other Federal law."

(2) The Indian Health Care Improvement Act (as amended by section 134(b) of the bill referred to in subsection (a)) is amended by striking section 125 (relating to treatment of scholarships for certain purposes).

(3) Section 806 of the Indian Health Care Improvement Act (25 U.S.C. 1676) is amended—

(A) by striking "Any limitation" and inserting the following:

"(a) **HHS APPROPRIATIONS.**—Any limitation"; and

(B) by adding at the end the following:

"(b) **LIMITATIONS PURSUANT TO OTHER FEDERAL LAW.**—Any limitation pursuant to

other Federal laws on the use of Federal funds appropriated to the Service shall apply with respect to the performance or coverage of abortions."

(4) The bill referred to in subsection (a) is amended by striking section 201.

Subtitle C—Provisions Relating to Title III

SEC. 10301. PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR AMBULATORY SURGICAL CENTERS.

(A) **IN GENERAL.**—Section 3006 is amended by adding at the end the following new subsection:

"(f) **AMBULATORY SURGICAL CENTERS.**—

"(1) **IN GENERAL.**—The Secretary shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for ambulatory surgical centers (as described in section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i))).

"(2) **DETAILS.**—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

"(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A of such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in ambulatory surgical centers.

"(B) The reporting, collection, and validation of quality data.

"(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

"(D) Methods for the public disclosure of information on the performance of ambulatory surgical centers.

"(E) Any other issues determined appropriate by the Secretary.

"(3) **CONSULTATION.**—In developing the plan under paragraph (1), the Secretary shall—

"(A) consult with relevant affected parties; and

"(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

"(4) **REPORT TO CONGRESS.**—Not later than January 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1)."

(B) **TECHNICAL.**—Section 3006(a)(2)(A) is amended by striking clauses (i) and (ii).

SEC. 10302. REVISION TO NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE.

Section 399HH(a)(2)(B)(iii) of the Public Health Service Act, as added by section 3011, is amended by inserting "(taking into consideration the limitations set forth in subsections (c) and (d) of section 1182 of the Social Security Act)" after "information".

SEC. 10303. DEVELOPMENT OF OUTCOME MEASURES.

(A) **DEVELOPMENT.**—Section 931 of the Public Health Service Act, as added by section 3013(a), is amended by adding at the end the following new subsection:

"(f) **DEVELOPMENT OF OUTCOME MEASURES.**—

"(1) **IN GENERAL.**—The Secretary shall develop, and periodically update (not less than every 3 years), provider-level outcome measures for hospitals and physicians, as well as other providers as determined appropriate by the Secretary.

"(2) **CATEGORIES OF MEASURES.**—The measures developed under this subsection shall

include, to the extent determined appropriate by the Secretary—

“(A) outcome measurement for acute and chronic diseases, including, to the extent feasible, the 5 most prevalent and resource-intensive acute and chronic medical conditions; and

“(B) outcome measurement for primary and preventative care, including, to the extent feasible, measurements that cover provision of such care for distinct patient populations (such as healthy children, chronically ill adults, or infirm elderly individuals).

“(3) GOALS.—In developing such measures, the Secretary shall seek to—

“(A) address issues regarding risk adjustment, accountability, and sample size;

“(B) include the full scope of services that comprise a cycle of care; and

“(C) include multiple dimensions.

“(4) TIMEFRAME.—

“(A) ACUTE AND CHRONIC DISEASES.—Not later than 24 months after the date of enactment of this Act, the Secretary shall develop not less than 10 measures described in paragraph (2)(A).

“(B) PRIMARY AND PREVENTIVE CARE.—Not later than 36 months after the date of enactment of this Act, the Secretary shall develop not less than 10 measures described in paragraph (2)(B).”

(b) HOSPITAL-ACQUIRED CONDITIONS.—Section 1890A of the Social Security Act, as amended by section 3013(b), is amended by adding at the end the following new subsection:

“(f) HOSPITAL ACQUIRED CONDITIONS.—The Secretary shall, to the extent practicable, publicly report on measures for hospital-acquired conditions that are currently utilized by the Centers for Medicare & Medicaid Services for the adjustment of the amount of payment to hospitals based on rates of hospital-acquired infections.”

(c) CLINICAL PRACTICE GUIDELINES.—Section 304(b) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275) is amended by adding at the end the following new paragraph:

“(4) IDENTIFICATION.—

“(A) IN GENERAL.—Following receipt of the report submitted under paragraph (2), and not less than every 3 years thereafter, the Secretary shall contract with the Institute to employ the results of the study performed under paragraph (1) and the best methods identified by the Institute for the purpose of identifying existing and new clinical practice guidelines that were developed using such best methods, including guidelines listed in the National Guideline Clearinghouse.

“(B) CONSULTATION.—In carrying out the identification process under subparagraph (A), the Secretary shall allow for consultation with professional societies, voluntary health care organizations, and expert panels.”

SEC. 10304. SELECTION OF EFFICIENCY MEASURES.

Sections 1890(b)(7) and 1890A of the Social Security Act, as added by section 3014, are amended by striking “quality” each place it appears and inserting “quality and efficiency”.

SEC. 10305. DATA COLLECTION; PUBLIC REPORTING.

Section 3991I(a) of the Public Health Service Act, as added by section 3015, is amended to read as follows:

“(a) IN GENERAL.—

“(1) ESTABLISHMENT OF STRATEGIC FRAMEWORK.—The Secretary shall establish and implement an overall strategic framework to

carry out the public reporting of performance information, as described in section 399JJ. Such strategic framework may include methods and related timelines for implementing nationally consistent data collection, data aggregation, and analysis methods.

“(2) COLLECTION AND AGGREGATION OF DATA.—The Secretary shall collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery, and may award grants or contracts for this purpose. The Secretary shall align such collection and aggregation efforts with the requirements and assistance regarding the expansion of health information technology systems, the interoperability of such technology systems, and related standards that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

“(3) SCOPE.—The Secretary shall ensure that the data collection, data aggregation, and analysis systems described in paragraph (1) involve an increasingly broad range of patient populations, providers, and geographic areas over time.”

SEC. 10306. IMPROVEMENTS UNDER THE CENTER FOR MEDICARE AND MEDICAID INNOVATION.

Section 1115A of the Social Security Act, as added by section 3021, is amended—

(1) in subsection (a), by inserting at the end the following new paragraph:

“(5) TESTING WITHIN CERTAIN GEOGRAPHIC AREAS.—For purposes of testing payment and service delivery models under this section, the Secretary may elect to limit testing of a model to certain geographic areas.”;

(2) in subsection (b)(2)—

(A) in subparagraph (A)—

(i) in the second sentence, by striking “the preceding sentence may include” and inserting “this subparagraph may include, but are not limited to,”; and

(ii) by inserting after the first sentence the following new sentence: “The Secretary shall focus on models expected to reduce program costs under the applicable title while preserving or enhancing the quality of care received by individuals receiving benefits under such title.”;

(B) in subparagraph (B), by adding at the end the following new clauses:

“(xix) Utilizing, in particular in entities located in medically underserved areas and facilities of the Indian Health Service (whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act)), telehealth services—

“(I) in treating behavioral health issues (such as post-traumatic stress disorder) and stroke; and

“(II) to improve the capacity of non-medical providers and non-specialized medical providers to provide health services for patients with chronic complex conditions.

“(xx) Utilizing a diverse network of providers of services and suppliers to improve care coordination for applicable individuals described in subsection (a)(4)(A)(i) with 2 or more chronic conditions and a history of prior-year hospitalization through interventions developed under the Medicare Coordinated Care Demonstration Project under section 4016 of the Balanced Budget Act of 1997 (42 U.S.C. 1395b-1 note).”; and

(C) in subparagraph (C), by adding at the end the following new clause:

“(viii) Whether the model demonstrates effective linkage with other public sector or private sector payers.”;

(3) in subsection (b)(4), by adding at the end the following new subparagraph:

“(C) MEASURE SELECTION.—To the extent feasible, the Secretary shall select measures under this paragraph that reflect national priorities for quality improvement and patient-centered care consistent with the measures described in 1890(b)(7)(B).”; and

(4) in subsection (c)—

(A) in paragraph (1)(B), by striking “care and reduce spending; and” and inserting “patient care without increasing spending.”;

(B) in paragraph (2), by striking “reduce program spending under applicable titles.” and inserting “reduce (or would not result in any increase in) net program spending under applicable titles; and”; and

(C) by adding at the end the following:

“(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable title for applicable individuals.

In determining which models or demonstration projects to expand under the preceding sentence, the Secretary shall focus on models and demonstration projects that improve the quality of patient care and reduce spending.”

SEC. 10307. IMPROVEMENTS TO THE MEDICARE SHARED SAVINGS PROGRAM.

Section 1899 of the Social Security Act, as added by section 3022, is amended by adding at the end the following new subsections:

“(i) OPTION TO USE OTHER PAYMENT MODELS.—

“(1) IN GENERAL.—If the Secretary determines appropriate, the Secretary may use any of the payment models described in paragraph (2) or (3) for making payments under the program rather than the payment model described in subsection (d).

“(2) PARTIAL CAPITATION MODEL.—

“(A) IN GENERAL.—Subject to subparagraph (B), a model described in this paragraph is a partial capitation model in which an ACO is at financial risk for some, but not all, of the items and services covered under parts A and B, such as at risk for some or all physicians’ services or all items and services under part B. The Secretary may limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary.

“(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments to an ACO for items and services under this title for beneficiaries for a year under the partial capitation model shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the model were not implemented, as estimated by the Secretary.

“(3) OTHER PAYMENT MODELS.—

“(A) IN GENERAL.—Subject to subparagraph (B), a model described in this paragraph is any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under this title.

“(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) in a similar manner as such subparagraph (B) applies to the payment model under paragraph (2).

“(j) INVOLVEMENT IN PRIVATE PAYER AND OTHER THIRD PARTY ARRANGEMENTS.—The Secretary may give preference to ACOs who are participating in similar arrangements with other payers.

“(k) TREATMENT OF PHYSICIAN GROUP PRACTICE DEMONSTRATION.—During the period beginning on the date of the enactment of this

section and ending on the date the program is established, the Secretary may enter into an agreement with an ACO under the demonstration under section 1866A, subject to rebasing and other modifications deemed appropriate by the Secretary.”.

SEC. 10308. REVISIONS TO NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

(a) IN GENERAL.—Section 1866D of the Social Security Act, as added by section 3023, is amended—

(1) in paragraph (a)(2)(B), in the matter preceding clause (i), by striking “8 conditions” and inserting “10 conditions”;

(2) by striking subsection (c)(1)(B) and inserting the following:

“(B) EXPANSION.—The Secretary may, at any point after January 1, 2016, expand the duration and scope of the pilot program, to the extent determined appropriate by the Secretary, if—

“(i) the Secretary determines that such expansion is expected to—

“(I) reduce spending under title XVIII of the Social Security Act without reducing the quality of care; or

“(II) improve the quality of care and reduce spending;

“(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under such title XVIII; and

“(iii) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under this title for individuals.”; and

(3) by striking subsection (g) and inserting the following new subsection:

“(g) APPLICATION OF PILOT PROGRAM TO CONTINUING CARE HOSPITALS.—

“(1) IN GENERAL.—In conducting the pilot program, the Secretary shall apply the provisions of the program so as to separately pilot test the continuing care hospital model.

“(2) SPECIAL RULES.—In pilot testing the continuing care hospital model under paragraph (1), the following rules shall apply:

“(A) Such model shall be tested without the limitation to the conditions selected under subsection (a)(2)(B).

“(B) Notwithstanding subsection (a)(2)(D), an episode of care shall be defined as the full period that a patient stays in the continuing care hospital plus the first 30 days following discharge from such hospital.

“(3) CONTINUING CARE HOSPITAL DEFINED.—In this subsection, the term ‘continuing care hospital’ means an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units (as defined in section 1886(d)(1)(B)(ii)), long term care hospitals (as defined in section 1886(d)(1)(B)(iv)(I)), and skilled nursing facilities (as defined in section 1819(a)) that are located in a hospital described in section 1886(d).”.

(b) TECHNICAL AMENDMENTS.—

(1) Section 3023 is amended by striking “1886C” and inserting “1866C”.

(2) Title XVIII of the Social Security Act is amended by redesignating section 1866D, as added by section 3024, as section 1866E.

SEC. 10309. REVISIONS TO HOSPITAL READMISSIONS REDUCTION PROGRAM.

Section 1886(q)(1) of the Social Security Act, as added by section 3025, in the matter preceding subparagraph (A), is amended by striking “the Secretary shall reduce the payments” and all that follows through “the product of” and inserting “the Secretary

shall make payments (in addition to the payments described in paragraph (2)(A)(ii)) for such a discharge to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) in an amount equal to the product of”.

SEC. 10310. REPEAL OF PHYSICIAN PAYMENT UPDATE.

The provisions of, and the amendment made by, section 3101 are repealed

SEC. 10311. REVISIONS TO EXTENSION OF AMBULANCE ADD-ONS.

(a) GROUND AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)), as amended by section 3105(a), is further amended—

(1) in the matter preceding clause (i)—

(A) by striking “2007, for” and inserting “2007, and for”; and

(B) by striking “2010, and for such services furnished on or after April 1, 2010, and before January 1, 2011” and inserting “2011”; and

(2) in each of clauses (i) and (ii)—

(A) by striking “, and on or after April 1, 2010, and before January 1, 2011” each place it appears; and

(B) by striking “January 1, 2010” and inserting “January 1, 2011” each place it appears.

(b) AIR AMBULANCE.—Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275), as amended by section 3105(b), is further amended by striking “December 31, 2009, and during the period beginning on April 1, 2010, and ending on January 1, 2011” and inserting “December 31, 2010”.

(c) SUPER RURAL AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)), as amended by section 3105(c), is further amended by striking “2010, and on or after April 1, 2010, and before January 1, 2011” and inserting “2011”.

SEC. 10312. CERTAIN PAYMENT RULES FOR LONG-TERM CARE HOSPITAL SERVICES AND MORATORIUM ON THE ESTABLISHMENT OF CERTAIN HOSPITALS AND FACILITIES.

(a) CERTAIN PAYMENT RULES.—Section 114(c) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by section 4302(a) of the American Recovery and Reinvestment Act (Public Law 111-5) and section 3106(a) of this Act, is further amended by striking “4-year period” each place it appears and inserting “5-year period”.

(b) MORATORIUM.—Section 114(d) of such Act (42 U.S.C. 1395ww note), as amended by section 3106(b) of this Act, in the matter preceding subparagraph (A), is amended by striking “4-year period” and inserting “5-year period”.

SEC. 10313. REVISIONS TO THE EXTENSION FOR THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) IN GENERAL.—Subsection (g) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; 117 Stat. 2272), as added by section 3123(a) of this Act, is amended to read as follows:

“(g) FIVE-YEAR EXTENSION OF DEMONSTRATION PROGRAM.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 5-year period (in this section referred to as the ‘5-year extension period’) that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

“(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding subsection (a)(2),

during the 5-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 5-year period.

“(3) INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding subsection (a)(4), during the 5-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

“(4) HOSPITALS IN DEMONSTRATION PROGRAM ON DATE OF ENACTMENT.—In the case of a rural community hospital that is participating in the demonstration program under this section as of the last day of the initial 5-year period, the Secretary—

“(A) shall provide for the continued participation of such rural community hospital in the demonstration program during the 5-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may specify, to discontinue such participation; and

“(B) in calculating the amount of payment under subsection (b) to the rural community hospital for covered inpatient hospital services furnished by the hospital during such 5-year extension period, shall substitute, under paragraph (1)(A) of such subsection—

“(i) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the first day of the 5-year extension period, for

“(ii) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program.”.

(b) CONFORMING AMENDMENTS.—Subsection (a)(5) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; 117 Stat. 2272), as amended by section 3123(b) of this Act, is amended by striking “1-year extension” and inserting “5-year extension”.

SEC. 10314. ADJUSTMENT TO LOW-VOLUME HOSPITAL PROVISION.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)), as amended by section 3125, is amended—

(1) in subparagraph (C)(i), by striking “1,500 discharges” and inserting “1,600 discharges”; and

(2) in subparagraph (D), by striking “1,500 discharges” and inserting “1,600 discharges”.

SEC. 10315. REVISIONS TO HOME HEALTH CARE PROVISIONS.

(a) REBASING.—Section 1895(b)(3)(A)(iii) of the Social Security Act, as added by section 3131, is amended—

(1) in the clause heading, by striking “2013” and inserting “2014”; and

(2) in subclause (I), by striking “2013” and inserting “2014”; and

(3) in subclause (II), by striking “2016” and inserting “2017”.

(b) REVISION OF HOME HEALTH STUDY AND REPORT.—Section 3131(d) is amended to read as follows:

“(d) STUDY AND REPORT ON THE DEVELOPMENT OF HOME HEALTH PAYMENT REVISIONS IN ORDER TO ENSURE ACCESS TO CARE AND PAYMENT FOR SEVERITY OF ILLNESS.—

“(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ‘Secretary’) shall conduct a study

on home health agency costs involved with providing ongoing access to care to low-income Medicare beneficiaries or beneficiaries in medically underserved areas, and in treating beneficiaries with varying levels of severity of illness. In conducting the study, the Secretary may analyze items such as the following:

“(A) Methods to potentially revise the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to account for costs related to patient severity of illness or to improving beneficiary access to care, such as—

“(i) payment adjustments for services that may involve additional or fewer resources;

“(ii) changes to reflect resources involved with providing home health services to low-income Medicare beneficiaries or Medicare beneficiaries residing in medically underserved areas;

“(iii) ways outlier payments might be revised to reflect costs of treating Medicare beneficiaries with high levels of severity of illness; and

“(iv) other issues determined appropriate by the Secretary.

“(B) Operational issues involved with potential implementation of potential revisions to the home health payment system, including impacts for both home health agencies and administrative and systems issues for the Centers for Medicare & Medicaid Services, and any possible payment vulnerabilities associated with implementing potential revisions.

“(C) Whether additional research might be needed.

“(D) Other items determined appropriate by the Secretary.

“(2) CONSIDERATIONS.—In conducting the study under paragraph (1), the Secretary may consider whether patient severity of illness and access to care could be measured by factors, such as—

“(A) population density and relative patient access to care;

“(B) variations in service costs for providing care to individuals who are dually eligible under the Medicare and Medicaid programs;

“(C) the presence of severe or chronic diseases, which might be measured by multiple, discontinuous home health episodes;

“(D) poverty status, such as evidenced by the receipt of Supplemental Security Income under title XVI of the Social Security Act; and

“(E) other factors determined appropriate by the Secretary.

“(3) REPORT.—Not later than March 1, 2014, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

“(4) CONSULTATIONS.—In conducting the study under paragraph (1), the Secretary shall consult with appropriate stakeholders, such as groups representing home health agencies and groups representing Medicare beneficiaries.

“(5) MEDICARE DEMONSTRATION PROJECT BASED ON THE RESULTS OF THE STUDY.—

“(A) IN GENERAL.—Subject to subparagraph (D), taking into account the results of the study conducted under paragraph (1), the Secretary may, as determined appropriate, provide for a demonstration project to test whether making payment adjustments for home health services under the Medicare program would substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries.

“(B) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset any increase in payments during such period resulting from the application of the payment adjustments under subparagraph (A).

“(C) NO EFFECT ON SUBSEQUENT PERIODS.—A payment adjustment resulting from the application of subparagraph (A) for a period—

“(i) shall not apply to payments for home health services under title XVIII after such period; and

“(ii) shall not be taken into account in calculating the payment amounts applicable for such services after such period.

“(D) DURATION.—If the Secretary determines it appropriate to conduct the demonstration project under this subsection, the Secretary shall conduct the project for a four year period beginning not later than January 1, 2015.

“(E) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of \$500,000,000 for the period of fiscal years 2015 through 2018. Such funds shall be made available for the study described in paragraph (1) and the design, implementation and evaluation of the demonstration described in this paragraph. Amounts available under this subparagraph shall be available until expended.

“(F) EVALUATION AND REPORT.—If the Secretary determines it appropriate to conduct the demonstration project under this subsection, the Secretary shall—

“(i) provide for an evaluation of the project; and

“(ii) submit to Congress, by a date specified by the Secretary, a report on the project.

“(G) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply with respect to this subsection.”

SEC. 10316. MEDICARE DSH.

Section 1886(r)(2)(B) of the Social Security Act, as added by section 3133, is amended—

(1) in clause (i)—

(A) in the matter preceding subclause (I), by striking “(divided by 100)”;

(B) in subclause (I), by striking “2012” and inserting “2013”;

(C) in subclause (II), by striking the period at the end and inserting a comma; and

(D) by adding at the end the following flush matter:

“minus 1.5 percentage points.”

(2) in clause (ii)—

(A) in the matter preceding subclause (I), by striking “(divided by 100)”;

(B) in subclause (I), by striking “2012” and inserting “2013”;

(C) in subclause (II), by striking the period at the end and inserting a comma; and

(D) by adding at the end the following flush matter:

“and, for each of 2018 and 2019, minus 1.5 percentage points.”

SEC. 10317. REVISIONS TO EXTENSION OF SECTION 508 HOSPITAL PROVISIONS.

Section 3137(a) is amended to read as follows:

“(a) EXTENSION.—

“(1) IN GENERAL.—Subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note), as

amended by section 117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173) and section 124 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275), is amended by striking ‘September 30, 2009’ and inserting ‘September 30, 2010’.

“(2) SPECIAL RULE FOR FISCAL YEAR 2010.—

“(A) IN GENERAL.—Subject to subparagraph (B), for purposes of implementation of the amendment made by paragraph (1), including (notwithstanding paragraph (3) of section 117(a) of the Medicare, Medicaid and SCHIP Extension Act of 2007 (Public Law 110-173), as amended by section 124(b) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275)) for purposes of the implementation of paragraph (2) of such section 117(a), during fiscal year 2010, the Secretary of Health and Human Services (in this subsection referred to as the ‘Secretary’) shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on August 27, 2009 (74 Fed. Reg. 43754), and any subsequent corrections.

“(B) EXCEPTION.—Beginning on April 1, 2010, in determining the wage index applicable to hospitals that qualify for wage index reclassification, the Secretary shall include the average hourly wage data of hospitals whose reclassification was extended pursuant to the amendment made by paragraph (1) only if including such data results in a higher applicable reclassified wage index.

“(3) ADJUSTMENT FOR CERTAIN HOSPITALS IN FISCAL YEAR 2010.—

“(A) IN GENERAL.—In the case of a subsection (d) hospital (as defined in subsection (d)(1)(B) of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which—

“(i) a reclassification of its wage index for purposes of such section was extended pursuant to the amendment made by paragraph (1); and

“(ii) the wage index applicable for such hospital for the period beginning on October 1, 2009, and ending on March 31, 2010, was lower than for the period beginning on April 1, 2010, and ending on September 30, 2010, by reason of the application of paragraph (2)(B); the Secretary shall pay such hospital an additional payment that reflects the difference between the wage index for such periods.

“(B) TIMEFRAME FOR PAYMENTS.—The Secretary shall make payments required under subparagraph by not later than December 31, 2010.”

SEC. 10318. REVISIONS TO TRANSITIONAL EXTRA BENEFITS UNDER MEDICARE ADVANTAGE.

Section 1853(p)(3)(A) of the Social Security Act, as added by section 3201(h), is amended by inserting “in 2009” before the period at the end.

SEC. 10319. REVISIONS TO MARKET BASKET ADJUSTMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1886(b)(3)(B)(xii) of the Social Security Act, as added by section 3401(a), is amended—

(1) in subclause (I), by striking “and” at the end;

(2) by redesignating subclause (II) as subclause (III);

(3) by inserting after subclause (II) the following new subclause:

“(II) for each of fiscal years 2012 and 2013, by 0.1 percentage point; and”; and

(4) in subclause (III), as redesignated by paragraph (2), by striking “2012” and inserting “2014”.

(b) LONG-TERM CARE HOSPITALS.—Section 1886(m)(4) of the Social Security Act, as added by section 3401(c), is amended—

(1) in subparagraph (A)—
 (A) in clause (i)—
 (i) by striking “each of rate years 2010 and 2011” and inserting “rate year 2010”; and
 (ii) by striking “and” at the end;
 (B) by redesignating clause (ii) as clause (iv);
 (C) by inserting after clause (i) the following new clauses:
 “(ii) for rate year 2011, 0.50 percentage point;
 “(iii) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point; and”;
 and
 (D) in clause (iv), as redesignated by subparagraph (B), by striking “2012” and inserting “2014”; and
 (2) in subparagraph (B), by striking “(A)(ii)” and inserting “(A)(iv)”.
(c) INPATIENT REHABILITATION FACILITIES.—Section 1886(j)(3)(D)(i) of the Social Security Act, as added by section 3401(d), is amended—
 (1) in subclause (I), by striking “and” at the end;
 (2) by redesignating subclause (II) as subclause (III);
 (3) by inserting after subclause (II) the following new subclause:
 “(II) for each of fiscal years 2012 and 2013, 0.1 percentage point; and”; and
 (4) in subclause (III), as redesignated by paragraph (2), by striking “2012” and inserting “2014”.
(d) HOME HEALTH AGENCIES.—Section 1895(b)(3)(B)(vi)(II) of such Act, as added by section 3401(e), is amended by striking “and 2012” and inserting “, 2012, and 2013”.
(e) PSYCHIATRIC HOSPITALS.—Section 1886(s)(3)(A) of the Social Security Act, as added by section 3401(f), is amended—
 (1) in clause (i), by striking “and” at the end;
 (2) by redesignating clause (ii) as clause (iii);
 (3) by inserting after clause (ii) the following new clause:
 “(ii) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point; and”; and
 (4) in clause (iii), as redesignated by paragraph (2), by striking “2012” and inserting “2014”.
(f) HOSPICE CARE.—Section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)), as amended by section 3401(g), is amended—
 (1) in clause (iv)(II), by striking “0.5” and inserting “0.3”; and
 (2) in clause (v), in the matter preceding subclause (I), by striking “0.5” and inserting “0.3”.
(g) OUTPATIENT HOSPITALS.—Section 1833(t)(3)(G)(i) of the Social Security Act, as added by section 3401(i), is amended—
 (1) in subclause (I), by striking “and” at the end;
 (2) by redesignating subclause (II) as subclause (III);
 (3) by inserting after subclause (II) the following new subclause:
 “(II) for each of 2012 and 2013, 0.1 percentage point; and”; and
 (4) in subclause (III), as redesignated by paragraph (2), by striking “2012” and inserting “2014”.
SEC. 10320. EXPANSION OF THE SCOPE OF, AND ADDITIONAL IMPROVEMENTS TO, THE INDEPENDENT MEDICARE ADVISORY BOARD.
 (a) IN GENERAL.—Section 1899A of the Social Security Act, as added by section 3403, is amended—
 (1) in subsection (c)—
 (A) in paragraph (1)(B), by adding at the end the following new sentence: “In any year

(beginning with 2014) that the Board is not required to submit a proposal under this section, the Board shall submit to Congress an advisory report on matters related to the Medicare program.”;
 (B) in paragraph (2)(A)—
 (i) in clause (iv), by inserting “or the full premium subsidy under section 1860D–14(a)” before the period at the end of the last sentence; and
 (ii) by adding at the end the following new clause:
 “(vii) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination described in subsection (e)(3)(B)(i)(II) in the determination year, the proposal shall be designed to help reduce the growth rate described in paragraph (8) while maintaining or enhancing beneficiary access to quality care under this title.”;
 (C) in paragraph (2)(B)—
 (i) in clause (v), by striking “and” at the end;
 (ii) in clause (vi), by striking the period at the end and inserting “; and”; and
 (iii) by adding at the end the following new clause:
 “(vii) take into account the data and findings contained in the annual reports under subsection (n) in order to develop proposals that can most effectively promote the delivery of efficient, high quality care to Medicare beneficiaries.”;
 (D) in paragraph (3)—
 (i) in the heading, by striking “TRANSMISSION OF BOARD PROPOSAL TO PRESIDENT” and inserting “SUBMISSION OF BOARD PROPOSAL TO CONGRESS AND THE PRESIDENT”;
 (ii) in subparagraph (A)(i), by striking “transmit a proposal under this section to the President” and insert “submit a proposal under this section to Congress and the President”; and
 (iii) in subparagraph (A)(ii)—
 (I) in subclause (I), by inserting “or” at the end;
 (II) in subclause (II), by striking “; or” and inserting a period; and
 (III) by striking subclause (III);
 (E) in paragraph (4)—
 (i) by striking “the Board under paragraph (3)(A)(i) or”; and
 (ii) by striking “immediately” and inserting “within 2 days”;
 (F) in paragraph (5)—
 (i) by striking “to but” and inserting “but”; and
 (ii) by inserting “Congress and” after “submit a proposal to”; and
 (G) in paragraph (6)(B)(i), by striking “per unduplicated enrollee” and inserting “(calculated as the sum of per capita spending under each of parts A, B, and D)”;
 (2) in subsection (d)—
 (A) in paragraph (1)(A)—
 (i) by inserting “the Board or” after “a proposal is submitted by”; and
 (ii) by inserting “subsection (c)(3)(A)(i) or” after “the Senate under”; and
 (B) in paragraph (2)(A), by inserting “the Board or” after “a proposal is submitted by”;
 (3) in subsection (e)—
 (A) in paragraph (1), by inserting “the Board or” after “a proposal submitted by”; and
 (B) in paragraph (3)—
 (i) by striking “EXCEPTION.—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by” and inserting “EXCEPTIONS.—
 “(A) IN GENERAL.—The Secretary shall not implement the recommendations contained

in a proposal submitted in a proposal year by the Board or”;
 (ii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting appropriately; and
 (iii) by adding at the end the following new subparagraph:
 “(B) LIMITED ADDITIONAL EXCEPTION.—
 “(i) IN GENERAL.—Subject to clause (ii), the Secretary shall not implement the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in a proposal year (beginning with proposal year 2019) if—
 “(I) the Board was required to submit a proposal to Congress under this section in the year preceding the proposal year; and
 “(II) the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the growth rate described in subsection (c)(8) exceeds the growth rate described in subsection (c)(6)(A)(i).
 “(ii) LIMITED ADDITIONAL EXCEPTION MAY NOT BE APPLIED IN TWO CONSECUTIVE YEARS.—This subparagraph shall not apply if the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in the year preceding the proposal year were not required to be implemented by reason of this subparagraph.
 “(iii) NO AFFECT ON REQUIREMENT TO SUBMIT PROPOSALS OR FOR CONGRESSIONAL CONSIDERATION OF PROPOSALS.—Clause (i) and (ii) shall not affect—
 “(I) the requirement of the Board or the President to submit a proposal to Congress in a proposal year in accordance with the provisions of this section; or
 “(II) Congressional consideration of a legislative proposal (described in subsection (c)(3)(B)(iv)) contained such a proposal in accordance with subsection (d).”;
 (4) in subsection (f)(3)(B)—
 (A) by striking “or advisory reports to Congress” and inserting “, advisory reports, or advisory recommendations”; and
 (B) by inserting “or produce the public report under subsection (n)” after “this section”; and
 (5) by adding at the end the following new subsections:
 “(n) ANNUAL PUBLIC REPORT.—
 “(1) IN GENERAL.—Not later than July 1, 2014, and annually thereafter, the Board shall produce a public report containing standardized information on system-wide health care costs, patient access to care, utilization, and quality-of-care that allows for comparison by region, types of services, types of providers, and both private payers and the program under this title.
 “(2) REQUIREMENTS.—Each report produced pursuant to paragraph (1) shall include information with respect to the following areas:
 “(A) The quality and costs of care for the population at the most local level determined practical by the Board (with quality and costs compared to national benchmarks and reflecting rates of change, taking into account quality measures described in section 1890(b)(7)(B)).
 “(B) Beneficiary and consumer access to care, patient and caregiver experience of care, and the cost-sharing or out-of-pocket burden on patients.
 “(C) Epidemiological shifts and demographic changes.
 “(D) The proliferation, effectiveness, and utilization of health care technologies, including variation in provider practice patterns and costs.

“(E) Any other areas that the Board determines affect overall spending and quality of care in the private sector.

“(o) ADVISORY RECOMMENDATIONS FOR NON-FEDERAL HEALTH CARE PROGRAMS.—

“(1) IN GENERAL.—Not later than January 15, 2015, and at least once every two years thereafter, the Board shall submit to Congress and the President recommendations to slow the growth in national health expenditures (excluding expenditures under this title and in other Federal health care programs) while preserving or enhancing quality of care, such as recommendations—

“(A) that the Secretary or other Federal agencies can implement administratively;

“(B) that may require legislation to be enacted by Congress in order to be implemented;

“(C) that may require legislation to be enacted by State or local governments in order to be implemented;

“(D) that private sector entities can voluntarily implement; and

“(E) with respect to other areas determined appropriate by the Board.

“(2) COORDINATION.—In making recommendations under paragraph (1), the Board shall coordinate such recommendations with recommendations contained in proposals and advisory reports produced by the Board under subsection (c).

“(3) AVAILABLE TO PUBLIC.—The Board shall make recommendations submitted to Congress and the President under this subsection available to the public.”.

(b) NAME CHANGE.—Any reference in the provisions of, or amendments made by, section 3403 to the “Independent Medicare Advisory Board” shall be deemed to be a reference to the “Independent Payment Advisory Board”.

(c) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall preclude the Independent Medicare Advisory Board, as established under section 1899A of the Social Security Act (as added by section 3403), from solely using data from public or private sources to carry out the amendments made by subsection (a)(4).

SEC. 10321. REVISION TO COMMUNITY HEALTH TEAMS.

Section 3502(c)(2)(A) is amended by inserting “or other primary care providers” after “physicians”.

SEC. 10322. QUALITY REPORTING FOR PSYCHIATRIC HOSPITALS.

(a) IN GENERAL.—Section 1886(s) of the Social Security Act, as added by section 3401(f), is amended by adding at the end the following new paragraph:

“(4) QUALITY REPORTING.—

“(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

“(i) IN GENERAL.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a psychiatric hospital or psychiatric unit that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (2), shall be reduced by 2 percentage points.

“(ii) SPECIAL RULE.—The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

“(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply

only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

“(C) SUBMISSION OF QUALITY DATA.—For rate year 2014 and each subsequent rate year, each psychiatric hospital and psychiatric unit shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

“(D) QUALITY MEASURES.—

“(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

“(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

“(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

“(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a psychiatric hospital and a psychiatric unit has the opportunity to review the data that is to be made public with respect to the hospital or unit prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in psychiatric hospitals and psychiatric units on the Internet website of the Centers for Medicare & Medicaid Services.”.

(b) CONFORMING AMENDMENT.—Section 1890(b)(7)(B)(i)(I) of the Social Security Act, as added by section 3014, is amended by inserting “1886(s)(4)(D),” after “1886(o)(2),”.

SEC. 10323. MEDICARE COVERAGE FOR INDIVIDUALS EXPOSED TO ENVIRONMENTAL HEALTH HAZARDS.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1881 the following new section:

“SEC. 1881A. MEDICARE COVERAGE FOR INDIVIDUALS EXPOSED TO ENVIRONMENTAL HEALTH HAZARDS.

“(a) DEEMING OF INDIVIDUALS AS ELIGIBLE FOR MEDICARE BENEFITS.—

“(1) IN GENERAL.—For purposes of eligibility for benefits under this title, an individual determined under subsection (c) to be an environmental exposure affected individual described in subsection (e)(2) shall be deemed to meet the conditions specified in section 226(a).

“(2) DISCRETIONARY DEEMING.—For purposes of eligibility for benefits under this title, the Secretary may deem an individual determined under subsection (c) to be an environmental exposure affected individual described in subsection (e)(3) to meet the conditions specified in section 226(a).

“(3) EFFECTIVE DATE OF COVERAGE.—An individual who is deemed eligible for benefits under this title under paragraph (1) or (2) shall be—

“(A) entitled to benefits under the program under Part A as of the date of such deeming; and

“(B) eligible to enroll in the program under Part B beginning with the month in which such deeming occurs.

“(b) PILOT PROGRAM FOR CARE OF CERTAIN INDIVIDUALS RESIDING IN EMERGENCY DECLARATION AREAS.—

“(1) PROGRAM; PURPOSE.—

“(A) PRIMARY PILOT PROGRAM.—The Secretary shall establish a pilot program in accordance with this subsection to provide innovative approaches to furnishing comprehensive, coordinated, and cost-effective care under this title to individuals described in paragraph (2)(A).

“(B) OPTIONAL PILOT PROGRAMS.—The Secretary may establish a separate pilot program, in accordance with this subsection, with respect to each geographic area subject to an emergency declaration (other than the declaration of June 17, 2009), in order to furnish such comprehensive, coordinated and cost-effective care to individuals described in subparagraph (2)(B) who reside in each such area.

“(2) INDIVIDUAL DESCRIBED.—For purposes of paragraph (1), an individual described in this paragraph is an individual who enrolls in part B, submits to the Secretary an application to participate in the applicable pilot program under this subsection, and—

“(A) is an environmental exposure affected individual described in subsection (e)(2) who resides in or around the geographic area subject to an emergency declaration made as of June 17, 2009; or

“(B) is an environmental exposure affected individual described in subsection (e)(3) who—

“(i) is deemed under subsection (a)(2); and

“(ii) meets such other criteria or conditions for participation in a pilot program under paragraph (1)(B) as the Secretary specifies.

“(3) FLEXIBLE BENEFITS AND SERVICES.—A pilot program under this subsection may provide for the furnishing of benefits, items, or services not otherwise covered or authorized under this title, if the Secretary determines that furnishing such benefits, items, or services will further the purposes of such pilot program (as described in paragraph (1)).

“(4) INNOVATIVE REIMBURSEMENT METHODOLOGIES.—For purposes of the pilot program under this subsection, the Secretary—

“(A) shall develop and implement appropriate methodologies to reimburse providers for furnishing benefits, items, or services for which payment is not otherwise covered or authorized under this title, if such benefits, items, or services are furnished pursuant to paragraph (3); and

“(B) may develop and implement innovative approaches to reimbursing providers for any benefits, items, or services furnished under this subsection.

“(5) LIMITATION.—Consistent with section 1862(b), no payment shall be made under the pilot program under this subsection with respect to benefits, items, or services furnished to an environmental exposure affected individual (as defined in subsection (e)) to the extent that such individual is eligible to receive such benefits, items, or services through any other public or private benefits plan or legal agreement.

“(6) WAIVER AUTHORITY.—The Secretary may waive such provisions of this title and title XI as are necessary to carry out pilot programs under this subsection.

“(7) FUNDING.—For purposes of carrying out pilot programs under this subsection, the

Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in such proportion as the Secretary determines appropriate, of such sums as the Secretary determines necessary, to the Centers for Medicare & Medicaid Services Program Management Account.

“(8) **WAIVER OF BUDGET NEUTRALITY.**—The Secretary shall not require that pilot programs under this subsection be budget neutral with respect to expenditures under this title.

“(c) **DETERMINATIONS.**—

“(1) **BY THE COMMISSIONER OF SOCIAL SECURITY.**—For purposes of this section, the Commissioner of Social Security, in consultation with the Secretary, and using the cost allocation method prescribed in section 201(g), shall determine whether individuals are environmental exposure affected individuals.

“(2) **BY THE SECRETARY.**—The Secretary shall determine eligibility for pilot programs under subsection (b).

“(d) **EMERGENCY DECLARATION DEFINED.**—For purposes of this section, the term ‘emergency declaration’ means a declaration of a public health emergency under section 104(a) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

“(e) **ENVIRONMENTAL EXPOSURE AFFECTED INDIVIDUAL DEFINED.**—

“(1) **IN GENERAL.**—For purposes of this section, the term ‘environmental exposure affected individual’ means—

“(A) an individual described in paragraph (2); and

“(B) an individual described in paragraph (3).

“(2) **INDIVIDUAL DESCRIBED.**—

“(A) **IN GENERAL.**—An individual described in this paragraph is any individual who—

“(i) is diagnosed with 1 or more conditions described in subparagraph (B);

“(ii) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to an emergency declaration specified in subsection (b)(2)(A), during a period ending—

“(I) not less than 10 years prior to such diagnosis; and

“(II) prior to the implementation of all the remedial and removal actions specified in the Record of Decision for Operating Unit 4 and the Record of Decision for Operating Unit 7;

“(iii) files an application for benefits under this title (or has an application filed on behalf of the individual), including pursuant to this section; and

“(iv) is determined under this section to meet the criteria in this subparagraph.

“(B) **CONDITIONS DESCRIBED.**—For purposes of subparagraph (A), the following conditions are described in this subparagraph:

“(i) Asbestosis, pleural thickening, or pleural plaques as established by—

“(I) interpretation by a ‘B Reader’ qualified physician of a plain chest x-ray or interpretation of a computed tomographic radiograph of the chest by a qualified physician, as determined by the Secretary; or

“(II) such other diagnostic standards as the Secretary specifies,

except that this clause shall not apply to pleural thickening or pleural plaques unless there are symptoms or conditions requiring medical treatment as a result of these diagnoses.

“(ii) Mesothelioma, or malignancies of the lung, colon, rectum, larynx, stomach, esophagus, pharynx, or ovary, as established by—

“(I) pathologic examination of biopsy tissue;

“(II) cytology from bronchioalveolar lavage; or

“(III) such other diagnostic standards as the Secretary specifies.

“(iii) Any other diagnosis which the Secretary, in consultation with the Commissioner of Social Security, determines is an asbestos-related medical condition, as established by such diagnostic standards as the Secretary specifies.

“(3) **OTHER INDIVIDUAL DESCRIBED.**—An individual described in this paragraph is any individual who—

“(A) is not an individual described in paragraph (2);

“(B) is diagnosed with a medical condition caused by the exposure of the individual to a public health hazard to which an emergency declaration applies, based on such medical conditions, diagnostic standards, and other criteria as the Secretary specifies;

“(C) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to the emergency declaration involved, during a period determined appropriate by the Secretary;

“(D) files an application for benefits under this title (or has an application filed on behalf of the individual), including pursuant to this section; and

“(E) is determined under this section to meet the criteria in this paragraph.”

(b) **PROGRAM FOR EARLY DETECTION OF CERTAIN MEDICAL CONDITIONS RELATED TO ENVIRONMENTAL HEALTH HAZARDS.**—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.), as amended by section 5507, is amended by adding at the end the following:

“SEC. 2009. PROGRAM FOR EARLY DETECTION OF CERTAIN MEDICAL CONDITIONS RELATED TO ENVIRONMENTAL HEALTH HAZARDS.

“(a) **PROGRAM ESTABLISHMENT.**—The Secretary shall establish a program in accordance with this section to make competitive grants to eligible entities specified in subsection (b) for the purpose of—

“(1) screening at-risk individuals (as defined in subsection (c)(1)) for environmental health conditions (as defined in subsection (c)(3)); and

“(2) developing and disseminating public information and education concerning—

“(A) the availability of screening under the program under this section;

“(B) the detection, prevention, and treatment of environmental health conditions; and

“(C) the availability of Medicare benefits for certain individuals diagnosed with environmental health conditions under section 1881A.

“(b) **ELIGIBLE ENTITIES.**—

“(1) **IN GENERAL.**—For purposes of this section, an eligible entity is an entity described in paragraph (2) which submits an application to the Secretary in such form and manner, and containing such information and assurances, as the Secretary determines appropriate.

“(2) **TYPES OF ELIGIBLE ENTITIES.**—The entities described in this paragraph are the following:

“(A) A hospital or community health center.

“(B) A Federally qualified health center.

“(C) A facility of the Indian Health Service.

“(D) A National Cancer Institute-designated cancer center.

“(E) An agency of any State or local government.

“(F) A nonprofit organization.

“(G) Any other entity the Secretary determines appropriate.

“(c) **DEFINITIONS.**—In this section:

“(1) **AT-RISK INDIVIDUAL.**—The term ‘at-risk individual’ means an individual who—

“(A)(i) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to an emergency declaration specified under paragraph (2), during a period ending—

“(I) not less than 10 years prior to the date of such individual’s application under subparagraph (B); and

“(II) prior to the implementation of all the remedial and removal actions specified in the Record of Decision for Operating Unit 4 and the Record of Decision for Operating Unit 7; or

“(ii) meets such other criteria as the Secretary determines appropriate considering the type of environmental health condition at issue; and

“(B) has submitted an application (or has an application submitted on the individual’s behalf), to an eligible entity receiving a grant under this section, for screening under the program under this section.

“(2) **EMERGENCY DECLARATION.**—The term ‘emergency declaration’ means a declaration of a public health emergency under section 104(a) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

“(3) **ENVIRONMENTAL HEALTH CONDITION.**—The term ‘environmental health condition’ means—

“(A) asbestosis, pleural thickening, or pleural plaques, as established by—

“(i) interpretation by a ‘B Reader’ qualified physician of a plain chest x-ray or interpretation of a computed tomographic radiograph of the chest by a qualified physician, as determined by the Secretary; or

“(ii) such other diagnostic standards as the Secretary specifies;

“(B) mesothelioma, or malignancies of the lung, colon, rectum, larynx, stomach, esophagus, pharynx, or ovary, as established by—

“(i) pathologic examination of biopsy tissue;

“(ii) cytology from bronchioalveolar lavage; or

“(iii) such other diagnostic standards as the Secretary specifies; and

“(C) any other medical condition which the Secretary determines is caused by exposure to a hazardous substance or pollutant or contaminant at a Superfund site to which an emergency declaration applies, based on such criteria and as established by such diagnostic standards as the Secretary specifies.

“(4) **HAZARDOUS SUBSTANCE; POLLUTANT; CONTAMINANT.**—The terms ‘hazardous substance’, ‘pollutant’, and ‘contaminant’ have the meanings given those terms in section 101 of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9601).

“(5) **SUPERFUND SITE.**—The term ‘Superfund site’ means a site included on the National Priorities List developed by the President in accordance with section 105(a)(8)(B) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9605(a)(8)(B)).

“(d) **HEALTH COVERAGE UNAFFECTED.**—Nothing in this section shall be construed to affect any coverage obligation of a governmental or private health plan or program relating to an at-risk individual.

“(e) FUNDING.—

“(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary, to carry out the program under this section—

“(A) \$23,000,000 for the period of fiscal years 2010 through 2014; and

“(B) \$20,000,000 for each 5-fiscal year period thereafter.

“(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

“(f) NONAPPLICATION.—

“(1) IN GENERAL.—Except as provided in paragraph (2), the preceding sections of this title shall not apply to grants awarded under this section.

“(2) LIMITATIONS ON USE OF GRANTS.—Section 2005(a) shall apply to a grant awarded under this section to the same extent and in the same manner as such section applies to payments to States under this title, except that paragraph (4) of such section shall not be construed to prohibit grantees from conducting screening for environmental health conditions as authorized under this section.”.

SEC. 10324. PROTECTIONS FOR FRONTIER STATES.

(a) FLOOR ON AREA WAGE INDEX FOR HOSPITALS IN FRONTIER STATES.—

(1) IN GENERAL.—Section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(A) in clause (i), by striking “clause (ii)” and inserting “clause (ii) or (iii)”; and

(B) by adding at the end the following new clause:

“(iii) FLOOR ON AREA WAGE INDEX FOR HOSPITALS IN FRONTIER STATES.—

“(I) IN GENERAL.—Subject to subclause (IV), for discharges occurring on or after October 1, 2010, the area wage index applicable under this subparagraph to any hospital which is located in a frontier State (as defined in subclause (II)) may not be less than 1.00.

“(II) FRONTIER STATE DEFINED.—In this clause, the term ‘frontier State’ means a State in which at least 50 percent of the counties in the State are frontier counties.

“(III) FRONTIER COUNTY DEFINED.—In this clause, the term ‘frontier county’ means a county in which the population per square mile is less than 6.

“(IV) LIMITATION.—This clause shall not apply to any hospital located in a State that receives a non-labor related share adjustment under paragraph (5)(H).”.

(2) WAIVING BUDGET NEUTRALITY.—Section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended in the third sentence by inserting “and the amendments made by section 10324(a)(1) of the Patient Protection and Affordable Care Act” after “2003”.

(b) FLOOR ON AREA WAGE ADJUSTMENT FACTOR FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES IN FRONTIER STATES.—Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), as amended by section 3138, is amended—

(1) in paragraph (2)(D), by striking “the Secretary” and inserting “subject to paragraph (19), the Secretary”; and

(2) by adding at the end the following new paragraph:

“(19) FLOOR ON AREA WAGE ADJUSTMENT FACTOR FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES IN FRONTIER STATES.—

“(A) IN GENERAL.—Subject to subparagraph (B), with respect to covered OPD services furnished on or after January 1, 2011, the area wage adjustment factor applicable

under the payment system established under this subsection to any hospital outpatient department which is located in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II)) may not be less than 1.00. The preceding sentence shall not be applied in a budget neutral manner.

“(B) LIMITATION.—This paragraph shall not apply to any hospital outpatient department located in a State that receives a non-labor related share adjustment under section 1886(d)(5)(H).”.

(c) FLOOR FOR PRACTICE EXPENSE INDEX FOR PHYSICIANS’ SERVICES FURNISHED IN FRONTIER STATES.—Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)), as amended by section 3102, is amended—

(1) in subparagraph (A), by striking “and (H)” and inserting “(H), and (I)”; and

(2) by adding at the end the following new subparagraph:

“(I) FLOOR FOR PRACTICE EXPENSE INDEX FOR SERVICES FURNISHED IN FRONTIER STATES.—

“(i) IN GENERAL.—Subject to clause (ii), for purposes of payment for services furnished in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II)) on or after January 1, 2011, after calculating the practice expense index in subparagraph (A)(i), the Secretary shall increase any such index to 1.00 if such index would otherwise be less than 1.00. The preceding sentence shall not be applied in a budget neutral manner.

“(ii) LIMITATION.—This subparagraph shall not apply to services furnished in a State that receives a non-labor related share adjustment under section 1886(d)(5)(H).”.

SEC. 10325. REVISION TO SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.

(a) TEMPORARY DELAY OF RUG-IV.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to October 1, 2011, implement Version 4 of the Resource Utilization Groups (in this subsection referred to as “RUG-IV”) published in the Federal Register on August 11, 2009, entitled “Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2010; Minimum Data Set, Version 3.0 for Skilled Nursing Facilities and Medicaid Nursing Facilities” (74 Fed. Reg. 40288). Beginning on October 1, 2010, the Secretary of Health and Human Services shall implement the change specific to therapy furnished on a concurrent basis that is a component of RUG-IV and changes to the lookback period to ensure that only those services furnished after admission to a skilled nursing facility are used as factors in determining a case mix classification under the skilled nursing facility prospective payment system under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)).

(b) CONSTRUCTION.—Nothing in this section shall be interpreted as delaying the implementation of Version 3.0 of the Minimum Data Sets (MDS 3.0) beyond the planned implementation date of October 1, 2010.

SEC. 10326. PILOT TESTING PAY-FOR-PERFORMANCE PROGRAMS FOR CERTAIN MEDICARE PROVIDERS.

(a) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall, for each provider described in subsection (b), conduct a separate pilot program under title XVIII of the Social Security Act to test the implementation of a value-based purchasing program for payments under such title for the provider.

(b) PROVIDERS DESCRIBED.—The providers described in this paragraph are the following:

(1) Psychiatric hospitals (as described in clause (i) of section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))) and psychiatric units (as described in the matter following clause (v) of such section).

(2) Long-term care hospitals (as described in clause (iv) of such section).

(3) Rehabilitation hospitals (as described in clause (ii) of such section).

(4) PPS-exempt cancer hospitals (as described in clause (v) of such section).

(5) Hospice programs (as defined in section 1861(dd)(2) of such Act (42 U.S.C. 1395x(dd)(2))).

(c) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary solely for purposes of carrying out the pilot programs under this section.

(d) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments under this section under the separate pilot program for value based purchasing (as described in subsection (a)) for each provider type described in paragraphs (1) through (5) of subsection (b) for applicable items and services under title XVIII of the Social Security Act for a year shall be established in a manner that does not result in spending more under each such value based purchasing program for such year than would otherwise be expended for such provider type for such year if the pilot program were not implemented, as estimated by the Secretary.

(e) EXPANSION OF PILOT PROGRAM.—The Secretary may, at any point after January 1, 2018, expand the duration and scope of a pilot program conducted under this subsection, to the extent determined appropriate by the Secretary, if—

(1) the Secretary determines that such expansion is expected to—

(A) reduce spending under title XVIII of the Social Security Act without reducing the quality of care; or

(B) improve the quality of care and reduce spending;

(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under such title XVIII; and

(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under such title XIII for Medicare beneficiaries.

SEC. 10327. IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM.

(a) IN GENERAL.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w-4(m)) is amended by adding at the end the following new paragraph:

“(7) ADDITIONAL INCENTIVE PAYMENT.—

“(A) IN GENERAL.—For 2011 through 2014, if an eligible professional meets the requirements described in subparagraph (B), the applicable quality percent for such year, as described in clauses (iii) and (iv) of paragraph (1)(B), shall be increased by 0.5 percentage points.

“(B) REQUIREMENTS DESCRIBED.—In order to qualify for the additional incentive payment described in subparagraph (A), an eligible professional shall meet the following requirements:

“(i) The eligible professional shall—

“(I) satisfactorily submit data on quality measures for purposes of paragraph (1) for a year; and

“(II) have such data submitted on their behalf through a Maintenance of Certification Program (as defined in subparagraph (C)(i)) that meets—

“(aa) the criteria for a registry (as described in subsection (k)(4)); or

“(bb) an alternative form and manner determined appropriate by the Secretary.

“(ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—

“(I) participates in such a Maintenance of Certification program for a year; and

“(II) successfully completes a qualified Maintenance of Certification Program practice assessment (as defined in subparagraph (C)(ii)) for such year.

“(iii) A Maintenance of Certification program submits to the Secretary, on behalf of the eligible professional, information—

“(I) in a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of clause (ii) (which may be in the form of a structural measure);

“(II) if requested by the Secretary, on the survey of patient experience with care (as described in subparagraph (C)(ii)(II)); and

“(III) as the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

“(C) DEFINITIONS.—For purposes of this paragraph:

“(i) The term ‘Maintenance of Certification Program’ means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism. Such a program shall include the following:

“(I) The program requires the physician to maintain a valid, unrestricted medical license in the United States.

“(II) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

“(III) The program requires a physician to demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.

“(IV) The program requires successful completion of a qualified Maintenance of Certification Program practice assessment as described in clause (ii).

“(i) The term ‘qualified Maintenance of Certification Program practice assessment’ means an assessment of a physician’s practice that—

“(I) includes an initial assessment of an eligible professional’s practice that is designed to demonstrate the physician’s use of evidence-based medicine;

“(II) includes a survey of patient experience with care; and

“(III) requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under subclause (I) and then to remeasure to assess performance improvement after such intervention.”.

(b) AUTHORITY.—Section 3002(c) of this Act is amended by adding at the end the following new paragraph:

“(3) AUTHORITY.—For years after 2014, if the Secretary of Health and Human Services determines it to be appropriate, the Secretary may incorporate participation in a Maintenance of Certification Program and

successful completion of a qualified Maintenance of Certification Program practice assessment into the composite of measures of quality of care furnished pursuant to the physician fee schedule payment modifier, as described in section 1848(p)(2) of the Social Security Act (42 U.S.C. 1395w-4(p)(2)).”.

(c) ELIMINATION OF MA REGIONAL PLAN STABILIZATION FUND.—

(1) IN GENERAL.—Section 1858 of the Social Security Act (42 U.S.C. 1395w-27a) is amended by striking subsection (e).

(2) TRANSITION.—Any amount contained in the MA Regional Plan Stabilization Fund as of the date of the enactment of this Act shall be transferred to the Federal Supplementary Medical Insurance Trust Fund.

SEC. 10328. IMPROVEMENT IN PART D MEDICATION THERAPY MANAGEMENT (MTM) PROGRAMS.

(a) IN GENERAL.—Section 1860D-4(c)(2) of the Social Security Act (42 U.S.C. 1395w-104(c)(2)) is amended—

(1) by redesignating subparagraphs (C), (D), and (E) as subparagraphs (E), (F), and (G), respectively; and

(2) by inserting after subparagraph (B) the following new subparagraphs:

“(C) REQUIRED INTERVENTIONS.—For plan years beginning on or after the date that is 2 years after the date of the enactment of the Patient Protection and Affordable Care Act, prescription drug plan sponsors shall offer medication therapy management services to targeted beneficiaries described in subparagraph (A)(ii) that include, at a minimum, the following to increase adherence to prescription medications or other goals deemed necessary by the Secretary:

“(i) An annual comprehensive medication review furnished person-to-person or using telehealth technologies (as defined by the Secretary) by a licensed pharmacist or other qualified provider. The comprehensive medication review—

“(I) shall include a review of the individual’s medications and may result in the creation of a recommended medication action plan or other actions in consultation with the individual and with input from the prescriber to the extent necessary and practicable; and

“(II) shall include providing the individual with a written or printed summary of the results of the review.

The Secretary, in consultation with relevant stakeholders, shall develop a standardized format for the action plan under subclause (I) and the summary under subclause (II).

“(ii) Follow-up interventions as warranted based on the findings of the annual medication review or the targeted medication enrollment and which may be provided person-to-person or using telehealth technologies (as defined by the Secretary).

“(D) ASSESSMENT.—The prescription drug plan sponsor shall have in place a process to assess, at least on a quarterly basis, the medication use of individuals who are at risk but not enrolled in the medication therapy management program, including individuals who have experienced a transition in care, if the prescription drug plan sponsor has access to that information.

“(E) AUTOMATIC ENROLLMENT WITH ABILITY TO OPT-OUT.—The prescription drug plan sponsor shall have in place a process to—

“(i) subject to clause (ii), automatically enroll targeted beneficiaries described in subparagraph (A)(ii), including beneficiaries identified under subparagraph (D), in the medication therapy management program required under this subsection; and

“(ii) permit such beneficiaries to opt-out of enrollment in such program.”.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall limit the authority of the Secretary of Health and Human Services to modify or broaden requirements for a medication therapy management program under part D of title XVIII of the Social Security Act or to study new models for medication therapy management through the Center for Medicare and Medicaid Innovation under section 1115A of such Act, as added by section 3021.

SEC. 10329. DEVELOPING METHODOLOGY TO ASSESS HEALTH PLAN VALUE.

(a) DEVELOPMENT.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”), in consultation with relevant stakeholders including health insurance issuers, health care consumers, employers, health care providers, and other entities determined appropriate by the Secretary, shall develop a methodology to measure health plan value. Such methodology shall take into consideration, where applicable—

(1) the overall cost to enrollees under the plan;

(2) the quality of the care provided for under the plan;

(3) the efficiency of the plan in providing care;

(4) the relative risk of the plan’s enrollees as compared to other plans;

(5) the actuarial value or other comparative measure of the benefits covered under the plan; and

(6) other factors determined relevant by the Secretary.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report concerning the methodology developed under subsection (a).

SEC. 10330. MODERNIZING COMPUTER AND DATA SYSTEMS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES TO SUPPORT IMPROVEMENTS IN CARE DELIVERY.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall develop a plan (and detailed budget for the resources needed to implement such plan) to modernize the computer and data systems of the Centers for Medicare & Medicaid Services (in this section referred to as “CMS”).

(b) CONSIDERATIONS.—In developing the plan, the Secretary shall consider how such modernized computer system could—

(1) in accordance with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, make available data in a reliable and timely manner to providers of services and suppliers to support their efforts to better manage and coordinate care furnished to beneficiaries of CMS programs; and

(2) support consistent evaluations of payment and delivery system reforms under CMS programs.

(c) POSTING OF PLAN.—By not later than 9 months after the date of the enactment of this Act, the Secretary shall post on the website of the Centers for Medicare & Medicaid Services the plan described in subsection (a).

SEC. 10331. PUBLIC REPORTING OF PERFORMANCE INFORMATION.

(a) IN GENERAL.—

(1) DEVELOPMENT.—Not later than January 1, 2011, the Secretary shall develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program under section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) and other

eligible professionals who participate in the Physician Quality Reporting Initiative under section 1848 of such Act (42 U.S.C. 1395w-4).

(2) **PLAN.**—Not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, the Secretary shall also implement a plan for making publicly available through Physician Compare, consistent with subsection (c), information on physician performance that provides comparable information for the public on quality and patient experience measures with respect to physicians enrolled in the Medicare program under such section 1866(j). To the extent scientifically sound measures that are developed consistent with the requirements of this section are available, such information, to the extent practicable, shall include—

(A) measures collected under the Physician Quality Reporting Initiative;

(B) an assessment of patient health outcomes and the functional status of patients;

(C) an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;

(D) an assessment of efficiency;

(E) an assessment of patient experience and patient, caregiver, and family engagement;

(F) an assessment of the safety, effectiveness, and timeliness of care; and

(G) other information as determined appropriate by the Secretary.

(b) **OTHER REQUIRED CONSIDERATIONS.**—In developing and implementing the plan described in subsection (a)(2), the Secretary shall, to the extent practicable, include—

(1) processes to assure that data made public, either by the Centers for Medicare & Medicaid Services or by other entities, is statistically valid and reliable, including risk adjustment mechanisms used by the Secretary;

(2) processes by which a physician or other eligible professional whose performance on measures is being publicly reported has a reasonable opportunity, as determined by the Secretary, to review his or her individual results before they are made public;

(3) processes by the Secretary to assure that the implementation of the plan and the data made available on Physician Compare provide a robust and accurate portrayal of a physician's performance;

(4) data that reflects the care provided to all patients seen by physicians, under both the Medicare program and, to the extent practicable, other payers, to the extent such information would provide a more accurate portrayal of physician performance;

(5) processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of a patient;

(6) processes to ensure timely statistical performance feedback is provided to physicians concerning the data reported under any program subject to public reporting under this section; and

(7) implementation of computer and data systems of the Centers for Medicare & Medicaid Services that support valid, reliable, and accurate public reporting activities authorized under this section.

(c) **ENSURING PATIENT PRIVACY.**—The Secretary shall ensure that information on physician performance and patient experience is not disclosed under this section in a manner that violates sections 552 or 552a of title 5, United States Code, with regard to the privacy of individually identifiable health information.

(d) **FEEDBACK FROM MULTI-STAKEHOLDER GROUPS.**—The Secretary shall take into consideration input provided by multi-stakeholder groups, consistent with sections 1890(b)(7) and 1890A of the Social Security Act, as added by section 3014 of this Act, in selecting quality measures for use under this section.

(e) **CONSIDERATION OF TRANSITION TO VALUE-BASED PURCHASING.**—In developing the plan under this subsection (a)(2), the Secretary shall, as the Secretary determines appropriate, consider the plan to transition to a value-based purchasing program for physicians and other practitioners developed under section 131 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275).

(f) **REPORT TO CONGRESS.**—Not later than January 1, 2015, the Secretary shall submit to Congress a report on the Physician Compare Internet website developed under subsection (a)(1). Such report shall include information on the efforts of and plans made by the Secretary to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(g) **EXPANSION.**—At any time before the date on which the report is submitted under subsection (f), the Secretary may expand (including expansion to other providers of services and suppliers under title XVIII of the Social Security Act) the information made available on such website.

(h) **FINANCIAL INCENTIVES TO ENCOURAGE CONSUMERS TO CHOOSE HIGH QUALITY PROVIDERS.**—The Secretary may establish a demonstration program, not later than January 1, 2019, to provide financial incentives to Medicare beneficiaries who are furnished services by high quality physicians, as determined by the Secretary based on factors in subparagraphs (A) through (G) of subsection (a)(2). In no case may Medicare beneficiaries be required to pay increased premiums or cost sharing or be subject to a reduction in benefits under title XVIII of the Social Security Act as a result of such demonstration program. The Secretary shall ensure that any such demonstration program does not disadvantage those beneficiaries without reasonable access to high performing physicians or create financial inequities under such title.

(i) **DEFINITIONS.**—In this section:

(1) **ELIGIBLE PROFESSIONAL.**—The term “eligible professional” has the meaning given that term for purposes of the Physician Quality Reporting Initiative under section 1848 of the Social Security Act (42 U.S.C. 1395w-4).

(2) **PHYSICIAN.**—The term “physician” has the meaning given that term in section 1861(r) of such Act (42 U.S.C. 1395x(r)).

(3) **PHYSICIAN COMPARE.**—The term “Physician Compare” means the Internet website developed under subsection (a)(1).

(4) **SECRETARY.**—The term “Secretary” means the Secretary of Health and Human Services.

SEC. 10332. AVAILABILITY OF MEDICARE DATA FOR PERFORMANCE MEASUREMENT.

(a) **IN GENERAL.**—Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

“(e) **AVAILABILITY OF MEDICARE DATA.**—

“(1) **IN GENERAL.**—Subject to paragraph (4), the Secretary shall make available to qualified entities (as defined in paragraph (2))

data described in paragraph (3) for the evaluation of the performance of providers of services and suppliers.

“(2) **QUALIFIED ENTITIES.**—For purposes of this subsection, the term ‘qualified entity’ means a public or private entity that—

“(A) is qualified (as determined by the Secretary) to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use; and

“(B) agrees to meet the requirements described in paragraph (4) and meets such other requirements as the Secretary may specify, such as ensuring security of data.

“(3) **DATA DESCRIBED.**—The data described in this paragraph are standardized extracts (as determined by the Secretary) of claims data under parts A, B, and D for items and services furnished under such parts for one or more specified geographic areas and time periods requested by a qualified entity. The Secretary shall take such actions as the Secretary deems necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts.

“(4) **REQUIREMENTS.**—

“(A) **FEE.**—Data described in paragraph (3) shall be made available to a qualified entity under this subsection at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited into the Federal Supplementary Medical Insurance Trust Fund under section 1841.

“(B) **SPECIFICATION OF USES AND METHODOLOGIES.**—A qualified entity requesting data under this subsection shall—

“(i) submit to the Secretary a description of the methodologies that such qualified entity will use to evaluate the performance of providers of services and suppliers using such data;

“(ii)(I) except as provided in subclause (II), if available, use standard measures, such as measures endorsed by the entity with a contract under section 1890(a) and measures developed pursuant to section 931 of the Public Health Service Act; or

“(II) use alternative measures if the Secretary, in consultation with appropriate stakeholders, determines that use of such alternative measures would be more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by such standard measures;

“(iii) include data made available under this subsection with claims data from sources other than claims data under this title in the evaluation of performance of providers of services and suppliers;

“(iv) only include information on the evaluation of performance of providers and suppliers in reports described in subparagraph (C);

“(v) make available to providers of services and suppliers, upon their request, data made available under this subsection; and

“(vi) prior to their release, submit to the Secretary the format of reports under subparagraph (C).

“(C) **REPORTS.**—Any report by a qualified entity evaluating the performance of providers of services and suppliers using data made available under this subsection shall—

“(i) include an understandable description of the measures, which shall include quality measures and the rationale for use of other measures described in subparagraph (B)(ii)(II), risk adjustment methods, physician attribution methods, other applicable methods, data specifications and limitations, and the sponsors, so that consumers, providers of services and suppliers, health plans,

researchers, and other stakeholders can assess such reports;

“(ii) be made available confidentially, to any provider of services or supplier to be identified in such report, prior to the public release of such report, and provide an opportunity to appeal and correct errors;

“(iii) only include information on a provider of services or supplier in an aggregate form as determined appropriate by the Secretary; and

“(iv) except as described in clause (ii), be made available to the public.

“(D) APPROVAL AND LIMITATION OF USES.—The Secretary shall not make data described in paragraph (3) available to a qualified entity unless the qualified entity agrees to release the information on the evaluation of performance of providers of services and suppliers. Such entity shall only use such data, and information derived from such evaluation, for the reports under subparagraph (C). Data released to a qualified entity under this subsection shall not be subject to discovery or admission as evidence in judicial or administrative proceedings without consent of the applicable provider of services or supplier.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2012.

SEC. 10333. COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following new subpart:

“Subpart XI—Community-Based Collaborative Care Network Program

“SEC. 340H. COMMUNITY-BASED COLLABORATIVE CARE NETWORK PROGRAM.

“(a) IN GENERAL.—The Secretary may award grants to eligible entities to support community-based collaborative care networks that meet the requirements of subsection (b).

“(b) COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.—

“(1) DESCRIPTION.—A community-based collaborative care network (referred to in this section as a ‘network’) shall be a consortium of health care providers with a joint governance structure (including providers within a single entity) that provides comprehensive coordinated and integrated health care services (as defined by the Secretary) for low-income populations.

“(2) REQUIRED INCLUSION.—A network shall include the following providers (unless such provider does not exist within the community, declines or refuses to participate, or places unreasonable conditions on their participation):

“(A) A hospital that meets the criteria in section 1923(b)(1) of the Social Security Act; and

“(B) All Federally qualified health centers (as defined in section 1861(aa) of the Social Security Act located in the community.

“(3) PRIORITY.—In awarding grants, the Secretary shall give priority to networks that include—

“(A) the capability to provide the broadest range of services to low-income individuals;

“(B) the broadest range of providers that currently serve a high volume of low-income individuals; and

“(C) a county or municipal department of health.

“(c) APPLICATION.—

“(1) APPLICATION.—A network described in subsection (b) shall submit an application to the Secretary.

“(2) RENEWAL.—In subsequent years, based on the performance of grantees, the Sec-

retary may provide renewal grants to prior year grant recipients.

“(d) USE OF FUNDS.—

“(1) USE BY GRANTEEES.—Grant funds may be used for the following activities:

“(A) Assist low-income individuals to—

“(i) access and appropriately use health services;

“(ii) enroll in health coverage programs; and

“(iii) obtain a regular primary care provider or a medical home.

“(B) Provide case management and care management.

“(C) Perform health outreach using neighborhood health workers or through other means.

“(D) Provide transportation.

“(E) Expand capacity, including through telehealth, after-hours services or urgent care.

“(F) Provide direct patient care services.

“(2) GRANT FUNDS TO HRSA GRANTEEES.—The Secretary may limit the percent of grant funding that may be spent on direct care services provided by grantees of programs administered by the Health Resources and Services Administration or impose other requirements on such grantees deemed necessary.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2011 through 2015.”

SEC. 10334. MINORITY HEALTH.

(a) OFFICE OF MINORITY HEALTH.—

(1) IN GENERAL.—Section 1707 of the Public Health Service Act (42 U.S.C. 300u-6) is amended—

(A) in subsection (a), by striking “within the Office of Public Health and Science” and all that follows through the end and inserting “. The Office of Minority Health as existing on the date of enactment of the Patient Protection and Affordable Care Act shall be transferred to the Office of the Secretary in such manner that there is established in the Office of the Secretary, the Office of Minority Health, which shall be headed by the Deputy Assistant Secretary for Minority Health who shall report directly to the Secretary, and shall retain and strengthen authorities (as in existence on such date of enactment) for the purpose of improving minority health and the quality of health care minorities receive, and eliminating racial and ethnic disparities. In carrying out this subsection, the Secretary, acting through the Deputy Assistant Secretary, shall award grants, contracts, enter into memoranda of understanding, cooperative, interagency, intra-agency and other agreements with public and nonprofit private entities, agencies, as well as Departmental and Cabinet agencies and organizations, and with organizations that are indigenous human resource providers in communities of color to assure improved health status of racial and ethnic minorities, and shall develop measures to evaluate the effectiveness of activities aimed at reducing health disparities and supporting the local community. Such measures shall evaluate community outreach activities, language services, workforce cultural competence, and other areas as determined by the Secretary.”; and

(B) by striking subsection (h) and inserting the following:

“(h) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2016.”

(2) TRANSFER OF FUNCTIONS.—There are transferred to the Office of Minority Health in the office of the Secretary of Health and Human Services, all duties, responsibilities, authorities, accountabilities, functions, staff, funds, award mechanisms, and other entities under the authority of the Office of Minority Health of the Public Health Service as in effect on the date before the date of enactment of this Act, which shall continue in effect according to the terms in effect on the date before such date of enactment, until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, the Secretary, a court of competent jurisdiction, or by operation of law.

(3) REPORTS.—Not later than 1 year after the date of enactment of this section, and biennially thereafter, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under section 1707 of the Public Health Service Act (as amended by this subsection) during the period for which the report is being prepared. Not later than 1 year after the date of enactment of this section, and biennially thereafter, the heads of each of the agencies of the Department of Health and Human Services shall submit to the Deputy Assistant Secretary for Minority Health a report summarizing the minority health activities of each of the respective agencies.

(b) ESTABLISHMENT OF INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—

(1) IN GENERAL.—Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended by inserting after section 1707 the following section:

“SEC. 1707A. INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN THE DEPARTMENT.

“(a) IN GENERAL.—The head of each agency specified in subsection (b)(1) shall establish within the agency an office to be known as the Office of Minority Health. The head of each such Office shall be appointed by the head of the agency within which the Office is established, and shall report directly to the head of the agency. The head of such agency shall carry out this section (as this section relates to the agency) acting through such Director.

“(b) SPECIFIED AGENCIES.—The agencies referred to in subsection (a) are the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services.

“(c) DIRECTOR; APPOINTMENT.—Each Office of Minority Health established in an agency listed in subsection (a) shall be headed by a director, with documented experience and expertise in minority health services research and health disparities elimination.

“(d) REFERENCES.—Except as otherwise specified, any reference in Federal law to an Office of Minority Health (in the Department of Health and Human Services) is deemed to be a reference to the Office of Minority Health in the Office of the Secretary.

“(e) FUNDING.—

“(1) ALLOCATIONS.—Of the amounts appropriated for a specified agency for a fiscal year, the Secretary must designate an appropriate amount of funds for the purpose of carrying out activities under this section through the minority health office of the agency. In reserving an amount under the preceding sentence for a minority health office for a fiscal year, the Secretary shall reduce, by substantially the same percentage,

the amount that otherwise would be available for each of the programs of the designated agency involved.

“(2) AVAILABILITY OF FUNDS FOR STAFFING.—The purposes for which amounts made available under paragraph may be expended by a minority health office include the costs of employing staff for such office.”

(2) NO NEW REGULATORY AUTHORITY.—Nothing in this subsection and the amendments made by this subsection may be construed as establishing regulatory authority or modifying any existing regulatory authority.

(3) LIMITATION ON TERMINATION.—Notwithstanding any other provision of law, a Federal office of minority health or Federal appointive position with primary responsibility over minority health issues that is in existence in an office of agency of the Department of Health and Human Services on the date of enactment of this section shall not be terminated, reorganized, or have any of its power or duties transferred unless such termination, reorganization, or transfer is approved by an Act of Congress.

(c) REDESIGNATION OF NATIONAL CENTER ON MINORITY HEALTH AND HEALTH DISPARITIES.—

(1) REDESIGNATION.—Title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended—

(A) by redesignating subpart 6 of part E as subpart 20;

(B) by transferring subpart 20, as so redesignated, to part C of such title IV;

(C) by inserting subpart 20, as so redesignated, after subpart 19 of such part C; and

(D) in subpart 20, as so redesignated—

(i) by redesignating sections 485E through 485H as sections 464z-3 through 464z-6, respectively;

(ii) by striking “National Center on Minority Health and Health Disparities” each place such term appears and inserting “National Institute on Minority Health and Health Disparities”; and

(iii) by striking “Center” each place such term appears and inserting “Institute”.

(2) PURPOSE OF INSTITUTE; DUTIES.—Section 464z-3 of the Public Health Service Act, as so redesignated, is amended—

(A) in subsection (h)(1), by striking “research endowments at centers of excellence under section 736.” and inserting the following: “research endowments—

“(1) at centers of excellence under section 736; and

“(2) at centers of excellence under section 464z-4.”;

(B) in subsection (h)(2)(A), by striking “average” and inserting “median”; and

(C) by adding at the end the following:

“(h) INTERAGENCY COORDINATION.—The Director of the Institute, as the primary Federal officials with responsibility for coordinating all research and activities conducted or supported by the National Institutes of Health on minority health and health disparities, shall plan, coordinate, review and evaluate research and other activities conducted or supported by the Institutes and Centers of the National Institutes of Health.”.

(3) TECHNICAL AND CONFORMING AMENDMENTS.—

(A) Section 401(b)(24) of the Public Health Service Act (42 U.S.C. 281(b)(24)) is amended by striking “Center” and inserting “Institute”.

(B) Subsection (d)(1) of section 903 of the Public Health Service Act (42 U.S.C. 299a-1(d)(1)) is amended by striking “section 485E” and inserting “section 464z-3”.

SEC. 10335. TECHNICAL CORRECTION TO THE HOSPITAL VALUE-BASED PURCHASING PROGRAM.

Section 1886(o)(2)(A) of the Social Security Act, as added by section 3001, is amended, in the first sentence, by inserting “, other than measures of readmissions,” after “shall select measures”.

SEC. 10336. GAO STUDY AND REPORT ON MEDICARE BENEFICIARY ACCESS TO HIGH-QUALITY DIALYSIS SERVICES.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on the impact on Medicare beneficiary access to high-quality dialysis services of including specified oral drugs that are furnished to such beneficiaries for the treatment of end stage renal disease in the bundled prospective payment system under section 1881(b)(14) of the Social Security Act (42 U.S.C. 1395rr(b)(14)) (pursuant to the proposed rule published by the Secretary of Health and Human Services in the Federal Register on September 29, 2009 (74 Fed. Reg. 49922 et seq.)). Such study shall include an analysis of—

(A) the ability of providers of services and renal dialysis facilities to furnish specified oral drugs or arrange for the provision of such drugs;

(B) the ability of providers of services and renal dialysis facilities to comply, if necessary, with applicable State laws (such as State pharmacy licensure requirements) in order to furnish specified oral drugs;

(C) whether appropriate quality measures exist to safeguard care for Medicare beneficiaries being furnished specified oral drugs by providers of services and renal dialysis facilities; and

(D) other areas determined appropriate by the Comptroller General.

(2) SPECIFIED ORAL DRUG DEFINED.—For purposes of paragraph (1), the term “specified oral drug” means a drug or biological for which there is no injectable equivalent (or other non-oral form of administration).

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

Subtitle D—Provisions Relating to Title IV

SEC. 10401. AMENDMENTS TO SUBTITLE A.

(a) Section 4001(h)(4) and (5) of this Act is amended by striking “2010” each place such appears and inserting “2020”.

(b) Section 4002(c) of this Act is amended—

(1) by striking “research and health screenings” and inserting “research, health screenings, and initiatives”; and

(2) by striking “for Preventive” and inserting “Regarding Preventive”.

(c) Section 4004(a)(4) of this Act is amended by striking “a Gateway” and inserting “an Exchange”.

SEC. 10402. AMENDMENTS TO SUBTITLE B.

(a) Section 399Z-1(a)(1)(A) of the Public Health Service Act, as added by section 4101(b) of this Act, is amended by inserting “and vision” after “oral”.

(b) Section 1861(hhh)(4)(G) of the Social Security Act, as added by section 4103(b), is amended to read as follows:

“(G) A beneficiary shall be eligible to receive only an initial preventive physical examination (as defined under subsection (ww)(1)) during the 12-month period after the date that the beneficiary’s coverage begins

under part B and shall be eligible to receive personalized prevention plan services under this subsection each year thereafter provided that the beneficiary has not received either an initial preventive physical examination or personalized prevention plan services within the preceding 12-month period.”.

SEC. 10403. AMENDMENTS TO SUBTITLE C.

Section 4201 of this Act is amended—

(1) in subsection (a), by adding before the period the following: “, with not less than 20 percent of such grants being awarded to rural and frontier areas”;

(2) in subsection (c)(2)(B)(vii), by striking “both urban and rural areas” and inserting “urban, rural, and frontier areas”; and

(3) in subsection (f), by striking “each fiscal year” and inserting “each of fiscal year”.

SEC. 10404. AMENDMENTS TO SUBTITLE D.

Section 399MM(2) of the Public Health Service Act, as added by section 4303 of this Act, is amended by striking “by ensuring” and inserting “and ensuring”.

SEC. 10405. AMENDMENTS TO SUBTITLE E.

Subtitle E of title IV of this Act is amended by striking section 4401.

SEC. 10406. AMENDMENT RELATING TO WAIVING COINSURANCE FOR PREVENTIVE SERVICES.

Section 4104(b) of this Act is amended to read as follows:

“(b) PAYMENT AND ELIMINATION OF COINSURANCE IN ALL SETTINGS.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 4103(c)(1), is amended—

“(1) in subparagraph (T), by inserting ‘(or 100 percent if such services are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual)’ after ‘80 percent’;

“(2) in subparagraph (W)—

“(A) in clause (i), by inserting ‘(if such subparagraph were applied, by substituting ‘100 percent’ for ‘80 percent’))’ after ‘subparagraph (D)’; and

“(B) in clause (ii), by striking ‘80 percent’ and inserting ‘100 percent’;

“(3) by striking ‘and’ before ‘(X)’; and

“(4) by inserting before the semicolon at the end the following: ‘, and (Y) with respect to preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount paid shall be 100 percent of (i) except as provided in clause (ii), the lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part, and (ii) in the case of such services that are covered OPD services (as defined in subsection (t)(1)(B)), the amount determined under subsection (t).’.

SEC. 10407. BETTER DIABETES CARE.

(a) SHORT TITLE.—This section may be cited as the “Catalyst to Better Diabetes Care Act of 2009”.

(b) NATIONAL DIABETES REPORT CARD.—

(1) IN GENERAL.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention (referred to in this section as the “Director”), shall prepare on a biennial basis a national diabetes report card (referred to in this section as a “Report Card”) and, to the extent possible, for each State.

(2) CONTENTS.—

(A) IN GENERAL.—Each Report Card shall include aggregate health outcomes related to individuals diagnosed with diabetes and prediabetes including—

- (i) preventative care practices and quality of care;
- (ii) risk factors; and
- (iii) outcomes.

(B) UPDATED REPORTS.—Each Report Card that is prepared after the initial Report Card shall include trend analysis for the Nation and, to the extent possible, for each State, for the purpose of—

- (i) tracking progress in meeting established national goals and objectives for improving diabetes care, costs, and prevalence (including Healthy People 2010); and
- (ii) informing policy and program development.

(3) AVAILABILITY.—The Secretary, in collaboration with the Director, shall make each Report Card publicly available, including by posting the Report Card on the Internet.

(C) IMPROVEMENT OF VITAL STATISTICS COLLECTION.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in collaboration with appropriate agencies and States, shall—

(A) promote the education and training of physicians on the importance of birth and death certificate data and how to properly complete these documents, including the collection of such data for diabetes and other chronic diseases;

(B) encourage State adoption of the latest standard revisions of birth and death certificates; and

(C) work with States to re-engineer their vital statistics systems in order to provide cost-effective, timely, and accurate vital systems data.

(2) DEATH CERTIFICATE ADDITIONAL LANGUAGE.—In carrying out this subsection, the Secretary may promote improvements to the collection of diabetes mortality data, including the addition of a question for the individual certifying the cause of death regarding whether the deceased had diabetes.

(d) STUDY ON APPROPRIATE LEVEL OF DIABETES MEDICAL EDUCATION.—

(1) IN GENERAL.—The Secretary shall, in collaboration with the Institute of Medicine and appropriate associations and councils, conduct a study of the impact of diabetes on the practice of medicine in the United States and the appropriateness of the level of diabetes medical education that should be required prior to licensure, board certification, and board recertification.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report on the study under paragraph (1) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

SEC. 10408. GRANTS FOR SMALL BUSINESSES TO PROVIDE COMPREHENSIVE WORKPLACE WELLNESS PROGRAMS.

(a) ESTABLISHMENT.—The Secretary shall award grants to eligible employers to provide their employees with access to comprehensive workplace wellness programs (as described under subsection (c)).

(b) SCOPE.—

(1) DURATION.—The grant program established under this section shall be conducted for a 5-year period.

(2) ELIGIBLE EMPLOYER.—The term “eligible employer” means an employer (including a non-profit employer) that—

(A) employs less than 100 employees who work 25 hours or greater per week; and

(B) does not provide a workplace wellness program as of the date of enactment of this Act.

(c) COMPREHENSIVE WORKPLACE WELLNESS PROGRAMS.—

(1) CRITERIA.—The Secretary shall develop program criteria for comprehensive workplace wellness programs under this section that are based on and consistent with evidence-based research and best practices, including research and practices as provided in the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry for Effective Programs.

(2) REQUIREMENTS.—A comprehensive workplace wellness program shall be made available by an eligible employer to all employees and include the following components:

(A) Health awareness initiatives (including health education, preventive screenings, and health risk assessments).

(B) Efforts to maximize employee engagement (including mechanisms to encourage employee participation).

(C) Initiatives to change unhealthy behaviors and lifestyle choices (including counseling, seminars, online programs, and self-help materials).

(D) Supportive environment efforts (including workplace policies to encourage healthy lifestyles, healthy eating, increased physical activity, and improved mental health).

(d) APPLICATION.—An eligible employer desiring to participate in the grant program under this section shall submit an application to the Secretary, in such manner and containing such information as the Secretary may require, which shall include a proposal for a comprehensive workplace wellness program that meet the criteria and requirements described under subsection (c).

(e) AUTHORIZATION OF APPROPRIATION.—For purposes of carrying out the grant program under this section, there is authorized to be appropriated \$200,000,000 for the period of fiscal years 2011 through 2015. Amounts appropriated pursuant to this subsection shall remain available until expended.

SEC. 10409. CURES ACCELERATION NETWORK.

(a) SHORT TITLE.—This section may be cited as the “Cures Acceleration Network Act of 2009”.

(b) REQUIREMENT FOR THE DIRECTOR OF NIH TO ESTABLISH A CURES ACCELERATION NETWORK.—Section 402(b) of the Public Health Service Act (42 U.S.C. 282(b)) is amended—

(1) in paragraph (22), by striking “and” at the end;

(2) in paragraph (23), by striking the period and inserting “; and”; and

(3) by inserting after paragraph (23), the following:

“(24) implement the Cures Acceleration Network described in section 402C.”.

(c) ACCEPTING GIFTS TO SUPPORT THE CURES ACCELERATION NETWORK.—Section 499(c)(1) of the Public Health Service Act (42 U.S.C. 290b(c)(1)) is amended by adding at the end the following:

“(E) The Cures Acceleration Network described in section 402C.”.

(d) ESTABLISHMENT OF THE CURES ACCELERATION NETWORK.—Part A of title IV of the

Public Health Service Act is amended by inserting after section 402B (42 U.S.C. 282b) the following:

“SEC. 402C. CURES ACCELERATION NETWORK.

“(a) DEFINITIONS.—In this section:

“(1) BIOLOGICAL PRODUCT.—The term ‘biological product’ has the meaning given such term in section 351 of the Public Health Service Act.

“(2) DRUG; DEVICE.—The terms ‘drug’ and ‘device’ have the meanings given such terms in section 201 of the Federal Food, Drug, and Cosmetic Act.

“(3) HIGH NEED CURE.—The term ‘high need cure’ means a drug (as that term is defined by section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act, biological product (as that term is defined by section 262(i)), or device (as that term is defined by section 201(h) of the Federal Food, Drug, and Cosmetic Act) that, in the determination of the Director of NIH—

“(A) is a priority to diagnose, mitigate, prevent, or treat harm from any disease or condition; and

“(B) for which the incentives of the commercial market are unlikely to result in its adequate or timely development.

“(4) MEDICAL PRODUCT.—The term ‘medical product’ means a drug, device, biological product, or product that is a combination of drugs, devices, and biological products.

“(b) ESTABLISHMENT OF THE CURES ACCELERATION NETWORK.—Subject to the appropriation of funds as described in subsection (g), there is established within the Office of the Director of NIH a program to be known as the Cures Acceleration Network (referred to in this section as ‘CAN’), which shall—

“(1) be under the direction of the Director of NIH, taking into account the recommendations of a CAN Review Board (referred to in this section as the ‘Board’), described in subsection (d); and

“(2) award grants and contracts to eligible entities, as described in subsection (e), to accelerate the development of high need cures, including through the development of medical products and behavioral therapies.

“(c) FUNCTIONS.—The functions of the CAN are to—

“(1) conduct and support revolutionary advances in basic research, translating scientific discoveries from bench to bedside;

“(2) award grants and contracts to eligible entities to accelerate the development of high need cures;

“(3) provide the resources necessary for government agencies, independent investigators, research organizations, biotechnology companies, academic research institutions, and other entities to develop high need cures;

“(4) reduce the barriers between laboratory discoveries and clinical trials for new therapies; and

“(5) facilitate review in the Food and Drug Administration for the high need cures funded by the CAN, through activities that may include—

“(A) the facilitation of regular and ongoing communication with the Food and Drug Administration regarding the status of activities conducted under this section;

“(B) ensuring that such activities are coordinated with the approval requirements of the Food and Drug Administration, with the goal of expediting the development and approval of countermeasures and products; and

“(C) connecting interested persons with additional technical assistance made available under section 565 of the Federal Food, Drug, and Cosmetic Act.

“(d) CAN BOARD.—

“(1) ESTABLISHMENT.—There is established a Cures Acceleration Network Review Board (referred to in this section as the ‘Board’), which shall advise the Director of NIH on the conduct of the activities of the Cures Acceleration Network.

“(2) MEMBERSHIP.—

“(A) IN GENERAL.—

“(i) APPOINTMENT.—The Board shall be comprised of 24 members who are appointed by the Secretary and who serve at the pleasure of the Secretary.

“(ii) CHAIRPERSON AND VICE CHAIRPERSON.—The Secretary shall designate, from among the 24 members appointed under clause (i), one Chairperson of the Board (referred to in this section as the ‘Chairperson’) and one Vice Chairperson.

“(B) TERMS.—

“(i) IN GENERAL.—Each member shall be appointed to serve a 4-year term, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which the member's predecessor was appointed shall be appointed for the remainder of such term.

“(ii) CONSECUTIVE APPOINTMENTS; MAXIMUM TERMS.—A member may be appointed to serve not more than 3 terms on the Board, and may not serve more than 2 such terms consecutively.

“(C) QUALIFICATIONS.—

“(i) IN GENERAL.—The Secretary shall appoint individuals to the Board based solely upon the individual's established record of distinguished service in one of the areas of expertise described in clause (ii). Each individual appointed to the Board shall be of distinguished achievement and have a broad range of disciplinary interests.

“(ii) EXPERTISE.—The Secretary shall select individuals based upon the following requirements:

“(I) For each of the fields of—

“(aa) basic research;

“(bb) medicine;

“(cc) biopharmaceuticals;

“(dd) discovery and delivery of medical products;

“(ee) bioinformatics and gene therapy;

“(ff) medical instrumentation; and

“(gg) regulatory review and approval of medical products, the Secretary shall select at least 1 individual who is eminent in such fields.

“(II) At least 4 individuals shall be recognized leaders in professional venture capital or private equity organizations and have demonstrated experience in private equity investing.

“(III) At least 8 individuals shall represent disease advocacy organizations.

“(3) EX-OFFICIO MEMBERS.—

“(A) APPOINTMENT.—In addition to the 24 Board members described in paragraph (2), the Secretary shall appoint as ex-officio members of the Board—

“(i) a representative of the National Institutes of Health, recommended by the Secretary of the Department of Health and Human Services;

“(ii) a representative of the Office of the Assistant Secretary of Defense for Health Affairs, recommended by the Secretary of Defense;

“(iii) a representative of the Office of the Under Secretary for Health for the Veterans Health Administration, recommended by the Secretary of Veterans Affairs;

“(iv) a representative of the National Science Foundation, recommended by the Chair of the National Science Board; and

“(v) a representative of the Food and Drug Administration, recommended by the Commissioner of Food and Drugs.

“(B) TERMS.—Each ex-officio member shall serve a 3-year term on the Board, except that the Chairperson may adjust the terms of the initial ex-officio members in order to provide for a staggered term of appointment for all such members.

“(4) RESPONSIBILITIES OF THE BOARD AND THE DIRECTOR OF NIH.—

“(A) RESPONSIBILITIES OF THE BOARD.—

“(i) IN GENERAL.—The Board shall advise, and provide recommendations to, the Director of NIH with respect to—

“(I) policies, programs, and procedures for carrying out the duties of the Director of NIH under this section; and

“(II) significant barriers to successful translation of basic science into clinical application (including issues under the purview of other agencies and departments).

“(ii) REPORT.—In the case that the Board identifies a significant barrier, as described in clause (i)(II), the Board shall submit to the Secretary a report regarding such barrier.

“(B) RESPONSIBILITIES OF THE DIRECTOR OF NIH.—With respect to each recommendation provided by the Board under subparagraph (A)(i), the Director of NIH shall respond in writing to the Board, indicating whether such Director will implement such recommendation. In the case that the Director of NIH indicates a recommendation of the Board will not be implemented, such Director shall provide an explanation of the reasons for not implementing such recommendation.

“(5) MEETINGS.—

“(A) IN GENERAL.—The Board shall meet 4 times per calendar year, at the call of the Chairperson.

“(B) QUORUM; REQUIREMENTS; LIMITATIONS.—

“(i) QUORUM.—A quorum shall consist of a total of 13 members of the Board, excluding ex-officio members, with diverse representation as described in clause (iii).

“(ii) CHAIRPERSON OR VICE CHAIRPERSON.—Each meeting of the Board shall be attended by either the Chairperson or the Vice Chairperson.

“(iii) DIVERSE REPRESENTATION.—At each meeting of the Board, there shall be not less than one scientist, one representative of a disease advocacy organization, and one representative of a professional venture capital or private equity organization.

“(6) COMPENSATION AND TRAVEL EXPENSES.—

“(A) COMPENSATION.—Members shall receive compensation at a rate to be fixed by the Chairperson but not to exceed a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which the member is engaged in the performance of the duties of the Board. All members of the Board who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

“(B) TRAVEL EXPENSES.—Members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for persons employed intermittently by the Federal Government under section 5703(b) of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

“(e) GRANT PROGRAM.—

“(1) SUPPORTING INNOVATION.—To carry out the purposes described in this section, the

Director of NIH shall award contracts, grants, or cooperative agreements to the entities described in paragraph (2), to—

“(A) promote innovation in technologies supporting the advanced research and development and production of high need cures, including through the development of medical products and behavioral therapies.

“(B) accelerate the development of high need cures, including through the development of medical products, behavioral therapies, and biomarkers that demonstrate the safety or effectiveness of medical products; or

“(C) help the award recipient establish protocols that comply with Food and Drug Administration standards and otherwise permit the recipient to meet regulatory requirements at all stages of development, manufacturing, review, approval, and safety surveillance of a medical product.

“(2) ELIGIBLE ENTITIES.—To receive assistance under paragraph (1), an entity shall—

“(A) be a public or private entity, which may include a private or public research institution, an institution of higher education, a medical center, a biotechnology company, a pharmaceutical company, a disease advocacy organization, a patient advocacy organization, or an academic research institution;

“(B) submit an application containing—

“(i) a detailed description of the project for which the entity seeks such grant or contract;

“(ii) a timetable for such project;

“(iii) an assurance that the entity will submit—

“(I) interim reports describing the entity's—

“(aa) progress in carrying out the project; and

“(bb) compliance with all provisions of this section and conditions of receipt of such grant or contract; and

“(II) a final report at the conclusion of the grant period, describing the outcomes of the project; and

“(iv) a description of the protocols the entity will follow to comply with Food and Drug Administration standards and regulatory requirements at all stages of development, manufacturing, review, approval, and safety surveillance of a medical product; and

“(C) provide such additional information as the Director of NIH may require.

“(3) AWARDS.—

“(A) THE CURES ACCELERATION PARTNERSHIP AWARDS.—

“(i) INITIAL AWARD AMOUNT.—Each award under this subparagraph shall be not more than \$15,000,000 per project for the first fiscal year for which the project is funded, which shall be payable in one payment.

“(ii) FUNDING IN SUBSEQUENT FISCAL YEARS.—An eligible entity receiving an award under clause (i) may apply for additional funding for such project by submitting to the Director of NIH the information required under subparagraphs (B) and (C) of paragraph (2). The Director may fund a project of such eligible entity in an amount not to exceed \$15,000,000 for a fiscal year subsequent to the initial award under clause (i).

“(iii) MATCHING FUNDS.—As a condition for receiving an award under this subsection, an eligible entity shall contribute to the project non-Federal funds in the amount of \$1 for every \$3 awarded under clauses (i) and (ii), except that the Director of NIH may waive or modify such matching requirement in any case where the Director determines that the goals and objectives of this section cannot adequately be carried out unless such requirement is waived.

“(B) THE CURES ACCELERATION GRANT AWARDS.—

“(i) INITIAL AWARD AMOUNT.—Each award under this subparagraph shall be not more than \$15,000,000 per project for the first fiscal year for which the project is funded, which shall be payable in one payment.

“(ii) FUNDING IN SUBSEQUENT FISCAL YEARS.—An eligible entity receiving an award under clause (i) may apply for additional funding for such project by submitting to the Board the information required under subparagraphs (B) and (C) of paragraph (2). The Director of NIH may fund a project of such eligible entity in an amount not to exceed \$15,000,000 for a fiscal year subsequent to the initial award under clause (i).

“(C) THE CURES ACCELERATION FLEXIBLE RESEARCH AWARDS.—If the Director of NIH determines that the goals and objectives of this section cannot adequately be carried out through a contract, grant, or cooperative agreement, the Director of NIH shall have flexible research authority to use other transactions to fund projects in accordance with the terms and conditions of this section. Awards made under such flexible research authority for a fiscal year shall not exceed 20 percent of the total funds appropriated under subsection (g)(1) for such fiscal year.

“(4) SUSPENSION OF AWARDS FOR DEFAULTS, NONCOMPLIANCE WITH PROVISIONS AND PLANS, AND DIVERSION OF FUNDS; REPAYMENT OF FUNDS.—The Director of NIH may suspend the award to any entity upon noncompliance by such entity with provisions and plans under this section or diversion of funds.

“(5) AUDITS.—The Director of NIH may enter into agreements with other entities to conduct periodic audits of the projects funded by grants or contracts awarded under this subsection.

“(6) CLOSEOUT PROCEDURES.—At the end of a grant or contract period, a recipient shall follow the closeout procedures under section 74.71 of title 45, Code of Federal Regulations (or any successor regulation).

“(7) REVIEW.—A determination by the Director of NIH as to whether a drug, device, or biological product is a high need cure (for purposes of subsection (a)(3)) shall not be subject to judicial review.

“(f) COMPETITIVE BASIS OF AWARDS.—Any grant, cooperative agreement, or contract awarded under this section shall be awarded on a competitive basis.

“(g) AUTHORIZATION OF APPROPRIATIONS.—

“(1) IN GENERAL.—For purposes of carrying out this section, there are authorized to be appropriated \$500,000,000 for fiscal year 2010, and such sums as may be necessary for subsequent fiscal years. Funds appropriated under this section shall be available until expended.

“(2) LIMITATION ON USE OF FUNDS OTHERWISE APPROPRIATED.—No funds appropriated under this Act, other than funds appropriated under paragraph (1), may be allocated to the Cures Acceleration Network.”.

SEC. 10410. CENTERS OF EXCELLENCE FOR DEPRESSION.

(a) SHORT TITLE.—This section may be cited as the “Establishing a Network of Health-Advancing National Centers of Excellence for Depression Act of 2009” or the “ENHANCED Act of 2009”.

(b) CENTERS OF EXCELLENCE FOR DEPRESSION.—Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb et seq.) is amended by inserting after section 520A the following:

“SEC. 520B. NATIONAL CENTERS OF EXCELLENCE FOR DEPRESSION.

“(a) DEPRESSIVE DISORDER DEFINED.—In this section, the term ‘depressive disorder’ means a mental or brain disorder relating to depression, including major depression, bipolar disorder, and related mood disorders.

“(b) GRANT PROGRAM.—

“(1) IN GENERAL.—The Secretary, acting through the Administrator, shall award grants on a competitive basis to eligible entities to establish national centers of excellence for depression (referred to in this section as ‘Centers’), which shall engage in activities related to the treatment of depressive disorders.

“(2) ALLOCATION OF AWARDS.—If the funds authorized under subsection (f) are appropriated in the amounts provided for under such subsection, the Secretary shall allocate such amounts so that—

“(A) not later than 1 year after the date of enactment of the ENHANCED Act of 2009, not more than 20 Centers may be established; and

“(B) not later than September 30, 2016, not more than 30 Centers may be established.

“(3) GRANT PERIOD.—

“(A) IN GENERAL.—A grant awarded under this section shall be for a period of 5 years.

“(B) RENEWAL.—A grant awarded under subparagraph (A) may be renewed, on a competitive basis, for 1 additional 5-year period, at the discretion of the Secretary. In determining whether to renew a grant, the Secretary shall consider the report cards issued under subsection (e)(2).

“(4) USE OF FUNDS.—Grant funds awarded under this subsection shall be used for the establishment and ongoing activities of the recipient of such funds.

“(5) ELIGIBLE ENTITIES.—

“(A) REQUIREMENTS.—To be eligible to receive a grant under this section, an entity shall—

“(i) be an institution of higher education or a public or private nonprofit research institution; and

“(ii) submit an application to the Secretary at such time and in such manner as the Secretary may require, as described in subparagraph (B).

“(B) APPLICATION.—An application described in subparagraph (A)(ii) shall include—

“(i) evidence that such entity—

“(I) provides, or is capable of coordinating with other entities to provide, comprehensive health services with a focus on mental health services and subspecialty expertise for depressive disorders;

“(II) collaborates with other mental health providers, as necessary, to address co-occurring mental illnesses;

“(III) is capable of training health professionals about mental health; and

“(ii) such other information, as the Secretary may require.

“(C) PRIORITIES.—In awarding grants under this section, the Secretary shall give priority to eligible entities that meet 1 or more of the following criteria:

“(i) Demonstrated capacity and expertise to serve the targeted population.

“(ii) Existing infrastructure or expertise to provide appropriate, evidence-based and culturally and linguistically competent services.

“(iii) A location in a geographic area with disproportionate numbers of underserved and at-risk populations in medically underserved areas and health professional shortage areas.

“(iv) Proposed innovative approaches for outreach to initiate or expand services.

“(v) Use of the most up-to-date science, practices, and interventions available.

“(vi) Demonstrated capacity to establish cooperative and collaborative agreements with community mental health centers and other community entities to provide mental health, social, and human services to individuals with depressive disorders.

“(6) NATIONAL COORDINATING CENTER.—

“(A) IN GENERAL.—The Secretary, acting through the Administrator, shall designate 1 recipient of a grant under this section to be the coordinating center of excellence for depression (referred to in this section as the ‘coordinating center’). The Secretary shall select such coordinating center on a competitive basis, based upon the demonstrated capacity of such center to perform the duties described in subparagraph (C).

“(B) APPLICATION.—A Center that has been awarded a grant under paragraph (1) may apply for designation as the coordinating center by submitting an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

“(C) DUTIES.—The coordinating center shall—

“(i) develop, administer, and coordinate the network of Centers under this section;

“(ii) oversee and coordinate the national database described in subsection (d);

“(iii) lead a strategy to disseminate the findings and activities of the Centers through such database; and

“(iv) serve as a liaison with the Administration, the National Registry of Evidence-based Programs and Practices of the Administration, and any Federal interagency or interagency forum on mental health.

“(7) MATCHING FUNDS.—The Secretary may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to \$1 for each \$5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

“(c) ACTIVITIES OF THE CENTERS.—Each Center shall carry out the following activities:

“(1) GENERAL ACTIVITIES.—Each Center shall—

“(A) integrate basic, clinical, or health services interdisciplinary research and practice in the development, implementation, and dissemination of evidence-based interventions;

“(B) involve a broad cross-section of stakeholders, such as researchers, clinicians, consumers, families of consumers, and voluntary health organizations, to develop a research agenda and disseminate findings, and to provide support in the implementation of evidence-based practices;

“(C) provide training and technical assistance to mental health professionals, and engage in and disseminate translational research with a focus on meeting the needs of individuals with depressive disorders; and

“(D) educate policy makers, employers, community leaders, and the public about depressive disorders to reduce stigma and raise awareness of treatments.

“(2) IMPROVED TREATMENT STANDARDS, CLINICAL GUIDELINES, DIAGNOSTIC PROTOCOLS, AND CARE COORDINATION PRACTICE.—Each

Center shall collaborate with other Centers in the network to—

“(A) develop and implement treatment standards, clinical guidelines, and protocols that emphasize primary prevention, early intervention, treatment for, and recovery from, depressive disorders;

“(B) foster communication with other providers attending to co-occurring physical health conditions such as cardiovascular, diabetes, cancer, and substance abuse disorders;

“(C) leverage available community resources, develop and implement improved self-management programs, and, when appropriate, involve family and other providers of social support in the development and implementation of care plans; and

“(D) use electronic health records and telehealth technology to better coordinate and manage, and improve access to, care, as determined by the coordinating center.

“(3) TRANSLATIONAL RESEARCH THROUGH COLLABORATION OF CENTERS AND COMMUNITY-BASED ORGANIZATIONS.—Each Center shall—

“(A) demonstrate effective use of a public-private partnership to foster collaborations among members of the network and community-based organizations such as community mental health centers and other social and human services providers;

“(B) expand interdisciplinary, translational, and patient-oriented research and treatment; and

“(C) coordinate with accredited academic programs to provide ongoing opportunities for the professional and continuing education of mental health providers.

“(d) NATIONAL DATABASE.—

“(1) IN GENERAL.—The coordinating center shall establish and maintain a national, publicly available database to improve prevention programs, evidence-based interventions, and disease management programs for depressive disorders, using data collected from the Centers, as described in paragraph (2).

“(2) DATA COLLECTION.—Each Center shall submit data gathered at such center, as appropriate, to the coordinating center regarding—

“(A) the prevalence and incidence of depressive disorders;

“(B) the health and social outcomes of individuals with depressive disorders;

“(C) the effectiveness of interventions designed, tested, and evaluated;

“(D) other information, as the Secretary may require.

“(3) SUBMISSION OF DATA TO THE ADMINISTRATOR.—The coordinating center shall submit to the Administrator the data and financial information gathered under paragraph (2).

“(4) PUBLICATION USING DATA FROM THE DATABASE.—A Center, or an individual affiliated with a Center, may publish findings using the data described in paragraph (2) only if such center submits such data to the coordinating center, as required under such paragraph.

“(e) ESTABLISHMENT OF STANDARDS; REPORT CARDS AND RECOMMENDATIONS; THIRD PARTY REVIEW.—

“(1) ESTABLISHMENT OF STANDARDS.—The Secretary, acting through the Administrator, shall establish performance standards for—

“(A) each Center; and

“(B) the network of Centers as a whole.

“(2) REPORT CARDS.—The Secretary, acting through the Administrator, shall—

“(A) for each Center, not later than 3 years after the date on which such center of excellence is established and annually thereafter,

issue a report card to the coordinating center to rate the performance of such Center; and

“(B) not later than 3 years after the date on which the first grant is awarded under subsection (b)(1) and annually thereafter, issue a report card to Congress to rate the performance of the network of centers of excellence as a whole.

“(3) RECOMMENDATIONS.—Based upon the report cards described in paragraph (2), the Secretary shall, not later than September 30, 2015—

“(A) make recommendations to the Centers regarding improvements such centers shall make; and

“(B) make recommendations to Congress for expanding the Centers to serve individuals with other types of mental disorders.

“(4) THIRD PARTY REVIEW.—Not later than 3 years after the date on which the first grant is awarded under subsection (b)(1) and annually thereafter, the Secretary shall arrange for an independent third party to conduct an evaluation of the network of Centers to ensure that such centers are meeting the goals of this section.

“(f) AUTHORIZATION OF APPROPRIATIONS.—

“(1) IN GENERAL.—To carry out this section, there are authorized to be appropriated—

“(A) \$100,000,000 for each of the fiscal years 2011 through 2015; and

“(B) \$150,000,000 for each of the fiscal years 2016 through 2020.

“(2) ALLOCATION OF FUNDS AUTHORIZED.—Of the amount appropriated under paragraph (1) for a fiscal year, the Secretary shall determine the allocation of each Center receiving a grant under this section, but in no case may the allocation be more than \$5,000,000, except that the Secretary may allocate not more than \$10,000,000 to the coordinating center.”

SEC. 10411. PROGRAMS RELATING TO CONGENITAL HEART DISEASE.

(a) SHORT TITLE.—This subtitle may be cited as the “Congenital Heart Futures Act”.

(b) PROGRAMS RELATING TO CONGENITAL HEART DISEASE.—

(1) NATIONAL CONGENITAL HEART DISEASE SURVEILLANCE SYSTEM.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 5405, is further amended by adding at the end the following:

“SEC. 399V-2. NATIONAL CONGENITAL HEART DISEASE SURVEILLANCE SYSTEM.

“(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may—

“(1) enhance and expand infrastructure to track the epidemiology of congenital heart disease and to organize such information into a nationally-representative, population-based surveillance system that compiles data concerning actual occurrences of congenital heart disease, to be known as the ‘National Congenital Heart Disease Surveillance System’; or

“(2) award a grant to one eligible entity to undertake the activities described in paragraph (1).

“(b) PURPOSE.—The purpose of the Congenital Heart Disease Surveillance System shall be to facilitate further research into the types of health services patients use and to identify possible areas for educational outreach and prevention in accordance with standard practices of the Centers for Disease Control and Prevention.

“(c) CONTENT.—The Congenital Heart Disease Surveillance System—

“(1) may include information concerning the incidence and prevalence of congenital heart disease in the United States;

“(2) may be used to collect and store data on congenital heart disease, including data concerning—

“(A) demographic factors associated with congenital heart disease, such as age, race, ethnicity, sex, and family history of individuals who are diagnosed with the disease;

“(B) risk factors associated with the disease;

“(C) causation of the disease;

“(D) treatment approaches; and

“(E) outcome measures, such that analysis of the outcome measures will allow derivation of evidence-based best practices and guidelines for congenital heart disease patients; and

“(3) may ensure the collection and analysis of longitudinal data related to individuals of all ages with congenital heart disease, including infants, young children, adolescents, and adults of all ages.

“(d) PUBLIC ACCESS.—The Congenital Heart Disease Surveillance System shall be made available to the public, as appropriate, including congenital heart disease researchers.

“(e) PATIENT PRIVACY.—The Secretary shall ensure that the Congenital Heart Disease Surveillance System is maintained in a manner that complies with the regulations promulgated under section 264 of the Health Insurance Portability and Accountability Act of 1996.

“(f) ELIGIBILITY FOR GRANT.—To be eligible to receive a grant under subsection (a)(2), an entity shall—

“(1) be a public or private nonprofit entity with specialized experience in congenital heart disease; and

“(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.”

(2) CONGENITAL HEART DISEASE RESEARCH.—Subpart 2 of part C of title IV of the Public Health Service Act (42 U.S.C. 285b et seq.) is amended by adding at the end the following:

“SEC. 425. CONGENITAL HEART DISEASE.

“(a) IN GENERAL.—The Director of the Institute may expand, intensify, and coordinate research and related activities of the Institute with respect to congenital heart disease, which may include congenital heart disease research with respect to—

“(1) causation of congenital heart disease, including genetic causes;

“(2) long-term outcomes in individuals with congenital heart disease, including infants, children, teenagers, adults, and elderly individuals;

“(3) diagnosis, treatment, and prevention;

“(4) studies using longitudinal data and retrospective analysis to identify effective treatments and outcomes for individuals with congenital heart disease; and

“(5) identifying barriers to life-long care for individuals with congenital heart disease.

“(b) COORDINATION OF RESEARCH ACTIVITIES.—The Director of the Institute may coordinate research efforts related to congenital heart disease among multiple research institutions and may develop research networks.

“(c) MINORITY AND MEDICALLY UNDERSERVED COMMUNITIES.—In carrying out the activities described in this section, the Director of the Institute shall consider the application of such research and other activities to minority and medically underserved communities.”

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to

carry out the amendments made by this section such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 10412. AUTOMATED DEFIBRILLATION IN ADAM'S MEMORY ACT.

Section 312 of the Public Health Service Act (42 U.S.C. 244) is amended—

(1) in subsection (c)(6), after “clearing-house” insert “, that shall be administered by an organization that has substantial expertise in pediatric education, pediatric medicine, and electrophysiology and sudden death,”; and

(2) in the first sentence of subsection (e), by striking “fiscal year 2003” and all that follows through “2006” and inserting “for each of fiscal years 2003 through 2014”.

SEC. 10413. YOUNG WOMEN'S BREAST HEALTH AWARENESS AND SUPPORT OF YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.

(a) **SHORT TITLE.**—This section may be cited as the “Young Women's Breast Health Education and Awareness Requires Learning Young Act of 2009” or the “EARLY Act”.

(b) **AMENDMENT.**—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by this Act, is further amended by adding at the end the following:

“PART V—PROGRAMS RELATING TO BREAST HEALTH AND CANCER

“SEC. 399NN. YOUNG WOMEN'S BREAST HEALTH AWARENESS AND SUPPORT OF YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.

“(a) **PUBLIC EDUCATION CAMPAIGN.**—

“(1) **IN GENERAL.**—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct a national evidence-based education campaign to increase awareness of young women's knowledge regarding—

“(A) breast health in young women of all racial, ethnic, and cultural backgrounds;

“(B) breast awareness and good breast health habits;

“(C) the occurrence of breast cancer and the general and specific risk factors in women who may be at high risk for breast cancer based on familial, racial, ethnic, and cultural backgrounds such as Ashkenazi Jewish populations;

“(D) evidence-based information that would encourage young women and their health care professional to increase early detection of breast cancers; and

“(E) the availability of health information and other resources for young women diagnosed with breast cancer.

“(2) **EVIDENCE-BASED, AGE APPROPRIATE MESSAGES.**—The campaign shall provide evidence-based, age-appropriate messages and materials as developed by the Centers for Disease Control and Prevention and the Advisory Committee established under paragraph (4).

“(3) **MEDIA CAMPAIGN.**—In conducting the education campaign under paragraph (1), the Secretary shall award grants to entities to establish national multimedia campaigns oriented to young women that may include advertising through television, radio, print media, billboards, posters, all forms of existing and especially emerging social networking media, other Internet media, and any other medium determined appropriate by the Secretary.

“(4) **ADVISORY COMMITTEE.**—

“(A) **ESTABLISHMENT.**—Not later than 60 days after the date of the enactment of this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an advisory committee to assist in creating and con-

ducting the education campaigns under paragraph (1) and subsection (b)(1).

“(B) **MEMBERSHIP.**—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall appoint to the advisory committee under subparagraph (A) such members as deemed necessary to properly advise the Secretary, and shall include organizations and individuals with expertise in breast cancer, disease prevention, early detection, diagnosis, public health, social marketing, genetic screening and counseling, treatment, rehabilitation, palliative care, and survivorship in young women.

“(b) **HEALTH CARE PROFESSIONAL EDUCATION CAMPAIGN.**—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, and in consultation with the Administrator of the Health Resources and Services Administration, shall conduct an education campaign among physicians and other health care professionals to increase awareness—

“(1) of breast health, symptoms, and early diagnosis and treatment of breast cancer in young women, including specific risk factors such as family history of cancer and women that may be at high risk for breast cancer, such as Ashkenazi Jewish population;

“(2) on how to provide counseling to young women about their breast health, including knowledge of their family cancer history and importance of providing regular clinical breast examinations;

“(3) concerning the importance of discussing healthy behaviors, and increasing awareness of services and programs available to address overall health and wellness, and making patient referrals to address tobacco cessation, good nutrition, and physical activity;

“(4) on when to refer patients to a health care provider with genetics expertise;

“(5) on how to provide counseling that addresses long-term survivorship and health concerns of young women diagnosed with breast cancer; and

“(6) on when to provide referrals to organizations and institutions that provide credible health information and substantive assistance and support to young women diagnosed with breast cancer.

“(c) **PREVENTION RESEARCH ACTIVITIES.**—The Secretary, acting through—

“(1) the Director of the Centers for Disease Control and Prevention, shall conduct prevention research on breast cancer in younger women, including—

“(A) behavioral, survivorship studies, and other research on the impact of breast cancer diagnosis on young women;

“(B) formative research to assist with the development of educational messages and information for the public, targeted populations, and their families about breast health, breast cancer, and healthy lifestyles;

“(C) testing and evaluating existing and new social marketing strategies targeted at young women; and

“(D) surveys of health care providers and the public regarding knowledge, attitudes, and practices related to breast health and breast cancer prevention and control in high-risk populations; and

“(2) the Director of the National Institutes of Health, shall conduct research to develop and validate new screening tests and methods for prevention and early detection of breast cancer in young women.

“(d) **SUPPORT FOR YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.**—

“(1) **IN GENERAL.**—The Secretary shall award grants to organizations and institu-

tions to provide health information from credible sources and substantive assistance directed to young women diagnosed with breast cancer and pre-neoplastic breast diseases.

“(2) **PRIORITY.**—In making grants under paragraph (1), the Secretary shall give priority to applicants that deal specifically with young women diagnosed with breast cancer and pre-neoplastic breast disease.

“(e) **NO DUPLICATION OF EFFORT.**—In conducting an education campaign or other program under subsections (a), (b), (c), or (d), the Secretary shall avoid duplicating other existing Federal breast cancer education efforts.

“(f) **MEASUREMENT; REPORTING.**—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

“(1) measure—

“(A) young women's awareness regarding breast health, including knowledge of family cancer history, specific risk factors and early warning signs, and young women's proactive efforts at early detection;

“(B) the number or percentage of young women utilizing information regarding lifestyle interventions that foster healthy behaviors;

“(C) the number or percentage of young women receiving regular clinical breast exams; and

“(D) the number or percentage of young women who perform breast self exams, and the frequency of such exams, before the implementation of this section;

“(2) not less than every 3 years, measure the impact of such activities; and

“(3) submit reports to the Congress on the results of such measurements.

“(g) **DEFINITION.**—In this section, the term “young women” means women 15 to 44 years of age.

“(h) **AUTHORIZATION OF APPROPRIATIONS.**—To carry out subsections (a), (b), (c)(1), and (d), there are authorized to be appropriated \$9,000,000 for each of the fiscal years 2010 through 2014.”.

Subtitle E—Provisions Relating to Title V

SEC. 10501. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT, THE SOCIAL SECURITY ACT, AND TITLE V OF THIS ACT.

(a) Section 5101 of this Act is amended—

(1) in subsection (c)(2)(B)(i)(II), by inserting “, including representatives of small business and self-employed individuals” after “employers”; and

(2) in subsection (d)(4)(A)—

(A) by redesignating clause (iv) as clause (v); and

(B) by inserting after clause (iii) the following:

“(iv) An analysis of, and recommendations for, eliminating the barriers to entering and staying in primary care, including provider compensation.”; and

(3) in subsection (i)(2)(B), by inserting “occupational therapists,” after “occupational therapists.”.

(b) Subtitle B of title V of this Act is amended by adding at the end the following:

“SEC. 5104. INTERAGENCY TASK FORCE TO ASSESS AND IMPROVE ACCESS TO HEALTH CARE IN THE STATE OF ALASKA.

“(a) **ESTABLISHMENT.**—There is established a task force to be known as the ‘Interagency Access to Health Care in Alaska Task Force’ (referred to in this section as the ‘Task Force’).

“(b) **DUTIES.**—The Task Force shall—

“(1) assess access to health care for beneficiaries of Federal health care systems in Alaska; and

“(2) develop a strategy for the Federal Government to improve delivery of health care to Federal beneficiaries in the State of Alaska.

“(c) MEMBERSHIP.—The Task Force shall be comprised of Federal members who shall be appointed, not later than 45 days after the date of enactment of this Act, as follows:

“(1) The Secretary of Health and Human Services shall appoint one representative of each of the following:

“(A) The Department of Health and Human Services.

“(B) The Centers for Medicare and Medicaid Services.

“(C) The Indian Health Service.

“(2) The Secretary of Defense shall appoint one representative of the TRICARE Management Activity.

“(3) The Secretary of the Army shall appoint one representative of the Army Medical Department.

“(4) The Secretary of the Air Force shall appoint one representative of the Air Force, from among officers at the Air Force performing medical service functions.

“(5) The Secretary of Veterans Affairs shall appoint one representative of each of the following:

“(A) The Department of Veterans Affairs.

“(B) The Veterans Health Administration.

“(6) The Secretary of Homeland Security shall appoint one representative of the United States Coast Guard.

“(d) CHAIRPERSON.—One chairperson of the Task Force shall be appointed by the Secretary at the time of appointment of members under subsection (c), selected from among the members appointed under paragraph (1).

“(e) MEETINGS.—The Task Force shall meet at the call of the chairperson.

“(f) REPORT.—Not later than 180 days after the date of enactment of this Act, the Task Force shall submit to Congress a report detailing the activities of the Task Force and containing the findings, strategies, recommendations, policies, and initiatives developed pursuant to the duty described in subsection (b)(2). In preparing such report, the Task Force shall consider completed and ongoing efforts by Federal agencies to improve access to health care in the State of Alaska.

“(g) TERMINATION.—The Task Force shall be terminated on the date of submission of the report described in subsection (f).”

(c) Section 399V of the Public Health Service Act, as added by section 5313, is amended—

(1) in subsection (b)(4), by striking “identify, educate, refer, and enroll” and inserting “identify and refer”; and

(2) in subsection (k)(1), by striking “, as defined by the Department of Labor as Standard Occupational Classification [21–1094]”.

(d) Section 738(a)(3) of the Public Health Service Act (42 U.S.C. 293b(a)(3)) is amended by inserting “schools offering physician assistant education programs,” after “public health,”.

(e) Subtitle D of title V of this Act is amended by adding at the end the following:

“SEC. 5316. DEMONSTRATION GRANTS FOR FAMILY NURSE PRACTITIONER TRAINING PROGRAMS.

“(a) ESTABLISHMENT OF PROGRAM.—The Secretary of Health and Human Services (referred to in this section as the ‘Secretary’) shall establish a training demonstration program for family nurse practitioners (referred to in this section as the ‘program’) to employ and provide 1-year training for nurse practitioners who have graduated from a

nurse practitioner program for careers as primary care providers in Federally qualified health centers (referred to in this section as ‘FQHCs’) and nurse-managed health clinics (referred to in this section as ‘NMHCs’).

“(b) PURPOSE.—The purpose of the program is to enable each grant recipient to—

“(1) provide new nurse practitioners with clinical training to enable them to serve as primary care providers in FQHCs and NMHCs;

“(2) train new nurse practitioners to work under a model of primary care that is consistent with the principles set forth by the Institute of Medicine and the needs of vulnerable populations; and

“(3) create a model of FQHC and NMHC training for nurse practitioners that may be replicated nationwide.

“(c) GRANTS.—The Secretary shall award 3-year grants to eligible entities that meet the requirements established by the Secretary, for the purpose of operating the nurse practitioner primary care programs described in subsection (a) in such entities.

“(d) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall—

“(1)(A) be a FQHC as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)); or

“(B) be a nurse-managed health clinic, as defined in section 330A-1 of the Public Health Service Act (as added by section 5208 of this Act); and

“(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(e) PRIORITY IN AWARDED GRANTS.—In awarding grants under this section, the Secretary shall give priority to eligible entities that—

“(1) demonstrate sufficient infrastructure in size, scope, and capacity to undertake the requisite training of a minimum of 3 nurse practitioners per year, and to provide to each awardee 12 full months of full-time, paid employment and benefits consistent with the benefits offered to other full-time employees of such entity;

“(2) will assign not less than 1 staff nurse practitioner or physician to each of 4 precepted clinics;

“(3) will provide to each awardee specialty rotations, including specialty training in prenatal care and women’s health, adult and child psychiatry, orthopedics, geriatrics, and at least 3 other high-volume, high-burden specialty areas;

“(4) provide sessions on high-volume, high-risk health problems and have a record of training health care professionals in the care of children, older adults, and underserved populations; and

“(5) collaborate with other safety net providers, schools, colleges, and universities that provide health professions training.

“(f) ELIGIBILITY OF NURSE PRACTITIONERS.—

“(1) IN GENERAL.—To be eligible for acceptance to a program funded through a grant awarded under this section, an individual shall—

“(A) be licensed or eligible for licensure in the State in which the program is located as an advanced practice registered nurse or advanced practice nurse and be eligible or board-certified as a family nurse practitioner; and

“(B) demonstrate commitment to a career as a primary care provider in a FQHC or in a NMHC.

“(2) PREFERENCE.—In selecting awardees under the program, each grant recipient

shall give preference to bilingual candidates that meet the requirements described in paragraph (1).

“(3) DEFERRAL OF CERTAIN SERVICE.—The starting date of required service of individuals in the National Health Service Corps Service program under title II of the Public Health Service Act (42 U.S.C. 202 et seq.) who receive training under this section shall be deferred until the date that is 22 days after the date of completion of the program.

“(g) GRANT AMOUNT.—Each grant awarded under this section shall be in an amount not to exceed \$600,000 per year. A grant recipient may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary.

“(h) TECHNICAL ASSISTANCE GRANTS.—The Secretary may award technical assistance grants to 1 or more FQHCs or NMHCs that have demonstrated expertise in establishing a nurse practitioner residency training program. Such technical assistance grants shall be for the purpose of providing technical assistance to other recipients of grants under subsection (c).

“(i) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2014.”

(f)(1) Section 399W of the Public Health Service Act, as added by section 5405, is redesignated as section 399V-1.

(2) Section 399V-1 of the Public Health Service Act, as so redesignated, is amended in subsection (b)(2)(A) by striking “and the departments of 1 or more health professions schools in the State that train providers in primary care” and inserting “and the departments that train providers in primary care in 1 or more health professions schools in the State”.

(3) Section 934 of the Public Health Service Act, as added by section 3501, is amended by striking “399W” each place such term appears and inserting “399V-1”.

(4) Section 935(b) of the Public Health Service Act, as added by section 3503, is amended by striking “399W” and inserting “399V-1”.

(g) Part P of title III of the Public Health Service Act 42 U.S.C. 280g et seq.), as amended by section 10411, is amended by adding at the end the following:

“SEC. 399V-3. NATIONAL DIABETES PREVENTION PROGRAM.

“(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a national diabetes prevention program (referred to in this section as the ‘program’) targeted at adults at high risk for diabetes in order to eliminate the preventable burden of diabetes.

“(b) PROGRAM ACTIVITIES.—The program described in subsection (a) shall include—

“(1) a grant program for community-based diabetes prevention program model sites;

“(2) a program within the Centers for Disease Control and Prevention to determine eligibility of entities to deliver community-based diabetes prevention services;

“(3) a training and outreach program for lifestyle intervention instructors; and

“(4) evaluation, monitoring and technical assistance, and applied research carried out by the Centers for Disease Control and Prevention.

“(c) ELIGIBLE ENTITIES.—To be eligible for a grant under subsection (b)(1), an entity shall be a State or local health department, a tribal organization, a national network of community-based non-profits focused on

health and wellbeing, an academic institution, or other entity, as the Secretary determines.

“(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.”.

(h) The provisions of, and amendment made by, section 5501(c) of this Act are repealed.

(i)(1) The provisions of, and amendments made by, section 5502 of this Act are repealed.

(2)(A) Section 1861(aa)(3)(A) of the Social Security Act (42 U.S.C. 1395w(aa)(3)(A)) is amended to read as follows:

“(A) services of the type described in subparagraphs (A) through (C) of paragraph (1) and preventive services (as defined in section 1861(ddd)(3)); and”.

(B) The amendment made by subparagraph (A) shall apply to services furnished on or after January 1, 2011.

(3)(A) Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by section 4105, is amended by adding at the end the following new subsection:

“(o) DEVELOPMENT AND IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—

“(1) DEVELOPMENT.—

“(A) IN GENERAL.—The Secretary shall develop a prospective payment system for payment for Federally qualified health center services furnished by Federally qualified health centers under this title. Such system shall include a process for appropriately describing the services furnished by Federally qualified health centers and shall establish payment rates for specific payment codes based on such appropriate descriptions of services. Such system shall be established to take into account the type, intensity, and duration of services furnished by Federally qualified health centers. Such system may include adjustments, including geographic adjustments, determined appropriate by the Secretary.

“(B) COLLECTION OF DATA AND EVALUATION.—By not later than January 1, 2011, the Secretary shall require Federally qualified health centers to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system under this subsection, including the reporting of services using HCPCS codes.

“(2) IMPLEMENTATION.—

“(A) IN GENERAL.—Notwithstanding section 1833(a)(3)(A), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2014, for payments of prospective payment rates for Federally qualified health center services furnished by Federally qualified health centers under this title in accordance with the prospective payment system developed by the Secretary under paragraph (1).

“(B) PAYMENTS.—

“(i) INITIAL PAYMENTS.—The Secretary shall implement such prospective payment system so that the estimated aggregate amount of prospective payment rates (determined prior to the application of section 1833(a)(1)(Z)) under this title for Federally qualified health center services in the first year that such system is implemented is equal to 100 percent of the estimated amount of reasonable costs (determined without the application of a per visit payment limit or productivity screen and prior to the application of section 1866(a)(2)(A)(ii)) that would have occurred for such services under this title in such year if the system had not been implemented.

“(ii) PAYMENTS IN SUBSEQUENT YEARS.—Payment rates in years after the year of implementation of such system shall be the payment rates in the previous year increased—

“(I) in the first year after implementation of such system, by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved; and

“(II) in subsequent years, by the percentage increase in a market basket of Federally qualified health center goods and services as promulgated through regulations, or if such an index is not available, by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.

“(C) PREPARATION FOR PPS IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may establish and implement by program instruction or otherwise the payment codes to be used under the prospective payment system under this section.”.

(B) Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 4104, is amended—

(i) by striking “and” before “(Y)”;

(ii) by inserting before the semicolon at the end the following: “, and (Z) with respect to Federally qualified health center services for which payment is made under section 1834(o), the amounts paid shall be 80 percent of the lesser of the actual charge or the amount determined under such section”.

(C) Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended—

(i) in paragraph (3)(B)(i)—

(I) by inserting “(I)” after “otherwise been provided”; and

(II) by inserting “, or (II) in the case of such services furnished on or after the implementation date of the prospective payment system under section 1834(o), under such section (calculated as if ‘100 percent’ were substituted for ‘80 percent’ in such section) for such services if the individual had not been so enrolled” after “been so enrolled”; and

(ii) by adding at the end the following flush sentence:

“Paragraph (3)(A) shall not apply to Federally qualified health center services furnished on or after the implementation date of the prospective payment system under section 1834(o).”.

(j) Section 5505 is amended by adding at the end the following new subsection:

“(d) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).”.

(k) Subtitle G of title V of this Act is amended by adding at the end the following:

“SEC. 5606. STATE GRANTS TO HEALTH CARE PROVIDERS WHO PROVIDE SERVICES TO A HIGH PERCENTAGE OF MEDICALLY UNDERSERVED POPULATIONS OR OTHER SPECIAL POPULATIONS.

“(a) IN GENERAL.—A State may award grants to health care providers who treat a high percentage, as determined by such State, of medically underserved populations or other special populations in such State.

“(b) SOURCE OF FUNDS.—A grant program established by a State under subsection (a) may not be established within a department, agency, or other entity of such State that

administers the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and no Federal or State funds allocated to such Medicaid program, the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), or the TRICARE program under chapter 55 of title 10, United States Code, may be used to award grants or to pay administrative costs associated with a grant program established under subsection (a).”.

(l) Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended—

(1) after the part heading, by inserting the following:

“Subpart I—Medical Training Generally”;

and

(2) by inserting at the end the following:

“Subpart II—Training in Underserved Communities

“SEC. 749B. RURAL PHYSICIAN TRAINING GRANTS.

“(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a grant program for the purposes of assisting eligible entities in recruiting students most likely to practice medicine in underserved rural communities, providing rural-focused training and experience, and increasing the number of recent allopathic and osteopathic medical school graduates who practice in underserved rural communities.

“(b) ELIGIBLE ENTITIES.—In order to be eligible to receive a grant under this section, an entity shall—

“(1) be a school of allopathic or osteopathic medicine accredited by a nationally recognized accrediting agency or association approved by the Secretary for this purpose, or any combination or consortium of such schools; and

“(2) submit an application to the Secretary that includes a certification that such entity will use amounts provided to the institution as described in subsection (d)(1).

“(c) PRIORITY.—In awarding grant funds under this section, the Secretary shall give priority to eligible entities that—

“(1) demonstrate a record of successfully training students, as determined by the Secretary, who practice medicine in underserved rural communities;

“(2) demonstrate that an existing academic program of the eligible entity produces a high percentage, as determined by the Secretary, of graduates from such program who practice medicine in underserved rural communities;

“(3) demonstrate rural community institutional partnerships, through such mechanisms as matching or contributory funding, documented in-kind services for implementation, or existence of training partners with interprofessional expertise in community health center training locations or other similar facilities; or

“(4) submit, as part of the application of the entity under subsection (b), a plan for the long-term tracking of where the graduates of such entity practice medicine.

“(d) USE OF FUNDS.—

“(1) ESTABLISHMENT.—An eligible entity receiving a grant under this section shall use the funds made available under such grant to establish, improve, or expand a rural-focused training program (referred to in this section as the ‘Program’) meeting the requirements described in this subsection and to carry out such program.

“(2) STRUCTURE OF PROGRAM.—An eligible entity shall—

“(A) enroll no fewer than 10 students per class year into the Program; and

“(B) develop criteria for admission to the Program that gives priority to students—

“(i) who have originated from or lived for a period of 2 or more years in an underserved rural community; and

“(ii) who express a commitment to practice medicine in an underserved rural community.

“(3) CURRICULA.—The Program shall require students to enroll in didactic coursework and clinical experience particularly applicable to medical practice in underserved rural communities, including—

“(A) clinical rotations in underserved rural communities, and in applicable specialties, or other coursework or clinical experience deemed appropriate by the Secretary; and

“(B) in addition to core school curricula, additional coursework or training experiences focused on medical issues prevalent in underserved rural communities.

“(4) RESIDENCY PLACEMENT ASSISTANCE.—Where available, the Program shall assist all students of the Program in obtaining clinical training experiences in locations with postgraduate programs offering residency training opportunities in underserved rural communities, or in local residency training programs that support and train physicians to practice in underserved rural communities.

“(5) PROGRAM STUDENT COHORT SUPPORT.—The Program shall provide and require all students of the Program to participate in group activities designed to further develop, maintain, and reinforce the original commitment of such students to practice in an underserved rural community.

“(e) ANNUAL REPORTING.—An eligible entity receiving a grant under this section shall submit an annual report to the Secretary on the success of the Program, based on criteria the Secretary determines appropriate, including the residency program selection of graduating students who participated in the Program.

“(f) REGULATIONS.—Not later than 60 days after the date of enactment of this section, the Secretary shall by regulation define ‘underserved rural community’ for purposes of this section.

“(g) SUPPLEMENT NOT SUPPLANT.—Any eligible entity receiving funds under this section shall use such funds to supplement, not supplant, any other Federal, State, and local funds that would otherwise be expended by such entity to carry out the activities described in this section.

“(h) MAINTENANCE OF EFFORT.—With respect to activities for which funds awarded under this section are to be expended, the entity shall agree to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the entity for the fiscal year preceding the fiscal year for which the entity receives a grant under this section.

“(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated \$4,000,000 for each of the fiscal years 2010 through 2013.”

(m)(1) Section 768 of the Public Health Service Act (42 U.S.C. 295c) is amended to read as follows:

“SEC. 768. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING GRANT PROGRAM.

“(a) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention,

shall award grants to, or enter into contracts with, eligible entities to provide training to graduate medical residents in preventive medicine specialties.

“(b) ELIGIBILITY.—To be eligible for a grant or contract under subsection (a), an entity shall be—

“(1) an accredited school of public health or school of medicine or osteopathic medicine;

“(2) an accredited public or private non-profit hospital;

“(3) a State, local, or tribal health department; or

“(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

“(c) USE OF FUNDS.—Amounts received under a grant or contract under this section shall be used to—

“(1) plan, develop (including the development of curricula), operate, or participate in an accredited residency or internship program in preventive medicine or public health;

“(2) defray the costs of practicum experiences, as required in such a program; and

“(3) establish, maintain, or improve—

“(A) academic administrative units (including departments, divisions, or other appropriate units) in preventive medicine and public health; or

“(B) programs that improve clinical teaching in preventive medicine and public health.

“(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.”

(2) Section 770(a) of the Public Health Service Act (42 U.S.C. 295e(a)) is amended to read as follows:

“(a) IN GENERAL.—For the purpose of carrying out this subpart, there is authorized to be appropriated \$43,000,000 for fiscal year 2011, and such sums as may be necessary for each of the fiscal years 2012 through 2015.”

(n)(1) Subsection (i) of section 331 of the Public Health Service Act (42 U.S.C. 254d) of the Public Health Service Act is amended—

(A) in paragraph (1), by striking “In carrying out subpart III” and all that follows through the period and inserting “In carrying out subpart III, the Secretary may, in accordance with this subsection, issue waivers to individuals who have entered into a contract for obligated service under the Scholarship Program or the Loan Repayment Program under which the individuals are authorized to satisfy the requirement of obligated service through providing clinical practice that is half time.”;

(B) in paragraph (2)—

(i) in subparagraphs (A)(ii) and (B), by striking “less than full time” each place it appears and inserting “half time”;

(ii) in subparagraphs (C) and (F), by striking “less than full-time service” each place it appears and inserting “half-time service”;

(iii) by amending subparagraphs (D) and (E) to read as follows:

“(D) the entity and the Corps member agree in writing that the Corps member will perform half-time clinical practice;

“(E) the Corps member agrees in writing to fulfill all of the service obligations under section 338C through half-time clinical practice and either—

“(i) double the period of obligated service that would otherwise be required; or

“(ii) in the case of contracts entered into under section 338B, accept a minimum service obligation of 2 years with an award amount equal to 50 percent of the amount that would otherwise be payable for full-time service; and”;

(C) in paragraph (3), by striking “In evaluating a demonstration project described in paragraph (1)” and inserting “In evaluating waivers issued under paragraph (1)”.

(2) Subsection (j) of section 331 of the Public Health Service Act (42 U.S.C. 254d) is amended by adding at the end the following:

“(5) The terms ‘full time’ and ‘full-time’ mean a minimum of 40 hours per week in a clinical practice, for a minimum of 45 weeks per year.

“(6) The terms ‘half time’ and ‘half-time’ mean a minimum of 20 hours per week (not to exceed 39 hours per week) in a clinical practice, for a minimum of 45 weeks per year.”

(3) Section 337(b)(1) of the Public Health Service Act (42 U.S.C. 254j(b)(1)) is amended by striking “Members may not be reappointed to the Council.”

(4) Section 338B(g)(2)(A) of the Public Health Service Act (42 U.S.C. 254l-1(g)(2)(A)) is amended by striking “\$35,000” and inserting “\$50,000, plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation.”

(5) Subsection (a) of section 338C of the Public Health Service Act (42 U.S.C. 254m), as amended by section 5508, is amended—

(A) by striking the second sentence and inserting the following: “The Secretary may treat teaching as clinical practice for up to 20 percent of such period of obligated service.”; and

(B) by adding at the end the following: “Notwithstanding the preceding sentence, with respect to a member of the Corps participating in the teaching health centers graduate medical education program under section 340H, for the purpose of calculating time spent in full-time clinical practice under this section, up to 50 percent of time spent teaching by such member may be counted toward his or her service obligation.”

SEC. 10502. INFRASTRUCTURE TO EXPAND ACCESS TO CARE.

(a) APPROPRIATION.—There are authorized to be appropriated, and there are appropriated to the Department of Health and Human Services, \$100,000,000 for fiscal year 2010, to remain available for obligation until September 30, 2011, to be used for debt service on, or direct construction or renovation of, a health care facility that provides research, inpatient tertiary care, or outpatient clinical services. Such facility shall be affiliated with an academic health center at a public research university in the United States that contains a State’s sole public academic medical and dental school.

(b) REQUIREMENT.—Amount appropriated under subsection (a) may only be made available by the Secretary of Health and Human Services upon the receipt of an application from the Governor of a State that certifies that—

(1) the new health care facility is critical for the provision of greater access to health care within the State;

(2) such facility is essential for the continued financial viability of the State’s sole public medical and dental school and its academic health center;

(3) the request for Federal support represents not more than 40 percent of the total cost of the proposed new facility; and

(4) the State has established a dedicated funding mechanism to provide all remaining funds necessary to complete the construction or renovation of the proposed facility.

SEC. 10503. COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS FUND.

(a) PURPOSE.—It is the purpose of this section to establish a Community Health Center

Fund (referred to in this section as the "CHC Fund"), to be administered through the Office of the Secretary of the Department of Health and Human Services to provide for expanded and sustained national investment in community health centers under section 330 of the Public Health Service Act and the National Health Service Corps.

(b) FUNDING.—There is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, to the CHC Fund—

(1) to be transferred to the Secretary of Health and Human Services to provide enhanced funding for the community health center program under section 330 of the Public Health Service Act—

- (A) \$700,000,000 for fiscal year 2011;
- (B) \$800,000,000 for fiscal year 2012;
- (C) \$1,000,000,000 for fiscal year 2013;
- (D) \$1,600,000,000 for fiscal year 2014; and
- (E) \$2,900,000,000 for fiscal year 2015; and

(2) to be transferred to the Secretary of Health and Human Services to provide enhanced funding for the National Health Service Corps—

- (A) \$290,000,000 for fiscal year 2011;
- (B) \$295,000,000 for fiscal year 2012;
- (C) \$300,000,000 for fiscal year 2013;
- (D) \$305,000,000 for fiscal year 2014; and
- (E) \$310,000,000 for fiscal year 2015.

(c) CONSTRUCTION.—There is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, \$1,500,000,000 to be available for fiscal years 2011 through 2015 to be used by the Secretary of Health and Human Services for the construction and renovation of community health centers.

(d) USE OF FUND.—The Secretary of Health and Human Services shall transfer amounts in the CHC Fund to accounts within the Department of Health and Human Services to increase funding, over the fiscal year 2008 level, for community health centers and the National Health Service Corps.

(e) AVAILABILITY.—Amounts appropriated under subsections (b) and (c) shall remain available until expended.

SEC. 10504. DEMONSTRATION PROJECT TO PROVIDE ACCESS TO AFFORDABLE CARE.

(a) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the "Secretary"), acting through the Health Resources and Services Administration, shall establish a 3 year demonstration project in up to 10 States to provide access to comprehensive health care services to the uninsured at reduced fees. The Secretary shall evaluate the feasibility of expanding the project to additional States.

(b) ELIGIBILITY.—To be eligible to participate in the demonstration project, an entity shall be a State-based, nonprofit, public-private partnership that provides access to comprehensive health care services to the uninsured at reduced fees. Each State in which a participant selected by the Secretary is located shall receive not more than \$2,000,000 to establish and carry out the project for the 3-year demonstration period.

(c) AUTHORIZATION.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

Subtitle F—Provisions Relating to Title VI

SEC. 10601. REVISIONS TO LIMITATION ON MEDICAL CARE EXCEPTION TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.

(a) IN GENERAL.—Section 1877(i) of the Social Security Act, as added by section 6001(a), is amended—

(1) in paragraph (1)(A)(i), by striking "February 1, 2010" and inserting "August 1, 2010"; and

(2) in paragraph (3)(A)—

(A) in clause (iii), by striking "August 1, 2011" and inserting "February 1, 2012"; and

(B) in clause (iv), by striking "July 1, 2011" and inserting "January 1, 2012".

(b) CONFORMING AMENDMENT.—Section 6001(b)(2) of this Act is amended by striking "November 1, 2011" and inserting "May 1, 2012".

SEC. 10602. CLARIFICATIONS TO PATIENT-CENTERED OUTCOMES RESEARCH.

Section 1181 of the Social Security Act (as added by section 6301) is amended—

(1) in subsection (d)(2)(B)—

(A) in clause (ii)(IV)—

(i) by inserting "as described in subparagraph (A)(ii)," after "original research"; and

(ii) by inserting "as long as the researcher enters into a data use agreement with the Institute for use of the data from the original research, as appropriate" after "publication"; and

(B) by amending clause (iv) to read as follows:

"(iv) SUBSEQUENT USE OF THE DATA.—The Institute shall not allow the subsequent use of data from original research in work-for-hire contracts with individuals, entities, or instrumentalities that have a financial interest in the results, unless approved under a data use agreement with the Institute.";

(2) in subsection (d)(8)(A)(iv), by striking "not be construed as mandates for" and inserting "do not include"; and

(3) in subsection (f)(1)(C), by amending clause (ii) to read as follows:

"(ii) 7 members representing physicians and providers, including 4 members representing physicians (at least 1 of whom is a surgeon), 1 nurse, 1 State-licensed integrative health care practitioner, and 1 representative of a hospital.".

SEC. 10603. STRIKING PROVISIONS RELATING TO INDIVIDUAL PROVIDER APPLICATION FEES.

(a) IN GENERAL.—Section 1866(j)(2)(C) of the Social Security Act, as added by section 6401(a), is amended—

(1) by striking clause (i);

(2) by redesignating clauses (ii) through (iv), respectively, as clauses (i) through (iii); and

(3) in clause (i), as redesignated by paragraph (2), by striking "clause (iii)" and inserting "clause (ii)".

(b) TECHNICAL CORRECTION.—Section 6401(a)(2) of this Act is amended to read as follows:

"(2) by redesignating paragraph (2) as paragraph (8); and".

SEC. 10604. TECHNICAL CORRECTION TO SECTION 6405.

Paragraphs (1) and (2) of section 6405(b) are amended to read as follows:

"(1) PART A.—Section 1814(a)(2) of the Social Security Act (42 U.S.C. 1395(a)(2)) is amended in the matter preceding subparagraph (A) by inserting "or, in the case of services described in subparagraph (C), a physician enrolled under section 1866(j)," after "in collaboration with a physician,".

"(2) PART B.—Section 1835(a)(2) of the Social Security Act (42 U.S.C. 1395n(a)(2)) is amended in the matter preceding subparagraph (A) by inserting "or, in the case of services described in subparagraph (A), a physician enrolled under section 1866(j)," after "a physician".

SEC. 10605. CERTAIN OTHER PROVIDERS PERMITTED TO CONDUCT FACE TO FACE ENCOUNTER FOR HOME HEALTH SERVICES.

(a) PART A.—Section 1814(a)(2)(C) of the Social Security Act (42 U.S.C. 1395f(a)(2)(C)), as amended by section 6407(a)(1), is amended by inserting "or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5)) under the supervision of the physician," after "himself or herself".

(b) PART B.—Section 1835(a)(2)(A)(iv) of the Social Security Act, as added by section 6407(a)(2), is amended by inserting "or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5)) under the supervision of the physician," after "must document that the physician".

SEC. 10606. HEALTH CARE FRAUD ENFORCEMENT.

(a) FRAUD SENTENCING GUIDELINES.—

(1) DEFINITION.—In this subsection, the term "Federal health care offense" has the meaning given that term in section 24 of title 18, United States Code, as amended by this Act.

(2) REVIEW AND AMENDMENTS.—Pursuant to the authority under section 994 of title 28, United States Code, and in accordance with this subsection, the United States Sentencing Commission shall—

(A) review the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses;

(B) amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs to provide that the aggregate dollar amount of fraudulent bills submitted to the Government health care program shall constitute prima facie evidence of the amount of the intended loss by the defendant; and

(C) amend the Federal Sentencing Guidelines to provide—

(i) a 2-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than \$1,000,000 and less than \$7,000,000;

(ii) a 3-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than \$7,000,000 and less than \$20,000,000;

(iii) a 4-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than \$20,000,000; and

(iv) if appropriate, otherwise amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs.

(3) REQUIREMENTS.—In carrying this subsection, the United States Sentencing Commission shall—

(A) ensure that the Federal Sentencing Guidelines and policy statements—

(i) reflect the serious harms associated with health care fraud and the need for aggressive and appropriate law enforcement action to prevent such fraud; and

(ii) provide increased penalties for persons convicted of health care fraud offenses in appropriate circumstances;

(B) consult with individuals or groups representing health care fraud victims, law enforcement officials, the health care industry, and the Federal judiciary as part of the review described in paragraph (2);

(C) ensure reasonable consistency with other relevant directives and with other guidelines under the Federal Sentencing Guidelines;

(D) account for any aggravating or mitigating circumstances that might justify exceptions, including circumstances for which the Federal Sentencing Guidelines, as in effect on the date of enactment of this Act, provide sentencing enhancements;

(E) make any necessary conforming changes to the Federal Sentencing Guidelines; and

(F) ensure that the Federal Sentencing Guidelines adequately meet the purposes of sentencing.

(b) **INTENT REQUIREMENT FOR HEALTH CARE FRAUD.**—Section 1347 of title 18, United States Code, is amended—

(1) by inserting “(a)” before “Whoever knowingly”; and

(2) by adding at the end the following:

“(b) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.”.

(c) **HEALTH CARE FRAUD OFFENSE.**—Section 24(a) of title 18, United States Code, is amended—

(1) in paragraph (1), by striking the semicolon and inserting “or section 1128B of the Social Security Act (42 U.S.C. 1320a-7b); or”; and

(2) in paragraph (2)—

(A) by inserting “1349,” after “1343,”; and

(B) by inserting “section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331), or section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131),” after “title,”.

(d) **SUBPOENA AUTHORITY RELATING TO HEALTH CARE.**—

(1) **SUBPOENAS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.**—Section 1510(b) of title 18, United States Code, is amended—

(A) in paragraph (1), by striking “to the grand jury”; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking “grand jury subpoena” and inserting “subpoena for records”; and

(ii) in the matter following subparagraph (B), by striking “to the grand jury”.

(2) **SUBPOENAS UNDER THE CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT.**—The Civil Rights of Institutionalized Persons Act (42 U.S.C. 1997 et seq.) is amended by inserting after section 3 the following:

“SEC. 3A. SUBPOENA AUTHORITY.

“(a) **AUTHORITY.**—The Attorney General, or at the direction of the Attorney General, any officer or employee of the Department of Justice may require by subpoena access to any institution that is the subject of an investigation under this Act and to any document, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report relating to any institution that is the subject of an investigation under this Act to determine whether there are condi-

tions which deprive persons residing in or confined to the institution of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States.

“(b) **ISSUANCE AND ENFORCEMENT OF SUBPOENAS.**—

“(1) **ISSUANCE.**—Subpoenas issued under this section—

“(A) shall bear the signature of the Attorney General or any officer or employee of the Department of Justice as designated by the Attorney General; and

“(B) shall be served by any person or class of persons designated by the Attorney General or a designated officer or employee for that purpose.

“(2) **ENFORCEMENT.**—In the case of contumacy or failure to obey a subpoena issued under this section, the United States district court for the judicial district in which the institution is located may issue an order requiring compliance. Any failure to obey the order of the court may be punished by the court as a contempt of that court.

“(c) **PROTECTION OF SUBPOENAED RECORDS AND INFORMATION.**—Any document, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report or other information obtained under a subpoena issued under this section—

“(1) may not be used for any purpose other than to protect the rights, privileges, or immunities secured or protected by the Constitution or laws of the United States of persons who reside, have resided, or will reside in an institution;

“(2) may not be transmitted by or within the Department of Justice for any purpose other than to protect the rights, privileges, or immunities secured or protected by the Constitution or laws of the United States of persons who reside, have resided, or will reside in an institution; and

“(3) shall be redacted, obscured, or otherwise altered if used in any publicly available manner so as to prevent the disclosure of any personally identifiable information.”.

SEC. 10607. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by this Act, is further amended by adding at the end the following:

“SEC. 399V-4. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

“(a) **IN GENERAL.**—The Secretary is authorized to award demonstration grants to States for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. In awarding such grants, the Secretary shall ensure the diversity of the alternatives so funded.

“(b) **DURATION.**—The Secretary may award grants under subsection (a) for a period not to exceed 5 years.

“(c) **CONDITIONS FOR DEMONSTRATION GRANTS.**—

“(1) **REQUIREMENTS.**—Each State desiring a grant under subsection (a) shall develop an alternative to current tort litigation that—

“(A) allows for the resolution of disputes over injuries allegedly caused by health care providers or health care organizations; and

“(B) promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to dis-

putes resolved under subparagraph (A) by organizations that engage in efforts to improve patient safety and the quality of health care.

“(2) **ALTERNATIVE TO CURRENT TORT LITIGATION.**—Each State desiring a grant under subsection (a) shall demonstrate how the proposed alternative described in paragraph (1)(A)—

“(A) makes the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes;

“(B) encourages the efficient resolution of disputes;

“(C) encourages the disclosure of health care errors;

“(D) enhances patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events;

“(E) improves access to liability insurance;

“(F) fully informs patients about the differences in the alternative and current tort litigation;

“(G) provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative;

“(H) would not conflict with State law at the time of the application in a way that would prohibit the adoption of an alternative to current tort litigation; and

“(I) would not limit or curtail a patient's existing legal rights, ability to file a claim in or access a State's legal system, or otherwise abrogate a patient's ability to file a medical malpractice claim.

“(3) **SOURCES OF COMPENSATION.**—Each State desiring a grant under subsection (a) shall identify the sources from and methods by which compensation would be paid for claims resolved under the proposed alternative to current tort litigation, which may include public or private funding sources, or a combination of such sources. Funding methods shall to the extent practicable provide financial incentives for activities that improve patient safety.

“(4) **SCOPE.**—

“(A) **IN GENERAL.**—Each State desiring a grant under subsection (a) shall establish a scope of jurisdiction (such as Statewide, designated geographic region, a designated area of health care practice, or a designated group of health care providers or health care organizations) for the proposed alternative to current tort litigation that is sufficient to evaluate the effects of the alternative. No scope of jurisdiction shall be established under this paragraph that is based on a health care payer or patient population.

“(B) **NOTIFICATION OF PATIENTS.**—A State shall demonstrate how patients would be notified that they are receiving health care services that fall within such scope, and the process by which they may opt out of or voluntarily withdraw from participating in the alternative. The decision of the patient whether to participate or continue participating in the alternative process shall be made at any time and shall not be limited in any way.

“(5) **PREFERENCE IN AWARDING DEMONSTRATION GRANTS.**—In awarding grants under subsection (a), the Secretary shall give preference to States—

“(A) that have developed the proposed alternative through substantive consultation with relevant stakeholders, including patient advocates, health care providers and health care organizations, attorneys with expertise in representing patients and health care providers, medical malpractice insurers, and patient safety experts;

“(B) that make proposals that are likely to enhance patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events; and

“(C) that make proposals that are likely to improve access to liability insurance.

“(d) APPLICATION.—

“(1) IN GENERAL.—Each State desiring a grant under subsection (a) shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

“(2) REVIEW PANEL.—

“(A) IN GENERAL.—In reviewing applications under paragraph (1), the Secretary shall consult with a review panel composed of relevant experts appointed by the Comptroller General.

“(B) COMPOSITION.—

“(i) NOMINATIONS.—The Comptroller General shall solicit nominations from the public for individuals to serve on the review panel.

“(ii) APPOINTMENT.—The Comptroller General shall appoint, at least 9 but not more than 13, highly qualified and knowledgeable individuals to serve on the review panel and shall ensure that the following entities receive fair representation on such panel:

“(I) Patient advocates.

“(II) Health care providers and health care organizations.

“(III) Attorneys with expertise in representing patients and health care providers.

“(IV) Medical malpractice insurers.

“(V) State officials.

“(VI) Patient safety experts.

“(C) CHAIRPERSON.—The Comptroller General, or an individual within the Government Accountability Office designated by the Comptroller General, shall be the chairperson of the review panel.

“(D) AVAILABILITY OF INFORMATION.—The Comptroller General shall make available to the review panel such information, personnel, and administrative services and assistance as the review panel may reasonably require to carry out its duties.

“(E) INFORMATION FROM AGENCIES.—The review panel may request directly from any department or agency of the United States any information that such panel considers necessary to carry out its duties. To the extent consistent with applicable laws and regulations, the head of such department or agency shall furnish the requested information to the review panel.

“(e) REPORTS.—

“(1) BY STATE.—Each State receiving a grant under subsection (a) shall submit to the Secretary an annual report evaluating the effectiveness of activities funded with grants awarded under such subsection. Such report shall, at a minimum, include the impact of the activities funded on patient safety and on the availability and price of medical liability insurance.

“(2) BY SECRETARY.—The Secretary shall submit to Congress an annual compendium of the reports submitted under paragraph (1) and an analysis of the activities funded under subsection (a) that examines any differences that result from such activities in terms of the quality of care, number and nature of medical errors, medical resources used, length of time for dispute resolution, and the availability and price of liability insurance.

“(f) TECHNICAL ASSISTANCE.—

“(1) IN GENERAL.—The Secretary shall provide technical assistance to the States applying for or awarded grants under subsection (a).

“(2) REQUIREMENTS.—Technical assistance under paragraph (1) shall include—

“(A) guidance on non-economic damages, including the consideration of individual facts and circumstances in determining appropriate payment, guidance on identifying avoidable injuries, and guidance on disclosure to patients of health care errors and adverse events; and

“(B) the development, in consultation with States, of common definitions, formats, and data collection infrastructure for States receiving grants under this section to use in reporting to facilitate aggregation and analysis of data both within and between States.

“(3) USE OF COMMON DEFINITIONS, FORMATS, AND DATA COLLECTION INFRASTRUCTURE.—States not receiving grants under this section may also use the common definitions, formats, and data collection infrastructure developed under paragraph (2)(B).

“(g) EVALUATION.—

“(1) IN GENERAL.—The Secretary, in consultation with the review panel established under subsection (d)(2), shall enter into a contract with an appropriate research organization to conduct an overall evaluation of the effectiveness of grants awarded under subsection (a) and to annually prepare and submit a report to Congress. Such an evaluation shall begin not later than 18 months following the date of implementation of the first program funded by a grant under subsection (a).

“(2) CONTENTS.—The evaluation under paragraph (1) shall include—

“(A) an analysis of the effects of the grants awarded under subsection (a) with regard to the measures described in paragraph (3);

“(B) for each State, an analysis of the extent to which the alternative developed under subsection (c)(1) is effective in meeting the elements described in subsection (c)(2);

“(C) a comparison among the States receiving grants under subsection (a) of the effectiveness of the various alternatives developed by such States under subsection (c)(1);

“(D) a comparison, considering the measures described in paragraph (3), of States receiving grants approved under subsection (a) and similar States not receiving such grants; and

“(E) a comparison, with regard to the measures described in paragraph (3), of—

“(i) States receiving grants under subsection (a);

“(ii) States that enacted, prior to the date of enactment of the Patient Protection and Affordable Care Act, any cap on non-economic damages; and

“(iii) States that have enacted, prior to the date of enactment of the Patient Protection and Affordable Care Act, a requirement that the complainant obtain an opinion regarding the merit of the claim, although the substance of such opinion may have no bearing on whether the complainant may proceed with a case.

“(3) MEASURES.—The evaluations under paragraph (2) shall analyze and make comparisons on the basis of—

“(A) the nature and number of disputes over injuries allegedly caused by health care providers or health care organizations;

“(B) the nature and number of claims in which tort litigation was pursued despite the existence of an alternative under subsection (a);

“(C) the disposition of disputes and claims, including the length of time and estimated costs to all parties;

“(D) the medical liability environment;

“(E) health care quality;

“(F) patient safety in terms of detecting, analyzing, and helping to reduce medical errors and adverse events;

“(G) patient and health care provider and organization satisfaction with the alternative under subsection (a) and with the medical liability environment; and

“(H) impact on utilization of medical services, appropriately adjusted for risk.

“(4) FUNDING.—The Secretary shall reserve 5 percent of the amount appropriated in each fiscal year under subsection (k) to carry out this subsection.

“(h) MEDPAC AND MACPAC REPORTS.—

“(1) MEDPAC.—The Medicare Payment Advisory Commission shall conduct an independent review of the alternatives to current tort litigation that are implemented under grants under subsection (a) to determine the impact of such alternatives on the Medicare program under title XVIII of the Social Security Act, and its beneficiaries.

“(2) MACPAC.—The Medicaid and CHIP Payment and Access Commission shall conduct an independent review of the alternatives to current tort litigation that are implemented under grants under subsection (a) to determine the impact of such alternatives on the Medicaid or CHIP programs under titles XIX and XXI of the Social Security Act, and their beneficiaries.

“(3) REPORTS.—Not later than December 31, 2016, the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission shall each submit to Congress a report that includes the findings and recommendations of each respective Commission based on independent reviews conducted under paragraphs (1) and (2), including an analysis of the impact of the alternatives reviewed on the efficiency and effectiveness of the respective programs.

“(i) OPTION TO PROVIDE FOR INITIAL PLANNING GRANTS.—Of the funds appropriated pursuant to subsection (k), the Secretary may use a portion not to exceed \$500,000 per State to provide planning grants to such States for the development of demonstration project applications meeting the criteria described in subsection (c). In selecting States to receive such planning grants, the Secretary shall give preference to those States in which State law at the time of the application would not prohibit the adoption of an alternative to current tort litigation.

“(j) DEFINITIONS.—In this section:

“(1) HEALTH CARE SERVICES.—The term ‘health care services’ means any services provided by a health care provider, or by any individual working under the supervision of a health care provider, that relate to—

“(A) the diagnosis, prevention, or treatment of any human disease or impairment; or

“(B) the assessment of the health of human beings.

“(2) HEALTH CARE ORGANIZATION.—The term ‘health care organization’ means any individual or entity which is obligated to provide, pay for, or administer health benefits under any health plan.

“(3) HEALTH CARE PROVIDER.—The term ‘health care provider’ means any individual or entity—

“(A) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or

“(B) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

“(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, \$50,000,000 for the 5-fiscal year period beginning with fiscal year 2011.

“(l) CURRENT STATE EFFORTS TO ESTABLISH ALTERNATIVE TO TORT LITIGATION.—Nothing

in this section shall be construed to limit any prior, current, or future efforts of any State to establish any alternative to tort litigation.

“(m) **RULE OF CONSTRUCTION.**—Nothing in this section shall be construed as limiting states’ authority over or responsibility for their state justice systems.”.

SEC. 10608. EXTENSION OF MEDICAL MALPRACTICE COVERAGE TO FREE CLINICS.

(a) **IN GENERAL.**—Section 224(o)(1) of the Public Health Service Act (42 U.S.C. 233(o)(1)) is amended by inserting after “to an individual” the following: “, or an officer, governing board member, employee, or contractor of a free clinic shall in providing services for the free clinic.”.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall take effect on the date of enactment of this Act and apply to any act or omission which occurs on or after that date.

SEC. 10609. LABELING CHANGES.

Section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended by adding at the end the following:

“(10)(A) If the proposed labeling of a drug that is the subject of an application under this subsection differs from the listed drug due to a labeling revision described under clause (i), the drug that is the subject of such application shall, notwithstanding any other provision of this Act, be eligible for approval and shall not be considered misbranded under section 502 if—

“(i) the application is otherwise eligible for approval under this subsection but for expiration of patent, an exclusivity period, or of a delay in approval described in paragraph (5)(B)(iii), and a revision to the labeling of the listed drug has been approved by the Secretary within 60 days of such expiration;

“(ii) the labeling revision described under clause (i) does not include a change to the ‘Warnings’ section of the labeling;

“(iii) the sponsor of the application under this subsection agrees to submit revised labeling of the drug that is the subject of such application not later than 60 days after the notification of any changes to such labeling required by the Secretary; and

“(iv) such application otherwise meets the applicable requirements for approval under this subsection.

“(B) If, after a labeling revision described in subparagraph (A)(i), the Secretary determines that the continued presence in interstate commerce of the labeling of the listed drug (as in effect before the revision described in subparagraph (A)(i)) adversely impacts the safe use of the drug, no application under this subsection shall be eligible for approval with such labeling.”.

Subtitle G—Provisions Relating to Title VIII
SEC. 10801. PROVISIONS RELATING TO TITLE VIII.

(a) Title XXXII of the Public Health Service Act, as added by section 8002(a)(1), is amended—

(1) in section 3203—

(A) in subsection (a)(1), by striking subparagraph (E);

(B) in subsection (b)(1)(C)(i), by striking “for enrollment” and inserting “for reenrollment”; and

(C) in subsection (c)(1), by striking “, as part of their automatic enrollment in the CLASS program.”; and

(2) in section 3204—

(A) in subsection (c)(2), by striking subparagraph (A) and inserting the following:

“(A) receives wages or income on which there is imposed a tax under section 3101(a) or 3201(a) of the Internal Revenue Code of 1986; or”;

(B) in subsection (d), by striking “subparagraph (B) or (C) of subsection (c)(1)” and inserting “subparagraph (A) or (B) of subsection (c)(2)”;

(C) in subsection (e)(2)(A), by striking “subparagraph (A)” and inserting “paragraph (1)”;

(D) in subsection (g)(1), by striking “has elected to waive enrollment” and inserting “has not enrolled”.

(b) Section 8002 of this Act is amended in the heading for subsection (d), by striking “INFORMATION ON SUPPLEMENTAL COVERAGE” and inserting “CLASS PROGRAM INFORMATION”.

(c) Section 6021(d)(2)(A)(iv) of the Deficit Reduction Act of 2005, as added by section 8002(d) of this Act, is amended by striking “and coverage available” and all that follows through “that program.”.

Subtitle H—Provisions Relating to Title IX

SEC. 10901. MODIFICATIONS TO EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

(a) **LONGSHORE WORKERS TREATED AS EMPLOYEES ENGAGED IN HIGH-RISK PROFESSIONS.**—Paragraph (3) of section 4980I(f) of the Internal Revenue Code of 1986, as added by section 9001 of this Act, is amended by inserting “individuals whose primary work is longshore work (as defined in section 258(b) of the Immigration and Nationality Act (8 U.S.C. 1288(b)), determined without regard to paragraph (2) thereof,” before “and individuals engaged in the construction, mining”.

(b) **EXEMPTION FROM HIGH-COST INSURANCE TAX INCLUDES CERTAIN ADDITIONAL EXCEPTED BENEFITS.**—Clause (i) of section 4980I(d)(1)(B) of the Internal Revenue Code of 1986, as added by section 9001 of this Act, is amended by striking “section 9832(c)(1)(A)” and inserting “section 9832(c)(1) (other than subparagraph (G) thereof)”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 10902. INFLATION ADJUSTMENT OF LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.

(a) **IN GENERAL.**—Subsection (i) of section 125 of the Internal Revenue Code of 1986, as added by section 9005 of this Act, is amended to read as follows:

“(i) **LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.**—

“(1) **IN GENERAL.**—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of \$2,500 made to such arrangement.

“(2) **ADJUSTMENT FOR INFLATION.**—In the case of any taxable year beginning after December 31, 2011, the dollar amount in paragraph (1) shall be increased by an amount equal to—

“(A) such amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting ‘calendar year 2010’ for ‘calendar year 1992’ in subparagraph (B) thereof. If any increase determined under this paragraph is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.”.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 10903. MODIFICATION OF LIMITATION ON CHARGES BY CHARITABLE HOSPITALS.

(a) **IN GENERAL.**—Subparagraph (A) of section 501(r)(5) of the Internal Revenue Code of 1986, as added by section 9007 of this Act, is amended by striking “the lowest amounts charged” and inserting “the amounts generally billed”.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

SEC. 10904. MODIFICATION OF ANNUAL FEE ON MEDICAL DEVICE MANUFACTURERS AND IMPORTERS.

(a) **IN GENERAL.**—Section 9009 of this Act is amended—

(1) by striking “2009” in subsection (a)(1) and inserting “2010”;

(2) by inserting “(\$3,000,000,000 after 2017)” after “\$2,000,000,000”; and

(3) by striking “2008” in subsection (i) and inserting “2009”.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall take effect as if included in the enactment of section 9009.

SEC. 10905. MODIFICATION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.

(a) **DETERMINATION OF FEE AMOUNT.**—Subsection (b) of section 9010 of this Act is amended to read as follows:

“(b) **DETERMINATION OF FEE AMOUNT.**—

“(1) **IN GENERAL.**—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to the applicable amount as—

“(A) the covered entity’s net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, bears to

“(B) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year.

“(2) **AMOUNTS TAKEN INTO ACCOUNT.**—For purposes of paragraph (1), the net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

“With respect to a covered entity’s net premiums written during the calendar year that are:

The percentage of net premiums written that are taken into account is:

Not more than \$25,000,000	0 percent
More than \$25,000,000 but not more than \$50,000,000	50 percent
More than \$50,000,000	100 percent.

“(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity’s fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity’s net premiums written with respect to any United States health risk on

the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.”.

(b) APPLICABLE AMOUNT.—Subsection (e) of section 9010 of this Act is amended to read as follows:

“(e) APPLICABLE AMOUNT.—For purposes of subsection (b)(1), the applicable amount shall be determined in accordance with the following table:

“Calendar year

Calendar year	Applicable amount
2011	\$2,000,000,000
2012	\$4,000,000,000
2013	\$7,000,000,000
2014, 2015 and 2016	\$9,000,000,000
2017 and thereafter	\$10,000,000,000.”.

(c) EXEMPTION FROM ANNUAL FEE ON HEALTH INSURANCE FOR CERTAIN NONPROFIT ENTITIES.—Section 9010(c)(2) of this Act is amended by striking “or” at the end of subparagraph (A), by striking the period at the end of subparagraph (B) and inserting a comma, and by adding at the end the following new subparagraphs:

“(C) any entity—

“(i) which is incorporated as, is a wholly owned subsidiary of, or is a wholly owned affiliate of, a nonprofit corporation under a State law, or

“(II) which is described in section 501(c)(4) of the Internal Revenue Code of 1986 and the activities of which consist of providing commercial-type insurance (within the meaning of section 501(m) of such Code),

“(ii) the premium rate increases of which are regulated by a State authority,

“(iii) which, as of the date of the enactment of this section, acts as the insurer of last resort in the State and is subject to State guarantee issue requirements, and

“(iv) for which the medical loss ratio (determined in a manner consistent with the determination of such ratio under section 2718(b)(1)(A) of the Public Health Service Act) with respect to the individual insurance market for such entity for the calendar year is not less than 100 percent,

“(D) any entity—

“(i) which is incorporated as a nonprofit corporation under a State law, or

“(II) which is described in section 501(c)(4) of the Internal Revenue Code of 1986 and the activities of which consist of providing commercial-type insurance (within the meaning of section 501(m) of such Code), and

“(ii) for which the medical loss ratio (as so determined)—

“(I) with respect to each of the individual, small group, and large group insurance markets for such entity for the calendar year is not less than 90 percent, and

“(II) with respect to all such markets for such entity for the calendar year is not less than 92 percent, or

“(E) any entity—

“(i) which is a mutual insurance company, “(ii) which for the period reported on the 2008 Accident and Health Policy Experience Exhibit of the National Association of Insurance Commissioners had—

“(I) a market share of the insured population of a State of at least 40 but not more than 60 percent, and

“(II) with respect to all markets described in subparagraph (D)(ii)(I), a medical loss ratio of not less than 90 percent, and

“(iii) with respect to annual payment dates in calendar years after 2011, for which the medical loss ratio (determined in a manner consistent with the determination of such ratio under section 2718(b)(1)(A) of the Public Health Service Act) with respect to all such markets for such entity for the preceding

calendar year is not less than 89 percent (except that with respect to such annual payment date for 2012, the calculation under 2718(b)(1)(B)(ii) of such Act is determined by reference to the previous year, and with respect to such annual payment date for 2013, such calculation is determined by reference to the average for the previous 2 years).”.

(d) CERTAIN INSURANCE EXEMPTED FROM FEE.—Paragraph (3) of section 9010(h) of this Act is amended to read as follows:

“(3) HEALTH INSURANCE.—The term ‘health insurance’ shall not include—

“(A) any insurance coverage described in paragraph (1)(A) or (3) of section 9832(c) of the Internal Revenue Code of 1986,

“(B) any insurance for long-term care, or

“(C) any medicare supplemental health insurance (as defined in section 1882(g)(1) of the Social Security Act).”.

(e) ANTI-AVOIDANCE GUIDANCE.—Subsection (i) of section 9010 of this Act is amended by inserting “and shall prescribe such regulations as are necessary or appropriate to prevent avoidance of the purposes of this section, including inappropriate actions taken to qualify as an exempt entity under subsection (c)(2)” after “section”.

(f) CONFORMING AMENDMENTS.—

(1) Section 9010(a)(1) of this Act is amended by striking “2009” and inserting “2010”.

(2) Section 9010(c)(2)(B) of this Act is amended by striking “(except)” and all that follows through “1323”.

(3) Section 9010(c)(3) of this Act is amended by adding at the end the following new sentence: “If any entity described in subparagraph (C)(i)(I), (D)(i)(I), or (E)(i) of paragraph (2) is treated as a covered entity by reason of the application of the preceding sentence, the net premiums written with respect to health insurance for any United States health risk of such entity shall not be taken into account for purposes of this section.”.

(4) Section 9010(g)(1) of this Act is amended by striking “and third party administration agreement fees”.

(5) Section 9010(j) of this Act is amended—

(A) by striking “2008” and inserting “2009”, and

(B) by striking “, and any third party administration agreement fees received after such date”.

(g) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 9010.

SEC. 10906. MODIFICATIONS TO ADDITIONAL HOSPITAL INSURANCE TAX ON HIGH-INCOME TAXPAYERS.

(a) FICA.—Section 3101(b)(2) of the Internal Revenue Code of 1986, as added by section 9015(a)(1) of this Act, is amended by striking “.5 percent” and inserting “.9 percent”.

(b) SECA.—Section 1401(b)(2)(A) of the Internal Revenue Code of 1986, as added by section 9015(b)(1) of this Act, is amended by striking “.5 percent” and inserting “.9 percent”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration received, and taxable years beginning, after December 31, 2012.

SEC. 10907. EXCISE TAX ON INDOOR TANNING SERVICES IN LIEU OF ELECTIVE COSMETIC MEDICAL PROCEDURES.

(a) IN GENERAL.—The provisions of, and amendments made by, section 9017 of this Act are hereby deemed null, void, and of no effect.

(b) EXCISE TAX ON INDOOR TANNING SERVICES.—Subtitle D of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new chapter:

“CHAPTER 49—COSMETIC SERVICES

“Sec. 5000B. Imposition of tax on indoor tanning services.

“SEC. 5000B. IMPOSITION OF TAX ON INDOOR TANNING SERVICES.

“(a) IN GENERAL.—There is hereby imposed on any indoor tanning service a tax equal to 10 percent of the amount paid for such service (determined without regard to this section), whether paid by insurance or otherwise.

“(b) INDOOR TANNING SERVICE.—For purposes of this section—

“(1) IN GENERAL.—The term ‘indoor tanning service’ means a service employing any electronic product designed to incorporate 1 or more ultraviolet lamps and intended for the irradiation of an individual by ultraviolet radiation, with wavelengths in air between 200 and 400 nanometers, to induce skin tanning.

“(2) EXCLUSION OF PHOTOTHERAPY SERVICES.—Such term does not include any phototherapy service performed by a licensed medical professional.

“(c) PAYMENT OF TAX.—

“(1) IN GENERAL.—The tax imposed by this section shall be paid by the individual on whom the service is performed.

“(2) COLLECTION.—Every person receiving a payment for services on which a tax is imposed under subsection (a) shall collect the amount of the tax from the individual on whom the service is performed and remit such tax quarterly to the Secretary at such time and in such manner as provided by the Secretary.

“(3) SECONDARY LIABILITY.—Where any tax imposed by subsection (a) is not paid at the time payments for indoor tanning services are made, then to the extent that such tax is not collected, such tax shall be paid by the person who performs the service.”.

(c) CLERICAL AMENDMENT.—The table of chapter for subtitle D of the Internal Revenue Code of 1986, as amended by this Act, is amended by inserting after the item relating to chapter 48 the following new item:

“CHAPTER 49—COSMETIC SERVICES”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services performed on or after July 1, 2010.

SEC. 10908. EXCLUSION FOR ASSISTANCE PROVIDED TO PARTICIPANTS IN STATE STUDENT LOAN REPAYMENT PROGRAMS FOR CERTAIN HEALTH PROFESSIONALS.

(a) **IN GENERAL.**—Paragraph (4) of section 108(f) of the Internal Revenue Code of 1986 is amended to read as follows:

“(4) **PAYMENTS UNDER NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM AND CERTAIN STATE LOAN REPAYMENT PROGRAMS.**—In the case of an individual, gross income shall not include any amount received under section 338B(g) of the Public Health Service Act, under a State program described in section 338I of such Act, or under any other State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas (as determined by such State).”.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall apply to amounts received by an individual in taxable years beginning after December 31, 2008.

SEC. 10909. EXPANSION OF ADOPTION CREDIT AND ADOPTION ASSISTANCE PROGRAMS.

(a) **INCREASE IN DOLLAR LIMITATION.**—

(1) **ADOPTION CREDIT.**—

(A) **IN GENERAL.**—Paragraph (1) of section 23(b) of the Internal Revenue Code of 1986 (relating to dollar limitation) is amended by striking “\$10,000” and inserting “\$13,170”.

(B) **CHILD WITH SPECIAL NEEDS.**—Paragraph (3) of section 23(a) of such Code (relating to \$10,000 credit for adoption of child with special needs regardless of expenses) is amended—

(i) in the text by striking “\$10,000” and inserting “\$13,170”, and

(ii) in the heading by striking “\$10,000” and inserting “\$13,170”.

(C) **CONFORMING AMENDMENT TO INFLATION ADJUSTMENT.**—Subsection (h) of section 23 of such Code (relating to adjustments for inflation) is amended to read as follows:

“(h) **ADJUSTMENTS FOR INFLATION.**—

“(1) **DOLLAR LIMITATIONS.**—In the case of a taxable year beginning after December 31, 2010, each of the dollar amounts in subsections (a)(3) and (b)(1) shall be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting ‘calendar year 2009’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of \$10, such amount shall be rounded to the nearest multiple of \$10.

“(2) **INCOME LIMITATION.**—In the case of a taxable year beginning after December 31, 2002, the dollar amount in subsection (b)(2)(A)(i) shall be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting ‘calendar year 2001’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of \$10, such amount shall be rounded to the nearest multiple of \$10.”.

(2) **ADOPTION ASSISTANCE PROGRAMS.**—

(A) **IN GENERAL.**—Paragraph (1) of section 137(b) of the Internal Revenue Code of 1986 (relating to dollar limitation) is amended by striking “\$10,000” and inserting “\$13,170”.

(B) **CHILD WITH SPECIAL NEEDS.**—Paragraph (2) of section 137(a) of such Code (relating to \$10,000 exclusion for adoption of child with special needs regardless of expenses) is amended—

(i) in the text by striking “\$10,000” and inserting “\$13,170”, and

(ii) in the heading by striking “\$10,000” and inserting “\$13,170”.

(C) **CONFORMING AMENDMENT TO INFLATION ADJUSTMENT.**—Subsection (f) of section 137 of such Code (relating to adjustments for inflation) is amended to read as follows:

“(f) **ADJUSTMENTS FOR INFLATION.**—

“(1) **DOLLAR LIMITATIONS.**—In the case of a taxable year beginning after December 31, 2010, each of the dollar amounts in subsections (a)(2) and (b)(1) shall be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting ‘calendar year 2009’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of \$10, such amount shall be rounded to the nearest multiple of \$10.

“(2) **INCOME LIMITATION.**—In the case of a taxable year beginning after December 31, 2002, the dollar amount in subsection (b)(2)(A) shall be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting ‘calendar year 2001’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of \$10, such amount shall be rounded to the nearest multiple of \$10.”.

(b) **CREDIT MADE REFUNDABLE.**—

(1) **CREDIT MOVED TO SUBPART RELATING TO REFUNDABLE CREDITS.**—The Internal Revenue Code of 1986 is amended—

(A) by redesignating section 23, as amended by subsection (a), as section 36C, and

(B) by moving section 36C (as so redesignated) from subpart A of part IV of subchapter A of chapter 1 to the location immediately before section 37 in subpart C of part IV of subchapter A of chapter 1.

(2) **CONFORMING AMENDMENTS.**—

(A) Section 24(b)(3)(B) of such Code is amended by striking “23.”.

(B) Section 25(e)(1)(C) of such Code is amended by striking “23,” both places it appears.

(C) Section 25A(i)(5)(B) of such Code is amended by striking “23, 25D,” and inserting “25D”.

(D) Section 25B(g)(2) of such Code is amended by striking “23.”.

(E) Section 26(a)(1) of such Code is amended by striking “23.”.

(F) Section 30(c)(2)(B)(ii) of such Code is amended by striking “23, 25D,” and inserting “25D”.

(G) Section 30B(g)(2)(B)(ii) of such Code is amended by striking “23.”.

(H) Section 30D(c)(2)(B)(ii) of such Code is amended by striking “sections 23 and” and inserting “section”.

(I) Section 36C of such Code, as so redesignated, is amended—

(i) by striking paragraph (4) of subsection (b), and

(ii) by striking subsection (c).

(J) Section 137 of such Code is amended—

(i) by striking “section 23(d)” in subsection (d) and inserting “section 36C(d)”, and

(ii) by striking “section 23” in subsection (e) and inserting “section 36C”.

(K) Section 904(i) of such Code is amended by striking “23.”.

(L) Section 1016(a)(26) is amended by striking “23(g)” and inserting “36C(g)”.

(M) Section 1400C(d) of such Code is amended by striking “23.”.

(N) Section 6211(b)(4)(A) of such Code is amended by inserting “36C,” before “53(e)”.

(O) The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code of 1986 is amended by striking the item relating to section 23.

(P) Paragraph (2) of section 1324(b) of title 31, United States Code, as amended by this Act, is amended by inserting “36C,” after “36B.”.

(Q) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986, as amended by this Act, is amended by inserting after the item relating to section 36B the following new item:

“Sec. 36C. Adoption expenses.”.

(c) **APPLICATION AND EXTENSION OF EGTRRA SUNSET.**—Notwithstanding section 901 of the Economic Growth and Tax Relief Reconciliation Act of 2001, such section shall apply to the amendments made by this section and the amendments made by section 202 of such Act by substituting “December 31, 2011” for “December 31, 2010” in subsection (a)(1) thereof.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 2009.

SA 3277. Mr. REID proposed an amendment to amendment SA 3276 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the end of the amendment, add the following:

The provisions of this Act shall become effective 5 days after enactment.

SA 3278. Mr. REID proposed an amendment to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the end of the language proposed to be stricken, insert the following:

This section shall become effective 4 days after enactment.

SA 3279. Mr. REID proposed an amendment to amendment SA 3278 proposed by Mr. REID to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of

the Armed Forces and certain other Federal employees, and for other purposes; as follows:

In the amendment, strike “4” and insert “3”.

SA 3280. Mr. REID proposed an amendment to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the end, insert the following:

The provisions of this Act shall become effective 2 days after enactment.

SA 3281. Mr. REID proposed an amendment to amendment SA 3280 proposed by Mr. REID to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees; and for other purposes; as follows:

Strike “2 days” and insert “1 day”.

SA 3282. Mr. REID proposed an amendment to amendment SA 3281 proposed by Mr. REID to the amendment SA 3280 proposed by Mr. REID to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

Strike “1 day” and insert “immediately”.

SA 3283. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Patients’ Choice Act”.

(b) **TABLE OF CONTENTS.**—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—INVESTING IN PREVENTION

Sec. 101. Strategic approach to outcome-based prevention.

Sec. 102. State grants for outcome-based prevention effort.

Sec. 103. Focusing the food stamp program on nutrition.

Sec. 104. Immunizations.

TITLE II—STATE-BASED HEALTH CARE EXCHANGES

Sec. 201. State-based health care exchanges.

Sec. 202. Requirements.

Sec. 203. State Exchange incentives.

TITLE III—FAIR TAX TREATMENT FOR ALL AMERICANS TO AFFORD HEALTH CARE

Sec. 300. Reference.

Sec. 301. Refundable and advanceable credit for certain health insurance coverage.

Sec. 302. Requiring employer transparency about employee benefits.

Sec. 303. Changes to existing tax preferences for medical coverage, etc., for individuals eligible for qualified health insurance credit.

Sec. 304. Adjustments.

TITLE IV—FAIRNESS FOR EVERY AMERICAN PATIENT

Subtitle A—Medicaid Modernization

Sec. 401. Medicaid modernization.

Sec. 402. Outreach.

Sec. 403. Transition rules; miscellaneous provisions.

Subtitle B—Supplemental Health Care Assistance for Low-Income Families

Sec. 411. Supplemental Health Care Assistance for Low-Income Families.

TITLE V—FIXING MEDICARE FOR AMERICAN SENIORS

Subtitle A—Increasing Programmatic Efficiency, Economy, and Accountability

Sec. 501. Eliminating inefficiencies and increasing choice in Medicare Advantage.

Sec. 502. Medicare Accountable Care Organization demonstration program.

Sec. 503. Reducing government handouts to wealthier seniors.

Sec. 504. Rewarding prevention.

Sec. 505. Promoting healthcare provider transparency.

Sec. 506. Availability of Medicare and Medicaid claims and patient encounter data.

Subtitle B—Reducing Fraud and Abuse

Sec. 511. Requiring the Secretary of Health and Human Services to change the Medicare beneficiary identifier used to identify Medicare beneficiaries under the Medicare program.

Sec. 512. Use of technology for real-time data review.

Sec. 513. Detection of Medicare fraud and abuse.

Sec. 514. Edits on 855S Medicare enrollment application and exemption of pharmacists from surety bond requirement.

Sec. 515. GAO study and report on effectiveness of surety bond requirements for suppliers of durable medical equipment in combating fraud.

TITLE VI—ENDING LAWSUIT ABUSE

Sec. 601. State grants to create health court solutions.

TITLE VII—PROMOTING HEALTH INFORMATION TECHNOLOGY

Subtitle A—Assisting the Development of Health Information Technology

Sec. 701. Purpose.

Sec. 702. Health record banking.

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Sec. 711. Safe harbors to antikickback civil penalties and criminal penalties for provision of health information technology and training services.

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TITLE VIII—HEALTH CARE SERVICES COMMISSION

Subtitle A—Establishment and General Duties

Sec. 801. Establishment.

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Sec. 821. Certain administrative authorities.

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Sec. 831. Termination of Agency for Healthcare Research and Quality.

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Subtitle E—Independent Health Record Trust

Sec. 841. Short title.

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Sec. 844. Establishment, certification, and membership of Independent Health Record Trusts.

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Sec. 846. Availability and use of information from records in IHRT consistent with privacy protections and agreements.

Sec. 847. Voluntary nature of trust participation and information sharing.

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TITLE IX—MISCELLANEOUS

Sec. 901. Health care choice for veterans.

Sec. 902. Health care choice for Indians.

Sec. 903. Termination of Federal Coordinating Council for Comparative Effectiveness Research.

Sec. 904. HHS and GAO joint study and report on costs of the 5 medical conditions that have the greatest impact.

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Sec. 907. Prohibition on government entities using comparative effectiveness research for certain purposes.

Sec. 908. Solvency of Medicare program.

Sec. 909. To ensure patients receive doctor recommendations for preventive health services, including mammograms and cervical cancer screening, without interference from government or insurance company bureaucrats.

Sec. 910. Ensuring that government health care rationing does not harm, injure, or deny medically necessary care.

Sec. 911. Identification of Federal Government health care rationing.

Sec. 912. Using health care professionals to reduce fraud.

TITLE I—INVESTING IN PREVENTION**SEC. 101. STRATEGIC APPROACH TO OUTCOME-BASED PREVENTION.**

(a) INTERAGENCY COORDINATING COMMITTEE.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this title as the “Secretary”) shall convene an interagency coordinating committee to develop a national strategic plan for prevention. The Secretary shall serve as the chairperson of the committee.

(2) COMPOSITION.—In carrying out paragraph (1), the Secretary shall include the participation of—

(A) the Director of the National Institutes of Health;

(B) the Director of the Centers for Disease Control and Prevention;

(C) the Administrator of the Agency for Healthcare Research and Quality;

(D) the Administrator of the Substance Abuse and Mental Health Services Administration;

(E) the Administrator of the Health Resources and Services Administration;

(F) the Secretary of Agriculture;

(G) the Director of the Centers for Medicare & Medicaid Services;

(H) the Administrator of the Environmental Protection Agency;

(I) the Director of the Indian Health Service;

(J) the Administrator of the Administration on Aging;

(K) the Secretary of Veterans Affairs;

(L) the Secretary of Defense;

(M) the Secretary of Education; and

(N) the Secretary of Labor.

(3) REPORT AND PLAN.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the coordinating committee convened under paragraph (1), shall submit to Congress a report concerning the recommendation of the committee for health promotion and disease prevention activities. Such report shall include a specific strategic plan that shall include—

(A) a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification (smoking cessation, proper nutrition, and appropriate exercise) and the prevention measures for the 5 leading disease killers in the United States;

(B) specific science-based initiatives to achieve the measurable goals of Healthy People 2010 regarding nutrition, exercise, and smoking cessation, and targeting the 5 leading disease killers in the United States;

(C) specific plans for consolidating Federal health programs and Centers that exist to promote healthy behavior and reduce disease risk (including eliminating programs and offices determined to be ineffective in meeting the priority goals of Healthy People 2010), that include transferring the nutrition guideline development responsibility from the Secretary of Agriculture to the Director of the Centers for Disease Control and Prevention;

(D) specific plans to ensure that all Federal health care programs are fully coordinated with science-based prevention recommendations promulgated by the Director of the Centers for Disease Control and Prevention;

(E) specific plans to ensure that all non-Department of Health and Human Services prevention programs are based on the science-based guidelines developed by the Centers for Disease Control and Prevention under subparagraph (D); and

(F) a list of new non-Federal and non-government partners identified by the com-

mittee to build Federal capacity in health promotion and disease prevention efforts.

(4) ANNUAL REQUEST TO GIVE TESTIMONY.—The Secretary shall annually request an opportunity to testify before Congress concerning the progress made by the United States in meeting the outcome-based standards of Healthy People 2010 with respect to disease prevention and measurable outcomes and effectiveness of Federal programs related to this goal.

(5) PERIODIC REVIEWS.—The Secretary shall conduct periodic reviews, not less than every 5 years, and grading of every Federal disease prevention and health promotion initiatives, programs, and agencies. Such reviews shall be evaluated based on effectiveness in meeting metrics-based goals with an analysis posted on such agencies’ public Internet websites.

(b) FEDERAL MESSAGING ON HEALTH PROMOTION AND DISEASE PREVENTION.—

(1) MEDIA CAMPAIGNS.—

(A) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and implement a national science-based media campaign on health promotion and disease prevention.

(B) REQUIREMENTS OF CAMPAIGN.—The campaign implemented under subparagraph (A)—

(i) shall be designed to address proper nutrition, regular exercise, smoking cessation, obesity reduction, the 5 leading disease killers in the United States, and secondary prevention through disease screening promotion;

(ii) shall be carried out through competitively bid contracts awarded to entities providing for the professional production and design of such campaign;

(iii) may include the use of television, radio, Internet, and other commercial marketing venues and may be targeted to specific age groups based on peer-reviewed social research;

(iv) shall not be duplicative of any other Federal efforts relating to health promotion and disease prevention; and

(v) may include the use of humor and nationally recognized positive role models.

(C) EVALUATION.—The Secretary shall ensure that the campaign implemented under subparagraph (A) is subject to an independent evaluation every 2 years and shall report every 2 years to Congress on the effectiveness of such campaigns towards meeting science-based metrics.

(2) WEBSITE.—The Secretary, in consultation with private-sector experts, shall maintain or enter into a contract to maintain an Internet website to provide science-based information on guidelines for nutrition, regular exercise, obesity reduction, smoking cessation, and specific chronic disease prevention. Such website shall be designed to provide information to health care providers and consumers.

(3) DISSEMINATION OF INFORMATION THROUGH PROVIDERS.—The Secretary, acting through the Centers for Disease Control and Prevention, shall develop and implement a plan for the dissemination of health promotion and disease prevention information consistent with national priorities described in the strategic and implementing plan under subsection (a)(3)(A), to health care providers who participate in Federal programs, including programs administered by the Indian Health Service, the Department of Veterans Affairs, the Department of Defense, and the Health Resources and Services Administration, and the Medicare and Medicaid Programs.

(4) PERSONALIZED PREVENTION PLANS.—

(A) CONTRACT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into a contract with a qualified entity for the development and operation of a Federal Internet website personalized prevention plan tool.

(B) USE.—The website developed under subparagraph (A) shall be designed to be used as a source of the most up-to-date scientific evidence relating to disease prevention for use by individuals. Such website shall contain a component that enables an individual to determine their disease risk (based on personal health and family history, BMI, and other relevant information) relating to the 5 leading diseases in the United States, and obtain personalized suggestions for preventing such diseases.

(5) INTERNET PORTAL.—The Secretary shall establish an Internet portal for accessing risk-assessment tools developed and maintained by private and academic entities.

(6) PRIORITY FUNDING.—Funding for the activities authorized under this section shall take priority over funding from the Centers for Disease Control and Prevention provided for grants to States and other entities for similar purposes and goals as provided for in this section. Not to exceed \$500,000,000 shall be expended on the campaigns and activities required under this Act.

SEC. 102. STATE GRANTS FOR OUTCOME-BASED PREVENTION EFFORT.

(a) IN GENERAL.—If the Secretary determines that it is essential to meeting the national priorities described in the plan required under section 101(a)(3)(A), the Secretary may award grants to States for the conduct of specific health promotion and disease prevention activities.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a strategic plan that shall—

(1) describe the specific health promotion and disease prevention activities to be carried out under this grant;

(2) include a list of the barriers that exist within the State to meeting specific goals of Healthy People 2010;

(3) include targeted demographic indicators and measurable objectives with respect to health promotion and disease prevention;

(4) contain a set of process outcomes and milestones, based on the process outcomes and milestones developed by the Secretary, for measuring the effectiveness of activities carried out under the grant in the State; and

(5) outline the manner in which interventions to be carried out under this grant will reduce morbidity and mortality within the State over a 5-year period (or over a 10-year period, if the Secretary determines such period appropriate for adequately measuring progress).

(c) PROCESS OUTCOMES AND MILESTONES.—

(1) IN GENERAL.—The Secretary shall develop process outcomes and milestones to be used to measure the effectiveness of activities carried out under a grant under this section by a State.

(2) DETERMINATIONS.—If, beginning 2 years after the date on which a grant is awarded to a State under this section, the Secretary determines that the State is failing to make adequate progress in meeting the outcomes and milestones contained in the State plan under subsection (b)(4), the Secretary shall provide the State with technical assistance

on how to make such progress. Such technical assistance shall continue for a period of 2 years.

(3) **CONTINUED FAILURE TO MEET OBJECTIVES.**—If after the expiration of the 2-year period described in paragraph (2), the Secretary determines that the State is failing to make adequate progress in meeting the outcomes and milestones contained in the State plan under subsection (b)(4) over a 5-year period, the Secretary shall terminate all funding to the State under a grant under this section.

(d) **REGIONAL ACTIVITIES.**—A State may use an amount, not to exceed 15 percent of the total grant amount to such State, to carry out regional activities in conjunction with other States.

(e) **TARGETED ACTIVITIES.**—A State may use grant funds to target specific populations within the State to achieve specific outcomes described in Healthy People 2010.

(f) **INNOVATIVE INCENTIVE STRUCTURES.**—The Secretary may award grants to States for the purposes of developing innovative incentive structures to encourage individuals to adopt specific prevention behaviors such as reducing their body mass index or for smoking cessation.

(g) **WELLNESS BONUSES.**—

(1) **IN GENERAL.**—The Secretary shall award wellness bonus payments to at least 5, but not more than 10, States that demonstrate the greatest progress in reducing disease rates and risk factors and increasing healthy behaviors.

(2) **REQUIREMENT.**—To be eligible to receive a bonus payment under paragraph (1), a State shall demonstrate—

(A) the progress described in paragraph (1); and

(B) that the State has met a specific floor for progress outlined in the science-based metrics of Healthy People 2010.

(3) **USE OF PAYMENTS.**—Bonus payments under this subsection may only be used by a State for the purposes of health promotion and disease prevention.

(4) **FUNDING.**—Out of funds appropriated to the Director of the Centers for Disease Control and Prevention for each fiscal year beginning with fiscal year 2010, the Director shall give priority to using \$50,000,000 of such funds to make bonus payments under this subsection.

(h) **ADMINISTRATIVE EXPENSES.**—A State may use not more than 5 percent of the amount of a grant under this section to carry out administrative activities.

(i) **STATE.**—In this section, the term “State” means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Mariana Islands.

(j) **AUTHORIZATION OF APPROPRIATIONS.**—Funding for the activities authorized under this section shall take priority over funding from the Centers for Disease Control and Prevention provided for grants to States and other entities for similar purposes and goals as provided for in this section, not to exceed \$300,000,000 for each fiscal year.

SEC. 103. FOCUSING THE FOOD STAMP PROGRAM ON NUTRITION.

(a) **COUNSELING BROCHURE.**—The Director of the Centers for Disease Control and Prevention shall develop, and the Secretary of Agriculture shall distribute to each individual and family enrolled in the Food Stamp Program under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.), a science-based nutrition counseling brochure.

(b) **LIMITATIONS ON FOOD STAMP PURCHASES.**—

(1) **IN GENERAL.**—Not later than 6 months after the date of enactment of this Act, the Secretary of Agriculture shall, based on scientific, peer-reviewed recommendations provided by a Commission that includes public health, medical, and nutrition experts and the Director of the Centers for Disease Control and Prevention, develop lists of foods that do not meet science-based standards for proper nutrition and that may not be purchased under the food stamp program. Such list shall be updated on an annual basis to ensure the most current science-based recommendations are applied to the food stamp program.

(2) **AUTOMATED ENFORCEMENT.**—The Secretary of Agriculture shall, through regulations, ensure that the limitations on food purchases under paragraph (1) is enforced through the food stamp program's automated system.

(3) **IMPLEMENTATION.**—The Secretary of Agriculture shall promulgate the regulations described in paragraph (2) by the date that is not later than 1 year after the date of enactment of this section.

SEC. 104. IMMUNIZATIONS.

(a) **PURCHASE OF VACCINES.**—Notwithstanding any other provision of law, a State may use amounts provided under section 317 of the Public Health Service Act (42 U.S.C. 247b) for immunization programs to purchase vaccines for use in health care provider offices and schools.

(b) **TECHNICAL ASSISTANCE AND REDUCTION IN FUNDING.**—If a State does not achieve a benchmark of 80 percent coverage within the State for Centers for Disease Control and Prevention-recommended vaccines, the Director of the Centers shall provide technical assistance to the State for a period of 2 years. If after the expiration of such 2-year period the State continues to fail to achieve such benchmark, the Secretary shall reduce funding provided under section 317 of the Public Health Service Act to such State by 5 percent.

(c) **BONUS GRANT.**—A State achieving a benchmark of 90 percent or greater coverage within the State for Centers for Disease Control and Prevention-recommended vaccines shall be eligible for a bonus grant from amounts appropriated under subsection (d).

(d) **AUTHORIZATION OF APPROPRIATIONS.**—Out of funds appropriated to the Director of the Centers for Disease Control and Prevention for each fiscal year beginning with fiscal year 2010, there shall be made available to carry out this section, \$50,000,000 for each fiscal year.

(e) **FUNDING FOR SECTION 317.**—Section 317(j)(1) of the Public Health Service Act (42 U.S.C. 247b(j)(1)) is amended by striking “2005” and inserting “2012”.

TITLE II—STATE-BASED HEALTH CARE EXCHANGES

SEC. 201. STATE-BASED HEALTH CARE EXCHANGES.

(a) **IN GENERAL.**—The Secretary of Health and Human Services (referred to in this title as the “Secretary”) shall establish a process for the review of applications submitted by States for the establishment and implementation of State-based health care Exchanges (referred to in this title as a “State Exchange”) and for the certification of such Exchanges. The Secretary shall certify a State Exchange if the Secretary determines that such Exchange meets the requirements of this title.

(b) **CONTINUED CERTIFICATION.**—The certification of a State Exchange under subsection (a) shall remain in effect until the Secretary determines that the Exchange has failed to

meet any of the requirements under this title.

SEC. 202. REQUIREMENTS.

(a) **GENERAL REQUIREMENTS FOR CERTIFICATION.**—An application for certification under section 201(a) shall demonstrate compliance with the following:

(1) **PURPOSE.**—The primary purpose of a State Exchange shall be the facilitation of the individual purchase of innovative private health insurance and the creation of a market where private health plans compete for enrollees based on price and quality.

(2) **ADMINISTRATION.**—A State shall ensure the operation of the State Exchange through direct contracts with the health insurance plans that are participating in the State Exchange or through a contract with a third party administrator for the operation of the Exchange.

(3) **PLAN PARTICIPATION.**—A State shall not restrict or otherwise limit the ability of a health insurance plan to participate in, and offer health insurance coverage through, the State Exchange, so long as the health insurance issuers involved are duly licensed under State insurance laws applicable to all health insurance issuers in the State and otherwise comply with the requirements of this title.

(4) **PREMIUMS.**—

(A) **AMOUNT.**—A State shall not determine premium or cost sharing amounts for health insurance coverage offered through the State Exchange.

(B) **COLLECTION METHOD.**—A State shall ensure the existence of an effective and efficient method for the collection of premiums for health insurance coverage offered through the State Exchange.

(b) **BENEFIT PARITY WITH MEMBERS OF CONGRESS.**—With respect to health insurance issuers offering health insurance coverage through the State Exchange, the State shall not impose any requirement that such issuers provide coverage that includes benefits different than requirements on plans offered to Members of Congress under chapter 89 of title 5, United States Code.

(c) **FACILITATING UNIVERSAL COVERAGE FOR AMERICANS.**—

(1) **AUTOMATIC ENROLLMENT.**—The State Exchange shall ensure that health insurance coverage offered through the Exchange provides for the application of uniform mechanisms that are designed to encourage and facilitate the enrollment of all eligible individuals in Exchange-based health insurance coverage. Such mechanisms shall include automatic enrollment through various venues, which may include emergency rooms, the submission of State tax forms, places of employment in the State, and State departments of motor vehicles.

(2) **OTHER ENROLLMENT OPPORTUNITIES.**—

(A) **IN GENERAL.**—The State Exchange shall ensure that health insurance coverage offered through the Exchange permits enrollment, and changes in enrollment, of individuals at the time such individuals become eligible individuals in the State.

(B) **ANNUAL OPEN ENROLLMENT PERIODS.**—The State Exchange shall ensure that health insurance coverage offered through the Exchange permits eligible individuals to annually change enrollment among the coverage offered through the Exchange, subject to subparagraph (A).

(C) **INCENTIVES FOR CONTINUOUS ANNUAL COVERAGE.**—The State Exchange shall include an incentive for eligible individuals to remain insured from plan year to plan year, and may include incentives such as State tax incentives or premium-based incentives.

(3) **GUARANTEED ACCESS FOR INDIVIDUALS.**—The State Exchange shall ensure that, with

respect to health insurance coverage offered through the Exchange, all eligible individuals are able to enroll in the coverage of their choice provided that such individuals agree to make applicable premium and cost sharing payments.

(4) **LIMITATION ON PRE-EXISTING CONDITION EXCLUSIONS.**—The State Exchange shall ensure that health insurance coverage offered through the Exchange meets the requirements of section 9801 of the Internal Revenue Code of 1986 in the same manner as if such coverage was a group health plan.

(5) **OPT-OUT.**—Nothing in this title shall be construed to require that an individual be enrolled in health insurance coverage.

(d) **LIMITATION ON EXORBITANT PREMIUMS.**—

(1) **ESTABLISHMENT OF MECHANISM.**—With respect to health insurance coverage offered through the State Exchange, the Exchange shall establish a mechanisms to protect enrollees from the imposition of excessive premiums, to reduce adverse selection, and to share risk.

(2) **MECHANISM OPTIONS.**—The mechanisms referred to in paragraph (1) may include the following:

(A) **INDEPENDENT RISK ADJUSTMENT.**—The implementation of risk-adjustment among health insurance coverage offered through the State Exchange through a contract entered into with a private, independent board. Such board shall include representation of health insurance issuers and State officials but shall be independently controlled. The State Exchange shall ensure that risk-adjustment implemented under this subparagraph shall be based on a blend of patient diagnoses and estimated costs.

(B) **HEALTH SECURITY POOLS.**—The establishment (or continued operation under section 2745 of the Public Health Service Act) of a health security pool to guarantee high-risk individuals access to affordable, quality health care.

(C) **REINSURANCE.**—The implementation of a successful reinsurance mechanisms to guarantee high-risk individuals access to affordable, quality health care.

(e) **MEDICAID AND SCHIP BENEFICIARIES.**—The State Exchange shall include procedures to permit eligible individuals who are receiving (or who are eligible to receive) health care under title XIX or XXI of the Social Security Act to enroll in health insurance coverage offered through the Exchange.

(f) **DISSEMINATION OF COVERAGE INFORMATION.**—The State Exchange shall ensure that each health insurance issuer that provides health insurance coverage through the Exchange disseminate to eligible individuals and employers within the State information concerning health insurance coverage options, including the plans offered and premiums and benefits for such plans.

(g) **REGIONAL OPTIONS.**—

(1) **INTERSTATE COMPACTS.**—Two or more States that establish a State Exchange may enter into interstate compact providing for the regulations of health insurance coverage offered within such States.

(2) **MODEL LEGISLATION.**—States adopting model legislation as developed by the National Association of Insurance Commissioners shall be eligible to enter into an interstate compact as provided for in this section.

(3) **MULTI-STATE POOLING ARRANGEMENTS.**—State Exchanges may implement a multi-state health care coverage pooling arrangement under this title.

(h) **PURCHASE ACROSS STATE LINES.**—Notwithstanding any other provision of law, an eligible individual may enroll in health in-

surance coverage offered through the Exchange in any State. The regulation of such coverage (and the addressing of grievances relating to such coverage) shall be subject to the laws of the State in which such coverage is purchased, regardless of the State in which the eligible individual resides.

(i) **ELIGIBLE INDIVIDUAL.**—In this title, the term “eligible individual” means an individual who is—

(1) a citizen or national of the United States or an alien lawfully admitted to the United States for permanent residence or otherwise residing in the United States under color of law;

(2) not incarcerated; and

(3) not eligible for coverage under parts A and B (or C) of the Medicare program under title XVIII of the Social Security Act.

SEC. 203. STATE EXCHANGE INCENTIVES.

(a) **GRANTS.**—The Secretary may award grants, pursuant to subsection (b), to States for the development, implementation, and evaluation of certified State Exchanges and to provide more options and choice for individuals purchasing health insurance coverage.

(b) **ONE-TIME INCREASE IN MEDICAID PAYMENT.**—In the case of a State awarded a grant to carry out this section, the total amount of the Federal payment determined for the State under section 1913 of the Social Security Act (as amended by section 401) for fiscal year 2011 shall be increased by an amount equal to 1 percent of the total amount of payments made to the State for fiscal year 2010 under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for purposes of carrying out a grant awarded under this section. Amounts paid to a State pursuant to this subsection shall remain available until expended.

TITLE III—FAIR TAX TREATMENT FOR ALL AMERICANS TO AFFORD HEALTH CARE

SEC. 300. REFERENCE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

SEC. 301. REFUNDABLE AND ADVANCEABLE CREDIT FOR CERTAIN HEALTH INSURANCE COVERAGE.

(a) **ADVANCEABLE CREDIT.**—Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits) is amended by adding at the end the following new section:

“SEC. 25E. QUALIFIED HEALTH INSURANCE CREDIT.

“(a) **ALLOWANCE OF CREDIT.**—In the case of an individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year the sum of the monthly limitations determined under subsection (b) for the taxpayer and the taxpayer’s spouse and dependents.

“(b) **MONTHLY LIMITATION.**—

“(1) **IN GENERAL.**—The monthly limitation for each month during the taxable year for an eligible individual is 1/12th of—

“(A) the applicable adult amount, in the case that the eligible individual is the taxpayer or the taxpayer’s spouse,

“(B) the applicable adult amount, in the case that the eligible individual is an adult dependent, and

“(C) the applicable child amount, in the case that the eligible individual is a child dependent.

“(2) **LIMITATION ON AGGREGATE AMOUNT.**—Notwithstanding paragraph (1), the aggregate

monthly limitations for the taxpayer and the taxpayer’s spouse and dependents for any month shall not exceed 1/12th of the applicable aggregate amount.

“(3) **NO CREDIT FOR INELIGIBLE MONTHS.**—With respect to any individual, the monthly limitation shall be zero for any month for which such individual is not an eligible individual.

“(4) **APPLICABLE AMOUNT.**—

“(A) **IN GENERAL.**—For purposes of this section—

“(i) **APPLICABLE ADULT AMOUNT.**—The applicable adult amount is \$2,290.

“(ii) **APPLICABLE CHILD AMOUNT.**—The applicable child amount is \$1,710.

“(iii) **APPLICABLE AGGREGATE AMOUNT.**—The applicable aggregate amount is \$5,710.

“(B) **COST-OF-LIVING ADJUSTMENTS.**—

“(i) **IN GENERAL.**—In the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in subparagraph (A) shall be increased by an amount equal to such dollar amount multiplied by the blended cost-of-living adjustment.

“(ii) **BLENDED COST-OF-LIVING ADJUSTMENT.**—For purposes of clause (i), the blended cost-of-living adjustment means one-half of the sum of—

“(I) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins by substituting ‘calendar year 2010’ for ‘calendar year 1992’ in subparagraph (B) thereof, plus

“(II) the cost-of-living adjustment determined under section 213(d)(10)(B)(ii) for the calendar year in which the taxable year begins by substituting ‘2010’ for ‘1996’ in subclause (II) thereof.

“(iii) **ROUNDING.**—Any increase determined under clause (i) shall be rounded to the nearest multiple of \$10.

“(C) **REVENUE NEUTRALITY ADJUSTMENTS.**—

“(i) **IN GENERAL.**—In the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in subparagraph (A), as adjusted under subparagraph (B), shall be further adjusted (if necessary) such that the aggregate of such dollar amounts allowed as credits under this section for such taxable year equals but does not exceed the total increase in revenues in the Treasury resulting from the amendments made by sections 303 and 401 of the Patients’ Choice Act for such taxable year as estimated by the Secretary.

“(ii) **DATE OF ADJUSTMENT.**—The Secretary shall announce the adjustments for any taxable year under this subparagraph not later than the preceding October 1.

“(c) **LIMITATION BASED ON AMOUNT OF TAX.**—In the case of a taxable year to which section 26(a)(2) does not apply, the credit allowed under subsection (a) for the taxable year shall not exceed the excess of—

“(1) the sum of the regular tax liability (as defined in section 26(b)) plus the tax imposed by section 55, over

“(2) the sum of the credits allowable under this subpart (other than this section) and section 27 for the taxable year.

“(d) **EXCESS CREDIT REFUNDABLE TO CERTAIN TAX-FAVORED ACCOUNTS.**—If—

“(1) the credit which would be allowable under subsection (a) if only qualified refund eligible health insurance were taken into account under this section, exceeds

“(2) the limitation imposed by section 26 or subsection (c) for the taxable year, such excess shall be paid by the Secretary into the designated account of the taxpayer.

“(e) **ELIGIBLE INDIVIDUAL.**—For purposes of this section—

“(1) IN GENERAL.—The term ‘eligible individual’ means, with respect to any month, an individual who—

“(A) is the taxpayer, the taxpayer’s spouse, or the taxpayer’s dependent, and

“(B) is covered under qualified health insurance as of the 1st day of such month.

“(2) MEDICARE COVERAGE, MEDICAID DISABILITY COVERAGE, AND MILITARY COVERAGE.—The term ‘eligible individual’ shall not include any individual who for any month is—

“(A) entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title, and the individual is not a participant or beneficiary in a group health plan or large group health plan that is a primary plan (as defined in section 1862(b)(2)(A) of such Act),

“(B) enrolled by reason of disability in the program under title XIX of such Act, or

“(C) entitled to benefits under chapter 55 of title 10, United States Code, including under the TRICARE program (as defined in section 1072(7) of such title).

“(3) IDENTIFICATION REQUIREMENTS.—The term ‘eligible individual’ shall not include any individual for any month unless the policy number associated with the qualified health insurance and the TIN of each eligible individual covered under such health insurance for such month are included on the return of tax for the taxable year in which such month occurs.

“(4) PRISONERS.—The term ‘eligible individual’ shall not include any individual for a month if, as of the first day of such month, such individual is imprisoned under Federal, State, or local authority.

“(5) ALIENS.—The term ‘eligible individual’ shall not include any alien individual who is not a lawful permanent resident of the United States.

“(f) HEALTH INSURANCE.—For purposes of this section—

“(1) QUALIFIED HEALTH INSURANCE.—The term ‘qualified health insurance’ means any insurance constituting medical care which (as determined under regulations prescribed by the Secretary)—

“(A) has a reasonable annual and lifetime benefit maximum, and

“(B) provides coverage for inpatient and outpatient care, emergency benefits, and physician care.

Such term does not include any insurance substantially all of the coverage of which is coverage described in section 223(c)(1)(B).

“(2) QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.—The term ‘qualified refund eligible health insurance’ means any qualified health insurance which is coverage under a group health plan (as defined in section 5000(b)(1)).

“(g) DESIGNATED ACCOUNTS.—

“(1) DESIGNATED ACCOUNT.—For purposes of this section, the term ‘designated account’ means any specified account established and maintained by the provider of the taxpayer’s qualified refund eligible health insurance—

“(A) which is designated by the taxpayer (in such form and manner as the Secretary may provide) on the return of tax for the taxable year,

“(B) which, under the terms of the account, accepts the payment described in subsection (d) on behalf of the taxpayer, and

“(C) which, under such terms, provides for the payment of expenses by the taxpayer or on behalf of such taxpayer by the trustee or custodian of such account, including payment to such provider.

“(2) SPECIFIED ACCOUNT.—For purposes of this paragraph, the term ‘specified account’ means—

“(A) any health savings account under section 223 or Archer MSA under section 220, or

“(B) any health insurance reserve account.

“(3) HEALTH INSURANCE RESERVE ACCOUNT.—For purposes of this subsection, the term ‘health insurance reserve account’ means a trust created or organized in the United States as a health insurance reserve account exclusively for the purpose of paying the qualified medical expenses (within the meaning of section 223(d)(2)) of the account beneficiary (as defined in section 223(d)(3)), but only if the written governing instrument creating the trust meets the requirements described in subparagraphs (B), (C), (D), and (E) of section 223(d)(1). Rules similar to the rules under subsections (g) and (h) of section 408 shall apply for purposes of this subparagraph.

“(4) TREATMENT OF PAYMENT.—Any payment under subsection (d) to a designated account shall not be taken into account with respect to any dollar limitation which applies with respect to contributions to such account (or to tax benefits with respect to such contributions).

“(h) OTHER DEFINITIONS.—For purposes of this section—

“(1) DEPENDENT.—The term ‘dependent’ has the meaning given such term by section 152 (determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof). An individual who is a child to whom section 152(e) applies shall be treated as a dependent of the custodial parent for a coverage month unless the custodial and noncustodial parent provide otherwise.

“(2) ADULT.—The term ‘adult’ means an individual who is not a child.

“(3) CHILD.—The term ‘child’ means a qualifying child (as defined in section 152(c)).

“(i) SPECIAL RULES.—

“(1) COORDINATION WITH MEDICAL DEDUCTION.—Any amount paid by a taxpayer for insurance which is taken into account for purposes of determining the credit allowable to the taxpayer under subsection (a) shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a) or 162(1).

“(2) COORDINATION WITH HEALTH CARE TAX CREDIT.—No credit shall be allowed under subsection (a) for any taxable year to any taxpayer and qualifying family members with respect to whom a credit under section 35 is allowed for such taxable year.

“(3) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual’s taxable year begins.

“(4) MARRIED COUPLES MUST FILE JOINT RETURN.—

“(A) IN GENERAL.—If the taxpayer is married at the close of the taxable year, the credit shall be allowed under subsection (a) only if the taxpayer and his spouse file a joint return for the taxable year.

“(B) MARITAL STATUS; CERTAIN MARRIED INDIVIDUALS LIVING APART.—Rules similar to the rules of paragraphs (3) and (4) of section 21(e) shall apply for purposes of this paragraph.

“(5) VERIFICATION OF COVERAGE, ETC.—No credit shall be allowed under this section with respect to any individual unless such individual’s coverage (and such related information as the Secretary may require) is verified in such manner as the Secretary may prescribe.

“(6) INSURANCE WHICH COVERS OTHER INDIVIDUALS; TREATMENT OF PAYMENTS.—Rules

similar to the rules of paragraphs (7) and (8) of section 35(g) shall apply for purposes of this section.

“(j) COORDINATION WITH ADVANCE PAYMENTS.—

“(1) REDUCTION IN CREDIT FOR ADVANCE PAYMENTS.—With respect to any taxable year, the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 7527A for months beginning in such taxable year.

“(2) RECAPTURE OF EXCESS ADVANCE PAYMENTS.—If the aggregate amount paid on behalf of the taxpayer under section 7527A for months beginning in the taxable year exceeds the sum of the monthly limitations determined under subsection (b) for the taxpayer and the taxpayer’s spouse and dependents for such months, then the tax imposed by this chapter for such taxable year shall be increased by the sum of—

“(A) such excess, plus

“(B) interest on such excess determined at the underpayment rate established under section 6621 for the period from the date of the payment under section 7527A to the date such excess is paid.

For purposes of subparagraph (B), an equal part of the aggregate amount of the excess shall be deemed to be attributable to payments made under section 7527A on the first day of each month beginning in such taxable year, unless the taxpayer establishes the date on which each such payment giving rise to such excess occurred, in which case subparagraph (B) shall be applied with respect to each date so established. The Secretary may rescind or waive all or any portion of any amount imposed by reason of subparagraph (B) if such excess was not the result of the actions of the taxpayer.”

(b) ADVANCE PAYMENT OF CREDIT.—Chapter 77 (relating to miscellaneous provisions) is amended by inserting after section 7527 the following new section:

“SEC. 7527A. ADVANCE PAYMENT OF CREDIT FOR QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.

“(a) IN GENERAL.—The Secretary shall establish a program for making payments on behalf of individuals to providers of qualified refund eligible health insurance (as defined in section 25E(f)(2)) for such individuals.

“(b) LIMITATION.—The Secretary may make payments under subsection (a) only to the extent that the Secretary determines that the amount of such payments made on behalf of any taxpayer for any month does not exceed the sum of the monthly limitations determined under section 25E(b) for the taxpayer and taxpayer’s spouse and dependents for such month.”

(c) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 (relating to information concerning transactions with other persons) is amended by inserting after section 6050W the following new section:

“SEC. 6050X. RETURNS RELATING TO CREDIT FOR QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.

“(a) REQUIREMENT OF REPORTING.—Every person who is entitled to receive payments for any month of any calendar year under section 7527A (relating to advance payment of credit for qualified refund eligible health insurance) with respect to any individual shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to each such individual.

“(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

“(1) is in such form as the Secretary may prescribe, and

“(2) contains, with respect to each individual referred to in subsection (a)—

“(A) the name, address, and TIN of each such individual,

“(B) the months for which amounts payable under section 7527A were received,

“(C) the amount of each such payment,

“(D) the type of insurance coverage provided by such person with respect to such individual and the policy number associated with such coverage,

“(E) the name, address, and TIN of the spouse and each dependent covered under such coverage, and

“(F) such other information as the Secretary may prescribe.

“(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

“(1) the contact information of the person required to make such return, and

“(2) the information required to be shown on the return with respect to such individual.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

“(d) RETURNS WHICH WOULD BE REQUIRED TO BE MADE BY 2 OR MORE PERSONS.—Except to the extent provided in regulations prescribed by the Secretary, in the case of any amount received by any person on behalf of another person, only the person first receiving such amount shall be required to make the return under subsection (a).”.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) (relating to definitions) is amended by striking “or” at the end of clause (xxii), by striking “and” at the end of clause (xxiii) and inserting “or”, and by inserting after clause (xxiii) the following new clause:

“(xxiv) section 6050X (relating to returns relating to credit for qualified refund eligible health insurance), and”.

(B) Paragraph (2) of section 6724(d) is amended by striking “or” at the end of subparagraph (EE), by striking the period at the end of subparagraph (FF) and inserting “, or” and by inserting after subparagraph (FF) the following new subparagraph:

“(GG) section 6050X (relating to returns relating to credit for qualified refund eligible health insurance).”.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting “25E,” before “35,”.

(2)(A) Section 24(b)(3)(B) is amended by inserting “, 25E,” after “25D”.

(B) Section 25(e)(1)(C)(ii) is amended by inserting “25E,” after “25D,”.

(C) Section 25B(g)(2) is amended by inserting “25E,” after “25D,”.

(D) Section 26(a)(1) is amended by inserting “25E,” after “25D,”.

(E) Section 30(c)(2)(B)(ii) is amended by inserting “25E,” after “25D,”.

(F) Section 30D(c)(2)(B)(ii) is amended by striking “and 25D” and inserting “, 25D, and 25E”.

(G) Section 904(i) is amended by inserting “25E,” after “25B,”.

(H) Section 1400C(d)(2) is amended by inserting “25E,” after “25D,”.

(3) The table of sections for subpart A of part IV of subchapter A of chapter 1 is amended by inserting after the item relating to section 25D the following new item:

“Sec. 25E. Qualified health insurance credit.”.

(4) The table of sections for chapter 77 is amended by inserting after the item relating to section 7527 the following new item:

“Sec. 7527A. Advance payment of credit for qualified refund eligible health insurance.”.

(5) The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new item:

“Sec. 6050X. Returns relating to credit for qualified refund eligible health insurance.”.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 302. REQUIRING EMPLOYER TRANSPARENCY ABOUT EMPLOYEE BENEFITS.

(a) IN GENERAL.—Section 6051(a) (relating to W-2 requirement) is amended by striking “and” at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting “, and” and by inserting after paragraph (13) the following new paragraph:

“(14) the aggregate cost (within the meaning of section 4980B(f)(4)) for coverage of the employee under an accident or health plan which is excludable from the gross income of the employee under section 106(a) (other than coverage under a health flexible spending arrangement).”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to statements for calendar years beginning after 2009.

SEC. 303. CHANGES TO EXISTING TAX PREFERENCES FOR MEDICAL COVERAGE, ETC., FOR INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE CREDIT.

(a) EXCLUSION FOR CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.—

(1) IN GENERAL.—Section 106 (relating to contributions by employer to accident and health plans) is amended by adding at the end the following new subsection:

“(f) NO EXCLUSION FOR INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE CREDIT.—Subsection (a) shall not apply with respect to any employer-provided coverage under an accident or health plan for any individual for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month. The amount includible in gross income by reason of this subsection shall be determined under rules similar to the rules of section 4980B(f)(4).”.

(2) CONFORMING AMENDMENTS.—

(A) Section 106(b)(1) is amended—

(i) by inserting “gross income does not include” before “amounts contributed”, and

(ii) by striking “shall be treated as employer-provided coverage for medical expenses under an accident or health plan”.

(B) Section 106(d)(1) is amended—

(i) by inserting “gross income does not include” before “amounts contributed”, and

(ii) by striking “shall be treated as employer-provided coverage for medical expenses under an accident or health plan”.

(b) AMOUNTS RECEIVED UNDER ACCIDENT AND HEALTH PLANS.—Section 105 (relating to amounts received under accident and health plans) is amended by adding at the end the following new subsection:

“(f) NO EXCLUSION FOR INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE CREDIT.—

Subsection (b) shall not apply with respect to any employer-provided coverage under an accident or health plan for any individual for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.”.

(c) SPECIAL RULES FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—Subsection (1) of section 162 (relating to special rules for health insurance costs of self-employed individuals) is amended by adding at the end the following new paragraph:

“(6) NO DEDUCTION TO INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE.—Paragraph (1) shall not apply for any individual for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.”.

(d) EARNED INCOME CREDIT UNAFFECTED BY REPEALED EXCLUSIONS.—Subparagraph (B) of section 32(c)(2) is amended by redesignating clauses (v) and (vi) as clauses (vi) and (vii), respectively, and by inserting after clause (iv) the following new clause:

“(v) the earned income of an individual shall be computed without regard to sections 105(f) and 106(f).”.

(e) MODIFICATION OF DEDUCTION FOR MEDICAL EXPENSES.—Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

“(12) PREMIUMS FOR QUALIFIED HEALTH INSURANCE.—The term ‘medical care’ does not include any amount paid as a premium for coverage of an eligible individual (as defined in section 25E(e)) under qualified health insurance (as defined in section 25E(f)) for any month.”.

(f) REPORTING REQUIREMENT.—Subsection (a) of section 6051 is amended by striking “and” at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting “and”, and by inserting after paragraph (13) the following new paragraph:

“(14) the total amount of employer-provided coverage under an accident or health plan which is includible in gross income by reason of sections 105(f) and 106(f).”.

(g) RETIRED PUBLIC SAFETY OFFICERS.—Section 402(l)(4)(D) is amended by adding at the end the following: “Such term shall not include any premium for coverage by an accident or health insurance plan for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.”.

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

(i) NO INTENT TO ENCOURAGE STATE TAXATION OF HEALTH BENEFITS.—No intent to encourage any State to treat health benefits as taxable income for the purpose of increasing State income taxes may be inferred from the provisions of, and amendments made by, this section.

SEC. 304. DETERMINATION OF ELIGIBILITY.

(a) APPLICATION OF INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS) AND THE SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS (SAVE) PROGRAMS.—In order to obtain coverage through an Exchange, an individual must have had his or her eligibility determined and approved under the Income and Eligibility Verification System (IEVS) and the Systematic Alien Verification for Entitlements (SAVE) programs under section 1137 of the Social Security Act. The benefit determination and approval under this subsection shall be the responsibility of the Exchange-participating health plans involved.

(b) CREDITS.—In addition to satisfying the eligibility requirements specified in subsection (a), to be considered a credit eligible

individual under the amendments made by this title, an individual must have had his or her eligibility for the credit determined and approved under the Income and Eligibility Verification System (IEVS) and the Systematic Alien Verification for Entitlements (SAVE) programs under section 1137 of the Social Security Act. The benefit determination and approval under this subsection shall be the responsibility of the Exchange-participating health plans in which the individual enrolls and attempts to utilize the credit.

(c) **EFFECTIVE DATE.**—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.

SEC. 305. ADJUSTMENTS.

Notwithstanding any other provision of law, the Secretary of the Treasury shall adjust the growth of tax credits provided for under this amendments made by this title at such levels as appropriate so that this Act will remain budget neutral.

TITLE IV—FAIRNESS FOR EVERY AMERICAN PATIENT

Subtitle A—Medicaid Modernization

SEC. 401. MEDICAID MODERNIZATION.

(a) **IN GENERAL.**—Effective January 1, 2011, title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended to read as follows:

“TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

“TABLE OF CONTENTS OF TITLE

“Sec. 1900. References to pre-modernized Medicaid provisions; continuity for commonwealths and territories.

“PART A—GRANTS TO STATES FOR ACUTE CARE FOR INDIVIDUALS WITH DISABILITIES AND CERTAIN LOW-INCOME INDIVIDUALS

“Sec. 1901. Purpose; Appropriation.

“Sec. 1902. Payments to States for acute care medical assistance.

“Sec. 1903. Definitions of eligible individuals and acute care medical assistance.

“Sec. 1904. State plan requirements for acute care medical assistance.

“Sec. 1905. Definitions.

“Sec. 1906. Enrollment of individuals under group health plans and other arrangements.

“Sec. 1907. Drug rebates.

“Sec. 1908. Managed care.

“Sec. 1909. Annual reports.

“PART B—GRANTS TO STATES FOR LONG-TERM CARE SERVICES AND SUPPORTS

“Sec. 1911. Purpose.

“Sec. 1912. State plan.

“Sec. 1913. State allotments.

“Sec. 1914. Use of grants.

“Sec. 1915. Administrative provisions.

“Sec. 1916. Definition of long-term care services and supports.

“Sec. 1917. Provision requirements for long-term care services and supports, including option for self-directed services and supports.

“Sec. 1918. Treatment of income and resources for certain institutionalized spouses.

“Sec. 1919. Annual reports.

“PART C—GRANTS TO STATES FOR SURVEY AND CERTIFICATION OF MEDICAL FACILITIES AND OTHER REQUIREMENTS

“Sec. 1931. Authorization of appropriations.

“Sec. 1932. Application of certain requirements under pre-modernized Medicaid.

“PART D—GRANTS TO STATES FOR PROGRAM INTEGRITY

“Sec. 1941. Authorization of appropriations.

“Sec. 1942. Application of certain requirements under pre-modernized Medicaid.

“PART E—GRANTS TO STATES FOR ADMINISTRATION

“Sec. 1951. Authorization of appropriations; payments to states.

“Sec. 1952. Cost-sharing protections.

“Sec. 1953. Application of certain requirements under pre-modernized Medicaid.

“PART F—OTHER PROVISIONS

“Sec. 1961. Application of certain requirements under pre-modernized Medicaid.

“SEC. 1900. REFERENCES TO PRE-MODERNIZED MEDICAID PROVISIONS; CONTINUITY FOR COMMONWEALTHS AND TERRITORIES.

“(a) **IN GENERAL.**—In this title, if a reference to this title or to a provision of this title is prefaced by the term ‘old’, such reference is to this title or a provision of this title as in effect on December 31, 2010.

“(b) **REGULATIONS.**—The Secretary shall promulgate regulations to bring requirements imposed under an old provision of this title that applies under this title after December 31, 2010, into conformity with the policies embodied in this title as in effect on and after January 1, 2011.

“(c) **CONTINUITY FOR COMMONWEALTHS AND TERRITORIES.**—In the case of Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, this title as in effect on and after January 1, 2011, shall not apply to such commonwealths and territories, and old title XIX shall apply to a Medicaid program operated by such commonwealths or territories on and after that date.

“PART A—GRANTS TO STATES FOR ACUTE CARE FOR INDIVIDUALS WITH DISABILITIES AND CERTAIN LOW-INCOME INDIVIDUALS

“SEC. 1901. PURPOSE; APPROPRIATION.

“(a) **PURPOSE.**—It is the purpose of this part to enable each State, as far as practicable under the conditions in the State, to provide acute care medical assistance to eligible individuals described in section 1903 whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such individuals attain or retain capability for independence or self-care.

“(b) **APPROPRIATION.**—For the purpose of making payments to States under this part, there is appropriated out of any money in the Treasury not otherwise appropriated, such sums as are necessary for fiscal year 2011 and each fiscal year thereafter.

“SEC. 1902. PAYMENTS TO STATES FOR ACUTE CARE MEDICAL ASSISTANCE.

“(a) **IN GENERAL.**—From the amounts appropriated under section 1901 for a fiscal year, the Secretary shall pay to each State which has a plan approved under this part, for each quarter, beginning with the quarter commencing January 1, 2011, an amount equal to the Federal medical assistance percentage (as defined in section 1905(b)) of the total amount expended during such quarter as acute care medical assistance under the State plan under this part.

“(b) **ADMINISTRATIVE EXPENSES.**—Each State with a plan approved under this part shall receive a payment determined in accordance with part E for administrative expenses incurred in carrying out the plan under this part and part B (if the State has a plan approved under that part).

“SEC. 1903. DEFINITIONS OF ELIGIBLE INDIVIDUALS AND ACUTE CARE MEDICAL ASSISTANCE.

“(a) **ELIGIBLE INDIVIDUALS.**—

“(1) **IN GENERAL.**—In this part, the term ‘eligible individual’ means an individual—

“(A) who is—

“(i) a blind or disabled individual; or

“(ii) an individual described in paragraph (2); and

“(B) who the State determines satisfies—

“(i) the income and resources eligibility requirements established by the State under the State plan under this part; and

“(ii) such other requirements for assistance as are imposed under this title, including documentation of citizenship or status as a qualified alien under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

“(2) **INDIVIDUALS DESCRIBED.**—For purposes of paragraph (1)(A)(ii), the following individuals are described in this paragraph:

“(A) A child in foster care under the responsibility of the State.

“(B) A low-income woman with breast or cervical cancer described in old section 1902(aa).

“(C) Certain TB-infected individuals described in old section 1902(z)(1).

“(3) **GRANDFATHERED INDIVIDUALS.**—An individual shall be an eligible individual under the State plan under this part if—

“(A) the individual is described in paragraph (1)(A);

“(B) the individual satisfies the documentation requirements referred to in paragraph (1)(B)(ii); and

“(C) the State would have provided medical assistance under the State plan under old title XIX to the individual, but only so long as the individual continues to satisfy such old eligibility requirements.

“(4) **CONCURRENT ELIGIBILITY FOR PART B.**—An eligible individual under this part may be eligible under part B, but only if the individual satisfies the eligibility requirements of part B in addition to satisfying the requirements for eligibility under this part.

“(5) **PRESUMPTIVE ELIGIBILITY FOR CERTAIN BREAST OR CERVICAL CANCER PATIENTS.**—Old section 1920B (relating to presumptive eligibility for certain breast or cervical cancer patients) shall apply under this part.

“(b) **BENEFITS.**—Subject to paragraph (3), in this part, the term ‘acute care medical assistance’ means the following:

“(1) **MANDATORY BENEFITS.**—The care and services listed in paragraphs (1) through (5), (17), and (21) of old section 1905(a) (but, in the case of paragraph (4)(A) of such section, without regard to any limitation based on age or services in an institution for mental diseases).

“(2) **OPTIONAL BENEFITS.**—Any care or services listed in a paragraph of old section 1905(a) (other than paragraph (16)).

“(3) **EXCEPTIONS.**—

“(A) **CERTAIN SERVICES LIMITED TO PART B.**—Services described in paragraphs (15), (22), (23), (24), and (26) of old section 1905(a) shall only be provided under the State plan under part B.

“(B) **LIMIT ON PROVISION OF LONG-TERM CARE SERVICES AND SUPPORTS.**—A care or service that the Secretary determines is a long-term care service and support (including nursing facility services described in old section 1905(a)(4)(A)) shall not be provided to an individual under the State plan under this part for more than 30 days within any 12-month period.

“(C) **EXCLUSIONS.**—Such term shall not include any payments with respect to care or services for any individual who is an inmate

of a public institution or a patient in an institution for mental diseases (regardless of age).

"SEC. 1904. STATE PLAN REQUIREMENTS FOR ACUTE CARE MEDICAL ASSISTANCE.

"(a) IN GENERAL.—In order to receive payments under this part, a State shall have an approved State plan for acute care medical assistance. For purposes of this part, such assistance includes payments for preventive care, primary care, diagnosis and treatment of acute and chronic health conditions, emergency care, diagnosis and treatment of mental illnesses and related conditions, and rehabilitation and other services to help eligible individuals attain or retain capability for independence or self-care. A State medical assistance plan shall include a description, consistent with the requirements of this part of—

"(1) eligibility standards, including income and asset standards;

"(2) benefits, including the amount, duration, and scope of covered items and services;

"(3) strategies for improving access and quality of care; and

"(4) methods of service delivery.

"(b) PUBLIC AVAILABILITY OF STATE PLAN.—The State shall make available to the public the State plan under this part and any amendments submitted by the State to the plan.

"(c) AMOUNT, DURATION, AND SCOPE.—The State plan shall provide that the acute care medical assistance made available to any eligible individual shall not be less in amount, duration, or scope than the acute care medical assistance made available to any other eligible individual.

"(d) APPLICATION OF CERTAIN PRE-MODERNIZED MEDICAID REQUIREMENTS.—

"(1) OLD STATE PLAN REQUIREMENTS.—The following provisions of old section 1902 shall apply to the State plans under this part:

"(A) Old section 1902(a)(10)(C) (relating to certain eligibility and other requirements).

"(B) Old section 1902(a)(10)(D) (relating to home health services).

"(C) Old section 1902(a)(10)(G) (relating to nonapplication of certain supplemental security income eligibility criteria).

"(D) The subclauses in the flush matter following old section 1902(a)(10)(G) (relating to the provision of certain services) other than subclauses (V), (VII), (VIII), and (IX).

"(E) Old section 1902(a)(17) (relating to reasonable standards for determining eligibility).

"(F) Old section 1902(a)(19) (relating to eligibility safeguards).

"(G) Old section 1902(a)(34) (relating to eligibility beginning with the third month prior to the month of application).

"(H) Subparagraphs (A), (B), and (C) of old section 1902(a)(43) (relating to early and periodic screening, diagnostic, and treatment services).

"(I) Old section 1902(a)(46)(A) (relating to compliance with section 1137 requirements).

"(J) The fourth and sixth sentences of old section 1902(a) (relating to eligibility for certain individuals).

"(2) OTHER OLD TITLE XIX REQUIREMENTS.—

"(A) Old section 1902(e)(3) (relating to optional eligibility for certain disabled individuals).

"(B) Old section 1902(e)(9) (relating to optional respiratory care services).

"(C) Old section 1902(f) (relating to eligibility of certain aged, blind, or disabled individuals).

"(D) Old section 1902(m) (relating to eligibility of certain aged or disabled individuals), other than paragraph (4).

"(E) Old section 1902(o) (relating to disregard of certain supplemental security income benefits).

"(F) Old section 1902(v) (relating to eligibility determinations of blind or disabled individuals).

"(e) OTHER REQUIREMENTS.—The State plan under this part shall—

"(1) comply with the requirements of the other parts of this title; and

"(2) provide that the State will make the contributions specified under section 340A-1(e) of the Public Health Service Act.

"SEC. 1905. DEFINITIONS.

"(a) IN GENERAL.—The definitions specified in this section shall apply for purposes of this part and, to the extent applicable and consistent with the policy embodied in such part, parts B, C, D, E, and F.

"(b) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' for any State shall be 100 percent less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 percent as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii, except that the Federal medical assistance percentage shall in no case be less than 50 percent or more than 83 percent. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B).

"(c) APPLICATION OF CERTAIN PRE-MODERNIZED MEDICAID PROVISIONS.—The following old provisions shall apply under this part:

"(1) OLD SECTION 1905 PROVISIONS.—The following provisions of old section 1905:

"(A) Old section 1905(d) (relating to the definition of an intermediate care facility for the mentally retarded).

"(B) Old section 1905(e) (relating to the definition of physicians services).

"(C) Old section 1905(f) (relating to the definition of nursing facility services).

"(D) Old section 1905(g) (relating to the provision of chiropractors' services).

"(E) Old section 1905(j) (relating to State supplementary payments).

"(F) Old section 1905(k) (relating to supplemental security income benefits payable pursuant to section 211 of Public Law 93-66).

"(G) Old section 1905(l)(1) (relating to rural health clinic services).

"(H) Old section 1905(o) (relating to hospice care).

"(I) Old section 1905(q) (relating to the definition of a qualified severely impaired individual).

"(J) Old section 1905(r) (relating to the definition of early and periodic screening, diagnostic, and treatment services).

"(K) Old section 1905(s) (relating to the definition of a qualified disabled and working individual).

"(L) Old section 1905(t) (relating to the definition of primary care case management services).

"(M) Old section 1905(v) (relating to the definition of an employed individual with a medically improved disability).

"(N) Paragraphs (1) and (3) of old section 1905(w) (relating to the definition of an independent foster care adolescent).

"(O) Old section 1905(x) (relating to strategies, treatment, and services for individuals with Sickle Cell Disease).

"(2) OTHER OLD PROVISIONS.—

"(A) Old section 1903(m) (relating to the definition of a medicaid managed care organization).

"SEC. 1906. ENROLLMENT OF INDIVIDUALS UNDER GROUP HEALTH PLANS AND OTHER ARRANGEMENTS.

"The following old provisions shall apply under this part:

"(1) Old section 1906 (relating to enrollment of individuals under group health plans).

"(2) Old section 1902(a)(70) (relating to State option to establish a non-emergency medical transportation brokerage program).

"(3) Paragraphs (2) and (11) of old section 1902(e) (relating to eligibility for individuals enrolled with a group health plan or under a managed care arrangement during a minimum enrollment period).

"SEC. 1907. DRUG REBATES.

"Old sections 1902(a)(54) and 1927 (relating to payment for covered outpatient drugs and rebates) shall apply under this part.

"SEC. 1908. MANAGED CARE.

"The following old provisions shall apply under this part:

"(1) Old section 1932 (relating to managed care), other than subsection (a)(2) of such section.

"(2) Old section 1903(k) (relating to technical and actuarial assistance for States).

"SEC. 1909. ANNUAL REPORTS.

"(a) IN GENERAL.—Each State that receives payments under this part shall submit an annual report to the Secretary, in such form and manner as the Secretary shall specify.

"(b) APPLICATION OF OLD EPSDT REPORTING REQUIREMENTS.—Each annual report shall include the information required to be reported under old section 1902(a)(43)(D)(iv).

"PART B—GRANTS TO STATES FOR LONG-TERM CARE SERVICES AND SUPPORTS

"SEC. 1911. PURPOSE.

"(a) IN GENERAL.—The purpose of this part is to increase the flexibility of States in operating a system of long-term care services and supports designed to—

"(1) provide assistance to needy families so that individuals with disabilities and low-income senior citizens may be served and supported in their own homes and communities;

"(2) emphasize the independence and dignity of the person served by public programs;

"(3) end the institutional bias that existed under the Medicaid program prior to January 1, 2011;

"(4) provide stable and predictable funding for States as they rebalance their long-term care systems from institutions to communities;

"(5) provide flexibility to States to adopt new and innovative service delivery methods; and

"(6) promote independence and support activities that will enable individuals to return or maintain ties to the community, including through employment.

"(b) NO INDIVIDUAL ENTITLEMENT.—No individual determined eligible for long-term care services and supports under this part shall be entitled to a specific service or type of delivery of service.

"SEC. 1912. STATE PLAN.

"(a) IN GENERAL.—In order to receive payments under this part, a State must have an approved State plan for long-term care services and supports. A State long term care services and supports plan shall include a description, consistent with the requirements of this part, of—

"(1) income and assets eligibility standards and spousal impoverishment protections consistent with subsection (b);

"(2) the standardized assessments tools used to determine eligibility for specific long-term care services and supports;

“(3) the person-centered plans used to provide such services and supports;

“(4) the proposed uses of funding, if applicable, to provide targeted methods to meet individual level of support needs including tiering (preventive, emergency, low, medium, high); and

“(5) the long-term care services and supports to be available under the plan based on individual assessment of need in accordance with sections 1916 and 1917.

“(b) MINIMUM ELIGIBILITY STANDARDS.—

“(1) POPULATIONS COVERED.—The State plan shall specify the disabled and elderly populations who are eligible for long-term care services and supports.

“(2) NEEDS-BASED CRITERIA.—The plan shall include a description of the needs-based criteria the State will use to assess an individual's need for specific services and supports available under the State plan.

“(3) OTHER ELIGIBILITY REQUIREMENTS.—

“(A) INCOME AND ASSETS.—A State may use different income and asset standards and methodologies for determining eligibility than those used for determining eligibility for acute care medical assistance under part A. A State may not make eligibility standards related to income, asset, and spousal impoverishment protection more restrictive than the Federal minimum requirements of December 31, 2008.

“(B) APPLICATION OF SPOUSAL IMPOVERISHMENT PROTECTIONS.—The State plan shall provide that the State shall comply with the requirements of section 1918 (relating to spousal impoverishment protections).

“(C) STATEWIDENESS.—The State plan shall provide that, except with respect to methods used for determining homestead exemptions, the income and asset standards and methodologies shall be in effect in all political subdivisions of the State.

“(4) TRANSITION ASSISTANCE.—The State plan shall specify how the State will provide transition assistance for individuals who, on December 31, 2010, are enrolled under the State plan under old title XIX (or under a waiver of that plan) and receiving long-term care services or supports on that date. The State shall provide such assistance to individuals who are and are not likely to be determined eligible for long-term care services and supports under the State plan under this part, as in effect on January 1, 2011 (or the first day on which the State plan is in effect under this part).

“(c) PAYMENT METHODOLOGIES TO PROVIDERS.—

“(1) IN GENERAL.—The State plan shall describe the methodologies used to determine payments to providers. Such methodologies—

“(A) may be varied to assist in transitioning from facilities-based to community-based care; and

“(B) shall not be subject to Secretarial approval.

“(2) TRANSPARENCY.—The State plan shall provide that the State shall make publicly available—

“(A) the payment methodologies applicable under the plan; and

“(B) the name of any provider that receives \$1,000,000 or more in any 12-month period and the actual amount paid to the provider during that period.

“(d) COORDINATION OF EFFORT WITH OTHER RELATED PUBLIC AND PRIVATE PROGRAMS.—The plan shall include a description of the State's efforts to coordinate the delivery of services and supports under the plan with other related public and private programs that serve individuals with disabilities or aged populations that need or may be at risk of needing long term care.

“(e) PUBLIC AVAILABILITY OF STATE PLAN.—The State shall make available to the public the State plan under this part and any amendments submitted by the State to the plan.

“(f) APPLICATION OF OLD TITLE XIX REQUIREMENTS.—The following old title XIX provisions shall apply to a State plan under this part:

“(1) Subsections (a)(50) and (q) of old section 1902 (relating to a monthly personal needs allowance for certain institutionalized individuals and couples).

“(2) Old section 1902(a)(67) (relating to payment for certain services furnished to a PACE program eligible individual).

“(3) Paragraph (1) of old section 1902(r) (relating to the post-eligibility treatment of income for certain individuals) and paragraph (2) of such section (relating to methodologies for determining income and resource eligibility for individuals, but only with respect to individuals who are eligible under this part on or after January 1, 2011).

“(4) Old section 1905(i) (relating to the definition of an institution for mental diseases).

“(g) OTHER REQUIREMENTS OF OTHER PARTS.—The State plan under this part shall—

“(1) comply with the requirements of the other parts of this title; and

“(2) provide that the State will make the contributions specified under section 340A-1(e) of the Public Health Service Act.

“SEC. 1913. STATE ALLOTMENTS.

“(a) APPROPRIATION.—For the purpose of providing allotments to States under this section, there is appropriated out of any money in the Treasury not otherwise appropriated—

“(1) for fiscal year 2011, \$65,274,560,000;

“(2) for fiscal year 2012, \$67,885,540,000;

“(3) for fiscal year 2013, \$70,600,964,100;

“(4) for fiscal year 2014, \$73,425,000,000;

“(5) for fiscal year 2015, \$76,362,000,000;

“(6) for fiscal year 2016, \$79,416,480,000;

“(7) for fiscal year 2017, \$82,593,140,000;

“(8) for fiscal year 2018, \$85,896,870,000; and

“(9) for fiscal year 2019, \$89,332,743,000.

“(b) ALLOTMENTS TO 50 STATES AND THE DISTRICT OF COLUMBIA.—

“(1) FISCAL YEAR 2011 ALLOTMENTS.—Subject to subsection (e), the Secretary shall allot to each State with a long term care plan approved under this title an amount in fiscal year 2011 equal to the Federal expenditures made by the State for long-term care as defined in section 1916 in fiscal year 2008, increased by 8 percent.

“(2) SUBSEQUENT FISCAL YEAR ALLOTMENTS.—For fiscal year 2012 and each subsequent fiscal year through fiscal year 2019, the allotment for a State under this section is equal to the allotment for the State determined for the preceding fiscal year, increased by 4 percent.

“(c) LIMITATION.—

“(1) IN GENERAL.—Except as provided in paragraph (2), no other Federal funds are available under this title for expenditures incurred for long-term care services and supports after December 31, 2010, except as provided under a State plan approved under this part.

“(2) EXCEPTION.—

“(A) IN GENERAL.—If a State does not have an approved State plan by October 1, 2010, the Secretary may make payments equal to 85 percent of the State's estimated quarterly allotment until June 30, 2011.

“(B) FULL FUNDING.—A State shall receive 100 percent of its allotment for fiscal year 2011 if the State has a plan approved under this part by June 30, 2011.

“(d) MAINTENANCE OF EFFORT.—In order to qualify for the grant payable under this section, the State must demonstrate in each fiscal year that it made long-term care service and supports expenditures (including funding from local government sources) equal to the amount of not less than 95 percent of the nonfederal share amount spent in fiscal year 2009 under the State plan under old title XIX on long term care services and supports (as defined in section 1916). Expenditures not made under this part shall not be recognized by the Secretary for purposes of this requirement.

“(e) GRANTS REDUCED IF INSUFFICIENT APPROPRIATIONS.—

“(1) IN GENERAL.—If the amount appropriated for fiscal year 2011 under subsection (a)(1) is less than the amount necessary to fund each State's allotment for that fiscal year, the Secretary shall reduce the allotment for each State for that fiscal year based on the applicable percentage determined for the State under paragraph (2).

“(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage determined with respect to a State is as follows:

“If the ratio of the State's non-institutional spending to total long-term care spending for fiscal year 2009 is:

	The applicable percentage is:
50 percent or greater	100
at least 46, but less than 50 percent	99
at least 40, but less than 46 percent	98
at least 36, but less than 40	97
at least 30, but less than 36	96
less than 30 percent	95.

“(f) ADMINISTRATIVE EXPENSES.—

“(1) IN GENERAL.—Each State with a plan approved under this part shall receive a payment determined in accordance with amounts appropriated for part E for adminis-

trative expenses incurred in carrying out the plan under this part and part A.

“(2) ASSESSMENT-RELATED COSTS.—Costs attributable to providing an individualized needs-based assessment for purposes of iden-

tifying the long-term care services and supports to be provided under the State plan to an individual shall be considered a long-term care service and support and shall not be treated as an administrative expense.

"SEC. 1914. USE OF GRANTS.

"(a) IN GENERAL.—A State shall use funds for long-term care services and supports as defined in section 1916.

"(b) SELF-DIRECTION.—A State shall offer individuals the opportunity to self-direct their long-term care services and supports.

"SEC. 1915. ADMINISTRATIVE PROVISIONS.

"(a) FUNDING ON A QUARTERLY BASIS.—The Secretary shall make payments to States in equal amounts of a State's annual allotment on a quarterly basis. Each quarterly payment shall remain available for use by the State for twelve succeeding fiscal year quarters.

"(b) PUBLICATION.—The Secretary shall publish each State's allotment—

"(1) for fiscal year 2011 not later than December 15, 2009; and

"(2) for each subsequent fiscal year, not later than December 15 of the calendar year preceding the calendar year in which the fiscal year begins.

"SEC. 1916. DEFINITION OF LONG-TERM CARE SERVICES AND SUPPORTS.

"(a) DEFINITION.—

"(1) IN GENERAL.—Subject to subsection (e), in this part, the term 'long-term care services and supports' means any of the services or supports specified in paragraphs (2) or (3) that may be provided in a nursing facility, an institution, a home, or other setting.

"(2) SERVICES AND SUPPORTS DESCRIBED.—For purposes of paragraph (1), the services and supports described in this paragraph include assistive technology, adaptive equipment, remote monitoring equipment, case management for the aged, case management for individuals with disabilities, nursing home services, long-term rehabilitative services necessary to restore functional abilities, services provided in intermediate care facilities for people with disabilities, habilitation services (including adult day care programs), community treatment teams for individuals with mental illness, home health services, services provided in an institution for mental disease, a Program of All-Inclusive Care for the Elderly (PACE), personal care (including personal assistance services), recovery support including peer counseling, supportive employment, training skills necessary to assist the individual in achieving or maintaining independence, training of family members including foster parents in supportive and behavioral modification skills, ongoing and periodic training to maintain life skills, transitional care including room and board not to exceed 60 days within a 12-month period.

"(3) INCLUSION OF CERTAIN BENEFITS UNDER OLD TITLE XIX.—Such services and supports may include any of the following services:

"(A) Old section 1905(a)(15) (relating to services in an intermediate care facility for the mentally retarded).

"(B) Services described in subsections (a)(16) and (h) of old section 1905, but without regard to any restriction on such services on the basis of age (relating to inpatient psychiatric hospital services).

"(C) Old section 1905(a)(22) (relating to home and community care (to the extent allowed and as defined in old section 1929) for functionally disabled elderly individuals).

"(D) Old section 1905(a)(23) (relating to community supported living arrangements services (to the extent allowed and as defined in old section 1930)).

"(E) Subject to subsection (e), old section 1905(a)(24) but without regard to any restriction on furnishing services to patients or residents of facilities or institutions (relating to personal care services).

"(F) Old sections 1905(a)(26) and 1934 (relating to services furnished under a PACE program under old section 1934 to PACE program eligible individuals enrolled under the program under such old section).

"(G) Old section 1915(c)(5) (relating to the definition of habilitation services).

"(4) LIMITATION.—Long-term care services and supports cannot be used for services and administrative costs provided through the foster care (with the exception of training of foster care parents), child welfare, adult protective services, juvenile justice, public guardianship, or correctional systems.

"(b) REHABILITATIVE CARE.—For purposes of rehabilitation due to acute care medical needs, a State may claim rehabilitative services provided in an institutional setting, nursing home, or as part of home health expenditures as acute care benefits under the State plan under part A rather than under the State plan under this part for a cumulative period of 30 days within a 12-month period if such care is directly related to the onset of an acute care need. A State shall demonstrate the services were provided as a direct result of an acute care need.

"(c) MANAGED CARE.—If a State provides long-term care services and supports through managed care, the State shall submit a methodology for determining the level of expenditures attributed to long term care for approval by the Secretary.

"(d) APPLICATION OF PART A DEFINITIONS.—A definition specified in section 1905 shall apply to the same term used in this part, unless the Secretary determines that the application of such definition would be inconsistent with the purpose of this part.

"(e) EXCLUSION.—No payments shall be made under the State plan under this part with respect to long-term care supports and services provided for any individual who is an inmate of a public institution. Nothing in the preceding sentence shall be construed as precluding the provision of long-term care services and supports under the State plan under this part to an individual who is a patient in an institution for mental diseases.

"SEC. 1917. PROVISION REQUIREMENTS FOR LONG-TERM CARE SERVICES AND SUPPORT, INCLUDING OPTION FOR SELF-DIRECTED SERVICES AND SUPPORTS.

"(a) REQUIREMENTS FOR THE PROVISION OF LONG-TERM CARE SERVICES AND SUPPORTS.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a State may provide through a State plan amendment for the provision of long-term care services and supports for individuals eligible under the State plan under this part, subject to the following requirements:

"(A) NEEDS-BASED CRITERIA FOR ELIGIBILITY FOR, AND RECEIPT OF, LONG-TERM CARE SERVICES AND SUPPORTS.—The State establishes needs-based criteria for determining an individual's eligibility under the State plan for medical assistance for such long-term care services and supports, and if the individual is eligible for such services and supports, the specific services and supports that will be available under the State plan to the individual.

"(B) CRITERIA FOR INSTITUTIONALIZED VERSUS NON-INSTITUTIONALIZED SERVICES.—In establishing needs-based criteria, the State may establish criteria for determining eligibility for, and receipt of, services and supports provided in a facility or institution that are more stringent than the criteria established for eligibility and receipt of services and supports in a non-facility or non-institutionalized setting.

"(C) AUTHORITY TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS.—A State may limit the

number of individuals who are eligible for such services and supports and may establish waiting lists for the receipt of such services and supports.

"(D) CRITERIA BASED ON INDIVIDUAL ASSESSMENT.—

"(i) IN GENERAL.—The criteria established by the State shall require an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities, and such other risk factors as the State determines to be appropriate.

"(ii) ADJUSTMENT AUTHORITY.—The State plan amendment provides the State with the option to modify the criteria established under subparagraph (A) (without having to obtain prior approval from the Secretary) in the event that the enrollment of individuals eligible for services exceeds the projected enrollment, but only if—

"(I) the State provides at least 60 days notice to the Secretary and the public of the proposed modification;

"(II) the State deems an individual receiving long-term care services and supports on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to be eligible for such services and supports for a period of at least 12 months beginning on the date the individual first received medical assistance for such services and supports; and

"(III) after the effective date of such modification, the State, at a minimum, applies the criteria for determining whether an individual requires the level of care provided in a facility or institutionalized setting which applied under the State plan immediately prior to the application of the modified criteria.

"(E) INDEPENDENT EVALUATION AND ASSESSMENT.—

"(i) ELIGIBILITY DETERMINATION.—The State uses an independent evaluation for making the determinations described in subparagraph (A).

"(ii) ASSESSMENT.—In the case of an individual who is determined to be eligible for long-term care services and supports, the State uses an independent assessment, based on the needs of the individual to—

"(I) determine a necessary level of services and supports to be provided, consistent with an individual's physical and mental capacity;

"(II) prevent the provision of unnecessary or inappropriate care; and

"(III) establish an individualized care plan for the individual in accordance with subparagraph (G).

"(F) ASSESSMENT.—The independent assessment required under subparagraph (E)(ii) shall include the following:

"(i) An objective evaluation of an individual's inability to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities.

"(ii) A face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for long-term care services and supports.

"(iii) Where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual.

“(iv) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

“(v) An examination of the individual’s relevant history, medical records, and care and support needs, guided by best practices and research on effective strategies that result in improved health and quality of life outcomes.

“(vi) An evaluation of the ability of the individual or the individual’s representative to self-direct the purchase of, or control the receipt of, such services and supports if the individual so elects.

“(G) INDIVIDUALIZED CARE PLAN.—

“(i) IN GENERAL.—In the case of an individual who is determined to be eligible for long-term care services and supports, the State uses the independent assessment required under subparagraph (E)(ii) to establish a written individualized care plan for the individual.

“(ii) PLAN REQUIREMENTS.—The State ensures that the individualized care plan for an individual—

“(I) is developed—

“(aa) in consultation with the individual, the individual’s treating physician, health care or support professional, or other appropriate individuals, as defined by the State, and, where appropriate the individual’s family, caregiver, or representative; and

“(bb) taking into account the extent of, and need for, any family or other supports for the individual;

“(II) identifies the long-term care services and supports to be furnished to the individual (or, if the individual elects to self-direct the purchase of, or control the receipt of, such services and supports, funded for the individual); and

“(III) is reviewed at least annually and as needed when there is a significant change in the individual’s circumstances.

“(iii) STATE REQUIREMENT TO OFFER ELECTION FOR SELF-DIRECTED SERVICES AND SUPPORTS.—

“(I) INDIVIDUAL CHOICE.—The State shall allow an individual or the individual’s representative the opportunity to elect to receive self-directed long-term care services and supports in a manner which gives them the most control over such services and supports consistent with the individual’s abilities and the requirements of subclauses (II) and (III).

“(II) SELF-DIRECTED.—The term ‘self-directed’ means, with respect to the long-term care services and supports offered under the State plan amendment, such services and supports for the individual which are planned and purchased under the direction and control of such individual or the individual’s authorized representative, including the amount, duration, scope, provider, and location of such services and supports, under the State plan consistent with the following requirements:

“(aa) ASSESSMENT.—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services and supports.

“(bb) SERVICE PLAN.—Based on such assessment, there is developed jointly with such individual or the individual’s authorized representative a plan for such services and supports for such individual that is approved by the State and that satisfies the requirements of subclause (III).

“(III) PLAN REQUIREMENTS.—For purposes of subclause (II)(bb), the requirements of this subclause are that the plan—

“(aa) specifies those services and supports which the individual or the individual’s au-

thorized representative would be responsible for directing;

“(bb) identifies the methods by which the individual or the individual’s authorized representative will select, manage, and dismiss providers of such services and supports;

“(cc) specifies the role of family members and others whose participation is sought by the individual or the individual’s authorized representative with respect to such services and supports;

“(dd) is developed through a person-centered process that is directed by the individual or the individual’s authorized representative, builds upon the individual’s capacity to engage in activities that promote community life and that respects the individual’s preferences, choices, and abilities, and involves families, friends, and professionals as desired or required by the individual or the individual’s authorized representative;

“(ee) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services and supports in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual’s authorized representative; and

“(ff) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual’s authorized representative.

“(IV) BUDGET PROCESS.—With respect to individualized budgets described in subclause (III)(ff), the State plan amendment—

“(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

“(bb) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

“(cc) provides a procedure to evaluate expenditures under such budgets.

“(H) QUALITY ASSURANCE; CONFLICT OF INTEREST STANDARDS.—

“(i) QUALITY ASSURANCE.—The State ensures that the provision of long-term care services and supports meets Federal and State guidelines for quality assurance.

“(ii) CONFLICT OF INTEREST STANDARDS.—The State establishes standards for the conduct of the independent evaluation and the independent assessment to safeguard against conflicts of interest.

“(I) REDETERMINATIONS AND APPEALS.—The State allows for at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

“(J) PRESUMPTIVE ELIGIBILITY FOR ASSESSMENT.—The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to believe may be eligible for long-term care services and supports. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment under subparagraph (E) to determine an individual’s eligibility for such services and if the individual is so eligible, the specific long-term care services and supports that the individual will receive.

“(2) DEFINITION OF INDIVIDUAL’S REPRESENTATIVE.—In this section, the term ‘individual’s representative’ means, with respect to an individual, a parent, a family member, or a guardian of the individual, an advocate for the individual, or any other individual who is authorized to represent the individual.

“(b) SELF-DIRECTED PERSONAL ASSISTANCE SERVICES.—If a State includes personal care or personal assistance services in the long-term care services and supports available under the State plan, the State shall comply with the requirements of old section 1915(j) in the case of an individual who elects to self-direct the receipt of such care or services.

“SEC. 1918. TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES.

“Old section 1924 (relating to treatment of income and resources for certain institutionalized spouses), other than paragraphs (2) and (4)(A) of subsection (a) of such section, shall apply under this part.

“SEC. 1919. ANNUAL REPORTS.

“(a) IN GENERAL.—Each State that receives payments under this part shall submit an annual report to the Secretary, in such form and manner as the Secretary shall specify.

“(b) REQUIREMENTS.—The report shall include the following with respect to the most recent fiscal year ended:

“(1) The number of individuals served under the plan.

“(2) The number of individuals served by tier (preventive, emergency, low, medium, and high needs).

“(3) The number of individuals known to the State on waiting list for services (if any) and type of disability (physical, developmental, mental health) or aged.

“(4) Expenditures by service category.

“PART C—GRANTS TO STATES FOR SURVEY AND CERTIFICATION OF MEDICAL FACILITIES AND OTHER REQUIREMENTS

“SEC. 1931. AUTHORIZATION OF APPROPRIATIONS.

“For the purpose of carrying out Federal activities and providing grants to States for expenses necessary to carry out this part, there is authorized to be appropriated—

“(1) for fiscal year 2011, \$300,000,000; and

“(2) for each succeeding fiscal year, the amount authorized under this section for the preceding fiscal year, increased by 5 percent.

“SEC. 1932. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

“The following old provisions shall apply under this part:

“(1) Old section 1902(a)(9) (relating to health standards and applicable requirements for laboratory services).

“(2) Old section 1902(a)(28) (relating to nursing facilities and nursing facility services).

“(3) Old sections 1902(a)(29) and 1908 (relating to a State program for the licensing of administrators of nursing homes).

“(4) Old section 1902(a)(33)(B) (relating to licensing health institutions).

“(5) Old section 1902(d) (relating to medical or utilization review functions).

“(6) Old section 1902(i) (relating to intermediate care facilities for the mentally retarded).

“(7) Old section 1902(y) (relating to psychiatric hospitals).

“(8) Paragraphs (2) and (6) of old section 1903(g) (relating to the Secretarial requirement to conduct sample onsite surveys of private and public institutions and recertifications for the need for certain services).

“(9) Old section 1903(q)(4)(B) (relating to the definition of a board and care facility).

“(10) Old section 1910 (relating to certification and approval of rural health clinics and intermediate care facilities for the mentally retarded).

“(11) Old section 1911 (relating to Indian Health Service facilities).

“(12) Old section 1913 (relating to hospital providers of nursing facility services).

“(13) Old section 1919 (relating to requirements for nursing facilities).

“PART D—GRANTS TO STATES FOR PROGRAM INTEGRITY

“SEC. 1941. AUTHORIZATION OF APPROPRIATIONS.

“(a) IN GENERAL.—For the purpose of carrying out Federal activities under this part and providing grants to States for expenses necessary to carry out this part, there is authorized to be appropriated—

“(1) for fiscal year 2011, \$100,000,000; and

“(2) for each succeeding fiscal year, the amount authorized under this section for the preceding fiscal year, increased by 5 percent.

“(b) AVAILABILITY; AUTHORITY FOR USE OF FUNDS.—

“(1) AVAILABILITY.—Amounts appropriated pursuant to subsection (a) shall remain available until expended.

“(2) AUTHORITY FOR USE OF FUNDS FOR TRANSPORTATION AND TRAVEL EXPENSES FOR ATTENDEES AT EDUCATION, TRAINING, OR CONSULTATIVE ACTIVITIES.—

“(A) IN GENERAL.—The Secretary may use amounts appropriated pursuant to subsection (a) to pay for transportation and the travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business, of individuals described in subsection (b)(4) who attend education, training, or consultative activities conducted under the authority of that subsection.

“(B) PUBLIC DISCLOSURE.—The Secretary shall make available on a website of the Centers for Medicare & Medicaid Services that is accessible to the public—

“(i) the total amount of funds expended for each conference conducted under the authority of subsection (b)(4); and

“(ii) the amount of funds expended for each such conference that were for transportation and for travel expenses.

“(c) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year, the Secretary shall submit a report to Congress which identifies—

“(1) the use of funds appropriated pursuant to subsection (a); and

“(2) the effectiveness of the use of such funds.

“SEC. 1942. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

“The following old provisions shall apply under this part:

“(1) Old subsections (a)(25) (other than subparagraph (E)) and (g) of section 1902 and section 1903(o) (relating to third party liability).

“(2) Old section 1902(a)(30)(B) (relating to hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases admission screening and review requirements).

“(3) Old section 1902(a)(32) (relating to certain payment requirements).

“(4) Old section 1902(a)(35) (relating to disclosing entities under section 1124).

“(5) Old section 1902(a)(37) and the fifth sentence (relating to claims payment procedures).

“(6) Old section 1902(a)(44) (relating to payment for inpatient hospital services, services in an intermediate care facility for the mentally retarded, or inpatient mental hospital services).

“(7) Old sections 1902(a)(45) and 1912 (relating to assignment of rights of payment).

“(8) Old sections 1902(a)(49) and 1921 (relating to information and access to information

concerning sanctions taken by State licensing authorities against health care practitioners and providers).

“(9) Old sections 1902(a)(61) and 1903(q) (relating to requirements for a medicaid fraud and abuse control unit).

“(10) Old section 1902(a)(64) (relating to reports from beneficiaries and others and data compilation requirements concerning alleged instances of waste, fraud, and abuse).

“(11) Old section 1902(a)(65) (relating to provider number and surety bond requirement for suppliers of durable medical equipment).

“(12) Old section 1902(a)(68) (relating to requirements for certain entities).

“(13) Old sections 1902(a)(69) and 1936 (relating to the Medicaid Integrity Program) other than paragraphs (1), (2)(A), and (3) of old section 1936(e).

“(14) Old section 1902(a)(70)(B)(iv) (relating to prohibitions on referrals and conflict of interest for certain brokers of non-emergency medical transportation).

“(15) Old sections 1902(a)(71) and 1940 (relating to a required asset verification program).

“(16) Old section 1902(p) (relating to exclusion of certain individuals or entities).

“(17) Old section 1902(x) (relating to unique identifiers for physicians).

“(18) Old section 1903(p) (relating to interstate collection of rights of support).

“(19) Old section 1903(r)(2) (relating to requirements for mechanized claims processing and information retrieval systems).

“(20) Old section 1903(u) (relating to erroneous excess payments), other than clause (v) of paragraph (1)(D).

“(21) Old section 1903(v) and the seventh sentence of old section 1902(a) (relating to limitations on payments for services furnished to aliens), other than subparagraphs (A) and (B) of paragraph (4).

“(22) Old section 1903(x) (relating to citizenship documentation).

“(23) Old section 1909 (relating to State false claims act requirements for increased State share of recoveries).

“(24) Old section 1914 (relating to withholding of Federal share of payments for certain Medicare providers).

“(25) Old section 1917 (relating to liens, adjustments and recoveries, and transfers of assets).

“(26) Old section 1922 (relating to correction and reduction plans for intermediate care facilities for the mentally retarded).

“PART E—GRANTS TO STATES FOR ADMINISTRATION

“SEC. 1951. AUTHORIZATION OF APPROPRIATIONS; PAYMENTS TO STATES.

“(a) IN GENERAL.—For the purpose of providing grants to States for administrative expenses necessary to carry out parts A and B, there is authorized to be appropriated—

“(1) for fiscal year 2011, \$7,000,000,000; and

“(2) for each succeeding fiscal year, the amount authorized under this subsection for the preceding fiscal year, increased by 3 percent.

“(b) PAYMENTS TO STATES.—

“(1) IN GENERAL.—From the amount appropriated pursuant to subsection (a) for a fiscal year, the Secretary shall pay each State with approved plans under parts A and B for the fiscal year an amount equal to the product of the amount appropriated for the fiscal year and the ratio of the total amount of payments made to the State under paragraphs (2) through (7) of section 1903(a) for fiscal year 2008 (as such section was in effect for that fiscal year) to the total amount of such payments made to all States for such fiscal year.

“(2) PRO RATA ADJUSTMENT.—The Secretary shall make pro rata adjustments to the amounts determined under paragraph (1) for a fiscal year as necessary so as to not exceed the amount appropriated pursuant to subsection (a) for the fiscal year.

“SEC. 1952. COST-SHARING PROTECTIONS.

“(a) IN GENERAL.—A State may impose cost-sharing for individuals provided acute care medical assistance under a State plan under part A or long-term care services and supports under a State plan under part B consistent with the following:

“(1) The State may (in a uniform manner) require payment of monthly premiums or other cost-sharing set on a sliding scale based on family income.

“(2) A premium or other cost-sharing requirement imposed under paragraph (1) may only apply to the extent that, in the case of an individual whose family income—

“(A) exceeds 150 percent of the poverty line, the aggregate annual amount of such premium and other cost-sharing charges imposed under the plan does not exceed 5 percent of the individual's annual income; and

“(B) exceeds 250 percent of the poverty line, the aggregate annual amount of such premium and other cost-sharing charges do not exceed 7.5 percent of the individual's annual income.

“(3) A State shall not require prepayment of any premium or cost-sharing imposed pursuant to paragraph (1) and shall not terminate eligibility of an individual under the State plan on the basis of failure to pay any such premium or cost-sharing until such failure continues for a period of at least 60 days from the date on which the premium or cost-sharing became past due. The State may waive payment of any such premium or cost-sharing in any case where the State determines that requiring such payment would create an undue hardship.

“(b) APPLICATION TO INSTITUTIONALIZED INDIVIDUALS.—A State may impose cost-sharing consistent with subsection (a) to individuals who are patients in, or residents of, a medical institution or nursing facility except that rules relating to the post-eligibility treatment of income (including a minimum monthly personal needs allowance) applicable to institutionalized individuals under old title XIX shall apply in the same manner to individuals eligible for long-term care services and supports under a State plan under part B.

“(c) POVERTY LINE DEFINED.—In this section, the term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

“SEC. 1953. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

“The following old provisions shall apply to the State plans under this title:

“(1) OLD STATE PLAN REQUIREMENTS.—

“(A) Old section 1902(a)(1) (relating to the requirement for plans to be in effect in all political subdivisions of the State).

“(B) Old section 1902(a)(2) (relating to State financial participation).

“(C) Old section 1902(a)(3) (relating to opportunity for a fair hearing).

“(D) Old section 1902(a)(4) (relating to administration).

“(E) Old section 1902(a)(5) (relating to designation of a single State agency).

“(F) Old section 1902(a)(6) (relating to reporting requirements).

“(G) Old section 1902(a)(7) (relating to restrictions on the use or disclosure of information).

“(H) Old section 1902(a)(8) (relating to applications for assistance).

“(I) Old section 1902(a)(11) (relating to cooperative agreements with other State agencies).

“(J) Old section 1902(a)(12) (relating to terminations of blindness).

“(K) Old section 1902(a)(13) (relating to determination of rates of payment for certain services), other than clause (iv) of subparagraph (A).

“(L) Subsections (a)(15) and (bb) of old section 1902(a) (relating to payment for services provided by rural health clinics and federally qualified health centers).

“(M) Old section 1902(a)(16) (relating to furnishing services to individuals when absent from the State).

“(N) Old section 1902(a)(22) (relating to certain administrative provisions).

“(O) Paragraphs (23) and (25)(D) of old section 1902(a) (relating to any willing provider requirements).

“(P) Old section 1902(a)(24) (relating to consultative services by other agencies).

“(Q) Old section 1902(a)(26) (relating to review of need for inpatient mental hospital services and written plan of care requirements).

“(R) Old section 1902(a)(27) (relating to provider record keeping requirements).

“(S) Old section 1902(a)(30)(A) (relating to utilization review).

“(T) Old section 1902(a)(31) (relating to written plan of care for services and review for intermediate care facility for the mentally retarded services).

“(U) Old section 1902(a)(33)(A) (relating to quality review requirements).

“(V) Old section 1902(a)(36) (relating to public availability of facility surveys).

“(W) Old section 1902(a)(38) (relating to the provision of information described in section 1128(b)(9) by certain entities).

“(X) Old section 1902(a)(39) (relating to the exclusion of certain entities).

“(Y) Old section 1902(a)(40) (relating to requirement for uniform reporting systems).

“(Z) Old section 1902(a)(41) (relating to notice to State medical licensing boards).

“(AA) Old section 1902(a)(42) (relating to certain audit requirements).

“(BB) Old section 1902(a)(48) (relating to eligibility cards).

“(CC) Old section 1902(a)(55) (relating to the receipt and initial processing of applications, but only to the extent such section is consistent with the policy embodied in the State plans under parts A and B).

“(DD) Subsections (a)(56) and (s) of old section 1902 (relating to adjusted payments for certain inpatient hospital services).

“(EE) Old section 1902(a)(59) (relating to maintenance of list of participating physicians).

“(FF) The second sentence of old section 1902 (relating to designation of certain State agencies).

“(GG) Old section 1902(b) (relating to limitations on approval of plans).

“(HH) Old section 1902(j) (relating to application of requirements to American Samoa and the Northern Mariana Islands).

“(2) OTHER OLD TITLE XIX REQUIREMENTS.—

“(A) Old section 1903(b)(4) (relating to limitations on payments to enrollment brokers).

“(B) Old section 1903(c) (relating to furnishing of services included in a program or plan under part B or C of the Individuals with Disabilities Education Act).

“(C) Old section 1903(d) (relating to payments).

“(D) Old section 1903(e) (relating to costs with respect to certain hospital services).

“(E) Old section 1903(i) (relating to limitations on payments).

“(F) Old section 1903(r) (relating to requirements for mechanized claims processing and information retrieval systems).

“(G) Subsections (b)(5) and (w) of old section 1903 (relating to limitations on payments related to provider taxes).

“(H) Old section 1904 (relating to operation of State plans).

“(I) Old sections 1902(a)(60) and 1908A (relating to medical child support).

“(J) Paragraphs (32)(D) and (62) of old section 1902(a) and section 1928 (relating to program for distribution of pediatric vaccines).

“PART F—OTHER PROVISIONS

“SEC. 1961. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

“The following old provisions shall apply under this part:

“(1) The third sentence of old section 1902 (relating to nonapplication of certain old provisions to a religious nonmedical health care institution).

“(2) Old section 1918 (relating to application of provisions of title II relating to subpoenas).

“(3) Old section 1939 (relating to references to laws directly affecting the Medicaid program.”.

(b) REPEAL OF TITLE XXI.—Effective January 1, 2011, title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is repealed.

SEC. 402. OUTREACH.

(a) AUTHORIZATION OF APPROPRIATIONS.—The following amounts are authorized to be appropriated to the Secretary of Health and Human Services:

(1) For fiscal year 2009, \$100,000,000 for the design and implementation of a public outreach campaign to inform the public about the changes to the programs under such titles that take effect on January 1, 2011, as a result of the amendment made by section 401.

(2) For each of fiscal years 2010 and 2011, \$200,000,000 to carry out such public outreach campaign.

(3) For fiscal year 2012, \$50,000,000 to carry out such public outreach campaign.

(b) AVAILABILITY.—Funds appropriated under subsection (a) shall remain available for expenditure through September 30, 2012.

(c) AUTHORITY FOR USE OF FUNDS.—The Secretary may use funds made available under paragraphs (2) and (3) of subsection (a) to award grants to, or enter into contracts with, public or private entities, including States, local governments, schools, churches, and community groups.

SEC. 403. TRANSITION RULES; MISCELLANEOUS PROVISIONS.

(a) IN GENERAL.—

(1) Not later than June 30, 2010, a State that is one of the 50 States or the District of Columbia shall inform all individuals enrolled in a State plan under title XIX or XXI of the Social Security Act on such date (and any new enrollees after such date) of the changes to the programs under such titles that take effect on January 1, 2011, as a result of the amendment made by section 401.

(2) No State that is one of the 50 States or the District of Columbia shall approve any applications for medical assistance or child health assistance under a State plan under title XIX or XXI (as in effect for fiscal year 2010) after December 31, 2010.

(b) SUBMISSION OF LEGISLATIVE PROPOSAL FOR TECHNICAL AND CONFORMING AMENDMENTS.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit

to Congress a legislative proposal for such technical and conforming amendments as are necessary to carry out the amendments made by this Act.

Subtitle B—Supplemental Health Care Assistance for Low-Income Families

SEC. 411. SUPPLEMENTAL HEALTH CARE ASSISTANCE FOR LOW-INCOME FAMILIES.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

“Subpart XI—Health Care Assistance to Low-Income Families

“SEC. 340A-1. FINANCIAL ASSISTANCE TO LOW-INCOME FAMILIES.

“(a) IN GENERAL.—The Secretary shall supplement the costs of private health insurance for eligible low-income families through the distribution of supplemental debit cards to eligible families, which may be used to pay for costs associated with health care for the members of such eligible families and provide direct support to such families in accessing health care.

“(b) ELIGIBILITY.—

“(1) ELIGIBLE FAMILIES.—To be eligible for financial assistance under this section—

“(A) a family shall—

“(i) consist of 2 or more individuals living together who are related by marriage, birth, adoption, or guardianship;

“(ii) have a gross income that does not exceed 200 percent of the poverty line, as applicable to a family of the size involved; and

“(iii) include at least 1 individual who is a dependent under the age of 19; and

“(B) no member of the family shall be covered by private health insurance.

“(2) DETERMINATION OF GROSS INCOME.—The gross income of a family shall be determined by taking the sum of the income of each family member who is at least age 21 but not older than age 65, except that the income of any member of the family who qualifies for coverage under Medicaid Part A or B shall not be counted.

“(3) LIMITATION ON INDIVIDUAL ELIGIBILITY; ASSISTANCE.—

“(A) IN GENERAL.—No individual who is a member of an eligible family under paragraph (1) is eligible to qualify separately for financial assistance under this section.

“(B) ALIENS.—The Secretary shall ensure that financial assistance under this section is not provided for costs associated with health care for any member of an eligible family who is an alien individual who is not a lawful permanent resident of the United States.

“(c) SUPPLEMENTAL DEBIT CARD FOR HEALTH CARE EXPENDITURES.—

“(1) IN GENERAL.—The Secretary shall issue to each eligible family that enrolls in the program in accordance with subsection (f) a supplemental debit card with a dollar-amount value, in accordance with subsection (d), that may be used to pay for qualifying health care expenses.

“(2) USE OF THE DEBIT CARD.—

“(A) QUALIFYING HEALTH CARE EXPENSES.—A supplemental debit card issued under this section may be used by members of the eligible family to pay for—

“(i) the purchase of health care insurance for any member of the family;

“(ii) cost sharing expenses related to health care, including deductibles, copayments, and coinsurance, for any member of the family; and

“(iii) the direct purchase of health care services and supplies for any member of the family.

“(B) GEOGRAPHIC RANGE.—Each supplemental debit card may be used to pay for

qualifying health care expenses incurred anywhere in the 50 States or the District of Columbia.

“(C) LIMITATIONS.—No supplemental debit card shall be used to make a payment for any cost—

“(i) incurred prior to the determination of the family’s eligibility for assistance under this section; or

“(ii) that is not a health-related expense.

“(3) ROLLOVER OF UNUSED AMOUNTS.—Not more than one-quarter of the annual dollar amount of a supplemental debit card that is unexpended at the end of each 12-month period may rollover—

“(A) to the family’s supplemental debit card for expenditure during the subsequent 12-month period, provided that the family to which the supplemental debit card was issued in the previous 12-month period is eligible to receive a supplemental debit card in the subsequent 12-month period; or

“(B) to the family’s health savings account (as defined in section 223(g)(2) of the Internal Revenue Code of 1986).

“(4) MONTHLY STATEMENTS.—The Secretary shall issue a monthly statement to each family to which a supplemental debit card has been issued under this section, which shall state each payment made with the family’s supplemental debit card during the month covered by the statement, the dollar amount of each such payment, and the provider to which each such payment was made.

“(d) AMOUNT OF FINANCIAL ASSISTANCE.—

“(1) AMOUNTS FOR CALENDAR YEAR 2011.—Subject to paragraph (5), the amount of financial assistance available to each eligible family during the calendar year 2011 shall be determined as follows:

“(A) Each family whose annual income does not exceed 100 percent of the poverty level, as applicable to a family of the size involved, shall receive \$5,000.

“(B) Each family whose annual income exceeds 100 percent, but does not exceed 200 percent, of the poverty level, as applicable to a family of the size involved, shall receive an amount as follows:

“(i) For families whose annual income exceeds 100 percent but does not exceed 120 percent, of the poverty level, \$4,000.

“(ii) For families whose annual income exceeds 120 percent but does not exceed 140 percent, of the poverty level, \$3,500.

“(iii) For families whose annual income exceeds 140 percent but does not exceed 160 percent, of the poverty level, \$3,000.

“(iv) For families whose annual income exceeds 160 percent but does not exceed 180 percent, of the poverty level, \$2,500.

“(v) For families whose annual income exceeds 180 percent but does not exceed 200 percent, of the poverty level, \$2,000.

“(2) ADDITIONAL AMOUNTS.—In addition to the amounts under paragraph (1), subject to paragraph (5), the following amounts shall be added to the supplemental debit cards of qualifying families:

“(A) For each pregnancy during which a pregnant woman’s family is eligible for assistance under this section, an additional amount of \$1,000 shall be added to the family’s supplemental debit card, except that no family shall receive such additional \$1,000 for any pregnancy for which the family received such amount in the previous 12-month period.

“(B) For each member of an eligible family who is less than 1 year old on any day within the calendar year in which the family is eligible for assistance, an additional amount of \$500 shall be added to the family’s supplemental debit card.

“(3) COST OF LIVING ADJUSTMENTS.—In the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in paragraphs (1) and (2) shall be increased in the same manner as the dollar amounts specified in section 25E(b)(3) of the Internal Revenue Code of 1986 are increased by the blended cost-of-living adjustment determined under subsection (k)(2) of section 25E of the Internal Revenue Code for the taxable year involved.

“(4) STATE OPTION TO INCREASE AMOUNTS.—At the option of each State, amounts in excess of the annual dollar amounts under paragraphs (1) and (2) may be provided through the supplemental debit card to eligible families in that State, but no Federal funds shall be paid to any State for any amount provided in excess of such annual dollar amount.

“(5) RISK ADJUSTMENT.—The Secretary may adjust the amount of financial assistance available to an eligible family for a calendar year under this section based on age, health indicators, and other factors that represent distinct patterns of health care services utilization and costs.

“(e) CONTRIBUTIONS OF STATES.—

“(1) IN GENERAL.—As a condition for receiving Federal funds under Part A or Part B of Medicaid, each State shall contribute 50 percent of the total amount expended under the supplemental debit card program by the participating families that reside within the State during the time that the family resides in that State. For purposes of this section, the residency of a family is determined by the residency the legally responsible head of the household.

“(2) PAYMENTS FROM STATES.—

“(A) BILLING NOTIFICATION.—

“(i) TIMING.—On June 30th and December 31st of each year, the Secretary shall send written notification to each State of that State’s 50 percent share of expenses, as described in paragraph (1), for the 6-month period ending on the last day of the month previous to such notification.

“(ii) CONTENTS.—Each such notification to a State shall clearly state—

“(I) the payment amount due from the State;

“(II) the name of each individual for whom payment was made through the supplemental debit card program;

“(III) the health care provider to whom each payment was made;

“(IV) the amount of each payment; and

“(V) any other information, as the Secretary requires.

“(B) PAYMENTS.—Each State shall make a payment to the Secretary, in the amount billed, not later than 30 days after the billing notification date, in accordance with subparagraph (A)(i).

“(C) PENALTIES.—If a State fails to pay to the Secretary an amount required under subparagraph (B), interest shall accrue on such amount at the rate provided under old section 1903(d)(5) of the Social Security Act. The amount so owed and applicable interest shall be immediately offset against amounts otherwise payable to the State under this section, in accordance with the Federal Claims Collection Act of 1996 and applicable regulations.

“(f) ENROLLMENT.—

“(1) IN GENERAL.—The Secretary shall establish procedures and times for enrollment in the supplemental debit card program. Open enrollment shall be available not less than 4 times per calendar year.

“(2) TRANSITION OF INDIVIDUALS ENROLLED IN MEDICAID OR THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM.—

“(A) INFORMATION FROM THE STATES.—Each State shall—

“(i) not later than June 30, 2010, inform all individuals then enrolled in Medicaid or the State Children’s Health Insurance Program (SCHIP), of the changes in effect beginning on January 1, 2011; and

“(ii) not later than October 31, 2010, redetermine the eligibility of each individual enrolled in Medicaid or SCHIP, other than those individuals who qualify for Medicaid or SCHIP as disabled, elderly, or a special population, for the supplemental debit card program, according to the eligibility criteria under subsection (b).

“(B) AUTOMATIC ENROLLMENT.—The Secretary shall provide for the automatic enrollment in the supplemental debit card program of all individuals who are enrolled in Medicaid or SCHIP and who have been redetermined by a State under subparagraph (A) to be eligible for Medicaid or SCHIP. Any individual who is determined by a State not to qualify for the supplemental debit card program may retain coverage under Medicaid or SCHIP until June 30, 2011.

“(3) ASSISTANCE WITH QUALIFIED HEALTH INSURANCE CREDIT.—Each State shall, to the extent practicable, provide individuals residing within the State with information regarding the qualified health insurance credit described in section 25E of the Internal Revenue Code of 1986, including information regarding eligibility for, and how to claim, such credit.

“(g) ADMINISTRATION.—

“(1) NATIONAL SYSTEM.—The Secretary may enter into contracts or agreements with a State, a consortium of States, or a private entity, including a bank, enrollment broker, or similar entity, to establish and maintain a unified national system to support the processes and transactions necessary to administer this section.

“(2) AUTOMATED SYSTEM.—The Secretary shall establish an automated means, such as an electronic benefit transfer system, by which the benefits under this section shall be transferred to eligible families.

“(3) VERIFICATION OF APPLICANT INFORMATION.—The Secretary may verify information provided by applicants with the appropriate Federal, State, and local agencies, including the Internal Revenue Service, the Social Security Administration, the Department of Labor, and child support enforcement agencies.

“(4) CHOICE COUNSELING.—The Secretary may enter into contracts or agreements with a State, a consortium of a State, or a private entity, including an enrollment broker or community organization or other organization, to educate eligible families about their options and to assist in their enrollment in the supplemental debit card plan.

“(5) APPEALS.—The Secretary shall establish an independent appeals process, to be administered by an entity separate from the entity that makes initial eligibility determinations, which shall be available to individuals who are denied benefits under the supplemental debit card program.

“(6) RESOLUTION OF ERRORS.—The Secretary shall provide for a reconciliation process with the States to resolve any errors and adjudicate disputes due to incomplete or false information in a family’s application or in the billing process described in subsection (e).

“(7) PENALTIES FOR FALSE INFORMATION.—Any person who provides false information to qualify for the supplemental debit card program shall pay a penalty in the amount of 110 percent of the amount of assistance

paid on behalf of such person and all members of such person's family.

“(h) IMPLEMENTATION PLAN.—Not later than 6 months after the date of enactment of this section, the Secretary shall submit to Congress a plan for implementing this program during fiscal years 2009–2012.

“(i) AUTHORIZATION OF APPROPRIATIONS.—

“(1) ADMINISTRATION OF THE SUPPLEMENTAL DEBIT CARD PROGRAM.—To administer the program under this section, there are authorized to be appropriated—

“(A) for fiscal year 2009, \$300,000,000, for the design of a unified, national system of conducting the supplemental debit card program;

“(B) for fiscal year 2010, \$1,000,000,000 for start-up costs, including, contracting, hiring and training employees, and testing the program; and

“(C) for fiscal year 2011 and each subsequent fiscal year, \$3,000,000,000.

“(2) AUTHORIZATION OF BENEFITS UNDER THE SUPPLEMENTAL DEBIT CARD PROGRAM.—To provide the supplemental debit card benefits described in this section, there are authorized to be appropriated—

“(A) for fiscal year 2011, \$24,020,000,000;

“(B) for fiscal year 2012, \$25,220,000,000;

“(C) for fiscal year 2013, \$26,480,000,000;

“(D) for fiscal year 2014, \$27,810,000,000; and

“(E) for fiscal year 2015, \$29,200,000,000.”.

TITLE V—FIXING MEDICARE FOR AMERICAN SENIORS

Subtitle A—Increasing Programmatic Efficiency, Economy, and Accountability

SEC. 501. ELIMINATING INEFFICIENCIES AND INCREASING CHOICE IN MEDICARE ADVANTAGE.

Part C of title XVIII of the Social Security Act is amended by adding at the end the following new section:

“PROTECTING MEDICARE BENEFITS FOR SENIORS

“SEC. 1860C–2. (a) COMPETITIVE BIDDING.—

“(1) IN GENERAL.—In order to promote competition among Medicare Advantage plans and to increase the quality of care furnished under such plans, the Secretary shall establish and implement a competitive bidding mechanism under this part.

“(2) MECHANISM TO BEGIN IN 2011.—The mechanism established under paragraph (1) shall apply to all MA organizations and plans beginning in 2011.

“(3) NO EFFECT ON PART D BENEFITS.—The mechanism established under paragraph (1) shall not affect the provisions of this part relating to benefits under part D, including the bidding mechanism used for benefits under such part.

“(b) RULES FOR COMPETITIVE BIDDING MECHANISM.—Notwithstanding any other provision of this part, the following rules shall apply under the competitive bidding mechanism established under subsection (a).

“(1) BENCHMARK.—Benchmark amounts for an area for a year shall be established solely through the competitive bids of MA plans. The benchmark amount for each area for a year shall be the average bid of the plans in that area for that year. In establishing the benchmark for an area for a year under the preceding sentence, the Secretary shall exclude the highest and lowest bid for that area and year. The benchmark amount for an area for a year may not exceed the benchmark amount for that area and year that would have applied if this section had not been enacted.

“(2) BIDS.—The MA plan bid shall reflect the per capita payments that the MA plan will accept for providing a benefit package that is actuarially equivalent to 106 percent

of the value of the original Medicare fee-for-service program option. MA plan bid submissions shall include data on plan average provider network contract rates compared to the rates under the original Medicare fee-for-service program option for the top 5 most common claim submissions per provider type.

“(3) RISK ADJUSTMENT.—The benchmark under paragraph (1) and the MA plan bid shall be risk adjusted using the risk adjustment requirements under this part.

“(4) BENEFICIARY PREMIUMS.—The MA monthly basic beneficiary premium for a beneficiary who enrolls in an MA plan whose plan bid is at or below the benchmark shall be zero and the beneficiary shall receive the full difference (if any) between the bid and the benchmark in the form of additional benefits or as a rebate on their premiums under this title. The MA monthly basic beneficiary premium for a beneficiary who enrolls in an MA plan whose plan bid is above the benchmark shall be equal to the amount by which the bid exceeds the benchmark.

“(5) BENCHMARK AMOUNTS FOR RURAL COUNTIES.—The Secretary may adjust the benchmark amount established under paragraph (1) for any rural county (as identified by the Secretary after consultation with the Secretary of Commerce) to encourage plan participation in such county.

“(6) EXISTING REQUIREMENTS.—Requirements relating to licensure, quality, and beneficiary protections that would otherwise apply under this part shall apply under the competitive bidding mechanism established under subsection (a).

“(c) WAIVER.—In order to implement the competitive bidding mechanism under established subsection (a), the Secretary may waive or modify requirements under this part.”.

SEC. 502. MEDICARE ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—In order to promote innovative care coordination and delivery that is cost-effective, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct a demonstration program under the Medicare program under which—

(A) groups of providers meeting certain criteria may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an Accountable Care Organization (in this section referred to as an “ACO”); and

(B) providers in participating ACOs are eligible for bonuses based on performance.

(2) MEDICARE FEE-FOR-SERVICE BENEFICIARY DEFINED.—In this section, the term “Medicare fee-for-service beneficiary” means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act and not enrolled in an MA plan under part C of such title.

(b) ELIGIBLE ACOS.—

(1) IN GENERAL.—Subject to paragraph (2), the following provider groups are eligible to participate as ACOs under the demonstration program under this section:

(A) Physicians in group practice arrangements.

(B) Networks of individual physician practices.

(C) Partnerships or joint venture arrangements between hospitals and physicians.

(D) Partnerships or joint ventures, which may include pharmacists providing medication therapy management.

(E) Hospitals employing physicians.

(F) Integrated delivery systems.

(G) Community-based coalitions of providers.

(2) REQUIREMENTS.—An ACO shall meet the following requirements:

(A) The ACO shall have a formal legal structure that would allow the organization to receive and distribute bonuses to participating providers.

(B) The ACO shall include the primary care providers of at least 5,000 Medicare fee-for-service beneficiaries.

(C) The ACO shall be willing to become accountable for the overall care of the Medicare fee-for-service beneficiaries.

(D) The ACO shall provide the Secretary with a list of primary care and specialist physicians participating in the ACO to support the beneficiary assignment, implementation of performance measures, and the determination of bonus payments under the demonstration program.

(E) The ACO shall have in place contracts with a core group of key specialist physicians, a leadership and management structure, and processes to promote evidence-based medicine and to coordinate care.

(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES.—

(1) IN GENERAL.—Under the demonstration program under this section, each Medicare fee-for-service Medicare beneficiary shall be automatically assigned to a primary care provider. Such assignment shall be based on the physician from whom the beneficiary received the most primary care in the preceding year.

(2) BENEFICIARIES MAY CONTINUE TO SEE PROVIDERS OUTSIDE OF THE ACO.—Under the demonstration program under this section, a Medicare fee-for-service Medicare beneficiary may continue to see providers in and outside of the ACO to which they have been assigned.

(d) BONUS PAYMENTS.—

(1) IN GENERAL.—Under the demonstration program, Medicare payments shall continue to be made to providers under the original Medicare fee-for-service program in the same manner as they would otherwise be made except that a participating ACO is eligible for bonuses if—

(A) it meets certain quality performance measures; and

(B) spending for their Medicare fee-for-service beneficiaries meets the requirement under paragraph (3).

(2) QUALITY.—Under the demonstration program under this section, providers meet the requirement under paragraph (1)(A) if they generally follow consensus-based guidelines established by non-government professional medical societies. Patient satisfaction and risk-adjusted outcomes shall be determined through an independent entity with medical expertise.

(3) REQUIREMENT RELATING TO SPENDING.—

(A) IN GENERAL.—An ACO shall only be eligible to receive a bonus payment if the average Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries over a two-year period is at least 2 percent below the average benchmark for the corresponding two-year period. The benchmark for each ACO shall be set using the most recent three years of total per-beneficiary spending for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be updated by the projected rate of growth in national per capita spending for the original Medicare fee-for-service program, as projected (using the most recent three years of data) by the Chief Actuary of

the Centers for Medicare & Medicaid Services.

(4) **AMOUNT OF BONUS PAYMENTS.**—The amount of the bonus payment to a participating ACO shall be one-half of the percentage point difference between the two-year average of their patients' Medicare expenditures and 98 percent of the two-year average benchmark. The bonus amount, in dollars, shall be equal to the bonus share multiplied by the benchmark for the most recent year.

(5) **LIMITATION.**—Bonus payments may only be made to an ACO if the primary care provider to which the Medicare fee-for-service beneficiary has been assigned under subsection (c) elects to participate in such ACO.

(e) **WAIVER AUTHORITY.**—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be appropriate for the purpose of carrying out the demonstration program under this section.

(f) **REPORT.**—Upon completion of the demonstration program under this section, the Secretary shall submit to Congress a report on the program together with such recommendations as the Secretary determines appropriate.

SEC. 503. REDUCING GOVERNMENT HANDOUTS TO WEALTHIER SENIORS.

(a) **ELIMINATION OF ANNUAL INDEXING OF INCOME THRESHOLDS FOR REDUCED PART B PREMIUM SUBSIDIES.**—

(1) **IN GENERAL.**—Paragraph (5) of section 1839(i) of the Social Security Act (42 U.S.C. 1395i(i)) is repealed.

(2) **EFFECTIVE DATE.**—The repeal made by paragraph (1) shall apply to premiums for months beginning after December 2010.

(b) **INCOME-RELATED REDUCTION IN PART D PREMIUM SUBSIDY.**—

(1) **INCOME-RELATED REDUCTION IN PART D PREMIUM SUBSIDY.**—

(A) **IN GENERAL.**—Section 1860D-13(a) of the Social Security Act (42 U.S.C. 1395w-113(a)) is amended by adding at the end the following new paragraph:

“(7) **REDUCTION IN PREMIUM SUBSIDY BASED ON INCOME.**—

“(A) **IN GENERAL.**—In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section) for the calendar year, the monthly amount of the premium subsidy applicable to the premium under this section for a month after December 2010 shall be reduced (and the monthly beneficiary premium shall be increased) by the monthly adjustment amount specified in subparagraph (B).

“(B) **MONTHLY ADJUSTMENT AMOUNT.**—The monthly adjustment amount specified in this subparagraph for an individual for a month in a year is equal to the product of—

“(i) the quotient obtained by dividing—

“(I) the applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section) for the individual for the calendar year reduced by 25.5 percent; by

“(II) 25.5 percent; and

“(ii) the base beneficiary premium (as computed under paragraph (2)).

“(C) **MODIFIED ADJUSTED GROSS INCOME.**—For purposes of this paragraph, the term ‘modified adjusted gross income’ has the meaning given such term in subparagraph (A) of section 1839(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

“(D) **DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.**—The Commissioner of Social Security shall make any determination

necessary to carry out the income-related reduction in premium subsidy under this paragraph.

“(E) **PROCEDURES TO ASSURE CORRECT INCOME-RELATED REDUCTION IN PREMIUM SUBSIDY.**—

“(i) **DISCLOSURE OF BASE BENEFICIARY PREMIUM.**—Not later than September 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as computed under paragraph (2)) for the purpose of carrying out the income-related reduction in premium subsidy under this paragraph with respect to the following year.

“(ii) **ADDITIONAL DISCLOSURE.**—Not later than October 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related reduction in premium subsidy under this paragraph with respect to the following year:

“(I) The modified adjusted gross income threshold applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section).

“(II) The applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section).

“(III) The monthly adjustment amount specified in subparagraph (B).

“(IV) Any other information the Commissioner of Social Security determines necessary to carry out the income-related reduction in premium subsidy under this paragraph.

“(F) **RULE OF CONSTRUCTION.**—The formula used to determine the monthly adjustment amount specified under subparagraph (B) shall only be used for the purpose of determining such monthly adjustment amount under such subparagraph.”.

(B) **COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.**—Section 1860D-13(c) of the Social Security Act (42 U.S.C. 1395w-113(c)) is amended—

(i) in paragraph (1), by striking “(2) and (3)” and inserting “(2), (3), and (4)”;

(ii) by adding at the end the following new paragraph:

“(4) **COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.**—

“(A) **IN GENERAL.**—Notwithstanding any provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related reduction in premium subsidy for an individual for a month (as determined under subsection (a)(7)) shall be paid through withholding from benefit payments in the manner provided under section 1840.

“(B) **AGREEMENTS.**—In the case where the monthly benefit payments of an individual that are withheld under subparagraph (A) are insufficient to pay the amount described in such subparagraph, the Commissioner of Social Security shall enter into agreements with the Secretary, the Director of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in subparagraph (A) that was not withheld under such subparagraph.”.

(2) **CONFORMING AMENDMENTS.**—

(A) **MEDICARE.**—Part D of title XVIII of the Social Security Act (42 U.S.C. 1395w-101 et seq.) is amended—

(i) in section 1860D-13(a)(1)—

(I) by redesignating subparagraph (F) as subparagraph (G);

(II) in subparagraph (G), as redesignated by subparagraph (A), by striking “(D) and (E)” and inserting “(D), (E), and (F)”;

(III) by inserting after subparagraph (E) the following new subparagraph:

“(F) **INCREASE BASED ON INCOME.**—The monthly beneficiary premium shall be increased pursuant to paragraph (7).”; and

(ii) in section 1860D-15(a)(1)(B), by striking “paragraph (1)(B)” and inserting “paragraphs (1)(B) and (1)(F)”.

(B) **INTERNAL REVENUE CODE.**—Section 6103(l)(20) of the Internal Revenue Code of 1986 (relating to disclosure of return information to carry out Medicare part B premium subsidy adjustment) is amended—

(i) in the heading, by striking “PART B PREMIUM SUBSIDY ADJUSTMENT” and inserting “PARTS B AND D PREMIUM SUBSIDY ADJUSTMENTS”;

(ii) in subparagraph (A)—

(I) in the matter preceding clause (i), by inserting “or 1860D-13(a)(7)” after “1839(i)”;

(II) in clause (vii), by inserting after “subsection (i) of such section” the following: “or under section 1860D-13(a)(7) of such Act”;

(iii) in subparagraph (B)—

(I) by inserting “or such section 1860D-13(a)(7)” before the period at the end;

(II) as amended by clause (i), by inserting “or for the purpose of resolving tax payer appeals with respect to any such premium adjustment” before the period at the end; and

(III) by adding at the end the following new sentence: “Officers, employees, and contractors of the Social Security Administration may disclose such return information to officers, employees, and contractors of the Department of Health and Human Services, the Office of Personnel Management, the Railroad Retirement Board, the Department of Justice, and the courts of the United States to the extent necessary to carry out the purposes described in the preceding sentence.”;

(iv) by adding at the end the following new subparagraph:

“(C) **TIMING OF DISCLOSURE.**—Return information shall be disclosed to officers, employees, and contractors of the Social Security Administration under subparagraph (A) not later than the date that is 90 days prior to the date on which the taxpayer first becomes entitled to benefits under part A of title XVIII of the Social Security Act or eligible to enroll for benefits under part B of such title.”.

SEC. 504. REWARDING PREVENTION.

Section 1839 of the Social Security Act (42 U.S.C. 1395r) is amended—

(1) in subsection (a)(2), by striking “and (i)” and inserting “(i), and (j)”;

(2) by adding at the end the following new subsection:

“(j)(1) With respect to the monthly premium amount for months after December 2010, the Secretary may adjust (under procedures established by the Secretary) the amount of such premium for an individual based on whether or not the individual participates in certain healthy behaviors, such as weight management, exercise, nutrition counseling, refraining from tobacco use, designating a health home, and other behaviors determined appropriate by the Secretary.

“(2) In making the adjustments under paragraph (1) for a month, the Secretary shall ensure that the total amount of premiums to be paid under this part for the month is equal to the total amount of premiums that would have been paid under this part for the month if no such adjustments had been made, as estimated by the Secretary.”.

SEC. 505. PROMOTING HEALTHCARE PROVIDER TRANSPARENCY.

(a) **TRANSPARENCY.**—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

“PRICE TRANSPARENCY REQUIREMENTS

“SEC. 1899. (a) **PRE-TREATMENT DISCLOSURE.**—A provider of services (as defined in section 1861(u)) and a supplier (as defined in section 1861(d)) shall provide to each individual (regardless of whether or not the individual is a beneficiary under this title) who is scheduled to receive a treatment (or to begin a course of treatment) that is not for an emergency medical condition the estimated price that the provider of services or supplier will charge for the treatment (or course of treatment). Such price shall be determined at the time of scheduling.

“(b) **POST-TREATMENT DISCLOSURE.**—A provider of services (as so defined) and a supplier (as so defined) shall include with any bill that includes the charges for a treatment with respect to an individual (regardless of whether or not the individual is a beneficiary under this title), an itemized list of component charges for such treatment, including charges for drugs and medical equipment involved, as determined at the time of billing. With respect to each item included on such list, the provider of services or supplier shall include the price charged for the item.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to providers of services and suppliers on and after January 1, 2011.

SEC. 506. AVAILABILITY OF MEDICARE AND MEDICAID CLAIMS AND PATIENT ENCOUNTER DATA.

(a) **PUBLIC AVAILABILITY.**—Not later than 1 year after the date of enactment of this Act (and annually thereafter), the Secretary of Health and Human Services (in this section referred to as the “Secretary”), shall make available to the public (including through an Internet website) data on claims and patient encounters under titles XVIII and XIX of the Social Security Act during the preceding calendar year. Such data shall be appropriately disaggregated and patient deidentified, as determined necessary by the Secretary in order to comply with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

(b) **PROVISION OF DATA TO STATE EXCHANGES AND HEALTH INSURANCE ISSUERS UNDER THE STATE EXCHANGE.**—The Secretary shall submit such data directly to a State Exchange under title II and health insurance issuers under such Exchange (in a form and manner determined appropriate by the Secretary).

(c) **MATCHING OF DATA.**—The Secretary shall ensure that the total amount of claims under such titles during the preceding year for which data is made available under subsection (a) is equal to the reported outlays from the Federal government and the States under such titles during the preceding years.

Subtitle B—Reducing Fraud and Abuse**SEC. 511. REQUIRING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO CHANGE THE MEDICARE BENEFICIARY IDENTIFIER USED TO IDENTIFY MEDICARE BENEFICIARIES UNDER THE MEDICARE PROGRAM.**

(a) **PROCEDURES.**—

(1) **IN GENERAL.**—Not later than 1 year after the date of enactment of this Act, in order to protect beneficiaries from identity theft, the

Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish and implement procedures to change the Medicare beneficiary identifier used to identify individuals entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title so that such an individual's social security account number is not used. Such procedures shall provide that the new Medicare beneficiary identifier includes biometric identification protections.

(2) **MAINTAINING EXISTING HICN STRUCTURE.**—In order to minimize the impact of the change under paragraph (1) on systems that communicate with Medicare beneficiary eligibility systems, the procedures under paragraph (1) shall provide that the new Medicare beneficiary identifier maintain the existing Health Insurance Claim Number structure.

(3) **PROTECTION AGAINST FRAUD.**—The procedures under paragraph (1) shall provide for a process for changing the Medicare beneficiary identifier for an individual to a different identifier in the case of the discovery of fraud, including identity theft.

(4) **PHASE-IN AUTHORITY.**—

(A) **IN GENERAL.**—Subject to subparagraphs (B) and (C), the Secretary may phase in the change under paragraph (1) in such manner as the Secretary determines appropriate.

(B) **LIMIT.**—The phase-in period under subparagraph (A) shall not exceed 10 years.

(C) **NEWLY ENTITLED AND ENROLLED INDIVIDUALS.**—The Secretary shall ensure that the change under paragraph (1) is implemented not later than January 1, 2010, with respect to any individual who first becomes entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title on or after such date.

(b) **EDUCATION AND OUTREACH.**—The Secretary shall establish a program of education and outreach for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title, providers of services (as defined in subsection (u) of section 1861 of such Act (42 U.S.C. 1395x)), and suppliers (as defined in subsection (d) of such section) on the change under paragraph (1).

(c) **DATA MATCHING.**—

(1) **ACCESS TO CERTAIN INFORMATION.**—Section 205(r) of the Social Security Act (42 U.S.C. 405(r)) is amended by adding at the end the following new paragraph:

“(9)(A) The Commissioner of Social Security shall, upon the request of the Secretary—

“(i) enter into an agreement with the Secretary for the purpose of matching data in the system of records of the Commissioner with data in the system of records of the Secretary, so long as the requirements of subparagraphs (A) and (B) of paragraph (3) are met, in order to determine—

“(I) whether a beneficiary under the program under title XVIII, XIX, or XXI is dead, imprisoned, or otherwise not eligible for benefits under such program; and

“(II) whether a provider of services or a supplier under the program under title XVIII, XIX, or XXI is dead, imprisoned, or otherwise not eligible to furnish or receive payment for furnishing items and services under such program; and

“(ii) include in such agreement safeguards to assure the maintenance of the confidentiality of any information disclosed and procedures to permit the Secretary to use such information for the purpose described in clause (i).

“(B) Information provided pursuant to an agreement under this paragraph shall be pro-

vided at such time, in such place, and in such manner as the Commissioner determines appropriate.

“(C) Information provided pursuant to an agreement under this paragraph shall include information regarding whether—

“(i) the name (including the first name and any family name or surname), the date of birth (including the month, day, and year), and social security number of an individual provided to the Commissioner match the information contained in the Commissioner's records, and

“(ii) such individual is shown on the records of the Commissioner as being deceased.”

(2) **INVESTIGATION BASED ON CERTAIN INFORMATION.**—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

“SEC. 1128G. ACCESS TO CERTAIN DATA AND INVESTIGATION OF CLAIMS INVOLVING INDIVIDUALS WHO ARE NOT ELIGIBLE FOR BENEFITS OR ARE NOT ELIGIBLE PROVIDERS OF SERVICES OR SUPPLIERS.

“(a) **DATA AGREEMENT.**—The Secretary shall enter into an agreement with the Commissioner of Social Security pursuant to section 205(r)(9).

“(b) **INVESTIGATION OF CLAIMS INVOLVING CERTAIN INDIVIDUALS WHO ARE NOT ELIGIBLE FOR BENEFITS OR ARE NOT ELIGIBLE PROVIDERS OF SERVICES OR SUPPLIERS.**—

“(1) **IN GENERAL.**—The Secretary shall, in the case where a provider of services or a supplier under the program under title XVIII, XIX, or XXI submits a claim for payment for items or services furnished to an individual who the Secretary determines, as a result of information provided pursuant to such agreement, is not eligible for benefits under such program, or where the Secretary determines, as a result of such information, that such provider of services or supplier is not eligible to furnish or receive payment for furnishing such items or services, conduct an investigation with respect to the provider of services or supplier. If the Secretary determines further action is appropriate, the Secretary shall refer the investigation to the Inspector General of the Department of Health and Human Services as soon as practicable.

“(2) **ASSESSMENT OF IMPLEMENTATION AND EFFECTIVENESS BY THE OIG.**—The Inspector General of the Department of Health and Human Services shall test the implementation of the provisions of this section (including the implementation of the agreement under section 205(r)(9)) and conduct such period assessments of such implementation as the Inspector General determines necessary to determine the effectiveness of such implementation.”

(d) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 512. USE OF TECHNOLOGY FOR REAL-TIME DATA REVIEW.

Title XVIII of the Social Security Act, as amended by this Act, is amended by adding at the end the following new section:

“USE OF TECHNOLOGY FOR REAL-TIME DATA REVIEW

“SEC. 1899A. (a) **IN GENERAL.**—The Secretary shall establish procedures for the use of technology (including front-end, pre-payment technology similar to that used by hedge funds, investment funds, and banks) to provide real-time data analysis of claims for payment under this title to identify and investigate unusual billing or order practices

under this title that could indicate fraud or abuse.

“(b) **COMPETITIVE BIDDING.**—The procedures established under subsection (a) shall ensure that the implementation of such technology is conducted through a competitive bidding process.”.

SEC. 513. DETECTION OF MEDICARE FRAUD AND ABUSE.

(a) **IN GENERAL.**—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

“(7) Implementation of fraud and abuse detection methods under subsection (i).”;

(2) in subsection (c), by adding at the end of the flush matter following paragraph (4), the following new sentence “In the case of an activity described in subsection (b)(8), an entity shall only be eligible to enter into a contract under the Program to carry out the activity if the entity is selected through a competitive bidding process in accordance with subsection (i)(3).”; and

(3) by adding at the end the following new subsection:

“(i) **DETECTION OF MEDICARE FRAUD AND ABUSE.**—

“(1) **ESTABLISHMENT OF SYSTEM TO IDENTIFY COUNTIES MOST VULNERABLE TO FRAUD.**—Not later than 6 months after the date of enactment of this subsection, the Secretary shall establish a system to identify the 50 counties most vulnerable to fraud with respect to items and services furnished by providers of services (other than hospitals and critical access hospitals) and suppliers based on the degree of county-specific reimbursement and analysis of payment trends under this title. The Secretary shall designate the counties identified under the preceding sentence as ‘high risk areas’.

“(2) **FRAUD AND ABUSE DETECTION.**—

“(A) **INITIAL IMPLEMENTATION.**—The Secretary shall establish procedures for the implementation of fraud and abuse detection methods under this title with respect to items and services furnished by such providers of services and suppliers in high risk areas designated under paragraph (1) (and, beginning not later than 18 months after the date of enactment of this subsection, with respect to items and services furnished by such providers of services and suppliers in areas not so designated) including the following:

“(i) Data analysis to establish prepayment claim edits designed to target the claims for payment under this title for such items and services that are most likely to be fraudulent.

“(ii) Prepayment benefit integrity reviews for claims for payment under this title for such items and services that are suspended as a result of such edits.

“(B) **REQUIREMENT FOR PARTICIPATION.**—In no case may a provider of services or supplier who does not meet the requirements under subparagraph (A) participate in the program under this title.

“(C) **EXPANDED IMPLEMENTATION.**—Not later than 24 months after the date of enactment of this subsection, the Secretary shall establish procedures for the implementation of such fraud and abuse detection methods under this title with respect to items and services furnished by all providers of services and suppliers, including those not in high risk areas designated under paragraph (1).

“(3) **COMPETITIVE BIDDING.**—In selecting entities to carry out this subsection, the Secretary shall use a competitive bidding process.

“(4) **REPORT TO CONGRESS.**—The Secretary shall submit to Congress an annual report on

the effectiveness of activities conducted under this subsection, including a description of any savings to the program under this title as a result of such activities and the overall administrative cost of such activities and a determination as to the amount of funding needed to carry out this subsection for subsequent fiscal years, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.”.

(b) **AUTHORIZATION OF APPROPRIATIONS.**—To carry out the amendments made by this section, there are authorized to be appropriated—

(1) such sums as may be necessary, not to exceed \$50,000,000, for each of fiscal years 2010 through 2014; and

(2) such sums as may be necessary, not to exceed an amount the Secretary determines appropriate in the most recent report submitted to Congress under section 1893(j)(4) of the Social Security Act, as added by subsection (a), for each subsequent fiscal year.

SEC. 514. EDITS ON 855S MEDICARE ENROLLMENT APPLICATION AND EXEMPTION OF PHARMACISTS FROM SURETY BOND REQUIREMENT.

(a) **EDITS ON 855S MEDICARE ENROLLMENT APPLICATION.**—Section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) is amended by adding at the end the following new paragraphs:

“(22) **CONFIRMATION WITH NATIONAL SUPPLIER CLEARINGHOUSE PRIOR TO PAYMENT.**—

“(A) **IN GENERAL.**—Not later than 1 year after the date of enactment of this paragraph, the Secretary shall establish procedures to require carriers, prior to paying a claim for payment for durable medical equipment, prosthetics, orthotics, and supplies under this title, to confirm with the National Supplier Clearinghouse—

“(i) that the National Provider Identifier of the physician or practitioner prescribing or ordering the item or service is valid and active;

“(ii) that the Medicare identification number of the supplier is valid and active; and

“(iii) that the item or service for which the claim for payment is submitted was properly identified on the CMS-855S Medicare enrollment application.

“(B) **ONLINE DATABASE FOR IMPLEMENTATION.**—Not later than 18 months after the date of enactment of this paragraph, the Secretary shall establish an online database similar to that used for the National Provider Identifier to enable providers of services, accreditors, carriers, and the National Supplier Clearinghouse to view information on specialties and the types of items and services each supplier has indicated on the CMS-855S Medicare enrollment application submitted by the supplier.

“(C) **NOTIFICATION OF CLAIM DENIAL AND RESUBMISSION.**—In the case where a claim for payment for durable medical equipment, prosthetics, orthotics, and supplies under this title is denied because the item or service furnished does not correctly match up with the information on file with the National Supplier Clearinghouse—

“(i) the National Supplier Clearinghouse shall—

“(I) provide the supplier written notification of the reason for such denial; and

“(II) allow the supplier 60 days to provide the National Supplier Clearinghouse with appropriate certification, licensing, or accreditation; and

“(ii) the Secretary shall waive applicable requirements relating to the time frame for the submission of claims for payment under this title in order to permit the resubmission

of such claim if payment of such claim would otherwise be allowed under this title.

“(D) **IMPROVEMENTS TO MEDICARE ENROLLMENT APPLICATION.**—The Secretary shall establish procedures under which a prospective supplier of durable medical equipment, prosthetics, orthotics, and supplies under this title shall certify, as part of the CMS-855S Medicare enrollment application submitted by such supplier, under penalty of perjury, that the information provided by the supplier on such application is accurate to the best of the supplier's knowledge.

“(23) **TERMINATION OF PARTICIPATION FOR SUBMISSION OF FRAUDULENT CLAIMS.**—If the Secretary finds that a supplier of durable medical equipment, prosthetics, orthotics, and supplies under this title has submitted fraudulent claims for payment under this title, the Secretary shall terminate the suppliers participation under this title. Not later than 1 year after the date of enactment of this paragraph, the Secretary shall establish a process under which a supplier whose participation has been terminated under the preceding sentence may appeal such termination and such appeal shall be resolved not later than 60 days after the date on which the appeal was made.”.

(b) **EXEMPTION OF PHARMACISTS FROM SURETY BOND REQUIREMENT.**—Section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)) is amended, in the second sentence, by inserting “and shall waive such requirement in the case of a pharmacist” before the period at the end.

SEC. 515. GAO STUDY AND REPORT ON EFFECTIVENESS OF SURETY BOND REQUIREMENTS FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT IN COMBATING FRAUD.

(a) **STUDY.**—The Comptroller General of the United States shall conduct a study on the effectiveness of the surety bond requirement under section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)) in combating fraud.

(b) **REPORT.**—Not later than 1 year after the date of enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

TITLE VI—ENDING LAWSUIT ABUSE

SEC. 601. STATE GRANTS TO CREATE HEALTH COURT SOLUTIONS.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

“SEC. 399R. STATE GRANTS TO CREATE HEALTH COURT SOLUTIONS.

“(a) **IN GENERAL.**—The Secretary may award grants to States for the development, implementation, and evaluation of alternatives to current tort litigation that comply with this section, for the resolution of disputes concerning injuries allegedly caused by health care providers or health care organizations.

“(b) **CONDITIONS FOR DEMONSTRATION GRANTS.**—

“(1) **APPLICATION.**—To be eligible to receive a grant under this section, a State shall submit to the Secretary an application at such time, in such manner, and containing such information as may be required by the Secretary. A grant shall be awarded under this section on such terms and conditions as the Secretary determines appropriate.

“(2) **STATE REQUIREMENTS.**—To be eligible to receive a grant under this section, a State shall—

“(A) develop and implement an alternative to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations based on one or more of the models described in subsection (d); and

“(B) implement policies that provide for a reduction in health care errors through the collection and analysis by organizations that engage in voluntary efforts to improve patient safety and the quality of health care delivery, of patient safety data related to disputes resolved under the alternatives under subparagraph (A).

“(3) DEMONSTRATION OF EFFECTIVENESS.—To be eligible to receive a grant under subsection (a), a State shall demonstrate how the proposed alternative to be implemented under paragraph (2)(A) will—

“(A) make the medical liability system of the State more reliable through the prompt and fair resolution of disputes;

“(B) encourage the early disclosure of health care errors;

“(C) enhance patient safety; and

“(D) maintain access to medical liability insurance.

“(4) SOURCES OF COMPENSATION.—To be eligible to receive a grant under subsection (a), a State shall identify the sources from, and methods by which, compensation would be paid for medical liability claims resolved under the proposed alternative to current tort litigation implemented under paragraph (2)(A). Funding methods shall, to the extent practicable, provide financial incentives for activities that improve patient safety.

“(5) SCOPE.—

“(A) IN GENERAL.—To be eligible to receive a grant under subsection (a), a State shall utilize the proposed alternative identified under paragraph (2)(A) for the resolution of all types of disputes concerning injuries allegedly caused by health care providers or health care organizations.

“(B) CURRENT STATE EFFORTS TO ESTABLISH ALTERNATIVE TO TORT LITIGATION.—

“(i) IN GENERAL.—Nothing in this section shall be construed to limit the efforts that any State has made prior to the date of enactment of this section to establish any alternative to tort litigation.

“(ii) ALTERNATIVE FOR PRACTICE AREAS OR INJURIES.—In the case of a State that has established an alternative to tort litigation for a certain area of health care practice or a category of injuries, the alternative selected as provided for in this section shall supplement not replace or invalidate such established alternative unless the State intends otherwise.

“(6) NOTIFICATION OF PATIENTS.—To be eligible to receive a grant under subsection (a), the State shall demonstrate how patients will be notified when they are receiving health care services that fall within the scope of the alternative selected under this section by the State to current tort litigation.

“(c) REPRESENTATION BY COUNSEL.—A State that receives a grant under this section may not preclude any party to a dispute that falls within the jurisdiction of the alternative to current tort litigation that is implemented under the grant from obtaining legal representation at any point during the consideration of the claim under such alternative.

“(d) MODELS.—

“(1) IN GENERAL.—The models in this section are the following:

“(2) EXPERT PANEL REVIEW AND EARLY OFFER GUIDELINES.—

“(A) IN GENERAL.—A State may use amounts received under a grant under this

section to develop and implement an expert panel and early offer review system that meets the requirements of this paragraph.

“(B) ESTABLISHMENT OF PANEL.—Under the system under this paragraph, the State shall establish an expert panel to review any disputes concerning injuries allegedly caused by health care providers or health care organizations according to the guidelines described in this paragraph.

“(C) COMPOSITION.—

“(i) IN GENERAL.—An expert panel under this paragraph shall be composed of 3 medical experts (either physicians or health care professionals) and 3 attorneys to be appointed by the head of the State agency responsible for health.

“(ii) LICENSURE AND EXPERTISE.—Each physician or health care professional appointed to an expert panel under clause (i) shall—

“(I) be appropriately credentialed or licensed in the State in which the dispute takes place to deliver health care services; and

“(II) typically treat the condition, make the diagnosis, or provide the type of treatment that is under review.

“(iii) INDEPENDENCE.—

“(I) IN GENERAL.—Subject to subclause (II), each individual appointed to an expert panel under this paragraph shall—

“(aa) not have a material familial, financial, or professional relationship with a party involved in the dispute reviewed by the panel; and

“(bb) not otherwise have a conflict of interest with such a party.

“(II) EXCEPTION.—Nothing in subclause (I) shall be construed to prohibit an individual who has staff privileges at an institution where the treatment involved in the dispute was provided from serving as a member of an expert panel merely on the basis of such affiliation, if the affiliation is disclosed to the parties and neither party objects.

“(iv) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

“(I) IN GENERAL.—In a dispute before an expert panel that involves treatment, or the provision of items or services—

“(aa) by a physician, the medical experts on the expert panel shall be practicing physicians (allopathic or osteopathic) of the same or similar specialty as a physician who typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

“(bb) by a health care professional other than a physician, at least two medical experts on the expert panel shall be practicing physicians (allopathic or osteopathic) of the same or similar specialty as the health care professional who typically treats the condition, makes the diagnosis, or provides the type of treatment under review, and, if determined appropriate by the State agency, the third medical expert shall be a practicing health care professional (other than such a physician) of such a same or similar specialty.

“(II) PRACTICING DEFINED.—In this paragraph, the term ‘practicing’ means, with respect to an individual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days a week.

“(v) PEDIATRIC EXPERTISE.—In the case of dispute relating to a child, at least 1 medical expert on the expert panel shall have expertise described in clause (iv)(I) in pediatrics.

“(D) DETERMINATION.—After a review, an expert panel shall make a determination as to the liability of the parties involved and

compensation based on a schedule of compensation that is developed by the panel. Such a schedule shall at least include—

“(i) payment for the net economic loss incurred by the patient, on a periodic basis, reduced by any payments received by the patient under—

“(I) any health or accident insurance;

“(II) any wage or salary continuation plan; or

“(III) any disability income insurance;

“(ii) payment for the non-economic damages incurred by the patient, if appropriate for the injury, based on a defined payment schedule developed by the State, in consultation with relevant experts and with the Secretary;

“(iii) reasonable attorney’s fees; and

“(iv) regular updates of the schedule under clause (ii) as necessary.

“(E) ACCEPTANCE.—If the parties to a dispute who come before an expert panel under this paragraph accept the determination of the expert panel concerning liability and compensation, such compensation shall be paid to the claimant and the claimant shall agree to forgo any further action against the health care providers or health care organizations involved.

“(F) FAILURE TO ACCEPT.—If any party decides not to accept the expert panel’s determination under this paragraph, the State may choose whether to allow the panel to review the determination de novo, with deference, or to provide an opportunity for parties to reject the determination of the panel.

“(G) REVIEW BY STATE COURT AFTER EXHAUSTION OF ADMINISTRATIVE REMEDIES.—

“(i) RIGHT TO FILE.—If the State elects not to permit the expert panel under this paragraph to conduct its own reviews of determinations, or if the State elects to permit such reviews but a party is not satisfied with the final decision of the panel after such a review, the party shall have the right to file a claim relating to the injury involved in a State court of competent jurisdiction.

“(ii) FORFEIT OF AWARDS.—Any party filing an action in a State court under clause (i) shall forfeit any compensation award made under subparagraph (C).

“(iii) ADMISSIBILITY.—The determinations of the expert panel pursuant to a review under subparagraph (C) shall be admissible into evidence in any State court proceeding under this subparagraph.

“(3) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

“(A) IN GENERAL.—A State may use amounts received under a grant under this section to develop and implement an administrative health care tribunal system under which the parties involved shall have the right to request a hearing to review any dispute concerning injuries allegedly caused by health care providers or health care organizations before an administrative health care tribunal established by the State involved.

“(B) REQUIREMENTS.—In establishing an administrative health care tribunal under this paragraph, a State shall—

“(i) ensure that such tribunals are presided over by special judges with health care expertise who meet applicable State standards for judges and who agree to preside over such court voluntarily;

“(ii) provide authority to such judges to make binding rulings, rendered in written decisions, on standards of care, causation, compensation, and related issues with reliance on independent expert witnesses commissioned by the tribunal;

“(iii) establish a legal standard for the tribunal that shall be the same as the standard

that would apply in the State court of competent jurisdiction which would otherwise handle the claim; and

“(iv) provide for an appeals process to allow for review of decisions by State courts.

“(C) DETERMINATION.—After a tribunal conducts a review under this paragraph, the tribunal shall make a determination as to the liability of the parties involved and the amount of compensation that should be paid based on a schedule of compensation developed by the tribunal. Such a schedule shall at a minimum include—

“(i) payment for the net economic loss incurred by the patient, on a periodic basis, reduced by any payments received by the patient under—

“(I) any health or accident insurance;

“(II) any wage or salary continuation plan; or

“(III) any disability income insurance;

“(ii) payment for the non-economic damages incurred by the patient, if appropriate for the injury, based on a defined payment schedule developed by the State in consultation with relevant experts and with the Secretary;

“(iii) reasonable attorney’s fees; and

“(iv) regular updates of the schedule under clause (i) as necessary.

“(D) REVIEW BY STATE COURT AFTER EXHAUSTION OF ADMINISTRATIVE REMEDIES.—

“(i) RIGHT TO FILE.—Nothing in this paragraph shall be construed to prohibit any individual who is not satisfied with the determinations of a tribunal under this paragraph, from filing a claim for the injury involved in a State court of competent jurisdiction.

“(ii) FORFEIT OF AWARD.—Any party filing an action in a State court under clause (i) shall forfeit any compensation award made under subparagraph (C).

“(iii) ADMISSIBILITY.—The determinations of the tribunal under subparagraph (C) shall be admissible into evidence in any State court proceeding under this subparagraph.

“(4) EXPERT PANEL REVIEW AND ADMINISTRATIVE HEALTH CARE TRIBUNAL COMBINATION MODEL.—

“(A) IN GENERAL.—A State may use amounts received under a grant under this section to develop and implement an expert panel review and administrative health care tribunal combination system to review any dispute concerning injuries allegedly caused by health care providers or health care organizations. Under such system, a dispute concerning injuries allegedly caused by health care providers or health care organizations shall proceed through the procedures described in this subparagraph prior to the submission of such dispute to a State court.

“(B) GENERAL PROCEDURE.—

“(i) ESTABLISHMENT OF EXPERT PANEL.—Prior to submitting any dispute described in subparagraph (A) to an administrative health care tribunal under the system established under this paragraph, the State shall establish an expert panel (in accordance with subparagraph (C)) to review the allegations involved in such dispute.

“(ii) REFERRAL TO TRIBUNAL.—If either party to a dispute described in clause (i) fails to accept the determination of the expert panel, the dispute shall then be referred to an administrative health care tribunal (in accordance with subparagraph (D)).

“(C) EXPERT REVIEW PANEL.—

“(i) IN GENERAL.—The provisions of paragraph (2) shall apply with respect to the establishment and operation of an expert review panel under this subparagraph, except that the subparagraphs (F) and (G) of such paragraph shall not apply.

“(ii) FAILURE TO ACCEPT DETERMINATION OF PANEL.—If any party to a dispute before an expert panel under this subparagraph refuses to accept the panel’s determination, the dispute shall be referred to an administrative health care tribunal under subparagraph (D).

“(D) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

“(i) IN GENERAL.—Upon the failure of any party to accept the determination of an expert panel under subparagraph (C), the parties shall request a hearing concerning the liability or compensation involved by an administrative health care tribunal established by the State involved under this subparagraph.

“(ii) REQUIREMENTS.—The provisions of paragraph (3) shall apply with respect to the establishment and operation of an administrative health care tribunal under this subparagraph.

“(iii) FORFEIT OF AWARDS.—Any party proceeding to the second step-administrative health care tribunal under this model shall forfeit any compensation awarded by the expert panel.

“(iv) ADMISSIBILITY.—The determinations of the expert panel under subparagraph (C) shall be admissible into evidence in any administrative health care tribunal proceeding under this subparagraph.

“(E) RIGHT TO FILE.—Nothing in this paragraph shall be construed to prohibit any individual who is not satisfied with the determination of the tribunal (after having proceeded through both the expert panel under subparagraph (C) and the tribunal under subparagraph (D)) from filing a claim for the injury involved in a State court of competent jurisdiction.

“(F) ADMISSIBILITY.—The determinations of both the expert panel and the tribunal under this paragraph shall be admissible into evidence in any State court proceeding under this paragraph.

“(G) FORFEIT OF AWARDS.—Any party filing an action in State court under subparagraph (E) shall forfeit any compensation award made by both the expert panel and the administrative health care tribunal under this paragraph.

“(e) DEFINITIONS.—In this section:

“(1) CURRENT TORT LITIGATION.—The term ‘current tort litigation’ means the tort litigation system existing in the State on the date on which the State submits an application under subsection (b)(1), for the resolution of disputes concerning injuries allegedly caused by health care providers or health care organizations.

“(2) HEALTH CARE ORGANIZATION.—The term ‘health care organization’ means any individual or entity that is obligated to provide, pay for, or administer health benefits under any health plan.

“(3) NET ECONOMIC LOSS.—The term ‘net economic loss’ means—

“(A) reasonable expenses incurred for products, services and accommodations needed for health care, training and other remedial treatment and care of an injured individual;

“(B) reasonable and appropriate expenses for rehabilitation treatment and occupational training;

“(C) 100 percent of the loss of income from work that an injured individual would have performed if not injured, reduced by any income from substitute work actually performed; and

“(D) reasonable expenses incurred in obtaining ordinary and necessary services to replace services an injured individual would have performed for the benefit of the individual or the family of such individual if the individual had not been injured.

“(4) NON-ECONOMIC DAMAGES.—The term ‘non-economic damages’ means losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), injury to reputation, and all other non-pecuniary losses of any kind or nature, to the extent permitted under State law.

“(f) FUNDING.—

“(1) ONE-TIME INCREASE IN MEDICAID PAYMENT.—In the case of a State awarded a grant to carry out this section, the total amount of the Federal payment determined for the State under section 1913 of the Social Security Act (as amended by section 401) for fiscal year 2011 (in addition to the any increase applicable for that fiscal year under section 203(b) but determined without regard to any such increase) shall be increased by an amount equal to 1 percent of the total amount of payments made to the State for fiscal year 2010 under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for purposes of carrying out a grant awarded under this section. Amounts paid to a State pursuant to this subsection shall remain available until expended.

“(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for any fiscal year such sums as may be necessary for purposes of making payments to States pursuant to paragraph (1).”

TITLE VII—PROMOTING HEALTH INFORMATION TECHNOLOGY

Subtitle A—Assisting the Development of Health Information Technology

SEC. 701. PURPOSE.

It is the purpose of this subtitle to promote the utilization of health record banking by improving the coordination of health information through an infrastructure for the secure and authorized exchange and use of healthcare information.

SEC. 702. HEALTH RECORD BANKING.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate regulations to provide for the certification and auditing of the banking of electronic medical records.

(b) GENERAL RIGHTS.—An individual who has a health record contained in a health record bank shall maintain ownership over the health record and shall have the right to review the contents of the record.

SEC. 703. APPLICATION OF FEDERAL AND STATE SECURITY AND CONFIDENTIALITY STANDARDS.

(a) IN GENERAL.—Current Federal security and confidentiality standards and State security and confidentiality laws shall apply to this subtitle until such time as Congress acts to amend such standards.

(b) DEFINITIONS.—In this section:

(1) CURRENT FEDERAL SECURITY AND CONFIDENTIALITY STANDARDS.—The term “current Federal security and confidentiality standards” means the Federal privacy standards established pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note) and security standards established under section 1173(d) of the Social Security Act (42 U.S.C. 1320d-2(d)).

(2) STATE SECURITY AND CONFIDENTIALITY LAWS.—The term “State security and confidentiality laws” means State laws and regulations relating to the privacy and confidentiality of individually identifiable health information or to the security of such information.

(3) STATE.—The term “State” has the meaning given such term for purposes of title XI of the Social Security Act, as provided under section 1101(a) of such Act (42 U.S.C. 1301(a)).

Subtitle B—Removing Barriers to the Use of Health Information Technology to Better Coordinate Health Care

SEC. 711. SAFE HARBORS TO ANTICKBACK CIVIL PENALTIES AND CRIMINAL PENALTIES FOR PROVISION OF HEALTH INFORMATION TECHNOLOGY AND TRAINING SERVICES.

(a) FOR CIVIL PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

“(4) For purposes of this subsection, inducements to reduce or limit services described in paragraph (1) shall not include the practical or other advantages resulting from health information technology or related installation, maintenance, support, or training services.”; and

(2) in subsection (i), by adding at the end the following new paragraph:

“(8) The term ‘health information technology’ means hardware, software, license, right, intellectual property, equipment, or other information technology (including new versions, upgrades, and connectivity) designed or provided primarily for the electronic creation, maintenance, or exchange of health information to better coordinate care or improve health care quality, efficiency, or research.”.

(b) FOR CRIMINAL PENALTIES.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is amended—

(1) in subsection (b)(3)—

(A) in subparagraph (G), by striking “and” at the end;

(B) in the subparagraph (H) added by section 237(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2213)—

(i) by moving such subparagraph 2 ems to the left; and

(ii) by striking the period at the end and inserting a semicolon;

(C) in the subparagraph (H) added by section 431(a) of such Act (117 Stat. 2287)—

(i) by redesignating such subparagraph as subparagraph (I);

(ii) by moving such subparagraph 2 ems to the left; and

(iii) by striking the period at the end and inserting “; and”; and

(D) by adding at the end the following new subparagraph:

“(J) any nonmonetary remuneration (in the form of health information technology, as defined in section 1128A(i)(8), or related installation, maintenance, support or training services) made to a person by a specified entity (as defined in subsection (g)) if—

“(i) the provision of such remuneration is without an agreement between the parties or legal condition that—

“(I) limits or restricts the use of the health information technology to services provided by the physician to individuals receiving services at the specified entity;

“(II) limits or restricts the use of the health information technology in conjunction with other health information technology; or

“(III) conditions the provision of such remuneration on the referral of patients or business to the specified entity;

“(ii) such remuneration is arranged for in a written agreement that is signed by the parties involved (or their representatives)

and that specifies the remuneration solicited or received (or offered or paid) and states that the provision of such remuneration is made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research; and

“(iii) the specified entity providing the remuneration (or a representative of such entity) has not taken any action to disable any basic feature of any hardware or software component of such remuneration that would permit interoperability.”; and

(2) by adding at the end the following new subsection:

“(g) SPECIFIED ENTITY DEFINED.—For purposes of subsection (b)(3)(J), the term ‘specified entity’ means an entity that is a hospital, group practice, prescription drug plan sponsor, a Medicare Advantage organization, or any other such entity specified by the Secretary, considering the goals and objectives of this section, as well as the goals to better coordinate the delivery of health care and to promote the adoption and use of health information technology.”.

(c) EFFECTIVE DATE AND EFFECT ON STATE LAWS.—

(1) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect on the date that is 120 days after the date of the enactment of this Act.

(2) PREEMPTION OF STATE LAWS.—No State (as defined in section 1101(a) of the Social Security Act (42 U.S.C. 1301(a))) for purposes of title XI of such Act) shall have in effect a State law that imposes a criminal or civil penalty for a transaction described in section 1128A(b)(4) or section 1128B(b)(3)(J) of such Act, as added by subsections (a)(1) and (b), respectively, if the conditions described in the respective provision, with respect to such transaction, are met.

(d) STUDY AND REPORT TO ASSESS EFFECT OF SAFE HARBORS ON HEALTH SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine the impact of each of the safe harbors described in paragraph (3). In particular, the study shall examine the following:

(A) The effectiveness of each safe harbor in increasing the adoption of health information technology.

(B) The types of health information technology provided under each safe harbor.

(C) The extent to which the financial or other business relationships between providers under each safe harbor have changed as a result of the safe harbor in a way that adversely affects or benefits the health care system or choices available to consumers.

(D) The impact of the adoption of health information technology on health care quality, cost, and access under each safe harbor.

(2) REPORT.—Not later than 3 years after the effective date described in subsection (c)(1), the Secretary of Health and Human Services shall submit to Congress a report on the study under paragraph (1).

(3) SAFE HARBORS DESCRIBED.—For purposes of paragraphs (1) and (2), the safe harbors described in this paragraph are—

(A) the safe harbor under section 1128A(b)(4) of such Act (42 U.S.C. 1320a–7a(b)(4)), as added by subsection (a)(1); and

(B) the safe harbor under section 1128B(b)(3)(J) of such Act (42 U.S.C. 1320a–7b(b)(3)(J)), as added by subsection (b).

SEC. 712. EXCEPTION TO LIMITATION ON CERTAIN PHYSICIAN REFERRALS (UNDER STARK) FOR PROVISION OF HEALTH INFORMATION TECHNOLOGY AND TRAINING SERVICES TO HEALTH CARE PROFESSIONALS.

(a) IN GENERAL.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is

amended by adding at the end the following new paragraph:

“(6) INFORMATION TECHNOLOGY AND TRAINING SERVICES.—

“(A) IN GENERAL.—Any nonmonetary remuneration (in the form of health information technology or related installation, maintenance, support or training services) made by a specified entity to a physician if—

“(i) the provision of such remuneration is without an agreement between the parties or legal condition that—

“(I) limits or restricts the use of the health information technology to services provided by the physician to individuals receiving services at the specified entity;

“(II) limits or restricts the use of the health information technology in conjunction with other health information technology; or

“(III) conditions the provision of such remuneration on the referral of patients or business to the specified entity;

“(ii) such remuneration is arranged for in a written agreement that is signed by the parties involved (or their representatives) and that specifies the remuneration made and states that the provision of such remuneration is made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research; and

“(iii) the specified entity (or a representative of such entity) has not taken any action to disable any basic feature of any hardware or software component of such remuneration that would permit interoperability.

“(B) HEALTH INFORMATION TECHNOLOGY DEFINED.—For purposes of this paragraph, the term ‘health information technology’ means hardware, software, license, right, intellectual property, equipment, or other information technology (including new versions, upgrades, and connectivity) designed or provided primarily for the electronic creation, maintenance, or exchange of health information to better coordinate care or improve health care quality, efficiency, or research.

“(C) SPECIFIED ENTITY DEFINED.—For purposes of this paragraph, the term ‘specified entity’ means an entity that is a hospital, group practice, prescription drug plan sponsor, a Medicare Advantage organization, or any other such entity specified by the Secretary, considering the goals and objectives of this section, as well as the goals to better coordinate the delivery of health care and to promote the adoption and use of health information technology.”.

(b) EFFECTIVE DATE; EFFECT ON STATE LAWS.—

(1) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 120 days after the date of the enactment of this Act.

(2) PREEMPTION OF STATE LAWS.—No State (as defined in section 1101(a) of the Social Security Act (42 U.S.C. 1301(a))) for purposes of title XI of such Act) shall have in effect a State law that imposes a criminal or civil penalty for a transaction described in section 1877(b)(6) of such Act, as added by subsection (a), if the conditions described in such section, with respect to such transaction, are met.

(c) STUDY AND REPORT TO ASSESS EFFECT OF EXCEPTION ON HEALTH SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine the impact of the exception under section 1877(b)(6) of such Act (42 U.S.C. 1395nn(b)(6)), as added by subsection (a). In particular, the study shall examine the following:

(A) The effectiveness of the exception in increasing the adoption of health information technology.

(B) The types of health information technology provided under the exception.

(C) The extent to which the financial or other business relationships between providers under the exception have changed as a result of the exception in a way that adversely affects or benefits the health care system or choices available to consumers.

(D) The impact of the adoption of health information technology on health care quality, cost, and access under the exception.

(2) REPORT.—Not later than 3 years after the effective date described in subsection (b)(1), the Secretary of Health and Human Services shall submit to Congress a report on the study under paragraph (1).

SEC. 713. RULES OF CONSTRUCTION REGARDING USE OF CONSORTIA.

(a) APPLICATION TO SAFE HARBOR FROM CRIMINAL PENALTIES.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a-7b(b)(3)) is amended by adding after and below subparagraph (J), as added by section 711(b)(1), the following: “For purposes of subparagraph (J), nothing in such subparagraph shall be construed as preventing a specified entity, consistent with the specific requirements of such subparagraph, from forming a consortium composed of health care providers, payers, employers, and other interested entities to collectively purchase and donate health information technology, or from offering health care providers a choice of health information technology products in order to take into account the varying needs of such providers receiving such products.”.

(b) APPLICATION TO STARK EXCEPTION.—Paragraph (6) of section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)), as added by section 712(a), is amended by adding at the end the following new subparagraph:

“(D) RULE OF CONSTRUCTION.—For purposes of subparagraph (A), nothing in such subparagraph shall be construed as preventing a specified entity, consistent with the specific requirements of such subparagraph, from—

“(i) forming a consortium composed of health care providers, payers, employers, and other interested entities to collectively purchase and donate health information technology; or

“(ii) offering health care providers a choice of health information technology products in order to take into account the varying needs of such providers receiving such products.”.

TITLE VIII—HEALTH CARE SERVICES COMMISSION

Subtitle A—Establishment and General Duties

SEC. 801. ESTABLISHMENT.

(a) IN GENERAL.—There is hereby established a Health Care Services Commission (in this title, referred to as the “Commission”) to be composed of 5 commissioners (in this title referred to as the “Commissioners”) to be appointed by the President by and with the advice and consent of the Senate. Not more than 3 of such Commissioners shall be members of the same political party, and in making appointments members of different political parties shall be appointed alternately as nearly as may be practicable. No Commissioner shall engage in any other business, vocation, or employment than that of serving as Commissioner. Each Commissioner shall hold office for a term of 5 years and until a successor is appointed and has qualified, except that—

(1) such Commissioner shall not so continue to serve beyond the expiration of the

next session of Congress subsequent to the expiration of said fixed term of office;

(2) any Commissioner appointed to fill a vacancy occurring prior to the expiration of the term for which a predecessor was appointed shall be appointed for the remainder of such term; and

(3) the terms of office of the Commissioners first taking office after the date of the enactment of this Act shall expire as designated by the President at the time of nomination, 1 at the end of 1 year, 1 at the end of 2 years, 1 at the end of 3 years, 1 at the end of 4 years, and 1 at the end of 5 years, after the date of the enactment of this Act.

(b) PURPOSE.—The purpose of the Commission is to enhance the quality, appropriateness, and effectiveness of health care services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical practice and in the organization, financing, and delivery of health care services.

(c) APPOINTMENT OF CHAIRMAN.—The President shall, from among the Commissioners appointed under subsection (a), designate an individual to serve as the Chairman of the Commission.

SEC. 802. GENERAL AUTHORITIES AND DUTIES.

(a) IN GENERAL.—In carrying out section 801(b), the Commissioners shall conduct and support research, demonstration projects, evaluations, training, guideline development, and the dissemination of information, on health care services and on systems for the delivery of such services, including activities with respect to—

(1) the effectiveness, efficiency, and quality of health care services;

(2) the outcomes of health care services and procedures;

(3) clinical practice, including primary care and practice-oriented research;

(4) health care technologies, facilities, and equipment;

(5) health care costs, productivity, and market forces;

(6) health promotion and disease prevention;

(7) health statistics and epidemiology; and

(8) medical liability.

(b) REQUIREMENTS WITH RESPECT TO RURAL AREAS AND UNDERSERVED POPULATIONS.—In carrying out subsection (a), the Commissioners shall undertake and support research, demonstration projects, and evaluations with respect to—

(1) the delivery of health care services in rural areas (including frontier areas); and

(2) the health of low-income groups, minority groups, and the elderly.

SEC. 803. DISSEMINATION.

(a) IN GENERAL.—The Commissioners shall—

(1) promptly publish, make available, and otherwise disseminate, in a form understandable and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations conducted or supported under this title and the guidelines, standards, and review criteria developed under this title;

(2) promptly make available to the public data developed in such research, demonstration projects, and evaluations; and

(3) as appropriate, provide technical assistance to State and local government and health agencies and conduct liaison activities to such agencies to foster dissemination.

(b) PROHIBITION AGAINST RESTRICTIONS.—Except as provided in subsection (c), the Commissioners may not restrict the publication or dissemination of data from, or the re-

sults of, projects conducted or supported under this title.

(c) LIMITATION ON USE OF CERTAIN INFORMATION.—No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under this title may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose. Such information may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Secretary) to its publication or release in other form.

(d) CERTAIN INTERAGENCY AGREEMENT.—The Commissioners and the Director of the National Library of Medicine shall enter into an agreement providing for the implementation of subsection (a)(1).

Subtitle B—Forum for Quality and Effectiveness in Health Care

SEC. 811. ESTABLISHMENT OF OFFICE.

There is established within the Commission an office to be known as the Office of the Forum for Quality and Effectiveness in Health Care. The office shall be headed by a director (referred to in this title as the “Director”) who shall be appointed by the Commissioners.

SEC. 812. MEMBERSHIP.

(a) IN GENERAL.—The Office of the Forum for Quality and Effectiveness in Health Care shall be composed of 15 individuals nominated by private sector health care organizations and appointed by the Commission and shall include representation from at least the following:

- (1) Health insurance industry.
- (2) Health care provider groups.
- (3) Non-profit organizations.
- (4) Rural health organizations.

(b) TERMS.—

(1) IN GENERAL.—Except as provided in paragraph (2), members of the Office of the Forum for Quality and Effectiveness in Health Care shall serve for a term of 5 years.

(2) STAGGERED ROTATION.—Of the members first appointed to the Office of the Forum for Quality and Effectiveness in Health Care, the Commission shall appoint 5 members to serve for a term of 2 years, 5 members to serve for a term of 3 years, and 5 members to serve for a term of 4 years.

(c) TREATMENT OF OTHER EMPLOYMENT.—Each member of the Office of the Forum for Quality and Effectiveness in Health Care shall serve the Office independently from any other position of employment.

SEC. 813. DUTIES.

(a) ESTABLISHMENT OF FORUM PROGRAM.—The Commissioners, acting through the Director, shall establish a program to be known as the Forum for Quality and Effectiveness in Health Care. For the purpose of promoting transparency in price, quality, appropriateness, and effectiveness of health care, the Director, using the process set forth in section 814, shall arrange for the development and periodic review and updating of standards of quality, performance measures, and medical review criteria through which health care providers and other appropriate entities may assess or review the provision of health care and assure the quality of such care.

(b) CERTAIN REQUIREMENTS.—Guidelines, standards, performance measures, and review criteria under subsection (a) shall—

(1) be based on the best available research and professional judgment regarding the effectiveness and appropriateness of health care services and procedures; and

(2) be presented in formats appropriate for use by physicians, health care practitioners, providers, medical educators, and medical review organizations and in formats appropriate for use by consumers of health care.

(c) **AUTHORITY FOR CONTRACTS.**—In carrying out this subtitle, the Director may enter into contracts with public or nonprofit private entities.

(d) **PUBLIC DISCLOSURE OF RECOMMENDATIONS.**—For each fiscal year beginning with 2010, the Director shall make publicly available the following:

(1) Quarterly reports for public comment that include proposed recommendations for guidelines, standards, performance measures, and review criteria under subsection (a) and any updates to such guidelines, standards, performance measures, and review criteria.

(2) After consideration of such comments, a final report that contains final recommendations for such guidelines, standards, performance measures, review criteria, and updates.

(e) **DATE CERTAIN FOR INITIAL GUIDELINES AND STANDARDS.**—The Commissioners, by not later than January 1, 2012, shall assure the development of an initial set of guidelines, standards, performance measures, and review criteria under subsection (a).

SEC. 814. ADOPTION AND ENFORCEMENT OF GUIDELINES AND STANDARDS.

(a) **ADOPTION OF RECOMMENDATIONS OF FORUM FOR QUALITY AND EFFECTIVENESS IN HEALTH CARE.**—For each fiscal year, the Commissioners shall adopt the recommendations made for such year in the final report under subsection (d)(2) of section 813 for guidelines, standards, performance measures, and review criteria described in subsection (a) of such section.

(b) **ENFORCEMENT AUTHORITY.**—The Commissioners, in consultation with the Secretary of Health and Human Services, have the authority to make recommendations to the Secretary to enforce compliance of health care providers with the guidelines, standards, performance measures, and review criteria adopted under subsection (a). Such recommendations may include the following, with respect to a health care provider who is not in compliance with such guidelines, standards, measures, and criteria:

(1) Exclusion from participation in Federal health care programs (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a-7b(f))).

(2) Imposition of a civil money penalty on such provider.

SEC. 815. ADDITIONAL REQUIREMENTS.

(a) **PROGRAM AGENDA.**—The Commissioners shall provide for an agenda for the development of the guidelines, standards, performance measures, and review criteria described in section 813(a), including with respect to the standards, performance measures, and review criteria, identifying specific aspects of health care for which the standards, performance measures, and review criteria are to be developed and those that are to be given priority in the development of the standards, performance measures, and review criteria.

Subtitle C—General Provisions

SEC. 821. CERTAIN ADMINISTRATIVE AUTHORITIES.

The Commissioners, in carrying out this title, may accept voluntary and uncompensated services.

SEC. 822. FUNDING.

For the purpose of carrying out this title, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.

SEC. 823. DEFINITIONS.

For purposes of this title:

(1) The term “Commissioners” means the Commissioners of the Health Care Services Commission.

(2) The term “Commission” means the Health Care Services Commission.

(3) The term “Director” means the Director of the Office of the Forum for Quality and Effectiveness in Health Care.

(4) The term “Secretary” means the Secretary of Health and Human Services.

Subtitle D—Terminations and Transition

SEC. 831. TERMINATION OF AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.

As of the date of the enactment of this Act, the Agency for Healthcare Research and Quality is terminated, and title IX of the Public Health Service Act is repealed.

SEC. 832. TRANSITION.

All orders, grants, contracts, privileges, and other determinations or actions of the Agency for Healthcare Research and Quality that are effective as of the date before the date of the enactment of this Act, shall be transferred to the Secretary and shall continue in effect according to their terms unless changed pursuant to law.

Subtitle E—Independent Health Record Trust

This subtitle may be cited as the “Independent Health Record Trust Act of 2009”.

SEC. 842. PURPOSE.

It is the purpose of this subtitle to provide for the establishment of a nationwide health information technology network that—

(1) improves health care quality, reduces medical errors, increases the efficiency of care, and advances the delivery of appropriate, evidence-based health care services;

(2) promotes wellness, disease prevention, and the management of chronic illnesses by increasing the availability and transparency of information related to the health care needs of an individual;

(3) ensures that appropriate information necessary to make medical decisions is available in a usable form at the time and in the location that the medical service involved is provided;

(4) produces greater value for health care expenditures by reducing health care costs that result from inefficiency, medical errors, inappropriate care, and incomplete information;

(5) promotes a more effective marketplace, greater competition, greater systems analysis, increased choice, enhanced quality, and improved outcomes in health care services;

(6) improves the coordination of information and the provision of such services through an effective infrastructure for the secure and authorized exchange and use of health information; and

(7) ensures that the health information privacy, security, and confidentiality of individually identifiable health information is protected.

SEC. 843. DEFINITIONS.

In this subtitle:

(1) **ACCESS.**—The term “access” means, with respect to an electronic health record, entering information into such account as well as retrieving information from such account.

(2) **ACCOUNT.**—The term “account” means an electronic health record of an individual

contained in an independent health record trust.

(3) **AFFIRMATIVE CONSENT.**—The term “affirmative consent” means, with respect to an electronic health record of an individual contained in an IHRT, express consent given by the individual for the use of such record in response to a clear and conspicuous request for such consent or at the individual’s own initiative.

(4) **AUTHORIZED EHR DATA USER.**—The term “authorized EHR data user” means, with respect to an electronic health record of an IHRT participant contained as part of an IHRT, any entity (other than the participant) authorized (in the form of affirmative consent) by the participant to access the electronic health record.

(5) **CONFIDENTIALITY.**—The term “confidentiality” means, with respect to individually identifiable health information of an individual, the obligation of those who receive such information to respect the health information privacy of the individual.

(6) **ELECTRONIC HEALTH RECORD.**—The term “electronic health record” means a longitudinal collection of information concerning a single individual, including medical records and personal health information, that is stored electronically.

(7) **HEALTH INFORMATION PRIVACY.**—The term “health information privacy” means, with respect to individually identifiable health information of an individual, the right of such individual to control the acquisition, uses, or disclosures of such information.

(8) **HEALTH PLAN.**—The term “health plan” means a group health plan (as defined in section 2208(1) of the Public Health Service Act (42 U.S.C. 300bb-8(1))) as well as a plan that offers health insurance coverage in the individual market.

(9) **HIPAA PRIVACY REGULATIONS.**—The term “HIPAA privacy regulations” means the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note).

(10) **INDEPENDENT HEALTH RECORD TRUST; IHRT.**—The terms “independent health record trust” and “IHRT” mean a legal arrangement under the administration of an IHRT operator that meets the requirements of this subtitle with respect to electronic health records of individuals participating in the trust or IHRT.

(11) **IHRT OPERATOR.**—The term “IHRT operator” means, with respect to an IHRT, the organization that is responsible for the administration and operation of the IHRT in accordance with this subtitle.

(12) **IHRT PARTICIPANT.**—The term “IHRT participant” means, with respect to an IHRT, an individual who has a participation agreement in effect with respect to the maintenance of the individual’s electronic health record by the IHRT.

(13) **INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.**—The term “individually identifiable health information” has the meaning given such term in section 1171(6) of the Social Security Act (42 U.S.C. 1320d(6)).

(14) **SECURITY.**—The term “security” means, with respect to individually identifiable health information of an individual, the physical, technological, or administrative safeguards or tools used to protect such information from unwarranted access or disclosure.

SEC. 844. ESTABLISHMENT, CERTIFICATION, AND MEMBERSHIP OF INDEPENDENT HEALTH RECORD TRUSTS.

(a) **ESTABLISHMENT.**—Not later than one year after the date of the enactment of this

Act, the Federal Trade Commission, in consultation with the National Committee on Vital and Health Statistics, shall prescribe standards for the establishment, certification, operation, and interoperability of IHRTs to carry out the purposes described in section 842 in accordance with the provisions of this subtitle.

(b) CERTIFICATION.—

(1) CERTIFICATION BY FTC.—The Federal Trade Commission shall provide for the certification of IHRTs. No IHRT may be certified unless the IHRT is determined to meet the standards for certification established under subsection (a).

(2) DECERTIFICATION.—The Federal Trade Commission shall establish a process for the revocation of certification of an IHRT under this section in the case that the IHRT violates the standards established under subsection (a).

(c) MEMBERSHIP.—

(1) IN GENERAL.—To be eligible to be a participant in an IHRT, an individual shall—

(A) submit to the IHRT information as required by the IHRT to establish an electronic health record with the IHRT; and

(B) enter into a privacy protection agreement described in section 846(b)(1) with the IHRT.

The process to determine eligibility of an individual under this subsection shall allow for the establishment by such individual of an electronic health record as expeditiously as possible if such individual is determined so eligible.

(2) NO LIMITATION ON MEMBERSHIP.—Nothing in this subsection shall be construed to permit an IHRT to restrict membership, including on the basis of health condition.

SEC. 845. DUTIES OF IHRT TO IHRT PARTICIPANTS.

(a) FIDUCIARY DUTY OF IHRT; PENALTIES FOR VIOLATIONS OF FIDUCIARY DUTY.—

(1) FIDUCIARY DUTY.—With respect to the electronic health record of an IHRT participant maintained by an IHRT, the IHRT shall have a fiduciary duty to act for the benefit and in the interests of such participant and of the IHRT as a whole. Such duty shall include obtaining the affirmative consent of such participant prior to the release of information in such participant's electronic health record in accordance with the requirements of this subtitle.

(2) PENALTIES.—If the IHRT knowingly or recklessly breaches the fiduciary duty described in paragraph (1), the IHRT shall be subject to the following penalties:

(A) Loss of certification of the IHRT.

(B) A fine that is not in excess of \$50,000.

(C) A term of imprisonment for the individuals involved of not more than 5 years.

(b) ELECTRONIC HEALTH RECORD DEEMED TO BE HELD IN TRUST BY IHRT.—With respect to an individual, an electronic health record maintained by an IHRT shall be deemed to be held in trust by the IHRT for the benefit of the individual and the IHRT shall have no legal or equitable interest in such electronic health record.

SEC. 846. AVAILABILITY AND USE OF INFORMATION FROM RECORDS IN IHRT CONSISTENT WITH PRIVACY PROTECTIONS AND AGREEMENTS.

(a) PROTECTED ELECTRONIC HEALTH RECORDS USE AND ACCESS.—

(1) GENERAL RIGHTS REGARDING USES OF INFORMATION.—

(A) IN GENERAL.—With respect to the electronic health record of an IHRT participant maintained by an IHRT, subject to paragraph (2)(C), primary uses and secondary uses (described in subparagraphs (B) and (C),

respectively) of information within such record (other than by such participant) shall be permitted only upon the authorization of such use, prior to such use, by such participant.

(B) PRIMARY USES.—For purposes of subparagraph (A) and with respect to an electronic health record of an individual, a primary use is a use for purposes of the individual's self-care or care by health care professionals.

(C) SECONDARY USES.—For purposes of subparagraph (B) and with respect to an electronic health record of an individual, a secondary use is any use not described in subparagraph (B) and includes a use for purposes of public health research or other related activities. Additional authorization is required for a secondary use extending beyond the original purpose of the secondary use authorized by the IHRT participant involved. Nothing in this paragraph shall be construed as requiring authorization for every secondary use that is within the authorized original purpose.

(2) RULES FOR PRIMARY USE OF RECORDS FOR HEALTH CARE PURPOSES.—With respect to the electronic health record of an IHRT participant (or specified parts of such electronic health record) maintained by an IHRT standards for access to such record shall provide for the following:

(A) ACCESS BY IHRT PARTICIPANTS TO THEIR ELECTRONIC HEALTH RECORDS.—

(i) OWNERSHIP.—The participant maintains ownership over the entire electronic health record (and all portions of such record) and shall have the right to electronically access and review the contents of the entire record (and any portion of such record) at any time, in accordance with this subparagraph.

(ii) ADDITION OF PERSONAL INFORMATION.—The participant may add personal health information to the health record of that participant, except that such participant shall not alter information that is entered into the electronic health record by any authorized EHR data user. Such participant shall have the right to propose an amendment to information that is entered by an authorized EHR data user pursuant to standards prescribed by the Federal Trade Commission for purposes of amending such information.

(iii) IDENTIFICATION OF INFORMATION ENTERED BY PARTICIPANT.—Any additions or amendments made by the participant to the health record shall be identified and disclosed within such record as being made by such participant.

(B) ACCESS BY ENTITIES OTHER THAN IHRT PARTICIPANT.—

(i) AUTHORIZED ACCESS ONLY.—Except as provided under subparagraph (C) and paragraph (4), access to the electronic health record (or any portion of the record)—

(I) may be made only by authorized EHR data users and only to such portions of the record as specified by the participant; and

(II) may be limited by the participant for purposes of entering information into such record, retrieving information from such record, or both.

(ii) IDENTIFICATION OF ENTITY THAT ENTERS INFORMATION.—Any information that is added by an authorized EHR data user to the health record shall be identified and disclosed within such record as being made by such user.

(iii) SATISFACTION OF HIPAA PRIVACY REGULATIONS.—In the case of a record of a covered entity (as defined for purposes of HIPAA privacy regulations), with respect to an individual, if such individual is an IHRT participant with an independent health record trust

and such covered entity is an authorized EHR data user, the requirement under the HIPAA privacy regulations for such entity to provide the record to the participant shall be deemed met if such entity, without charge to the IHRT or the participant—

(I) forwards to the trust an appropriately formatted electronic copy of the record (and updates to such records) for inclusion in the electronic health record of the participant maintained by the trust;

(II) enters such record into the electronic health record of the participant so maintained; or

(III) otherwise makes such record available for electronic access by the IHRT or the individual in a manner that permits such record to be included in the account of the individual contained in the IHRT.

(iv) NOTIFICATION OF SENSITIVE INFORMATION.—Any information, with respect to the participant, that is sensitive information, as specified by the Federal Trade Commission, shall not be forwarded or entered by an authorized EHR data user into the electronic health record of the participant maintained by the trust unless the user certifies that the participant has been notified of such information.

(C) DEEMED AUTHORIZATION FOR ACCESS FOR EMERGENCY HEALTH CARE.—

(i) FINDINGS.—Congress finds that—

(I) given the size and nature of visits to emergency departments in the United States, readily available health information could make the difference between life and death; and

(II) because of the case mix and volume of patients treated, emergency departments are well positioned to provide information for public health surveillance, community risk assessment, research, education, training, quality improvement, and other uses.

(ii) USE OF INFORMATION.—With respect to the electronic health record of an IHRT participant (or specified parts of such electronic health record) maintained by an IHRT, the participant shall be deemed as providing authorization (in the form of affirmative consent) for health care providers to access, in connection with providing emergency care services to the participant, a limited, authenticated information set concerning the participant for emergency response purposes, unless the participant specifies that such information set (or any portion of such information set) may not be so accessed. Such limited information set may include information—

(I) patient identification data, as determined appropriate by the participant;

(II) provider identification that includes the use of unique provider identifiers;

(III) payment information;

(IV) information related to the individual's vitals, allergies, and medication history;

(V) information related to existing chronic problems and active clinical conditions of the participant; and

(VI) information concerning physical examinations, procedures, results, and diagnosis data.

(3) RULES FOR SECONDARY USES OF RECORDS FOR RESEARCH AND OTHER PURPOSES.—

(A) IN GENERAL.—With respect to the electronic health record of an IHRT participant (or specified parts of such electronic health record) maintained by an IHRT, the IHRT may sell such record (or specified parts of such record) only if—

(i) the transfer is authorized by the participant pursuant to an agreement between the participant and the IHRT and is in accordance with the privacy protection agreement

described in subsection (b)(1) entered into between such participant and such IHRT;

(ii) such agreement includes parameters with respect to the disclosure of information involved and a process for the authorization of the further disclosure of information in such record;

(iii) the information involved is to be used for research or other activities only as provided for in the agreement;

(iv) the recipient of the information provides assurances that the information will not be further transferred or reused in violation of such agreement; and

(v) the transfer otherwise meets the requirements and standards prescribed by the Federal Trade Commission.

(B) TREATMENT OF PUBLIC HEALTH REPORTING.—Nothing in this paragraph shall be construed as prohibiting or limiting the use of health care information of an individual, including an individual who is an IHRT participant, for public health reporting (or other research) purposes prior to the inclusion of such information in an electronic health record maintained by an IHRT.

(4) LAW ENFORCEMENT CLARIFICATION.—Nothing in this subtitle shall prevent an IHRT from disclosing information contained in an electronic health record maintained by the IHRT when required for purposes of a lawful investigation or official proceeding inquiring into a violation of, or failure to comply with, any criminal or civil statute or any regulation, rule, or order issued pursuant to such a statute.

(5) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require a health care provider that does not utilize electronic methods or appropriate levels of health information technology on the date of the enactment of this Act to adopt such electronic methods or technology as a requirement for participation or compliance under this subtitle.

(b) PRIVACY PROTECTION AGREEMENT; TREATMENT OF STATE PRIVACY AND SECURITY LAWS.—

(1) PRIVACY PROTECTION AGREEMENT.—A privacy protection agreement described in this subsection is an agreement, with respect to an electronic health record of an IHRT participant to be maintained by an independent health record trust, between the participant and the trust—

(A) that is consistent with the standards described in subsection (a)(2);

(B) under which the participant specifies the portions of the record that may be accessed, under what circumstances such portions may be accessed, any authorizations for indicated authorized EHR data users to access information contained in the record, and the purposes for which the information (or portions of the information) in the record may be used;

(C) which provides a process for the authorization of the transfer of information contained in the record to a third party, including for the sale of such information for purposes of research, by an authorized EHR data user and reuse of such information by such third party, including a provision requiring that such transfer and reuse is not in violation of any privacy or transfer restrictions placed by the participant on the independent health record of such participant; and

(D) under which the trust provides assurances that the trust will not transfer, disclose, or provide access to the record (or any portion of the record) in violation of the parameters established in the agreement or to any person or entity who has not agreed to

use and transfer such record (or portion of such record) in accordance with such agreement.

(2) TREATMENT OF STATE LAWS.—

(A) IN GENERAL.—Except as provided under subparagraph (B), the provisions of a privacy protection agreement entered into between an IHRT and an IHRT participant shall preempt any provision of State law (or any State regulation) relating to the privacy and confidentiality of individually identifiable health information or to the security of such health information.

(B) EXCEPTION FOR PRIVILEGED INFORMATION.—The provisions of a privacy protection agreement shall not preempt any provision of State law (or any State regulation) that recognizes privileged communications between physicians, health care practitioners, and patients of such physicians or health care practitioners, respectively.

(C) STATE DEFINED.—For purposes of this section, the term “State” has the meaning given such term when used in title XI of the Social Security Act, as provided under section 1101(a) of such Act (42 U.S.C. 1301(a)).

SEC. 847. VOLUNTARY NATURE OF TRUST PARTICIPATION AND INFORMATION SHARING.

(a) IN GENERAL.—Participation in an independent health record trust, or authorizing access to information from such a trust, is voluntary. No employer, health insurance issuer, group health plan, health care provider, or other person may require, as a condition of employment, issuance of a health insurance policy, coverage under a group health plan, the provision of health care services, payment for such services, or otherwise, that an individual participate in, or authorize access to information from, an independent health record trust.

(b) ENFORCEMENT.—The penalties provided for in subsection (a) of section 1177 of the Social Security Act (42 U.S.C. 1320d-6) shall apply to a violation of subsection (a) in the same manner as such penalties apply to a person in violation of subsection (a) of such section.

SEC. 848. FINANCING OF ACTIVITIES.

(a) IN GENERAL.—Except as provided in subsection (b), an IHRT may generate revenue to pay for the operations of the IHRT through—

(1) charging IHRT participants account fees for use of the trust;

(2) charging authorized EHR data users for accessing electronic health records maintained in the trust;

(3) the sale of information contained in the trust (as provided for in section 846(a)(3)(A)); and

(4) any other activity determined appropriate by the Federal Trade Commission.

(b) PROHIBITION AGAINST ACCESS FEES FOR HEALTH CARE PROVIDERS.—For purposes of providing incentives to health care providers to access information maintained in an IHRT, as authorized by the IHRT participants involved, the IHRT may not charge a fee for services specified by the IHRT. Such services shall include the transmittal of information from a health care provider to be included in an independent electronic health record maintained by the IHRT (or permitting such provider to input such information into the record), including the transmission of or access to information described in section 846(a)(2)(C)(ii) by appropriate emergency responders.

(c) REQUIRED DISCLOSURES.—The sources and amounts of revenue derived under subsection (a) for the operations of an IHRT shall be fully disclosed to each IHRT participant of such IHRT and to the public.

(d) TREATMENT OF INCOME.—For purposes of the Internal Revenue Code of 1986, any revenue described in subsection (a) shall not be included in gross income of any IHRT, IHRT participant, or authorized EHR data user.

SEC. 849. REGULATORY OVERSIGHT.

(a) IN GENERAL.—In carrying out this subtitle, the Federal Trade Commission shall promulgate regulations for independent health record trusts.

(b) ESTABLISHMENT OF INTERAGENCY STEERING COMMITTEE.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish an Interagency Steering Committee in accordance with this subsection.

(2) CHAIRPERSON.—The Secretary of Health and Human Services shall serve as the chairperson of the Interagency Steering Committee.

(3) MEMBERSHIP.—The members of the Interagency Steering Committee shall consist of the Attorney General, the Chairperson of the Federal Trade Commission, the Chairperson for the National Committee for Vital and Health Statistics, a representative of the Federal Reserve, and other Federal officials determined appropriate by the Secretary of Health and Human Services.

(4) DUTIES.—The Interagency Steering Committee shall coordinate the implementation of this title, including the implementation of policies described in subsection (d) based upon the recommendations provided under such subsection, and regulations promulgated under this subtitle.

(c) FEDERAL ADVISORY COMMITTEE.—

(1) IN GENERAL.—The National Committee for Vital and Health Statistics shall serve as an advisory committee for the IHRTs. The membership of such advisory committee shall include a representative from the Federal Trade Commission and the chairperson of the Interagency Steering Committee. Not less than 60 percent of such membership shall consist of representatives of non-government entities, at least one of whom shall be a representative from an organization representing health care consumers.

(2) DUTIES.—The National Committee for Vital and Health Statistics shall issue periodic reports and review policies concerning IHRTs based on each of the following factors:

(A) Privacy and security policies.

(B) Economic progress.

(C) Interoperability standards.

(d) POLICIES RECOMMENDED BY FEDERAL TRADE COMMISSION.—The Federal Trade Commission, in consultation with the National Committee for Vital and Health Statistics, shall recommend policies to—

(1) provide assistance to encourage the growth of independent health record trusts;

(2) track economic progress as it pertains to operators of independent health records trusts and individuals receiving nontaxable income with respect to accounts;

(3) conduct public education activities regarding the creation and usage of the independent health records trusts;

(4) establish standards for the interoperability of health information technology to ensure that information contained in such record may be shared between the trust involved, the participant, and authorized EHR data users, including for the standardized collection and transmission of individual health records (or portions of such records) to authorized EHR data users through a common interface and for the portability of such records among independent health record trusts; and

(5) carry out any other activities determined appropriate by the Federal Trade Commission.

(e) **REGULATIONS PROMULGATED BY FEDERAL TRADE COMMISSION.**—The Federal Trade Commission shall promulgate regulations based on, at a minimum, the following factors:

(1) Requiring that an IHRT participant, who has an electronic health record that is maintained by an IHRT, be notified of a security breach with respect to such record, and any corrective action taken on behalf of the participant.

(2) Requiring that information sent to, or received from, an IHRT that has been designated as high-risk should be authenticated through the use of methods such as the periodic changing of passwords, the use of biometrics, the use of tokens or other technology as determined appropriate by the council.

(3) Requiring a delay in releasing sensitive health care test results and other similar information to patients directly in order to give physicians time to contact the patient.

(4) Recommendations for entities operating IHRTs, including requiring analysis of the potential risk of health transaction security breaches based on set criteria.

(5) The conduct of audits of IHRTs to ensure that they are in compliance with the requirements and standards established under this subtitle.

(6) Disclosure to IHRT participants of the means by which such trusts are financed, including revenue from the sale of patient data.

(7) Prevention of certification of an entity seeking independent health record trust certification based on—

(A) the potential for conflicts between the interests of such entity and the security of the health information involved; and

(B) the involvement of the entity in any activity that is contrary to the best interests of a patient.

(8) Prevention of the use of revenue sources that are contrary to a patient's interests.

(9) Public disclosure of audits in a manner similar to financial audits required for publicly traded stock companies.

(10) Requiring notification to a participating entity that the information contained in such record may not be representative of the complete or accurate electronic health record of such account holder.

(f) **COMPLIANCE REPORT.**—Not later than 1 year after the date of the enactment of this Act, and annually thereafter, the Commission shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, a report on compliance by and progress of independent health record trusts with this subtitle. Such report shall describe the following:

(1) The number of complaints submitted about independent health record trusts, which shall be divided by complaints related to security breaches, and complaints not related to security breaches, and may include other categories as the Interagency Steering Committee established under subsection (b) determines appropriate.

(2) The number of enforcement actions undertaken by the Commission against independent health record trusts in response to complaints under paragraph (1), which shall be divided by enforcement actions related to security breaches and enforcement actions not related to security breaches and may include other categories as the Interagency Steering Committee established under subsection (b) determines appropriate.

(3) The economic progress of the individual owner or institution operator as achieved through independent health record trust usage and existing barriers to such usage.

(4) The progress in security auditing as provided for by the Interagency Steering Committee council under subsection (b).

(5) The other core responsibilities of the Commission as described in subsection (a).

(g) **INTERAGENCY MEMORANDUM OF UNDERSTANDING.**—The Interagency Steering Committee shall ensure, through the execution of an interagency memorandum of understanding, that—

(1) regulations, rulings, and interpretations issued by Federal officials relating to the same matter over which 2 or more such officials have responsibility under this subtitle are administered so as to have the same effect at all times; and

(2) the memorandum provides for the coordination of policies related to enforcing the same requirements through such officials in order to have coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

TITLE IX—MISCELLANEOUS

SEC. 901. HEALTH CARE CHOICE FOR VETERANS.

Beginning not later than 2 years after the date of the enactment of this Act, the Secretary of Veterans Affairs may—

(1) permit veterans, and survivors and dependents of veterans, who are eligible for health care and services under the laws administered by the Secretary to receive such care and services through such non-Department of Veterans Affairs providers and facilities as the Secretary may approve for purposes of this section; and

(2) pursuant to such procedures as the Secretary of Veteran Affairs shall prescribe for purposes of this section, make payments to such providers and facilities for the provision of such care and services to veterans, and such survivors and dependents, at such rates as the Secretary may specify in such procedures and in such manner so that the Secretary ensures that the aggregate payments made by the Secretary to such providers and facilities do not exceed the aggregate amounts which the Secretary would have paid for such care and services if this section had not been enacted.

SEC. 902. HEALTH CARE CHOICE FOR INDIANS.

(a) **IN GENERAL.**—Beginning not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) permit Indians who are eligible for health care and services under a health care program operated or financed by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (and any such other individuals who are so eligible as the Secretary may specify), to receive such care and services through such non-Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization providers and facilities as the Secretary shall approve for purposes of this section; and

(2) pursuant to such procedures as the Secretary of Health and Human Services shall prescribe for purposes of this section, make payments to such providers and facilities for the provision of such care and services to Indians and individuals described in paragraph (1), at such rates as the Secretary shall specify in such procedures and in such manner so that the Secretary ensures that the aggregate payments made by the Secretary to such providers and facilities do not exceed the aggregate amounts which the Secretary

would have paid for such care and services if this section had not been enacted.

(b) **DEFINITIONS.**—In this section, the terms “Indian”, “Indian Health Program”, “Indian Tribe”, “Tribal Organization”, and “Urban Indian Organization” have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.

SEC. 903. TERMINATION OF FEDERAL COORDINATING COUNCIL FOR COMPARATIVE EFFECTIVENESS RESEARCH.

The Federal Coordinating Council for Comparative Effectiveness Research is hereby terminated and section 804 of the American Recovery and Reinvestment Act of 2009 establishing and funding such Council is hereby repealed.

SEC. 904. HHS AND GAO JOINT STUDY AND REPORT ON COSTS OF THE 5 MEDICAL CONDITIONS THAT HAVE THE GREATEST IMPACT.

(a) **STUDY.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) and the Comptroller General of the United States (in this section referred to as the “Comptroller General”) shall jointly conduct a study on the costs of the top 5 medical conditions facing the public which have the greatest impact in terms of morbidity, mortality, and financial cost. Such study shall include—

(1) current estimates as well as a “generational score” to capture the financial cost and health toll certain medical conditions will inflict on the baby boomer generation and on other individuals; and

(2) a careful review of certain medical conditions, including heart disease, obesity, diabetes, stroke, cancer, Alzheimers, and other medical conditions the Secretary and Comptroller General determine appropriate.

(b) **REPORT.**—Not later than 1 year after the date of enactment of this Act, the Secretary and the Comptroller General shall jointly submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary and the Comptroller General determine appropriate.

(c) **TARGETING OF PREVENTION AND WELLNESS EFFORTS.**—The Secretary shall target prevention and wellness efforts conducted under the provisions of and amendments made by this Act in order to combat medical conditions identified in the report submitted under subsection (b), including such medical conditions identified as the top 5 medical conditions facing the public which have the greatest impact in terms of morbidity, mortality, and financial cost as of or after the date of enactment of this Act.

SEC. 905. CONSCIENCE PROTECTION.

(a) **IN GENERAL.**—None of the funds made available in this Act (or an amendment made by this Act) may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(b) **HEALTH CARE ENTITY.**—In this section, the term “health care entity” shall include an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

SEC. 906. NONDISCRIMINATION ON ABORTION AND RESPECT FOR RIGHTS OF CONSCIENCE.

(a) **NONDISCRIMINATION.**—A Federal agency or program, and any State or local government, or institutional health care entity that receives Federal financial assistance under this Act (or an amendment made by this Act), shall not—

(1) subject any individual or institutional health care entity to discrimination; or

(2) require any health care entity that is established or regulated under this Act (or an amendment made by this Act) to subject any individual or institutional health care entity to discrimination;

on the basis that such health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(b) **DEFINITION.**—In this section, the term “health care entity” includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, a plan sponsor, a health insurance issuer, a qualified health plan or issuer offering such a plan, or any other kind of health care facility, organization, or plan.

(c) **ADMINISTRATION.**—The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on this section, and coordinate the investigation of such complaints.

SEC. 907. PROHIBITION ON GOVERNMENT ENTITIES USING COMPARATIVE EFFECTIVENESS RESEARCH FOR CERTAIN PURPOSES.

Comparative effectiveness research and clinical effectiveness research shall not be used by any government entity for payment, coverage, or treatment decisions based on costs. Nothing in the preceding sentence shall limit a physician or other health care provider from using reports and recommendations of a government entity when making decisions about the best treatment for an individual patient in an individual circumstance.

SEC. 908. SOLVENCY OF MEDICARE PROGRAM.

Any savings achieved under the Medicare program pursuant to the measures developed and implemented by the Secretary of Health and Human Services under this Act (or an amendment made by this Act) shall be reinvested into the Federal Hospital Insurance Trust Fund, as established under section 1817 of the Social Security Act (42 U.S.C. 1395i), or the Federal Supplementary Medical Insurance Trust Fund, as established under section 1841 of such Act (42 U.S.C. 1395t).

SEC. 909. TO ENSURE PATIENTS RECEIVE DOCTOR RECOMMENDATIONS FOR PREVENTIVE HEALTH SERVICES, INCLUDING MAMMOGRAMS AND CERVICAL CANCER SCREENING, WITHOUT INTERFERENCE FROM GOVERNMENT OR INSURANCE COMPANY.

(a) **IN GENERAL.**—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not use any recommendation made by the United States Preventive Services Task Force to deny coverage of an item or service by a group health plan or health insurance issuer offering group or individual health insurance coverage or under a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a-7b(f))) or private insurance.

(b) **DETERMINATIONS OF BENEFITS COVERAGE.**—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, in determining which preventive items and services to provide coverage for under the plan or coverage, consult the medical guidelines and recommendations of relevant professional medical organizations of relevant medical practice areas (such as the American Society of Clinical Oncology, the American College of Surgeons, the American College of Radiation Oncology, the American College of Obstetricians and Gynecologists, and other similar organizations), including guidelines and recommendations relating to the coverage of women's preventive services (such as mammograms and cervical cancer screenings).

SEC. 910. ENSURING THAT GOVERNMENT HEALTH CARE RATIONING DOES NOT HARM, INJURE, OR DENY MEDICALLY NECESSARY CARE.

Notwithstanding any other provision of law—

(1) no individual may be denied health care based on age or life expectancy by any Federal health program; and

(2) no entity of the Federal Government may develop Quality-Adjusted Life Year measures or other similarly designed government formulas based on an individual's social utility for limiting access to necessary medical treatment.

SEC. 911. IDENTIFICATION OF FEDERAL GOVERNMENT HEALTH CARE RATIONING.

(a) **IN GENERAL.**—The Comptroller General of the United States shall conduct, and submit to Congress a report describing the results of, a study that compares, with regard to the programs described in subsection (b)—

(1) any restrictions or limitations regarding access to health care providers (including the percentage of health care providers willing or permitted to care for patients insured by each program);

(2) any restrictions, denials, or rationing relating to the provision of health care, including medical procedures, tests (including mammograms and cervical cancer screenings), and prescription drug formularies;

(3) average wait times to see a primary care doctor;

(4) average wait times for medically necessary surgeries and medical procedures; and

(5) the estimated waste, fraud, and abuse (including improper payments) in each program.

(b) **PROGRAMS.**—The programs referred to in subsection (a) are—

- (1) Medicare;
- (2) Medicaid;
- (3) the Indian Health Service;
- (4) the Department of Veterans Affairs; and
- (5) the Federal Employee Health Benefits Program.

SEC. 912. USING HEALTH CARE PROFESSIONALS TO REDUCE FRAUD.

(a) **IN GENERAL.**—The Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall establish a demonstration project that uses practicing health care professionals to conduct undercover investigations of other health care professionals.

(b) **DEMONSTRATION PROJECT.**—

(1) **IN GENERAL.**—The Secretary, in coordination with the Office of the Inspector Gen-

eral of the Department of Health and Human Services (referred to in this section as the “Inspector General”), shall establish a demonstration project in which the Secretary enters into contracts with practicing health care professionals to conduct investigations of health care providers that receive reimbursements through any Federal public health care program.

(2) **SCOPE.**—The Secretary shall conduct the demonstration project under this section in States or regions that have—

(A) above-average rates of Medicare fraud; or

(B) any level of Medicaid fraud.

(c) **ELIGIBILITY.**—To be eligible to receive a contract under subsection (b)(1), a health care professional shall—

(1) be a licensed and practicing medical professional who holds an advanced medical degree from an accredited American university or college and has experience within the health care industry; and

(2) submit to the Secretary such information, at such time, and in such manner, as the Secretary may require.

(d) **ACTIVITIES.**—Each health care professional awarded a contract under subsection (b)(1) shall assist the Secretary and the Inspector General in conducting random audits of the practices of health care providers that receive reimbursements through any Federal public health care program. Such audits may include—

(1) statistically random visits to the practices of such health care providers;

(2) attempts to purchase pharmaceutical products illegally from such health care providers;

(3) purchasing durable medical equipment from such health care providers;

(4) hospital visits; and

(5) other activities, as the Secretary determines appropriate.

(e) **FOLLOW-UP BY THE INSPECTOR GENERAL.**—The Inspector General shall follow up on any notable findings of the investigations conducted under subsection (d) in order to report fraudulent practices and refer individual cases to the appropriate State and local authorities.

(f) **LIMITATION.**—The Secretary shall not contract with a health care professional if, due to physical proximity or a personal, familial, proprietary, or monetary relationship with such health care professional to individuals that such professional would be investigating, a conflict of interest could be inferred.

(g) **FUNDING.**—To carry out this section, the Secretary and the Inspector General are each authorized to reserve, from amounts appropriated to the Department of Health and Human Services and the Office of the Inspector General of the Department of Health and Human Services, respectively, \$500,000 for each of fiscal years 2010 through 2014.

ADJOURNMENT UNTIL 1 P.M.
TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 1 p.m. tomorrow.

There upon the Senate, at 5:34 p.m., adjourned until Sunday, December 20, 2009, at 1 p.m.

EXTENSIONS OF REMARKS

ON THE RETIREMENT OF SENATOR
JERAHMIEL "JERRY"
GRAFSTEIN OF CANADA

HON. ALCEE L. HASTINGS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Saturday, December 19, 2009

Mr. HASTINGS of Florida. Madam Speaker, as Co-Chairman of the US Commission on Security and Cooperation in Europe (the Helsinki Commission), and a former President of the OSCE Parliamentary Assembly, it is bitter-sweet that I rise today to honor the retirement of one of this nation's closest friends north of our border. Senator Jerahmiel "Jerry" Grafstein of Canada is well known to many in this House. To me, he has been a mentor, friend, and colleague for the past 15 years or so. Senator Grafstein ends his service to the Canadian Senate this month. The distinguished Chairman of the Helsinki Commission, my very good friend BEN CARDIN of Maryland, recently gave an eloquent tribute on the Senate floor to Jerry Grafstein. Rather than try to be redundant to what Chairman CARDIN has already said, I thought to honor Senator Grafstein by sharing with this House his insightful final speech in the Senate of Canada. I hope my colleagues will read it and learn from it for years to come. Let me finally say to Sen. Grafstein that I thank him for his service to his country, his friendship to our country, and his tireless work on behalf of humanity. I look forward to seeing him in Washington or the great State of Florida sometime very soon.

SENATE OF CANADA, DECEMBER 9, 2009

HON. JERAHMIEL S. GRAFSTEIN: Honourable senators, thank you for those most generous words. My late father would have been surprised. My late mother would have said, "Not nearly enough." Honourable senators, I have always been curious about the words, "maiden speech." By custom, it designates the first speech a parliamentarian makes when a parliamentarian enters a house of Parliament. What do we call a farewell speech in Parliament when we are no longer a maiden? I leave that to honourable senators' imagination.

It has been over 25 years since I was first summoned to the Senate by Mr. Trudeau. When he called to appoint me, he said, "We need you in the Senate; take your time, Jerry, to think about it." I told the Prime Minister I did not need any time, that I accepted. "This is the greatest honour anyone has ever bestowed on me," I told him. "However, Prime Minister, I do have one question." Mr. Trudeau laughed. "What is your question, Jerry?" he asked. I asked, "What did you mean when you said, 'We need you in the Senate'?"

Mr. Trudeau laughed again and I heard the phone drop. A second later he apologized and said he did not mean to laugh. He said, "Jerry, you are the very first person I have ever appointed who asked me why." "Well,

Prime Minister, why?" I repeated. "Why am I needed in the Senate?" He responded so graciously, and he said these words—I made notes at the time: "You have provided me with great ideas. Now I want you to use the Senate as a platform to share those ideas with the Canadian public."

Honourable senators, I have tried. Sometimes I succeeded. Many times I failed. However, I have been motivated by three pieces of advice that Mr. Pearson gave me when I first entered politics and I sat beside him. He told me these three things: Aim high, work hard, and be fair. Some time before my appointment, Mr. Trudeau told me at a meeting, "Jerry, you have great ideas, but you have not overcome one problem that you have." "What is that?" I said. "I do not have any problems."

"Yes, you do," he said. "Each time you advocate a great idea, automatically and spontaneously, a coalition of 'antis' spring up to fight any good idea. Your job as a politician is to navigate around that coalition and get to the other side." Then he said these words that I have never forgotten: "Never give up."

Honourable senators, each day when I awake at the Chateau Laurier, I say a short Hebrew prayer: *Modeh ani Lefanecha*—Thank God who has awakened my soul to live another day. I walk a hundred steps from the Chateau Laurier across the historic bridge over the Rideau Canal and look up to the statue of my great political hero, as Senator Munson mentioned, Sir Wilfrid Laurier, and give him a morning salute. Then I take another hundred steps, past the East Block, and the most beautiful building in Canada looms into sight. What a sight it is.

I see the Parliament buildings, the Peace Tower and, on top of it, the Canadian flag flying. I remember the courage of Mr. Pearson, who introduced the flag in the face of great division in this country. I swear every morning that I will do my very best that day for the privilege of serving in the Senate and here in Parliament. Honourable senators, I have served under eight Prime Ministers and twelve leaders in the Senate. I want to thank all of my colleagues, but especially the current deputy leaders, Senator Tardif and Senator Comeau, who have the most complex jobs in the Senate. I want to say how much I admire both of them.

Hon. Senators: Hear, hear.

Senator Grafstein: Of course, I salute my own leader, the graceful Senator Cowan, and the Leader of the Government in the Senate, Senator LeBreton, both of whom lead us here so very ably. Thank you so much. May I thank the reporters who have reproduced—do not be shocked—almost 5 million words of my speeches, resolutions, comments and reports. I would be remiss if I did not mention the researchers of the Library of Parliament who have responded to my needs. To Mark Audcent and to the legislative staff who drafted my bills, motions and resolutions with skill and professionalism, I thank you.

For the many courtesies offered to me by the Speaker, his predecessors, by the Deputy Speaker, and to all the table officers, my sincere appreciation for your patience and advice. I have learned much from all of you. Of course my special appreciation goes to my

executive assistant, who is sitting up in the gallery, Mary de Toro, who leads my mighty staff of one, the wisest woman on Parliament Hill who has kept me from making disastrous mistakes.

My first decision when I came to the Senate was what name and what designation I should use as senator. I chose my first given name, Jerahmiel, although people have called me Jerry. People have been curious about why that name and not my customary name, Jerry. Jerahmiel is mentioned only once in the Bible. He was the son of the last King of Israel. The name means "the mercy of God." It is meant to remind the holders of that name to remember that they are here to help the less fortunate. My other designation as senator is Metro Toronto, to remind me of the great city of Toronto and the regional base of the key of my responsibilities here.

What lessons have I learned in the Senate? Honourable senators, I will not predict the future. I have always worked hard in the past and in the present. In the process, I became a much better criminal lawyer, a substantial constitutional lawyer, as my friend Senator Nolin has become, and an expert international lawyer. The future, honourable senators, I leave to you.

The precious gift that the Fathers of Confederation bestowed on the Senate and senators was independence and the freedom to make choices. That is what Sir John A. Macdonald and the Fathers of Confederation gave each and every one of us. Most of my choices I shared with my party and my leader, and sometimes I disagreed and did as Mr. Trudeau advised, spoke my mind to the discomfort at times of my leaders and my colleagues on this side.

I have served on all the committees of the Senate, and I have been kicked off several committees several times when I did so, and I do not regret it. I always believed that the Senate acts best when it is true to its mandate as a chamber of second sober thought. The Senate has always made mistakes when there has been a rush to judgment. "Principles and pragmatism," so said Lloyd George, "march best when they march together."

This chamber, following the teachings of the great Blackstone, is a chamber dedicated to checks and balances. To check and balance the executive and the other house of Parliament is our constitutional mandate. Hence, we should not place our trust blindly in government. Governments do what they do and do what they want and do what they must. It can be best summed up in Psalm 146: "Put not your trust in princes." We are here to speak truth to power. That is our constitutional duty.

I recall my maiden speech when I advocated an apology to Canadians of Japanese descent. Mr. Trudeau, who had just appointed me, disagreed. He argued that we cannot correct the past but can only improve the future. I disagreed with him on the facts. Citizens of Japanese origin had been deprived of their rights and property during the war, and there was no evidence whatsoever provided to me or to the Prime Minister at the time to call in or question their loyalty to Canada. I advocated for an apology, and ultimately it was given by Brian Mulroney, and I respect him for that.

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

I recall the extradition bill, as Senator Joyal pointed out, passed by a Liberal government in haste, with barely a debate in the other place. Under that bill, the Liberal Attorney General of Canada of the day would have had the power to extradite Canadians to a state that practiced capital punishment even though Parliament had abolished capital punishment under Mr. Trudeau after a fantastic and unbelievable fight across the country. The government wanted that bill. They wanted it then. They urged it was important because of pending decisions.

I disagreed, and so did my colleague Senator Joyal. Together, with other colleagues in this chamber, we kept that debate going for several months, but finally we succumbed to our leadership and to government pressure. Senator Joyal and I decided to make our arguments in the Senate at third reading as if we were arguing before the Supreme Court of Canada because we felt that that bill would be ultimately challenged and would be shown to be unconstitutional. We sent the Senate Hansard, a public document, to all the judges of the Supreme Court, and we were so pleased over a year later when the Supreme Court of Canada upheld our major arguments.

I remember another important debate on a resolution introduced in the other place declaring Quebec "a distinct society." The government introduced that resolution here shortly after the referendum. I angered my colleagues on this side, I angered the Prime Minister, I angered the leader of the Senate, my great friend Allan MacEachen, and other colleagues on this side, when I refused to support that resolution. I gave the shortest speech I have ever given in the Senate, and I repeat it here now: Canada is a distinct society. All the rest is commentary.

While Quebecers are different, so are Newfoundlanders, so are Acadians, so are hundreds and hundreds of Aboriginal tribes and many other groups in Canada. Honourable senators, I believed then and I believe now in one Canada, bilingual and multicultural—one Canada.

One of my most stimulating periods was as chairman of the Standing Senate Committee on Banking, Trade and Commerce with Senator Angus as my congenial deputy chairman. Together, with a total consensus of all members on both sides, we did a number of important, sharp and pointed studies dealing with consumer protection of the financial securities sector, the volunteer and charitable sector, the demographic time bomb, stemming the flow of illicit money to Canada and others.

Hopefully the work we commenced on hedge funds and derivatives, started well before the last financial meltdown, and the work on reducing interprovincial trade barriers to make Canada one dynamic competitive marketplace will be completed by others in the Senate. Being a Canadian senator offers unique opportunities to travel and to participate in international affairs. One of my most satisfying experiences has been as co-chairman of the Canada-U.S. Inter-Parliamentary Group. I was elected to that office by members of Parliament in both houses for eight successive terms and served for over 16 years in that position.

The Canada-U.S. Inter-Parliamentary Group was founded in 1959 and recently celebrated its fiftieth anniversary. During my term in office, with the support of colleagues on all sides, bipartisan, we transformed that organization from one annual meeting with the Americans to an active, vigorous advocacy group meeting with state legislators,

governors in every corner of America, in addition to regular meetings on Capitol Hill in Washington with congressmen and senators to advocate one thing, Canada's interest. We learned that all politics is local, and so we have to work at the local level in the United States, and hence our meeting with state officials and governors. All problems in the United States affecting Canada start at the local level and, if detected early enough, can be diluted if not resolved.

After each meeting, honourable senators, as I will do later today, we tabled a complete report of our activities to the Senate to ensure that the senators who were interested could benefit from our experience. We were not there to represent ourselves. We were there to represent Canada, and that is why we tabled these reports. I want to thank my current co-chair in the house, Gord Brown, and my current American co-chairs, Senator Amy Klobuchar of Minnesota and Congressman James Oberstar of Minnesota, who is the only member of our group who has served the Canada-U.S. Inter-Parliamentary Group longer than I.

When I first came to the Senate, I was able to travel to a number of international organizations consistent with my work on the Standing Senate Committee on Foreign Affairs and International Trade, where I and my colleague Senator Stollery have been the longest serving members. I decided that I would focus my activities where Canada and the United States both had a vote, the Organization for Security and Co-operation in Europe, Parliamentary Assembly, which flowed out of the Helsinki Accord in 1974, currently with 56 member states from Vladivostok to Vancouver.

There I became an active member on the executive and served as an elected member for 15 years. This organization is the largest parliamentary assembly dedicated to human rights, economic rights and democratic rights in the world. I became a witness to history serving as one of the heads of election monitoring in Russia, Ukraine during the Orange Revolution, Georgia during the Rose Revolution and on the Independence Referendum for Montenegro and many others. Senator Di Nino has also served on a number of those committees with great skill and expertise.

I learned how precious democracy is and how important democracy building is for the future of the world. I worked closely with elected presidents of the assembly, and I want to pay special tribute to two recent presidents: Congressmen Alcee Hastings of Florida and João Soares, the head of the Portuguese Delegation and current Vice-President of the OSCE Parliamentary Assembly, who have done outstanding work travelling the length and breadth of the OSCE space. We have become great personal friends.

A sparkplug in this organization, which is headquartered in Copenhagen, is Spencer Oliver, the long-serving Secretary General, who is the most brilliant and knowledgeable American I have ever met, with a deep and penetrating insight into foreign affairs. He has become one of my closest friends in public life. While at the OSCE PA, I served as leader of the Liberal group there, and I finally resigned this year after 12 years. They elected me as Liberal Leader Emeritus Perpetual, a title I will cherish all my life. I do not kid myself: I achieved these offices overseas because I was Canadian, because the world respects Canada and Canadians who represent Canada.

I think the Senate should have a brief explanation, particularly those senators who

have been mildly critical of the numerous OSCE resolutions combating anti-Semitism on the Order Paper that I tabled and that are still on the Order Paper. Why those many resolutions? After the Berlin Wall came down in 1989—and I was in Germany before and after the wall came down—I thought I would finally close my dossier on anti-Semitism. There was hope for a new world order. But it was not to be. The UN had passed an invidious resolution equating Zionism with racism.

Anti-Semitism was on the rise not only across the face of the earth and around the globe, not only across Europe, but also in South America and in Canada. In 1994, a diligent congressman from New Jersey, Chris Smith, approached me to work on a resolution to combat anti-Semitism and to present it to the OSCE parliamentary assembly annual meeting. I agreed. We were joined by Congressman Steny Hoyer, now the majority leader of the Congress and one of the most powerful men in the United States, a good friend; Congressman Alcee Hastings; Congressman Ben Cardin, now a senator from Maryland; Gert Weisskirchen of the German Parliament and parliamentarians from Italy, France, Austria, Ukraine, Poland and others.

That first resolution was passed by a bare majority. Thereafter, across the face of Europe, in Copenhagen, twice in Berlin, Oporto, Cordoba, Rotterdam, Edinburgh, Vienna, London, Rome, St. Petersburg, Kazakhstan, Madrid, Washington and so forth, we continued the thrust of those resolutions, parliamentary, ministerial and side meetings.

There were two chilly experiences. I spoke on these resolutions in the Berlin Reichstag at the very podium where Hitler had declared the Nuremberg Laws in 1933. I spoke in the Hofberg Palace at the very same place in Vienna where Hitler announced the Anschluss between Germany and Austria in 1938 that most historians agree ignited World War II. This work continued, meeting after meeting, and finally, honourable senators, I brought one of these resolutions to the Senate in 2002. It was passed in 2004 and was referred to the Standing Senate Committee on Human Rights. That committee held meetings for a day or so, and then, without explanation, decided not to complete its work.

It is the first time I can recall that a resolution passed by the Senate was not followed by a committee of the Senate. I urged members of the committee to complete their work, but without success. I decided to put down resolution after resolution on the Order Paper until there could be some closure and conclusion to this matter. I was pleased some years ago that the UN would use those very resolutions to hold a one-day conference on anti-Semitism, the first of its kind at the UN. I was delighted when the British Parliament did a landmark study on this topic several years ago and published it. I am pleased that, finally, parliamentarians on the other side, under the leadership of Mario Silva and Scott Reid, are holding hearings on combating anti-Semitism. I live in hope that the Senate will consider its findings and add its considerable expertise and credit to its recommendations.

I have learned two things about this topic, "anti-Semitism," the oldest of all prejudices. First, that discrimination starts with Jews, but never ends with Jews, as one great Danish Prime Minister once said. Second, what to do? Education is the answer. The Nobel Prize winner Elie Wiesel said these words at the Berlin conference: "You can teach a child to love or you can teach a child to hate." So education is an answer. A word

about Senator Di Nino: I admire very much his work with respect to human rights not only at the OSCE but also with respect to the Dalai Lama. He has been a great and compatible companion at the OSCE, and he will continue to do great and important work over there. My congratulations to him.

Senators, I am coming to the close, but before I end, I would like to say a word about the current atmosphere in the Senate that I dislike. While I am as partisan—as everyone knows—as any senator, and will vigorously attack on behalf of my party and on behalf of my principles, I also believe in political companionship and congeniality that rises above partisan politics. I do not enjoy those who downgrade the Senate, the institution we are all privileged and summoned to serve. I have made good friends on both sides of the aisle here and in the other place. I take my leave of this hallowed hall with no regrets. I tried my best, and if I failed, I have failed trying to do my best.

Honourable senators opposite will forgive me if I remind them that my great parliamentary hero was and is Sir Winston Churchill, whose printed works and speeches I have read avidly. When Britain was in the most desperate straits in the early part of World War II, he gave this advice to his colleagues, and this is my advice to my colleagues on this side: KBO, keep buggering on. As for my colleagues on the other side, I recall that Sir Winston Churchill in his dotage confessed that he had always been a Liberal. Good advice.

If I have succeeded, I owe it to my late father and the great mentors I have encountered in politics: Mr. Pearson, Mr. Trudeau, Mr. Turner, Mr. Chrétien and Mr. Martin, and, of course, Keith Davey, our former col-

league, who taught us all on this side to love the Liberal Party. I will not say goodbye, but au revoir. On January 2, I start my third act. Regretfully, you have not heard the last of me yet. To my wife who might feel trepidation on my return to Toronto: Do not worry. I have lots of new projects that will keep me eternally occupied. All the very best to all of you, Godspeed and thank you so much.

IN HONOR AND REMEMBRANCE OF
LEO A. DIEGIDIO

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Saturday, December 19, 2009

Mr. KUCINICH. Madam Speaker, I rise today in honor and remembrance of Leo A. “Lal” DiEgidio; devoted husband, father, grandfather, great-grandfather, great-great grandfather and dear friend to many. His generosity, concern for others and gift for singing uplifted countless people throughout our community.

Mr. DiEgidio’s life was centered on family, faith, hard work and his love of song. For more than forty years, he lifted the spirits of people of all ages with his beautiful singing voice. Mr. DiEgidio volunteered his time and talents by visiting nursing homes and singing for residents and staff. During many of these visits, he sang with another local celebrity singer, Rocco Scotti. Mr. DiEgidio directed the

choir at Gunning Park Golden Age Center in Cleveland, and was a founding member of the Choir at Holy Name Church, where he sang for nearly eighty years. Mr. DiEgidio often sang duets with the late Father John Dalton, whose favorite was “Danny boy.” Mr. DiEgidio was also known for his powerful versions of “The Star Spangled Banner” and “God Bless America.”

Mr. DiEgidio lived his life with a spirit of generosity, a compassion for others, and a joy of living. His quick smile easily drew others to him. He was a devoted husband to the late Harriette, and was a devoted father to the late Leo, Ronald and Lalene. Together, Lal and Harriette worked hard to provide a wonderful and loving home for their family. In 1951, he established Lal’s Cleaners and Tailors on Garfield Boulevard in the heart of Garfield Heights, Ohio. Now owned by his grandson, the business continues. Mr. DiEgidio was active in the Italian-American community of Garfield Heights. He was a longtime member of the Knights of Columbus Council and the Solon Italian-American Club.

Madam Speaker and colleagues, please join me in honor and remembrance of Leo A. “Lal” DiEgidio, whose joyous spirit and love for others will exist forever within the hearts and memories of those who loved and knew him best—his family and friends. His life, framed by his gift of song, compassion for others, devotion to family and commitment to community, will be always celebrated and remembered.

SENATE—Sunday, December 20, 2009

The Senate met at 1 p.m. and was called to order by the Honorable JEANNE SHAHEEN, a Senator from the State of New Hampshire.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Most merciful God, the fountain of wisdom and goodness, on this snowy weekend, guide our lawmakers with Your insights. When confused thoughts emerge, clarify and straighten them with Your wisdom. Bring their desires and powers into conformity to Your will. May their lives be as lighted windows amid the encircling gloom. Lord, save them from a cynical pessimism by reminding them that these challenging times are in Your Hands. Strengthen their resolve to press on with focused attention on the duties of this day.

Bless also the many unseen workers who support our Senators with sacrificial and faithful labors. Lord, reward them for their diligence and patriotism.

We pray in Your merciful Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable JEANNE SHAHEEN led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The bill clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 20, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable JEANNE SHAHEEN, a Senator from the State of New Hampshire, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mrs. SHAHEEN thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. REID. Madam President, following leader remarks, the Senate will resume consideration of the health care legislation, with the time until 1:30 p.m. equally divided and controlled between the two leaders or their designees. Beginning at 1:30 p.m., and until 11:30 p.m. tonight, the time will be controlled in alternating hours, with the Republicans controlling the first hour.

At 11:30 p.m., the Senate will recess until 12:01 a.m., with the time until 1 a.m. equally divided and controlled between the leaders or their designees, with the majority leader controlling the final 10 minutes and the Republican leader controlling the 10 minutes prior to that.

At 1 a.m., tomorrow, the Senate will vote on the motion to invoke cloture on the managers' amendment to the health care bill.

Madam President, the time I have until 1:30 p.m., I designate to the majority whip, the senior Senator from Illinois.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of H.R. 3590, which the clerk will report.

The bill clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time home buyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid amendment No. 2786, in the nature of a substitute.

Reid amendment No. 3276 (to amendment No. 2786), of a perfecting nature.

Reid amendment No. 3277 (to amendment No. 3276), to change the enactment date.

Reid amendment No. 3278 (to the language proposed to be stricken by amendment No. 2786), to change the enactment date.

Reid amendment No. 3279 (to amendment No. 3278), to change the enactment date.

Reid motion to commit the bill to the Committee on Finance, with instructions to report back forthwith, with Reid amendment No. 3280, to change the enactment date.

Reid amendment No. 3281 (to the instructions (amendment No. 3280) of the motion to commit), to change the enactment date.

Reid amendment No. 3282 (to amendment No. 3281), to change the enactment date.

The ACTING PRESIDENT pro tempore. Under the previous order, the

time until 1:30 p.m. shall be equally divided and controlled between the two leaders or their designees.

The Senator from Illinois.

Mr. DURBIN. Madam President, I thank the majority leader for designating that I should control half the time between now and 1:30.

I would like to, first, thank all the people who are here, the staff and the pages. This has been a tough session for many but tougher for many of them than some Members of the Senate because many times they have had to wait until the very last Senator of either political party has finished for the day before they go home. I was reflecting on that yesterday afternoon in the midst of one of the toughest, historic snowstorms in Washington, DC; that hundreds of staff people were waiting at their post, doing their jobs on a Saturday, in the middle of a snowstorm, when virtually every business around Washington was closing down. I wish to thank them and the pages on both sides of the aisle for their patience and commitment to this great country and this great institution.

Why are we here on Sunday? Why were we here on Saturday? Why are we going to take a vote at 1 in the morning on Monday? Good questions, and I am not sure there are satisfying answers. But there are answers. We are here because we are trying to finish health care reform. It has been a project that has been underway for almost a year now, since the President challenged us to do something, and a lot of effort has been expended on both sides of the aisle. But I will say I can speak for our side of the aisle.

Senator MAX BAUCUS came to me more than a year ago and sat down in my office to talk about health care reform. He was preparing for this battle as chairman of the Senate Finance Committee and knew he would play a central role, gathering the opinions of members of his committee and Members of the Senate.

Efforts were underway with Senator Kennedy from his remote location in Massachusetts, recuperating from surgery and from cancer therapy, trying to keep his committee on track toward health care reform. He turned over that mantle to Senator CHRISTOPHER DODD of Connecticut, who did an admirable job with the Senate Health, Education, Labor, and Pensions Committee.

They prepared for and had hearings. They entertained hundreds of amendments. In fact, I believe there were over 160 amendments that were proposed by the Republicans, and many of

them were adopted in the HELP Committee.

Senator COBURN of Oklahoma filed 212 amendments during the HELP Committee markup. He offered 38 amendments to the bill. Nineteen of his amendments—half of them—were agreed to. Of those that were offered, 15 were not agreed to—all by rollcall vote. So 13 amendments offered by the Senator from Oklahoma were included in the bill that is before us today.

He has questioned whether the current procedure gives him an opportunity to offer amendments. The fact is, we are now on our 21st day of considering health care reform. Exactly 4 amendments have been offered by the Republican side of the aisle, 4 substantive amendments to change provisions in this bill of 2,000 pages—in 21 days, 4 amendments. They offered six motions to stop the debate, send the bill back to committee. They were generic motions. They did not ask for specific changes. They just take on an issue in the bill and say: Send it back to the committee and tell them to solve this problem and then bring it back to the floor at a later time. Well, that is kind of a procedural and, if I might say, political statement more than a substantive statement about a provision in the bill.

So exactly four amendments have been offered by the Republican side of the aisle that deal with substance. Some of their efforts have been in protection of the health insurance industry, particularly a program called Medicare Advantage, which was created by private health insurance companies to prove to government they could provide Medicare more cheaply.

Some did but most did not, and now we are paying up to \$17 billion a year subsidizing private health insurance companies that told us at the start: We will save you money. It turns out they are costing us money—a lot of money—and many of us think it is wasteful. We would rather have that money spent on basic Medicare, making certain there is solvency in Medicare and a good, strong future.

So when you look at the state of the situation, we are now on a cloture motion to bring a close to the debate on health care reform, after almost 3 weeks and four Republican amendments—only four were offered. There never was a Republican substitute, no Republican proposal for health care reform. We have been told this might exist. We have never seen it. Of the four amendments they offered, not one was this substitute that was going to deal with the health care system. It is a promise that has not been kept. They kept saying: It is coming. Pretty soon we are just going to put this thing right in the RECORD. Well, it never happened. In 3 weeks, it never happened.

It is hard work to prepare a substitute. The reason this took so long

and has dragged on for so long is we had to take every page of this and turn it over to the Congressional Budget Office. They sit there with their economists, pore over it and say: Well, is it going to add to the deficit or reduce the deficit? Is it going to reduce health care costs? What is the impact? It takes them some time to do that. The Republicans know if they are going to have a substitute, it will have to go through the same rigorous appraisal, and they have not done that, I think because it is hard. In fact, from their political point of view, it might be impossible to try to solve the problems facing health care in America without taking the path we have taken.

What does this bill do? The basics are obvious. First,—and this is all backed up by the Congressional Budget Office—it will reduce the cost of health care. It will make it more affordable. A health care policy for a family of four offered by an employer, on average, cost \$6,000 10 years ago. Today, it costs \$12,000 a year. It has doubled in 10 years, and in 8 years it will double again to \$24,000. We have to slow this down or it will reach a point where more and more people will be uninsured, fewer businesses will offer health insurance, and more individuals will find themselves unable to afford the basic protections they need for themselves and their families.

So the Congressional Budget Office tells us we reduce the growth in the cost of health care, and that is a good thing. They came through with a dramatic revelation yesterday when they said this bill will reduce our deficit as well. If the cost of health care goes down, the cost of health care programs offered by government goes down. They tell us in 10 years we will save \$130 billion from the deficit. That is a dramatic savings—the largest in history. But then the news got better. They said, in the second 10 years, instead of saving \$650 billion from our debt and deficit, it could reach double that amount: \$1.3 trillion in savings in the second 10 years.

I would say to those who give speeches day after day about our deficit, I invite you—in fact, I challenge you to come up with a bill that does this, that gives us actual savings of \$130 billion in 10 years and \$1.3 trillion in the next 10 years. It is hard to do. It may be impossible for some to come up with such a bill.

This bill also will extend the coverage of health insurance so 94 percent of Americans will have coverage. Madam President, 30 million Americans today who have no health insurance will have health insurance under this bill. Half of them are poor enough that they will receive Medicaid; the other half will qualify for the insurance exchanges and other tax credits to help them pay their premiums so they can have and afford health insurance.

Ninety-four percent of Americans—we have never, ever achieved a level of insured Americans that reached that number. Thirty million Americans will be receiving health insurance at the end of the day.

This bill will start giving consumers across America protections they need against abuses from health insurance companies. One of the things near and dear to my heart about this amendment, which has been criticized by some, is this amendment, which was offered yesterday, has been on the Internet, for those who are interested to read it, for 24 hours, and will continue to be available.

This amendment says that as soon as this is signed, health insurance companies across America cannot deny coverage to children, those under the age of 18, because of a preexisting condition. That means if your son or daughter is diagnosed with diabetes, juvenile diabetes, and you find it difficult to get health insurance today because of that preexisting condition, they will no longer be able to discriminate against your child and your family because of this bill. That is one thing. There are many others.

This whole notion of health insurance companies waiting until you get sick and cut you off when you need them the most, that comes to an end, under this amendment, in 6 months. So over and over again, we give consumers across America a chance to have the coverage they paid for when they need it the most. We used to call it the Patients' Bill of Rights, and it used to be bipartisan. It was Senator Kennedy and Senator MCCAIN who brought it to us, and it failed because the health insurance companies were so politically powerful. But we have got them this time. If we can pass this bill, we finally have the protections the American people so desperately need.

There are other provisions in the bill. Right from the beginning, we provide more help to small businesses. These are businesses with 50, 25 employees and an average payroll of \$50,000 an employee to \$25,000 an employee or less. For each of those businesses, we say: We are going to help you buy health insurance for the owners of the business as well as for the employees. Those are the folks who are struggling and losing coverage, people such as the realtors in your hometown. Did you know one out of four realtors in America has no health insurance. I did not know it until they came to see me. Well, this gives them a hand. It gives them a tax break as a small business to provide health insurance for their people.

I am going to reserve the remainder of my time. I will tell you, we are here today. We are burning the hours off the clock to vote at 1 a.m. in the morning. It would be more humane to the people who work here, to the Members of the Senate and their families, for us to

reach a gentlemanly and gentlewomanly agreement that we will have this vote at a more reasonable time. If we have the 60 votes, which I think we have the commitments for, then we can decide how to move forward.

We have had a long, arduous, and sometimes taxing debate leading to this moment. I think it is time for a vote. The sooner we can reach that vote, the sooner the American people will know that we will either succeed or fail in bringing stability and security when it comes to their health insurance, making that health insurance more affordable, extending the reach and protection of health insurance to record levels of Americans, making sure we have health insurance reform as part of this, and at the same time, at the very same time reducing our deficit.

I reserve the remainder of our time.

The ACTING PRESIDENT pro tempore. Who yields time?

Mr. DURBIN. Madam President, how much time do I have remaining?

The ACTING PRESIDENT pro tempore. There is 1 minute 50 seconds.

Mr. DURBIN. Madam President, I wish to suggest the absence of a quorum and ask unanimous consent that the time under the quorum be allotted equally to both sides.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The clerk will call the roll.

The assistant bill clerk (Sara Schwartzman) proceeded to call the roll.

Mr. CHAMBLISS. Madam President, I ask unanimous consent the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. CHAMBLISS. Is it correct, Madam President, the minority side has the hour from 1:30 to 2:30?

The ACTING PRESIDENT pro tempore. That is correct. Under the previous order, the time until 11:30 p.m. shall be controlled in alternative 1-hour blocks with the Republicans controlling the first hour.

Mr. CHAMBLISS. I, then, Madam President, ask unanimous consent Senators CORNYN, GRAHAM, ISAKSON, and myself be allowed to have a colloquy during this first hour, from 1:30 to 2:30.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. CHAMBLISS. Madam President, here we are on our 21st legislative day, less than 4 weeks, on the most major piece of health care legislation ever proposed in the history of our great country. That is less than weeks that we have been on this bill that seeks to change the way health care is delivered in America and also seeks to change the way individuals have access both to health care itself as well as to insur-

ance. During this period of time—and we are headed, I might say, too, toward passage of this bill in the Senate over the next couple of days.

I do not remember, in my 15 years in the Congress, both in the House and in the Senate, any major piece of legislation such as this being debated and ultimately brought to a final vote within such a short period of time. I have been involved in farm bills that have been on the Senate floor for longer than this—any number of other pieces of legislation that we deal with on a regular basis that have been on the Senate floor for longer than that period of time.

I heard the assistant majority leader a little earlier talking about the fact that we have had the opportunity to amend this bill. The fact is, the Republicans have been offered the opportunity to introduce 10 amendments to this massive piece of legislation for debate on the floor. We have a number of other amendments that have been filed. The four of us here today have significant amendments that we filed that now we are not going to have the opportunity to call up. It is extremely unusual for such a massive change in American policy being debated and voted upon without not only bipartisan support but without bipartisan participation from the standpoint of giving us the opportunity to file amendments, to have those amendments debated and voted upon.

The assistant majority leader also referenced amendments by Senator COBURN. I am not going to speak for him. He will be on the floor of the Senate later today to certainly speak well for himself. But the fact is, he and other Members of the HELP Committee offered any number of amendments, as well as Members of the Finance Committee offered any number of amendments, that were voted down in the HELP Committee and in the Finance Committee on a pure partisan vote.

It was the opportunity for meaningful participation by Republicans, who have some pretty good ideas about health care, to participate in the development of this bill, and it simply did not happen.

Let me say what Republicans are for. There have been comments on this floor that there has been no substitute bill offered. The fact is, Senator BURR and Senator COBURN, who will be on the floor a little bit later, have spent hours on the floor of this Senate talking about their proposed bill that is not going to see the light of day. It has never been allowed to come up in committee, and it is not going to be allowed to come up on the floor of the Senate because the majority leader has done what we call fill the tree. That is the Washington speak way of saying that all amendments are now cut off. There will be no more additional

amendments debated and brought up for a vote. But that is just one of four separate plans that have been filed and laid on the table, not just for the last 72 hours but for the last several months. They have been available to look at online. There are any number of cosponsors to the bipartisan Wyden-Bennett bill. There is also the Gregg bill. There is the Coburn-Burr bill. There are any number of alternate proposals out there that the majority has simply decided: We do not think those bills are worth even debating on the Senate floor, so they have not allowed those bills to come up.

But what are Republicans for? We have said this over and over. Let me just say, No. 1, we are for meaningful, affordable access to health insurance by every single American. We can do it in a way that does not raise taxes. We are for providing coverage for all Americans, including those who have had preexisting conditions. We can do it in a way that does not raise taxes.

We are for trending down the cost curve; when it comes to health care reform, if we do not turn that cost curve downward, then we have failed the American people. Frankly, the independent Congressional Budget Office has said health care cost under the Reid proposal is going to not only continue to go up but it is likely—not only will it continue on its current curve, but it is going to go up and not down.

The way you can ensure that cost curve turns down, just two Republican proposals that we think have an awful lot of merit but are not going to be considered and certainly are not going to be included—are not included in the managers' amendment that has now been filed—one of those is tort reform. Physicians all across the country have been crying for this for years. But, more so, health agencies and individuals who have to pay health care bills have been crying for this for years. We can do it in a way that will allow every aggrieved individual who is injured as a result of negligent health care being delivered to have their day in court. Yet we need to provide some means of the elimination of the frivolous lawsuits that go so much toward physicians having to call for tests that they might not otherwise need; and also to prevent the spiraling costs, on the delivery side, of health care because of the high cost of malpractice insurance as well as other measures.

The other way we can trend that curve down is to provide preventive incentives to individuals across America to live healthier lives. There is example after example that we have talked about on the floor of the Senate—from health care providers, employers who have provided incentives in their program, their health insurance program, that have in fact lowered costs. We can do that. There are proposals to do that, but they are not included in the managers' package.

Insurance reform—Republicans have been very strong about the fact that, as a part of overall health care reform, we need to reform the insurance industry, rein in some measures that have caused the cost of health insurance that is provided by employers to, again, not only level off but ultimately trend downward.

How do we do that, and what ideas have been proposed? We have proposed the sale of insurance policies across State lines. There is a provision in the underlying bill that does that. I am very pleased to see that included.

Another thing we can do is to allow for what is called associated health plans that Republicans have been promoting for years. Every time it has come up for a vote in this body, the Democrats have opposed allowing individuals across State lines to group together and spread the risk of health insurance coverage. It would go a long way toward reducing the cost of health insurance premiums. But, unfortunately, we have not been allowed to move forward with that proposal.

Let me mention a couple of things, before I turn to my friend from Texas, with respect to the changes in the Reid amendment that was filed yesterday. Again, there have been a number of individuals who have come to the floor since that amendment was filed yesterday to talk about the fact that it is online, and as we look through it more and more we are finding more and more about it, that is true. But it certainly does not meet the test of giving us 72 hours before we vote on it.

The number of pages in the bill now, the base bill plus the Reid amendment plus the Indian health bill, which is now included by reference, totals 2,733 pages. The gross Medicare cuts—and these are not slowing the growth of Medicare. These are direct Medicare cuts that are being used to finance the underlying health care bill—now totaling \$470.70 billion. The gross tax increases in the Reid amendment now total \$518.5 billion. CBO says the gross cost of the insurance coverage expansion is \$23 billion higher under the Reid amendment than it was under the base bill. Federal revenues or Federal taxes increase by almost \$26 billion under the managers' package.

All told, the amendment reduces the deficit by \$2 billion—going from \$130 to \$132 billion. But, boy, is that ever a figleaf. We are going to talk about the CLASS Act that provides for that increase in the deficit.

The Federal cost curve, according to CBO, still goes up. I alluded to that a little bit earlier.

There is a slight increase in additional coverage—but still under the Reid amendment there will be 23 million Americans left uninsured. That is not what we have heard from the other side of the aisle from day one about making sure that every single American was covered.

Despite the fact the Democrats have said changes in the managers' package would improve the delivery system, CBO also says it is likely that the amendment would have little impact on premiums.

As we move toward the cloture votes on this bill over the next couple of days, I think it is important for the American people to get some understanding of the fact that the deals that have been made, the deals that have been cut to get the Democrats to 60 votes on this bill do not do what has been said over and over by folks on the other side of the aisle.

I would now like to ask my friend from Texas how it impacts Texas, the managers' amendment, as well as the underlying bill and other comments he has relative to the bill.

The ACTING PRESIDENT pro tempore. The Senator from Texas is recognized.

Mr. CORNYN. Madam President, I look forward to engaging with both the Senator from Georgia and the Senator from South Carolina, Mr. GRAHAM. I have been in the Senate now for 7 years, which is not all that long compared to the length of service of a number of Senators. I was and have been proud to represent the 24 million citizens of the State of Texas here in the Senate and the seat that was first held by Sam Houston in 1846.

Sometimes the Senate is referred to as the world's greatest deliberative body. I think that description is a description that inspires schoolchildren and lovers of this great democracy of ours to admire and respect this body. But I have to tell you, I think the world's greatest deliberative body might not apply to this particular piece of legislation. It might, rather, be called the world's biggest railroad because of the railroading of the legislation that was revealed here only yesterday by Senator REID, cooked up behind closed doors with a variety of interest groups negotiating deals on the side, deals that are unknown.

We know some of those pertain to hospitals, some to the pharmaceutical companies. Then I heard one of our other Senators from North Carolina yesterday say we should call this "The Price Is Right" because we know a number of Senators held out for various inducements, financial inducements, to encourage them to get to the 60 votes.

So we do not know what kind of deals have been cut behind closed doors, what kind of deals individual Senators may have made. But the American people need to know what is in this legislation and how it will affect them.

Unfortunately, notwithstanding the fact that the President of the United States said, You know what, when I am elected President, we are going to have negotiations around a big table and televise it on C-SPAN, good luck. So much for that broken promise.

We know other Senators who expressed the same concerns the Senator from Georgia did about having at least 72 hours by posting this on the Internet so the American people can read it and so we can consult with our constituents—the hospitals, the small businesses, the doctors—to say how does this affect you?

We had eight Democratic Senators on October 6, 2009, who said they wanted the CBO scores and they wanted them posted 72 hours ahead of time before the first vote. So much for that. We know that is going to be thrown out the door as well.

That demand, I suppose, was made more for public relations rather than any real desire to find out what is in the bill and share it with the American people because we know legislative language will be available only 40 hours before the first vote at 1 a.m. this morning, literally in the middle of the night. The Congressional Budget Office score is available only 37 hours before the first vote.

What we are talking about is this legislation. The Senator from Georgia said 2,700 pages, I believe, when you consider all of the legislation we are going to be asked to vote on the first time on a cloture vote at 1 in the morning, about 12 hours from now. We have been feverishly reviewing this language to find out what is in it. Frankly, what we find out is that it makes things worse rather than better in a number of key respects.

For example, we know that America spends near double what any other industrialized Nation does on health care. One of the stated goals, one which the Democrats and Republicans both agree on, is that this reform ought to control those costs rather than make it worse. I have an amendment, amendment No. 2806, designed to ensure that health care reform achieves the goal we all support.

We know that private insurance premiums have more than doubled in the last 10 years for American families. The Congressional Budget Office estimates that taxpayer spending on government health programs will rise to 12 percent of our economy by 2050. That will be a debt of \$322,000 for the unfunded liabilities of Medicare alone. This bill does not make things better. It makes things worse, according to the Obama administration Chief Actuary.

I have an amendment which would apply the truth test to the Obama administration's own independent Actuary, based on the evidence the Reid bill would increase health care costs for the Nation, for American families, for American taxpayers. This amendment leaves it up to the Office of the Actuary of the Centers for Medicare and Medicaid Services. If that office finds the Reid bill does lower health costs as advertised, the bill would then proceed

to go into effect. But if, in fact, it does not, then it will not.

Advocates of the Reid health bill continue to promise it lowers health care costs, but this amendment will apply the truth test to the Obama administration's own independent Actuary.

I see the distinguished majority whip on the floor. I am glad he is here because he may have something to say about this.

I ask unanimous consent that the pending amendment be set aside and that I be allowed to call up amendment No. 2806.

The ACTING PRESIDENT pro tempore. Is there objection?

Mr. DURBIN. Reserving the right to object.

The ACTING PRESIDENT pro tempore. The Senator from Illinois.

Mr. DURBIN. Madam President, this is the 21st day of debate. There have been four substantive amendments offered by the Republican side. They have had ample opportunity to call for this—

Mr. CORNYN. I call for the regular order.

The ACTING PRESIDENT pro tempore. Regular order has been called for. Does the Senator object?

Mr. DURBIN. I object.

The ACTING PRESIDENT pro tempore. Objection has been heard.

Mr. CORNYN. Madam President, I ask my colleagues to comment on some of the other broken promises. The President made a solemn pledge that he would sign a universal health care bill. This bill, as I understand it, still leaves 15 million people without insurance coverage. He says the costs will be cut by up to \$2,500 a year. The reality is the average premiums would increase by \$2,100.

I ask perhaps our distinguished colleagues from South Carolina and Georgia to comment on the promises that the President has made with regard to transparency, the promises he has made with regard to premiums going down rather than up, the promises he has made with regard to Medicare—promises it appears this bill will not allow him to keep.

Mr. GRAHAM. Everything the 2008 campaign was about has basically been discredited and discarded in this whole health care debate. I thought it was change we could believe in. I thought there was going to be a new way of doing business in Washington, and God knows there needs to be. I thought we were going to negotiate the health care bill on C-SPAN and everybody would have a seat at the table, including the drug companies. I thought we were going to allow reimportation of prescription drugs to allow American consumers to purchase drugs dramatically cheaper.

Not only have we not had any negotiations on C-SPAN, you couldn't find the room where the negotiations were

going on. The old way of doing business looks good compared to this process. There was a negotiation going on on the biggest proposal we will probably ever vote on, one-sixth of the economy, between two people: the Senate majority leader and the Senator from Nebraska.

The second in command on the Democratic side told Senator McCain: I am just as in the dark as you are. We have gone to a promise of being on C-SPAN to everybody was in the dark. I don't know how that plays. I hope it plays poorly because at the end of the day, what we are doing here is absolutely unconscionable. When you thought it couldn't get any worse in Washington, when you thought your government had reached a low point, well, it has gotten worse. I will be talking about the 60th vote here soon, how they got that 60th vote. And if that is OK with the American people, which I do not believe it will be, if that is OK with our body, then our best days are behind us as a country.

Mr. CORNYN. May I ask the Senator from South Carolina about this other promise? Does he recall the President saying in July of 2009, if you like what you have, you can keep it? Is the Senator aware of the fact that according to the Congressional Budget Office, between 8 and 9 million people who would have been covered by employment-based plans under the current law would not have an offer of such coverage under this bill if passed, and seniors, because of the cuts to Medicare, particularly Medicare Advantage, will actually have their benefits cut? How do you reconcile those promises with what we see in this monstrosity of a bill?

Mr. GRAHAM. They cannot be reconciled. I hope American seniors are paying attention. We are going to take \$470 billion out of Medicare in the next decade and use that money to create new government programs. If you are senior citizens out there, the doctors and hospitals you go to—and it is hard to find Medicare doctors right now; a lot of doctors are reluctant to take Medicare patients because the reimbursement rates are so low. Rural hospitals are on their knees because the Medicare rates are so low. Take \$470 billion out of the system and see what happens to the provider community.

What does it mean to seniors? It means your chance of finding the doctor or hospital to take care of you as a Medicare patient is going down, not up. What does it mean to Medicare? It is due to go bankrupt by 2017. By taking money out of the system, not reforming Medicare, but using it as another purpose has accelerated the problems of Medicare. Not only has that promise been broken, we have done something no other Congress has ever done to Medicare—take money out of it and give it to somebody else. That is not

right. We were within inches of expanding Medicare to people from 55 to 64 which would put the system at risk.

My point is simply this. We started this debate as a way to reform health care, and a lot of us agree on many things. It wound up being what does the Democratic Party need to do to pass a bill. Nobody cares what is in this bill anymore. All the objections about the CLASS Act and about fiscal responsibility and about the public options being in or out have given way to get this thing done before Christmas.

This is not about health care reform. It is about one political party feeling as though they have to pass a bill no matter what is in it. And that is sad.

Mr. CORNYN. I wonder if my colleagues will comment. I have one last chart I want to share with them and anybody who might be watching on this Sunday afternoon shortly before Christmas.

Every public opinion poll I have seen says the American people do not want us to pass this bill. So one has to wonder: All of us have to run for election in our States. Obviously, to win an election, you have to get a majority of voters. But 56 percent of U.S. voters in the country say they do not want this bill to pass. And yet this thing seems as though it is on an unstoppable path toward passage because 60 Senators, apparently defying the will of their constituents, seem determined to pass the bill.

Can my colleagues explain to me what they think is going on here?

Mr. CHAMBLISS. I think it is obvious it is pure arrogance on the part of the folks on the other side of the aisle. The American people do not want it, but they are saying Washington knows better than the people back home know. That is pretty clear.

I know my colleague from Georgia is like me, when we go back home, we get stopped in the airport, in the grocery store, on the streets, all around different parts of Georgia. People are not happy about what is going on up here with respect to this bill. I wish to ask him about his comments with respect to where we are.

Mr. ISAKSON. Like the Senators from Texas and South Carolina and my senior Senator from Georgia, we all represent the people who vote for us. And in reference to Senator Cornyn's question about popularity, about the way people feel about this legislation, I ask unanimous consent to have printed in the RECORD two letters—one from the Medical Association of Georgia and one from a consolidated group of medical associations representing 92,000 physicians.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MAG IN GROUP REPRESENTING 92,000 DOCTORS
OPPOSING SENATE HEALTH BILL

ATLANTA.—The Medical Association of Georgia (MAG) is part of a group of state and

national specialty medical societies that represents more than 92,000 practicing physicians from across the U.S. that sent a letter to U.S. Senators today urging them to oppose the "Patient Protection and Affordable Care Act" (H.R. 3590) because it clears the way for government-controlled medical care.

MAG President Gary C. Richter, M.D., says, "We believe that this bill would create a staggering volume of new federal regulatory requirements for medicine, that it isn't sustainable from a budget standpoint, that a 'public' or 'community' health insurance option may lead to a single-payer system, that the measure lacks meaningful tort reform and actually discourages proven reforms like limiting attorney fees and malpractice caps, and that the bill does not fix the Medicare Sustainable Growth Rate, or SGR, formula."

In the letter, the physician groups ask Senate leaders to "draft a more targeted bill that will reform the country's flawed system for financing health care, while preserving the best health care in the world." The letter states, "We are therefore united in our resolve to achieve health system reform that empowers patients and preserves the practice of medicine—without creating a huge government bureaucracy."

The letter also highlights some of the bill's more "problematic provisions," stressing that it undermines the patient-physician relationship. The correspondence points out that the bill does not provide for the right to privately contract—a "touchstone of American freedom and liberty"—and it stresses that "patients should have the right to choose their doctor and enter into agreements for fees and services without penalty." The letter urges lawmakers to develop legislation that "allows patients and physicians to take a more direct role in their health care decisions," and it points out that decisions surrounding medical care isn't an appropriate role for the government or other third party payers.

Along with MAG, signatories include the Medical Association of the State of Alabama, the Medical Society of Delaware, the Medical Society of the District of Columbia, the Florida Medical Association, the Kansas Medical Society, the Louisiana State Medical Society, the Missouri State Medical Association, the Nebraska Medical Association, the Medical Society of New Jersey, the Medical Society of South Carolina, the American Academy of Cosmetic Surgery, the American Academy of Facial Plastic and Reconstructive Surgery, the American Association of Neurological Surgeons, the American Society of Breast Surgeons, the American Society of General Surgeons, and the Congress of Neurological Surgeons. Three past presidents of the American Medical Association—Donald J. Palmisano, M.D., William G. Plested III, M.D., and Daniel H. Johnson Jr., M.D.—also signed the letter.

DECEMBER 7, 2009.

Hon. HARRY REID,
Majority Leader, U.S. Senate,
Washington, DC.

DEAR SENATOR REID: The undersigned state and national specialty medical societies are writing you on behalf of more than 92,000 physicians in opposition to passage of the "Patient Protection and Affordable Care Act" (H.R. 3590) and to urge you to draft a more targeted bill that will reform the country's flawed system for financing healthcare, while preserving the best healthcare in the world. While continuance of the status quo is not acceptable, the shifting to the federal

government of so much control over medical decisions is not justified. We are therefore united in our resolve to achieve health system reform that empowers patients and preserves the practice of medicine—without creating a huge government bureaucracy.

H.R. 3590 creates a number of problematic provisions, including:

The bill undermines the patient-physician relationship and empowers the federal government with even greater authority. Under the bill, (1) employers would be required to provide health insurance or face financial penalties; (2) health insurance packages with government prescribed benefits will be mandatory; (3) doctors would be forced to participate in the flawed Physician Quality Reporting Initiative (PQRI) or face penalties for nonparticipation; and (4) physicians would have to comply with extensive new reporting requirements related to quality improvement, case management, care coordination, chronic disease management, and use of health information technology.

The bill is unsustainable from a financial standpoint. It significantly expands Medicaid eligibility, shifting healthcare costs to physicians who are paid below the cost of delivering care and to the states that are already operating under severe budget constraints. It also postpones the start of subsidies for the uninsured long after the government levies new user fees and new taxes to cover expanded coverage and benefits. This "back-loading" of new spending makes the long-term costs appear deceptively low.

The government run community health insurance option eventually will lead to a single-payer, government run healthcare system. Despite the state opt-out provision, the community health insurance option contains the same liabilities (i.e. government-run healthcare) as the public option that was passed by the House of Representatives. Such a system will ultimately limit patient choice and put the government between the doctor and the patient, interfering with patient care decisions.

Largely unchecked by Congress or the courts, the federal government would have unprecedented authority to change the Medicare program through the new Independent Medicare Advisory Board and the new Center for Medicare & Medicaid Innovation. Specifically, these entities could arbitrarily reduce payments to physicians for valuable, life-saving care for elderly patients, reducing treatment options in a dramatic way.

The bill is devoid of real medical liability reform measures that reduce costs in proven demonstrable ways. Instead, it contains a "Sense of the Senate" encouraging states to develop and test alternatives to the current civil litigation system as a way of addressing the medical liability problem. Given the fact that costs remain a significant concern, Congress should enact reasonable measures to reduce costs. The Congressional Budget Office (CBO) recently confirmed that enacting a comprehensive set of tort reforms will save the federal government \$54 billion over 10 years. These savings could help offset increased health insurance premiums (which, according to the CBO, are expected to increase under the bill) or other costs of the bill.

The temporary one-year SGR "patch" to replace the 21.2 percent payment cut in 2010 with a 0.5 percent payment increase fails to address the serious underlying problems with the current Medicare physician payment system and compounds the accumulated SGR debt, causing payment cuts of nearly 25 percent in 2011. The CBO has confirmed that a

significant reduction in physicians' Medicare payments will reduce beneficiaries' access to services.

The excise tax on elective cosmetic medical procedures in the bill will not produce the revenue projected. Experience at the state level has demonstrated that this is a failed policy. In addition, this provision is arbitrary, difficult to administer, unfairly puts the physician in the role of tax collector, and raises serious patient confidentiality issues. Physicians strongly oppose the use of provider taxes or fees of any kind to fund healthcare programs or to finance health system reform.

Our concerns about this legislation also extend to what is not in the bill. The right to privately contract is a touchstone of American freedom and liberty. Patients should have the right to choose their doctor and enter into agreements for the fees for those services without penalty. Current Medicare patients are denied that right. By guaranteeing all patients the right to privately contract with their physicians, without penalty, patients will have greater access to physicians and the government will have budget certainty. Nothing in the Patient Protection and Affordable Care Act addresses these fundamental tenets, which we believe are essential components of real health system reform.

Senator Reid, we are at a critical moment in history. America's physicians deliver the best medical care in the world, yet the systems that have been developed to finance the delivery of that care to patients have failed. With congressional action upon us, we are at a crossroads. One path accepts as "necessary" a substantial increase in federal government control over how medical care is delivered and financed. We believe the better path is one that allows patients and physicians to take a more direct role in their healthcare decisions. By encouraging patients to own their health insurance policies and by allowing them to freely exercise their right to privately contract with the physician of their choice, healthcare decisions will be made by patients and physicians and not by the government or other third party payers.

We urge you to slow down, take a step back, and change the direction of current reform efforts so we get it right for our patients and our profession. We have a prescription for reform that will work for all Americans, and we are happy to share these solutions with you to improve our nation's healthcare system.

Thank you for considering our views.

Sincerely,

Medical Association of the State of Alabama; Medical Society of Delaware; Medical Society of the District of Columbia; Florida Medical Association; Medical Association of Georgia; Kansas Medical Society; Louisiana State Medical Society; Missouri State Medical Association; Nebraska Medical Association; Medical Society of New Jersey; South Carolina Medical Association; American Academy of Cosmetic Surgery; American Academy of Facial Plastic and Reconstructive Surgery; American Association of Neurological Surgeons; American Society of Breast Surgeons; American Society of General Surgeons; Congress of Neurological Surgeons.

Past Presidents of the American Medical Association: Daniel H. Johnson, Jr., MD, AMA President 1996-1997; Donald J. Palmisano, MD, JD, FACS, AMA

President 2003–2004; William G. Plested III, MD, FACS, AMA President 2006–2007.

Mr. ISAKSON. I want to tell my colleagues what these letters say. The first one is to me from Gary Richter, the president of the Medical Association of Georgia. He writes in great detail about the difficulties and problems they have with this legislation, beginning with the stonewall against tort reform by only putting in a demonstration project.

The Senator from Texas is aware of what tort reform can do because his State has made a great improvement in medical malpractice costs because of tort reform, and we in Georgia have tried to experience the same type of thing.

There are many other reasons in here as well. The interesting thing about the letter from the 92,000 physicians represented by their medical associations is they talk not only about what is in the bill but what is not in the bill. I want to read, if I may, one paragraph to demonstrate that point:

Our concerns about this legislation also extend to what is not in the bill. The right to privately contract is a touchstone of American freedom and liberty. Patients should have the right to choose their doctor and enter into agreements for the fees for those services without penalty. Current Medicare patients are denied that right. By guaranteeing all patients the right to privately contract with their physicians, without penalty, patients will have greater access to physicians and the government will have budget certainty. Nothing in the Patient Protection and Affordable Care Act addresses these fundamental tenets, which we believe are essential components of real health system reform.

That is a pretty strong statement from 92,000 American physicians about this particular piece of legislation.

To follow up on the point made by the distinguished Senator from South Carolina, I have a vested interest. I just got my Medicare card. December 1 I became Medicare eligible. When you talk about cutting \$470 billion, it gets personal. It gets personal with all those other seniors.

Think about this. Seniors in America have paid their entire lives, at least since 1966 when it was created. They have paid a tax and their employers have paid a payroll tax to go into a trust fund to pay for their health care after they are 65 years old.

We are now basically saying, I say to the Senator from South Carolina, we are taking \$470 billion of the tax money you have paid over years of work and we are going to put it in a plan to pay for somebody else's health care. That is basically what it does, and that is patently wrong.

One other thing I want to mention that is critical to me. We are all professionals at what we do. We all argue from our point of view. I understand that and respect that. But something was said earlier today which draws me

to have a flashback to make the point about how much we tried on this side to contribute to improvements in health care and better access for all.

The very distinguished majority whip said he talked with realtors and that three in four realtors were uninsured and this would help. The reason they are uninsured is they are not able to form risk groups together associated and affiliated as a like practice. Because of the IRS Code, which this does not amend, a company's employer, who has independent contractors working for them, cannot by law provide them with medical insurance.

In 2006 on the floor of the Senate, 57 Republicans and Democrats offered and voted for the associated health care bill or the small business access to health reform—57 out of 100. We needed 60 like this bill needs to get to cloture. That bill would have allowed associated professions to join together, compete for insurance nationwide, form risk pools that are large enough to mediate and ameliorate high rates and have a more competitive rate.

He was correct in his statement that three in four do not have health insurance. I was in that business. I know. The reason they do not is because they have to buy on the spot market because they cannot have a group plan. When they buy on the spot market, we are talking about \$1,500, \$1,800, \$2,000 a month, which is unaffordable and unsustainable. But this bill does nothing to address that situation which is one of the largest holes in the uninsured problem.

In fact, when you see the estimates, those who are still left uninsured, a great many of them are going to end up being just those kinds of people— independent contractors that the tax laws prohibit from associating and affiliating with others. And I was proud to be part of that 57, along with the other three distinguished Senators on the floor and a number of Democrats.

There have been lots of efforts made by people on both sides to get us better access and affordable health care. But, unfortunately, they have been blocked all over this philosophic argument of whether health care is going to be government provided or competitive in the private sector. Unfortunately, the ship of state is moving toward the government provision with this legislation, which is one of the reasons I oppose it.

I turn it back to the distinguished senior Senator from Georgia.

Mr. CHAMBLISS. I rise to pose a question to the Senator, and I would ask my colleagues to comment with respect to their States.

The Senator served in the State legislature for many years, and is very familiar with our SCHIP program, which is called PeachCare, and he is also familiar with the rising Medicaid costs that we have seen in our State. What this bill does, in seeking to reach out,

as I understand, is to expand the eligibility for Medicaid. We are all for Medicare, but this raises the eligibility level for Medicaid from 100 percent of the poverty level to 150 percent of the poverty level. That will have a huge impact on every single State that is now going through very difficult financial times.

We in Georgia have had a \$3 billion shortfall this past year that had to be plugged. I saw the other day in the press where we have almost another \$2 billion our legislature is going to have to deal with next month in reducing services around our State. Every State is having that same experience. Yet what this bill does is to put a mandate on States to increase the amount of money that States put into Medicaid. I know the Senator is very familiar with that, and I would ask him to comment.

Mr. ISAKSON. I appreciate the Senator bringing it up. It is what is known in the trade as an unfunded mandate, but I will put some meat on that bone.

This year the State of Georgia had a budget of about \$17 billion, and the Medicaid portion—just the Medicaid portion in Georgia—was over \$2 billion. So it is approaching, or getting close to, 16, 17, or 18 percent of the entire budget. If this bill passes raising the eligibility from 100 percent to 150 percent, then in 2017—which is the trigger date on this Medicaid provision—Georgia would go from \$2.15 billion to over \$3¼ billion in its share of Medicaid, and this at a time of declining revenues and greater pressure. That is a recipe for disaster.

Our State, like 43 other States in the United States, can't borrow money. We have to have a balanced budget. If the Federal Government mandates that we spend \$3 billion, we have to cut it out of someplace else in our State, such as education or our prisons or the park system or somewhere else.

But it is ironic that Senator CHAMBLISS asked me that question because this morning, as I was preparing to come over, I had the television on, and Arnold Schwarzenegger, Governor of California, was being interviewed. He endorsed this provision originally, but he raised the question that the provisions in this amendment will raise by \$3 billion the cost of Medicaid, just in the State of California—a State that had a \$60 billion shortfall last year, and next year, he estimates, will have a \$20 billion shortfall. If we continue in Washington to mandate funding and don't put our money behind it, we are pushing our States to the brink of bankruptcy, where a number of them already are. It is not fair to say we are covering more people when we are bankrupting our States. We are not covering anybody if we are pushing the cost off on someone else.

So I appreciate the senior Senator from Georgia raising that point, and I associate myself with Governor

Schwarzenegger and his remarks this morning about urging us not to force unfunded mandates on our States.

The Senator from Texas.

Mr. CORNYN. If I can respond to the senior and junior Senators from Georgia on this point, my State population is 24 million. Over a 10-year period of time, this is a \$20 billion unfunded mandate—\$20 billion. Of course, we know—or at least we read and hear from some in the press—that not all States are going to be treated the same. That was, in fact, an inducement on the part of some Senators to vote for the bill—to be one of the 60 votes—because they were either going to get a sweetener, in terms of being held harmless for at least a portion of that, or in the case of Nebraska, I guess all of it.

That strikes me as fundamentally unfair, but it also demonstrates the flaw in the way this bill has been negotiated. In order to try to get to the 60 votes, there has basically been a pay-to-play sort of approach to this, and it is just repulsive to me, frankly. Certainly, a lot of my constituents would wonder: What kind of games are going on there?

I know the Senator from South Carolina has some thoughts about that.

Mr. GRAHAM. Well, this started out as a noble effort to reform health care because it needs reforming. The inflationary cost of the government is unsustainable. Medicare and Medicaid, as the Senators from Georgia indicated, are becoming huge problems that are unsustainable. Medicare is \$36 trillion underfunded.

Now, what does that mean? It means that over the next 75 years, there is a \$36 trillion shortfall of money to pay the benefits that have been promised, and that has to be dealt with.

What we are doing to Medicare makes the problem worse, not better. Medicaid is the largest expense in my State. It is a matching program. So listen to this—if you are out there on a Sunday with nothing else to do but listen to me. If you don't live in Nebraska, here is what is coming your way. Your State will be required to cover more people under Medicaid because the eligibility goes up to 133 percent above poverty, which is an increase over the current system. So throughout the Nation, there are going to be thousands more people enrolled in Medicaid, and every State, except one, is going to have to come up with matching money.

I have 12 percent unemployment in South Carolina. My State is on its knees. I have a 31-percent African American population in South Carolina. Yet how did the majority get the 60th vote on this bill? It was the weekend before Christmas, and they were one vote short—here is what they did to get that one vote. They had a deal cooked up that no one knew about but the two people talking. There was no

input from anybody other than the majority leader and the Senator from Nebraska. After that meeting was over, they came up with a 380-page amendment to a 2,000-page bill. They filed it yesterday, and we made them read it. We heard it for the first time yesterday. Then the majority leader filled up the tree so that there is no ability by any Republican or Democrat to amend their work product.

This is a transparent new way of doing business: you cook up a deal in a back room—that is essentially sleazy, in my view—to allow one State, in order to get that vote, be held harmless for Medicare enrollees, and the rest of us have to go home and hear our constituents say: Why can't you in South Carolina and Georgia get that deal? What kind of Senator are you?

Well, I will tell you; this is the kind of Senators we are. We are not going to do that. We are not going to put the whole Nation at risk and take a broken system and make it worse just to get a vote. No way in hell.

On abortion, you are either for it or against it or you are indifferent. You can be whatever you are on abortion and be just as good an American as I am. I am pro-life and proud of it. Most of us in America, whether you are pro-choice or pro-life, don't want our Federal taxpayer dollars to be used to pay for abortions. For 32 years, the Hyde amendment has been the law of the land, preventing taxpayer dollars to be used for abortion. In this health care reform, guess what. That is exactly what is going to happen. There is a brave Democrat in the Congress—Bart Stupak, from a blue State—who stood up to his Democratic leadership and said: I will not vote for a bill that allows Federal taxpayer dollars in the form of subsidies to be used to fund abortion because I find that morally offensive, and I think most Americans agree with me. He brought the House to its knees, saying: You will not pass this bill to use federally funded Federal dollars to fund abortion.

What did he get out of it? Nothing. Not one thing for Wisconsin. He got out of that deal the pride of knowing that he stood up for the unborn.

So the bill comes to the Senate, and Senator NELSON from Nebraska tries to introduce the Stupak language that would be an absolute bar from using taxpayer dollars to fund abortion. He lost that amendment. He said he could not vote for a bill that would allow taxpayer dollars to be used to fund abortion. But then he gets in a room with Senator REID, and he comes up with a compromise and he claims it solves the problem. The problem is, his claim is not accepted by all those who follow this. The compromise he has achieved on abortion is a miserable failure.

Congressman STUPAK says it is unacceptable. The National Right to Life

Committee says it is unacceptable. The Nebraska Right to Life Committee says it is unacceptable. The Council of Catholic Bishops says it is unacceptable. There is not one pro-life group in this country that believes Senator NELSON has protected the rights of the unborn. So how, in good conscience, do you vote for a bill when that was the big issue?

At the end of the day—one last thought—this bill would make an Enron accountant blush. They are talking about how it lowers the deficit by \$132 billion. But they do not tell you that the \$247 billion doctor fix is not in the bill. What am I saying? Over the next 10 years, doctors, under the 1997 balanced budget agreement, will have \$247 billion taken out of their practices unless Congress acts.

Since 1997, Congress, every year, has stepped to the plate and forgiven that cut, which is double digits. Everybody knows we are going to do that. But when it came to health care reform, they left out the doctor fix because if you include it, it no longer is revenue neutral. It no longer does what they say.

They say this bill cuts the deficit by \$132 billion, but if you include the \$247 billion, it runs up the deficit in the first 10 years, and in the second 10 years it adds \$2 trillion to the deficit.

Long story short, this is what Enron did. People went to jail for doing this in the private sector. They took the liabilities of the company and they hid them, making their balance sheet look better than it actually was. So when you hear this reduces the deficit by \$132 billion, they took out a liability that they know we are going to fund, just to cook the books.

If this is going to be OK for the country, then we have no hope as a Nation of ever solving any hard problem. And I would like to say to my colleagues: I know you want to be home. I know everybody on the other side wants to be home. I know you want to find ways to solve hard problems. Troops in Afghanistan want to be home, too. At least they are away from home for a noble purpose. We are here trying to stop a legislative process that, if it becomes legitimate—if this becomes the OK way of doing business, giving one Senator a deal you will not give anybody else and putting the whole country at risk just to get one vote—then I hope the American people will rise up in righteous indignation and throw us all out because nobody should be representing the country this way.

Mr. CHAMBLISS. The Senator from South Carolina raises the point about this bill being revenue neutral and it actually decreases the deficit. How do they achieve that? They achieve that through some truly Enron accounting, as the Senator from South Carolina just said. But here is what happens: There is a certain amount of money

that is projected by CBO to be generated in insurance premiums being paid by young individuals across this country under what is called the CLASS Act. The CLASS Act is a new health care-generated program, a new entitlement program that is included in this bill that is going to provide long-term care benefits for young, healthy Americans who, ultimately, are going to become invalid and need that long-term care.

Well, the fallacy in the numbers game that is being played is that CBO is saying it is true there will be a projection that we are going to save—the projection they are using says we are going to generate premiums from these young people who are not going to be entitled to the benefits under this bill for 20, 30, 40 years from now. But even CBO recognizes that when these benefits begin being paid out, there is going to be an entitlement created that is going to blow the budget of this particular new program all the way out the top.

In fact, the chairman of the Budget Committee, a Democrat from North Dakota whom I admire and respect so much, has even said this particular provision in this bill is a Ponzi scheme. It is something Bernie Madoff would love. Yet here they are with straight faces on the other side of the aisle coming in and saying we are really going to reduce the deficit by passing this provision called the CLASS Act. It is beyond me how anybody, with a straight face, can say that is actually a fact.

Mr. ISAKSON. Will the Senator yield?

Mr. CHAMBLISS. Absolutely.

Mr. ISAKSON. Isn't it true that is what is wrong with Social Security today? We have spent it for years and years rather than putting it in a trust fund, and now the baby boomers are going: The money is not there? Isn't that the same thing?

Mr. CHAMBLISS. The Senator is exactly right, and exactly the same situation with Medicare.

Mr. ISAKSON. Just a question on a followup on the fiscal part the Senator from South Carolina brought up. It is also still true that the taxes on this bill begin in 11 days—January 1, 2010—but the benefits begin on January 1, 2014, and in that score of the first 10 years of cost, you have years of program that are not costing anything while you are raising revenues. So it is a ruse and a masking of the actual fiscal effect on the United States of America.

Mr. CHAMBLISS. The only way Senator REID could get the score that he kept going back and forth with the Congressional Budget Office on was to make sure the taxes started immediately. And they will. He has increased taxes by \$26 billion to come up with a proposal that he says is revenue neutral. That is an additional \$26 bil-

lion. So it makes it a total of \$518.5 billion in new taxes that are going to be paid by hard-working, tax-paying Americans, and no benefits under this bill are going to start accruing until the year 2014.

Mr. CORNYN. Will my friend yield for a question?

Mr. CHAMBLISS. Absolutely.

Mr. CORNYN. I ask the senior Senator from Georgia, does he remember this statement by President Obama? He said he will not sign a plan that adds one dime to our deficits, either now or in the future, period. Yet David Broder, perhaps one of the most respected journalists here in Washington, DC, who has been around a long time, said he has talked to all the experts and everybody he has talked to said these bills as they stand are “budget-busters.” Of course, I am sure the Senator also remembers a Washington Post-ABC poll that said 66 percent of those who responded to the poll think this bill will make the deficit worse, not better.

In other words, we have a credibility problem between what is being promised here by the President and presumably by the proponents of this bill and the American people because they simply do not buy it. They do not believe it. Maybe that is why that earlier number from the Rasmussen poll said a majority of Americans do not want us to pass this bill but, rather, want us to start over and take a step-by-step or incremental approach.

Mr. CHAMBLISS. There is just no question but that the American people understand this. They get it. When we talk about cutting Medicare by \$450 billion, do they really not think the quality of care under Medicare is going to be diminished? Of course it is. Do the American people really think we are not going to have an increase in the deficit when we are going to have almost a trillion-dollar bill in real, live dollars that is going to be passed by this body in the next couple of days, in all probability? Surely the American people get that. They know this is going to increase the cost of health care and it is going to increase the deficit. That is why they are opposed to this.

Mr. GRAHAM. Will the Senator yield for another question?

Mr. CHAMBLISS. Sure.

Mr. GRAHAM. Let's talk about the CLASS Act a little bit more. It is a new program that doesn't exist today where the Federal Government, as I understand it, will be offering long-term health care insurance to the American people. It is a voluntary program at first, just like everything else around here. Guess who is going to sign up. It is called adverse selection. The sickest people in the country are going to sign up.

Under the bill as it is written, it is just like what Senator ISAKSON said

about the underlying bill. You collect taxes for 10 years; you pay out benefits for 6. That is the way you get the money to make the numbers come out right.

Guess what happens in this CLASS Act, the new program no one has heard much about. You start collecting premiums in 2011, but you don't pay any benefits until 2016. Guess what happens. That generates \$73 billion of money to be used to say to the American people that this bill is paid for. But when you ask the CBO about what happens after 2016, they say that by 2029, I think it is, the whole thing falls apart because the only people in the program are the sickest folks because it is a voluntary program, and at the end of the day, you have created a new entitlement, and everybody in this body is going to be rushing to subsidize premiums and get more people into this system. It will be another entitlement that grows, and CBO says it will be a death blow to our fiscal soundness.

I ask the Senator from Georgia, when Senator CONRAD, whom we all respect, said this is a giant Ponzi scheme that Bernie Madoff would have been proud of, do you think that is what he meant? You collect premiums and you make it look as if you have money you really do not have and you put off paying out benefits. And at the end of the day, would the Senator agree with me—I have a letter from October 23, 2009, from Senators CONRAD, LANDRIEU, LINCOLN, WARNER, LIEBERMAN, BAYH, and NELSON to the majority leader saying: Please take the CLASS Act out of the bill.

Would the Senator agree that the CLASS Act is still in the bill and that anybody who votes to send this off to the President to become law has become a coconspirator to the giant Ponzi scheme?

Mr. CHAMBLISS. I don't think there is any question about that. The Senator is exactly right. It is what we in Washington call fuzzy math—utilization of money from one pocket to pay for something on the other side. At the end of the day, it just does not add up. The Senator from North Dakota was exactly right, it is a huge Ponzi scheme.

I ask unanimous consent to have printed in the RECORD the letter dated October 23, 2009, just referenced by the Senator from South Carolina.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. SENATE,

Washington, DC, October 23, 2009.

Hon. HARRY REID,
Majority Leader, The Capitol,
Washington, DC.

DEAR LEADER REID: We write regarding the merger of the Finance and HELP Committee health reform bills. We know you face a great many difficult decisions now, one of which is whether to include provisions from the HELP Committee bill known as the CLASS Act in the merged bill.

We urge you not to include these provisions in the Senate's merged bill, nor to use the savings as an offset for other health items in the merger.

While the goals of the CLASS Act are laudable—finding a way to provide long term care insurance to individuals—the effect of including this legislation in the merged Senate bill would not be fiscally responsible for several reasons.

CBO currently estimates the CLASS Act would reduce the deficit by \$73 billion over ten years. But nearly all the savings result from the fact that the initial payout of benefits wouldn't begin until 2016 even though the program begins collecting premiums in 2011. It is also clear that the legislation increases the deficit in decades following the first ten years. CBO has confirmed that the legislation stand-alone would face a long-term deficit point of order in the Senate.

Some have argued that the program is actuarially sound. But this is the case because premiums are collected and placed in a trust fund, which begins earning interest, and because the HHS Secretary is instructed to increase premiums to maintain actuarial solvency. We have grave concerns that the real effect of the provisions would be to create a new federal entitlement program with large, long-term spending increases that far exceed revenues. This is especially the case if savings from the first decade of the program are spent on other health reform priorities.

Slowing the growth of health care costs should be a top priority as we move forward with health reform. Inclusion of the CLASS Act would reduce the amount of long-term cost savings that would otherwise occur in the merged bill. The CLASS Act bends the health care cost curve in the wrong direction and should not be used to help pay for other health provisions that will become more expensive over time and increase deficits.

Thank you for your consideration. We hope that fiscally responsible measures to improve access to long-term care can be considered in the future.

Sincerely,

KENT CONRAD.
MARY L. LANDRIEU.
BLANCHE L. LINCOLN.
MARK R. WARNER.
JOSEPH I. LIEBERMAN.
EVAN BAYH.
BEN NELSON.

U.S. Senators.

Mr. CORNYN. I am wondering if the Senator would yield for a question since we have a unanimous consent for a colloquy.

The Senator was talking about this a little earlier, but one of the things that has not been adequately discussed and because of the way this bill has been railroaded and we have been denied an opportunity to offer amendments and we will be voting on the bill on Christmas Eve, as it is currently scheduled, I want to ask about the impact on businesses. You were in the real estate business and employed a number of people in your company. You had to meet a payroll and make sure you ended up in the black and not in the red.

One of the things the National Federation of Independent Business said was that this bill will actually increase health care costs for businesses and the cost of doing business. I can't imagine

anything worse that we could be doing during a recession, during a time when unemployment is at 10 percent, than making it more expensive to do business and thus keep people on your payroll. Won't that be the impact of this, with higher taxes, with increased health care costs going to employers, that it is actually going to make the unemployment problem worse rather than better?

Mr. ISAKSON. I think the Senator from Texas is exactly right. I will be the first to tell you, I am in the process of reading the 400-some-odd page managers' amendment. I haven't read all of it yet. It does take out the public option, which, by the way, that was originally in. It still may reappear at some date in the future. That was a real killer. That raised tremendous costs. In fact, it made it more beneficial for a company not to provide insurance and pay the fine and put people in the government option. That is not in the bill now, I understand that.

But let me tell you what is in the bill. What is in the bill are a number of taxes on small businesses that produce medical devices and medical treatments. You know as well as I do that when the government raises your taxes, you have to raise your price to the consumer. What does that mean? It is not lowering the cost of health care. It is, through the tax mechanism, raising the cost of health care, either to the insurance company that is in the exchange or to Medicaid or to Medicare or to the individual person in terms of their copayments.

You cannot hide the fact that when you are raising those types of revenues—\$514 billion; \$50 billion a year over 10 years—that money is going to ultimately be paid by the consumer of health care. It may be paid by the company on its tax return, but it is a pass-through cost that they are going to pass through to their consumer, which in turn is going to put more pressure on whoever insures that consumer, if, in fact, they are insured. So anytime the government raises taxes, it raises the cost of living for the American people. That is just a common, well-known fact. The Senator is exactly correct.

Mr. CHAMBLISS. We have talked a little bit about the negotiations that took place behind closed doors over the last few days. It is unfortunate that we have gotten to the point in this body and on this particular piece of legislation where the issue of abortion has injected itself into meaningful and affordable health care reform measures. But that is, in fact, what has happened. Similar to my friend from South Carolina, I am pro-life. We all are. I am very proud to be and have a strong voting record on that. The law of the land for well over 30 years has been that no Federal funds should be used to fund abortions. It makes no difference whether you are in one part of the

country or the other; that is the law. That is the way it ought to be. It ought not to be changed.

We have had any number of votes on abortion issues over the years. In every instance, we have failed to pass a law that would provide for the use of Federal funds for abortions. That is changing. Irrespective of what the Senator from Nebraska thinks he negotiated, that has changed.

I have three letters I will include for the RECORD. One is pretty interesting because it is from a group of African-American ministers in my home State. This group is headed by Bishop Wellington Boone. He wrote me a letter yesterday. Here is part of what he says:

We cannot emphasize enough that abortion is not health care.

He is absolutely right.

There is also a letter from Cindy O'Keary, executive director of the HOPE Center in Woodstock, GA, who is appalled at the discussions and the fact that we now are going to be using Federal money to fund abortions, and also a letter from Sadie Fields, State chairman of the Georgia Christian Alliance, imploring us not to pass any kind of bill that sets the precedent of providing Federal funds for the use of abortion.

I ask unanimous consent to have all three letters printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

WELLINGTON BOONE MINISTRIES,

Norcross, GA, December 19, 2009.

Senator SAXBY CHAMBLISS,
*Russell Senate Office Building,
Washington, DC.*

DEAR SENATOR CHAMBLISS: We would like to take the time to thank you for your service to our country and to the citizens of Georgia. We thank you and your colleagues in the Senate who have stood against the terrible healthcare bill which mocks reform and increases taxes, debt and federal power while decreasing the freedom that Georgians value so highly. All of these concerns, however, pale in comparison to fact that the Senate version of the bill opens the door for the federal funding of abortion.

Those of us who have stood for life over the years have long known that the abortion lobby would never be satisfied with the mere legalization of abortion: they want it to be paid for by taxpayers. Many of your nominally pro-life colleagues have proven that their support of human life has a price: the Manager's amendment does nothing to prevent federal funds from paying for abortion in the federally subsidized healthcare exchanges. The charade that this is some sort of compromise is insulting not only to pro-life activists, but to the overwhelming majority of Americans who don't believe that taxpayer money should pay for abortions.

Who will be aborted with this federal money? In Georgia, 56% of all abortions are performed on black women and nationwide blacks have lost 35% of their population to abortion since *Roe v. Wade*. The Senate also opened the door for the federal funding of abortion among the indigenous peoples of this country by excluding the Hyde amendment from the reauthorization of the Indian

Health Service. Perhaps your colleagues in the Senate are not satisfied with how few American Indians there are left.

We cannot emphasize enough that abortion is NOT healthcare. It seems some members of the Senate want to take a practice that was supposed to be "safe, legal and rare" and make it "common, legal and subsidized." To overturn longstanding policy restricting the federal funding of the destruction of American lives while calling it "healthcare" is nothing short of evil.

We remain strongly opposed to the use of our tax dollars to fund abortion. We ask you, as our Senator, not to let your colleagues forget the line they are crossing if they vote for cloture. Only time will tell if they can escape judgment for their vote in their home states. But there is one Judgment not one of us can escape. Your colleagues who have not yet turned their backs on that Judge would do well to remember this as they cast their votes.

BISHOP WELLINGTON
BOONE,
Fellowship of International Churches.
DR. CREFLO DOLLAR,
Creflo Dollar Ministries.
DR. ALVEDA KING,
King for America.
MR. DAN BECKER,
Georgia Right to Life.

From: Cindy O'Leary [cindyhopecenter@bellsouth.net].

Sent: Saturday, December 19, 2009, 4:48 p.m.

To: Harman, Charlie (Chambliss).

Subject: Senate Discussion and Vote on Health Care Legislation.

SENATOR CHAMBLISS, As a registered nurse and the executive director for a pregnancy resource center that helps women and men explore alternatives to abortion as they seek solutions to what are often unexpected or unplanned pregnancies, I am gravely concerned about the potential impact of government-subsidized abortions, not only for the unborn, but for their parents who may feel overwhelmingly swayed by economic factors to make the most devastatingly wrong decision of their lives.

I want to thank you for standing strong tomorrow on the floor of the Senate in expressing the views of your constituents and, according to the recent CNN poll which revealed that six out of ten Americans are opposed to federal funding of abortion, we the people of the United States, as you promote a NO vote on the current health care legislation before the Senate. The only conscientious YES vote will come later for legislation that explicitly excludes the use of federal funds for abortion.

It is my understanding that the so-called "compromise" language included in Senator Reid's Manager's Amendment would actually ensure that, for the first time EVER, federal funds would be made available for the payment of elective abortions. It is also my understanding that the Manager's Amendment rejects other "compromise" proposals on abortion that would have codified the House-approved "Weldon Amendment" which prohibits government bodies from discriminating against health care providers. Such compromises included an "individual" opt-out from abortion coverage, which the Manager's Amendment does not. The Manager's Amendment rejects even the most broadly accepted agreements on this issue.

Thank you for your courageous support for life and for fighting against allowing the

government of the people and for the people to pick up the tab for abortions in America.

CINDY O'LEARY, BSN,
Executive Director, The HOPE Center.

GEORGIA CHRISTIAN ALLIANCE,
December 19, 2009.

Hon. SAXBY CHAMBLISS,
U.S. Senate, Washington, DC.

DEAR SENATOR CHAMBLISS: The Georgia Christian Alliance and its 65,000-plus supporters in Georgia strongly object to the language contained in the newest version of the Democrat's Health Care Reform bill that ensures, for the first time ever, federal tax dollars will pay for elective abortions.

If this bill passes, millions of pro-life Americans who believe that abortion is biblically and morally wrong will be forced to fund an act that takes an innocent human life. A Gallup Poll conducted in May 2009 finds 51% of Americans identifying themselves as "pro life" on the issue of abortion and 42% identifying themselves as "pro choice." This is the first time a majority of U.S. adults have identified themselves as pro-life since Gallup began asking this question in 1995.

For weeks, Democrat Senators and Representatives have ensured pro-life Americans they would never vote for a bill that contained federal funding for abortion. It would seem they sold their pro-life position for a bowl of porridge. We are deeply disappointed that they have gone back on their word, and ask you and your colleagues in the U.S. Senate to stand strong for innocent life as this bill moves forward in any Senate vote and in any subsequent conference committee.

Sincerely,

SADIE FIELDS,
State Chairman.

Mr. CHAMBLISS. Madam President, in closing, let me say, the Senator from South Carolina said it strongly and he is right: We have reached a new day in this body. We have had deals cut behind closed doors that are going to provide benefits for individual Senators and their States—whether Vermont, New Hampshire, Nebraska, Florida, or wherever—and that are going to require those of us who didn't have the opportunity to participate in the discussions and negotiations on this bill to represent to our citizens that they are going to have to pay more for services than everybody all across America gets. There is nothing right about that. There is nothing fair about it.

I daresay, I have some relatives who live in Nebraska. They have to be embarrassed and ashamed about this. They are going to be getting a huge benefit simply because the Democrats needed 60 votes to pass the health care bill.

Mr. GRAHAM. One last thought, if I may. The Senator mentioned the people in Nebraska. I know there are good, hard-working people all over the country, particularly in Nebraska. A lot has been said about Nebraska. I hope the people in Nebraska will be heard. This is not over. They may get 60 votes in the next couple days, but this is not over. We are going into the fourth quarter, and the most valuable player on our team is the American people.

Speak up, speak out. If you don't like what is going on, if you don't like the phony baloney accounting, if you are upset about your taxpayer dollars being used to fund abortions, speak up. If you think there is a better way of doing business, let us know about it. There is a long way to go. It has to go back to the House. The House has a say. One Senator indicated the House better take it or leave it. That is not good government. That is not the way it works. Three of us have been in the House. I want you to know this is far from over. Public opinion matters to us all. To the American people who are concerned about this being a done deal, it is not. You can change the outcome. I hope you will get involved. At the end of the day, it is your country we are talking about.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Madam President, it has been more than a month since the majority leader moved to proceed to the health care bill before us today. This bill will provide real reform for our Nation's flawed health care system. This bill is the product of years of hard work, study, and deliberation in both the Finance Committee and the HELP Committee—and I mean years—all transparent, all aboveboard, all out in the open. In fact, in the Finance Committee, we initiated a new requirement that all amendments to the bill would have to be posted in advance on the Internet so everybody could know what they were, the same with the bill itself. The mark was on the Internet for a couple 3 days before we even went to markup. It is unprecedented how open and transparent the process has been. The same is true in the HELP Committee.

The culmination of these efforts has been the weeks of debate on this bill in the Senate. These provisions have been in the public domain for a long time. It is true there could be minor changes here and there, but most of this has been in the public domain for a long time. We have considered numerous amendments. We have engaged in a full and healthy discussion. The bill before us is fully paid for. It is important to keep reminding colleagues over and over again: This is fully paid for. Don't take my word for it. That is what the CBO said. The American people trust and realize, according to the Congressional Budget Office, a nonpartisan organization, that this bill is fully paid for. It does not add one thin dime to the deficit. You are going to hear others who don't have their own proposals just want to be negative, want to try to shoot holes in this, try to say it adds to the deficit. That is their opinion. That is not the opinion of the CBO. CBO says it does not add one thin dime.

This bill will also reduce the Federal deficit in the short term and over the long term. It reduces the Federal deficit. We are so very concerned about

deficits. We in the Congress are and the country is. We have to begin as soon as we can to start getting those deficits down and the national debt lowered. This health care reform bill not only provides health insurance coverage and reforms the insurance industry dramatically, it also takes the steps of lowering the deficit and lowering the long-term debt.

Let me quote from the Congressional Budget Office letter of yesterday:

CBO and [Joint Committee on Taxation] estimate that, on balance, the direct spending and revenue effects of enacting the Patient Protection and Affordable Care Act incorporating the managers' amendment would yield a net reduction in federal deficits of \$132 billion over the [10-year] period.

A net reduction of \$132 billion. That is even better than the merged bill was just before we included the managers' amendment. That was a \$130 reduction in the national deficit. With the managers' amendment, according to the CBO, there is a net reduction in the Federal deficit of \$132 billion over the 10-year period. What about later? Often people say: Gee, I hear you, Senator, you are taking care of things in the short term, but you are enacting legislation that will have an adverse long-term effect. That is what you guys do back there.

You hear that often. Let me disclose what the Congressional Budget Office says about that. This legislation will reduce the deficit markedly in the out-years. Here is what the CBO says in a letter released today:

All told, the [Congressional Budget Office] expects that the legislation, if enacted, would reduce federal budget deficits over the decade after 2019 relative to those projected under current law—with a total effect during that decade that is in the broad range [of] between one-quarter and one-half percent of GDP.

What are they saying? They are saying that in the second 10 years, the deficit will be reduced between one-quarter and one-half percent of GDP. That is between \$630 billion and \$1.3 trillion. That is real money. We are going to reduce the Federal deficit by this legislation alone. Let's take the between \$630 billion and \$1.3 trillion—roughly, \$1 trillion in the next decade. That is important. That is significant. That is a good start.

The legislation before us will extend insurance coverage to more than 30 million Americans. Think of that, 30 million Americans who today do not have insurance will get health insurance. That is so important. I have forgotten the exact figure, but I remember there was a Harvard study that concluded that 45,000 Americans die every year because they have no health insurance. Obviously, people without health insurance die earlier, at an earlier age. Just for the sake of their own health, it is good those people get health insurance, let alone the benefit to hospitals by reducing uncompensated care.

This legislation will increase insurance coverage to more than 30 million Americans. I have just been passed a note that people have a 40-percent higher chance of dying without health insurance. We are saying to those folks, those 31 million Americans, we are going to figure out a way so you have health insurance so you do not have that 40-percent higher risk of death.

Here is what CBO says about coverage:

By 2019, the CBO and [Joint Committee on Taxation] estimate that the number of non-elderly people who are uninsured will be reduced by about 31 million.

CBO goes on to say:

Under the legislation, the share of legal nonelderly residents with insurance coverage would rise from 83 percent currently to about 94 percent.

That is 94 percent of the folks in our country, excluding seniors, because they have insurance under Medicare, excluding them and excluding the unauthorized, the total number of Americans who have health insurance will rise from the current number of 83 percent to about 94 percent.

This legislation will drive down premium costs for virtually all of us. It will drive down premium costs for virtually all. In an earlier letter, the CBO indicated premiums would go down for roughly 93 percent of Americans under the underlying bill. Premiums would go down about 93 percent for Americans. I was going to put a table in the record, but our rules don't allow us to put tables in, so I summarized. The conclusion of that summary is 93 percent of Americans will experience lower premiums—not dramatic for some folks but nevertheless down, and down is better than not down.

Insurance costs would go down significantly for those receiving tax credits in the new insurance exchanges. It will protect consumers from harmful insurance company practices. This is so important. As you know, no longer will insurance companies be able to deny coverage for those with pre-existing conditions. It is an outrage how much insurance companies deny coverage based on preexisting conditions. We all hear stories many times, if not from direct family members, from friends of family who run into this. It is so common, especially in the individual market as people buy insurance for themselves. Insurance companies deny coverage, deny giving health insurance to somebody because of a preexisting condition. It is wrong.

No longer will insurance companies be able to drop coverage for those who are sick. That is very important too. Companies often rescind willy-nilly. They found something in the background of the person, you didn't tell us about that so we are rescinding your policy. That is not right. That is just not right. We prevent that from happening in this legislation.

It will also improve choice and competition in the insurance market. We talk a lot about choice and competition. This legislation provides more choice in choosing policies and more competition in the insurance market. It will also create a true marketplace where plans compete on cost and quality rather than on their ability to cherry-pick the healthiest among us.

It will represent the largest tax cut for American families that Congress has passed since 2001. This legislation includes the largest tax cut for American families that Congress has passed since that tax cut bill in 2001, the largest. It is the tax credits people will receive to help them buy insurance. That totals up, I think, to \$440 billion. I have forgotten the exact figures. But this is the largest tax cut for American families since 2001. It will provide billions of dollars in tax credits to help families, workers, and small businesses to buy quality, affordable health care insurance. The managers' amendment makes this good bill even better. It will provide even more consumer protections against harmful insurance industry practices.

For example, it will hold companies accountable for excessive premium rate increases. It will require them to spend more on consumer benefits and less on administrative costs and profits. That is new. That is even better consumer protection compared with the underlying bill. It will restrict the ability of health plans to impose annual limits on benefits. That is new, restricting the ability of health plans to impose annual limits on benefits. It is wrong if you have an insurance policy that, lo and behold, the company says: We didn't know you were going to be that sick so we stopped the benefits you can get, annually and also lifetime. We do both. We restrict the ability of health plans to impose not only annual limits but also lifetime limits on benefits.

This managers' package will ensure that companies cannot discriminate against children with preexisting conditions and do so right away, beginning with plans that become effective mid-year next year. The preexisting condition restriction would ordinarily not take effect for a couple years, but for children the preexisting condition prohibition will take effect right away. There are other provisions to help people between now and 2014. There is high-risk pooling, for example, lots of different provisions in this bill which will help people get good benefits and protection very quickly.

This legislation will provide tax credits to even more small businesses. The managers' amendment will provide even more tax credits than the underlying bill. These benefits will now be available right away, in 2010. It is also a concern when will the tax credits for small business go into effect—shouldn't

they go into effect earlier. Under this managers' amendment, these benefits will be available in 2010.

This will also provide more health insurance choices through a new multistate option. That option offers consumers the same health insurance Congress has today—no small matter. It will extend extra funding for the Children's Health Insurance Program for 2 additional years. We are all very concerned about kids' health care. The children's health care program has done a pretty good job. This has been extended, under the managers' amendment, for an additional 2 years. It will do even more to control rising health care costs and reward even more providers for providing quality care to seniors through the Medicare Program. It will invest \$10 billion in community health centers. They are so important, community health centers, for folks who need help right away and don't have insurance, just need the care right away. Especially in rural communities, it will provide access to critical care where often that care is most needed.

These are the reforms which Americans have been waiting for, for decades. Americans are waiting for these changes. They are waiting for these reforms and have been for a long time. Decades may be an understatement. Our health insurance system just doesn't do what it should for Americans, the people we represent. Finally, we are taking a very significant first step to providing those reforms. These are reforms American families, workers, and businesses desperately need. They are reforms on which our economic stability depends. That is no small matter either. If we get our insurance costs under control, that is more economic stability for everyone. It is not just for families who don't know what the insurance company is or is not going to do, it is for small businesses that don't know whether premiums will be up or by how much next year. Why? It is more economic stability for families and small businesses and soon more economic stability for budgets, State budgets, our Federal budget.

We need to get a little more control over all the excessive costs that are going up, and also the volatility, the yo-yo effect that premiums have and out-of-pocket cost impositions have on people. This will help them very significantly.

So by and large, to be honest—I know this sounds a little naive, perhaps—I do not know why this bill does not get an overwhelming endorsement. This is a big vote on both sides of the aisle. Then we can, next year, keep going from there; add new provisions that need to be added, correct mistakes that probably this legislation is going to have, but work together because most Americans want us to work together

back here. They do not like us being partisan or political.

I must say, this place is getting a little more partisan over the last couple years than it was earlier. It is not what the American people want. They want us to do our job, do what is right. This bill clearly is in the bounds of reasonableness of what is right and what is the right thing to do to get control of our health care system.

Again, I hope we can get this passed by a large margin. It will pass. But I would like it passed by a large margin.

Madam President, I now yield 20 minutes to the Senator from Rhode Island, Mr. WHITEHOUSE.

The ACTING PRESIDENT pro tempore. The Senator from Rhode Island.

Mr. WHITEHOUSE. Madam President, I thank Chairman BAUCUS.

As we are here in the Senate today, Washington rests under a blanket of snow, reminding us here of the Christmas spirit across the Nation, the spirit that is bringing families happily together for the holidays. Unfortunately, a different spirit has descended on this Senate. The spirit that has descended on the Senate is one described by Chief Justice John Marshall back in the Burr trial: "those malignant and vindictive passions which . . . rage in the bosoms of contending parties struggling for power."

Two-time Pulitzer Prize winner Richard Hofstadter captured some examples in his famous essay, "The Paranoid Style in American Politics." The malignant and vindictive passions often arise, he points out, when an aggrieved minority believes that "America has been largely taken away from them and their kind, though they are determined to try to repossess it and to prevent the final destructive act of subversion."

Does that sound familiar in this health care debate? Forty years ago, he wrote that. Hofstadter continued, those aggrieved fear what he described as "the now familiar sustained conspiracy"—familiar then, 40 years ago; persistent now—whose supposed purpose, Hofstadter described, is "to undermine free capitalism, to bring the economy under the direction of the federal government, and to pave the way for socialism. . . ." Again, familiar words here today.

More than 50 years ago, he wrote of the dangers of an aggrieved rightwing minority, with the power to create what he called "a political climate in which the rational pursuit of our well-being and safety would become impossible"—"a political [environment] in which the rational pursuit of our well-being and safety would become impossible."

The malignant and vindictive passions that have descended on the Senate are busily creating just such a political climate. Far from appealing to the better angels of our nature, too

many colleagues are embarked on a desperate no-holds-barred mission of propaganda, falsehood, obstruction, and fear.

History cautions us of the excesses to which these malignant, vindictive passions can ultimately lead: tumbrels have rolled through taunting crowds; broken glass has sparkled in darkened streets; "strange fruit" has hung from southern trees; even this great institution of government that we share has cowered before a tail gunner waving secret lists.

Those malignant moments rightly earned what Lord Acton called "the undying penalty which history has the power to inflict on wrong." But history also reminds us that in the heat of those vindictive passions, some people earnestly believed they were justified. Such is the human capacity for intoxication by those malignant and vindictive political passions Chief Justice Marshall described. I ask my colleagues to consider what judgment history will inflict on this current spirit that has descended on the Senate.

Let's look at what current observers are saying as a possible early indicator of the judgment history will inflict. Recently, the editor of the Manchester Journal Inquirer editorial page wrote of the current GOP, which he called this "once great and now mostly shameful party," that it "has gone crazy," is "more and more dominated by the lunatic fringe," and has "poisoned itself with hate." He concluded, they "no longer want to govern. They want to emote."

A well-regarded Philadelphia columnist recently wrote of the "conservative paranoia" and "lunacy" on the Republican right. The respected Maureen Dowd, in her eulogy for her friend, William Safire, lamented the "vile and vitriol of today's howling pack of conservative pundits."

A Washington Post writer with a quarter century of experience observing government, married to a Bush administration official, noted about the House health care bill, "the appalling amount of misinformation being peddled by its opponents"; she called it a "flood of sheer factual misstatements about the health-care bill," and noted that "[t]he falsehood-peddling began at the top. . . ."

The respected head of the Mayo Clinic described recent health care antics as "scare tactics" and "mud."

Congress itself is not immune. Many of us felt President Bush was less than truthful, yet not one of us yelled out "You lie!" at a President during a joint session of Congress. Through panics and depressions, through world wars and civil wars, no one ever has—never—until President Obama delivered his first address. And this September, 179 Republicans in the House voted to support their heckler comrade. Here in the Senate, this month,

one of our Republican colleagues regretted, "Why didn't I say that?"

A Nobel prize-winning economist recently concluded thus:

The takeover of the Republican Party by the irrational right is no laughing matter. Something unprecedented is happening here—and it's very bad for America.

History's current verdict is not promising.

How are these unprecedented passions manifest in the Senate? Well, several ways.

First, through a campaign of obstruction and delay affecting every single aspect of the Senate's business. We have crossed the mark of over 100 filibusters and acts of procedural obstruction in less than 1 year. Never since the founding of the Republic—not even in the bitter sentiments preceding the Civil War—was such a thing ever seen in this body. It is unprecedented.

Second, through a campaign of falsehood: about death panels, and cuts to Medicare benefits, and benefits for illegal aliens, and bureaucrats to be parachuted in between you and your doctor. Our colleagues terrify the public with this parade of imagined horrors. They whip up concerns and anxiety about "socialized medicine" and careening deficits, and then they tell us: The public is concerned about the bill. Really?

Third, we see it in bad behavior. We see it in the long hours of reading by the clerks our Republican colleagues have forced. We see it in Christmases and holidays ruined by the Republicans for our loyal and professional Senate employees.

It is fine for me. It is fine for the Presiding Officer. We signed up for this job. But why ruin it for all the employees condemned by the Republicans to be here?

We see it in simple agreements for Senators to speak broken. We see it, tragically, in gentle and distinguished Members, true noblemen of the Senate, who have built reputations of honor and trustworthiness over decades being forced to break their word, and double-cross their dearest friends and colleagues. We see it in public attacks in the press by Senators against the parliamentary staff.

The parliamentary staff is non-partisan; they are professional employees of the Senate who cannot answer back. Attacking them is worse than kicking a man when he is down. Attacking them is kicking a man who is forbidden to hit back. It is dishonorable.

The lowest of the low was the Republican vote against funding and supporting our troops in the field in a time of war. As a device to stall health care, they tried to stop the appropriation of funds for our soldiers. There is no excuse for that. From that there is no return. Every single Republican Member was willing to vote against cloture on

funding our troops, and they admitted it was a tactic to obstruct health care reform.

The Secretary of Defense warned us all that a "no" vote would immediately create a "serious disruption in the worldwide activities of the Department of Defense." And yet every one of them was willing to vote "no." Almost all of them did vote "no." Some stayed away, but that is the same as "no" when you need 60 "yes" votes to proceed. Voting "no" and hiding from the vote are the same result. And for those of us here on the floor to see it, it was clear: The three who voted "yes" did not cast their "yes" votes until all 60 Democratic votes had been tallied and it was clear that the result was a foregone conclusion.

And why? Why all this discord and discourtesy, all this unprecedented, destructive action? All to break the momentum of our new, young President. They are desperate to break this President. They have ardent supporters who are nearly hysterical at the very election of President Barack Obama: the "birthers," the fanatics, the people running around in rightwing militias and Aryan support groups. It is unbearable to them that President Barack Obama should exist. That is one powerful reason.

It is not the only one. The insurance industry, one of the most powerful lobbies in politics, is another reason. The bad behavior you see on the Senate floor is the last thrashing throes of the health insurance industry as it watches its business model die. You who are watching and listening know this business model if you or a loved one has been sick: the business model that will not insure you if they think you will get sick or if you have a preexisting condition; the business model that, if you are insured and you do get sick, job one is to find loopholes to throw you off your coverage and abandon you alone to your illness; the business model, when they cannot find that loophole, that they will try to interfere with or deny you the care your doctor has ordered; and the business model that, when all else fails, and they cannot avoid you or abandon you or deny you, they stiff the doctor and the hospital and deny and delay their payments for as long as possible—or perhaps tell the hospital to collect from you first, and maybe they will reimburse you.

Good riddance to that business model. We know it all too well. It deserves a stake through its cold and greedy heart, but some of our colleagues here are fighting to the death to keep it alive.

But the biggest reason for these desperate acts by our colleagues is that we are gathering momentum, and we are gathering strength, and we are working toward our goal of passing this legislation. And when we do—when we do—

the lying time is over. The American public will see what actually comes to pass when we pass this bill as our new law. The American public will see firsthand the difference between what is and what they were told.

(Mr. FRANKEN assumed the chair.)

Facts, as the Presiding Officer has often said, are stubborn things. It is one thing to propagandize and scare people about the unknown. It is much tougher to propagandize and scare people when they are seeing and feeling and touching something different.

When it turns out there are no death panels, when there is no bureaucrat between you and your doctor, when the ways your health care changes seem like a good deal to you, and a pretty smart idea—when the American public sees the discrepancy between what is and what they were told by the Republicans—there will be a reckoning.

There will come a day of judgment about who was telling the truth. Our colleagues are behaving in this way—unprecedented, malignant, and vindictive—because they are desperate to avoid that day of judgment. Frantic and desperate now and willing to do strange and unprecedented things, willing to do anything—even to throw our troops at war—in the way of that day of reckoning.

If they can cause this bill to fail, the truth will never stand up as a living reproach to the lies that have been told, and on through history our colleagues could claim they defeated a terrible monstrosity. But when the bill passes and this program actually comes to life and it is friendly, when it shelters 33 million Americans, regular American people, in the new security of health insurance, when it growls down the most disgraceful abuses of the insurance industry, when it offers better care, electronic health records, new community health centers, new opportunities to negotiate fair and square in a public market, and when it brings down the deficit and steers Medicare toward a safe harbor—all of which it does—Americans will then know, beyond any capacity of spin or propaganda to dissuade them, that they were lied to. And they will remember. There will come a day of judgment, and our Republican friends know that. That is why they are terrified.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I yield 15 minutes to the Senator from Oregon.

The PRESIDING OFFICER. The Senator from Oregon is recognized.

Mr. WYDEN. Mr. President, I thank you, and I thank the chair for his courtesy as well.

At this time of the year, millions of Americans are out in the stores doing their holiday shopping. That is because we Americans enjoy our free markets and our free enterprise system. Whether it is for a holiday or we are shopping

for a car or food or a house, we Americans believe we ought to have quality choices in our marketplace, and Americans, our people, ought to be rewarded when they shop wisely.

The American economy works this way for just about everything except health care. Today, American health care is mostly a competition-free zone. Insurance companies enjoy extraordinary privileges as monopolies. Insurers are exempt from the antitrust laws, and in scores of American towns, our people can only get their health care under the heel of just one health insurance company.

Today's health insurance market is essentially dysfunctional, and for most Americans, they have no way to hold the insurance companies accountable. It has been that way since the middle of the last century, since the days of wage and price controls. For literally 60-plus years, American consumers have not been in the position to be able to hold the insurance companies accountable and to get the value for their dollar that they get in every other part of our economy.

Changing this broken health care marketplace is the heart of real health reform. The legislation we will vote on tonight—and, I might add, the chairman of the Finance Committee is on the floor, and this essentially began with his white paper when we started working on it in the Finance Committee—the legislation we are going to vote on tonight, in my view, starts the long march to empowering consumers, to turning the tables on the insurance lobby, and to getting more value for our health care dollar. This can be done through a part of the health reform debate that got some discussion in the Finance Committee and then, because people liked it and didn't know much about it, has since essentially gotten lost in the discussion; that is, the health insurance exchanges.

For folks listening at home today, an exchange is going to be like a farmers market. Various types of health plans are going to be marketed through the exchange, and for the first time—this was an area in which Chairman BAUCUS and I had a great interest in the committee—it is going to be possible for folks to make apples-to-apples comparisons of these various health plans.

There are requirements in the bill that keep the low-quality products out of the exchange. Chairman BAUCUS and I got interested in the need for consumer protection particularly early on in programs, back in the days after Medicare got established when seniors were buying 15 or so private policies to supplement their Medicare and most of them weren't worth the paper they were written on. So with these exchanges as they are designed, that is not going to happen. People are going to get value for their dollar on day one.

There are also some important consumer protection requirements, and I

particularly wish to commend the Presiding Officer of the Senate, whose work I have been following. These consumer protection requirements will ensure that now when a consumer pays a dollar in a premium, they are going to get a lot more back in benefits for their dollar. This protection is called a loss ratio. People are going to hear a lot about that concept. It is new, but it essentially means the insurance companies can't walk off with their premium dollar, use it on administrative expenses, use it on salaries, but will instead return it to the public and the consumer in the form of benefits and premiums. I commend the Presiding Officer, the Senator from Minnesota, for ensuring this was all put in place. In my view, these ideas ought to appeal to both Democrats and Republicans—these market-oriented consumer protection principles—simply because they are just common sense.

So should section 10108 of Senator REID's managers' amendment on which the majority leader, Chairman BAUCUS, and I worked very closely. It is entitled "Free Choice Vouchers." This section creates something that has never existed before: a concrete way for middle-income Americans who cannot afford their health care to actually push back against the insurance lobby and force insurance companies to compete for the business of covering those middle-class folks in the insurance exchanges. Unlike today, where if a hard-working, middle-class American can't afford just the one health insurance policy available to him and, thus, is out of luck, with this new provision, there will be a different health care marketplace, with free enterprise choices that can actually drive down costs for the middle class while ensuring those choices are of good quality.

So the big hurdle, it seems to me, in setting up a new health care marketplace, which began with Chairman BAUCUS's white paper in the Senate Finance Committee, is getting these exchanges and getting these vouchers in place.

We are going to be able to build on it. In my view, I think we will have additional opportunities to build on these ideas before the legislation goes to the President. For example, Senator COLLINS, our Republican colleague from Maine, Senator BAYH, and I have written bipartisan legislation that has been endorsed by the influential National Federation of Independent Business and we are working to include that proposal in this legislation. This bipartisan proposal would permit employers who are in the insurance exchange and who voluntarily choose to do so—let me emphasize that this is a matter of a voluntary choice by employers—if they choose to do so, they could give their workers a voucher so that those workers could shop for their coverage. What this means is for millions of em-

ployers and employees, the amendment would provide the opportunity to have a choice of American health care plans.

These are unquestionably challenging days for American employers and workers trying to be as competitive as possible in tough global markets. For employers who want more ways to help their workers and the employers' bottom line and for workers who would like more take-home pay and lower health expenses, this bipartisan amendment can be a lifeline. We hope our colleagues of both parties will agree and join our effort, and this can be part of the legislation that ultimately will go to the President.

Let me close with this. My great hope is that long after 24/7 cable TV has moved on to other topics, Democrats and Republicans here in the Senate can figure out a new strategy for working together, a bipartisan strategy that will let us, together, tap the full potential of real health care reform. That potential is for holding down costs, getting more value for our health care dollar, and, finally, achieving quality, affordable health coverage for all Americans.

I offer this thought because I have long felt both parties have valid views on this topic. I believe our party is absolutely right in saying you cannot fix American health care unless all Americans get good-quality, affordable coverage. If you don't do that, too often uninsured folks will shift their bills to insured folks, there won't be enough prevention, and you won't be in a position to get the most value for the health care dollar.

I continue to believe our colleagues on the other side of the aisle have valid points as well. They make valid points about the role of marketplace forces, the role of competition, the role of choice.

There has to be a way in the days ahead—one of the things that has pleased me is Chairman BAUCUS has said we are going to have a lot of oversight hearings and a lot of work in the days ahead to actually implement this. None of us think we can create a new health care marketplace where there hasn't been one for 70 years in a matter of minutes. So I am very pleased Chairman BAUCUS has indicated we will be doing a lot of the painstaking oversight work in the days ahead to actually implement this transformation in American health care, and I think the chairman knows I will be his partner in those efforts to get this implemented.

So after a year of tough financial hardships, let's find a way to bring to this Senate floor bipartisanship, common sense, and the good will that is public service at its best.

I close by saying that I look forward to working with the chairman of the Finance Committee, who I know shares these views as well.

With that, Mr. President, I yield the floor.

Mr. BAUCUS. Mr. President, I wish to thank the Senator from Oregon for many reasons, one of which is his kind words, which are really appreciated but, much more important than that, his long dedication to health care reform. He even worked for the Gray Panthers way back before he came here. I remember the name RON WYDEN, Gray Panthers, a good number of years ago. Then, lo and behold, both Houses of Congress together—we worked together on reforming Medigap coverage. It was an outrage. Today we talk about medical loss ratios of maybe 80 percent, 85 percent, up to 90 percent, and so forth. I can remember back when it was an outrage, the degree to which Medigap insurance coverage had medical loss ratios of not 80 percent, not 70 percent, not 60 percent; it would be below 50 percent. Insurance companies were selling insurance to seniors trying to cover that gap between what Medicare would and would not cover, and just tragically low, embarrassingly low, outrageously low medical loss ratios.

Senator WYDEN and I got together and got legislation passed to reform the Medigap market—to make Medigap insurance plans more fair. They were ripping seniors off, there was no doubt about it, and we got that changed.

Now, on health care reform, an ardent advocate of more competition, more choice in our health care system—it is clear we need more competition. It is clear we need more choice. On the competition side, in many of our States we find there is only one or two insurance companies that dominate the entire State. That is very true around our country. There is just not the competition there should be.

In addition, there is not the choice. A lot of employees would like to have more choice among insurance companies in their kinds of policies, and so on and so forth. We have a system where most employees are tied to their employer; it is pretty much insurance coverage the employer offers.

If we were starting from scratch maybe 20, 30, 40, 60, maybe 80 years ago, we may not have had such an employer-based system as we have today. Our current Tax Code also tends to encourage excessive insurance coverage because of our employer-based system.

Anyway, I am digressing. Senator WYDEN got us thinking a lot earlier about the problems that caused, and, frankly, I think he is right. I think a lot of Americans think he is right. You can only take things a step at a time here, and we are probably not going nearly as far as the Senator from Oregon wishes to go. But I thank him. He is there, he is dogged, and he works hard on behalf of seniors. He is an advocate of American consumers, respected by health insurance companies, not letting the companies take advantage of citizens. I thank the Senator for that.

I do not see any Senators on the floor on our side. If there were, it would be a good time for them to speak. Pending the arrival of the Democratic Senators, let me say a few things about small business.

Clearly, one of the goals of health care reform is to ensure that employees of small businesses have good, quality, affordable health care options. We all know that is clear. I have talked to small businesspeople.

I will never forget a conversation I had with a logger who has four or five or six people working for him. It was about 2 or 3 years ago. I asked him if he had health insurance. He said, yes, for his family—his wife and himself.

I asked: How about your employees? He said, no; he didn't. You could tell he wanted to, and he wasn't just blowing smoke. He clearly wanted to provide insurance for his employees, but it just pained him because it was too expensive.

We all hear stories like that; they are legion. I can remember talking to another small businessman in my State of Montana, a contractor, who has 5, 6, 8, 10, people working for him. He is just beside himself because the insurance company told him his premiums are going to go up 40 percent next year.

He said: Max, I can't deal with that.

I asked: Why are they going up 40 percent?

He said: Well, they found a pre-existing condition with respect to one of my employees. He said: Max, I was beside myself. I can't afford a 40-percent increase. They said it would only be a 20-percent increase if I let him go. But he has been with me 15, 20 years and is one of my best employees. I can't let him go.

He found another carrier and kept his employee. So he did find another insurance carrier, but he had to pay about a 20-percent increase in premiums. He was able to keep his employee, but that is just wrong. It is so hard for small businesses to provide health insurance to their employees. I know it is a trite thing to say, but most jobs in our country are created by small businessmen. That is where most of the jobs are, and it is where most of the creativity is. That is, in many cases, where the greatest need is to help encourage entrepreneurship, American ingenuity, and where a small businessperson can do a good job with the service he is providing.

Last year, 62 percent of small businesses did offer health insurance to their employees. Compare that with other companies that have, say, 200 employees. Among all companies in America that have 200 or more employees, 99 percent of them have offered their employees health insurance. Contrast 62 percent of small businesses offer health insurance and 99 percent of businesses with more than 200 employees offer health insurance.

Among the very small businesses in our country it is lower, lower than 69 percent. Now it is only 49 percent—a very small number of employees—that have health insurance through their small business employer. There are clearly very significant reasons for that. There are barriers that prevent small businesses from finding affordable health insurance options. What are they?

Small businesspeople tell us the main reason—at least one of them—is that the premiums are just too high. I mentioned an example of the contractor I talked with in my State, who said they are going to charge a 40-percent increase in premiums as further evidence that premiums are too high. It is understandable that is one of the main reasons small businesses can't get health insurance.

In the past 10 years, premiums have risen 82 percent for single workers and 93 percent for families employed by small business—virtually doubled premiums in the last 10 years if you are a single person and work for a very small business. That is not true for big business.

As health care costs rise, small businesses are forced to make workers pay a greater portion of these expensive premiums. In 2008, for example, employees at small businesses that did provide health insurance paid more than twice what they paid just 8 years earlier—twice as much.

The low rate of offering and higher cost-sharing responsibilities for employees in small businesses often limit the ability of small businesses to attract and retain employees.

That is why the health care bill before us includes many provisions to make quality coverage for small business more affordable not only for the businesspeople but for their employees. Before the managers' amendment, the bill did include \$24 billion in tax credits to help small businesses and charitable organizations purchase health insurance for their employees.

The managers' amendment dedicates additional billions to providing tax credits to small businesses to make health insurance more affordable. The Congressional Budget Office and the Joint Committee on Taxation, which I know is near and dear to the heart of the Presiding Officer—after all, they are an independent arbiter. They can tell us with objectivity what this legislation is or is not—they estimate that the tax credit for small businesses will provide \$40 billion in tax relief to small businesses over their first 10 years.

In addition, we start the tax credits a year early; that is, we start them in 2010. In the earlier bill, it was 2011. In the managers' amendment, we start in 2010, right away. This means that in just over a week, after the legislation is passed and signed into law, eligible small businesses will be able to receive

tax credits to help them buy health insurance for their employees. This expansion of the tax credits means eligible small businesses will now be able to receive up to 6 years of tax credits. So now starting in 2010, eligible small businesses will receive tax credits worth up to 35 percent of the employer's contribution to employee health insurance plans—35 percent.

Then in 2014, it is even better. Eligible small businesses will receive tax credits worth up to 50 percent of the employer's contribution to employee health insurance plans purchased in health insurance exchanges. The employer would get 50 percent of the cost of the health insurance, that would be available for credit; that is, the employer can credit 50 percent, subtract from his income taxes 50 percent of the cost of insurance.

What do you have to do to qualify? Businesses must cover at least 50 percent of employee premium costs. If you cover half the employee costs, you get to subtract your half from your income taxes. The value tax credit is based on the size of the business and the average wage paid to its employees.

The managers' amendment strengthens the assistance to small businesses by expanding the small business tax credit. In the managers' amendment, the tax credit will be available to small businesses with fewer than 25 employees and less than \$50,000 average annual wages. And the full value of the tax credit is now available to small businesses with 10 or fewer employees and \$25,000 or less in average annual wages. It moved up from \$20,000 to \$25,000 so more small businesses can qualify and take advantage of that tax credit. By expanding the wage thresholds, which I just described, more small businesses will be able to claim the tax credits. And tax credits will phase out more slowly as wages increase. This was a high priority for small businesses. We recognized that and responded to it.

The small business tax credit will help make insurance affordable for many small businesses. In 2011, 4.2 million Americans will be covered by quality, affordable health coverage; 4.2 million Americans will be able to take advantage of this. On average, small businesses across the country would receive a new tax credit of about \$4,900 to help them purchase insurance. That is per employee, \$4,900 to help them purchase insurance for their employees.

The CBO estimates that the small business tax credit will help lower insurance costs by 8 to 11 percent for the employees of small businesses receiving the credit. Let me say that again. CBO estimates that the small business credit will help lower insurance costs by 8 to 11 percent for the employees of small businesses who receive their credit. Without the small business tax credit, many people would have to buy insurance through the exchange on

their own without the benefit of a contribution from their employer.

One of the reasons many small businesses are currently unable to afford health insurance is because small businesses lack the buying power larger companies have to negotiate affordable group rates. The Senate bill creates small business insurance exchanges, known as SHOP exchanges, where small businesses can band together and pool their risks, which will enhance their choice and buying power. These State-based exchanges will be a critical tool to help small businesses with fewer than 100 employees shop for health insurance plans and determine their eligibility for tax credits to buy health insurance. Small businesses that prosper and grow beyond 100 employees would be allowed to continue shopping through the exchanges—pooling. The insurance plans sold in SHOP exchanges would be subject to the same transparency requirements and consumer protections, so small businesses can feel confident they are purchasing high-quality plans that will provide quality, affordable coverage for their workers.

The legislation also institutes reforms in the insurance market that will protect individuals and small businesses purchasing plans both inside and outside these SHOP exchanges. These reforms will stop insurance companies from denying coverage based on a person's preexisting health condition or increasing a person's health insurance premiums based on health status or on gender and occupation—a practice that just has to be stopped.

These new regulations are essential to helping small businesses keep health care costs predictable from year to year. That is one of the big problems. Small businesses face this sea of chaos, of volatility, uncertainty, unpredictability in knowing what their insurance costs will or will not be. That is why insurance companies cherry-pick and take advantage for themselves to maximize their profits, but it has the opposite effect on small businesses. This will help, frankly, to buy a lot more certainty that we desperately need.

The changes in the managers' amendment will go the extra step and ensure this bill provides small businesses with the help they so desperately need. Passing health care reform is critical to small businesses. Without reform—this is no small matter; I am not blowing smoke here—without reform, many small businesses will be forced to drop their health insurance coverage they may already have because they can no longer afford it. They cannot afford the increase in premiums. This will leave many employees to fend for themselves in the individual market. We know without this bill passing how unfair the individual market is to people.

Many of the provisions in this bill were designed with small businesses in

mind. The bill gives small businesses access to a reformed marketplace where they will have improved buying power to negotiate rates. And the Senate bill provides tax credits to help small businesses buy health insurance for their employees.

Data from CBO tells us that these reforms will make coverage more affordable for millions of small business employees. The small business tax credit will help reduce health care costs for small businesses and their employees. As a result of the larger health reform proposals in the bill, there will be an increase in the percentage of small firms that offer health insurance coverage.

We must act to help small businesses access to quality, affordable health care options for their employees. Too many small businesses around the country are waiting.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. BARRASSO. Mr. President, I just heard my colleague from Montana talk about jobs that are going to be lost, and the jobs are going to be lost if this bill passes.

There was an article in the Wall Street Journal that quoted the Federation of Independent Business, a wonderful organization that works so well with small businesses in this country. Their prediction is that if this passes—if this passes—the mandates in this bill will mandate that employers provide health care. This is going to cost 1.6 million jobs by 2013.

Then I got an e-mail from a friend in Dubois, WY, who says that if this bill passes, he knows he is going to lay off workers—quite to the contrary of what my colleague from Montana says when he says it is going to help keep people working.

At a time when the country is experiencing 10 percent unemployment, at a time when the people's No. 1 concern is jobs and the economy of this country, we are now embarking on an additional spending spree when our national debt is at the highest levels ever.

I disagree with my colleague from Montana. I think, contrary to what he suggested—he said: I am not just blowing smoke—I believe we will lose jobs if this passes.

Mr. BAUCUS. Will the Senator yield for one brief minute?

Mr. BARRASSO. When I am finished with our comments on this side.

Mr. BAUCUS. I thank the Senator.

Mr. BARRASSO. I also heard the majority whip come to the floor and say the Republicans have only offered four amendments. I offered 19 amendments. So I ask unanimous consent that the pending amendment be set aside and that I be allowed to call up my amendment No. 3148 to protect individuals facing skyrocketing premiums.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Reserving the right to object.

Mr. BARRASSO. The purpose of this amendment is—

Mr. BAUCUS. Reserving the right to object, and I will object, we have been—

Mr. BARRASSO. Regular order.

The PRESIDING OFFICER. Is there objection to the request?

Mr. BAUCUS. I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from Wyoming.

Mr. BARRASSO. So we have a 383-page amendment brought to the floor, read on the floor yesterday. I worked my way through it, along with my staff—383 pages. And the majority whip comes to the floor and says the Republicans have not offered amendments. I just tried to offer one, unsuccessfully, and it has been objected to.

So I ask unanimous consent that the pending amendment be set aside and that I be allowed to call up amendment No. 3153 to protect young, healthy persons from increased insurance premiums.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Mr. President, clearly this is a stunt. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. BARRASSO. Mr. President, I ask unanimous consent that the pending—and these are—I just heard the comments—these are amendments that are aimed to keep the President's words that we will get insurance premiums under control, people will notice their premiums go down, that we will make it better for people, easier for people. The Democrats ought to accept all these amendments because they are intended to do just that.

I ask unanimous consent that the pending amendment be set aside and that I be allowed to call up amendment No. 3146. This amendment deals with individual mandate penalties and creates personal accounts for young people who are penalized and they have to pay a fee and a fine if they do not obey the individual mandate, and that would go into an account for them so they could use that money to buy their own health insurance.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Reserving the right to object, this is the fourth time today Senators on the other side—

Mr. BARRASSO. Regular order.

Mr. COBURN. Regular order.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. BARRASSO. Mr. President, I understand this is going to improve Medicare. I heard the chairman of the Finance Committee say this is going to

make Medicare stronger. I believe Medicare patients ought to have the freedom to contract and the right to privately contract for medical services with the physician of their choice.

If, as the chairman of the Finance Committee has now recommended in his statement, it doesn't work out the way it is suggested—I ask unanimous consent that the pending amendment be set aside and I be allowed to call up amendment No. 2984, Medicare patient freedom to contract.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. For the fifth time, I object.

The PRESIDING OFFICER. Objection is heard.

Mr. BARRASSO. Mr. President, that is why I am not surprised when I read polls that say negatives abound in polls about this bill, written in secret, brought to us just a little over 24 hours ago with a 383-page amendment, one that is now not going to be allowed to have any amendments offered.

I just offered four different amendments aimed to strengthen the health care system of the country. Each time, the chairman of the Finance Committee is not even interested in hearing what the amendments are about.

The people of Wyoming say: Don't cut my Medicare, don't raise my taxes, don't make things worse for me, especially in these economic times. This is a bill that is going to cut people's Medicare by \$500 billion, it is going to raise their taxes, and it is going to make things worse for the people of Wyoming and this country. That is why the front page of a local newspaper has a story, "Doctor Shortage Will Worsen." Great concerns.

Even the Actuary of Medicare and Medicaid says that if all of this goes through—and this is before we had the 383 new pages—if all of this goes through, one in five hospitals is going to have significant problems within the next 10 years and one in five doctors' offices may have to close. That is why this health bill is scary.

For anyone who has not had an opportunity to read Dr. COBURN's, Senator COBURN's article in the Wall Street Journal, an editorial, Thursday, December 17, I recommend the editorial to them. It is titled "The Health Bill Is Scary."

I ask unanimous consent to have this editorial printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Wall Street Journal]

THE HEALTH BILL IS SCARY

(By Tom Coburn)

I recently suggested that seniors will die sooner if Congress actually implements the Medicare cuts in the healthcare bill put forward by Senate Majority Leader Harry Reid. My colleagues who defend the bill—none of whom have practiced medicine—predictably

dismissed my concern as a scare tactic. They are wrong. Every American, not just seniors, should know that the rationing provisions in the Reid bill will not only reduce their quality of life, but their life spans as well.

My 25 years as a practicing physician have shown me what happens when government attempts to practice medicine: Doctors respond to government coercion instead of patient cues, and patients die prematurely. Even if the public option is eliminated from the bill, these onerous rationing provisions will remain intact.

For instance, the Reid bill (in sections 3403 and 2021) explicitly empowers Medicare to deny treatment based on cost. An Independent Medicare Advisory Board created by the bill—composed of permanent, unelected and, therefore, unaccountable members—will greatly expand the rationing practices that already occur in the program. Medicare, for example, has limited cancer patients' access to Epogen, a costly but vital drug that stimulates red blood cell production. It has limited the use of virtual, and safer, colonoscopies due to cost concerns. And Medicare refuses medical claims at twice the rate of the largest private insurers.

Section 6301 of the Reid bill creates new comparative effectiveness research (CER) programs. CER panels have been used as rationing commissions in other countries such as the U.K., where 15,000 cancer patients die prematurely every year according to the National Cancer Intelligence Network. CER panels here could effectively dictate coverage options and ration care for plans that participate in the state insurance exchanges created by the bill.

Additionally, the Reid bill depends on the recommendations of the U.S. Preventive Services Task Force in no fewer than 14 places. This task force was responsible for advising women under 50 to not undergo annual mammograms. The administration claims the task force recommendations do not carry the force of law, but the Reid bill itself contradicts them in section 2713. The bill explicitly states, on page 17, that health insurance plans "shall provide coverage for" services approved by the task force. This chilling provision represents the government stepping between doctors and patients. When the government asserts the power to provide care, it also asserts the power to deny care.

If the bill expands Medicaid eligibility to 133% of the poverty level, that too will lead to rationing. Because Washington bureaucrats have created a system that underpays doctors, 40% of doctors already restrict access to Medicaid patients, and therefore ration care.

Medicaid demonstrates, tragically in some cases, that access to a government program does not guarantee access to health care. In Maryland, 17,000 Medicaid patients are currently on a waiting list for medical services, and as many as 250 may have died while awaiting care, according to state auditors. Kansas, the home state of Health and Human Services Secretary Kathleen Sebelius, faces a Medicaid backlog of more than 15,000 applicants.

Other unintended consequences of the Reid bill could wreak havoc on patients' lives. What happens, for instance, when savvy consumers commanded to buy insurance realize the penalty is the de facto premium? It won't take long for younger, healthier Americans to realize it's cheaper to pay a \$750 tax for coverage instead of, say, \$5,000 in annual premiums when coverage can't be denied if you get sick.

OMB Budget Director Peter Orszag's belief that mandatory health insurance will become a "cultural norm" is bureaucratic naïveté that will produce skyrocketing premiums and reduced care for everyone. My state's own insurance commissioner, a Democrat, recently confirmed this concern to me in a letter noting that "the result will be higher insurance rates due to a higher percentage of insured being higher risk/expense individuals."

But the most fundamental flaw of the Reid bill is best captured by the story of one my patients I'll call Sheila. When Sheila came to me at the age of 33 with a lump in her breast, traditional tests like a mammogram under the standard of care indicated she had a cyst and nothing more. Because I knew her medical history, I wasn't convinced. I aspirated the cyst and discovered she had a highly malignant form of breast cancer. Sheila fought a heroic battle against breast cancer and enjoyed 12 good years with her family before succumbing to the disease.

If I had been practicing under the Reid bill, the government would have likely told me I couldn't have done the test that discovered Sheila's cancer because it wasn't approved under CER. Under the Reid bill, Sheila may have lived another year instead of 12, and her daughters would have missed a decade with their mom.

The bottom line is that under the Reid bill the majority of America's patients might be fine. But some will be like Sheila—patients whose it lives hang in the balance and require the care of a doctor who understands the science and art of medicine, and can make decisions without government interference.

The American people are opposing this bill in greater numbers every day because the facts of the bill—not any tactic—are cause for serious concern.

Mr. BARRASSO. Mr. President, here you have it. We have a bill that is going to be voted on at 1 in the morning on a Monday morning. Why? Because the people who are proposing the bill are scared to let the American people know what is in it. That is why public opinion has soured on this proposal to the point that it is at the lowest level ever, with just 32 percent of Americans in favor, just less than one in three. Less than one in three Americans supports what is being proposed.

I believe each one of my amendments would have raised the level of support, would have made this better for American taxpayers, for American citizens, for American patients, for the patients who depend on our health care system, for the providers who give the care, and for the people who pay for it.

I see my colleague from North Carolina ready to rise. I am so happy to be joined on the Senate floor by these two wonderful colleagues who have a great bill of their own that has gotten very little hearing, very little opportunity, certainly no opportunity for a vote on the Senate floor.

As my Senate colleague from North Carolina gets his microphone ready to go, I will say that to be held to a false deadline of Christmas Day on something as important as a bill that is going to impact the health of every person in this country, impact one-

sixth of the economy of the United States—it is much more important that we get it right than that it gets rushed through with speed and secrecy, with not being able to offer amendments when a 383-page amendment by Senator REID is dropped on the table yesterday and a vote is going to be held at 1 in the morning on a Monday morning.

It is astonishing that we do not have bipartisan support, people working together to find solutions. It is astonishing when you have a body such as this of 100 Members, 2 of whom are physicians with 50 years of experience practicing medicine, working with the system, fighting against insurance companies and fighting against the government, two physicians who know that you do not want anybody between you and your physician, you do not want a government bureaucrat, you do not want an insurance bureaucrat, you do not want anyone. But what we are looking at is the worst of all possible worlds.

I ask my colleague from North Carolina if he has some additional thoughts.

Mr. BURR. I do, Mr. President.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. BURR. Mr. President, I look around this Chamber, and I see the busts of many Vice Presidents who have served as the leaders of this Chamber. It makes me wonder what would they think of the process in which we are currently engaged, individuals who, in a time of history of our country, took so seriously what went on in this Chamber and the effects it had on the American people.

I look at the process we are going through right now and see the way we have trivialized this process—votes in the middle of the night. Twenty-four hours ago, there was not a managers' amendment. There was not a score. Then yesterday morning we got a managers' amendment, 380-some pages, and we got a score. Today we get a notice from the Congressional Budget Office saying that in their score, they made a \$½ trillion error, a \$500 billion, ½ trillion error in the projection they sent to Congress. In 24 hours, \$½ trillion.

Why doesn't this seem to bother those who are the authors of the bill? It is because it is not their money. It is the American people's money. That is the only way you could rationalize how you could be in Washington talking about spending \$2.5 trillion at best to stop waste, fraud, and abuse, because, let's face it, Republicans and Democrats agree: There is no health care reform in here. There is a coverage expansion, but there is no health care reform.

Democrats have walked to the floor and said that we lie. I am not lying. Show me the health care reform. Show me where you have drastically

changed, transformed health care. If you transform health care, then you wouldn't have to steal \$464 billion from Medicare.

Mr. BAUCUS. Will the Senator yield so I can show him?

Mr. BURR. Regular order, Mr. President.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. BAUCUS. He doesn't—

The PRESIDING OFFICER. The Senator from North Carolina has the floor.

Mr. BURR. I appreciate that, Mr. President.

We have gone through this, and we are refused the ability to offer amendments. We are refused the opportunity to sit in the back room where the legislation was constructed. It is shared with us when they are ready. But they use everybody's money. Tell me how it is fair to the American people.

When Nebraska gets a sweetheart deal under Medicaid, and Massachusetts and Vermont, in the managers' amendment, when Nebraska is told: We are going to expand Medicaid and we are going to hold you harmless in perpetuity, you will not have to pay, tell me how that is fair to the taxpayers of Virginia, tell me how it is fair to the taxpayers of Ohio, tell me how it is fair to the taxpayers of North Carolina that they are going to pay for what Nebraskans should be obligated to pay. I believe, knowing Nebraska, that the people of Nebraska would want to pay their fair share. But, no, to buy a vote, they have been given a deal.

This bill is still \$2.5 trillion. It still steals \$464 billion from Medicare. It still puts a tremendous unfunded mandate on every State in this country with the exception of the State of Nebraska. There are a number of States that have a grace period for some period of time, whatever it took to get their comfort level of their vote, but for every other State, at some point they are going to be obligated to pick up that difference.

We cover 31 million Americans who were not covered—that is a wonderful thing—and 15 million of them are dumped into Medicaid, the worst health care delivery system that exists in this country, a health care system that only has the opportunity today to see 60 percent of the available doctors because the other 40 percent will not see them.

Oh, by the way, what did the Chief Actuary of the Centers for Medicare and Medicaid Services say?

The Reid bill is especially likely to result in providers being unwilling—

Unwilling—

to treat Medicare and Medicaid patients, meaning that a significant portion of the increased demand for Medicaid services would be difficult to meet.

The Chief Actuary went on to say:

The CMS actuary noted that the Medicare cuts in the bill could jeopardize Medicare beneficiaries' access to care.

I just heard the Senator from Rhode Island basically come out and say that was a fabricated thing on the part of somebody on this side of the aisle. I am quoting the Chief Actuary, the President's chief health care budgetary person. The Actuary said it "could jeopardize Medicare beneficiaries' access to care." He goes on to say that he finds that roughly 20 percent of all Part A providers—hospitals, nursing homes, et cetera—would become unprofitable within the next 10 years as a result of these cuts. Hospitals will close, nursing homes will close. This isn't fabrication. This is the Chief Actuary of the Centers for Medicare & Medicaid Services, who is part of this administration. The CMS's Actuary found that further reductions in Medicare growth, through the actions of the independent Medicare advisory board—this is the advisory board that is being set up to make determinations about coverage in the future—which advocates have pointed to as a central linchpin to reducing health care spending, may be difficult to achieve in practice.

In other words, we are making claims that aren't right, it is the authors of the bill who are making claims that are not accurate, according to the Chief Actuary.

I yield to the minority leader.

Mr. MCCONNELL. I say to my friend from North Carolina, if that were not bad enough—and it may have been referenced here on the floor before I came out—we have an announcement from the Congressional Budget Office just today. The Senator from North Carolina may have referred to this. On the Director's blog today—the Director of the Congressional Budget Office—is the headline: "Correction Regarding the Longer-Term Effects of the Manager's Amendment to the Patient Protection and Affordable Care Act."

CBO has discovered an error in the cost estimate released yesterday—yesterday—related to the long-term budgetary effect of the manager's amendment. They go on to say they were about $\frac{1}{2}$ trillion off in looking at the long-term effects beyond the 10-year window, which further illustrates why we ought not to be rushing this thing through, and we ought to have further opportunity to discover what other problems there are, in addition to the ones the Senator from North Carolina has outlined with regard to special treatment for some States which all the rest of our States have to pay for.

Mr. BURR. The minority leader makes a great point. If we waited another day to vote, we might save another $\frac{1}{2}$ trillion. That is probably in the best interest of the American taxpayer.

I will wrap up, Mr. President, because I know Dr. COBURN wants to speak. Let me say this. I said earlier this still steals \$464 billion from Medicare. It also still raises taxes and fees to the

tune of \$519 billion. Many of those taxes and fees, by the way, are going to impact people well below the \$200,000 threshold the President promised he would never touch.

We have just learned in the managers' amendment that we have dropped the doctor fix. They should be comforted in knowing that they have a 2-month extension, but the 1-year extension was dropped in the managers' amendment. Dropped. Why? Because they had to pay for what they were doling out to get extra votes.

I ask unanimous consent at this time, Mr. President, to set aside the pending amendment, and I wish to call up amendment 3134, which is a 3-year doctor fix of the SGR and ask for its immediate consideration.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. For the sixth time we are engaged in this stunt, so I object.

The PRESIDING OFFICER. Objection is heard.

Mr. BURR. Well, Mr. President, my hope is no other Member from the other side will come to the floor and say that Republicans haven't come up with substantive amendments to this bill.

Dr. COBURN and I participated in 56½ hours in the HELP Committee. We offered numerous amendments. Some technical amendments were accepted. The amendments that meant anything were rejected along party lines. We have filed a comprehensive health care reform bill—the first one introduced in Congress—in May of this year, I believe. Still, Members from the other side come to the floor and say Republicans haven't offered anything. We were the first. They may not have liked it, but we were the first.

You know what, it doesn't cost this much and it doesn't raise taxes. I think Dr. COBURN will later talk about that bill a little.

I was glad to see that politics comes from all sides. In the managers' amendment we dropped the tax on botox. Hollywood spoke out about this tax on one of their health care tools. And what did we replace it with? We have now put a 10-percent tax on tanning salons. How in the hell does that affect health care? Explain that to me. Are we going to tax everything in this country? I can make a tremendous case that the 10-percent tanning salon tax gets exactly the person that the President said he wasn't going to affect, people who make under \$200,000—or are we income testing the tanning tax, too?

Mr. COBURN. Would the Senator yield for a question?

Mr. BURR. I yield to the Senator from Oklahoma.

Mr. COBURN. If we are going to tax tanning salons, why don't we tax anybody who goes to the beach? Because true sunlight is much worse for your skin than a tanning salon. So if the in-

tention was to prevent disease, why wouldn't we tax it where most of the disease occurs? Or how about kids' sports in the summer. Let's tax kids' baseball. Or swimming. Let's tax all the swimming pools because we have exposure to UV light.

This shows the precariousness and the silliness of a large portion of this, and I yield back.

Mr. BURR. The Senator makes a great point, and I am sure we have loaded the chairman of the Finance Committee with additional good ideas he can go back and think on. I am sure before it is over, we will fine parents who don't put suntan lotion on their children—especially if it doesn't meet high enough SPF to block everything the Sun might produce.

This is out of control. This is not the way to write a bill that affects one-sixth of the U.S. economy. I mean it is bad enough it is done behind closed doors, in a back room, with only a few people there, but when the No. 2 Democrat can walk on the floor and say: I haven't seen it, either—well, if the No. 2 Democrat hasn't seen it, how many people were there? How many people had input into this? Was it just Leader REID and Senator NELSON? Was it the Presiding Officer from Minnesota? Nobody knows. Nobody knows. The truth is, and what we do know is that the American people don't like the process, and more importantly the American people don't like the bill.

The chairman of the Finance Committee and others have said: But once it is out there and they get a taste of this, they are going to like it then. Well, let me remind my colleagues: It is too late. The Chief Actuary already told us: Hospitals are going to close, nursing homes are going to close, doctors are going to quit practicing medicine. They will quit seeing Medicare and Medicaid beneficiaries. How do you repair that after you have done the damage? Are we willing to risk that for the future of this country and generations yet to come?

Boy, we have a few hours—8 or 10 hours—before we vote. I hope people get some sense. I hope they pull back from this. Let's leave for Christmas. Let's think about this. Let's go home and talk to people. Let's listen to people in this country. If we do, we might come back, get a new piece of paper, take some of the things in this bill and take some of the things we have talked about on this side of the aisle, take some of the things the American people have talked about, and find a way for 100 percent of the doctors, nurses, and hospitals to survive; find a way for 100 percent of the American people to have coverage, and not the 31 million covered in this bill, leaving 24 million outside the scope of coverage.

You see, when we set out we had three objectives: One was to cover all the American people. We flunked. Another was to invest in prevention,

wellness, and chronic disease management. The doctor and I both say we haven't come anywhere close to doing that. The third and most important was to make sure it is fiscally sustainable. CBO, CMS, wherever you want to go, the only way this is fiscally sustainable is if the independent Medicare advisory board continues to cut reimbursements, the scope of coverage, to meet how much we are willing to spend on health care to say it is affordable.

I don't believe that is reform. I believe that is legislation that picks winners and losers, and that is not the role of the Senate of the United States.

I yield to the good doctor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. I want to raise an issue. It was raised in the Finance Committee markup; it was raised in the health care markup. I have behind me the Medicare cuts, and I understand they have been slightly reduced in home health—in the rebuild—but we are going to cut Medicare. We are not going to cut it significantly in the fraud—\$2 billion. That is where the real waste is.

The Senator from Rhode Island came down here and said we are trying to scare people, but when we offered the opportunity for the chairman of the committee to prohibit rationing of health care in this country, both the chairman and the Senator from Rhode Island voted against it. It was simple, straightforward, saying no matter what we do in health care, we are not going to do what other countries have done, and that is ration health care. Straight up-and-down votes—party-line votes—against it.

In fact, we are going to ration health care. That is what this bill does. The way we are going to control cost is through the mechanisms outlined in this bill that are going to allow government bureaucrats to decide what you can get treated for, when you can get treated for it, and where you can get treated for it. The rebuttal to that is: In Medicare, it is already illegal for them to ration care, so we don't need a prohibition. The fact is Medicare is rationing right now. They are rationing virtual colonoscopies, they are rationing bone densitometry, they are rationing Epogen, they are rationing Neupogen—two key drugs to maintain survival during the treatment of chemotherapy. They are practicing medicine.

So when given the opportunity to vote and put an absolute prohibition on the rationing of health care, what did the chairman of the Finance Committee do? He voted against that. Because what he recognizes is the ultimate plan. And the answer to Senator BURR's question is: This will collapse. It is not going to be sustainable. The Medicare cuts won't be made by us. We will put it off on a commission and say:

Oh, we had to do it, and the result of that will be rationing.

The other result will be what the Senator from Vermont actually wants, which is a single-payer, government-run system. That is why he is intellectually honest. He brought it to the floor and said this is how I think we ought to solve health care. We ought to have the government run it, and we ought to have the government make the decisions. He was honest about it. That is where this bill is going. So if you are a Medicare patient, you should be concerned. If you are a Medicare Advantage patient, you should be concerned.

I have had criticism leveled at me because I do what the chairman of the Finance Committee suggests—I make competitive bidding for Medicare Advantage. But there is a big difference. Mine has no cuts in benefits. They cut benefits 50 percent, in terms of the Medicare Advantage differential.

There are three things you can do to fix health care in this country: You can incentivize prevention and the treatment of chronic disease based on outcome; you can create transparency so that purchasers in the market can actually make a judgment about value and quality; and you can assist those who are on the lower rungs of the economic ladder to get the same kind of care we get. Those are the three things you can do.

I readily admit we don't have a great competitive model in the insurance industry. I want to change that. We had Senator WYDEN come to the floor and say that he loves the free enterprise spirit, yet we want to put an artificial fix in terms of the insurance company, in terms of what you have to have for a return. What if an insurance company came up with 20 percent greater efficiency in terms of outcomes and benefits? They still have to spend that money? In the name of the free enterprise system we are going to kill free enterprise? As a practicing physician, I bristle at the way I run into insurance companies. There is no question about it. We need to fix that.

The point Senator BURR was making is this says it is this way or the high way, when the option we offered—the Patients' Choice Act—cuts taxes, doesn't raise taxes; expands exactly to the level or beyond of this bill and it does at in a faster rate. It extends the life of Medicare. It gives Medicaid patients the same kind of care we get. But it was defeated in committee on a party-line vote. It was filed as an amendment here but not accepted. We had 10 amendments voted on from our side on 2,400 pages of legislation—10 amendments. So it is not about being bipartisan, it is about you have to take this or leave it.

What the American people ought to pray for is that somebody can't make the vote tonight. That is what they

should be praying for, so that we can actually get the middle—not me, not mine. I understand I am way over here. But we ought to get the middle of America and the middle of the Senate a bill that can run through this country and actually do what we say we all want to do. There is a large difference of opinion, and it is not rhetoric that is unfounded, as Senator BURR outlined, and as Dr. BARRASSO outlined with an estimate by NFIB of 1.6 million jobs lost. That may be old data, because who knows what the data is now. We haven't had a chance to look at it, because 30 hours after the bill is introduced for cloture and the cloture motion is filed, we are going to vote on it. I am not sure this is a great way to run the country.

What is in the bill? There are zero guarantees that taxpayers won't finance abortion.

There are zero prohibitions on the rationing of health care—zero. There is not one shred of evidence that we are not going to ultimately ration health care under this bill. We are. And the only reason you would vote against a rationing amendment is because you intend to see rationing carried out.

There are zero Senators required to enroll in either Medicaid or a government-run option, either through OPM or Medicaid.

There are now 10 new taxes created. There are 71 new government programs created. There are 1,697 times that the Secretary of HHS is going to write the regulations, and based on CRS calculations there are between 15,000 and 20,000 new Federal employees who are going to be required to carry out this legislation.

There are 3,607 times, before we got the Reid amendment, that the legislation says the word "shall." "Shall" is a very important word because the word "shall" takes away your options. There is no option when the word "shall" is used. The word "shall" also says whoever is directing the "shall" obviously has more wisdom, more knowledge, more experience than the person the "shall" is applied to.

What we have said is, in all our wisdom, in all our many years of practicing medicine and being involved in the care of patients, that 3,607 times we are going to tell the American people what to do.

One of the big "shall also's" that I do not think will ever hold scrutiny before the Supreme Court is, you shall buy an insurance policy. That doesn't fit anywhere in the Constitution that I read. If you do the legal research on it, as my staff lawyers from the Judiciary Committee have done, it is highly unlikely that will ever hold up. So the whole premise of a large portion of the taxes collected in this bill will be out the window.

It also will totally change, through adverse selection, all of the insurance

premiums in this country because, if you do not have an individual mandate making people buy insurance, the costs relative to the illness and the age, even though we have compressed the ratios, will rise exorbitantly.

There are still going to be 24 million people left without health insurance in this country. There is a \$10 billion cost just for the IRS implementation of this bill. There is at least \$25 billion in mandates placed on the States, unfunded mandates. Actually it is much higher now. There is \$28 billion-plus in new taxes on employers. There is \$100 billion, by conservative estimates, in fraud and Medicare and Medicaid a year, and this bill goes after \$2 billion over 10 years. So we are going to go after \$2 billion out of \$1 trillion—not \$200 billion, not \$20 billion—we are going after \$2 billion.

There is \$118 billion in cuts to Medicare Advantage but only for those people who do not live in the State of Florida and a couple of other places. If you happen to live in Oklahoma, citizens under the Medicare Advantage are going to lose.

This is now over \$500 billion in new taxes on Americans. There is a quarter of a trillion dollars not in this in expense that everybody knows is an expense. We are going to restore the SGR. We are going to fix that. And that quarter of a trillion dollars is based on no increase in physicians over the next 10 years. How many in this body think we are not going to increase the pay of physicians in Medicare under the next 10 years? The assumptions in the CBO report that accompanied the Reid amendment, if you read what they said, they said it is highly unlikely. So that is a quarter of a trillion dollars even though it was not in their numbers.

It also said if, in fact, the cuts came through, which they thought highly unlikely that they would, and if they didn't, then the fiscal numbers associated with the bill are out the window. The final number everybody ought to be paying attention to is \$12.1 trillion; \$12.1 trillion is what our kids owe outside of owing ourselves—\$1.1 trillion. That is going to double in the next 10 years.

Anybody with a lick of common sense who looked at the numbers on this bill would say: Washington, your accounting programs aren't any different from Enron. The same fate of those who created the Enron scam ought to apply to the Congress of the United States. The very fact we are not considering an SGR fix is evidence of that. At least you have to add a quarter of a trillion dollars every 10 years to this bill just to keep doctors even. And don't forget the fact that 34 million new Americans over the next 10 years are going to enter Medicare—are going to enter Medicare.

What are the alternatives? I will not offer other amendments and make the

chairman object to them because I know his answer. He calls it a stunt. It is not a stunt when you do not have vigorous amendments offered on the Senate floor. It is not a stunt. The stunt is not allowing amendments to be offered. To allow only 10 of our amendments to be offered on this bill is beneath the dignity of the Senate—on the biggest bill in the last 100 years in this Congress, the only bill in the last 100 years that is going to affect every American in a personal way but also in a fiscal way, a financial way.

There was an amendment to be offered, a conscience protection for physicians. We didn't get a vote on it. Should we force physicians in this country to perform abortions or should we have a vote on whether, if they have a conscience protection, they ought to be exempted from that? Should that not be a part of health care reform? We are not going to get a vote on that.

How about an amendment to reduce the waste, fraud, and abuse in Medicare and Medicaid Programs and protecting Medicare benefits? And increasing the fraud and waste from \$2 billion to \$100 billion over the next 10 years, that is just 10 percent of what is there. We are not going to get a vote on that. It is not going to be available. The American people are not going to get to hear the debate on that. They are not going to make up their mind. Why? You don't want them to hear the debate on it. If you truly wanted to have a debate on fraud we would have a debate on fraud, and we would have an amendment saying put your stamp down, or are you for the people who are defrauding? Or are you for the status quo? We are for the status quo. We are for the well-connected.

The amendment on rationing that I talked about—or an amendment to limit the bureaucratic increase associated with this bill, which is an amendment I offered, we are not going to get a debate on that. That is a very straightforward amendment. It just says we are not going to increase the number of bureaucrats to implement this bill. We are going to drive efficiency in HHS; that is where this is going to. We are going to say: You can't get a net increase in bureaucrats so get more efficient. Since we are running \$1.4 trillion or \$1.5 trillion deficits, that is something that everybody else in the country would be doing, but we are not going to do that. We are not going to allow an opportunity for a vote or debate on that. We are not going to have that opportunity.

I have heard the majority mention several times that we didn't have anything to offer. We offered the Patients' Choice Act. CBO said it cut long-term costs on Medicaid, that it saved money on Medicare. They said it saved \$1 trillion over the first 10 years for the State and the estimates. Because we couldn't get the commitment that was

made to us by the chairman of the HELP Committee that he would score the bill, the bill didn't ever get scored by CBO—but an outside score says it saves at least \$70 billion the first 10 years and far in excess of that afterwards. It covers more people than this bill, saves personal choice, doesn't put somebody between you and your doctor.

I heard the Senator from Rhode Island say we were lying about that happening. It is happening today, both from insurance companies and Medicare and Medicaid. So if we really wanted to reform health care we would be attacking that. Instead, we are going to make it worse.

Let me tell you how we are going to make it worse. We are going to use cost comparative effectiveness, which is exactly what the U.S. Task Force on Prevention Services did. They used cost comparative effectiveness, and when they looked at breast cancer, they said it is not cost effective to screen women before the age of 50. You know what. They are right. It is not cost effective. But it certainly is clinically effective, especially if your wife is the one who is 40 and has breast cancer and it was found by a mammogram.

You see, judgment goes out the window. What do we do? We reversed that finding, one of the first things we did as we started the debate.

Are we going to do that every time the U.S. Preventive Services Task Force issues a ruling that is cost effective but not clinically effective? Are we going to do that every time the cost comparative effectiveness panel says: You will do this, and the American people say: That isn't right, the American Cancer Society says: That isn't right. Every time we get one of those rulings will we have to pass a piece of legislation to change it?

The purpose of the three panels is well intended. The Medicare Payment Advisory Commission is well intended. Help us cut costs. But the only way you go for cost is through prevention and management of chronic disease. You are not going to cut costs any other way because 75 percent of everything we spend is on five chronic diseases. So unless you attack the real problem, the real disease, with our health care system, you are not going to solve it.

The lack of art in medicine will become readily apparent in 2015, 2016, and 2017. We will see bureaucratic decisions in between a patient and their provider. That is not a scare tactic. That is absolute fact. We have it now with Medicare. It is there. If I have a woman who is 55 years of age today and I order bone density testing on her and find she has severe osteoporosis, I put her on medicine but am forbidden by Medicare to do the followup exam that is clinically necessary to see if the medicine is working, and not only that,

under Medicare rules, she can't even use her own money to buy that test. So 2 years later, we do the test, and we haven't corrected her disease. Now we change medicines to try to find out, but we can't find out again. So she ultimately falls and breaks her hip. There is a 20-percent mortality rate from falling and breaking one's hip. But those are the rules we are operating under now, right now, that you want to expand.

Government isn't ever compassionate. It is never compassionate. People are compassionate. Thought has to be in the middle of the practice of medicine, not distant thought, near thought. The very fact that an insurance company tells the doctors what they can and cannot do is no worse than what we are getting ready to do with the rest of government-run health care. We didn't fix that problem. We didn't address that problem with this. We didn't guarantee that you could walk with your feet. We said: Here is how much money you can earn, but we didn't address that.

I will give two examples. Two people I have taken care of for over 15 years, both had no clinical indications that they had anything wrong. I contacted the insurance company. I thought they needed an MRI of the brain. Both of them were denied. I got friends who are radiologists to do their MRI. They both had brain tumors. One is still alive. What we are setting up isn't any different than what you have a complaint and gripe about now with the insurance industry. You didn't fix that in this bill. There is no health care reform in this bill. There is health coverage expansion, but there is no reform.

One of those people is still alive, but had we followed either Medicare guidelines, cost comparative effectiveness panel guidelines, which would have forbidden doing an MRI, that one person out of the two would be dead today. So as we sit here and look at our health care system, my biggest worry is, I will be in Medicare. I will get rationed. I know that. The way we are going about it, that is what is going to happen. We are going to ration care. We will not vote to not ration it. You know it is going to be rationed or you would have voted for the amendment in committee that provided a prohibition.

But my real concern is not my generation. My real concern is those who will follow us with \$12.1 trillion worth of debt and the fact that every one of those is 25 years of age and younger today. Twenty years from now, they will be responsible for \$1 million of both debt and unfunded liabilities for which we will have to collect, on average, \$70,000 a year just to pay the interest on what we are sending them. Before they pay the rest of their income taxes, before they pay payroll taxes, before they pay unemployment taxes, before they send their kids to school,

before they buy health insurance, before they buy a home, before they buy transportation, the real worry that should be in front of this country, which is the No. 1 issue on the public's mind, is: How do we get out of this financial mess? That is the No. 1 issue on people's minds. It is not health care.

I have no hopes of convincing my colleagues that through 25 years of practicing medicine, dealing with Medicare, dealing with Medicaid, that that is of any value to you. Because we are hell-bent on passing a health care bill and dealing to make sure we can and creating inequities throughout this country and dividing our country.

We heard the Senator from Rhode Island characterize us as liars, birthers, supporters of the Aryan nation. That is what I heard. I sat and listened to it. I think he doth protest too much, for he knows that is not true. There is nobody on our side of the aisle who cares any less than anybody on the other side of the aisle about fixing health care. The rub is, you believe the government is the most powerful thing and the best way to do it. We don't agree with that. We actually believe in the American people. We actually believe in the entrepreneurial spirit of the average American making good decisions for themselves every day, doing things we never do, which is prioritizing where their money is going to go and how they are going to spend it and working like heck to advance the cause of their own family, their own freedom, and their own liberty. You don't believe that because, if you did, you would never put this kind of bill on the floor. This bill limits liberty. This bill says you shall.

Think of the first big step in this bill. In the United States, you no longer have the ability to not buy health insurance. If you have $\$1\frac{1}{2}$ million in the bank and you want to put that at risk and say: I don't want to, you either have to pay a fine, a tax, or you have to buy health insurance. So where is the liberty and where is the commerce clause in that and where does that tie in with individual liberty and individual responsibility? We say: If you don't want to be responsible, then we will make you responsible. We don't say: You have to suffer the consequences of your lack of responsibility.

What built this country was people figuring out if you don't act responsibly, it is going to cost you. We are going to put a block on that and say: You don't have to act responsibly. You don't have to act in your own best economic interest. Don't worry. We will take care of it.

Jefferson warned of that. One of the Founders of this country warned us against doing the very thing we are doing today. If you read the Federalist Papers, you will see what Madison wrote about the welfare clause and the

commerce clause. He said, whenever the Senate starts to think about claiming it means something different than it does, here is what we want you to know. It doesn't. It is very limited in scope.

I said yesterday in a press conference that this country is at the point of a crisis of confidence such as we have not seen in hundreds of years. It is true. Whether you are a very liberal individual or a very conservative individual, you don't have any confidence in us. The reason you don't is because we don't act in the country's best interest. We act in our political best interest. Republicans are equally guilty. We look at partisan issues rather than principled issues. What we miss in all that is the best right thing for the country. We are missing it with this bill. We are missing the best right thing for the country.

Mr. CORKER. Will the Senator yield?

Mr. COBURN. I am happy to yield.

Mr. CORKER. I was listening to the Senator from Oklahoma. I know he cares deeply about his patients and continues to treat patients as he serves in the Senate. What he has done is pointed out the fact that there will be much interruption, changes in the physicians' and patients' relationship. But the big picture is what the Senator is concerned about, too; that is, the tremendous indebtedness this country has by the fact that—the good chairman of the Finance Committee is here today listening patiently, and I know this has to be painful to him—half the reform we are talking about is actually putting people in Medicaid, a program that 40 percent of physicians will not see and 50 percent of specialists will not see.

Mr. COBURN. And the outcomes are poor.

Mr. CORKER. Last weekend, the New York Times talked about many physicians prescribing antipsychotic drugs to young people because they don't want to deal with them on Medicaid. So half this reform is people going into this type of program and half the money is coming from Medicare, which is insolvent.

We have spent all this time, all kinds of bipartisan meetings. I know you spoke about the issue of partisanship. I know the good chairman is here. We, early on, said we wanted to join in health care reform. We just didn't want to take money from Medicare, which was an insolvent program, to fund it. What was the major building block of this program? Taking \$464 billion from Medicare to fund reform. We were, in essence, blocked out on the front end saying something we thought was the wrong type of principle to build upon.

Mr. COBURN. Mr. President, if, in fact, we got rid of 50 percent of the fraud in Medicare and Medicaid, we would generate \$600 billion every 10 years, more than offsetting the cuts that have been outlined in this bill.

Mr. CORKER. So if I understand correctly, of the new patients going into Medicaid, 50 percent of the money comes from an insolvent program. We are not dealing with the doc fix. Much of the savings they have talked about is just like the doc fix that back in 1997, the AMA, both sides of the aisle agreed to do something to save money for Medicare. As the Senator knows now, the Reid amendment takes out all the doc fix, now with a \$285 billion gap over the next 10 years to deal with physicians. It is another example of how we don't have the courage. We put in place cuts. We are not going to do that. We know what damage that will cause to patients. In this particular case, we should not do that. But the fact is many of these cuts that have been discussed will never take place. They will never take place. At the end of the day, I come back to the very thing you talked about; that is, we have \$12 trillion in debt, \$38.6 trillion in unfunded liabilities for Medicare alone, and here we are passing a bill that is using up the resources we might otherwise use to make it solvent.

Instead of doing that, we are leveraging a whole new entitlement. I heard some of the pundits this morning parroting some of the things I have heard from my friends on the other side of the aisle. Let's pass this bill. We know it is not very good, but we will fix it as we move along.

What I fear is the way we are going to fix it, we are going to fix it by adding tremendous debt on future generations. My guess is over the next very short period—2 or 3 months—the other side of the aisle is going to come right back up here with a huge, several hundred billion dollar unpaid bill to deal with one of these issues we have been talking about. That is the way business is done here.

Mr. COBURN. The Senator raises a good question. How long have we known and how long has Medicare been in trouble that we haven't fixed it? We will not fix it. We will do exactly what the Senator says, what we always do, what we have done since I have been in this body. We put the credit card into the machine and say: Transfer this to your grandkids. We take no pain ourselves. What is lacking in our country today is moral character to lead on the basis of sacrifice. It should start with us as Senators in this body.

Mr. President, I understand our time has expired.

The PRESIDING OFFICER. The minority's time has expired.

Mr. COBURN. Mr. President, I thank the Chair, and I look forward to hearing the remarks in the cloakroom of the chairman of the Finance Committee.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, just a couple, three points here, and I see the Senator from Ohio wishes to speak.

Several times during this afternoon, Senators on the other side of the aisle, in my judgment, put on a little demonstration of trying to offer amendments. They repeatedly asked consent to suspend the normal working of the cloture rule to offer amendments. Earlier, I note for the RECORD, they slow-walked the process when an amendment was in order. They wanted the whole amendment read. And now they are trying to offer amendments, again, to slow down the process. This is clearly a tactic to slow the process. It is not part of the regular order. That is clearly what is going on here. Those were not, despite the protestations to the contrary, serious amendments.

Normally, when a Senator offers a unanimous consent request, they allow the other side to speak briefly on the subject, at least on the reservation of the right to object. That was not allowed here. My colleagues did not allow me that courtesy earlier today, to comment with a reservation of the right to object. So I want to take a moment now to explain what they are really up to. I could not because they would not give me the courtesy to say any words during the reservation. That is why I made that statement.

I heard one Senator from the other side of the aisle complain that the majority is holding tonight's vote at 1 a.m. in the morning on the cloture motion. Let me set the record straight. The majority would be happy to have this vote earlier. We would be happy to have this vote maybe in 10 or 15 minutes from now. We would be happy to have this vote at a decent time. It does not have to be at 1 a.m. tomorrow. It is the other side which is insisting that vote be at 1 a.m. in the morning. So it is they who are insisting on enforcing the letter of the Senate rules. It is their right, but it is also they who are insisting on delay.

I also want to put to bed some of the assertions that they claim this bill does not do real health care reform. Let me mention a few health care reform provisions in this bill.

Mr. President, I do not know if you or any of my colleagues have read this second article in the New Yorker magazine by Atul Gawande. The first article talks about two towns in Texas, basically. The second is basically looking to see whether this bill does reform health care and whether it does cut down health care costs. It is an article I highly recommend to all of my colleagues in a recent issue of the New Yorker magazine.

But, basically, Dr. Gawande concludes this bill includes all of the constructive provisions health care economists, stakeholders, and people who have studied this issue suggest should be part of health care reform. That is his conclusion anyway. I am happy he said that because we worked mightily to make sure we have all the provisions

we can here to help constrain health care costs.

What are they? Well, one—although some may disagree with the policy—is an excise tax on high-cost plans, so-called Cadillac plans. It is a bit debatable. Last night I saw a TV ad where a group was advocating passage of this bill: But just not my high-cost plan. Pass the bill, but just not my high-cost plan. I understand the tenor and import of that TV ad, but the main point is, we do have to begin to limit to some degree the excessive cost of some plans, and I think we are very fair and modest here in proposing an excise tax on those high-cost plans. The trick is to set the level at the proper level, not too high, not too low. I think this bill does that.

In addition, all the delivery system reforms this bill enacts with respect to Medicare are so important to improving quality and reducing excess costs. We all know through history that when we reform Medicare and make changes in Medicare, the private sector follows. So the private commercial market will follow whatever Congress does with respect to Medicare; and that is, make good, positive changes. Why? Because Medicare is such a large provider of care, it tends to have a real effect on what other providers do.

What are some of those? Well, basically, we start to change the way we pay doctors and hospitals; that is, we start to pay on the basis of value rather than volume, that is quality rather than quantity. The paradox of that is, when people stop to think about it, we are going to both cut down costs and increase value at the same time because we will be focused on quality. When you focus on quality—not just quantity, not the whole volume of services, but, rather, focus on quality—you are going to get better quality, but your costs are going to go down because you are not reimbursing things such as excessive MRIs, excessive CAT scans, excessive high-cost procedures that do not, in many cases, get to the quality of health care but, rather, are very expensive, and Medicare pays for them. So we are moving more toward reimbursing based on quality and value than quantity.

What else is reform of the health care industry? One is bundled payments and the shared-savings program, which we refer to as accountable care organizations. This allows hospitals and groups to get together to cut down costs. We have bundling in here, which is another idea that moves along the same lines. I might add, too, the CMS Innovation Center and the Independent Payment Advisory Board suggest some of these.

The bill makes it easier for employers to offer workplace wellness programs. We give employers greater flexibility to offer premium discounts for workers who are committed to leading healthier lifestyles. There is a lot

of emphasis here on wellness and lifestyles. We give incentives to employers to have wellness programs and preventive programs, which will help, obviously, the worker, but, in addition to that, cut down costs.

There are other provisions here. This bill keeps getting stronger. The so-called freshmen package, led by Senator WARNER, will give the Secretary additional authority to expand delivery system reforms. It expands the scope of the Medicare board to the private sector.

There are many other provisions in here.

The Nation's employers, through the leadership of the BRT, played an important role in developing that package.

And the manager's amendment included a provision that will provide greater access to Medicare data to measure performance.

It is no exaggeration to say that this bill will revolutionize health care.

But don't take my word for it. The 23 economists who wrote to the President agree.

Mr. President, I ask unanimous consent that letter from these economists be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

STANFORD UNIVERSITY,
CENTER FOR HEALTH POLICY,
Stanford, CA, November 17, 2009.

President BARACK OBAMA,
The White House,
Washington, DC.

DEAR MR. PRESIDENT: On behalf of my colleagues, a group of distinguished economists, I am pleased to transmit this letter regarding essential components of health reform legislation.

Sincerely yours,

Alan M. Garber, M.D., Ph.D.

Henry J. Kaiser, Jr., Professor, Professor of Medicine, Professor of Economics, Health Research and Policy, and of Economics in the Graduate School of Business (courtesy), Director, Center for Primary Care and Outcomes Research and Center for Health Policy Stanford University.

NOVEMBER 17, 2009.

President BARACK OBAMA,
The White House,
Washington, DC.

DEAR MR. PRESIDENT, As the full Senate prepares to debate comprehensive health reform legislation, we write as economists to stress the potential benefits of health reform for our nation's fiscal health, and the importance of those features of the bill that can help keep health care costs under control. Four elements of the legislation are critical: (1) deficit neutrality, (2) an excise tax on high-cost insurance plans, (3) an independent Medicare commission, and (4) delivery system reforms.

Including these four elements in the reform legislation—as the Senate Finance Committee bill does and as we hope the bill brought to the Senate floor will do—will reduce long-term deficits, improve the quality of care, and put the nation on a firm fiscal footing. It will help transform the health care system from delivering too much care,

to a system that consistently delivers higher-quality, high-value care. The projected increases in federal budget deficits, along with concerns about the value of the health care that Americans receive, make it particularly important to enact fiscally responsible and quality-improving health reform now.

In developing our analysis and recommendation, we received input and suggestions from Administration officials, including the Office of Management and Budget and others, as well as from economists who disagree with the Administration's views.

The four key measures are:

Deficit neutrality. Fiscally responsible health reform requires budget neutrality or deficit reduction over the coming years. The Congressional Budget Office (CBO) must project that the bill be at least deficit neutral over the 10-year budget window, and deficit reducing thereafter. Covering tens of millions of currently uninsured people will increase spending, but the draft health reform legislation contains offsetting savings sufficient to cover those costs and the seeds of further reforms that will lower the growth of spending. Deficit neutrality over the first decade means that, even during the start-up period, the legislation will not add to our deficits. After the first decade, the legislation should reduce deficits.

Excise tax on high-cost insurance plans. The Senate Finance Committee's bill includes an excise tax on high-cost health insurance plans. Like any tax, the excise tax will raise federal revenues, but it has additional advantages for the health care system that are essential. The excise tax will help curtail the growth of private health insurance premiums by creating incentives to limit the costs of plans to a tax-free amount. In addition, as employers and health plans redesign their benefits to reduce health care premiums, cash wages will increase. Analysis of the Senate Finance Committee's proposal suggests that the excise tax on high-cost insurance plans would increase workers' take-home pay by more than \$300 billion over the next decade. This provision offers the most promising approach to reducing private-sector health care costs while also giving a much needed raise to the tens of millions of Americans who receive insurance through their employers.

Medicare Commission. Rising Medicare expenditures pose one of the most difficult fiscal challenges facing the federal government. Medicare is technically complex and the benefits it underwrites are of critical importance to tens of millions of seniors and Americans with disabilities. We believe that a commission of medical experts should be empowered to suggest changes in Medicare to improve the quality and value of services. In particular, such a commission should be charged with developing and suggesting to Congress plans to extend the solvency of the Medicare program and improve the quality of care delivered to Medicare beneficiaries. Creating such a commission will make sure that reforming the health care system does not end with this legislation, but continues in future decades, with new efforts to improve quality and contain costs.

Delivery system reforms. Successful reform should improve the care that individual patients receive by rewarding health care professionals for providing better care, not just more care. Studies have shown that hundreds of billions of dollars are spent on care that does nothing to improve health outcomes. This is largely a consequence of the distorted incentives associated with paying for volume rather than quality. Health

care reform must take steps to change the way providers care for patients, to reward care that is better coordinated and meets the needs of each patient. In particular, the legislation should include additional funding for research into what tests and treatments work and which ones do not. It must also provide incentives for physicians and hospitals to focus on quality, such as bundled payments and accountable care organizations, as well as penalties for unnecessary readmissions and health-facility acquired infections. Aggressive pilot projects should be rapidly introduced and evaluated, with the best strategies adopted quickly throughout the health care system.

As economists, we believe that it is important to enact health reform, and it is essential that health reform include these four features that will lower health care costs and help reduce deficits over the long term. Reform legislation that embodies these four elements can go a long way toward delivering better health care, and better value, to Americans.

Sincerely,

Dr. Henry Aaron, The Brookings Institution.

Dr. Kenneth Arrow, Stanford University, Nobel Laureate in Economics.

Dr. Alan Auerbach, University of California, Berkeley.

Dr. Katherine Baicker, Harvard University.

Dr. Alan Blinder, Princeton University.

Dr. David Cutler, Harvard University.

Dr. Angus Deaton, Princeton University.

Dr. J. Bradford DeLong, University of California, Berkeley.

Dr. Peter Diamond, Massachusetts Institute of Technology.

Dr. Victor Fuchs, Stanford University.

Dr. Alan Garber, Stanford University.

Dr. Jonathan Gruber, Massachusetts Institute of Technology.

Dr. Mark McClellan, The Brookings Institution.

Dr. Daniel McFadden, University of California, Berkeley, Nobel Laureate in Economics.

Dr. David Meltzer, University of Chicago.

Dr. Joseph Newhouse, Harvard University.

Dr. Uwe Reinhardt, Princeton University.

Dr. Robert Reischauer, The Urban Institute.

Dr. Alice Rivlin, The Brookings Institution.

Dr. Meredith Rosenthal, Harvard University.

Dr. John Shoven, Stanford University.

Dr. Jonathan Skinner, Dartmouth College.

Dr. Laura D'Andrea Tyson, University of California, Berkeley.

Mr. BAUCUS. The CMS Actuary agrees that this bill bends the cost curve. The folks at the Commonwealth Fund say the bill will save families \$2,000 per year.

Mr. President, I ask unanimous consent that an excerpt from Dr. Gawande's article from the New Yorker be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

EXCERPT FROM GAWANDE ARTICLE IN NEW YORKER

There are hundreds of pages of these programs, almost all of which appear in the House bill as well. But the Senate reform package goes a few U.S.D.A.-like steps further. It creates a center to generate innovations in paying for and organizing care. It

creates an independent Medicare advisory commission, which would sort through all the pilot results and make recommendations that would automatically take effect unless Congress blocks them. It also takes a decisive step in changing how insurance companies deal with the costs of health care. In the nineteen-eighties, H.M.O.s tried to control costs by directly overruling doctors' recommendations (through requiring pre-authorization and denying payment); the backlash taught them that it was far easier to avoid sicker patients and pass along cost increases to employers. Both the House and the Senate bills prevent insurance companies from excluding patients. But the Senate plan also imposes an excise tax on the most expensive, "Cadillac" insurance plans. This pushes private insurers to make the same efforts that public insurers will make to test incentives and programs that encourage clinicians to keep costs down.

Mr. BAUCUS. Mr. President, the Senator from Oklahoma at one point questioned the constitutionality of the mandate to buy health insurance. I might say, we thoroughly studied this issue. I believe there is ample authority for Congress to enact such a provision under the Commerce Clause, and also under the congressional authority to tax and spend for the general welfare provided for in the Constitution.

I might also add, Prof. Mark Hall of Wake Forest University has done an excellent survey article on this subject. Mr. President, I ask unanimous consent that the conclusion of Professor Hall's article, found at www.oneillinstitute.org, be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

LEGAL SOLUTIONS IN HEALTH REFORM—THE CONSTITUTIONALITY OF MANDATES TO PURCHASE HEALTH INSURANCE

(By Mark A. Hall, JD)

EXECUTIVE SUMMARY

Prepared by the O'Neill Institute

INTRODUCTION

Health insurance mandates have been a component of many recent health care reform proposals. Because a federal requirement that individuals transfer money to a private party is unprecedented, a number of legal issues must be examined. This paper analyzes whether Congress can legislate a health insurance mandate and the potential legal challenges that might arise, given such a mandate. The analysis of legal challenges to health insurance mandates applies to federal individual mandates, but can also apply to a federal mandate requiring employers to purchase health insurance for their employees. There are no Constitutional barriers for Congress to legislate a health insurance mandate as long as the mandate is properly designed and executed, as discussed below. This paper also considers the likelihood of any change in the current judicial approach to these legal questions.

POTENTIAL SOLUTIONS

Congress's Authority to Regulate Commerce: The federal government has the authority to legislate a health insurance mandate under the Commerce Clause of the United States Constitution. A federal mandate to purchase health insurance is well

within the breadth of Congress' power to regulate interstate commerce. Congress can avoid legal challenges related to the 10th Amendment and states' rights by preempting state insurance laws and implementing the mandate on a federal level. If Congress wants states to implement a federal mandate, it has the following two options:

Conditional Spending: Congress may condition federal funding, such as that for Medicaid or public health, on state compliance with federal initiatives.

Conditional Preemption: Congress may allow states to opt out of complying with direct federal regulation as long as states implement a similar regulation that meets federal requirements.

Congress's Authority to Tax and Spend for the General Welfare: Congress also has the authority to legislate a health insurance mandate under its Constitutional authority to tax and spend. There are no plausible Tenth Amendment and states' rights issues arising from Congress's taxing and spending power. However, Congress' taxation power cannot be used in a way that burdens a fundamental right recognized in the Constitution's Bill of Rights and judicial interpretations by the U.S. Supreme Court. Since there is no fundamental right to be uninsured, no fundamental rights challenge exists.

Other Relevant Constitutional Rights: Challenges under the First and Fifth Amendments relating to individual rights may arise, but are unlikely to succeed. The federal government should include an exemption on religious grounds to a health insurance mandate as an added measure of protection from legal challenges based on religious freedom. In the alternative, the federal government can simply exempt a federal insurance mandate from existing federal legislation protecting religious freedom.

Considerations: To avoid a heightened level of scrutiny in any judicial review, the federal government should articulate its substantive rationale for mandating health insurance during the legislative process.

LEGAL ISSUES & APPLICABLE LAW

Commerce Clause: Congress has the power to regulate interstate commerce, including local matters that substantially affect interstate commerce. Health care and health insurance both affects and is distributed through interstate commerce, giving Congress the power to legislate an insurance mandate using its Commerce Clause powers.

Taxing and Spending Power: Congress has the power to tax and spend for the general welfare. It can use its taxing power to implement a "pay or play" model to tax individuals that did not purchase insurance or provide tax benefits to those that do purchase insurance. Congress can also use its spending powers to influence state action. The taxing power of the federal government can be limited if a tax intentionally and directly burdens the exercise of a fundamental right.

Federalism: The 10th Amendment and principle of state sovereignty in the Constitution prohibit the federal government from commanding the states to implement federal law or policies that would interfere with state sovereignty. This is referred to as the "anti-commandeering" principle. A federal employer mandate covering state and local government workers appears consistent with existing Constitutional decisions but still might be susceptible to challenge under the Tenth Amendment.

Individual Rights: The First and Fifth Amendment contain provisions that may have some bearing on a health insurance mandate.

Free Exercise of Religion: The First Amendment's Free Exercise Clause protects the free exercise of religion. In addition, the Religious Freedom Restoration Act (RFRA) prevents the federal government from enacting a law that substantially burdens an individual's exercise of religion, unless the government has a compelling interest.

Due Process and Takings Clauses: The Fifth Amendment includes two relevant provisions. The Due Process Clause guarantees that no person shall be deprived of life, liberty, or property without due process of law. The Takings Clause states that the government may not take an individual's property without just compensation.

CONCLUSION

The Constitution permits Congress to legislate a health insurance mandate. Congress can use its Commerce Clause powers or its taxing and spending powers to create such a mandate. Congress can impose a tax on those that do not purchase insurance, or provide tax benefits to those that do purchase insurance. If Congress would like the states to implement an insurance mandate, it can avoid conflicts with the anti-commandeering principle by either preempting state insurance laws or by conditioning federal funds on state compliance. A federal employer mandate for state and local government workers may be subject to a challenge; however, such a challenge is unlikely to be successful. Individual rights challenges under the First Amendment's Free Exercise Clause or RFRA are unlikely to succeed, although a federal insurance mandate should include a statement that RFRA does not apply or provide for a religious exemption. Fifth Amendment Due Process and Takings Clause challenges are also unlikely to be successful. The legal analysis presented is likely to endure, as the Supreme Court's current position and approach to interpreting relevant constitutional issues appear to be stable.

Mr. BAUCUS. I might also say, Mr. President, the Senator from Oklahoma said the independent Medicare advisory board would ration care. In fact, he even accused us in the Congress—myself included—of voting against a prohibition on rationing. But, I might say, I am not for rationing care in the sense that the Senator from Oklahoma talked about. I do not think anybody in this Congress is. We have to find a system that starts to control costs in a fair way, that increases quality but also cuts costs. That is the underlying premise of the delivery system reforms in this bill. But do not just take my word for it. Right here in the bill, on page 1004, the bill says, with regard to the advisory board:

The proposal shall not include any recommendation to ration health care.

I chuckle a little bit when I say that because the Senator from Oklahoma is very concerned about using the word "shall." If he does not like "shall," then I suppose he means the board would have discretion. But we say "shall not include any recommendation to ration health care." That is on page 1004 of the bill. It is right there in black and white letters. Read the bill. The prohibition against rationing of health care is right there.

Mr. President, I see the Senator from Ohio, who wishes to speak.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. BROWN. Mr. President, I thank the Finance chairman for his leadership.

I have sat here listening. I was watching the debate in the last hour from my office, and then I came over in the last 20 minutes or half hour and watched from here. I am incredulous when I hear my colleagues on the other side of the aisle talk about "saving Medicare." This is the same group of people, with only one exception on the whole Republican side of the aisle, in 2003, who rammed through the Medicare privatization bill that was written by the drug companies and the insurance companies for the drug companies and the insurance companies.

Two things: One, they never paid for it. There was no discussion, no interest, no move to pay for their bill at all. Then they criticize that our bill is costing too much and running up the debt, when the Congressional Budget Office—which everyone knows is fair—they complain about the Congressional Budget Office. It is like at a sporting event. The losing team complains about the ref.

The other side, because they are losing, complains about the Congressional Budget Office. We know it plays fair. We cite it. We must. We do. It helps us move forward and helps us figure things out. But they did not even try to pay for their Medicare privatization bill because the drug companies and the insurance companies would not have gotten their way so much if they tried to pay for it. But the second thing is, their bill shortened the life expectancy of Medicare.

Our bill increases the life expectancy of Medicare for 10 years. And they have the gall to come to the floor and say our bill does not treat Medicare right, that our bill is going to ruin Medicare, that our bill whatever.

If you are a senior citizen in our country, understand what this bill does for Medicare. This bill guarantees benefits, No. 1. No. 2, this bill lengthens the life of Medicare for several years, as I said. No. 3, this bill helps with the cost of prescription drugs by closing that doughnut hole my friends on the other side of the aisle created back in 2003 with President Bush because the drug companies wanted it that way and the insurance companies wanted it that way.

Last, this bill provides all kinds of services to seniors they were not getting before—mammograms, colonoscopies—for free because we want—not that we want to do a giveaway but we want seniors to be healthy and live longer and have healthier lives. We know that is good for our country. It is good for them. It is good for our families. I am incredulous when I hear them talk about Medicare.

The second thing I am incredulous about when I hear them, that is pretty

unbelievable, is how they talk about partisanship. In the Health, Education, Labor, Pensions Committee, which Senator COBURN sits on and Senator BURR sits on—two of the people who were talking earlier—and the Presiding Officer sits on, we accepted 160 amendments. I voted for almost all of them. They made sense. Some were minor; some were more major. That gave this bill a bipartisan flavor to it.

But now they say the bill is too partisan and we were not listening, they say we are rushing it through—whatever they say. But the reason, even with those 160 Republican amendments, they do not want to pass it is twofold. One is people such as Senator DEMINT said: This is the President's Waterloo. If we can defeat this, we can end his presidency. So part of their opposition is strict win-at-any-cost partisanship.

The other reason is, even though there are 160 Republican amendments, on the big questions of the day, it is a philosophical difference. Go back to 1965. Very few Republicans supported Medicare. On the key vote in the House of Representatives, only 10 out of 160 or 170 Republicans supported Medicare. Over here, in those days, there were a few sort of "Rockefeller Republicans" who supported it. But, by and large, the mainstream Republican party, at least in Congress, opposed Medicare.

So just like they opposed Medicare because it was a big question, they are opposing this bill because it is a big philosophical question. That is fine they disagree with us, but do not accuse us of partisanship when, one, many of them want President Obama to fail. That is a strategy. It is a political strategy. But, second, do not accuse us of partisanship when 160 Republican amendments were in this bill in my committee, and in Senator BAUCUS's committee many amendments were accepted that were Republican amendments.

Then to say we have to slow this down because it has gone too fast, these negotiations have been going on for months. In the Finance Committee, the Gang of 6 started in mid-June officially, and it began before that.

I want to put a human face on this. When they say, let's not move too fast, do you know why I want to move, why I want to get this done by Christmas? We do not deserve to have Christmas with our families until we finish this. Do you know why? Because every day in my State—in Defiance and in Williwick and in Warren and in Steubenville—every day in my State, 390 Ohioans—lose health insurance.

Do you know what else? One thousand people every single week in this country die because they did not have insurance. So 390 people in my State alone—probably 350 in Michigan; probably 250 in Minnesota—every single day are losing their health insurance, and

in this country 1,000 people a week are dying because they do not have health insurance. A woman with breast cancer is 40 percent more likely to die if she is uninsured than if she is insured—40 percent more likely to die if she is uninsured than if she is insured.

So when I see my friends stall and stall, and they have all kinds of reasons—they have the clerk read the bill, they try to talk too long—whatever it is, however they are stalling in so many different ways, they should think about those 390 Ohioans who lose their insurance every day, think about the 1,000 people a week who die because they don't have insurance, and think of the woman with breast cancer without insurance who just has more trouble fighting back.

To further put a human face on this, I wish to share some letters from people in Ohio who have written me. These are people who understand how important it is because it is important to their personal lives, their families, their loved ones, themselves, that we take care of this bill by Christmas.

Sandra from Franklin County writes:

In December 2008, my partner lost her job. In July of this year she started working part-time in the evening, which didn't offer insurance. In October she found full-time work. We are grateful she is now employed. The job has no coverage. While she was unemployed, it hurt us financially. We are behind on some bills. But we can't afford health insurance for her now. It's a similar story with a friend of mine. He lost his job last year. After looking for a job, he decided to go back to school. He finally found a job and is happy for that. But he also doesn't get insurance.

Maria from Montgomery County writes:

I work in a school and come in contact daily with struggling families who can't afford basic medical care for their families. Please help. We want an America that sees health care as a right for all.

Today, I was on "Face the Nation" with Senator LANDRIEU and Senator ALEXANDER. A woman I was talking to works there part time as a contractor. She has a contracting relationship with them. She helps prepare people before they go on the air. She is not employed by CBS; she is an independent contractor. She has her small business. She has insurance and she pays a whole lot of money for it, and she said: Five years from now, I am going to be on Medicare. I look forward to having the stability and predictability of real health insurance. That is why this is so very important.

Robertta from Greene County down in Xenia, between Dayton and Columbus:

I am a senior citizen who feels uncomfortable using my fabulous Medicare benefits when others—parents, ill people, the unemployed—don't have any health care at all. Please pass health care reform for all who need and are without medical care.

Robertta, who is on Medicare, knows and understands, No. 1, how important Medicare is to her. She also knows she

is going to get more from this bill, including free screenings for mammograms, a free physical every year, and the cost of prescription drugs will be less because we are closing the doughnut hole. She knows this bill—unlike when the Republicans tried to privatize Medicare in 2003—actually lengthens the life of Medicare.

Mr. DURBIN. Mr. President, would the Senator yield for a question? I am going to be speaking at the end of this hour that has been allocated to our side, and I don't want to interrupt the Senator from Ohio but for one reason. I don't know if the Senator from Ohio heard or is aware of a statement made earlier today by our colleague from Oklahoma, Senator COBURN, who came to the floor and said:

What the American people ought to pray is that somebody can't make the vote tonight. That is what they ought to pray.

I have been trying to reach Senator COBURN because he is on a committee on which I serve and I work with him. This statement troubles me. I am trying to reach him to come back to the floor and explain exactly what he meant about a Senator not being able to make the vote tonight.

I don't know if the Senator from Ohio is familiar with this statement, but I am reaching out to Senator COBURN. I will be on the floor in the next 45 minutes, and I hope he will join me.

I thank the Senator from Ohio for yielding.

Mr. BROWN. I did not see that quote, but I watched what happened here 2 nights ago when we were trying to pass the Defense appropriations bill to make sure our troops were funded in Afghanistan, Iraq, and stateside and in Europe and everywhere else—Korea, everywhere. The Republicans wanted to kill that even though it would mean no funding, it would mean military layoffs, it would mean we wouldn't be able to get the things and supplies we need for the troops, because they said: We want to kill health care reform. I don't understand the desperation—except maybe I do because everything about this debate is protecting the insurance companies. I guess that is more important to them than anything else. So I will be interested too. I appreciate the assistant majority leader's comments on why Senator COBURN said that.

Let me close with one last letter.

Valerie from Cuyahoga County, which is in northeast Ohio:

I thank the Lord that my husband has a job with health benefits. If he didn't have it, I would be knee deep in medical bills. I know how important insurance is. I could never imagine not being able to go to the doctor. I have had many surgeries and had my fair share of doctors' visits. Could you imagine yourself without medical insurance or not being able to go to the doctor?

She says:

I bet most Senators and Congressmen never had to worry about that. But many

Americans have that worry and it is a scary, scary feeling. The time is now to pass health reform.

I know my colleagues have good health insurance. Of course they do. That is a good thing. But I also know many of my colleagues don't spend much time talking to people who don't.

Most people in our—if you are a Congressman or a Senator making \$170,000 a year, most people you see and socialize with probably are pretty upscale, probably have insurance. Most of us don't spend nearly enough time—I know the Presiding Officer does this in Duluth and Rochester and all over Minnesota. I know the Senator from Colorado, who worked on a lot of these issues with me in the House, when he goes to Boulder and when he goes home to Denver, he talks to people who don't have insurance.

I just wish more of my colleagues who oppose this bill would meet some of the 390 people in my State or in their States who lose their insurance every day. I wish they would talk to a woman who has breast cancer without insurance, knowing she is more likely to die. I wish they would talk to some of those people whose family members die because they don't have insurance. Because most of us dress like this and most of us hang around with people who dress like this and generally we have good insurance, I think we are a little out of touch. I hope we can pass this bill, go back home, and meet some of these people for whom this is going to matter because I think it will make a difference in how we all look at this.

I thank the Presiding Officer, and I yield the floor.

Mr. BAUCUS. Mr. President, I yield 10 minutes to the Senator from Colorado, Mr. UDALL.

The PRESIDING OFFICER. The Senator from Colorado.

Mr. UDALL of Colorado. Mr. President, I thank the Senator from Montana for yielding. I thank him for his tremendous leadership on this important fight here on the floor of the Senate.

First, I commend my colleagues for strapping on their snow gear. The Presiding Officer comes from the State of Minnesota, where this kind of a storm we have had over the last few days is not that unusual a development. I like a good 16-inch dusting from time to time. We all know what an important issue reforming our health care system is, and braving the elements is a small price to pay.

I have come to the floor a lot over the past few months to discuss the challenges that are facing us as we work toward fixing our broken health care system. One overarching theme I continue to emphasize is just how important this is to putting our economy back on track.

We have a bloated \$12 trillion Federal debt which is being fed daily by grow-

ing health care costs. Every day, employers, small and large, are laying off workers and slashing benefits for their employees. Great American businesses, especially in our manufacturing sector, have nearly collapsed because of the rising costs of providing health care for their workers.

Those Americans who have coverage lack the peace of mind in knowing that their insurance will be there just when they need it. This lack of stability and peace of mind is a fundamental problem with the status quo today because it takes away one of the things valued most by Americans: their freedom. Today, they are reluctant to move to a new job, to advance their education, or start a small business for fear they won't be able to provide health care for their families.

As we struggle to mend our economy, we can't afford to tell people to stay put. We know from history that encouraging the entrepreneurial spirit of Americans is the key to promoting small business, creating jobs, and driving our economic recovery. Small businesses have accounted for 65 percent of all new jobs created in the past 15 years, but today anyone who owns or has ever tried to start their own business can attest to why rising health care costs is such a major problem in this country.

Take, for example, the story of a gentleman who just recently contacted me from Denver. I will pick up on the theme the Senator from Ohio was touching upon. If we listened to the people in our States, there would be no question that this reform is necessary. Dave is a small business owner. Last year, he saw his insurance premiums skyrocket 27 percent for his employees. When he questioned this unbelievable increase, his insurance company said all he needed to do to save money was just stop offering coverage to his employees. Just let them buy their own insurance, his insurance company told him. When he looked into that, when he checked it out, he found out that nearly half of his workforce would be ineligible for coverage because of pre-existing conditions and that those who could obtain coverage were priced out and couldn't even afford it.

I hear this story time and time again—small business owners who want to do the right thing but end up facing annual double-digit increases in their costs. This is so troubling in this economic time because small businesses pay on average 18 percent more than large employers for the same level of coverage.

The status quo—and the Presiding Officer has been articulate and eloquent and involved in this fight—as he knows, is unacceptable, and we can't kick the can down the road any longer. The good news is the legislation we are

considering contains essential provisions aimed at helping small businesses, individuals, and American families across our country. Let me touch on a few of the important provisions that are in this final package.

Health insurers will be organized into well-regulated marketplaces and finally forced to compete. This would then involve a creation of a more transparent process for individuals and small businesses, so, for the first time, you can actually compare insurance plans side by side.

The legislation helps individuals pay for these newfound health insurance options. More than half of the cost of reform goes to financing tax credits to put money back in the pockets of middle-class families to help them purchase a health plan. As Chairman BAUCUS has pointed out, these tax credits represent the biggest tax cut since 2001.

In addition, starting in 2010, many small businesses will also qualify for new tax credits worth up to 50 percent of the cost of providing health insurance to their employees.

Also in this bill—I can't emphasize this enough—Americans will no longer go bankrupt because of health care costs. We are the only developed country in the world where citizens go bankrupt because they have health care costs they can't afford.

Insurers will be prohibited from denying access to health care because of preexisting conditions, limiting coverage because of age or gender, or dropping the insurance someone has already paid for simply because they get sick.

Regardless of what we hear from our friends on the other side of the aisle, this legislation saves money, it strengthens Medicare, it reduces the deficit, and it puts us on a path to finally addressing our growing national debt. In fact, noted MIT economist Jon Gruber estimates this bill will save small businesses 25 percent, or about \$65 billion per year, on health insurance. That translates into \$30 billion in take-home pay and an estimated 80,000 saved jobs.

While the bill before us makes important improvements, I would also like to say a few words about the package of amendments offered by the distinguished majority leader. I took some time, as I think we all did over the last snowy 24 hours, to familiarize myself with the changes, and I wish to touch on some of the most promising revisions that have been made.

I wish to first note my appreciation for including the freshman package. These amendments were offered by myself and the freshman class, of which the Presiding Officer is a member, and they have attracted bipartisan support. They boast the endorsements of business, labor, and consumer groups. The provisions inject more cost containment in the bill, cut down on regu-

latory and bureaucratic redtape, and push even more aggressively toward a reformed health care system.

I am particularly pleased to see a provision I worked on that would expand the scope of a new board designed to strengthen Medicare. The amendment would task this board not only to monitor Medicare but to look for ways to improve the entire health care system as a whole. I believe the independent payment advisory board is one of the best cost-containment tools in the bill, and I want to acknowledge Senator ROCKEFELLER for his work in developing the idea, as well as Leader REID for putting even more bite into the authority of this important panel of experts.

Second, I wish to express how proud I am that Majority Leader REID put so much emphasis in the managers' amendment on improving health care in rural America. The difficulty of accessing health care in rural communities is a unique struggle I have been increasingly concerned about, especially as I have traveled around Colorado's rural areas in the past several months. I am glad to see the inclusion of an amendment I authored to establish a rural physician pipeline training program designed to help bolster our rural health care workforce. Many of my colleagues joined me in offering this important amendment which has the potential to recruit and train more doctors to practice in rural areas.

In addition, I also authored an amendment that would establish an explicitly rural element to the community transformation grant program which is aimed at helping prevent and reduce chronic disease in communities across the country.

My amendment would ensure that rural areas are getting their share of this critical prevention and wellness funding, and I was very proud to see this important change included as well.

As I begin to close, I wish to say that although this bill has been strengthened significantly by the majority leader's efforts, it is not perfect. But I do not think anyone expects Congress to craft a perfect piece of legislation. We could never send the President a bill that fixes all the problems in our health care system or exactly reflects the priorities of every single Member of Congress, including myself. But what I am confident of is, this legislation can establish a sturdy foundation upon which we will build, improve, and strengthen access to health care in America.

Will there be mistakes made along the way? I do not doubt it. But as a lifelong mountain climber, I know from experience that the stumbles you experience along the way are a necessary part of reaching any mountain-top. Providing insurance and quality care for all our citizens is a once-in-a-lifetime opportunity to improve the

health and well-being of every American. These are the goals of our health insurance reform and, over the next few days, I look forward to passing a bill which modernizes our health care delivery system, increases much needed choice and competition in the health insurance industry, and helps put our economy back on track, while improving the financial security of middle-class working families.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I yield 10 minutes to the senior Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Mr. LEVIN. Mr. President, first, let me thank the Senator from Montana for the extraordinary work he has put in on this bill for so long, so many months, so many years. Thanks also go, of course, to the Democratic leader, our majority leader; Senator DODD; and others who have worked so hard to get us here.

We are in a pivotal moment in the long fight to reform our health care system. Everyone should, by now, be well aware of the history—how Presidents of both parties have tried and failed to achieve reform and how, after months of painstaking review, we have arrived at this instant, closer than ever to health care reform.

It would be impossible to fashion legislation on an issue so massive and so complex on which all could agree in every detail. Those seeking perfection will have to look outside this Chamber or, for that matter, in any piece of complex legislation.

But when they look outside the walls of this Capitol, Senators will also find problems that dwarf the imperfections in this bill. They will find a broken health care system, one in which we pay vastly more than other wealthy nations for care that is, in many cases, demonstrably inferior. They will find Americans struggling to afford the health care coverage they have and employers struggling to provide insurance to their employees. They will find manufacturers struggling under a costly health care burden, from which their international competitors were long ago freed. They will find employee and employer alike plagued by never-ending uncertainty about the cost and availability of health insurance, an instability that haunts families and hinders job creation. They will find costs rising so fast they threaten to swallow the rest of the Federal budget and sink family budgets. They will find astonishing amounts of money spent, not on better care or innovative treatments but on overhead and bureaucracy. They will find millions of Americans with no coverage at all—a tragedy for the uninsured and a source of inefficiency and expense that make health care more expensive for all of us.

So the choice before us now is whether any imperfections we might see in this bill outweigh the mountain of evidence that our current system is in dire need of repair. It is between moving forward on a significant repair of a broken system or quashing yet another attempt to reform health care in surrender to the status quo and to the rhetoric of distortion and fear.

To me, this choice is clear: We cannot wait any longer for health care reform. The people of my State cannot wait. The people of this Nation cannot wait. Now is the time for all those years of frustrated effort, all the research and analysis, all the debate and discussion, for us to reform a broken system. We must vote for cloture on the managers' amendment before us and continue to vote for cloture on the endless filibusters that confront us because we cannot wait.

We cannot wait any longer to reform this system because its costs are out of control. In 1990, this Nation, 12.3 percent of its gross domestic product on health care. That is \$1 in \$8. By 2018, the Centers for Medicare and Medicaid Services, CMS, estimates that figure will increase to 20 percent, and \$1 in every \$5 will go to health care. CMS estimates that after spending about \$6,000 per capita on health care in 2003, we will spend more than \$13,000 per capita in 2018, more than doubling our per-person expenditures in 15 years.

This translates directly into unsustainable costs for the American people. According to the Kaiser Family Foundation, thousands fewer of our businesses are offering insurance than a decade ago, a clear sign they can no longer sustain cost increases of 6 percent or more, year after year. If we do nothing, these costs will continue to rise at a rate which will swallow the budgets of families, businesses, and government.

We cannot wait any longer because, even for those fortunate enough to have insurance where they work, they are increasingly unsure it will be there when they need it most. Every Member of this body has heard from constituents who thought they had solid health insurance, only to find out their insurer had wriggled out of paying for desperately needed care or found a convenient preexisting condition that voided their coverage or capped their coverage, so they faced a crushing choice between treatments they had to have and costs they could not afford. Even in cases where families have health insurance, medical emergencies can leave debilitating costs in their wake. According to a study in the *American Journal of Medicine*, 62 percent of all bankruptcies filed in the United States in 2007 involved medical costs; and even more compelling, three-quarters of those bankruptcies involved people who had health insurance when they got sick. There can be

no more clear sign of the need to act than the fact that having health insurance is no insurance against bankruptcy from medical costs.

We cannot wait any longer because so much of the enormous cost at the heart of this health care crisis is money spent on that having little or nothing to do with quality care. For example, for those who purchase insurance in the individual market, roughly 30 percent of the costs they pay will stem from the insurance company's administrative expenses—on bureaucracy, not medicine. A 2003 study published in the *New England Journal of Medicine* found that, in 1999, Americans spent over \$1,000 per capita on health care administration costs—more than \$1,000 for every man, woman, and child in this Nation spent on paperwork and redtape. Electronic medical records, which make administration more efficient and improve the quality of care, are still not in use for most patients.

Finally, we cannot wait any longer because the inefficiencies of our system are crushing us and our budgets and, even more pointedly, because so many lives are at stake. One hundred forty thousand Americans have lost their lives since 2000 because they lacked health insurance. We cannot afford to walk down this road any longer. We must change direction. This bill will do it in a positive way.

An analysis by the Urban Institute, using methodology developed by the Institute of Medicine, determined that since 2000, nearly 140,000 Americans have lost their lives because they lacked health insurance. Other studies show that breast cancer patients, stroke victims and other patients are, as common sense suggests, far more likely to die from their conditions if they lack adequate health insurance. These are rigorous studies that bring us to an inescapable conclusion: If we fail to act, Americans will continue to lose their lives when they need not, simply because they don't have adequate health insurance, or any health insurance at all.

For these reasons and many others, it is long past time to reform our system. The question we must then answer is, will we come closer to a health care system worthy of this Nation if we pass this bill?

I believe we will. The legislation before us will reform the insurance system in powerful ways, protecting patients from the host of abuses they now so often face. We will begin to control spiraling costs in many ways, and establish research centers to find new ways to improve care and lower costs. We will create powerful incentives to reduce administrative burdens and costs. And we will bring millions of Americans into the health care system, reducing the number of uninsured, and reducing what is both a burden of inef-

iciency on the system and a moral blemish on our Nation.

We are out of time and out of excuses. Now we must choose. Choose between beginning to reform on the one hand and continuing the status quo on the other. Our individual problems with this bill cannot be allowed to overshadow the much larger problems with our health care system. Near the end of this long path toward health care reform, we cannot turn back. The Senate needs to move forward.

Again, I thank my good friend from Montana and the other leaders who have made it possible for us to get to this point.

The PRESIDING OFFICER (Mr. UDALL of Colorado). The Senator from Montana is recognized.

Mr. BAUCUS. I yield 10 minutes to the Senator from Illinois.

Mr. DURBIN. Mr. President, I thank my colleague. I wish to renew my invitation to Senator COBURN to please come to the floor but do it soon before my time expires. I called his office to make sure he knew I was trying to reach him. I have spoken on the floor to alert the Republican side that I wished to ask him to explain a statement he made on the floor earlier today. The statement of Senator COBURN of Oklahoma said:

What the American people ought to pray is that somebody can't make the vote tonight. That's what they ought to pray.

I am troubled by this statement. I want to give the Senator from Oklahoma an opportunity to explain it because the simple reality is, I don't think we should be wishing misfortune on any of our Senate colleagues on either side of the aisle. I don't know if this was an innocent statement or something he now wants to clarify. But as stated, it troubles me.

It troubles me because I am afraid it reflects the situation we find ourselves in too often in the Senate, where people are literally invoking God's name in prayer for political purposes—in this case, to wish misfortune on one of our colleagues who would not be able to make our 1 a.m. scheduled rollcall. I do not wish misfortune on any of our colleagues.

Mr. BAUCUS. Will my colleague yield on that point?

Mr. DURBIN. I am happy to yield.

Mr. BAUCUS. I wish to ask my colleague, who knows the Senate procedures so very well, why are we having a 1 a.m. vote? Isn't it possible it could be a different time?

Mr. DURBIN. I thank the Senator because he is exactly right. Under the usual business of the Senate, we agree that we will do something more thoughtful and humane and a vote at an earlier time. Senator REID has approached Senator MCCONNELL and said we have one of our Senators, Senator BYRD of West Virginia, with significant health problems, who was been brought

to the floor now early in the morning, late at night, and in a wheelchair. He looks better than ever, I might add. He is being asked to show up at 1 in the morning because we could not reach what is usual comity and gentlemanly accord on scheduling a vote.

It is unfortunate because now we face this 1 a.m. vote and with no cooperation on the other side to even change the vote for a very humane reason.

Mr. BAUCUS. The requests on this side for a vote at a reasonable hour—now it is 10 after 5 say maybe 5, 6, 7, 8 eight clock—a reasonable time, instead of 1 a.m., have been rejected by the other side?

Mr. DURBIN. Unfortunately, the Senator from Montana is correct. What the Senator from Oklahoma says is:

What the American people ought to pray is that somebody can't make the vote tonight. That's what they ought to pray.

I do not think it is appropriate to be invoking prayer to wish misfortune on a colleague. I want him to clarify that. I have invited him. I tried to reach out to him. He is my friend and I have worked with him. But this statement goes too far.

The simple reality is this. We are becoming more coarse and more divided. It is understandable we would disagree on political issues. That happens all the time. But, unfortunately, we have allowed that political disagreement to spill over into our personal relationships and friendships and that does hurt this institution.

We rely on one another on both sides of the aisle so much. I would say from the start that Senator REID has offered the Republican side of the aisle accommodations and asked we try to do things that might help the families and individuals in the Senate, and we have not had any luck to date.

Hope springs eternal. I hope Senator COBURN can make it to the floor to explain his statement. Earlier this week, there was a prayercast involving several Senators—I did not hear it; I only heard references to it—where they were actually in a group praying for the defeat of this legislation on health care reform. It is their right to do that.

I can recall as a high school football player saying a prayer my team would win a football game. I don't know if God had any time to worry about my little football game. But when it reaches a point where we are praying, asking people to pray that Senators won't be able to answer a rollcall, I think it has crossed the line. I hope my friend and colleague from Oklahoma will come and explain exactly what he meant.

I wish the bill before us were different. I wish it had a strong public option. I wish it offered Medicare to people 55 years and older. I wish it eliminated the McCarran-Ferguson anti-trust exemption for health insurance companies. Unfortunately, it does not do those things.

My disappointment over those elements should not lead me to conclude this bill is wanting or bad. The opposite is true. We have to look to the positive side of what this legislation will do.

This health care reform will extend the reach of health insurance coverage to 30 million more Americans. I see on the floor this evening my colleague from Arizona. He and I were on a television show early this morning. I am sure we got great ratings because the public can't wait to hear us, but during the course of that television show, the Senator from Arizona expressed concern that 20 million Americans would not be covered by our bill.

Interesting, isn't it? Today 50 million Americans are not insured; 50 million Americans are uninsured. This bill will provide insurance for 30 million more, meaning 94 percent of Americans will have coverage, the highest percentage in the history of our country. The Senator from Arizona says it does not go far enough to include more people.

We have waited patiently now for 21 days during the course of this debate on health care reform for the Republican plan for reforming health care. It has never been produced. Promised but never produced. I think the reason is obvious. It does not exist. Several times they have said on the floor: We have a plan, and they will wave a bill at us. When the Republicans had a chance over a 3-week period of time to offer their substitute, they never did. In fact, in over 20 days of active debate on the floor, there were exactly four Republican amendments on health care reform. Four in 20 days, 1 every 5 days. At that rate, how long would the Republicans have us stay on the floor waiting for the next amendment?

That is the reality. They offered six motions to stop the debate, remove the bill from the floor, and send it back to committee. Of course, when it came to actual substantive amendments changing sections of the bill, they would not do it. So the Republicans have come up empty. They are running on empty when it comes to health care reform which means this task of writing a bill is either beyond their pay grade or beyond their will and they like the system as it exists.

I do not. Fifty million uninsured Americans is unacceptable in this country. I think we have to reach a point where we move forward with 30 million now and then find ways to bring in the additional 20 million. Remember, when Social Security was enacted into law, with the resistance of the Republicans—they resisted it saying it is too much government—the safety net extended to widows. We extended in years that followed Social Security protection to dependents, survivors, and the disabled and we added a cost-of-living adjustment.

It was not the end of Social Security in the 1930s. In the years that followed,

we built on the original bill and we will build on this original model of health care reform. The same thing is true under Medicare. Medicare as originally offered did not cover disabled people. It did not provide home health care, therapy, or prescription drugs. Over the years, we added those benefits.

I believe this is an important starting point. I also think it is important we provide insurance protection for Americans. When it comes right down to it, too many people are denied the therapies, the surgeries, the medications their doctors recommend because some clerk in an office at a health insurance company is instructed to just say no, and they say no repeatedly.

We also make sure that patients are first, even with our additional amendment guaranteeing the right of people to pick their doctor and keep their doctor. It is a patient-first approach that we are using on this bill.

We hold the health insurance companies accountable and say if they turn around and gouge the patients before they want to be part of the insurance exchange, they can be disqualified. We saw what happened with credit card reform. When the banks had their way after the passage of credit card reform and during the period before it went into law, they ran up the interest rates on credit cards. I got letters in the mail from American Express and others saying: Incidentally, because of the new Federal law, we are going to raise your interest rate on your credit card over 20 percent. We know some of these merchants, given enough time, will capitalize on that time and try to exploit that system. Our bill is going to go after them.

The medical loss ratio is an important part in the bill. I am sure the health insurance companies are not going to be happy with it. It says: Stop taking those premium dollars and turning them into administrative expenses, advertising, bonuses for CEOs' high-paid salaries. Take the money and pay for medical services for the people you insure. If you do not, if you take too much of this money for profiteering, you are going to have to rebate it to your customers. It is changing the balance, giving customers a chance when it comes to health insurance—something that is long overdue.

We extend the health care safety net in this bill. Mr. President, 1.8 million people in my home State of Illinois will have access to affordable health insurance. I have met them. They are hard-working people, small businesses, part-time employees, unemployed people—none of them has health insurance. Again, 1.8 million in my State of almost 13 million are going to have the chance to be covered.

We will have 10,000 more community health centers.

I cannot tell you what an exciting idea this is. If you visit a community

health center in Arizona or Illinois, you know what I am talking about. This is a clinic in a neighborhood, usually, or small town where people can literally walk through the front door and get access to primary care physicians who will help them through their medical difficulties. They do not have to wait until they are so bad they end up in an emergency room where costs are dramatically higher. They have a doctor, a nurse, a medical professional, a dentist right there in their community. We estimate this bill will add 10,000 more community health clinics across the United States. That is going to be a dramatic change.

It also will create the opportunity for 20,000 more primary care physicians across America. If there is anything more we need, it is family care, internists who can deal with the medical needs of people before they are referred to a specialist or before their situation has deteriorated.

This bill is going to provide for all people under 133 percent of poverty—that is about \$29,000 for a family of four—the security of knowing they are under Medicaid protection without health insurance costs, without health insurance premiums. We will say to those working poor people: You are going to have health insurance. We also believe that progress is going to take some time.

I recall that Senator Teddy Kennedy, who I wish were here for this great battle for which he prepared for four decades, said in his book “True Compass” toward the end that real reform is never over. It is not. This is a beginning. It is an important beginning. It establishes important principles.

I say to the critics, we don’t expect every aspect of this bill to work perfectly. It is an imperfect product made by mere humans trying to do their best. But some of the things in this bill are going to dramatically change health care in America for the better. We are going to find ways to deliver quality care to people in a cost-effective way. We are going to change parts of our system today which, unfortunately, under this current system are out of control. The costs are out of control.

Moving coverage to an additional 30 million people, 94 percent of Americans under coverage, something no other bill from either side of the aisle has proposed, reducing our deficit—incidentally, we now have a CBO statement which makes it clear that the budget savings in the second 10 years—the first 10 years is \$130 billion; the second 10 years is up to \$1.3 trillion. They qualified it, but it still is the most dramatic deficit reduction bill in the history of the United States. There has never been a bill that has come before us that reduces our deficit so dramatically.

It reduces it because it works. It brings down the cost of health care. As

far as Medicare is concerned, this bill will add at least 9 years of life to Medicare. Medicare, which is going to face serious financial problems in about 7 or 8 years, has a new lease on life with this bill of 9 or 10 years.

To say this saves Medicare and puts it on sound footing is a fact that has been confirmed by the Congressional Budget Office, all the speeches on the floor notwithstanding.

This bill is also going to move us forward in the whole area of looking at ways to deal with medical negligence and medical malpractice. We provide incentives and grants to States to find ways, without penalizing the true victims of medical malpractice, to reduce the incidence of lawsuits, to reduce defensive medicine. That is a conscientious and thoughtful way to approach this.

I would say, if I were to ask anyone to offer a prayer—and I don’t do that very often—I would say a prayer for the 50 million uninsured Americans, folks who go to bed without peace of mind that they have health insurance for themselves and their families. I would say a prayer for those turned down by health insurance companies when their doctor says they need a certain therapy or a certain medication or a certain surgery. Those are the people I think of. I pray good fortune for them. I do not pray for misfortune for anyone in the Senate—not for any of my colleagues, not for any of my political opponents. I do not think that is appropriate use of prayer to do that.

I am sorry, as I bring this to an end, that the Senator from Oklahoma has not been able to come to the floor. I have tried now on several occasions through the cloakroom and other ways to invite him to come and explain his remarks. I am troubled when he says the American people ought to pray that somebody can’t make the vote tonight. I pray for everybody. I don’t pray for misfortune for anyone in the Senate. Let’s have the vote. Let’s have all 100 Senators here voting their conscience, voting their heart.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I will be a bit presumptuous here that I can speak for most Senators and probably most of the American people. One thing in life that is so difficult to deal with is when you are working with somebody, irrespective of a situation, and trying to resolve an issue, a problem, and the person you are talking to or working with is not dealing in good faith. When each side is dealing in good faith, then each side will begin to recognize the merits of the other person’s point of view and each person tends to recognize the deficiencies and faults of his own point of view. It is a good-faith exchange.

Not very many things in life are black and white and not many issues

are black and white. Most of them are some shade of gray. I may think that even though my issues—I am not white and the other guy is black, I like to think my shade of gray is more light than his shade of gray. That is not relevant. What works is when both sides talk to each other and try to make an accommodation.

I think I can safely say most Americans think our health care system needs some repair. It is too costly. There are too many cases when the insurance industry cherry-picks and takes advantage of people. It is not the right thing to do.

Also, we have to find a different way to pay for doctors and hospitals, reimbursing on basic quality, not quantity. Almost all doctors agree we should move in that direction.

A few minutes earlier, one Senator got up and said CBO has made this huge error, a $\frac{1}{2}$ trillion error. He goes on and on about this $\frac{1}{2}$ trillion error. To be honest, if we are going to deal in good faith, we should mention the pluses and the minuses, and let the Senators and the public figure out where all this nets out.

CBO has made many statements, most of which I think the Democratic side has relied on, and CBO has made statements that the Republican side has relied on. It is not black and white. It is a shade of gray.

In this case, it is true that CBO sent a letter, I think it was today—in fact, I have it here with me—that said they made a $\frac{1}{2}$ trillion error in the second 10 years. What was the error? I don’t remember the exact figure, but essentially I think CBO said this legislation will reduce the debt in the last 10 years by I think it was $\frac{1}{2}$ percent of GDP which comes out to about \$1.3 trillion to the good. It reduces the debt by \$1.3 trillion.

CBO in a letter to us came back and said they made a mistake. This legislation does reduce the Federal budget deficits over the subsequent 10 years but not by as much. A $\frac{1}{2}$ percent GDP should have been between a $\frac{1}{4}$ percent GDP and $\frac{1}{2}$ percent GDP.

Half the story is CBO said they made an error of $\frac{1}{2}$ percent GDP. But the full story is, still, nevertheless, the Congressional Budget Office says:

All told, CBO expects that the legislation, if enacted, would reduce federal budget deficits over the decade over 2019 relative to those projected under current law—with the total effect during that decade that is in a broad range between one-quarter and one-half percent of GDP.

Essentially, they are saying: We made a mistake at CBO, but still this is going to reduce deficits between \$615 billion and, say, \$1.3 trillion. That is the full story.

I hope when we debate here that we give both sides of the story. That way we can work more toward common ground what is right. Nobody is totally

right. Each of us is here serving in good faith. We want to do what is best for our people in our home States, and we are trying. Different States have different points of view. We are going to get better solutions in health care reform if we talk to each other in good faith and give the whole story, not just part of it.

The PRESIDING OFFICER. The Republican whip.

Mr. KYL. Mr. President, I appreciate the comments my colleague from Montana made. I think the point my colleague earlier was trying to make was that we just got the bill yesterday and have not gotten a full CBO or final CBO score; that the correction simply revealed the fact there is a lot there to digest, and we ought to have more time to understand exactly how the inter-related pieces of the bill work, how all the CBO scoring relates, and so on. When CBO can make about a \$600 billion error, as I understand, that is a big error. So there is probably more and a lot we don't understand. It would be helpful if we had more time to understand this and how it all works, and that was the point my colleague was making, I believe.

But I do appreciate my colleague pointing out it is better we work in good faith and, for the most part, I certainly recall the long conversations the ranking Republican, Senator GRASSLEY, and the chairman of the committee had. I know they worked in good faith, and it would be best if we did that. It is to that end I wish to speak to some comments a colleague made earlier today.

I don't know whether it is frustration or maybe just the lens through which partisans view things and their opponents, unfortunately, that spawned the remarks earlier today from one of our Democratic colleagues, but in either event, his characterization of his Republican colleagues, I think, requires response.

He began by talking about the malignant and vindictive passions that have descended on the Senate. Here is what he said, and I am quoting:

... too many colleagues are embarked on a desperate, "no holds barred" mission of propaganda, obstruction and fear. History cautions us of the excesses to which these malignant, vindictive passions can ultimately lead. Tumbrils have rolled through taunting crowds, broken glass has sparked in darkened streets, strange fruit has hung from southern trees.

I couldn't believe my ears, these references to Kristallnacht, one of the first and most vicious attacks on the Jews by the Nazis, and hanging of Blacks. The majority leader's remarks last week, comparing the Republicans' position on health care to the proslavery movement, remain largely ignored as the clumsy, offhand remarks of a partisan, but the references earlier today appeared not to be off-the-cuff mistakes but prepared text, delib-

erately delivered by one of the brighter minds of the Senate.

Our colleague went on to acknowledge, and I quote again:

... that in the heat of those vindictive passions, some people earnestly believed they were justified. Such is the human capacity for intoxication by those malignant and vindictive political passions.

Well, yes, Republican Senators do believe our position is justified—in fact, correct. There are honorable people on both sides of the aisle who obviously have to agree to disagree. But our colleague attributes no good motive to Republicans, whose passions are simply "malignant and vindictive." He adduces evidence to support his claim. First, an unnamed editor of the *Manchester Inquirer* who wrote that the GOP "has gone crazy" and an unnamed economist who believes our party has been taken over by the "irrational right." A Philadelphia columnist talked about "lunacy on the Republican right."

Further quoting now: "... it has gone crazy, is more and more dominated by the lunatic fringe and has poisoned itself with hate."

I wonder if my colleagues believe our position is animated by hatred. Why else would we oppose this legislation? Well, he answers that question too. It is because, he says, first of all:

... to break the momentum of our new young President. They are desperate to break this President. They have ardent supporters who are nearly hysterical at the very election of President Barack Obama—the birthers, the fanatics, the people running around in right-wing militias and Aryan support groups. It is unbearable to them that President Barack Obama should exist. That is one powerful reason. It is not the only one.

Well, talk about vindictive passions. Does my colleague believe that is why I oppose the legislation—or my colleague JOHN MCCAIN? I hate to disappoint some folks, but I don't care about the political fortunes of the President, at least not right now. I may about 3 years from now. I don't like this bill. That is why I oppose it.

My colleague says there is another reason. He says it is the "insurance industry," which he proceeded to demonize. I am not one to defend the insurance industry, but it is strange to see it so demonized by my colleague, whose party brags of getting another 30 million people insured by what? The insurance industry. Why subject these folks to such awful torture? But the real irony is, the legislation which we oppose, the insurance industry supported. It made a deal with the Obama administration and key Senate Democrats: You mandate that every American has to buy one of our policies, and we will support your bill. There was a deal all right, but it was between the insurance industry and key Democrats. The insurance industry obviously didn't dictate the Republican position, which largely opposes the individual mandate.

Well, finally, our colleague also accused Republicans of engaging in something else. He said we were engaged in a:

... campaign of falsehood about death panels and cuts to Medicare benefits and benefits for illegal aliens and bureaucrats to be parachuted in between you and your doctor.

He went on to state:

Our colleagues terrify the public with this parade of imagined horrors. They whip up concerns and anxiety ... then they tell us the public is concerned about the bill.

So the reason the public is opposed to the bill is because of the power of Republican Senators to terrify our constituents about imagined horrors. Let us look at the examples given.

I don't know of any Republican Senator who has characterized the health care rationing as coming from death panels. I heard that phrase in another context. We have tried to discuss the provisions of the bill we believe do result in rationing. The chairman of the committee and I have had a lot of debate on this subject. I wish Senator ROBERTS and I could offer a couple of the amendments we wanted to offer to make sure there is no rationing in the bill. I think it is a real problem and should be debated on its merits.

The benefits for illegal aliens, I suspect he was referring there to the House debate, but it is still the case that there are completely inadequate provisions in the bill to verify eligibility for benefits. You can even apply by telephone, so just about anybody could apply for some of the benefits.

Third, the matter of Medicare benefits. I don't think we are terrorizing our constituents about Medicare benefits, unless they understand the facts, and the facts are that Medicare benefits are going to be cut. The Congressional Budget Office says the Medicare Advantage benefits are going to be reduced from a monthly actuarial value of \$135 down to \$49 a month. That is CBO saying there is going to be reduction in the benefits for those who have the private Medicare Advantage policies. That includes dental, vision, hearing, vision care, fitness, and a variety of other programs.

We have had a semantic debate in this Chamber between those who say: Well, the fundamental benefits of the Medicare law are not specifically eliminated or reduced in the legislative language of the bill. That is true. But what is also true is, the additional benefits in Medicare Advantage are being reduced. That is unassailable. It is also true—and CMS, for example, refers to this—that enrollment is going to be reduced because of these reductions in benefits. They talk about the lower benchmarks, and they say when it is fully phased in, enrollment in Medicare Advantage plans would decrease by about 33 percent. So this is not some kind of fantasy. This is taken from the Congressional Budget Office and from the CMS Actuary.

Finally, in addition to the Medicare Advantage, the Actuary says simulations by the Office of the Actuary suggest that roughly 20 percent of party providers; that is, hospitals, nursing homes, home health care, would be unprofitable within the 10-year projection period as a result of productivity adjustments. That means they would go out of business. Obviously, senior care is going to be affected by this legislation, and we believe negatively so. That is an honest debate to have, and it is one which we would like to have.

But, finally, my colleague turned the world upside down by arguing the only reason we are here the week before Christmas is because of Republican bad behavior; that we ruined the holidays for the professional staff because we followed the procedures of the Senate that require the reading of the bill.

It is true that requirement is usually waived, but then we usually have plenty of time to know what is in a bill. Usually, a bill works its way through committee and both parties know what is in it. We both help to write the bill. It is transparent. It is usually printed long before it comes to the Senate floor so we know what is in it. The reason it was read was so our staff would, in fact, have time to read it, to advise us—because we didn't all have time to read it ourselves—and to advise the public, our constituents, of what is in it. Again, we received it yesterday and we are voting on it tonight. That is very little time to know everything that is in there.

The more we learn about what is in there, the angrier a lot of people get. The special deals for one State, for example, are simply wrong. That is why you take time to see what is in it. The majority of the public, according to opinion polls, want us to take more time to understand what is in this bill.

A final point on this. I have to say, the majority leader dictates the schedule of the Senate. All Senators are pretty much equal, but the majority leader has two things he can do and only he can do. He has the right of first recognition, and he has the right to set the schedule. By the schedule, I mean when he files a cloture motion, which is what brings this bill to the floor or this amendment to the floor. When he files the cloture motion, that is what determines when the vote will be. He determines when to bring the Senate back in session. Under the rules, an hour after he brings us back in session, the cloture motion ripens and we have a vote.

He can set that time at any time. He can say tomorrow morning, at 9 a.m., the Senate will come back in session and we will vote at 10 a.m. The leader could do that. That is his right, and he is the only one who has the right to do that. But instead, he says we will come in at 1 minute past midnight tonight. Therefore, the vote will be 1 minute

past 1 a.m. tomorrow morning. It is his right to do that.

We didn't do that; he did that. He is the only one who has the right to set that schedule. If he wanted to set a schedule that was a little more convenient for all the Members—including our dear friend, the Senator from West Virginia, who is ill and indeed does have to get out of a bed to come in a wheelchair to this Chamber—the majority leader has it within his power to say we will do it at a more convenient time.

Why would he do it in this way? Because he has deliberately decided—and all majority leaders have not done quite this but have done similar things—to set a recess and then work us up against the recess so we will have an incentive to finish. It is usually a pretty good incentive. Certainly, going home for Christmas is a big incentive. So the majority leader figures, if he can schedule this bill and the various votes in such a way that we end up voting on it on Christmas Eve, that maybe then we will hurry up and try to do it because, as one Democratic staffer is quoted as saying: "We need to hurry up and pass this bill because the longer it hangs around the harder it will be"—meaning to pass it. That is true. The more the public finds out about it, the less they like it.

So the majority leader is trying to get it done as quickly as he can, and "as quickly as he can" means scheduling us for a vote 1 hour after we come in. Since there has to be an intervening day—and today is the intervening day—tonight, at 1 minute after midnight, we will reconvene for the next day and then have the vote at 1 a.m. It is purely the majority leader's decision to do it that way. Republicans have nothing to do with it.

If I had my way, we would vote at 10 o'clock in the morning. But that is not the way it is going to be. So please don't say it is Republican bad behavior that results in having to vote on this bill late at night. The process is determined by the majority leader.

I guess I am going to conclude by saying I don't believe this bill can be sold on its merits, and I think that is another reason why we have to hurry up and do it—before the public figures out what is in it. The public opposes this bill not for the reasons imagined by my colleague but because it will cut Medicare benefits, it will increase insurance premiums—not cause them to go down—it will raise taxes, put the government in charge of too much, it will cost trillions of dollars, and it will result in the delay and denial of care. That is why the majority of Americans want us to start over and address the problems on a step-by-step basis.

I was amused by my counterpart, the Democratic whip, saying Republicans have only offered four amendments. I think it was seven but say it is four. Guess who determines how many

amendments we get to offer? The majority leader. He sets that schedule as well. He says now it is our turn to offer an amendment. Then it is your turn. The way he managed the schedule, we only got to file either four or seven amendments. We have 200 amendments pending. We would love to get as many of these pending and voted on as possible. Believe me, it is not Republicans who don't want to vote on our amendments. The majority leader, again, has set the schedule.

This is why we oppose the bill. It is why we don't like the process. We respect what our constituents are telling us. We believe this bill will be bad for them, and it will be bad for our country. Our Democratic colleagues have a different position. Neither their position nor ours is malignant, nor should they be expressed vindictively.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, we have all been waiting for many weeks while the Democratic leadership worked behind closed doors, out of public view, to write this new health care reform bill, and this process, of course, is very much contrary to what the President promised during the campaign—that negotiations on the health care reform bill would even be on C-SPAN so everybody in the country could see it. So now a very secretly put together bill is out for our consideration with just a few days to consider it.

Last week, they were considering expanding Medicare to people between 55 and 64 years of age—also, increasing Medicare to cover people up to 150 percent of poverty—and thirdly, having a government-run plan run by the Office of Personnel Management.

Now we have something entirely different. We have the Reid amendment, and it is chock full of special deals. It does nothing to fix the fatal flaws in the 2,074-page bill we started with, and now we have a bill that is probably 400 pages longer than 2,074 pages.

What kind of changes does this new amendment make to the original Reid amendment? Well, one tax disappears—it was a tax on cosmetic surgery—and in its place we have a new tax, a tax on tanning bed services. The dial on the Medicare payroll tax is turned up. So the first-time marriage penalty in a Medicare tax—one that hits about half the two-earner couples—is enhanced. Well over 1 million couples get to look forward to that tax hit—can you believe it?—just for being married. So the old marriage penalty is back. The dial on the insurance fee is also turned up in the back end of the bill.

But with respect to a few favored insurance companies, the fee is turned off. The very limited small business tax credit is expanded—over \$½ trillion in new taxes, according to the official congressional scorekeepers. What kind

of tax changes stay the same? Basically, the managers' amendment in the underlying Reid amendment still imposes new taxes—new taxes on everything from tanning beds to insurance companies to wages to heart valves to drugs and even more.

Contrary to what has been said on the Senate floor this very day, the tax burden still rests on many middle-class folks. As has been said, there is a sizable subsidy that 12 million tax-filing families and individuals receive. We do not dispute that. But what the other side does not want to acknowledge is this: There are 42 million tax-filing, middle-class families and individuals who will pay higher taxes under this 2,000-plus page bill. For every middle-class, tax-filing family who receives an insurance subsidy, three middle-class families will pay higher taxes.

I ask unanimous consent to have printed in the RECORD a copy of a corrected version of an article from Congressional Daily, dated December 18, of this year.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From CongressDaily AM, Dec. 18, 2009]

LABOR CITES JCT ANALYSIS TO ARGUE
AGAINST CADILLAC TAX

(By Peter Cohn)

Labor officials Thursday unveiled new ammunition in their fight against a proposal to tax high-cost health insurance plans in the Senate health bill, citing a congressional analysis that found more than 22 million households earning less than \$200,000 would see a tax increase by 2019.

That figure could rise a bit as the Joint Committee on Taxation did not distribute information on tax returns for married couples earning up to \$250,000, which is the threshold set by President Obama when he pledged not to tax the middle class. The tax issue could be the most intractable difference between Senate and House-passed legislation—which instead relies on a millionaires' surtax—as Democratic leaders struggle to cobble together a bill that can pass in both chambers next year. Communications Workers of America President Larry Cohen, whose group released the JCT figures, said they demonstrate “irrefutably that the excise tax—which will result in reduced coverage and increased costs for our middle class families—is the opposite of reform.”

Most House Democrats and union officials are adamant that the final version does not break Obama's pledge and tax those households earning less than \$250,000. Obama at one point appeared to endorse the House bill's surtax, which is the single-biggest revenue source in either bill at \$460.5 billion. There are major problems with that tax in the Senate, however, not least because it is not indexed for inflation. It also could affect about one-third of all income earned by small business owners that file individual tax returns, according to JCT.

“This is going to be a major problem, no question about it,” said a senior Democratic aide. “The White House is going to have to weigh in and provide some direction.”

There have been some mixed signals. The president in a July press conference said the House surtax “meets my principle” of not

burdening “families who are already having a tough time.” In a speech to Congress after Labor Day, however, Obama endorsed the Senate excise tax as a “modest change that could help hold down the cost of health care for all of us in the long run.”

The 40 percent excise tax in the Senate bill would affect employer-sponsored coverage worth more than \$8,500 for single workers and \$23,000 for family plans beginning in 2013. Those figures would rise with inflation, plus 1 percent each year, with higher beginning thresholds for older workers and those in high-risk professions. Certain high-cost states would be granted additional room before the tax kicks in.

In a White House blog post Wednesday, National Economic Council Deputy Director Jason Furman said the Senate bill would not hike taxes on the middle class and actually would provide a net tax cut.

He noted JCT estimates that only 3 percent of health premiums would be affected in 2013, a figure that rises to 8 percent by 2019, as well as the higher wages that would accompany a decrease in costly health benefits.

One school of thought holds that whatever bill is able to muster 60 Senate votes will form the basis for the final legislation, and House Speaker Pelosi will have to deliver the votes in her chamber. Another says 188 House Democrats that oppose the Senate tax—a broad cross-section led by second-term Rep. Joe Courtney of Connecticut, who requested the new JCT data, and Rep. Sander Levin of Michigan—won't allow the House to be steamrolled.

“How did they get into this mess?” one labor official asked. “They've set this thing up terribly, and they have a huge problem in their Caucus.”

The senior Democratic aide said another Senate provision, an increase in the Medicare payroll tax for those earning above the \$200,000 and \$250,000 thresholds, could meet the House test. Another idea, promoted by Sen. Debbie Stabenow, D-Mich., would apply the Medicare tax to unearned income such as capital gains and dividends and also has some cache in the House.

But those proposals also have the disadvantage of being prime revenue sources to help shore up Medicare's finances over the long haul, which could be negated if used up to help expand healthcare benefits to younger workers.

House moderates at one point considered a plan authored by the centrist Democratic think tank Third Way to tax “excess medical inflation,” or healthcare premiums that are rising much faster than overall economic growth. Sen. Thomas Carper, D-Del., an honorary Third Way co-chairman, has pitched the idea in his chamber as well. He continues to argue it could be a fallback position; other sources on and off Capitol Hill suggested the train has already left the station and it was too late to inject a new and untested idea into the mix.

What is striking is the amount of agreement between unions and Republicans on the Senate's excise tax, however. Republicans, including Sen. John McCain, R-Ariz., have long held that taxing employer-provided health coverage is the best way to keep costs down and raise revenues. But in opposing the overall health bill, they have latched on to the fact that the excise tax and other taxes in the bill would hit those middle-class workers Obama wants to protect.

According to JCT data analyzed by Senate Finance Committee Republicans, the number of households earning less than \$200,000 that

would be hit with a tax increase number closer to 42 million in 2019, or about 25 percent of all tax filers under that threshold.

They looked not only at the excise tax but also a scaled-back itemized deduction for medical expenses for those with costs not covered by insurance, and those affected by the Medicare tax that have losses bringing their income under the thresholds.

The numbers factor in those who receive premium tax credits and subsidies to offset the cost of buying health coverage in the bill. Most of those hit with net tax increases earn between \$50,000 and \$200,000 annually. Of those households earning under \$75,000, roughly 12 million would come out ahead, JCT found, including many who earn too little to pay taxes.

Mr. GRASSLEY. This new compromise does not fix any of the core problems in this original 2,074-page Reid bill. It is still that long of a bill. It is still a \$2.5 trillion massive bill as far as costs are concerned. The Reid amendment actually adds 400 more pages.

These closed-door negotiations did not produce a better product. Quite the opposite. It still taxes middle-class families, seniors, and veterans. Millions of people still will not be able to keep what they have, as the President promised in the last campaign. A lot of people who were hoping to pay less as a result of the word “reform” will still end up paying more.

I am not just talking about the young and the healthy. It still imposes higher premiums for prescription drug coverage on seniors and the disabled. It still permanently cuts all annual Medicare provider payment updates based on productivity gains outside of health care. These cuts still go into effect, even if it means providers will get a negative payment update, and these permanent cuts still threaten Medicare access to care.

The bill still cuts \$120 billion from Medicare Advantage, cuts that will reduce Medicare benefits for 11 million beneficiaries, contrary to what the President told us in his speech in September—that nobody is going to get cut in Medicare. This bill still creates a new body of unelected officials with broad authority to make further cuts in Medicare beyond the \$40-some billion that are in this bill.

This bill still unwisely makes the board permanent. This bill still requires this board to continue making even more cuts in Medicare and to do that forever into the future.

The damage this group of unelected people could do to Medicare is unknown, but we certainly do know how impossible it will be to undo any damage that unelected board does, if Congress decides we ought to undo it. That is because whatever cuts they make we have to offset, and stirring up that money is very difficult for offsets.

This bill passes a \$26 billion unfunded mandate on to the States because the Reid amendment even made this problem worse by adding \$1 billion to that

unfunded mandate for States under Medicaid. These increased costs will cause States to raise taxes, maybe cut education, maybe cut transportation, and maybe cut law enforcement. But it is still money the States have to dig up.

This bill still has the CLASS Act in it, even though the administration's own Health and Human Services Chief Actuary says it runs the risk—a great risk—of being unsustainable.

It still has a special carve-out for committee and leadership staff from having to use the health insurance exchanges. This is a cute move on the part of somebody in these closed-door offices. I got an amendment through the Senate Finance Committee on a unanimous basis that, if the people of this country have to use the exchange, employees and Congressmen on Capitol Hill ought to use it. But, no; when you get to the secrecy behind doors, just the Congressmen and their permanent staffs but not the thousands of people who serve on leadership staff or committee staff, they still got the deal they have today. So they are not going to know what the American people are going through by using the exchange.

This bill still has special deals for brand-name drug makers that will reduce access to generic drugs, making drug costs even higher for everyone. What this process has shown is that there is a clear and significant philosophical difference between this side of the aisle versus that side of the aisle. Those differences are still there, and the lines between us on this specific piece of legislation become brighter still, even though maybe on 90 percent of the legislation going before this body, there is bipartisan cooperation. But on this one, restructuring one-sixth of the economy, health care being a life-or-death issue for 306 million Americans, this is different from anything this body has tried before. On something such as this, maybe there is a legitimate reason for having differences.

Republicans tried to reduce the overall cost. They said no. They increased the spending in the bill. Republicans tried to reduce the pervasive role of government. They said no, and they increased the role of government. Republicans tried to make it harder for illegal immigrants to get benefits. They said no, and that still has not been fixed. Republicans tried to guarantee that Federal funding for abortions would not be allowed under this bill. That has been the Federal policy since 1976. That has even had bipartisan support ever since the Hyde amendment was put in place that year. But they said no. They wouldn't agree to apply that policy. That still has not been fixed. Republicans tried to allow alternatives to the individual mandate and the harsh penalties associated with it. They said no. They have subjected even

more people to the mandate, and they have raised penalties. Republicans tried to raise medical malpractice reform. They said no. Real lawsuit reform is still not in this bill.

We have watched while the other side has expanded government coverage. Since this process began, the other side has been working hard to move millions of people from private coverage to government-subsidized coverage. The bill creates new government programs that cover families making close to \$100,000 a year. When we hear about that in rural America, in the Midwest part of the United States, they think we have gone bananas in this body by subsidizing families making \$100,000.

At the end of the day, after raising billions in new taxes, cutting about $\frac{3}{2}$ trillion from Medicare, imposing stiff new penalties for people who don't buy insurance and increasing costs for those who do, still 23 million people will not have health insurance. I don't think this is what the American people had in mind when we promised to fix health care.

The Reid bill imposes a \$2.5 trillion tab on Americans. It kills jobs with taxes and fees that go into effect 4 years before the benefits of the bill take hold. It kills jobs with that employer mandate. It imposes $\frac{3}{2}$ trillion in higher taxes on premiums, on medical devices, on prescription drugs, and yet more. It jeopardizes access to care with massive Medicare cuts. It imposes higher costs. It raises premiums. It bends the cost curve in the wrong way because people would expect you to bend inflation down, but this bill takes it up. This is not what people have in mind when they think about health care reform.

We have been hearing repeatedly from the majority whip from Illinois that the Republican side has offered only four amendments. I found this to be rather astonishing. The majority whip should know, because they are filed at the desk, that Republicans have put forth 214 amendments. In addition to striking some of the bad ideas in the Reid bill, these amendments also contain Republican proposals that are improvements over the Reid bill. But in this rush to get it done, the majority has decided they don't want to consider any more of the 440 amendments filed at the desk.

Let's be clear. We keep them so people can have access to them anytime they want to, the 440 amendments that have been filed, that we are accused of not offering any suggestions or improvements. Right here in these three binders, any one of the amendments you want, it is there.

Since this happens to be the case, I would like to take them up on their interest in considering additional amendments. The majority leader and my friend, the Senator from Montana, have both said they want this bill to

fill the doughnut hole in the Medicare Part D Program. I share my colleagues' desire to provide even more protection than seniors get under Medicare. I filed an amendment that is in this binder, amendment No. 3182, that would use the savings from medical liability reform, which happens to be about the second or third thing that always comes up at my town meetings that the people in this country feel we ought to be working on if we are going to make real the word "reform." It would put that \$50 billion into savings toward eliminating the doughnut hole. The amendment puts the needs of 27 million seniors ahead of the needs of trial lawyers. I can't speak for my colleagues, but that seems like a pretty easy decision.

To my good friend from Montana, I only have one unanimous consent request. I ask unanimous consent to set aside the pending amendment in order to offer amendment No. 3182, which is at the desk.

THE PRESIDING OFFICER. Is there objection?

MR. BAUCUS. Mr. President, reserving the right to object, the doughnut hole will be filled. I have made that promise. Senator REID has made that promise. The White House made that promise. When the bill is presented on the President's desk, the doughnut hole will be filled but not in the way suggested by my friend from Iowa. He is one of my best friends in the Senate, and it is with regret that I must object.

THE PRESIDING OFFICER. Objection is heard.

MR. GRASSLEY. I find it disappointing that we would miss the opportunity to forgo \$50 billion in savings that could make prescription drugs more affordable for 27 million seniors. Even though my friend has just said they are filling the doughnut hole, I would quickly say it is being filled in a way that the big pharmaceutical companies are going to make sure they are selling prescription drugs, prescribed drugs, for a long period of time and not have the savings that ought to come from using generics to a greater extent. This \$50 billion—actually \$54 billion—that CBO says we would save with medical malpractice reform would be a better way of filling that doughnut hole.

I have a parliamentary inquiry of the Chair.

THE PRESIDING OFFICER. The Senator will state his inquiry.

MR. GRASSLEY. I want to make a parliamentary inquiry about the pending managers' amendment. My inquiry will be whether the pending amendment, which everyone agrees is critical to the health care reform legislation before us, complies with Senate rule XLIV.

Senate rule XLIV was adopted as part of major ethics and government reform legislation. It was passed in

2007. Its title was the "Honest Leadership and Open Government Act." The Democratic leadership made it the first bill introduced when they took over the majority in 2007. It enjoyed broad bipartisan support. I wish the reform had been tougher. The part of the legislation that became Senate rule XLIV dealt with the transparency of earmarks. They are technically defined as "limited tax benefits" and "congressionally directed spending items."

Rule XLIV applies to floor amendments such as the pending managers' amendment. Rule XLIV requires the sponsor of the amendment—in this case, Senator REID—to provide a list of these narrow provisions. Senator REID has not provided the list. We received the several-hundred-page amendment yesterday morning. Republican staff have performed a preliminary review. That review finds that some items might—I repeat, might—be limited tax benefits. There are press reports about narrowly crafted exceptions to the insurance fee.

I ask unanimous consent to have printed in the RECORD a copy of the Dow Jones article dated December 19, 2009.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From Dow Jones Newswires]

SENATOR NELSON WINS TAX CARVE-OUT FOR
MUTUAL OF OMAHA IN HEALTH BILL

(By Martin Vaughan)

WASHINGTON (Dow Jones)—Insurance giant Mutual of Omaha will see less of a hit from a \$10 billion-a-year industry-wide tax on health insurance providers, under the terms of a deal worked out between Senate Democratic leaders and Sen. Ben Nelson (D., Neb.).

Under revised Senate health legislation unveiled Saturday by Senate Majority Leader Harry Reid (D., Nev.), the tax on insurers will begin in 2011 at \$2 billion a year, eventually rising to \$10 billion annually. The tax is to be divided up based on each company's market share.

Senate aides who reviewed the legislation said provisions in the revised bill are specifically crafted to protect Nebraska insurers, including Mutual of Omaha.

The tax carve-out appears to be one of several concessions Nelson won from Democratic leaders before agreeing to add his vote, the final one needed to secure passage in the Senate, to the healthcare measure.

"The biggest issue for us was abortion," said Jake Thompson, a Nelson spokesman. "But Sen. Nelson also wanted to ensure that Nebraskans won't face increased premiums as a result of a fee that was going to be imposed."

Nelson inserted a provision that will carve out supplemental Medicare insurance from that tax. That provision will benefit Mutual of Omaha, but also other insurers that offer so-called Medigap policies, Thompson said.

Nelson also won support for a provision ensuring that Nebraska won't have to foot any costs for new Medicaid enrollees. That is important because the Senate bill expands Medicaid eligibility, potentially increasing costs for many states under a cost-sharing system with the federal government.

Most other states will be required to pick up between 5% and 18% of coverage costs for

new Medicaid enrollees, with the federal government picking up the remainder.

The revised bill introduced by Reid also carves out non-profit insurers that meet certain criteria, especially in Nebraska and Michigan, from the new industry-wide tax.

"Several states had unique circumstances, and [Reid] thought it was appropriate to provide a narrow exemption from the fee for a couple of states that had unique circumstances," a Senate Democratic aide said in a conference call with reporters.

"Nebraska also had circumstances that necessitated the relief," the aide said, without elaborating.

"This legislation is good for our country and good for Nebraska," Nelson said in announcing his support for the healthcare bill Saturday.

One provision in the bill is narrowly tailored to apply to Blue Cross/Blue Shield of Nebraska, Nelson's spokesman said. It says that a company that is a mutual insurance company and had a market share in a state of between 40% and 60% in 2008 would be exempt from the tax.

Senate transparency rules enacted after Democrats took over the chamber in 2006 discourage narrowly crafted tax breaks, also called tax earmarks. Senators are required when offering amendments that include such provisions to publish a list in the Congressional Record, and the amendments could be subject to procedural objections.

The Senate GOP aide said that carving one insurance provider out of the tax could put it at a distinct advantage with respect to competitors. The Joint Tax Committee has estimated that the tax could result in increased premiums to consumers of between 1% and 1.5%.

"If one company is protected from that fee, you're talking about a significant pricing differential," the aide said.

Mr. GRASSLEY. Likewise, single State Medicaid provisions might be determined to be congressionally directed spending items. Under rule XLIV, the determinations are not made by the minority staff.

In order to ensure transparency of narrow provisions, the burden is on the sponsor to provide the list.

This is my parliamentary inquiry: Does rule XLIV of the Standing Rules of the Senate require that if a Senator proposes an amendment containing congressionally directed spending or a limited tax benefit, that the sponsor of those provisions and the names of the Senators requesting them be printed in the RECORD?

The PRESIDING OFFICER. Paragraph 4(a) of rule XLIV requires that a Senator proposing an amendment containing a congressionally directed spending item ensure as soon as practicable that a list of such items be printed in the CONGRESSIONAL RECORD.

Mr. GRASSLEY. Has the majority leader provided a list of these special deals and of the Members requesting them for the RECORD as required by the Senate rules?

The PRESIDING OFFICER. The Chair is not aware of whether that has occurred at this time.

Mr. GRASSLEY. So what is the situation as far as the rule being provided, as long as the Senate has not been made aware of this?

The PRESIDING OFFICER. This part of rule XLIV simply requires that the Senator mentioned make a good-faith effort to comply with paragraph 4(a). It does not impose a condition that would precede the amendment, that it could not be heard.

Mr. GRASSLEY. I yield the floor.

The PRESIDING OFFICER. The minority whip.

Mr. KYL. Mr. President, a lot of attention has been paid to the position of the senior Senator from Nebraska on this legislation. Page 98 of the amendment provides that the State of Nebraska is carved out from being responsible for paying for additional Medicaid patients added under the bill. It is the only State explicitly carved out from this requirement.

I address this as well to the chairman of the committee.

I ask unanimous consent that the pending amendment be set aside and it be in order to offer an amendment to extend to all States the same benefit that provides 100 percent Federal funding to the State of Nebraska for their expanded Medicaid Program. This would give the same treatment to other States that currently only Nebraska would enjoy under this bill. If the bill is a good thing for all States, then it seems to me it should be applied equally to all States.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, since that was the broader context of that intent and there are other States that are hurting as well, I ask unanimous consent that the pending amendment be set aside in order to offer an amendment to the extent that Colorado and Montana and Virginia would get the same benefit that provides 100 percent Federal funding to the State of Nebraska forever for their expanded Medicaid Program, which would give the same treatment to these other States that I have mentioned that currently only Nebraska would enjoy under the bill.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Mr. President, reserving the right to object, as enticing as that might sound, I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from Alabama is recognized.

Mr. SESSIONS. Mr. President, following up on that, I happened to see Governor Schwarzenegger on television today. He said he had initially been inclined to support this legislation until he realized what it would do to his Medicaid budget in California—it would cost them \$3 billion and they do

not have that \$3 billion. Indeed, they didn't have the money necessary to meet their current obligations under Medicare.

Therefore, I ask unanimous consent that the pending amendment be set aside and it be in order to offer an amendment to extend to the State of California the same benefit that provides 100 percent Federal funding to the State of Nebraska for their expanded Medicaid Program. This would give the same treatment to California as Nebraska would obtain.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from Alabama.

Mr. SESSIONS. Mr. President, I think I would be remiss if I did not ask unanimous consent that the amendment be set aside and that these provisions be extended to my State of Alabama which is also in a serious condition financially and whose Governor has expressed unequivocal opposition to the burdens on the State Medicaid Program that passing this legislation would impose. I ask unanimous consent that the same benefit that provides 100 percent Federal funding to the State of Nebraska for their expanded Medicaid Program apply to the State of Alabama.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from Alabama.

Mr. SESSIONS. Mr. President, why are we here voting tonight at 1 a.m. and probably voting all the way to Christmas Eve? I think the answer fundamentally is on the health care matter, that after much talk about a bipartisan health reform effort and some work toward that end, the President and the Democratic leadership in the Congress decided they had the majorities in the House and the Senate and that they would use those majorities to pass the legislation that they wanted without Republican input. I know that has happened on occasion around this Senate, but I don't believe it has ever happened on a matter of such significance.

These major kinds of policy matters have historically been bipartisan or had substantial bipartisan support. We are talking about health care, involving every American. We are talking about raiding, not strengthening, Medicare, a program that is already in deep trouble. We are talking about a major governmental intervention into one-sixth of the American economy. These are pretty big issues.

Even more significantly, our Democratic colleagues are concerned about the American people, who, by consistent majorities, reject this plan.

They are fearful of them. So they want to move this bill forward now, sooner, faster, quicker, with less discussion and less debate. Instead of working together to improve a broken health care system, the decision has been reached to railroad this bill through before Christmas.

They say the President promised reform. He was elected and so they will just ram it through no matter what the American people, for that matter, think.

Just for example, a recent CNN poll—I do not think that is a rightwing entity—61 percent oppose the Senate bill, only 36 percent support it. Just a little more than one-third support and over 60 percent oppose. Those are lower numbers than President Bush received for his plan to reform Social Security.

So, why do they do this? Well, because they think they know better than you do, because they want to make history. And if you object—as the Senator from Rhode Island said this morning—you and the rabble disagree with us, why, you are mean-spirited, coldhearted, and fearful—as to whatever those words were—you are just like those great unwashed whom you represent. So I think there is an unusual amount of disdain here for any political and substantive disagreement about this incredibly important legislation and I think a disdain for the concerns of the American people, as represented in rallies, in tea parties, and in polling data.

Is this all just illogical fear? Are these people totally irresponsible to worry about the future financial condition of their children?

A colleague of mine showed me this great cartoon that showed a man standing beside Santa Claus, and Santa said: What would you like? I think the man was President Obama. And he said: Health care. And there was also a little boy, sitting on Santa's lap, and he said: What do I get? And Santa said: You get the bill.

Well, the people know this is a significant issue for the future direction of our country, and I think they are saying that this what not what they intended during the last campaign. I remember this defining moment—do you not?—when Joe the plumber accosted President Obama, and they discussed redistributing the wealth around. And what an effort there was to suggest that President Obama did not really believe in that idea, but that he believed in freedom and individual responsibility and was not going to tax the average person, and those kinds of things. So the campaign survived that little dust-up.

But I think the American people are saying: Fool me once—during the campaign—shame on you. Fool me twice, shame on me. They are not happy with this bill. Polls show the tea parties are more popular than the Republican or

Democratic Parties. So I think this use of raw power—the idea that we must get this bill done before Christmas, and we will pay any price necessary to get the votes to do it—is not good.

I am amazed that people would criticize those of us who do not agree with this legislation—and I am prepared to talk at some length about the substantive reasons about it—that we are somehow obstructionist because we would like to have more than 1 day, really, to consider a 383-page amendment and see what all was placed in it.

So my colleagues have been saying the people are misinformed and they have been subjected to lies and misinformation. Well, just a few days ago, I heard the President declare that if you do not pass this legislation, your insurance premiums are going to go up, which is not untrue. But what he did not convey—and I think most people understand already, however—is that even if the bill passes, premiums will go up some, double digits more than they would have gone up if the bill had not passed. A few people will see a modest—less than 1 percent, maybe some over 1 percent—reduction in the rate of increase in their insurance premium, but a lot of people are going to see double-digit increases in their premium, particularly the people who are not in group plans. Those are the ones for whom insurance premiums are the most unfair and who are getting rooked the most by insurance. We ought to be taking care of this problem because they are not in group plans and they are not in companies that subsidize it. They do not work for the government that subsidizes their health care.

But the President has the bully pulpit. He lectured the whole Congress. He hauled us out and talked about it in a joint address to Congress. He got \$150 million from the big PhRMA drug companies to advertise in support of this bill, as it has been reported. Robert Reich, a great liberal, Secretary of Labor under President Clinton, scathingly condemned that deal that PhRMA made with the White House over the doughnut hole and their contribution for advertising.

I will just have to say, the majority has found no price too high, no depth too low in order to get that 60th vote so they can go forward. And we have got to get it done now, pass this managers' amendment that the majority leader has plopped down—the one that was written in secret and we just saw yesterday morning at about 10 o'clock.

Well, I will just say, how should we judge the overall merits of the bill? How should we decide whether to vote for it or against it? I would say that one good way is to judge it by its own promises, to judge it by what the American people have been told the bill will do, how much it will cost, and those kinds of things.

Well, there are some facts and some fictions here. We just need to be frank about it.

Fiction No. 1: We have been told that the total cost of the legislation is \$871 billion. That is a lot of money, \$871 billion. But what are the facts? When the new programs created by this bill are fully implemented, the bill will actually cost, over the first 10 years of full implementation, \$2.5 trillion—three times as much.

Now, who is giving the best numbers here? Since we know most of the benefits do not start until 5 years from now, they score the first 10 years of the budget, the cost of the bill, and say it costs \$871 billion. But if you take it from the first 10 years of the bill, as we would normally score a piece of legislation, it is \$2.5 trillion—\$2,500 billion. That is a stunning difference. It just shows what a massive piece of legislation this bill is.

According to the bill, Medicaid will be expanded up to 133 percent of the poverty level, but that will not happen until 2014. The insurance subsidies funded by the bill do not begin until 2014. So this is how they manipulated the numbers. So they say \$871 billion. Not so. In fact, the managers' amendment increases Federal spending on health care to \$200 billion rather than \$160 billion projected under the original bill that came forward.

So we currently spend one-sixth of our GDP on health care. How much more can we afford to pay? And wasn't the original intent to rein in health care spending, to reduce the percentage of GDP going to health care?

Mr. President, how much time is left on this side?

The PRESIDING OFFICER. The Senator from Alabama has 6 minutes remaining.

Mr. SESSIONS. The business community as well as many others are expressing concern about the fact that this bill would not actually rein in health care spending. I thought the goal and I think most Americans thought the goal of the legislation was to figure ways to contain the growing cost of health care in America without reducing our quality and the magnificent care so many Americans receive. But it does not do that. In fact, the numbers show, independent accounts show that the percentage of our national wealth, our GDP, that will go to health care once this bill is passed—if it is—will be greater than if it is not passed. We should wrestle with those issues and do better.

What about another fiction? The President had promised—you have heard him—along with other leaders on this floor: This bill will not add one dime to the Nation's surging debt. But by any fair analysis, the bill increases both spending and debt.

First, I just have to say, when you pass 70 new government programs, ex-

pand Medicaid, and create millions of dollars in new subsidies, how can that not increase spending? But the bill is structured in a way so that its spending is covered by its new \$519 billion in taxes. Well, if you raise taxes enough, you can make anything come out to a balance. They call some of these taxes fees, but they are still taxes and increased cost in the system. They include a \$6 billion annual tax on the insurance industry as a whole. For the people we want to reduce premiums, we raise taxes on them \$6 billion. It includes a \$2.3 billion annual tax on the pharmaceutical industry. We would like to see less cost for drugs, not more. It includes taxes on medical device companies, \$28 billion on employers that do not provide enough coverage according to the new standards and a 40-percent tax on plans that provide too much coverage, and \$43 billion in total taxes raised through penalties on employers and individual mandates. All in all, you are taxed if you sell insurance, taxed if you buy it at the wrong level, and taxed if you do not buy it at all. Yet, contrary to promises, the bill does not lower individual family premiums, and for many, their out-of-pocket costs will increase. So this is not the kind of reform we were promised.

But one more thing. Always a part of health care reform was the acknowledged necessity to do something about the reductions in payments, reimbursements to doctors. This bill proposes cutting physicians' pay 21 percent. That is what it does—they ignore a \$250 billion cost, and act as though they can use that money for the bill's new programs. But doctors were promised from the beginning that their payment reimbursements would be fixed. They cannot sustain a 21-percent reduction in pay. Doctors will quit doing Medicare work all over the country if that occurs.

Mr. ENSIGN. Will the Senator yield?

Mr. SESSIONS. I will be glad to yield.

Mr. ENSIGN. So let me ask the Senator, from what I understand about the so-called doctors fix, there is around a \$250 billion cost to that. In this bill, there is no fix to that, from what I understand. Is that correct?

Mr. SESSIONS. That is correct.

Mr. ENSIGN. So the bill is either dishonest as far as the deficit is concerned because if you put the doctors fix in there, this thing actually hurts the deficit, or we are actually seriously hurting doctors because this bill will require a lot more doctors in the country to take care of those new people who will now have health insurance in the country. Is that correct?

Mr. SESSIONS. Exactly correct. What we are doing, I think you can say fairly—boil it down to this—we are raising taxes over \$500 billion, we are cutting Medicare nearly \$500 billion—

so, around \$1 trillion total. And we are using none of that money to fix the doctor payment deficit we know has to be fixed. Instead that money is going to new programs. We cannot cut the doctors 21 percent. Congress has filled that money in every year for nearly 10 years now, and we have to fill it in in the future. Any good health care reform would do what it promised to do from the beginning, which was to eliminate this cut.

One proposal has been to do it simply by adding, throwing it to the debt.

Mr. ENSIGN. Will the Senator yield further?

Mr. SESSIONS. I will be pleased to.

Mr. ENSIGN. So would the Senator describe this almost as a shell game?

Mr. SESSIONS. Absolutely.

Mr. ENSIGN. The doctors fix would be the pea. Where are they hiding the pea? Because we know this is going to be fixed. It is always fixed. Every year, we fix the doctors' pay. And yet, to hide the true costs of the bill, then, the doctors' fix is really the pea in that little shell game and they are just hiding it. Is that correct?

Mr. SESSIONS. Exactly. The President looked the American people in the eye and he said: This legislation will not add one dime to the national debt.

The PRESIDING OFFICER. This block of the minority's time has expired.

Mr. SESSIONS. Mr. President, if I could ask for 30 seconds to finish.

The PRESIDING OFFICER. Is there objection?

Mr. HARKIN. How much time did he ask for, Mr. President?

The PRESIDING OFFICER. The Senator asked for 30 seconds.

Mr. HARKIN. No objection.

Mr. SESSIONS. So the President promised to end the doctors coming to Washington every year to try to make sure they don't get cut 21 percent, but he has not done it. This bill's promises simply do not add up. This bill, when you assume the doctor fix, clearly adds to the debt. It must be added as part of the reform. There are a number of reasons to oppose the legislation, and I urge my colleagues to do so.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. I understand now the Democratic side has 1 hour, from 6:30 to 7:30?

The PRESIDING OFFICER. The Senator from Iowa is correct.

Mr. HARKIN. Mr. President, I yield myself the time from 6:30 to 7.

Mr. President, I was in my office a little bit ago, and I was watching the comments made by the distinguished minority whip, the Senator from Arizona, Mr. KYL. He went on at some length about how this vote at 1 a.m. we are going to be taking is tough on some Members. He mentioned specifically our distinguished colleague, Senator

ROBERT BYRD, who is not up and about at those hours, and they would have to drag him out of bed and bring him down here for this vote. Senator KYL felt very sorry for Senator BYRD that we would do that at 1 a.m.

He said the majority leader has the power to put this vote back. We could do it at 9 a.m. in the morning. Well, he is absolutely right; we could do it at 9 a.m. in the morning. But because of the intransigence of the Republican side, because they are not willing to let us have these votes without expending the 30 hours under the rules—under the rules—the cloture motions have been filed and, of course, the Republicans, which is their right, can burn up 30 hours.

Well, after the first vote at 1 a.m., the clock starts ticking on the next 30 hours for the underlying substitute. And then after that 30 hours, there is the underlying bill itself, and that gets 30 hours. So if the Republicans really want, they can burn up 90 hours. I ask, to what end? To what end? We have the 60 votes. No one doubts that. There are 60 votes now to pass this bill. So to drag this out and to cause people to come in at 1 a.m. in the morning is not on the Democratic side, it is on the Republican side.

So when I heard the distinguished Senator from Arizona pleading to put the vote off, I thought to myself: Well, if that is what the Republicans would like to do, there is a simple way to do that. You simply move the vote we are going to have at 1 a.m. to 9 a.m. tomorrow morning, and then you have the intervening hours from 1 a.m. to 9 a.m. count toward the 30 hours for the next vote. It is simple, very simple.

So I took that to heart, and I asked our staff to type up a unanimous consent request, and we have given a copy to the other side. So that is what my unanimous consent will do. It will ask that the vote occur at 9 a.m. tomorrow morning, but that the intervening hours from 1 to 9 would count toward the 30 hours for the underlying substitute.

So, Mr. President, I ask unanimous consent that the cloture vote scheduled to occur at 1 a.m. Monday, December 21, occur at 9 a.m. Monday, December 21; and that if cloture is invoked, the postcloture time be considered to have begun at 1 a.m.

The PRESIDING OFFICER. Is there objection?

Mr. ENZI. Mr. President, reserving the right to object, we are not the party that spent 8 weeks putting this together to delay everything. We are not the party that spent all the time putting this amendment together that we are trying to do without any input from the Republicans. We are trying to have time to both review this and let America know what is happening. We know the Democrats have kept people from going home now for 3 weeks so

they wouldn't have to listen to the voters at home who are really upset with this bill.

So we would agree to the request to set the vote at 9 a.m. if the Senator will modify and strike the retroactive cloture time. We want the time.

Mr. HARKIN. My initial request stands, Mr. President.

The PRESIDING OFFICER. Is there objection?

Mr. ENZI. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. HARKIN. So, Mr. President, here we go again. There they go again. You know, they want to delay, delay, delay, delay; obfuscate, obfuscate, obfuscate, and try to kill this bill by delaying it ad infinitum. They would be happy to delay this through Christmas, through the New Year, and January and February. Why? They would be happy to delay this bill for 10 years or more because they don't want it to happen. That is really what is going on.

I say to my good friend from Wyoming—and he is my good friend; he is a great Senator—I thought—we did—in our committee, we got the bill through open and aboveboard. I think the reason we are here at this time is because we Democrats bent over backwards to accommodate the minority. We did in our committee, and I can say that Senator BAUCUS went the extra mile—no, he went the extra 10 miles. He went the extra 100 miles on the Finance Committee to involve and to get the minority side involved. In the end, only one Republican would vote for it, and we know who that was, the Senator from Maine.

We could have emulated the Republicans. We could have emulated what they did when they were in the majority in 2001. I was here. I remember it well. When they came up with this crazy tax package that cut taxes for the wealthiest in our country, stole the surplus we had built up under President Clinton by the year 2000 where we were looking at surpluses on into the future, and they came up with all of these big tax cuts for the wealthy, guess what they did. They didn't involve us at all. They did reconciliation where they only needed 51 votes. Under reconciliation, under the rules of the Senate, as the Presiding Officer knows, there is no filibuster. You cannot filibuster a reconciliation bill under the rules.

So if they had done their tax bill in 2001 like we are doing this, we could have delayed. We could have had some input into that, but they said no. They just went right to reconciliation. We could have done that with this bill. We could have done that with this bill.

I remember having discussions with members of our caucus and others saying: No, no. And the President, President Obama, wanted to do this as bipartisanly as possible to involve the

minority in a constructive process. So that is what we decided to do, to do it in a very constructive, open process. What it has gotten us is total—total—obfuscation and delay and trying to kill the bill by the minority. But we will persevere. We started this open process, and we are going to finish this open process. The die is cast.

We have a vote at 1 a.m. I wish it could be 9 a.m., but you just heard the Republicans object to that because I just asked that the intervening hours be counted toward the next 30 hours, and they wouldn't even do that. So the reason we are here is not because of the Democrats. We are here because the Republicans simply don't want this bill to pass.

That is really the reason.

So we are going to vote. We are going to vote at 1 a.m. On the face of it, it is really a technical, procedural vote, but it is something more than that. With that vote at 1 a.m. on the managers' package, on cloture on the managers' package, we will have reached a pivotal point at 1 a.m., a pivotal point in a decade-long quest to pass comprehensive health care reform. We have reached a crossroads, a kind of a point in time just as the Senate did in 1935 when we passed Social Security, or in 1965 when we passed the Medicare bill. Each of those bills was a giant step forward for the American people, but each was bitterly opposed in this body by defenders of the status quo, the Republicans.

In each case, Senate opponents waged a strident campaign of fear, warning that the passage of the legislation would lead to socialism. Senator Robert Taft from Ohio kept calling it socialism. We are going to "Sovietize" America. You can read it in our history books. But in the end, a critical mass of Senators rose to the historic occasion. Senators ignored the dark warnings and the demagoguery. They voted their hopes and not their fears. As we know now, in retrospect they passed laws that transformed America in profoundly positive ways.

The Senate has arrived at another one of those rare historic moments. This time, we are attempting to pass comprehensive health care reform, a goal that has alluded Congresses and Presidents going back to the administration of Roosevelt. People think I am talking about Franklin Roosevelt. No. I am talking about the administration of Theodore Roosevelt.

Once again, advocates of reform faced bitter opposition, including the filibuster we are seeing now and that has been going on for weeks by defenders of intense interests in the status quo. Once again, each Member of this body must make a choice: fear or hope; stick with the broken status quo or embrace bold change with all of its uncertainties.

The other side is saying what about this? What is going to happen here? I

keep talking about this bill we are passing. It is not like the Ten Commandments carved in stone. It is a bill. It is a law. Laws change as times and conditions change, as we get different information. So there are uncertainties in the future. The future is uncertain. But we can lay down a good start toward bringing people into a health insurance system and stopping some of the most horrible practices of the health insurance industry, moving us toward more of a health care system rather than a sick care system.

So, yes, there are uncertainties, but we know one thing: The certainty of the status quo leads to too many people not having any kind of health care whatsoever. It leads to people dying younger than they should because they don't go in for their checkups and their screenings, children and others.

We know the other side made clear sometime ago they wanted to obstruct and delay and filibuster and kill this bill. As far as my friends on the other side of the aisle are concerned, this floor debate is not about offering amendments to improve the bill. It is really not about allowing more time to fully read it and understand the bill. That is nonsense. It is not about playing a constructive role to pass a better bill. All the other side wants to do is kill this bill. Period.

All this yakking that is going on—I was home this afternoon and I turned on C-SPAN and I was listening to the debate. And I thought, you know, people are at home. They are getting ready for Christmas. The trees are up. People are feeling good. Here we are going back and forth, back and forth, back and forth, but people have tuned this out.

They really have. It is Christmastime and people have tuned this out. Yet we are here.

We are here for a good reason. We are here because we are determined to pass meaningful health care reform for America, and we need to do it before Christmas.

Well, again, in the defense of the broken system and the status quo, the Republicans joined at the hip with the health insurance companies. They use the same talking points, the same distortions, the same bogus, cooked-up studies, the same outrageous stories about death panels and pulling the plug on grandma. We have heard all that from the other side, week after week, month after month. Every step, as I said, we on this side have acted in good faith. We did not go the reconciliation route. In our futile quest for bipartisanship, we have repeatedly given the Republicans more time.

In the Senate HELP Committee, under the great leadership of Senator DODD, we spent nearly 3 weeks marking up the bill. No amendments were denied. Republicans could offer any amendment they wanted. It took 13

days, a total of 54 hours of meetings. We went out of our way to accommodate our Republican colleagues. We accepted 161 of their amendments, either by vote or just by accepting them. After all that time, all that goodwill on our side, accepting 161 of their amendments, every Republican on the committee voted against the bill.

Now, every time I have told this story in Iowa or wherever I have been, people shake their heads. They say: What? They offered 161 amendments? Surely, they would have been kind of happy with that. They might have voted for the bill. They don't understand that. Every single Republican voted against it after all of those amendments.

In the Finance Committee, deliberation on the bill stretched out for months solely to accommodate the wishes of the Republican members of the committee. Yet after all that time, despite the fact that Senator BAUCUS had bent over backwards to pursue bipartisanship and to accommodate the minority's requests—he acted in good faith at every step of the way—all but one Republican on the committee voted against the bill.

Now, today, Republican Senators say they are opposing the cloture motion because they need more time. They say we are rushing things, rushing things, there is a big rush going on. Good grief. This bill has been on the Senate floor for 21 days. We have been deliberating about health care reform for almost the entire year. Congresses and Presidents, as I have said, have been trying to get this done since Theodore Roosevelt.

So Republican colleagues say: Slow down. You are moving too fast. Well, that is absurd and disingenuous. We have to ask ourselves: Are our Republican friends going to be more constructive, more willing to act in good faith after the Christmas or New Year's break? Of course not. Their aim, understand, is not to improve the bill or to even understand it; it is to kill health care reform. Period. That is all it is. They just want to kill it.

Now, because they don't have enough votes to kill it outright, they have opted for a course of delay and obstruction and filibustering. But let's be clear. They are not only delaying and obstructing the Senate; they are delaying and obstructing the millions of Americans who desperately need the reforms in this bill. They are delaying and obstructing the 31 million Americans who will finally get health coverage. They are delaying and obstructing the underinsured, millions of Americans who know they are just one serious illness away from bankruptcy and financial catastrophe. They are delaying and obstructing millions of Americans with preexisting conditions who can't get insurance. They are delaying and obstructing women in this country

who face systematic discrimination by health insurance companies. They are delaying and obstructing Americans who fear if they get cancer or heart disease, their health insurance company will cancel their coverage.

Let's be clear. Again, Republicans are not only trying to kill health care reform, in doing so they are killing the hope for millions of Americans who are desperate for reform of the current broken system. Too many Americans are literally dying because they do not have health coverage and proper access to a doctor.

All told, nearly 45,000 Americans die each year because they lack meaningful health insurance. A Johns Hopkins study found that children without health insurance who are hospitalized are 60 percent more likely to die than those with insurance. Why? It is obvious. Kids without health insurance are much less likely to get preventive care or to be taken to a doctor in the early stages of their illness—60 percent more. Think about that. Children without health insurance who are hospitalized are 60 percent more likely to die than children who have health insurance. So that is the real cost of delay and obstruction on the floor of the Senate. This is our job. We are here. We are going to finish this job. But it is a tragic human cost. And these victims can be found in every one of our cities, our farms, our rural communities.

I refuse to allow any obstacle to stand in the way of the Senate addressing the needs of these Americans. I have, along with my friends on this side, opposed the Republicans' filibuster. Likewise, I have been willing to disappoint many whose views I respect by agreeing to painful compromises in order to keep this bill on track. I agreed to those compromises not because I lacked passion or fight—I think my colleagues who know me know well enough that I can fight—I did so because of the harsh but unavoidable reality that because of the Republicans' obstructionism, we need 60 votes to pass this bill, and the only path to securing 60 votes was by making necessary compromises. But I add, that is also the way our predecessors in this body were able to get the votes to pass Social Security and Medicare, both of which had big gaps in coverage when they were first enacted. What they did is they passed bills that were sort of a half a loaf. Then they came back for the remainder of the loaf in the following years.

Despite these compromises, make no mistake, this remains a profoundly progressive bill. One analyst put it this way:

This legislation will be the most important social policy achievement since the Great Society.

That is exactly why the rightwing in this country is pulling out the stops to kill it. This bill will usher in three

huge reforms. First, this bill will be the biggest expansion of health coverage since the creation of Medicare. Some 31 million Americans who do not have coverage now will get it, thanks to this bill. This is a monumental achievement. We do this by expanding Medicaid and by providing subsidies to low-income, modest-income families.

In addition, if you are a small business owner, this bill will offer tax credits of 35 percent of employer contributions toward premiums in order to make it more affordable for small businesses and their employees to have health insurance. That 35 percent will go up to 50 percent. But the 35 percent starts next year. That is why I have said many times in my State of Iowa, and around it, that actually the biggest winners under this bill, aside from the totally uninsured, are small businesses and the self-employed. Small businesses and the self-employed are the big winners in this bill.

What is more, our bill will end the discriminatory practice of jacking up premiums for businesses because an employee is older or has a preexisting condition. They will not be able to do that anymore.

Through these new health insurance exchanges, small businesses and people currently without access to affordable coverage will be able to shop and choose from a menu of quality health plans, much in the same way Members of Congress do.

This bill does much more than extend health coverage. The second great reform in this bill is an array of provisions cracking down on pervasive, outrageous abuses by the health insurance companies, abuses that currently leave most Americans just one serious illness away from financial catastrophe.

Right now, the health insurance industry in this country is extraordinarily profitable. But these profits come at a staggering human cost. Think about it. When Americans get a diagnosis, let's say, of cancer or some other grave illness, they fear two things: First, they fear the illness and, second, they fear the health insurance company. They wonder, is my company going to authorize treatment and pay the bills or will I have to go to war to prevent it from sticking me or rescinding my policy?

I always tell people: Look at your policy. Is there a rescission clause in there? I have had so many people say: What is a rescission clause? It is a little clause in there, probably in the fine print, and it says that when your policy is up for renewal, the insurance company can terminate you. They do not have to renew your policy. This is what happens. Someone gets a very serious long-term illness such as cancer or heart disease. When their policy is up for renewal, the insurance company says, no, they will not renew your policy. Now you are out in the cold with a

preexisting condition. Now you can't get insurance anywhere. This bill will end that practice.

Health insurance companies now employ whole armies of claim adjusters just to deny requests. In fact, the health insurance companies give bonuses—they reward people for denying claims, saying no to policyholders. In the State of California, the largest insurers deny one out of every five requests for medical claims, even when recommended by the patient's doctor. One large insurer, PacifiCare, denies medical claims nearly 40 percent of the time. Think about that. That is almost one out of two. CIGNA denies claims 33 percent of the time. So if you get a terrible illness and you are insured by PacifiCare, good luck in getting them to pay for your medical treatment.

Republican Senators give us all the scare talk about a government bureaucrat standing between you and your doctor. Right now, we have corporate bureaucrats standing between you and your doctor, and they earn good evaluations and bonuses and money for denying you coverage.

I can remember a town meeting I had in Mason City in August, one of those famous town meetings. Toward the end of it—it was OK. There was a lot of contention there, people voicing their concerns, as they ought to do, as they have a right to do. But at the end, there was a man sitting down in the front. I thought, this will be my last one. I called on him. He stood up and he said: You know, I have been a doctor here for over 40 years in Mason City—40 years.

He said: I can say honestly during those 40 years, I have never once had a government bureaucrat come between me and my patients on Medicare or Medicaid. He said: However, I can't tell you how many times during those 40 years I have had insurance bureaucrats come between me and my patients.

This is a doctor, practicing for 40 years, and never once did he have a government bureaucrat come between him and his patients.

Nearly 62 percent of bankruptcies in the United States are linked to medical bills. And here is the kicker: Nearly 80 percent of those are people who had health insurance.

When is the last time you ever heard of a health insurance executive claiming bankruptcy? I would like to find one someplace.

The American people have lived in fear and under the heavy hand of these health insurance companies long enough. But help is on the way.

Let me mention a few of the ways this bill immediately cracks down on abuses by the health insurance industry. First, if you are uninsured with a preexisting condition, the bill would give you access to affordable coverage without discrimination. Our bill immediately bans those rescissions I talked

about where the insurance company can rescind your policy. We stop that right away.

We prohibit insurers from imposing lifetime limits on benefits, and we impose and restrict the use of annual limits.

Our bill ends discrimination against women. As I said, currently they pay as much as 48 percent more for the same coverage a man has.

Our bill requires insurers right away, next year, to let children stay on their family's policy until they are age 26. Those are a few of the things.

But there is a third area in this bill I have championed for many years, and in many ways I think it may be the most profound part of the bill, and that is a whole array of provisions promoting wellness and prevention, turning America into a general wellness society.

To this end, at the clinical level, the bill requires reimbursement for proven, cost-effective preventive services such as cancer screenings, nutrition counseling, and smoking cessation programs. This means health professionals will be able to offer these services to you before you get diabetes or cancer or emphysema.

For essential screenings and annual physicals, there are no copays, no deductibles. We encourage people to do this so they will not have to pay a copay or deductible.

Our bill makes major new investments in community wellness and public health, and we help businesses both large and small create workplace wellness programs for their employees.

One thing I do not think has been mentioned before, our bill requires large chain restaurants to post basic nutritional information right on the menu so consumers, when they are going out to eat, can make healthy choices.

What we are trying to do is change the paradigm from our current sick care system to a true health care system—one that keeps people out of the hospital in the first place. Our aim is to recreate America as a wellness society focused on healthful lifestyles, good nutrition, physical activity, and preventing the chronic diseases that take such a toll.

As a proud progressive, I make no bones about my enthusiasm for the three great reforms in this bill—vastly expanding coverage, cracking down on the abuses by the health insurance companies, and making robust investments in wellness and disease prevention.

Today we are closer than we have ever been to making Senator Ted Kennedy's dream of universal health insurance a reality. This bill has many authors. We have all been involved in it. But in a very real sense, this is Senator Kennedy's bill.

I urge Senators, when the vote occurs at 1 a.m., to vote their hopes, not their

fears. Seize the moment. Let's move ahead. Let's vote for cloture. At long last, let's give every American access to the quality, affordable health care they need and they deserve.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, before my friend from Iowa, the distinguished Chair of the HELP Committee, leaves the floor, I thank him for his wonderful leadership and friendship in so many capacities and passion for what we are doing now. We are all here together knowing that in the process of legislating, you don't always get every idea you want. But you come together and you work for something that is good for the American people, and that is what we have done. I thank him very much for all of his leadership.

I wish to take a few moments to talk about how we actually got to this point on a Sunday evening—we are voting at 1 o'clock in the morning—and, frankly, what has been happening all year. I want to take a few minutes to talk about what has happened this entire year, the first year of President Obama's presidency, our first year in the majority, and then to speak a little bit as well about the very important legislation that is in front of us.

I do think it is important that we take a moment to recognize and address a very unfortunate milestone, look back on the year on what we have accomplished in spite of that milestone.

In April, the media celebrated President Obama's first 100 days in office. But here in the Senate, we can measure our progress by something else—not 100 days, but 100 objections from the minority party. Actually, 101 as of yesterday; objections, filibusters, delays, stalling tactics designed to stop us from helping the American people who are hurting in these tough economic times. That is more true in my State than any other place in this country. Our people, the great people of Michigan, have been hurting longer, have been hurting much more deeply than other places in the country because of the major economic transition, as well as the recession in which we are involved.

There is good news because while the Republicans were stalling and wasting time, we were working hard doing what the people of America sent us to do. I want to talk about what we have done in spite of the stalling. But I also want to take a brief moment to explain something hard to explain about Senate rules because people look at us and say: They objected, but why does that matter? Why does that matter?

Mr. President, as you know, when there is an objection, in order to overcome it—and it is called a filibuster—it involves invoking motions called cloture and it takes time. It plain takes

time. So 101 times we have not been able to move forward because of an objection or we have had to go through this long process we are involved in right now.

I think it is important to briefly explain it because when Republicans object, as they are now, as they have been on so many occasions, our leader has to file what is called a cloture motion, and then you wait 2 days. You cannot do other business for those 2 days. We have done that over and over, wasting time while people in my State want us to be focused on jobs, on lowering their health care costs, on making sure we are doing the things that matter to them every day. But we stop and we wait 2 days. Then we vote on stopping the filibuster. Then we wait 30 hours, which is what we are doing right now. Then we vote on whether to proceed to the item. There are filibusters again. Then we file a cloture motion on the amendments or the bill. We wait 2 more days. Then we vote on closing a filibuster, and then we wait 30 hours, and then we vote on the amendment, which we will do tonight, and then we have to wait another 30 hours. In this case, another 30 hours.

It does matter when we say there have been 101 objections that have either stopped us or forced this process. It does matter. It matters because it has slowed down the ability to move to get things done.

The good news is that we have gotten things done anyway. We have gotten things done anyway because we are focused and committed to getting things done. We know the American people have waited too long. The last 8 years were about taking us in the wrong direction, with things that did not help most people, that put us in a huge deficit hole, that did not address health care or health care costs or jobs, or policies that made it worse.

We know that even though there have been 101 objections so far this year—and there will be more; there will be more—we are going to get things done for the American people.

It is amazing the stalling actually happened on the very first day of the 111th Congress on January 6 when Republicans objected to moving forward with an important public lands bill, something we had been trying to do for some time to protect and preserve our national parks, forests, and wilderness areas. But we passed that important bill anyway over their objections and three different filibusters, as the chart showed. Three different times we had to wait, wait 2 days, wait 30 hours, wait 2 days, wait 30 hours. But we passed it.

Since then, nearly every single week we have been in session, every single week but 4 out of 41 weeks, we have had to go through this process or have had objections. They have found something to object to or something to filibuster.

As I said, yesterday they objected for the 101st time, this time with a fili-

buster against providing affordable health insurance for over 30 million Americans. They have misused longstanding Senate rules and traditions to stall everything that might give this President and this Congress a victory.

I think it hurts all of us when the Senate breaks down as it has. Everybody is hurt by that—to stall everything that would help get Americans back to work or that would help 15.4 million Americans who are looking for work, and now to stop us, as I said, from extending health insurance coverage to over 30 million Americans. Their objections are about policy. They are about politics.

Earlier this year, objection 74, they stalled the unemployment bill, and their delaying tactics caused nearly 200,000 Americans to lose their unemployment benefits a couple of months before Christmas. They objected to the bill twice. They filibustered not once but three times before they voted unanimously. They voted unanimously for the bill. Why would you filibuster something three times and then vote for it unanimously? Not because you are concerned about the policy. The only explanation is that Republicans were trying to waste time—time that cost 200,000 Americans their unemployment benefits; the difference between paying the mortgage, keeping the heat on, putting food on the table, and possibly trying to keep health care going with a COBRA payment or in some other fashion.

Objection 4 was the Republican filibuster of the Lilly Ledbetter Fair Pay Act to make sure women get equal pay for equal work. Republicans filibustered and held up that bill, but we pushed forward. We passed it. We passed a very important equal pay for equal work bill in spite of it.

Objection 6 was to the American Recovery and Reinvestment Act which has been absolutely critical to creating jobs, keeping our economy out of a depression. They filibustered that bill three times as well. But we overcame the objections, passed the Recovery Act, and made critical investments in transportation, in our schools, in our police officers, and in clean energy technology and manufacturing.

And, yes, we are seeing the difference in Michigan right now. Mr. President, \$2 billion was part of the Recovery Act. I am pleased to say we have received a large part of that in Michigan to develop new battery technology manufacturing. We have at least six different firms that have announced and begun to develop manufacturing facilities for advanced battery development. Those manufacturing facilities are going to put thousands of people back to work. That was in the Recovery Act that was filibustered three times.

Objection 20 was to Senator Kennedy's Serve America Act, which we passed despite their filibuster, to help

young people give back to their country through voluntarism and community service.

Objection 24 was to the Fraud Enforcement Recovery Act which cracked down on predatory lending and abuses by banks and mortgage companies. That bill was held up for nearly a month. But we passed it, giving real relief to millions of American homeowners.

We passed the credit card bill, Republican objection 32.

We passed the Helping Families Save Their Homes Act, Republican objection 33.

We gave the FDA the authority, finally, to regulate tobacco to help keep kids from smoking. That was Republican objection 38.

We passed the Travel Promotion Act which will help stimulate the suffering tourism industry across the country. That was objection 45.

We passed a true funding bill to make sure our soldiers in Iraq and Afghanistan had the support they needed despite having to file cloture to stop a filibuster—objection 47.

We passed the Defense authorization bill that included a pay raise for our troops and other help for our military and their families despite repeated filibusters and objections. And these were objections 54, 56, 57, and 58. Can you imagine? This was a Defense bill.

We passed the veterans health care bill, despite Republican stalling, to help caregivers of disabled veterans, women veterans, rural health improvements for veterans, mental health care for veterans, and support for homeless veterans. This was Republican objection 89.

Objection 98 was another filibuster against those pay raises for our troops just 9 days before Christmas.

Despite all of those objections, 101, we have been doing what we were sent here to do. We have focused on actions to help create jobs and strengthen our economy and focus on the things that families struggle with and care about every day to make people's lives better, not just a few, not just investment bankers on Wall Street, not just the wealthy folks who got the tax cuts in the last 8 years, but middle-class families every day who are trying to figure out: What about them? What about us? That is what we have been focused on.

We passed an extension of the Children's Health Insurance Program to provide health and dental care to nearly 10 million children. We passed legislation to reform government contracting and protect taxpayer dollars. We passed legislation to invest in health care, energy, and education. We passed the cash for clunkers bill, as you know, that I was proud to lead in the Senate that moved over 650,000 fuel-efficient cars off dealer lots and brought thousands of laid-off manufacturing workers back to work.

We passed legislation to support the growth of small businesses and to extend the first-time home buyers tax credit. And now, just a few days before Christmas, we are working to pass this critical, historic health insurance reform legislation. We are committed to getting it done.

Republican colleagues can object 100 times or 1,000 times, but we are not wavering in our commitment to do the right thing. Even though inaccuracies abound, even though misinformation has been said over and over about what this bill would do, we are committed to overcoming what has been the tidal wave of opposition from the special interests who control the status quo, who like it the way it is right now. We are determined to get beyond that and do the right thing for American families. Whether our Republican colleagues work with us or not—and we sincerely hope they do, and we have spent a tremendous amount of time this year reaching out to get bipartisan support—whether they stall or object, our job is to do everything we can to move America forward, and that will continue to be our focus.

As the distinguished Presiding Officer knows because we both sit on the Finance Committee, we have spent months reaching out with committees, with processes to get bipartisan support. But, as my dad used to say, it takes two to tango. It takes both sides to want to work together. Unfortunately, it appears the strategy that was put in place back at the beginning of the year, the very first day of session, with the very first filibuster, was just to stop us from being able to move America forward, to stop this great new President, to stop the majority in the Congress. But we have moved forward despite that.

I think often of what we could do if we hadn't had to deal with 101 filibusters, what we could have done in creating a clean energy bill, which would create more jobs in my great State, or dealing with other critical issues we need to deal with and we will deal with. As we slog through filibuster after filibuster in the coming year, we will do that. But now we have the opportunity in front of us to pass historic health insurance reform that, frankly, people have talked about for 100 years.

This legislation is not perfect, but nothing ever is when you start. It is a great framework, however, for putting in place the value, the principle that every American should be able to have affordable health insurance and that we are going to tackle the explosion of costs that have hit businesses large and small, that have hit taxpayers, and to bring those costs down over time. That is what we are involved in right now, and we are going to get it done.

We could have voted much earlier, rather than keeping our staff here until 1 a.m., and we will vote again

after we run the next 30 hours, which will be, I believe, Tuesday morning. We could vote and be done with the final passage at that point. We know where the votes are. We have the votes to pass this. But it appears we will be here until Christmas Eve. Mr. President, I do not mind for myself. I, of course, want to be home with my family, as I know you do. But I think about my brother, who drives for UPS, and I know he will be working on Christmas Eve, as a lot of Americans will be working on Christmas Eve. And if we need to be here until Christmas Eve to do something that will positively affect every American, I am willing to do that. I am willing to do that if that is what we need to do.

Let me take a moment to talk about the bill in front of us. The bill in front of us literally saves lives, saves money, and saves Medicare, and I am very proud that in the managers' amendment, the amendment we will be voting on at 1 a.m. today, we have made it even better.

I am very pleased to have helped to lead a section related to small business tax cuts. Along with our chair of the Small Business Committee, Senator LANDRIEU, and another strong advocate, Senator LINCOLN, we have been working on provisions that will make sure there are small business tax cuts that start immediately—next year—after the bill passes, \$40 billion in tax cuts in total to help small businesses afford health insurance for themselves and their workers.

In our amendment, we also provide even tougher insurance reforms.

In the underlying bill, we lay out a whole health care bill of rights. I remember coming here in the year 2000, and the Patients' Bill of Rights was the major thing we were trying to get done. We were in the minority, the Democratic minority, but we were working hard to do that. It was my first opportunity to work with Senator Kennedy. We believed strongly that we needed to take insurance company bureaucrats out of the middle—from between doctors and patients. That is in this bill. Those kinds of reforms are in this bill and only one of many things that are in this bill.

We have toughened it up so that if insurance companies, between now and when the new group insurance pool takes effect, are raising their rates too high, spending too much on profit and administration, then taxpayers, ratepayers, will get a refund. And we hope that will put pressure on them not to continue to raise rates or try to do what the credit card companies have done before the bill takes effect—raise their rates. So we have put new protections in and other protections as well to make sure that the majority—the vast majority—of every dollar a family puts into premiums actually goes for their medical care rather than for profits and administration.

In total, we have \$430 billion in tax cuts to create affordability for families and for individuals, to help them afford health insurance. With that, overall, this is a tax reduction—this bill is—for the American people, and it is a reduction for taxpayers because it lowers the deficit in the first 10 years and on into the future.

I am going to take just a moment to give a sense of what is in the bill as it relates to new coverage and the benefits.

We know the majority of us have health insurance already. In Michigan, it is about 60 percent of the people, and in other places it is 50 or 55 percent. But we have what is called an employer-based health insurance system. So we have started from the basis that people should be able to keep what they have, and we have built on that. The majority of people have either employer-based insurance or they have Medicare or Medicaid or veterans services or other public services. So we started from the basis that we want to make current health insurance more secure, more stable. The insurance reforms we are putting in place for those plans that take effect—or new plans after this takes effect—will include the elimination of preexisting conditions, the elimination of what is called rescissions—the ability to drop someone if they have gotten sick—and the elimination of discrimination.

One of the things I was surprised to learn about, in terms of how extensive it is, as we went through this process is that women are paying, on average, 50 percent more than men for the same coverage in the individual insurance market or maybe even less coverage. Because a woman is in her childbearing years or perhaps has been pregnant and may be viewed as having a preexisting condition, some women might not be able to find health insurance.

So those who have insurance today, as they attempt to get new plans, will be able to take advantage of all of the insurance protections—our health care insurance bill of rights—in the bill. And this is very important.

Also, people with insurance today will actually, over time—and it will take some time for this to happen—but as others who do not have insurance now are able to afford health insurance and become able to get health care, there will be fewer people using emergency rooms. There will be fewer people needing other kinds of services that actually end up coming back, in terms of cost, to all of us who have insurance today because when someone walks into the emergency room sicker than they otherwise would be if they had seen a doctor, they get treated, as they should, but then the hospital has to make up the cost, so they put it on people who have insurance today. That is estimated to be about \$1,100 in hidden costs for individuals. So we are

going to see those kinds of costs come down and other changes and efficiencies and quality that will help people with insurance today. So coupled with the insurance reforms, we will see more stability and more quality for people who have insurance today.

The major area of new coverage is in what is called the insurance exchange. For the 15 to 20 percent of the people who can't find affordable insurance today—and most of them, as our Presiding Officer knows, are small businesses or people who are self-employed or people who have lost their jobs and then lose their insurance—we set up a new group pool, which is a way for people to use the same leverage a big business does or the Federal Government does, just as the insurance policy for Members of Congress uses a pool. Then everyone can choose the insurance coverage they want within that pool and get a better deal. That is what we are setting up in the insurance exchange, with helpful tax cuts for families and for businesses and individuals to help them afford health insurance.

We are also giving a choice to States. For lower income working people, a State may choose to provide a basic health insurance plan rather than people getting a tax cut to go into the exchange. They can set up their own basic health insurance plan and bring down costs as well through the State.

For young workers—and this is one of the things I wish had been around a couple of years ago—we will be allowing parents who have their children on their insurance policies—after the effective date of the act, they will be able to keep their children on their insurance policies until the age of 26. That will give young people a chance to get a start in that first job knowing they have insurance until they are 26. And there are a number of other provisions in the bill for young people as well.

We are making Medicaid a true safety net for low-income people up to 133 percent of poverty. We are truly going to be able to say: If you lose your job, you won't have to lose your insurance. What an important thing to be able to say in terms of taking away that fear of losing your job and having nowhere to turn.

Improving Medicare. We are going to stop what have been overpayments to for-profit insurance companies and put that money back into closing the gap in prescription drug coverage under Medicare. It has been called the doughnut hole. We are going to close that. We are going to provide preventive care for seniors without out-of-pocket costs and lengthen the Medicare trust fund so that it is stronger for a longer period of time.

I am very proud to have worked with Senator KERRY to develop a way to provide support and help for companies that pay for the health insurance of

early retirees, to lower their costs so that, in fact, we will be able to help those who have retired, voluntarily or involuntarily, so they will have the insurance they need until they can qualify for Medicare.

Let me close by saying this legislation is very much about saving lives. Forty-five thousand people lose their lives every year because they can't find health insurance they can afford. That is 45,000 families who will have one less person at the dinner table over the holidays because of lack of health insurance. Surely we can do better than that in our great country.

We will be saving money for small businesses, for families, for taxpayers, and bringing down the deficit—beginning to turn those costs downward rather than keeping them going upward in such an uncontrollable way.

Saving Medicare. We will be making sure Medicare is stronger out into the future and that our seniors have more help paying for their prescription drugs and preventative services as well.

When you get through all of it, we know it is hard to change the status quo because those who benefit from the current system don't want it changed.

The PRESIDING OFFICER (Mr. WYDEN). The Senator's time has expired.

Ms. STABENOW. But we do.

I thank the Presiding Officer.

The PRESIDING OFFICER. The Democratic block of time has expired. The Senator from Utah, Mr. HATCH, is recognized.

Mr. HATCH. Mr. President, after weeks of closed-door clandestine negotiations, Senator REID finally emerged with a 383 page manager's amendment yesterday to the 2,074 page, \$2.5 trillion tax-and-spend Washington takeover of our health care system.

Despite all the promises of ushering a new era of accountability and transparency in Washington by the President and the Democratic Party, the Reid amendment represents everything that Americans hate about Washington right now Chicago-style backroom buy-offs at the expense of American taxpayers.

At yesterday's press conference, when Democrats were asked about the Nebraska earmark for Medicaid funding, the majority leader simply replied, "A number of States are treated differently than other States. That's what legislation is all about. That's compromise."

So in addition to the Medicare Advantage deal to grandfather only Florida's seniors and the \$300 million giveaway known as the Louisiana Purchase, we now know what the Democrats' version of compromise really looks like. In the Reid amendment, released yesterday, Vermont gets a 2.2-percent increase for 6 years in its Medicaid Federal match rate while Massachusetts gets a 0.5 percent increase for

3 years for its entire program. But the deal for the State of Nebraska takes the cake. Now we all know that any one Congress can't bind future Congresses but somehow Nebraska will receive a special carve out that would have the Federal Government pay for every dollar of its Medicaid expansion. The total cost of these Medicaid special deals—\$1.2 billion.

So the next logical question is pretty straightforward—who will pay for these special deals? Well, the answer is simple. Every other State in the Union, including Utah, which are collectively facing \$200 billion in deficits and are cutting jobs and education services to survive; our States will now pay to support these special deals for Nebraska, Massachusetts and Vermont.

According to the Congressional Budget Office, the Medicaid expansion in the Reid bill creates a \$26 billion unfunded mandate on our cash-strapped States. Coincidentally, only one State avoids this unfunded mandate—Nebraska.

Let me now focus my attention on over a \$½ trillion worth of new taxes, fees, and penalties on individuals, families, and businesses imposed by the Reid bill. The new fees begin in 2010, while the major coverage provisions do not start until 2014. Almost \$57 billion in new taxes are collected before any American sees the major benefits of this bill, which are largely delayed until 2014. It is no wonder why this budget gimmickry creates an illusion of this bill reducing our national deficit.

Based on data from the Joint Committee on Taxation—the nonpartisan congressional scorekeeper—this bill would break President Obama's campaign promise by increasing taxes on 42 million individuals and families making less than \$250,000 a year. This is even after taking into account the government subsidies provided to low- and certain middle-income individuals and families.

The Reid bill not only increases payroll taxes by nearly \$87 billion but also imposes \$28 billion in new taxes on employers who do not provide government approved health plans. These new taxes will ultimately be paid by American workers in the form of reduced wages and lost jobs.

According to a recent study of similar proposals by the Heritage Foundation, these new job killing taxes will place approximately 5.2 million low income workers at risk of losing their jobs or having their hours reduced and an additional 10.2 million workers could see lower wages and reduced benefits.

So with nearly \$½ trillion in Medicare cuts and more than \$½ trillion in new taxes, does the Reid bill actually do anything to control our Nation's skyrocketing health care costs? The answer, according to the Congressional

Budget Office, is no. In fact, it will actually increase our national health care spending. I quote: "Under the legislation, Federal outlays for health care would increase during the 2010–2019 period, as would the Federal budgetary commitment to health care. The net increase would be about \$200 billion over that 10-year period." So what is the bottom-line? More taxes, more spending and bigger government.

Let me take a moment to talk about the so-called abortion compromise in this bill. The language to prevent taxpayer dollars from being used to fund elective abortions in the Reid amendment is completely unacceptable. The new abortion provisions are significantly weaker than the amendment I introduced with Senator BEN NELSON to ensure that the Hyde amendment, which prohibits Federal dollars from paying for elective abortions, also applies to any new Federal health programs created by Congress. The Hyde amendment has been public law since 1976.

The Nelson-Hatch-Casey amendment, which is almost identical to the Stupak amendment that was included in the House-passed health reform bill in early November by a vote of 240 to 194; it is important to note that 64 of those Congressmen voting for the amendment were Democrats. Let me repeat that—the Stupak amendment was supported by 64 House Democrats. And, despite that vote and the support of seven Senate Democrats, the majority decided not to include this language in the Reid bill or the Reid managers' amendment. I find that absolutely outrageous.

Moreover, the Reid conscience protections are much weaker than those included in the House passed health reform bill. The House bill included the Hyde-Weldon conscience protections that have been included in the HHS appropriations bills since 2004; the Reid health reform legislation does not. The Hyde-Weldon language ensures that strong conscience protections are in place for medical providers who oppose abortion. These strong protections, which are currently Federal law, should also apply to the new programs created through the Reid managers' package.

The so-called abortion compromise does not stop there. The Reid amendment also creates a state opt-out charade. As noted by Cardinal Daniel DiNardo, the Archbishop of Galveston-Houston and the Chairman of the U.S. Catholic Conference of Bishops' Committee on Pro-Life Activities, allowing "individuals to 'opt-out' of abortion coverage actually underscores how radically the underlying Senate bill would change abortion policy. Excluding elective abortions from overall health plans is not a privilege that individuals should have to seek as the exception to the norm. In all other fed-

eral health programs, excluding abortion is the norm. And numerous opinion polls should that the great majority of Americans do not want abortion coverage."

Additionally, this provision does nothing to prevent one State's tax dollars from being used to fund abortions in other States. In other words, tax dollars from Nebraska or Utah could be paying for abortions in California or New York.

The Reid amendment also creates a new public option that will be run by the Office of Personnel Management, OPM, which, for the first time, creates a federally funded and managed plan that will cover elective abortions. Should this legislation be signed into law, the Federal Government will be funding elective abortions for the first time in over 30 years, against the will of the vast majority of Americans. For these reasons, I believe that the Senate health reform legislation is far inferior to the House passed bill when it comes to protecting the sanctity of life. It should come as no surprise to anyone that pro-life organizations from the U.S. Conference of Catholic Bishops to the National Right to Life Committee and the Family Research Council have expressed their strong opposition to this so-called compromise.

Finally, let me take a moment to talk about the individual mandate tax which has almost doubled from \$8 billion to \$15 billion in the Reid amendment. I have long argued that forcing Americans to either buy a Washington-defined level of coverage or face a tax penalty collected through the Internal Revenue Service is unconstitutional. The Constitution empowers Congress to do many things for the American people. Just as important, however, is that the Constitution also sets limits on our power. We cannot take advantage of the power without recognizing the limits.

We hear a lot about how Senators on this side of the aisle are supposedly defending the big, evil insurance companies while those on the other side of the aisle are the defenders of American families. This insurance mandate exposes such partisan hypocrisy. Let me ask one simple question: who would benefit the most from this unprecedented mandate to purchase insurance or face a penalty enforced by our friends at the Internal Revenue Service?

The answer is simple. There are two clear winners under this draconian policy and neither is the American family. The first winner is the Federal Government, which could easily use this authority to increase the penalty, or impose similar ones, to create new streams of revenue to fund more out of control spending. Second, the insurance companies are the most direct winners under this insurance mandate because it would force millions of

Americans who would not otherwise do so to become their customers. If you do not believe me, then just look at the stock prices of the insurance companies that have recently shot to their 52-week highs.

Right now, States are responsible for determining policies that best meet the particular demographic needs and challenges of their own residents. Massachusetts, for example, has decided to implement a health insurance mandate while Utah has decided not to do so. This bill would eliminate this State flexibility so that the Federal Government may impose yet another one-size-fits-all mandate on all 50 States and on every American. I cannot think of anything more at odds with the system of federalism that America's founders established—a system designed to limit government and protect liberty.

As I have said all year long, ensuring access to affordable and quality care for Americans is not a Republican or Democrat issue—it is an American issue. Unfortunately, the majority's arrogance of power has forced us down a path where ideology has trumped policy and big government has trumped American families.

Town hall after town hall and poll after poll tell us that Americans want us to step back, start over and reform our healthcare system in a step-by-step, fiscally responsible manner. This is a moment for courage and leadership. All we need is one Democrat to listen to a growing chorus of concerns from Americans across this great nation and stand up against this bill. I am going to do everything possible to make sure that the voice of Utahns and Americans everywhere is heard loud and clear in this Senate Chamber.

A vote to move this bill forward will be one of the most important votes this body has ever taken—a vote that is bigger than our parties or our ideologies; a vote that will fundamentally change the American landscape for generations to come and restructure one-sixth of our economy; a vote that will determine if we will give our future generations the same opportunities and the same sense of pride that has been our privilege. Make no mistake, our actions on this vote will not be without consequences. History and our future generations will judge us on this vote.

Despite the harsh realities of skyrocketing deficits and an exploding national debt, the majority's insatiable appetite to spend has not changed. Last weekend was a perfect example. At a time when we are already debating a \$2.5 trillion tax-and-spend Washington takeover of our health care system, the majority jammed through a \$1.1 trillion appropriations bill with a 12-percent year-over-year increase in Federal spending. But this is only the tip of the iceberg. There is already talk of raising our Nation's debt limit by al-

most \$2 trillion to accommodate Washington's out of control spending habits.

Enough is enough. It is time to stand up and do what is right and there is no better time to do it than to vote against moving forward on this health care bill. The time for courage is now.

The historic blizzard in Washington yesterday was a perfect symbol of anger and frustration brewing in the hearts of the American people against this bill. I urge the majority once again to listen to the voices of the American people. My Republican colleagues and I are united with the American people in our fight against this \$2.5 trillion tax-and-spend bill. There is still time to step back and start over.

One last thing. When you have one-sixth of the American economy involved, it deserves a bipartisan vote. To be honest, almost every major reform we have ever passed—in fact, every one I can think of—had a huge bipartisan vote. In this particular case, I don't know of one Republican who is going to vote for this. If you can't get 75 to 80 votes on something this important, this much of a reform, then we should start over and do it the right way.

I yield the floor.

The PRESIDING OFFICER. The Senator from Utah.

Mr. BENNETT. Mr. President, I have been interested in the conversation that has gone on this afternoon and this evening. I have heard, once again, the statement made on the floor about the number of people who die every year because they don't have insurance and how that is an absolutely essential reason why we have to pass this bill and indeed pass it now; we have to pass it before Christmas; we have to pass it immediately because there are tens of thousands of people who are dying because they don't have insurance; we have to pass this bill so it will provide insurance for them in January of 2014; we have to pass this bill because people are dying right now, but we are not going to have any of the things that will take care of them available for 4 years. So we can't take an extra week—we can't take an extra 10 days—because people are dying. But we can take an extra 4 years before we give them anything. I have had a very hard time understanding that logic. The mathematics do not add up for me. Delaying everything for 4 years—why?

We know why. The reason they are delaying the implementation of this bill for 4 years has nothing whatever to do with people's health or the fact that some people are dying. The reason the implementation date of this bill is delayed 4 years is entirely due to the computers in the Congressional Budget Office which say, if you started this program immediately, it would bankrupt the United States. It would blow the budget right out of the water. How

do we make it look as if this bill is budget neutral? The way we make it look as if the bill is budget neutral is tell the computers—which cannot think, they can only add—we will start the revenue in this bill, the taxes in this bill, the increased premiums in this bill right away. But we don't start spending on any of the things we are giving the people to save their lives for 4 years. So the computers will say: All right, you will accumulate revenue for 4 years and that will be a big pot of money. Then, in the remaining 6 years of the 10-year term, which is all the computers are allowed to look at, you will have enough money over a 10-year period to pay for 6 years' worth of benefits. I will grant that. Actually, it isn't 6 years' worth of benefits because the money coming in will not be enough. So in order to make it look even better, they will project. The computers—which don't think, just add—say: Yes, this is right. We will project taking roughly $\frac{1}{2}$ trillion out of Medicare and putting it into the same pot of money that is coming in, in the 4-year period, when nothing is going out.

But wait a minute. If we have 4 years of money coming in and nothing going out and we take $\frac{1}{2}$ trillion out of Medicare and put it in the same pot of money, the unthinking computers can add that very well. They can come up and say: You know, this is going to be revenue neutral. Anybody who thinks this is going to be revenue neutral does not understand reality, certainly does not understand history.

Let's look at the CBO record of projecting health care costs. I remember when the Congress passed Medicare. There were very firm costs associated with Medicare. It was going to cost so much. We look back on Medicare, it has cost 20 times what was projected. In the first year, it cost more than was projected. This is in constant dollars, not in inflation-adjusted dollars. In constant dollars, Medicare costs 20 times what we were told. I remember during the debate in 1994, Joe Califano, the father of Medicare, the member of the White House staff who wrote the bill, wrote an op-ed piece in the Washington Post. He said: Congress, pay attention to our experience with Medicare. He said: We put Medicare together, but we got the cost projections. We put the whole thing together. We knew within months after it had passed we were wrong. We knew within months the costs were going to go way out of sight. We went to the Congress and told them and at that point it was too late. This thing had taken root. It had its followers. It had people who were solidly behind it. It was too late to fix it. It has ended up costing us 20 times.

Let's look ahead and see what we are doing if we pass this bill. No. 1, we are doing nothing for people who need coverage for 4 years. But we are locking

into the Federal budget situation a brandnew entitlement. That is a word we use in Washington. Many of my constituents don't understand what it means. Let me do my very best to try to help people understand. First, as the word implies, the people who are receiving the money under an entitlement are entitled to it, whether we have the money to give it to them or not. They are entitled to it whether they need it or not. They are entitled to it whether it makes any sense for them to get it or not. It is an entitlement that they will receive this money.

When Medicare was passed, the only entitlement we had was Social Security. Now we have Social Security, Medicare, and Medicaid. Along with the other entitlements built into the Federal budget, how much of the Federal budget goes out in entitlements? If we look at the budget for 2010, here is the cautionary lesson. The budget in 2010 on which we voted—I didn't vote for it—listed the projections out of the Congressional Budget Office as to how much revenue the Federal Government was going to have in 2010. The answer was \$2.2 trillion. That is a lot of money. Then it said, next line, entitlement spending or mandatory spending, \$2.2 trillion, which meant that in 2010, with the economy on its back and the revenue coming down as a result, every single dime we received out of the economy in 2010 was already committed.

So people would say: Senator, why don't you balance the budget? I would say: How am I going to balance the budget? How am I going to balance the budget with every dime that is coming in already committed and going out as an entitlement and outside the appropriations process?

Vote against an earmark.

Pardon me. The entire government, all the Embassies overseas, the Defense Department, Transportation, Education, national parks, name it, whatever it is, every dime to keep the government going had to be borrowed, not because we didn't have any revenue. We had \$2.2 trillion worth of revenue which, by itself, would have covered the cost of keeping the government open. But we couldn't touch a single dime of that \$2.2 trillion because all of it was tied up with entitlements. So what are we doing in the face of that experience? We are creating a new entitlement to add to those we already have.

The realities of Federal budgeting are these, and they are not unlike the realities of running a business. I have run a business. I understand how the very best projections, the very best forecasts can go awry. You have a new product. You think it is going to do well and you forecast X millions of dollars in revenue from this new product. You look at what the product is going

to cost you and you forecast that cost and you put the two together and you say: All right, we will have X in revenue and we will have Y in costs. As a result, we are going to have Z in profit. So you go out and you build the product. You commit for the raw materials. You pay the people in your factory to produce it, and you put it on the shelves. Now you are at the mercy of the customer, because if the customer decides he doesn't like the product, your projections of the amount of revenue will not save you from the enormous loss that will come.

Yes, you are right on the Y you are spending, but you were wrong on the X you thought you would get in. Instead of having the Z you planned to have as profit, you have a huge loss on your hands. Conversely, I have this happen, too. I have done my forecasting. I have laid down the plan for how much of the product we are going to produce. I have done my forecasting of how many will sell, and the product went crazy. It jumped off the shelves. All of a sudden, I was stuck with empty shelves and had to scramble to produce more and more and more in order to meet demand.

In the Federal Government, we don't have a product but we have expenses, just the same as doing a manufacturing operation. We don't have sales, but we have taxes. Our taxes are dependent upon the viability of the economy. The one fundamental lesson we all should learn is this: We can accurately predict the expenditures that are going out, just like in the business I could predict what it would cost me to produce the product, but we cannot accurately predict the revenue that will come in, just like I can't accurately be sure what the sales will be. We did a spending pattern based on revenue when the economy was strong. Suddenly, the economy turned weak and the revenue dropped off to \$2.2 trillion. We were stuck.

Does this make any sense in the face of that reality? We can determine the spending, but we can't determine the revenue. Does it make any sense in the face of that reality to spend in increased spending in the form of another entitlement in the hope that the revenue will be there? The only way the majority leader is able to make this bill look as if the revenue will be there is with a series of budget gimmicks the likes of which I have never seen, some of which I have already discussed.

The first budget gimmick is to say the revenue will be there because we will have 10 years of it and only 6 years of expenditure. The revenue will be there because we will be able to find \$½ trillion worth of waste, fraud, and abuse in Medicare. I will stipulate there is probably \$½ trillion worth of waste, fraud, and abuse in Medicare over the period of time we are discussing in this bill. We have been looking for it for more than 10 years and

have been unable to find it. This bill, instead of trying to take a scalpel to Medicare and cut out the areas of waste, fraud, and abuse, uses a sledgehammer to smash Medicare and say we are going to knock \$½ trillion out of it and hope that in the process of doing so, we will hit the waste, fraud, and abuse without hitting anything else.

We have 4 years on the timetable laid down by the majority in which to get this right. The majority has decided that if, indeed, people are dying because they don't have health care, they can continue to die because they don't have health care for 4 more years. I think in the face of the smoke and mirrors we are seeing with respect to this budget, we can afford, during that 4-year period, at the front end of that 4-year period, to take a few more weeks to do this right. That is why I am here and that is why my Republican colleagues are here, not because we don't say there is a problem, not because we don't have any ideas as to how to deal with the problem, not because we don't want to join hands with our friends across the aisle to solve the problem but because we know this bill is the wrong solution. Our constituents are pleading with us. They know this bill is the wrong solution. Every poll shows that. They are pleading with us: Don't let it happen. Don't let it happen. No matter what you have to do, don't let it happen.

It may well be that all our efforts are in vain. It may be we are washed aside in a tide of 60 votes. But we will not be washed aside by complacency or the desire to get along because the stakes are too high.

I conclude with this one last analogy. There was another very large organization that handed out a large series of entitlements to people with whom it was connected. These entitlements were not directly involved with the business of that organization, but they got bigger and bigger and bigger, and, ultimately, this organization suddenly discovered it could not function because of the financial drain of the entitlements it faced. The organization is now owned by the Federal Government. It is called General Motors. They discovered they could no longer be a car company because they were buried by the kind of entitlements they had built into their own situation.

Let us take a lesson from General Motors. We do not want the Federal Government to go bankrupt the way that company did. If we do, there is no other organization to bail us out the way the U.S. Government ultimately felt forced to bail out General Motors. It is a cautionary tale we all need to heed.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. VITTER. Thank you, Mr. President.

I, too, rise to voice my very strong concerns about this latest version of

so-called comprehensive health care reform. I will speak of my strong concerns starting with the process we are in the midst of because I am still digesting the particulars of this latest megabill.

As you know, it was divulged yesterday, a 383-page amendment to the underlying bill. The amendment references another bill which is 286 pages. The underlying bill is 2,074 pages. It makes for the seventh—count them—the seventh version of so-called comprehensive health care reform, Obamacare for short, in a few weeks. That grand total would be 2,733 pages. So, certainly, I am still digesting this latest version. My staff is helping me, but I wish to rise to begin to express my concerns.

The first concern is what I just referenced, this process we are in the midst of. When I went around Louisiana and when I continue to go around Louisiana—have townhall meetings—of course, health care comes up first and often. The themes I hear over and over are: This is too important to rush. This is too important to have some arbitrary deadline, whether it was last summer or Christmas. We need to get it right, not have arbitrary deadlines, and we need to know what we are voting for or against. That is what I hear about the right process to use over and over and over.

Well, unfortunately, clearly, this process we are in the midst of does not honor those wishes of Louisiana citizens, of American citizens. Before this latest megahealth care bill was unveiled yesterday, everyone it seems—including Members of the majority party who, at least, were involved in the negotiations, unlike Republicans—was in the dark.

Let me mention a few statements Democratic Senators made over the last week or so before yesterday's unveiling.

Senator DURBIN, in the leadership, said:

I would say to the Senator from Arizona, that I'm in the dark almost as much as he is. And I'm in the leadership.

Senator SCHUMER of New York, also in the leadership:

I can't say what there is, because we're not allowed to talk about what's submitted to CBO.

Senator BAYH of Indiana:

We're all being urged to vote for something and we don't know the details of what's in it.

Senator BILL NELSON of Florida:

I don't know what the deal is.

My colleague, Senator LANDRIEU, of Louisiana:

There's no specific compromise. There were discussions. . . . Until the package that was sent is scored, we really don't even know what's in it.

Senator CASEY of Pennsylvania:

Any big agreement is progress . . . even if we do not know any of the details.

Senator FEINSTEIN of California referred to a meeting on the majority side recently:

There was no explanation. It was sort of go team, go.

Senator BEN NELSON of Nebraska, talking about a similar majority meeting:

General concepts, but nothing very specific at all.

Then, at least yesterday, this new megabill—this 383-page amendment, referencing another 286-page bill, attached to an underlying 2,074-page bill—was unveiled. That finally happened yesterday morning.

Well, that is some progress. But I am afraid it is not progress enough. It is not time enough, considering we are set to vote on this new megabill in just a few hours, starting at 1 a.m. tomorrow morning.

Listening to American citizens all over the country, several Senators, including myself, have advocated we need at least 72 hours of final bill text on the Internet before we take any votes about this sort of major legislation. We need at least 72 hours of the official Congressional Budget Office cost estimate being on the Internet before we start any of those votes. I have certainly advocated that. Many of my colleagues on the Republican side have advocated that, listening, responding to American citizens who say: No arbitrary deadlines. Know what you are voting on. Get it right.

Perhaps even more importantly than my advocating it or other Republicans advocating it, at least eight Democrats have specifically demanded the same thing. In fact, on October 6 of this year, eight Democrats wrote a very clear, strongly worded letter to the majority leader, Senator REID, and they demanded exactly the same thing: 72 hours of final legislative language on the Internet before any vote on the matter, a full Congressional Budget Office cost estimate on the Internet for at least 72 hours before any vote on the matter. I applaud these Senators for demanding that: Senator LINCOLN, Senator LANDRIEU, Senator MCCASKILL, Senator PRYOR, Senator BAYH, Senator LIEBERMAN, Senator BEN NELSON, and Senator WEBB.

But, again, this process we are in the midst of certainly does not honor that minimal demand. We are set to vote on this in just a few hours. When we do, we will have only had the final legislative language for about 40 hours. We will have only had the full Congressional Budget Office cost estimate for about 37 hours. That is 56 percent or less of this minimum timeframe that so many of us, including eight Democrats, have demanded.

Again, this rush to judgment, this rush to beat an arbitrary Christmas deadline, is clearly ignoring the common sense of the American people, the common sense I heard in my dozens of

townhalls all across Louisiana: no arbitrary deadlines. Know what you are voting on. Get it right. Do not rush to judgment.

I have strong concerns about this process. Where are the 72 hours? Where is the opportunity for Members and the American people to know what is in this latest version of a megabill on so-called comprehensive health care reform? Where is the 72 hours' notice of a Congressional Budget Office cost estimate?

Given that rush to judgment and arbitrary timeline, I am rushing to digest this latest version of the bill. But certainly, already, I have other very strong substantive concerns. I will be coming back to the floor within the next few days to more precisely outline those concerns as I digest more of the details of this latest megabill. But let me mention at least six of the big Louisiana-based questions I am focused on in terms of this latest megabill, this latest so-called comprehensive health care reform or Obamacare.

No. 1 is the impact on the Louisiana State budget. There has been a lot of discussion about that because of the particular language included in the bill pertaining to Louisiana that apparently gives Louisiana a \$300 million benefit. The problem, from the Louisiana perspective, is in the Medicaid system, and that \$300 million is directly related to Medicaid. In Medicaid, there is a much greater additional burden put on all States, including Louisiana. In Louisiana's case, apparently, that is going to far surpass \$300 million.

So I am concerned about the overall, the net, impact on the Louisiana State budget, particularly because of the dramatic expansion of Medicaid. Medicaid is the health care program for the poor. It is dramatically expanded in the bill. Every State—except perhaps Nebraska because of special language put in for Nebraska—every State pays a match for both existing Medicaid and Medicaid expansion. That is going to put a big extra burden on the Louisiana State budget, and that big extra burden is apparently going to be much more than the \$300 million of benefit that has been so widely talked about. I am looking, right now, at the details of that.

My second big Louisiana-based concern has to do with the Louisiana seniors—Louisiana seniors who have paid into Medicare, the health care system for retirees, for years and have assumed it would be there for them, as they paid in, as they followed the rules every step of the way. I know from the study I have done already that this new, latest version of the megabill, so-called comprehensive health care reform, involves a \$464.6 billion cut to Medicare. That is going to impact every Louisiana senior, and it is going

to impact tens of thousands of Louisiana seniors on Medicare Advantage particularly onerously.

My third big Louisiana-based concern is the Louisiana taxpayer because this bill contains massive tax increases to pay for all these new entitlements. Apparently, the total figure of tax increases in the bill is \$518 billion—over \$½ trillion—more tax increases than in any of the six previous megabills, the six previous versions of Obamacare. A lot of these taxes are clearly going on individuals who earn less than \$200,000 per year, families who earn less than \$250,000 per year. A lot of Louisiana taxpayers are going to be hit. That is a big concern.

Fourth, I am concerned about Louisianians who have health care now and who pay premiums because those premiums, by all accounts, by all independent estimates, are going to go up because of the taxes and fees and other burdens in this bill.

Fifth, what about Louisiana small businesses, businesses that are struggling right now in a serious recession, the most serious recession since the Great Depression? We are in the midst of an extremely serious recession, and we are putting new mandates, new burdens, and new taxes on Louisiana small business. By all accounts, that is going to cost jobs, pure and simple, as we are in the midst of a very serious recession. I am concerned about that impact on Louisiana small business.

Sixth, and finally, Louisiana defenders of life. I am very proud to say Louisiana is one of the most pro-life States in the Nation—very strong values which hold up life and the defense of life in all its forms. Apparently—it is clear to me—this bill has taxpayer funding of abortion, the first time ever in Federal legislation, breaking tradition from the Hyde amendment, which has been the law since early 1977.

I am very concerned about that radical, truly radical departure from the past.

So in closing, let me say I hope we can adopt a different process, one that reflects the common sense of the American people and Louisianans when they say no arbitrary deadlines, no rush to judgment, and know what you are voting on. Also, I hope we will adopt a different approach that doesn't involve all of the downside I have mentioned, those six major categories.

I am still digesting this latest megabill. I will return to the Senate floor in the next few days to talk more and in more detail about those concerns I have laid out. But I hope all of my colleagues, Democrats and Republicans, look hard at those and similar concerns, look hard at the process and resolve to not just do this quick, not just do it before Christmas by some arbitrary deadline, but to do it right and to honor the American people in our work.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Florida.

Mr. LEMIEUX. Mr. President, I am new to this Chamber, and as I have sat here today and listened to my distinguished colleagues speak about this bill, watching some of my other colleagues on television in my office this evening, I can't help but think how fortunate I am to be here, to be a part of this process. It makes me think back also to the Founders who put together this great constitutional system of democracy that we have in this country, with the three branches of government, and here in the Senate, the sober and reflective legislative body that thinks through the great issues of the day to make sure we get them right for the American people.

In listening to this great debate, I wonder what they would think about what we are doing here. Putting aside the substance, what would they think of the procedure? Because I am new to this Chamber, I think I still have fresh eyes as to what is normal as compared to perhaps what is a little bit departed from normal. Would they think it was within their intentions as the Founders that we would be coming here to vote at 1 o'clock in the morning? Would they think it would be within their intention of how things would work in the Senate that we would get an amendment to the bill that is 400 pages long, we would get it yesterday and would have just a little time to consider it before we try to vote on it? Would it be what they intended, that we would press this vote up against Christmas, and we would try to get it done quickly while most of the people in our country are off with their families and preparing for the holidays? Would that be what they intended, the process of this great deliberative body, arguably, it is often said, the greatest debating institution in the world? Is that the way they would want us to achieve policy that is going to affect one-sixth of our economy? I don't think so. In fact, I don't think the American people think so either.

That is why they are so bewildered as to what we are doing here in the Senate and why we are, as my friend and colleague from Louisiana said, rushing to judgment; why we must get this done before Christmas. If it is such a good bill, why do we have to get it done so quickly? If it is such a good bill, why can't we take some more time to evaluate it? If it is such a good bill, why can't we offer more amendments to it?

So I am sure the American people, if they are home watching this—and they are probably watching Sunday night football—but if they are watching this, they would say: Of course, my Senator from Florida or the Senators from the other States can now offer amend-

ments to try to improve the bill. But that is not the case because the leader of the Democratic Party, the majority leader, has done something called filling the tree.

Now, look, I am new here, too, so this is all new to me, but it is a process by which no other amendments are allowed. So if we want to change the bill, if we have ideas to improve it, that is not allowed. Is that what the American people want from us? Is that what our Founders intended? I don't think so.

So we have this new amendment. It is 400-some pages long. I guess it is the amendment to fix the problems that were in the bill, or at least to get 60 votes. And what do we know about this amendment? What does it do, for example, to Medicare cuts? We know the previous bill before the Senate cut nearly \$½ trillion out of health care for seniors. What does this amendment do? Well, it still cuts health care for seniors. It actually cuts a little bit more, but it is still around that same number: \$½ trillion.

We know also that it raises taxes. Does it raise taxes \$½ trillion as the previous measure did? Yes, it does. In fact, it raises taxes a little more. Now it is \$518 billion.

Well, what about the question that is the most pressing on the minds of most Americans, the very reason we are here, according to the President of the United States, which is to impact the cost of health insurance for most Americans. What does it do about that? Does the amendment do something about that? We know the underlying bill does nothing to impact the cost of health insurance for most Americans. We are here about to change one-sixth of the U.S. economy, and this bill does nothing to impact the cost of health insurance for folks who already have health insurance in this country. That is not me saying it; that is the Congressional Budget Office.

If you are one of the 170 million Americans who already have health insurance, this bill is not going to lower your costs. In fact, for some Americans, it is going to increase your costs over the next 10 years.

Well, does this amendment fix it? No. So we are still in the same situation—cutting \$½ trillion out of health care for seniors, raising taxes by \$½ trillion, with nothing in it for most Americans in terms of the cost of their health insurance.

How is this going to affect the American people? Well, if you have Medicare, if you are a senior who has been paying into it, it is going to affect you.

My friends on the other side of the aisle will say: Look, the nearly \$½ trillion that we are going to take out of Medicare is just waste, fraud, and abuse. We will get that money out. Well, the Congressional Budget Office says the measures that are in the bill will take out \$1½ billion worth of

waste, fraud, and abuse, not \$500 billion. So where is the rest going to come from? It is going to be decreased benefits. It is going to be decreased access to doctors.

We know right now in Medicare, nearly 24 percent of medical health care providers—your doctors, for example—will not take Medicare anymore, 24 percent, one in four of them. In Medicaid it is 40 percent.

What is going to happen when you reduce the amount of money you are paying into Medicare? You are going to reduce the amount of money that is being paid to providers, which means providers are not going to see their patients. If the doctor is not in, it is not health care reform.

This really impacts my State of Florida. We have the highest number of seniors per capita, 3 million seniors, on Medicare, and they are going to be impacted.

I wish to read from a letter that was sent to me by Mr. Richard Mullaney. I received it at the end of November. It says:

Dear Senator LeMieux. I thought you might like to see this letter I received from my cardiologist.

It attaches that letter from the Palm Beach Cardiovascular Clinic in Jupiter, FL, down in southeast Florida.

I ask unanimous consent that this letter be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

PALM BEACH CARDIOVASCULAR CLINIC,
Jupiter, FL.

AN OPEN LETTER TO OUR PATIENTS: The 2010 Medicare Fee Schedule mandates that on January 1, 2010 severe cuts in cardiology physician fees will begin. This cut is being phased in over four years because the government used flawed data to make their calculations. In addition, there are Congressionally mandated cuts of more than 20 percent to all Medicare physician fees, regardless of specialty. The result of these combined government policies are that our practice is facing payment cuts ranging from 25 to almost 50 percent.

Such drastic reduction in fees are going to seriously hamper our ability to continue to see you, our patients, as we do today. We feel the need to warn you that these reductions will translate into much longer waiting periods for you to schedule an appointment or a procedure with your doctor, longer telephone response times to you, and not having the convenience of in-office Nuclear and Echo diagnostic testing available to you. Making sure you have the best quality of care will always be our number one priority. Caring for people is why we all dedicated our lives to heart patients. In the very near future—it is going to be a difficult climate to operate in our current manner.

We have built our office facility and trained our staff to best take care of each patient. We believe that the care you receive is critical to your quality of life. Wish these cuts we may not be able to provide some of the services that patients have come to depend on and in the long run; if the current policies are not changed, we may be forced to close our doors.

As a cardiovascular patient we urge you to contact our lawmakers (see attached for their information) about the impact of our changing practice on you. The law is clear—we face cuts unless Congress acts. In advance we thank you for understanding our changing environment.

Sincerely,

GABRIEL E. BREUER.
CHAUNCEY W. CRANDALL
IV.
AUGUSTO E. VILLA.
AGUSTIN A. VARGAS.
GONZALO J. LOVEDAY.
BURTON H. GREENBERG.
SIDNEY M. RICHMAN.

Mr. LEMIEUX. Mr. President, it is an open letter to patients, and it is signed by some seven doctors who are in this cardiovascular clinic practice. I will read portions of it. It says:

Drastic reduction in fees are going to seriously hamper our ability to continue to see you, our patients, as we do today. We feel the need to warn you that these reductions will translate into much longer waiting periods for you to schedule an appointment or a procedure with your doctor, longer telephone response times to you, and not having the convenience of in-office Nuclear and Echo diagnostic testing available to you.

The letter goes on to say:

With these cuts we may not be able to provide some of the services that patients have come to depend on and in the long run, if the current policies are not changed, it may force us to close our doors.

So these are doctors, real doctors, and this is a letter from their real patient saying: If these cuts to reimbursements to doctors and providers aren't addressed, then we are going to have an inability for doctors to perform health care.

Those are real-world problems that are going to occur if this bill is passed.

So this is no great shakes for seniors. This isn't health care improvement for seniors. Those that we already have on a government entitlement program, those who have already paid into the program are going to have a cut in their benefits. That is exactly what the Chief Actuary, we found out last week from the Center for Medicare and Medicaid Services, said. He said it is plausible, even probable, that there will be shortages for Medicare and Medicaid beneficiaries because there is not going to be doctors who are available to see them.

Let's talk about the taxes: \$518 billion in tax increases. What is that going to do to the cost of health care? We are going to tax medicine. We are going to tax lifesaving devices. Those taxes, of course, will be passed along to you, the consumer. So for you, your cost of health care will go up, taxes on health insurance of almost \$60 billion; taxes on medical devices, \$19 billion; taxes on medicine, \$22 billion. If you don't have health insurance now and you don't get it, you will be taxed. If you are a small business and you don't provide health insurance to your employees, you will be taxed.

I had a telephone townhall meeting this week, and I talked to a gentleman from central Florida who had been laid off from his job at a restaurant. He said to me: The reason I got laid off is because the restaurant couldn't afford the health care benefits. So when health care benefits went up, the restaurant raised its prices for its food, people stopped coming to the restaurant, and the restaurant went out of business. Then there wasn't health care for any of the employees.

You can't get blood from a stone. While the benefits of this plan as laid out by my Democratic colleagues may sound great—33 million more Americans who are going to have some kind of health insurance—you have to look at the details. How are you going to pay for it, and what is the effect going to be? When you raid nearly \$½ trillion out of Medicare, you are going to decline the quality of health care for our seniors. When you raise taxes by \$½ trillion, you are going to pass those costs along to consumers who already have health insurance, and their prices are going to go up. You are going to pass them along to small businesses that would not be able to afford them, that will let people go.

We have 11.5 percent unemployment in Florida. When small businesses can't afford this, they are going to let people go or, like that restaurant, close their doors. That is not good for a country that is fighting through the worst recession since the Great Depression.

Now we find out there are a bunch of special deals in this bill. We find out that the Senator from Nebraska has been able to get a special fix for his State.

See, another thing this bill does is it puts a big unfunded mandate on the States. What do I mean by that? An unfunded mandate is a requirement that the States must fulfill that they don't get paid for. This time it comes in the form of Medicaid, which is health care for the poor. Medicaid, under this proposal, is going to be increased. We are going to put 15 million more Americans into Medicaid.

If you think Medicare recipients are having a tough time finding a doctor, in Medicaid, 40 percent of health care providers will not take it; 50 percent of specialists will not take it. Now we are going to put 15 million more Americans into it.

What it does to the States, in a State such as Florida, it is going to cost us in 10 years nearly \$1 billion to accept this unfunded mandate. The Senator from Nebraska apparently got a fix for this so his State would not have to pay the \$1 billion. Well, Florida would like that same fix. If it is good for Nebraska, it is good for Florida. I am sure Iowa would like that fix as well. I am sure all the States would.

So I ask unanimous consent that the pending amendment be set aside and it

be in order to offer an amendment to extend to the State of Florida the same benefits that provide 100 percent Federal funding to the State of Nebraska for their expanded Medicaid Program.

The PRESIDING OFFICER. Is there objection?

Mr. HARKIN. Objection.

Mr. LEMIEUX. For the folks who are watching at home, the reason my distinguished colleague from Iowa objected to this is because this deal would not go through if they provide it for every State. So some States are going to get it better and some States are going to get less, and that is not fair. But that is the process that has put this bill together, to cobble together 60 votes.

So at the end of the day—may I ask how much time I have remaining?

The PRESIDING OFFICER. Fifteen seconds.

Mr. LEMIEUX. At the end of the day, I have 15 seconds left. I will be back to the floor to speak about this again. But this is not a good bill for America, and that is why my colleagues on this side of the aisle have been debating and showing our objections so the American people can understand.

I yield the floor.

The PRESIDING OFFICER. The Republicans' block of time has expired.

The Senator from Massachusetts.

Mr. KIRK. Mr. President, I rise to, first, commend my distinguished colleagues, Majority Leader HARRY REID of Nevada, Senators BEN NELSON of Nebraska, BARBARA BOXER of California, BOB CASEY of Pennsylvania, and CHUCK SCHUMER of New York for the principled and practical compromise they reached on the difficult issue of abortion. Their work allows the U.S. Senate to now march with our House colleagues toward the forward edge of history and the enactment of The Patient Protection and Affordable Care Act, and I congratulate them for that important contribution.

I would also like to commend my colleague, the assistant majority leader, DICK DURBIN of Illinois, for bringing to the Senate's attention during yesterday's debate an op-ed that appeared in the Washington Post this morning written by our dear friend Victoria Reggie Kennedy entitled "The Moment Ted Kennedy Would Not Want to Lose."

Vicki Kennedy was Senator Kennedy's partner in all things, including his final efforts to move health reform forward even as he valiantly fought his own battle with cancer.

In more than 17 years of marriage, Ted and Vicki were inseparable, bonded by the love of friends, family and most obviously by their love for one another. Vicki displayed inspirational grace in leading us all in our grief and in the memorable celebration of his life on the occasion of Senator Kennedy's death.

And today, she continues as his partner paying tribute to Ted's legacy by respectfully urging his colleagues to move forward on the health reform he would have wanted.

I feel certain that Vicki's voice and his will make us more determined than ever to complete Ted's work for the American people. We thank you, Vicki.

Mr. President, I would now like to respond to an argument made in another op-ed in Thursday's Washington Post and in an interview on "Meet the Press" this morning by my friend, and a former Democratic Party chairman, Howard Dean.

Chairman Dean said in his opinion piece: "If I were a Senator, I would not vote for the current health-care bill," because it does not bring "real reform."

With all due respect, before anyone swallows Howard's faulty prescription, as they say in the field of health care, "It's time for a second opinion!"

As a former national chairman of the Democratic Party myself, I'll take my equal time to offer my opinion and say I am a U.S. Senator, and I will vote for the current health care bill precisely because it does bring "real reform."

Is it all the reform for which our friend and colleague Ted Kennedy, "the Father of Modern Health Care Reform", fought so valiantly and tirelessly throughout his legislative career? No.

Is it all the reform for which I and many of my distinguished colleagues advocated so passionately here on the floor of this Chamber throughout this intense debate? No.

But, is it a quantum leap forward that will bring "real reform" to a broken, discriminatory, bankrupting, deficit-busting health care system that will only get worse without immediate action and passage of this legislation?

The answer is clearly: Yes.

One of the reasons history will record that Ted Kennedy was the greatest legislator of our time was that he respected the need and the art of compromise.

And he would argue that a choice between a solid, sound, significant and long overdue start at "real reform" of our health care system and the choice of leaving American families to continue to fall behind because we refused to seize the historic moment before us—is the easiest choice and, perhaps, the most historic vote we may ever cast as U.S. Senators.

Does anyone in this Chamber—or in Massachusetts—or anywhere else for that matter, doubt Ted Kennedy's commitment to legitimate, credible, real reform of our system in order to make affordable, quality health care accessible to the greatest number of Americans? The answer is clearly: No.

Is this a bill of "real reform" that Ted Kennedy would champion and vote for? Absolutely, yes!

Ted Kennedy knew real reform when he saw it, and so do I.

Here are the real health care reform measures of this Senate bill, many of which Senator Kennedy helped to craft. Think about this.

It will save money and save lives; expand coverage and bring over 30 million uninsured Americans into the community of the insured; It will control costs and lower premiums; stimulate competitive choices so consumers can choose the best policy at the most affordable price; relieve the costly health care burden on the small businesses of America through tax credits; provide a discount to countless seniors like my own sister Maud, who are squeezed by the cost of prescription drugs under Medicare D's so-called doughnut hole.

The real reforms in this bill will strengthen Medicare and Medicaid; reduce the deficit by hundreds of billions of dollars; attack waste, fraud and abuses; eliminate lifetime limits on needed care; reward wellness and preventive practices; increase transparency and insurance company accountability; promote flexibility, innovation and best business practices; reward the quality and value of care instead of the quantity and volume of procedures.

This bill will eliminate unjust discrimination against women or those afflicted with preexisting conditions; it will provide the elderly and disabled a voluntary choice to self-fund a plan that will provide financial security to purchase long-term services when they are needed most; it will require insurance companies to cover children and dependents up to age 26; and prohibit insurance companies from dropping coverage for Americans who get sick—the very reason they buy health insurance in the first place!

In these and many other ways, this Senate bill is real reform—for a senior citizen who cannot afford the drugs she needs; for the 31 million people who will now have the health insurance they deserve; for families who worry that hospital bills will wipe out their life savings; and for a system that presently fails to serve the needs of the American people, this is real reform.

For those well-meaning progressives who say they oppose this bill because it does not go far enough and to my colleagues on the other side of the aisle who want to defeat this bill and start over, I say they are both mistaken.

We need to win this fight now and we need to win this fight together! Will there be more to do after its enactment?

Mark my words. There will always be more to do. But this historic piece of legislation will be a giant step forward toward a health care system that truly begins to serve the needs of the American people.

President Kennedy offered two profound observations that have helped

me keep things in perspective throughout my life, and they have particular application at this moment in our time. He once said:

Wisdom requires the long view.

And on another occasion, he said:

Democracy is never a final achievement; it is a call to an untiring effort.

John Kennedy's words apply so well to the work of health care reform before us this evening and to the legislation that will pass this Senate within the next several days.

We are all called upon to exercise our wisdom and to take the long view of history. We must understand that passage of this legislation will not be a final achievement. It will be a compelling first call to an untiring effort to continue with our responsibility to do what the American people deserve—provide affordable, accessible, quality health care for them as a matter of right.

I am old enough to recall the Civil Rights Act of 1960, and the Civil Rights Act of 1964, and the Civil Rights Act of 1968. With the passage of each of those laws, there was always more to do. But each began the march of progress toward equality under our laws. And each created a responsibility to assure that our country's laws more aptly reflected our national character and our principle of equal justice.

The same is true of this moment in our national history. The bill before this Senate is not perfect, nor will it be the final product. But make no mistake, it is real reform, and it will provide enormous benefits to America's workers, America's seniors, and America's families.

I urge my Republican colleagues not to be held hostage by the raw and divisive politics of the moment, not to be the captives of those who may threaten with some meaningless political litmus-test score cards, but to step back and to think about the positive difference these reforms will make in the lives of the millions of American families you represent—and, finally, to reflect wisely upon the long view of history and decide that this is the moment to join the majority of this U.S. Senate in moving toward history's enlightened edge by voting for this landmark legislation.

I yield the floor.

The PRESIDING OFFICER. Who seeks time? The Senator from Connecticut.

Mr. DODD. Mr. President, before he leaves the floor, let me commend our colleague from Massachusetts, PAUL KIRK, who has only been with us a brief amount of time under circumstances he has said on numerous occasions over the last several weeks he would much prefer to have avoided. I commend him.

Many of my colleagues know that PAUL KIRK is no stranger to this institution, having worked as a member of the staff in Senator Kennedy's office

for many years. He has had a distinguished career in his own right in Boston. We welcome him here under those very sad circumstances. But his remarks this evening are evidence of the value he has placed in coming to this Chamber and filling a gap here and articulating a view our colleague from Massachusetts would be expressing were he here these days and tonight.

Said so well, if it has not been printed in the RECORD, I ask unanimous consent to have printed in the RECORD an editorial piece written by Senator Kennedy's wife Vicki Kennedy.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Washington Post, Dec. 20, 2009]

THE MOMENT TED KENNEDY WOULD NOT WANT TO LOSE

(By Victoria Reggie Kennedy)

My late husband, Ted Kennedy, was passionate about health-care reform. It was the cause of his life. He believed that health care for all our citizens was a fundamental right, not a privilege, and that this year the stars—and competing interests—were finally aligned to allow our nation to move forward with fundamental reform. He believed that health-care reform was essential to the financial stability of our nation's working families and of our economy as a whole.

Still, Ted knew that accomplishing reform would be difficult. If it were easy, he told me, it would have been done a long time ago. He predicted that as the Senate got closer to a vote, compromises would be necessary, coalitions would falter and many ardent supporters of reform would want to walk away. He hoped that they wouldn't do so. He knew from experience, he told me, that this kind of opportunity to enact health-care reform wouldn't arise again for a generation.

In the early 1970s, Ted worked with the Nixon administration to find consensus on health-care reform. Those efforts broke down in part because the compromise wasn't ideologically pure enough for some constituency groups. More than 20 years passed before there was another real opportunity for reform, years during which human suffering only increased. Even with the committed leadership of then-President Bill Clinton and his wife, reform was thwarted in the 1990s. As Ted wrote in his memoir, he was deeply disappointed that the Clinton health-care bill did not come to a vote in the full Senate. He believed that senators should have gone on the record, up or down.

Ted often said that we can't let the perfect be the enemy of the good. He also said that it was better to get half a loaf than no loaf at all, especially with so many lives at stake. That's why, even as he never stopped fighting for comprehensive health-care reform, he also championed incremental but effective reforms such as a Patients' Bill of Rights, the Children's Health Insurance Program and COBRA continuation of health coverage.

The bill before the Senate, while imperfect, would achieve many of the goals Ted fought for during the 40 years he championed access to quality, affordable health care for all Americans. If this bill passes:

Insurance protections like the ones Ted fought for his entire life would become law.

Thirty million Americans who do not have coverage would finally be able to afford it. Ninety-four percent of Americans would be

insured. Americans would finally be able to live without fear that a single illness could send them into financial ruin.

Insurance companies would no longer be able to deny people the coverage they need because of a preexisting illness or condition. They would not be able to drop coverage when people get sick. And there would be a limit on how much they can force Americans to pay out of their own pockets when they do get sick.

Small-business owners would no longer have to fear being forced to lay off workers or shut their doors because of exorbitant insurance rates. Medicare would be strengthened for the millions of seniors who count on it.

And by eliminating waste and inefficiency in our health-care system, this bill would bring down the deficit over time.

Health care would finally be a right, and not a privilege, for the citizens of this country. While my husband believed in a robust public option as an effective way to lower costs and increase competition, he also believed in not losing sight of the forest for the trees. As long as he wasn't compromising his principles or values, he looked for a way forward.

As President Obama noted to Congress this fall, for Ted, health-care reform was not a matter of ideology or politics. It was not about left or right, Democrat or Republican. It was a passion born from the experience of his own life, the experience of our family and the experiences of the millions of Americans across this country who considered him their senator, too.

The bill before Congress will finally deliver on the urgent needs of all Americans. It would make their lives better and do so much good for this country. That, in the end, must be the test of reform. That was always the test for Ted Kennedy. He's not here to urge us not to let this chance slip through our fingers. So I humbly ask his colleagues to finish the work of his life, the work of generations, to allow the vote to go forward and to pass health-care reform now. As Ted always said, when it's finally done, the people will wonder what took so long.

Mr. DODD. Mr. President, she said it very well, as Senator KIRK has, that this is far from a perfect bill. We all know that. It is far from a finished product in terms of health care. The Presiding Officer spent a good part of his career as well working on this issue and would be the first to acknowledge as well that we have a lot more work to be done.

Congresses long after all of us who serve in this Chamber are gone will be grappling with the issue of how we can better deliver health care services, create greater access, and reduce the cost of health care while extending quality of life for our fellow citizens and removing the fear so many families feel when they discover that a loved one—a child, particularly—is suffering from some illness or disease that requires attention and yet to be informed that the costs of providing that attention, that care is so prohibitive that they cannot afford to do it and wondering why they, because they lack the economic circumstances, cannot take as good care of their children as someone with access to greater economic power can.

That is what we are trying to achieve, to create that availability. I don't know anybody who disagrees with the statement that health care in America ought to be a right, not a privilege. And if it is a right—then, just as other rights are extended to every citizen regardless of their economic circumstances, their ethnicity, their background, their gender, certainly this right ought to be no different in that regard and available to all of our fellow citizens regardless of their financial circumstances. That is what we are starting to do here. It does not achieve that goal perfectly, but it puts us on that path to achieving that equity, that ability for families and individuals to take care of themselves and their families when afflicted by a medical crisis or medical problem.

Having been deeply involved in this issue now for not quite a year but almost a year, since it became very difficult for my friend and colleague from Massachusetts to conduct the kind of daily and hourly efforts he would have been involved in but for his health condition, we have come to a moment now to decide whether we go forward, whether we accept the responsibility as being Members of this body to do the best we can when trying to design something written by 100 people, not to mention 435 in the other body, not to mention an administration and all of their interests, not to mention all of the stakeholders who are involved in health care, which is so voluminous that it would be impossible, even in the time remaining this evening, to mention everyone who has a stake in the outcome of this discussion.

Taking all of those elements and trying to bring them together to fashion an ideal or set of ideas to go forward has defied, as I have said on so many occasions in this Chamber over the past number of months, has defied every administration and every Congress since this first challenge was posed by—well, going back to the days of Theodore Roosevelt but more recently since the time of Harry Truman. Every Congress, Republican and Democratic, every President, Democratic and Republican, has at least thought about doing this. Some have actually tried. President Nixon actually tried. President Clinton actually tried to come forward. Those who remember those days, for a variety of reasons, some that seem more clear today than the hour they were being debated, those efforts failed. We are now that third administration, that third effort that has come this far, if you will.

My hope is that this evening and in the ensuing few days, we will complete our task in this body and continue the effort by working with the House of Representatives to fashion a final product for the signature of the President of the United States to allow us to begin what will be a long journey to

make sure that right of health care is available to all of our citizens.

Many of us here may never see the benefits of that just because of life expectancy, I suppose. But to know you are leaving a health care system in place for the coming generation where they can look back on these wintry days in the Senate and be reminded that there was a Congress at the outset of the 21st century willing to face up to the challenges, with all of the accusations, all of the barbs, all of the ad hominem arguments hurled at people, and make an effort to correct a wrong, to right a wrong, to make a difference and improve the quality of life for all of our fellow citizens—that is something I hope coming generations will recognize as a result of the efforts we have made here.

Let me take a few minutes to wrap up this part of the debate with my views as to where we stand at this hour.

When this body began the process of writing health care reform over a year ago, we knew it would represent a mammoth undertaking, and we knew it would get more difficult as we got closer to the goal line, as every major effort I have been involved in for three decades here has certainly evidenced. As you get closer to the goal line of major undertakings, it gets harder and harder to cross that finish line.

This issue involves one-sixth of our economy, affects 100 percent of our fellow citizens, and has been the center of American public policy debate since before many of us were even born.

Our path has been long and winding and has been difficult. It has been illuminated by a torch lit long ago in the days of Harry Truman and those who even preceded him and sustained for decades by very good people—Democrats, Republicans, and others—who believe that in a nation founded on freedom and sustained by unimaginable prosperity, no one—no one—in our country ought to have to go to sleep on a night such as this feeling that if they get sick or a loved one does, they will go broke or, worse, be unable to afford the care they or that loved one needs to get well.

As I said so many times before, the person who carried this torch as long and proudly as anyone since this debate began so many years ago is not here with us tonight, but he is here in spirit and good conscience. I speak, of course, of our colleague from Massachusetts, Ted Kennedy. He never expected that he or we would cure all our ills in one fell swoop, in one massive bill that would, once and for all, right this problem of health care. Progress, he would argue, is hard, and the simple mathematics of the Senate make it harder all the time.

I know our Republican leadership has basically advised their fellow members of their caucus not to vote for this bill

no matter what is in it. I regret that. I think it is a sad moment but one with which we have to grapple. We cannot quit because of that political conclusion. We have to move forward. In fact, they went so far as to write a playbook for how to disrupt, delay, and obstruct progress on this issue. I know they do not like the bill and many parts of it. I also know many of them like many parts of this bill, and they acknowledge that when they talk about greater access, cost reductions, and the quality of health care. As one who conducted the hearings and the markup on health care over the last year, I heard over and over that members of that committee, Republicans and Democrats, speak of the very same goals we all seek with health care reform. I know, as a matter of fact, that many of them wrote major provisions of this bill. This bill is not devoid of the involvement and participation of members of the minority party this evening as we come close to voting on a final choice. But I regret it has come to that. I think our best efforts do emerge when we work together as citizens of this great country, regardless of the political labels we bear.

My hope will be in the coming days that those doors may open and participation may, in fact, flow and we will end up with a product coming back from conference that is even stronger than the one we are being asked to make a decision on this evening.

Someday we will look back on this moment in our Nation's history, and many of those not part of this decision will wish they stood in the arena instead of lobbing rhetorical grenades and cheap shots at a bill that deserves so much better. There is still time for my colleagues to stand and do what is right. I hope they will before the process is over.

As it is, our caucus had to work at finding compromise language we could all stand behind, and we have tried to do that over these days. The resulting bill is not one that any one of us would have written on our own given that opportunity. And that goes for me as well, as I know it does the Presiding Officer. We have fought for a strong public option in our committee. I fought to have it included in the bill the majority leader brought to the floor, and I would have happily been fighting for it even today given that opportunity. But as I have said, it is always easier to envision the legislation you want than to pass the legislation we can get.

Our country badly needs this legislation, even as imperfect as it may be in some aspects. The preferred outcome of our Republican friends we have in the Senate—deadlock within our caucus and a resulting failure to pass a reform bill—will result in more family bankruptcies, more deficits, and, sadly, more deaths that could have been prevented if everyone had access to decent

health care. We do not have to let that happen. In fact, we will not let that happen. We have to be better than that.

Yesterday, the majority leader offered a managers' amendment to the original Patient Protection and Affordable Care Act which we have been debating since prior to Thanksgiving.

It toughens accountability policies for insurance companies, requiring them to spend more on health care and less on administrative costs and profits, holding them accountable for jacking up premiums, and prohibiting them from excluding coverage of preexisting conditions for children, effective immediately.

It provides American families with more health care choices, guaranteeing that in addition to a variety of private sector options, families can choose from at least two national plans similar to the ones we receive right here in the Senate, one of which will be a not-for-profit plan.

It strengthens affordability provisions in the bill, starting a tax credit for small businesses in 2010, giving families more information to shop for better deals, and helping to spread cost-saving innovations across the country.

It builds on the bill's protections for seniors, children, rural communities, and other vulnerable populations.

It preserves the bill's core commitments that no American should go broke because they get sick and no American should die because they cannot afford the care they need to get well.

After more than a year of legislating and more than 60 years of hard work on the part of advocates across the Nation, we have an unprecedented opportunity, both later this evening as well as the remaining days of this week. We are standing on the floor of the Senate with a chance to pass legislation that puts our focus on preventing disease, not just treating it, a bill that insures those 31 million of our fellow citizens who today lack any health insurance at all, a bill that guarantees every American access to quality health care at a lower cost.

Senator Ted Kennedy always believed we would someday have this chance, and I think he knew this year might be the best and for our generation the last chance. These opportunities do not come around very often. We fought for reform in the 1970s and failed. We fought for health care reform in the 1990s and failed as well. If we fail this time, if we let partisanship triumph over progress, if we lose sight of the goal in the face of political gamesmanship, we who stand here today may never get that other chance.

We came here to make this country a better place. I believe every person who serves here believes they came to the Senate to make our country a stronger and a better place. We have before us a

bill that saves lives, lowers costs, and frees tens of millions of our fellow Americans from the fear that grips them, as I address this Chamber on this evening. Let's do our jobs. Let's pass this bill. Let's make America stronger and a better place because this Congress and this administration rose to the challenge to grapple with a magnificent issue that deserves our attention and our support.

I urge our colleagues to support this bill.

I yield the floor.

The PRESIDING OFFICER (Mr. KIRK). The Senator from Illinois.

Mr. DURBIN. Mr. President, let me first acknowledge the Senator from Connecticut, who played a critical role in not only the inspiration but the preparation of this important landmark legislation. Senator DODD has been given some tough assignments in his career. He has been handed some of the toughest, and this was one. His Health, Education, Labor, and Pensions Committee met, I understand, 54 hours, if I am not mistaken. I think that is what he said earlier on the floor. It considered hundreds of amendments with the notion that we could create a better, more effective health care system in America. I have yet to hear anyone criticize his chairing that committee. He was evenhanded and fair. He entertained and accepted some 150 or 160 Republican amendments to this bill in an effort to try to build some bipartisan support for it. He went the extra mile with extra hearings. His committee was weary at the end, but he proved that his experience in the Senate had taught him valuable lessons about what it took to be respectful to the other side of an issue. He was not rewarded with a final vote in committee. Not a single Republican Senator would vote for the bill. It was not for any lack of effort on the part of Senator DODD.

When this bill passes—and this bill will pass—he deserves special credit for it, and I am going to be one of the first to applaud him. He included a provision in this bill near and dear to me on congenital heart research that will save lives and will spare suffering to families across America. I will forever be indebted to him for it.

In just 4 hours, in the early morning hours of Monday, December 21, 2009, one of the most significant votes in the history of the Senate will take place. It is hard for us in the midst of this debate, after all that has come before us and all that is likely to follow, to properly put this in historical context. For those of us who were honored by the people of our State to be here at this moment in history, it is humbling to know we will be called on to cast a vote that can change a nation.

It has happened here before but only rarely. It happened 75 years ago when other Senators, in a much different

era, battling through the worst depression in our Nation's modern history, were called on by a President in a wheelchair to rally and stand for the elderly of America. He asked to create Social Security, an insurance plan primarily for widows. President Franklin Roosevelt came to this Senate in this Chamber asking each and every one of the Senators to be mindful of the plight of our parents and grandparents in that time.

I can recall, in my family, it was not uncommon for grandparents to end up living in the same home as their children because after they reached the point where they could no longer work for a variety of reasons—physical, retirement, whatever it happened to be—their savings were meager and the chance of living independently was limited. So their children took them in in that spare bedroom, made them part of the family and welcomed, but understood that was the only way mom and dad were going to have the dignity they deserved in life.

Franklin Roosevelt had a different vision. He thought if workers throughout their worklife paid a little bit of money each week into a fund, they could be ensured there would be a check waiting for them at retirement that would allow them independence and dignity. He prevailed, and Senators stood up in that era of the 1930s and gave him the votes that were needed to change our Nation when it came to the way we treat the elderly.

Those on the other side of the aisle—Republicans—were skeptical. They were fearful of government; fearful of a new program. They argued we were headed down a path we would regret—echoes of many arguments we are hearing today in opposition to health care reform. When their time came later, even as recently as a few years ago, they tried to dramatically change and rewrite the Social Security Program. They called for privatizing it, saying we would be much better off if the Social Security trust fund were actually in the stock market. Thank goodness the wisdom of America rejected that idea. Within months of the suggestion, it was proven to be totally false, as life savings were lost with the recession that we now are enduring.

It is an indication of the bravery of a President, the courage of a Senate, and the fact that they rejected the pleas of those who would say: "Do nothing. Don't touch it. Leave that problem alone."

It was about 45 years ago when another great President had another great idea, and that idea was to create Medicare, and with the creation of Medicare to say to those same elderly: It isn't enough to give you a check to get by each month. We want to make sure you have access to doctors and hospitals when you need it. Lyndon

Baines Johnson, the master of the Senate, then President, managed to engineer the passage of that legislation against critics who once again said: It is too much government. It is a program that will cost too much money. It is not needed. We shouldn't do it.

Their counsel was rejected. Medicare was created. It wasn't the Medicare we know today. It didn't reach the disabled. It didn't provide some of the basic services that many seniors now desperately need, and it didn't cover prescription drugs, but it was a start. It was a critical decision made to move forward. The same Republican Party that objected to the creation of Medicare has been critical of the program ever since. They have argued that it is wasteful, that it is doomed, that it should be allowed to wither on the vine. That was actually a quote from a leading Republican not that long ago.

They suggested there was a better way—let's privatize Medicare. They love the notion of privatizing. Get government out of the picture. They came up with this theory, with the health insurance industry, of something called Medicare Advantage. This was where those flinty-eyed entrepreneurs would teach government a lesson. They would offer the benefits of Medicare and show how to do it at a lower cost. Well, we accepted their challenge and gave them their opportunity, and what we found was: They failed. Oh, some succeeded, but by and large when the final count took place, those private insurance companies couldn't help but have the urge to maximize profits at the expense of Medicare. So now we spend about \$17 billion a year out of Medicare subsidizing private health insurance under the so-called Medicare Advantage Program. The experiment has failed.

The basic idea of Medicare was proven right. It gave to our seniors something that we had promised and hoped we could deliver—longer healthier lives. It also triggered the creation of a medical health establishment across America—the building of hospitals and medical schools and more medical professionals than our Nation had ever seen—because of Medicare, because of a President, Lyndon Baines Johnson, and his courage, and because of a Senate that could rise to the challenge of passing it, despite the critics.

Well, in the early hours of Monday, December 21, 2009, our generation of the United States Senate will face our rendezvous with destiny, our opportunity to change this Nation, to make such a significant change in the way health care is delivered in America that we can say to future generations: We had our moment, and we seized it. To think that we will—with the passage of this bill in perhaps just a few days in the Senate, and a few weeks on Capitol Hill—enlarge the percentage of Americans with the security of health insurance from 83 percent to 94 per-

cent—the highest percentage of Americans ever insured in the history of our Nation. Of 50 million uninsured Americans today, 30 million of those people will finally be able to rest at night knowing they are covered; that they have health insurance.

It will be Judy, a worker in Marion, IL, at a hotel, making \$8 an hour, working 30 hours a week, \$12,000 in annual wages. She is a diabetic. She has never had health insurance in her life. She goes to work every day. She is 60 years old. She will have health insurance because of this bill. She will be covered by Medicaid, and she won't have to pay for it because Judy's wages are at the low end of workers in America.

I said to her: If you had health insurance, Judy, what would you do?

She said: Senator, I have a few lumps I have been worried about a long time, and I can't afford to go to the doctor. I would go to the doctor.

Thank God she can. Thank God for a lot of others—those who have lost their jobs, who are unemployed, who have exhausted their savings, who stand to lose their homes—who will at least have the peace of mind they will have health insurance. That is going to come too.

If you have a child with a health problem, as many people do, something they call a preexisting condition, this bill will tell the health insurance companies immediately: You can no longer discriminate against that child. You can't turn down the family or that child for coverage. As someone who has been through that experience, I can't tell you what that means, to know that you have that kind of coverage; that your child, with that health care challenge, can go to the doctor they need to see and the hospital they need to be in.

When my wife and I were first married and had our first baby, I was in law school, and we had no health insurance. When our baby had a problem, I had to go to Children's Hospital here in Washington and sit in a room filled with people who had no health insurance. I took a number, and we waited for a doctor. Every time we went, it was a different one. I felt like I had let my family down. At a time when my family needed health insurance, I had not delivered. I know that feeling personally, and I know what it must mean to 50 million Americans who face it today. For 30 million of those Americans, this bill will give them the peace of mind that they have health insurance.

It also says to companies across America, we are going to change the terms of this relationship between health insurance companies and the people they insure. We are going to finally step in on the side of the consumers of America—the families of America, the ones that are so often

turned down because of preexisting conditions, turned down because companies canceled their insurance when they started running into high medical bills. For the first time, these people will have legal rights created by this bill to stand up and be covered and to be confident at the end of the day that they will have the coverage they paid for their whole life.

It is an amazing thing we are considering. In the middle of it, with all these speeches and all the press releases and all the charts and all the time, it is sometimes difficult to focus on the historical impact of what we are about to do at 1 a.m. on December 21, 2009. But if we do this, and do it right; if 60 Senators step forward, as I think they will—commitments have been made—we will make history. It will be reported across America that for the first time in memory, the United States Senate has voted for comprehensive health care reform.

The critics will still be there, and they will say the same thing they did about Social Security and the same thing they did about Medicare: It is too much government. It is not going to work. We shouldn't do it.

Thank God, that counsel was rejected in the 1930s and the 1960s, and it should be rejected on December 21, 2009. We need to stand together for people who otherwise have no voice—the uninsured, many of whom have low-wage jobs, or maybe no jobs at all, and their children, who really can't afford the best lobbyist in Washington. It is time for us to lobby for them.

I know there are a lot of critics of this plan. We have heard them. They have talked about Medicare and what this will do to this bill. But we know what the professionals have told us. This comprehensive health care reform legislation will add 9 or 10 years of solvency to Medicare, put Medicare on sound financial footing. And that is exactly what we should do.

The bill has a bonus. The bonus is that, at a time when we are facing deficits and debt, which have to be taken seriously, this bill charts a path for us to start retiring that debt. The Congressional Budget Office says that over the first 10 years, \$130 billion in debt will be relieved by this bill; then in the second decade of this bill's existence and changes, we are going to find up to \$1.3 trillion in deficit reduction.

There has never been a bill considered on the floor of the Senate that has had that kind of impact on our Nation's debt. It is going to change life not only for uninsured families but even those with insurance. For some, it will give the luxury that we have as Members of Congress.

I think we are the luckiest people on Earth when it comes to health insurance. We team up with 8 million Federal employees and their families, and each year we have an open enrollment.

If we don't like the way we are treated by our health insurance company in the previous year, we can go shopping, just like you would shop for a car or a refrigerator, and pick the right one for your family. We pick the right health insurance for our families. Every American should have that luxury, and we move toward creating that in this legislation.

It was several years ago that I teamed up with Senator BLANCHE LINCOLN of Arkansas and Senator OLYMPIA SNOWE of Maine. We tried to create a program for small businesses in America called the SHOP Act. This program would give those small businesses the same shopping opportunities for health insurance as Members of Congress and Federal employees. I came up with an unlikely ally in the National Federation of Independent Businesses. They decided they wanted to join us.

When their lobbyist called and said he wanted to meet with me, I said: I can't wait to meet you. His organization had done everything in their power to defeat me in every election I had been in, and I wanted to see what he looked like.

He came in and sat down and said: We have to do something about health insurance for small business. We ended up creating an unlikely but powerful alliance of the National Federation of Independent Businesses, the realtors, the Service Employees International Union, Families USA—from both sides of the political spectrum—standing behind the SHOP bill.

The SHOP bill, with some changes, is now part of health care reform. It is an idea that has been endorsed, and it is one that I think is going to make a big difference for individuals. The bill also contains help for small businesses to pay for the premiums. Critics on the other side of the aisle say: Oh, the taxes go up, but the benefits don't start for years. They have missed it because initially we are going to be offering tax assistance to small businesses with 50 employees or fewer. Those who have an average payroll of \$50,000 a worker are going to get a helping hand to buy health insurance not only for their workers but for the owner of the company.

I have seen this in my own life. I have friends who run a small business who have lost their health insurance because one employee's wife had a very sick baby. That is exactly what happened to my friend. They went out shopping for insurance on the open market and it was brutal. My friends were in their early sixties, and they couldn't buy insurance. Everything they could buy was loaded with exclusions and deductibles and copays.

Well, we are going to make sure that businesses have a helping hand with a tax credit, and that helping hand is going to allow them to buy good insurance that covers their employees.

Those on the other side talk about the tax increases in this bill. Let's be very blunt what they are. There is a .9 percent payroll tax increase for individuals making over \$200,000 a year and families making over \$250,000 a year. What it means is this: Roughly \$2,000 a year for families making over \$250,000 will have to be paid to make sure that Medicare is solvent and that this program is funded. That may affect some Members of Congress, with their spouses working. But I don't think it is unfair. It is a tax we should be willing to pay to solve major problems in this country.

There will be taxes on high-end health insurance policies, and it is a very controversial provision with some of my friends in organized labor. But I hope we have hit the right number of \$23,000 and I hope our escalator clause to try to keep up with inflation is a reasonable one. If it is not, we will revisit it. The only law ever written that didn't need amendment might have been the Ten Commandments, and I don't think this bill, as good as it is, will rise to that level. We are prepared to return to it if we need to, to make sure it works and works well, and we have the time to do that.

This is critical. I also know this bill is going to change—you will be able to see the change across America with the construction of community health clinics. One of our great Senators here, BERNIE SANDERS of Vermont, has been a clarion voice on behalf of community health clinics. He knows, as we all do, that these clinics, placed in cities and towns across America, are a lifeline to low-income people so that they have primary care at a fraction of the cost of a visit to an emergency room—good care. I have seen it. I have visited the Erie Clinic in Chicago, Alia Clinic in Chicago. These are good, clean, modern clinics, with people dedicated to health care and dentistry who are helping these people.

We envision 10,000 more community health clinics as a result of this bill, at least, and thousands of primary care physicians to be there to help. That will mean we will be creating, across America, a network of care and peace of mind for people who otherwise have few places, if any, to turn.

I think the day will come soon when this bill, after it is passed, will become evident to America in terms of what we set out to do and what we achieved. If history serves, as it has in the past, many of today's critics will not dwell on the fact that they voted no, but rather say I had some problems with it. I guess it worked out OK. They may be afraid to acknowledge that now. I think ultimately they will have to.

This is clearly an idea whose time has come, and it has come because we have a President with the courage, the political courage, to step up and make sure that we not back away. As Frank-

lin Roosevelt did in Social Security, as Lyndon Johnson did with Medicare, Barack Obama, with health care reform, has challenged this Congress not to ignore a problem that has haunted the Presidencies of seven great men who have previously served in that office.

We need to do our historic duty in the early morning hours so that Americans across this Nation can wake up to the stories on the news that, finally, hope is on the way.

I said the other night when I was talking about this—Senator DODD put Vicki Kennedy's Washington Post column in the RECORD, and I am glad he did so—that this has been called many things. It has an official name. I am going to call it "Kennedy Care." I hope some others will too, because we do it because of the inspiration of a great friend, a great Senator, and a great statesman, Edward Kennedy, who I am sorry cannot be here to enjoy this historic moment. But he led us to this moment. As he said in one of his last columns he wrote about health care: We are almost there. In four hours, we will be there.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. HARKIN. Mr. President, first, I commend Senator DURBIN for his great leadership—he is our assistant majority leader—and for all of his handiwork on this bill. He has been one of our strongest proponents for making coverage more affordable for small businesses. He just spoke about that.

In fact, under the managers' amendment, we have expanded, even more than what we did in the original bill, credits for small businesses. These credits now start in 2010. They start next year. They are available to more small business firms than we had in the original bill—all of that, thanks to the hard work and intervention by Senator DURBIN.

I might note we have a provision also in the managers' amendment relating to cardiac care, congenital heart disease. I know Senator DURBIN had a personal tragedy in his own family because of that. So we now have a new program to track the epidemiology of congenital heart disease; it is section 10411, in case anyone is taking notes. It expands on research at NIH on congenital heart disease. We are grateful to Senator DURBIN for including that.

Basically, of all the things we have for consumer protection, consumers of America have no more dogged champion here in the Congress than Senator DURBIN of Illinois. No matter what it is we are passing here, Senator DURBIN always looks to see how consumers are affected. He has done that also on this health care bill, by making sure that consumers have better protections and health care is more affordable. I personally thank Senator DURBIN for all of his hard work on this bill.

As Senator DURBIN said, and as our leader, Senator DODD, said, in about 4 hours—a little less than 4 hours now—the historic vote will take place in the Senate. It will be the defining vote of my Senate career. That has been about 25 years, I guess, I have been here. It will probably be the defining vote for all of us during our tenure here in the Senate. It will be the cloture vote on the managers' package. From that we move forward.

I hope after that cloture vote, and after we take that cloture vote, the minority side would see fit, then, since we have the 60 votes, after we have crossed that hurdle, that perhaps they would be willing to close up the debate a little bit sooner than ending on Christmas Eve. But if that is their desire—I mean, they have the rules. We will abide by the rules. If the Republicans want to exercise every single right they have under the rules, they can keep us here until Christmas Eve. There is no doubt about it. But to what end, I ask? To what end?

We are going to have the vote at 1 o'clock that is going to require the 60 votes. Then why stay here until Christmas Eve to do what they know we are going to do, and that is to have the 60 votes on the managers' amendment, on the substitute, and on the underlying bill? I hope our Republican leader and others on the other side would perhaps see that it is not in the best interest of the Chamber, it is not in the best interests of the country.

I know one of the Senators on the other side was talking about waste today. I am thinking, you know, this is kind of a waste, that we are here yakking about this and doing it up until Christmas Eve, when we could collapse all these votes and get it done tomorrow. We could actually be done here tomorrow with this whole bill if the Republicans would see fit. Like I say, it is up to them. They can keep us here if they want to. But the managers' amendment we are going to vote on at 1 o'clock—again, I keep hearing all day today from the Republicans that they have not had a chance to read it, we are rushing it, and it just came out the other day. The Republicans had it read word for word. The few times I came on the floor during the reading, I didn't see many Republicans over there listening to it. You have to wonder, did they all go home and read it? They made the clerk read it. Why didn't they sit here and listen to it? They would have found out what was in it if they were so interested.

Anyway, this is all gamesmanship around here right now. People of America understand that, too. They know we are going to pass health reform, and the first vote is going to be at 1 a.m. this morning. I heard the Senator from Arizona earlier today talking about why should we have it at 1? Why can't we have it at 9 a.m. in the morning? He

said the majority leader, Senator REID, has the power. He could move it to 9 a.m. in the morning and we would not have to bring people here at 1 a.m. He referred to the Senator from West Virginia, Senator BYRD, by name—elderly, frail, but he shows up here to vote. But dragging him out of bed at 1 in the morning to come here? He said, Why don't we do it at 9 in the morning?

I thought that was a pretty good idea. When I got to the floor a couple of hours ago, I asked unanimous consent at that time that we have the vote at 9 a.m. but that the hours from 1 to 9 be counted for purposes of the 30 hours. The Republicans objected. So much for their concern for the Senator from West Virginia.

We are on the cusp. We are going to expand small business credits. We are going to reduce administrative costs. We are requiring insurance companies to spend 80 to 85 percent of their income on health care—on health care, not fancy corporate offices, not high, expensive CEO salaries of millions of dollars a year, not fancy jets, but 80 to 85 percent must be spent on health care and paying medical claims.

As Senator DURBIN said, we make major investments in community health centers—10,000 more community health centers in America. We are investing in the National Health Service Corps to get more young people to serve in the National Health Service Corps. We have new protections for patients, access to a primary care provider of their choice, and an important provision championed by the Senator from Maryland—I think Senator CARDIN—to provide access for women in their choice of an OB-GYN. In other words, they get to pick who their OB-GYN is, not their primary care provider, not the health insurance company, not anyone else. The individual woman can pick her own OB-GYN.

The amendment we have before us immediately allows children to stay on their parents' health insurance until they are age 26. The managers' amendment also prohibits insurance companies from imposing preexisting conditions on children up through the age of 18 right away, next year. Think about that. Think about what that means to a family who has a child who maybe was born with a defect—something that is chronic. The insurance companies tend to exclude them. Our bill says that beginning next year they cannot do that anymore to children. That is a big deal for so many families in this country who have kids who have been afflicted with a birth defect or maybe something happened, maybe they had an accident, maybe they had an illness early in life that has turned chronic. This is a very big deal for those families.

Last, for someone like me who represents a lot of rural areas and small towns, we have increased, in the man-

agers' amendment, more workforce. We are going to have more people for rural and underserved communities. We will increase the funding in the training programs for rural health providers, so small towns and rural areas of the country have a big boost in the managers' amendment.

We are going to put more money and more loan repayments for people who want to serve in underserved areas, in rural areas, to make sure they do not have to go someplace where they get a lot of money to pay back their debts for medical school. We are going to be providing some of those payments if they serve in a rural area, an underserved area.

I know we have now another hour to listen to the Republicans tell us why we ought to put this off for another century or so, I suppose. The people of America know the time has come now. We are committed to this. At 1 a.m., we will have the 60 votes, and we will get this passed before Christmas. It will be one of the best Christmas presents this Congress has ever given the American people.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, the reason I wasn't on the floor for a large part of yesterday is I was wading through this amendment and also the CBO score and also the Joint Tax score. Then I had to talk to experts who could interpret what is in there. The American people don't have that privilege. They have to rely on the stuff they are hearing on the floor. I can tell you, they are pretty upset. I get letters and calls from all over the country saying: Stop this bill any way you can. Make them get it right. I have to tell you, some of those from other States, they are saying: My Senator is not listening to me. I am counting on you.

I rise to speak on the issue of the health care reform. I rise with a great sense of disappointment as I reflect on the debate that might have been. From the very start, I have said we need to reform our health care system. Everyone agrees we need real changes that will allow every American to purchase high-quality, affordable health insurance. Not a single one of my Senate colleagues on either side of the aisle supports the status quo. The argument that Republicans support the status quo is simply false. We understand the current system fails too many Americans. We want to support reforms that will provide real insurance options to all Americans and help lower the cost of that insurance. I have said from the start of this year—and, frankly, throughout my 13 years in the Senate—that true reform should be developed on a bipartisan basis so the legislation will incorporate the best ideas from both sides and will have the broad support of the American people. That

should be a prerequisite to any proposal that will affect nearly 20 percent of our Nation's economy and the health care of every single American.

Unfortunately, that was not the process followed in developing this bill. Instead, we have the Reid bill, which was developed in secret without the input of a single Republican. This morning an adviser to President Obama was asked about the partisan nature of this bill and the overwhelming opposition of the American people. His response spoke volumes of what is wrong with Washington today. He essentially responded that the American people don't understand what is in this bill and that once it is implemented, they will come to support it. In plain English, the White House is saying: Washington knows best. That attitude is part of the reason why support for Congress is at a historic low and why public support for this bill is so weak.

Instead of having a bill that will provide greater choices and reduce costs, we have a bill that will do the opposite. The Reid bill will deny consumers the ability to make choices and instead substitute the judgment of government bureaucrats who will decide what kinds of insurance you will be allowed to purchase. The bill also fails to address the most important issue for the majority of Americans. It fails to do anything to help reduce the cost of health care. President Obama promised the American people that health care reform would reduce health care costs. Yet this bill fails to deliver on the President's promise.

According to the President's own independent Medicare Actuary, this bill will actually increase how much we spend on health care. According to Rick Foster, the person from the administration who keeps track of all Medicare and Medicaid spending, the bill increases health care costs \$234 billion more than if we did nothing. That is a huge cost.

In addition to increasing total costs, the Reid bill will increase our national debt and threaten the health care provided to millions of Medicare beneficiaries. Some of my Democratic colleagues are going to come down to the floor and argue that the Reid bill will reduce the deficit and extend the solvency of the Medicare Program. They have been doing that for days. They will even cite the Congressional Budget Office to support their arguments. I hope every American hears those arguments and remembers a few inconvenient truths my Democratic colleagues are going to forget to mention. The way my colleagues on the other side of the aisle were able to force CBO to conclude that the Reid bill will not increase the deficit was by requiring them to use budget gimmicks and assumptions that would make Bernie Madoff blush.

Every time you hear one of my Democratic colleagues argue that the

bill reduces the deficit, you should ask that Senator if he believes that Medicare will cut physician payments by 21 percent in March. That is right. While the Reid bill cuts over \$470 billion from the Medicare Program, it will also require that every doctor treating Medicare patients have his or her payments cut by 21 percent in just 2 months. That is what CBO had to assume when they did their estimate. If you believe Congress will never allow this to happen—and we never have—you cannot believe this bill will actually reduce the deficit. The truth is Congress has never allowed that level of cut. Senate Democrats, however, chose to ignore this reality and relied on the promise of a cut to make their bill add up. You should also ask my Democratic colleagues if they believe that Medicare payments to doctors will be cut more than 45 percent over the next decade.

Again, that is what the Reid bill required CBO to assume. If you don't think that will happen, then you cannot believe this bill reduces the deficit.

You should also ask my Democratic colleagues if they think that within a decade one out of every five hospitals, nursing homes, and home health agencies will be operating at a loss because of the unsustainable payment cuts in this bill. We just got a revised CBO estimate that says there was a little error there, and so there will be less savings by \$600 billion. According to the administration's Actuary, Rick Foster, that is exactly what is going to happen if the Reid bill is enacted. He said if these policies have to be modified, such changes would likely result in smaller actual savings. This means this bill will not reduce the deficit.

Finally, you should ask anyone arguing that this bill reduces the deficit whether they believe Medicare patients will not be able to get the care they need. Again, the administration's own Actuary says payment cuts in the Reid bill could jeopardize access to care for beneficiaries. I do not know if my colleagues believe these things will happen. Taking note of these facts pushes up the total cost of the bill well over \$1 trillion and destroys any pretense of budget balance. Unless all the things CBO was required to assume actually happen, this bill will actually increase the deficit.

Health care reform has to be truly paid for. Why? Because the Federal Government has maxed out its credit cards. Our out-of-control spending is now even driving down the value of our money. As the government borrows more money to finance even more spending, the devalued dollar will drive up the cost of goods. Oil is a good example. Take a country such as Saudi Arabia, which is already raising prices for their oil to compensate for the lower value of our dollars. This means every American will end up paying more for a gallon of gas because of our

failure to address growing deficits. If we are going to enact real health reform, we need to use honest accounting and not budget gimmicks and fake assumptions that we all know will not happen.

We should pay for expenses such as fixing doctors' Medicare payments, and we should not delay the start of spending 4 years after the start of the new taxes just to make the bill look good over 10 years.

The problem for the President and my Democratic colleagues is their bill is being sold on the strength of accounting tricks that make it appear that it will not add to the deficit. In case they have not noticed, they are not fooling the American people. It showed up in August. It showed up every time since then. That is why we are not getting to go home on weekends. We don't want the Democrats to hear from the people at home who are upset about this.

In a recent poll, 68 percent of Americans said they believe the Democrats' health reform bill will increase the deficit. They are right. The American people understand that if the Reid bill is enacted, deficits will increase. They are right. The same is true for the claims that the Reid bill will extend the solvency of the Medicare Program or reduce beneficiary premiums. That can only happen if you make all the assumptions I previously described. If you don't believe those things will actually happen, then this bill will do nothing to extend Medicare or lower premiums.

Besides driving up the deficit, the Reid bill will also eliminate more than 1 million jobs. The mandate that employers offer health insurance or pay a penalty will be a massive new job-killing tax. Our national unemployment rate is at 10 percent. The majority leader is attempting to cut off debate on a bill and force its passage before Christmas, again, because he doesn't want the people to hear what is happening, but we are going to see that that does happen—that will force employers to eliminate jobs and reduce wages. Businesses do not deny health care to their employees because they are cruel or mean-spirited. They do it because they can't afford it.

Most businesses that do not provide coverage do so because they cannot afford health insurance. They can't afford it for their employees or for their own families. They have looked at the cost and figured out they cannot pay for health care and still stay in business. The Reid bill fails to do anything to actually lower the cost of health insurance, which might mean these businesses could actually afford health insurance. Instead, it will place a new tax on these businesses, which the CBO has said will lead to these businesses reducing wages for their workers and

eliminating jobs. That is why the National Federation of Independent Business, which represents small business across America, estimated the Reid bill would cause 1.6 million jobs to be eliminated. That is why they said the Reid bill will create a reality that is worse than the status quo for small business.

The worst thing about the Reid bill is not how it will increase the deficit or kill 1 million American jobs. The worst thing about the Reid bill is it will reduce the quality of health care we all receive. No longer will you and your employer be able to choose the health insurance that best meets your needs. The government will tell you what kind of insurance you have to buy, and if you don't, you are told the government will place a fine on you. Under the Reid bill, the government will tell your health plan which types of doctors they have to contract with, irrespective of whether that is a doctor you want or need to see. The Reid bill also traps 15 million Americans in the worst health care program in America. Approximately half the people who get the promised health care coverage under the Reid bill will get it through the broken Medicaid Program.

States already use price fixing to limit how much they have to pay doctors under the Medicaid Program. That is why as many as 40 percent of all doctors will not see Medicaid patients. I have said, if you can't see a doctor, you don't have health care. Yet that is exactly what the Reid bill will do: Promise 15 million people coverage but trap them in a system where we know they will not be able to get the care they need.

If anyone doubts what effect the Reid bill will have, they only need to look at Massachusetts. The Massachusetts plan was the model for many of the reforms in this bill. The problems they are encountering give us a good indication of what will happen to us all if the Reid bill is enacted.

To make the Massachusetts reforms work, they now have a 10-member commission trying to impose a global payment system. Under this system, doctors and hospitals will be forced to join large networks and be paid at a set rate for each patient. This is the same kind of government control we already see with Medicaid. The results of these changes are equally predictable. Fewer doctors will be willing to see people at the exact time when the number of people seeking care is increasing.

These are just some of the more serious problems with this bill. Because many of my colleagues want to be able to discuss the problems with this bill, I have limited my remarks for now. Because the bill was drafted behind closed doors and thrust upon the American people without time to consider all the ramifications, I am sure we will find more problems with the legislation after this rushed vote.

Over the next few days, I plan to lay out specific and concrete alternatives to how we could do better. I have been doing that for a long time, but they have not been accepted. Republicans have many ideas on how to make this bill better, including several that have bipartisan support. However, if Senator REID is successful in cutting off debate, we will never get the chance to discuss any of these ideas.

Health care reform is too important for too many Americans to be rammed through the Senate with little or no debate on the weekend before Christmas. It appears my colleagues understand how deeply unpopular this bill is with the American people, and they want to force it through when they believe most Americans are not paying attention. I wish to assure my Democratic colleagues that the American people are watching, and the voices of August will only grow louder. They will remember the vote to cut off debate on this bill for a long time because they understand what it will mean for their health care and the future of this country. The person with whom I served in the Wyoming Legislature sent me a little note and said: If it is broken, don't break it more. That is what we are doing.

I have some articles I wish to include in the RECORD. One is by Howard Dean that suggests this reform falls short. Of course, he is the former chairman of the Democratic National Committee. Another is an editorial by Matthew Dowd, a political analyst for ABC News, who talks about the danger of success and where the polls are on this and says:

If this legislation passes, Democrats will be held accountable for any failures or problems in the system. So if any Americans' insurance premiums rise, they will blame the Democrats. If patients have to wait in line at emergency rooms, it will be seen as the Democrats' fault. If health care costs don't drop, the Democrats will face the wrath of the electorate.

I also have an editorial by E.J. Dionne, Jr., about Democratic fratricide and an article by George Will, where he says "More talk, less support." The more we talk, the less support there is for this bill.

Finally, I have an editorial by David Broder, of December 18, 2009.

I ask unanimous consent to have these articles printed in the RECORD.

There being no objection the material was ordered to be printed in the RECORD as follows:

[From the Washington Post, Dec. 17, 2009]

REFORM THAT FALLS SHORT

(By Howard Dean)

If I were a senator, I would not vote for the current health-care bill. Any measure that expands private insurers' monopoly over health care and transfers millions of taxpayer dollars to private corporations is not real health-care reform. Real reform would insert competition into insurance markets, force insurers to cut unnecessary adminis-

trative expenses and spend health-care dollars caring for people. Real reform would significantly lower costs, improve the delivery of health care and give all Americans a meaningful choice of coverage. The current Senate bill accomplishes none of these.

Real health-care reform is supposed to eliminate discrimination based on pre-existing conditions. But the legislation allows insurance companies to charge older Americans up to three times as much as younger Americans, pricing them out of coverage. The bill was supposed to give Americans choices about what kind of system they wanted to enroll in. Instead, it fines Americans if they do not sign up with an insurance company, which may take up to 30 percent of your premium dollars an spend it on CEO salaries—in the range of \$20 million a year—and on return on equity for the company's shareholders. Few Americans will see any benefit until 2014, by which time premiums are likely to have doubled. In short, the winners in this bill are insurance companies; the American taxpayer is about to be fleeced with a bailout in a situation that dwarfs even what happened at AIG.

From the very beginning of this debate, progressives have argued that a public option or a Medicare buy-in would restore competition and hold the private health insurance industry accountable. Progressives understood that a public plan would give Americans real choices about what kind of system they wanted to be in and how they wanted to spend their money. Yet Washington has decided, once again, that the American people cannot be trusted to choose for themselves. Your money goes to insurers, whether or not you want it to.

To be clear, I'm not giving up on health-care reform. The legislation does have some good points, such as expanding Medicaid and permanently increasing the federal government's contribution to it. It invests critical dollars in public health, wellness and prevention programs; extends the life of the Medicare trust fund; and allows young Americans to stay on their parents' health-care plans until they turn 27. Small businesses struggling with rising healthcare costs will receive a tax credit, and primary-care physicians will see increases in their Medicare and Medicaid reimbursement rates.

Improvements can still be made in the Senate, and I hope that Senate Democrats will work on this bill as it moves to conference. If lawmakers are interested in ensuring that government affordability credits are spent on health-care benefits rather than insurers' salaries, they need to require state-based exchanges, which act as prudent purchasers and select only the most efficient insurers. Sen. John Kerry (D-Mass.) offered this amendment during the Finance Committee markup, and Democrats should include it in the final legislation. A stripped-down version of the current bill that included these provisions would be worth passing.

In Washington, when major bills ear final passage, an inside-the-Beltway mentality takes hold. Any bill becomes a victory. Clear thinking is thrown out the window for political calculus. In the heat of battle, decisions are being made that set an irreversible course for how future health reform is done. The result is legislation that has been crafted to votes, not to reform health care.

I have worked for health-care reform all my political life. In my home state of Vermont, we have accomplished universal health care for children younger than 18 and real insurance reform—which not only bans

discrimination against preexisting conditions but also prevents insurers from charging outrageous sums for policies as away of keeping out high-risk people. I know health reform when I see it, and there isn't much left in the Senate bill. I reluctantly conclude that, as it stands, this bill would do more harm than good to the future of America.

THE DANGER OF SUCCESS

(By Matthew Dowd)

President Obama needs an exit strategy. I am not referring to Afghanistan or Iraq (though there are quite a few similarities between the situation Obama is in on health-care reform and the political difficulties President George W. Bush faced on Iraq). Congressional Democrats and Obama are headed toward a "catastrophic success" politically if they pass health-care reform in its current legislative form. And catastrophic success was a term then-President Bush used on Iraq when he acknowledged the great initial victory but didn't take into account the long-term calamity and costs.

I am not seeking to argue the substance of health care and the merits or demerits of the bills, and will leave that to experts in policy and its effects. I am talking about the politics of the legislation and the effect it is likely to have on Obama and Democrats in Congress.

Unlike many other pundits and political experts in both parties, I think that passage of a bill by the Democrats at this point will be politically damaging to both the president and congressional Democrats. Conversely defeat of the legislation is much more likely to hurt Republicans in Congress.

The latest Post-ABC News poll shows the president's overall approval rating at a new low of 50 percent—about the rating President Bush had going into the November 2004 election, when Democrats said Bush was ripe for defeat.

There are many reasons for this drop in support for Obama. The stagnant economy is the biggest factor, but close behind is the fact that the administration is pushing health-reform efforts that have polarized the electorate, and that independent and swing voters have moved against in large measure.

As Wednesday's Post-ABC poll shows, a majority of Americans believe that if this bill passes, their healthcare costs will rise, the federal deficit will increase, the costs of the overall health-care system will climb, and their own care would be better if the system stays as is. Democrats (including former president Bill Clinton) claim that they need this bill to pass for political reasons. But let's examine that. At present, a majority of Americans are against the effort, the legislation lacks bipartisan support, the costs of the reforms are upfront, and the benefits won't kick in until after the 2012 elections. When has that ever been a formula for political success?

If this legislation passes, Democrats will be held accountable for any failures or problems in the system. So if Americans' insurance premiums rise, they will blame the Democrats. If patients have to wait in line at emergency rooms, it will be seen as the Democrats' fault. If health-care costs don't drop, the Democrats will face the wrath of the electorate.

Many Democrats, including people in the administration, blame poor marketing for their difficulties in passing health reform. They say they haven't gotten the message out. But advocates of reform have spent millions on advertising and lobbying this year. And Obama, who many say is the best orator

ever to occupy the White House, has pushed for this legislation constantly over the past six months. In that time, support for Obama's handling of health-care reform has dropped by more than a net of 30 points.

Yet before Republicans cheer that they may defeat this effort, they should beware what they wish for. A vast majority of Americans still believes that we need fundamental health-care reform. If the legislation fails, Democrats can blame Republicans by saying reform was in sight and the GOP blocked it without offering a real alternative to decrease costs and increase access.

The dominant issues today are the economy and jobs, and the public doesn't see either party making these a real priority. Further, polls show trust in government handling of domestic issues remains at historic lows. What most voters hear from Washington these days is squabbling over health reform involving a government role they don't trust and don't want.

My advice? Leaders in Washington ought to concentrate on what matters to Americans, not on what they think should matter to voters. Come up with a health-care bill that draws real bipartisan support. And before pushing a bigger role for government, begin to restore trust in the government's ability to do even small things. Democrats pushing so hard for success on health care could find themselves in a situation resembling President Bush's situation on Iraq. They could topple the statue and win the day, but lose politically over the coming months and years.

DEMOCRATIC FRATRICIDE

(By E.J. Dionne, Jr.)

Here's what Democrats need to ponder: Can they prosper in the absence of George W. Bush?

His presidency was a tonic for Democrats and led to a blossoming of political creativity on the center-left not seen since the 1930s. No tactic, no program, no leader ever did more to catalyze the party than the rage Bush inspired.

The whole effort was summarized nicely by the party's slogan in 2006, "A New Direction for America." There was no need to specify north or south, east or west, up or down. Compared with Bush, any alternative destination seemed appealing. And by becoming the apotheosis of the fresh and the new, Barack Obama emerged as the most attractive guide to this unknown promised land.

The consequence is that Democrats must govern in one of the most difficult periods in American history while managing a sprawling coalition and working through a political structure near the point of breakdown—largely because of the dilapidated state of that dysfunctional and undemocratic partisan hothouse, the United States Senate.

Especially if you take into account the scope of the problems confronted, Democrats could argue they are doing pretty well. It's no small thing to save the economy from collapse. Winding down two wars is no picnic.

But politically, the Democrats are in trouble. They are at one another's throats over healthcare legislation that should be seen as one of the party's greatest triumphs. They are being held hostage by political narcissists and narrow slivers of their coalition.

When Democrats make deals, they are accused of selling out. When they fail to make deals, they are accused of not reaching out. Moderates complain that their party has gone too far left. Progressives chortle bitterly at this, asking: What's left-wing about policies that shore up banks and protect drug companies?

Rural-state centrists insist on more fiscal discipline—as long as it doesn't affect farmers and small-town hospitals. Progressives ask why debt should be the priority when so much more needs to be done to relieve unemployment.

This is a recipe for political catastrophe. An increasingly bitter and negative Republican Party may not be able to win the midterm elections, but Democrats definitely can lose them.

Their fractiousness is dispiriting to their supporters, which set off this urgent warning bell in the latest Post-ABC News poll: For the first time in his presidency, more Americans strongly disapprove of Obama's performance in office (33 percent) than strongly approve (31 percent).

Putting aside margins of error and the fact that the Dec. 10-13 poll showed a sudden bump in Republican identification, that might be a statistical anomaly. The point is that the trend is perilous. In June, strong approvers of Obama outnumbered strong disapprovers 36 percent to 22 percent. Ardor and energy are switching sides.

There are no instant cures, but there is one thing that must be done fast: Democrats need to agree on a health bill and sell it with enthusiasm and conviction. Their own turmoil and back-stabbing are making what is a rather good plan look like a failure while convincing political independents that they are a feuding gang rather than a governing party.

They have to focus in 2010 on immediate job creation and long-term economic mobility while explaining how aggressive measures to boost the economy now go hand in hand with eventual deficit reduction.

Congressional moderates must understand that their fate is linked with the party's ability to govern, and grass-roots progressives have to be less on a hair trigger to shout betrayal. (I wish I knew what to do about Joe Lieberman.)

For his part, Obama has not appreciated until recently how closely he has been tied to Wall Street and the banks. He has been too reluctant to underscore how much of Washington's dysfunction has been pushed to new levels by the Republican Party's decision to grind the Senate to a halt. He has tried to make clear the size of the mess he inherited from Bush, but has not sold the country on the extent to which he has begun to clean it up.

Americans may not be sold on anything until unemployment starts dropping. Even then, Democrats will have a tough time making the sale if the process that produced the health-care bill comes to define the image of how they govern the country. Democrats have every right to blame Bush for the fix we're in. They can't blame him for the problems they're creating for themselves.

MORE TALK, LESS SUPPORT

(By George F. Will)

Rushing to lock the nation into expensive health-care and climate-change commitments, Democrats are in an understandable frenzy because public enthusiasm for both crusades has been inversely proportional to the time the public has had to think about them. And the president pushing this agenda has, with his incontinent hunger for attention, seen his job approval vary inversely with his ubiquity. Consider his busy December—so far.

His Dec. 1 Afghanistan speech to the nation was followed on Dec. 3 by his televised "jobs summit." His Dec. 8 televised economic speech at the Brookings Institution was

followed on Dec. 10 by his televised Nobel Peace Prize acceptance speech, which was remarkable for 38 uses of the pronoun "I."

And for disavowing a competence no one suspected him of. ("I do not bring with me today a definitive solution to the problems of war." Note the superfluous adjective) And for an unnecessary notification. ("Evil does exist in the world.") And for delayed utopianism. ("We will not eradicate violent conflict in our lifetimes." But in someone's.) And for solemnly announcing something undisputed. (There can be a just war.) And for intellectual apoplexy that should get speechwriters fired and editors hired. ("We do not have to think that human nature is perfect for us to still believe that the human condition can be perfected." If the human "condition" can attain perfection anyway, human nature cannot be significantly imperfect.)

Then on Dec. 13, he was on "60 Minutes" praising himself with another denigration of his predecessor, a.k.a. "the last eight years." (Blighted by "a triumphant sense about war.") When Attorney General Eric Holder announced last month that five suspected terrorists would be tried in federal courts, he said: "After eight years of delay. . . ." When the U.S. Preventive Services Task Force made the controversial recommendation that women should get fewer mammograms, Secretary of Health and Human Services Kathleen Sebelius said: This panel was appointed by the prior administration, by former President George Bush." In congressional testimony, Treasury Secretary Timothy Geithner almost deviated from the script. He said the Obama administration began after "almost a decade"—slight pause—"certainly eight years of basic neglect."

Abroad, the fruits of the president's policy of "engagement" have been meager: Witness Iran continuing its nuclear program and China being difficult about carbon emissions. Here is a history lesson for an administration that, considering itself the culmination of history, is interested only in the past eight years of it:

At a Vienna summit in June 1961, President John Kennedy, fresh from his Bay of Pigs fiasco, was unnerved by the brutal disdain of Soviet Premier Nikita Khrushchev, who considered Kennedy callow. Britain's Prime Minister Harold Macmillan astutely noted that Kennedy had "met a man who was impervious to his charm."

A person can be a novelty only once, and only briefly, and charm, like any commodity, when used uneconomically, becomes a wasting asset. All this is pertinent to the Senate health-care debate, now coming to a curious climax amid another glut of careless grandiosity.

Supporters of the Senate bill say it will insure the uninsured. The Congressional Budget Office says 24 million of the 46.3 million uninsured will remain so. Supporters say it will lower aggregate and individual health-care spending. The government's Centers for Medicare and Medicaid Services says the nation's health-care spending and insurance premium costs will increase.

Today there are more independents than Democrats, more independents than Republicans, and according to a recent Gallup poll, independents approval of the Democratic-controlled Congress (14 percent) is lower than Republicans' approval (17 percent). This is partly a function of the majority party's health-care monomania. Consider what happened recently in Kentucky.

There a Republican candidate succeeded in nationalizing a state Senate race. Hugely

outsent in a district in which Democrats have a lopsided registration advantage, the Republican, by 12 points, won a seat in Frankfort by running against Washington—against Nancy Pelosi, Harry Reid and their health-care legislation.

A CNN poll shows 36 percent of the public in favor of what the Democratic Senate is trying to do to health care, 61 percent opposed. It is clear what the public wants Congress to do: Take a mulligan and start over.

So Republicans can win in 2009 by stopping the bill or in 2010 by saying: Unpopular health-care legislation passed because of a 60-40 party-line decision to bring it to a Senate vote. Therefore each incumbent Democrat is responsible for everything in the law.

DISHING OUT SOME SHOCK ON DEBT

(By David Broder)

The 34 names are familiar to anyone who has followed economic policy in Washington for the past generation, one-third of them former chairmen or members of key committees of Congress, seven of them former comptroller generals of the United States, seven of them former directors of the Congressional Budget Office and one of them—Paul Volcker—the former chairman of the Federal Reserve System and now an adviser to President Barack Obama.

Both political parties are well represented in their number. But they came together this week as signatories of a nonpartisan manifesto, essentially a stark warning to the president and Congress and a plea for action on behalf of the next generation.

The United States, they unanimously said, is facing "a debt-driven crisis—something previously viewed as almost unfathomable in the world's largest economy."

Under the impact of the worst economic calamity since the Great Depression, the federal government ran a deficit of \$1.4 trillion this past year. The rescue effort was necessary, but in 2009 alone, the public debt grew 31 percent from \$5.8 trillion to \$7.6 trillion, rising from 41 percent to 53 percent of gross domestic product (GDP).

Unless strong remedial steps are taken, the debt is projected to rise to 85 percent of GDP by 2018 and 100 percent four years later. Barely a dozen years from now, these deeply experienced folks say, the American economy will likely be in ruins.

All of us have become accustomed to hearing lamentations about the changes in the annual budget deficits, the gap between federal revenues and spending in a particular year. But this commission deliberately shifted its focus from the deficit to the underlying debt.

The reason was explained to me by Alice Rivlin, formerly a director of both the Congressional Budget Office and the Office of Management and Budget. "Previously, when we were worried about deficits, we could take comfort in the fact that the debt was not very high relative to the economy," she said. "But now that debt has shot up. The cushion has gone. If the same thing (a severe recession) happened again, we wouldn't be able to borrow to deal with it."

In addition to robbing us of the flexibility to deal with future crises, the rapidly rising debt level could push up interest rates, threatening economic recovery, slow the growth of wages, depress living standards, make the United States even more dependent on foreign lenders and leave us vulnerable to a shock wave if those lenders lose confidence in our ability to repay the loans.

These experts—writing under the auspices of the Peter G. Peterson Foundation, The

Pew Charitable Trusts and The Committee for a Responsible Federal Budget—suggest a series of steps.

First, they want Obama in his State of the Union address to urge Congress to join in a pledge to stabilize the debt, at no higher than 60 percent of GDP, by 2018. This would require actions by both Congress and the administration to start reducing the projected annual deficits, which add to the debt. That would make debt-management an economic priority once the effects of the current severe recession have eased. To assure the pledge is kept, those who signed this report would ask Congress and the president to set up an enforcement mechanism that would automatically reduce spending or increase taxes when the debt target is missed in any year between 2012 and 2018.

This is stiff medicine, but the message of this report is that temporizing on this issue poses such perils to the nation's future that the risk is unacceptable.

When Congress this week ducked its responsibility again by deciding to enact a temporary, two-month increase in the debt ceiling, the need for a shock treatment like this report could not be plainer.

Mr. ENZI. I yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

Mr. CORNYN. Mr. President, I thank the Senator from Wyoming for his important leadership. He is absolutely right. As much as we would all like to be home with our families, especially at this time of year, this battle to inform the American people about what is about to happen to them is too important for us to simply give up or acquiesce to what the Senator from Iowa seems to think is inevitable.

There is nothing inevitable about this. The only thing I think inevitable about it is, in light of the unpopularity of what is being jammed down the throats of the American people, there will be a day of accounting. We do not know when that day of accounting will be. Perhaps one of the first days of accounting will be election day 2010. I do not understand how people who are elected to represent their constituents can try to impose something that is so obviously unpopular with their constituents and expect somehow to be patted on the back and told: Well, you are right, you are smarter than we are. You do know better than we do what is better for our families and what we ought to be limited to when it comes to health care choices.

I think that is an upside down way of looking at the world. Maybe that is the reason why we have such disparate views of what we are engaged in here. Clearly, on the other side of the aisle, they believe that government is the answer. They believe government can do a lot better than the private sector in providing choices and providing cost controls. Well, the only way government can do that, of course, is by price controls, which we have seen happen in Medicare and Medicaid, which have not worked very well. Here we are 5 days before Christmas, and we are going to be having a vote tonight at 1 a.m. on a

2,733-page health care bill that we got yesterday morning. We do not know what is in the bill. We are still reading, and apparently the Congressional Budget Office is still trying to figure out the impact of the bill. They have already had to correct one mistake because they are being asked to rush to judgment on this bill that will affect one-sixth of our economy and all 300 million Americans.

But we do know this: We do know it will cut Medicare by \$470 billion. Medicare is paid for by employers and the workers into a trust fund, and that trust fund is going to be pilfered, robbed, in order to create a brandnew entitlement program that the beneficiaries of that entitlement program never paid for as did the beneficiaries of Medicare. That is one part of this. We also know it is going to increase taxes by \$518 billion.

We already know President Obama's promise as to people making less than \$250,000 a year will not be kept under this bill, and that this bill, according to the National Federation of Independent Business, will impact small businesses and their ability to create jobs and retain workers during one of the worst recessions we have had in this country.

Then, of course, we know this bill—without the phony accounting gimmicks, such as implementing a bill 4 years into a 10-year budget window—will actually fail in universal coverage. It will leave 23 million people uninsured, and it will cost roughly \$2.5 trillion, and it will increase the cost of premiums for people who already have insurance.

What is so disgusting about this process is, this exactly confirms the most cynical view that the American people have about Congress and Washington, DC. Rather than a change in that process—one that is more transparent, one in which everybody's views are considered, and where we try to come together in a bipartisan consensus for a solution—this is going to be passed strictly along party lines by a political party and by their leadership who apparently care more about chalking up a victory, albeit a Pyrrhic victory, rather than listening to their constituents. The American people want Washington to start over again. Fifty-six percent of voters in this most recent poll said they want us to stop this bill and start over.

We know this process is a product of deals struck behind closed doors with special interest groups and their lobbyists. The pharmaceutical industry got 24 Democrats to switch their votes on reimportation. What is that all about? To preserve a special deal cut behind closed doors? The insurance industry will get \$476 billion of tax money from this bill. Then other parts of the health care community are going to be exempted from cuts by the payment advi-

sory board because they cut their deal behind closed doors. We know this bill is being attempted to be jammed through when most people are spending time with their families because of the Christmas season.

Even the distinguished majority whip, last week, said: I am in the dark almost as much as other Senators are. He said: I am in leadership. So this bill has been written with a small group of people behind closed doors, including the Senator from Nebraska, who spent 13 hours—13 hours—on Friday behind closed doors with Democratic leadership and White House officials. In the meantime, we are left completely in the dark as to what is in this bill other than what we could glean in the limited time we have been given.

After the ill-fated stimulus bill passed in the first part of the year, I remember we got that bill about late Thursday night, and then we were asked to vote on it less than 24 hours later—less than 24 hours later. We—like that—spent \$1.1 trillion, including the interest, in this stimulus bill that was supposed to keep unemployment below 8 percent. Well, we know how well that worked with unemployment going as high as 10.2 percent and now at 10 percent. One thing the American people told us after that is, they want us—well, I almost hate to say it, it seems so simple and straightforward—they want us to read the bill. They want us to understand the bill. They want to be able to read it and understand it before they give their consent to our voting for it. They want to know what the impact is going to be on their coverage. Is it going to raise their taxes? Is it going to raise their premiums? Is it going to cut into their Medicare benefits? If you are a Medicare Advantage beneficiary, we know it will for 11 million Americans, including half a million in Texas.

Then there was this discussion, and I guess this is all for show too. This was not, obviously, a sincere effort where we had eight Democrats who wrote a letter on October 6 to the majority leader and said they want the bill 72 hours before the first vote. Well, guess what. This historic vote we are going to have at 1 in the morning will occur 40 hours, roughly, after we got the bill. So much for 72 hours. We know the CBO, the Congressional Budget Office, score, the cost, their estimate, even with the phony assumptions that are included in this bill, will only be available for 37 hours.

Then we find out there are other sweetheart deals which makes this begin to stink to high heaven—things such as special legislative language saying the State of Nebraska—the State of Nebraska—gets a special pass from new Medicaid mandates. Vermont and Massachusetts have special deals. Then there is a \$100 million earmark for an unknown hospital. Boy, I cannot

wait to find out what that is about. Those are just some of the sweetheart deals we know are in these bills, and I am sure there are more we will find out about.

This process has gone too fast and gone too far off track. It reminds me of what Rahm Emanuel, the President's Chief of Staff, said when they jammed through the stimulus bill earlier this year. He said: A crisis is a terrible thing to waste.

It is one thing if we were acting in response to a crisis in a responsible manner, but what this is going to do is make it even worse, as the Senator from Wyoming pointed out.

I think people listening—the 56 percent and growing number of Americans who are concerned about this deal—are wondering: Are the politicians in Washington more interested in jamming this through or getting it right?

Senator OLYMPIA SNOWE from Maine, a member of the Finance Committee—the one Republican to vote for the Finance Committee bill—said she will not vote for cloture on this bill at 1 this morning because this is simply an arbitrary deadline. Oh—and guess what—most of the provisions do not kick in for 4 years. So why are we doing this literally in the dead of night on a phony timetable?

We know according to experts, such as the dean of the Harvard Medical School—he said:

In discussions with dozens of health-care leaders and economists, I find near unanimity of opinion that, whatever its shape, the final legislation that will emerge from Congress will markedly accelerate national health-care spending rather than restrain it.

You do not have to go to Harvard to figure that out. Just go to Houston, TX. A small business owner in Houston wrote to me and said:

The proposed Health Care bill is going to have a negative impact on my business because the cost of employee health insurance will go up.

... I don't believe what some are saying that costs will go down. ... This bill does not make economic common sense.

Those are true words from a small business owner in Houston, TX, who I suspect has a greater understanding of what this bill will be than some of the so-called experts here inside the Beltway.

We know from the Congressional Budget Office, though, that the premiums for an average American family under this bill will go up \$2,100 a year for those purchasing insurance on their own in the so-called individual market.

An independent study talked about premiums in Texas specifically and said premiums in Texas, for those who purchase insurance on their own, will go up for 61 percent—61 percent—of Texans purchasing insurance on their own, that their premiums will go up under this bill. What in the world are we doing? Under the Reid bill, a family

of four in Houston would see their premiums more than double to \$1,352 a month.

I find it supremely ironic that perhaps the next vote we will have here on the Senate floor, after this health care bill, is going to be a vote to increase the statutory debt limit because Congress has maxed out its credit card. Currently our credit limit is \$12 trillion, and now that is not enough because of unwise and reckless spending such as that reflected here in this bill. I find that supremely ironic. But I suspect there are a lot of Americans who find it very sad and even scary.

We know in a time when people are struggling to keep their job, when businesses are struggling to keep their employees rather than have to lay them off and make the unemployment statistics even worse, when people are losing their home because they no longer have a job, this bill will be a job killer.

The only way this is going to be paid for—the pay-or-play mandates put on businesses—is for businesses to take some of the money they would have used to hire new employees and pay this new punitive tax being imposed by the Federal Government.

Businesses in Texas know this is true. The Lubbock Chamber of Commerce said:

An employer mandate would be a “job killer”, raising the costs of maintaining a workforce. . . .

. . . small businesses and our consumers will be the ones who suffer. . . .

Then there is this Medicaid expansion that Senator ENZI from Wyoming talked about. There is an unfunded mandate here because Texas did not get the sweetheart deal that Louisiana or Nebraska or Vermont or Massachusetts got—an unfunded mandate of \$21 billion over 10 years. So not only are people's Federal taxes going to go up, they are going to wreck the State budget too by pushing aside other priorities such as public education and the like—totally irresponsible.

Then there is a so-called Nelson amendment on abortion that was supposed to strike a “compromise.” Well, one of my other constituents, Cardinal Daniel DiNardo, who leads Texas' largest archdiocese and is chairman of the U.S. Conference of Catholic Bishops' Committee on Pro-Life Activities, said this:

[T]he legislation will be morally unacceptable “unless and until” it complies with longstanding current laws on abortion funding such as the Hyde amendment. . . .

. . . This legislation should not move forward in its current form. It should be opposed unless and until such serious concerns have been addressed.

I am staggered at what we are about to witness here, at the sheer irresponsibility of the way this is being done, with artificial deadlines, votes in the dead of night, bills cooked up behind closed doors as special deals jammed down the throats of the American people who do not want it.

I yield the floor.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. THUNE. Mr. President, I appreciate the comments of my colleague from Texas, and my colleague from Wyoming prior to that. Many have come down here, as our colleagues on our side have, day after day, time after time, and continue to point out what we believe is wrong with the approach that is being taken by the majority, and also pointing out where we would do things differently.

Remember, this is the first bill: 2,100 pages long; \$1.2 billion per page; \$6.8 million actually per word. Then yesterday, we got the managers' amendment: another 400 pages. You add yet another amendment that is going to go on this stack, and you are talking about 2,700 pages of bill language.

What I think is interesting—and I see a pattern emerging here almost every single day—it is like *deja vu* all over again. The other side comes down here and talks about the need for health care reform, which we all concede. We all believe we need to reform health care in this country. We all hear from our small businesses. We all hear from individuals and families who are having a difficult time keeping up with the high cost of health care. So that is something on which there is broad agreement on both sides. Yet that seems to be sort of the MO for the other side, to come down here and talk about how we need to do health care reform. We agree with that.

The other strategy is to come down here and attack Republicans for not having their own ideas. We have been trying to offer amendments to this bill forever. We had several amendments offered today. We asked consent to bring up amendments, to get them pending, to get them voted on. They were blocked by the other side. We have full alternatives to the current bill. Senator BURR and Senator COBURN have an alternative, a comprehensive alternative they would like to offer, being blocked by the other side.

So the recurring pattern that has emerged day after day in the debate in the Senate is Democrats come down here and talk about how bad the current system is and point out examples of those who are falling through the cracks in the current system. Exactly. We agree with that. We have acknowledged there is a problem. They come down here and attack Republicans for not having alternatives. In fact, the Senator from Rhode Island this afternoon essentially said that Republicans have been coming down here and telling lies.

What the Republicans have been doing day after day after day is coming down and talking about the bill and the impact the bill would have on health care delivery, the impact the bill would have on the economy, the

impact the bill would have on small businesses and their ability to create jobs. We have been talking about the Congressional Budget Office report that describes the cost of the bill and goes into great detail about how it will impact individual families as well as the overall cost of health care in this country. We have come down here day after day to talk about the CMS Actuary's report, the Center for Medicare Services, about the cost of the bill and how it would impact the cost of health care in this country. So we continue to come down here and talk about the bill.

The other side—the one thing they don't do is they don't come down here and talk about the bill. I don't hear Democrats coming down here and offering full-throated defenses for this bill, because the bill is indefensible. It is 2,700 pages, and it doesn't do anything to lower the cost of health care, according to the Congressional Budget Office.

So we come down here day after day and talk about the Congressional Budget Office report, come down here and talk about the CMS Actuary's report. They come down and talk about how bad the current system is, say this is going to fix it, but then when they are challenged on the CMS Actuary's report and the Congressional Budget Office report, they can't defend that.

What they should be doing instead of accusing the Republicans of telling lies and attacking Republicans is accusing the CMS Actuary and the Congressional Budget Office. They ought to be coming down and attacking them because all we are doing is pointing out the facts as they pertain to the current bill that is before the Senate, this 2,700 pages right here.

What I would like to point out are some of the promises that have been made by the President and by Democrats with regard to this bill.

The President made it very clear, when he was running for President:

I can make a firm pledge: Under my plan, no family making less than \$250,000 will see their taxes increase—not your income taxes, not your payroll taxes, not your capital gains taxes, not any of your taxes.

Yet the Joint Committee on Taxation analysis—by the way, that is another report, and maybe they ought to be coming down here and attacking that report rather than attacking Republicans who are quoting from the report. The Joint Committee on Taxation analysis shows those people earning less than \$200,000 a year will see a tax increase under the Reid bill. Even after you account for taxpayers who are going to receive the premium tax credit, 24 percent of tax returns under \$200,000 will, on average, see their taxes go up. There are 42 million Americans who are going to see higher taxes who make less than 200,000 a year. So the no tax increase for the middle class we would have to say is a broken promise.

The second thing they say is that it will lower health care costs. We all know—and the President said this as recently as June 23:

And I've said very clearly: If any bill arrives from Congress that is not controlling costs, that's not a bill I can support. It's going to have to control costs. It's going to have to be paid for.

So the Democrats have shifted the benchmarks about what that means and what impact it is going to have on America's health care premiums.

The President's first promise, going back to the campaign, was that the typical family's premiums would go down by \$2,500 per year—a \$2,500-per-year reduction, according to the President when he was campaigning—and that everybody would be covered. Well, we all know that even this bill, which is touted as expanding coverage—well, it does expand coverage. It puts 15 million more people on Medicaid; that is one way it expands coverage. But under this bill, there are still 23 million Americans who don't get health insurance coverage. So the President's promise that he was going to cover everybody, that he was going to lower health care costs, again, you would have to say it is a broken promise.

I want to show my colleagues how this would impact a typical family's insurance costs. If you are a family who is paying \$13,300 today and you are getting your insurance in the large employer market—in other words, if you work for a large employer, you get it in the large group market—and you are looking at the year 2016, you are going to be paying over \$20,000 a year for insurance. That doesn't lower health care costs; that increases health care costs.

What they will say is: Well, this is better than it would have been if we had done nothing. The honest truth is that if we do nothing, we still would have 5 percent to 6 percent increases year over year in the cost of health insurance for most Americans whether you get your insurance in the large group market or the small group market. You are still going to have a 5- to 6-percent increase in the cost of your health insurance if this bill is passed. You don't see any improvement. The best you can hope for is the status quo, which is year-over-year increases that are twice the rate of inflation. That is the impact on an average family. So the whole notion that this is going to lower health care costs just doesn't pass the truth test, according to the Congressional Budget Office.

The next promise that was made is that it would bend the cost curve down. What is interesting about that—and, of course, this was the President in the joint session of Congress on September 9 of this year:

The plan I am announcing tonight . . . will slow the growth of health care costs for our families, our businesses, and our government.

Well, according to the Congressional Budget Office, again—and if my colleagues want to attack us, let's have them attack the Congressional Budget Office, the CMS Actuary, the Joint Tax Committee, because everything I am saying tonight I am quoting from those reports. According to the Congressional Budget Office analysis of the Reid amendment, the cost curve bends up, not down. In fact, in the first 10 years, the net increase would be about \$200 billion a year in overall health care costs.

This is an outdated chart, I have to say, because this is the chart we used before this amendment was added. This is the managers' amendment, the 400-page amendment I alluded to earlier that was just added to the 2,100 page bill. In the 2,100 page bill, the Congressional Budget Office said the cost of health care in this country is going to go up, not down, by \$160 billion.

So what is the cost of doing nothing? The blue line represents the cost of doing nothing. That is Federal health care spending today and what it is projected to be into the future if we do nothing. The red line, according to the Congressional Budget Office, represents what health care costs would do if the Reid bill passes. The ironic thing is that with the 400-page amendment that was added yesterday, this number gets bigger, not smaller.

I said this is an outdated chart. This only represents a \$160 billion increase in the cost of health care. According to CBO's analysis on the amendment, it increases the cost of health care by \$200 billion. The CMS Actuary came to a slightly different conclusion. They said health care costs would go up in the next 10 years by \$234 billion. So you have all the experts—the Congressional Budget Office, the CMS Actuary—all coming to the same conclusion; that is, health care costs go up, not down. So we would have to say that is yet another broken promise.

The other thing that has been said throughout the course of this debate is that you could keep the insurance you have. In his joint session of Congress address on September 9, the President said:

Nothing in our plan requires you to change what you have.

Well, interestingly enough, according, again, to the Congressional Budget Office, between 9 million and 10 million people who would be covered by an employment-based plan under current law would not have an offer of such coverage under the proposal, the Reid proposal. So we have 10 million people, according to CBO, who are going to lose their employer-based coverage, and you also have the 11 million people who get Medicare Advantage which is being cut. They aren't going to be able to keep what they have. You can argue that maybe their benefits are too rich today. That has been the argument

made by the other side. But you can't say they are going to be able to keep what they have. If you are going to cut \$118 billion out of Medicare Advantage, the 11 million people in this country who get Medicare Advantage are going to see their benefits cut. They are not going to be able to keep what they have.

In fact, the Senator from Pennsylvania, Mr. CASEY, said recently on these Medicare Advantage cuts:

We are not going to be able to say if you like what you have you can keep it, and that basic commitment that a lot of us around here have made will be called into question.

Eleven million people who get Medicare Advantage aren't going to be able to keep what they have, nor are the 10 million people, according to the CBO, who are going to lose their employer-based coverage if this plan passes—another broken promise.

No cuts to Medicare—we all know about that. We talked about that for about a week here and offered amendments to get rid of the Medicare cuts.

The President said when he was running for office:

I want to assure [you] we're not talking about cutting Medicare benefits.

He reiterated that in his State of the Union Address.

This bill, as we know, cuts \$470 billion out of Medicare in the first 10 years, and when it is fully implemented, it cuts over \$1 trillion out of Medicare. In the first 10 years, \$135 billion out of hospitals; \$120 billion, as I said earlier, out of Medicare Advantage; \$15 billion out of nursing homes; \$40 billion out of home health care; and \$7 billion out of hospice care—these are all Medicare cuts. These are all going to affect people in a very real way whether you get Medicare Advantage or whether you are a provider.

These are just the facts of this legislation. I am talking about the bill. I am talking about the bill, and I am talking about what the experts have said about the bill. So we would have to say, another broken promise.

The first of the last two here: open and transparent process.

We all know that when the President campaigned, he said:

We'll have the negotiations televised on C-SPAN so that people can see who is making arguments on behalf of their constituents and who is making arguments on behalf of the drug companies or the insurance companies. And so that approach I think is what is going to allow people to stay involved in this process.

That was what the President said when he was campaigning.

We all know this bill, almost in its entirety, has been written behind closed doors. We just saw this 400-page amendment yesterday. It was interesting; earlier—it was last week, I guess—in a discussion on the floor between Senator MCCAIN and Senator DURBIN, the No. 2

Democrat in the leadership on the Democratic side, said:

I would say to the Senator from Arizona that I am in the dark almost as much as he is and I am in the leadership.

Even some of the leaders on the other side—there are only three people, four people sitting in a room writing this bill, and what is the most offensive thing about this came out yesterday when we found out that the Senator from Nebraska had carved out a special sweetheart deal with a goody for his State that all the rest of the States get to pay for. He gets his Medicaid for his State paid for entirely by the Federal taxpayers, and no other State gets that particular arrangement. So the Federal taxpayers in every other State, in my State of South Dakota—Nebraska borders South Dakota. I think the people in our part of the country are going to say this really smells. This is the way they are doing business in Washington, DC? This is business as usual.

The final thing I will say is this: The argument was that it won't add a dime to the deficit. Well, here I give the Democrats a little bit of credit because they did raise taxes enough and cut Medicare enough that they could actually raise quite a bit of revenue. But saying it won't add a dime to the deficit assumes there isn't going to be any payment to physicians. The physicians' fee fix, which takes about \$250 billion, was completely cut out of here. They are going to have to fix that at some point. So we are not counting that.

We are counting \$72 billion from a program called the CLASS Act which the chairman of the Senate Budget Committee, the Democrat from North Dakota, KENT CONRAD, called a "Ponzi scheme of the first order," something Bernie Madoff would be proud of. The CBO says of the CLASS Act:

The program would add to future budget deficits in large and growing fashion.

Even the Washington Post has editorialized about this, and they came to the same conclusion:

The CLASS Act is a gimmick designed to pretend that health care is fully paid for.

It goes on to say:

The money that flows in during the 10-year budget window will flow back out again. These are not savings that can honestly be counted on the budget sheet of reform.

Then we all know we have 10 years of revenue coming in, with only 6 years of spending in the first 10 years. Phony budgeting, gimmicks—all of these things are used to mask the true size of the cost of this program: \$2.5 trillion over 10 years when it is fully implemented.

So if you do not use the gimmicks, if you do not use the CLASS Act, if you discount the doc fix and don't count that in there, sure, you can make it look like it doesn't add to the deficit, but the American people know better, and they have come to the conclusion this is going to add to the deficit. Even

David Broder, who is the Pulitzer Prize winner for his commentary, said:

While the CBO said that both the House-passed bill and the one Reid has drafted meet the test by being budget-neutral, every expert I have talked to says that the public has it right. These bills, as they stand, are budget-busters.

This is going to add to the deficit. These are all broken promises. That is why this bill needs to be voted down. We need to vote it down tonight. I am hoping there is a courageous Democrat or two who will join us and defeat this bad legislation and move forward to something we can pass that will meaningfully lower health care costs for the American people.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. BROWNBACK. Mr. President, I appreciate the chance to hear my colleague from South Dakota speak and talk about the bill. Statements he has made I am in agreement with. This is a huge bill the American public doesn't want. Gallup polling finds 61 percent of the American public oppose the Senate Democratic health care bill. In Kansas, I find widespread opposition—much higher than that. You can look at these numbers and quickly see why. Just one of the pieces of it—the Medicare cuts—will hurt Kansas. There is a 63.7-percent cut in Medicare Advantage. The benefits will affect more than 1 in 10 of Kansas Medicare beneficiaries. Those cuts are to the point that the program will no longer exist.

There is \$1.5 billion in cuts to Kansas hospitals—many of our rural hospitals operating on the margins, on the edge. They get cuts. There is \$239.8 million in cuts to home health agencies. This is going to put over 60 percent of them out of business in a 10-year timeframe. They don't like this. Great Christmas present.

There is an 11.8-percent cut in hospice payments. Hospice? Of all things to cut. It is a program that has been helpful to so many people late in life, and it is being cut. There is \$124.2 million in cuts to skilled nursing facilities. All of those are things being cut directly to Kansans, directly to people who benefit under current programs, and this is all to start a new entitlement program—cuts Medicare and raises taxes, neither of which we can afford. Medicare is already scheduled to go bankrupt, as we well know, so this is like writing a big fat check on an overdrawn bank account and saying we will come up with the money. It is not going to work. It is going to take money from Medicare. It is going to raise taxes in a weak economy. It is going to hurt overall.

One of the issues that has come down to be one of the final pieces of this that the Democrats have put forward is the issue of funding of abortion. We have had 30 years of agreement in this body

and in this Capitol that the Federal Government would not fund abortions other than in cases of rape, incest, and saving the life of the mother. That was it.

Thirty years ago, the Hyde amendment was put in place. It said we would not fund abortions. There was a big debate in the country about abortion, but there has been no debate about funding of abortion. We said we are not going to fund it. Taxpayers should not be funding abortions. If people want to do that, that is their choice on elective abortion. We are not going to fund it.

In this bill, we are going to break that amendment for the first time in 30 years.

What the President said in the joint session of Congress is no longer true. This will not be true if this passes in this bill. What the President said in the joint session of Congress:

One more misunderstanding I want to clear up.

I was listening.

Under our plan no Federal dollars will be used to fund abortions, and Federal conscience laws will remain in place.

I point out that he said "no Federal dollars" and "Federal conscience laws will remain in place." He said he wanted to clear up the misunderstanding. This is not the case.

We just got the managers' amendment recently, so this has been feverishly where we have had to go through what is actually in the managers' amendment. What you will find is that all the major pro-life groups are opposed to the managers' amendment because it does fund abortion. I will go through the specifics.

BART STUPAK a Democratic Member on the House side. He has been the lead guy on the House side to say we should continue with the Hyde language. There are disputes about abortions. There is not a dispute about the funding of it by taxpayer money. So BART STUPAK has led a group of Democratic Members on the issue overall and said we are going to pull it out. It is not in the House bill, but now it is in the Senate bill. He says:

Not acceptable . . . a dramatic shift in Federal policy that would allow the Federal Government to subsidize insurance policies with abortion coverage.

That is what BART STUPAK says about it. What do some of the other pro-life groups say about what is in the managers' amendment. These groups track this stuff. The U.S. Conference of Catholic Bishops, which wants a health care bill—I think they are a pretty fair reviewer of this because they want a health care bill to go through, but they are committed to life. They do not want taxpayer money to go to end a child's life. They are opposed to that—completely opposed to that on moral grounds, saying this is the highest moral order that has to be protected. Human life has to be protected, and

they say, of this legislation, the managers' amendment:

This legislation should not move forward in its current form. It should be opposed, unless and until such serious concerns have been addressed.

This is on the abortion language. Now let's look at the National Right to Life Committee. The National Right to Life Committee—they are the gold standard of review. They have been looking at this issue and tracking it since *Roe v. Wade* was passed. They are committed to life at all stages, in all places, believing that life is sacred; it is unique; it is beautiful; and it should be protected. What do they say about the managers' amendment? They say:

Light years removed from the Stupak-Pitts amendment that was approved in the House of Representatives on November 8 by a bipartisan vote of 240–194.

The new abortion language solves none of the fundamental abortion-related problems with the Senate bill, and it actually creates some new abortion-related problems.

Let's go through the specifics, because I think what we should do is go through the specifics of this bill and look at what are the specific areas of concern. Many of the abortion changes that Senator REID smuggled into his managers' bill behind closed doors make the bill worse than ever before. It violates the Hyde amendment and Hyde principles set in precedent through all other Federal administered health programs like Medicare and Medicaid. It preempts State laws and conflicts with some existing laws on abortion.

Third is the so-called firewall. There is a firewall provision between Federal and private funds. That is inconsistent with the Hyde and Stupak-Pitts amendment. The firewall language is not very fireproof. It is a mere accounting gimmick, where they put the money in one pocket and pay for abortions from the other. It is still money that goes through the Federal Government to the Federal Government to pay for abortions.

Fourth, it departs from the way the Federal Employee Health Benefit Program is governed with respect to private plans covering abortion, so it changes that.

Fifth, it allows executive branch officials to require private health plans to cover abortions simply by defining them as "preventive care."

We have debated this piece calling abortions preventive care in committee and on the Senate floor. Both times we have tried to take that out and say preventive care does not include abortions, and we have not been able to get that definition to the point where abortion can still be called preventive care. This is the Mikulski amendment, which mandates that all plans cover abortion by defining abortion as a preventive service. If you just define it as a preventive service, you can pay for it. But it is still being paid for then, and that is in this bill.

No. 6, it inserts text of the Indian health reauthorization bill. That passed last year and didn't get signed into law. It passed this body. That does not contain the Senate-passed Vitter amendment to permanently prohibit coverage of elective abortions in the federally funded Indian health programs.

And, No. 7, basic conscience protections, like the Weldon language, are not included in the Senate version. There are other problems, but these are just seven of the most egregious. I can't imagine that people across the country—certainly people across my State and other places, such as Virginia, Missouri, California, Wisconsin, or anyplace else would agree that the Federal Government should break with longstanding policy against federally funded abortions, but that is exactly what has happened and what is in this bill.

Abortion is not health care. Why is it even in this bill at all? The President himself said that at the joint session of Congress.

At the end of the day, the vote for cloture is an affirmative vote for the Federal funding of abortion. There is no way around that fact. Some people on the Democratic side, particularly Senator NELSON of Nebraska, with whom I have been working closely on this issue, want to keep abortion out of this bill. I believe there are huge flaws still in it. He has been fighting to keep abortion out of it. He said this:

Taxpayers shouldn't be required to pay for abortions.

That is his statement on the issue. He says it should not be in there. He worked to try to get this out. I think there are still enormous flaws and holes in this.

If we start the funding of abortions, the last time we did fund them, over 300,000 were paid for by the Federal Government in a 1-year period of time through Medicaid Programs; 300,000 annually were funded from 1973 to 1976. How many are we looking at now if we start down this road?

We need one Democrat in the Senate who will stand and say this is not taking care of the unborn. This is breaking the Hyde language that many on the other side have supported for years, saying they are pro-choice, but they don't think the Federal Government should fund abortions. This breaks the Hyde language in the six ways I mentioned and, seven, it does not provide for conscious clause protection so someone, maybe they are in a Catholic hospital and they do not agree with providing abortion services. They would be required to do things in certain circumstances—maybe that is not one of them—but certain circumstances to which they would not agree.

This is a big part of this debate, and it has certainly elevated it here. The

American public does not want the abortion language in the bill. Mr. President, 6 in 10, in a CNN survey, say they do not want it in this bill. In fact, one-quarter of House Democrats voted for the Stupak-Pitts amendment. That is the compromise that continued on the Hyde principle and said we will not fund this.

National Right to Life, I mentioned earlier, goes through some of the specifics on this language.

I will just say, where we are right now all seems so odd to me. We are in the final days of Advent season. We are here when we should be home with our families. I am missing a lot of the celebration of the Christmas season. This is the final days of Advent. Advent is the season of anticipating the birth of a child. It is a season of joy, a season of happiness. You are looking forward to the day of the birth of Christ, December 25. That is the season we are in right now. It is a season of joy. How sad we might see the end of lives of children in this bill, in this season of joy. It does not have to be that way. It should not be that way.

But now this is, I believe, the central issue in this health care debate. If this body passes this bill—and I do not think it should—it goes back to the House of Representatives, where Congressman STUPAK and a group of others have said they will not support the language if it has the abortion language.

The issue of funding abortion has now become a central issue in the health care debate. It should not be there. It is wrong. It is opposed by the American public. I ask my colleagues on the other side, please, please, please take this out. It does not belong here. It is not the thing to do. It is harmful. It is hurtful to the country, and it does not belong anywhere near the health care bill.

I yield the floor.

Mr. MCCAIN. Mr. President, much has been spoken about the need for Americans to access safe and affordable drugs and therapies. We know that the pharmaceutical industry has cut numerous deals to protect their interests and line their pockets at the expense of the taxpayers, including seniors and the uninsured. I don't think it is a secret that PhRMA cut a deal with the White House to block legislation allowing for the importation of safe and affordable prescription drugs from Canada and other approved countries. And it seems that PhRMA cut a deal to line their pockets by locking in more expensive brand drugs in the Medicare Part D doughnut hole. Finally, it appears that PhRMA made sure that their profitable biologic medicines are protected for 12 years from competition from FDA-licensed safe and affordable biosimilars.

This legislation has so many sweetheart deals that we probably haven't even found them all yet.

Today, I am filing an amendment that improves the biologic pathway in the bill. It creates a fair pathway for competitive biologics that balances incentives for innovation with patient access to safe and affordable biosimilar medicines.

It is a fact that the cost to discover biologic therapies can be astronomical. That, unfortunately, leads to some patients being unable to afford the needed therapies. Patients benefit from continued innovation but they also benefit from safe and affordable competitive biologics that may not occur under the proposal in the Reid bill. My amendment ensures that incentives to innovate remain in the law.

It is accepted that biologic therapies are different than chemical medicines. That is why there needs to be a unique structure for the approval and licensure of biosimilar medicines.

In creating a pathway to competitive biologics we need to strike a balance that provides patients greater access to more affordable, safe biologic therapies and ensures innovation continues to thrive.

Today, biologics have a monopoly for years and years. I am worried that the underlying legislation would allow biologics to game the system and block competition beyond the 12 years provided in the bill. Some have argued that brand biologic companies will be able to stack 12-year periods of exclusivity on top of each other. My amendment addresses this issue.

My amendment also addresses patient safety issues. FDA has very specific recommendations that I wanted to recognize in this pathway. Access to safe, competitive biologics is only as good as the therapies are safe. My amendment seeks to ensure the pathway for generic biologic therapies is as safe and effective as the original product.

Highlights of my amendment include 10 years of initial data exclusivity for the original product—a decade is enough. Reid—Hatch/Enzi/Hagan, has 12 years of data exclusivity. It also includes two extra years of data exclusivity if the manufacturer conducts additional research and finds new indications for the original medicine. My amendment also incentivizes additional innovation and encourages second generation therapies to come to market as soon as possible rather than companies waiting until the end of the initial exclusivity period to introduce new versions. Additionally, prescribing physician must authorize therapeutic appropriateness for a biosimilar and finally, the competitive biologic manufacturer is required to ensure the biosimilar medicine is safe and effective through clinical studies.

My goal in introducing this amendment is to ensure patient access to safe and competitive biosimilar medicines, to guarantee innovation thrives and to

bring down cost while ensuring safety and innovation.

The PRESIDING OFFICER. The Senator from Maryland.

Mr. CARDIN. Mr. President, in a few hours, we in the Senate by our votes will be able to clear the way for the United States at long last to join every other industrial nation in the world and declare that health care is a right.

I thank our leader, Senator REID, for his extraordinary courage and leadership during these many weeks as we have been able to bring together the necessary votes to move this legislation forward.

I thank Senator BAUCUS, Senator DODD, and many of my colleagues who have worked on so many provisions that are in the managers' amendment and are in the underlying bill.

For 23 years, I have been in Congress, and for 23 years I have been supporting universal coverage. I believe every American should have access to affordable, quality health insurance and health care. By our votes later on this evening, we will have a chance to take a giant step forward in accomplishing that goal.

As I pointed out, the United States, although we spend more than any other nation in the world by far on health care, whether you want to do it in absolute dollars or on a per capita basis, we spend more than any other nation. Yet we are the only industrialized nation in the world that does not provide universal insurance and universal care.

Americans have to make a difficult choice. If someone happens to be walking on the ice tonight and does not have health insurance and they fall and hurt themselves, they have to make a decision whether their arm or leg hurts badly enough to go see a doctor or perhaps to have an x-ray to see whether a bone has been broken because they do not have the money to pay for that type of care.

Many people go without checkups because they cannot afford the cost of seeing a doctor today. They do not have insurance or their insurance does not cover what they need.

Many people who are on medications have to decide whether they can split their pills to make their dollars last a little bit longer because they literally are choosing between taking their medicines or having food on the table in the United States of America in 2009, the wealthiest nation in the world.

We have a chance to change that situation. One can argue this issue on many grounds, and I have. One can argue we need to bring down the growth rate of health care costs, and I certainly believe that or one can argue that we need to provide more people with health insurance or we need to take on the health insurance industry. But I think the most persuasive argument for passing this legislation is the

moral argument. It is the right thing to do. It is what America stands for.

I met with some students this week, and we were talking about the bill. These were high school students. They said it is the right thing to do, and they are right. This is the right thing for our Nation to do, to make sure everybody has access to affordable health care.

In Maryland, this takes on a special note because I know my colleagues have heard me talk frequently about Deamonte Driver, a 12-year-old who lived in Prince George's County, MD, just 7 miles from here. His mom tried to get him to a dentist because he had a toothache. They did not have insurance. No dentist would see him. After many efforts to try to get him to a dentist, he ultimately went to an emergency room. They operated on him because the tooth had become abscessed because of the delay in getting care. He needed emergency surgery. It went into his brain, and he lost his life because in the United States of America, we could not provide someone who was poor access to see a dentist. Tonight we can change that by our votes on this bill.

At long last, we have a chance to do something about that. In the last Congress, I introduced a bill that provided universal care by saying each of us has a personal responsibility to make sure we have health insurance. I did that because I think the first thing we need to do as a prerequisite to health care reform is to be sure everyone is covered, everyone is in the system.

This bill and the managers' amendment not only provides for universal coverage but makes it affordable for every person in this country.

We use the Congressional Budget Office as the objective scorekeeper. Everybody agrees to that—Democrats and Republicans. They are the professionals who tell us whether our numbers add up. The Congressional Budget Office tells us the bill with the managers' amendment will mean 31 million more Americans will have health coverage as a result of the enactment of this legislation. That will take our under 65 group from 83 percent coverage to 94 percent coverage, and for all Americans we will attain 98 percent. Sure, we want to get to 100 percent, but we are making a giant step forward for universal coverage.

The Congressional Budget Office tells us that for the overwhelming majority of Americans, they will either see no increase in their health insurance premiums from what it would otherwise be or they will see a decrease, a decline, a reduction in the cost of the health insurance premiums they would otherwise have to pay. For all Americans, they are going to have a better insurance product that is going to cover more. They are going to have less out-of-pocket costs than they would otherwise have. That is what the Congressional Budget Office tells us. Why

is that true? The legislation provides for prevention and wellness. It provides that preventive services will be required to be covered in your insurance plan.

We even do that for our government programs by providing an enhanced match for States that expand the Medicaid program for our poor to cover the preventive services. It covers oral health for our children as a required part of a required essential coverage package and provides additional help to help people through education and demonstration programs.

I could give many examples, but let me give one example from the point of view of trying to expand preventive services, and that is colon cancer. We know that if you have colon screenings, you actually can discover a polyp before it becomes cancerous. You can avoid cancer. The test costs a couple hundred dollars. If you do not have a test and you have cancer and need an operation, that costs tens of thousands of dollars.

Prevention and wellness works. It brings down the growth rate of health care costs. It saves us money. This bill invests billions in prevention and wellness directly and through required coverage in our private and public insurance programs.

We bring down the growth rate of health care costs by managing complex diseases. We know we spend most of our health care dollars because of major diseases. This bill helps us manage those diseases so people can get the care they need in a more cost-effective way.

The legislation invests in health information technology so we can reduce the administrative costs of health care. I was surprised to find that Maryland, similar to most States, if you go into an emergency room, it is very unlikely they will have your medical records. If they do not have your medical records because their information technology is not sophisticated enough to get those records, then surely they are going to do tests they would not otherwise have to do, which ends up costing us all more money.

By using health information technology, we can not only take better care of you, we can do it in a less costly way. By reducing the number of uninsured dramatically, we save money. How? Because someone who is uninsured who should see a doctor or go to a clinic instead goes to an emergency room which is much more expensive. By the way, they sometimes do not pay their bills.

Each of our families, if you live in Maryland and you have insurance, you pay an extra \$1,100 a year on your health insurance because you are paying for people who do not have health insurance and they access the system in a more costly way. This bill brings down the cost. You bring down the cost

of health care because of competition. We believe in competition, market forces. That is what made America great.

If you live in Maryland and you have private insurance, 71 percent of Marylanders are insured by two companies. That is not competitive. I have talked with more and more business owners who tell me they have no choice. There is one plan they can get. If they do not like that plan, there is no insurance they can get. That is not competition.

This bill brings competition by the exchanges that will invite more insurance companies to participate in our States and by the program that is in the managers' package that allows us, for the first time, to have plans available across State lines. That will be particularly helpful for a State such as Maryland, where many of our employers employ people who not only live in Maryland but live in Virginia, live in Pennsylvania, live in Delaware, live in West Virginia. That will certainly help us.

This legislation also reduces our Federal budget deficit. That is a challenge. Let me tell you why it is a challenge. There are two different issues. Reducing health care cost growth and reducing Federal spending are two different issues because to get everybody insured, which will help us bring down health care costs, we need to provide subsidies so people can afford their health insurance and provide businesses some help.

As more and more people become insured, they can use our tax advantages and pay less income taxes by using before-tax dollars rather than after-tax dollars. All that costs revenue to the Federal Treasury, so it is a challenge to bring this in without adding to the deficit, but we knew we had to do that. The Congressional Budget Office, again our objective scorekeeper, tells us that in the 10-year budget window, it will reduce the Federal budget by \$131 billion, but in the next 10 years, which all of us will admit is difficult to predict, they tell us we can reduce Federal spending by one-half percent of our GDP, which can translate to over \$1 trillion.

My point is, we are reducing the deficit while we are reducing the growth rate of health care costs.

The Congressional Budget Office does not score us for a lot of the results from our prevention programs. They cannot assume less people will get cancer and, therefore, the preventive services will save us money. I am convinced the dollar savings will be a lot greater than that for health care costs, for our economy, and for the taxpayers of this country.

This legislation protects consumers. That is why the consumer union supports moving this bill forward. The insurance reform that is in the underlying bill is well known. I tell you, the

people of Maryland want that. I am sure the people of Massachusetts also do.

The insurance reform says: Look, let's get rid of preexisting conditions. Let's not let insurance companies pick and choose whom they want to insure. They should insure everyone. The managers' package makes that available immediately for our children. We eliminate the lifetime caps, put restrictions on the annual caps. We make immediately available coverage for children under the age of 26 and provide a reinsurance program for those between 55 and 64.

We provide for an independent appeal from an insurance company's decision on coverage. Too many insurance companies have an internal mechanism to determine coverage which is stacked against the policyholder.

The managers' amendment provides for loss ratios. Loss ratios mean a certain amount of the insurance dollar must go back to pay benefits. We know a large amount is spent on advertising, spent on salaries, spent on profits. For the first time, the consumers will know how much of that is actually going to their benefits, and we start to put into law that a certain amount must be returned to the policyholders in benefits and important consumer protection information.

I am particularly pleased the Patients' Bill of Rights, an amendment I offered, is included in the managers' package. I thank the leader for including that.

In the Balanced Budget Act of 1997, a provision that I authored included a lot of the Patients' Bill of Rights in the Medicare and Medicaid Programs. President Clinton, in 1998, by executive order, extended it to all the government programs.

We passed that bill in the House and it passed in the Senate, but we never passed it in both bodies and sent it to the President the basic Bill of Rights for patients. We are making a giant step forward in the managers' package to cover those Bill of Rights. Let me give an example. Access to emergency care that I authored is now in this bill. There are insurance companies today that tell you, you have to get preauthorization before you can go to an emergency room. Think about that. You are having chest pains and sweating and you try to find your insurance card to call your insurance company? That is not what a doctor tells you to do. You go to an emergency room.

Suppose the closest emergency room is not in your network. Does that mean you will not get full coverage? Some insurance companies say that is the case. We put in the prudent layperson standard: If it is prudent to go to the emergency room to get care, the insurance company must cover your bill.

I cannot tell you the people I talked with on both sides—I had chest pains,

sweating, et cetera; I went to the emergency room, found out I did not have a heart attack and almost had one when my insurance company refused to pay the bill. I did what the doctor told me to do, and now they are not covering it. This provision will make sure that person's bill is covered.

Frankly, we have had people who delayed treatment who should have gone to an emergency room whose circumstances became much worse and some actually died. We cover access to emergency care in the managers' package, an important consumer protection.

We also allow you, as the subscriber, to determine whom you want your primary care provider to be. We give you protection as you make your decision as to whom your primary care provider will be. If you have a child, the pediatrician can be the primary care provider. If you are a woman, the OB-GYN can be your primary care provider. Many insurance companies deny you that today. That protection is in this bill for everyone.

I am also pleased to have joined Senator BROWN in a matter I worked very closely on when I was in the House for clinical trials. A lot of insurance companies today will not cover the cost of clinical trials, even though it might be the best care option available for an individual and, by the way, sometimes compromises the integrity of the clinical trial if they can't get a representative group to participate. Well, we provide protection in this bill to cover you for clinical trials that your insurance company has to cover.

So there is a lot in this bill for consumer protection—the bill of rights. Mr. President, there is a long list of organizations that support the patients' rights amendment that I offered, from the AARP, to the Consumers Union, Families USA, National Women's Law Center—all the different specialists. It is an important amendment, and I am glad to see it is in the managers' amendment.

I am proud of a major new effort that has been included in the managers' amendment. I want to talk about minority health for one moment, and I particularly want to thank a member of my staff, Priscilla Ross, who has been working on this issue for many years. She has pointed out to me the vulnerability of minority populations in America. Let me give a couple of examples.

The life expectancy for an African American is 5.3 years less than someone who is White. Minorities are two times more likely to have diabetes. African Americans have 33 percent higher death rates for heart disease than the White population. And the list goes on and on.

Access to care in the minority communities is much less than in the general communities at large. So we need-

ed to do something about this, and the amendment I offered, which is included in the managers' package, elevates minority health in our government agencies. It provides statutory authority for the Office of Minority Health at the Department of Health and Human Services. It codifies the network of minority health offices located within the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, the Food and Drug Administration, the Substance Abuse and Mental Health Services Administration, and the Health Resources and Services Administration.

Mr. President, it elevates the Office of Minority Health at the National Institutes of Health from a center to an institute. That is making a commitment to attack this disparity that currently exists in health care in America.

Let me talk about one other issue in this bill that I am proud to work with Senator SANDERS on which involves the community health centers and primary care. Senator SANDERS was able to get \$10 billion in the managers' package so that we could dramatically expand access to care. You see, if you are a Latino in America, there is a 35-percent chance you have no dependable source of health care, compared to 15 percent in the White community. We need more federally qualified health centers. You can have universal health coverage, but if you don't have facilities, it will be difficult to get access to care. The community health center expansion will provide access in underserved areas. Maryland needs this help, and there is substantial investment in primary care in this legislation.

This bill will help. It will help those who have good insurance coverage today by protecting that coverage and making sure it is available tomorrow and stopping the erosion that is taking place today with insurance companies cutting back on what is covered and employers putting more of the cost on the employee. This legislation will help. It will help small business owners who today have very little choice as to what insurance plan they can get. They are paying 20 percent more, on average, than a large company pays for the same insurance protection. This will offer choice.

We also offer tax credits to help small businesses in order to make it easier for small businesses—which are the economic engine of America—to be able to provide health benefits for their employees. It will help individuals who cannot find insurance today by having large pools they can enter without being discriminated against by the way the actuaries work and will provide subsidies for low-wage workers so they can afford the coverage.

The bill will help our Medicare population by starting to close the doughnut hole on prescription drugs, making prescription medicines much more af-

fordable for our seniors, and providing preventative services, such as annual physicals so that seniors can stay healthy. And it provides sustainability to the Medicare Program.

Most importantly, this legislation reflects the values of our Nation—affordable, quality health care for all Americans. I am proud to support this legislation, the managers' package, and the underlying bill, and I urge my colleagues to be on the right side of history. I support moving forward with health care reform.

With that, Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Mr. BEGICH. Mr. President, thank you for the opportunity to be here this evening. I thank Senator CARDIN for a great presentation on the real facts behind this bill.

You know, being from Alaska, we see a lot of storms. We saw a great blizzard here which brought a lot of snow. I see a lot of blizzards and storms in Alaska. But I have to be honest with you, I have never seen anything like the blizzard of misinformation I have seen in Washington regarding this bill.

Over the course of the next few minutes, I want to talk about the general bill and what it means for all Americans, including Alaskans, and then specifically about the effect on Alaska.

First, I want to walk through a couple of large issues. I know people watching are hearing this over and over while we are on this bill, and the details of it, but I think it is important that we repeat it enough for people to be reminded of the positive impacts the bill will have on America and my State of Alaska. It is not a perfect bill. There are pieces I would like to have improved, and I am sure everyone in this Chamber feels the same. But it is a step in the right direction—a significant step.

On the financial end, in the first 10 years, the bill reduces our deficit by \$130 billion. In the next 10 years, with the improvements in the managers' amendment and what it did for the deficit reduction, it is now \$1.2 trillion—a significant impact on the national debt.

People call my office and say: How does it reduce the debt? I remind them that between Medicare, Medicaid, the VA, Indian Health Services, and many other health care programs that we deliver, anything we do to improve the system will mean taxpayers will save money. So, again, \$130 billion in the first 10 years, and the next 10 years, \$1.2 trillion in deficit reduction.

The other issue—and again these are broad sweeps—is stronger medical loss ratios. This is important because this starts now, 2010, once this bill is passed, a few months after implementation. Health insurers will be required to spend more of their premiums—

which really are your premiums—on clinical services and quality activities, with less going to administration—advertising, profits, excessive pay packages. If they do not adhere to the new limits, they will have to pay rebates to the policyholders. These stricter limits will continue even after the exchange starts in 2011 and apply to all plans, including grandfathered plans. That is a significant benefit to the individual—the person who has to pay the premium.

Accountability for excess rate increases: The health insurer's participation in the exchange will depend on its performance. Insurers that jack up their premiums before the exchange begins will be excluded—a powerful incentive to keep premiums affordable.

There is an immediate ban on preexisting conditions for children under the age of 18. This is in the managers' package. To me, this is unbelievable. Many families struggle, and sometimes the parents will forego their health care in order to make sure their child is as healthy as possible. But when a child has a preexisting condition, just to get coverage for them is sometimes almost impossible. So this makes sure that no insurance company can ban or deny them access to health care with preexisting conditions.

Ensuring the needy have access to care: The use of annual limits on benefits will be tightly restricted, ensuring access to needed care. And those limits will be prohibited completely by 2014. Starting in 2010, new policies will eliminate the lifetime caps.

Also, on the broader scheme, there will be innovation. Medicare will be able to test new models. I can't tell you the number of times I have had a public hearing or a public meeting in Alaska, or I have had phone calls come in from people who have asked me: Can we do something different? How can we improve Medicare? This creates some new incentives to move forward on innovation within our Medicare system.

When you look at the small business end of it, the package improves, including starting the health insurance tax credit in 2010, with almost \$40 billion of tax credits. Tax savings to small business will be available.

Transparency: New requirements will ensure that insurers and health care providers report on their performance, allowing patients to make the best possible choice.

The next issue—multistate options. This is something during my campaign I talked a lot about—a program we all have in Congress, and so do almost 4 million Federal employees and their dependents. How do we replicate that to give a benefit to the taxpayers of this country, if they want to access something similar? Well, now we have the multistate option. Health insurance carriers will offer plans under the supervision of the Office of Personnel

Management, the same entity that oversees the health plans of Members of Congress and for Federal employees. At least one plan must be a nonprofit, and the plans will be available nationwide. This will truly promote competition and choice for individuals.

Another new idea, which Senator WYDEN had sponsored for many months and talked a lot about, is free choice vouchers, giving more choices to individuals with their money.

As mentioned earlier, the community health centers: It is estimated this bill will now be able to put in place almost 10,000 community health centers throughout this country, providing easy and affordable access for folks.

On the small business end, I want to again just broadly sweep on this. The credits will be available on a sliding scale to small businesses, those small businesses with fewer than 25 employees, and average annual wages of less than \$50,000. All small businesses will truly benefit, but if you are a small business with 50 or less employees, you will be exempt. If you want to provide insurance to your employees, and you are in a small group of 25 employees or under, there will be credits available for you.

The bill also clarifies part-time because we have so many part-time employees who work within the seasonal businesses in Alaska—retail, fishing, tourism. It makes sure that small businesses are not hampered by this legislation but enhanced. Again, 96 percent of the small businesses will be exempt from this law, unless they decide to provide health care, and then they can get some benefits through tax credits—up to \$40 billion available.

I am a member of a group of freshmen who came to Washington this cycle. We came with all kinds of ideas on how we wanted to change Washington in short order. We sat down with this bill in mind, and as a group of freshmen, we put together a cost containment package with many ideas—very technical in a lot of ways, but just in the broader sense, it creates administration simplification. It helps ensure we go after health care fraud. With regard to Medicare system upgrades, we make sure that as we develop new systems for Medicare and for the providers, we do some pay-for-performance testing, which will save individuals, save Medicare, and save the Medicare system over time.

The freshmen spent many weeks on the cost containment package we put together, and I want to give credit to Senator WARNER for leading the charge, though everyone participated to try to make a difference and bring cost containment to the issue of health care.

I want to go through a quick list on this broader perspective of the legislation and what happens now, because we hear always from the other side that so

many things are delayed way out; that they will not happen right away. Let me walk through several items that happen right away.

The Senate bill will make it illegal for insurance companies to drop coverage for Americans who are sick—basically, they call them rescissions—beginning 6 months after the date of enactment. Insurance companies will be barred from limiting the total benefits Americans can use over the course of a year—otherwise known as lifetime caps—beginning 6 months after the date of enactment. Affordable insurance coverage options will be made available for high-risk pools of Americans who have been uninsured and have been denied coverage because they have preexisting conditions, effective 90 days after enactment.

Early retirees between 55 and 64: I hear from a lot of them who are trying to figure out, as they are now retired and still have some coverage from their former employer, but it is expensive. What this does is set up a new program, and access to a program that will reduce their premiums beginning 90 days after enactment. Insurance companies will be required to start posting their overhead costs on a public Web site so consumers can better compare the deal they are getting effective July 1, 2010.

Insurance companies will have to start providing external review processes beginning 6 months after the date of enactment. Dependents will be able to receive coverage up to the age of 26 on their parents' policy, beginning 6 months after the date of enactment.

This is one again I hear so much when I am back home and from e-mails and letters, people wanting to keep their kids on their policy. Again, coverage up to the age of 26.

The insurance companies will be required to begin covering preventive services and immunization without copays on payments beginning 6 months after the date of enactment. Seniors will have access to dramatic discounts in the purchase of name brand prescription drugs in the Medicare Part D Program beginning July 1.

As I said earlier, children under age 18 cannot be denied for preexisting coverage.

There will be free preventive services for seniors—\$500 reduction in the doughnut hole for seniors.

Again, the issue with Medicare, I want to say, when we started this effort to reform health care, Medicare was in trouble and could be in serious trouble by 2017. This legislation adds 10 more years to Medicare.

To be specific to Alaska—and I will be brief on this but I think it is important—many of these issues I laid out are important to Alaska, but there are quite a few very specific. First, I remind folks what the impact is currently in Alaska—133,000 Alaskans do

not currently have insurance; 27,000 residents who now buy expensive individual premiums will now get affordable coverage. We double enrollment in Alaska's Kid Care, what we call here in Washington SCHIP, to more than 15,000 young people, ending the hidden tax on families. About \$119 million is spent on uncompensated care, averaging about \$1,900 per year. By creating a larger program as we are doing here, we can eliminate that cost.

I have heard over and over about Medicare Advantage. Let me tell you how that works for Alaskans. What we will be doing, we have 60,000 Medicare beneficiaries paying a price for excessive overpayments in higher premiums, even though 99 percent of our Alaskan seniors do not participate in Medicare Advantage.

What you hear when you hear about Medicare Advantage—and those who have it I am sure enjoy it—but in my State we are subsidizing that even though 99 percent of Alaska seniors do not take that program. So we pay an extra approximately \$90 to subsidize that program for those extra things they claim they have. The reality is that was supposed to be run by the private sector, saving money to Medicare. It is now costing us more, it is costing my State \$90 per Medicare family.

About 10,600 Alaskans hit the doughnut hole in Alaska through the Medicare drug coverage, which can cost some of our seniors up to \$4,000 additional a year. They will see a 50-percent reduction.

As I mentioned under early retirees on the national program, 7,300 Alaskans will be affected in a positive way; 8,600 Alaska small businesses could be helped by the small business tax credit. Again, Alaska is benefiting a great deal from this legislation.

Even more specific—and these are items I added specifically in the bill to focus on Alaska's specific issues. I thank Senator HARKIN on this next one, which is important. It is providing more primary care providers. It is a loan repayment program. I know he has been an advocate of getting more primary providers within the system—physicians, nurse practitioners, physicians assistants—from \$3,500 to \$5,000 for the National Health Service Corps in this country. It serves health professional shortage areas, including 77 in Alaska.

In part, because of this, and due to other major expansion, the Senate HELP Committee has estimated the bill will attract 24,000 new primary care providers. If you want to make a difference to the health care system, this is one critical piece. Again, Senator HARKIN, I know, has been an advocate for this for many years. To see us get to this state and be able to move this forward is significant. It will have a positive impact.

Another one which is a program that is a great benefit for hospitals in

Soldotna, Juneau, and Sitka, is an amendment which reauthorizes a Medicare project supporting hospitals in rural communities in smaller States, extending that for an additional 5 years, moving it from 10 States to 20 States and creating another 15 hospitals that can participate.

Alaska health care task force—specifically in this legislation, to deal with our Medicare provider issue in Alaska but also our TRICARE, making sure we deliver the right kind of hospital and medical care to our veterans.

More physicians assistants—we inserted specific language to make sure we allow loan repayments for physician assistant teaching faculty, to be also included in loan forgiveness. Last year we had 375 PAs who handled 1.2 million office visits in Alaska.

After 21 years, the Indian Health Service is now in this bill to be reauthorized. For 21 years it has not been reauthorized.

There are many great things in this legislation, from a broader perspective, as I mentioned earlier in my comments, but also very specific to Alaska.

Could it be better? Absolutely. But do we think we have a piece of legislation that is going to make an impact on people's lives? Yes, we do. If we want to keep it the same old business as usual, I guarantee, in 5 years or 10 years from now we will be in this hall, trying to figure out what to do at a bigger crisis.

This is the right decision. It will be an honor for me later this evening to make a vote in the affirmative to move past the cloture vote, getting on to voting for this bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. HARKIN. Mr. President, first I thank the Senator from Alaska for all of his hard work on this bill. I think it is fair to say the Senator from Alaska, a new Member of the Senate, I might add, has been very much involved in this bill and his focus has been on rural health and better health care for native Alaskans. As the Senator knows, the Indian Health Care Improvement Act, which also covers Native Alaskans, is included in this bill. I thank the Senator from Alaska for insisting on that and for being a strong supporter of making sure we do help primary care practitioners, both doctors but also nurse practitioners, physicians assistants, other health care and primary health care people who are going to serve in our small towns and rural communities. The Senator from Alaska has been one of our best leaders on making sure that we have this in the bill. I thank him for that very much.

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. NELSON of Florida. Mr. President, I have been listening on C-SPAN 2, in addition to having the privilege of

being over here on the floor, to this debate that has been going on. The debate has been going on ever since the summer when we in the committee were fashioning this legislation. I must say that to hear one side of this debate, I would not recognize all of those hearings we had last summer and all the markup we did in the Finance Committee last September because what has been presented to the Senate, and what has been presented to the public through press conferences by the opposition to this bill in most cases simply is not correct.

I want to give a couple of examples here this evening. In attacking this, saying what dastardly things this is going to do for the country and how this is going to increase costs and raise taxes—each one of these things can be refuted. But it is a typical tactic that, when you want to attack something and tear it down, you go after a specific item instead in order to obfuscate, which then misses the point of the whole piece of legislation.

The point of the whole piece of legislation is to make health care available and affordable, in most cases through health insurance, in other cases through Medicare and Medicaid, and making it available, efficient, and affordable.

I want to give one specific example. It is a technical term in the insurance industry called the "medical loss ratio." It is the ratio in what an insurance company actually pays out in medical claims as opposed to what it pays for administrative expenses such as marketing, insurance agent commissions, underwriting, and an insurance company's profit. It is interesting that the term medical loss ratio tells you a lot about the insurance industry, because if you look at it only from their perspective, this percentage is their loss but in fact the percentage is the amount of the premium dollar that goes to actual medical care. What this amendment, this managers' amendment we are going to vote on in less than 2 hours right now says, is it causes a specific ratio so you are getting a high amount of return on the insurance premium dollar.

Let me give an example. This is an example of the medical loss ratio of a number of small employers—small employers, that is group policies—as well as policies in the individual market. This is where you have an employer who pays for your health insurance but it is a small employer, usually under 50 employees.

This is where you have policies that are given to individuals. The premiums usually are much higher if you are an individual buying insurance than if you are buying it in a group, by an employer-sponsored group.

These are specific examples in a particular year of the loss ratio. Interestingly, for Aetna, here, at 82 percent—

that is not actually a loss to Aetna. It is interesting they call it a loss. That is actually 82 cents of premium dollar, an insured policyholder's premium dollar, that actually goes to medical coverage. That is good.

United Health: 79; Humana, down at 77—77 cents of that \$1 are going to health care.

And the balance, 23 cents, is going to things such as administrative expenses, paying for insurance agents, commissions, paying for their profit. What does the bill do? The bill brings that up to 80 percent. And that is all policies, not just the new policies on the health insurance exchange. That is not just the policies insurance companies are going to write new for the small group. It is all those policies that are in existence.

Look at the individual. The experience isn't quite as good. As a matter of fact, here is a company, Coventry, that was only paying 66 cents on every premium dollar that was actually going to health care, and the rest of that, 34 cents, was going to profit and administrative expenses and executive salaries and bonuses and so forth. And lo and behold, what we are going to vote on tonight in less than 2 hours is going to have to be 80 cents on every dollar. If they don't make that 80 cents on every dollar, they are going to get penalized. We are putting some real teeth in this on insurance companies for the first time.

Look at the large group, the employer-sponsored insurance, the large group. These are five of the larger insurance companies. You can see they have a pretty good record thus far: WellPoint, 85, Humana, 82 cents on every dollar. They have a better record because they have a lot more individual lives over which they can spread the insurance risk, and so they can pay out more in health insurance for health care and take out less for administrative expenses. But in this bill tonight, in an hour and 45 minutes, we are going to raise that to 85 percent, 85 cents on every dollar.

Before I came to the Senate—and I have had the good fortune of serving the public for now going on over 35 years—I had the privilege of being elected to one of the toughest jobs I have ever had in a lifetime of public service, and that was the elected insurance commissioner of Florida. It is also the elected treasurer. That position has morphed into what is called the chief financial officer. It is a member of the Florida cabinet. For 6 years, I got to see what insurance companies will do. I can tell you, instead of 85 percent and 80 percent that we are going to require in this bill of every insurance premium dollar they pay out in medical care, I can tell you that some of the insurance companies I regulated back in the State of Florida were down in the sixties. A lot of that was going

into big-time administrative offices, all kinds of jets, all kinds of padded expense accounts. You can see what we are trying to do here with this bill tonight.

Let's ask, why do we have to have a ratio such as this and why is it important? It certainly is getting more medical care to the individual policyholder. But listen to this: A study that was done by the Senate Commerce Committee shows that the ratios are often below what is considered to be fair. Our Commerce Committee found that in the small business market, those with fewer than 50 employees, insurers spend only 79 cents out of every dollar on health care. That is in the Commerce Committee study. In the individual market, it is even worse. It is 74 cents. In the individual market, the insurer keeps more than a quarter of every individual premium dollar for overhead and profit.

We need to ensure that the policyholder's premiums and the Federal subsidies that are going into the purchase of private health insurance on the exchange are used for actual medical care and not for wasteful administrative spending and marketing and profits. If we don't do this kind of thing, regulating insurance companies, then they are going to take advantage. They are going to take the advantage of making more money at the expense of patient care.

I want to give an example. In spite of this recession, this economic recession we are in and the increasing unemployment over the past year, what has happened to the big insurance companies? They are posting big profits. They seem to be making more money by insuring fewer people. The only way you make more money with fewer customers is you get rid of your less profitable customers—in other words, the sick ones. That is called cherry-picking. You pick the good risks, which are the healthy ones, and you try to get rid of the sick ones.

Let me give some examples. In the second quarter of this year, 2009, the largest health insurance company, UnitedHealth Group, announced a 3-month profit of \$859 million in one quarter, and it more than doubled the profits from the previous year. UnitedHealth earned these record profits in spite of the fact that it was insuring 600,000 fewer people than it did a year ago.

Let me give another example. In the second quarter of this year, another large insurer, CIGNA, saw its profits jump 60 percent to \$435 million. CIGNA earned these healthy profits in spite of the fact that it is insuring 200,000 fewer people than a year ago.

Another example: In the second quarter of 2009, Humana saw its profits rise 34 percent to \$282 million. Humana earned those healthy profits in spite of the fact that it was insuring 100,000 fewer people than a year ago.

At the same time they are dropping beneficiaries, insurance companies are paying their CEOs record salaries. In 2008, Aetna's CEO earned over \$24 million. That is the equivalent of more than \$66,000 per day. If you want to know where some of that administrative padding that is not coming back to the policyholder in health care is going, there is a good example. Aetna's CEO earned over \$24 million in that 1 year, 2008.

This medical loss ratio we are building into this bill on which we will vote shortly builds on other insurance provisions in this legislation which include guaranteed issue, which include prohibiting cancellations, banning pre-existing conditions so that they can't terminate you or not insure you because they cook up some excuse, some flimsy excuse. I am not sure this has been brought out in this debate, but I think it is worthy of consideration by the Senate.

In my closing minutes, I want to now step back and look at the overall package. Why is this a good deal for America, and why is it going to pass with an extraordinary threshold of 60 votes tonight? Because we are not going to allow in this legislation excessive rate increases in the health insurance exchange that is created new, that is going to insure 31 million new people. A lot of those people are people who don't have insurance now. A company will be banned from that health insurance exchange if it starts jacking up its rates excessively. You talk about an insurance commissioner's dream, a regulator's dream—often your hands are tied and you are put into a straitjacket by the insurance laws of your State and you can't crack the whip on them. We are cracking the whip on them in this legislation.

There has been a lot of talk about the program on Medicare other than Medicare fee-for-service called Medicare Advantage and how it is going to be whacked. I can tell you, for my State of Florida, there are 950,000 senior citizens on Medicare Advantage, and it is not going to be whacked. There have been a lot of statements out here by people attributing it to Florida, that it was going to be cut. In this bill we are voting on tonight and whenever we go to final passage, it is not.

By the way, there was a statement made here and something that was entered into the RECORD, a letter from a cardiologist from Jupiter, FL, who was complaining about how cardiologists' fees are being squeezed and they may not be able in the future to take care of Medicare recipients. I happen to know about this. I have been trying to help the cardiologists. But it was stated out here on the floor of the Senate that it is this bill that is doing that. That has nothing to do with this legislation. That has to do with the administrative

functions of government in existing law, CMS, that, in my opinion, has used incomplete data to cut cardiologists, particularly that are needed in a State such as Florida where, in fact, so many senior citizens are needing the service in Medicare of cardiologists.

Here is another major thing in this bill. We are setting up a nationwide insurance plan that will be sold on these health insurance exchanges, and it will be operated by the Office of Personnel Management, the same office that governs the health insurance of Federal employees and Members of Congress.

There is a part in this bill on tort reform. It sets up State grants to test alternatives to litigation.

In my remaining minute, let's don't forget the 31 million more people who are going to come in insured and how this, over time, is going to bring down the cost of Medicare. It is not going to cut Medicare. It is going to save Medicare. It is going to do that with efficiencies such as electronic records and accountable care organizations and emphasis on primary care physicians.

To conclude, what else does the bill do? It lowers the deficit over the next 10 years by \$132 billion. In the second 10-year period, it is going to lower it by up to \$1.3 trillion. That is serious deficit reduction.

On that happy note, I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Let me thank Senator NELSON for his strong commitment to Medicare. I know of no Senator who fights harder for Medicare and for making prescription drugs more affordable to seniors than the Senator from Florida. He has contributed his great expertise as a former insurance commissioner to the provisions we have in this bill on cracking down on insurance company abuses, and he just went through some of them there. I thank my good friend Senator NELSON from Florida for all of his great input into this bill.

In a few minutes, the Senate will close its doors for a brief recess. When those doors reopen just after midnight, the Senate will reconvene for a historic purpose: to bring the promise of quality, affordable health care to millions of Americans. When those doors reopen, we who have the privilege of serving in this body will have the opportunity to vote for hope and opportunity and new help for working families who worry every day that their illness will cause them to go bankrupt.

Mr. President, I yield the floor.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3284. Mr. GREGG submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue

Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 3285. Mr. GREGG submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3286. Mr. GREGG submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3287. Mr. GREGG submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3288. Mr. REID submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3289. Mr. REID submitted an amendment intended to be proposed to amendment SA 3288 submitted by Mr. REID and intended to be proposed to the amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3290. Mr. REID submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3291. Mr. REID submitted an amendment intended to be proposed to amendment SA 3290 submitted by Mr. REID and intended to be proposed to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3292. Mr. REID submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3293. Mr. MCCAIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 3284. Mr. GREGG submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE —HEALTHY MOTHERS AND HEALTHY BABIES

SEC. 01. SHORT TITLE.

This title may be cited as the "Healthy Mothers and Healthy Babies Access to Care Act".

SEC. 02. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON WOMEN'S ACCESS TO HEALTH SERVICES.—Congress finds that—

(A) the current civil justice system is eroding women's access to obstetrical and gynecological services;

(B) the American College of Obstetricians and Gynecologists (ACOG) has identified nearly half of the States as having a medical liability insurance crisis that is threatening access to high-quality obstetrical and gynecological services;

(C) because of the high cost of medical liability insurance and the risk of being sued, one in seven obstetricians and gynecologists have stopped practicing obstetrics and one in five has decreased their number of high-risk obstetrics patients; and

(D) because of the lack of availability of obstetrical services, women—

(i) must travel longer distances and cross State lines to find a doctor;

(ii) have longer waiting periods (in some cases months) for appointments;

(iii) have shorter visits with their physicians once they get appointments;

(iv) have less access to maternal-fetal medicine specialists, physicians with the most experience and training in the care of women with high-risk pregnancies; and

(v) have fewer hospitals with maternity wards where they can deliver their child, potentially endangering the lives and health of the woman and her unborn child.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this title to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of "defensive medicine" and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 03. DEFINITIONS.

In this title:

(1) **ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.**—The term “alternative dispute resolution system” or “ADR” means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) **CLAIMANT.**—The term “claimant” means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) **COLLATERAL SOURCE BENEFITS.**—The term “collateral source benefits” means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers’ compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) **COMPENSATORY DAMAGES.**—The term “compensatory damages” means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) **CONTINGENT FEE.**—The term “contingent fee” includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) **ECONOMIC DAMAGES.**—The term “economic damages” means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) **HEALTH CARE GOODS OR SERVICES.**—The term “health care goods or services” means any obstetrical or gynecological goods or

services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any obstetrical or gynecological-related human disease or impairment, or the assessment of the health of human beings.

(8) **HEALTH CARE INSTITUTION.**—The term “health care institution” means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) **HEALTH CARE LAWSUIT.**—The term “health care lawsuit” means any health care liability claim concerning the provision of obstetrical or gynecological goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) obstetrical or gynecological goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a physician or other health care provider who delivers obstetrical or gynecological services or a health care institution (only with respect to obstetrical or gynecological services) regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) **HEALTH CARE LIABILITY ACTION.**—The term “health care liability action” means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider who delivers obstetrical or gynecological services or a health care institution (only with respect to obstetrical or gynecological services) regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) **HEALTH CARE LIABILITY CLAIM.**—The term “health care liability claim” means a demand by any person, whether or not pursuant to ADR, against a health care provider who delivers obstetrical or gynecological services or a health care institution (only with respect to obstetrical or gynecological services), including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) obstetrical or gynecological services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) **HEALTH CARE PROVIDER.**—

(A) **IN GENERAL.**—The term “health care provider” means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) **TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.**—For purposes of this title, a professional association that is organized

under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) **MALICIOUS INTENT TO INJURE.**—The term “malicious intent to injure” means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) **NONECONOMIC DAMAGES.**—The term “noneconomic damages” means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) **OBSTETRICAL OR GYNECOLOGICAL SERVICES.**—The term “obstetrical or gynecological services” means services for prenatal care or labor and delivery, including the immediate postpartum period (as determined in accordance with the definition of postpartum used for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)).

(16) **PUNITIVE DAMAGES.**—The term “punitive damages” means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider who delivers obstetrical or gynecological services or a health care institution. Punitive damages are neither economic nor noneconomic damages.

(17) **RECOVERY.**—The term “recovery” means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys’ office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(18) **STATE.**—The term “State” means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 04. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) **IN GENERAL.**—Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) **GENERAL EXCEPTION.**—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) **MINORS.**—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or

prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) **RULE 11 SANCTIONS.**—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this title applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. 05. COMPENSATING PATIENT INJURY.

(a) **UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.**—In any health care lawsuit, nothing in this title shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) **HEALTH CARE PROVIDERS.**—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as \$250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) **SINGLE INSTITUTION.**—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as \$250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) **MULTIPLE INSTITUTIONS.**—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as \$250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed \$500,000.

(c) **NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.**—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations provided for in subsection (b), the future noneconomic damages shall be reduced first.

(d) **FAIR SHARE RULE.**—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 06. MAXIMIZING PATIENT RECOVERY.

(a) **COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—**

(1) **IN GENERAL.**—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) CONTINGENCY FEES.—

(A) **IN GENERAL.**—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) **LIMITATION.**—The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first \$50,000 recovered by the claimant(s).

(ii) 33½ percent of the next \$50,000 recovered by the claimant(s).

(iii) 25 percent of the next \$500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of \$600,000.

(b) APPLICABILITY.—

(1) **IN GENERAL.**—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) **MINORS.**—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) **REQUIREMENT.**—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education,

knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) **PHYSICIAN REVIEW.**—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) **SPECIALTIES AND SUBSPECIALTIES.**—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) **LIMITATION.**—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. 07. ADDITIONAL HEALTH BENEFITS.

(a) **IN GENERAL.**—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) **PRESERVATION OF CURRENT LAW.**—Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) **APPLICATION OF PROVISION.**—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. 08. PUNITIVE DAMAGES.

(a) PUNITIVE DAMAGES PERMITTED.—

(1) **IN GENERAL.**—Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) **FILING OF LAWSUIT.**—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) **SEPARATE PROCEEDING.**—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive

damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) **LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.**—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) **DETERMINING AMOUNT OF PUNITIVE DAMAGES.**—

(1) **FACTORS CONSIDERED.**—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) **MAXIMUM AWARD.**—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or \$250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) **LIABILITY OF HEALTH CARE PROVIDERS.**—

(1) **IN GENERAL.**—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) **MEDICAL PRODUCT.**—The term “medical product” means a drug or device intended for humans. The terms “drug” and “device” have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. 09. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) **IN GENERAL.**—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding \$50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments. In any health care lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) **APPLICABILITY.**—This section applies to all actions which have not been first set for trial or retrial before the effective date of this title.

SEC. 10. EFFECT ON OTHER LAWS.

(a) **GENERAL VACCINE INJURY.**—

(1) **IN GENERAL.**—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this title shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such title XXI shall not apply to such action.

(2) **EXCEPTION.**—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(b) **SMALLPOX VACCINE INJURY.**—

(1) **IN GENERAL.**—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this title shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such part C shall not apply to such action.

(2) **EXCEPTION.**—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(c) **OTHER FEDERAL LAW.**—Except as provided in this section, nothing in this title shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 11. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) **HEALTH CARE LAWSUITS.**—The provisions governing health care lawsuits set forth in this title shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this title. The provisions governing health care lawsuits set forth in this title supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this title; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) **PREEMPTION OF CERTAIN STATE LAWS.**—No provision of this title shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this title, notwithstanding section 05(a).

(c) **PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.**—

(1) **IN GENERAL.**—Any issue that is not governed by a provision of law established by or under this title (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) **RULE OF CONSTRUCTION.**—Nothing in this title shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections for a health care provider or health care institution from liability, loss, or damages than those provided by this title;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this Act;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. 12. APPLICABILITY; EFFECTIVE DATE.

This title shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3285. Mr. GREGG submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 80, line 22, strike “and”.

On page 80, after line 25, add the following:

“(i) adherence to or participation in reasonably designed programs of health promotion and disease prevention, if such programs exist; and”.

On page 81, line 4, insert before the period the following: “, except that group health plans and health insurance issuers offering group or individual health insurance coverage may establish premium discounts or rebates for modifying otherwise applicable copayments or deductibles in return for adherence to or participation in reasonably designed programs of health promotion or disease prevention”.

Beginning on page 84, strike line 15 and all that follows through line 3 on page 94, and insert the following:

“(j) **PROGRAMS OF HEALTH PROMOTION OR DISEASE PREVENTION.**—

“(1) **GENERAL PROVISIONS.**—

“(A) **GENERAL RULE.**—For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a ‘wellness program’) shall be a program that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

“(B) **NO CONDITIONS BASED ON HEALTH STATUS FACTOR.**—If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

“(C) CONDITIONS BASED ON HEALTH STATUS FACTOR.—If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

“(2) WELLNESS PROGRAMS NOT SUBJECT TO REQUIREMENTS.—If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

“(A) A program that reimburses all or part of the cost for memberships in a fitness center.

“(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

“(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under an individual or group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

“(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

“(E) A program that provides a reward to individuals for attending a periodic health education seminar.

“(3) WELLNESS PROGRAMS SUBJECT TO REQUIREMENTS.—If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

“(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the

cost of coverage if the Secretaries determine that such an increase is appropriate.

“(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease. The plan or issuer shall evaluate the program's reasonableness at least once per year.

“(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

“(D) The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

“(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows—

“(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

“(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

“(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

“(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

“(K) EXISTING PROGRAMS.—Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to the date of enactment of this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

“(1) REGULATIONS.—Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection with this section.”.

SA 3286. Mr. GREGG submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 114, beginning with line 17, strike all through page 116, line 6, and insert the following:

(e) CATASTROPHIC PLAN.—A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if the plan provides—

(1) except as provided in paragraph (1), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

(2) coverage for at least three primary care visits.

On page 155, beginning with line 22, strike all through page 156, line 3, and insert the following:

(A) INDIVIDUALS ALLOWED TO ENROLL IN ANY PLAN.—A qualified individual may enroll in any qualified health plan.

On page 250, lines 7 through 10, strike “, except that such term shall not include a qualified health plan which is a catastrophic health plan described in section 1302(e) of such Act”.

SA 3287. Mr. GREGG submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. . PREVENTING THE GAMING OF THE 10 YEAR BUDGET WINDOW.

Section 402 of the Congressional Budget Act of 1974 (52 U.S.C. 653) is amended—

(1) in paragraph (2), by striking “and” after the semicolon;

(2) in paragraph (3), by striking the period and insert “; and”;

(3) by inserting at the end the following:

“(4) for any provisions with delayed effective dates or phase-in periods, an estimate of the costs for the year that the provision first becomes fully effective and for each of the following 9 fiscal years.”.

SA 3288. Mr. REID submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of the amendment, insert the following: The provisions of this section shall be effective upon enactment.

SA 3289. Mr. REID submitted an amendment intended to be proposed to amendment SA 3289 submitted by Mr. REID and intended to be proposed to the amendment SA 2786 proposed by

Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

In the amendment, strike “upon enactment” and insert “5 days after enactment”.

SA 3290. Mr. REID submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of the language proposed to be stricken, insert the following:

This section shall become effective 4 days after enactment.

SA 3291. Mr. REID submitted an amendment intended to be proposed to amendment SA 3290 submitted by Mr. REID and intended to be proposed to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

In the amendment, strike “upon enactment” and insert “5 days after enactment”.

SA 3292. Mr. REID submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of the amendment, insert the following:

This section shall become effective 5 days after enactment.

SA 3293. Mr. MCCAIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1859, strike line 6 and all that follows through line 5 on page 1906, and insert the following:

Subtitle A—Patient Access to Safe and Competitive Biologics

SEC. 7001. SHORT TITLE.

(a) IN GENERAL.—This subtitle may be cited as the “Patient Access to Safe and Competitive Biologics Act”.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that a biosimilars pathway balancing innovation and consumer interests should be established.

SEC. 7002. APPROVAL PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR THERAPEUTICALLY EQUIVALENT.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting “under this subsection or subsection (k)” after “biologics license”; and

(2) by adding at the end the following:

“(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR THERAPEUTICALLY EQUIVALENT.—

“(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

“(2) CONTENT.—

“(A) IN GENERAL.—

“(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

“(I) the biological product is biosimilar to a reference product based upon data derived from—

“(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

“(bb) animal studies (including the assessment of toxicity); and

“(cc) a clinical study or studies (including the assessment of immunogenicity and pharmacokinetics or pharmacodynamics) conducted by the applicant that are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which licensure is sought for the biological product;

“(II) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanism or mechanisms of action are known for the reference product;

“(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

“(IV) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

“(V) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent.

“(ii) DETERMINATION BY SECRETARY.—The Secretary may determine, after public notice and comment, that an element described in item (aa) or (bb) of clause (i)(I) is unnecessary in an application submitted under this subsection.

“(iii) ADDITIONAL INFORMATION.—An application submitted under this subsection—

“(I) shall include publicly-available information regarding the Secretary’s previous determination that the reference product is safe, pure, and potent; and

“(II) may include any additional information in support of the application, including publicly-available information with respect to the reference product or another biological product.

“(B) THERAPEUTIC EQUIVALENCE.—If a sponsor submits an application (or supplement to

an application) under this subsection claiming that the biologics product is therapeutically equivalent to the reference product, such application (or supplement) shall include information demonstrating that the biological product meets the standards described in paragraph (4)(A).

“(3) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

“(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

“(i) is biosimilar to the reference product; or

“(ii) meets the standards described in paragraph (4)(A), and therefore is therapeutically equivalent to the reference product; and

“(B) the applicant (or other appropriate person) consents to the inspection of the facility that is the subject of the application, in accordance with subsection (c).

“(4) SAFETY STANDARDS FOR DETERMINING THERAPEUTIC EQUIVALENCE.—

“(A) DETERMINATION BY THE SECRETARY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product to have demonstrated therapeutic equivalence to the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that—

“(i) the biological product—

“(I) is biosimilar to the reference product; and

“(II) can be expected to produce the same clinical result as the reference product in any given patient; and

“(ii) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

“(B) APPLICATION OF THERAPEUTIC EQUIVALENCE ONLY WITH PRESCRIPTION.—Notwithstanding any other provision of law, no biological product determined to be therapeutically equivalent to a reference product under subparagraph (A) shall be deemed to be therapeutically appropriate with respect to an individual unless so determined by a health care professional treating such individual.

“(5) GENERAL RULES.—

“(A) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

“(B) REVIEW.—An application submitted under this subsection shall be reviewed by the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

“(C) RISK EVALUATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsection (a).

“(6) EXCLUSIVITY FOR FIRST THERAPEUTICALLY EQUIVALENT BIOLOGICAL PRODUCT.—Upon review of an application submitted

under this subsection relying on the same reference product for which a prior biological product has received a determination of therapeutic equivalence for any condition of use, the Secretary shall not make a determination under paragraph (4)(A) that the second or subsequent biological product is therapeutically equivalent for any condition of use until the earlier of—

“(A) 1 year after the first commercial marketing of the first biosimilar biological product to be approved as therapeutically equivalent for that reference product;

“(B) 18 months after—

“(i) a final court decision on all patents in suit in an action instituted under subsection (1)(6) against the applicant that submitted the application for the first approved therapeutically equivalent biosimilar biological product; or

“(ii) the dismissal with or without prejudice of an action instituted under subsection (1)(6) against the applicant that submitted the application for the first approved therapeutically equivalent biosimilar biological product; or

“(C)(i) 42 months after approval of the first therapeutically equivalent biosimilar biological product if the applicant that submitted such application has been sued under subsection (1)(6) and such litigation is still ongoing within such 42-month period; or

“(ii) 18 months after approval of the first therapeutically equivalent biosimilar biological product if the applicant that submitted such application has not been sued under subsection (1)(6).

For purposes of this paragraph, the term ‘final court decision’ means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

“(7) EXCLUSIVITY FOR REFERENCE PRODUCT.—

“(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—

“(i) IN GENERAL.—Except as provided in clause (ii) and (iii), approval of an application under this subsection may not be made effective by the Secretary until the date that is 10 years after the date on which the reference product was first licensed under subsection (a).

“(ii) EXTENSION OF EXCLUSIVITY.—The period of exclusivity described in clause (i) for a reference product shall be extended for an additional 2 years beyond the 10 years provided in such clause if the sponsor or manufacturer of the reference product submits a subsequent application for a change (not including a modification to the structure of the reference product) that results in a new indication for the reference product.

“(iii) SIGNIFICANT THERAPEUTIC ADVANCEMENT.—If a reference product represents a significant therapeutic advancement (including a modification that results in a new dosage form, new dosing regimen, or new route of administration of such biological product) of a biological product that was previously licensed under subsection (a) and that has the same sponsor or manufacturer as such reference product, then the period of exclusivity for such reference product shall be the number of years equal to the sum of—

“(I) the remaining period of exclusivity under clause (i) for biological product on which the reference product representing the significant therapeutic advancement was based, plus

“(II) 2 years.

“(iv) NO EXTENSION FOR SIGNIFICANT THERAPEUTIC ADVANCEMENT.—In no case may the

period of exclusivity under clause (iii) be extended.

“(B) FILING PERIOD.—An application under this subsection may not be submitted to the Secretary until the date that is 4 years after the date on which the reference product was first licensed under subsection (a).

“(C) FIRST LICENSURE.—The date on which the reference product was first licensed under subsection (a) does not include the date of approval of a supplement or of a subsequent application for a new indication, route of administration, dosage form, or strength for the previously licensed reference product.

“(8) GUIDANCE DOCUMENTS.—

“(A) IN GENERAL.—The Secretary may, after opportunity for public comment, issue guidance in accordance, except as provided in subparagraph (B)(i), with section 701(h) of the Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

“(B) PUBLIC COMMENT.—

“(i) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance.

“(ii) INPUT REGARDING MOST VALUABLE GUIDANCE.—The Secretary shall establish a process through which the public may provide the Secretary with input regarding priorities for issuing guidance.

“(C) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

“(D) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

“(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

“(ii) the criteria, if available, that the Secretary will use to determine whether a biological product meets the standards described in paragraph (4)(A).

“(E) CERTAIN PRODUCT CLASSES.—

“(i) GUIDANCE.—The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance, with respect to a product or product class (not including any recombinant protein) does not allow approval of an application for a license as provided under this subsection for such product or product class.

“(ii) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under subparagraph (A) to modify or reverse a guidance document under clause (i).

“(iii) NO EFFECT ON ABILITY TO DENY LICENSURE.—Clause (i) shall not be construed to require the Secretary to approve a product with respect to which the Secretary has not indicated in a guidance document that the science and experience, as described in clause (i), does not allow approval of such an application.

“(1) PATENTS.—

“(I) CONFIDENTIAL ACCESS TO SUBSECTION (K) APPLICATION.—

“(A) APPLICATION OF PARAGRAPH.—Unless otherwise agreed to by a person that submits an application under subsection (k) (referred to in this subsection as the ‘subsection (k) applicant’) and the sponsor of the application for the reference product (referred to in this subsection as the ‘reference product

sponsor’), the provisions of this paragraph shall apply to the exchange of information described in this subsection.

“(B) IN GENERAL.—

“(i) PROVISION OF CONFIDENTIAL INFORMATION.—When a subsection (k) applicant submits an application under subsection (k), such applicant shall provide to the persons described in clause (ii), subject to the terms of this paragraph, confidential access to the information required to be produced pursuant to paragraph (2) and any other information that the subsection (k) applicant determines, in its sole discretion, to be appropriate (referred to in this subsection as the ‘confidential information’).

“(ii) RECIPIENTS OF INFORMATION.—The persons described in this clause are the following:

“(I) OUTSIDE COUNSEL.—One or more attorneys designated by the reference product sponsor who are employees of an entity other than the reference product sponsor (referred to in this paragraph as the ‘outside counsel’), provided that such attorneys do not engage, formally or informally, in patent prosecution relevant or related to the reference product.

“(II) IN-HOUSE COUNSEL.—One attorney that represents the reference product sponsor who is an employee of the reference product sponsor, provided that such attorney does not engage, formally or informally, in patent prosecution relevant or related to the reference product.

“(iii) PATENT OWNER ACCESS.—A representative of the owner of a patent exclusively licensed to a reference product sponsor with respect to the reference product and who has retained a right to assert the patent or participate in litigation concerning the patent may be provided the confidential information, provided that the representative informs the reference product sponsor and the subsection (k) applicant of his or her agreement to be subject to the confidentiality provisions set forth in this paragraph, including those under clause (ii).

“(C) LIMITATION ON DISCLOSURE.—No person that receives confidential information pursuant to subparagraph (B) shall disclose any confidential information to any other person or entity, including the reference product sponsor employees, outside scientific consultants, or other outside counsel retained by the reference product sponsor, without the prior written consent of the subsection (k) applicant, which shall not be unreasonably withheld.

“(D) USE OF CONFIDENTIAL INFORMATION.—Confidential information shall be used for the sole and exclusive purpose of determining, with respect to each patent assigned to or exclusively licensed by the reference product sponsor, whether a claim of patent infringement could reasonably be asserted if the subsection (k) applicant engaged in the manufacture, use, offering for sale, sale, or importation into the United States of the biological product that is the subject of the application under subsection (k).

“(E) OWNERSHIP OF CONFIDENTIAL INFORMATION.—The confidential information disclosed under this paragraph is, and shall remain, the property of the subsection (k) applicant. By providing the confidential information pursuant to this paragraph, the subsection (k) applicant does not provide the reference product sponsor or the outside counsel any interest in or license to use the confidential information, for purposes other than those specified in subparagraph (D).

“(F) EFFECT OF INFRINGEMENT ACTION.—In the event that the reference product sponsor

files a patent infringement suit, the use of confidential information shall continue to be governed by the terms of this paragraph until such time as a court enters a protective order regarding the information. Upon entry of such order, the subsection (k) applicant may redesignate confidential information in accordance with the terms of that order. No confidential information shall be included in any publicly-available complaint or other pleading. In the event that the reference product sponsor does not file an infringement action by the date specified in paragraph (6), the reference product sponsor shall return or destroy all confidential information received under this paragraph, provided that if the reference product sponsor opts to destroy such information, it will confirm destruction in writing to the subsection (k) applicant.

“(G) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

“(i) as an admission by the subsection (k) applicant regarding the validity, enforceability, or infringement of any patent; or

“(ii) as an agreement or admission by the subsection (k) applicant with respect to the competency, relevance, or materiality of any confidential information.

“(H) EFFECT OF VIOLATION.—The disclosure of any confidential information in violation of this paragraph shall be deemed to cause the subsection (k) applicant to suffer irreparable harm for which there is no adequate legal remedy and the court shall consider immediate injunctive relief to be an appropriate and necessary remedy for any violation or threatened violation of this paragraph.

“(2) SUBSECTION (k) APPLICATION INFORMATION.—Not later than 20 days after the Secretary notifies the subsection (k) applicant that the application has been accepted for review, the subsection (k) applicant—

“(A) shall provide to the reference product sponsor a copy of the application submitted to the Secretary under subsection (k), and such other information that describes the process or processes used to manufacture the biological product that is the subject of such application; and

“(B) may provide to the reference product sponsor additional information requested by or on behalf of the reference product sponsor.

“(3) LIST AND DESCRIPTION OF PATENTS.—

“(A) LIST BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after the receipt of the application and information under paragraph (2), the reference product sponsor shall provide to the subsection (k) applicant—

“(i) a list of patents for which the reference product sponsor believes a claim of patent infringement could reasonably be asserted by the reference product sponsor, or by a patent owner that has granted an exclusive license to the reference product sponsor with respect to the reference product, if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application; and

“(ii) an identification of the patents on such list that the reference product sponsor would be prepared to license to the subsection (k) applicant.

“(B) LIST AND DESCRIPTION BY SUBSECTION (k) APPLICANT.—Not later than 60 days after receipt of the list under subparagraph (A), the subsection (k) applicant—

“(i) may provide to the reference product sponsor a list of patents to which the sub-

section (k) applicant believes a claim of patent infringement could reasonably be asserted by the reference product sponsor if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application;

“(ii) shall provide to the reference product sponsor, with respect to each patent listed by the reference product sponsor under subparagraph (A) or listed by the subsection (k) applicant under clause (i)—

“(I) a detailed statement that describes, on a claim by claim basis, the factual and legal basis of the opinion of the subsection (k) applicant that such patent is invalid, unenforceable, or will not be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application; or

“(II) a statement that the subsection (k) applicant does not intend to begin commercial marketing of the biological product before the date that such patent expires; and

“(iii) shall provide to the reference product sponsor a response regarding each patent identified by the reference product sponsor under subparagraph (A)(ii).

“(C) DESCRIPTION BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after receipt of the list and statement under subparagraph (B), the reference product sponsor shall provide to the subsection (k) applicant a detailed statement that describes, with respect to each patent described in subparagraph (B)(ii)(I), on a claim by claim basis, the factual and legal basis of the opinion of the reference product sponsor that such patent will be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application and a response to the statement concerning validity and enforceability provided under subparagraph (B)(ii)(I).

“(4) PATENT RESOLUTION NEGOTIATIONS.—

“(A) IN GENERAL.—After receipt by the subsection (k) applicant of the statement under paragraph (3)(C), the reference product sponsor and the subsection (k) applicant shall engage in good faith negotiations to agree on which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6).

“(B) FAILURE TO REACH AGREEMENT.—If, within 15 days of beginning negotiations under subparagraph (A), the subsection (k) applicant and the reference product sponsor fail to agree on a final and complete list of which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6), the provisions of paragraph (5) shall apply to the parties.

“(5) PATENT RESOLUTION IF NO AGREEMENT.—

“(A) NUMBER OF PATENTS.—The subsection (k) applicant shall notify the reference product sponsor of the number of patents that such applicant will provide to the reference product sponsor under subparagraph (B)(i)(I).

“(B) EXCHANGE OF PATENT LISTS.—

“(i) IN GENERAL.—On a date agreed to by the subsection (k) applicant and the reference product sponsor, but in no case later than 5 days after the subsection (k) applicant notifies the reference product sponsor under subparagraph (A), the subsection (k) applicant and the reference product sponsor shall simultaneously exchange—

“(I) the list of patents that the subsection (k) applicant believes should be the subject of an action for patent infringement under paragraph (6); and

“(II) the list of patents, in accordance with clause (ii), that the reference product sponsor believes should be the subject of an action for patent infringement under paragraph (6).

“(ii) NUMBER OF PATENTS LISTED BY REFERENCE PRODUCT SPONSOR.—

“(I) IN GENERAL.—Subject to subclause (II), the number of patents listed by the reference product sponsor under clause (i)(II) may not exceed the number of patents listed by the subsection (k) applicant under clause (i)(I).

“(II) EXCEPTION.—If a subsection (k) applicant does not list any patent under clause (i)(I), the reference product sponsor may list 1 patent under clause (i)(II).

“(6) IMMEDIATE PATENT INFRINGEMENT ACTION.—

“(A) ACTION IF AGREEMENT ON PATENT LIST.—If the subsection (k) applicant and the reference product sponsor agree on patents as described in paragraph (4), not later than 30 days after such agreement, the reference product sponsor shall bring an action for patent infringement with respect to each such patent.

“(B) ACTION IF NO AGREEMENT ON PATENT LIST.—If the provisions of paragraph (5) apply to the parties as described in paragraph (4)(B), not later than 30 days after the exchange of lists under paragraph (5)(B), the reference product sponsor shall bring an action for patent infringement with respect to each patent that is included on such lists.

“(C) NOTIFICATION AND PUBLICATION OF COMPLAINT.—

“(i) NOTIFICATION TO SECRETARY.—Not later than 30 days after a complaint is served to a subsection (k) applicant in an action for patent infringement described under this paragraph, the subsection (k) applicant shall provide the Secretary with notice and a copy of such complaint.

“(ii) PUBLICATION BY SECRETARY.—The Secretary shall publish in the Federal Register notice of a complaint received under clause (i).

“(7) NEWLY ISSUED OR LICENSED PATENTS.—In the case of a patent that—

“(A) is issued to, or exclusively licensed by, the reference product sponsor after the date that the reference product sponsor provided the list to the subsection (k) applicant under paragraph (3)(A); and

“(B) the reference product sponsor reasonably believes that, due to the issuance of such patent, a claim of patent infringement could reasonably be asserted by the reference product sponsor if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application,

not later than 30 days after such issuance or licensing, the reference product sponsor shall provide to the subsection (k) applicant a supplement to the list provided by the reference product sponsor under paragraph (3)(A) that includes such patent, not later than 30 days after such supplement is provided, the subsection (k) applicant shall provide a statement to the reference product sponsor in accordance with paragraph (3)(B), and such patent shall be subject to paragraph (8).

“(8) NOTICE OF COMMERCIAL MARKETING AND PRELIMINARY INJUNCTION.—

“(A) NOTICE OF COMMERCIAL MARKETING.—The subsection (k) applicant shall provide notice to the reference product sponsor not

later than 180 days before the date of the first commercial marketing of the biological product licensed under subsection (k).

“(B) PRELIMINARY INJUNCTION.—After receiving the notice under subparagraph (A) and before such date of the first commercial marketing of such biological product, the reference product sponsor may seek a preliminary injunction prohibiting the subsection (k) applicant from engaging in the commercial manufacture or sale of such biological product until the court decides the issue of patent validity, enforcement, and infringement with respect to any patent that is—

“(i) included in the list provided by the reference product sponsor under paragraph (3)(A) or in the list provided by the subsection (k) applicant under paragraph (3)(B); and

“(ii) not included, as applicable, on—

“(I) the list of patents described in paragraph (4); or

“(II) the lists of patents described in paragraph (5)(B).

“(C) REASONABLE COOPERATION.—If the reference product sponsor has sought a preliminary injunction under subparagraph (B), the reference product sponsor and the subsection (k) applicant shall reasonably cooperate to expedite such further discovery as is needed in connection with the preliminary injunction motion.

“(9) LIMITATION ON DECLARATORY JUDGMENT ACTION.—

“(A) SUBSECTION (k) APPLICATION PROVIDED.—If a subsection (k) applicant provides the application and information required under paragraph (2)(A), neither the reference product sponsor nor the subsection (k) applicant may, prior to the date notice is received under paragraph (8)(A), bring any action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that is described in clauses (i) and (ii) of paragraph (8)(B).

“(B) SUBSEQUENT FAILURE TO ACT BY SUBSECTION (k) APPLICANT.—If a subsection (k) applicant fails to complete an action required of the subsection (k) applicant under paragraph (3)(B)(ii), paragraph (5), paragraph (6)(C)(i), paragraph (7), or paragraph (8)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent included in the list described in paragraph (3)(A), including as provided under paragraph (7).

“(C) SUBSECTION (k) APPLICATION NOT PROVIDED.—If a subsection (k) applicant fails to provide the application and information required under paragraph (2)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that claims the biological product or a use of the biological product.”

(b) DEFINITIONS.—Section 351(i) of the Public Health Service Act (42 U.S.C. 262(i)) is amended—

(1) by striking “In this section, the term ‘biological product’ means” and inserting the following: “In this section:

“(1) The term ‘biological product’ means”;

(2) in paragraph (1), as so designated, by inserting “protein (except any chemically synthesized polypeptide),” after “allergenic product,”; and

(3) by adding at the end the following:

“(2) The term ‘biosimilar’ or ‘biosimilarity’, in reference to a biological product that is the subject of an application under subsection (k), means—

“(A) that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components; and

“(B) there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

“(3) The term ‘reference product’ means the single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k).

“(4) The term ‘therapeutically equivalent’ or ‘therapeutic equivalence’, in reference to a biological product, means that such product has been determined to meet the standards described in subsection (k)(4).”

(c) CONFORMING AMENDMENTS RELATING TO PATENTS.—

(1) PATENTS.—Section 271(e) of title 35, United States Code, is amended—

(A) in paragraph (2)—

(i) in subparagraph (A), by striking “or” at the end;

(ii) in subparagraph (B), by adding “or” at the end; and

(iii) by inserting after subparagraph (B) the following:

“(C)(i) with respect to a patent that is identified in the list of patents described in section 351(1)(3) of the Public Health Service Act (including as provided under section 351(1)(7) of such Act), an application seeking approval of a biological product, or

“(ii) if the applicant for the application fails to provide the application and information required under section 351(1)(2)(A) of such Act, an application seeking approval of a biological product for a patent that could be identified pursuant to section 351(1)(3)(A)(i) of such Act,”; and

(iv) in the matter following subparagraph (C) (as added by clause (iii)), by striking “or veterinary biological product” and inserting “, veterinary biological product, or biological product”;

(B) in paragraph (4)—

(i) in subparagraph (B), by—

(I) striking “or veterinary biological product” and inserting “, veterinary biological product, or biological product”; and

(II) striking “and” at the end;

(ii) in subparagraph (C), by—

(I) striking “or veterinary biological product” and inserting “, veterinary biological product, or biological product”; and

(II) striking the period and inserting “, and”;

(iii) by inserting after subparagraph (C) the following:

“(D) the court shall order a permanent injunction prohibiting any infringement of the patent by the biological product involved in the infringement until a date which is not earlier than the date of the expiration of the patent that has been infringed under paragraph (2)(C), provided the patent is the subject of a final court decision, as defined in section 351(k)(6) of the Public Health Service Act, in an action for infringement of the patent under section 351(1)(6) of such Act, and the biological product has not yet been approved because of section 351(k)(7) of such Act.”; and

(iv) in the matter following subparagraph (D) (as added by clause (iii)), by striking “and (C)” and inserting “(C), and (D)”;

(C) by adding at the end the following:

“(6)(A) Subparagraph (B) applies, in lieu of paragraph (4), in the case of a patent—

“(i) that is identified, as applicable, in the list of patents described in section 351(1)(4) of the Public Health Service Act or the lists of patents described in section 351(1)(5)(B) of such Act with respect to a biological product; and

“(ii) for which an action for infringement of the patent with respect to the biological product—

“(I) was brought after the expiration of the 30-day period described in subparagraph (A) or (B), as applicable, of section 351(1)(6) of such Act; or

“(II) was brought before the expiration of the 30-day period described in subclause (I), but which was dismissed without prejudice or was not prosecuted to judgment in good faith.

“(B) In an action for infringement of a patent described in subparagraph (A), the sole and exclusive remedy that may be granted by a court, upon a finding that the making, using, offering to sell, selling, or importation into the United States of the biological product that is the subject of the action infringing the patent, shall be a reasonable royalty.

“(C) The owner of a patent that should have been included in the list described in section 351(1)(3)(A) of the Public Health Service Act, including as provided under section 351(1)(7) of such Act for a biological product, but was not timely included in such list, may not bring an action under this section for infringement of the patent with respect to the biological product.”

(2) CONFORMING AMENDMENT UNDER TITLE 28.—Section 2201(b) of title 28, United States Code, is amended by inserting before the period the following: “, or section 351 of the Public Health Service Act”.

(d) CONFORMING AMENDMENTS UNDER THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.—

(1) CONTENT AND REVIEW OF APPLICATIONS.—Section 505(b)(5)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)(5)(B)) is amended by inserting before the period at the end of the first sentence the following: “or, with respect to an applicant for approval of a biological product under section 351(k) of the Public Health Service Act, any necessary clinical study or studies”.

(2) NEW ACTIVE INGREDIENT.—Section 505B of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355c) is amended by adding at the end the following:

“(n) NEW ACTIVE INGREDIENT.—

“(1) NON-THERAPEUTICALLY EQUIVALENT BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is biosimilar to a reference product under section 351 of the Public Health Service Act, and that the Secretary has not determined to meet the standards described in subsection (k)(4) of such section for therapeutic equivalence with the reference product, shall be considered to have a new active ingredient under this section.

“(2) THERAPEUTICALLY EQUIVALENT BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is therapeutically equivalent with a reference product under section 351 of the Public Health Service Act shall not be considered to have a new active ingredient under this section.”

(e) PRODUCTS PREVIOUSLY APPROVED UNDER SECTION 505.—

(1) REQUIREMENT TO FOLLOW SECTION 351.—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) EXCEPTION.—An application for a biological product may be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if—

(A) such biological product is in a product class for which a biological product in such product class is the subject of an application approved under such section 505 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this subtitle as the “Secretary”) before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) LIMITATION.—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(4) DEEMED APPROVED UNDER SECTION 351.—An approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) shall be deemed to be a license for the biological product under such section 351 on the date that is 10 years after the date of enactment of this Act.

(5) DEFINITIONS.—For purposes of this subsection, the term “biological product” has the meaning given such term under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(f) FOLLOW-ON BIOLOGICS USER FEES.—

(1) DEVELOPMENT OF USER FEES FOR BIOSIMILAR BIOLOGICAL PRODUCTS.—

(A) IN GENERAL.—Beginning not later than October 1, 2010, the Secretary shall develop recommendations to present to Congress with respect to the goals, and plans for meeting the goals, for the process for the review of biosimilar biological product applications submitted under section 351(k) of the Public Health Service Act (as added by this Act) for the first 5 fiscal years after fiscal year 2012. In developing such recommendations, the Secretary shall consult with—

(i) the Committee on Health, Education, Labor, and Pensions of the Senate;

(ii) the Committee on Energy and Commerce of the House of Representatives;

(iii) scientific and academic experts;

(iv) health care professionals;

(v) representatives of patient and consumer advocacy groups; and

(vi) the regulated industry.

(B) PUBLIC REVIEW OF RECOMMENDATIONS.—After negotiations with the regulated industry, the Secretary shall—

(i) present the recommendations developed under subparagraph (A) to the Congressional committees specified in such subparagraph;

(ii) publish such recommendations in the Federal Register;

(iii) provide for a period of 30 days for the public to provide written comments on such recommendations;

(iv) hold a meeting at which the public may present its views on such recommendations; and

(v) after consideration of such public views and comments, revise such recommendations as necessary.

(C) TRANSMITTAL OF RECOMMENDATIONS.—Not later than January 15, 2012, the Sec-

retary shall transmit to Congress the revised recommendations under subparagraph (B), a summary of the views and comments received under such subparagraph, and any changes made to the recommendations in response to such views and comments.

(2) ESTABLISHMENT OF USER FEE PROGRAM.—It is the sense of the Senate that, based on the recommendations transmitted to Congress by the Secretary pursuant to paragraph (1)(C), Congress should authorize a program, effective on October 1, 2012, for the collection of user fees relating to the submission of biosimilar biological product applications under section 351(k) of the Public Health Service Act (as added by this Act).

(3) TRANSITIONAL PROVISIONS FOR USER FEES FOR BIOSIMILAR BIOLOGICAL PRODUCTS.—

(A) APPLICATION OF THE PRESCRIPTION DRUG USER FEE PROVISIONS.—Section 735(1)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379g(1)(B)) is amended by striking “section 351” and inserting “subsection (a) or (k) of section 351”.

(B) EVALUATION OF COSTS OF REVIEWING BIOSIMILAR BIOLOGICAL PRODUCT APPLICATIONS.—During the period beginning on the date of enactment of this Act and ending on October 1, 2010, the Secretary shall collect and evaluate data regarding the costs of reviewing applications for biological products submitted under section 351(k) of the Public Health Service Act (as added by this Act) during such period.

(C) AUDIT.—

(i) IN GENERAL.—On the date that is 2 years after first receiving a user fee applicable to an application for a biological product under section 351(k) of the Public Health Service Act (as added by this Act), and on a biennial basis thereafter until October 1, 2013, the Secretary shall perform an audit of the costs of reviewing such applications under such section 351(k). Such an audit shall compare—

(I) the costs of reviewing such applications under such section 351(k) to the amount of the user fee applicable to such applications; and

(II)(aa) such ratio determined under subclause (I); to

(bb) the ratio of the costs of reviewing applications for biological products under section 351(a) of such Act (as amended by this Act) to the amount of the user fee applicable to such applications under such section 351(a).

(ii) ALTERATION OF USER FEE.—If the audit performed under clause (i) indicates that the ratios compared under subclause (II) of such clause differ by more than 5 percent, then the Secretary shall alter the user fee applicable to applications submitted under such section 351(k) to more appropriately account for the costs of reviewing such applications.

(iii) ACCOUNTING STANDARDS.—The Secretary shall perform an audit under clause (i) in conformance with the accounting principles, standards, and requirements prescribed by the Comptroller General of the United States under section 3511 of title 31, United States Code, to ensure the validity of any potential variability.

(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection such sums as may be necessary for each of fiscal years 2010 through 2012.

(g) PEDIATRIC STUDIES OF BIOLOGICAL PRODUCTS.—

(1) IN GENERAL.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended by adding at the end the following:

“(m) PEDIATRIC STUDIES.—

“(1) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (a), (d), (e), (f),

(i), (j), (k), (l), (p), and (q) of section 505A of the Federal Food, Drug, and Cosmetic Act shall apply with respect to the extension of a period under paragraphs (2) and (3) to the same extent and in the same manner as such provisions apply with respect to the extension of a period under subsection (b) or (c) of section 505A of the Federal Food, Drug, and Cosmetic Act.

“(2) MARKET EXCLUSIVITY FOR NEW BIOLOGICAL PRODUCTS.—If, prior to approval of an application that is submitted under subsection (a), the Secretary determines that information relating to the use of a new biological product in the pediatric population may produce health benefits in that population, the Secretary makes a written request for pediatric studies (which shall include a timeframe for completing such studies), the applicant agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

“(A) the periods for such biological product referred to in subsection (k)(7)(B) are deemed to be 4 years and 6 months rather than 4 years and the date that is 6 months after the date described in subsection (k)(7)(A) rather than the date described in such subsection; and; and

“(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

“(3) MARKET EXCLUSIVITY FOR ALREADY-MARKETED BIOLOGICAL PRODUCTS.—If the Secretary determines that information relating to the use of a licensed biological product in the pediatric population may produce health benefits in that population and makes a written request to the holder of an approved application under subsection (a) for pediatric studies (which shall include a timeframe for completing such studies), the holder agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

“(A) the periods for such biological product referred to in subsection (k)(7)(B) are deemed to be 4 years and 6 months rather than 4 years and the date that is 6 months after the date described in subsection (k)(7)(A) rather than the date described in such subsection; and

“(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

“(4) EXCEPTION.—The Secretary shall not extend a period referred to in paragraph (2)(A), (2)(B), (3)(A), or (3)(B) if the determination under section 505A(d)(3) is made later than 9 months prior to the expiration of such period.”.

(2) STUDIES REGARDING PEDIATRIC RESEARCH.—

(A) PROGRAM FOR PEDIATRIC STUDY OF DRUGS.—Subsection (a)(1) of section 409I of the Public Health Service Act (42 U.S.C. 284m) is amended by inserting “, biological products,” after “including drugs”.

(B) INSTITUTE OF MEDICINE STUDY.—Section 505A(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355b(p)) is amended by

striking paragraphs (4) and (5) and inserting the following:

“(4) review and assess the number and importance of biological products for children that are being tested as a result of the amendments made by the Patient Access to Safe and Competitive Biologics Act and the importance for children, health care providers, parents, and others of labeling changes made as a result of such testing;

“(5) review and assess the number, importance, and prioritization of any biological products that are not being tested for pediatric use; and

“(6) offer recommendations for ensuring pediatric testing of biological products, including consideration of any incentives, such as those provided under this section or sec-

tion 351(m) of the Public Health Service Act.”.

(h) ORPHAN PRODUCTS.—If a reference product, as defined in section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act) has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition, a biological product seeking approval for such disease or condition under subsection (k) of such section 351 as biosimilar or therapeutically equivalent to, such reference product may be licensed by the Secretary only after the expiration for such reference product of the later of—

(1) the 7-year period described in section 527(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360cc(a)); and

(2) the period of exclusivity described in subsection (k)(7)(A) of such section 351.

RECESS UNTIL 12:01 A.M.
TOMORROW

The PRESIDING OFFICER. The time of the Senator has expired.

Under the previous order, the Senate stands in recess until 12:01 a.m., Monday, December 21, 2009.

Thereupon, the Senate, at 11:31 p.m., recessed until Monday, December 21, 2009, at 12:01 a.m.

SENATE—Monday, December 21, 2009*(Legislative day of Sunday, December 20, 2009)*

The Senate met at 12:01 a.m., on the expiration of the recess, and was called to order by the Honorable MARK UDALL, a Senator from the State of Colorado.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Eternal God, help of the ages, as we labor a great while before day, give our lawmakers the wisdom to see the right and the courage to do it. Cause them to be men and women of integrity, so that our citizens can lead quiet and peaceful lives in all godliness and honesty. Remind our Senators that You have called them to be servants of the people during this challenging season, so that they must not succumb to pessimism and cynicism or grow weary in well doing. Gird them with fortitude. Illumine them with the light of truth, and make them more than conquerors in the faith that the kingdoms of this world are to become the one and radiant Kingdom of Your redeeming love.

Lord, please remind the many workers who support the legislative process that You see their diligence and will reward their faithful sacrifices.

We pray in Your great Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable MARK UDALL led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 21, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable MARK UDALL, a Senator from the State of Colorado, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. UDALL of Colorado thereupon assumed the chair as Acting President pro tempore.

SERVICE MEMBERS HOME OWNER-SHIP TAX ACT OF 2009—Resumed**Pending:**

Reid amendment No. 2786, in the nature of a substitute.

Reid amendment No. 3276 (to amendment No. 2786), of a perfecting nature.

Reid amendment No. 3277 (to amendment No. 3276), to change the enactment date.

Reid amendment No. 3278 (to the language proposed to be stricken by amendment No. 2786), to change the enactment date.

Reid amendment No. 3279 (to amendment No. 3278), to change the enactment date.

Reid motion to commit the bill to the Committee on Finance, with instructions to report back forthwith, with Reid amendment No. 3280, to change the enactment date.

Reid amendment No. 3281 (to the instructions (amendment No. 3280) of the motion to commit), to change the enactment date.

Reid amendment No. 3282 (to amendment No. 3281), to change the enactment date.

The ACTING PRESIDENT pro tempore. Under the previous order, the time until 1 a.m. will be equally divided and controlled between the two leaders or their designees, with the majority leader controlling the final 10 minutes prior to 1 a.m., and the Republican leader controlling the 10 minutes immediately prior to that.

The Senator from Tennessee.

Mr. ALEXANDER. Mr. President, I intend to take 10 minutes of the Republican time. Will you please let me know when 1 minute remains?

The ACTING PRESIDENT pro tempore. The Senator will be notified.

Mr. ALEXANDER. Thank you, Mr. President.

Mr. President, there may be a number of Americans who are switching over from the Minnesota v. Carolina football game and they may be wondering what in the world is the U.S. Senate doing coming into session at midnight on a Sunday in the middle of a snowstorm and getting ready to vote at 1 a.m.? So let me try to explain that for a moment.

The reason is, the Democratic majority leader, who is the only one who can set our schedule, showed up yesterday with a 400-page amendment—yesterday. This amendment had been written in secret for the last 6 weeks. The assistant Democratic leader said, last week, on the floor, he had no idea what was in it. Of course, none of us on the Republican side knew what was in it. So almost no one here knew what was in it. It was presented to us. Then the Democratic leader said: Well, we are going to start voting on it, and we are going to pass it before Christmas.

This is an amendment to the health care bill, which when fully imple-

mented, will cost about \$2.5 trillion over 10 years, according to the Senate Budget Committee; which restructures a sixth of our economy; which affects 300 million people; which will raise taxes by about \$1 trillion when fully implemented over 10 years; and which will cut Medicare by about \$1 trillion when fully implemented over 10 years. It doesn't cut Medicare to make Medicare more solvent which, as we know, it is going to become insolvent, according to its trustees, by 2015, but to spend on a new entitlement.

It will also shift to the States a great many expenses, so much so that our Democratic Governor in Tennessee has said it is the mother of all unfunded mandates. The Governor of California says it is the last thing we need, take your time, get it right. But the Democratic leader and his colleagues insist that we need to bring this up in the middle of a snowstorm, write it in secret, vote on it in the middle of the night, and get it passed before Christmas Eve.

Why would they want to do that? Well, I think the answer is very clear. It is because they want to make sure they pass it before the American people find out what is in it. Because the American people, by nearly two to one, according to a CNN poll, do not like what they have heard about the health care bill. When they have to start explaining what is in it, they are afraid it will be worse, and it will never pass.

Republicans are not the only ones who believe we ought to stop and think about big issues before we deal with it. Eight Democratic Senators—Senators LINCOLN, BAYH, LANDRIEU, LIEBERMAN, MCCASKILL, NELSON, PRYOR, and WEBB—wrote Senator REID on October 6, saying to Senator REID:

As you know, Americans across our country have been actively engaged in the debate on health care reform. . . . Without a doubt, reforming health care in America is one of the most monumental and far-reaching undertakings considered by this body in decades. We believe the American public's participation in this process is critical to our overall success. . . .

I am quoting from the eight Democratic Senators. They go on to say they want to make sure the bill is on a Web site "for at least 72 hours" before we vote on it. This bill was given to us yesterday—400 pages of it—we had not seen before. Seventy-two hours would be Tuesday. So the minimum requirement, according to the eight Democratic Senators and all 40 Republican Senators, would be that we should not even think about voting on it until at

least Tuesday. And then one would think we would be amending it and debating it and considering it and thinking about it and trying to find out what it actually does.

According to the eight Democratic Senators:

By publicly posting the legislation and its [Congressional Budget Office] scores 72 hours before it is brought to a vote in the Senate and by publishing the text of amendments before they are debated, our constituents will have the opportunity to evaluate these policies. . . . As their democratically-elected representatives . . . it is our duty to listen . . . and to provide them with the chance to respond to proposals that will impact their lives.

Yet, we are presented with it in the middle of a snowstorm on Saturday, we are meeting at midnight, we are voting at 1 a.m. It is being demanded that it be passed, even though most of the provisions, as the Senator from Maine has said, do not even begin to take effect for 4 more years.

What is the rush? I think the rush is that our friends on the other side do not want to explain to 40 million seniors how you can cut \$1 trillion out of Medicare—it is exactly \$470 billion over the next 10 years, but when fully implemented \$1 trillion out of Medicare—and spend it on a new program without reducing Medicare services to 40 million seniors. The Director of the Congressional Budget Office has already said that for the 11 million seniors who are on Medicare Advantage that fully half their benefits will be affected.

I think our friends on the other side do not want the American people to understand why the \$578 billion in new taxes that are going to begin to be imposed next year—they are going to have a hard time explaining how that will create new jobs in America, at a time when we have 10 percent unemployed. New taxes?

They do not want the American people to find out the Director of the Congressional Budget Office said that if we put those new taxes on insurance providers, on medical devices, almost all of those taxes will be passed on to the consumers and, as a result, premiums will go up.

There are some very strong words that have been coming from the other side about Republicans saying this bill will actually increase the cost of health care. It is not Republicans who are saying that. Here is what David Brooks of the New York Times said in his analysis of the bill when he gave the reasons for it and the reasons against it this week and came to the conclusion that if he were a Senator he would vote against it. Mr. Brooks said:

The second reason to oppose this bill is that, according to the chief actuary for Medicare, it will cause national health care spending to increase faster.

That is right, we are going to raise taxes, cut Medicare, send a big bill to the States—all for what? “. . . accord-

ing to the chief actuary for Medicare, it will cause national health care spending to increase faster.” So if you are paying X for premiums, you are going to be paying more as a result of this bill.

Continuing, David Brooks said:

Health care spending is already zooming past 17 percent of [our gross domestic product] to 22 percent and beyond.

Then it is going to be hard to explain to the 9 million people who the Congressional Budget Office letter said would lose their employer insurance under this bill why that will happen. Of course, it will happen because under the bill as a whole, as employers look at the mandates and the costs, many will decide not to offer health insurance, and so those employees will find themselves either in Medicaid, the program for low-income Americans—into which 15 million more Americans are going; a program for which 50 percent of doctors will not see new Medicaid patients; it is like giving you a ticket to a bus when the bus only runs half the time—that is where many of these Americans will go, or they will go into the individual market, and the individual market will have higher premiums.

The other side says: Ah, but there will be subsidies for some of you. But the premiums are going to be higher, the health care costs are going to be higher.

The majority does not want to explain why this bill changes the bipartisan agreement not to have Federal funding for abortion that has been agreed to since 1977.

They do not want to take time for the American people to understand the CLASS Act, the long term insurance act, a new entitlement which sounds wonderful, but the Democratic chairman of the Budget Committee described it as a Ponzi scheme worthy of Bernie Madoff. That is because the amount of money that would be paid in, if a person pays a premium of \$2,880 per year for 5 years, would be \$14,000, and then they would have a \$1,500 monthly benefit for a long time after that.

It is obvious why the majority has cooked up this amendment in secret, has introduced it in the middle of a snowstorm, has scheduled the Senate to come in session at midnight, has scheduled a vote for 1 a.m., is insisting it be passed before Christmas, because they do not want the American people to know what is in it.

It is a deeply disappointing legislative result. But our friends on the Democratic side seem determined to pursue a political kamikaze mission toward a historic mistake, which will be bad for the Democrats, I am convinced, but, unfortunately, even much worse for our country.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Arizona is recognized.

Mr. MCCAIN. Mr. President, as we approach in less than an hour a very important vote—some have called it historic, some call it pivotal; it has been given various adjectives and adverbs—I think it might be appropriate to discuss for a minute or two how this all began.

It all began in the Presidential campaign. I do not like to spend much time recalling it. But health care was a big issue in the Presidential campaign. On October 8, 2008, less than a month before the election, then-Candidate Obama said, concerning health care reform:

I'm going to have all the negotiations around a big table. . . . What we'll do is we'll have the negotiations televised on C-SPAN, so that people can see who is making arguments on behalf of their constituents and who are making arguments on behalf of drug companies—

Keep that in mind: the drug companies—
or the insurance companies.

That was the statement made by then-Senator/Candidate Obama. What we have is a dramatic departure. There has never been a C-SPAN camera. There has never been a negotiation, a serious negotiation between Republicans and the other side. There has never been. I say that with the knowledge of someone who has negotiated many times across the aisle on many agreements. So don't stand and say there were serious negotiations between Republicans and Democrats. There never were.

But there were negotiations with the special interests, with PhRMA, the same ones the President said he was going to see who the American people were on the side of. Clearly, this administration and that side of the aisle was on the side of PhRMA because they got a sweetheart deal of about \$100 billion that would have been saved if we had been able to reimport prescription drugs. The AARP has a sweetheart deal. There is a provision in this deal for them, plans that Medigap insurance sold by AARP are exempt from tax on insurance companies. The AMA signed up because of the promise of a doc fix. Throughout we should have set up a tent out in front and put Persian rugs out in front of it. That is the way this has been conducted.

Of course, after the special interests were taken care of, then we had to take care of special Senators. One deal is called—we have new words in our lexicon now—the Louisiana purchase, the corn husker kickback. I have a new name: the Florida flimflam, the one that gives the Medicare Advantage members in Florida the benefit, but my constituents in Medicare Advantage don't get it.

So in answer to this, in answer to a question today, the majority leader said:

A number of States are treated differently than other States.

Really?

A number of States are treated differently than other States. That is what legislation is all about. That is compromise.

Where is that taught? Where is that taught?

A number of States are treated differently than other States. That is what legislation is all about. That is compromise.

My friends, that is not what the American people call governing. That is called exactly an opposite contradiction of what the President of the United States said, where he says:

We will have negotiations televised on C-SPAN so that people can see who is making arguments.

I see the leader from Illinois over there. Just a few days ago, I said: What is in the bill?

The Senator from Illinois said: I don't know. I am in the dark too. I can give him his own quote.

So here we are, as the Senator from Tennessee said, in the middle of the night, and here we are, my friends, about to pass a bill with 60 votes. Sixty votes represent 60 percent of this body, but I can assure my friends on the other side of the aisle it doesn't represent 60 percent of the American people. In fact, 61 percent of the American people, according to a CNN poll, say they want this stopped. They disapprove of it. I guarantee you, when you go against the majority opinion of the American people, you pay a heavy price, and you should.

I will tell my colleagues right now that when you—this will be, if it is passed—and we are not going to give up after this vote, believe me. For the first time in history, for the first time in history, there will be a major reform passed on a party-line basis. Every reform—and I have been part of them—has been passed on a bipartisan basis. This will be a strict party-line basis.

I was thinking today about this vote, and I was thinking about other times and other examples I have had of courage or lack of or the fact that in the face of odds, you have to stand for what you believe in. I thought about back when I first entered the U.S. Naval Academy at the young age of 17. One of the first things they told us about in our learning of naval traditions was about a battle that took place early in the Revolutionary War. An American ship run by a captain engaged a British ship, the mighty British Navy. The American ship was outgunned and was outmanned. As they came together in mortal combat, with dead and dying all around, the British captain said: Do you surrender? The captain, John Paul Jones, said: I have not yet begun to fight.

I tell the American people: We are going to go around this country. We

are going to the townhalls, we are going to the senior centers, we are going to the rotary clubs. We are going to carry this message: We will not do this. We will not commit generational theft on future generations of Americans. We will not give them another \$2½ trillion in debt. We will not give them an unfair policy where deals are done in back rooms, and we—all of us on this side of the aisle—will stand for the American people, and we have just begun to fight.

The ACTING PRESIDENT pro tempore. Who yields time?

The Senator from Iowa is recognized.

Mr. HARKIN. Mr. President, for the last several weeks, all we have heard from the other side is attack, attack, attack. All we have heard from the other side is no, no, no. They keep talking. I just heard the Senator from Arizona saying this is not a bipartisan bill. I have heard so much talk on the other side in the last several weeks about how this should be bipartisan. Well, let's look at that for a second.

As I see it, the Republicans have no bill of their own. Our bill has 60 Democrats, a supermajority, a supermajority. Well, I guess there is a bill over there. It is the Coburn-Burr bill. It has seven cosponsors. That is it. That is it. Nothing else. Not all the Republicans are supporting it. My friends on the other side are all over the place. They can't even agree among themselves what they want to do. They have no comprehensive bill as we have come up with.

So I keep hearing that we Democrats are not bipartisan, but whom do we deal with? Just the Senator from Arizona? Just the Senator from Tennessee? How about the Senator from Oklahoma or the Senator from South Carolina? So I am sorry. I feel sorry the Republicans are all split up. They have not done their own homework to pull their own Senators together for something positive. So what they have done is they pulled together to say no, to try to kill the reform bill we have worked so hard on all year.

We extended a hand. If we had wanted to ace out the Republicans, we would have followed their lead on what they did in 2001, when they rammed through that tax cut for the wealthy. They did it on reconciliation so we couldn't filibuster it, so we couldn't have any debate on it. That is what they did. We didn't do it that way.

President Obama said we want to hold out the olive branch. We want to work with Republicans, so that is what we tried to do. Under the leadership of Senator DODD on our committee, we had numerous meetings with Republicans. We had a markup session that lasted 13 days 54 hours. We accepted 161 of their amendments and, in the end, everyone on the Republican side voted against it.

Senator BAUCUS bent over backward, week after week. He not only went the

extra mile, he went the extra 100 miles to try to get Republicans to work with him on this bill. In the end, only one Republican would vote for the bill out of committee.

So that is what we have. I am sorry to say my friends on the other side are in total disarray. They have nothing they can agree on. Well, we have something we have agreed on. Sixty, a supermajority, have agreed on moving a bill forward, a pivotal point in our history, in a decades-long march toward comprehensive health reform. It has alluded Congresses and Presidents going back to Theodore Roosevelt.

My friends on the other side defend the status quo. They want us to vote our fears—fear, fear, fear. Everything you hear, it seems, on the other side is fear. Be afraid. Well, it is not going to work this time because what the American people want is not fear, they want hope. They want the hope they will have the health care they need when they have to have it at a price that is affordable. They want to have the peace of mind and security of knowing that their children, if they have a pre-existing condition, will be covered by health insurance. They want to have the peace of mind of knowing that if they lose a job, they don't lose their health insurance. The American people want the hope and the security of knowing that if they get ill, they will not be dropped by their insurance company. They want the hope and the security to know they aren't just one illness away from bankruptcy.

We are the only country in the world—the only one—where people can go bankrupt because they owe a medical bill. No other country would allow that to happen. We are the only one. This bill is going to stop that. People will not have to fear going bankrupt because someone in their family got a chronic illness or a disease that is going to cost a lot of money. The American people want us to move forward, and we are going to do it tonight at 1 o'clock. We are going to move forward. We are not going to vote fears, we are going to vote hope.

We are going to tell the American people we are going to do three big things. First of all, we are going to cover 94 percent of Americans with health insurance—94 percent. Thirty-one million people out there without health insurance are going to get health insurance.

Secondly, we are going to crack down on the abuses of the insurance companies. No more cancelling your policy just because you got sick. No more lifetime caps which basically cause more and more people to go into bankruptcy. No more of those lifetime caps. We are going to make sure your kids can stay on your policy until they are age 26. We are going to do away with all these preexisting condition clauses next year for children, up to age 18, and then for

everyone later on after we get the exchanges set up.

Insurance companies will not be able to rescind your policy or drop you because you got cancer or heart disease. If you are a person out there who has your own health insurance policy right now and you like it, you can keep it. But guess what this bill will do. It will lower your premiums, and it will improve your coverage if you want to keep your own health insurance that you have right now.

Every year, about 45,000 Americans die in this country because they have no health insurance. Johns Hopkins did a study and said that children who have no health insurance are 60 percent more likely to die because of hospitalizations than kids who have health insurance coverage. It is a moral disgrace. The health insurance policies of America, what we have right now is a moral disgrace. You can talk to people from other countries, our closest allies, our closest friends who share so many of our values, and when they find out about our health care system, they say: How can you put up with it? This is disgraceful. You are the leader of the free world. You are supposed to set the example. And what a terrible example we have set in health care, what a terrible example.

Well, we have finally arrived at one of the most significant moments in the history of the Senate, one of the most significant. Our former chairman, Senator Ted Kennedy, fought all his life for national health insurance, and years ago, back in the 1960s, said health care ought to be a right, not a privilege.

He said that over 40 years ago, almost 50 years ago, that health care should be a right and not a privilege. It was always his highest priority. It was his great dream of an America where quality, affordable health care is that right. He thought of it as a moral imperative—a moral imperative. A lot of times, we lose that. We hear a lot of debate about how much this is, who is going to lose this, all these scare tactics. We see all these numbers and all that kind of stuff. We forget the essence of it. It is a moral imperative. We are called upon to right a great injustice, a great wrong that has been put upon the American people for far too long. It is a moral imperative that confronts us now that we will vote on in half an hour. We are closer than we have ever been to making Ted Kennedy's dream a reality.

A lot of people have worked very hard on this bill. I mentioned Senator BAUCUS. I mentioned Senator DODD; Senator REID, our leader, the amount of hours he has spent and the days he has spent here without his family, without going home, being here all the time working; our assistant leader, Senator DURBIN. So many people have worked so hard on this bill. We have

had so much input. Everyone has had input on this bill. Our Republican friends have had input on this bill. They had it in our committee. As I said, we accepted 161 amendments. So I guess you can say this bill has a lot of authors. But there is really only one author of this bill—Senator Ted Kennedy. It is his bill because it does get us the start.

To my friends, I say this is not the end of health care reform, it is the beginning. But we must make this beginning in order to fulfill that dream and really make health care a right, not a privilege.

In half an hour, let's make history. The other side says fear. We say hope. The other side says no. We say yes. We say yes to progress, yes to people, yes to health care as an inalienable right of every American citizen.

I yield the floor.

Mr. CORNYN. Parliamentary inquiry.

The ACTING PRESIDENT pro tempore. The Senator from Texas is recognized.

Mr. CORNYN. Mr. President, earlier today Senator GRASSLEY raised a parliamentary inquiry on rule XLIV of the Standing Rules of the Senate. As my colleagues recall, this was a rule that the Senate passed pursuant to the Honest Leadership and Open Government Act of 2007. The question had to do with whether the managers' amendment we are getting ready to vote on complied with rule XLIV's earmark disclosure requirement. At the time, the Chair indicated that the disclosure list was not submitted at the time. That was 6 p.m. today.

My inquiry is this: Is the Chair aware of the disclosure list being made available as required by rule XLIV now as we vote in the next 30 minutes?

The ACTING PRESIDENT pro tempore. The Chair is not aware at this time whether that statement has been made.

The Senator from Connecticut is recognized.

Mr. DODD. Mr. President, I wish to take a few minutes in closing, if I may.

I spoke earlier this evening about the importance of the moment we have all come to appreciate, I believe, a moment that has been years in the making, dating back, as all have pointed out or most have pointed out who spoke in favor of this legislation, to the early part of the last century with Theodore Roosevelt, a former Republican, who first advocated the notion of a national health care system in our Nation. Franklin Roosevelt picked up that challenge, and Harry Truman, of course, was the one who articulated it in specific terms.

It was 69 years ago this very month that Franklin Roosevelt identified the four freedoms: freedom of religion, freedom of speech, the freedom from want, and the freedom from fear. It is

that last freedom that Franklin Roosevelt talked about in December of 1941 that is deserving of our attention in these closing minutes.

Whatever else one may argue about the specifics of this bill, it is that fear that so many of our fellow citizens have over whether they will be confronted with a health care crisis and have the resources to address it and the ability to have a doctor, a physician, a health care provider, a hospital to provide them with that kind of help when they need it. That fear is not just for those without health care; it is even for those who have health care insurance. That fear persists.

This evening, more than anything else, beyond the specifics of the legislation in front of us is our desire to address that freedom from fear that was addressed so eloquently almost 70 years ago. So this evening we attempt, anyway, to begin that journey of eliminating those fears so many of our fellow citizens have over the loss or inability to acquire that kind of health insurance or the inability to have a doctor.

So we are poised to make a monumental vote on legislation that finally makes access to quality health care a right for every American. If you do not believe it is a right, that it is only a privilege, then I suppose you could come to a different conclusion. And there are those, I guess, who believe it is a privilege to have access to health care as an American citizen. Those of us on this side of the aisle believe it is a right, and as a right, you ought not to be denied that right based on economic circumstances, your gender, or your ethnicity in this Nation. You ought to have access to health care as a fundamental right in our Nation.

Obviously, we need to participate, engage in responsible activities that will make sure we contribute to the well-being of all our Nation to reduce the cost of health care.

This is a comprehensive bill. It has been more than just a year specifically on this effort but goes back 40 or 50 years in terms of drafting, and efforts have been made to achieve what we are trying to achieve this evening.

At the end of the day, however, this legislation is really about freedom from fear, as I said a moment ago. The bill frees Americans from the fear that if they lose their job, they will never find insurance coverage again. The bill frees Americans from the fear that they might get sick and be unable to afford the treatment they need. And the bill frees Americans from the fear that one illness, one accident could cost them everything they built—their homes, their retirement, their life savings.

In a nation founded on freedom and sustained by unimaginable prosperity, as I mentioned before, this bill is long overdue and critically important. No

American can be free from fear when getting sick could mean going broke.

This fight is older than most of us who serve in this body. Our path has been illuminated by a torch lit years ago in the days of Harry Truman and sustained for decades by good people, Republicans and Democrats—the Nixon administration, the Clinton administration, Members such as John Chafee, who worked tirelessly in trying to craft a good health care bill. We heard others talk about the regrets they had not acknowledging his ideas when he proposed them or we might have been able to address this issue years ago. Good people have tried to come up with some answers to this issue. It is with a note of sadness this evening that we are going to have a partisan vote on this matter. I wish it was otherwise.

I would like to point out that many of us have fought and challenged us to come up with these answers, but tonight this is our answer, the 60 of us who will vote to go forward with this bill. As Senator HARKIN just pointed out, it is hardly the final answer on this matter, but it allows us to begin that process of addressing these issues in a more thoughtful and comprehensive way in the years ahead.

Of course, no one was a better champion of all of this, as Senator HARKIN pointed out, than our deceased and beloved colleague from Massachusetts, Senator Ted Kennedy. He fought these battles for so many years. He understood that you could never solve all of these issues in one fell swoop. It was going to take an incremental approach to get us there.

I can guarantee that if he read this bill, there would be disappointments he would have in it. I knew him well enough to say that this evening. If he had written it on his own, he would have written it differently. Were he here among us this evening, he would urge all of us to move forward on this bill to address it, to vote for it, to allow this Nation to begin to grapple with this issue that should have been solved more than 50 years ago.

So this evening, again, as we come down to the final minutes of this debate, let's remind ourselves that history will judge us well for taking up this challenge once again and asking ourselves to give Americans the opportunity to live free from those fears they have this very evening. And tonight, we begin to alleviate those fears.

I urge my colleagues to support this effort.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Republican leader is recognized.

Mr. McCONNELL. Mr. President, tonight marks the culmination of a long national debate. Passions have run high, and that is appropriate because the bill we are voting on tonight will impact the life of every American. It

will shape the future of our country. It will determine whether our children can afford the Nation they inherit. It is one of the most consequential votes any of us will ever take, and none of us take it lightly. But make no mistake, if the people who wrote this bill were proud of it, they would not be forcing this vote in the dead of night.

Here are just some of the deals we have noticed: \$100 million for an unnamed health care facility at an unnamed university somewhere in the United States. The bill does not say where and no one will even step forward to claim it. Mr. President, 1 State out of 50—1 State out of 50—gets to expand Medicaid at no cost to itself while taxpayers in the other 49 States pick up the tab. The same Senator who cut that deal secured another one that benefits a single insurance company—just one insurance company—in his State. Do the supporters of the bill know this? I say to my colleagues, do you think that is fair to all of your States? What about the rest of the country?

The fact is, a year after the debate started, few people would have imagined this is how it would end—with a couple of cheap deals—a couple of cheap deals—and a rushed vote at 1 o'clock in the morning. But that is where we are. And Americans are wondering tonight: How did this happen? How did this happen? So I would like to take a moment to explain to the American people how we got here, to explain what has happened and, yes, what is happening now.

Everyone in this Chamber agrees we need health care reform. Everybody agrees on that. The question is how. Some of us have taken the view that the American people want us to tackle the cost issue, and we proposed targeted steps to do it. Our friends on the other side have taken the opposite approach, and the result has been just what you would expect. The final product is a mess—a mess. And so is the process that has brought us here to vote on a bill that the American people overwhelmingly oppose.

Any challenge of this size and scope has always been dealt with on a bipartisan basis. The senior Senator from Maine made that point at the outset of the debate and reminded us all of how these issues have typically been handled throughout our history. The Social Security Act of 1935 was approved by all but six Members of the Senate. The Medicare Act of 1965 only had 21 dissenters, and the Americans with Disabilities Act in 1990 only had eight Senators who voted no.

Americans believe that on issues of this importance, one party should never be allowed to force its will on the other half of the Nation. The proponents of this bill felt differently.

In a departure from history, Democratic leaders put together a bill so heavy with tax hikes, Medicare cuts,

and government intrusion that, in the end, their biggest problem wasn't convincing Republicans to support it, it was convincing the Democrats.

In the end, the price of passing this bill wasn't achieving the reforms Americans were promised, it was a blind call to make history, even if it was a historical mistake, which is exactly what this bill will be if it is passed. Because in the end, this debate isn't about differences between two parties, it is about a \$2.3 trillion, 2,733-page health care reform bill that does not reform health care, and, in fact, makes the price of it go up.

"The plan I am announcing tonight," the President said on September 9, "will slow the growth of health care costs for our families, our businesses and our government. My plan," the President said, "would bring down premiums by \$2,500 for the typical family. I will not sign a plan that adds a dime to our deficit," the President said, "either now or in the future." And on taxes, "No family making less than \$250,000 a year will see any form of tax increase," he said.

He said he wouldn't cut Medicare. He said people who liked the plans they have wouldn't lose their coverage, and Americans were promised an open and honest debate. "That is what I will do in bringing all parties together," then-Senator Obama said on the campaign trail, "not negotiating behind closed doors, but bringing all parties together and broadcasting these negotiations on C-SPAN."

Well, that was then and this is now. But here is the reality. The Democratic bill we are voting on tonight raises health care costs. That is not me talking, it is the administration's own budget scorekeeper. It raises premiums. That is the nonpartisan Congressional Budget Office talking. It raises taxes on tens of millions of middle-class Americans, and it plunders Medicare by $\frac{1}{2}$ trillion. It forces people off the plans they have, including millions of seniors. It allows the Federal Government, for the first time in our history, to use taxpayer dollars for abortions.

So a President who was voted into office on the promise of change said he wanted to lower premiums. That changed. He said he wouldn't raise taxes. That changed. He said he wanted lower costs. That changed. He said he wouldn't cut Medicare. And that changed too.

And 12 months and \$2.3 trillion later, lawmakers who made these same promises to their constituents are poised to vote for a bill that won't bend the cost curve, that won't make health care more affordable, and it will make real reform even harder to achieve down the road.

I understand the pressure our friends on the other side are feeling, and I don't doubt for a moment their sincerity. But my message tonight is this:

The impact of this vote will long outlive this one frantic snowy weekend in Washington. Mark my words: This legislation will reshape our Nation, and Americans have already issued their verdict: They do not want it. They do not like this bill, and they do not like lawmakers playing games with their health care to secure the votes they need to pass it.

Let's think about that for a moment. We know the American people are overwhelmingly opposed to this bill, and yet the people who wrote it will not give the 300 million Americans whose lives will be profoundly affected by it as much as 72 hours to study the details. Imagine that. When we all woke up yesterday morning, we still hadn't seen the details of the bill we are being asked to vote on before we go to sleep tonight.

When we woke up yesterday morning, we still hadn't seen the details of the bill we are going to be asked to vote on before we go to sleep tonight.

How can anybody justify this approach, particularly in the face of such widespread and intense public opposition? Can all of these Americans be wrong? Don't their concerns count?

Party loyalty can be a powerful force. We all know that. But Americans are asking the Democrats to put party loyalty aside tonight, to put the interest of small business owners, taxpayers, and seniors first.

And there is good news: It is not too late. All it takes is one—just one. All it takes is one. One can stop it. One can stop it or everyone will own it. One can stop it or every single one will own it.

My colleagues, it is not too late.

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

Mr. REID. Mr. President, all over this great country of ours, people are dying soon—far too soon. More and more Americans who come down with the flu, develop diabetes, or suffer a stroke are dying far earlier than modern science says they should die. More and more Americans who contract skin cancer or have a heart condition are dying rather than being cured.

Pull out the medical records of these patients and the official forms will tell you they died from complications of disease or maybe some surgery. But what is really killing more and more Americans every day are complications due to our health care system.

Much of our attention this year has been consumed by this health care debate. A national study done by Harvard University found that 45,000 times this year, nearly 900 times every week, more than 120 times every day, on average every 10 minutes, on end, an American died as a result of not having health insurance. Every 10 minutes. The numbers are numbing, and they don't even include those who did have health insurance but who died because

they couldn't afford a plan that met their most basic needs.

This country—the greatest and richest the world has ever seen—is the only advanced Nation on Earth where dying for lack of health insurance is even possible. To make matters worse, we are paying for that privilege. The price of staying healthy in America goes up, it goes up, it goes up and, not surprisingly, so do the numbers of Americans who can't afford it. In fact, medical bills are the leading cause of bankruptcy in America. And the second choice is way down the list—it is medical bills.

That is why we are here. Just as we have the ability to prevent diseases from killing us too soon, we have before us the ability to provide quality health care to every American. We have the ability to treat our unhealthy health care system. That is what this historic bill does. It protects patients and consumers. It lowers the cost of staying healthy and greatly reduces our debt.

This landmark legislation protects America's youngest citizens by making it illegal for insurance companies to refuse to cover a child because of a pre-existing condition.

It protects America's oldest citizens by strengthening Medicare and extending its life for almost a decade. We are also taking the first steps to closing the notorious loophole known as the doughnut hole that costs seniors thousands of dollars each year for prescription drugs. These are some of the reasons the AARP—the American Association of Retired People—and its 40 million Americans are supporting this bill.

Contrary to what we heard from my distinguished friend, the Republican leader, premiums are reduced by 93 percent. Ninety-three percent of people who have insurance will have reduced premiums.

This effort also strengthens our future by cutting our towering national deficit by as much as \$1.3 trillion over the next two decades. What my distinguished Republican counterpart is saying is without basis in fact. These aren't numbers that I came up with, these are numbers that the Congressional Budget Office came up with—\$1.3 trillion. That is trillion with a “t.” It cuts the deficit more sharply than anything Congress has done in a long time. It lowers costs. I have talked about Medicare.

My friend, the Republican leader, said it is going to reshape our Nation. That is why we are doing it. That is why we are doing this. We want to reshape the health care delivery system in our country. Is it right that America has 750,000 bankruptcies a year, about 80 percent of them caused by health care costs, and 62 percent of the people who have filed bankruptcy have health care costs? We are reshaping the Nation. That is what we want to do. That is what we have to do.

With this vote, we are rejecting a system in which one class of people can afford to stay healthy while another cannot. It demands for the first time in American history good health will not depend on great wealth. Good health should not depend on how much money you have. It acknowledges, finally, that health care is a fundamental right, which my friend Senator HARKIN spoke about so clearly—a human right—and not just a privilege for the most fortunate.

President Johnson, former majority leader of the Senate, signed Medicare into law when he was President, with the advice: “We need to see beyond the words to the people they touch.” That is just as true today as it was 44 years ago when he signed that legislation.

This is not about partisanship or about procedure. And everyone knows we are here at 1 o'clock in the morning because of my friends on the other side of the aisle. For them to say with a straight face—and I know some of them didn't have that straight face—that we are here because of us is without any foundation whatsoever. And everyone knows that.

This is not about politics. It certainly is not about polling. It is about people. It is about life and death in America. It is about human suffering. Given the chance to relieve the suffering, we must.

Citizens in each of our States have written to tell us they are broke because of our broken health care system. Some have sent letters with even worse news—news of grave illness and preventable death. For weeks, we have heard opponents complain about the number of pages in this bill, but I prefer to think of this bill in terms of the people it will help.

A woman named Lisa Vocolka, who lives in Gardnerville, NV—a beautiful city below the Sierra Nevada mountains—lives with her two daughters, both of whom are in elementary school. The youngest suffers seizures. Her teachers now think she has a learning disability.

Because of her family history, Lisa, the girl's mom, is at high risk of cervical cancer. Although she is supposed to get an exam every 3 months, she doesn't go. She is lucky if she goes once a year, and most of the time she is not very lucky. When Lisa lost her job, she lost her health coverage. Now both Lisa and her daughter miss the tests and preventive medicine that could keep them healthy. Her long letter ended with a simple plea. It was: “We want to be able to go to the doctor.”

That is why this bill will ensure all Americans can get the preventive tests and screenings they need. I am voting yes because I believe Lisa and her daughter deserve to be able to go to the doctor.

A teenager named Caleb Wolz is a high school student from Sparks, NV.

Like so many students, he used to play soccer when he was younger. Now he sticks to skiing and rock climbing. You can forgive him, I am sure, for giving up soccer. You see, Caleb was born with legs that end above his knees.

As children mature, even Caleb, they grow out of their clothes. Most kids grow out of their shoes. Caleb doesn't. A lot of kids probably get a new pair every year but Caleb has needed a new pair of prosthetic legs every year since he was 5 years old. Unfortunately and unbelievably, Caleb's insurance company has decided it knows better than his doctor and has decided Caleb doesn't need those legs. That is why this bill will make it illegal for those insurance companies to use preexisting conditions as an excuse for taking our money but not giving coverage.

This is a big change. But isn't it a good change? I am voting yes because I believe Caleb deserves a set of prosthetics that fit.

Ken Hansen wrote to me from Mesquite, NV, a town on the border of Nevada, Utah, and Arizona. He has chronic heart problems and parts of his feet have been amputated but Ken can't go to the doctor because he makes too much to qualify for Medicaid and too little to afford private insurance. I share with the Senate exactly what Ken wrote me:

I am very frustrated because it seems my only hope is that I die very soon, because I cannot afford to stay alive.

That is why this bill will expand Medicaid to cover people like Ken from Mesquite, NV, who are caught in the middle. I am voting yes because when someone tells me his only hope is to die, I think we have to take a close look at that. I can't look away. I cannot possibly do nothing.

A man by the name of Mike Tracy lives in North Las Vegas. His 26-year-old son has been an insulin-dependent diabetic since he was a baby. The insurance Mike's son gets through work will not cover his treatments and the Tracys can't afford to buy more insurance on their own. But his family's troubles are about more than just money. Since they couldn't afford to treat his diabetes, it developed into Addison's disease—which of course they can't afford to treat either. It could be fatal.

This is what he wrote to me 2 weeks ago:

I don't know what to pray for first: that I will die before my son will so I don't have to bear the burden, or that I outlive him so I can provide support to his family when he is gone.

Quite a set of prayers. This should not be a choice any American should have to make. It should not be a choice any father or mother should have to make—and when given the chance to help people like Mike, our choice should be very easy.

That is what this legislation is all about. These are hard-working citizens

with heartbreaking stories. They are people who played by the rules and simply want their insurance company to also do the same. They are not alone. These tragedies do not happen only to Nevadans. They don't happen only to people who, despite all their pain, find time to write their leaders in Congress. These tragic events happen to people on the east coast, the west coast, and everywhere in between. These tragedies happen to Americans in small towns and in big cities. These tragedies happen to citizens on the left side of the political spectrum and on the right side. As Mike Tracy wrote in his powerful letter about his son:

Democrats need health care. Republicans need health care. Independents need health care. All Americans need health care.

Get it done.

He is right. Every single Senator, every one of us, comes from a State where these injustices happen every single day. Every single Senator represents hundreds, thousands of people who have to choose between paying an electricity bill or a medical bill; between filling a doctor's prescription or—well, maybe just hoping for the best—between their mother's chemotherapy treatment and their daughter's college tuition.

As I mentioned earlier, on average an American dies from lack of health insurance every 10 minutes. That means in the short time I have been speaking our broken system has claimed at least two lives. Another American has died, another American has died—two have died a preventable death, each of them.

So as our citizens face heart-rending decisions every day, tonight every Senator has a choice to make as well. That choice: Are you going to do all you can to avert the next preventable death? I hope so. I urge an aye vote to stop this filibuster.

Mr. President, I advise my Members that in 1984 the Senate adopted a resolution, S. 40, to impose a requirement that Senators vote from their desks. I know we do not do this all the time but I ask tonight we do vote from our desks and follow the rule, S. Res. 40, and have Senators vote from their desks.

CLOTURE MOTION

The PRESIDING OFFICER. The motion to invoke cloture having been presented under rule XXII, the Chair directs the clerk to read the motion.

The legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the Reid amendment No. 3276 to the Reid substitute amendment No. 2786 to H.R. 3590, the Service Members Home Ownership Tax Act of 2009.

Christopher J. Dodd, Richard Durbin, Max Baucus, Paul G. Kirk, Jr., Claire McCaskill, Jon Tester, Maria Cantwell, Barbara A. Mikulski, Mark Udall, Arlen Specter, Sherrod Brown, Mark

Begich, Sheldon Whitehouse, Bill Nelson, Roland W. Burris, Kirsten E. Gillibrand, Ron Wyden.

The PRESIDING OFFICER. By unanimous consent the mandatory quorum call is waived. The question is, Is it the sense of the Senate that debate on amendment No. 3276 to the Reid substitute amendment No. 2786 to H.R. 3590, the Service Members Home Ownership Tax Act of 2009, shall be brought to a close?

The yeas and nays are mandatory under the rule.

The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

The yeas and nays resulted—yeas 60, nays 40, as follows:

[Rollcall Vote No. 385 Leg.]

YEAS—60

Akaka	Franken	Mikulski
Baucus	Gillibrand	Murray
Bayh	Hagan	Nelson (NE)
Begich	Harkin	Nelson (FL)
Bennet	Inouye	Pryor
Bingaman	Johnson	Reed
Boxer	Kaufman	Reid
Brown	Kerry	Rockefeller
Burris	Kirk	Sanders
Byrd	Klobuchar	Schumer
Cantwell	Kohl	Shaheen
Cardin	Landrieu	Specter
Carper	Lautenberg	Stabenow
Casey	Leahy	Tester
Conrad	Levin	Udall (CO)
Dodd	Lieberman	Udall (NM)
Dorgan	Lincoln	Warner
Durbin	McCaskill	Webb
Feingold	Menendez	Whitehouse
Feinstein	Merkley	Wyden

NAYS—40

Alexander	DeMint	McCain
Barrasso	Ensign	McConnell
Bennett	Enzi	Murkowski
Bond	Graham	Risch
Brownback	Grassley	Roberts
Bunning	Gregg	Sessions
Burr	Hatch	Shelby
Chambliss	Hutchison	Snowe
Coburn	Inhofe	Thune
Cochran	Isakson	Vitter
Collins	Johanns	Voinovich
Corker	Kyl	Wicker
Cornyn	LeMieux	
Crapo	Lugar	

The PRESIDING OFFICER (Mrs. SHAHEEN). On this vote, the yeas are 60, the nays are 40. Three-fifths of the Senators duly chosen and sworn having voted in the affirmative, the motion is agreed to.

The Chair announces that because cloture has been invoked, the motion to refer falls.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. REID. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, I would like to thank the employees in the Office of the Secretary of the Senate who read the managers' amendment aloud for more than 7 hours on Saturday, December 19, 2009. They are:

Kathie Alvarez, John Merlino, Mary Anne Clarkson, Scott Sanborn, Leigh Hildebrand, Sheila Dwyer, Adam Gottlieb, Joe Johnston, Elizabeth MacDonough, Ken Dean, Michelle Haynes, Patrice Boyd, William Walsh, Valentin Mihalache, and Cassie Byrd.

The readers represent the offices of the Legislative Clerk, Assistant Secretary of the Senate, Parliamentarian, Bill Clerk, Journal Clerk, Executive Clerk, Daily Digest, Enrolling Clerk, and the Official Reporters of Debates.

Mr. CARDIN. Mr. President, on Wednesday, the junior Senator from Vermont offered his "single-payer" health insurance amendment, amdt. No. 2837, to H.R. 3590. Under rule XV of the Standing Rules of the Senate, an amendment must be read aloud into the RECORD unless its reading is dispensed with by unanimous consent. Such consent is routinely granted but in this instance, the junior Senator from Oklahoma objected so the clerks commenced with reading the 767-page amendment. After several hours passed, Senator SANDERS withdrew his amendment.

Later in the day, the Republican leader came to the floor and complained that "the majority somehow convinced the Parliamentarian to break with the longstanding precedent and practice of the Senate" with regard to the reading of the amendment. He claimed that continued reading of the amendment could not be dispensed with absent consent being granted, suggesting that Senator SANDERS had no right to interrupt the reading to withdraw his amendment. The Republican leader cited Riddick's *Senate Procedure: Precedents and Practices*, pages 43-44, which states, in part:

Under Rule XV, paragraph 1, and Senate precedents, an amendment shall be read by the Clerk before it is up for consideration or before the same shall be debated unless a request to waive the reading is granted; in practice that includes an ordinary amendment or an amendment in the nature of a substitute, the reading of which may not be dispensed with except by unanimous consent, and if the request is denied the amendment must be read and further interruptions are not in order; interruptions of the reading of an amendment that has been proposed are not in order, even for the purpose of proposing a substitute amendment to a committee amendment which is being read.

When an amendment is offered the regular order is it reading, and unanimous consent is required to call off the reading.

A Senator has, at the sufferance of the Senate, reserved the right to object to dispensing with further reading of an amendment.

Later on Wednesday, the senior Senator from Illinois ably addressed the Republican leader's concerns but I bring the matter up again because I was presiding at the time Senator SANDERS withdrew his amendment and Senator COBURN called for regular order. I received several phone calls afterwards from individuals who claimed that I acted erroneously in permitting Senator SANDERS to with-

draw his amendment so I would like to set the record straight.

First of all, before Senator SANDERS withdrew his amendment, I consulted with the Senior Assistant Parliamentarian, who was on the floor while I was presiding. He assured me that a Senator has the right to withdraw an amendment if no action has been taken on it. No action can be taken on an amendment until it is officially pending. An amendment is not officially pending until it has been read into the RECORD or such reading has been waived by unanimous consent.

It is important to understand that while the Presiding Officer, not the Parliamentarian, makes rulings, it would be unusual for him or her to ignore the advice of the Parliamentarian. Martin Gold, who was the senior floor staffer to two former Republican majority leaders, Howard H. Baker, Jr., and William H. Frist, MD, of Tennessee, writes in his definitive book, "Senate Procedure and Practice," that former Parliamentarian Floyd M. Riddick "claimed that in twenty-five years of advising the presiding officer, the Senate only once voted to overturn him on appeal. He also cites an example of Vice President Alben Barkley ignoring the parliamentarian's advice, only to be overturned on appeal." The Parliamentarian is a nonpartisan officer of the Senate. In the 72 years since the position was created, there have been just five Parliamentarians. The Parliamentarian and his staff are experienced professionals. I sought and received the Parliamentarian's advice on this matter and I followed it, which is how the Senate usually operates.

The Parliamentarian and his staff conducted extensive research on rule XV and the precedents governing the reading and withdrawal of amendments prior to what happened during Wednesday's session. While the Riddick's text the Republican leader cited seems plain enough, it is trumped by section 2 of rule XV itself, which clearly and succinctly states:

Any motion, amendment, or resolution may be withdrawn or modified by the mover at any time before a decision, amendment, or ordering of the yeas and nays, except a motion to reconsider, which shall not be withdrawn without leave.

Prior to the time Senator SANDERS withdrew his amendment, no action had been taken on it that would have prevented such a move without consent for a very simple reason: the amendment wasn't officially pending while it was being read into the RECORD. So Senator SANDERS had an unfettered right to withdraw it under such conditions.

The precedent for a Senator's ability to withdraw an amendment while it is being read without gaining consent first, either to dispense with the reading or to withdraw it, was firmly established in 1950 and reiterated in 1992. On

April 14, 1950, Senator Forrest C. Donnell insisted that an amendment being offered by Senator William Benton be read in its entirety. Afterwards, Senator Benton sought unanimous consent to withdraw his amendment. Senator Donnell made a parliamentary inquiry of the Chair, asking the Presiding Officer whether a Senator may withdraw an amendment while it is being read. He further stated that if consent were necessary he would object. The Presiding Officer replied that an amendment may indeed be withdrawn while it is being read, citing the language in rule XV I just mentioned. And Senator Benton withdrew his amendment.

On September 24, 1992, Senator Brock Adams offered an amendment to a tax bill and sought consent twice to dispense with reading it. In both instances, Senator Bob Packwood objected so the clerk proceeded to read the amendment aloud. Later, Senator Adams asked for "permission" to withdraw the amendment and the Chair replied affirmatively that he had the right to do so.

The 1950 precedent is cited on page 119 of Riddick's for the proposition that an amendment may be withdrawn "even as soon as it has been read" but it is, in fact, the same ruling as the 1992 precedent, that a Senator may withdraw his amendment while it is being read.

The Republican leader did not refer to the 1950 precedent in his comments on Wednesday but spoke disparagingly of what happened in 1992, saying, "the Chair made a mistake and allowed something similar (to Senator SANDERS' move) to happen. But one mistake does not a precedent make."

The Parliamentarian doesn't share the Republican leader's contention that the 1992 action was a "mistake," not a precedent. The Parliamentarian's view is echoed by Walter Oleszek, the noted senior specialist in American National Government at the Congressional Research Service, CRS, who wrote last year, "Senators are free to modify or withdraw their amendments until the Senate takes 'action' on them." This is from *Senate Amendment Process: General Conditions and Principles*, CRS Report 98-707, May 19, 2008. Martin Gold's book, "Senate Procedure and Practice," states:

When a senator sends an amendment to the desk, he continues to "own" that amendment in the sense that he can modify or withdraw it *at will* (my emphasis) . . . Once "action" has been taken on the amendment, that situation changes, and the senator can modify or withdraw his amendment only by unanimous consent. This is from page 102.

The minority has tried to argue that there was Senate action on the Sanders amendment because the Senate previously had agreed to a unanimous consent request defining the amendment and the Hutchison motion to recommit as the only propositions in order at

that stage and prohibiting amendments to them. It is true that if an amendment is on a defined list of the only amendments made in order, that amendment when pending cannot be withdrawn except by unanimous consent. But that order is irrelevant in this case because, as I mentioned before, the Sanders amendment was not pending and could not be until it was read in full or unless the reading was dispensed with by unanimous consent. Another way to put it is that the reading of the amendment was not "interrupted" by Senator SANDERS; in withdrawing it he obviated the reason for a reading. The order allowed but did not require, as it could not, that Senator SANDERS offer the amendment and take steps to make it pending.

So, to summarize, rule XV of the Standing Rules of the Senate and the 1950 and 1992 precedents are clear that Senator SANDERS was well within his rights to withdraw the amendment, the reading of it notwithstanding. The Parliamentarian advised me accordingly and I followed his advice. I would add that Senator COBURN never explicitly objected to Senator SANDERS withdrawing the amendment. He called for regular order. While regular order was indeed the reading of the amendment, that status couldn't prevent Senator SANDERS from exercising his right to withdraw it.

Finally, I regret that several of my colleagues on the other side of the aisle made comments that were critical of the Parliamentarian and his staff following this incident. The current Parliamentarian helped to write, edit, and revise Riddick's Senate Procedure and he has served in his current capacity as Chief Parliamentarian for 17 years and counting, and as a Senate Parliamentarian for 33 years. He and his staff have a combined total of 84 years of experience. They are professionals who serve this institution and the American people with distinction.

ORDERS FOR MONDAY, DECEMBER 21, 2009

Mr. KAUFMAN. Madam President, I ask unanimous consent that the Senate now stand in recess until 12 noon today, that immediately upon reconvening at noon and after any leader time, the Senate then resume consideration of H.R. 3590, with the time until 12:30 p.m. equally divided and controlled between the two leaders or their designees; that from 12:30 p.m. to 6:30 p.m., there be 1-hour alternating blocks of time, with the majority controlling the first block; that all postcloture time continue to run during any recess, adjournment, or period of morning business until 6:30 p.m. Monday.

The PRESIDING OFFICER. Without objection, the request is agreed to.

RECESS UNTIL 12 P.M. TODAY

The PRESIDING OFFICER. The Senate stands in recess until 12 p.m. today.

Thereupon, the Senate, at 1:33 a.m., recessed until 12 p.m. and reassembled when called to order by the Presiding Officer (Mr. ROCKEFELLER).

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The PRESIDING OFFICER. Under the previous order, the Senate will resume consideration of H.R. 3590, which the clerk will now report.

The bill clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

The PRESIDING OFFICER. Under the previous order, the time until 12:30 shall be equally divided and controlled between the two leaders or their designees.

The assistant Democratic leader is recognized.

Mr. DURBIN. Mr. President, this morning we are continuing to run time postcloture on the managers' amendment. Following any leader remarks, the time until 12:30 p.m. is equally divided between the two leaders or their designees. Senator REID has asked me to serve as his designee on the Democratic side. At 12:30 p.m., we will begin alternating 1-hour blocks of time until 6:30 p.m., with the majority controlling the first hour. If all 30 hours postcloture is required, then the rollcall vote on the managers' amendment will occur about 7:15 a.m. tomorrow, Tuesday morning, and the cloture vote on the substitute will occur immediately after that. So we expect at least two rollcall votes early Tuesday morning. Hopefully, votes will not be needed today to recess or adjourn this evening. That is the state of play and business on the floor.

I see the majority leader has arrived on the floor, and I wish to give him a chance, if he is seeking that opportunity, to make any announcements he believes will be timely and appropriate.

The majority leader indicates he is not going to make an announcement, so I wish to make some comments about where we are at this moment.

I can't imagine there are many people in America who have been following this day's session because it began at 12:01 a.m., when the Senate was reconvened for a vote on the managers' amendment to health care reform, which took place just a few minutes after 1 a.m. this morning. We recessed and now are returning for the rest of the legislative day.

When the history of the Senate is written, I think this vote will be included because it is a historic vote. We consider many issues in the Senate of great importance to individuals,

groups, States, and to our Nation, but seldom do we address an issue of this magnitude or scope. This health care reform issue literally touches every person who is following this debate and many who are not even aware of it. What we are doing is addressing some of the fundamentals of our health care system in America that need to be changed.

Whenever you are suggesting change in America, there is resistance. There are people who are currently comfortable with the health care system as we have it, and there are people who are benefiting from the system as we know it, particularly health insurance companies which enjoy great profits because of the current system of health care in America. But at the heart of the issue, we know this system is unsustainable and, as a result, we have engaged in almost a 1-year effort to thoroughly investigate our health care system and to find ways to change it for the better. This has called on so many of our colleagues to make extraordinary contributions to this search for reform.

I wish to commend, first, our majority leader HARRY REID, who usually stands at our caucus meetings and says: Stop congratulating me; I am just doing my job. I am going to do it anyway. Senator REID has worked tirelessly—and I have seen most of it firsthand—to build a coalition for health care reform within the Democratic caucus. We didn't have a single Republican vote that was in support of reform in the early morning hours. I hope that changes as time passes, but he had to build a coalition within our caucus of conservative and progressive Senators, and he did it, so we had all 60 Democratic Members voting for health care reform.

We are united in the belief that there are fundamental things that need to be changed in our health care system. First, it needs to be more affordable. People cannot afford this dramatic escalation in the cost of health care. Ten years ago, a health care policy for a family of four offered through their employer cost about \$6,000 a year in premiums. That is \$500 a month which, instead of being paid to an employee as salary, was taken from them for health insurance—\$500 a month.

Today, that number has grown to \$12,000 a year for an average family of four for health insurance through their employment. One thousand dollars a month that might otherwise go to a family for basic necessities of life and savings and buying things that are important to their future instead goes to pay for health insurance. That escalation, that 100-percent increase in health insurance premiums in 10 years, is troubling but not nearly as troubling as the projection that if we continue to see an escalation in costs of health insurance premiums based on what we

have seen in the past, in another 8 years it will double again. Imagine 8 years from now, in 2017, that you have to work and earn \$2,000 a month just to pay for your health insurance. How many people will be able to do that? How many businesses will be able to afford it? The answer is obvious. More and more people will be dropped. Today, 50 million Americans have no health insurance. Many of them go to work every single day, but their employers can't afford to provide health insurance or they are unemployed or they have some other problem where they have been excluded by a health insurance company. So in addition to dealing with the fundamental issue of health care reform, we are focusing on affordability, how to bend the cost curve, as they say, or reduce the increase in costs of health insurance premiums. I wouldn't stand here and say to the people of America, with the passage of the bill we are now considering, everyone's health insurance is going down, but I think I can say, with some confidence, the rate of increase is going to decline, and that will give people a better chance of affordability. That is essential.

Secondly, what about those 50 million uninsured people? I have met them, as the Senator from West Virginia has as well. These are not lazy, shiftless people who aren't trying. Many of them are trying hard, but they don't have a chance for health insurance coverage for a variety of reasons. We are going to change that. Of the 50 million currently uninsured, over 30 million will have insurance under this bill. Those in the lower income categories will qualify for what we call Medicaid, which is a Federal-State health insurance program for the poor and disabled. Most of those people—those who make less than \$15,000 a year—will not pay any premiums because they can't. They don't have enough money. For those who are making slightly more, we provide in this bill tax credits that will help people pay for their premiums. So if your family is making up to \$80,000 a year, the Tax Code will now help you pay for your monthly premium for health insurance.

So we are going to expand coverage. Thirty million people are going to have the security of health insurance coverage. We are bending the cost curve so the increase in health insurance premiums is not as steep, making sure more people are covered, and then, equally important, we are changing the rules when it comes to health insurance companies.

For too long, these health insurance companies have ruled the roost. Since the early 1940s, they have been exempt from antitrust laws which allow them to literally collude and conspire with these set prices. Over half the insurance markets in America are domi-

nated by only two companies, and it is legal under our law for those two companies to sit down and say: OK, how much are we going to charge? They don't compete with one another, they conspire with one another to set premium rates. If you think I am a conspiracy theorist, what I am stating to you is what the law clearly says in the McCarran-Ferguson Act—something I think should be repealed posthaste—because they can sit down and set premiums. They can also allocate markets. They can say to two companies: You take over St. Louis and those two companies will do Chicago and these two companies are going to do Wheeling, WV. They can set up the market structures so there is little or no competition. How can that be good? If we truly believe in a free market system, how can this be good for America?

So what we are doing as well is saying: We are going to change some of these rules, some of the most egregious abuses by these health insurance companies—first and foremost, preexisting conditions. How many of us are in such perfect health that we can count on a health insurance company covering us without delving into our background, finding something in our family history or something in our own personal history and saying: Well, we are either not going to cover you or we are going to charge you dramatically more. Those days have to end.

Let me tell my colleagues what this bill does. It says immediately—immediately—children under the age of 18 with preexisting conditions cannot be discriminated against by health insurance companies. You can't deny them coverage because a child is born and develops diabetes. You can't deny coverage because a child has had cancer and is fighting that cancer. You cannot deny coverage because of those preexisting conditions. That is fundamentally fair. It gets to the heart of what we should be doing as a nation.

Senator TOM HARKIN of Iowa stood at this podium early this morning and said: What this debate is about is whether health insurance is a right or a privilege. If it is a privilege only for the wealthy in America, then we have lost our way as a nation. We have to understand that protection of our well-being and health through health insurance is something every American is entitled to. We have to understand we are the only developed Nation on Earth where a person could literally die because they don't have health insurance.

If you think that is overly dramatic, let me give an illustration.

A man I met in Illinois had a health insurance policy that wasn't very good. It had a \$5,000 copay. He had to take that copay so his premiums would be low enough so he could afford it. That man went to a doctor who said to him: I see some indications from tests that

you need a colonoscopy. You may be developing colon cancer. So the man went and priced a colonoscopy procedure and found out it was \$3,000 he would have to pay out-of-pocket and he said: I don't have it. So he didn't go through with the procedure. That is a risky thing, and it is something no one should have to face, but that is the current system.

What we are trying to do is change that system so that basically preexisting conditions are excluded from the discrimination of health insurance companies, that basic procedures that are needed for prevention and wellness are included in every health insurance policy. We are also making certain that these health insurance companies can't cut you off when you need them the most, can't cancel your policy when you face an accident or a diagnosis where medical bills are going to pile up. That is one of the provisions of this bill as well.

We also say, for families with young children who are off to college—and my wife and I have been through this—that you reach the point where you finally say: Wait a minute. My daughter is graduating from college. I wonder if she is still under my family health insurance plan. Today, in most cases, if your child has reached the age of 24, they are off your family plan. Well, we extend that now so those 24 and 25 will have the protection of their family health insurance plan while they finish school, look for their first job and obtain their own health insurance. That is going to be peace of mind for a lot of families across America, just those 2 years when young people are the most vulnerable and need the protection of their family health insurance plan.

Are these worth anything, these changes? I think they are worth a lot. I think that is why 60 Democrats stood proudly and voted for this.

Senator MCCONNELL, the Republican leader, turned to us in the midst of this dramatic debate early this morning and said: If one of you—and he pointed to all of us sitting here—doesn't vote against it, then all of you Democratic Senators will own this.

We know that, and we have pride in that ownership because we know the alternative. Those who voted against change are voting for a system that is unsustainable and morally indefensible—a system which, frankly, today puts good, hard-working people, folks who follow the rules, Americans who believe they are doing the very best for their country, at a distinct disadvantage for one of the most basic things we expect in life: protection of good health care when we are facing illness and when we need a helping hand.

This bill is also going to change the face of health care in America. I don't think I overstated it. Our bill has \$10 billion to be invested in community health clinics. Senator BERNIE SANDERS of Vermont has been such a leader

on this issue and deserves credit for it. He was dogged. Some Members looked to this bill for a variety of things, but Senator SANDERS looked to this bill to provide a helping hand across America through community health clinics. As those clinics are built and expanded, more and more small towns in West Virginia and in Illinois are going to have satellite clinics where people, regardless of whether they are wealthy or not as wealthy, will have a chance to walk in the front door and see a medical professional. They will not be queuing outside the emergency rooms of hospitals, where their care is much more expensive. They will be going to these community health clinics and meeting primary care physicians who will give them the basic care they need before their medical problems become much more serious.

That is what this bill is fundamentally about. There are many other parts to it, parts I am proud to be co-sponsoring and proud to be supporting—giving a hand to small businesses, giving a hand to individuals to expand health insurance coverage.

Some might ask: If you voted on it at 1 o'clock this morning, why are you still here? Because the minority is exercising its right under the Senate rules which requires us now to wait 30 hours before we can vote again on this one section of the bill. As I announced this morning, that means that in the early hours tomorrow morning, about 7:15 or 7:20, Senators will be coming to the floor again for two votes to move this process forward. I understand it is the right of the minority to ask us to come in at 1 in the morning or early in the morning. They have that right. Historically, we have usually reached some accommodation and agreement, and I hope we can here. The 60 votes that were there last night will be there again tomorrow morning, and they will be there every time needed until this bill is finally passed.

Those on the other side believe this bill is so bad that it is going to revitalize the Republican Party in the next election. I disagree with them. I think the American people, as they come to understand this bill, will view it in its historic context, one of the most dramatic steps forward to provide peace of mind and security to families and businesses across America for an issue we know needs to be addressed.

There are some who came to the floor yesterday—there was one Senator. I invited him to come in and explain his remarks. He said people should say a prayer that someone would miss the vote at 1 a.m. I do not think we should be praying for misfortune for our Senators, that they would be delayed or for some other reason could not make the vote. Instead, we should be praying to overcome the misfortune of 30 million Americans who will not have health insurance if this bill fails. That

is the kind of misfortune I want to avoid in the future.

We also have one other item of business remaining, and that is the debt ceiling of America. It is something none of us want to face. It is almost like making your monthly payment for the mortgage, and that is what it is, the mortgage of America. We have to acknowledge the fact that as we fight a war and incur the costs, as we have the workings of government assessed, and we know there are costs, it adds to the expense of our government, and some of it is in debt, and that debt needs to be extended for a short period of time as we move forward into the next year that begins in just a few days. This debt ceiling issue is one we need to come to grips with before we leave at the end of this month. There is a short-term extension which I hope the Senate will consider.

I wish to also say that Senator CONRAD of North Dakota, chairman of the Senate Budget Committee, has been a real leader in talking about coming to grips with this long-term debt. I have said to him, in the midst of a recession, with high unemployment, most economists believe it would be a mistake for us to pull back in terms of the safety net for families out of work, to pull back in terms of the investment in infrastructure to put people to work, and Senator CONRAD says he agrees. Although he believes we need to be honest about the debt of America, he has said to me repeatedly that he is not a Hooverite, referring to that period in history when the Great Depression hit and President Herbert Hoover believed government should address the debt of America instead of the depression of America. He lost that election to Franklin Roosevelt in 1932 as a result of that point of view.

Many of us believe the debt is a serious issue to be grappled with, but at the current moment we have to focus on the millions of Americans out of work who need a helping hand, first with unemployment benefits, COBRA benefits, food stamps, the basic necessities of life. We have to provide opportunities for education and training, and then we have to find a way to spark this economy and move it forward.

Senator REID has given to me and Senator DORGAN of North Dakota the responsibility of looking at the Senate jobs-creation package. We have been working on that, and we are close with our colleagues in the House in coming up with some ideas on how to expand employment. I hope we can have bipartisan support for that. It would certainly make it a lot easier, and it would be done more quickly so that we do not lose jobs in the next construction season coming up next year.

That is the reality of the agenda we face when we return. I did tell you that now most Members of the Senate on

both sides of the aisle are anxious to share their holiday season with their families. It is one of those special times of the year. We now have a record vote of 60 Members on this side on health care reform. I hope we can get the agreement from the Republican side to bring this matter to closure soon, to vote on the debt ceiling, and to have at least a short adjournment for some time for us to return home to our States and home to our families.

Mr. President, if there is no one seeking recognition at this time, I suggest the absence of a quorum and ask that the time under the quorum call be assessed against both sides.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will call the roll.

The assistant bill clerk proceeded to call the roll.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Under the previous order, the time until 6:30 p.m. will be divided in 1-hour alternating blocks of time, with the majority controlling the first block.

Mr. BAUCUS. Mr. President, I wish to take a few moments this morning to talk about a provision in this package about which I am particularly proud. This would finally follow through on the Federal Government's responsibility to provide screening and medical care to residents at Superfund public health emergency sites.

The term "public health emergency" is defined by the Comprehensive Environmental Response Compensation and Liability Act of 1980, otherwise known as CERCLA. People call that the Superfund law—CERCLA. That law reserves the declaration of public health emergency for the most hazardous Superfund sites. These are sites where the release or potential release of a hazardous substance rises to the level of an emergency.

When a public health emergency is declared, the law requires that the Secretary of Health and Human Services provide screening and medical care services to people who have been exposed. But to date, the government has not created a mechanism to allow the Secretary to deliver the screening and medical care required under current law. The bill before us finally provides that mechanism.

First, it authorizes a grant program for the screening services. These screenings would determine if a medical condition is present that is attributable to environmental exposure. Then, it allows those individuals with a diagnosed medical condition due to the environmental exposure at the site to get medical care services.

It also establishes a pilot program to provide additional medical care appropriate for the residents of the Superfund site at Libby, MT. This language

responds to Libby's rural nature and the lack of access to traditional care. This provision is important because it will provide vital medical services to Americans who, through no fault of their own, have suffered horrible effects from their exposure to deadly poisons. It will provide the vital medical services we owe these Americans under our commitment in prior legislation; that is, the Superfund Act.

This provision is especially important to me for a special reason. The Environmental Protection Agency currently has 1,270 sites designated where pollution contamination presents a danger to public health and welfare. Throughout the history of the program, the EPA has found only one site where conditions are so severe and the contamination so pervasive to have it warranted a declaration of a "public health emergency." That declaration occurred on June 17 of this year. EPA Administrator Jackson found that a public health emergency exists at the Superfund site in Libby, MT.

Many Senators have heard me speak about Libby. Libby, MT, is a beautiful little town, a small town in northeastern Montana, surrounded by millions of acres of Federal forest lands. It appears to be an idyllic spot. It is home to families of all ages. It is a place where people spend their lives creating a sense of community not often found in the country today. It is also a town that has gone through lots of stress, lots of economic difficulties. The timber industry has virtually shut down Libby, one of the mainstays in Libby. Mining there is not quite what it used to be in years past. Here the people work together. They love Libby. It is tucked away, almost isolated in the northeastern part of Montana. Most people in Montana have never been to Libby, and some don't even know where Libby is, but they have this wonderful sense of community in their own town.

However, Libby is also a Superfund site. It is the home of a big mine. It is a place where hundreds of people have grown sick and died—died due to pervasive presence of asbestos spewed from the vermiculite mining and milling operations of W.R. Grace.

Gold miners discovered vermiculite in Libby in 1881. In the 1920s, the Zonolite Company formed and began mining vermiculite. In 1963, W.R. Grace bought the Zonolite mining operations, operated it, and made a lot of money, frankly, and the mine closed in 1990.

The EPA first visited Libby in 1999. In October 2002, EPA declared it a Superfund site. Cleanup was begun. It was very pervasive, very difficult, and it was a hard time getting the trust between the EPA and the people in the community. A lot of people didn't trust that EPA was doing the right job, not doing it the right way. In fact, I had to get so involved in so many ways in

holding EPA's feet to the fire because they weren't doing something such as a base-level study. They didn't know how clean clean was. They did not do a very good job.

A guy named Paul Peronard was the onsite coordinator, who was finally able to convince EPA back in Denver what they had to do. In my personal judgment, they didn't send Paul back because he was doing such a good job. Anyway, cleanup began in 2002, and we still have a long way to go.

For decades, the W.R. Grace operation belched 5,000 pounds of asbestos into the air in and around Libby every day. Deadly asbestos coated the town and its inhabitants. People used raw vermiculite ore or expanded vermiculite to fill their gardens, their driveways, they put the stuff on the high school track, the little league ballfield, and put the stuff up in their attics. It was used everywhere, this stuff. People sort of sensed there was something not quite right with all this vermiculite and asbestos, but it was kind of hard to put your finger on.

One day, I visited Libby, and I will never forget, when I went to the mine, I was stunned to see these miners come off the mine and into their buses. They were caked with dust. I mean, it added new meaning to a dustbin. They were just caked with the stuff on their clothes. They got on the bus, went home.

The one person I talked to and who got me interested in doing something about this—a guy named Les Scramsted—told me, when he got off the bus, he would go home—caked with dust—and embrace his wife, his kids would jump in his lap, and guess what: Les is now dead from asbestos-related vermiculite. His wife is ill, and one of his children has died as a consequence. Think of the pain he went through. He died because of mesothelioma asbestos. Also, even worse, he caused his wife to be ill and caused his son to die because of this disease.

Mine workers brought the dust home with them, as I mentioned, on their clothing. They contaminated their own families without knowing the dust was poison. We knew something was wrong, but we didn't know it was that wrong.

I think the company knew exactly what it was doing. In fact, I might say, the company has been subject to a criminal action against their officers, with allegations the officers knew they were contaminating the people and didn't disclose it. That suit went on for a year. It is true the officers were acquitted not long ago, but in my personal judgment, it was because of a lousy prosecution. But it is an example where somebody thought—a lot of people thought—not only did the officers of this company contaminate people, but they knew they were contaminating people at Libby, MT.

Asbestos was everywhere in Libby for decades. I must say, W.R. Grace Com-

pany sure did not help matters. I might say, parenthetically, this is the same company that is the subject of a book and a movie called "Civil Action," where W.R. Grace contaminated the water in Woburn, MA. In my judgment, they knew what they were doing. It is clear they knew what they were doing. As I recall, a big civil judgment was rendered against W.R. Grace because it was clear they knew what they were doing. They are now bankrupt. W.R. Grace shoved all their assets to another location so the plaintiffs in the suit against W.R. Grace could not attach their assets—and all the shenanigans this company undertook for their own benefit and at the expense of the people in Libby.

The type of asbestos in Libby is particularly deadly, and so many people in Libby are dead, dying, and sick because of this tremolite asbestos, an especially vicious, pernicious form of asbestos. This is not regular asbestos, such as chrysotile, this was tremolite asbestos mined at Libby, MT, where the fibers are deeper and they are stronger. They get in your lungs and they cause more damage and it takes longer to detect. It is that vicious.

The effect on Libby has been severe. Today, we know that nearly 300 residents of Libby have died—300. It is a small town. Thousands more have become sick with asbestos-related disease. That is 291 deaths in a county of 18,000. Lincoln County, MT, home to Libby, has the highest age-adjusted death rate due to asbestosis in the Nation.

Libby is an isolated community with limited access to health care. The median household income in Libby in 2007 was \$30,000. When I say "isolated community with limited access to medical care," what do I mean? There is just not that much there. And the company has reneged on its insurance policies. The company had mediocre insurance policies for folks, but as time goes on, the company just backs off—backs off. It is really what is happening in the health care reform here. They rescind—renege on their policies for one reason after another. The poor folks, when they know they have asbestos-related—either cancer or other lung-related disease, they do not have the resources to go to get the medical attention.

I have been at this for years. It is so frustrating, it is so wrong what has happened to the people of Libby, MT.

It is this combination of devastating characteristics that led the EPA Administrator in June to find that the public health emergency does exist at the Libby Superfund site. This finding was based on years of work, having originally been recommended by the EPA in 2001.

I might say, I read the transcripts between EPA Administrators and OMB back in those years. The EPA Administrator under the Republican administration recommended that this action

be taken, but it was squelched at the White House by OMB. The correspondence is clear. This is exactly what happened back then in a previous administration. That is why EPA has never used this authority, and the Agency indicates there are currently no sites on the National Priorities List that come close to the conditions at Libby.

It is worth highlighting a few parts of the Administrator's findings. Let me indicate what they are. The Administrator has said:

The Libby Asbestos Site is unique with respect to the multiplicity of exposure routes [all ways this stuff gets to them], the cumulative exposures experienced by community members, and the adverse health effects from asbestos exposure already present and documented in the residents.

Investigations performed by the Agency for Toxic Substances and Disease Registry (ATSDR) have found hundreds of cases of asbestos-related disease in this relatively small community. ATSDR documented a disease and death rate from asbestosis in the Libby area significantly higher than the national average for the period from 1979–1998. The occurrences of disease are not limited to vermiculite facility workers or their families, but are spread throughout the population.

This is pervasive in the town—ball fields, tracks, lawns; it is awful.

Medical care in Libby has historically been limited due to Libby's isolated location and economic situation, thus reducing the chance of early detection and treatment of asbestos-related disease.

This piece bears repeating:

Let me refine that point. For a long time, we have been talking to lung specialists across the country about the Libby tremolite asbestos, and we got just so-so responses about how dangerous it was. Why? Because virtually none of those doctors had experience dealing with the pernicious kind of asbestos we have in Libby, MT. It took a long time to get their attention. We finally got some doctors to say this stuff in Libby is wicked stuff. That is why, frankly, EPA has started to understand how bad this really is.

Essentially, the lack of access to health care services in Libby—I will say it again—has actually worsened the effects of this contamination. It just worked to their disadvantage.

The language before us today helps to solve this. It allows us to fulfill the commitment we made to the people of Libby when we passed the Superfund Act 30 years ago. Heaven forbid, if in the future another Superfund site like Libby emerges, the bill before us today will allow the Secretary to use the authorities in this provision to fulfill our commitment to provide health care services for those residents as well.

I can never talk about Libby without remembering my friend Les Skramsted. I mentioned his name a few moments ago. I first met Les in the year 2000 at the home of Gayla Benefield. Les was there, Gayla was there, and lots of other miners were

there pleading for help, for some attention: We are dying. Someone pay attention to us. We are a small, isolated community up here in northwestern Montana. Please, someone, pay attention to us.

This did get our attention. I was stunned by the stories they told. I was talking to Les over coffee and huckleberry pie—a very popular pie up in Libby. Les was watching me very closely when I said: You bet, I will help do something about this. He was very wary.

After his neighbors and friends had finished telling me their stories, I will never forget that Les came up to me and said: Senator, a lot of people have come to Libby, and they told us they would help. Then they leave and nothing happens.

He told me, I remember, I think at that instant—you know, in life sometimes you find four, five, six, seven instances, man to man, whatever it takes, you are going to make sure they get justice; whatever it takes, whatever it takes. Such a commitment. That was one. I said to myself: Boy, I am going to do whatever it takes to take care of this because these people of Libby deserve justice. They have not received it.

He said: Senator, I heard you say that, but I will be watching you.

I knew he would watch. I knew that would help. I didn't actually say it because I was going to do it anyway. I accepted Les's offer, and I have a big photograph of Les behind my desk.

Les passed away a couple or 3 years ago. I spent a lot of time with him and his family at the hospital. I have a wonderful picture of Les Skramsted that reminds me what we have to do for the people of Libby but also for all the people in the Nation, people like Les Skramsted. It means that much to me.

I have not forgotten Les. I will not forget Les. That is why this provision is in here. I think Les, right now, up there, may be smiling, saying: Yup, he did not forget Libby, he did not forget Les. That is what this provision is all about.

This is a photograph behind me of Les Skramsted in Libby, MT. He is in a cemetery there, graves of lots of people in Libby who died. Les played a pretty mean guitar. He was a great guy—still is, always will be.

I yield to my colleague from Montana, Senator TESTER.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. TESTER. Mr. President, come snow or sunshine—day or night—we are close to sealing the deal to change our country for the better, to finally hold insurance companies accountable, and to make health care affordable for all folks in this country.

Right now we are all paying far too much for health insurance. Many of us

can not get health insurance at all. And even worse, insurance companies don't always live up to their end of the bargain.

Sure, a lot of folks are happy with the health care they have.

Our doctors, nurses and hospitals and medical research are the best in the world.

But when you add it all up, many are paying too much for it. Or nothing for it. Too many lives are lost. Too much money is wasted. And too many folks are falling through the cracks.

They are calling out for help. I have heard their voices. Now I want you to hear their stories. They are ordinary people who stand to lose everything unless we reform our health care system.

I support this health care reform bill because it saves lives. It saves money. It saves Medicare. And it is tough on insurance companies—taking them to task to ensure affordable, fair coverage.

I have a perspective different than most of my friends in the Senate.

I am—and always will be—a third generation Montana farmer. My wife Sharla and I do all the work on our farm. I am the guy sitting on the tractor.

A farmer knows a good year from a bad year. And I have had my share of bad years. In fact, for a few of those years—not long after our first kid was born—Sharla and I had to give up health insurance to make ends meet. We had no other choice but to hope and pray for health and safety.

Thank God our prayers were answered.

Now, I have the honor of serving Montana in the Senate.

But mine is one of the thousands of real Montana families that has been forced to wing it, rather than depend on a health care system that works. And that holds insurance companies accountable.

I know of a woman from Ravalli, MT, who cannot afford health insurance because of her pre-existing condition. She and her husband got letters from the insurance company telling them their premiums were going up, \$500, to \$600, to \$700 per month. Through no fault of her own, her insurance just became too expensive. So she gave up.

This legislation will prevent that sort of nonsense in the insurance industry from happening again. In this bill, a health insurer's participation in the exchanges will depend on its performance.

Insurers that jack up their premiums before the exchanges begin will not be included. That is a powerful incentive to keep premiums affordable.

We all have friends and relatives who aren't fortunate enough to have a job where health insurance is part of the deal. So they do what millions of others are forced to do: they hope and pray they stay healthy.

We have a problem. It is time for a solution using common sense and fiscal responsibility. And that is why I am going to vote for this health care reform bill, so we can save lives, save money, save Medicare. And so we can hold insurance companies accountable, so they don't drop people when they are sick, or drive families into bankruptcy.

Because of tax credits, this bill is good for small businesses. It gives eligible small businesses access to up to 6 years of tax credits. That will help small businesses buy health insurance for their employees.

Because of tough new rules for the insurance industry, it is good for families and kids.

And because of commonsense ideas like cross-State insurance markets, more competition, and more choices, it is good for millions of Americans who—until now—have had to rely on hope and prayers.

If we do not pass this bill, our entire economy could fall apart beyond repair. Right now we are working hard to rebuild our economy, and it is working.

We are creating jobs and investing in the basic infrastructure needed to get our economy back out of the ditch. Fixing our broken health care system is part of that job.

Over the past few years, I have heard from thousands of Montanans telling me about the need to fix health care.

One of them is Roxy Burley. Roxy owns a hair salon in Billings, MT.

She just bought a home. She works hard. But she just can't afford health insurance. So, she says, she is walking a tightrope. Her home and her business are on one side. Her health is on the other side.

If Roxy gets sick, she worries she will lose her home and her business.

In Montana, our economy relies on people like Roxy Burley. We can't afford to have our economy walking a tightrope.

In this bill, Roxy will be protected from losing her home and business. Her annual out of pocket expenses are capped at no more than \$5,950 per year.

I want to share another story that hits home for me. It is the story of Mindy Renfro. She lives in Missoula, MT.

Mindy got breast cancer not just once, not just twice, not just three times—four times: Breast cancers, four different cancers.

The same cancer didn't come back. She got a different cancer each time. The first two times, Mindy's insurance paid for her treatment.

The third time, the insurance company called her and said: We are sorry, but we are not going to pay. The underwriter, she says, determined her chances of survival were just too slim, so instead they offered to send a hospice nurse.

Mindy was a single mom in her early 40s, and she was simply not ready to

check out. So she asked about her options. She was told if she wanted to start chemo, she would have to come up with more than \$100,000 in cash. Her only option was to sell her home. Mindy and her children sold their home, and moved into an apartment. They packed up and moved out of their home so they could sell it and she could start the treatment she needed to stay alive. After many years of trying to repay that debt, Mindy recently declared bankruptcy.

I have heard many stories from folks in Montana who are in the same boat that Mindy is in. This isn't good business. This needs to stop. It is why I support this health care reform bill. I support it because under this bill, Mindy and people like her wouldn't have to declare bankruptcy. She would have had insurance, despite her pre-existing condition of being a cancer survivor, and her annual out-of-pocket expenses would have been capped at no more than \$5,950 per year, not the \$100,000 in cash she needed to start cancer treatment. This bill is strong and decisive and tough on insurance companies so they cannot say, sorry, but no, when you get sick; so they cannot say, sorry, but no, if you have a pre-existing condition.

Another story is about former ranchers Dan and Pat Dejong. This picture is of Pat. Dan and Pat used to own a cattle ranch in northwestern Montana. The ranch had been in their family for four generations. Dan and Pat couldn't afford health insurance. Then Dan was diagnosed with cancer. To pay the bills they had to make the painful decision to sell off their ranch.

I am going to tell you, when a piece of land has been in the family for four generations, you develop an attachment to that piece of land. But nonetheless when Dan got cancer, they had to pay the bills. They sold the family ranch. Under this bill, the Dejonges would have had access to subsidies so that they could have afforded health insurance in the first place. They never would have had to sell the ranch to pay the doctors' bills.

I want to read what Pat wrote to me about that experience:

The cancer ravaged Dan's body, but selling our ranch to pay for medical costs broke his spirit.

Dan Dejong lost his battle with cancer 2 years ago. All his bills were paid, but the ranch that had been in the family for four generations was gone, as well as Dan. After all that, Pat still cannot afford health insurance today.

Under this health care reform bill, getting sick won't force folks such as Dan and Pat Dejong to sell the land that has been in their family for generations. That is because it limits the amount of money you would have to pay out-of-pocket to a rate you can afford based on how much you earn. That means no Americans would have to sell

their homes or their family ranches to pay the medical bills.

I know a lot of folks already have health insurance, and they are wondering, how is this going to affect me. Let me be clear: If you like your plan, you get to keep it. If you don't, you can look for a more affordable plan that works best for you and your family. Everyone will have access to affordable health insurance. Right now those with health insurance are subsidizing those without.

The other day I struck up a conversation with a trucker back in Montana who told me: I don't need insurance. I don't want insurance. I don't get sick. I asked: What happens if you get into an accident? You are a trucker; that is always a possibility. He said: All I have to do is go to the emergency room where they take care of me, no questions asked.

That is exactly the problem. When everybody is insured, costs will go down, because no one will be paying extra to cover the folks who rely on the emergency room for health care that they eventually never pay for. It is common sense. It saves lives, and it saves money.

I have been on the phone with tens of thousands of Montanans over the past few weeks answering questions about health care. A lot of them want to know how we are going to pay for this bill. How much will it increase our debt?

It won't increase our debt one thin dime. In fact, it will lower our deficit by hundreds of billions of dollars, \$132 billion over the next 10 years alone. It reduces the deficit even more in the decade after that. The fact that this bill saves money is pretty important to me. It doesn't add to the deficit. It cuts billions of dollars of government waste. It requires a bigger chunk of your premiums to go directly to better health care instead of administrative costs and profits, it saves money for families by lowering costs for everyone and by limiting the amount of money you have to pay out-of-pocket for health care and by emphasizing wellness and prevention—the low-hanging fruit of health care reform, and by holding insurance companies accountable so we don't pay more than our fair share for the health care we need.

When you turn on the TV these days or open the newspaper, you see all sorts of spin about the health care reform and Medicare. It amazes me how distorted the facts have become. I have read the bill. The plain-as-dirt fact is it makes Medicare stronger. All guaranteed Medicare benefits stay as they are. They are just that—guaranteed. Seniors are guaranteed to keep their benefits, such as hospital stays, access to doctors, home health care, nursing homes, and prescription drugs. How do we make Medicare stronger? We make it stronger by getting rid of wasteful

spending, by making prescription drugs for seniors more affordable, and by spending your money smarter.

Without this bill, Medicare will be on the rocks within a matter of years. If we don't fix it now, it will go broke, leaving entire generations in the lurch. Millions of Americans have worked hard all their lives for Medicare benefits. They have earned it. That is why we are making Medicare better, not worse. That is common sense.

The same goes for VA health care. This bill does not affect VA health care or TRICARE. I serve on the Veterans' Affairs committee. Over the past 3 years we have made good progress in delivering the promises made to veterans. We still have a lot of work to do, but this health care reform legislation takes us forward even further for America's veterans.

Finally, this bill preserves some of the most important parts of quality health care: the relationship between you and your doctor and the freedom of choice you have as a patient. In Montana, as in many parts of the country, we don't tolerate the government snooping around our private lives or making personal decisions for us. Health care is no exception. This health care reform bill not only saves lives, it saves money and saves Medicare. It keeps the government out of the exam room and waiting room.

I go home to Montana about every weekend to visit with the folks and hear what is on their minds. I meet with doctors and nurses, hospital administrators and regular folks from all over the State to hear their concerns. Everywhere I go, health care is the No. 1 issue. It is clear that the worst option is to do nothing at all. If that happens, insurance companies won't be held accountable. As costs go up, health care costs will continue to break families and people who need treatment to stay alive won't get it.

I know a fellow farmer who worked some land back in Montana. When he got sick, he had to sell off entire chunks of his family farm to pay the bills, piece by piece. Piece by piece, I watched as he made painful sacrifices for his health care. Piece by piece, his livelihood was broken apart. No American deserves that.

People are calling out for help, because a lot of folks are falling through the cracks. I say to them: We are listening. We hear you, and we are doing something about it. That is why this is a good bill. It is a bill I support. It will allow Americans to get the health insurance they have needed, and the insurance will be affordable. It is the result of a lot of hard work and working together to do what is right for the country—for America's rural families, seniors, veterans, small businesses, family farms, and ranchers. The people of this country deserve no less.

I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. SANDERS. Mr. President, I was proud last night to have voted for the health care bill. The reason is, as Senator TESTER indicated, this bill accomplishes a whole lot. Before I go on to talk about what I want to focus on this afternoon, I do want to say there are a number of provisions in the Senate bill I don't support and I hope we can improve in the conference committee by adopting the House language. One is the issue of the public option, with which the Presiding Officer has been so strongly involved. At the end of the day, it seems to me the American people have been very clear. If they are not happy with their private insurance, they want the option of a Medicare type public option. I think we should give them that.

Furthermore, as we look at the soaring cost of health care, we understand that one important mechanism to control escalating health care costs is a public option which provides real competition to private insurance companies that are only concerned about making as much money as possible. I know the Presiding Officer has worked very hard in that effort. I hope we can, in that regard, take the House language which includes a public option.

The other area where I disagree with the Senate and agree with the House is on the issue of taxing health benefits for middle-income workers. The House provision raises substantial funding by putting a surtax on the very wealthiest people in the country, people who received huge tax breaks during the Bush years. That makes a lot more sense to me than taxing the health benefits of middle-income workers.

Having said that, I want to focus on one new provision that was placed in the health care reform bill by Majority Leader REID. I thank him very much for his strong support for this concept. I also thank DICK DURBIN, CHUCK SCHUMER, PATTY MURRAY, the Presiding Officer, and the entire Democratic leadership for their support.

That provision simply provides \$10 billion over a 5-year period to the Federally Qualified Health Center Program and the National Health Service Corps. In my view, these two programs are some of the best and most effective public health care programs in the United States. They enjoy widespread bipartisan support. President Bush was a supporter. JOHN MCCAIN, when he ran for President, was a supporter of community health centers. Many Republicans have spoken positively of community health centers, as have virtually all Democrats. The reality, however, is that both community health centers and the National Health Service Corps have been starved for funding for many years. We are finally, in this bill, doing right by them.

I should mention, importantly, that while we have placed \$10 billion in the

Senate bill, in the House bill there is \$14 billion. My strong hope, expectation, and belief—and I have talked to the White House about this and the Senate leadership and House leadership—is that when this bill is finally passed, we will adopt the House language which calls for \$14 billion.

Let me tell you why this money is so terribly important. In a few days, the Senate will be voting on final passage of a historic health reform bill that will insure an additional 31 million Americans who have no health insurance. That is a huge accomplishment. About half of the new people who will get health insurance will be enrolled in an expanded Medicaid Program. While this reduction in the number of uninsured is an essential step in achieving reform, we have to ask a very simple question: If 15 million more people go into Medicaid, where are they going to access the health care they need?

It is no secret that today Medicare is a strained program. When some of my Republican friends make that point, I have to say they are right; it is a strained program. That is why expanding community health centers in the National Health Service Corps is so important.

We talk about the number of people uninsured—a very important number—46 million. But we do not talk about the number of people who every day do not have access to a physician or a dentist on a regular basis, and that number is close to 60 million. These are people who, when they get sick, cannot find a doctor. Where do they go?

Well, several things happen. They may end up going to the emergency room, which is the most expensive form of primary health care we have—that is where they go—or even worse, they do not go to any doctor at all. What happens is, they get sicker and sicker. Then they go stumbling into a doctor's office, and the doctor says: Why didn't you come in here 6 months ago?

And the person says: I don't have any health insurance. I couldn't afford it.

Then they go to the hospital, and we spend tens and tens of thousands of dollars treating somebody who is now suffering in a way they should not be suffering, at greater expense to the system than should have been the case. Now, what sense does that make?

Let me tell you the worst-case scenario. The worst-case scenario is, they walk into the doctor's office, and the doctor says: It is too late. I can't help you anymore. You should have been in here 6 months ago. I have talked to physicians who have told me about that. I suspect the Presiding Officer has as well. That is why this year we are going to see 45,000 of our fellow Americans die because they do not have health insurance, and they do not get to the doctor when they should.

Now, one of the advantages of the community health care program is

that it is an enormously cost-effective program. One study recently reported that \$20 billion is wasted every year in this country in unnecessary and inappropriate use of hospital emergency rooms for nonemergency care. When you walk into an emergency room—I do not know about West Virginia—but in Vermont it is about \$600. If you get that similar care for a nonemergency-type ailment, the cost is \$100. So think about all of the money we save—we save—when we have community health centers expanding all over the country.

One of the issues we have not focused on enough, in my view, in this whole health care debate is the very serious crisis in primary health care in general. The American College of Physicians, in a recent report, warned that the Nation's primary care workforce—which it called “the backbone of our health care system”—is, in its own words, “on the verge of collapse.” That is the American College of Physicians.

Over the past 8 years, for example, the number of family practice residents fell 22 percent, while the overall number of medical residents rose 10 percent. Currently—this is an extraordinarily frightening statistic—only 2 percent of medical students interested in internal medicine intend to pursue primary care as their specialty—2 percent.

This growing crisis was recently underscored in a report by the Association of Academic Health Centers, which warned that the country is rapidly running “out of time to address what is out of order in our health workforce.”

The good news is that 20 million of those people who live in medically underserved areas are fortunate to live where there are federally qualified community health centers.

Let me explain a bit. What is a federally qualified health center—which exists in all of our 50 States? It is a center which says: If you have no health insurance, you can walk in and do you know what. You will pay not only for primary health care but for dental care—which is a huge problem all over this country—for mental health counseling, and you will get the lowest cost prescription drugs available in America. And if you do not have any health insurance, you get it on a sliding-scale basis. If you have Medicaid, you are welcome into the center. If you have Medicare, you are welcome. If you have private health insurance, you are welcome into these centers. Currently, these centers serve 20 million Americans in all of our 50 States.

Conceived in 1965 as a bold, new experiment in the delivery of preventive and primary health care services to our Nation's most vulnerable people and communities, community health centers are an enduring model of primary care for the country and are designed to empower communities to create lo-

cally tailored solutions that improve access to care and the health of those they serve.

West Virginia centers will be different than Vermont centers, which will be different than California centers because they are designed and locally controlled to serve the needs of the local population.

By mission and mandate, community health centers must see all those who seek their care regardless of health status, income level, or insurance status. If you are rich, if you are poor, you will gain access to these community centers. Nobody is tossed away. Today, these health centers are America's health care home to one out of every four low-income uninsured individuals, one out of every six rural Americans, as well as one out of every seven Medicaid beneficiaries, and one in four low-income people of color. We need to guarantee that as we expand coverage, we expand community health centers as well. They are the one primary care provider who will see those on Medicaid without restrictions.

Furthermore, community health centers already employ so many of the features of what we seek in the medical home model. They provide integrated health care, which is what we are talking about.

A study recently by George Washington University—we are talking about spending money. What is so exciting about this whole concept is you are going to create more health care opportunities for people, and you save money—save money—by keeping them out of the emergency room and out of the hospital. A study by George Washington University found that patients using health centers have annual overall medical care costs that are more than \$1,000 lower than those who do not use a health center—\$1,000. That translated to more than \$24 billion in savings for the health care system last year alone.

We are keeping people out of the emergency room, we are keeping people out of hospitals, and we are keeping them from getting sicker than they otherwise would be. That is why I am so pleased Majority Leader REID has looked at this track record and concurred that we will guarantee—guarantee—funding of health centers over the next 5 years in order to provide health care to more people and to save money at the same time.

Let me tell you in concrete terms what \$14 billion—the amount of money that is in the House bill—will mean to the American people. What it will do is it will increase the number of people who have access to community health centers, from the current 20 million to 45 million over a 5-year period—20 million to 45 million. We are more than doubling the number of people who will be able to walk into a clinic for health care, dental care, low-cost prescription

drugs, primary health care—in 5 years going from 20 million to 45 million people.

This funding would create new or expanded health centers in an additional 10,000 communities—10,000 communities—from one end of our country to the other. In some cases, entirely new federally qualified health centers would be established. In other cases, new satellite centers would be created. In Vermont, for example, we have eight community health centers. We have 40 total sites. That is true all over this country.

But can you imagine, Mr. President, that in the United States of America, within a 5-year period, 10,000 new community health centers in this country would be established? People would not have to go 50 or 100 miles to find access to health care. It would be there in their own community. It would be in urban areas, in rural areas. This is extraordinary.

Now, these community health centers and the growth of these community health centers do not mean much unless we have the medical personnel to adequately staff them.

As I mentioned a moment ago, everybody concludes we have a real crisis in terms of access to primary health care in this country and the number of physicians and dentists and nurses who serve in the primary care area. What this language does, that we have just added, is it would—if we adopt the House numbers—triple funding in a 5-year period for the National Health Service Corps, which provides loan repayments and scholarships to medical students.

For the University of Vermont Medical School, if my memory is correct—this is fairly typical for America—the average medical school student graduates with \$150,000 of debt. Well, if you graduate with \$150,000 of debt, what are you going to do? You are not going to do primary health care. You are going to go into some fancy specialty and start making a whole lot of money to pay off that debt. But what the National Health Service Corps will be able to do is provide debt forgiveness and scholarships for an additional 20,000—an additional 20,000—primary care doctors, dentists, and nurses. That is a lot of new medical personnel that is going to get out into underserved areas all over America. That is a very exciting thought.

In short, when we more than double, in 5 years, the number of people who have access to community health centers, and within that same period of time we add an additional 20,000 primary health care doctors, dentists, and nurses, we are talking about nothing less than a revolution in primary health care in America—something which we have needed for a long time.

So let me conclude by saying: I want to again thank the majority leader,

Senator REID. I want to thank Senator DURBIN, Senator SCHUMER, Senator MURRAY, and thank the Presiding Officer and the Democratic leadership for their support of this concept. As you know, this idea was developed back in the 1960s with Senator Ted Kennedy, who developed this concept in the first place. It has expanded, and now we are going to take it a giant step forward and, in the process, I think we are going to make a difference—a real difference—in improving the lives and the well-being and the access to health care of tens of millions of Americans.

Mr. President, thank you very much. With that, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, I would call to the attention of the leadership of the majority party that I have a unanimous consent request I wish to make. I am going to be visiting with my colleagues about the issue of taxes on medical devices, so my unanimous consent is in regard to that. I hope people would observe that if there is an effort to block this motion I am going to make, I think it is an endorsement of the tax on medical devices such as the Berlin heart and hundreds of others that children across this country rely on.

With that in mind, I ask unanimous consent to set aside the pending amendment in order to offer my motion to commit.

The PRESIDING OFFICER. Is there objection?

Mr. DURBIN. With regret, I object.

The PRESIDING OFFICER. Objection is heard.

Mr. GRASSLEY. Mr. President, it is disappointing for those of us on this side of the aisle to not be permitted to offer an amendment or motion that is as important as this, so I will go ahead with my remarks.

This is another major problem in the Reid bill. Of the many taxes in this bill, I am especially worried about the excise tax on medical devices. Medical device technology is responsible for saving many lives and extending the overall life expectancy of people in the United States.

In the United States, over 6,000 companies are in the business of developing lifesaving medical products. The majority of these companies are very small businesses. Small business we tend to measure around here as being those with less than 500 employees. So what will happen when the Reid amendment imposes a tax hike of \$20 billion on these innovative medical de-

vices? I think that is something we ought to consider if we are considering the quality of life in America and quality health care to preserve that life and extend life expectancy.

During the markup of the Finance Committee bill, I asked the question to the nonpartisan Congressional Budget Office and the nonpartisan Joint Committee on Taxation—and let me emphasize the word “nonpartisan” because these folks are professionals. So both of these organizations, the Congressional Budget Office and the Joint Committee on Taxation, said these excise taxes will be passed on to consumers in the form of higher prices and higher insurance premiums.

Also, I wish to emphasize in this chart a statement of the Chief Actuary of the HHS. The Congressional Budget Office, the Joint Committee on Taxation, and the Chief Actuary all say the tax gets passed on to consumers. Who are the consumers of these devices? Who is going to bear the cost of the new medical device excise tax? Well, it is quite a burden, so I am going to share some real-life stories here.

I will start by telling the story of the Tillman family, a family who would bear the burden of this new medical device tax. At only 5 months old, Tiana Tillman had her life saved by a medical device. This story has received a lot of attention because Tiana's father is a professional football player for the Chicago Bears. However, lifesaving stories such as this happen all across the country regularly.

When Charles Tillman reported to training camp in 2008, it wasn't long before his coach told him that his 5-month-old daughter Tiana had been rushed to the hospital. When Charles got to the hospital, Tiana's heart rate was over 200 beats per minute. That doctor told Charles and his wife Jackie that Tiana may not make it through the night. Tiana survived that night, and after a series of tests, she was diagnosed with cardio myopathy, an enlarged heart that is unable to function properly. Her condition was critical, and without a heart transplant she would not survive. But finding pediatric donors is very difficult and many children do not survive the long wait time, so Tiana was immediately put on an ECMO, a device that would help the function of the heart while Tiana waited for a transplant.

However, ECMO is an old device that has many shortcomings. Infants can only survive on ECMO for about 3 weeks, much shorter than the average wait for a donor heart. ECMO also requires that the patient take a paralytic medication which prevents a patient from moving and at the same time that obviously weakens the body.

The Tillmans waited for one of two outcomes: Either Tiana would receive a transplant or she would die waiting on ECMO.

But then the doctors told them about a new pediatric medical device called the Berlin heart. The Berlin heart is an external device that performs the function of the heart and lungs. It is designed for a long-term support to keep infants and young children alive for up to 421 days while they wait for the donor heart—obviously a lot longer than the 3 weeks on ECMO. So the Tillmans decided to move forward with the Berlin heart.

After 13 days of being on ECMO without any movement, Tiana underwent surgery to connect the Berlin heart. So we have pictures here that show what this is like. These two photos are of Tiana with the Berlin heart. You can see that this device is run by a laptop at the foot of the hospital bed. It pumps the blood through her body, a job that her heart could not perform on its own.

Unlike ECMO, the Berlin heart and its long-term support capabilities allowed the Tillmans some peace of mind while they waited for that donor. The doctor said that the Berlin heart helped Tiana regain her strength because she was off the paralytic medication and was finally able to move. Not long after Tiana was connected to the Berlin heart, a donor was found and Tiana underwent an 8-hour transplant surgery. The risky surgery was a success. Usually it takes some time for the new heart to start working, but doctors said that due to Tiana's strength, her new heart started working immediately.

I wish to talk about the tax on devices such as this.

This picture shows Tiana today holding a football. That is Tiana today, and we shouldn't be surprised about her love for football, considering her father is a professional football player. She enjoys playing on her swing set and watching her dad play football.

There are many people responsible for the successful effort to save Tiana's life, but without the Berlin heart to keep her alive and help her to gain strength, they may not have had that opportunity.

What does this legislation have to do with this story about Tiana? Well, the Reid bill would increase costs for families such as the Tillmans. In fact, the Reid bill would tax every pediatric medical device.

Pediatric devices aren't the only devices affected by the tax on medical devices in the Reid bill. The Reid bill also taxes one of the most important modern technologies: automatic external defibrillators. The defibrillator is used to save people from sudden cardiac arrest, and that is the leading cause of death in this country. Each year, nearly 325,000 people die from sudden cardiac arrest. That is nearly 1,000 deaths a day. Sudden cardiac arrest occurs when the heart's electrical system malfunctions and the heart stops beating

abruptly and without warning. When this happens, the heart is no longer able to pump blood to the rest of the body, and for about 95 percent of the victims, death occurs. Once cardiac arrest occurs, the clock starts ticking and the victim's proximity to a defibrillator could mean the difference between living and dying. As many as 30 to 50 percent of the victims could survive if such a device is used within 5 minutes of sudden cardiac arrest.

Here we have the story then of Mari Ann Wearda. Mari Ann is a constituent of the county I have lived my entire 76 years in, Butler County, IA. She is also a survivor of a sudden cardiac arrest, thanks to the prompt response of the Hampton Police Department and the availability of a defibrillator.

On July 26, 2002, Mari Ann pulled up to a stoplight in Hampton, IA. Without any warning, Mari Ann experienced sudden cardiac arrest. As she slumped over the steering wheel, her car drifted across the road, climbed the curb, knocked over a sign, and came to rest against a tree. She was only minutes away from brain damage and death. At 11:38 a.m. the police station dispatched Officer Chad Elness, who arrived at the scene 2 minutes later, at 11:40. When Officer Elness arrived, Mari Ann was as blue as his uniform, according to his own report.

Officer Elness attached the defibrillator to Mari Ann and pushed the button, sending 200 joules of electricity through her heart. That was one of the two shocks that Mari Ann required. Between the shocks, the defibrillator prompted officer Elness to perform CPR. Twice he almost lost Mari Ann. But by 11:50 a.m., Mari Ann had a pulse and her color was improving. At 11:52, just 11 minutes after the defibrillator was turned on, it had saved her life and was turned off.

Mari Ann then was taken by helicopter to Mercy Hospital, Mason City, IA, where she received care. One week later—just one week later—she was back home with no permanent damage.

Defibrillators are only effective if they are used within minutes of cardiac arrest, which means that in order to save more lives, there needs to be more of these devices. But do you know what this bill would do about all that? It would increase the cost, meaning there would then be fewer defibrillators.

We understand the laws of economics. If we increase a price, we get less of it. If we lower a price, we get more of it. So we are going to increase the price of these devices. That would make it more difficult for police departments, schools, libraries, churches, and other public places to purchase defibrillators, or for an individual to have one. If you have to be within 5 minutes of their use, you can understand why they have to be in every police department, school, library,

church, and a lot of other places. Right now, only one-third of police departments are equipped with defibrillators. However, Mari Ann was lucky that the Hampton Police Department had already purchased the device.

Increasing the cost of defibrillators will make it more difficult for communities to make this lifesaving investment. We already have 62—62—defibrillator stations throughout the Capitol and the three Senate office buildings. So you and I are protected, but we are going to put a tax on them for the people in the rest of the country. It seems as though around here we have one set of morals and ethics for Capitol Hill and another set of morals and ethics for the rest of the country. Congress clearly understands why having so many of these devices, the importance of them and having them on hand to protect us and to protect our staffs and the million visitors who come to the Capitol.

I made a motion that was objected to, so I cannot go through with that motion. My motion would have stopped this new Federal tax from increasing the cost of defibrillators and hurting the chances of placing the devices where they need to be—hopefully, within 5 minutes of people who need them. It is a disappointment my colleagues on the other side of the aisle would not allow that motion to go through.

It is a sad state of affairs when the majority is not only blocking the offering of the motions and amendments that will improve the bill but also trying to ram through a bill before the American people even know what is in it.

Yesterday, we heard things about Republicans having not offered amendments. There are 214 Republican amendments at the desk. One would think we would have a chance to offer more than a dozen or so—I doubt it is even a dozen at this point—on a bill that is going to restructure one-sixth of the economy.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

Mrs. HUTCHISON. Mr. President, may I ask, is it 10 minutes—what is the procedural position as of now?

The PRESIDING OFFICER. The minority party controls the time until 2:30 and there are no individual limits.

Mrs. HUTCHISON. I thank the Chair.

Mr. President, for weeks we have been debating legislation that will dramatically and permanently reform our health care industry. It will impact the life of every American, and it will add to our growing national debt.

On Saturday, the majority leader filed an amendment increasing the size of this bill. Early this morning at 1 a.m., we had a vote to proceed to the revised bill that makes a mockery of transparency and public policy. Yet even though the majority took the op-

portunity to amend the bill, it is clear the concerns of the American people were not heard by my friends on the other side of the aisle.

I was astounded to see this revised bill still contains \$½ trillion in new taxes, \$½ trillion in Medicare cuts and mandates and penalties on individuals and businesses throughout our country at a time when businesses are struggling, unemployment is up, and families are trying to make ends meet.

I wish to talk about the taxes. The revised bill has an additional \$25 billion in taxes than the bill as introduced. We have been hearing for weeks about families who are struggling to pay their mortgage, struggling to find a job, struggling to pay their utility bills. Yet what do we find in this new bill? More taxes and more mandates.

The American people overwhelmingly oppose this bill, and just when we thought the final product could not get any worse, it does.

Under the revised bill, the taxes collected from individuals who cannot afford health insurance has been raised from \$8 billion to \$15 billion—almost double. Why? Because the penalty for not purchasing insurance has become more severe. If you cannot afford insurance, the tax is either \$750 or 2 percent of your taxable income, whichever is higher.

There are still taxes that begin next month, less than 2 weeks from now. Less than 2 weeks from now in this bill, \$22 billion in taxes on prescription drug companies will start, and the public can expect to see higher prices for medicines.

In 2011, we see \$60 billion in taxes on insurance companies except for companies in two particular States. That does not seem fair. Fortunately, the Constitution's equal protection clause may have something to say about this gross situation. This will not stand the test of the Constitution, I hope, because the deals that have been made to get votes from specific Senators cannot be considered equal protection under the law.

If it does stand and the taxes start in 2011, people who have insurance are going to pay higher premiums—even higher than what has been projected already.

In 2011, we also see the taxes on medical device manufacturers. So the public can expect to see higher prices for devices—thermometers, blood sugar machines, canes, walkers—the things people need to stay healthy. That is another \$19 billion in taxes.

Then there is another round of taxes in 2013: \$149 billion in taxes on high-benefit plans; a 40-percent excise tax on the amount by which premiums exceed \$8,500 for individuals and \$23,000 for families; \$87 billion collected from a Medicare payroll tax. This tax is actually \$33 billion higher than in the prior bill. Individuals earning more than

\$200,000 and couples earning more than \$250,000 are now assessed at a tax rate of 2.35 percent for a new Medicare payroll tax rather than 1.45 percent. So if you are a couple earning \$125,000 each, you have another tax increase, in addition to possibly a tax on not having insurance or a high-benefit plan.

Also, \$15 billion will be collected by raising the threshold for the medical deduction. To receive the medical deduction, you must now spend 10 percent of your income on medical expenses rather than 7.5 percent. This tax will impact those who have high medical costs or are suffering from a catastrophic or chronic illness.

This bill taxes those who have insurance and those who do not. All these taxes are collected. All the taxes I have mentioned will be collected before there would be the option that is the purpose of this bill. Whatever the insurance option becomes, it takes effect in 2014. All the taxes I have mentioned start before 2014.

Senator THUNE and I had a motion that would have sent this bill back to the committee and required that everything in this bill start at the same time. So if the program starts in 2014, the taxes would start in 2014. Under our motion, not one dime in taxes would be paid before Americans are offered the insurance option in the bill. The motion was defeated. Now the Democrats have revised their bill and the taxes collected are even higher than the previous bill.

But do not forget the penalties to businesses that cannot afford to offer health insurance to their employees. A tax of \$750 per employee is assessed. This at a time when unemployment has reached double digits. We should be encouraging employers to hire new workers. Yet this bill imposes \$28 billion in new taxes on employers.

What will these taxes do to small businesses which create 70 percent of the new jobs in our country? In a letter sent to the majority leader, the Small Business Coalition for Affordable Health Care stated:

With its new taxes, mandates, growth in government programs and overall price tag, the Patient Protection and Affordable Care Act—

The bill we are discussing—costs too much and delivers too little. . . . Any potential savings from those reforms are more than outweighed by the new taxes, new mandates and expensive new government programs included in this bill.

That letter is signed, in addition to the Small Business Coalition, by associations such as the Farm Bureau, Associated Builders and Contractors, Associated General Contractors of America, the National Association of Homebuilders, the National Association of Manufacturers, the National Automobile Dealers Association, the National Retail Federation, and more.

The National Federation of Independent Business, which is the voice of

small business, sent a letter expressing their strong concerns over this bill. It says:

The current bill does not do enough to reduce costs for small business owners and their employees. Despite the inclusion of insurance market reforms in the small-group and individual marketplaces, the savings that may materialize are too small for too few and the increase in premium costs are too great for too many.

That is the tax situation. How about the $\frac{3}{4}$ trillion in Medicare cuts? They are still there. They were in the first bill, and they are there now.

There are \$120 billion in cuts to Medicare Advantage, which we know reduces choices for seniors. In my State of Texas, over 500,000 currently enrolled enjoy the benefits of Medicare Advantage. That is in my State alone. Millions across the country like Medicare Advantage, but many seniors, without a doubt, are going to lose this option.

Oddly enough, once again, one of the points in the new bill is, there was an opt-out for certain States on Medicare Advantage cuts. So some States are going to have the Medicare Advantage cuts while other States will not.

The individual fixes for certain States, presumably to get the votes of certain Senators, do not pass the test of transparency. If you put it in the nicest way, it does not pass the test for fairness, for due process and equal treatment under the law, and it certainly does not pass the test for what is the right way for us to pass comprehensive reform legislation.

The other health care cuts in Medicare would be \$186 billion in cuts to nursing homes, home health care, and hospice providers.

Then there are the cuts to hospitals, approximately \$135 billion in cuts to hospitals. The Texas Hospital Association has estimated that hospitals in my State will suffer almost \$10 billion in reduced payments.

I have a letter from the Texas Hospital Association that outlines their concerns with these cuts and this bill and they are very concerned. Here is one of the quotes from their letter. The Texas Hospital Association says:

With a significant reduction in payments, hospitals may be forced to reduce medical services. [H]ospitals . . . may be forced to close or merge with another hospital, or severely reduce the services they provide to their community. Essential services, such as maternity care, emergency services, medical-surgical services or wellness programs may be reduced or entirely eliminated.

I have talked with so many hospital administrators and people on hospital boards, and they are very concerned about the cuts in this bill because most of them are on very thin margins. They are struggling, especially in our rural areas. They are very worried there are going to be shutdowns of hospitals throughout our State and certainly our country.

Our aging population is growing, so cutting payments to providers who treat those patients, whether it is in hospitals or health care providers, does not seem to be a way to reform Medicare.

Cuts in Medicare, and especially the payments for treating low-income seniors, will disproportionately impact rural hospitals which are the safety net for health care outside the metropolitan areas. The Texas Organization of Rural and Community Hospitals, which represents 150 rural hospitals in Texas, said in a letter:

We also fear the Medicare cuts as proposed could disproportionately hurt rural hospitals which are the health care safety net for more than 2 million rural Texans. Because of lower financial margins and higher percentage of Medicare patients, rural hospitals will be impacted more than urban hospitals by any reductions in reimbursement. These proposed Medicare cuts could have a devastating effect . . . which could lead to curtailment of certain services. And the closure of some of these Texas hospitals is a very real possibility. . . .

How could anyone support a reform bill that will result in seniors having to drive 30, 60, 90 miles and more to get the care they need—care that was accessible in their own community before this bill took effect?

Mr. President, what we have is a bill heavy with tax hikes, Medicare cuts, and government intrusion. This bill is being forced through Congress the week of Christmas because everyone knows this is not the reform that Americans want. The polls are showing that. We all know polls can have margins of error, and maybe they are not completely accurate, but the trend in the polls is clear: It has gone from people thinking that health care reform is a good thing and supporting it, in the majority, to going down now to the point where the trend is clear the American people now do not support this bill, they would rather have nothing, according to the latest polls, and have Congress start all over and do what they hoped it would do, and that is bring down the cost of health care not have this be a big government increase in debt, cuts to Medicare, and increases on taxes to small business and families, especially at this time in our country's economic period.

My Republican colleagues and I have tried to offer fiscally responsible alternatives to reform, allowing small businesses to pool together, increase the size of their risk pools, which will bring premiums down. If you have an exchange it would be fine unless you have so many mandates, such as we see in this bill, that are going to cause the prices to stay up and even go higher because of all the taxes on the underlying companies that are providing the health care.

Creating an online marketplace free from mandates and government interference where the public can easily

compare and select insurance plans would be a Republican proposal, something that I think would be a point at which we could start having health care reform that would be truly effective for America, if you didn't have the mandates that would drive up the cost.

Offering tax credits to individuals and families who purchase insurance on their own, that is a bill that we have put forward. Five thousand dollars per family would cut the cost and make it affordable without any government intervention that would be necessary.

Of course, medical malpractice reform could take \$54 billion out of the cost of health care by stopping the frivolous lawsuits, or at least limiting them. Yet Republicans were really not at the table. The bill was written in a room, with no transparency, no C-SPAN cameras, and no Republicans. We did not have input into this bill. That is why it is a partisan bill. That is why the vote last night—or this morning at 1 a.m.—was completely, 100 percent partisan. Why would a Republican vote for a bill that goes against every principle we have—higher taxes, higher mandates, and cuts in Medicare—and in which we had not one amendment pass? We offered amendments, but there were hundreds of amendments left on the table that we were closed out of offering because of the rush to pass this bill before Christmas.

Mr. President, Americans asked for reform; they deserve it. This bill is not the reform Americans hoped to get from a Congress that should have acted responsibly but did not.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. CORNYN. Mr. President, as my colleagues on this side of the aisle, I voted against the Reid health care bill last night because it cuts \$470 billion from Medicare to create a brand-new entitlement program that will cost approximately \$2.5 trillion over the next 10 years—a price we cannot afford. It increases premiums for American families who currently have health insurance and who are struggling to make ends meet during tough economic times. It increases taxes on small businesses and individuals, which is a terrible idea, particularly at a time when our economy is struggling and our job creators are struggling to be able to keep people on their payroll and possibly expand their payroll and hire people back and bring down the unemployment rate.

I want to talk about the way this bill came to pass—at least the cloture vote this morning at 1 a.m.—and I want to talk about the process. I recall when Senator Obama was running for President, he talked about wanting to change politics as usual in Washington, DC. But I have to tell you, the major-

ity and this administration have, in many ways, confirmed people's worst suspicions about Washington politics as usual. They have taken it to a new level—and not a higher level; it is a lower level.

As a matter of fact, the bartering for votes for cloture, the special sweetheart deals with drug industries, with Senators, in order to get the 60 votes last night, does nothing more than confirm the worst fears and cynicism the American people have about the way Washington works.

We know this bill is a direct result of many special deals with special interest groups and their lobbyists. We heard the President say when he campaigned that he wanted to have a transparent process; that this would take place in front of C-SPAN and at a roundtable so people could see who was making arguments on behalf of the drug companies and the insurance companies. But that rhetoric conflicts with the reality, where the drug companies and the insurance companies and others were negotiating behind closed doors for sweetheart deals that ultimately ended up getting 60 votes.

So it turned out it was the Obama administration that cynically said one thing during the campaign and then, when it came to actually passing legislation, did completely the opposite. This is tragic, in my view, Mr. President. The American people want to believe in their government. They want to believe their elected leaders are trying to do their best on behalf of the American people. But this process confirms their worst suspicions. No wonder public opinion of Congress is in the toilet.

Rather than listening to the American people, the creators of this bill started cutting deals with special interests first and cut those deals early. The White House struck a deal with the pharmaceutical industry, as you know, which produced in part, as the New York Times reported, about \$150 million in television advertising supporting this bill. This deal got 24 Democrats when we were debating the issue of drug reimportation to switch their votes from their previous position against drug reimportation earlier this month.

Notwithstanding all the rhetoric about insurance companies, basically this is a sweetheart deal with insurance companies because insurance companies will get \$476 billion of your tax dollars and my tax dollars to pay for the subsidies and the insurance provided in this bill.

The hospital industry cut a special deal that provided them an exemption from the payment advisory board. Then there were groups such as AARP that purport to serve seniors as a public interest but, as we know, primarily pocket money as a result of the sale of insurance policies—insurance policies

that are going to be necessary because of cuts in Medicare Advantage for 11 million seniors, just to name one example.

This bill was the result of backroom deals with specific Senators, persuading them to vote for cloture, which has caused some people on the blogs and the Internet to call it "Cash for Cloture." In order to get 60 votes for cloture, we know one of the first examples of that was the so-called "Louisiana purchase." Charles Krauthammer said it well:

Well, after watching Louisiana get \$100 million in what some have called "The Louisiana Purchase," she ought to ask for \$500 million at least. And that's because Obama said he would end business as usual in Washington. So it's a new kind of business as usual.

In other words, I guess the price has gone up. But as one business leader in Louisiana points out, notwithstanding the special sweetheart deal for the State of Louisiana directing \$300 million to the State, the Medicare expansion alone will result in the taxpayers and the people of Louisiana being a net loser.

We also know in order to get 60 votes, the majority leader had to cut a deal with a Senator from Nebraska—the senior Senator from Nebraska—in order to get the vote for cloture. It has been widely reported that the meeting with the senior Senator from Nebraska took place for 13 hours behind closed doors, after which they negotiated some language which, purportedly, no longer allowed the use of tax dollars to pay for abortions. But according to the Conference of Catholic Bishops and other pro-life groups, the language is completely ineffectual and it restores or actually produces taxpayer-paid-for abortions for the first time in three decades.

What else did the senior Senator from Nebraska get? Well, the State of Nebraska purportedly got a free ride from Washington's new unfunded Medicare mandates on the States. But, of course, we know every other State ends up paying for that sweetheart deal the senior Senator got for Nebraska. What do Nebraskans think about it? Well, ask the Governor—Governor Dave Heineman—who said yesterday he had nothing to do with that bill, and called the overall bill bad news for Nebraska and bad news for Americans. Governor Heineman said Nebraskans did not ask for a special deal, only a fair deal.

We also know that in order to get 60 votes, the majority leader had to cut a special deal for Vermont. One Senator from Vermont threatened to vote against the bill, but then, lo and behold, the managers' package included \$600 million benefiting only that one State. The Senator who threatened to vote no decided to vote yes after that special deal was concluded.

The New York Times lists several other sweetheart deals that produced

this monstrous piece of legislation. The intended beneficiaries, though, in many instances, were identified in a vague and sort of cryptic way, such as: Individuals exposed to environmental health hazards recognized as a public health emergency in a declaration issued by the Federal Government on June 17. Well, there is only one State that would qualify for that, notwithstanding this sort of vague description designed to hide the ball and obscure what was actually happening through another sweetheart deal as part of this bill.

Another item in the package would increase Medicare payments to doctors and hospitals in any States where at least 50 percent of the counties are "frontier counties," defined as those having a population density of less than six people per square mile.

Then we know there was another \$100 million sweetheart deal for an unnamed health care facility affiliated with an academic health center at a public research university in a State where there is only one public medical and dental school. The Associated Press reports that the State that qualifies for that special deal is the State of Connecticut, where the senior Senator currently is in a tough reelection fight.

When asked about these special deals in the managers' amendment, the response of Mr. Axelrod—the architect of the campaign strategy for this administration to bring change to Washington—was pretty telling. He said: That is the way it has been; that is the way it will always be.

Well, maybe in Chicago, but not in my State, and not in the heartland and the vast expansion of this great country where the American people want us to come and represent our constituents and vote for what is right in terms of policy, not what kind of sweetheart deals we can eke out at the expense of the rest of the American people.

The very thing that is happening with this health care bill demonstrates why Washington takeovers are such a terrible idea because instead of health care decisions being made between patients and doctors, health care decisions are overcome through a political process where elected officials choose winners and losers.

Politics has become a dirty word outside the beltway, and certainly we can understand why. This process has only reconfirmed in the minds of many people that what we are doing here is not the people's business but protecting special interests and special sweetheart deals. Rather than making decisions about what is best for the American people, this deal has been driven by deals with special interest groups and lobbyists. Rather than listen to constituents, individual Senators have decided that their votes should be traded for tax dollars and other sweetheart benefits that go to their States. No

doubt about it, this bill takes the power from individual Americans to make their own health care decisions and transfers that to Washington, DC, and this new low level of politics as usual.

According to one recent poll that was reported today, Rasmussen, for one State I will not mention by name, found only 30 percent of the respondents to this poll favor this health care bill and 64 percent are opposed. The Senators from those States voted for the bill where only 30 percent of their constituents reportedly support the bill. That is not the only example.

You can only ask yourself why in the world would Senators vote for a bill when two-thirds of their constituents are opposed to it. Who must they be listening to? Are they listening to the people whom they represent and who sent them here to Washington to represent them or are they listening to the special interests or have they decided somehow that they have become miraculously smarter than their constituents and they know what is better for their constituents than what their constituents know themselves?

This debate is not over. There is still a chance to vote against this bill. As Senator MCCONNELL said last night, any single Senator on the other side of the aisle can stop this bill or every one who votes for it will own it.

I yield the floor.

The PRESIDING OFFICER (Mr. WARNER). The Senator from Nebraska.

Mr. JOHANNIS. Mr. President, let me start my comments today by complimenting the Senator from Texas. I thought he did an excellent job of shining the light on something that is now gathering a lot of attention because the managers' amendment is out and we can read the words and we can start to understand the special deals that were cut to get the votes to make this happen. I applaud the Senator for standing here so courageously.

My State, the great State of Nebraska, has been pulled into the debate. I want to start out today by saying here on this Senate floor that I am enormously proud of my State, probably like all Senators in reference to their State. I am enormously proud of the people of Nebraska. I have gotten to know them well. I was their Governor. On a more localized basis, I was also the mayor of Lincoln. I date my time in public service back to the time when I was Lancaster County commissioner and a city council member in Lincoln. These are good, decent, honorable people who are always looking to try to figure out the right way of doing things.

I stand here today to acknowledge that and to tell all Nebraskans how proud I am to be here today. But I rise today to share with my colleagues the reactions of Nebraskans to the special deal that got cut for Nebraska that

came to light over the weekend as the managers' amendment was released and analyzed.

Less than 24 hours after the announcement of the special carve-out for Nebraska, with virtually no warning, no preparation to speak of, 2,000 people gathered in Omaha, NE, Nebraskans who, in one voice, cried foul. Nebraskans are frustrated and angry that our beloved State has been thrust into the same pot with all of the other special deals that get cut here. In fact, they are outraged that a backroom deal for our State might have been what puts this bill across the finish line.

You see, I fundamentally believe that if this health care bill is so good, it should stand on its own merits. There should be no special deals, no carve-outs for anyone in this health care bill—not for States, not for insurance companies, and not for individual Senators.

I stand here today and I find it is enormously ironic that advocates for this bill, who worked overtime to vilify insurance companies, in the last hours of putting this bill together struck a special deal with two insurance companies in Omaha, NE, that they would be carved out of their responsibility in this bill to pay taxes. I find it painful to even acknowledge that happened.

I said at the beginning of this debate that changes of this magnitude, affecting one-sixth of our economy, must be fair and they must be believed to be fair by the people. The special deal for Nevada was wrong. I said that. In fact, one of the six reform principles I publicly outlined and took out to townhall meetings I stand by today. It simply said: No special deals.

The special deal for Nevada was wrong, as is the carve-out for Louisiana. And the same applies for the backroom deal that was struck for my State, the great State of Nebraska.

All of the special deals should be removed from this legislation. If this bill cannot pass without the carve-outs and the special deals, what further evidence could we possibly need to draw the conclusion that this is enormously bad policy? If you literally had to sit down in the last hours of negotiations and strike a special deal, do we need any other argument about how bad the policy of this bill is for my State and the citizens of Nebraska?

Our Governor said it well: Nebraskans don't want a special deal. You see, I went around the State for months doing townhalls and listening to Nebraskans. They do not want a special deal. No Nebraskan came up to me and said: MIKE, give me a special deal. You see, their request is simple: They want to be able to see the doctor of their choice and to keep the current plan they have. They want our job creators, our small businesses, to get our economy moving and create jobs in our

communities from large to small, free of the \$½ trillion in taxes and fees this bill will keep on our employers.

The managers' amendment does nothing to change the core problems with this bill. The nearly \$500 billion in Medicare cuts will be devastating to Nebraska. No special deal with an insurance company is going to make Nebraskans feel better about that. No special deal to make the State budget look better is going to make Nebraskans feel any better about the Medicare cuts and the impacts on our hospitals, our nursing homes, our home health care industry, and our hospice industry. Nationally, Governors—Republicans and Democrats—have stepped forward to say they cannot afford the unfunded mandates that come from Washington and drive their budgets into the red.

The special deal struck on abortion is enormously tragic and insufficient. It breaks my heart. This is a far cry from the 30 years of policy by this U.S. Government. You see, when this is done and over, what we will be reporting to our citizens is that taxpayer funds will fund abortions if this bill passes. You see, no watered-down accounting gimmick will convince the pro-life community in my State otherwise. In fact, they have publicly said they feel betrayed.

I will wrap up with this. This bad deal is not sealed. There is time for truly pro-life Senators to stand tall and say no. There is still time for principled Senators to reject the carve-outs and to cast aside the bad backroom deals. There is still time for Senators to listen to the people and reject reckless Federal policy.

Fair treatment is not too much to ask of Washington. I know in my State, that is what they are asking for. I will firmly stand behind any Senator who has the courage to stop this train wreck. I will be the first to lead the applause. I am confident that the standing ovation for that courageous Senator will extend all the way back to Nebraska and it will be deafening.

I yield the floor.

Mr. GRASSLEY. Mr. President, how much time remains?

The PRESIDING OFFICER. There is 2½ minutes.

Mr. GRASSLEY. I would think one of the things we would have seen from the majority at this point is a list of what the last two Senators were talking about, all the earmarks that are in this bill, because I asked for a parliamentary inquiry yesterday—I am not going to ask that again—but, as we said yesterday, rule XLIV was adopted as part of a major ethics and reform legislation, adopted in 2007. It was part of the Honest Leadership and Open Government Act. The Democratic leadership made it the first bill to be introduced when they took the majority in 2007, taking control of Congress for the first

time for a long period of time. This bill passed by unanimous consent.

When rule XLIV was passed, the theory behind it was that we ought to have total transparency on earmarks. It applies to floor amendments such as the pending Reid bill. It requires the sponsor of the amendment to provide a list of earmarks in that amendment.

Earmarks are provisions that provide limited tax benefits. Those words, "limited tax benefits," are words out of the rule. Another substitute language for limited tax benefits is "congressionally-directed spending items" or "earmarks," as they are generally referred to by the public at large.

Given what a priority the new rule passed in 2007 was given and the importance of it, one would expect that the majority leader would be making every effort to comply with it. One would think he would be wanting to set a good example in complying with the rule and disclosing these earmarks. In order to assure transparency of these very narrow provisions, such as what Senator JOHANNIS just referred to, to get the votes of specific Members of the majority party who probably would not have voted for this bill, you would think that ought to be made public. That is what rule XLIV is about. Of course, that burden under that rule is on the sponsor to provide the list.

Once again, I am going to ask the Democratic leadership to comply with the Honest Leadership and Open Government Act.

The PRESIDING OFFICER. The time for the minority has expired.

The Senator from Montana.

THE CALENDAR

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Senate proceed en bloc to the following bills: Calendar Nos. 235 through 242; that the bills be read a third time and passed en bloc, the motion to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to these matters be printed in the RECORD.

The PRESIDING OFFICER. Is there objection?

Mr. GRASSLEY. I object. I don't know what this is all about. Has this been cleared with our side?

Mr. BAUCUS. These are post office bills.

Mr. GRASSLEY. I withdraw my objection.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senate proceeded to consider the bills.

1ST LIEUTENANT LOUIS ALLEN POST OFFICE

The bill (H.R. 2877) to designate the facility of the United States Postal Service located at 76 Brookside Avenue

in Chester, New York, as the "1st Lieutenant Louis Allen Post Office", was ordered to a third reading, read the third time, and passed.

COACH JODIE BAILEY POST OFFICE BUILDING

The bill (H.R. 3072) to designate the facility of the United States Postal Service located at 9810 Halls Ferry Road in St. Louis, Missouri, as the "Coach Jodie Bailey Post Office Building", was ordered to a third reading, read the third time, and passed.

ARMY SPECIALIST JEREMIAH PAUL McCLEERY POST OFFICE BUILDING

The bill (H.R. 3319) to designate the facility of the United States Postal Service located at 440 South Gullwing Street in Portola, California, as the "Army Specialist Jeremiah Paul McCleery Post Office Building", was ordered to a third reading, read the third time, and passed.

PATRICIA D. MCGINTY-JUHL POST OFFICE BUILDING

The bill (H.R. 3539) to designate the facility of the United States Postal Service located at 427 Harrison Avenue in Harrison, New Jersey, as the "Patricia D. McGinty-Juhl Post Office Building", was ordered to a third reading, read the third time, and passed.

CLYDE L. HILLHOUSE POST OFFICE BUILDING

The bill (H.R. 3667) to designate the facility of the United States Postal Service located at 16555 Springs Street in White Springs, Florida, as the "Clyde L. Hillhouse Post Office Building", was ordered to a third reading, read the third time, and passed.

W. HAZEN HILLYARD POST OFFICE BUILDING

The bill (H.R. 3767) to designate the facility of the United States Postal Service located at 170 North Main Street in Smithfield, Utah, as the "W. Hazen Hillyard Post Office Building", was ordered to a third reading, read the third time, and passed.

CORPORAL JOSEPH A. TOMCI POST OFFICE BUILDING

The bill (H.R. 3788) to designate the facility of the United States Postal Service located at 3900 Darrow Road in Stow, Ohio, as the "Corporal Joseph A. Tomci Post Office Building", was ordered to a third reading, read the third time, and passed.

JOHN S. WILDER POST OFFICE
BUILDING

The bill (H.R. 1817) to designate the facility of the United States Postal Service located at 116 North West Street in Somerville, Tennessee, as the "John S. Wilder Post Office Building", was ordered to a third reading, read the third time, and passed.

SERVICE MEMBERS HOME
OWNERSHIP TAX ACT OF 2009

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. I yield 20 minutes to the chairman of the HELP Committee, Senator HARKIN, and 18 minutes to the Senator from Colorado, Senator BENNET.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Mr. President, I guess I can say we crossed the Rubicon last night at 1 o'clock. Reading some of the press reports, of course, most of the news didn't have it because it occurred at 1 a.m. Some of the different reports have been online this morning. It occurred to me that a lot of people are missing the overall importance of what happened last night. We can get into the fine tuning and the nitpicking and sort of the fear and the anger I hear from the other side. Every time I listen to speeches over there, with the exception of the last speaker, almost all the speeches I hear from the other side, it is fear, be afraid, be afraid. It is some built-up anger over there. I think what happened last night is, we crossed a demarcation line, the demarcation line of which on one side health care is a privilege. We have been on that side of the line for a long time. On the other side of that line, health care is a right. We stepped across that line last night. We are now in the process of saying health care is a right, an inalienable right of every American citizen.

Is that what so upsets my friends on the Republican side? I don't know. Something is upsetting them. Because this is a momentous change we are doing.

I keep hearing from Republicans they want us to deal in a bipartisan way. We tried all this year, both in the HELP Committee and in the Finance Committee. Senator BAUCUS bent over backward to accommodate. But at every turn, Republicans said no, no, no, no, no—all year long. How can you be bipartisan when the other side has nothing to offer? There is no bill on the Republican side. There is a bill. It has about nine cosponsors—Senator COBURN, Senator BURR, maybe seven others, but not every Republican is on that. I hear bits and pieces of this and that every time I hear these speeches. Most of it is attacking what we have done. I hear nothing positive from their side. It is very hard to deal with a party that is in total disarray as the

Republicans are. If they had a bill they were supporting and that was supported by all of them, such as the bill we have here which is supported by 60 Democrats, I think then you could find some reason for meeting and working things out. But since there is no one on that side who has a comprehensive proposal, it is hard to do that. We have had to kind of plow ahead as best we can. We have not done this alone. In our committee, we met for 13 days. We had 54 hours of markup. No amendment was denied. Republicans offered over 200 amendments. We adopted 161 of them. That is pretty good. Yet in the end, every Republican voted against it. So it is not as if we didn't try and we didn't hold out an olive branch to work with people to get a bill that was truly bipartisan. We did in our committees, both the Finance and HELP Committees. Now it has come down to fear and anger on the other side and some nitpicking.

My friend from Iowa—and he is truly my friend—was talking about some provisions put in the bill for special reasons and so forth. I admit fully and openly that I was part of that. Did I put something in the bill that was sort of particular to my State of Iowa? Yes, I did. But it doesn't just affect Iowa. There are several States in which we have hospitals that are not as big as the big hospitals with the volume. They are not so small that they are low-volume hospitals that get help. They are kind of in between. They call them tweener hospitals. We have eight of them in Iowa: at Grinnell, Keokuck, Spencer Municipal, in Carroll, St. Anthony Regional; Muscatine; Fort Madison; and Lake Regional Hospital at Spirit Lake. There are a number of these in the United States. I forget the total number; not a large number, they just fall in a place where they are too small for the big and too big for the small. As a result, they have been getting a bad deal from Medicare reimbursement. There is a fix in this bill that will allow them to get adequate reimbursement. I don't see anything wrong with that. It is fixing a specific problem that the bureaucracy can't seem to quite get fixed. That is in the bill. I make no bones about having put that in there. I think it is a good deal. It is something that is going to help a lot of hospitals, not only in Iowa but a few other States.

One of the things I wish to talk about today is something I have been on for many years, and that is the huge amount in this bill on prevention and wellness. It has not been written about a lot. People have been focused on the public option and the abortion issue and a few other items such as that. Perhaps one of the most profound parts of this bill and the one I believe will do more to bend the cost curve, as they say, than any other single thing is the provisions dealing with prevention and

wellness. In the past I have said many times that we don't have a health care system in America. We have a sick care system. When you think about it, if you get sick, you get care. But precious little is spent out there to keep one healthy in the first place. So people get sick. You go to the doctor, the hospital. We patch and fix and mend and try to make them well.

Your mother was right, you know: Prevention is worth a pound of cure. We have fallen far short of that in this country. There is a remarkable array of provisions in this bill that promote wellness, disease prevention, and public health. Together they will move us from a sick care society into a genuine wellness society, into a true health care system, not just sick care. What better way to reform our health care system than to restrain health care costs by helping Americans to prevent chronic diseases, stay healthy and out of the hospital in the first place. Right now, as we have heard so many times, we spend more than \$2 trillion each year on sick care. But 4 cents of every dollar is invested in prevention and public health. I submit this is a major reason why Americans spend twice as much per capita on health care as European countries, but we are twice as sick with chronic disease. We spend twice as much as Europe on health care, but we are twice as sick with chronic diseases.

The good news is that by ramping up the emphasis on wellness and prevention, we have tremendous opportunities to both improve the health of the American people and to restrain health care spending. That is the aim of this bill which makes significant new investments in prevention. For example, our bill would ensure that seniors have access to free annual wellness visits and personalized prevention plans under Medicare. We have never had that. For the first time seniors will have access to free annual wellness visits and personalized prevention plans under Medicare. That is a big deal. So many seniors today, if they get sick, go to the doctor and get more pills. Now they will be able to go in, have their annualized checkup, see what is wrong, and have a personalized prevention plan for each person under Medicare.

It will also encourage States to improve coverage and access to recommended preventative services and immunizations under Medicaid. At a minimum, States will provide Medicaid coverage for comprehensive tobacco cessation services for pregnant women. That is just the start. Right away, at a minimum, they have to do that. In addition, the bill requires insurance companies to cover recommended preventative services with no copayments or deductibles. This is critical because we know that all too often people forgo their yearly checkups or essential

screenings because either their insurance companies don't cover them or because they have high copays and deductibles.

Another critical element in the bill essential to a sustainable push for wellness is the creation of a prevention and public health trust fund. Typically prevention and public health initiatives are subject to unpredictable and unstable funding. This means that important interventions, things such as education about nutrition and assistance for smokers who want to quit, often go unfunded from one year to the next. They get funded a little bit one year or cut the next; funded a little bit the next year, cut the next. The prevention and public health fund in this bill will provide an expanded and sustained national investment in programs that promote physical activity, improve nutrition, and reduce tobacco use. We all appreciate that checkups and immunizations and other clinical services are important. But this bill also recognizes that where Americans live and work and go to school also has a profound impact on our health. That is why a number of provisions in the bill focus on creating healthier communities with better access to nutritious foods as well as safe places to engage in physical activity.

A 2007 study by the Trust for America's Health found major savings from community-based prevention programs designed to increase levels of physical activity, improve nutrition, and reduce smoking rates. This study concluded that a national investment of \$10 per person per year in these kinds of community-based programs could yield net savings of more than \$2.8 billion annually in health care costs in the first 1 and 2 years, more than \$16 billion savings within 5 years, and nearly \$18 billion savings annually within 10 to 20 years, starting at \$10 per person per year.

More generally, this bill aims to give Americans the tools and information they need to take charge of their own health. For example, it requires large chain restaurants to post basic nutrition information on the menu so consumers can make healthy choices. That is in this bill. It will start next year.

The bill also focuses on prevention and public health needs of a number of generally overlooked populations, including children, individuals with disabilities, Americans living in rural communities, and certain ethnic minorities. For many months I have made the case that it is not enough to talk about how to expand insurance coverage, how to pay the bills—those are important—but it makes no sense to figure out a better way to pay the bills for a system that is dysfunctional, ineffective, and broken.

We have to change the health care system itself, beginning with a sharp new emphasis on prevention and public

health. We also have to realize that wellness and prevention must be truly comprehensive. It is not only about what just goes on in the doctor's office; it also encompasses community-wide wellness programs, about which I just spoke, things such as building bike paths, walking trails, getting junk food out of our schools, out of the vending machines, making our school breakfasts and lunches more nutritious, increasing the amount of physical activity our children get, and so much more.

Some of this is going to be addressed in other bills. For example, next year, in the Agriculture Committee, we will be reauthorizing the child nutrition bill. That deals with school lunches and school breakfasts. We need a major effort there to make our lunches and our breakfasts more nutritious for our kids in school.

Next year, in the committee I chair, the HELP Committee, we are going to reauthorize the Elementary and Secondary Education Act, the so-called No Child Left Behind Act. There are a lot of things we are going to be doing on that. I see one of our committee members, the Senator from Colorado, Mr. BENNET, in the Chamber, a former superintendent of schools, who is going to play a key role in helping get that Elementary and Secondary Education Act through and refined and brought up to date where we will make some changes.

But there is one other part of that bill we have to focus on; that is, the amount of physical activity kids get in school. I talked many times both to Secretary Duncan and, before him, to Secretary Spellings about this idea of No Child Left Behind. If we are not going to leave kids behind in terms of their writing and their math and their English, how about not leaving them behind in terms of their health? Yet recess is gone. I saw a statistic this year that said 80 percent of elementary school kids in America today get less than 1 hour of physical exercise a week in school—80 percent get less than 1 hour a week.

Mr. President, I do not know about you, but I remember when I was in school, in elementary school, we had an hour a day for recess. We had 15 minutes in the morning, 15 minutes in the afternoon, and a half hour at lunch. So there was 1 hour every day, and we had to go out and do stuff. We couldn't sit around and play with Game Boys and things like that. So we got an hour a day of physical exercise. Well, we need to reinvigorate our schools to make sure they get that physical exercise.

So we have done a lot in this bill to move this paradigm toward a health care society rather than a sick care society. There is more to do, as I said, in both the Education bill next year and in the Agriculture Committee in terms of the child nutrition reauthorization.

But in this bill we have made a great start. We have laid a great foundation. I am just thrilled so many of the wellness and prevention initiatives I have championed for so many years are included in this bill.

As I look forward to going to conference, we look forward to working with the House to strengthen it even more and to put more emphasis on wellness and prevention.

Just about an hour ago or so, we had a press conference with the president-elect of the American Medical Association, Dr. Wilson. I am proud of the fact that the American Medical Association has now endorsed our bill. As I said at the time, I said the doctors of America have examined this bill, and they have made the right prescription: Pass it. Pass the health care reform bill.

But Dr. Wilson, in his statement, made particular note of the wellness and prevention programs we have in this bill. He did not say this, but I was thinking, when he was talking, that it made sense. Doctors want to keep people healthy. They do not want to see people go to the hospital. They would rather be working with their patients one on one. How can they structure a patient's profile so the patient stays healthy, does not get sick so often? That is what Dr. Wilson was talking about: letting doctors practice medicine in a way that focuses on a person's health and keeping them healthy.

As President Obama said in his speech to Congress early this year:

[It is time] to make the largest investment ever in preventive care, because that's one of the best ways to keep our people healthy and our costs under control.

That was the President of the United States in his State of the Union message. Well, President Obama has it right. It is one of the best ways to keep our people healthy and our costs under control, and that is a big part of this bill. I do not know—I have not listened to every speech made by the Republicans on the other side—but I hardly ever hear them talk about this, but it is a very important part of the bill.

So, Mr. President, we are changing the paradigm. We are going to extend quality, affordable health coverage to nearly every American. We are going to transform ourselves into a genuine wellness society, and we are going to give our citizens access to a 21st-century health care system, one that is focused on helping us to live healthy, active, and happy lives.

Mr. President, I yield the floor.

THE PRESIDING OFFICER. The Senator from Colorado.

Mr. BENNET. Mr. President, I would like to first thank the Senator from Iowa for his leadership over many years, especially on prevention and wellness, and to see so much of this bill devoted to that is a real testament to his efforts. So I thank the Senator for that.

Mr. President, a number of years ago, I left a rewarding job in business because I had a chance to lend a hand to my community during a very difficult time in Denver. The economy was slow and the city was facing a record budget deficit. Our great mayor, John Hickenlooper, asked me to come be his chief of staff. It was not a glamorous job, but it was rewarding because we got results—not by seeking out what divided the people of Denver, who were going through a very rough time, but by reaching out time and time again to what the mayor called “our alignment of self-interest.”

We fixed the city's budget, and then I had the chance of a lifetime to become the superintendent of public schools and serve our children and the people who work so hard every day to support them. I came away from that experience believing that much of the Republican and Democratic orthodoxies relating to public education are essentially useless to our children—and maybe worse—and that Washington as a whole has absolutely no clue about what is going on in America's classrooms.

So it is fair to say I did not come to Washington with a partisan ax to grind. As is probably obvious to everyone around here—for good or for ill—I am not a career politician. I did not come here to win political points so that someone else could lose. I am not interested in that. I am here as the father of three little girls with an abiding concern we are at risk of being the first generation of Americans to leave less opportunity to our kids and our grandkids than our parents and grandparents left us. That prospect is shameful.

We are not the only Americans who have been working weekends and late into the night recently. There are people in small towns and big cities all across America doing jobs much harder than ours, who are taking an extra shift before Christmas so they can afford that extra gift beneath the tree—Americans who are unemployed in this savage economy and still trying to make sure the kids know Santa remembered them.

These same people are reading their papers and watching their televisions wondering what in the world we are doing here in Washington. All they see are talking heads yelling at each other on cable news, needless partisanship paralyzing their government, and even people praying that Senators will not be able to make votes.

I am not naïve about politics, but I expected more. I will vote for health care reform because it is a step in the right direction. But I will not go home and defend the actions of a Washington that is out of touch, a Washington that is more interested in scoring political points, more interested in the 278 health care lobbyists who used to work

for Members of Congress than it is in what our constituents have to say, a Washington that is more concerned with the millions being spent by big insurance companies than the thousands of dollars being lost by working families who are struggling to pay for coverage.

Columnists opposed to reform have criticized me for saying that I am willing to lose my seat to enact meaningful health care reform. Now I am being asked why I did not negotiate a special deal with leadership. In fact, there was a report this morning criticizing me because the National Republican Senatorial Committee was rejoicing that I did not ask for special favors. Only in Washington would someone be attacked for not negotiating a backroom deal. Just because others choose to engage in the same tired Washington rituals does not mean I have to.

So I have a message for the columnists, the political professionals, and those back home: I am not happy about the backroom deals. I am not happy that the public option was held hostage by people in our own party. I do not support rewarding delay with special deals. I will let others justify their vote and their tactics.

As for me, I am voting to provide coverage to 840,000 uninsured Coloradans, voting to extend Medicare for our seniors and provide free preventive care for everyone, voting to close the prescription drug loophole and provide tax cuts to small business, voting to make health care more affordable and eliminate exclusions based on pre-existing conditions, voting for health care reform that is fully paid for.

The people in my State and in our country deserve better than a politics that cares more about lobbyists and talk show hosts than the people we represent. I am committed to delivering on that despite what the political experts have to say. And, in the end, when the dust settles and the stories focus more on substance and process, I am confident Coloradans will see it the same way.

I also commit to the people of Colorado and the people of this Chamber that I will do everything I can to make sure this bill is fully paid for. That is why I submitted an amendment that will ensure that health care will help pay down the deficit by forcing Congress to make adjustments if reform does not meet the cost estimates we have projected.

I urge my colleagues and the leadership in the Senate to see to it that this amendment is included in the conference report. If not, I will fight to get it passed on its own. I believe so strongly in this because everyone here knows that keeping things the way they are is no longer acceptable.

When I first started in the Senate, 800,000 Coloradans were without health insurance. That number has grown by

40,000 in the months we have debated this bill. On average, 111 Coloradans have lost their health insurance every single day. This number will only get worse if we do nothing. Our State has spent \$600 million in the last year alone on uncompensated care.

Colorado's working families suffered double-digit health insurance cost increases year after year for the last decade. Many families have made terrible sacrifices—no longer investing in their children's futures, saving for a home, or carrying crushing credit card balances—all to pay for health care.

Small businesses pay 20 percent more for health insurance than large businesses do just because they are small.

I think back to the Coloradans who shared their stories with me during this debate.

I remember Bob and Deb Montoya of Pueblo. They were torn between providing health care for their small business employees and keeping their business afloat. Last year, their business paid out \$36,000 to cover two families and one employee. They could not afford to give their other 12 employees health care or they would be literally forced out of business. So they dropped coverage for the 12 employees to keep their doors open.

Hollis Berendt owns a small business in Greeley and told me about her daughter Abby who graduated from Colorado State University in 2004 and found a job in New York with a large company. Her daughter's company made her wait a year before she was eligible for health insurance, and during that time Abby was diagnosed with ovarian cancer. Hollis took out a second mortgage to pay for her daughter's bills and told me:

This experience brought to light, all too clearly, how close we all are to losing everything due to a health issue.

I have spoken here before about a young boy named Alex Lange. Alex's parents' insurance company refused to cover Alex because he was 4 months old and 17 pounds. They said he had a pre-existing condition, at 4 months, of obesity.

Then there was 2-year-old Aislin Bates, whose parents' insurance company denied her coverage because she was underweight. One child too big, the other too small. Today in America, you have to be just right to get insurance.

There was Peggy Robertson of Golden, CO, who was told she could not receive coverage unless she was sterilized, Mr. President. She came and bravely testified in Washington about the need for reform. There was Matthew Temme of Castle Rock, who could not receive coverage because his wife was pregnant, even though she had her own health insurance.

The sad thing is, there is nothing unusual about these stories. None of these people were trying to cheat or game the system. They were trying to

gain some peace of mind, some stability in their lives and, instead, they wasted weeks of their lives fighting against insurance company bureaucracy and mounting bills.

We have debated health care reform for over a year. Some have been working on these issues for decades. Killing health care reform under the guise of starting over is not an option. We cannot wait until after the next election. We cannot wait until our economy recovers or until we have come home from Afghanistan to deal with our broken health care system.

Now standing so close to the finish line, it is completely understandable that some Americans doubt whether this bill will improve their situation. They understand we cannot live with the current system. But they are also deeply concerned about our capacity to make it worse.

The special interests are using tried-and-true tactics that have been employed over and over across the decades to prevent reform: phone calls to scare seniors, direct mail to scare those already covered, television ads to scare just about everyone else, and opponents of this reform in this body are trying every delay tactic permitted by the Senate rules.

Amidst all this, there is still a reason to hope. After almost a century of trying, the Senate is very close to finally passing a meaningful health care reform bill, a piece of legislation that while not perfect, represents a substantial step forward from business as usual. We have a bill that does three important things: It saves money, it saves lives, and it gives families a fighting chance in their relentless struggle with health insurance companies.

This bill will save money. It reduces the deficit by \$130 billion over the first 10 years, according to the nonpartisan Congressional Budget Office, and is projected to reduce the deficit by 10 times that—up to \$1.3 trillion—in the second decade. We will save $\frac{1}{2}$ trillion by improving the way we deliver services to our seniors. These savings will prevent Medicare from going broke in 7 years by extending the life of the Medicare trust fund.

This bill will save lives. It will extend health insurance coverage to 31 million Americans who don't have it today. Over 90 percent of Americans will have health insurance coverage, the highest percentage in the history of the United States. For Colorado, that means over 840,000 people who don't have insurance will now have access and another 300,000 people who have insurance in the unstable individual market will be able to get affordable coverage through the new health insurance exchange.

The Senate bill makes preventive services, such as breast cancer and colorectal cancer screening, available

without copayments. Now mammograms and colonoscopies, which can cost between \$150 and \$200, on average, will be free as well for seniors—half a million seniors in my home State alone. This means catching diseases earlier, promoting wellness, and saving millions of lives.

For our Nation's working families, this bill will also rein in the worst practices of private insurance companies. They will have to commit to covering patients instead of gouging them for excessive profits and overhead. Starting in 2011, if an insurance company doesn't give you value for your dollar, they will have to refund you back the difference. They will not be able to impose arbitrary lifetime limits on consumers and punish you just for getting sick or deny you insurance because of a preexisting condition. The newest Senate bill does more to contain costs, more to demand accountability and transparency from insurance companies, and more to give consumers a better choice.

For my home State, in particular, I am glad the bill addresses other critical areas. This reform does more for small business and small business workers than ever before. Small business tax credits will begin next year, giving eligible businesses a tax credit for 6 years to purchase health insurance for their employees. We have extended tax credits for small businesses, allowing more than 68,000 small businesses in Colorado to buy health insurance.

This bill makes a significant investment in Medicare payments to rural areas. When I first joined the Senate, my first piece of legislation called for a deficit-neutral reserve to address the differences in Medicare payments between urban and rural areas. This Senate bill recognizes the geographic differences between rural and urban areas and makes sure providers in rural Colorado that provide higher quality at lower cost receive higher Medicare payments.

This bill also delivers on its promise to seniors. It doesn't use a dime of the Medicare trust fund to pay for reform and does not cut guaranteed benefits. That is why, on the first day of the health care reform debate, I introduced an amendment that would make sure seniors will still see their guaranteed benefits, such as hospital stays and prescription drug coverage, no matter what changes we make in health reform. It was the most bipartisan piece of legislation we have had this year, with 100 Senators agreeing health reform would not take away guaranteed Medicare benefits for seniors. For Colorado, that means half a million Medicare beneficiaries will continue to have their guaranteed benefits protected and preventive services free of charge through health reform.

I am very pleased Majority Leader REID included a version of a piece of

legislation I wrote based on the work in Mesa County, home of Grand Junction, CO. Currently, one out of every five Medicare patients who is released from the hospital in this country winds up back in the hospital in the same month they were released but not in Mesa County. They have reduced the readmission rates at the hospital to about 2 percent, compared to the national average of 20 percent. That is 12 million patients who aren't receiving the care they need. In Mesa County, they have lowered readmissions by creating a transitional model that makes sure that when patients leave the hospital, they do so with a coach. That coach helps them go from the emergency room to their primary care physician, their mental health provider, making sure they get the care they need over a period of time, making sure they don't forget their prescriptions, and making sure they have the guidance they need to take responsibility for their own care. I am pleased the Senate bill compensates and reimburses hospitals and providers that set up models such as the one in Mesa County that actually saves money.

On another note, I wish to thank the Presiding Officer and my fellow freshmen. Together, we worked hard to introduce a package of amendments to further contain costs and make our system more efficient. As I traveled throughout Colorado on the August break, I heard from doctors and nurses who told me repeatedly all they wanted to do was work with patients, while all the government was doing was making them fill out one form after another. When I came back, I was determined to do something to help cut the red tape and bureaucracy for these people so they could spend more time with their patients. That is why, as part of the freshman package, I introduced an amendment to put an end to multiple forms, confusing codes, and unnecessary paperwork that burden providers. If health plans don't follow the rules, they will suffer financial penalties. Our health care workers deserve better, and this amendment gives them back time to spend with their patients.

Our freshman package rewards and emphasizes efficiency: one form to fill out, not 10; less red tape; fewer bureaucrats; a system that makes sense. Thanks to the leadership of the Presiding Officer, that package was endorsed by the Business Roundtable, the AFL-CIO, and the Consumers Union—proof that at least off this floor, there are still people from all different points of view who are willing to work together.

This bill also makes progress in the area of tort reform. It includes language I worked on with Senators BAUCUS, CARPER, and LINCOLN to create a State grant program for States to develop, implement, and evaluate alternatives to tort litigation for medical

malpractice claims. The purpose of these grants is to limit litigation while preserving access to courts for patients and promoting strategies to reduce medical errors.

I know many in this Chamber take issue with one particular part of this bill or another. I have my own issues with the bill. I am one of many who have expressed their strong preference for a public option. But I urge my colleagues to consider how much good this bill can do for the American people—those with skyrocketing health care costs, small businesses forced with the impossible choice of helping workers keep their coverage or even just maintaining their business. To have the nonpartisan experts at the Congressional Budget Office validate that in the second decade we will have cut health care costs by up to \$1.3 trillion and that we will reduce the rise in costs of Medicare from 8 percent in the next two decades to 6 percent in the next two decades, while covering 31 million insured Americans, is truly groundbreaking.

We know what more time elapsing without fixing this system means for Colorado's working families and small businesses. It means more double-digit premium increases, less time to fix Medicare before it goes bankrupt in 2017, and more names added to the rolls of the uninsured. It means another big win for the special interests, more people denied coverage for preexisting conditions, and more small business employers will have to make impossible decisions about covering their workers or keeping their doors open.

So let's reject business as usual. Let's look at the promise of this Senate bill as a whole. Let's put the pettiness, scare tactics, and obstruction aside. Reform is what is needed to control costs, give people more choice, and provide support for our small businesses. This package will reduce our deficit, and it does so by reforming the way we provide health care.

We have much to do. Even before we were in the worst recession since the Great Depression, during the last period of economic recovery, working families' incomes in this country actually declined, the first time in the history of the United States, the first time our economy grew and left the middle class behind. At the same time, in my State of Colorado and in all States across the country, the cost of health insurance rose by 97 percent and the cost of higher education in my State went up by 50 percent. Finally, because of the short-term politics practiced around here, we now have an annual deficit and long-term debt that is cheating our children and constraining our choices.

We still have a lot to do to live up to the legacy that our parents and grandparents left us. It has taken me less than a year to understand that Wash-

ington still doesn't get it. I know we can do better, and despite so much evidence to the contrary, I believe we will.

I believe we will because, in the end, the national creed that each generation of Americans has fought for and fulfilled—the idea expressed in our Constitution that our responsibility lies not just with ourselves but to our posterity—is so much more powerful than the trivial politics that animate so many of the charges and countercharges that ricochet around this building.

It is for this reason I urge my colleagues to come together and support this meaningful improvement in our health care system.

I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Ms. KLOBUCHAR. I ask unanimous consent to yield myself 10 minutes.

The PRESIDING OFFICER. The Senator is recognized.

Ms. KLOBUCHAR. Mr. President, late last night, as my colleagues are aware, the Senate took the important step to move forward on health care reform. After all the work, the debate that has gone on for this entire year, we owe the American people a vote on this issue. We can't afford to ignore this situation anymore.

I know some of my colleagues on the other side of the aisle have been talking about a lack of debate. I think anyone who has turned on C-SPAN for the last few months will tell you there has been a lot of debate—not only that, a number of Republican amendments were actually included in the original bill, the HELP Committee bill. When it came out, I believe it was something like 130 amendments that were included that came from their side—and the Finance Committee as well.

I remember the first bipartisan meeting we had on health care reform was something called Ready to Launch that the Finance Committee put together. I remember Senator WHITEHOUSE and I were there. It was literally a year and a half ago. So many of the ideas that are now incorporated in this bill that Senator BENNET from Colorado just so eloquently went through in this bill, so many of the bipartisan ideas to kick off cost reform, to start rewarding high-quality care, to start bringing down those costs in a way that gives us the high-quality care.

We all know that rising costs are not sustainable. If we don't act, these costs are going to continue to skyrocket.

So what was the vote about last night? The vote last night was to say we are not going to put our heads in the sand anymore. We are not going to keep letting these costs go up.

Ten years ago, the average family was paying \$6,000 a year for their health insurance. Now they are paying \$12,000 a year. Well, 10 years from now, if we don't do anything about this,

they are going to be paying \$24,000 to \$36,000 a year for their health insurance. Just look at these numbers. Look at where we are. In 1999, a single person was paying about \$2,100 for their health care. They were paying for a family, \$5,790 for their health care. Where are we now? Last year, in 2008, a single person was paying \$4,700 for their health care and then a family was paying \$12,680. Especially during this difficult economic time when wages haven't been going up, people have been losing their jobs, cutting back on their hours, and look what their health care costs have been. It has been a higher and higher percentage of their family budget, a higher and higher percentage.

At the same time, health care expenditures are going up and up and up. In 1995, we were spending something like \$12 billion and now it is way up to \$2.5 trillion. This is the kind of money we are talking about when we look at why we have to do something to bend the cost curve. When people at home hear this term "cost curve" and they don't know what it means—well, this is exactly what it is: The cost curve has been going up and up and up for health care in America.

So \$1 out of every \$6 spent in our economy is on health care. Over 20 percent of our economy, by 2018, we believe, will be spent on health care. American families can no longer afford it.

Who has been taking it the worst? Small businesses. They are paying 20 percent more than large businesses for their health care. In a recent survey, nearly three-quarters of small businesses that did not offer benefits cited high premiums as the reason.

These are little companies such as Granite Gear up in northern Minnesota and Two Harbors. I went up there and visited them. They are a thriving little company. They now have 15 employees. They are making backpacks for our Nation's soldiers because they make such high-quality backpacks. Do you know what the man who started that company told me? That if he had known how much his health care would cost with his family of four—he did not have kids when he started the business—he would not have started it today. He is paying \$24,000 in Two Harbors, MN, for a family of four.

This is what it really means when you look at the numbers. Inflation usually raises the cost of most goods and services between 2 and 3 percent a year. What have health care premiums been doing? Health care premiums have been going up close to 8 percent a year, and that is an increase Americans simply cannot afford.

What does this bill do? I was listening to some of the commentary and taking part in it myself over the weekend. There seems to have been a lot of talk about these delayed benefits. Why don't we talk about the benefits that

are taking place right when the President signs this bill, within the first year of this bill?

The first thing is, if your kid loses their coverage because something goes wrong—if they get diabetes or if they have some childhood disease—guess what. They are going to be able to get health care. There is no longer a ban on preexisting conditions immediately, and then in later years that applies for adults as well but immediately for kids.

Immediately, by 2011, within the first year of the bill, our seniors are going to be covered in that doughnut hole for their prescription drugs. So many of them for so long—I know my own mother would complain about this doughnut hole where they fall off a cliff and are not able to pay for their drugs because they do not have enough money. That will be covered.

A number of the small business tax credits take effect by 2011. These are real benefits for the people of this country—real benefits.

The thing I care most about in this bill which Senator BENNET discussed is this idea of getting our money's worth for our health care dollars. What does this bill do? This new bill—we have taken a lot of the good from the original bill and made things even better: \$132 billion off the deficit in the first 10 years and in the next 10 years, \$1.3 trillion off the deficit. That was the most important thing to people in my State when I went around. They said: We want to get rid of these preexisting conditions, we want to make things better so we have better health care, but we want to make sure we do something about the deficit, start doing something about costs.

As you know, Mr. President, Minnesota is a mecca for health care. We have one of the high-quality, cost-efficient, low-cost States in the country. In fact, when we look at some of the numbers, one of my favorite ones—and maybe this will be the last time I will say this before the end of the year—is Mayo Clinic. They did a study out of Dartmouth, and they looked at what Mayo did with chronically ill patients. What they found was this: If other hospitals in the country simply use the same high-quality care Mayo uses—bring the family in, talk to them about what the care should be for the patient—they talk to the patient and then figure out what is the best course. They work as a team, like a quarterback with a team working with that quarterback. They do not have 20 specialists falling all over each other; they work as a team. What this study showed was this kind of health care for that subset of chronically ill patients in the last 4 years of their lives, the quality ratings were sky high for the Mayo Clinic. The families felt good about how their loved ones were treated.

What Dartmouth found is if all the hospitals in the country followed the same protocol, we would save, for this subset alone, \$50 billion every 5 years in taxpayer money, giving patients that Mayo health care, giving them high-quality health care. It is counter-intuitive to people. If you go to a hotel and you pay the most, you are going to get the best room with the best view. That has not been the same in American health care. In fact, there is an inverse relationship.

I see my friend from Ohio. Ohio has the Cleveland Clinic, and there is Geisinger. Those places that offer high-quality care also tend to have some of the lowest costs.

Those are the incentives we are putting in this bill—incentives for accountable care organizations, incentives for that integrated care I talked about instead of people running around with x rays to 20 specialists, getting charged every single time, but then one specialist does not know what the other specialist is doing. They don't know what kind of drugs you are allergic to when you go in for surgery. This is because there is no communication. This bill promotes that integrated care where you put the patient in the driver's seat so they have their pick of a doctor. That is what we want—bundling of payment so you start rewarding outcomes instead of the number of tests and procedures.

My favorite example of this came out of the Geisinger Clinic in Pennsylvania, where they said: We are not that happy with how we are treating diabetes patients. So instead of having everyone wait to see an endocrinologist, a doctor, we are going to have some of the routine cases see nurses, and the nurses will report to the doctors, and the patients will be happier because they will be able to see a nurse more often. The most difficult cases will be treated by endocrinologists.

They did that for about a year and looked to see what the results were. Guess what. The patients were much happier because they were able to communicate one-on-one with the nurse. The doctors were able to handle the most difficult cases and monitor the other cases. They saved \$200 a month per patient with this kind of system. Higher quality care and better patient outcomes.

What does our system do when they see this kind of smart, cost-effective result for the doctors and for the system and for the taxpayers? They actually are told: You get punished for this under our system. You are going to get a lot less money if you do something like this. That is what I am talking about.

On hospital readmissions, we could save \$18 billion a year. If you go in the hospital and you are treated, you want to go home. You don't want to go back into the hospital because someone

made a mistake or they gave you an infection. Let's provide incentives—that is what this bill does—so that we reduce those hospital readmissions, make life better for the patient and at the same time reduce taxpayer money. That is what this bill is about.

Right now, fraud is \$60 billion. I don't think anyone would believe this. A senior who just depends on Medicare, right—we have to tell our seniors today that \$60 billion a year is wasted on Medicare fraud, going to con men, going to people who set up storefronts and they get fake checks and they are not even real. That is where the money is going right now—down the tube, siphoned off by fraudsters. What this bill does is give the tools to improve that situation so that will not happen anymore.

That is what we are doing with this bill. It is about reducing costs, it is about raising quality, and it is about saving Medicare so it does not go in the red by 2017, giving it 10 more years and beyond because of the delivery system changes.

I am proud to support this bill. We continue to work for reform. As you know, this is not just an end, this is a beginning. There will be more work to do in the future, but we cannot put our heads in the sand. We have to vote on this bill. We have to get this done.

I yield the floor.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. BROWN. Mr. President, it has been said that a cynic knows the price of everything and the value of nothing. I spent, as we all have, as the Senator from Minnesota has, as the Presiding Officer has, the last 4 weeks listening to my colleagues come to the Senate floor to describe health reform legislation that bears no resemblance to what is actually before us. They take liberties with the cost of the bill. They seem to have no concept of the value of health care to a family who has it and to a family who does not have it. I guess they believe it is not important for us to get this done, it is not important for other Americans to have affordable health insurance.

My colleagues are not at risk of losing their coverage. They can afford the health care they and their families need. So what is it to them if another 14,000 people lose their insurance every day? Mr. President, 390 people every single day in my State lose their insurance. What is it to them if people with preexisting conditions cannot get coverage, if women are overcharged for insurance, if the self-employed cannot afford the outrageous premiums they are charged, if too often American small businesses pay more for health coverage than they earn in profits? What is it to them?

I have listened as Republican Senators have come to the Senate floor day after day to tell tales about health

care reform and try to manipulate public opinion by any means possible. I hear them mostly stalling: Slow down, not yet. They have done it since the Gang of 6 in the Finance Committee met in June. No, actually they had begun to stall even before that when the Finance Committee and the HELP Committee began their deliberations, informal deliberations.

What they forget or what they do not want to think about, perhaps, is that every day they stall, 390 people from Galion to Gallipolis, from Buckeye Lake to Avon Lake, from Ashtabula to Cincinnati, 390 people in my State lose their insurance every day. Every day, we see 14,000 Americans lose their insurance, and 1,000 Americans die every week because they do not have insurance. One thousand Americans die every week because they do not have insurance, and on the other side of the aisle they say: Slow down. What is the rush? Why do we have to move into this?

They forget or maybe they just do not want to hear that a woman with breast cancer is 40 percent more likely to die if she is uninsured than if she has insurance. Women with breast cancer are 40 percent more likely to die if uninsured than if they have insurance. Yet they continue to say: Slow down.

I wish my friends on the other side of the aisle would actually meet some of these people who do not have insurance. Let me put a human face on this, if I can. Let me share three letters from Ohioans. I have come to the floor since July day after day reading letters from people directly affected by this health insurance situation, if you will. In most cases, these are people who were happy with their health insurance a year ago, and something happened in their lives—they got laid off and lost their insurance; had a child with a pre-existing condition for whom they could not get insurance; maybe they got sick and the cost of their health care was so high that the insurance industry cut them off, simply eliminated their coverage. Let me read a couple of these.

Marie from Hancock County, OH:

My husband and I both have preexisting conditions and are stuck paying \$1,300 a month for health insurance. He has been out of work for 2 years and we are living off the money that we got when we sold our house. We are afraid to go without insurance. We are in a fix and in our late middle ages and find ourselves watching our retirement savings go down the drain. Please fight for us and others like us.

Think about that. Does anyone in this Chamber, does anyone who comes to work as a Senator or down the hall as a Congressman—can any of us really understand what this couple is all about, this couple from rural, smalltown Ohio paying \$1,300 a month? How are they paying for their insurance? They sold their house so they could pay for their health insurance. They are in their late middle ages. I

am guessing they are probably in their late fifties, early sixties. They are not eligible for Medicare.

So many people say to me through these letters and through my meetings and discussions and when I am traveling around my State: I am 63. I only have 2 years before Medicare because I trust Medicare. It is stable, predictable. It will be there for me, and it will help.

Instead, Republicans in this body, all 40 of whom even voted against the bill last night—40 said: Stop. Don't even move forward on this bill. Do any of those 40 really understand people such as Marie from Hancock County? Do any of them understand? Do any of them understand that 390 people are losing their insurance every day in just one State? Do any of them understand that 1,000 people a week are dying in this country because they do not have insurance? Do any of them understand, any of the Members of Congress, the House of Representatives or the Senators, the 40 Senators who said no and stall and stall, saying: Not yet; can't do this yet; have to slow it down. Do any of them understand that a woman with breast cancer is 40 percent more likely to die if she does not have insurance than if she does?

Charles from Cuyahoga County, the Cleveland area, writes me:

The hands-off-health-care people claim that many Americans are very satisfied with their own health insurance. I am one of those. I have Medicare. But I don't believe their implication that health care reform is not needed. I think if you were to really ask those lucky people who were somewhat satisfied with their plan—a great majority would say they support reform that would benefit everyone.

Charles understands. He is on Medicare. He understands the stability and predictability of the Medicare system.

I might add parenthetically that my Republican friends, all 40 of whom last night said: Stop, slow down, stop, slow down, all 40 of them understand that their party overwhelmingly opposed the creation of Medicare. When they had a chance, they tried to cut it and privatize it in the nineties. Then when President Bush was sworn in, with Republican leadership in the House and Senate, they moved forward on their giveaway to the drug companies and insurance companies in their attempts to privatize Medicare. Now they say they are all for Medicare.

Understand, Charles knows what this bill is going to do. It is going to strengthen Medicare. It is going to lengthen the lifespan of Medicare. It is going to give free physicals, once-a-year checkups, colonoscopies, and mammograms for people on Medicare, and it is going to close the doughnut hole so fewer people will have to pay so much out of pocket.

Last letter. Raymond from Delaware County:

My wife and I had to drop our coverage because it cost us \$30,000. The country needs re-

form that bars insurance companies from denying coverage or charging higher premiums on the basis of preexisting conditions. Health reform is the right solution for the people of Ohio.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. BROWN. I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. BARRASSO. Mr. President, I just heard my colleague, the Senator from Ohio, say: I wish some of my colleagues on the other side of the aisle would understand families who don't have insurance.

I practiced medicine for 25 years, taking care of families in the State of Wyoming. During that time, I took care of all patients, regardless of their ability to pay. I will tell you, I believe, as a physician who practiced medicine for 25 years—and as someone whom the Obama administration has decided to completely ignore, as he did the other Senator of this Chamber who is a physician—that I know specifically and personally about what happens to families who lose their insurance. My colleague and I know specifically what happens to families who are on Medicaid, a health care program which my colleague who is now leaving the Chamber after asking if anyone in this body understands people without insurance but not staying to hear the discussion for the next hour—making statements and then leaving—I understand those families. I understand the families on Medicare, I understand the families on Medicaid, I understand the families without insurance, I understand the families worried about losing their insurance, I understand about the families worried about disease.

My colleague from Ohio said: Do people understand women with breast cancer? Well, my wife is a—

Mr. BROWN. Will the Senator from Wyoming yield?

Mr. BARRASSO. Regular order, Mr. President.

Mr. BROWN. I just wished to let the Member know I am still in the Senate.

Mr. BARRASSO. My wife was a breast cancer survivor, and her breast cancer was discovered in her forties by a screening mammogram. It was that screening mammogram that saved her life because the cancer had already spread. It had already spread to a lymph node. She had three operations, two bouts of full chemotherapy, radiation—35 treatments and all—all—because of the screening mammogram that saved her life. Yet because of this bill that was brought to the Senate floor—with the government knowing better than the rest of America, knowing what health care ought to be given and shouldn't be given—all of a sudden what we see is the government knows best, people don't know—her life would have been lost because she is one of those 1,900.

So I understand, having practiced medicine, having lived that life as a physician—taken care of people without health insurance and on Medicaid and Medicare and those worrying about losing their insurance when they lose their job—the implications. Yet I took care of all of them, as did all my partners. We dealt with all these people, trying to help each and every one of them, regardless of their ability to pay. It is why we need health reform in this country that actually works on availability of care, affordability of care, access to care, and quality care. This bill that I voted against last night doesn't address the needs of the country. It fails time and time again.

The President made a number of promises—a number of promises—to the people of this country. He said people would see their insurance premiums drop by \$2,500. Instead, the budget officers say: Oh, no, it is going to go up \$2,100 for a family. Has the President not read the bill, not read the responses that have come from the Congressional Budget Office? Does he not see the difference there of \$4,600 per family?

The President said this wouldn't add a dime to the deficit. Well, it is going to add a lot of dimes to the deficit. This is going to add \$1 trillion to the deficit. He said: Oh no, will not at all. Yet they didn't do the doctor fix—the Medicare doctor fix. Now the Speaker of the House says: Oh, we will handle that in January or February for \$250 billion, since they are not going to pay for it here.

The President said: Taxes will not go up on anybody making under \$250,000 for a family. There are a dozen taxes in the bill that will be passed on to the American people. Now any teenager who goes to a tanning salon is going to get taxed 10 percent. I don't think any of those people are making over \$250,000 apiece.

The President said: People will not lose their coverage. Oh, they are going to lose their coverage. Many will lose the coverage they have, coverage they like, because they have cut 11 million people on Medicare Advantage—a program people like, a program my patients like. People whom I have taken care of like it because there is actually an advantage to the program. It is a program that deals specifically with preventive care. It is coordinated care. That is what happens with Medicare Advantage. The President doesn't like. They will lose their coverage.

Of course, the President said we wouldn't see any cuts to Medicare. Yet the bill says \$500 billion of cuts to Medicare for the seniors who depend upon Medicare.

The President said we would have an open, honest debate. He said C-SPAN would be there covering the debates. Those of us with the most experience—the two physicians, with 50 years in the

practice of medicine and taking care of families in this country—were completely excluded—completely excluded—even though we offered to go to the White House and read the bill with the President.

So what do we have? What is the verdict of the American people on the vote that was taken in the dark of night—at 1 a.m. in the morning—a Monday morning vote, taken at 1 a.m. so the American people, hopefully, according to the Democrats, would be asleep and not see what they were doing to the American people? The verdict is the American people are overwhelmingly opposed—opposed—to the bill the Senate last night voted 60 to 40 on cloture and decided to move ahead on.

The deals in the bill are absolutely astonishing: \$100 million for a hospital in a State we still can't identify and no one is claiming, a payoff to one State, a payoff to another State, and then the cuts in Medicare for our seniors who depend on Medicare, a program that is going to go broke in the year 2017—not to save Medicare. Instead of saving Medicare, to start a whole new government program.

I see my colleague from the State of Tennessee is standing, and he has worked closely with people on Medicare in his home State. He is familiar with that and with Medicaid and he knows how difficult it is for patients to get to see a doctor. With the cuts in Medicare, it is going to make it harder for those hospitals to stay alive and open in your community, and for patients to get the kind of care they need.

So I would ask my friend from Tennessee: Are there concerns you have about the cuts to Medicare and how they are going to impact on the care of people in your home State?

Mr. ALEXANDER. I thank the Senator from Wyoming and appreciate his leadership on this bill. It is of tremendous value to have within our body two practicing medical doctors to help us interpret the effect of this bill, which affects all 300 million Americans so dramatically.

We find, when we discuss this bill with our colleagues on the other side of the aisle, we sometimes become exasperated with one another because it seems like they are talking about one set of facts and we are talking about another set of facts. So what I would like to do is take a moment and talk about Medicare.

If anyone is watching our debate, you hear the Democrats talk about three things: We are saving Medicare, we are extending its length, and you hear Republicans say they are cutting Medicare. So who is right?

Well, let me tell you why we talk about Medicare cuts. Medicare, of course, is a government program which 40 million seniors depend on. We all pay into it, and then when we get to be

of a certain age we depend upon it for our medical care. For many Americans, it is very important. It was established with broad bipartisan support in the 1960s.

What are the proposals that have to do with Medicare? Well, basically half this health care bill is paid for by reductions in the growth of Federal spending for Medicare. Those are Medicare cuts. Who says they are? Well, the President of the United States, for one, says we will have no deficit from this bill. So the way we are going to do that, for this bill, which the Congressional Budget Office figures show us will cost \$2.5 trillion over 10 years when fully implemented, is basically paid for one-half by Medicare cuts and one-half by new taxes. Give the Democrats credit for that, that helps to avoid a large part of the deficit. The rest is done by sending a huge bill to States to help pay for another big government program called Medicaid, but I will leave that to the side for a moment.

The Medicare cuts which are reductions in the spending for Medicare, are \$466 billion over the first 10 years and over a fully implemented 10 years it is about \$1 trillion in Medicare cuts. That is money coming out of the Medicare Program and going somewhere. Where does it go? Well, it goes to start a new program.

What is wrong with that? Well, one thing wrong with it is the trustees of Medicare say that there is already more money coming out of Medicare than is being paid in, and by the year 2015 or 2017 it will be insolvent. That means going broke. These aren't Republican trustees or Democratic trustees, these are the men and women whose job it is to report to the Nation on the condition of this program that takes care of 40 million people and their medical care.

Already we see that the Medicare Program is under some stress. The doctors, for example, who serve Medicare are only paid about 83 or 84 percent as much as doctors who serve patients with private health care. As a result of that, we have to come along year after year and appropriate more money to reimburse doctors who serve Medicare patients. If we do not do that, they will not be serving Medicare patients, and Medicare will become similar to Medicaid, the program for low-income Americans, where about 50 percent of doctors will not take a new Medicaid patient. It is akin to telling somebody: I am going to give you a ticket to a bus line where the bus only runs about half the time.

So what the Democrats are saying to us is that by taking \$1 trillion out of Medicare over 10 years when fully implemented, and there is no dispute about that amount of money, and spending it to pay for this new program that is somehow good for Medicare and

for the seniors who depend upon it. I mean, they are suggesting we believe if you take \$135 billion from hospitals and \$120 billion from the 11 million seniors who participate in Medicare Advantage and \$15 billion from nursing homes and \$40 billion from home health agencies and \$7 billion from hospices, that somehow that is good for seniors.

Perhaps it could be, if all that money were put back into Medicare; if the money were taken from grandma and spent on grandma. But no, this money is taken out and spent on a new program. The Director of the Congressional Budget Office—not a Republican, not a Democrat, the nonpartisan Director said, for the 11 million on Medicare Advantage that one-half of their benefits will be diminished. That is what he said about these cuts.

Even when it is all said and done, we completely leave out the $\frac{1}{4}$ trillion that we need to appropriate to pay the physicians to serve Medicare patients. Because if we don't, their payments are going to be cut by 21 percent next year and fewer of them will see Medicare patients. We have already heard the Mayo Clinic, for example, is beginning to restrict some patients on Medicare because they lost \$840 million serving Medicare patients last year.

I have taken a few moments to talk about Medicare. That is just one thing wrong with this bill. But when you hear the other side say they are helping Medicare, and if you listen to what I said about how can you take \$1 trillion out of the Medicare Program—which is going broke—when it is fully implemented over 10 years and claim you are helping Medicare by starting a new program, I don't think that is possible. That is the source of the great concern on our side of the aisle about this bill on that one issue.

I see the assistant Republican leader, the whip. I have heard a number of people say, and I will just propound this question and then I will yield the floor, if I may, to the Senator from Arizona. But I have heard them say: Why are Republicans keeping everybody in here this week? We want to go home and see our families.

We all want to see our families. But there is a reason this bill was suddenly presented to us in the middle of the greatest snowstorm in the history of Washington in the month of December, and we were asked to start voting on it in the middle of the night on the same day, and to finish the work by Christmas. If I am not mistaken, and this is my question to the distinguished assistant Republican leader who has been here a number of years, who is in the leadership and whose job is to help manage the floor: Is it not entirely the prerogative of the majority leader of the Senate to schedule what comes up on the floor? Is that not his job? Isn't it true that if Senator REID wanted to say let's take this bill down, let's go

home, let's let the people hear about it, let's come back and vote on it after Christmas, after New Year, after Valentine's Day, could he not do that and isn't that peculiarly his power and not our power?

Mr. KYL. Mr. President, I would say to our colleague, as a general rule that is correct. The majority leader has two great powers that no one else in the Senate has. One is the right of first recognition by the Presiding Officer and the other is the power to set the schedule. That power is limited by Senate rules, and it can be altered by unanimous consent. I can go on and explain a little bit to folks who are wondering why we would be in this predicament of voting on Christmas Eve based upon the majority leader's decision. If I can just proceed, I will do that.

All of these rather odd times for debates, 1 o'clock in the morning, 7:20 a.m. in the morning, and so on, are as a result of the majority leader's decision to make sure that this bill is completed by Christmas. That is the precipitating cause for everything else that follows because once he says the bill has to be completed by Christmas, then he has to, in effect, count backwards on how long it takes to do the various things the Senate rules say we have to do.

If there are three cloture motions filed—which is what the majority leader did; he filed three cloture motions simultaneously—under Senate rules certain timeframes then attach.

You have to take the vote with 1 day intervening between the filing of the cloture motion and the vote. If cloture is invoked, then 30 hours for debate is permitted after which there can be additional action by the Senate. So when the majority leader takes all that into account, he finds that he has to vote at 1 a.m. in the morning, 7:20 a.m., and so on.

He could change that, of course. He could change that by saying we do not actually have to have the whole thing completed by Christmas. That is strictly an arbitrary date he set.

There have been some who said: Why don't we have a unanimous consent request to not put us through all of this and try to complete the debate a couple of days earlier?

Republicans have said: Now wait a minute. You are telling us on the one hand that the majority leader is saying we have to have this completed by Christmas, but since that is kind of tough on all of us, now you are saying let's move that up a couple of days.

Republicans are saying: We have had barely enough time to consider this bill as it is. We are not going to agree to move it up any more than that. We don't like voting on Christmas Eve any more than you do, but the answer to it is not making the time even shorter but, rather, taking our time and doing it right. As the Senator from Maine

has pointed out, let's go home for the Christmas recess, stop and listen to what our constituents are telling us they would like to have us do, and then come back and complete it. That could all be done by unanimous consent. My colleague is correct that once the majority leader made the decision that this has to be done by Christmas, then the time is pretty well set by the Senate rules, absent a unanimous consent by the body that would either extend the time or shorten that amount of time.

I would like to make another point, off that subject if I could, but if my colleague has another question in that regard I would be happy to try to respond to it.

Mr. ALEXANDER. No, I thank the Senator. I yield the floor.

Mr. KYL. I talked to the Senator from Wyoming. Of course, Arizona is a State that has a lot of Medicare patients. Our State is hurt as much as any by the cuts to Medicare and particularly the Medicare Advantage cuts. We do not have the benefit that was extended to residents of other States, primarily the State of Florida, by a special provision that was inserted into the bill. As a result, our constituents are going to suffer more than those of some other States.

But the more we read this bill—and one of the reasons Republicans have not been willing to truncate this debate is that the more we read it the more we find in it that is troublesome. We found yesterday that the Congressional Budget Office—actually the Congressional Budget Office brought to our attention the fact that they had made a little mistake. I think it was a quarter of 1 percent in one of their calculations. That quarter of 1 percent amounted to \$600 billion. So a small error by the Congressional Budget Office can make a huge difference to the people of America. That is \$600 billion.

We also saw there were special provisions in the bill for residents of one particular State, and that has gotten quite a bit of attention lately. There has also been a dental/vision clinic in a State that has benefited. I am still not sure we have figured out exactly what that State is, but I understand one of the Senators from Connecticut has taken credit for it. I don't know if that is true. It is hearsay. If that is incorrect, I can be corrected. But the more we see about it, the more we realize that support for it was garnered, not on the merits but on the basis of special favors done to certain Members.

My staff has indicated there is yet another one of these in the bill, and it has to do with so-called specialty hospitals or, as they are referred to in the legislation, physician self-referral hospitals, that have physician ownership.

Just a little bit of background on this. The Hospital Association that is primarily representative of the community hospitals has been pleading for

a long time that they are not adequately reimbursed, and we need to try to help them. I have been an advocate for that. I have tried to help them, for example, for reimbursement in the care provided to illegal immigrants, and we were successful in that.

But one area I departed from that is when they concluded the best way to help themselves was to hurt their competition. At that point I said no. Their competition is the physician-owned, self-referral hospitals. These are generally specialty hospitals in a community that provide very good care. While they do in one sense provide competition to the community hospitals, they are all in the same boat in terms of the kind of reimbursement that Congress provides. What I have said is you should not solve your problem by hurting your competition but having Congress solve the problems that affect you both. I have been willing to try to help on that.

In this legislation what they have done, they struck a deal with the Hospital Association to stop the competitors, the physician self-referred hospitals, from building any more hospitals. You have to be under construction by a certain date under the bill—it is February 10, 2010. You have to have a provider agreement in operation—that is the technical term—or else you cannot go any further with your new physician self-referred hospital. That is going to hurt a lot of communities. It turns out that some of the communities hurt were in a particular State, the State of Nebraska.

Again, I have an affinity for Nebraska because I was born there, and I know a lot of people there. The Senator from Nebraska, Mr. JOHANNIS, a little bit earlier today said he didn't think the special deals that were created for the State of Nebraska were appreciated by Nebraskans who stand more on principle and have the view that if something is bad for Nebraskans and it is bad for the folks in other States, therefore it ought to be solved for all of the States, not just for the State of Nebraska.

It turns out that is the case with this particular provision on page 332 of the Reid so-called managers' amendment, which would extend the date on which a hospital may have physician investment and a provider agreement in place for the purpose of being grandfathered. That date was extended until August 1, 2010.

It turns out that helps, at least according to staff, at least three hospitals in the State of Nebraska—one in Omaha, one in Kearney, and one in Bellevue. In fact, I will just quote briefly from an article that Robert Pear of the New York Times did on this.

The Senate health bill, would impose tough restrictions like the one passed by the House last month, would impose tough new

restrictions on referrals of Medicare patients by doctors to hospitals in which the doctors have financial interests. The package assembled by Mr. Reid would provide exemptions to a small number of such hospitals, including one in Nebraska.

He goes on to describe this and then quotes Molly Sandvig, executive director of Physician Hospitals of America, which represents doctor-owned hospitals, who said the change would benefit Bellevue Medical Center, scheduled to open next year in Bellevue, NE.

Under the proposal Ms. Sandvig said, "doctor-owners can continue to refer Medicare patients to the hospital" in eastern Nebraska.

"Senator Nelson has always been a friend to our industry," she said. "But doctor-owned hospitals in other states were not so fortunate. They would not meet the August 1 deadline."

I would like to help all the physician-owned hospitals. I agree that all of them should have the same kind of support that was gained by the Senator from Nebraska for three specific hospitals in Nebraska. I understand, by the way, that three or four hospitals in Arizona would also benefit from that. I think that is a great thing.

But instead of just benefiting the hospitals in a few States by moving the date back to where you catch the ones in the State of Nebraska, we ought to eliminate this requirement altogether because what you are going to do is prevent more competition from very high-quality hospitals in communities that can provide a real service to constituents in all of our States, not just one State.

It is just one more example, I say to my friend from Tennessee, that the more we read the bill and learn what is in it, the more we find that the 60 votes for it were obtained less by persuasion and on the merits of the bill than by special provisions that were inserted to assist folks in particular States.

As I said, I think if something is good for one State, it ought to be good for all States. If it is not good for one State, it ought not be a requirement on the other States as well.

Mr. BARRASSO. Mr. President, what you are hearing is what we are noticing as Republicans take a look at the bill. I saw the majority whip come onto the Senate floor a few minutes ago. Yesterday he was on the floor and said the Republicans have not offered amendments to this bill, so I brought four amendments yesterday. The chairman of the Finance Committee objected.

One had to do with letting people on Medicare keep their own doctors or choose who they want to go to see for a doctor. The purpose of this what was called "Medicare Patient Freedom to Contract" is it "allows Medicare patients the right to privately contract for medical services with the physician of their choice."

I ask my friend from Tennessee, who has just spoken about Medicare,

wouldn't he think that patients who have been promised that they can keep the health care they want should be able, or at least this Senate ought to be able to debate an amendment about allowing Medicare patients the right to privately contract for medical services with the physician of their choice? Wouldn't that seem fair?

Mr. ALEXANDER. Mr. President, I agree with the Senator from Wyoming. I think it is important for the American people to know, the 400-page amendment that was added to the underlying bill over the weekend is being presented to us in way that will not allow the bill to be amended. So something that affects one-sixth of the economy, which we have had a day and a half to read, which is part of an overall bill that will raise taxes, cut Medicare, and send big bills to States could be improved with amendments but cannot be amended under the current procedure.

Mr. BARRASSO. Another amendment—I see my colleague from South Dakota is here—is an amendment I offered on the floor of the Senate yesterday to protect individuals from skyrocketing insurance premiums. You may recall the President of the United States said premiums—families in Wyoming and other States, families across the country—health insurance premiums would go down \$2,500 per family. Yet what I read and studied, and as I look at this, it says to me it looks like premiums will go up instead of going down. Instead of going down \$2,500, they will go up \$2,100. I think for 90 percent of the families in this country, their insurance premiums will either stay the same or go up more because the bill is passed than if we did nothing.

I ask my friend from South Dakota—I know he has been bringing forth information; I know he put a chart together on it—would there not be some value in allowing the Senate to discuss an amendment because this amendment basically said let the State insurance commissioners—because every State has an insurance commissioner—let the State insurance commissioner take a look at what happens to insurance premiums in their State. If the insurance commissioner finds that the premiums have gone up faster than the Consumer Price Index, then in that State where those premiums have gone up faster than the Consumer Price Index, all of these laws and regulations and rules would no longer apply. The mandates, the rating rules, the benefit mandate, all of those included in the Reid bill would not apply.

Wouldn't that make sense, I ask my colleague from South Dakota? What is the Senator's understanding of this and should not we be allowed to at least discuss and debate that as a Senate when we have been promised as citizens of this country that premiums would go down?

(Mrs. HAGAN assumed the Chair.)

Mr. THUNE. Madam President, the Senator from Wyoming is correct. Of course, we would like to offer amendments. I know the Senator from Wyoming has deep experience in this field, being a practicing physician, someone who brings great knowledge and background to the debate and obviously has great insight about how this 2,100-page bill could be improved upon. What we have here is the 2,100 pages that we started with, and this represents one-sixth of our entire economy. We are talking about reordering one-sixth of the entire economy. Saturday we received an amendment, a 400-page amendment which nobody up until Saturday had seen. In fact, many of the Democrats hadn't seen it either, including members of the Democratic leadership. There was a discussion on the floor last week between Senator MCCAIN and Senator DURBIN in which Senator MCCAIN said: They are writing this amendment behind closed doors. We don't have any idea what is in it. The Senator from Illinois, the No. 2 person in the Democratic leadership, said: I am in the dark just like you are. You had a handful of people who were adding 400 pages of content to the 2,100 pages we already have.

In addition, there is another amendment that adds another 300. We are talking about 2,700 pages that will reorder and restructure literally one-sixth of the entire American economy. Right now what we are being told is that we are not going to be allowed to offer amendments to that humongous piece of legislation. When you get this much legislation coming at you and receiving this on Saturday, not having the opportunity to read it for the first time, is why we have been saying we need to push this back and not try to jam it through before the Christmas holiday. You find all kinds of things in these bills. Sometimes people take credit for those being there. Sometimes they don't. We have had a debate about some of the provisions that benefit specifically Nebraska. You have this Medicaid provision that requires the taxpayers of the other 49 States to subsidize and pay the Medicaid matching share for the State of Nebraska which will cost millions and millions of dollars. The Senator from Arizona mentioned this late add, a \$100 million item for construction of a university hospital which, again, is being reported as being inserted by the Senator from Connecticut. You have all these sorts of deals that get made to try and get that elusive sixtieth vote that are now coming to light. The American people have a right to know it. Frankly, Members of the Senate who have to vote on this have a right to know what is in these volumes of pages, 2,700 pages, that will spend \$2.5 trillion. The original 2,100-page bill spent \$1.2 billion per page, \$6.8 million per word. It creates

70 new government programs. This is a massive overhaul of health care delivery.

What it ought to be about is driving down the cost of health care for people. In fact, we have heard a lot of discussion from the other side about how this drives down the cost of health care. This bends the cost curve down. They can say that, but the experts we rely on, the referees or the umpires, say otherwise. In fact, what the CBO has said is that the cost curve would be bent up by this bill. The blue line on this chart represents the increasing health care costs year over year if we do nothing. The blue line represents what we would be looking at if we continue on the current course which everybody here acknowledges is unacceptable. We all want to see the cost curve go down and see overall health care costs go down. But the ironic thing is, according to the CBO, the red line represents what happens if the bill proposed by the Democratic majority actually becomes law. The cost curve is bent up. We will actually spend more on health care than we are spending today, even the year-by-year twice the rate of inflation increases in health care premiums today.

The Senator from Wyoming is absolutely right to be offering amendments to address the issue of premiums. This bill does not do anything to reduce premiums for most Americans. About 10 percent of Americans, because of the subsidies in the bill, would get their premium costs reduced, but 90 percent—we are told by the CBO—would see their premiums stay the same or go up. When I say stay the same, it means go up at the current rate of twice the rate of inflation. Worst-case scenario, if you are buying your insurance in the individual marketplace, you will see your insurance premiums go up above and beyond this by 10 to 13 percent. Health care costs for 90 percent of Americans, the best they can hope for, is the status quo which is year-over-year increases that are twice the rate of inflation. If you are one of the unlucky who buys their insurance in the individual marketplace, your premiums go up by another 10 to 13 percent. This ought to be about driving down health care costs and getting premiums under control.

The overall cost of health care in this country represents about one-sixth of our entire economy. If this bill passes, according to the Congressional Budget Office, according to the Actuary of CMS, health care spending will no longer be one-sixth of the economy; it will be more than one-fifth. Because if this bill passes, health care spending will go up to about 21 percent of our gross domestic product.

Tell me, what does this bill do then to get costs under control? If we are driving up the cost of health care for individuals in the form of higher pre-

miums, if we are driving up the overall cost of health care as a percentage of our economy, why would we be jamming this thing through before the Christmas holiday, these 2,700 pages, spending \$2.5 trillion of taxpayer money, raising taxes on small businesses, which obviously have weighed in on this, and the National Federation of Independent Business, which represents a lot of small businesses around the country, has said, if enacted, this bill would cost us 1.6 million jobs because of all the new taxes it imposes—you are raising taxes, when fully implemented, by about \$1 trillion, cutting Medicare by about \$1 trillion. After all that, what do you have? You have the same or worse insurance premiums for 90 percent of Americans. I argue that is a bad deal for the American people.

Coming back to the special deals, this is not the way to legislate. To carve out deals, to go and try and find or buy or however you want to characterize it that sixtieth vote is essentially what we are talking about. These are special goodies packed into this bill essentially because the majority decided that rather than trying to include Republicans and pass it with Republican votes, they had to pass it with all Democrats which meant that every one of the Democrats had tremendous leverage. Clearly, they decided to use it. There are lots of carve-outs, lots of special deals in this that cost the American taxpayers hundreds of millions of dollars in additional spending simply because they wanted to get this done by an artificial deadline and wanted to do it with all Democratic votes.

I say to my colleagues, this process itself, when the American people find out about particularly this latest deal, smells. I don't think they are going to like it. I don't think they are going to like the end product when they find out it will raise insurance premiums.

Mr. BARRASSO. I try to stay in close touch with the people of Wyoming. I go home every weekend. We have not been able to do that the last couple of weekends so I have had telephone townhall meetings. I know the Senator from Tennessee has done the same. There is a way people can push a button to indicate whether they are in favor or against. Ninety-three percent of the people of Wyoming are opposed to the bill the Democrats are trying to jam through in the middle of the night. I know the Senator from Tennessee has recently had telephone townhall meetings with his constituents because he was not able to be home personally with them. Maybe the Senator wants to share with us some of the experiences he has had and some of the messages he has heard from the fine folks of Tennessee.

Mr. ALEXANDER. Madam President, the telephone townhalls are interesting. This is the 21st consecutive day

and the third weekend we have been debating this bill. One would think we could probably do a better job of it, if we were going back home every weekend to hear what people thought about what we were doing. But maybe the strategy has been to keep us here talking to each other, bring the bill up in a snowstorm, pass it in the middle of the night and go home for Christmas, and the people won't find out what we are doing until it is too late. One way to find out is tele-townhalls. I was skeptical before I did one but it is a pretty interesting way to stay in touch with people from Tennessee. You get on the telephone and an automated system calls thousands of people and says: The Senator from Wyoming or Illinois or North Carolina or Tennessee wants to talk with you about health care. People can either stay on the phone when they get the call or they can hang up. What normally happens is a person stays on the call, this time a surprisingly large number of people stayed on the call, because of their strong interest in this issue.

The other night I did the phone call between 7:30 and 8:30. I called to about 18 west Tennessee counties, including Shelby, which is Memphis, and as reported to me by the service, about 30,000 people were on the telephone sometime during that hour, with a maximum number of 3,016 on the call at any one time. Someone might pick up the phone and say: Senator BARRASSO is on the phone. They might tune in for 15 or 20 minutes and then hang up. Maybe they have to cook dinner or the ball game comes on. Maybe they get tired of talking to you, but they are on for 15 or 20 minutes. During that time, I was able to take a number of questions. After it was over, 563 messages from constituents were sent to my Web site.

It was interesting to me. People who know my history, know that to be elected Governor 30 years ago, I walked across the State of Tennessee. Instead of going to a Republican meeting or a rotary club, I would visit with random people during my walk. It took me 6 months and I would see 1,000 people a day. These random phone calls kind of reminded me of that. It was as if the people were randomly selected. They were not on any Republican list or Democratic list or list of doctors or patients. They were just in the phonebook. They talked and acted like they were normal citizens who I had interrupted after dinner, probably because it was 6:30 to 7:30 in that part of Tennessee. I was able to ask those citizens three questions. I am not about to say this is a Gallup poll of Tennessee, because I know that surveys like that have to be done in a scientific way, but after being here for 21 straight days, not able to go home because we have been debating this bill, these opinions are straws in the wind.

The first question was: Do you believe the Senate should rush to pass this health care bill before Christmas? In this case, 943 people, 83 percent, said no, and 108 said yes; that is 9 percent.

Second question: Do you support the health care bill moving through the Senate? On this one, 1,496 said no, or 75 percent. 352 said I don't know, which is 18 percent, and 154 said yes, that is 8 percent.

No. 3: Do you agree that Congress doesn't do comprehensive legislation well and ought to go step by step to bring health care costs under control? On this question, 1,285 said yes, that is 80 percent, 14 percent said I don't know and 7 percent disagreed.

I have often heard our friends on the other side say: Where is the Republican bill? My response has been, day after day, if you are looking forward to seeing the Republican leader role a wheelbarrow in here with a 2,700-page Republican comprehensive bill, you will be waiting forever. We have a different approach. Our approach is to set a clear goal—reducing cost. The bill we are voting on increases costs. Our goal is to find five or six steps to go in the direction to reducing costs.

Without going into detail, although the Senators from South Dakota or Wyoming may want to, we focus on five or six steps that would clearly reduce health care costs. By that, I mean your premium, the cost of your government. And once we do those five or six steps, we could go on. We could do that without taxes, without mandates, without running up the debt, without a big bill with lots of surprises. Just to take one example—and then I will yield to my friends from Wyoming and South Dakota—one of those examples is the small business health care plan. The current bill, the Democratic bill, has in it a credit for small businesses, but we would argue that by the time small business men and women get through paying the mandates and the taxes the bill also imposes, it is not going to be much help to them.

What we have is a bill that would allow small businesses to pool their resources. In other words, if you are a small business man or woman and you have 60 employees and 2 get cancer, suddenly the costs of those 2 employees prohibit you from providing insurance to the other employees. But if you could pool your resources with small businesses all around the country, then the pool would be large enough that you could offer insurance.

That proposal has been made by Senator ENZI. It has been through the HELP Committee. The Congressional Budget Office said it did not add to the deficit. In fact, it reduces the deficit, and it would permit 750,000 more employees of small businesses to be insured and their premiums would be lower than they otherwise would be. That is a single step to moving toward

reducing health care costs, but if we took that step and the other steps we have proposed, that would be a good way to start. We could do that together, and we would not have this partisan bill with so many questions and so many concerns.

So I wonder if my friends from South Dakota and Wyoming—I know they have thought a good deal about this step-by-step approach toward actually solving the real problem of health care costs.

Mr. THUNE. If the Senator will yield on that suggestion of small business health plans, doesn't that enjoy wide support among small businesses in this country?

Mr. ALEXANDER. It clearly does. It enjoys widespread support everywhere, except the Senate. When Senator ENZI brought it up, it was rejected by our friends on the other side.

Mr. THUNE. If I might continue, the one thing that strikes me about this proposal that, as I said before, now is, in totality, 2,700 pages, is that it does not enjoy any support from any small business organization that I know of. Maybe there are some out there I cannot speak to. But I do know the organizations that represent small businesses that we are all well acquainted with—National Federation of Independent Business, the Chamber of Commerce, the National Association of Manufacturers, the National Association of Wholesalers and Distributors, builders and contractors, electric contractors, franchise associations—I can go right down the list—all say this does nothing to lower their costs. In fact, it increases the cost of doing business, increases the cost of doing health care.

What they have argued repeatedly is one of the suggestions the Senator from Tennessee mentioned, that small business health plans would drive their health care costs down, which is why they have been such strong advocates for this over the years.

I guess the other question I would ask of my colleague from Tennessee is, would an approach, a suggestion like small business health plans require tax increases that would hit small businesses?

Incidentally, the latest version with the managers' amendment, which we just received Saturday, increases the tax increases in the bill that were previously \$493 billion and are now \$518 billion. As the Senator mentioned, with the tax credit businesses get, they up that a little bit but not enough to help most small businesses in light of the \$518 billion in tax increases in the first 10 years, and when it is fully implemented it will be about \$1 trillion. But the payroll tax that is going to hit a lot of small businesses was increased dramatically in the managers' amendment. The individual mandate was almost doubled in the managers' amendment. So the taxes in the bill go up with this proposal.

I guess my question is, with all these tax increases that are going to have a crushing impact on small businesses, does a suggestion such as the one made by the Senator from Tennessee for small business health plans require tax increases or Medicare cuts, which is what is going to be necessary to finance this 2,700-page behemoth?

Mr. ALEXANDER. I thank the Senator from South Dakota. The answer is no. The difficulty with a big, comprehensive plan is it sounds good but has lots of unintended consequences. If our real concern right now is reducing costs in health care, then the idea of a small business health care plan that has no new taxes and no new mandates but creates opportunities for small businesses to pool their resources and offer more insurance at a lower cost to their employees would seem a logical place to start.

Mr. THUNE. I appreciate the Senator for his work on that issue. It is a view I share, a proposal I have been a big advocate of going back to my days in the House of Representatives and one which, as the Senator from Tennessee noted, has tremendous support among small businesses across the country. About the only place it does not have majority support is here in the U.S. Congress because maybe it makes too much sense.

But it seems to me there are suggestions and solutions out there which do not require $\frac{1}{2}$ trillion of tax increases on small businesses, which every small business organization has come out and said: It is going to drive up our cost of doing business, and at the end of the day, it is going to raise our health care costs—and does not require these steep Medicare cuts that the Senator from Wyoming has alluded to over and over again and the impacts those will have on the delivery of health care to seniors across this country but, rather, it would bend the cost curve down without tax increases and Medicare cuts.

Another example of that, I would argue, would be allowing for interstate competition, allowing people to buy their insurance across State lines, which is a suggestion we have made over and over on our side of the aisle. According to the Congressional Budget Office, both small business health plans and buying insurance across State lines actually would reduce health care costs and would do it without raising taxes or cutting Medicare, which, to me, would make a lot of sense, especially when you have an economy in recession, 10-percent unemployment, a \$1.5 trillion deficit last year and another \$1.5 trillion deficit this coming year, and when you are talking about a \$2.5 trillion cost in the growth of government here in Washington, DC, to implement these 2,700 pages.

Some suggestions along the lines of the one mentioned by the Senator from Tennessee and some of these others

would make a lot of sense, and I think they would enjoy tremendous support among small businesses, which create the jobs in this country, as well as among the American public.

So I thank the Senator from Tennessee for pointing out one of the many things Republicans are for and which we have tried to get in the debate.

I know the Senator from Wyoming has advocated for many of these same types of initiatives and solutions. As he mentioned earlier, he was prepared to offer an amendment to address the issue of premiums, but it looks as if we are going to be prevented from doing that.

Mr. BARRASSO. Our friends at the University of Minnesota said that if people were allowed to shop across State lines, shop around for insurance that is better for them and their family and their personal situation, we would have 12 million more Americans insured today than we have now, without a single page of legislation. That is all we need to do: allow people to shop across State lines. But when we talk about and look at this bill, which has mandates, there is going to be a mandate for people to buy insurance.

One of the amendments I tried to offer yesterday that I thought made a lot of sense for young people was that for individuals under the age of 30 or for those making less than \$30,000 a year, they would be exempted from the mandate, the individual mandate that they have to buy insurance.

I was involved in a discussion on a college campus in a debate on this topic, and in talking to the students, they were astonished to learn—because they were not focused on this; they were focused on their studies and working—they were astonished that they are all going to have to buy, as a matter of law, if this passes, health insurance immediately, and if they do not, they are going to have to start paying a tax or a fine, depending on how you describe it.

So in my amendment, I said, for those up to the age of 30 and making under \$30,000 a year, let's exempt them from the mandate. That amendment was rejected.

Then I said, well, if they are going to do this and force these people to buy insurance, and if they do not buy insurance, they have to pay these excessive fines or taxes—or however you want to define it—I said, how about that the penalties these people would have to pay, if they choose not to buy insurance—because it is going to be a lot cheaper to not buy insurance and to just pay the tax—what if that money could go into a personal account so that person can then use the money to then buy insurance? So it would be kind of like a savings account, so the money would be there for them to buy insurance. So individual mandate penalties would accrue not to the govern-

ment but in a personal account, so they could purchase health insurance within a 3-year period. The money would accumulate. That amendment was rejected as well.

So we have lots of ideas, good ideas, to help people with affordable care, available care, and yet one after another they have been rejected in a step-by-step process to try to find ways to solve the health care crisis we know faces the country. All 100 Members of the Senate know we need to find ways to make health care more affordable and to work on high-quality care.

It has been fascinating to see the dean of the Johns Hopkins Medical Center and the dean of Harvard and those who have looked at this bill closely say that the people who are supporting this are living in collective denial, that this bill is doomed to fail, that it will raise the cost of care, not lower the cost of care, and will do nothing to improve quality.

Mr. THUNE. If the Senator from Wyoming would yield on that point, that is why I think day after day after day—and I have said—there is a pattern emerging here in the Senate where the majority comes down and establishes the need for health care reform, which we all acknowledge, and illustrates examples of those who have fallen through the cracks, which we all know examples exist—all of us have dealt with those in our individual States—and then proceeds to attack Republicans for not having their own ideas, which we have just mentioned there are lots of good Republican ideas which do not raise taxes, which do not cut Medicare, and actually do something to reduce premiums. But that seems to be the strategy employed and the pattern that emerges in the rhetoric day after day down here from the other side.

The one thing I do not hear is them coming down here and talking about what this 2,700-page bill is going to do to reduce health care costs, because if we all submit to the experts on this—which, as I said earlier, the Congressional Budget Office is sort of the referee. They do not have a political agenda, or at least they are not supposed to. The Actuary at the Centers for Medicare and Medicaid Services does not have a political agenda, or at least they are not supposed to. They are sort of considered to be an umpire on this. The Joint Committee on Taxation, which looks at the distributional impacts of tax policy, is a referee and is not supposed to have a political agenda in all this. They all come to the same conclusions with regard to premium increases in this bill.

So if the overall objective is to reduce the cost of health care, and if, in fact, your legislation, according to all the referees, all the umpires, all the experts, not only increases premiums for most Americans but increases the overall cost of health care, which is what

they all conclude, it is pretty hard to come down and defend this product. That is why I think day after day they try to create distractions and counterattacks as opposed to actually coming down and talking about the substance of the bill because the substance of the bill does not accomplish the stated objective, which is to reduce the overall cost of health care and get premiums under control for families and small businesses in this country.

It is also hard, I would argue, because of the \$518 billion of tax increases that are in here and the unified opposition of the entire small business community, which creates 70 percent of the jobs in this country, to talk about how this can be anything but detrimental to job creation. This is going to cost us jobs. I think every business organization has made that abundantly clear. And all the analysis of this legislation that has been done comes to the same conclusion.

Mr. BARRASSO. When you take a look at what the Centers for Medicare and Medicaid Services has done, which is the group that oversees Medicare, they have said that 10 years from now, if this goes through, you are still going to have 24 million uninsured, you are going to have 18 million more on Medicaid, the program the Senator from Tennessee appropriately referred to as having a bus ticket for a bus that is not going to come, because that is what has happened. Half the doctors in the country do not take care of patients on Medicaid because the reimbursement is so low that they cannot afford to continue to care for those people. Five million people will lose the insurance they get through work, and health care costs will go up. The cost curve will go up instead of going down. But the whole purpose of this was to help drive the cost down.

Then, additionally, they said that 20 percent of providers—20 percent of the providers—of health care in this country—and that includes physicians, nurse practitioners, medical clinics, hospitals—20 percent of the providers in this country, under this plan, 10 years from now, will be unprofitable, unable to keep their doors open.

So we have heard about sweetheart deals. We have heard about taxes going up. We have heard about Medicare cuts. And what we have seen is one promise after another made by the President that has been unfulfilled and actually reversed by the bill we see ahead of us.

So I ask my friend from Tennessee, wouldn't he agree that in the next 2 days, the best thing for the country would be to have this bill not pass the Senate and instead go back in a step-by-step way and regain the trust of the American people?

Mr. ALEXANDER. I certainly do agree with that.

I think most Americans, when presented with a problem, would not try

to change it all at once but would say: Let's identify the goal which is reducing costs and go step by step.

Madam President, I ask unanimous consent to have printed in the RECORD a column by David Brooks in the New York Times on December 18.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the New York Times, Dec. 18, 2009]

THE HARDEST CALL

The first reason to support the Senate health care bill is that it would provide insurance to 30 million more Americans.

The second reason to support the bill is that its authors took the deficit issue seriously. Compared with, say, the prescription drug benefit from a few years ago, this bill is a model of fiscal rectitude. It spends a lot of money to cover the uninsured, but to help pay for it, it also includes serious Medicare cuts and whopping tax increases—the tax on high-cost insurance plans alone will raise \$1.1 trillion in the second decade.

The bill is not really deficit-neutral. It's politically inconceivable that Congress will really make all the spending cuts that are there on paper. But the bill won't explode the deficit, and that's an accomplishment.

The third reason to support the bill is that the authors have thrown in a million little ideas in an effort to reduce health care inflation. The fact is, nobody knows how to reduce cost growth within the current system. The authors of this bill are willing to try anything. You might even call this a Burkean approach. They are not fundamentally disrupting the status quo, but they are experimenting with dozens of gradual programs that might bend the cost curve.

If you've ever heard about it, it's in there—improved insurance exchanges, payment innovations, an independent commission to cap Medicare payment rates, an innovation center, comparative effectiveness research. There's at least a pilot program for every promising idea.

The fourth reason to support the bill is that if this fails, it will take a long time to get back to health reform. Clinton failed. Obama will have failed. No one will touch this. Meanwhile, health costs will continue their inexorable march upward, strangling the nation.

The first reason to oppose this bill is that it does not fundamentally reform health care. The current system is rotten to the bone with opaque pricing and insane incentives. Consumers are insulated from the costs of their decisions and providers are punished for efficiency. Burkean gradualism is fine if you've got a cold. But if you've got cancer, you want surgery, not nasal spray.

If this bill passes, you'll have 500 experts in Washington trying to hold down costs and 300 million Americans with the same old incentives to get more and more care. The Congressional Budget Office and most of the experts I talk to (including many who support the bill) do not believe it will seriously bend the cost curve.

The second reason to oppose this bill is that, according to the chief actuary for Medicare, it will cause national health care spending to increase faster. Health care spending is already zooming past 17 percent of G.D.P. to 22 percent and beyond. If these pressures mount even faster, health care will squeeze out everything else, especially on the state level. We'll shovel more money into insurance companies and you can kiss

goodbye programs like expanded preschool that would have a bigger social impact.

Third, if passed, the bill sets up a politically unsustainable situation. Over its first several years, the demand for health care will rise sharply. The supply will not. Providers will have the same perverse incentives. As a result, prices will skyrocket while efficiencies will not. There will be a bipartisan rush to gut reform.

This country has reduced health inflation in short bursts, but it has not sustained cost control over the long term because the deep flaws in the system produce horrific political pressures that gut restraint.

Fourth, you can't centrally regulate 17 percent of the U.S. economy without a raft of unintended consequences.

Fifth, it will slow innovation. Government regulators don't do well with disruptive new technologies.

Sixth, if this passes, we will never get back to cost control. The basic political deal was, we get to have dessert (expanding coverage) but we have to eat our spinach (cost control), too. If we eat dessert now, we'll never come back to the spinach.

So what's my verdict? I have to confess, I flip-flop week to week and day to day. It's a guess. Does this put us on a path toward the real reform, or does it head us down a valley in which real reform will be less likely?

If I were a senator forced to vote today, I'd vote no. If you pass a health care bill without systemic incentives reform, you set up a political vortex in which the few good parts of the bill will get stripped out and the expensive and wasteful parts will be entrenched.

Defenders say we can't do real reform because the politics won't allow it. The truth is the reverse. Unless you get the fundamental incentives right, the politics will be terrible forever and ever.

Mr. ALEXANDER. Most of us—we are pretty split up here: 60 there, 40 here. They are for it, and we are against it, this bill anyway.

The PRESIDING OFFICER. The minority time has expired.

Mr. ALEXANDER. I thank the Presiding Officer and I yield the floor.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. Madam President, we heard our Republican friends say it is very hard to defend our bill. Maybe it is hard for them, but it is not hard for the American Medical Association, the AMA, which has endorsed our bill. It is not hard for the American Heart Association, which has endorsed our bill. It is not hard for the American Cancer Society Action Network, which has endorsed our bill. The American Hospital Association has endorsed our bill. Families USA, the Business Roundtable, the Small Business Majority—we hear colleagues say small business opposes our bill. The Small Business Majority Organization supports it. And how about the AARP, which represents our seniors, millions of seniors. Those are a few. They not only defend our bill, they support our bill.

This is indeed an important moment in our Nation's history as we approach a final vote on major health care reform legislation. I think whenever you are trying to change something, you

have to take a look at how things are at the moment. So why is it we voted to change our current system? There are certain numbers that I think explain it. The first number is 14,000. We know that every single day 14,000 of our neighbors lose their health insurance through no fault of their own. They either lose their job, they can't afford to keep up the health insurance or they have a condition and the insurance company walks away from them or they are priced out of the market. Fourteen thousand a day. That is cruel, and we need to change it.

Sixty-two percent of bankruptcies are linked to health care crises. We are the only nation in the world where people go broke because they get sick.

If we do nothing, 45 percent of an average family's income will go for premiums in 2016. I ask everyone to think about it, paying 45 percent of your income for premiums. It is not sustainable. What about food? What about clothing? What about shelter? Can't do it.

We are 29th in the world in infant mortality. We come in behind Cuba. We come in behind Singapore. We come in behind South Korea. We are 29th in the world on infant mortality because people don't have good insurance or they don't have any insurance.

Fifty-two percent of women—fifty-two percent of women—don't seek the health care they need. They either put it off or they never get it because they may not be insured or they are afraid of the copays. They are afraid of what it would cost. They may have limits on their policies. We need to change that.

The United States spends twice as much on health care as most other industrialized nations. So what is the message here? We spend a huge amount. We are not doing very well in outcomes. By the way, I think we are 24th in life expectancy in the world—24th. We must do better.

I wish to share with my colleagues some of the letters and e-mails that have been sent to me from Californians that personalize the statistics I spoke about.

Mr. William Robinson wrote:

I am about to be laid off from the job I have had for 19 years. My biggest fear is not being employed, but being able to find and get affordable health care. I am 60 years old. I have a preexisting condition that will for certain make it impossible for me to buy health insurance.

Mr. and Mrs. Gilbert De La Cruz wrote:

We are at the point of losing our home because we have spent our savings on medical and prescription drugs. I am 67, retired, and my wife is 62. Because of the Medicare gap in prescription drug coverage, we have had to pay \$600 a month on prescription drugs. It's a huge portion of our monthly income. We will be selling our home shortly and perhaps moving in with one of our children because there doesn't seem to be any option.

Well, I want to say to Mr. De La Cruz: Help is on the way. If we get the

60 votes we are forced to get—not 51, a majority, but 60 votes because of a Republican filibuster—if we get those 60 votes each time, there is hope for you because we are going to fix that entire problem.

Mr. Ronald Kim says:

I am in the construction industry and my work is very slow.

He says he is in the design industry.

I am in danger of becoming financially ill and I am looking for ways to stay healthy, and one way may be to eliminate my medical insurance. It is a significant part of my budget. This may, heaven forbid, lead me to financial ruin if I get injured or sick. This is my situation.

I want to say to Mr. Kim: Help is on the way.

Ms. Madeleine Foot wrote—these are all Californians, my constituents:

I recently turned 25 and I lost my health coverage under my parents. I attempted to get coverage under a Blue Cross plan created for young people my age, but because I had taken medications, I was denied. I applied again for another plan, was offered a plan with a \$3,000 deductible, and it was \$300 a month on top of that. As a young person working in a restaurant, repaying student loans and trying to make it on my own, this is a huge financial burden. I cannot afford an insurance that charges me so much and won't be any benefit for me until I have shelled out a huge portion of my income.

To Madeleine Foot I say: Help is on the way, if we can break the Republican filibuster.

Mr. John Higdon wrote:

As a self-employed person, I had a pacemaker implanted. The cost was borne entirely by me at prices much higher than any insurance company would have had to pay. That was a wakeup call to get health insurance. I am told by every health insurance company I have contacted that no one will offer me health insurance at any price with a "preexisting heart condition."

I wish to say to Mr. Higdon: Help is on the way.

Dr. Robert Meagher, a pediatrician with Kaiser Permanente for over 30 years, do you know what he wrote and told me? That he has to fake—he is pressured to fake a diagnosis because when a parent comes in with a young child with asthma, they beg him not to write down asthma but write down bronchitis, because if he writes down asthma, that child will have a preexisting condition and when she turns 21 she won't be able to get insurance. Imagine, in America, a physician being pressured to lie on a form because of a health care system that is so cruel.

So, Dr. Meagher, we are going to change things here if we can break this filibuster.

Mr. Douglas Ingoldsby wrote:

I own a small business. I employ 11 people. I have been in business in California since 1972.

He says:

I used to provide health care for all my employees and all the members of their families, and if I want to remain profitable enough to stay in business now, I can't do it anymore.

He can only cover the employees, not their families. He feels terrible about it, and he says he may have to cut off his employees if prices keep going up.

I want to say to this fine small business owner: Douglas, help is on the way.

Mrs. Linda Schumacher wrote—and this is the one I will close with in this series of stories:

I am a Republican.

Let me repeat what she writes:

I am a Republican, and my husband and I are small business owners. The Senators and Congressmen of both parties who are against President Obama's plan have their own insurance, and it is my understanding that it does not cost what we pay. They do not understand what a huge expense this is. Please listen to the middle class who are in our position or who no longer have insurance. It keeps me up at night worrying. This time the Republicans have it wrong, and they need to know. Please push the health plan. The insurance companies only care about the bottom line, not people.

I wish to say to Mrs. Schumacher: Thank you for putting aside party politics, because this isn't about Republicans and it isn't about Democrats and it isn't about Independents. It is about all of us together.

What happens now? We are hearing the polls, and the polls show Americans don't want us to act. I understand why. There has been so much misinformation. Senator DURBIN, our assistant majority leader, and I were talking about the misinformation that is on this floor from the other side day in and day out, and I believe much of it, if I might say, is purposeful. If you listened to my Republican colleagues over the past few days and weeks, they have trashed this bill and they have trashed the process. Over the weekend the Republican leader said health reform is a legislative train wreck of historic proportions. That is a direct quote.

Earlier this month Senator COBURN used more inflammatory language when he said to seniors—I am quoting Senator COBURN: I have a message for you. You are going to die soon.

If you want to know what fearmongering is, that is the best example I can give you.

I decided to go back and look at the past CONGRESSIONAL RECORDS. I thought: Have Republicans spoken like this over the years every time we have tried to do some health care, every time we have tried to make life better for people, such as Social Security? I will let you be the judge.

In 1935, on the floor of the House of Representatives during the debate on Social Security, Republican Congressman Jenkins of Ohio said—a Social Security bill, remember, which hadn't passed:

This is compulsion of the rankest kind. Do not be misled by the title. The title says "Old-Age Benefits." Shame on you for putting such a misleading and unfair title on

such a nefarious bill. Old age benefits? Think of it. Oh, what a travesty! . . . Mr. Chairman, what is the hurry? Nobody is going to get a dime out of this until 1942 . . . what is the hurry about crowding an unconstitutional proposition like this through the House today?

If you listen to some of my colleagues, you will hear the same thing. What is the rush? As a matter of fact, they had four or five amendments to send it back to committee. What is the rush?

The rush is that 14,000 people are losing their health care every day. The rush is that 62 percent of bankruptcies are linked to a health care crisis, and in 2016 our people will be paying almost half of their income for premiums. Yes. We have to do this, and we started it 7 months ago, and 100 years ago Teddy Roosevelt, a Republican President, put it in his platform. What is the rush? What is the rush?

I wish to tell my colleagues about another Republican Congressman, J. William Ditter of Pennsylvania. This is what he said during the debate on Social Security:

. . . security for the individual, whether worker or aged, will be a mockery and a sham.

This is what he said about Social Security.

And it will allot to our people the role of puppets in a socialistic State.

That is what he said back then. I tell you, if you ask Republicans who are getting Social Security, Democrats who are getting Social Security, Independents who are getting Social Security, they will all tell you the same thing: Keep your hands off it. It works. It is good. It is fair. It is insurance.

It is what we did way back then.

In 1965, when Medicare passed, health care for those 65 and up, Republican Senator Carl Curtis said:

It is socialism. It moves the country in a direction which is not good for anyone.

Years later, we know Newt Gingrich when he was Speaker of the House said he wanted to see Medicare "wither on the vine," his words.

In 1995, while seeking the Republican nomination for President, Senator Bob Dole said:

I was there in 1965 fighting the fight, voting against Medicare, because we knew it wouldn't work in 1965.

So when you hear our Republican friends say, Oh, my goodness, they are making a lot of savings in Medicare; this is bad for the seniors, please, please, which party has stood for protecting our seniors? It is not a matter of being partisan; it is just the fact.

The echoes of the past fill this Chamber.

I am convinced now in 2009 that hope and reason and determination and good policy will triumph over fear and obstruction and the status quo.

Let's look at the immediate and near-term changes for the better that

people are going to have, because our colleagues say: Oh, we are raising revenues but there are no benefits right away.

Let's talk about what the benefits are. There will be a \$5 billion high-risk pool immediately for people with pre-existing conditions who cannot find insurance. There will be reinsurance for retirees, so if you are retired and you are getting your health care benefit and something happens to your company, there will be reinsurance so you can still get your benefits. We close that doughnut hole for the Medicare recipients who fall into it and suddenly they cannot afford their prescription drugs. There will be billions of tax credits—billions—up to 50 percent tax credits for small businesses. That is why we have the support of so many small businesses. For new policies, no discrimination against children with preexisting conditions, and children can stay on their family's policy until they are 26 years of age.

What else are the immediate and near-term changes for the better? For new policies, no lifetime limits, no more rescissions. They cannot walk away from you when you get sick. They are required to cover essential preventive health benefits such as mammograms. It prohibits discrimination by employers based on salary of their employees. An employer cannot say: If you earn over \$250,000, you get these great benefits, but if you earn under \$50,000, you get a worse array.

By 2011, standards for insurance overhead costs go into place. If your insurance company spends too much on overhead and too much on executive pay, let me tell you what happens. They have to rebate to you, the policyholder. We also see increased funding for community health care centers. This is going to make a huge difference. There will be a national Web site to shop for affordable insurance. There will be a long-term care program that is voluntary into which you can buy. Insurance companies with unreasonable premium increases can be barred from the exchanges that will be set up in 2014. So they will be making sure they do not increase your premiums beyond a reasonable amount.

This bill will benefit the insured in one way—I do not think people understand this—by 2014, 62 percent of families will no longer face unsustainable premium costs. If you are a family of four and make less than \$88,000 a year, you will never have to pay more than 9.8 percent of your income on health insurance premiums. This is an amazing thing most people do not focus on. I just explained that the nonpartisan studies show—and this is important—that they will be paying, the average family, 45 percent of their income for health care. In 2014, people in this country will not have to pay more than 9.8 percent of their income on health

insurance; otherwise, they will get tax credits. That is very important.

This bill is going to benefit our seniors. That is why it is endorsed by the AARP. We eliminate the prescription drug coverage gap. That is the doughnut hole. We extend the life of the Medicare trust fund by 9 years. We reduce waste and fraud in Medicare. We provide for free yearly wellness visits for seniors. This bill saves Medicare. This bill makes our seniors stronger. They will have more benefits, and they can never lose their guaranteed benefits.

Small businesses will be able to reduce their costs, again, by getting immediate tax credits. In 2014, they will be able to access the exchange, as will self-employed people. They will have the power of big business behind them as they go into those exchanges.

I want to talk about public interest provisions. I wanted a public option, let me be clear, because I felt it would keep the insurance companies honest. But let me tell you what we have in here that are definitely public interest provisions. We expand Medicaid. That is a public plan to cover an additional 14 million people, and that starts in 2014. That is 1.5 million Californians. In my State, the Federal Government will pay the full fare for those added people for 3 years, and after that, far more than we get paid now. HHS will set the initial rules for the State exchanges. So those getting into the exchanges have to be fair. The OPM plan—that is the plan that will be part of the exchange—will be set up by the government, the Office of Personnel Management.

Again, community health centers. A basic plan can be created by the States, which I think is very important. I thank MARIA CANTWELL for working so hard on that issue.

If people tell you we do not have anything to do with public options, they are really not right. You have to look carefully at this bill.

I want to talk about the deficit. We reduce the deficit between 2010 and 2019 by \$132 billion, and between 2020 and 2029, there is up to a \$1.3 trillion deficit reduction, according to the Congressional Budget Office. That is a nonpartisan office. This bill reduces the deficit. I am going to say it one more time. This bill reduces the deficit. And the reason is, we invest in prevention, and that pays off. We finally will be able to say to the insurance companies: Stop your gouging. And that pays off. We do have competition now because we will have that special plan run by OPM, the State option MARIA CANTWELL put in there. This is why we see the reduction, including taking the fraud and the waste out of Medicare. We do not need fraud and waste.

Here is how I want to close. Health care coverage for all Americans has been such an elusive goal for nearly a

century. If you look at Republican Presidents, Democratic Presidents, Republican Congresses, and Democratic Congresses, we have tried it over and over again, and the status quo has always prevailed.

Our beloved friend, Senator Ted Kennedy, whom we miss so much, particularly during a time such as this, fought for health care right here on the floor from the moment he became a Senator in 1962 to the moment he died. In an op-ed in the Washington Post this past Friday, Ted Kennedy's wife Vicki wrote:

Ted often said that we can't let the perfect be the enemy of the good.

I want to say to Vicki, she is exactly right. Each of us could write this bill our way. Believe me, if I wrote a bill, to me it would be perfect. But to my friend in the chair, she would say: I can make it better. And all of us could. This is the legislative process. This is a good bill.

Vicki goes on to say:

The bill before the Senate, while imperfect, would achieve many of the goals Ted fought for during the 40 years he championed access to quality, affordable health care for all Americans.

He is not here to urge us not to let this chance slip through our fingers.

And she says:

So I humbly ask his colleagues to finish the work of his life, the work of generations, to allow the vote to go forward and to pass health-care reform now. As Ted always said, when it's finally done, the people will wonder what took so long.

I thank Vicki, not only for writing that wonderful editorial but for actually being in the Chamber when we took that first vote to break down this filibuster.

I say to my colleagues, I am so proud that today we are moving closer to fulfilling the promise of health care for all Americans, including the 40 million Californians I am so privileged to represent. I thank my colleagues for all the work they put into this bill. I spent a lot of time on it myself, and this moment is very poignant. I hope we pass it.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KERRY. Madam President, let me begin by commending the Senator from California for an outstanding presentation regarding this legislation. I was listening to her in my office before I came over to the Chamber. I listened to her over here. She laid out in a very careful, deliberate, and thoughtful way the realities about this legislation before us. I thank her for a terrific presentation.

I wish to pick up a little bit where she has left off. But let me inquire so I understand where we are. How much time is remaining on the majority side?

The PRESIDING OFFICER. The majority side has 34½ minutes remaining.

Mr. KERRY. I thank the Chair.

Let me begin by saying I also listened to our colleagues on the other side of the aisle, particularly the Senator from South Dakota, just a little while ago. I was really struck by the chart they put up showing Medicare going up and up and up, and then they talk to Americans, basically scaring them, trying to say: If you pass this bill, it is not going to do anything to reduce the crisis in Medicare down the road.

The reality is, that is all they present, is the scary picture of a future which they are not even describing accurately. They have had a year and a half—a year and a half—that we have been working on this legislation, since it was announced in the Finance Committee, on which I serve, and we held a day-long—I think a 2-day long conference over at the Library of Congress and within the committee where we began the work, laying the groundwork and foundation for a new Presidency and for the work that has gone on this year. Many of their Members took part in that. So there is no secret here as to where we are.

This is a debate that has gone on in the United States of America since Harry Truman was President of the United States and before. We all know that President Teddy Roosevelt, a Republican, put before the country the notion that every American should be able to have their sickness dealt with.

Nobody has ever contemplated that you ought to go bankrupt in order to have health care. But, as we know, we have more bankruptcies in America—health care bankruptcies—every year than any other nation on the planet. I think we are the only nation that really knows health care bankruptcy. The stories we have heard—countless stories.

Earlier this morning—I guess to get my times correct—when we were here at 1 in the morning, we heard the majority leader talk about those very poignant, moving situations of individuals in Nevada. We heard the Senator from California. There are stories from every Senator, from every State. Yet it is only this dividing line, right here down the center of this Chamber—it is only the Senators on this side of that dividing line who seem to be prepared to try to address this issue. The fact is, the managers' amendment, which is now the pending business before the Senate, brings us even closer to being able to address many of the major concerns we have.

Senator after Senator has come to the floor and described the way in which this bill does not do everything we want it to do. I have been a passionate supporter, as was Ted Kennedy and a lot of our colleagues, of a public component of this plan. Why? Because I believe that is the best way to create the kind of competitive pressure that

will restrain a group of insurance companies that have shown no predilection to restraining themselves over these past years.

If you are for the status quo, then you will vote no, the way our colleagues have voted. But the American people are not satisfied with the status quo. People in America understand that health care costs are breaking the backs of families. They are breaking the backs of businesses. They are a huge albatross around the neck of American competitiveness.

Many of our companies have a harder time competing because there is a health care premium tax, if you will, for the uneven distribution of being sick in America. Obviously, if you are sick in America, you get care at some point in time. It may well be that point in time is when you are on your deathbed or when you are so sick that you finally go into the hospital, into an emergency room, and the emergency room becomes your first contact with the medical system or it becomes your primary care facility. We have almost 50 million Americans for whom that is true—50 million Americans who don't have health care. So they do not get an early screening, they do not get an early determination of what may be wrong with them. They do not get what somebody who has a health care plan gets, which may be a mammogram or a Pap smear or a PSA test for prostate cancer, or any number of evaluations, perhaps early detection of diabetes.

We spend almost \$100 billion in the United States for unnecessary dialysis and/or amputations that take place because people weren't able to go to a doctor earlier and learn that they had a type of diabetes that might have been able to be treated in a far less expensive and dramatic and personally costly way.

The word "history" gets thrown around in the Senate probably more than it ought to. We often refer to something as being historic, where sometimes it is a reach. There is no question that we are on the threshold of an unbelievably historic moment in the Senate. This is history we are living here now.

When I think of what we tried to do in 1993 and 1994, when President Clinton was in office and we tried to pass health care—we got beaten back by false advertisements—Harry and Louise—scare tactics, and I might add a plan that didn't quite pull the pieces together as effectively as we have. We have learned a lot of lessons since then. We have had many fits and starts, with children's health care, portability, and trying to deal with certain gender discrimination or other discrimination within the systems. We have gotten little pieces done. But all the time, the basics of the system have been without the reform necessary to bring down costs and make health care more accessible to more Americans.

So I have no doubt we are reaching a moment of historic importance here. This is a moment where we are going to finally provide access to almost all Americans. Thirty-one million Americans are going to gain health care coverage through this legislation when we pass it, and that will bring us up to 94 percent.

To give an example, in Massachusetts, where we passed health care reform a couple of years ago, we mandated that everybody be covered and we created a penalty for companies that don't offer the insurance, but we have a pool that helps provide coverage to people who can't afford it. We now have 97.6 percent of all our citizens covered in the State of Massachusetts. The fact is the premiums in the individual market, which is where it is most expensive for Americans to go out and buy health insurance, went down by 40 percent. The premiums went down by 40 percent in Massachusetts for a quality of care that people love. The premiums in the rest of the country went up 14 percent. That is a 54-percent spread in the cost of premiums between those who got health care reform and those who did not.

That is precisely what we are going to be able to provide Americans—beginning to provide Americans with this. One of the reasons we can't provide it as effectively as in Massachusetts is because there are certain things we do in Massachusetts that the other side, or some folks, have prevented us from being able to do here.

Let me sort of lay it out here. There are a couple of things that bother me about this. We keep hearing from our colleagues—and I heard this from the Senator from South Dakota—that we are not going to be able to save money in the legislation we are going to pass. In fact, nothing could be farther from the truth. All of us know, as a matter of common sense, that many of the measures in this legislation are going to reduce the cost of health care, and one of the reasons is that the CBO analysis is generally limited to the Federal budget. It doesn't attempt to account for savings in the health care system that come from policies that are implemented through reforms.

For example: The CBO found only \$19 billion in government savings from transitioning toward post-acute bundled payments in Medicare. But recent research in the *New England Journal of Medicine* suggests that bundled payments—bundled payment, for somebody listening who doesn't understand, is when you take all the payments that come to a hospital or to the providers who provide the care, and the payments are all put together for the various services that you get and they have to decide how to provide you those services in a cost-effective way based on the whole universe of money that has been put on the table. It is dif-

ferent from what we do today, where we don't bundle it and say: Take care of this patient, and all of your various parts have to fit into a whole. Today, we pay each of the separate parts without relationship to what their connection is to the total care of a patient. It is unbelievably wasteful, ineffective, sometimes redundant, it is noncommunicative, and that is one of the reasons why in America we don't get the same outcomes for less money that people get in Europe or in some other countries.

But we have learned from the *New England Journal of Medicine*, which is a highly respected medical journal, that the bundled payments for chronic diseases and for elective surgeries could reduce health care spending by as much as 5.4 percent from 2010 to 2019. Yet we don't credit for that savings. They do not talk about it. But common sense tells us, because we have seen it where they have done these bundled payments, that you are going to reduce the costs.

In addition, even if such savings only applied to half of the spending in the health care sector, the result would be more than \$900 billion of savings over the next 10 years. If bundled payments get expanded beyond the post-acute care, and even half of the potential savings from bundled payments were realized in the Medicare Program during the upcoming decade, these savings would translate to an additional .2 percent of savings per year or reduction in program expenditures, and that would be more than \$190 billion between 2010 and 2019.

I have talked about \$1 trillion—\$1 trillion—of savings that does not even get formally presented to the American people as part of this process because of bureaucratic technical rules about what the budget applies to. Everybody on the other side of this aisle knows, as a matter of common sense, if you look at the experience, the way it has already been proven in the marketplace, and if you apply your thinking to this, we are going to reduce the cost of health care.

Similarly, large reductions in Federal health care expenditures are plausible from the combination of other delivery system reforms. A lot of Americans aren't aware of this, but here is what we have. Accountable care organizations. We don't have that today. Suddenly, we are going to have an accountability in the care organizations delivering service. That is going to provide savings.

We have incentives to reduce hospital-acquired infections. One of the biggest single fears people have today in America when they go to the hospital is that they are actually going to get an infection in the hospital, and the chances of coming up with a staph infection or some other kind of infection are very real and very high. There

are actually different practices between different hospital operations. I happen to know this on a personal basis because my wife recently had an operation in one hospital system and they had a certain procedure to try to deal with the MRSA infection, and a certain washing and disinfection process you went through, and I know other hospitals where they do not do the same thing.

In addition, we are going to have health information technology reform adoption. There is going to be administrative simplification that would standardize and streamline insurance paperwork. I mean, if you go to the ATM machine and pull out some money, it is about a penny or half a penny per transaction. If you go to the hospital, where they do not have technology managing the records and people are doing it, it is about \$20 to \$25 per transaction to pull the records. In the age of computerization and information technology, it doesn't make sense, and all of us know that. But we also know that because we are putting money on the table and incentives in place to help do that, we are going to be able to get additional savings; all of the savings that are on top of the \$1 trillion of savings I have already talked about, and none of which gets measured when our colleagues come to the floor to say what a terrible bill this is.

CBO has also grossly underestimated savings in the past. I am not picking on CBO. They have had an incredibly hard job, and they have done an incredible job. They have been completely overworked on any number of efforts, where we have been asking for models and analyses. But it is automatic in a process that you are going to lose some things.

According to the Generic Pharmaceutical Association:

In 1984, it was predicted that the Hatch-Waxman Act would save our country \$1 billion in the first decade. Now, generic medicines save more than that every three days.

Every 3 days we do what was predicted to happen in savings every 10 years. In the mid 1990s, the Congressional Budget Office released an analysis showing that in 1994—the tenth anniversary of the Hatch-Waxman Act—annual savings of generics had reached approximately \$8 billion to \$10 billion. The new data released showed that by 1999—15 years after Hatch-Waxman became law—generics were generating \$49 billion in annual savings. In the last decade alone, generics have saved consumers, businesses, State and Federal governments \$734 billion.

I haven't even talked about the wellness provisions or the prevention provisions that are in here. When we start getting all of America more tuned in to the things we can do to prevent diseases by taking actions in our lives, our lifestyles, in our diet, and

any other number of things, we can bring the cost of health care down in America.

We keep hearing about the secrecy and how this legislation has been hidden from folks for a long period of time. Again, that is not true. There is nothing in this legislation that we haven't been working on or talking about or wrestling with in committee, out of committee, in hearings, in the public debate for over a year now. If the minority had taken a little less time to have press conferences and spending their time doing news conferences denouncing what they hadn't analyzed, they would have a better sense they might have been able to read the managers' amendment on the Internet for over a month—excuse me, the managers' amendment was on the Internet on Saturday, and many of us looked at it, because many of us have worked on provisions and we wanted to make sure they were in there. It wasn't hard to read it to see what was and wasn't included in it. In addition, the underlying bill has been posted on the Web for over 1 month.

But the fact is the minority has made a fundamental political calculation here. They do not want to work with us. In all the time we were in the Finance Committee trying to mark it up, we never had people come to us—as I often have here in the 25 years I have been here when you are legislating seriously—and say, hey, if you include this or if you work this a little or if you tweak this, I think I could support this bill. There is just a fundamental political divide, a fundamental philosophical divide. We are looking at a party whose opposition to health care for Americans is not new. My colleague from California talked about it a few minutes ago. In 1935, they tried to kill Social Security and succeeded in preventing health care from being included in the bill at that time. They argued in 1935 the same thing they argue now.

Madam President, may I ask how much time we have?

The PRESIDING OFFICER. The Senator has consumed 20 minutes.

Mr. KERRY. How much time do I have?

The PRESIDING OFFICER. The majority has 15 minutes remaining.

Mr. KERRY. And is that predesignated? Is the 15 minutes remaining predesignated, Madam President?

The PRESIDING OFFICER. Not by order.

Mr. KERRY. Madam President, in fairness, I was not aware; I thought I had the full amount of time, but I do not. I want the Senator from Connecticut to be able to share his thoughts also. Let me just say, and I will wrap it up here, that the insurance industry, which they sought to protect, survived the passage of the Social Se-

curity Act. In 1965, we passed Medicare. Medicaid came afterward. They opposed it. They opposed Medicare, one of the most important programs in the United States of America, that lifted countless numbers of seniors out of poverty. They said no. The insurance industry survived Medicare and Medicaid. They are doing very well.

According to CBO, the gross cost of the managers' amendment is, over the next 10 years, \$871 billion—less than the \$1 trillion we started with in our committee. But it buys a lot. I will talk at some time, perhaps tomorrow or afterward, about what this bill provides in addition. But I think it is critical for people to follow the truth, to look for the facts, and to measure the reality of the positive ways in which this legislation will provide additional help to seniors, will reduce premiums for many Americans, will help people afford coverage who do not have it today, will spread risks throughout the system more effectively, will improve care and delivery within the hospitals, will prevent people from being denied insurance if they have a preexisting condition, will prevent them from being kicked off insurance they paid for and thought they had when they get sick and they suddenly get that letter that says: Sorry, you are not covered anymore, and families go bankrupt—that is over. That alone is an enormous step forward for this country.

CBO has underestimated savings before.

According to the Generic Pharmaceutical Association . . . “In 1984, it was predicted that the Hatch-Waxman Act would save our country \$1 billion in the first decade. Now, generic medicines save more than that every three days.”

In the mid 1990s, the Congressional Budget Office released an analysis showing that in 1994, the 10th anniversary of the enactment of Hatch-Waxman, annual savings from generics had reached approximately \$8 billion to \$10 billion.

The new data released showed that by 1999—15 years after Hatch-Waxman became law—generics were generating \$49 billion in annual savings.

In the last decade alone, generics have saved consumers, businesses, and State and Federal Governments \$734 billion.

According to a December 14 report by the President's Council of Economic Advisors: CBO's analysis is generally limited to the Federal budget, and does not attempt to account for savings in the health care system more broadly from policies implemented through reform. For example, the CBO found only \$19 billion in Federal Government savings from transitioning toward post-acute bundled payments in Medicare. However, recent research published in the New England Journal of Medicine

suggests that bundled payments for chronic diseases and elective surgeries could reduce health care spending by as much as 5.4 percent from 2010 to 2019. Even if such savings applied to only half of spending in the health care sector, the result would be more than \$900 billion of savings over the decade. If bundled payments were expanded beyond post-acute care and even half of the potential savings from bundled payments were realized in the Medicare program during the upcoming decade, these savings would translate to an additional 0.2 percent per year reduction in program expenditures, or more than \$190 billion between 2010 and 2019.

Similarly large reductions in Federal health care expenditures are plausible from the combination of other delivery system reforms, including: Accountable care organizations, incentives to reduce hospital-acquired infections, health information technology adoption, and administrative simplification that would standardize and streamline insurance paperwork. This will help cut down on the \$23–\$31 billion time cost to medical practices of interacting with health plans and their administrators.

Another potentially significant cost saver within the Senate bill is the Independent Medicare Advisory Board—IMAB. The IMAB would recommend changes to the Medicare program that would both improve the quality of care and also reduce the growth rate of program spending. The CBO score of the Senate bill estimates that the IMAB would reduce Medicare spending by \$23 billion from 2015 to 2019, with the savings likely to continue in the subsequent decade. The IMAB has the potential to increase the savings from many of the delivery system reforms described above, which may not be fully captured by the CBO estimates for the reasons previously mentioned.

Taken together, the combination of Medicare- and Medicaid-related provisions in the Senate's Patient Protection and Affordable Care Act are estimated to reduce the annual growth rate of Federal spending on both programs by 1.0 percentage point in the upcoming decade and by an even greater amount in the subsequent decade. These savings would increase national savings and improve the long-run performance of the U.S. economy.

The PRESIDING OFFICER. The Senator from Connecticut is recognized.

Mr. LIEBERMAN. Madam President, I rise to declare and explain my support for the Patient Protection and Affordable Care Act. First, I commend Senator REID and all those who worked so long and hard, including my friend and colleague from Connecticut, Senator DODD, for all they have achieved in this legislation. The truth is, no piece of legislation, as significant and

complicated as this is, could possibly be totally satisfying to every one of us. In the end, each one of us has to ask ourselves: Do the positives in this legislation substantially outweigh the negatives? Are the things we like in the bill greater than the things that worry us? For me, the answer to both these questions is yes, because this bill makes real progress on the three important goals I have had, and I think most people have had, for health care reform.

First, most of us have wanted to stop the continuous increases in the cost of health care that burden every individual, family, business, our Government, and our economy. Second, we have wanted to regulate insurance companies to provide better protections for consumers and patients. Third, we have wanted to find a way to make it easier for millions of Americans who cannot afford health insurance today to be able to buy it tomorrow. I believe this bill makes real progress in achieving each of these three goals. Most importantly, it does so in a fiscally responsible way.

The Patient Protection and Affordable Care Act not only does not add to our national debt, through new health care delivery reforms it will help reduce the debt by \$130 billion over the first 10 years, according to the independent Congressional Budget Office. That figure could multiply many times over during the second 10 years, thanks, in part, to the managers' amendment that incorporated stronger cost-containment proposals that several of us, across party lines, made to Senator REID.

In addition, it is very significant that, according to the Actuary at the Center for Medicare & Medicaid Services, this bill will extend the solvency of the Medicare trust fund for an additional 9 years. This act will also take substantial steps toward creating a health care delivery system that pays for the quality of the care patients receive rather than the quantity of care. I am proud to have worked with Members of both sides of the aisle to include amendments that would do that.

For instance, Senator COLLINS and I introduced an amendment, parts of which were included in the managers' package, that will enhance transparency for consumers so they can make more informed decisions in choosing their health care providers and insurers. In fact, our amendment will create Physician Compare, a new Web site where physician quality measures that exist now but are not known by the rest of us will be posted for everyone to see and to use in the choice of physicians. This will also create incentives, we believe, for doctors to provide high-quality, more efficient care.

I also cosponsored an amendment introduced by Senator WARNER and some other freshman Senators that will con-

tain costs even more. This amendment creates prevention programs to help us understand how to effectively manage chronic diseases such as diabetes, and it requires prescription drug plans under Medicare Part D to offer medication therapy management services to beneficiaries so they can better adhere to their prescription treatments. All that is progress on the first goal that I and most others had, which is to reduce the cost of health care without compromising—in fact, improving—its quality.

The second goal. If this bill passes, insurance companies, as Senator KERRY said, will not only not be able to deny coverage if an individual has a preexisting condition, they will not be allowed to rescind coverage if you become sick, which is the outrageous reality today. Thanks to changes made by the managers' amendment, insurance companies will also be required to spend more of the premiums they collect on medical expenses for patients rather than on administrative costs and profits. That is real progress on the second goal I mentioned.

As for the third goal, the fact is attested to by the CMS Actuary and CBO, 31 million more Americans will be able to have health insurance as a result of this legislation. We say that so often I think we forget the power of it—31 million people who do not have health insurance today will have it after this bill passes. That is a giant step forward for our society. It is not only the right thing to do, but it will also eliminate the so-called hidden tax that each of us who has health insurance today pays in higher premiums when someone who has no health insurance gets sick and goes to the hospital to be treated. That is real progress on the third fundamental goal of health care reform that I mentioned.

Is there anything in the bill that worries me? Of course, there is. I would say, most of all, I worry that we, and future Congresses, will not have the discipline to keep many of the promises we have made in this bill to control costs by transforming the way health care is delivered because some of these reforms are controversial and they are going to be opposed by some health care providers and health care beneficiaries. Without the kind of discipline I have just mentioned, this bill will add to our national debt or increase taxes. Neither of those results is acceptable. If we stick to the contents of the bill, this bill will cut health care costs and it will reduce our national debt.

In my opinion, our exploding national debt is the biggest domestic threat to our country's future. That is why I have said this bill must reduce that debt, not increase it. Accumulated debt is currently over \$12 trillion, with our budget office estimating an additional \$9 trillion added in the next 10

years. That is unprecedented in our history. We are running up to the time when we can see a moment possible that we never thought would be possible, when our capacity as a nation to borrow will be imperiled, when we will have to raise interest rates so high it will constrict our economy and send us back into a recession, worse than the one we are coming out of now.

We cannot bring the fiscal books of our Government back into balance by only making the health care system more cost efficient, but we will never control our national debt without doing so. Medicare is in a particularly perilous condition today. Without reform, the Medicare trust fund will be broke in 8 years—broke. With tens of millions of baby boomers reaching the age of eligibility, we simply must protect Medicare so it remains a viable program for both current and future generations.

This leads me to my firm opposition to the creation of a new government-run insurance program and to lowering the age of eligibility for Medicare to 55 years. That opposition was rooted in my very serious concerns about our long-term national debt and the fragile fiscal condition of Medicare. For any new government-run insurance program, including the Medicare extension-expansion idea, the moment premiums do not cover costs the Federal Government—that is Federal taxpayers, the American people—would have to pay the difference. That could easily put our Federal Government and the taxpayers on the hook for billions and billions of dollars in future liabilities and further jeopardize the solvency of Medicare.

Because of the insurance market reforms in this bill and other measures—the creation of a new system of tax credits and subsidies for people making up to 400 percent of poverty—the creation of a new government-run health care, the so-called public option or the expansion of Medicare to people under 65 is not necessary. Neither proposal would extend coverage to one person who will not be benefited by the new provisions of this bill, neither the public option nor the expansion of Medicare. Yet both proposals would, in my opinion, lead to higher premiums for the 180 million people who have insurance today and are struggling to afford the health insurance they have now because of cost shifting.

According to studies by the CBO, a new government-run insurance program, a public option, would actually likely charge higher premiums than competing private plans on the exchange, and expanding Medicare to cover people 55 years or older would lead to additional cost shifting.

I know the removal of the public option from the bill in the Senate disappointed and angered many Members of the Senate and the House, while I

know it pleased and reassured others. I wish to say to those who were not happy about the removal of the public option from this bill that I believe President Obama never said a public option was essential to the reform goals he set out to achieve and that most of us have. When the President spoke earlier this year to the Joint Session of Congress, he said a public option is "an additional step we can take." An additional step, he said, but not an essential one. Then, he added, "The public option is only a means to that end." He concluded that we should remain "open to other ideas that accomplish our ultimate goal."

I am confident this bill accomplishes the goal the President and most of us set out to achieve without the creation of a brand-new government-run insurance company or the further weakening of Medicare. This bill, as it appears it will emerge from the Senate, is delicately balanced. I understand the normal inclination in a conference committee with our colleagues in the House is to split the difference. But splitting the difference on this bill runs a real risk of breaking the fragile 60-vote Senate consensus we have now and preventing us from adopting health care reform in this Congress.

That would be a very sad ending. Rather than splitting our differences, I hope the conferees will adopt our agreements so we can enact health care reform this year. The rules of the Senate require 60 votes to end debate on a conference report.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. LIEBERMAN. I ask unanimous consent for an additional moment, maybe 2 moments, to complete my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LIEBERMAN. Each Member of the Senate will have to decide once again when this bill emerges from the conference whether he or she wants to be one of the 60 votes necessary to take up and pass the conference report. In this case my own sense of the Senate is the same as that expressed in the last few days by Senators CONRAD, NELSON, and others. If significant changes are made to the Senate bill in conference, it will be difficult to hold the 60 votes we now have. I have two priorities that will matter a lot to me. The first is to continue and maintain the health care reforms that will improve the cost-effectiveness of our health care system and help reduce the national debt. Second, I hope there will be no attempt to reinsert a so-called public option in any form in the conference report. That would mean I will not be able to support the report.

I want to support it. I believe I am not alone in that opinion among the 60 who supported the bill last night. Our exploding national debt is the biggest

threat to our Nation's future. That means we must begin to make politically difficult decisions to reduce our debt. That means saying no to some groups and some ideas, including some we would otherwise support, because we simply cannot afford them.

A final hope about the conference report. Perhaps some will say it is naive. I hope the conferees will find a way to produce a report that can be supported by some Republican Members of the Senate and House. It is a sad commentary on this moment in our political history that so major a reform will be adopted with no bipartisan support. Hopefully the conference will find a way, difficult as I know it might be, to conclude this long legislative journey with a bill that is not only worth supporting, as I believe the Senate bill now surely is, but also engages the support of Members of both parties.

I yield the floor.

Mr. ENZI. I ask unanimous consent that our time be extended in the same amount as their time was extended.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ENZI. I yield myself 15 minutes.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, the majority has voted to cut off further amendments to this bill. Senator REID has used a procedural tool that prevents Republicans from offering amendments. Several of my Democratic colleagues have come to the floor to argue that Republicans don't have any ideas on how to improve the bill. Nothing could be further from the truth. Republicans have filed over 200 separate amendments. Yet the majority is refusing to allow us to vote on any. On a bill that will affect the health care of every American and one sixth of the Nation's economy, the majority has not allowed us to have more than 10 votes to try to improve the bill.

This bill needs to be fixed. We know this bill currently will cut Medicare, raise taxes, and increase insurance premiums. If we had the chance to offer amendments, I believe we could make changes to fix the problems. I filed nine amendments, but I have not been allowed to offer any. I believe any reform should reflect the following core principles: reducing health care costs so that all Americans get the quality, affordable care they need, ending discrimination based on preexisting conditions, ensuring everyone has access to at least catastrophic care, preserving the right of patients to choose the doctors and health insurance plans that meet their needs, eliminating junk lawsuits and reforming our medical liability system, reducing health care costs for all Americans, improving patient safety, encouraging incentives for healthy behaviors by allowing insurers to charge low premiums to people who eat healthy, exercise regularly,

and abstain from tobacco use, protecting Medicare for seniors by ensuring that any savings found in Medicare, a program that is going broke, are used to strengthen that program, not to create new entitlements, and helping all Americans afford health care coverage by fixing the flawed Tax Code so that all Americans can get tax benefits for purchasing health insurance.

Unfortunately, the bill fails to do these things. I know most Members agree on those principles for reform. The hard part is making the principles come to life by translating them into bill language. I did that a few years ago when I introduced 10 steps to transform health care. Once the bill was introduced, I went on a tour of Wyoming in March of 2008 and hosted town meetings to talk about health care to my constituents. Some of the ideas I included in my 10 steps plan I also filed as amendments to the Reid bill. We need to end discrimination based on preexisting conditions. No one that has at least catastrophic coverage should be denied coverage for a preexisting condition. Everyone should have catastrophic coverage, but no one should be forced to buy anything. If someone does not at least have catastrophic coverage, then they should have to pay more if they want coverage in the future.

Everyone should get the choices for health care that Senators get. Senators get to choose between competing private plans. So should all Americans. Senators get the same choices as any other Federal employee. No more, no less. The janitor in the building, the mailman, the forest ranger, we all get the same choices. All choices are from private insurance. The Federal Government does not have its own plan. Like other employers, the Federal Government does pay part of our health care, but not all of it. Our choices allow us to pick a plan with a higher premium at a lower deductible or a plan with a lower premium and a higher deductible. Everyone should have these same choices, but they would have to work for a company willing to make a contribution to be personally willing to make that contribution and pay the remaining premium and deductible.

No matter how the health care reform bill comes out, there will not be free insurance. Everyone will pay something. The amount we pay should have a relationship to the choices we make. Insurance costs will only come down if we are encouraged to make the best choices.

Speaking of choices, there is no reason shopping for health insurance should be any more complicated than purchasing an airline ticket. Everyone should be able to fire up their computer and look up health insurance options as they look up airline flights. Each State should set up a Web site or an exchange where consumers can find

the listing of all the health insurance plans sold in their State. The public should be able to pick their health insurance using the information on the Web site. Each health plan would list what is covered, the premium, the deductible, and the copay, not what Washington says they have to put on there. Every insurance company should be allowed to list their plan on any exchange, and the State could certify whether the plans meet the minimum requirements and whether subsidies could be used for those plans. There could also be ratings for how well the company provides for its insured customers, but people could buy from any company, having been warned.

Everyone could use the transparencies of the exchange to find the insurance that best suits them. Transparency would also bring the costs down. Another thing that will bring down cost is changing the system from one that provides sick care to one that provides health care. One way to do this is to focus more on preventing preventable diseases. We know that incentives to encourage changes in behavior can result in lower costs for patients and employers. We know this because 70 percent of all health care costs are driven by behaviors. If you provide incentives to change those behaviors, you have a potential decrease in cost of 70 percent of all of the health care costs for an organization.

Companies such as Safeway have designed plans that focus on personal responsibility and provide targeted incentives that lead to behavior changes that can reduce the risk of developing four of the most costly chronic conditions. Safeway's model, focused on four chronic conditions, can be attributed to 75 percent of all health care costs: Cardiovascular disease, which is 80 percent preventable; cancer, some types are 60 percent preventable; type 2 diabetes, which is 80 percent preventable; and obesity. As a result, Safeway has seen their health care costs remain flat over the past 4 years, while other employers experience annual cost increases as high as 6.3 percent. This is a huge accomplishment for Safeway and its employees, and the employee satisfaction is fantastic. Senator HARKIN and I had an amendment that would do that. It was inserted into the HELP Committee bill and then pulled out without talking to us before it was printed in September. Never heard of that being done to Senators before.

Health care reform legislation should include the necessary provisions to ensure that companies can continue to provide successful prevention programs that lead to better health and lower costs but also allow those programs to be replicated across public and private health programs. We should encourage these programs and allow people to reap the benefits of better health outcomes and lower health costs. Addi-

tionally, people who smoke should have to pay more. People who don't smoke should pay less. People should be encouraged to quit smoking, start exercising, and eat healthy. To put it simply, allow folks who follow healthy practices to pay less for their health insurance.

People should be able to buy insurance across State lines. Companies should be able to sell insurance anywhere in the United States. Policies should be listed on the State exchanges with a disclaimer stating the policy is an out-of-State policy. The exchanges would also say whether the policy meets minimum credible standards according to Washington and the State. Insurance commissioners in both the insurance company's State and consumer's State, each get their usual amount for the sale—originators, because they can be consulted, and purchaser State, as they have to handle complaints.

We need to help small businesses. I have been working on health care reform for some time. Small business owners are seeing their insurance premiums go up and up every year. They need real help. What they don't need is for the Federal Government to make their insurance even more expensive. CBO says the Reid bill will drive up insurance costs for small businesses. I have proposed a bill that CBO scored as saving small businesses money by lowering their health insurance premiums by up to 6 percent.

Small business health plans allow businesses to join together through their trade association across State lines even nationwide so they can form big enough purchasing pools to effectively negotiate with the insurance companies and providers. Ohio has enough people they were able to do this within their State. It is effective. It brought down the cost of health care. They were able to save 23 percent just on administrative costs. They were sure if I could get my bill through, they would save even more by going across State borders. That is one that has been in the lab. It has been proven to work. Not in the bill.

Small Business Health Plans, which was S. 1955, drafted by myself and Senator NELSON of Nebraska, former Governor and insurance commissioner, was voted out of the committee in March 2006. On May 2006, cloture on the bill was not allowed in the Senate by a vote of 55 to 43. I know how tough health care reform is to pass. I had a majority of the votes but not enough to begin debate. At the same time, Senator SNOWE was poised to do a single amendment that would have solved the objection for 80 percent of those who voted against it. Without cloture, that amendment could not be offered. The Snowe amendment would have solved the question of what health plan mandates would be required. The desire for

mandate clarification was the objection that had the disease groups working against the bill. The insurance companies worked against the bill and successfully defeated other versions called associated health plans for over a decade. I was able to neutralize much of the insurance lobby.

By creating Small Business Health Plans, we can put small business owners in the driver's seat instead of the Federal Government or insurance companies. Through their associations, small business owners will have the kind of clout in the marketplace needed to negotiate high-value and high-quality health insurance for their members on a regional or even national basis.

Additionally, throughout the health care debate, we have heard Democrats say we need a public option in order to keep insurers honest and to have more choices for Americans. However, the only place where we don't currently have competition is for the millions of Americans who are currently trapped in the Medicaid Program. Democrats believe it is OK to lock 54 million poor American people into Medicaid and have them languish in a system that is broken and they are unwilling fix. Their solution is to keep adding more Americans to this broken system. A 2007 Wall Street Journal article stated that Medicaid beneficiaries have poorer health than their peers with private insurance. A study published in the Journal of the American College of Cardiology found that Medicaid patients were almost 50 percent more likely to die after coronary artery bypass surgery than patients with private coverage. Merritt Hawkins found that in 15 major metropolitan areas and in seven particular cities, including Washington, DC, Medicaid acceptance was below 50 percent.

A 2002 MedPAC report stated that 40 percent of physicians—let me repeat that: 40 percent of physicians—will not treat Medicaid patients because of their concerns about reimbursement and the time and added cost of completing the billing paperwork. Even the Office of the Actuary at the Centers for Medicare and Medicaid Services has stated that providers will accept more patients with private insurance than government-run health care due to the more attractive private physician payment rates. If you cannot see a doctor, you do not have insurance, no matter what the special name.

As we increase dramatically the number of people eligible, we should find a way to offer them regular insurance so they do not have the stigma of being on Medicaid. They should be able to choose between the usual Medicaid and a private policy with a subsidy.

Unfortunately, the Reid bill expands Medicaid, and the reason is because it is cheap. According to the Congressional Budget Office, it costs 20 percent

more to cover a person in the exchange, funded by Federal dollars, than through Medicaid, which is shared between Federal and State governments.

One of my amendments would change all of this. Senators and their staffs all have the ability to choose between competing private plans, and I believe we should give that same kind of choice to low-income Americans. Instead of trapping people in a broken Medicaid Program, my amendment would provide individuals who would otherwise be enrolled in Medicaid through the expansion in this bill the right to choose to be covered by Medicaid or a qualified private health plan offered through their State exchange. Every American should be able to choose to enroll in private insurance, and my amendment would provide real choice access to a network of physicians and fix this problem. It would also assure them they would have coverage for an entire year, not just while their income fluctuates.

On the topic of expanding government programs, I would also like to mention that if you save money in Medicare, it should only be used to help Medicare because it is already going broke. The current bill takes money from Medicare and uses it for other government programs. This bill takes \$466 billion from Medicare and uses it to start new entitlements that have nothing to do with Medicare. Yet they start a new commission to figure out where to make additional Medicare cuts in order to keep the system going—doesn't that seem counterproductive—after limiting where the cuts can come from because of hidden deals to get support for the bill.

Whatever we do has to reduce costs for all individuals and be deficit neutral. It has to truly be paid for. Why does it have to be paid for? Because America is going broke. We have maxed out the credit cards, and now we are driving down the value of our money. We have to use honest cost, not gimmicks such as the doc fix delay or collecting revenues before the benefits kick in and showing years of revenue for a shorter time benefit.

What ways can the government pay for anything? Unfortunately, they can cut benefits, cut payments to doctors and other providers, increase taxes, or cut waste, fraud, and abuse—which government seldom does and even more seldom does effectively—or, more honestly, allow a checkoff for donations to other people's insurance—perhaps even a tax-free donation—so people who want a bigger role in seeing that everybody has insurance could directly participate. People who argue that it is imperative we extend health benefits to everyone should put their money where their mouth is. People should have an opportunity on their income taxes to make an instantly deductible gift to the health care of others. If the

deductible size of the gift is a refund, then they would not have to include a check.

On the subject of taxes, taxes have to be fair to everyone. Right now, big companies can write off the health care they provide their employees, so those employees are getting health care with zero income tax. Individuals who buy insurance pay income tax on all the money they use to buy insurance. That is not fair.

I have covered just a few of the ideas I have. I have several more ideas I have been talking about time and time again, none of which show up in the bill. These meet the promises that were made. The bill does not meet the promises that were made.

Health care is too complicated and encompassing to be done by a single bill. I have never worked on a bill that affects 100 percent of America. Adequately done, rather than assigning details to agencies, a comprehensive bill has to contain details. Assigning the tough parts to the Secretary of Health and Human Services makes it easier to legislate, but you don't know what the final outcome will be. Done in smaller incremental steps, the bill would be more understandable. More importantly, with the huge, more comprehensive bill, the more people who each don't like a particular part will defeat the whole bill over a few parts.

We need to start over. We need to pursue a step by step, bipartisan, approach. We need to match up a Republican idea with a Democrat idea. We need to leave out a Republican idea and leave out a Democrat idea. Pursuing this type of strategy, what I call the 80-percent rule, would likely mean broad support from both sides. This would mean that the rigid ideologies of both sides would oppose such a bill, but I am confident that majority of the American people would support a bill like this.

We need health care reform, but it has to be done the right way. The best way to reform our health care system is to do it step by step. We need to start by focusing on the issues where we already have broad, bipartisan agreement.

I know how to pass bipartisan legislation. Since I came to the Senate 13 years ago, I have worked with both Democrats and Republicans to reform our Nation's health care system. Over my years in the Senate, there have been several times when I have worked across the aisle to get health care bills signed into law.

When I joined the Senate, the Health, Education, Labor, and Pensions Committee was one of the more contentious committees. I believe that people can agree on 80 percent of the issues 80 percent of the time and, if they leave the other 20 percent out, they can get a lot done. With that in mind, Senator Kennedy and I worked to make it one of

the most productive and bipartisan committees, with a substantial number of bipartisan bills signed into law each year.

Whether it is the reauthorization of the National Institutes of Health or the renewal of the Ryan White and PEPFAR programs for people with HIV/AIDS here and abroad, I am committed to working across the aisle on issues of importance. Working together, we got patient safety, mental health parity, and genetic non-discrimination legislation over the finish line. These proposals had been pending for years. We were also able to have a strong bipartisan bill to overhaul the drug safety functions at the FDA. By working together, instead of against each other, we can achieve passage of many more pieces of critical legislation.

Everyone agrees we need real changes that will allow every American to purchase high-quality, affordable health insurance. Not a single one of my Senate colleagues on either side of the aisle supports the status quo. The argument that Republicans support the status quo is simply false. We understand that the current system fails too many Americans. We want to support reforms that will provide real insurance options to all Americans and help lower the cost of that insurance.

But I have said from the start of this year, and frankly throughout my 13 years in the Senate, true reform should be developed on a bipartisan basis, so that the legislation will incorporate the best ideas from both sides and will have the broad support of the America. That should be a prerequisite for any proposal that will affect the nearly 20 percent of our Nation's economy and the health care of every American.

We have only had 10 votes on Republican amendments. It is not because Republicans agree the status quo is acceptable or because we think the health care system works fantastically; quite the opposite. Republican Members have filed 223 amendments to this bill. Unfortunately the majority leader has blocked us from offering our amendments.

This bill is too important to get wrong. We need the opportunity to improve this bill, and I would urge my colleagues in the Democrat leadership to allow us the opportunity to do so.

Madam President, I ask unanimous consent that an editorial by David Broder, "One Is the Loneliest Number for President Obama," be printed in the RECORD. It mentions some of the editorials and key points of editorials that I put in my speech last night.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

ONE IS THE LONELIEST NUMBER FOR
PRESIDENT OBAMA
(By David Broder)

In the last year or so of George W. Bush's second term, commentators used to talk a

lot about the conspicuous scarcity of other Republicans willing to stand up and defend him. I never thought we'd see Barack Obama face the same problem before his first year was over.

But as Obama's approval scores (50 percent in the latest Washington Post-ABC News poll) sink, it is getting harder and harder to find a full-throated supporter of the president.

You need go no further from here than the op-ed page of Thursday's Washington Post to see what I mean. Time was, and not all that long ago, when the Post was thought of as the "liberal paper" in Washington, a reliable advocate for the kind of policies pursued by Democratic presidents.

Well, in the lead article on the op-ed page, a well-known member of the president's party said that Obama's prize piece of domestic legislation, the health care reform bill, has been so compromised that as it stands, "this bill would do more harm than good to the future of America."

"If I were a senator," wrote Howard Dean, former governor of Vermont and the chairman of the Democratic National Committee during Obama's run for the White House, "I would not vote for the current health-care bill."

Dean, who had been signaling his apostasy for some time, was far from alone in clobbering Obama, just as the president and Senate leaders were struggling to line up the 60 votes needed to pass the ever-changing legislation.

Across the Post's prized real estate, conservative columnist George F. Will gloated that the more Obama argued for the bill, the less the public supported it. And from across the aisle, Matthew Dowd, a former Democrat who served as chief strategist for the younger President Bush, offered congressional Democrats the free advice that they would be better off themselves if the Republicans managed to block Obama's bill.

It was left to my friend, E.J. Dionne, Jr., one of Obama's most passionate journalistic advocates, to tell the Democrats that they ought to mind their manners—and their words. The increasing flak between moderate and liberal Democrats "is a recipe for political catastrophe," Dionne warned, his tone suggesting that he thinks the Democrats are too far gone to heed him.

But this wasn't the worst I saw that day. The worst came in a news report of the year-end news conference by House Speaker Nancy Pelosi. Asked how she would deal with next year's looming tests of congressional Democratic support for Obama's decision to send 30,000 more U.S. troops into the Afghanistan struggle, she said, "the president's going to have to make his case" himself. Reminding reporters that she had told lawmakers in June, when funding was approved for 17,000 additional troops, that it would be the last time she would ever lobby her members to back such a step, she made it absolutely clear she felt no obligation of party loyalty to support Obama on the most important national security decision he has made.

The liberal legislator from San Francisco could not have been plainer if she had added, "You're on your own, buster."

With this as an example from the No. 1 Democrat on Capitol Hill, one has to wonder why liberal Democrats are so furious about senators such as Joe Lieberman and Ben Nelson negotiating their own deals with the White House on the health care bill.

I think Obama deserves more help than he is getting from his fellow Democrats in Con-

gress, given the boost he provided them in the last election, the difficulty of the problems he inherited, and the stiff-arm he has received from the Republicans.

But the reality is that, the closer the midterm election comes, when they will be on the ballot and he will not, the more members of Congress—and not just Pelosi—will judge what is best for themselves and the less they'll be swayed by Obama.

He may feel lonely now, but he ain't seen nothing yet.

Mr. ENZI. Madam President, I also ask unanimous consent that an editorial by George Will from the Washington Post titled "The Indispensable Dispenser Opens Up" be printed in the RECORD. It shows how Medicare is left up in the air after the Reid bill.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE INDISPENSABLE DISPENSER OPENS UP

(By George Will)

Ryan Bingham has a unique way of describing his life.

"Last year," he says, "I spent 322 days on the road, which means that I had to spend 43 miserable days at home." Home is an Omaha rental unit less furnished than a hotel room. He likes it that way.

Today he is where he feels at home, in an airport—glass walls and glistening steel, synthetic sincerity and antiseptic hospitality. Today he is showing Natalie, a ferocious young colleague, how an expert road warrior deals with lines at security screening:

Avoid, he says, getting behind travelers with infants ("I've never seen a stroller collapse in less than 20 minutes"). Or behind elderly people ("Their bodies are littered with hidden metal and they never seem to appreciate how little time they have left on earth"). Do get behind Asians: "They're light packers, treasure efficiency, and have a thing for slip-on shoes."

Natalie: "That's racist."

Bingham: "I stereotype. It's faster."

Played with seemingly effortless perfection by the preternaturally smooth George Clooney, Bingham is the cool porcelain heart of the movie "Up in the Air." It is a romantic comedy, although Bingham begins immune to romance. And the comedy is about pain—about administering it somewhat humanely to people who are losing their jobs.

Bingham is a "termination engineer." He fires people for companies that want to outsource the awkward, and occasionally dangerous, unpleasantness of downsizing. His pitter-patter for the fired—"Anybody who ever built an empire, or changed the world, sat where you are now"—rarely consoles. But with his surgeon's detachment, he is more humane than Natalie, who says this:

"This is the first step of a process that will end with you in a new job that fulfills you. I'd appreciate it if you didn't spread the news just yet. Panic doesn't help anybody."

A confident young cost-cutter from Cornell, her brainstorm is to fire people by videoconferencing. She tells one desolated man:

"Perhaps you're underestimating the positive effect your career transition may have on your children. Tests have shown that children under moderate trauma have a tendency to apply themselves academically as a method of coping."

Bingham considers his low emotional metabolism an achievement, and in motiva-

tional speeches he urges his audiences to cultivate it: "Your relationships are the heaviest components of your life. The slower we move, the faster we die. We are not swans. We're sharks."

The movie begins and ends with everyday people talking to the camera, making remarkably sensitive statements about the trauma of being declared dispensable. Some, however, recall that the consequences included being reminded that things they retained, such as their human connections, are truly indispensable.

The opening soundtrack is a weird version of Woody Guthrie's "This Land Is Your Land." This hymn to Depression-era radicalism is catnip for people eager to tickle a political manifesto from any movie that has a contemporary social setting.

But although "Up in the Air" might look like a meditation on the Great Recession, it is based on a novel published in 2001, during the mildest recession since the Depression, and written before that.

You must remember: In 2006, the last full year before this downturn, when the economy grew 2.7 percent and the unemployment rate was just 4.6 percent, 3.3 million people lost their jobs to the normal churning of a dynamic economy. This "creative destruction" has human costs, but no longer is optional.

America has an aging population, and has chosen to have a welfare state that siphons increasing amounts of wealth from the economy to give to the elderly. Having willed this end, America must will the means to it—sometimes severe economic efficiency to generate revenues to finance the entitlement culture. So "Up in the Air" is sobering entertainment for a nation contemplating a giant addition to the entitlement menu.

"Up in the Air" is two mature themes subtly braided and nuanced for grown-ups. One is the sometimes shattering sense of failure, desperation and worthlessness that overwhelms middle-aged people who lose their livelihoods. The other is that such shocks can be reminders that there is more to life than livelihoods.

But not for Bingham. He is, in his fashion, content. In E.M. Forster's novel "Howards End," Margaret famously exhorted, "Only connect!" Bingham would rather not.

Mr. ENZI. Madam President, I yield the floor and reserve the remainder of our time.

The PRESIDING OFFICER (Mrs. SHAHEEN). The Senator from South Carolina.

Mr. DEMINT. Madam President, we have heard a lot about the unsustainable mountain of government debt, bureaucracy, and spending the Democratic majority intends to create in rushing their health care proposal through this Chamber. We have also heard a lot about how much of this they inherited. We need to remember that this Congress—both Houses of Congress—has been controlled by the Democratic Party for 3 years now. The President does not write legislation or spend money; the Congress does. The only thing the Democratic majority has inherited is its own irresponsible spending.

Saturday's release of the final Democratic bill only increases America's concern with this Congress, its shadow negotiations, and our growing debt.

Early this morning, all 60 Democrats voted to force all the taxpayers of this country to pay for bailouts and special favors for several States. Rather than actually taking the time to put forth real health care reform proposals that would increase Americans' ability to buy and own health care plans they could really afford, this plan forces over 15 million Americans onto yet another bankrupt entitlement program, Medicaid.

While Medicaid is a State and Federal shared program, the Democratic majority saw fit for the Federal Government to pay 100 percent of the Medicaid Program in the State of Nebraska under this legislation at the expense of taxpayers in the other 49 States, who will now be forced not only to deal with the loss of their freedoms under this huge government takeover but to pay for special favors in other States.

This State bailout is not the only downside of the majority's health care proposal; there is a laundry list we could go through. Just a few include that the working American taxpayers and their employers will be taxed \$500 billion over the next 10 years, and the Congressional Budget Office has confirmed that nothing in this bill decreases the premiums for Main Street Americans.

Seniors will see their Medicare benefits changed as a result of the \$500 billion in Medicare cuts included in this bill, not to mention that this bill turns a blind eye to the physician payment system that is woefully underfunded and vitally necessary to maintain the Medicare Program and physician access for seniors. It does not matter how good the insurance is we give our seniors if they cannot find a doctor who will see them.

Another alarming part of this bill is it will, for the first time in decades, force every American taxpayer to pay for abortion services.

Frankly, after reading this bill, it seems the only Americans who are not going to be affected by the bill are Members of Congress, pharmaceutical companies, and insurance companies.

Madam President, for all the mind-boggling numbers and devastating facts we have heard about the majority's government takeover of health care, this debate is about much more than health care. It is about how we find ourselves in a situation where we are debating the best way to give the government control over another big part of our lives and our economy.

In the children's story of "Hansel and Gretel," the children drop a trail of breadcrumbs as they walk through the forest so they will be able to find their way out of the woods. But when the birds eat the breadcrumbs, the children find they are lost in the dark and frightening woods.

Well, lost in the woods is exactly where we find ourselves as a country

right now. We know we are in trouble, but there is no clearly marked path to get us back to where we were, and it is plenty frightening.

In the past year alone, this Federal Government has taken over two of our largest automakers, our largest insurance companies, the largest mortgage company, and hundreds of banks. It has bailed out Wall Street and attempted to stimulate the economy by taking \$1 trillion out of the private sector and spending it on wasteful government programs. It has thrown taxpayer money at people to encourage them to buy new cars and houses. And it is looking at imposing massive new job-killing taxes on businesses in the name of reducing global warming—all in the middle of a snowstorm.

One of the problems we have now in this country is, instead of asking if we should solve it, we are asking, how should we solve it? It is now considered a sign of admirable restraint to occasionally ask here in this Senate and in this Congress, how much should we spend? And somehow we started thinking that anything less than \$1 trillion is a good deal. There is not a pothole in America that most Members of the Congress do not believe should be filled with an earmark from the Federal Government. There is not a bridge to nowhere, a flat tire, a skinned knee—there is nothing off limits for this Congress today.

This matters not just because of our unsustainable debt and the huge amount of money we waste; it matters because every time we give a job to the government, we take away some control people have over their own lives, and we take away a little bit more of their freedom. In return for letting government try its hand at solving a problem, we as citizens cede our ability to try for ourselves to find a better way.

It is awkward to admit it, but my colleagues in Congress have led this country into the woods, despite our oath of office. We swore to protect and defend the Constitution of the United States and to bear true and faithful allegiance to it. The Constitution prescribes a very limited role for the Federal Government. There is not a word in our oath or in the Constitution about most of what we do. As we have wandered off the path of liberty, there are few crumbs left of the Constitution in the Halls of Congress to lead us out of the woods.

There is not a word in the Constitution about the government deciding what medical test private health insurers should pay for, nothing about the government deciding how much executives on Wall Street should earn or what kind of lightbulbs or cars we should buy. There is nothing about the thousands of parochial earmarks that fund local bridges to nowhere, golf courses, bike paths, sewer plants, and

teapot museums. There is nothing about these or many other things in the Constitution because they have nothing to do with the proper role of the Federal Government in a free society. But these are exactly the kinds of things our government spends its time and money on, and we do not even question anymore why that is.

Instead, it has gotten to the point where if we oppose the government doing anything, we are accused of being opposed to getting it done. That is patently absurd. If you really want to get something done and get it done right, the government is absolutely the last place we should turn.

The tea parties, townhalls, and rallies affirm that the American people are rethinking the appropriate role of the government in a free society. Hopefully, their discontent will be demonstrated in the 2010 elections. Only the American people can hold our elected Federal representatives accountable for fulfilling their oath of office. In the health care debate, this means deciding exactly what role the government should play to help people in the private sector find solutions, instead of creating a monstrous new bureaucracy that puts the government in charge of every decision.

But this debate is about much more than health care. It is a battle for the heart and soul of America. It is a struggle between freedom and socialism, between free markets and a centrally planned economy, and between "we the people" and an entrenched class of elite politicians.

The current debate over health care reform is a symptom of a bigger problem in Washington. But it can be the catalyst for a wider debate about the proper role of government in our lives. The same debate can lead us to a moment when Americans finally take a stand to return government to its proper place—and we can all start finding our way out of the woods.

Madam President, I yield the floor.

THE PRESIDING OFFICER. The Senator from North Carolina.

MR. BURR. Madam President, I am going to be joined by a number of my colleagues, so I ask unanimous consent that we be able to have a colloquy during the remainder of our time.

THE PRESIDING OFFICER. Without objection, it is so ordered.

MR. BURR. Madam President, I think many Members have to ask: Why are we here? We are here because at 1 a.m. this morning, there was a cloture vote on the consideration of the Reid managers' amendment. I think it is important that we discuss what that means. It means there are going to be no more amendments, no opportunity for any Senator from any State to propose a change to the bill. At some point, we will have an up-or-down vote on exactly what Senator REID has presented to us.

But here is what we do know. We are going to steal \$466 billion from Medicare. We are going to take that \$466 billion away from hospitals, from hospice, from nursing homes, from home care, and, yes, a popular target up here—the insurance product many Americans have chosen, 20 percent of the seniors, Medicare Advantage. We are going to eliminate that option. So this is one case where if you like your health care, you are going to lose it.

The bill that we are considering and that will be voted on later this week raises \$519 billion in new taxes and fees—\$519 billion in new taxes. I might add for my colleagues, we are taxing tanning salons at 10 percent. What in the hell does that have to do with health care? Well, the reason it is in there is because we dropped taxing Botox. Hollywood saw this was not advantageous to have Botox taxed, so when they dropped that, they had to find something else: poor tanning salons, small businesses in every community across this country. We are going to actually tax the majority of Americans the President said he would never tax: those under \$200,000, the ones who can't afford to go to the beach every weekend; the ones who don't have a beach house. They are going to pay a 10-percent tax when they go to get a little bit of a tan. Well, when they do that, how far off are we from fining parents because we don't put a high enough SPF on our children, or are we going to start charging when we go to the beach because we get exposure to the Sun? That is what happens when the government becomes a more dominant role in health care.

I might add: No doctor fix, something many of us have highlighted. In the bill, there was a 1-year fix. Doctors are going to be faced with a 21-percent cut in their reimbursements after this next 2 months. There was a 1-year fix to it. It didn't do away with the problem. It didn't fix the whole problem. But now there is no 1-year fix. We have said in 60 days doctors will be on their own.

Yes, there were some special deals—the cornhusker kickback, the windfall for Nebraska. I have to admit that I was proud of my colleague, Senator JOHANNES, who came to the floor and said: Let me assure you, the people in Nebraska have never asked for something different than everybody else. They are willing to pay their share of the way there. They haven't asked for it to be free for them and cost everybody else.

Yes, it will cost my constituents in North Carolina, and it will cost the constituents in Nevada—well, it won't in Nevada. I think maybe there is even a deal that affects them to some degree.

Is it fair? No, it is not fair. The fact that it wasn't fair was called: "That is compromise."

That is not compromise. We are here under an obligation to make this fair

to all of the American people. But in this case, it is not.

Yes, there are 31 million Americans who are going to have health insurance, 15 million of whom are delegated into Medicaid, the most dysfunctional delivery system that exists in the American health care system.

Yes, there is, for many States, an unfunded mandate to those States because after 5 years, for most States, except for those who got these special deals, the States are going to be responsible for some portion, an average of 10 percent of the cost of Medicaid.

Let me tell you what my Governor, Governor Bev Perdue of North Carolina, said earlier:

The absolute dealbreaker for me as governor is a Federal plan that shifts costs to the States.

Well, we are shifting costs to the States, and she is nowhere to be found now. But the people in North Carolina, the taxpayers of North Carolina are going to continue to be charged for this expansion of Medicaid when that is the most inefficient place for us to have put these 15 million Americans who were promised health care.

While we do all this, according to the Chief Actuary of the Centers for Medicare and Medicaid Services, CMS, 20 percent of our hospitals and nursing homes are going to go bankrupt. They are going to go out of business because as the Chief Actuary said:

They would be unprofitable within the next 10 years as a result of these cuts.

Hospitals, nursing homes, at a time that our senior population is getting ready to explode as the baby boomers hit it, we are cutting \$466 billion from Medicare, and we are starving the infrastructure of hospitals and nursing homes and hospice and home care.

What is going to happen to the providers? The Chief Actuary, again, said if we pass this plan, the result is providers will be unwilling to see Medicare and Medicaid patients.

Today, 40 percent of providers don't see Medicaid patients. Does that mean it is going to be 50 percent or 60 percent or 70 percent? We are ballooning a system that today is having a hard time finding providers. To most of us that doesn't make sense, but that is what the Senate is going to do.

I might also add that the attempt was to expand coverage; and, yes, sure, in numbers, we are expanding coverage. But, if passed, the Congressional Budget Office says 8 million to 9 million individuals who currently have employer-based health care will lose that health care. Eight million to nine million who currently have their health care will lose their health care with the passage of this bill. The net-net is not real pretty, and when you look at the \$2.3 trillion that health care costs, you have to ask yourself, where is the beef? Where is the value in this?

As hospitals close, as nursing homes close, as providers don't see Medicare

and Medicaid, ask yourself, have we really done something good? Chances are, you will find out if we do nothing, if we do nothing, we will actually save money in the health care system.

The last fact: The Chief Actuary of Medicare said: If you pass this bill, the cost of health care will be \$¼ trillion more than if we did nothing.

The President talked about bending the cost curve down. We are bending that cost curve up in this bill. We are bankrupting hospitals and nursing homes. We are chasing providers from seeing Medicare and Medicaid patients.

There are not too many things we can point to that are great about this bill. That is every reason we should start over.

I know my colleagues are here to join in and to offer some perspectives, and I would ask them to chime in.

Mr. ENSIGN. Madam President, let me just summarize a few problems I see in the bill, and maybe even offer a few suggestions about what I think we can do in a bipartisan fashion—kind of this step-by-step approach many of us have been talking about—instead of this massive government takeover of our health care system.

This is a—I have lost track—I think somewhere around a 2,700-page bill with incredibly complex legal language. In the 400-page amendment offered the other day, when I was sitting there listening to the reading of it, I can't tell my colleagues how many times I was listening to this and I thought: When the regulations are written to that particular small part of the amendment, it could be incredibly complex with all kinds of unintended consequences. I thought about the burdens on small business and the record keeping that small businesses are going to have in this bill.

I think what is going to also happen with small business, there is going to be a great incentive—if you are a small business owner, the complexities are so much and you can get yourself in so much trouble, you know what, I am just going to pay the fine. I will write a check to each one of my employees, but I am getting out of the health care business. I am going to let them go out and find their own health care, whether through the government exchanges or whatever it is, but I am getting out. That is one of those unintended consequences that a lot of people haven't focused on.

We talked a lot about this \$500 billion-plus cut in Medicare. My colleague from North Carolina mentioned that. Some of the biggest places—I had two grandmothers who were in hospice. Hospice care is the most compassionate care we have today, and we are going to cut hospice care. That actually puts dignity back into dying. That is just unconscionable. The Congressional Budget Office says these cuts actually will be cuts in service because you

can't just take money out of the system unless you make them more efficient. These cuts don't make the system more efficient, they just take money out of the system, whether it is out of hospice or nursing homes or the home care, but also out of Medicare cuts.

We know there is \$120 billion in cuts to Medicare Advantage. The Congressional Budget Office said by 2016, 64 percent of the extra benefits, whether those are prescription drugs or dental coverage or vision coverage, the seniors covered under Medicare Advantage are going to be cut 64 percent because of this legislation.

We also know there is around \$500 billion in new taxes, and this is a complete violation of the President's promise during the campaign when he said not one dime in new taxes will be raised on those individuals making less than \$200,000 or families making less than \$250,000. Yet in this bill, of the \$500 billion, 84 percent is paid by those people the President said wouldn't have their taxes raised by one dime.

We also know, because the Senator from North Carolina talked about it, this massive Medicaid expansion—I think it was the Democratic Governor from Tennessee who said it was the mother of all unfunded mandates. Well, we have to look at this one way. If the sweetheart deal that was made by the Senator from Nebraska—and, by the way, I agree with you. Senator JOHANNIS, who came to the floor, it takes a lot of courage to say it isn't about just helping my State; it is about thinking about the whole country as well. He isn't asking for something—which most Senators do around here, ask for something just special for the State that the rest of the States have to pay for—but he stood up with courage, and I think he deserves a lot of credit for that.

But if all the other States now come back and say: We want the Federal Government to pay for our States and Medicaid, this bill is going to do one thing. It is either going to be a massive unfunded mandate on our States or this bill is going to massively balloon the Federal debt.

Mr. COBURN. Madam President, I have a question for both the Senator from North Carolina and the Senator from Nevada. Can the State of Nevada or the State of North Carolina or the State of Nebraska or the State of Oklahoma be healthy if our country doesn't flourish? So no matter what we do for our own States, if, in fact, we are not thinking about the country as a whole, the best right thing for the country as a whole, none of our States can flourish.

Mr. ENSIGN. I think the Senator from Oklahoma has made a wonderful point. Right now, my State is suffering terribly, not because of anything individually, such as we didn't get our fair

share of something; my State is suffering because the whole economy is in the doldrums and because we are such a tourist economy, construction oriented, the housing industry, all of those things, and because the general economy went down, my State is suffering.

So the Senator is exactly right. We should be looking at what is best for the entire country. As John F. Kennedy said: A rising tide raises all boats. Well, if the whole country is doing better, whether it is on health care or whatever it is, instead of looking for something individual for our States, you are exactly right. I think our individual States will do better if the whole country does well.

Mr. COBURN. Madam President, I ask unanimous consent to have printed in the RECORD an article that appeared today. It is a quotation from the founder from the Daily Kos Web site. I will give it to the clerk in a moment. I wish to read a quote from it:

I don't think this is a reform bill. I mean, I think it is very clear this is not insurance or health care reform. What it is is allowing more people, 30 million people, to buy into an existing broken system. It is very important to keep in mind that health insurance is not the same as health care. If you go up to Massachusetts, they have a mandate as well. Last year, in Massachusetts, 21 percent of the people who are insured could not get health care because they could not afford it.

That is somebody who is very well respected on the majority side, and it is something we have been saying, and they are saying the same thing. The fact is, what we are going to do is put 15 million people into Medicaid that we know has worse outcomes, we know is an unfunded mandate on the States, and we know 40 percent of the doctors refuse to see them. So you are not going to get to choose the doctor you want to see. You are going to have State mandates in terms of what is available to you and what is not. So we have violated two of the key promises with which to reform health care.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MOULITSAS: WE'LL GET KILLED IN 2010

Markos Moulitsas, founder of the Daily Kos and an influential leader of the Web-based political left, said Sunday that Democrats are facing huge defeats in the 2010 elections because the Obama administration has alienated the Democratic Party's liberal political base with its escalating involvement in Afghanistan, and its failure to push for universal healthcare.

Speaking on NBC's "Meet the Press," Moulitsas offered a bleak scenario for House and Senate races next year.

Excerpts:

Mr. GREGORY: Markos Moulitsas, I want to start with you. You heard David Axelrod say this in keeping with the president's principles; it is in keeping, the compromise on health care, with the way the president campaigned on this. And this is the bill, essentially, the reform that Americans deserve. What do you say?

Mr. MARKOS MOULITSAS: Yeah, I don't think this is a reform bill. I mean, I think it's very clear, this is not insurance or healthcare reform. What it is, it's allowing more people, 30 million people, to buy into the existing broken system. It's very important to keep in mind that healthcare insurance is not the same as health care. Insurance, not the same as care, if you go up to Massachusetts, they have a mandate as well, and last year 21 percent of people in Massachusetts could not get health care because they could not afford it. Even though they had insurance, the premiums—not the premiums, the deductibles, copays and out-of-pocket expenses were too high. So really, this isn't reform. It's expanding the system, it's almost rewarding the existing system. Now, what is important about this is that it actually puts the federal government, plus America on the place to say health care is a right, it's not a privilege to just those who are—who can afford it or who are lucky enough to have a good job that has good benefits. But as far as reform goes, I think this is a long battle that we have ahead of us.

Mr. MOULITSAS: Well, you can't talk about health care and Afghanistan being distractions. They're the reasons that Obama won the White House and Democrats won control of Congress, including big, massive support from independents. Independents know what they were voting for when they voted for Obama and the Democrats. I think the problem with Obama's numbers and, and Congress' numbers is that people voted for a Congress and a president that was going to take on entrenched interests. Now, Republicans had jumped off the Obama bandwagon from day one. They were never on board. Independents have sort of been unhappy because I think independents really want results, and we haven't seen a lot of results. We've seen a log of bickering, and most of it has been internally within the Democratic Party, and I think that's why they're turning off. And a lot of Democrats are becoming disenchanted.

Mr. GREGORY: . . . What does the president need to address to keep his own party in line? Should there be personnel changes in the White House? What do you think the left is going to demand?

Mr. MOULITSAS: Well, 2006 is going to be a base year. It's going to be a base election.

MR. GREGORY: 2010, you mean.

Mr. COBURN. Madam President, I wish to also quote from what I think is a brilliant letter by a Dr. Robert Geist from St. Paul, MN, that was written as a letter to the editor in the Wall Street Journal today. The title of his letter to the editor is, "The First Cost Controller Will Be Your Own Doctor." It is something I have been talking about since we started this. The last thing we want to do in health care in America is to make it where the doctor is not a 100-percent advocate for the patient's best interest.

He quotes very directly the transfer. He said a previous article written:

. . . doesn't emphasize a potential stealth cost-control aspect proposed in the bill. It will start pilot programs that would transfer the gatekeeper role to doctors at the bedside, a role currently held by "payers" (HMOs and government-agency insurers, including Medicare and Medicaid).

The transfer will be via capitation fee payments, making clinics "responsible" for the cost of care of "insured lives" for one year.

... The illusion of many pundits and policy makers is that mini provider gatekeepers can control costs after the very powerful payer gatekeepers—

That is, Medicare, Medicaid, and the large insurance companies—

have failed for decades. The problem for patients is the dilemma of all managed-care gatekeepers: cost, quality, access; pick any two. It is not pleasant to think that one's gatekeeper doctor will have to decide whether to order surgery for your painful [worn out] hip or only to increase the dose of—

Anti-inflammatories because they are worried about costs.

That is the key point. We are going to now separate physicians in this country for doing what is best for the patient to meet the demands of the government.

Mr. ENSIGN. If the Senator will yield.

Mr. COBURN. I will be happy to yield.

Mr. ENSIGN. As a practicing physician, isn't this what the Senator saw in his practice with HMOs?

Mr. COBURN. That is exactly why I am not a member of any HMOs.

Mr. ENSIGN. Because we have kind of an insurance center system today, to a large degree, and now we are going to make that worse. Instead of going more toward a patient center, we are going to go from an insurance center to a government center to where these government bureaucrats now start being in control of eventually what kind of care you are going to get, what is paid for, and all that. We need to put the doctor and the patient back at the center of our health care system.

Mr. COBURN. Let me finish this for a minute, if I might. Here is the summarizing paragraph:

The economic reality is that no rationing of care supply will ever control costs, when the problem is demand inflation driven by popular insurance tax subsidies too sacred to repeal. Consider that when federal fiscal "necessity" overwhelms empty slogans,—

Our empty slogans—

scores of new bureaucracies created in [this bill] would be able to implement Draconian rationing in collusion with subservient insurance and "provider" corporations. The high costs, as well as the rationing powers included in the more than 2,000 pages of the ObamaCare Senate legislation are very real.

Which is the point I have been making all along. I am going to spend 30 minutes tomorrow talking about the rationing aspects of what we are about to do as we pass this bill.

Mr. BURR. If I can comment to my good friend, who started on a quest with me several years ago to try to put together a health care reform bill, I might say it was the first one introduced in the Congress in May of this year on comprehensive health care reform—not that it is better than anybody else's, but I can honestly say today it was true reform. I think that is what Dr. COBURN is trying to say.

In this bill, it lacks reform. What do I mean by that? Their reform is to set

up an advisory panel that if we exceed the costs we have designated for health care, they are going to cut the scope of coverage or the reimbursement. So either the array of coverage for a senior or for an American is "skinnied down" or we cut the reimbursement to the doctor or the hospital, and they call that reform.

What Dr. COBURN and I found out, as many other Members have, is if you look at the successful companies across this country that have held down their health care costs through doing real reform—paying for prevention and wellness in work, changing the lifestyles of the employees—we saw companies that, for 4 years, had a 45-percent increase in their health care. Where is any of that in this bill? Out of 2,700-plus pages, there is no attempt to do that. There is no attempt to try to affect the lifestyles through supporting chronic disease management, prevention, and wellness, but we set up a lot of independent advisory boards.

As a matter of fact, they were so scared that in the managers' amendment, it is no longer called the Medicare independent advisory board. It is called the independent advisory board. So the word "Medicare" was dropped, not to signify that they are going to cut Medicare, but that is exactly what CBO and CMS have said. These will kick in. The question is, Are they sustainable or will Congress legislatively override their authority to cut the spending?

Mr. ENSIGN. If my friend will yield, there is one part—actually one of the best parts in this bill—but there are so many other bad parts of this bill and the Senator from North Carolina mentioned them, and we have talked about a lot of them. The one place they actually have improved our health care system is the part that allows people to have larger discounts for healthier behaviors. Safeway was the model for this. They have done the most work on this in the last 4 years. Today, they can discount up to 20 percent of their health care premiums for people who engage in healthier behaviors—for not smoking, for being the proper body weight compared to their height, doing things such as that. If they are a non-smoker, they get a lower premium, and if they even quit smoking, Safeway pays for the cessation products. To be fair, that is in the bill. Senator CARPER and I got that in the Finance Committee. We were able to get that amendment drafted.

The problem is, that is a tiny part of this bill. That should be a major focus of the bill. We should be able to buy insurance across State lines. Many of us have supported that—small business health plans, where small businesses can join together and take advantage of purchasing power. We all, on this side, almost everybody on this side of the aisle agrees with medical liability

reform. The Congressional Budget Office said that would save \$100 billion.

The bottom line is, what we have been focused on—and I appreciate the efforts Senator BURR and Senator COBURN made in their bill last year—is trying to address the No. 1 problem we have in health care in the United States, which is costs. This bill does not address costs.

As a matter of fact, you said it in your opening remarks. Total health care costs actually, according to President Obama's CMS, go up \$234 billion if nothing is done. If nothing is done, we actually save money on total health care spending. But with this bill, it actually goes up by \$234 billion.

Mr. COBURN. What we also know from the Congressional Budget Office is that between 9 and 10 million people who today have insurance through their employer will actually lose it. They are going to lose their insurance. That may be good or bad for them. But if you look at the incentives, the subsidy for people who do not get insurance through their employer, if you make \$42,000 a year, today with your health insurance through your employer you get a benefit of about \$5,749 from the tax system. But under this bill, you will be eligible for \$12,500 worth of subsidy.

What do you think an employer is going to do? They are going to look at their employees and they are going to say: I have to pay this penalty if I don't offer this, but it is a significantly smaller amount than what I am paying today. Therefore, I am going to make a decision to no longer offer health insurance, give my employees a small raise because the government is going to come in with \$12,500 worth of subsidies to put them in a "private" plan inside the parameters of what is in the exchange. How many people do you think it is going to shift?

What we are going to get is adverse selection. So the individual—let's say I am working and I am making \$42,000 a year and my employer decides to do that and let's say I am 35 years old and I know available to me is \$12,500. Even though my earnings may go up, I am still 2½ times better off.

I also know I will have to pay \$3,000 or \$4,000 of my own money to get that benefit. I will not cover myself because I know I can cover my little incidentals. If I get sick, they have to cover me in the exchange.

So we are going to see adverse selection in the insurance market, people who are between 40 and 64 who are sick are going to pay far more for their health insurance and people who are sick who are younger than 40 are going to pay far more for their health insurance and everybody who is healthy under 40 is going to say: This is an economic bonanza for me. I am not going to buy insurance.

Mr. ENSIGN. I see our friend from South Carolina has joined us. He has

spoken eloquently about some of the sweetheart deals that have been made in this plan to “buy” votes. Could the Senator from South Carolina address those?

Mr. GRAHAM. I don't know if you could call it a sweetheart deal more than it is just repugnant. The campaign in 2008 was about change we could believe in. I do believe one of the reasons President Obama won is because he convinced young people in this country that if he got to be President, this country was going to change for the better; we were going to do things differently, and that resonated with people.

Quite frankly, when we were in charge, as Republicans, we let people down. We let things get out of control on our watch. Some of our people wound up going to jail. The Iraq war was not popular. So you had this new, young, exciting, articulate figure come along and promise a new way of doing business. That is what hurts so much about this bill. The special deals the Senator just mentioned remind us all why Congress is in such low standing.

The 60th vote—how did they get it? Did they negotiate the 60th vote on C-SPAN in a transparent manner promised in the campaign that we would have negotiations on C-SPAN so that you, the American people, could watch what was being given and what was being taken and there will be no more backroom deals?

Here is what happened. They took one Senator who was the key guy and they put him in a room. We had no access to that room and no Democrat did either. After it is all said and done, here is what resulted from those negotiations that were not on C-SPAN.

Nebraska is going to be the only State in the Union, ladies and gentlemen, that new Medicaid enrollees will be covered by the Federal Government. Every other State in the Union, when you sign up a new person on Medicaid, because you are expanding the number of people eligible for Medicaid, your State is going to have to make a matching contribution.

In my State of South Carolina, with 12 percent unemployment, there is going to be one-half million more people eligible for Medicaid under this bill than exists today. It will cost my State of South Carolina \$1 billion. But if you live in Nebraska, it doesn't cost you a damn dime because that is what it took to get a vote.

If that is change we can believe in, count me out. If that is OK with the American people, I can tell you our best days are behind us. The insurance companies in Nebraska got a deal that no other insurance company in the Nation got. Physician-owned hospitals in Nebraska got a deal that nobody else got. Louisiana got \$300 million to help with their Medicaid problems that nobody else got.

If you want your country to be run in a more businesslike fashion, then you need to speak up. You have a chance between now and sometime in January, when this goes back to the House, to let your voice be heard.

To my good friend from Nevada, the special deals in this bill are not special. They are the same old crap we have been putting up with for decades up here and that people thought was going to come to an end. It is going to hurt your children's ability to have half of what you have because they cannot make it because you are about to pass on a bill to them they cannot pay.

What I hope will happen, I say to my good friend, the Senator from Nevada, is that the people will take their government back. If you think this deal from Nebraska is unacceptable, speak up and speak out and let the House Members know you want it changed.

Mr. BURR. I thank our colleague from South Carolina. I know we are about to run out of time, but I wanted to go back to the Chief Actuary at Medicare because I think the way they analyzed the bill is absolutely essential for the American people to understand what is in it.

The Chief Actuary, the President's Actuary, said:

The Reid bill funds \$930 billion in new spending by relying on Medicare payment cuts which are unlikely to be sustainable on a permanent basis.

It gets to what Dr. COBURN said. By design, maybe this could work, but there is not a will because there is not reform. We have spent a lot of money, and at the end of the day, it looks as if the only thing we have done is tried to address waste, fraud, and abuse. For \$2.3 trillion, it seems as if you could bring more bacon to the table. It seems as if there would be a little more meat.

It seems as if there would be some substance there we could look at and say: Look at the improvements our health care system makes.

I know Dr. COBURN has said many times: If we do this wrong, what we do is we chase innovation out of this country, out of our system, the breakthroughs that go from maintenance to cure, the research on a bench that finds us new ways to address diabetes where amputation and blindness are not in somebody's future. If we go backward, if we chase that innovation out, we lock ourselves into not only the most costly health care but health care that achieves the least amount of quality for future generations.

Mr. ENSIGN. I wish to ask Senator COBURN to address, in the last couple of minutes here—because he has spoken so eloquently about debt and the Congressional Budget Office saying this helps the deficit by some \$100 billion—how the taxes go into effect right away and that the spending doesn't go into effect, and how that kind of smoke and

mirrors happens all the time around here; how they try to hide various expenses, and what this is going to do to our debt.

Mr. COBURN. Well, the disappointing thing—and I have worked on this for 5 years, since I have been here—is we are not honest with the American people about how we account for things, and this bill is another example of that. Let me give you the quantifications.

If you read the CBO report on this bill, they talk about it is highly unlikely we will ever actually make the Medicare cuts, because they have never seen it done, and every time we have said it in the past, we haven't done it, like the sustainable growth rate formula in the Balanced Budget Act of 1997. So if you match up revenues and expenses, what you see is a \$1 trillion tax increase, a \$1 trillion cut in Medicare, and an increasing cost to the economy.

But because there is not the sustainable growth rate—the doctor fix in the bill—that is \$247 billion not accounted for, and that is if you keep physician wages frozen over the next 10 years. That is \$247 billion, probably closer to \$300 billion. So that is \$300 billion. The fact is we know the taxes that are going to be collected, people are going to pull down the cost, which is one of their hopes, and they are going to pay for it out of their pocket.

So we are going to see that insurance plans not reach the Cadillac level, and we are counting on revenues from that in terms of billions and billions of dollars. But what they will do is change the deductibles—and that is a hidden tax. Because if your deductible goes up to keep your insurance from going too high, your tax goes up in actual expenditures. So your ability to invest and create additional jobs—in other words, it cascades. The honest accounting for this is that there is no way this saves any money. It will cost money.

The final point I will make is they won't put forward the cuts in Medicare that they are claiming in this bill. Because they know if they truly do put forth the cuts, and patients feel it, they won't be back here. So it won't happen.

I will go back to what Senator BURR started this out with. If you are going to start tomorrow and fix health care, what would you do? You would attack costs. Why are things so costly? One is because there is no transparency in markets. There is no real connectedness to your pocket. No. 3, there is no incentive for prevention of chronic disease or the management of it. In other words, we don't pay people to have less expensive outcomes. We won't incentivize better care in that way. We won't incentivize prevention.

We have done a lot of this on Medicare—and I will talk about it tomorrow—but they have three different

agencies within this bill that are going to ration care. They are going to make the decisions for you, and not just on Medicare and Medicaid. Everybody needs to understand that. It doesn't just apply to Medicare and Medicaid, it applies to your choice of your private insurance. The government is going to ration your care.

We know that is true because they wouldn't allow an amendment to prohibit rationing. They all voted against the amendments in committees when we offered amendments to limit rationing. So we know the intention is to ration care. If that is how we are going to control costs, then Bernie Sanders is right—go to a single-payer, government-run system. Bernie Sanders' system is far better than this one—far better than this one—if that is what we are going to do. If we are going to ration care, let everybody know it upfront. Let's be absolutely honest about it.

If you are 75 years of age and need a hip replacement but the quality of your life is not all that great, we are going to say you can't have it. That is what we are going to do, because that is exactly what they do in England. They have the National Institute of Comparative Effectiveness which makes an evaluation of what your worth is. And no matter what your history, no matter what your family situation, no matter your income, you can't have it.

Canada is getting around that, because they have said you get the right to buy what you want. Their Supreme Court ruled on that 2½ years ago. So we are seeing a two-tiered system developing in Canada, which ultimately will happen in this country—worse than what we have today.

Mr. ENSIGN. If the Senator will yield, though, if America does this with our health care system, where will the Canadians come for their health care when they need it? When they get it rationed up there, they usually come to the United States.

Mr. COBURN. They will go to Thailand or India.

Mr. ENSIGN. But where will Americans go?

Mr. COBURN. I thank the Senator for holding this colloquy, and I will make one final point before I stop.

I don't doubt the motivation of our colleagues on the other side of the aisle. They want us to fix this problem—the problem in health care. But the problem is cost. If you don't fix cost, and you expand the same broken system, you haven't fixed anything. You have added to the cost.

Mr. BURR. I thank the good doctor, and I thank the Presiding Officer, and I yield the floor.

The PRESIDING OFFICER (Mr. MERKLEY). The Senator from New Jersey is recognized.

Mr. MENENDEZ. Mr. President, I rise to speak to the great debate we are

having on historic health care reform, and I am reminded of the words of a great Republican, President Abraham Lincoln. He said:

We cannot escape history. The fiery trial through which we pass will light us down in honor or dishonor of the latest generation. The occasion is piled high with difficulty and we must rise with the occasion.

That is what Abraham Lincoln said. It is time to rise to the occasion because our friends on the other side of the aisle have chosen to sit on their hands and do nothing. They have no plan. They have chosen to delay and obfuscate.

If you look back in history, during the great debates on Social Security in 1935 and Medicare in 1965, our friends across the aisle were on the wrong side of history. But in the end, there was a minority that chose to stand up for historic social legislation and vote their conscience. They were not driven by the far rightwing of their party or by radio talk show hosts who demand ideological purity and see any attempt to support health care reform as an abandonment of principle.

Each of us is rarely called to act on such significant legislation, and when we are, it is our solemn duty to put aside our ideology—turn off Rush Limbaugh—and leave politics in the cloakroom. Our vote on this groundbreaking legislation—comparable to Social Security and Medicare—will be one of the most significant votes in American history. It should not be driven by the hope of failure that the other side prays for, rather by the will to succeed for the American people. This Congress will be remembered for this vote for generations to come, and our friends across the aisle will once again be on the wrong side of history.

We have heard the same tired arguments over and over. We heard those arguments in 1935 against Social Security. We heard them again in 1965 against Medicare—the same arguments we hear today. History has a way of repeating itself. If past is prologue, historic health care reform legislation will be signed into law despite the naysayers, the fearmongers, the panders to those who see any attempt at compromise as defeat.

To our friends on the other side, this is no longer about legislating, it is simply about obstructing. It is no longer about doing what is right for the American people but about stopping us from doing anything. It is not about finding common ground but drawing lines in the sand.

My friends on the other side have set up an army of straw men, as they did on Social Security and Medicare, manipulating the facts to create the illusion of refuting the false claims they created in an attempt to score political points.

They stand up the socialist straw man, call the bill a government take-

over of health care, and make Americans fear it. Well, we say: Let's make sure the Bernie Madoffs of the world, and people like him, are not selling health insurance.

They wave the flag, stand up the un-American straw man, saying the bill is against old-fashioned American values and denounce it. We say: Don't you dare question our patriotism. Do not dare question our commitment to doing what is right for the American people.

They stand up the death panel straw man, claiming the legislation would kill grandma, and denounce it as inhumane. We say: Stop the outrageous misinformation and tell the truth to the American people.

They stand up the taxing straw man, and say health care reform will increase taxes. We say: We are making health care entities, such as insurance companies, pay their fair share.

They set up the spending straw man, and say the bill will indebt the next generation, despite Congressional Budget Office estimates to the contrary. We say: You can't pick and choose when to believe the Congressional Budget Office and stand by their numbers only when it is convenient to your cause.

For instance, my friend Senator GREGG, the ranking member on the Budget Committee, touts CBO numbers even on his specific bill, when they benefit his arguments, for example, on malpractice provisions. But now my friends on the other side conveniently dismiss the Congressional Budget Office numbers showing our health care plan reduces the deficit. So you can't have it both ways.

They bring along their partisan straw man, accusing us of drafting a bill or having votes in the middle of the night. We say: How quickly you forget the 4 months that we waited for Republicans in the bipartisan Gang of 6, three Democratic Members, three Republican Members, working, supposedly, to achieve a bipartisan effort in health care reform. Four months. Four months we waited for them to work with us in a constructive way, and then they all walked away. So don't come back now and say you had no input in the process when you chose that course.

And, by the way, these votes that take place at the time they take place are because the Republicans insist on stopping the process and delaying it and drawing it out. So under the procedures, once we start the process to finish that delay, it ends up at certain hours—30 hours each time from the moment we file a motion to say that is enough of the delay, let us move forward. Whenever those 30 hours end, that is when we have to have the vote. But they could consent to have that vote in the fullness of the day and light. But no, they want to have the

vote as late as possible, hoping that 60 Members who want to see progress on this reform don't come to this Chamber and, therefore, cannot stop the filibuster. They want failure, and then they clamor about the time these votes take place.

Straw man after straw man. They have done nothing but block this legislation, as they have throughout the year on other legislation. They will do anything, say anything to delay, deny, and defeat health care reform.

They are on the wrong side of history now, as they were in 1935 and 1965. But the difference between 1935 and Social Security and 1965 and Medicare and today is that when the debates ended in 1935 and 1965, when the legislation was weighed on its merits, there were those few Republicans who voted their conscience, those who did not march in lockstep to the demands of rightwing talk show hosts or in fear of tea party anarchists.

In 1935 and 1965, there were a few on the other side, a few who voted for Social Security and Medicare because they knew it was right for America. But in 2009 it appears there will be no votes for health care reform—not one, not a single vote from the other side of the aisle.

The ideological differences were as intense then as they are now but pure obstinate ideology did not prevail then as it will in this Chamber when we vote. Before Social Security was debated, President Roosevelt laid out the changes in society and the reasons why we needed Social Security legislation before the Congress. He said then:

Security was attained in the early days through the interdependence of members of families upon each other and of the families within a small community upon each other.

The complexities of great communities and of organized industry make less real the simple means of security. Therefore, we are compelled to employ the active interests of the nation as a whole, through government, in order to encourage a greater security for each individual who composes it.

That is what he said about Social Security. That is why we needed Social Security and why we realize today that without Social Security more than half of our seniors in this country would be living in poverty—more than half—if the voices then in opposition had succeeded.

Then the debate began. There is no mention of death panels but there were those Republicans who raised similar straw men to the voices we hear today. A member of the New York delegation, a Republican, Daniel Reed said:

The lash of the dictator will be felt, and 25 million Americans will for the first time submit themselves to a fingerprint test.

Another said:

The bill . . . invites the entrance into the political field of a power so vast, so powerful as to threaten the integrity of our institutions and pull the pillars of the temple down upon the heads of our descendants.

John Taber, another member of the New York delegation, a Republican, raised the antibusiness straw man, saying:

Never in the history of the world has any measure been brought here so insidiously designed as to prevent business recovery, to enslave workers.

In this Chamber, in the Senate, Senator Daniel Hastings of Delaware, a Republican, raised the death-of-a-nation straw man, saying that Social Security would “end the progress of a great country.”

In this debate we have seen the same army of straw men standing against us. They have claimed that health care reform is a government takeover that will threaten the integrity of our institutions, when in fact we create an exchange of private insurance companies that people will be able to pursue.

They say it will “pull down the pillars of the temple on our descendants” and leave them in debt, that it will drive private health insurers out of business and put a bureaucrat between doctors and patients.

We already have bureaucrats between doctors and patients. They are health insurance company bureaucrats between doctors and patients. The difference is when the debate ended on Social Security in 1935, when the shouts of socialism and un-Americanism had faded, a few, a minority on the other side, had the political courage to cross the line and vote yes.

But there will not be a single vote from the Republicans in favor of this bill, not a single vote. Our colleagues on the other side want nothing more than to stop this bill, period, pure and simple. It is their intention to stand en bloc for insurance companies and against any health reform that would protect American families from losing everything if they get sick. Their plan is just to say no; and once again they will squarely be on the wrong side of history.

When President Kennedy and later Lyndon Johnson fought for Medicare, those on the other side raised the same army of straw men they raised 30 years earlier. They played the same game they are playing again now. Senator Curtis of Nebraska at that time voiced opposition in this Chamber saying, “Medicare is not needed.” He was a Republican Senator of the time, Mr. Curtis of Nebraska, who said:

[Medicare] is not needed. It is socialism. It moves the country in a direction which is not good for anyone, whether they be young or old. It charts a course from which there will be no turning back. It is not only socialism, it is brazen socialism.

In the other body, Congressman Hall of Missouri called it “an ill-conceived adventure in government medicine.”

Those were the Republican voices of the past on Medicare. What senior in this country today—which one of our parents or grandparents—believes

those words of the past as they relate to their health care today? More straw men, more fear, more naysaying—all of it wrong then, all of it wrong now.

They said bureaucrats would come between doctors and patients. They are wrong. That is why it is interesting to see that today the American Medical Association, the Nation's doctors—the people who take care of you when you are ill, the ones who follow your progress when you have, maybe, a debilitating disease or a lifetime health challenge, your doctor, the voice of your doctor, not any Members of the Senate, the voice of your doctor in support of this historic reform—said:

This is a time of great opportunity for the American health care system. We have the chance to substantially expand health insurance coverage, implement insurance market reforms that promote greater choice, affordability and security, improve [this is the doctors speaking] the quality of the care and help Americans live longer, healthier, happier and more productive lives. To that end [the doctors of the nation say] we urge all Senators to support passage of the Patient Protection and Affordable Care Act as amended.

This is the Nation's doctors. This is your doctor who is telling the Members of the Senate: Vote for it. They do not believe the line that bureaucrats are going to come between doctors and patients. They are wrong, those who are saying that.

They called Medicare unpatriotic and un-American. They were wrong again. They said it would mean the rationing of health care. They were wrong. They made the same argument they have been making for 74 years, and they are still wrong.

In 1965, the champion of my conservative friends, Ronald Reagan, issued a 19-minute-long LP, for those of us who still remember that, a long-playing vinyl recording at the time. It is past—gone. They are like antiques now. But it was entitled “Ronald Reagan Speaks Out Against Socialized Medicine.”

It featured an impassioned 2,000-word speech intended to get people to write to their Congressman against the idea of Medicare that was beginning to make its way through the Congress. That was 1965. It was referred to as Operation Coffee Cup, something of a precursor to today's tea parties. In his record message, Ronald Reagan said:

One of the traditional methods of imposing socialism on people has been by way of medicine. . . .

Does it sound familiar, in the year 2009, in the debates we have heard here on the floor? When he became President, one of the pillars of his health policy was cutting benefits, in particular through increased cost sharing for Medicare and Medicaid recipients. He was wrong then, just as our conservative friends are wrong now.

In the face of yet another landmark piece of legislation, is it possible there is not one of my friends on the other

side who does not in their heart believe we need to pass this legislation for the good of the American people, regardless of ideology? Is there not one of my friends on the other side who will vote yes to help Americans who have lost their jobs and their health care and stand to lose everything if they or a member of their family becomes ill?

My friends, saying no to accessible, affordable health care for the American people is too big a price to pay for ideological purity. When I think of what this legislation will do, I cannot believe there will not be one vote on the other side to provide competition and affordable choices for every American, as this bill does; not one vote for greater accountability for health insurance companies; not a vote for more choice and competition for consumers, for programs that will rein in health costs and make policies more affordable.

Is this bill perfect? No. But it is a great and historic foundation of reform. Yet there will not be one vote on the other side to improve access to quality care for children, as this bill provides for, and the most vulnerable among us, which the bill does. Not a single vote for tougher accountability policies, for health insurance companies that are included in this legislation? Not one vote to require insurers to spend more of the premium revenues on health care rather than on administrative costs, executive compensation, and boosting the bottom line? Not a vote to hold health insurers accountable for excessive rate increases? Not a single vote on the other side to immediately ban insurance companies from denying children—we hear a lot about the sanctity of life—coverage for a pre-existing condition? Not one vote for expanding eligibility for tax credits for small businesses and starting the health insurance tax credit next year? That is why it is interesting to note that among the many supporters of this, the Business Roundtable, they are quoted as saying:

The proposed legislation is a step towards our shared goal of providing high quality, affordable health care for all Americans.

It is why the Small Business Majority says the managers' amendment, Senator REID's amendment, "includes new provisions essential for small business protection and survival." That is the voice of business.

Not one vote for a bill that promotes competition for insurers and choice for workers? Or to test alternatives to civil tort legislation that emphasize patient safety, disclosure of health care errors, and resolutions of disputes? Not one vote.

Not one vote for people in my home State of New Jersey and every State who will see direct and immediate benefits from this legislation? Not a vote for every uninsured Jerseyan who has a preexisting condition and has been un-

able to find affordable health insurance in the marketplace? The health of our families is not a commodity. It is not a privilege for the wealthy. It is something everyone should be able to be protected from without going broke.

Under this legislation, 1.3 million seniors in my home State will be eligible for free preventive care for recommended services. Seniors will also be eligible for free annual wellness visits to their doctors, and will be provided with a personalized prevention plan so they can stay healthy.

When this legislation is signed, we will have lived up to our promise to fill the doughnut hole, that gap in coverage under Medicare Part D, to provide affordable prescription drugs to over 227,000 seniors in New Jersey and millions across the country so they will no longer have to choose between paying their bills and taking the medication.

When this legislation is signed, over 850,000 New Jerseyans will qualify for tax credits to help them pay for health insurance, easing the burdens, premiums, deductibles, and copayments. It will make tax credits for up to 50 percent of health care premiums available to over 100,000 small businesses in New Jersey. It will also put an end to the hidden tax that is passed along to everyone in my State through increased premiums and costs to pay for the over \$1 billion spent on uncompensated care in New Jersey.

This legislation includes a health insurance exchange that would provide portability, security, and choice for 1.3 million New Jersey residents who presently do not have any health insurance whatsoever. It will increase the number of doctors, nurses, and dentists for the 150,000 New Jerseyans, 2 percent of the population who live in areas where they do not have access to primary care because of a shortage of health care providers in their communities, yet there will not be one single vote for this legislation on the other side, not a single vote for any of these health reforms to help hard-working families in my State and in States across the country.

This is the politics of no, pure and simple. I suppose it is nice to say no to health care reform when you have the full protection of health care yourself. But it is wrong to say you are unwilling to afford the same protections to others. It is nice to say no to health care reform when you and your family will not be denied coverage because of the privileged position you hold but wrong to let even one mother, one father hear that their child has been denied the medical treatment they desperately need.

I say to my friends, how dare you stand in unison on the other side of the aisle and deny to others that which you so fully enjoy yourselves. How can you deny to others that which you so fully

enjoy yourselves. It is inconceivable to me that when all is said and done, when our differences have been aired and debate has ended, that not one of my colleagues on the other side will see the historic nature of this legislation. We can be proud of this legislation. I know when the dust settles and the provisions of the bill become clear, America will be proud of it as well.

This landmark reform legislation includes State-based insurance exchanges, creating a fair, open, competitive marketplace for affordable coverage. It includes an amendment I proposed for long overdue consumer protections for emergency services. When you are getting sent to a hospital, you are not thinking about calling your company and saying: Is this the right hospital? Am I going to be covered without regard to prior authorization?

It requires insurance plans to provide behavioral health treatments, such as those for children who are autistic, as part of the minimum benefits standard. It encourages investments in new therapy to prevent, diagnose, and treat acute and chronic disease with a tax credit for innovative biotechnology research. It ensures that minor children qualify as exchange-eligible and provides for the availability of child-only health insurance coverage in the exchanges. It stops insurance companies from denying coverage for preexisting conditions, health status, or gender, and it ends the medical benefits shell game that insurers have played with people's lives.

The bottom line is this legislation helps New Jersey and America. It is fair, balanced, and fixes a badly broken system. It is truly a historic piece of legislation and will be remembered as such. Yet every one of my colleagues on the other side will vote no. They will stand against all of it, all I have talked about, firmly, once again, on the wrong side of history.

Let me conclude by saying, as I have said before, and I will say again, history calls on us to stand up on rare occasions for what is fair and just and right for the American people. This is one of those occasions. This is a time to look into your heart, a time to see beyond your own political interests, your own hard ideology, and look at the lives of millions of Americans. Think about the millions of families on Main Street, in every community, where a child wakes up in the middle of the night to a parent who cannot afford to get them the basic care they need. Ask yourself: What is the right thing to do?

This is a time to do what is right for America. It requires more than parliamentary maneuvers to slow the process. It requires more than shrill voices raised under the banner of free market values at the expense of fundamental human values. It requires doing what is right for the millions of American families who have lost their jobs

and their health care, those who have suffered from the economic policies of the last 8 years and now find themselves hurting. This is a time to remember them, a time to remember every mother who cries herself to sleep at night because she lost her job, lost her health care for herself and her infant and could lose everything she struggled for in her life, if she gets sick.

I say again to my friends, how dare you deny to her the protections that you so fully enjoy yourself. How dare you turn this into a parliamentary game of delay, deny, and defeat. Those who have continuously said no to any attempt at health care reform and yes to the needs of the insurance industry believe that the business of government is business. But for all of us who know the business of government, what it really is, it is about people. It is about those who send us here. It is their lives, their hopes, their dreams for a better life for themselves and their families. This is an opportunity to stand up for them. This is an opportunity to take care of their health care. This is an opportunity to show whose side you are on.

Are you on the side of those families or are you on the side of the special interests that would have you vote no, or the ideological interests that would have you vote no against these families? This is historic legislation. I am afraid our friends on the other side will once again, as they did in Social Security and Medicare, find themselves on the wrong side of history.

I intend to be on the right side of history and to vote yes on this legislation.

I yield the floor.

Mr. JOHNSON. Mr. President, I wish today to recognize the progress made on health care reform, as well as stress the fact that we must press forward. Americans face out-of-control health care costs, great inequalities in access to care, eroding benefits, and the ever-increasing threat of losing their health insurance. While it has not been an easy task to reach a consensus, we find ourselves very close to fixing our health care system and extending access to health insurance to over 31 million Americans.

I have heard from countless South Dakotans whose stories illustrate the urgent need for reform. Just as the diseases and health care emergencies they face cannot be postponed, it is imperative we forge ahead and deliver reforms that will improve their health and security.

I would like to share the story of Susan from Rapid City, SD, a 57-year-old woman who has nearly depleted her savings and plans to sell her home in order to pay her bills and medical expenses. Her husband passed away several years ago and she now survives on his modest pension. After exhausting COBRA health insurance, she bought

the only private health insurance policy she could afford. She was forced to accept several riders for her pre-existing conditions, arthritis and hay fever, so her insurance "won't cover the problems that will soon need attention." She also has to pay out-of-pocket for most her preventative screenings and primary care because she has not reached her \$5,000 deductible. She writes, "I feel I am paying \$250 a month for unreliable health insurance." Until she reaches Medicare age or can qualify for Medicaid, her only option is to sell down her assets to pay the bills.

Like millions of Americans, Susan is vulnerable in the non-group health insurance market, where coverage is often expensive, inadequate and certainly not guaranteed. "Without the security of group coverage," she notes, "I am very vulnerable and am one illness away from a catastrophe." Several provisions in the Patient Protection and Affordable Care Act will help Americans like Susan gain access to quality, affordable health insurance.

Under the Senate reform bill, all health insurers will be prohibited from using preexisting conditions to deny health care and it will be illegal for them to drop coverage when illness strikes. Health insurance exchanges will create an accessible marketplace for Americans to shop for the best plan to meet their needs. Health insurers will offer national plans to all Americans under the supervision of the Office of Personnel Management, the same entity that oversees health plans for Members of Congress. Tax credits will be available to make insurance more affordable for those who need assistance, and the choice of doctor will be protected. These health insurance market reforms demand greater accountability from insurance companies while creating more choice and competition for consumers.

Despite a commitment by some to kill reform and defend the status quo, I am confident the strong consensus on the urgent need for reform will prevail. The cost of inaction is too great.

Mr. LEVIN. Mr. President, the health insurance provider annual fee in the so-called merged Senate health care reform bill did not distinguish between nonprofits and for-profit insurance companies in this country, although our current tax law properly does make the distinction.

I urged that the managers' package modify the fee to continue to recognize the distinction.

Imposing the annual fee on true nonprofits, particularly those with high pay-out rates to beneficiaries, would have pushed many of those true nonprofits into deep financial difficulties and would have caused significant hardships on the families who rely on their services.

Some nonprofit insurers have not maximized the amount they pay out in

medical expenses to beneficiaries. That is why I urged the managers to include in the managers' package a provision exempting from the tax only those nonprofits with very high payout rates. Those good performers are committed to their policyholders rather than to profits for stockholders, which is the goal of the for-profits. Those good performing nonprofits are unable, as a result, to absorb the fees.

The managers' amendment specifies two ways for nonprofits to be exempt from the fee.

The first way for a nonprofit insurer to be exempt from the fee: one, it can not refuse to insure anyone in the State and is the State's insurer of last resort; two, its premium prices are regulated by its State insurance regulator; and three, it must pay out in medical expenses 100 percent or more of its premium revenues in the individual market.

The second way for a nonprofit to be exempt: the nonprofit insurer must pay out a very high percentage of its premium dollars—at least 90 percent—in medical expenses in each of the three major market segments: individual market, small group market, and the large group market; and it also must have an even higher overall payout rate of at least 92 percent. A nonprofit that compresses its margins that far beyond its peers for the benefit of its policyholders also warrants the exemption.

These exemptions continue the distinction that our tax law has recognized—that true nonprofit insurance providers should not be treated the same as their for-profit counterparts.

Mr. LEAHY. Mr. President, after months of arduous work, the Senate will finally take the first significant step toward bringing needed reforms to health care in this Nation. Opponents of reform have wasted much of the public's time by provoking arguments over their distortions about what health reform means. Opponents have tried to demonize the plan, and have claimed it will never work. We have overcome weeks of delay tactics employed by the minority—inexplicably, the most recent delay due to a filibuster against a bill to provide funding for our troops. These are the tactics of obstruction, and further demonstrate Republicans' efforts to maintain the status quo.

Is this the exact bill that any one of us would have written? Probably not. I remain disappointed that the managers' amendment before us today strips the bill of a public insurance option to compete with private plans and does not include a provision I have sponsored to repeal the antitrust exemption for health insurers and medical malpractice insurers. I believe both of these provisions would go far in providing fair competition into the health insurance market.

But in looking at this bill as a whole, I believe it stands by the core principles I sought at the beginning of this debate. It gives Americans affordable access to health care coverage, it reduces costs for families, businesses and government, and it protects consumers' ability to choose doctors, hospitals and insurance plans.

The managers' amendment introduced by the majority leader incorporates many important changes to the underlying legislation that will improve the bill. It includes several provisions that I have long supported and promoted.

Vermont has always been a national leader in expanding access to health insurance. In coordinating care, offering comprehensive coverage to children, and developing a system of electronic health records, Vermont has been at the forefront of reform. It is no surprise that for the third year in a row Vermont has been ranked the healthiest State in the Nation.

Unfortunately, a provision included in the underlying bill to expand Medicaid coverage nationwide threatened to penalize Vermont by excluding the State from increased Federal funding, solely because Vermont acted early to do the right thing. We can all share the goal of increasing access to essential medical services by expanding Medicaid coverage nationwide, but we should not penalize States such as Vermont, which demonstrated the initiative to expand its Medicaid Program early.

Senator REID's amendment, however, remedies the anomaly in the underlying bill, and will allow Vermont to access additional Federal funding when the Medicaid expansion goes into effect. I thank Senators REID and BAUCUS for working with me to ensure that Vermont's efforts to expand coverage to low income individuals is not set back by inequities in the underlying legislation.

The managers' amendment also incorporates a vital antifraud amendment Senator KAUFMAN and I, as well as Senators SPECTER, KOHL, SCHUMER, and KLOBUCHAR, introduced, derived from the Health Care Fraud Enforcement Act which we introduced earlier this fall.

This antifraud initiative builds on the impressive steps the administration has already taken to step up health care fraud prevention and enforcement, and on the real progress represented by the antifraud provisions adopted by the Finance and HELP Committees and incorporated into the leader's health care reform bill. I was glad to contribute to those efforts, and I am glad we are now going even further.

The Kaufman-Leahy provision will provide prosecutors with needed tools for the effective investigation, prosecution, and punishment of health care

fraud. By making modest but important changes to the law, it ensures that those who drain our health care system of billions of dollars each year, driving up costs and risking patient lives, will go to jail, and that their fraudulent gains will be returned to American taxpayers and health care beneficiaries.

For more than three decades, I have fought in Congress to combat fraud and protect taxpayer dollars. This spring, I introduced with Senator GRASSLEY and Senator KAUFMAN the Fraud Enforcement and Recovery Act, the most significant antifraud legislation in more than a decade. When that legislation was enacted, it provided law enforcement with new tools to detect and prosecute financial and mortgage fraud. Now, as health care reform moves through the Senate, I am glad we are taking steps to do all we can to tackle the fraud that has contributed greatly to the skyrocketing cost of health care.

The scale of health care fraud in America today is staggering. According to even the most conservative estimates, at least 3 percent of the funds spent on health care are lost to fraud—more than \$60 billion a year. In the Medicare Program alone, the General Accountability Office estimates that more than \$10 billion was lost to fraud just last year. While Medicare and Medicaid fraud is significant, it is important to remember that health care fraud does not occur solely in the public sector. Private health insurers also see billions of dollars lost to fraud. That fraud is often harder for the government to track. Private companies have less incentive to report it, and in some cases, are responsible for the fraudulent practices themselves. Reining in private sector fraud must be a part of any comprehensive health care reform.

The Kaufman-Leahy provision makes a number of straightforward, important improvements to existing statutes to strengthen prosecutors' ability to combat health care fraud. The bill would increase the Federal sentencing guidelines for health care fraud offenses. Despite the enormous losses in many health care fraud cases, offenders often receive shorter sentences than other white-collar criminals. This lower risk is one reason criminals are drawn to health care fraud. By increasing the Federal sentencing guidelines for health care fraud offenses, we send a clear message that those who steal from the Nation's health care system will face swift prosecution and substantial punishment.

The provision provides for a number of statutory changes to strengthen fraud enforcement. For example, it would expand the definition of a "Federal health care fraud offense" to include violations of the antikickback statute and several other key health care-related criminal statutes, which

will allow for more vigorous enforcement of those offenses, including making their proceeds subject to criminal forfeiture. It also clarifies the intent requirement of another key health care fraud statute in order to facilitate effective, fair, and vigorous enforcement.

The managers' amendment also includes our provision amending the antikickback statute to ensure that all claims resulting from illegal kickbacks are considered false claims for the purpose of civil action under the False Claims Act, even when the claims are not submitted directly by the wrongdoers themselves. All too often, health care providers secure business by paying illegal kickbacks, which needlessly increases health care risks and costs. This change will help ensure that the government is able to recoup from wrongdoers the losses resulting from these kickbacks.

The Kaufman-Leahy measure gives the Department of Justice limited subpoena authority for civil rights investigations conducted pursuant to the Civil Rights for Institutionalized Persons Act. This provision allows the government to more effectively investigate conditions in publicly operated institutions, such as nursing homes, mental health institutions, and residential schools for children with disabilities, where there have been allegations of civil rights violations.

These changes will strengthen our ability to crack down on fraud and will ultimately result in significant savings that will make health care more efficient and more affordable.

I am also pleased Senator REID's amendment includes a key reform to the False Claims Act that Senator SANDERS, Senator GRASSLEY, and I have proposed. By fixing the False Claims Act's public disclosure provision, we can ensure that we fairly and appropriately empower whistleblowers to come forward to expose fraud, which is a crucial way to save the government money and ensure the health and well-being of Americans.

We all agree that reducing the cost of health care for American citizens is a critical goal of health care reform. We in Congress must do our part by ensuring that, when we pass a health care reform bill, it includes all the tools and resources needed to crack down on the scourge of health care fraud. This provision is an important part of that effort.

I am also very encouraged that the amendment before us includes a measure I proposed with Senator BROWN to expand Federal Tort Claims Act medical malpractice coverage for free medical clinics. This expanded coverage will help free clinics across the Nation continue to provide and improve a critical safety net for many Americans.

In 1996, Congress enacted legislation to cover volunteer medical professionals in free clinics with medical

malpractice liability insurance through the Federal Tort Claims Act. This coverage protects volunteer medical staff against liability by substituting the Federal Government for an individual defendant. But without any explanation in the legislative history, the coverage enacted in 1996 failed to provide coverage for others who are essential to the operation of free clinics, such as nonmedical staff, contractors, board members, and the clinic itself. As a result, free clinics must use scarce funding to purchase insurance on the private market to fill this gap. This lack of comprehensive coverage for free clinics is inconsistent with the coverage provided to community health centers, which benefit from coverage for all employees. This provision will remedy this discrepancy.

This measure will have no impact on the legal rights of a patient injured by a medical error; any victim of medical malpractice will still be able to pursue a remedy for an injury under the Federal Tort Claims Act. Instead, this amendment will free up scarce resources that are currently being used to purchase liability insurance on the private market. Informal estimates indicate that this amendment could save free clinics across the country \$15 to \$20 million a year. These are funds that will be redirected to providing essential medical services to low-income and other Americans in need. For example, as a result of this amendment, the Viola Startzman Free Clinic in Wooster, OH, will save \$17,000 a year. The Americares Clinic in Stamford, CT, will save \$31,000 each year. Our hard-working free clinics in Vermont will save \$12,000 each year and will be able to put those savings toward helping Vermonters in need of health care services. For free clinics operating through volunteerism and private donations and in a difficult economy, these are substantial sums that if devoted to the care of Americans in need will have a significant positive impact.

And the savings realized through this amendment will cost the taxpayers little if anything. Free clinics do not perform high-risk procedures such as obstetrics or surgeries, and thus are subject to a lesser risk of liability. Since 2004, when funds were first appropriated and set aside to cover any claims against free clinic doctors, no claims have been filed. The bottom line is that this amendment represents significant value to Americans in need of health care services at little cost to the government and the taxpayer.

I thank Senator BROWN for his support as a cosponsor, and I thank the majority leader, Senator HARKIN, and Senator BAUCUS for working with me to make this amendment part of the historic legislation before the Senate.

Over the course of the past month, I have listened to many of my friends on the other side of the aisle. It is not sur-

prising that frequently they have argued for one of their pet proposals—medical malpractice reform. For as long as I have served in this Chamber, I have fought against court-stripping measures that limit American's access to their justice system. I have also fought to protect the sovereignty of States to make rules for their own justice systems. Medical malpractice claims are based on State law and for the most part take place in State courts. I find it curious that some of the same Senators who pledge loyalty to federalism and the sovereignty of the States under the tenth amendment are some of the same Senators who are so aggressively pushing for a Federal "one-size-fits-all solution" for the justice systems in our 50 States.

The managers' amendment includes a provision addressing malpractice liability that has been introduced on a bipartisan basis several times over the past few years. I support this provision because it respects the States' primary role in adjudicating the claims of patients injured or killed by medical errors. I also support this provision because it resists the notion that "one-size-fits-all" when it comes to litigation issues and it includes the necessary safeguards for patients. I note for the RECORD that several States' efforts to reform medical malpractice liability have been struck down as unconstitutional. For example, Alabama, Florida, Georgia, Illinois, Kansas, New Hampshire, Ohio, Oregon, South Dakota, Washington, and Wisconsin have all enacted caps on damages associated with medical malpractice claims. And all of those State laws were struck down as unconstitutional for good reason. I am heartened that no such amendment was seriously considered in this Chamber because such arcane measures hurt our children, our senior citizens, and stay-at-home moms. The Wall Street Journal has reported on this clear fact when it pointed out that these caps deprive these groups of access to justice. If we create Federal caps on their ability to recover from serious injuries we are telling them that they are worth less because they are retired or they choose to stay home and raise a family or are young children. This is not fair. I know that no doctor wants to harm a patient, but the solution is not to take away the rights of patients who are seriously injured.

The provision in the managers' amendment does not encourage draconian damages caps and does not dictate what reforms States must consider. Importantly, however, it does include specific patient protections that must be in place before a State can receive a grant for liability reform measures. To the extent that States can pass measures that improve patient safety as well as expedite damages recovery for victims, those reforms will truly improve our health care system.

I am disappointed, however, that the Health Insurance Antitrust Enforcement Act, which I introduced in September, was not part of the managers' amendment, and will not be part of the Senate's health reform legislation. That legislation would repeal the antitrust exemption for health insurers and medical malpractice insurers, and is an integral part of injecting competition into the health insurance market.

While there are differing views on the best way to inject competition into the health insurance market, we can all agree that health and medical malpractice insurers should not be allowed to engage in blatantly anticompetitive practices, such as colluding to set prices and allocating markets. My repeal would ensure that basic rules of fair competition will apply to insurers, and is nonpartisan.

My amendment was cosponsored by 23 Senators, and has support from a cross-section of consumer rights organization. I look forward to working to include this repeal when the Senate and House conference to reconcile their versions of the legislation.

The managers' amendment will improve the underlying bill, and I hope my fellow Senators will support its passage so we can move toward final passage of the bill. Each day that passes without reform, 30 more Vermonters lose their health insurance. We know our current health system is unsustainable. That threatens not only our health security, but also our economic security. Doing nothing has been seen as an option before, but it simply is not an option now.

I hope now we can work together to pass a bill that will give millions more Americans access to quality, affordable health care. We should reject the tactics of delay and the efforts to obstruct, and remember that the Senate should be the conscience of the Nation. With the Christmas season upon us, our constituents are looking to us to do the right thing. We should adopt this amendment, advance this legislation, and work to send it to the President without undue delay.

Mr. GRASSLEY. Mr. President, one longstanding priority of mine has been to improve Medicare payments for hospitals known as tweekers. They tend to have too many beds, so they can't qualify as critical access hospitals, but they do not have sufficient volume to operate viably under Medicare's prospective payment systems. There are a number of these tweeker hospitals in Iowa.

Working closely with the Iowa Hospital Association and individual Iowa hospitals over the years, I introduced, last Congress, the Rural Hospital Assistance Act of 2008, S. 3300, which would improve the low-volume adjustment for hospitals under Medicare's hospital inpatient prospective payment

system. This improvement would enable twener hospitals to benefit from this adjustment.

In fact, the low volume adjustment provision in the Finance Committee's health reform bill, S. 1796, and the Reid substitute to H.R. 3590 is the language that I crafted. This language was crafted with the intention of benefiting all Iowa twener hospitals. I was assured by the Iowa Hospital Association that this language would do so, and they supported it.

Unfortunately, after the Finance Committee markup of S. 1796, I learned from the Iowa Hospital Association that the language they originally supported would not benefit all Iowa twener hospitals. I was informed that several Iowa twener hospitals had Medicare discharges in excess of the maximum in the provision, which was 1,500.

In an attempt to make sure that all Iowa twener hospitals benefit from this provision, I filed an amendment that would increase the maximum number of Medicare discharges from 1,500 to 1,600. This amendment was also offset. My staff was successful in working with the majority staff to include my amendment in the manager's amendment to the Reid substitute.

Mr. INHOFE. Mr. President, on Monday morning at 1 a.m., I voted no on the cloture motion to the latest Reid managers' package, which was only made available Saturday, because I am adamantly opposed to this \$2.5 trillion government-run health care system with its $\frac{1}{2}$ trillion increase in taxes on Americans and nearly $\frac{1}{2}$ trillion in cuts to Medicare to help pay for it. I am opposed to public financing of abortion this bill allows. I am opposed to a façade of health care reform that in no way seriously addresses tort reform and will only increase premiums and the cost of health care for all Americans. I am opposed to the special deals for only certain States in this bill to buy off votes. I am opposed to the special deals for only certain States in this bill to buy off votes. I am opposed to the increased burden of at least \$26 billion on States including Oklahoma mandated under this bill. I am opposed to no serious effort at all to include any amendments from Republicans. Republican amendments to block tax increases, block cuts to Medicare, impose tort reforms, try to impose some kind of discipline on the government take-over of health care in this country, among other amendments and motions have failed by nearly party-line votes. I am opposed to this bill, and most importantly, the American people are opposed to this bill. They know this bill is a complete disaster. The next few votes leading up to the final vote on this package are all procedural votes, and I will be opposed to them all. But all 60 Democrats will vote for them. Democrats do what they are

told. The votes include accepting this new Reid managers' package, cloture on the original Reid substitute, accepting the original Reid substitute, cloture on the underlying bill, and finally the final passage of his colossal mistake. Since I am opposed to each one of these votes, I will not remain in Washington to vote against these procedural maneuvers since that will have the same effect as voting no, and will return to vote against final passage of this bill.

MORNING BUSINESS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business with Senators permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

THE IMPORTANCE OF RENEWING THE BIODIESEL TAX CREDIT

Mr. MCCONNELL. Mr. President, on December 31, 2009, the current biodiesel tax credit will expire. This tax credit increases domestic demand and provides an incentive for U.S. producers to increase investment and output. It is essential in producing biodiesel and allowing it to compete with petroleum diesel. Without the tax credit, petroleum marketers will be unwilling to purchase the more expensive biodiesel, and demand will be heavily reduced.

As all of my colleagues know, the biodiesel tax credit provides a \$1-per-gallon credit for biodiesel made from soybean oil or yellow grease and animal fats. The original version of this tax credit was passed in 2004 and has been extended twice, most recently in October 2008.

As a result, the U.S. biodiesel industry has grown significantly over the past several years, providing not just jobs but also the green jobs this administration and many of my friends on the other side of the aisle have so adamantly supported. However, the combination of volatile commodity prices and weak motor fuel demand caused by the current recession has severely affected the biodiesel industry for the worse and therefore increases our urgency to extend the credit today.

In Kentucky, public school districts, universities, National and State parks, local governments, and the Transportation Cabinet are using biodiesel blends. These institutions and many Kentucky employers, including manufacturers in Kentucky, will be hurt beginning on January 1 if we allow this tax credit to expire. One executive of a biofuel manufacturing facility wrote to me to say:

The \$1-per-gallon tax incentive is truly the difference between the survival and collapse of this important industry. Without this tax incentive, thousands of jobs will be lost with

plants closing down almost immediately after January 1. And the nation will lose a vital link in its effort to reduce our dependence on foreign oil.

As we continue our important business, I implore my colleagues on the other side of the aisle to work to get the extenders finished this year and to include the renewal of the biodiesel tax credit.

LIU XIAOBO

Mr. LEAHY. Mr. President, I want to speak briefly about the indictment and trial by Chinese authorities of Mr. Liu Xiaobo for "incitement of state subversion." The evidence cited in support of the charges were Mr. Liu's essays and association with Charter 08, a framework for democracy, human rights and the rule of law that was made public a year ago this month.

That document was signed by Mr. Liu and some 300 other intellectuals and activists. Thousands more people have since added their names, most of them from inside China. I am told that Charter 08 is widely regarded as the most significant democratic reform movement in China in a decade.

The charges against Mr. Liu are very disappointing. They illustrate how little has improved in China regarding tolerance for freedom of expression. I am informed that the Chinese Government has decided to bring Mr. Liu to trial, that international observers are permitted under Chinese law, and this is consistent with international legal standards on the openness and transparency of legal proceedings. I mention this because I am aware that former Governor of Pennsylvania and U.S. Attorney General Richard Thornburgh has expressed a strong interest in attending the trial as an observer, to show support for Mr. Liu and to convey the concern that he and others around the world have for the larger implications of this case.

The arrest of Mr. Liu demonstrates a continuing, disturbing trend in China. As Governor Thornburgh has written:

in recent years, China's leaders seemed to be tolerating changes in the legal system. The number of private lawyers and law firms has grown exponentially. Lawyers and citizens energetically began pursuing rights in court. A "wei quan," or "rights defense" movement, grew up around lawyers and activists seeking to use the laws on the books, and the institutions allowed by law, to assert and defend human rights without challenging the underpinnings of China's communist system. Such efforts were tolerated at first, and there were even modest signs of greater professionalism in the communist judicial system.

Unfortunately, initial signs of progress have given way to serious setbacks. Many lawyers who take on politically-sensitive cases have been subject to a kind of backdoor disbarment, finding it impossible to renew their licenses. Some lawyers have been the target of surveillance, confined to house arrest, the victims of physical attacks,

raids and confiscation of their property. Law firms and other groups pursuing law in the public interest have been shut down.

Moreover, there has been an alarming increase in the use of "subversion" or state security charges leveled against activists. These cases have become a substitute for the old "counter-revolutionary" crimes. Others convicted on such grounds include Hu Jia, the AIDS activist who also criticized abuses surrounding the staging of the Summer 2008 Olympic Games and Huang Qi, who posted public information on his website about the government's response to the Sichuan earthquake.

Liu's prosecution requires a serious response from the United States. Cooperating with China on other issues like the environment or North Korea does not mean we must silence ourselves when it comes to the rights and freedoms of China's citizens. Indeed, we are unlikely to get meaningful cooperation on any issue when we appear weak in defense of our principles, which as President Obama has said many times—most recently in his speech accepting the Nobel Peace Prize—are universal principles.

I agree, and hope the Chinese authorities reconsider this case, release Mr. Liu, and dismiss the charges against him. There are so many issues on which we want to expand our cooperation with China, but the persecution of courageous Chinese citizens who are guilty of nothing more than exercising rights guaranteed by the Universal Declaration of Human Rights hinders that cooperation and China's own development.

If the charges are not dismissed, and Mr. Liu is brought to trial, his trial should be attended by outside observers including top officials of the U.S. Embassy and Governor Thornburgh. I hope the Department of State and our diplomats in Beijing will assist Governor Thornburgh, including in obtaining a visa and access to the trial. It is important that the Chinese Government, and the Chinese people, know how strongly we deplore what is being done to Mr. Liu, and what it says about the need for China to meet its own commitments to respect internationally recognized human rights.

NATIVE AMERICAN APOLOGY RESOLUTION

Mr. AKAKA. Mr. President, today, I want to speak about a matter of significance to our Nation. As part of the Defense appropriations bill, Congress has enacted an apology to our Native Peoples for the historical wrongs that our Nation has committed against them. I am proud to have served as a cosponsor of the stand-alone apology resolution, S.J. Res 14, and commend Senators BROWNBACK, DORGAN, and INOUE for ensuring this needed apology will be made.

From the beginning, Native peoples welcomed early colonists at Plymouth Rock and in Virginia, and in my home State of Hawaii, the Kingdom of Hawaii extended the aloha spirit to our visitors. During the American Revolution,

the United States entered into military alliances with Indian nations to secure assistance in winning our independence. As a nation, we pledged to respect the rights of Indian nations to self-government, self-determination and territorial integrity.

Our Constitution recognizes native nations as prior sovereigns, with a continuing right to self-government in the Indian commerce, apportionment, treaty and supremacy clauses. The United States entered into 370 treaties with Indian nations and treaties of peace, friendship and commerce with the Kingdom of Hawaii. In many ways, the United States broke these treaties and engaged in acts of war against our Native peoples, taking lands by force, displacing Native peoples and leaving them in poverty and suffering. At times, the United States informed indigenous, Native peoples that their continued residence on their original lands would be considered an act of war against the U.S. and if they did not leave, U.S. military forces commenced wars, imprisoned and killed Native leaders and people, and tragically, at places like Sand Creek and Wounded Knee massacred Native men, women, and children.

Congress and the executive branch enacted laws and policies that took Native children out of their homes and forced them to attend boarding schools, far from their families in an effort to suppress Native cultures and languages. Our Nation denied Indian nations religious freedom. And these wrongs did not end in the 19th century. The United States continued to take Native lands for various purposes, and in many cases has failed to safeguard Native lands, waters, and resources.

For these things, our Nation should and now does apologize. I commend my colleagues, Senator BROWNBACK, Senator DORGAN and our Senate Appropriations chairman, Senator INOUE, for leadership on this important and historic apology. I know from experience that an apology can bring healing and reconciliation. Congress passed the Native Hawaiian Apology Resolution, Public Law 103-150, in 1993 and it has had a profound impact.

I encourage President Obama to issue an apology to our Native peoples that truly reflects the many wrongs that we should apologize for to Native peoples. The strength and resilience of our indigenous people, America's first people must be acknowledged. Despite the many transgressions made against our Nation's first people, American Indians, Alaska Natives, and Native Hawaiians continue to make meaningful contributions to the United States. This apology will be a historic act that can bring reconciliation and healing between our Native peoples and the American people as a whole.

Mr. BROWNBACK. Mr. President, I would also like to highlight a section

of this conference report that means a great deal to many American Indian tribal leaders in this country, to several of my colleagues and to me personally, the Native American apology resolution.

I am very pleased to report that with the addition of this language in the defense appropriations conference report, we—the United States of America—will officially apologize for the past ill-conceived policies and maltreatment by the United States toward the Native peoples of this land.

With the passage of this language, we, as a Nation, will reaffirm our commitment toward healing our Nation's wounds rooted in a difficult past of Federal-tribal relations and work toward establishing better relationships rooted in reconciliation and forgiveness.

Native Americans have a vast and proud legacy on this continent. Long before 1776 and the establishment of the United States of America, native peoples inhabited this land and maintained a powerful physical and spiritual connection to it. In service to the Creator, Native peoples sowed the land, journeyed it, and protected it. The people from my State of Kansas have a similar strong attachment to the land.

Like many in my State, I was raised on the land. I grew up farming and caring for the land. I and many in my State established a connection to this land as well. We care for our Nation and the land of our forefathers so greatly that we too are willing to serve and protect it, as faithful stewards of the creation with which God has blessed us. I believe without a doubt citizens across this great Nation share this sentiment and know its unifying power. Americans have stood side by side for centuries to defend this land we love.

Both the Founding Fathers of the United States and the indigenous tribes that lived here were attached to this land. Both sought to steward and protect it. There were several instances of collegiality and cooperation between our forbears—for example, in Jamestown, VA, Plymouth, MA, and in aid to explorers Lewis and Clark.

Yet, sadly, since the formation of the American Republic, numerous conflicts have ensued between our government, the Federal Government, and many of these tribes, conflicts in which warriors on all sides fought courageously and which all sides suffered. Even from the earliest days of our Republic there existed a sentiment that honorable dealings and a peaceful coexistence were clearly preferable to bloodshed. Indeed, our predecessors in congress in 1787 stated in the northwest ordinance: "The utmost good faith shall always be observed toward the Indians."

Today we live up to this goal, today, we right a wrong that has been committed in this Nation.

This amendment extends a formal apology from the United States to tribal governments and Native peoples nationwide—something we have never done; something we should have done years and years ago.

Further, this resolution will not resolve the many challenges still facing Native Americans, nor will it authorize, support or settle any claims against the United States. It doesn't have anything to do with any property claims against the United States. That is specifically set aside and not in this bill.

What this amendment achieves is recognition, honor, and the importance of Native Americans to this land and to the United States in the past and today and offers an official apology for the poor and painful path the U.S. Government sometimes made in relation to our Native brothers and sisters by disregarding our solemn word to Native peoples. It recognizes the negative impact of numerous destructive Federal acts and policies on Native Americans and their culture, and it begins—begins—the effort of reconciliation.

Apologies are oftentimes difficult, but like treaties, go beyond mere words and usher in a true spirit of reconciling past differences and help to pave the way toward a united future—a future that transcends the individual but strives to reach into eternity. The notion of the creation of the “Beloved Community” that Dr. King spoke of . . . that my good friend representative JOHN LEWIS speaks of is very appropriate at this moment for this time. “The end is reconciliation, the end is redemption, the end is the creation of the beloved community.” This is our goal; this is my hope for our Nation united as one people.

AUNT ANNE IS 100 YEARS OLD TODAY

Mr. SPECTER. Mr. President, today is a momentous day in the history of the Specter/Shanin family. My aunt Anne Shanin Kleiman is 100 years old.

My Tante Annie, that's the Jewish name for Aunt Annie, is the younger sister of my mother, Lillie Shanin Specter. Annie is an outstanding scholar who published a book on Hebrew poetry.

She was the first person who taught me about Israel. She traveled to Israel before Israel was declared a state, when it was called Palestine. She sent me a beautiful wooden camel as a starting point to describe Biblical Canaan which later was called Palestine and is now Israel.

Annie married a distinguished scientist/chemist, Dr. Morton Kleiman, and had two brilliant children, Dr. Adina Sue Kensky and Dr. Jay Kleiman who has two accomplished children and two adorable grandchildren.

During the Depression when times were very tough and my family was struggling, Annie loaned my father \$500, an act of real generosity in tough times. Over the years, I have visited her many times, sought her advice, savored her excellent cooking, and enjoyed her company.

My first visit was to Chicago, where she has lived for many years. There I saw the marvels of the World's Fair. I rode in a scary cable car over Lake Michigan and was hoisted on to the stage by my father on a sideshow with an Indian chief. This occurred in the midst of the Depression when my family was en route from Wichita, KS, where we had lived, to Philadelphia, PA, to live with my father's sister because my father could not earn a living in Kansas.

Recently, not unexpectedly, Annie has become infirm. When I have visited in recent years, it has been difficult to talk to her, but last night we had a nice conversation over the phone.

Her longevity has set a remarkable family record evidencing good genes and setting a Strom Thurmond-like target to emulate. She is a wonderful woman, a wonderful aunt, and a wonderful role model.

Happy Birthday, Tante Annie!

ADDITIONAL STATEMENTS

RECOGNIZING ESTABROOK'S

• Ms. SNOWE. Mr. President, with Christmas just a few short days away, we have all witnessed the signs of the season popping up in our neighborhoods. From vibrant wreaths and Christmas trees to wind-blown snow banks, these peaceful symbols provide many of us with a comforting feeling of home. Today I recognize a small Maine nursery that grows its own beautiful poinsettias, and supplies many other seasonal flora, to accentuate the beauty of the Christmas season.

Estabrook's has been a reliable family-owned, full service garden center for more than 50 years. Located in the coastal town of Yarmouth, Estabrook's grows fresh plants in its over 20 greenhouses and outdoor growing areas. The company also operates seasonal locations in Scarborough and, beginning earlier this year, in Kennebunk. Home to an abundance of trees and shrubs, perennial and annual flowers, and seeds for growing vegetables, Estabrook's also carries a variety of gardening supplies, such as chemicals, fertilizers and tools. In an effort to better inform its customers about the wonders of gardening, Estabrook's user-friendly website offers a variety of tips and best practices regarding caring for flowers and plants.

To properly celebrate the holidays, Estabrook's provides its clients with an abundance of seasonal items. For

example, during the Christmas season the nursery creates stunning fresh centerpieces and grows its own brilliant red poinsettias. Additionally, aside from Christmas trees and wreaths, the company stocks a variety of garlands, roping, and other timely decorating supplies and ornaments to bring home the memorable sights and smells of the season.

Beyond its role as a stellar nursery, Estabrook's prides itself as being an extraordinarily active member of the local community. The company has widely promoted the Herbie Project, an undertaking to save New England's largest American Elm Tree, known to locals as Herbie. This initiative is particularly noteworthy given that Yarmouth has lost roughly 800 American Elm trees to Dutch Elm Disease over the past fifty years. Additionally, Estabrook's has donated its gift certificates, cleverly known as “Estabucks,” to community efforts, including the Holiday Boast N Toast Auction to benefit the Yarmouth Chamber of Commerce's Scholarship Fund and YarmouthCAN, a nonprofit that assists those needing a helping hand. The nursery has also taken great strides toward creating the Yarmouth Community Garden, which raises vegetables that are then donated to the area's disadvantaged individuals and families.

A well-known and trusted name in the community for over half a century, Estabrook's is a valued business in the town of Yarmouth because of its longstanding dedication to quality greenery and its visible presence in civic endeavors townwide. I thank everyone at Estabrook's for their caring and kind commitment to others, and wish them a happy and safe holiday season. •

SOUTH DAKOTA SCHOOL OF MINES AND TECHNOLOGY

• Mr. THUNE. Mr. President, today I recognize the South Dakota School of Mines and Technology, which will celebrate their 125th anniversary in 2010.

Located in Rapid City, the South Dakota School of Mines and Technology has been a national leader in preparing world-class engineers and scientists since 1885. Graduates design, construct, and operate the most modern technology to meet complex challenges such as climate change, bioenergy, mineral extraction and processing, advanced materials, environmental quality, and national defense. School of Mines alumni are held in the highest regard by their fellow leaders in industry, consulting, government, health, research, and education.

The School of Mines is proud to be a leading partner in bringing the Deep Underground Science and Engineering Laboratory, DUSEL, from an extraordinary vision to a phenomenal reality. The longstanding connections between the School of Mines and the Homestake

Mine began in 1885 when the university was established to meet the growing research needs of the mining industry, led by Homestake. These connections continued when nearly a decade ago, the School of Mines helped champion the conversion of the mine into a national laboratory. Today, as we continue to prepare leaders in engineering and science, we are collaborating with our colleagues to transform Homestake into a world-class laboratory to further exceptional research and discoveries not yet imagined.

Rugged individuals and pioneers in engineering and science founded the School of Mines' intellectual environment more than a century ago. The university's faculty, staff, students, and alumni carry on that tradition today. In 2010, the School of Mines celebrates 125 years of award-winning faculty, staff, and students collaborating to solve issues of critical importance to South Dakota, the nation, and the world. Please join me as we celebrate their legacy of educating the leaders of tomorrow.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mrs. Neiman, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC-4126. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Revisions to the California State Implementation Plan, South Coast Air Quality Management District" (FRL No. 9087-3) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Environment and Public Works.

EC-4127. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Approval and Promulgation of Air Quality Implementation Plans; Virginia; Update to Materials Incorporated by Reference; Correction" (FRL No. 9093-6) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Environment and Public Works.

EC-4128. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Change of Address for Submission of Certain Reports; Technical Corrections" (FRL No. 9093-5) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Environment and Public Works.

EC-4129. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Approval and Promulgation of Air Quality Implementation Plans; California; Monterey Bay Region 8-Hour Ozone Maintenance Plan" (FRL No. 8983-4) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Environment and Public Works.

EC-4130. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Approval and Promulgation of Maintenance Plan for Carbon Monoxide; State of Arizona; Tucson Air Planning Area" (FRL No. 8982-4) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Environment and Public Works.

EC-4131. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, a report entitled "National Coverage Determinations"; to the Committee on Finance.

EC-4132. A communication from the Chief of the Trade and Commercial Regulations Branch, Customs and Border Protection, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Countries Whose Pleasure Vessels May Be Issued Cruising Licenses" (CPB Dec. 08-27) received in the Office of the President of the Senate on December 15, 2009; to the Committee on Finance.

EC-4133. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Permitted Disparity in Employer-Provided Contributions or Benefits" (Rev. Rul. 2009-40) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC-4134. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Unpaid Loss Discount Factors for 2009" (Rev. Proc. 2009-55) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC-4135. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, a report entitled "Report to Congress on Head Start Efforts to Prevent and Reduce Obesity in Children"; to the Committee on Health, Education, Labor, and Pensions.

EC-4136. A communication from the Chairman, Securities and Exchange Commission, transmitting, pursuant to law, a report relative to the inventory of activities for fiscal year 2009 under the FAIR Act; to the Committee on Homeland Security and Governmental Affairs.

EC-4137. A communication from the Inspector General, General Services Adminis-

tration, transmitting, pursuant to law, the General Services Administration's Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC-4138. A communication from the Deputy Secretary of Defense, transmitting, pursuant to law, the Department's Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC-4139. A communication from the Staff Director, United States Commission on Civil Rights, transmitting, pursuant to law, the report of the appointment of members to the Iowa Advisory Committee; to the Committee on the Judiciary.

EC-4140. A communication from the Acting Chief of the Border Security Regulations Branch, Office of the Secretary, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Administrative Process for Seizures and Forfeitures Under the Immigration and Nationality Act and Other Authorities" (RIN1651-AA58) received in the Office of the President of the Senate on December 15, 2009; to the Committee on the Judiciary.

EC-4141. A communication from the Department of State, transmitting, pursuant to law, a report relative to the transfer of detainees (OSS Control No. 2009-2057); to the Committee on the Judiciary.

EC-4142. A communication from the Assistant Attorney General, Office of Legislative Affairs, Department of Justice, transmitting, pursuant to law, the Fourth Quarterly Report from the Attorney General to Congress; to the Committee on Veterans' Affairs.

EC-4143. A communication from the Secretary of the Federal Trade Commission, transmitting, pursuant to law, a report entitled "Federal Trade Commission Report to Congress on The U.S. SAFE WEB Act: The First Three Years"; to the Committee on Commerce, Science, and Transportation.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mrs. BOXER, from the Committee on Environment and Public Works, without amendment:

H.R. 2188. A bill to authorize the Secretary of the Interior, through the United States Fish and Wildlife Service, to conduct a Joint Venture Program to protect, restore, enhance, and manage migratory bird populations, their habitats, and the ecosystems they rely on, through voluntary actions on public and private lands, and for other purposes (Rept. No. 111-111).

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. SPECTER:

S. 2918. A bill to make improvements to certain loan programs under the Small Business Act and the Small Business Investment Act of 1958, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. UDALL of Colorado (for himself, Mr. SCHUMER, Mr. LIEBERMAN,

Ms. SNOWE, Mrs. BOXER, Ms. COLLINS, and Mrs. GILLIBRAND):

S. 2919. A bill to amend the Federal Credit Union Act to advance the ability of credit unions to promote small business growth and economic development opportunities, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. LAUTENBERG (for himself and Mr. UDALL of New Mexico):

S. 2920. A bill to amend chapter 1 of title 23, United States Code, to condition the receipt of certain highway funding by States on the enactment and enforcement by States of certain laws to prevent repeat intoxicated driving; to the Committee on Environment and Public Works.

By Mrs. FEINSTEIN:

S. 2921. A bill to provide for the conservation, enhanced recreation opportunities, and development of renewable energy in the California Desert Conservation Area, to require the Secretary of the Interior to designate certain offices to serve as Renewable Energy Coordination Offices for coordination of Federal permits for renewable energy projects and transmission lines to integrate renewable energy development, and for other purposes; to the Committee on Energy and Natural Resources.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mrs. FEINSTEIN (for herself, Mr. CORNYN, Mr. CARDIN, and Mr. BROWNBACK):

S. Res. 382. A resolution supporting the goals and ideals of observing the National Slavery and Trafficking Prevention Month from January 1 through February 1, 2010, to raise awareness of, and opposition to, modern slavery; considered and agreed to.

By Mr. MCCAIN (for himself, Mr. KERRY, Mrs. LINCOLN, Mr. INOUE, Mr. BEGICH, Mr. FEINGOLD, Mr. SPECTER, Mr. GRASSLEY, Mr. BURR, Ms. COLLINS, Ms. MURKOWSKI, and Mr. COCHRAN):

S. Res. 383. A resolution designating January 2010 as "National Mentoring Month"; considered and agreed to.

ADDITIONAL COSPONSORS

S. 583

At the request of Mr. PRYOR, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 583, a bill to provide grants and loan guarantees for the development and construction of science parks to promote the clustering of innovation through high technology activities.

S. 619

At the request of Mr. MENENDEZ, his name was added as a cosponsor of S. 619, a bill to amend the Federal Food, Drug, and Cosmetic Act to preserve the effectiveness of medically important antibiotics used in the treatment of human and animal diseases.

S. 1798

At the request of Mr. SANDERS, the name of the Senator from Alaska (Mr.

BEGICH) was added as a cosponsor of S. 1798, a bill to provide for the automatic enrollment of demobilizing members of the National Guard and Reserve in health care and dental care programs of the Department of Veterans Affairs, and for other purposes.

S. 1810

At the request of Mr. HARKIN, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 1810, a bill to direct the Secretary of Health and Human Services to publish physical activity guidelines for the general public, and for other purposes.

S. 2736

At the request of Mr. FRANKEN, the name of the Senator from Colorado (Mr. BENNET) was added as a cosponsor of S. 2736, a bill to reduce the rape kit backlog and for other purposes.

S. 2781

At the request of Ms. MIKULSKI, the names of the Senator from New York (Mrs. GILLIBRAND), the Senator from Minnesota (Ms. KLOBUCHAR), the Senator from Michigan (Ms. STABENOW) and the Senator from North Carolina (Mrs. HAGAN) were added as cosponsors of S. 2781, a bill to change references in Federal law to mental retardation to references to an intellectual disability, and to change references to a mentally retarded individual to references to an individual with an intellectual disability.

S. 2796

At the request of Mr. BARRASSO, his name was added as a cosponsor of S. 2796, a bill to extend the authority of the Secretary of Education to purchase guaranteed student loans for an additional year, and for other purposes.

S. 2917

At the request of Mr. BAUCUS, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. 2917, a bill to amend the Internal Revenue Code of 1986 to modify the penalty for failure to disclose certain reportable transactions and the penalty for submitting a bad check to the Internal Revenue Service, to modify certain rules relating to Federal vendors, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. SPECTER:

S. 2918. A bill to make improvements to certain loan programs under the Small Business Act and the Small Business Investment Act of 1958, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

Mr. SPECTER. Mr. President, I have sought recognition to introduce the Helping Small Business Succeed Act of 2009. My legislation will make it easier for small businesses to access credit, credit which they desperately need to be able to cover their costs, grow their businesses, and create jobs.

Small businesses are the engine of economic growth in this country, responsible for 60 percent of new jobs created. The Commonwealth of Pennsylvania alone has 978,831 small businesses, which bring economic opportunities to diverse groups of people, innovate new technologies, and provide valuable services to their communities. Of these small businesses, 236,775 are small employers who represent 98.4 percent of Pennsylvania's employers and 49.9 percent of its private-sector employment. It is not an understatement to say that small businesses and their ability to grow are vital to the health of Pennsylvania and of the Nation.

Earlier this month, the Labor Department released jobs figures indicating that unemployment has dropped from 10.2 percent in October to 10 percent in November, and that the economy shed only 11,000 jobs, which was well below analysts' expectations. While these numbers are encouraging, leading economists such as Joseph Stiglitz have stated that recovery will be slow unless we continue to take strong measures.

When I voted for the stimulus, we were facing a recession that could well have developed into a full-fledged depression like we faced in 1929. The stimulus provided \$630 million to the Small Business Administration, SBA, to guarantee private sector loans to small businesses, which allowed the SBA to raise its loan caps, and increased SBA guarantees from 75–80 percent to 90 percent in its two major business loan programs. These provisions have proven effective in providing credit to small business, but more needs to be done. My legislation permanently increases the loan limit from \$2 million to \$5 million on 7(a) loans, from \$1.5 million to \$5.5 million on 504 loans, and from \$35,000 to \$50,000 on microloans.

Simply raising loan limits is not enough, however. Raising the SBA's guarantee will increase commercial lenders' willingness to provide loans because it reduces the risk undertaken by lenders. My legislation raises the maximum loan guarantee percentage to 97.5 percent, which will quickly and efficiently incentivize the existing network of financial institutions to make affordable loans to small business. Additionally, my legislation extends the waivers for the 7(a) borrower fees and the 504 borrower and bank fees, which were enacted as part of the stimulus package, until 2011.

Finally, my legislation authorizes the SBA to declare certain communities "economic disaster areas" and to provide further assistance to small businesses within these areas. The economic situation in many towns across America has risen to emergency levels. Unemployment in some counties in Pennsylvania has risen as high as 12 and 14 percent. My legislation will provide the SBA with greater flexibility to

use its funds to target areas of the country where the level of unemployment exceeds the national level and where small businesses have been hit the hardest.

According to the October 2009 Special Inspector General Report to Congress, taxpayers have seen \$73 billion in TARP funds returned so far with a 10 percent return on their investment. As of September 30, 2009, \$9.5 billion in interest, dividends, and other income has had been received by the federal government. My legislation uses this revenue, derived from investments made through TARP, to pay for these urgently needed adjustments.

Small businesses need access to credit and they need it now more than ever, if they are to weather current economic conditions. I look forward to working with my colleagues to provide further assistance to the small business community and to help restore their ability to create jobs and stimulate our economy.

By Mrs. FEINSTEIN:

S. 2921. A bill to provide for the conservation, enhanced recreation opportunities, and development of renewable energy in the California Desert Conservation Area, to require the Secretary of the Interior to designate certain offices to serve as Renewable Energy Coordination Offices for coordination of Federal permits for renewable energy projects and transmission lines to integrate renewable energy development, and for other purposes; to the Committee on Energy and Natural Resources.

Mrs. FEINSTEIN. Mr. President, I rise today to introduce the California Desert Protection Act of 2010.

I strongly believe that conservation, renewable energy development, and recreation can and must coexist in the California Desert—and this legislation strikes a carefully conceived balance between these sometimes competing concerns.

The key provisions of this bill would designate two new national monuments—the Mojave Trails and the Sand to Snow National Monuments.

It would add adjacent lands to the Joshua Tree and Death Valley National Parks and the Mojave National Preserve; designate 5 new BLM wilderness areas and protect 4 important waterways, such as the Amargosa River and Deep Creek, as Wild and Scenic Rivers; improve the process to permit large-scale wind and solar development on suitable public and private lands in the California desert; and enhance recreational opportunities in the desert, while ensuring that the training needs of the military are met.

This bill is the product of painstaking discussions with key stakeholders—including environmental groups, local and State government, off-highway recreation enthusiasts,

hunters, cattle ranchers, mining interests, the Department of Defense, wind and solar energy companies, California's public utility companies, and many others. I am grateful for all of their efforts.

The bill is divided into two titles.

The first title primarily covers conservation, recreation, and other purposes.

The second title of the bill covers renewable energy development on suitable lands.

Taken together, this bill will shape the future of the Southern California Desert, and I believe it can serve as a model for future efforts to balance renewable energy development and conservation.

As of today, this bill has been endorsed by: the California Wilderness Coalition; the Wildlands Conservancy; the Wilderness Society; the National Parks Conservation Association; Friends of the River; Cogentrix Energy; Edison International, parent company of Southern California Edison; Friends of Big Morongo Canyon Preserve; Friends of the Desert Mountains; Mojave Desert Land Trust; Desert Protective Council; Amargosa Conservancy; Death Valley Conservancy; the Cities of Barstow, Desert Hot Springs, Hesperia, Indio, Palm Springs, San Bernardino and Yucaipa; Riverside County Supervisor Marion Ashley; San Bernardino County Supervisor Neil Derry; Imperial County Supervisor Wally Leimgruber; Coachella Valley Association of Governments; SummerTree Institute; and Route 66 Preservation Foundation.

The California Desert Protection Act, which was enacted in 1994, was a sweeping piece of legislation aimed at conserving some of the most beautiful and ecologically significant lands in my home State.

The law created Death Valley National Park, Joshua Tree National Park and the Mojave National Preserve, as well as 69 desert wilderness areas managed by the Bureau of Land Management, BLM.

Collectively, it protected over 7 million acres of desert lands, making it the largest land conservation bill in the lower 48 States in U.S. history.

To this day, it remains one of my proudest accomplishments since joining this body.

Much has changed since the passage of the California Desert Protection Act. Many of the impediments that prevented conservation of other pristine desert lands in the area no longer exist.

Department of Defense concerns with designating some wilderness areas near Fort Irwin have been resolved.

Many mining areas inside national parks and potential wilderness have closed.

Grazing allotments on both BLM and National Park Service land have been retired by willing sellers.

Hundreds of thousands of acres of privately owned land has been donated to or acquired by the Federal Government.

Yet even as these issues were resolved, new challenges have emerged. There are now competing demands over how best to manage hundreds of thousands of acres of public lands in the desert.

Some believe the lands should be used for large-scale solar and wind facilities and transmission lines. Others would like to conserve critical habitat for threatened and endangered species.

Some would like more acreage available for grazing or for off-road recreation.

Finally, some would like to see additional lands made available for military training and base expansion.

Earlier this year, I learned that BLM had accepted applications to build vast solar and wind energy projects on former railroad lands previously owned by the Catellus Corporation. These lands had been donated to the Federal Government or acquired with taxpayer funds for conservation.

I believe the development of these new cleaner energy sources is vital to addressing climate change, yet we must be careful about selecting where these facilities are located. The current process doesn't work because it allows energy firms to propose the sites for renewable energy development, including land donated or acquired specifically for conservation.

Approximately \$45 million of private donations—including a \$5 million land discount from Catellus Corporation—and \$18 million in Federal Land and Water Conservation grants was spent to purchase these lands, with the intent of conserving them in perpetuity.

As the sponsor of the legislative provisions that helped secure the deal to acquire the roughly 600,000 acres of former private land, I found the BLM's actions unacceptable.

We have an obligation to honor our commitment to conserve these lands—and I believe we can still accomplish that goal while also fulfilling California's commitment to develop a clean energy portfolio.

That is the purpose of this legislation.

The first title of the legislation is geared towards the goal of conserving the Desert's sensitive ecosystem.

First, this bill will ensure that hundreds of thousands of acres of land donated to the federal government for conservation will be protected by creating the Mojave Trails National Monument. This new monument would cover approximately 941,000 acres of Federal land, which includes approximately 266,000 acres of the former Catellus-owned railroad lands along historic Route 66. I visited the area earlier this year and was amazed by the beauty of the massive valleys, pristine dry lakes, and rugged mountains.

In addition to its iconic sweeping desert vistas and majestic mountain ranges, this area of the Eastern Mojave also contains critical wildlife corridors linking Joshua Tree National Park and the Mojave National Preserve. It also encompasses hundreds of thousands of acres designated as areas of critical environmental concern, critical habitat for the threatened desert tortoise, and ancient lava bed flows and craters. It is surrounded by more than a dozen BLM wilderness areas.

The BLM would be given the authority to both conserve the monument lands, and also to maintain existing recreational uses, including hunting, vehicular travel on open roads and trails, camping, horseback riding and rockhounding.

The bill also creates an advisory committee to help develop and oversee the implementation of the monument management plan. It would be comprised of representatives from local, State and Federal Government, conservation and recreation groups, and local Native American tribes.

Before I go on to the other conservation provisions in the bill, I would like to address one important issue—and that is what should be done about some of the proposed renewable energy development projects proposed for lands included in this monument.

Although it is true that the monument will prevent further consideration of some applications to develop solar and wind energy projects on former Catellus lands or adjoining lands in the monument, it is important to note that of the proposals in question, not a single one has been granted a permit nor is a single one under review at the California Energy Commission or under formal NEPA, National Environmental Policy Act, review at BLM.

To ensure that creation of the monument does not unnecessarily harm the firms that worked in good faith and invested substantial time and resources to produce renewable energy in California, the legislation will offer these companies an opportunity to relocate their projects to federal renewable energy zones currently being developed by the Department of the Interior.

Additionally, the monument would not prevent the construction or expansion of necessary transmission lines critical to linking renewable energy generation facilities with the electricity grid.

Second, the bill would establish the "Sand to Snow National Monument," encompassing 134,000 acres of land from the desert floor in the Coachella Valley up to the top of Mount San Gorgonio, the highest peak in Southern California.

The boundaries of this second, smaller new monument would include two Areas of Critical Environmental Concern: Big Morongo Canyon and White-

water Canyon, the BLM and U.S. Forest Service San Gorgonio Wilderness, the Wildlands Conservancy's Pipe's Canyon and Mission Creek Preserves, and additional public and private conservation lands, including two wildlife movement corridor areas connecting the Peninsular Ranges with the Transverse Ranges.

This area is truly remarkable, and would arguably be the most environmentally diverse national monument in the country. It serves as the intersection of three converging ecological systems—the Mojave Desert, the Colorado Desert, and the San Bernardino mountains—and is one of the most important wildlife corridors in Southern California.

This monument designation would protect 23.6 miles of the Pacific Crest Trail and the habitat for approximately 240 species of migrating and breeding birds, the second highest density of nesting birds in the U.S. It also serves as a home and a crucial migration corridor for animals traveling between Joshua Tree National Park, the oasis at Big Morongo, and the higher elevations of the San Bernardino Mountains.

I would like to make one additional point, and that is that despite its ecological significance, this area is not particularly well-known—largely because it is managed by a number of distinct entities, including the BLM, Forest Service, National Park Service and private preserves and conservation agencies. So, the monument designation would help to attract more attention to one of California's natural gems.

Third, the bill establishes new wilderness and allows more appropriate use of lands currently designated as Wilderness Study Areas.

The 1994 California Desert Protection Act extended wilderness protection to many areas in the desert, yet several areas near Fort Irwin were designated as wilderness study areas in order to allow the base to expand.

Now that Fort Irwin's expansion is complete, it is time to consider these areas for permanent wilderness designation.

The bill protects approximately 250,000 acres of BLM land as wilderness in five areas. These areas contain some of the most pristine and rugged landscapes in the California desert.

Beyond Fort Irwin, the bill also expands wilderness areas in Death Valley National Park, 90,000 acres, and the San Bernardino National Forest, 4,300 acres, inside the Sand to Snow National Monument created by this bill.

The bill also releases 126,000 acres of land from their existing wilderness study area designation in response to requests from local government and recreation users. This will allow the land to be made available for other purposes, including recreational off-

highway vehicle use on designated routes.

Fourth, this bill would create the Vinagre Wash Special Management Area.

The agreed-upon designation for this area in Imperial County, near the Colorado River, was reached after careful discussion with key stakeholders.

Although the land possesses some wilderness characteristics, there are also competing interests. The Navy Seals currently use some of this area for occasional training. Additionally, many local residents enjoy touring the rolling hills in the area by jeep.

Through the combined efforts of conservation groups, local residents and county government, and the Department of Defense, a compromise conservation designation was developed.

For the land known as the Vinagre Wash, the bill will create a "special management area" covering 76,000 acres, including 12,000 acres of former railroad lands donated to the Federal Government.

Of these, 49,000 acres are designated as potential wilderness and only become permanent wilderness if and when the Department of Defense determines these lands are no longer needed for Navy Seal training.

This designation will permit the area to continue to be accessed by vehicles and be used for camping, hiking, mountain biking, sightseeing, and off-highway vehicle use on designated routes and protect tribal cultural assets in the area.

Fifth, the bill adds to or designates four new Wild and Scenic Rivers, totaling 76 miles in length. This designation will ensure they remain clean and free-flowing and that their immediate environments are preserved. These beautiful waterways are Deep Creek and the Whitewater River in and near the San Bernardino National Forest, as well as the Amargosa River and Surprise Canyon Creek near Death Valley National Park.

Sixth, the bill includes adds approximately 74,000 acres of adjacent lands to the three National Parks established by the 1994 California Desert Protection Act.

The bill adds 41,000 acres in Death Valley National Park. This includes former mining areas where the claims have been retired and a narrow strip of BLM land between National Park and Defense Department boundaries that has made BLM management difficult.

The bill adds 30,000 acres in the Mojave National Preserve. This land was not included in the original Monument because of the former Viceroy gold mine. However, the mining operations ceased several years ago, and the reclamation process is nearly complete. Additionally, a 2007 analysis by the Interior Department recommended that this area would be suitable to add to the Preserve.

The bill adds 2,900 acres in Joshua Tree National Park. This includes multiple small parcels of BLM land identified for disposal on its periphery. Transferring this land to the Park Service would help protect Joshua Tree by preserving these undeveloped areas that border residential communities.

Seventh, the bill designates new lands as Off-Highway Vehicle Recreation Areas.

One of the key goals I have strived for in this bill is to find balance to ensure that the many different needs and uses in the desert are accommodated with the least possible conflict. Some of the most frequent visitors to the desert are the off-highway recreation enthusiasts.

In California alone, there are over 1 million registered off-highway vehicles, many of which can be found exploring thousands of miles of desert trails or BLM designated open areas.

However, in order to meet military training needs, the Marine Corps is studying the potential expansion of Marine Corps Air Ground Combat Center at Twentynine Palms into Johnson Valley, the largest OHV area in the country. I strongly support providing our troops with the best possible training, but if the Marines need to expand the base into Johnson Valley, this could have potentially resulted in the loss of tens of thousands of acres of OHV recreation lands.

But over the past year I met with Major General Eugene Payne, Assistant Deputy Commandant for Installations and Logistics, and Brigadier General Melvin Spiess, Commanding General, Training and Education Command, to discuss this issue, and I am very grateful for their efforts to consider base expansion options that would preserve much of Johnson Valley for recreation.

As the result of those meetings, the Marine Corps has committed to studying an alternative that would allow for a portion of Johnson Valley to be used exclusively for military training, a portion exclusively for continued OHV recreation and a third area for joint use. While the environmental review process must first be completed, I am hopeful that this option will prevail for the benefit of the Marines and recreational users of Johnson Valley.

The lesson learned from Johnson Valley is that, despite the vast size of the California desert, there are relatively few areas dedicated to OHV recreation, and even those areas face increasing competition from other types of uses. These areas are important not only to the hundreds of thousands of visitors who enjoy them, but also to the local economy that depends on their tourist dollars. Additionally, by protecting these areas, we also protect conservation areas by providing appropriate places for OHV recreation.

So, this bill will designate five existing OHV areas in the Mojave desert as

permanent OHV areas, providing off-highway groups some certainty that these uses will be protected as much as conservation areas. Collectively, these areas could be as much as 314,000 acres, depending on what, if any, of Johnson Valley is ultimately needed by the Marines.

This section of the bill also requires the Secretary of the Interior to conduct a study to determine what, if any, lands adjacent to these recreation areas would be suitable for addition. This will help make up for some of the lost acres in Johnson Valley should the Marines decide to expand there.

Finally, this title of the bill includes other key provisions that address various challenges and opportunities in the California desert, including: state land exchanges.

There are currently about 370,000 acres of state lands spread across the California desert in isolated 640 acre parcels. Because many of these acres are inside national parks, wilderness, the proposed monuments or conservation areas, they are largely unusable. The bill seeks to remedy that problem by requiring the Department of the Interior to develop and implement a plan with the state to complete the exchange of these lands for other BLM or GSA owned property in the next ten years. These land exchanges will help consolidate the state lands into larger, more usable areas that could potentially provide the state with viable sites for renewable energy development, off-highway vehicle recreation or other commercial purposes.

The bill ensures the right of the Department of Defense to conduct low-level overflights over wilderness, national parks and national monuments.

The bill requires the Department of the Interior to study the impact of climate change on California desert species migration, incorporate the study's results and recommendations into land use management plans, and consider the study's findings when making decisions granting rights of way for projects on public lands.

The bill requires the Secretary to ensure access for tribal cultural activities within national parks, monuments, wilderness and other areas designated within the bill. It also requires the Secretary to develop a cultural resources management plan to protect a sacred tribal trail along the Colorado River between southern Nevada and the California-Baja border.

In order to ensure that donated and acquired Catellus lands outside the Mojave Trails National Monument are maintained for conservation, the bill prohibits their use for development, mining, off-highway vehicle use, except designated routes, grazing, military training and other surface disturbing activities. The Secretary of the Interior is authorized to make limited exceptions in cases where it is deemed in

the public interest, but comparable lands would have to be purchased and donated to the Federal Government as mitigation for lost acreage.

So, all of these provisions, when taken together, would serve to complement the lasting conservation established by the California Desert Protection Act—while ensuring that other important local uses are maintained in appropriate areas.

The Mojave Desert is a spectacular national treasure worthy of protection, but it is also a unique national solar resource.

The Mojave has more than 350 sunny days per year; has large flat valleys and mesas; is close to major transmission lines and millions of electricity consumers in Southern California; and lies above 4,000 feet in elevation, where the sun is strongest.

There is no question that we need to harness the desert's plentiful solar energy—but in order to do that, we need to cut through a bureaucratic backlog of stalled permits, and ensure that development occurs on the most appropriate lands.

That is exactly what the second title of this legislation is intended to do.

For too many years the promise of utilizing desert lands to produce clean, renewable solar power was out of reach. The up-front technology costs were too expensive, while coal was deemed to be cheap and plentiful.

But the economics of solar power began to shift in the right direction in 2005, when Congress established a 30 percent investment tax credit for solar power facilities, a provision I championed. I was proud to work with Senator SNOWE and other members of the Senate Finance Committee to extend this tax credit through 2016 during the last Congress.

On December 17, I introduced new legislation with Senator MERKLEY to make sure solar companies can fully realize the benefits of these tax incentives.

The other chief roadblock to developing solar in the desert has been the broken permitting process.

The Federal Government has failed to focus wind and solar development on appropriate lands where it can be readily permitted.

There are currently more than 110 applications to develop more than 42,000 megawatts of renewable energy capacity on BLM land in the California desert.

Until very recently, nothing was done to evaluate these development proposals.

All but a few proposals have not even begun the formal environmental review process required by the National Environmental Policy Act, NEPA. The BLM has been slow to direct development towards disturbed lands or to discourage proposals on lands acquired for the purpose of conservation.

Wind developers have had to wait more than three years to receive permission to measure the wind above public lands.

The Fish and Wildlife Service has told renewable energy developers seeking to use disturbed private lands that they would need to develop complex habitat conservation plans for their projects, a process expected to take nine years.

Contrast that with the recent announcement from Interior Secretary Ken Salazar, who has pledged that the BLM will complete permitting of 10 "fast track" solar projects on public lands by December 2010.

So, the good news is that this administration has taken steps in the right direction to encourage this important shift to renewable energy.

But it is critical, nonetheless, that this legislation is enacted in order to codify and build upon these improvements to the permitting process and help establish the transmission lines needed to carry cleaner energy from the desert to consumers.

Key provisions of the bill: first, the bill will require BLM to put personnel in place focused exclusively on renewable energy development in the desert, make the staff accountable to Congress, and provide a reliable stream of funding to expedite the review of applications.

The BLM began establishing renewable energy permitting offices earlier this year, but this legislation would codify this new administrative policy, establish that the offices have a clear Congressional mandate, and ensure that they will focus specifically on renewable energy development in each state with significant wind and solar resources on public land.

These offices would be funded from the existing BLM permit improvement fund—a fund which is currently only available to supervise the permitting for oil and natural gas development.

It makes sense that this fund should go towards providing cleaner energy sources as well.

Second, the bill would help cut through the backlog of pending renewable development applications with a "use it or lose it" approach.

This would replace the "first come, first serve" approach the BLM currently employs.

The legislation would establish strict deadlines for developers to conduct necessary biological and cultural studies, ensure connection to the grid, and develop a plan for water. This would ensure that serious development proposals are moved to the front of the line—and help put an end to unfettered speculation on desert lands.

Third, this legislation will expedite the application process for solar development on private lands.

When I toured the desert last spring, I asked developers why they wanted to

develop pristine public lands, instead of using private lands.

The answer shocked me: they told me it was easier to permit a project on pristine public land than on private lands.

We need to ensure that it takes no longer to review an application to develop private lands than it does to develop public lands—without infringing upon important environmental regulations.

So, the bill would establish a pilot mitigation bank program—a new idea based on successful desert protection efforts in Nevada, wolf protection efforts in New Mexico, and Coral Reef protection efforts in the Caribbean.

The mitigation bank program would be a win-win, both accelerating permitting and coordinating endangered species protection efforts.

Developers seeking to utilize private lands would be able to contribute to a mitigation fund, instead of negotiating the terms of endangered species mitigation, which the Fish and Wildlife Service recently predicted would take nine years.

The interest from the funds contributed by developers would be used to better manage endangered species habitat in specific mitigation zones of federal land that would be permanently set aside for species protection.

The principal in this fund would be used to purchase new pristine habitat when it became available.

This Mitigation bank program would be run by BLM, and the Fish and Wildlife Service would consult with the BLM on renewable energy project review, just as they do now for renewable energy proposals on public land.

This would help level the playing field between public and private lands, and it could cut down the time it takes to permit projects for private lands considerably.

Fourth, the legislation would require the BLM, the Forest Service, and the military to complete Environmental Impact Statements to develop renewable energy on the lands they oversee.

This has two benefits.

First, it ensures that Federal land managers will proactively plan the use of public lands—instead of allowing private industry to make these de facto decisions.

Federal land managers will be required to identify renewable energy development areas where development is in the public interest through the programmatic EIS process. This will help avoid the sort of site-specific environmental conflicts that can delay projects for years.

The second benefit of this provision is that it will result in a formal evaluation of whether public land currently managed by the military will also be considered for solar development, instead of concentrating this development only on BLM land. There are cur-

rently approximately 3 million acres of California desert that are managed by the military, and much of this land could be developed for renewable energy consistent with the military mission.

By requiring the military to evaluate the impacts of a program to develop its solar resource, the legislation ensures that all available public lands are properly considered for renewable energy development in California.

Fifth, this legislation expedites the permitting of temporary meteorological measurement devices.

In California, it sometimes takes a wind developer three years to get a permit simply to measure wind speed. Such barriers to research are unnecessary and unwise, and this legislation assures that this type of research qualifies for existing categorical exclusions from complex environmental reviews.

Sixth, the legislation would provide grants and loan guarantees to innovative electricity transmission technologies that will reduce the need to build massive, visually and environmentally disruptive transmission lines in the desert.

Finally, the legislation would return 25 percent of the revenue generated by new renewable energy projects to the State, and 25 percent to local county governments. This would ensure that these entities have the resources to support permitting, public lands protection, and local conservation efforts.

Bottom line: The permitting process is broken. It is not facilitating solar and wind development where it belongs. This legislation intends to fix that.

It may surprise my colleagues that I am introducing such comprehensive legislation to ensure the protection of California's desert heritage, the development of our renewable resources, and the continued enjoyment of desert recreation.

After all, I am not from the desert. I have lived in or near San Francisco for most of my life.

But over the years I have come to truly appreciate California's sweeping desert landscapes.

I remember my first visits to the desert years ago. It was treated like a waste dump. It was full of abandoned cars. Old appliances littered the landscape.

But we have worked very hard to clean it up.

We have worked to make sure that the vast vistas and pristine desert habitat are respected by humanity, and that we give to our children a healthier, more beautiful desert than we inherited.

But if we are to remain successful in the long run, we must not only protect the desert land itself, we must also protect the broader environment from the ravages of climate change, and we

must offer economic opportunity to those who live in these areas.

That is the purpose of this legislation. There are many places in the California desert where development and employment are essential and appropriate.

But there are also places that future generations will thank us for setting aside.

I have worked painstakingly with stakeholders to ensure that this legislation balances sometimes competing needs.

This bill, if enacted, will have a positive and enduring impact on the landscape of the Southern California desert, and I hope it will stand as a model for how to balance renewable energy development and conservation.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 382—SUPPORTING THE GOALS AND IDEALS OF OBSERVING THE NATIONAL SLAVERY AND TRAFFICKING PREVENTION MONTH FROM JANUARY 1 THROUGH FEBRUARY 1, 2010, TO RAISE AWARENESS OF, AND OPPOSITION TO MODERN SLAVERY

Mrs. FEINSTEIN (for herself, Mr. CORNYN, Mr. CARDIN, and Mr. BROWNBACK) submitted the following resolution; which was considered and agreed to:

S. RES. 382

Whereas the United States has a tradition of advancing fundamental human rights, having abolished the Transatlantic Slave Trade in 1808 and having abolished chattel slavery and prohibited involuntary servitude in 1865;

Whereas because the people of the United States remain committed to protecting individual freedom, there is a national imperative to eliminate human trafficking, which is the recruitment, harboring, transportation, provision, or obtaining of persons for labor or services through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery, and the inducement of a commercial sex act by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age;

Whereas to combat human trafficking in the United States and globally, the people of the United States, the Federal Government, and State and local governments must be aware of the realities of human trafficking and must be dedicated to stopping this contemporary manifestation of slavery;

Whereas beyond all differences of race, creed, or political persuasion, the people of the United States face national threats together and refuse to let modern slavery exist in the United States and around the world;

Whereas the United States should actively oppose all individuals, groups, organizations, and nations who support, advance, or commit acts of human trafficking;

Whereas the United States must also work to end slavery in all of its forms around the world through education;

Whereas victims of modern slavery need support in order to escape and to recover from the physical, mental, emotional, and spiritual trauma associated with their victimization;

Whereas human traffickers use many physical and psychological techniques to control their victims, including the use of violence or threats of violence against the victim or the victim's family, isolation from the public, isolation from the victim's family and religious or ethnic communities, language and cultural barriers, shame, control of the victim's possessions, confiscation of passports and other identification documents, and threats of arrest, deportation, or imprisonment if the victim attempts to reach out for assistance or to leave;

Whereas although laws to prosecute perpetrators of modern slavery and to assist and protect victims of human trafficking, such as the Trafficking Victims Protection Act of 2000 (division A of Public Law 106-386; 114 Stat. 1466) and the William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008 (Public Law 110-457; 122 Stat. 5044), have been enacted in the United States, awareness of the issues surrounding slavery and trafficking by those people most likely to come into contact with victims is essential for effective enforcement because the techniques that traffickers use to keep their victims enslaved severely limit self-reporting;

Whereas January 1 is the anniversary of the effective date of the Emancipation Proclamation;

Whereas February 1 is the anniversary of the date that President Abraham Lincoln signed the joint resolution sending the 13th Amendment to the States for ratification, to forever declare that "Neither slavery nor involuntary servitude . . . shall exist within the United States, or any place subject to their jurisdiction" and is a date which has long been celebrated as National Freedom Day, as described in section 124 of title 36, United States Code;

Whereas, under its authority to enforce the 13th Amendment "by appropriate legislation," Congress in the Trafficking Victims Protection Act of 2000 updated the post-Civil War involuntary servitude and slavery statutes and adopted an approach known as the "3P" approach of victim protection, vigorous prosecution, and prevention of human trafficking; and

Whereas the effort by individuals, businesses, organizations, and governing bodies to commemorate January 11 as Human Trafficking Awareness Day represents one of the many positive examples of the commitment in the United States to raise awareness of and to actively oppose modern slavery: Now, therefore, be it

Resolved, That the Senate supports—

(1) the goals and ideals of observing the National Slavery and Trafficking Prevention Month from January 1 through February 1, 2010, to recognize the vital role that the people of the United States have in ending modern slavery;

(2) marking this observance with appropriate programs and activities culminating in the observance on February 1 of National Freedom Day, as described in section 124 of title 36, United States Code; and

(3) all other efforts to raise awareness of and opposition to human trafficking.

SENATE RESOLUTION 383—DESIGNATING JANUARY 2010 AS "NATIONAL MENTORING MONTH"

Mr. MCCAIN (for himself, Mr. KERRY, Mrs. LINCOLN, Mr. INOUE, Mr. BEGICH, Mr. FEINGOLD, Mr. SPECTER, Mr. GRASSLEY, Mr. BURR, Ms. COLLINS, Ms. MURKOWSKI, and Mr. COCHRAN) submitted the following resolution; which was considered and agreed to:

S. RES. 383

Whereas mentoring is a longstanding tradition in which a dependable, caring adult provides guidance, support, and encouragement to facilitate a young person's social, emotional, and cognitive development;

Whereas continued research on mentoring shows that formal, high-quality mentoring focused on developing the competence and character of the mentee promotes positive outcomes, such as improved academic achievement, self-esteem, social skills, and career development;

Whereas further research on mentoring provides strong evidence that mentoring successfully reduces substance use and abuse, academic failure, and delinquency;

Whereas mentoring, in addition to preparing young people for school, work, and life, is extremely rewarding for those serving as mentors;

Whereas more than 4,700 mentoring programs in communities of all sizes across the United States focus on building strong, effective relationships between mentors and mentees;

Whereas approximately 3,000,000 young people in the United States are in solid mentoring relationships due to the remarkable vigor, creativity, and resourcefulness of the thousands of mentoring programs in communities throughout the Nation;

Whereas in spite of the progress made to increase mentoring, the United States has a serious "mentoring gap", with nearly 15,000,000 young people in need of mentors;

Whereas mentoring partnerships between the public and private sectors bring State and local leaders together to support mentoring programs by preventing duplication of efforts, offering training in industry best practices, and making the most of limited resources to benefit young people in the United States;

Whereas the designation of January 2010 as "National Mentoring Month" will help call attention to the critical role mentors play in helping young people realize their potential;

Whereas a month-long celebration of mentoring will encourage more individuals and organizations, including schools, businesses, nonprofit organizations, faith institutions, and foundations, to become engaged in mentoring across the United States; and

Whereas National Mentoring Month will, most significantly, build awareness of mentoring and encourage more people to become mentors and help close the mentoring gap in the United States: Now, therefore, be it

Resolved, That the Senate—

(1) designates the month of January 2010 as "National Mentoring Month";

(2) recognizes with gratitude the contributions of the millions of caring adults and students who are already volunteering as mentors and encourages more adults and students to volunteer as mentors; and

(3) encourages the people of the United States to observe National Mentoring Month with appropriate ceremonies and activities that promote awareness of, and volunteer involvement with, youth mentoring.

PRIVILEGES OF THE FLOOR

Mr. BAUCUS. Mr. President, I ask unanimous consent that Daniel Barlava, an intern in Senator DODD's office, be granted the privilege of the floor for the remainder of today's session.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUPPORTING NATIONAL SLAVERY AND TRAFFICKING PREVENTION MONTH

Mr. DURBIN. I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 382 submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The bill clerk read as follows:

A resolution (S. Res. 382) supporting the goals and ideals of observing National Slavery and Trafficking Prevention Month from January 1 through February 1, 2010, to raise awareness of, and opposition to, modern slavery.

There being no objection, the Senate proceeded to consider the resolution.

Mrs. FEINSTEIN. Mr. President, today the Senate will take an important step to raise awareness of human trafficking, a form of modern-day slavery. The resolution, introduced by myself and Senators CORNYN, CARDIN, and BROWNBACK, observes National Slavery and Trafficking Prevention Month from January 1 through February 1 to raise awareness of, and opposition to, modern slavery and human trafficking. This bipartisan resolution was passed unanimously today by the Senate.

Human trafficking is a crime in which persons are forced to work against their will in sweatshops, prostitution rings, farm labor, private homes, and other enterprises. The traffickers use force, threats of force, and coercion to ensure that their victims believe they have no other choice but to work for their captors.

The resolution resolves that Congress supports (1) the goals and ideals of observing the National Slavery and Trafficking Prevention Month from January 1 through February 1 to recognize the vital role that the people of the United States have in ending modern slavery; (2) marking this observance with appropriate programs and activities culminating in the observance on February 1 of National Freedom Day; and (3) all other efforts to raise awareness of and opposition to human trafficking.

This resolution recognizes the month of January as significant for modern slavery and human trafficking. January 1 is the anniversary of the effective date of the Emancipation Proclamation and February 1 is the anniversary of the date that President Abraham Lincoln signed the joint resolution sending the 13th amendment to the States for ratification.

In addition, it recognizes that January 11 is a day that many have chosen to commemorate human trafficking. In the 110th Congress, I sponsored a concurrent resolution that passed the Senate supporting January 11 as a National Day of Human Trafficking Awareness.

In 2007, California passed a resolution, signed into law by Governor Schwarzenegger, designating January 11 as National Day of Human Trafficking Awareness. The Los Angeles City Council and the Los Angeles County Board of Supervisors did the same for the county of Los Angeles.

The issue of human trafficking has become particularly problematic in California. San Diego is an international trafficking gateway city used to traffic foreign children into the U.S. The United Nations has listed Mexico as the No. 1 exporter of exploited children into North America.

From 1998 to 2003, more than 500 people from 18 countries were ensnared in 57 forced labor operations throughout California. These statistics only represent the cases that were discovered. Frequently, human trafficking goes undetected because the victims are not only afraid of their traffickers, but they have been taught by their traffickers to fear U.S. law enforcement.

Congress has acted to broaden the tools available to prosecute perpetrators of modern slavery and to assist and protect victims of human trafficking. It has enacted the Trafficking Victims Protection Act of 2000 and the William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008.

California has taken a leadership role in identifying and prosecuting human trafficking cases. For example, San Diego received one of the first grants to train local law enforcement on identifying and prosecuting human trafficking. The U.S. attorneys offices in Oakland, Los Angeles, and San Diego have all created antitrafficking task forces.

Using these tools, this August five people in California were sentenced to Federal prison, all receiving multi-decade sentences for their roles in an international sex trafficking ring that lured young Guatemalan women and girls into the Los Angeles area and forced them into prostitution.

In this distressing case, the defendants intimidated and controlled their victims by threatening to beat them and kill their loved ones in Guatemala if they tried to escape. At least three of the defendants restrained the victims by locking them in at night and blocking windows and doors to prevent their escape.

In another recent case in Walnut Creek, CA, a woman was found guilty of trafficking a nanny from Peru. For nearly 2 years, the victim was forced to cook, clean, and take care of the fam-

ily's children through false promises of pay. The victim was eventually able to escape, with the assistance of local residents and officials and parents at a local elementary school.

Human trafficking is a pervasive global crime, with nearly 1 million people trafficked across international borders every year. According to the State Department, roughly 80 percent of the victims are women and children.

I believe that it is vital that we work together as a nation to eliminate human trafficking and prevent the victimization of the most vulnerable members of society.

Awareness of the issues surrounding slavery and trafficking by those people most likely to come into contact with vulnerable populations is essential for effective prevention and prosecution of this frequently hidden crime.

I thank my colleagues for their support of this resolution to help raise awareness of modern day slavery.

Mr. DURBIN. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and any statements related to the resolution be printed in the RECORD at the appropriate place.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 382) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 382

Whereas the United States has a tradition of advancing fundamental human rights, having abolished the Transatlantic Slave Trade in 1808 and having abolished chattel slavery and prohibited involuntary servitude in 1865;

Whereas because the people of the United States remain committed to protecting individual freedom, there is a national imperative to eliminate human trafficking, which is the recruitment, harboring, transportation, provision, or obtaining of persons for labor or services through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery, and the inducement of a commercial sex act by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age;

Whereas to combat human trafficking in the United States and globally, the people of the United States, the Federal Government, and State and local governments must be aware of the realities of human trafficking and must be dedicated to stopping this contemporary manifestation of slavery;

Whereas beyond all differences of race, creed, or political persuasion, the people of the United States face national threats together and refuse to let modern slavery exist in the United States and around the world;

Whereas the United States should actively oppose all individuals, groups, organizations, and nations who support, advance, or commit acts of human trafficking;

Whereas the United States must also work to end slavery in all of its forms around the world through education;

Whereas victims of modern slavery need support in order to escape and to recover from the physical, mental, emotional, and spiritual trauma associated with their victimization;

Whereas human traffickers use many physical and psychological techniques to control their victims, including the use of violence or threats of violence against the victim or the victim's family, isolation from the public, isolation from the victim's family and religious or ethnic communities, language and cultural barriers, shame, control of the victim's possessions, confiscation of passports and other identification documents, and threats of arrest, deportation, or imprisonment if the victim attempts to reach out for assistance or to leave;

Whereas although laws to prosecute perpetrators of modern slavery and to assist and protect victims of human trafficking, such as the Trafficking Victims Protection Act of 2000 (division A of Public Law 106-386; 114 Stat. 1466) and the William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008 (Public Law 110-457; 122 Stat. 5044), have been enacted in the United States, awareness of the issues surrounding slavery and trafficking by those people most likely to come into contact with victims is essential for effective enforcement because the techniques that traffickers use to keep their victims enslaved severely limit self-reporting;

Whereas January 1 is the anniversary of the effective date of the Emancipation Proclamation;

Whereas February 1 is the anniversary of the date that President Abraham Lincoln signed the joint resolution sending the 13th Amendment to the States for ratification, to forever declare that "Neither slavery nor involuntary servitude . . . shall exist within the United States, or any place subject to their jurisdiction" and is a date which has long been celebrated as National Freedom Day, as described in section 124 of title 36, United States Code;

Whereas, under its authority to enforce the 13th Amendment "by appropriate legislation," Congress in the Trafficking Victims Protection Act of 2000 updated the post-Civil War involuntary servitude and slavery statutes and adopted an approach known as the "3P" approach of victim protection, vigorous prosecution, and prevention of human trafficking; and

Whereas the effort by individuals, businesses, organizations, and governing bodies to commemorate January 11 as Human Trafficking Awareness Day represents one of the many positive examples of the commitment in the United States to raise awareness of and to actively oppose modern slavery: Now, therefore, be it

Resolved, That the Senate supports—

(1) the goals and ideals of observing the National Slavery and Trafficking Prevention Month from January 1 through February 1, 2010, to recognize the vital role that the people of the United States have in ending modern slavery;

(2) marking this observance with appropriate programs and activities culminating in the observance on February 1 of National Freedom Day, as described in section 124 of title 36, United States Code; and

(3) all other efforts to raise awareness of and opposition to human trafficking.

NATIONAL MENTORING MONTH

Mr. DURBIN. I ask unanimous consent that the Senate proceed to the im-

mediate consideration of S. Res. 383 submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The bill clerk read as follows:

A resolution (S. Res. 383) designating January 2010 as "National Mentoring Month."

There being no objection, the Senate proceeded to consider the resolution.

Mr. McCAIN. Mr. President, I am pleased today to join many of my colleagues in supporting a resolution designating January 2010 as "National Mentoring Month."

We all agree that young people need a supportive environment based on structured and trusting relationships with adults. The world is more complicated for children today than it ever was when I was growing up. Mentors can help young people through the difficult periods, help them see the difference between right and wrong, alleviate their doubts and concerns, and answer their questions frankly. Mentors can dramatically impact a young person's life by providing the support and encouragement that children need in order to grow into responsible, caring adults.

This resolution recognizes the value of volunteering time to make a difference in the life of a child. A growing body of research has shown that high-quality programs can make all the difference and help students in need achieve the type of future they might never have thought possible. Children with mentors are shown to improve in school performance and attendance. Also, they are more self-confident, have good social skills, and above all else, they are motivated to reach their full potential. Unfortunately, a severe shortage of volunteers has left over 15 million young people without mentors.

National Mentoring Month highlights the needs and goals of mentoring in this country and honors the contributions of the many volunteers across the country that are currently connecting with youth in such programs. Next month, nonprofit organizations, schools, businesses, faith communities, and government agencies—led by the National Mentoring Partnership and the Harvard School of Public Health—will join together to encourage adults to serve as mentors for our young people. Programs must be expanded to recruit more volunteers to help fill the mentoring gap. Mentoring has successfully helped many children in this country and we must work together to expand such valuable programs. I urge the Senate to approve this resolution.

Mr. DURBIN. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table with no intervening action or debate, and any statements related to the resolution be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 383) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 383

Whereas mentoring is a longstanding tradition in which a dependable, caring adult provides guidance, support, and encouragement to facilitate a young person's social, emotional, and cognitive development;

Whereas continued research on mentoring shows that formal, high-quality mentoring focused on developing the competence and character of the mentee promotes positive outcomes, such as improved academic achievement, self-esteem, social skills, and career development;

Whereas further research on mentoring provides strong evidence that mentoring successfully reduces substance use and abuse, academic failure, and delinquency;

Whereas mentoring, in addition to preparing young people for school, work, and life, is extremely rewarding for those serving as mentors;

Whereas more than 4,700 mentoring programs in communities of all sizes across the United States focus on building strong, effective relationships between mentors and mentees;

Whereas approximately 3,000,000 young people in the United States are in solid mentoring relationships due to the remarkable vigor, creativity, and resourcefulness of the thousands of mentoring programs in communities throughout the Nation;

Whereas in spite of the progress made to increase mentoring, the United States has a serious "mentoring gap", with nearly 15,000,000 young people in need of mentors;

Whereas mentoring partnerships between the public and private sectors bring State and local leaders together to support mentoring programs by preventing duplication of efforts, offering training in industry best practices, and making the most of limited resources to benefit young people in the United States;

Whereas the designation of January 2010 as "National Mentoring Month" will help call attention to the critical role mentors play in helping young people realize their potential;

Whereas a month-long celebration of mentoring will encourage more individuals and organizations, including schools, businesses, nonprofit organizations, faith institutions, and foundations, to become engaged in mentoring across the United States; and

Whereas National Mentoring Month will, most significantly, build awareness of mentoring and encourage more people to become mentors and help close the mentoring gap in the United States: Now, therefore, be it

Resolved, That the Senate—

(1) designates the month of January 2010 as "National Mentoring Month";

(2) recognizes with gratitude the contributions of the millions of caring adults and students who are already volunteering as mentors and encourages more adults and students to volunteer as mentors; and

(3) encourages the people of the United States to observe National Mentoring Month with appropriate ceremonies and activities that promote awareness of, and volunteer involvement with, youth mentoring.

ORDER OF PROCEDURE

Mr. DURBIN. Mr. President, I ask unanimous consent that the controlled time be extended for an additional 30 minutes under the control of the Republican side, and that all additional time, including that already utilized by Senator MENENDEZ, with postcloture time continue to run during this period.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDERS FOR TUESDAY,
DECEMBER 22, 2003

Mr. DURBIN. I ask unanimous consent that when the Senate completes its business today, it stand adjourned until 7 a.m., Tuesday, December 22; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, and the time for the two leaders be reserved for their use later in the day; that the Senate then resume consideration of H.R. 3590, with postcloture time continuing to run during the overnight adjournment, and that the time until the expiration of postcloture time be equally divided and controlled between the leaders or their designees; that upon the expiration of the time, the majority leader be recognized to move to table amendment No. 3278; that upon disposition of amendment No. 3278, amendment No. 3277 be withdrawn; that the Senate then proceed to vote on adoption of amendment No. 3276; that upon disposition of amendment No. 3276, the Senate then proceed to vote on the motion to invoke cloture on amendment No. 2786; that if cloture is invoked, the majority leader then be recognized and that the time until 9:30 a.m. then be equally divided and controlled between the leaders or their designees; further, that the Senate begin alternating one-hour blocks of time beginning at 9:30 a.m. until 5:30 p.m., with the Republicans controlling the first hour; that at 12:30 p.m., the Senate stand in recess until 2:30 p.m., and that upon reconvening, the Senate resume the alternating blocks until 5:30 p.m., with all postcloture time counting during any recess period and until 5:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDER FOR ADJOURNMENT

Mr. DURBIN. Mr. President, I ask unanimous consent that the Senate adjourn following the remarks of Senator VOINOVICH of Ohio and Senator DEMINT, if he chooses to speak.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Ohio.

HEALTH CARE REFORM

Mr. VOINOVICH. Mr. President, I wanted to take some time to talk

about the health care bill before the Senate which the majority leader is anxious to get passed before Christmas. I suspect that he knows if this bill sees too much light of day, he could lose 1 or 2 of his 60 votes, and that is why his managers' amendment was kept under wraps so that no one knew anything about it until the last minute.

On our side of the aisle, we would like to hold off until after Christmas to give all Members of the Senate and the American people a chance to review this legislation. Obviously, this is not going to happen. I think that is unfortunate.

When you compare the number of days we spent debating this bill to other major pieces of legislation that have come before this body in recent years, the Democrats' haste is obvious.

For example, in 2002, I was very much involved in the legislation that created the Department of Homeland Security. We spent 19 days over 7 weeks on the floor debating that bill. We took 20 votes on amendments during the debate. The final result was bipartisan. Ninety Members of the Senate voted for it.

Tragically, for the American people, unlike other important health care-related bills such as the Medicare Modernization Act that garnered wide bipartisan support, this bill is nowhere near bipartisan and did not receive a single Republican vote for cloture at 1 this morning, and only one Republican in the House of Representatives supported it.

In my humble opinion, the way this bill was negotiated behind closed doors, and without the input of Members from both sides, will sour relations and bipartisan discussion on other major issues to come before the Senate, such as debt and deficit reduction—notably bipartisan legislation that I have been working on very closely with Senators GREGG and CONRAD, a comprehensive energy bill, reauthorization of the surface transportation bill, climate change legislation, and—very important—a jobs bill.

The problems facing our country are too serious for business as usual, each side one-upping the other for political advantage, with the 2010 elections casting shadows on what we should be doing for the benefit of our country, at a time when this Nation is as fragile as I have seen it in my entire life.

Our future and the future of our children and grandchildren is in our hands. Our constituents and the world are watching. Our credibility and credit are on the line, and so is our economic and national security, and, quite frankly, our leadership position in the world. We need fewer partisans in this body and more statesmen.

Last week I came to the floor to remind my colleagues and the American people about the fiscal realities that face our Nation and explained how this

health reform legislation, which is now likely to pass based on this morning's cloture vote, would make an unsustainable fiscal situation even worse.

Let me remind you as we stand right now that our Nation's debt has exceeded \$12 trillion for the first time in our history. In fact, from 2008 to 2009 alone, the Federal debt increased 19 percent, boosting national debt as a percentage of GDP from 70 percent last year to 84 percent this year. We have not seen this kind of debt-to-GDP ratio since the end of the Second World War.

We have amassed a staggering \$70 trillion in unfunded obligations over the next 75 years or an estimated \$600,000 per American household.

Our Medicare Program is already on shaky footing with \$37 trillion in unfunded future Medicare costs, and the Medicare trust fund is expected to be insolvent by 2017. Frankly, this is why I am disappointed the Senate failed to support Senator GREGG's amendment we considered earlier in this debate to ensure that the savings achieved by Medicare cuts would be used to ensure the viability of the program, and not new entitlements.

I ask my colleagues, can our Nation take on new programs and costs when we cannot pay for what we are doing right now? Our Nation's fiscal picture is not pretty. Our obligations to our entitlement programs are exploding. If we keep going the way we are, our debt will double in 5 years and triple in 10.

Our budgets are unbalanced as far as the eye can see. Last year we borrowed \$1.4 trillion, and 50 percent of our debt is in the hands of foreign countries. The American people get it. They already know the Federal Government is the worst credit card abuser in the world, and we are putting everything on the tab of our children and grandchildren.

They are not the only ones. Internationally, our creditors are concerned. Chinese Premier Wen Jiabao has noted:

We have lent a huge amount of money to the United States and of course we're concerned about the security of our assets and, to be honest, I am a little bit worried. That's why here I would like to urge the US to keep its commitment and promise to ensure the safety of Chinese assets.

That is what he said to the President—anybody who goes to China today. They are worried about the fact they have lent us a lot of money and maybe they might not get it back.

While the international community understands our crisis, somehow Congress does not get it. Here we are considering a bill that, when fully implemented, spends more than \$2 trillion over 10 years to restructure our health care system.

I respect my friends on the other side of the aisle, but the assumptions they make are optimistic about the cuts in

this bill, especially when one considers this body's propensity for acting in a fiscally irresponsible manner.

Frankly, our history on the so-called doc fix is illustrative. We continue to kick the cost of fixing Medicare payments for physicians down the road, instead of dealing with its more than \$200 billion cost.

The bill before us does not even have the 1-year fix that the original bill had included. My friends on the other side of the aisle have decided to put it off and deal with it in a separate measure because it would make this bill even more expensive.

As congressional observers have noted, we continue to put off the difficult choices. The fact is, Congress is not willing to take short-term pain for long-term gain. This is my 11th year, and it is the same old story year after year.

This brings me back to the health care bill. I have heard all the arguments of why health care reform is needed, and—do you know something—I agree with most of them. Frankly, there are a number of incremental things we could do today to make real improvements in our system in a bipartisan way. In fact, I encourage my colleagues to take a look at some of the proposals contained in the alternatives offered by my colleagues, including Senators WYDEN and BENNETT.

These and other legislative proposals include things we can do on an incremental basis to improve our system, such as making it easier for small business to group together to reduce their health care costs; passing medical liability reform, where we have more tests being taken because doctors are afraid of being sued; increasing flexibility in the private market so people have more options and can choose insurance products that best meet their needs; implementing policies that encourage wellness and prevention; eliminating the fraud and abuse that have and will continue to plague our public health care programs; eliminating the ability of insurance companies to deny people insurance coverage because of preexisting conditions; or eliminating the caps that insurance companies put once an individual reaches a certain amount.

Instead, we are going to pass a massive new spending bill that does little to fix our problems in the long run. What too many of my colleagues do not understand is there are limits to what government can do. There are limits on what government can do. When I was mayor of the city of Cleveland, Governor of Ohio, people would come to me with ideas to expand programs and services. Often, even though I saw the merit of these proposals, just like I see the merit of a lot of the suggestions we need to have in terms of health care, I knew we did not have the money to pay for these proposals, especially because

we had to balance our budgets. In those situations, I had to be honest and say no.

It is the same thing here. I am sure the Presiding Officer has people coming into his office every day saying: I want you to help with this worthy cause. I sit, I listen patiently, and I say to them: If what you are asking me to do means we are going to have to borrow money, and it is going to be paid for by our children and grandchildren, what do you have to say? Nine times out of 10, they say: No. Thank you very much, Senator. And they go out the door. They get it. They understand that.

Unfortunately, Congress does not get it. It is not just my colleagues on the other side of the aisle, folks. No one's hands are completely clean. That is the way it is. We just keep on going the way we are, keep going down the road.

Here we are in the worst recession since the Great Depression. Millions of Americans are out of work. Others lucky enough to have a job are wondering if they will be next to be laid off or fired. In my State of Ohio, the unemployment rate is 10.6 percent. Yet we are talking about health care reform, cap and trade, which will put unsustainable burdens on doing business in this country and make it more difficult to get this economy going again.

What people in this country want is to go back to work and have some assurance that their jobs are safe. The best way to give them security and access to health insurance is to get them back to work.

We should not be asking our Nation's businesses to take on new tax burdens in the current recession. Yet this bill before us would impose \$28 billion in new taxes on employers—\$28 billion. Furthermore, the legislation creates a new Medicare payroll tax that will likely hit approximately one-third of the small businesses in this country, which employ some 30 million Americans. These new taxes are likely to significantly hinder these engines of job growth.

Another troubling tax that will impact businesses in my State is the tax on device manufacturers. I have heard from one of our Ohio companies that this tax could force it to move its operations overseas to keep its doors open. In fact—this is unbelievable—according to the company's own calculations, the new device tax will exceed 100 percent of its domestic earnings and research and development budget. It has nothing to do with their profitability. They say: You are this business. You have a percentage of it, and we are going to lay the tax right on your back.

Ohio cannot afford to lose these jobs to another country at any time but certainly not right now in this struggling economy. But this is just the beginning for businesses, large and small.

The bill will add a whole new, never seen before, layer of bureaucracy on our businesses. Think about that. Small and even large businesses are already overwhelmed with management and paperwork demands as a result of government mandates. Many of them have to hire multiple tax attorneys and accountants to help them navigate the Federal laws and their tax obligations.

I cannot help but wonder how many businesses, both large and small, will have to hire new "benefit managers." There is an area where we will create some new jobs. We are going to hire benefit managers to help them keep track of the new requirements to ensure they are offering the appropriate benefits or paying the appropriate fine. What a nightmare.

No one has mentioned the thousands of additional Federal workers. Nobody has talked about it. When we did Part D of Medicare, they had to hire over 500 people at CMS. So we will have to hire all kinds of people, including—listen to this—at the Internal Revenue Service. I bet you would have a hard time finding an American who thinks it is a good idea to get the IRS involved in delivering our Nation's health care.

The worst thing we can do is borrow another \$2.3 trillion, create additional Federal programs, and put a bigger burden on the engine of job creation. I find this especially troublesome after hearing the Chief Actuary at the Centers for Medicare & Medicaid Services last week report that under the original Reid health care bill costs would go up, not down. In fact, according to his analysis, the Federal Government would spend \$234 billion more on health care if this legislation became law than without it—\$234 billion more with this legislation than what we are spending right now.

It is not just the Federal Government. As I discussed in some detail last week, most States will have new fiscal obligations of about \$26 billion under this bill. If you are not lucky enough to be from one of the States, such as the Cornhusker State or another State that got a special deal in this legislation to get the Democratic leadership's 60 votes, your Governor is going to be hit with a portion of the cost of expanding the Medicaid Program to cover all individuals up to 133 percent of the Federal poverty level.

In the State of Ohio, we have had 154,000 more people come on Medicaid just with the current extent of poverty, and to go to 133 percent, it is going to be incredible.

As a former Governor of Ohio, former chairman of the National Governors Association, and past chairman of the National League of Cities, I am very familiar with what unfunded mandates can do to State and local governments.

By the way, there is a point of order that lies against this bill as an unfunded mandate in terms of local and

State government, and also business. The American people should understand that the new State obligations under the Medicare expansion will mean less funding, OK, less funding for primary and secondary education, higher education programs, roads and bridges, county and local government projects, and safety service programs run by their States. In fact, I used to call Medicaid the Pacman that gobbled up our State budget dollars.

So let's look at this. You take the side over here of Medicaid, but then what you do is you expand that, and it is going to be more expensive, and then you look around and you say: We have great needs with secondary and primary education. The kids are complaining about the fact that tuition is going up for our institutions of higher education. Our local government officials are complaining because the State and local government funds that are going to them are not available to them because all of this money is flowing in this direction. In other words, under the Reid bill, we will put more stress and further unfunded mandates on the States, making our health care fiscal picture even worse than it would be without doing anything at all. This doesn't make any sense.

As I have often said—in fact, when I was Governor, I said—Gone are the days when public officials will be judged by how much they spend on a problem; the new realities dictate that we work harder and smarter and more with less. In fact, I remember giving my state of the union addresses or state of the State addresses in Ohio, and they used to take a pool about how many times I would say “harder and smarter and more with less.” That is what our States are doing but not the Federal Government—not the Federal Government, oh, no. States are raising taxes and cutting but not the Federal Government. We are just in there borrowing and borrowing and borrowing as if there will be no tomorrow.

The costs incurred by our children and grandchildren as a result of this bill will be a crushing blow to their futures—a future that is already ominous because of this body. In other words, what we are saying to them is we are putting the cost on their credit card.

You are in a new world where the competition is going to be keener than ever. We have all kinds of competitors that we didn't have when I was growing up, so they are going to have to work harder. Then we are going to say to them: By the way, your taxes are going up. We are going to put a burden on your back because we weren't willing to pay for or do without during the time we were in a position of responsibility.

Another legacy I am upset about leaving for our children and grandchildren is the public funding of abortion. The other day, I explained to an

individual that since *Roe v. Wade*, we have had over 40 million abortions—40 million abortions. Yet I have friends of mine who are wanting children, and they are going to China, they are going to Russia, they are going to other places to find those children, but here in the United States over 40 million abortions. Unfortunately, the language that was inserted in the managers' amendment does not protect taxpayer dollars from being used to fund abortion. In fact, the U.S. Conference of Catholic Bishops and National Right to Life have said the language, and thus the bill, is unacceptable and should not move forward.

Turning back to the fiscal arguments against this bill, one of my colleagues said yesterday that those of us on this side of the aisle who argue we cannot afford this bill are being disingenuous and we are engaging in scare tactics, even asking when the “lying time”—from a colleague on the other side—the “lying time” for this side of the aisle will stop. Well, we will see. We will see. I am not going to be a Member of the U.S. Senate in 2012, but if God gives me the health and the energy, I will certainly be around to remind people who was telling the truth and who was not.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from South Carolina.

Mr. DEMINT. I ask unanimous consent to speak for 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DEMINT. Parliamentary inquiry, Mr. President:

Does rule XXII of the Standing Rules of the Senate provide that on a measure or motion to amend the Senate rules, the necessary affirmative vote shall be two-thirds of the Senators present and voting?

The PRESIDING OFFICER. It does.

Mr. DEMINT. Further parliamentary inquiry: Is it also the case that on numerous occasions, the Senate has required a two-thirds cloture vote on bills that combine amendments to the Senate rules with other legislative provisions that do not amend the rules?

The PRESIDING OFFICER. That would require a two-thirds vote.

Mr. DEMINT. I have numerous examples here. We did it twice this year on S. 2349, and I could read those, but I will spare the Chair all of these. I am just trying to get at a concern we have.

Am I correct that with respect to these bills, there was a combination of legislative provision and rules changes, and the Chair ruled that because there—and I am referring to earlier this year, those I referred to where we required the two-thirds cloture. Am I correct on these previous bills that with respect to the bills, there was a combination of legislative provisions and rules changes, and the Chair ruled that because there were rules changes, a two-thirds vote was required?

The PRESIDING OFFICER. If there were changes to the Standing Rules of the Senate, a two-thirds vote would have been required to invoke cloture.

Mr. DEMINT. I thank the Chair.

Am I also correct that the Senate has required a two-thirds cloture on amendments to bills, where the amendments combine legislative provisions and rules changes? I have a number of references to bills when this was done, if there is any question, and I have given them to the Parliamentarian for consideration. Is there an answer? I mean, I know there have been amendments to bills that we required two-thirds because they include rule changes. I just wanted to get a confirmation from our Parliamentarian.

Is that, in fact, the case, where two-thirds cloture on amendments to bills have been required to have a two-thirds vote because of the rules changes included in them?

The PRESIDING OFFICER. The Chair would have to check that for a future answer.

Mr. DEMINT. I believe the Parliamentarian does have references for when this has been done. I am quite certain it has.

But as the Chair has confirmed, rule XXII, paragraph 2, of the Standing Rules of the Senate states that on a measure or motion to amend the Senate rules, the necessary affirmative vote shall be two-thirds of the Senators present and voting.

Let me go to the bill before us because buried deep within the over 2,000 pages of this bill we find a rather substantial change to the Standing Rules of the Senate. It is section 3403, and it begins on page 1,000 of the Reid substitute. These provisions not only amend certain rules, they waive certain rules and create entirely new rules out of whole cloth.

Again, I will skip over some examples, but let me read a few of these provisions that amend the Senate rules which are contained in section 3403 of the Reid substitute.

Section D titled “Referral:”

The legislation introduced under this paragraph shall be referred by the Presiding Officers of the respective Houses to the Committee on Finance in the Senate and to the Committee on Energy and Commerce and the Committee on Ways and Means in the House of Representatives.

The bill creates out of whole cloth a new rule that this specific bill must be referred to the Senate Finance Committee.

Another example under section C, titled “Committee Jurisdiction:”

Notwithstanding rule 15 of the Standing Rules of the Senate, a committee amendment described in subparagraph (A) may include matter not within the jurisdiction of the Committee on Finance if that matter is relevant to a proposal contained in the bill submitted under subsection (c)(3).

Clearly a rule change.

So there is no pretense that this bill is being referred under the rules to the

committee of jurisdiction. Now it is allowing the Finance Committee to add whatever matter it wants to the bill regardless of any rules regarding committee jurisdiction. And for a good measure, the bill even specifically states that it is amending rule XV.

Let me just skip over a number of other examples referring to rules just to try to get to the point here because it goes on and on, and I have pages here.

There is one provision that I found particularly troubling, and it is under a section C titled "Limitation on Changes to This Subsection:"

It shall not be in order in the Senate or in the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change this subsection.

This is not legislation. This is not law. This is a rule change. It is a pretty big deal. We will be passing a new law and at the same time creating a Senate rule that makes it out of order to amend or even repeal the law. I am not even sure it is constitutional, but if it is, it most certainly is a Senate rule. I don't see why the majority party wouldn't put this in every bill. If you like your law, you most certainly would want it to have force for future Senates. I mean, we want to bind future Congresses.

This goes to the fundamental purpose of Senate rules, to prevent a tyrannical majority from trampling on the rights of the minority or of future Congresses.

Therefore, I would like to propound a parliamentary inquiry to the Chair. Does section 3403 of this bill propose amendments to the Standing Rules of the Senate? Further parliamentary inquiry: Does the inclusion of these proposed amendments to the Senate rules mean that the bill requires two-thirds present and voting to invoke cloture?

The PRESIDING OFFICER. The section of the proposed legislation addressed by the Senator does not amend the Standing Rules of the Senate, and therefore its inclusion does not affect the number of votes required to invoke cloture.

Mr. DEMINT. Is the Chair aware of any precedent where the Senate created a law and in doing so created a new rule that—and I am quoting from our bill:

It shall not be in order in the Senate or in the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change—

Such law?

Is the Chair aware that we have ever put this type of binding legislation on future Congresses in a bill?

The PRESIDING OFFICER. It is quite common to do that.

Mr. DEMINT. I would ask the Chair to get those references, if the Parliamentarian would, to us.

Mr. President, another parliamentary inquiry: If this new law will oper-

ate as a Senate rule, making it out of order for Senators to propose amendments to repeal or amend it—I have been in Congress 11 years. I have never heard of an amendment being called out of order because it changes something that was done before. How is that different than the types of Senate rule-making for which our predecessors in their wisdom provided a two-thirds cloture vote? This seems to be a redefinition of words, in my mind.

Mr. President, it is clear that the Parliamentarian is going to redefine words, as I am afraid he has done as part of this process before. But this is truly historic that we have included rules changes in legislation, and yet we are ignoring a rule that requires a two-thirds cloture vote to pass it. I believe it is unconstitutional. I believe it subverts the principle we have operated under, and it is very obvious to anyone that it does change a rule. It is clear that our rules mean nothing if we can redefine the words we use in them.

I yield the floor.

The PRESIDING OFFICER. The Chair will note that it is quite common to include provisions affecting Senate procedure in legislation.

Mr. DEMINT. Is there a difference between Senate procedures and rules?

The PRESIDING OFFICER. Yes.

Mr. DEMINT. So the language you see in this bill that specifically refers to a change in a rule is not a rule change, it is a procedure change?

The PRESIDING OFFICER. That is correct.

Mr. DEMINT. Then I guess our rules mean nothing, do they, if we can redefine them.

I thank the Chair. I yield the floor.

ADJOURNMENT UNTIL 7 A.M. TOMORROW

The PRESIDING OFFICER. The Senate stands adjourned until 7 a.m. tomorrow.

Thereupon, the Senate, at 7:41 p.m., adjourned until Tuesday, December 22, 2009, at 7 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

THEODORE W. TOZER, OF OHIO, TO BE PRESIDENT, GOVERNMENT NATIONAL MORTGAGE ASSOCIATION, VICE JOSEPH J. MURIN, RESIGNED.

DEPARTMENT OF COMMERCE

KEVIN WOLF, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF COMMERCE, VICE CHRISTOPHER R. WALL, RESIGNED.

TIMOTHY MCGEE, OF LOUISIANA, TO BE AN ASSISTANT SECRETARY OF COMMERCE, VICE PHILLIP A. SINGERMAN.

LEGAL SERVICES CORPORATION

SHARON L. BROWNE, OF CALIFORNIA, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE LEGAL SERVICES CORPORATION FOR A TERM EXPIRING JULY 13, 2010, VICE MICHAEL MCKAY, TERM EXPIRED.

CHARLES NORMAN WILTSE KECKLER, OF VIRGINIA, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE

LEGAL SERVICES CORPORATION FOR A TERM EXPIRING JULY 13, 2010, VICE FRANK B. STRICKLAND, TERM EXPIRED.

VICTOR B. MADDOX, OF KENTUCKY, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE LEGAL SERVICES CORPORATION FOR A TERM EXPIRING JULY 13, 2010, VICE LILLIAN R. BEVIER, TERM EXPIRED.

IN THE AIR FORCE

THE FOLLOWING NAMED AIR NATIONAL GUARD OF THE UNITED STATES OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE AIR FORCE UNDER TITLE 10, U.S.C., SECTIONS 12203 AND 12212:

To be colonel

FRANK R. AFLAGUE
CHRISTOPHER R. ALDERDICE
BORIS R. ARMSTRONG
CLARENCE ATTERBURY III
RICHARD T. BENNETT
JOHN E. BLICKENSDECKER
GARY D. BREWER, JR.
WILLIAM D. BUNCH
JEFFREY W. BURKETT
WADE K. CAUSEY
JOSEPH S. CHISOLM
JOHN L. CHURCH, JR.
GREGORY S. CLAPPER
SHAWN A. CLOUTHER
FRANK J. COPRIVNICAR, JR.
MICHAEL G. CRANSTON
MARK A. CROSBY
THOMAS T. CURRY
KEVIN S. DAILEY
JOSEPH C. DARROW, JR.
ELBURN H. DAUGHERTY III
CHARLES D. DAVIS III
THOMAS C. ECHOLS
REM B. EDWARDS III
DAVID L. EVANS
BILLIE J. FAUST
GREGORY P. FERNANDEZ
DAWN M. FERRELL
JAMES C. FOGLE
TROY A. FROST
WALTER E. GARTNER
MICHELE M. GAVIN
PETER T. GELESKIE
JASON W. GLASS
PETER T. GREEN III
THOMAS E. HANS
DOUGLAS D. HAYWORTH
PAUL F. HEYE, JR.
MICHAEL C. HIRST
GEORGE W. HOLT, JR.
CASSANDRA D. HOWARD
JEFFREY W. JACOBSON
WENDY K. JOHNSON
MARQUITA P. JOHNSONBAILEY
JEFFREY J. JORDAN
RICHARD J. KEASEY
JOHN R. KIRK
THADDEUS J. KOLWICZ
MEAGHAN Q. LECLERC
SUZANNE B. LIPCAMAN
SANDRA D. LONG
RONALD D. LOWERY
MARK S. LYON
MARK J. MACLEAN
CRAIG A. MANIFOLD
MICHAEL E. MANNING
ROBERT S. MARTIN
JOE A. MARTINEZ II
JAMES P. MOFFETT
MARK D. MURPHY
STEVEN S. NORDHAUS
TIMOTHY P. OBRIEN
LOUISE M. PARADIS
LOUIS J. PERINO
WILLIAM R. POST
JOSEPH S. ROBINSON
WILLIAM D. ROGERS, JR.
JON L. SCOTT
EDWIN B. SELF, JR.
RAY M. SHEPARD
RICHARD I. SIMMONS
JOHN D. SLOCUM
TIMOTHY G. SMITH
STANLEY U. SNOW
SEAN M. SOUTHWORTH
MICHAEL D. STOHLER
JEFFREY D. STOREY
STEPHEN L. SUAFILO
STEVEN R. SWETNAM
JAMES D. TAYLOR II
WILLIAM L. THOMAS
TAMI S. THOMPSON
CHRISTOPHER K. THOMSON
RANDALL TOM
JEFFREY R. VALLE
JEFFREY J. WAECHTER
CHRISTOPHER S. WALKER
JOSEPH G. WALSH IV
RODNEY WILLIAMS
JOSEPH B. WILSON
FRANK Y. YANG
WILLIAM T. YATES

IN THE MARINE CORPS

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES MARINE CORPS RESERVE UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

DAVID F. ALLEN
MICHAEL T. BARRY
WILLIAM M. BROWN, JR.
JAMES BURACK
ANTONIO J. CAPETILLO
DAVID H. CLEARY
BRUCE M. DOWNS
BARRY E. FEDERICI
THOMAS P. FORT
MICHAEL J. FROEDER
JAMES H. GRIFFIN
DAVID A. GRUSS
CHRISTOPHER N. HAMILTON
JOHN S. HOGAN
THADDEUS L. JANKOWSKI
TREVOR E. KLEINEAHLBRANDT
JOHN C. KRIZAN
JOHN H. LISTER
JAMES C. MCDONALD
WILLIAM M. MCGOWAN
PHILLIP A. MILLERD
WILLIAM F. MORGAN
MARK G. MURPHY
MATTHEW D. NAFUS
WILLIAM S. NAGLE, JR.
JACQUES C. NAVIAUX II
JOHN G. NETTLES
STEPHEN B. NICHOLS
JAMES L. PARKER
DAVID L. POHLMAN
DANIEL J. REBER
JOSEPH K. RILEY
EMILIO T. ROVIRA
DWIGHT C. SCHMIDT
JOHN A. SKINNER
WARREN J. SOONG
JOSEPH M. STUART, JR.
ERIC M. VEIT
MICHAEL A. WABREK
JAMES L. WATSON, JR.
MARVIN A. WILLIAMS

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT
TO THE GRADE INDICATED IN THE UNITED STATES MA-
RINE CORPS UNDER TITLE 10, U.S.C., SECTION 624:

To be major

JOSE M. ACEVEDO
DAVID AHN
DARRIAN H. AINSWORTH
CHRISTOPHER P. ALLAIN
DARREN G. ALLISON
NAIM I. ALQAADIR
CHAD J. ALTHISER
TIMOTHY D. ANDERLONIS
MICHAEL R. ANDERSON
SHAWN E. ANDERSON
KIELLY A. ANDREWS
JOSEPH F. ANDROSKI
CHRISTOPHER E. ANNUNZIATA
MICHAEL ANTHONY, JR.
ZACHARIAH E. ANTHONY
JOEL R. ARCHIBALD
JUSTIN M. ARGENTIERI
SARAH B. ARMSTRONG
MARC F. ARNOLD
JOSEPH A. ATKINSON
JOSHUA P. BAHR
COLIN F. BAILEY
DOUGLAS A. BAKER
NATHANIEL A. BAKER
PETER Y. BAN
JAMES H. BANTON, JR.
RICHARD S. BARCLAY
JAMES K. BARE, JR.
DONALD J. BARNES
RYAN D. BARNES
RICARDO A. BARTON
DANIEL M. BARTOS
KATHARINE A. BARWICK
JOSHUA R. BATES
LONNIE A. BAXLEY
JOHN R. BEAL
HOWARD G. BEASEY
MICHAEL S. BEASLEY
ZEB B. BEASLEY II
RICHARD T. BEESON
JOHN M. BEICHNER, JR.
DAVID M. BELL
SCOTT M. BENNINGHOFF
RYAN P. BENSON
JOHN L. BERAUD
NEIL R. BERRY
BART A. BETIK
NICHOLAS J. BEZANSON
KEVIN M. BICKING
JOSHUA P. BIGGERS
JAMES C. BISE
ALVIN C. BISSETTE
PAUL B. BISULCA
JOHN R. BITONTI II
ADAM W. BLANTON
KENDALL J. BODNAR
MICHAEL J. BORNEO
WILLIAM M. BOULWARE
DAVID J. BOWER
ROBERT R. BOYCE
DOUGLAS R. BOYLE
TIMOTHY F. BRADY, JR.
MARK P. BRAITHWAITE

BRIAN J. BRAUER
KEITH C. BRENIZE
KEVIN D. BRIGGS
ADAM W. BRILL
KATALIN C. BROGDON
MATTHEW R. BROWER
KEVIN M. BROWN
MATTHEW J. BROWN
PETER E. BROWN
KYLE A. BUCHINA
ROBERT S. BUNN
CHRISTOPHER M. BURNETT
EUGENE E. BURRELL, JR.
KYLE R. BUSH
JOHN M. BUSSARD
JARED E. CAGLE
STANLEY P. CALIXTE
GEORGE D. CAMIA
TOMMASO CAMILLERI
IAN S. CAMPBELL
CESAREON E. CARAMANZANA
REGINA V. CARBONARI
MICHAEL CARLSON
MANUEL F. CARPIO
MICHAEL J. CARROLL
CHRISTOPHER B. CARTER
CHRISTOPHER T. CASEY
ROBERT D. CASILLAS
MICHAEL R. CASSIDY
JOSHUA E. CAVAN
BOLO S. CAVANH
GREER C. CHAMBLESS
MICHAEL K. CHANKIJ
ROBERT F. CHAPELL
SHAWN M. CHARCHAN
DAVID P. CHEEK
TOM CHHABRA
RONALD G. CHINO
ERIC W. CHRISTENSON
BRIAN P. CHRISTIANSON
ALAN J. CLARKE
STEVEN M. CLIFTON
DANNY J. COHLMAYER
RAYMOND S. COLLINS
STACEY B. COLON
KEVIN T. CONLON
CHRISTOPHER S. CONNER
TRUSTUN G. CONNOR
SCOTT A. CONSTANTINEAU
JESSE B. COOK
NEIL A. CORDES
TIMOTHY F. COSTELLO
LUKE A. COYLE
JASON A. CRAIG
WILFREDO CRAVE, JR.
CHAD E. CRAVEN
TAMERSEN J. CRITCHLOWGLENN
WALTER D. CROMER, JR.
VICTOR M. CRUZ
CARLOS R. CUEVAS
SAMUEL C. CUNNINGHAM
SCOTT A. CUOMO
JEFFREY S. CURTIS
MARC R. DAIGLER
MATTHEW T. DAIGNEAULT
JOSEPH P. DAMICO
BRIAN R. DAVIS
EVAN A. DAY
LANCE C. DAY
WESLEY J. DEEVER
JEREMY R. DELBOS
ARLAN M. DELLA
CHRISTOPHER D. DELLOW
KENNETH J. DELMAZO
CHRISTOPHER G. DEMETRIADES
TERA D. DENIAL
LAUREN K. DIANA
MICHAEL J. DIGANGI
NATHANIEL P. DOHERTY
JAMES P. DOLLARD
DWAIN A. DONALDSON II
BRIAN C. DONNELLY
KIRK D. DOOLEY
DANIEL M. DOWD
MATTHEW S. DOWNS
ROY M. DRAA
GERMAN E. DUARTE
BRAD M. DUBINSKY
SHARON L. DUBOW
SHANE C. DUFFLE
DAMIAN J. DUHON
TYSON W. DUNKELBERGER
DUANE A. DURANT
ROBERT B. DYER
GARRETT C. EBEBY
SHANE A. EDWARDS
WILBURT A. ELLIOTT
DEREK I. EMERY
ANDREW J. ERICKSON
PAUL M. ERVASTI
ALBERT G. ESKALIS
LUKE T. ESPOSITO
TERRY R. EVANS
BENJAMIN D. EVERETT
LUKE L. FABIUNKE
ROBERTO C. FALCON
NATHAN D. FAUGHT
STEVEN M. FAYED
ETHAN R. FEATHERLY
RALPH L. FEATHERSTONE
RAYMOND P. FELTHAM
MARK R. FENWICK

MARK A. FERGUSON
CHARLES P. FERRER
CHAD R. FITZGERALD
DANIEL S. FITZPATRICK
JAMES P. FLASS
BRADLEY G. FLURRY
JASON T. FORD
TYLER R. FOTHERINGILL
DANIEL B. FRANCIS
JOHN J. FRANKLIN
JENNIFER A. FREDERICKSEN
BRIAN E. FRIESTMAN
GREGORY T. FUNK
DANIEL R. GABLE
KURT M. GALL
SCOTT P. GALLAGHER
MEREDITH E. GALVIN
JAVIER A. GARCIA
FRANCIS F. GARNER
JANINE K. GARNER
MICHAEL S. GARRISON
SERGIO A. GARZA
MARIO J. GASCA
AARON M. GATES
STEPHEN G. GAUGLER
RYAN M. GEER
ERIC P. GENTRUP
ERIC L. GEYER
JASON R. GIBBS
JOHN F. GIBSON
SETH F. GIBSON
CRAIG A. GIORGIS
JOSHUA GIRTON
JONATHAN P. GLASS
JOSHUA L. GLOVER
DANIEL V. GOFF
DANIEL R. GOHLKE
SETH P. GOLDSTEIN
MARK S. GOMBO
CARLOS E. GONZALEZDAVILA
GREGORY D. GOOBER
ANDREA C. GOODE
MARVIN D. GOODWIN
CHRISTOPHER R. GORDON
WILLIAM V. GORSUCH
JABBAR R. GOUGHNOUR
ANDREW G. GOURGOMIS
ANTHONY J. GRABICKI
THOMAS J. GRACE
MICHAEL R. GRAHAM
BENJAMIN W. GRANT
ROBERT C. GRASS
CHRISTOPHER G. GRASSO
BRYAN K. GRAYSON
ERIC D. GREGORY
JOSEPH I. GRIMM
DAVID M. GROSSO
JEFF D. GROVES
JOHN E. GRUNKE
ABEL J. GUILLEN
JOHN D. GWAZDAUSKAS
BRIAN L. HAAN
JEFFREY P. HAAS
AARON R. HAINES
CHRISTOPHER G. HAKOLA
MATTHEW E. HALBERT
JUSTIN J. HALL
CHAD P. HAMILTON
MARK A. HAMILTON
BRENT A. HAMPTON
ROBERT S. HARGATE
PAUL W. HARRIS II
RUSSELL D. HARRIS
SCOTT W. HARRIS
TRACEY L. HARTLEY
CHRISTOPHER B. HAUGHTON
BRADLEY J. HAUSMANN
CARL A. HAVENS
BRIAN M. HAWKINS
ROGER W. HEAD, JR.
RYAN R. HEISINGER
THOMAS J. HELLER
RUSSELL R. HENRY
JASON E. HERNANDEZ
ROBERT E. HERRMANN
MARCUS A. HINCKLEY
MICHAEL T. HLAD
GEOFFREY L. HOEY
NATHAN F. HOFF
DAVID B. HOLDSTEIN
KENNETH B. HOLLINGER
THOMAS M. HOLLMAN
PAUL J. HOLST
JOHN K. HOOD
ANGELA R. HOOPER
RANDY D. HOOPER
CHRISTOPHER M. HOOVER
SARA E. HOPE
CHRISTOPHER R. HORTON
TERRY W. HORTON, JR.
CLINT A. HOCHINS
MATTHEW W. HOWARD
DANIEL E. HUGHES
DAVID W. HUGHES
TIMOTHY J. HUMPHREYS
JOHN M. HUNT
SEAN M. HURLEY
MICHAEL W. HUTCHINGS
CALEB HYATT
JASON M. IVERSEN
EMILY A. JACKSONHALL
LUKE J. JACOBS

AMY J. JAMES
 GRACE K. JANOSEK
 SHANE B. JENSON
 BROOK K. JERUE
 ROBERT J. JHONESSEE
 CHRISTOPHER C. JOHNSON
 MELISSA J. JOHNSON
 COURTNEY A. JONES
 ELI J. JONES
 ERIC T. JONES
 GEORGE L. JONES, JR.
 JASON R. JONES
 JOHN D. JORDAN
 EDWARD J. JORGE
 DAVID L. JUPITER
 MICHAEL D. KANIUK
 STEPHAN P. KARABIN II
 KENNETH M. KARCHER
 MATTHEW B. KAVE
 JEFFREY P. KEATING
 RALPH O. KEENER, JR.
 NICHOLAS J. KELLER
 ANDREW W. KELLNER
 JOHN F. KELLY
 TIMOTHY E. KENT
 PATRICK C. KEPLINGER
 THOMAS W. KERSHUL
 BRYAN L. KILL
 SUSAN M. KILPATRICK
 ANDREW J. KINGSBURY
 JOHN S. KINITZ
 JOSHUA S. KIRK
 ROBERT A. KLEINPASTE
 MICHAEL W. KNAPP
 CHRISTOPHER T. KOCAB
 ERICK G. KOOB
 TY B. KOPKE
 MARCUS H. KRAUSS
 DOUGLAS P. KRUGMAN
 DAERYONG M. KU
 JASON K. KURZ
 ALEXANDER T. KUSHNIR
 JASON B. LADD
 TERESA N. LAKE
 DARRYL P. LAMBERTH
 ERIC M. LANDBLOM
 LERON E. LANE
 JENNIFER L. LARSEN
 MATTHEW P. LAVALLEE
 ERIC LECKIE
 DAVID J. LEE, JR.
 JASON T. LEIGH
 DAVID C. LEMKE
 AARON D. LENZ
 ROBERT A. LEONARD
 WARREN LEONG
 MICHAEL LEPORE
 MARC E. LEWIS
 WILLIAM B. LEWIS
 MICHAEL D. LIBRETTO
 CRAIG H. LIGUORI
 CHRISTOPHER S. LITTY
 TODD H. LITVIN
 MICHAEL J. LORINO
 DANIEL F. LOUGHRY
 DAVID A. LOUIE
 JASON D. LOVELL
 ERIK G. LOYA
 MICHELLE I. MACANDER
 WALTER A. MAESSEN III
 RICHARD S. MAIDENS
 ADAN C. MALDONADO
 AMY E. MALUGANI
 ARTURO MANZANEDO
 WILLIAM E. MARCANT'EL, JR.
 JOSEPH K. MARKEL
 PAUL J. MARKO
 SEAN K. MARLAND
 CLINT R. MARSHALL
 ZACHARY D. MARTIN
 CARL B. MARTINEZ
 RACHEL A. MATTHEES
 BRIAN D. MAURER
 STEVEN D. MAYS
 JOSEPH S. MCALARNEN
 MATTHEW A. MCBRIDE
 TREY M. MCBRIDE
 JEFFREY V. MCCARTHY
 JOHN M. MCCLENDON
 ADAM C. MCCULLY
 CHRISTOPHER C. MCDONALD II
 ROBB T. MCDONALD
 MICHAEL S. MCDOWELL
 THOMAS R. MCGOLDRICK
 WILSON R. MCGRAW
 DANIEL P. MCGUIRE
 MICHAEL D. MCGURREN
 PATRICK A. MCKINLEY
 WILLIAM R. MCLEAREN
 CHRISTOPHER D. MCCLIN
 WAYNE A. MCMILLAN
 MICHAEL C. MCVICKER
 RICHARD G. MCWILLIAMS
 CHRISTOPHER D. MEIKELL
 MADELINE M. MELENDEZ
 SEAN M. MELLON
 CHRISTOPHER M. MERCER
 ROBERT D. MERRILL, JR.
 DAVID A. MERRITT
 ROBYN E. MESTEMACHER
 JAMES R. MEYER
 MICHAEL T. MEYER

MICHAEL L. MEYERS
 JASON W. MILBRANDT
 MATTHEW T. MILBURN
 DAVID E. MILLER
 MICAH M. MILLER
 PATRICK A. MILLER
 RYAN L. MILLER
 ERICK MIN
 ROY L. MINER
 KEYSTELLA R. MITCHELL
 TONY M. MITCHELL
 BRENT S. MOLASKI
 MICHAEL V. MONETTE
 ADAM S. MONTEFORTE
 SCOTT J. MONTGOMERY
 JAMES M. MOORE
 JAMES M. MOORE, JR.
 JOHN T. MOORE
 NATHAN O. MORALES
 RICARDO R. MORENO
 DANICA J. MOTTOLA
 JOSHUA P. MOUNTAIN
 KATE L. MURRAY
 MATTHEW MURRAY
 MICHAEL W. MURRAY
 MIKEAL S. MURRAY
 NICHOLAS R. NAPPI
 KIMBERLY A. NARVID
 DAVID S. NASCA
 GLEN E. NEISES
 CHARLES D. NICOL, JR.
 DAVID C. NICOL
 JOSE A. NICOLAS
 CHRIS P. NIEDZIOCHA
 MARK A. NOBLE
 ANDREW J. NORRIS
 JOSHUA J. NORRIS
 DAVID S. NOWLIN
 LISA M. OBRIEN
 MATTHEW R. OHARA
 ELIZABETH A. OKOREHBAAH
 ERIC M. OLSON
 JAHN C. OLSON
 DANIEL J. OREILLY
 BRIAN J. OSHEA
 JEB A. OUTTRIM
 TERRY D. PARCHMAN
 CHARLES E. PARKER, JR.
 RANDALL L. PARKER
 DANIEL L. PARROTT, JR.
 JIEMAR A. PATACSIL
 JEFFREY B. PATTAY
 TRAVIS L. PATTERSON
 FERDINAND P. PECHE
 IAIN D. PEDDEN
 JAMES L. PELLAND
 JOHN W. PELZER
 OMAR N. PERALTA, JR.
 JOSE J. PEREIRA
 KEITH M. PETERSON
 BRADY P. PETRILLO
 DUY T. PHAM
 ELIZABETH PHAM
 SHAWN M. PHILLIPS
 BRADLEY A. PIERCE
 LAWRENCE V. PION III
 NUNO M. PIRES
 NICHOLAS M. POMARO
 DAVID W. POPE
 JACOB D. PORTARO
 ROBERT J. PORTER
 MATTHEW M. POWERS
 MICHAEL V. PRATO
 JOHN V. PRICEVANCELEVE
 LUKE J. PRIGG
 CARL J. PUNZEL
 JIM J. PUREKAL
 KERRY R. QUINBY
 ALEJANDRO D. QUINN
 MARTY L. RADDIGAN
 ZACHARY J. RASHMAN
 BILLY J. RATLIFF, JR.
 PHILIP M. RAYMOND
 ANTHONY J. RAYOME
 BENJAMIN M. READ
 WADE C. REAVES
 JASON B. REED
 FOREST J. REES III
 JUSTIN E. REETZ
 JACOB S. REEVES
 JAMES B. REID
 MATTHEW D. REIS
 LISA J. REUTER
 LETICIA REYES
 FRANK B. RHOBOTHAM IV
 STACEY W. RHODY
 NATHAN A. RICE
 PHILLIP N. RICHARDS
 KATHIA E. RIVAS
 JEFFREY M. ROBB
 KENT A. ROBBINS, JR.
 MICHAEL S. ROBERTS
 SEAN F. ROBERTSON
 RICHARD H. ROBINSON III
 SHAWN T. ROBINSON
 TIMOTHY J. ROBINSON
 FELIX A. RODRIGUEZ
 OSCAR E. RODRIGUEZ, JR.
 GERALD W. ROEDER, JR.
 JAYMES E. ROEDL
 ALEXANDER T. ROLOFF
 JOHN J. ROMA

JASON W. ROOKER
 SAMUEL ROSALES
 JAMES T. ROSE
 JOSHUA T. ROSE
 DANIEL H. ROSENBERG
 SHANE R. ROSENTHAL
 MICHAEL H. ROUNTREE, JR.
 IAN H. ROWE
 DANNY ROZEK
 AMY B. ROZNOWSKI
 CHRISTOPHER J. ROZSYPAL
 TARA A. RUSSELL
 THOMAS J. RYAN
 FRANKLIN V. SABLAN
 MATEO E. SALAS
 RUDY G. SALCIDO
 MARK D. SAMEIT
 GREGORY A. SAND II
 ERIC A. SANDBERG
 AARON D. SANDERS
 THOMAS W. SAVAGE
 RUSSELL W. SAVATT IV
 RICCARDO D. SCALISE
 JASON S. SCHERMERHORN
 KENNETH W. SCHOONOVER
 MATTHEW P. SCHROER
 MATTHEW T. SCOTT
 TIMOTHY J. SCOTT
 CHRISTOPHER R. SEIGH
 PATRICK J. SEIPEL
 PETRA L. SEIPEL
 JOE A. SERVIN
 OSCAR V. SESSOMS IV
 ROBERT S. SHEARER
 SCOTT A. SHIDELER
 THOMAS P. SHIELDS
 DERRICK SIMMONS
 THOMAS P. SIMS
 ERIC J. SJOBERG
 MICHAEL B. SLATT
 CHRISTOPHER T. SMITH
 MICHAEL F. SMITH
 OWEN A. SMITH
 RANDALL D. SMITH
 VICENTE A. SMITH
 CRAIG R. SNOW
 JARED M. SNOW
 DEREK J. SNYDER
 EDWARD T. SOLEY, JR.
 DAVID J. SON
 CHINPASSEU SONETHAVILAY
 ANTHONY G. SOUSA
 PATRICK S. SPENCER
 BRENT W. SPOOR
 JOHN W. SPORTSMAN
 PHILLIP K. SPRINCIN
 MATTHEW A. SPROAT
 PAUL E. STANKEVICH
 DAVID R. STARK
 KRISTOFOR W. STARK
 ROBERT P. STCROIX, JR.
 BRIAN J. STEPHENSON
 DOUGLAS R. STEVENS
 JOHN M. STEVENS
 ROBERT N. STONAKER
 RUSSELL A. STRANGE
 SCOTT T. STURROCK
 WALTER SUAREZ
 JEREMY L. SULLIVAN
 JUNWEI SUN
 NATHAN E. SWIFT
 ROBERT J. TART
 CHRISTOPHER A. TAYLOR
 ROBERT L. TAYLOR, JR.
 RONELLA P. TAYLOR
 ROY L. TAYLOR, JR.
 ARTHUR R. TERRY II
 KHALILAH M. THOMAS
 DANIEL W. THOMPSON
 MARK A. THOMPSON
 STEVEN R. THOMPSON
 JAMES D. THORNBURG, JR.
 JUANMICHAEL G. TIJERINA
 GORDON L. TOPPER
 JAMES S. TOPPING
 ANGEL M. TORRES
 PABLO J. TORRES
 JAMES H. TRAYLOR, JR.
 BRIAN K. TRIEVEL
 THOMAS N. TRIMBLE
 JOSEPH P. TROYAN III
 ANASTASIOS TSOUTIS
 ERIK K. TYLER
 WILLIAM L. TYREE, JR.
 SHAWN D. TYSON
 PAUL S. UMBRELL
 PAMELA N. UNGER
 JACOB C. URBAN
 DAVID A. VALENTINO
 MATTHEW A. VANECHO
 JORDAN V. VANNATTER
 MICHAEL C. VASQUEZ
 BLAKE E. VEATH
 SIDDHARTHA M. VELANDY
 JACOB P. VENEMA
 BRIAN R. VONKRAUS
 JOHN P. VOORHEES
 ROBERT S. VUOLO
 ARMIN H. WAHL
 NICHOLAS D. WALDRON
 EARLIE H. WALKER, JR.
 MARC T. WALKER

COURTNEY E. WALSH
KEVIN C. WALSH
WILLIAM T. WALSH
ROBIN J. WALTHER
ASA C. WARRINGTON
NICHOLAS G. WEBB
SCOTT M. WEINPEL
TONY J. WEIR
RYAN J. WEISHEYER
SCOTT D. WELBORN
JOSHUA O. WHAMOND
CHRISTOPHER S. WHITE
RONALD WHITE, JR.
EDWIN J. WHITEMAN

RUSSELL P. WIER
MICHAEL J. WILDAUER
TREVOR A. WILK
ERIC L. WILKERSON
RICHARD T. WILKERSON
CORBIN T. WILLIAMSON
JAMES H. WILLIAMSON
JOSEPH M. WILLS
CARLTON A. WILSON
BRADLEY J. WIMSATT
HUGH O. WINGATE
ADAM J. WINSLOW
BRIAN M. WLOCH
ROBERT D. WOLFE

MATTHEW D. WOODS
ADAM J. WORKMAN
LUKE R. WRIGHT
TIMOTHY D. WRIGHT
KEO S. YANG
BEATRIZ YARRISH
JEREMY R. YAUCK
ELGIN D. YOUNG II
MARCUS L. YOUNG
FRANCISCO X. ZAVALA
CARL L. ZEPPEGNO
CHAD W. ZIMMERMAN

EXTENSIONS OF REMARKS

SENATE COMMITTEE MEETINGS

Title IV of Senate Resolution 4, agreed to by the Senate on February 4, 1977, calls for establishment of a system for a computerized schedule of all meetings and hearings of Senate committees, subcommittees, joint committees, and committees of conference. This title requires all such committees to notify the Office of the Senate Daily Digest—designated by the Rules Committee—of the time, place, and purpose of the meetings, when scheduled, and any cancellations or changes in the meetings as they occur.

As an additional procedure along with the computerization of this information, the Office of the Senate Daily Digest will prepare this information for printing in the Extensions of Remarks section of the CONGRESSIONAL RECORD

on Monday and Wednesday of each week.

Meetings scheduled for Tuesday, December 22, 2009 may be found in the Daily Digest of today's RECORD.

MEETINGS SCHEDULED DECEMBER 24

10 a.m.

Judiciary

Business meeting to consider S. 714, to establish the National Criminal Justice Commission, S. 1624, to amend title 11 of the United States Code, to provide protection for medical debt homeowners, to restore bankruptcy protections for individuals experiencing economic distress as caregivers to ill, injured, or disabled family members, and to exempt from means testing debtors whose financial problems were caused by serious medical problems, S. 1765, to

amend the Hate Crime Statistics Act to include crimes against the homeless, S. 1554, to amend the Juvenile Justice and Delinquency Prevention Act of 1974 to prevent later delinquency and improve the health and well-being of maltreated infants and toddlers through the development of local Court Teams for Maltreated Infants and Toddlers and the creation of a National Court Teams Resource Center to assist such Court Teams, S. 1789, to restore fairness to Federal cocaine sentencing, H.R. 1741, to require the Attorney General to make competitive grants to eligible State, tribal, and local governments to establish and maintain certain protection and witness assistance programs, and the nomination of O. Rogerie Thompson, of Rhode Island, to be United States Circuit Judge for the First Circuit.

SD-226

● This “bullet” symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

SENATE—Tuesday, December 22, 2009

The Senate met at 7 a.m. and was called to order by the Honorable EDWARD E. KAUFMAN, a Senator from the State of Delaware.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Eternal Spirit, whom we seek in vain without unless first we find You within, may the hush of Your presence fall upon our spirits, quiet our minds, and allay the irritations that threaten our peace. Breathe through the heat of our desires Your coolness and balm.

Strengthen the Members of this body. Take their spirits from strain and stress, and let their ordered lives confess the beauty of Your peace. Fill them so full of Your goodness that they will know how to discern Your best for their decisions. Make them faithful leaders by Your standard of righteousness.

We pray in Your Holy Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable EDWARD E. KAUFMAN led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 22, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable EDWARD E. KAUFMAN, a Senator from the State of Delaware, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. KAUFMAN thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. REID. Mr. President, following leader remarks, the Senate will resume

consideration of the health care legislation. The time until 7:18 this morning is equally divided and controlled between the two leaders or their designees. The Senate will then proceed to a series of three rollcall votes—they will be stacked—in relation to the Reid motion to table the Reid amendment No. 3278, the Reid-Baucus-Dodd-Harkin amendment No. 3276, and a motion to invoke cloture on the Reid substitute No. 2786. If cloture is invoked, the majority leader will then be recognized, and then the time until 9:30 will be equally divided and controlled between the two leaders or their designees. Beginning at 9:30 a.m. and until 5:30 p.m. today, the time will be controlled in alternating 1-hour blocks of time, with the Republicans controlling the first hour. The Senate will recess from 12:30 until 2:30 p.m. today for the weekly conferences.

CHRISTMAS PEACE

Mr. REID. Mr. President, tensions have been high because of this legislation which has been on the floor for a considerable period of time. I hope everyone understands that this part of the session is winding down, and I hope everyone will go out of their way to be thoughtful and considerate to those on both sides of the aisle. This is not the time for any personal attacks or anything that is acrimonious. It is time to figure out a way to leave here in a peaceful nature. We have the Christmas holiday coming, and we know how important that is to families. I hope everyone will work toward getting us out of here and back to our families as quickly as we can.

I designate the time the Democrats have remaining to Senator DURBIN, the majority whip.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of H.R. 3590, which the clerk will report.

The legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid amendment No. 2786, in the nature of a substitute.

Reid amendment No. 3276 (to amendment No. 2786), of a perfecting nature.

Reid amendment No. 3277 (to amendment No. 3276), to change the enactment date.

Reid amendment No. 3278 (to the language proposed to be stricken by amendment No. 2786), to change the enactment date.

Reid amendment No. 3279 (to amendment No. 3278), to change the enactment date.

The ACTING PRESIDENT pro tempore. Under the previous order, the time until expiration of cloture on amendment No. 3276 shall be equally divided and controlled between the two leaders or their designees.

The Senator from Texas is recognized.

Mrs. HUTCHISON. Mr. President, I will be taking the leader time on our side. How much time is there?

The ACTING PRESIDENT pro tempore. Six minutes.

Mrs. HUTCHISON. I thank the Chair.

Mr. President, today we are taking another step toward passing a bill that has not seen the light of day for very long. It is a bill that is going to change health care policy in this country forever if it is finally coming to enactment. It will take effect in 2014. The reason we are talking about this bill and trying to let people know what is in it is because we hope there is still a chance this bill will not become law.

This bill was drafted behind closed doors without Republican input. The votes are 60 to 40. Sixty Democrats and 40 Republicans make up the Senate, and that is what is providing cloture on this bill.

This bill increases taxes by over \$½ trillion over a 10-year period—that is over \$500 billion—and \$½ trillion in cuts to Medicare. This is a time when we should not be increasing taxes. Small businesses are burdened already. This adds to their burden. Families are trying to make ends meet. They are trying to pay their mortgage so they will not be thrown out of their homes. They are trying to pay their bills. They are trying to find jobs in the highest level of unemployment in our country since World War II, and we are going to heap taxes and burdens on them starting as early as next year—in 2 weeks. This is not a time to raise taxes. We don't need a tax burden increase, we don't need Medicare cuts, and we do need health care reform that would lower the cost of health care. This is going to do the opposite. We are going to increase taxes and lower the service for Medicare in our country.

I remember reading some of the history and the anecdotes about the vote on the constitutional amendment to

allow women the right to vote. There was a Congressman from Tennessee who was wavering. He said what finally made up his mind—and he was the Congressman who made the difference—was that his mother wrote him a letter and said: Vote for ratification.

What is going to be said about this bill that changes health care policy for every American? What is going to be written about how the votes were brought together to have a bill that would tax our American people $\frac{1}{2}$ trillion and take Medicare as the pay-for for this program is that there will be essential protection for seniors in Florida and New York to prevent them from suffering the cuts to Medicare Advantage but no other State. Insurance companies in only two States, Nebraska and Michigan, are exempt from the taxes that will take effect on insurance companies, raising the premiums for every insured person in this country. Changes to the language restricting physician ownership of medical facilities appear only to benefit a single medical center in Nebraska, and additional Federal payments to Louisiana, Massachusetts, Nebraska, and Vermont to expand Medicaid will cost taxpayers in every other State in America over \$1 billion. This is part of the deal that was brokered to make sure 60 votes would pass this bill. The people of Nebraska will never pay a dime for Medicaid increases, whereas my State of Texas will carry a new burden of over \$9 billion, and every other State in America will eventually take the burden of the Medicaid increases but not Nebraska, not ever. Even the Governor of Nebraska has said he does not think that is fair.

So I think we can do better. We can do better in this country than having the history of the overhaul of our health care system that is going to affect the quality of life and the tax burden on every American. I think we should have a better history.

So I am asking my colleagues to think about this vote. We could change one vote, one person who says: I don't want the Senate to do something this way. I want the Senate to rise to the level that we know has been the tradition of this Senate for all of the years of our Republic, and that is that we would have an open, transparent process; that we would have bipartisan input; that a Republican amendment—one might have passed; that what we offer is what we promised the American people: lower costs in health care—

The ACTING PRESIDENT pro tempore. The Senator's time has expired.

Mrs. HUTCHISON.—and a way for people to have more affordable access.

We still have a chance. That is why we are here today. And I hope we can turn away from this process and share the light of day with our colleagues and with America.

Thank you, Mr. President. I yield the floor.

The ACTING PRESIDENT pro tempore. The deputy majority leader is recognized.

Mr. DURBIN. Mr. President, a famous Washington figure once wrote a book entitled "Slouching Towards Gomorrah." If you were to describe what is happening in the Senate procedurally, we would call it lurching toward cloture. The cloture rules in the Senate require 30 hours between votes, and as a consequence we find ourselves in the early morning hours trying to finish this bill before the Christmas holiday, and it calls for the Senate to convene at extraordinary times, as we did this morning, but it is for a good purpose.

This is to bring to a close a debate which has gone on for more than 3 weeks. You have noticed more and more Republican Senators now coming to the floor with ideas and amendments, and the obvious question we have to ask is, Where have you been? For the first 21 days of debate on this bill, the Republicans offered four substantive amendments. They offered six motions to take the bill off the floor, send it back to committee, and quit the deliberations, but only four substantive amendments. Now they say they are just brimming with all of these notions and ideas that can improve this bill. They had the chance. In fact, they had more than a chance. They were invited into this process early on.

I would say to the Senator from Texas, she knows that 3 of her colleagues met over 61 times with their Democratic counterparts trying to come up with a bipartisan approach, and they couldn't. We also know that in the Health, Education, Labor, and Pensions Committee, the Republicans came and engaged in more than 50 days of deliberations in that committee and offered and had accepted more than 150 Republican amendments to this bill. We were not excluding Republicans from the process; they excluded themselves. When it came time for a final vote in the Health, Education, Labor, and Pensions Committee, not a single Republican Senator would vote for it. Senator COBURN of Oklahoma offered and had accepted 38 amendments to this bill and wouldn't vote for it. Other Senators were the same. They had their chance, and they didn't use their chance. In fact, the record shows now that after almost a year of deliberations, we have one Republican Congressman from New Orleans, LA, who voted for the House health care reform proposal, and one Republican Senator, Ms. SNOWE of Maine, who voted for the Finance Committee proposal. To say the Republicans have been actively engaged in this process is a misstatement.

Here is why we have to go forward, even if we have to meet at 7 in the

morning or even if we have to meet this Christmas week. When this bill is passed, we know from the CBO several things will occur. First, 30 million Americans who currently don't have health insurance will have the peace of mind of knowing they have health insurance. Secondly, we know 94 percent of the American people will finally be insured—the highest percentage in the history of the United States. We know the rates for health insurance premiums will start to come down, as they must, so businesses and individuals can afford it. We know that, finally, consumers across America will be able to stand and fight back when health insurance companies turn them down in their moments of need.

We say in this new amendment we are going to say to health insurance companies: You cannot deny coverage to anybody under 18, any child, for a preexisting condition. That is going to bring peace of mind to millions of American families who understand that without this they couldn't get the health insurance they absolutely need for their children.

Let me address quickly this notion that this is somehow a mystery amendment. This amendment has now been before the American public for at least 70 hours on the Internet. The bill itself has been before the American public now for more than 3 weeks on the Internet. You can find it not only on the Democratic Senate Web site, you can find it on the Republican Web site. They put our bill on their Web site because they don't have a comprehensive health care reform bill. They put ours up for people to read. There has been ample opportunity for people to read, dissect, and to be critical of it and raise questions about it. Before our final vote, America will have had its chance to read and understand the import of this effort and this effort is substantial.

This is something we have built up to for decades. To finally put the Senate on record as to whether we are endorsing the current health care system in America that is unaffordable, discriminates against people, and leaves so many behind, a system that currently rations care and says to 50 million Americans you have no coverage, and to millions of others that you have coverage that will not be there when you need it—we have to bring that to an end.

As Senator HARKIN said the other day in closing the debate, this is a real debate over whether health care will be a right or a privilege in America. If you believe it is a privilege for those who are wealthy and well off, then, of course, you will vote against this. If you believe it is a right that should be extended to more Americans, I hope you will join us in supporting it.

I yield the floor.

Mr. REID. Mr. President, has all time expired?

The ACTING PRESIDENT pro tempore. Forty seconds remain.

Mr. REID. I yield back that time.

The ACTING PRESIDENT pro tempore. The time is yielded back.

Mr. REID. Mr. President, I move to table amendment No. 3278, and I ask for the yeas and nays.

The ACTING PRESIDENT pro tempore. Is there a sufficient second? There is a sufficient second.

The question is on agreeing to the amendment.

The clerk will call the roll.

Mr. KYL. The following Senator is necessarily absent: the Senator from Oklahoma (Mr. INHOFE).

The PRESIDING OFFICER (Mr. WHITEHOUSE). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 60, nays 39, as follows:

[Rollcall Vote No. 386 Leg.]

YEAS—60

Akaka	Franken	Mikulski
Baucus	Gillibrand	Murray
Bayh	Hagan	Nelson (NE)
Begich	Harkin	Nelson (FL)
Bennet	Inouye	Pryor
Bingaman	Johnson	Reed
Boxer	Kaufman	Reid
Brown	Kerry	Rockefeller
Burris	Kirk	Sanders
Byrd	Klobuchar	Schumer
Cantwell	Kohl	Shaheen
Cardin	Landrieu	Specter
Carper	Lautenberg	Stabenow
Casey	Leahy	Tester
Conrad	Levin	Udall (CO)
Dodd	Lieberman	Udall (NM)
Dorgan	Lincoln	Warner
Durbin	McCaskill	Webb
Feingold	Menendez	Whitehouse
Feinstein	Merkley	Wyden

NAYS—39

Alexander	Crapo	Lugar
Barrasso	DeMint	McCain
Bennett	Ensign	McConnell
Bond	Enzi	Murkowski
Brownback	Graham	Risch
Bunning	Grassley	Roberts
Burr	Gregg	Sessions
Chambliss	Hatch	Shelby
Coburn	Hutchison	Snowe
Cochran	Isakson	Thune
Collins	Johanns	Vitter
Corker	Kyl	Voinovich
Cornyn	LeMieux	Wicker

NOT VOTING—1

Inhofe

The motion was agreed to.

The PRESIDING OFFICER. The majority leader.

AMENDMENT NO. 3277 WITHDRAWN

Mr. REID. Mr. President, it is my understanding that the second-degree amendment has been withdrawn; is that right?

The PRESIDING OFFICER. Under previous order, amendment No. 3277 is withdrawn.

AMENDMENT NO. 3276

Mr. REID. Mr. President, I ask for the yeas and nays on amendment No. 3276.

The PRESIDING OFFICER. The yeas and nays were previously ordered.

The question is on agreeing to amendment No. 3276.

The clerk will call the roll.

The assistant legislative clerk called the role.

Mr. KYL. The following Senator is necessarily absent: the Senator from Oklahoma (Mr. INHOFE).

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 60, nays 39, as follows:

[Rollcall Vote No. 387 Leg.]

YEAS—60

Akaka	Franken	Mikulski
Baucus	Gillibrand	Murray
Bayh	Hagan	Nelson (NE)
Begich	Harkin	Nelson (FL)
Bennet	Inouye	Pryor
Bingaman	Johnson	Reed
Boxer	Kaufman	Reid
Brown	Kerry	Rockefeller
Burris	Kirk	Sanders
Byrd	Klobuchar	Schumer
Cantwell	Kohl	Shaheen
Cardin	Landrieu	Specter
Carper	Lautenberg	Stabenow
Casey	Leahy	Tester
Conrad	Levin	Udall (CO)
Dodd	Lieberman	Udall (NM)
Dorgan	Lincoln	Warner
Durbin	McCaskill	Webb
Feingold	Menendez	Whitehouse
Feinstein	Merkley	Wyden

NAYS—39

Alexander	Crapo	Lugar
Barrasso	DeMint	McCain
Bennett	Ensign	McConnell
Bond	Enzi	Murkowski
Brownback	Graham	Risch
Bunning	Grassley	Roberts
Burr	Gregg	Sessions
Chambliss	Hatch	Shelby
Coburn	Hutchison	Snowe
Cochran	Isakson	Thune
Collins	Johanns	Vitter
Corker	Kyl	Voinovich
Cornyn	LeMieux	Wicker

NOT VOTING—1

Inhofe

The amendment (No. 3276) was agreed to.

CLOTURE MOTION

The PRESIDING OFFICER. Pursuant to rule XXII, the Chair lays before the Senate the following cloture motion which the clerk will report.

The assistant legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the Reid substitute amendment No. 2786 to H.R. 3590, the Service Members Home Ownership Tax Act of 2009.

Christopher J. Dodd, Richard Durbin, Paul G. Kirk, Jr., Max Baucus, Claire McCaskill, Jon Tester, Maria Cantwell, Barbara A. Mikulski, Mark Udall, Sherrod Brown, Arlen Specter, Bill Nelson, Mark Begich, Sheldon Whitehouse, Roland W. Burris, Kirsten E. Gillibrand, Ron Wyden.

The PRESIDING OFFICER. By unanimous consent, the mandatory quorum call has been waived.

The question is, Is it the sense of the Senate that debate on amendment No. 2786, as amended, offered by the Senator from Nevada, Mr. REID, to H.R. 3590, the Service Members Home Own-

ership Tax Act of 2009, shall be brought to a close?

The yeas and nays are mandatory under the rule.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. KYL. The following Senator is necessarily absent: the Senator from Oklahoma (Mr. INHOFE).

The PRESIDING OFFICER (Mr. DURBIN). Are there any other Senators in the Chamber desiring to vote?

The yeas and nays resulted—yeas 60, nays 39, as follows:

[Rollcall Vote No. 388 Leg.]

YEAS—60

Akaka	Franken	Mikulski
Baucus	Gillibrand	Murray
Bayh	Hagan	Nelson (NE)
Begich	Harkin	Nelson (FL)
Bennet	Inouye	Pryor
Bingaman	Johnson	Reed
Boxer	Kaufman	Reid
Brown	Kerry	Rockefeller
Burris	Kirk	Sanders
Byrd	Klobuchar	Schumer
Cantwell	Kohl	Shaheen
Cardin	Landrieu	Specter
Carper	Lautenberg	Stabenow
Casey	Leahy	Tester
Conrad	Levin	Udall (CO)
Dodd	Lieberman	Udall (NM)
Dorgan	Lincoln	Warner
Durbin	McCaskill	Webb
Feingold	Menendez	Whitehouse
Feinstein	Merkley	Wyden

NAYS—39

Alexander	Crapo	Lugar
Barrasso	DeMint	McCain
Bennett	Ensign	McConnell
Bond	Enzi	Murkowski
Brownback	Graham	Risch
Bunning	Grassley	Roberts
Burr	Gregg	Sessions
Chambliss	Hatch	Shelby
Coburn	Hutchison	Snowe
Cochran	Isakson	Thune
Collins	Johanns	Vitter
Corker	Kyl	Voinovich
Cornyn	LeMieux	Wicker

NOT VOTING—1

Inhofe

The PRESIDING OFFICER. On this vote the yeas are 60, the nays are 39. Three-fifths of the Senators duly chosen and sworn having voted in the affirmative, the motion is agreed to.

The majority leader is recognized.

AMENDMENT NO. 2878

Mr. REID. Mr. President, I ask the clerk to call and report amendment No. 2878.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. CARDIN, proposes an amendment No. 2878.

Mr. REID. I ask unanimous consent the reading of the amendment be waived.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The amendment is printed in the RECORD of Thursday, December 3, 2009 under "Text of Amendments.")

Mr. REID. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.
The yeas and nays were ordered.

AMENDMENT NO. 3292 TO AMENDMENT NO. 2878

Mr. REID. I now ask the clerk to report amendment No. 3292.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID] proposes an amendment numbered 3292 to amendment No. 2878.

The amendment is as follows:

(Purpose: To change the effective date)

At the end of the amendment, insert the following:

This section shall become effective 5 days after enactment.

Mr. REID. Mr. President, it is my understanding—Senator McConnell and I have agreed—I should not say I understand—we have agreed that the time until 9:30 will be equally divided and controlled between the two leaders, and at 9:30 we will go, as we have worked in recent days, into having blocks of time until our caucuses, until 12:30.

The PRESIDING OFFICER. The majority leader is correct. Under the previous order, until 9:30 the time is equally divided and controlled between the leaders or their designees, and under the previous order the time until 5:30 today will be divided into 1-hour alternating blocks of time, the majority controlling the first block.

Mr. REID. Mr. President, I ask everyone to acknowledge that we have our regular weekly caucuses at 12:30. We will come back at 2:30, and we will be going back to blocks of time until 5:30 this evening.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, I said when the Senate opened today and I will say again, because of the long hours we have spent here for weeks now, there is a lot of tension in the Senate. Feelings are high, and that is fine. Everybody has very strong concerns about everything we have done and have to do. But I hope everyone would go back to their gentlemanly ways. I was trying to figure out how to say this—gentlemanly ways. We used to say in the House gentlemen, so I guess it is the same here.

Anyway I hope everyone has—I have said to a number of people—Rodney King—let's all just try to get along. That is the only way; we need to do it. This is a very difficult time in the next day or so. Let's try to work through this.

For those of the Christian faith we have the most important holiday, and that is Christmas.

I would hope everyone would keep in mind that this is a time when we reflect on peace and the good things in life. I would hope everyone would kind of set aside all the personal animosity, if they have any in the next little bit, and focus on the holiday.

The PRESIDING OFFICER. The minority leader.

Mr. McConnell. Mr. President, let me add, to my good friend the majority leader, he and I have an excellent relationship. We speak a number of times in the course of every day and have no animosity whatsoever. We are working on an agreement that will give certainty to the way to end this session. Hopefully, the two of us together can be recommending something that makes sense for both sides in the not-too-distant future.

The PRESIDING OFFICER. Who yields time?

The Senator from Montana.

Mr. BAUCUS. What is the regular order?

The PRESIDING OFFICER. The time until 9:30 is equally divided between the leaders or their designees.

The Senator from Montana.

Mr. BAUCUS. Mr. President, it has been more than a month since the majority leader moved to proceed to the health care reform bill before us today. At long last, the Senate is now in the final throes of passing this historic legislation.

From the beginning, this Senator has sought out what Abraham Lincoln called "the better angels of our nature." That is the way this Senator has always sought to legislate.

A year and a half ago, I convened a bipartisan retreat at the Library of Congress. Half a year ago, I convened three bipartisan roundtables with health care experts. Half a year ago, the Finance Committee conducted three bipartisan walk-throughs of the major concepts behind the bill before us today.

We went the extra mile. I reached out to my good friend, the ranking Republican member of the Finance Committee. I reached out to the ranking Republican member of the HELP Committee.

We sought to craft a bill that would appeal to the broad middle. We sought to craft a bill that could win the support of Republicans and Democrats alike.

We met, a group of six of us, three Democrats and three Republicans. We met more than 30 times. We met for months, encouraged by the President to do so. Our group met with the President several times. The President encouraged us to keep pursuing our negotiations, hoping to reach bipartisan agreements.

No, we did not reach a formal agreement. The leadership on the other side of the aisle went to great lengths to stop us from doing so.

But even though we did not reach a formal agreement, we came very close to doing so. The principles that we discussed are very much the principles upon which the Finance Committee built its bill. The principles that we discussed are very much the principles

reflected in the bill before us today. Our work began much earlier than I have indicated. We met all the preceding year, held about ten hearings in the Finance Committee working toward health care reform. We also finished a white paper in November 2008. I say with trepidation that basically that is the foundation from which almost all ideas in health care reform emanated. To be fair, the ideas in that paper had been floating around, principles from the Massachusetts health care reform, for example. Most policy experts and health care economists who had been working on reform published their ideas. We sought the best, compiled them, and put together that white paper published in November of last year.

From the debate that the Senate has conducted this past month, you would not know it. During this debate, some on the other side of the aisle have mischaracterized the bill before us. Some on the other side of the aisle have set about a systematic campaign to demonize this bill.

Through bare assertion alone, with the thinnest connection to fact, they have sought to vilify our work. If one listened to their assertions alone, one would not recognize the bill before us.

And so, let me, quite simply, state the facts.

Some on the other side of the aisle assert that this bill is a government takeover of health care.

The fact is that the nonpartisan Congressional Budget Office says that this bill would reduce the government's fiscal role in health care. Just 3 days ago, CBO wrote, and I quote:

CBO expects that the proposal would generate a reduction in the federal budgetary commitment to health care during the decade following the 10-year budget window.

Some on the other side of the aisle assert that this bill would add to our Nation's burden of debt.

The fact is that the nonpartisan Congressional Budget Office says that this bill would reduce the deficit by \$132 billion in the first 10 years and by between \$650 billion and \$1.3 trillion in the second 10 years. The fact is that this is the most serious deficit reduction effort in more than a decade.

Some on the other side of the aisle assert that this bill would harm Medicare.

The fact is that Medicare's independent actuary says that this bill would extend the life of Medicare by 9 years. The fact is that this is the most responsible effort to shore up Medicare in more than a decade.

Some on the other side of the aisle assert that this bill does not do enough to ensure the uninsured.

The fact is that the nonpartisan Congressional Budget Office says that this bill would extend access to health care to 31 million Americans who otherwise would have to go without. The fact is that CBO says, and I quote:

The share of legal nonelderly residents with insurance coverage would rise from about 83 percent currently to about 94 percent.

Nothing that Senators on the other side of the aisle have proposed would come close. CBO estimated that the Republican substitute offered in the House of Representatives would have extended coverage to just 3 million people. The fact is that CBO says of that plan, and I quote:

The share of legal nonelderly residents with insurance coverage in 2019 would be about 83 percent, roughly in line with the current share.

I would cite the facts about the Republican substitute in the Senate. But the fact is that there is no Republican substitute.

Some on the other side of the aisle assert that they simply prefer a more modest reform of health care.

The fact is that the Republicans controlled the Senate from 1995 to 2001 and from 2003 to 2006. The fact is that before they took control, in 1994, 36 million Americans, 15.8 percent of non-elderly Americans were without health insurance coverage. In the last year of their control, in 2006, nearly 47 million Americans, 17.8 percent of non-elderly Americans were without health insurance coverage. The legacy of Republican control was 10 million more Americans uninsured.

Some on the other side of the aisle say that we are moving too fast.

The fact is that it was 1912, when former President Theodore Roosevelt first made national health insurance part of the Progressive Party's campaign platform. The fact is that people of good will have been working at this for nearly a century.

The fact is, health care reform for America is now within reach. The fact is, the most serious effort to control health care costs is now within reach. The fact is, life-saving health care coverage for 31 million Americans is now within reach.

Let us, at long last, grasp that result. Let us, this time, not let this good thing slip through our hands. And let us, at long last, enact health care reform for all.

I suggest the absence of a quorum and ask unanimous consent that the time be charged equally to each side.

The PRESIDING OFFICER (Mr. WHITEHOUSE). Without objection, it is so ordered.

The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mrs. HUTCHISON. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. HUTCHISON. Mr. President, are we now in a period where we go back and forth without limit?

The PRESIDING OFFICER. We are.

Mrs. HUTCHISON. Mr. President, I ask to be notified after 5 minutes, after which Senator VITTER is going to speak.

The PRESIDING OFFICER. The Chair will so notify.

Mrs. HUTCHISON. Mr. President, we have talked a lot about what is in this bill, the massive tax increases, the massive cuts in Medicare. But there is another issue I think, looking down the road, we are going to need to pursue. We have talked about how groundbreaking this bill is. In fact, the majority calls it historic, and it is historic. We believe it is historic in the bad precedents it is setting, both in process and in substance. I think some of these precedents are going to be tested under the Constitution of the United States.

I wish to start by talking about a couple of those. No. 1, in the effort to get the last vote, clearly there were deals made. There were deals that affect individual States and even one that affects two insurance companies that will have a different treatment from all the other insurance companies in America. It is said there will be two Nebraska insurance companies that will not have to pay the tax increases of the insurance companies that will be levied on all the other health insurance companies. This is an issue that must be raised under the Constitution, the equal protection clause of the Constitution. To take a set of companies in an industry, competitors—and we value the free market system and the free enterprise system—to pluck out two competitors and say: You will be treated differently because we need your vote to pass this bill should be tested under the Constitution of the United States.

It is my hope some insurance company that has standing to bring this suit will be able to test this precedent. It is a very bad precedent, and it is certainly bad policy to start passing laws that distinguish some parts of an industry versus other parts of an industry that would be treated in a different way. I hope we will do that.

No. 2, I believe there is a 10th amendment issue. Here is my concern. Many States, including my State of Texas, have self-insurance plans for State employees. States with large numbers of State employees find that self-insurance is a better way to go than private insurance programs. In this bill, every insurance company that plans to increase its premiums must get approval from the Department of Health and Human Services first.

Now, my State of Texas, with its self-insurance plan, then, has to go to the Secretary of Health and Human Services to ask permission to increase the premiums on their State self-insured insurance plan. That is a violation of the 10th amendment, as I see it.

I am very concerned that a State that has State employees who accept a

self-insurance plan would then be able to be told by the Federal Government that they cannot increase their premiums to cover the cost and keep the sound system that they have in place.

Now, other States have self-insurance plans, so I believe they would also be very affected by this, and I believe there will be a standing for a State with this type of plan to be able to challenge this part of this bill and, hopefully, bring it down if it is a violation of the 10th amendment.

I want to talk about another area that I think is a stretch in this bill; that is, apparently the individual mandate is being justified by the commerce clause of our Constitution. Now, the commerce clause basically says no State may impede interstate commerce. You may say, out in America: I don't see the connection. I am going to be mandated to buy health insurance or be fined if I don't because States cannot impede interstate commerce?

Well, I would agree with people out there that seems like a disconnect because, apparently, using the commerce clause, the majority is saying the Federal Government has the right to manage insurance, and that a requirement of an individual mandate is part of the Federal capability to manage insurance in this country, and you cannot impede that right by the Federal Government because you cannot impede interstate commerce.

I think this whole individual mandate issue is going to be a center for discussion, debate, and opposition to the bill that is clearly moving down a track that we are trying to stop, but that train is moving. I think we are going to have to talk about the individual mandate. People are saying to me: How can the Federal Government tell me I have to buy insurance? I think they have a point.

You have to buy automobile insurance because, but that comes with the right to drive. So you get the right, licensed by the State, to drive your car, and in exchange for that a State may require that you have collision insurance on your automobile, and many States do. But when you say you have to buy an insurance policy, I think that crosses a line where a person has a right to say: I am not going to buy insurance if I guarantee that I am not going to be a burden to the Federal Government or to the State government or to any other taxpayer. I think you should have that right, but that is not the way this bill is written.

The bill is a Federal mandate that every person in America has to have health insurance or be fined if they do not. So at least if we were going to write such a provision, to keep the right of an individual not to have a mandate under the commerce clause of the Constitution, at least you ought to say that a person would have to sign something that says: I will give you a

promissory note if I do not choose to buy insurance. But that is not the way this bill is written.

So I think this, along with the State mandate on Medicaid—which, again, I think is an equal protection issue, and maybe that is a stretch—but that one State will not have to ever pay the State's share of the increase in Medicaid that is in this bill but the other 49 States in America will is certainly a violation of our responsibility to treat all States equally or to have formulas that have some ability to say there is a standard that has been set that should prevail. But not in this bill.

My State of Texas will have almost a \$10 billion increase in its State's share of Medicaid because of the expansion in this bill. But there are States that are exempted from the increases and one State that is exempted forever because of a deal made to get that 60th vote to pass this bill.

I think people are looking at this issue in America today and saying: What has gotten into the people in Congress who are voting for this bill?

So, Mr. President—

The PRESIDING OFFICER. The Chair apologizes. The Chair did not notify the Senator at 5 minutes. The Chair forgot. The Senator's 5 minutes has passed.

Mrs. HUTCHISON. Mr. President, thank you for the notification.

I think there are issues now that will be raised going forward in the future, and there is still time for one Senator in the 60 to change the vote. Therefore, I hope one will hear from his or her constituents enough that that person will say: It is time to slow this bill down. I am going to change my vote so people can see all the effects that we have not talked about yet, and let's do this right.

We can lower the cost of health care, we can provide more access to more people to have health care coverage, which should be the goal of this legislation, this massive reform of a health care system that is working for many and has provided the best quality of health care in the world. We have a chance to keep it by slowing this bill down. That is why we are fighting. That is why we are still here talking 3 days before Christmas. We want to stop this bill and do it right. Doing it right is more important than doing it fast, and I think the American people believe that too.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. VITTER. Mr. President, how much time remains on the minority side before 9:30 a.m.?

The PRESIDING OFFICER. There is 24 minutes remaining on the minority side.

Mr. VITTER. Thank you, Mr. President.

Mr. President, since this latest version of comprehensive health care reform was unveiled a few days ago—a 2,733-page bill—I have been looking at it very carefully, particularly, of course, with the Louisiana perspective, and I want to share my strong concerns with that Louisiana perspective with my colleagues today.

Of course, we have all heard this Senate health care reform bill referred to as the “Louisiana purchase” because of the special \$300 million provision in it related to our Medicaid match rate.

Quite frankly, I do not much like that nickname for two reasons. First of all, the fact that we in Louisiana have to pay a higher Medicaid match rate under present law because of the hurricanes is a real inequity, which I support fixing. It is a shame the merits of that fix, which are very real, have been completely lost in this debate because of the way this Louisiana fix has been used and abused, quite frankly, in trying to pass this megabill.

But, secondly, I do not like the phrase because it suggests that Louisiana in general would fare very well under the bill overall, and nothing could be further from the truth. This bill overall sells Louisiana short. It sells Louisiana out. In fact, rather than the “Louisiana purchase,” I think the bill could be very accurately called the “Louisiana sellout.”

What are those costs and those serious problems for Louisiana I am talking about?

Let's start with Medicaid, the program for the poor. Let's start with that \$300 million fix. It is certainly true that fix is there—a \$300 million benefit to the State under our Medicaid Program—but that is not all of the picture. It is not even all of the Medicaid picture because besides that fix, in the bill overall there is a dramatic expansion of Medicaid—a huge expansion—and the Louisiana State government and Louisiana taxpayers have to help pay for that expansion. That extra cost to the State government, to the State taxpayer, is way more than the \$300 million benefit.

By very conservative estimates by the Louisiana Department of Health and Hospitals, it is at least \$1.3 billion over 10 years of full implementation. So, sure, a \$300 million benefit but, at least, minimum, a \$1.3 billion cost—extra cost—to the State.

Now, three things are important about these figures. One is obvious: \$300 million is a whole lot less than \$1.3 billion. But, secondly, this \$1.3 billion over 10 years of full implementation is a very conservative estimate from the Louisiana Department of Health and Hospitals. And, No. 3, while this money, the \$300 million, is one time, this other goes on forever. This \$1.3 billion is the first decade cost, but it goes on forever from there; and every 10 years, this grows and is repeated.

So what does that mean? That means in the first 10 years of full implementation, the net impact on the State is very negative, at least \$1 billion, and it goes on from there.

I am very concerned about a lot of other groups in Louisiana, not just the State government and State budget. I am particularly concerned about Louisiana seniors. Of course, Louisiana seniors, like seniors everywhere, depend on Medicare. They have paid into it their whole lives. This bill—it is a simple fact; it is confirmed by the Congressional Budget Office, nonpartisan—this bill cuts Medicare \$466 billion. Medicare now is already facing insolvency by 2017. So instead of fixing that in a real way, the bill steals almost \$½ trillion from Medicare and uses it not within Medicare but to help pay for a brand-new entitlement.

Mr. BAUCUS. Mr. President, will the Senator yield for a question?

Mr. VITTER. I will not at this time. I will be happy to yield after my presentation.

That means real cuts in terms of hospitals, home and hospice, nursing homes, and Medicare Advantage. There are over 151,000 Louisiana seniors on Medicare Advantage. They are going to be particularly hard hit. They like that choice now. They will not have that choice as it exists now under this bill.

How about Louisiana taxpayers? I am also very concerned about Louisiana taxpayers. Again, according to the nonpartisan Congressional Budget Office, the bill contains \$518 billion of tax increases nationwide—over \$½ trillion of tax increases. As for that oft repeated promise that no one who earns under \$200,000 will be affected, well, again, think again. The Joint Committee on Taxation—nonpartisan—has said 42.1 million Americans earning below \$200,000 will get a tax increase over the next several years—42.1 million. That means hundreds of thousands of Louisiana taxpayers will be hit, will get a tax increase—I am talking about folks who earn well below \$200,000—will also pay more in the form of higher insurance premiums because, again, the nonpartisan Congressional Budget Office has said this bill increases overall health care costs. It does not decrease those costs.

Well, what about Louisiana small businesses? Surely, this bill protects them in the midst of this serious recession. Well, not exactly. The biggest impact on businesses is a brandnew mandate in the bill. Most businesses have to either provide a government-defined health insurance benefit or they have to pay a new tax to the government. NFIB, the National Federation of Small Business, says that is going to cost the Nation 1.6 million jobs. Translated to Louisiana, that is tens of thousands of additional lost jobs on top of our current high unemployment. Again, we are in the middle of a serious

recession. This will cost us jobs on top of that.

There is also another big problem, which is an incentive for businesses to drop coverage. I mentioned that brandnew mandate: Either you provide a government-defined health benefit or you pay a new tax to the Federal Government. The other problem with that is, for a lot of business, it is going to be cheaper to drop coverage and pay the new tax. So many employees who have coverage now that they are reasonably satisfied with are going to lose it, and that is a big concern as well.

Just for good measure, the bill forces pro-life taxpayers to, in many very meaningful ways, subsidize abortion. Louisiana is one of the most proudly pro-life States in the Nation, so that is particularly offensive. Everyone who cares about life, who has followed this issue, whether it is the Catholic Bishops, National Right to Life, and other organizations have said, clearly, the language in this bill doesn't protect against taxpayer-funded abortion. The language in this bill does not honor the Hyde amendment, which has been Federal law since 1977. The language in this bill crosses an important line, does not offer the conscience protections we have depended on for years. So this sets radical new precedent in terms of taxpayer and Federal Government support of abortion. That is a big Louisiana concern as well.

So what do we have? We have a 2,733-page bill, mega health care reform, with all these very serious problems for Louisiana and important Louisiana groups and important Louisiana citizens, including seniors, small business, taxpayers, and the State budget, which is already facing serious cuts and challenges.

If we want to put Louisiana first considering all these costs, we have to say no to this bill. If we want to put America first considering all these unsustainable costs, we have to say no to this bill. But we can and we should say yes to the right kind of health care reform. This isn't a debate about yes or no, health care reform or not; this is a debate about what the right kind of health care reform is.

To me, we need to start over with that right kind of reform. To me, that would mean something such as starting by passing five bills. Each one doesn't need to be longer than 25 pages. Each one would be focused like a laser beam on a real problem that affects real Louisianans, real Americans, offering a real, concrete, focused solution. My five bills would be this: Cover pre-existing conditions. That is a real problem in Louisiana. That is a real problem in America. Let's have a focused bill that does that.

Secondly, allow buying insurance across State lines. That would dramatically expand competition in the marketplace. That would lower pre-

miums. That would give all folks wanting health insurance dramatically decreased costs than they have now.

Third: Let's do something real about prescription drug prices. Let's not sell out to PhRMA and cut a special deal with the pharmaceutical industry, as the White House has. Let's pass re-importation and pass real generics reform.

Fourth: Let's pass tort reform and take all that unnecessary cost out of the system. That doesn't provide better health care for anyone. It doesn't do anything positive for anyone except wealthy trial lawyers. Let's pass tort reform.

And fifth: Let's allow small business to pool across State lines to form larger pools of insurance across State lines and gain from that extra buying power. Why shouldn't a restaurant in Baton Rouge that may only have seven or eight people to cover in health insurance, why shouldn't they be able to pool through the National Restaurant Association, create a pool of millions nationwide and enjoy the same buying power Apple Computers or Toyota has and get the same benefit in the insurance marketplace through that increased buying power and increased competition?

So I urge all my colleagues to put their State first and vote no, to put our Nation first and vote no, and to start anew with the right sort of focused reform as I have outlined.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I just have a couple statements to make, points to make, in view of the last statement, to correct some misimpressions given by the last statement.

The last speaker said Medicare cuts apply and this is going to cut Medicare. The fact is—I wish the previous speaker would stay on the floor, but he is fleeing the floor because he knows I am going to mention facts in total refutation to the assertions he is making. He leaves the floor. He will not stay with me to talk about what is going on. He makes statements that are misrepresentations and then he leaves the floor.

Let me talk about some of the things he said which are incorrect. One, he basically says Medicare is going to be hurt by these huge cuts to Medicare. The fact is, we are helping the Medicare trust fund with this legislation. The fact is, the Chief Actuary at HHS has said this legislation before us will increase the solvency of the Medicare trust fund another 9 years. That is a fact.

Second, he is trying to say there are a lot of big tax increases here. He is trying to direct the public away from what the fact is. The fact is, the Joint Committee on Taxation says there are \$436 billion of tax cuts in this legisla-

tion, reductions in taxes; \$436 billion in tax cuts in the form of tax credits for people who purchase insurance in the exchange. It is a tax cut of \$436 billion of tax cuts in the exchange. I might say \$40 billion of that is small business tax cuts. They are not increases, they are tax cuts for small business and the tax cuts for individuals is \$436 billion.

Frankly, I wish I had a lot of the data before me. I don't have it right now to refute other points he made. He talked about premiums going up. The Congressional Budget Office basically says 93 percent of Americans will find their premiums will come down because of this legislation, and for a certain class of individuals—those in the individual market and the small group market will get very significant reductions in premiums on account of this bill.

It irritates me, frankly, when Senators come to the floor and make all these misstatements and they are not based at all on fact.

In fact, what we need to do around here is get more and more institutions to objectively analyze policy so we know what the facts are. It is pretty hard to argue the facts. The CBO does a pretty good job. The Joint Committee on Taxation does a pretty good job. But if somehow this country could turn to an organization or organizations to find the facts—just the facts—I think it would help a little bit because it is hard to argue the facts. If you have good facts, you generally can create good policy.

Back to premiums. CBO says 93 percent of premiums go down. Actually, for about five-sixths of those insured—that is, those who work for larger companies, it is called the large group markets—premiums will go down not a lot but a little. According to CBO, it is up to a 3-percent reduction in premiums. They look at the year 2016 as a benchmark year, so CBO says that for those, about 70 percent of Americans who work for large markets, premiums will actually go down 3 percent.

What about 13 percent of Americans who work for small groups, small companies? Basically, CBO and the Joint Committee on Taxation say those could go up 1 percentage point as well as down 2 percentage points. It is about even. It is difficult to tell. But those who get credits in the small group market will find their premiums down by about 8 to 11 percent. Those who work for small companies will find their premiums go down 8 to 11 percent.

What about the nongroup market—individuals. Well, basically, if you compare today's insurance premiums with what it might be in the future, the premiums will go down 14 to 20 percent, but because of better benefits, premiums could go up 10 to 13 percent for 7 percent of Americans. As I mentioned earlier, 93 percent will find their premiums go down. For 7 percent they will

go up, but for those 7 percent, they are going to have a lot better coverage, a lot better insurance in 2016. All the insurance market reforms will have kicked in: denial of preexisting conditions, market status, health status and so on and so forth.

Get this: For the nongroup market, 17 percent of Americans who buy insurance through the nongroup market, 10 percent of that 17 percent, because of tax credits, will find their premiums go down by—guess how much—56 to 59 percent. Once more: 17 percent of Americans buy insurance individually. Of those 17 percent, 10 percent of them will find their premiums will be reduced 56 to 59 percent. That is according to the Joint Committee on Taxation. Only one small group, according to the Joint Committee on Taxation, will find an increase in 2016. That is 7 percent of Americans in 2016, but that will be compensated with a lot better insurance, high-quality insurance. No more rescissions. No more denial based on preexisting conditions. The rating reforms will have kicked in and the annual limits, the lifetime limits will have been repealed. It will be a heck of a lot better insurance. So maybe their premiums will go up a little bit, but they will get a heck of a lot better buy for what they are getting. It is similar to buying a new car instead of a used car—hopefully, a good new car. All in all, in a very real sense, all Americans are going to find his or her premiums will go down. Seven percent will find them go up a little bit, but they will get a heck of a lot better insurance for the premiums they will be paying.

The previous speaker is wrong when he says it will increase premiums. The Joint Committee on Taxation says it will not. I didn't hear him quote the Joint Committee on Taxation saying premiums will go up. If you look at the actual analysis by the Joint Committee on Taxation, they find the premiums will go down.

Seeing nobody who wishes to speak, I wish to address the question of the constitutionality of the individual mandate. Let me read into the RECORD an analysis by Mark Hall, prepared by the O'Neill Institute. Basically, he says the following:

Health insurance mandates have been a component of many recent health care reform proposals. Because a Federal requirement that individuals transfer money to a private party is unprecedented, a number of legal issues must be examined. This paper analyzes whether Congress can legislate a health insurance mandate and the potential legal challenges that might arise given such a mandate. The analysis of legal challenges to health insurance mandates applies to federal individual mandates, but can also apply to a federal mandate requiring employers to purchase health insurance for their employees. There are no constitutional barriers for Congress to legislate a health insurance mandate as long as the mandate is properly designed and executed as discussed below. This paper also considers the likelihood of

any change in the current judicial approach to these legal questions.

Potential solutions. Congress's Authority to Regulate Commerce: The federal government has the authority to legislate a health insurance mandate under the Commerce Clause of the United States Constitution. A federal mandate to purchase health insurance is well within the breadth of Congress's power to regulate interstate commerce. Congress can avoid legal challenges related to the 10th Amendment and states' rights by preempting state insurance laws and implementing the mandate on a Federal level. If Congress wants states to implement a federal mandate, it has the following two options:

Conditional Spending: Congress may condition federal funding, such as that for Medicaid or public health, on state compliance with federal initiatives. **Conditional Preemption:** Congress may allow states to opt out of complying with direct federal regulation as long as states implement a similar regulation that meets Federal requirements.

Congress's Authority to Tax and Spend for the General Welfare: Congress also has the authority to legislate a health insurance mandate under its Constitutional authority to tax and spend.

There are no plausible Tenth Amendment and states' rights issues arising from Congress's taxing and spending power. However, Congress's taxation power cannot be used in a way that burdens a fundamental right recognized in the Constitution's Bill of Rights and judicial interpretations by the U.S. Supreme Court. Since there is no fundamental right to be uninsured, no fundamental right challenge exists.

Other Relevant Constitutional Rights: Challenges under the First and Fifth Amendments relating to individual rights may rise, but are unlikely to succeed. The federal government should include an exemption on religious grounds to a health insurance mandate as an added measure of protection from legal challenges based on religious freedom. In the alternative, the federal government can simply exempt a federal insurance mandate from existing federal legislation protecting religious freedom.

Considerations: To avoid a heightened level of security in any judicial review, the federal government should articulate its substantive rationale for mandating health insurance during the legislative process.

It goes on, and it is probably too lengthy to read. Professor Hall wrote this. He is a professor at Wake Forest University.

I will read the conclusion:

The Constitution permits Congress to legislate a health insurance mandate. Congress can use its Commerce Clause powers or its taxing and spending powers to create such a mandate. Congress can impose a tax on those who do not purchase insurance, or provide tax benefits to those that do purchase insurance. . . . If Congress would like the States to implement an insurance mandate, it can avoid conflicts with the anti-commandeering principle by either preempting state insurance laws or by conditioning federal funds on State compliance. A federal employer mandate for state and local government workers may be subject to a challenge; however, such a challenge is unlikely to be successful. Individual rights challenges under the First Amendment's Free Exercise Clause or RFRA are unlikely to succeed, although a federal insurance mandate should include a statement that RFRA does not apply or provide

for a religious exemption. Fifth Amendment Due Process and Takings Clause challenges are also unlikely to be successful. A legal analysis presented is likely to endure, as the Supreme Court's current position and approach to interpreting relevant constitutional issues appear to be stable.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. BURRIS. Mr. President, as this debate draws to a close and my colleagues and I prepare to vote on a health care reform bill, I recognize that long hours and tense negotiations have left some nerves and tempers frayed. That is why I come to the floor.

Although our work keeps us away from our family and friends for much of this holiday season, I see no reason why we cannot share good cheer with one another right here in Washington.

So in the spirit of the season, I would like to share my own version of a classic holiday story with my good friends on both sides of the aisle.

It goes something like this:

"Twas the night before Christmas and all through the Senate
The Right held up our health bill, no matter what was in it.
The people had voted—they mandated reform—
But Republicans blew off the gathering storm.
"We'll clog up the Senate!" they cried with a grin,
"And in midterm elections, we'll get voted in!"
They knew regular folks need help right this second—
But fundraisers, lobbyists and politics beckoned.
So, try as they might, Democrats could not win
Because their majority was simply too thin.
Then, across every State there arose such a clatter
The whole Senate rushed out to see what was the matter!
All sprang up from their desks and ran from the floor
Straight through the cloakroom, and right out the door.
And what in the world could be quite this raucous?
But a mandate for change! From the Democratic caucus!
The President, the Speaker, and of course Leader Reid
Had answered the call in our hour of need.
More rapid than eagles the provisions they came,
And they whistled, and shouted, and called them by name:
"Better coverage! Cost savings! A strong public plan!
Accountable options? We said 'yes we can!' "No exclusions or changes for pre-existing conditions! Let's pass a bill that restores competition!"
The Democrats all came together to fight for the American people, that Christmas Eve night.
And then, in a twinkling, I heard under the dome—the rollcall was closed! It was time to go home.
Despite the obstructionist tactics of some, the filibuster had broken—the people had won!
A good bill was ready for President Obama, ready to sign, and end health care drama.

And Democrats explained, as they drove out of sight: "Better coverage for all, even our friends on the right!"

And I say to all of my colleagues: In this season, Merry Christmas and a happy, happy New Year.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Mr. President, in a little while, I will be making a constitutional point of order against the substitute amendment. I won't make that now because we are working on an agreement on when we can have that vote.

I want to start talking about the reason I believe this substitute amendment is unconstitutional—the individual mandate contained in it. I will be speaking for about 10 minutes now, and then I will resume my remarks at 9:30, after one of the Democrats comes down and uses their 15 minutes.

If this constitutional point of order is rejected and the health care reform bill is passed, I believe the Court should reject it on constitutional grounds.

Some of my colleagues may not be aware of the Finance Committee's debate on the constitutionality of this health care reform bill. During the committee markup of its version of the bill, Senator HATCH raised some thought-provoking constitutional questions. He offered an amendment, which I supported, to provide a process for the courts to promptly consider any constitutional challenge to the Finance Committee bill. He chose the same language that was put into the bipartisan Campaign Reform Act. Unfortunately, the amendment was deemed nongermane.

I am seriously concerned that the Democrats' health care reform bill violates the Constitution of these United States. As part of comprehensive health care reform, the Democrats would require every single American citizen to purchase health insurance. Americans who fail to buy health insurance that meets the minimum requirements would be subject to a financial penalty. This provision can be found in section 1501 of the Democrats' health care reform bill. It is called the "requirement to maintain minimal essential coverage."

While this is a constitutional point of order, I feel it is important to note that in the Declaration of Independence, America's Founding Fathers provided that:

We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life, liberty, and the pursuit of happiness.

What happened to life, liberty, and the pursuit of happiness? I guess Americans can only have them if they comply with this new bill and buy a bronze, silver, gold, or platinum health insurance program.

America's Founders and subsequent generations fought dearly for the freedoms we have today.

I question the appropriateness of this bill and specifically the constitutionality of this individual mandate. Is it really constitutional for this body to tell all Americans they must buy health insurance coverage? If so, what is next? What personal liberty or property will Congress seek to take away from Americans next? Will we consider legislation in the future requiring every American to buy a car, to buy a house, or to do something else the Federal Government wants?

My friend and colleague, Senator HATCH, raised similar questions during the debate in the Finance Committee. In fact, he raised the following question:

If we have the power simply to order Americans to buy certain products, why did we need a cash for clunkers program, or the upcoming program providing rebates for purchasing energy efficient appliances? We can simply require Americans to buy certain cars, dishwashers, or refrigerators.

Where do we draw the line? Will we even draw one at all? The Constitution draws that line. It is called the enumerated powers. I don't think Congress has ever required Americans to buy a product or service, such as health insurance, under penalty of law. I doubt Congress has the power to do that in the first place.

As the CBO explained during the 1990s:

A mandate requiring all individuals to purchase health insurance would be an unprecedented form of Federal action. The government has never required people to buy any good or service as a condition of lawful residence in the United States.

Yet that is exactly what this health care bill would do. This bill would require Americans to buy a product many of them do not want or simply cannot afford.

Some individuals have raised the example of car insurance in the context of this debate. But requiring someone to have car insurance for the privilege of being able to drive is much different from requiring someone to have health insurance. As Senator HATCH pointed out, people who do not drive do not have to buy car insurance. Senator HATCH is right. If you live in New York City, you probably rely on subways or some other form of mass transit. You probably do not own a car, so you have no reason to buy car insurance and you are not forced to do so. Yet this health care reform bill requires Americans to buy health insurance whether or not they ever visit a doctor, get a prescription, or have an operation.

Under this bill, if you do not buy health insurance coverage, you will be subject to a penalty. Let's call this penalty what it really is—a tax. Even worse, this penalty operates more like a taking than an ordinary tax. If an American chooses not to buy minimal

essential health coverage, he or she will face rapidly increasing taxes—up to \$750 or 2 percent of taxable income, whichever is greater, by the year 2016. There is no penalty for Americans who qualify for hardship or religious exemptions. There is also no penalty for illegal immigrants or prisoners.

Americans typically pay taxes on a product or service they buy or on income they earn. For example, if you fill up your car at the pump, you pay a gas tax. If you earn income, you pay an income tax. Yet this bill creates a new tax on Americans who choose not to buy a service. It is very counterintuitive. This bill taxes Americans for not doing anything at all, other than just existing. This penalty is assessed through the Internal Revenue Code.

Senator HATCH made the following statement:

If this is a tax at all, it is certainly not an excise tax. Instead, it is a direct tax. While the Constitution requires that excise taxes must be uniform throughout the United States, it requires that direct taxes must be apportioned among the States by population. Just as the excise tax on high premiums is not uniform, this direct tax on individuals who do not purchase health insurance is not apportioned.

I recognize that the authors of this health reform bill included an individual mandate in this bill based on the idea that health care costs would be spread among all Americans and would ultimately reduce their health insurance costs. The claim is, insurance costs will be lowered because cost shifting will be reduced. This cost shift arguably takes place because health care providers—doctors and hospitals—who provide free or uncompensated care to the uninsured, shift the cost to the insured or paying patients. The hospital or doctor then shifts the cost of that unpaid care to the insured patient in the form of higher charges in order to cover the cost of uninsured patients.

I understand this concept, but I am incredibly concerned that the individual mandate provision takes away too much freedom and choice from Nevadans and from Americans across the country.

I have read and studied multiple articles by scholars on the constitutionality of the individual mandate. I believe the individual mandate provision in this health care reform bill calls into question several provisions of the Constitution. I think the Congress does not have the authority, under the enumerated powers, to enact such a mandate.

I know the supporters of the individual mandate have claimed the commerce clause and the taxes and general welfare clause in article I, section 8 of the Constitution provide authority for Congress to enact such a mandate. I wholeheartedly disagree with that assessment.

According to the Constitution, the Federal Government only has limited

powers. Although the Supreme Court has upheld some far-reaching regulations of economic activity—most notably in *Wickard v. Filburn* and *Gonzales v. Raich*—neither case supports enacting the independent health insurance mandate based on the commerce clause. In these cases, the court held that Congress was allowed to regulate intrastate economic activity as a means to regulate interstate commerce in fungible goods. The mandate to purchase health insurance, however, is not proposed as a means to regulate interstate commerce, nor does it regulate or prohibit activity in either the health insurance or the health care industry.

The mandate to purchase health insurance does not purport to regulate or prohibit activity of any kind, whether economic or noneconomic. Instead, the individual mandate provision regulates no action. It purports to regulate inactivity by converting the inactivity of not buying insurance into commercial activity. In effect, advocates of the individual mandate contend that under congressional power to “regulate commerce . . . among the several states” Congress may reach the doing of nothing at all.

In recent years, the Supreme Court has invalidated two congressional statutes that attempted to regulate noneconomic activities. To uphold the individual mandate based on the commerce clause, the Supreme Court would have to concede that the commerce clause provides unlimited authority to regulate. This is a position that the Supreme Court has never affirmed and that it rejected in recent cases.

Congress lacks the authority to regulate the individual’s decision not to purchase a service or enter into a contract. Similarly, Congress cannot rely on its power to tax to justify imposing the individual mandate.

In addition to being beyond the scope of Congress’ enumerated powers, this individual mandate also amounts to a taking under the fifth amendment takings clause. I would like to take a moment to read the relevant parts of the fifth amendment. It says in part:

No person shall be . . . deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

Let me repeat the part of the fifth amendment that applies to the issue at hand. It says:

. . . nor shall private property be taken for public use, without just compensation.

The bill before us today would require an American citizen to devote a portion of income—his or her private property—to health insurance coverage. There is an exception, of course, for religious reasons and for financial hardships.

If one of my constituents in Nevada does not want to spend his or her hard-earned income on health insurance coverage and would prefer to spend it on

something else, such as rent or a car payment, this requirement could be a taking of private property under the fifth amendment.

As noted in a recent article coauthored by Dennis Smith and the former Deputy General Counsel of the Department of Health and Human Services, Peter Urbanowicz, requiring a citizen to purchase health insurance “could be considered an arbitrary and capricious ‘taking’ no matter how many hardship exemptions the federal government might dispense.”

Some of my colleagues may also be familiar with David B. Rivkin and Lee A. Casey. They are attorneys, based in Washington, DC, who served in the Department of Justice during the Reagan and Bush administrations. In September, Rivkin and Casey published an op-ed in the *Wall Street Journal* entitled: “Mandatory Insurance is Unconstitutional.” I urge my colleagues to read this article and many others I will be submitting for the *RECORD*.

Mr. President, I ask unanimous consent to have printed in the *RECORD* at the conclusion of my remarks this *Wall Street Journal* by David B. Rivkin, Jr., and Lee A. Casey.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. ENSIGN. In the op-ed, Rivkin and Casey argue that the health insurance mandate:

. . . would expand the federal government’s authority over individual Americans to an unprecedented degree. It is also profoundly unconstitutional.

Continuing the quote:

Making healthy young adults pay billions of dollars in premiums into the national health-care market is the only way to fund universal coverage without raising substantial new taxes.

In effect, this mandate would be one more giant, cross-generational subsidy—imposed on generations who are already stuck with the bill for the federal government’s prior spending sprees.

A “tax” that falls exclusively on anyone who is uninsured is a penalty beyond Congress’s authority. If the rule were otherwise, Congress could evade all constitutional limits by “taxing” anyone who doesn’t follow an order of any kind.

As the fourth Chief Justice of the Supreme Court, John Marshall, stated:

The power to tax involves the power to destroy.

Unfortunately, this could certainly be true in the context of this health bill.

We in Congress must zealously defend our citizens’ rights and prevent this from happening. I believe the legislation before us violates the greatest political document in the history of the world, the Constitution of the United States.

I urge my colleagues to think very carefully about the constitutional issues I have raised. I know most people around here do not like to talk

about whether something is constitutional. We just want to do what feels good because we think we are helping people. But our Founders set forth in the enumerated powers limits on what this body and this Federal Government could do.

As Members of Congress, one of our most important responsibilities is to protect, to defend, and preserve the Constitution of the United States. In that light, it is not only appropriate but essential for this body to question whether it is constitutional for the Federal Government to require Americans to buy health insurance coverage.

We should also question whether it is constitutional for the Federal Government to tell Americans what kind of health insurance coverage they have to purchase. So not only does this bill tell them they have to buy health insurance, it tells Americans what kind of health insurance must be purchased.

Americans also deserve to know how the bill will impact their ability to choose the health insurance coverage that best fits their needs. That is exactly why I will raise this constitutional point of order. Freedom and choice are very precious rights. Let’s not bury our heads in the sand and take away freedom and choice from American citizens. We need to think about this individual mandate very carefully.

I have several articles, and I would like to read a couple of quotes from these articles. The first one is from the *Washington Post*. The article is entitled, “Illegal Health Reform.” It is written by David Rivkin and Lee A. Casey. It says:

The otherwise uninsured would be required to buy coverage, not because they were even tangentially engaged in the “production, distribution or consumption of commodities,” but for no other reason than people without health insurance exist. The federal government does not have the power to regulate Americans simply because they are there. Significantly, in two cases, *United States v. Lopez* (1995) and *United States v. Morrison* (2000), the Supreme Court specifically rejected the proposition that the commerce clause allowed Congress to regulate noneconomic activities merely because, through a chain of causal effects, they might have an economic impact. These decisions reflect judicial recognition that the commerce clause is not infinitely elastic and that, by enumerating its powers, the framers denied Congress the type of general police power that is freely exercised by the states.

Mr. President, to read further from the article in the *Washington Post*:

Like the commerce power, the power to tax is the Federal Government’s vast authority over the public, and it is well settled that Congress can impose a tax for regulatory rather than purely revenue-raising purposes. Yet Congress cannot use its power to tax solely as a means of controlling conduct that it could not otherwise reach through the commerce clause or any other constitutional provision. In the 1922 case *Bailey v. Drexel Furniture*, the Supreme Court ruled that Congress could not impose a “tax” to penalize conduct (the utilization of child labor) it

could not also regulate under the commerce clause. Although the court's interpretation of the commerce power's breadth has changed since that time, it has not repudiated the fundamental principle that Congress cannot use a tax to regulate conduct that is otherwise indisputably beyond its regulatory power.

Of course, these constitutional impediments can be avoided if Congress is willing to raise corporate and/or income taxes enough to fund fully a new national health system. Absent this politically dangerous—and therefore unlikely—scenario, advocates of universal health coverage must accept Congress' power, like that of the other branches, has limits. These limits apply regardless of how important the issue may be, and neither Congress nor the president can take constitutional short cuts. The genius of our system is that, no matter how convinced our elected officials may be that certain measures are in the public interest, their goals can be accomplished only in accord with the powers and processes the Constitution mandates, processes that inevitably make them accountable to the American people.

I want to read from another article that was written by Randy Barnett, Nathaniel Stewart, and Todd Gaziano. This article is entitled, "Why the Personal Mandate to Buy Health Insurance is Unprecedented and Unconstitutional."

Members of Congress have the responsibility, pursuant to their oath, to determine the constitutionality of legislation independently of how the Supreme Court has ruled or may rule in the future. But Senators and Representatives also should know that, despite what they have been told, the health insurance mandate is highly vulnerable to challenge because it is, in truth, unconstitutional. And all other considerations aside, the highest obligation of each Member of Congress is fidelity to the Constitution.

I ask unanimous consent to have printed in the RECORD, following my remarks, the articles I have before me.

THE PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit No. 2.)

Mr. ENSIGN. Continuing to quote, Mr. President, from the Barnett, Stewart, and Gaziano article:

A long line of Supreme Court cases establishes that Congress may regulate three categories of activity pursuant to the commerce power. These categories were first summarized in *Perez v. United States*, and most recently reaffirmed in *Gonzalez v. Raich*. First, Congress may regulate the channels of interstate or foreign commerce such as the regulation of steamship, railroad, highway or aircraft transportation or prevent them from being misused, as, for example, the shipment of stolen goods or of persons who have been kidnapped. Second, the commerce power extends to protecting "the instrumentalities of interstate commerce," as, for example, the destruction of an aircraft, or persons or things in commerce, as, for example, thefts from interstate shipments. Third, Congress may regulate economic activities that "substantially affect interstate commerce."

Under the first prong of its Commerce Clause analysis, the Court asks whether the class of activities regulated by the statute falls within one or more of these categories. Since an individual health insurance man-

date is not even arguably a regulation of a channel or instrumentality of interstate commerce, it must either fit in the third category or none at all. . . . The Senate bill asserts (erroneously) that: "[t]he individual responsibility requirement . . . is commercial and economic in nature, and substantially affects interstate commerce. . . . The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased."

That is within the bill.

Continuing to quote:

The second prong of the Court's Commerce Clause analysis requires a determination that a petitioner has in fact engaged in the regulated activity, making him or her a member of the regulated class. In its modern Commerce Clause cases, the Supreme Court rejects the argument that a petitioner's own conduct or participation in the activity is, by itself, either too local or too trivial to have a substantial effect on interstate commerce. Rather, the Court has made clear that, "where the class of activities is regulated and that class is within the reach of federal power, the courts have no powers 'to excise, as trivial, individual instances' of the class." Thus, for example, a potential challenger of the proposed mandate could not argue that because her own decision not to purchase the required insurance would have little or no effect on the broader market, the regulation could not be constitutionally applied to her. The Court will consider the effect of the relevant "class of activity," not that of any individual member of the class.

To assess the constitutionality of a claim of power under the Commerce Clause, the primary question becomes, "what class of activity is Congress seeking to regulate?" Only when this question is answered can the Court assess whether that class of activity substantially affects interstate commerce. Significantly, the mandate imposed by the pending bills does not regulate or prohibit the economic activity of providing or administering health insurance. Nor does it regulate or prohibit the economic activity of providing health care, whether by doctors, hospitals, pharmaceutical companies, or other entities engaged in the business of providing a medical good or service. Indeed, the health care mandate does not purport to regulate or prohibit activity of any kind, whether economic or noneconomic. To the contrary, it purports to "regulate" inactivity.

In other words, not buying health insurance. Continuing once again:

Proponents of the individual mandate are contending that, under its power to "regulate commerce . . . among the several states," Congress may regulate the doing of nothing at all! In other words, the statute purports to convert inactivity into a class of activity. By its own plain terms, the individual mandate provision regulates the absence of action. To uphold this power under its existing doctrine, the Court must conclude that an individual's failure to enter into a contract for health insurance is an activity that is "economic" in nature—that is, it is part of a "class of activity" that "substantially affects interstate commerce."

Never in this Nation's history has the commerce power been used to require a person who does nothing to engage in economic activity.

Let me repeat that. "Never in this Nation's history has the commerce

power been used to require a person who does nothing to engage in economic activity."

Let me close with this because I see the senior Senator from Utah is on the Senate floor, and he has argued eloquently on the unconstitutionality of this particular provision.

Again, I am quoting:

Today, even voting is not constitutionally mandated. But if this precedent is established—

That is the precedent in this bill is established—

Congress would have the unlimited power to regulate, prohibit, or mandate any or all activities in the United States. Such a doctrine would abolish any limit on federal power and alter the fundamental relationship of the national government to the states and the people. For this reason it is highly doubtful that the Supreme Court will uphold this assertion of power.

Mr. President, I reserve the remainder of my time, and I yield to the senior Senator from Utah.

EXHIBIT 1

[From the Wall Street Journal, Sept. 18, 2009]

MANDATORY INSURANCE IS UNCONSTITUTIONAL
(By David B. Rivkin, Jr. and Lee A. Casey)

Federal legislation requiring that every American have health insurance is part of all the major health-care reform plans now being considered in Washington. Such a mandate, however, would expand the federal government's authority over individual Americans to an unprecedented degree. It is also profoundly unconstitutional.

An individual mandate has been a hardy perennial of health-care reform proposals since *HillaryCare* in the early 1990s. President Barack Obama defended its merits before Congress last week, claiming that uninsured people still use medical services and impose the costs on everyone else. But the reality is far different. Certainly some uninsured use emergency rooms in lieu of primary care physicians, but the majority are young people who forgo insurance precisely because they do not expect to need much medical care. When they do, these uninsured pay full freight, often at premium rates, thereby actually subsidizing insured Americans.

The mandate's real justifications are far more cynical and political. Making healthy young adults pay billions of dollars in premiums into the national health-care market is the only way to fund universal coverage without raising substantial new taxes. In effect, this mandate would be one more giant, cross-generational subsidy—imposed on generations who are already stuck with the bill for the federal government's prior spending sprees.

Politically, of course, the mandate is essential to winning insurance industry support for the legislation and acceptance of heavy federal regulations. Millions of new customers will be driven into insurance-company arms. Moreover, without the mandate, the entire thrust of the new regulatory scheme—requiring insurance companies to cover pre-existing conditions and to accept standardized premiums—would produce dysfunctional consequences. It would make little sense for anyone, young or old, to buy insurance before he actually got sick. Such a socialization of costs also happens to be an

essential step toward the single payer, national health system, still stridently supported by large parts of the president's base.

The elephant in the room is the Constitution. As every civics class once taught, the federal government is a government of limited, enumerated powers, with the states retaining broad regulatory authority. As James Madison explained in the *Federalist Papers*: "[I]n the first place it is to be remembered that the general government is not to be charged with the whole power of making and administering laws. Its jurisdiction is limited to certain enumerated objects." Congress, in other words, cannot regulate simply because it sees a problem to be fixed. Federal law must be grounded in one of the specific grants of authority found in the Constitution.

These are mostly found in Article I, Section 8, which among other things gives Congress the power to tax, borrow and spend money, raise and support armies, declare war, establish post offices and regulate commerce. It is the authority to regulate foreign and interstate commerce that—in one way or another—supports most of the elaborate federal regulatory system. If the federal government has any right to reform, revise or remake the American health-care system, it must be found in this all-important provision. This is especially true of any mandate that every American obtain health-care insurance or face a penalty.

The Supreme Court construes the commerce power broadly. In the most recent Commerce Clause case, *Gonzales v. Raich* (2005), the court ruled that Congress can even regulate the cultivation of marijuana for personal use so long as there is a rational basis to believe that such "activities, taken in the aggregate, substantially affect interstate commerce."

But there are important limits. In *United States v. Lopez* (1995), for example, the Court invalidated the Gun Free School Zones Act because that law made it a crime simply to possess a gun near a school. It did not "regulate any economic activity and did not contain any requirement that the possession of a gun have any connection to past interstate activity or a predictable impact on future commercial activity." Of course, a health-care mandate would not regulate any "activity," such as employment or growing pot in the bathroom, at all. Simply being an American would trigger it.

Health-care backers understand this and—like Lewis Carroll's Red Queen insisting that some hills are valleys—have framed the mandate as a "tax" rather than a regulation. Under Sen. Max Baucus's (D., Mont.) most recent plan, people who do not maintain health insurance for themselves and their families would be forced to pay an "excise tax" of up to \$1,500 per year—roughly comparable to the cost of insurance coverage under the new plan.

But Congress cannot so simply avoid the constitutional limits on its power. Taxation can favor one industry or course of action over another, but a "tax" that falls exclusively on anyone who is uninsured is a penalty beyond Congress's authority. If the rule were otherwise, Congress could evade all constitutional limits by "taxing" anyone who doesn't follow an order of any kind—whether to obtain health-care insurance, or to join a health club, or exercise regularly, or even eat your vegetables.

This type of congressional trickery is bad for our democracy and has implications far beyond the health-care debate. The Constitution's Framers divided power between the

federal government and states—just as they did among the three federal branches of government—for a reason. They viewed these structural limitations on governmental power as the most reliable means of protecting individual liberty—more important even than the Bill of Rights.

Yet if that imperative is insufficient to prompt reconsideration of the mandate (and the approach to reform it supports), then the inevitable judicial challenges should. Since the 1930s, the Supreme Court has been reluctant to invalidate "regulatory" taxes. However, a tax that is so clearly a penalty for failing to comply with requirements otherwise beyond Congress's constitutional power will present the question whether there are any limits on Congress's power to regulate individual Americans. The Supreme Court has never accepted such a proposition, and it is unlikely to accept it now, even in an area as important as health care.

EXHIBIT 2

[From the Washington Post, Aug. 22, 2009]

ILLEGAL HEALTH REFORM

(By David B. Rivkin, Jr. and Lee A. Casey)

President Obama has called for a serious and reasoned debate about his plans to overhaul the health-care system. Any such debate must include the question of whether it is constitutional for the federal government to adopt and implement the president's proposals. Consider one element known as the "individual mandate," which would require every American to have health insurance, if not through an employer then by individual purchase. This requirement would particularly affect young adults, who often choose to save the expense and go without coverage. Without the young to subsidize the old, a comprehensive national health system will not work. But can Congress require every American to buy health insurance?

In short, no. The Constitution assigns only limited, enumerated powers to Congress and none, including the power to regulate interstate commerce or to impose taxes, would support a federal mandate requiring anyone who is otherwise without health insurance to buy it.

Although the Supreme Court has interpreted Congress's commerce power expansively, this type of mandate would not pass muster even under the most aggressive commerce clause cases. In *Wickard v. Filburn* (1942), the court upheld a federal law regulating the national wheat markets. The law was drawn so broadly that wheat grown for consumption on individual farms also was regulated. Even though this rule reached purely local (rather than interstate) activity, the court reasoned that the consumption of homegrown wheat by individual farms would, in the aggregate, have a substantial economic effect on interstate commerce, and so was within Congress's reach.

The court reaffirmed this rationale in 2005 in *Gonzales v. Raich*, when it validated Congress's authority to regulate the home cultivation of marijuana for personal use. In doing so, however, the justices emphasized that—as in the wheat case—"the activities regulated by the [Controlled Substances Act] are quintessentially economic." That simply would not be true with regard to an individual health insurance mandate.

The otherwise uninsured would be required to buy coverage, not because they were even tangentially engaged in the "production, distribution or consumption of commodities," but for no other reason than that people without health insurance exist. The federal government does not have the power to regu-

late Americans simply because they are there. Significantly, in two key cases, *United States v. Lopez* (1995) and *United States v. Morrison* (2000), the Supreme Court specifically rejected the proposition that the commerce clause allowed Congress to regulate noneconomic activities merely because, through a chain of causal effects, they might have an economic impact. These decisions reflect judicial recognition that the commerce clause is not infinitely elastic and that, by enumerating its powers, the framers denied Congress the type of general police power that is freely exercised by the states.

This leaves mandate supporters with few palatable options. Congress could attempt to condition some federal benefit on the acquisition of insurance. States, for example, usually condition issuance of a car registration on proof of automobile insurance, or on a sizable payment into an uninsured motorist fund. Even this, however, cannot achieve universal health coverage. No federal program or entitlement applies to the entire population, and it is difficult to conceive of a "benefit" that some part of the population would not choose to eschew.

The other obvious alternative is to use Congress's power to tax and spend. In an effort, perhaps, to anchor this mandate in that power, the Senate version of the individual mandate envisions that failure to comply would be met with a penalty, to be collected by the IRS. This arrangement, however, is not constitutional either.

Like the commerce power, the power to tax gives the federal government vast authority over the public, and it is well settled that Congress can impose a tax for regulatory rather than purely revenue-raising purposes. Yet Congress cannot use its power to tax solely as a means of controlling conduct that it could not otherwise reach through the commerce clause or any other constitutional provision. In the 1922 case *Bailey v. Drexel Furniture*, the Supreme Court ruled that Congress could not impose a "tax" to penalize conduct (the utilization of child labor) it could not also regulate under the commerce clause. Although the court's interpretation of the commerce power's breadth has changed since that time, it has not repudiated the fundamental principle that Congress cannot use a tax to regulate conduct that is otherwise indisputably beyond its regulatory power.

Of course, these constitutional impediments can be avoided if Congress is willing to raise corporate and/or income taxes enough to fund fully a new national health system. Absent this politically dangerous—and therefore unlikely—scenario, advocates of universal health coverage must accept that Congress's power, like that of the other branches, has limits. These limits apply regardless of how important the issue may be, and neither Congress nor the president can take constitutional short cuts. The genius of our system is that, no matter how convinced our elected officials may be that certain measures are in the public interest, their goals can be accomplished only in accord with the powers and processes the Constitution mandates, processes that inevitably make them accountable to the American people.

EXECUTIVE SUMMARY: WHY THE PERSONAL MANDATE TO BUY HEALTH INSURANCE IS UNPRECEDENTED AND UNCONSTITUTIONAL

(By Randy Barnett, Nathaniel Stewart, and Todd F. Gaziano)

As the Congressional Budget Office explained: "A mandate requiring all individuals to purchase health insurance would be

an unprecedented form of federal action. The government has never required people to buy any good or service as a condition of lawful residence in the United States." Yet, all of the House and Senate health-care bills being debated require Americans to either obtain or purchase expensive health insurance, estimated to cost up to \$15,000 per year for a typical family, or pay substantial tax penalties for not doing so.

The purpose of this compulsory contract, coupled with the arbitrary price ratios and controls, is to require some people to buy artificially high-priced policies as a way of subsidizing coverage for others and an industry saddled with the costs of other government regulations. Rather than appropriate funds for higher federal health-care spending, the sponsors of the current bills are attempting, through the personal mandate, to keep the forced wealth transfers entirely off budget.

This takes congressional power and control to a strikingly new level. An individual mandate to enter into a contract with or buy a particular product from a private party is literally unprecedented, not just in scope but in kind, and unconstitutional either as a matter of first principles or under any reasonable reading of judicial precedents.

THE COMMERCE CLAUSE

Advocates of the individual mandate have claimed that the Supreme Court's Commerce Clause jurisprudence leaves "no doubt" that the insurance requirement is a constitutional exercise of that power. They are wrong.

Although the Supreme Court has upheld some far-reaching regulations of economic activity, most notably in *Wickard v. Filburn* and *Gonzales v. Raich*, neither case supports the individual health insurance mandate. In these cases, the Court held that Congress's power to regulate the interstate commerce in a fungible good—for example, wheat or marijuana—as part of a comprehensive regulatory scheme included the power to regulate or prohibit the intrastate possession and production of this good. In both cases, Congress was allowed to reach intrastate economic activity as a means to the regulation of interstate commerce in goods.

Yet, the mandate to purchase health insurance is not proposed as a means to the regulation of interstate commerce; nor does it regulate or prohibit activity in either the health insurance or health care industry. Indeed, the health care mandate does not purport to regulate or prohibit activity of any kind, whether economic or noneconomic. By its own plain terms, the individual mandate provision regulates no action. To the contrary, it purports to "regulate" inactivity by converting the inactivity of not buying insurance into commercial activity. Proponents of the individual mandate are contending that, under its power to "regulate commerce . . . among the several states," Congress may reach the doing of nothing at all!

In recent years, the Court invalidated two congressional statutes that attempted to regulate non-economic activities. In *United States v. Lopez* (1995), it struck down the Gun-Free School Zones Act, which attempted to reach the activity of possessing a gun within a thousand feet of a school. In *United States v. Morrison* (2000), it invalidated part of the Violence Against Women Act, which regulated gender-motivated violence. Because the Court found the regulated activity in each case to be noneconomic, it was outside the reach of Congress's Commerce power, regardless of its effect on interstate commerce.

To uphold the insurance purchase mandate, the Supreme Court would have to concede that the Commerce Clause has no limits, a proposition that it has never affirmed, that it rejected in *Lopez* and *Morrison*, and from which it did not retreat in *Raich*. Although Congress may possibly regulate the operations of health care or health insurance companies directly, given that they are economic activities with a substantial effect on interstate commerce, it may not regulate the individual's decision not to purchase a service or enter into a contract.

If Congress can mandate this, then it can mandate anything. Congress could require every American to buy a new Chevy Impala every year, or a pay a "tax" equivalent to its blue book value, because such purchases would stimulate commerce and help repay government loans. Congress could also require all Americans to buy a certain amount of wheat bread annually to subsidize farmers.

Even during wartime, when war production is vital to national survival, Congress has never claimed such a power, nor could it. No farmer was ever forced to grow food for the troops; no worker was forced to build tanks. And what Congress cannot do during wartime, with national survival at stake, it cannot do in peacetime simply to avoid the political cost of raising taxes to pay for desired government programs.

OTHER CONSTITUTIONAL PROBLEMS

Senators and Representatives should also know that:

There are four constitutionally relevant differences between a universal federal mandate to obtain health insurance and the state requirements that automobile drivers carry liability insurance for their injuries to others on public roads:

A review of the tax provisions in the House and Senate bills raises serious questions about the constitutionality of using the taxing power in this manner; and

Since there literally is no legal precedent for this decidedly unprecedented assertion of federal power, it is highly unlikely that the Supreme Court would break new constitutional ground to save an unpopular personal mandate.

Members of Congress have a responsibility, pursuant to their oath, to determine the constitutionality of legislation independently of how the Supreme Court has ruled or may rule in the future. But Senators and Representatives also should know that, despite what they have been told, the health insurance mandate is highly vulnerable to challenge because it is, in truth, unconstitutional. And all other considerations aside, the highest obligation of each Member of Congress is fidelity to the Constitution.

The PRESIDING OFFICER. The Senator from Utah is recognized.

Mr. HATCH. Mr. President, I rise to support the constitutional point of order raised against the legislation before us by the distinguished Senator from Nevada. I applaud the senior Senator from Nevada for taking this step so that all Senators can take a position on whether this legislation is constitutional, or whether this legislation is consistent with the Constitution each of us is sworn to protect and defend.

The Senator from Nevada serves with me on the Senate Finance Committee, and he will remember that I started raising constitutional questions and objections against this legislation

more than 3 months ago during the committee markup, and so has he.

This body has spent its time debating the policy of this legislation. This is a terrible piece of legislation that will raise insurance premiums, raise taxes, and limit access to care.

Mr. President, I ask unanimous consent that an editorial from yesterday's Wall Street Journal, titled "Change Nobody Believes In," be printed in the RECORD following my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered. (See exhibit 1.)

Mr. HATCH. From the standpoint of policy, Mr. President, we should not pass this bill. Perhaps more importantly, from the standpoint of the Constitution, we may not pass it.

Much has changed since the founding of this great country, but one thing has not: The liberty we love requires limits on government. It requires limits on government. It always has and it always will. America's founders knew that and built limits into the system of government they established. Those limits come primarily from a written Constitution that delegates enumerated powers to the Federal Government. We must point to at least one—at least one—of those powers as the basis for any legislation we pass.

The Constitution and the limits it imposes do not mean whatever we want them to mean.

This legislation brings America into completely uncharted political and legal waters and I will not be at all surprised if there is litigation challenging it on constitutional and other grounds. In the Finance Committee, I offered an amendment to add a procedure for the courts to handle constitutional challenges in an expedited fashion. The Finance Committee chairman ruled that amendment out of order so that it could not even be considered. That was his decision, but that means that any future challenges will be handled the old fashioned way, even if that means an extended, rather than an expedited, process.

I ask unanimous consent that a memo prepared by the Conservative Action Project be printed in the RECORD following my remarks. Its signatories include former U.S. Attorney General Edwin Meese; former Congressman David McIntosh; Karen Kerrigan, President of the Small Business and Entrepreneurship Council; and Brian McManus of the Council for Affordable Health Insurance.

The PRESIDING OFFICER. Without objection it is so ordered. (See exhibit 2.)

Mr. HATCH. Let me briefly repeat the constitution objections I have been raising for the past few months and which the Senator from Nevada carefully raised this morning. First, the only enumerated power that conceivably can support the mandate for individuals to purchase health insurance is

the power to regulate interstate commerce. Since the 1930s, the Supreme Court has expanded this to include regulation of activities that substantially affect interstate commerce. But the key word is activities. Congress has never crossed the line between regulating what people choose to do and ordering them to do it. The difference between regulating and requiring is liberty. I agree with the 75 percent of Americans who believe that the insurance mandate is unconstitutional because Congress's power to regulate interstate commerce does not include telling Americans what they must buy.

Second, the financial penalty enforcing the insurance mandate is just that, a penalty. It is not a tax and, therefore, it is constitutional only if the insurance mandate it enforces is constitutional. If it is a tax, it is a direct tax on individuals rather than an excise tax on transactions and, therefore, it violates article I, section 9, of the Constitution which requires that direct taxes be apportioned according to population.

Third, the excise tax on high-cost insurance plans, which applies differently in some states than in others, is unconstitutional because it is not uniform throughout the United States as required by article I, section 8. The Supreme Court has said that to be uniform as the Constitution requires, an excise tax must have the same force and effect wherever the subject of the tax is found. Not only is this not the case with this tax, which makes it plainly unconstitutional, but that is exactly the design and intention of those who drafted this legislation.

Fourth, the legislation orders states to establish health benefit exchanges which will require states to pass legislation and regulations. If they do not, or even if the Secretary of Health and Human Services believes they will not by a certain date, the Secretary will literally step into each state and establish and operate this exchange for them. This is a direct violation of the division between federal and state government power. The Supreme Court could not have been clearer on this point, ruling over and over that Congress may regulate individuals but may not regulate states. Congress has no authority to order states, in their capacity as states to pass legislation. We have encouraged states to pass legislation, we have bribed them, we have even extorted them by threatening to withhold federal funds. But this legislation simply commandeers states and makes them little more than subdivisions of the federal government. In 1997, the Supreme Court held "state legislatures are not subject to Federal direction" and reaffirmed "categorically" its earlier holding that "the federal government may not compel the states to enact or administer a federal regulatory program." That should be

clear enough for Senators to understand here in this body.

I was amazed to learn that when President Franklin D. Roosevelt chose Frances Perkins as his Secretary of Labor, they discussed social policy legislation including health insurance. As Secretary Perkins later described it, they agreed that such legislation would pose "very severe constitutional problems," including fundamentally altering federal-state relationships. That is why the Social Security Act relies on the payroll tax. Even the Roosevelt administration, which oversaw the most dramatic expansion of Federal power in our Nation's history, would not go as far as the legislation before us today would go.

Should this legislation become law, there would be nothing that the federal government could not do. Congress would be remaking the Constitution in its image, rather than abiding by the Constitution's limits as liberty requires. There must come a time when we say that the political ends cannot justify the constitutional means, that the Constitution and the liberty it protects are more important than we wonderful Members of Congress are. That time is now, and that is why we will vote to sustain this constitutional point of order.

I wish to personally thank and congratulate the distinguished Senator from Nevada for his work on this issue, for his work on the committee, because he was one of the more energetic and more capable people on the committee in raising some of these very important issues such as this constitutional set of issues we have been discussing over this short period of time today. I am grateful for him, I am grateful he has raised it, and I am grateful to be able to be here on the floor to support him in his raising of this constitutional point of order when he chooses to do so.

I yield the floor.

EXHIBIT 1

[From the Wall Street Journal, Dec. 21, 2009]

CHANGE NOBODY BELIEVES IN

And tidings of comfort and joy from Harry Reid too. The Senate Majority Leader has decided that the last few days before Christmas are the opportune moment for a narrow majority of Democrats to stuff ObamaCare through the Senate to meet an arbitrary White House deadline. Barring some extraordinary reversal, it now seems as if they have the 60 votes they need to jump off this cliff, with one-seventh of the economy in tow.

Mr. Obama promised a new era of transparent good government, yet on Saturday morning Mr. Reid threw out the 2,100-page bill that the world's greatest deliberative body spent just 17 days debating and replaced it with a new "manager's amendment" that was stapled together in covert partisan negotiations. Democrats are barely even bothering to pretend to care what's in it, not that any Senator had the chance to digest it in the 38 hours before the first cloture vote at 1 a. m. this morning. After procedural motions that allow for no amend-

ments, the final vote could come at 9 p.m. on December 24.

Even in World War I there was a Christmas truce.

The rushed, secretive way that a bill this destructive and unpopular is being forced on the country shows that "reform" has devolved into the raw exercise of political power for the single purpose of permanently expanding the American entitlement state. An increasing roll of leaders in health care and business are looking on aghast at a bill that is so large and convoluted that no one can truly understand it, as Finance Chairman Max Baucus admitted on the floor last week. The only goal is to ram it into law while the political window is still open, and clean up the mess later.

Health costs. From the outset, the White House's core claim was that reform would reduce health costs for individuals and businesses, and they're sticking to that story. "Anyone who says otherwise simply hasn't read the bills," Mr. Obama said over the weekend. This is so utterly disingenuous that we doubt the President really believes it.

The best and most rigorous cost analysis was recently released by the insurer WellPoint, which mined its actuarial data in various regional markets to model the Senate bill. WellPoint found that a healthy 25-year-old in Milwaukee buying coverage on the individual market will see his costs rise by 178%. A small business based in Richmond with eight employees in average health will see a 23% increase. Insurance costs for a 40-year-old family, with two kids living in Indianapolis will pay 106% more. And on and on.

These increases are solely the result of ObamaCare—above and far beyond the status quo—because its strict restrictions on underwriting and risk-pooling would distort insurance markets. All but a handful of states have rejected regulations like "community rating" because they encourage younger and healthier buyers to wait until they need expensive care, increasing costs for everyone. Benefits and pricing will now be determined by politics.

As for the White House's line about cutting costs by eliminating supposed "waste," even Victor Fuchs, an eminent economist generally supportive of ObamaCare, warned last week that these political theories are overly simplistic. "The oft-heard promise 'we will find out what works and what does not' scarcely does justice to the complexity of medical practice," the Stanford professor wrote.

Steep declines in choice and quality. This is all of a piece with the hubris of an Administration that thinks it can substitute government planning for market forces in determining where the \$33 trillion the U.S. will spend on medicine over the next decade should go.

This centralized system means above all fewer choices; what works for the political class must work for everyone. With formerly private insurers converted into public utilities, for instance, they'll inevitably be banned from selling products like health savings accounts that encourage more cost-conscious decisions.

Unnoticed by the press corps, the Congressional Budget Office argued recently that the Senate bill would so "substantially reduce flexibility in terms of the types, prices, and number of private sellers of health insurance" that companies like WellPoint might need to "be considered part of the federal budget."

With so large a chunk of the economy and medical practice itself in Washington's

hands, quality will decline. Ultimately, “our capacity to innovate and develop new therapies would suffer most of all,” as Harvard Medical School Dean Jeffrey Flier recently wrote in our pages. Take the \$2 billion annual tax—rising to \$3 billion in 2018—that will be leveled against medical device makers, among the most innovative U.S. industries. Democrats believe that more advanced health technologies like MRI machines and drug-coated stents are driving costs too high, though patients and their physicians might disagree.

“The Senate isn’t hearing those of us who are closest to the patient and work in the system every day,” Brent Eastman, the chairman of the American College of Surgeons, said in a statement for his organization and 18 other specialty societies opposing ObamaCare. For no other reason than ideological animus, doctor-owned hospitals will face harsh new limits on their growth and who they’re allowed to treat. Physician Hospitals of America says that ObamaCare will “destroy over 200 of America’s best and safest hospitals.”

Blowing up the federal fisc. Even though Medicare’s unfunded liabilities are already about 2.6 times larger than the entire U.S. economy in 2008, Democrats are crowing that ObamaCare will cost “only” \$871 billion over the next decade while fantastically reducing the deficit by \$132 billion, according to CBO.

Yet some 98% of the total cost comes after 2014—remind us why there must absolutely be a vote this week—and most of the taxes start in 2010. That includes the payroll tax increase for individuals earning more than \$200,000 that rose to 0.9 from 0.5 percentage points in Mr. Reid’s final machinations. Job creation, here we come.

Other deceptions include a new entitlement for long-term care that starts collecting premiums tomorrow but doesn’t start paying benefits until late in the decade. But the worst is not accounting for a formula that automatically slashes Medicare payments to doctors by 21.5% next year and deeper after that. Everyone knows the payment cuts won’t happen but they remain in the bill to make the cost look lower. The American Medical Association’s priority was eliminating this “sustainable growth rate” but all they got in return for their year of ObamaCare cheerleading was a two-month patch snuck into the defense bill that passed over the weekend.

The truth is that no one really knows how much ObamaCare will cost because its assumptions on paper are so unrealistic. To hide the cost increases created by other parts of the bill and transfer them onto the federal balance sheet, the Senate sets up government-run “exchanges” that will subsidize insurance for those earning up to 400% of the poverty level, or \$96,000 for a family of four in 2016. Supposedly they would only be offered to those whose employers don’t provide insurance or work for small businesses.

As Eugene Steuerle of the left-leaning Urban Institute points out, this system would treat two workers with the same total compensation—whatever the mix of cash wages and benefits—very differently. Under the Senate bill, someone who earned \$42,000 would get \$5,749 from the current tax exclusion for employer-sponsored coverage but \$12,750 in the exchange. A worker making \$60,000 would get \$8,310 in the exchanges but only \$3,758 in the current system.

For this reason Mr. Steuerle concludes that the Senate bill is not just a new health system but also “a new welfare and tax system” that will warp the labor market. Given

the incentives of these two-tier subsidies, employers with large numbers of lower-wage workers like Wal-Mart may well convert them into “contractors” or do more outsourcing. As more and more people flood into “free” health care, taxpayer costs will explode.

Political intimidation. The experts who have pointed out such complications have been ignored or dismissed as “ideologues” by the White House. Those parts of the health-care industry that couldn’t be bribed outright, like Big Pharma, were coerced into acceding to this agenda. The White House was able to, er, persuade the likes of the AMA and the hospital lobbies because the Federal government will control 55% of total U.S. health spending under ObamaCare, according to the Administration’s own Medicare actuaries.

Others got hush money, namely Nebraska’s Ben Nelson. Even liberal Governors have been howling for months about ObamaCare’s unfunded spending mandates: Other budget priorities like education will be crowded out when about 21% of the U.S. population is on Medicaid, the joint state-federal program intended for the poor. Nebraska Governor Dave Heineman calculates that ObamaCare will result in \$2.5 billion in new costs for his state that “will be passed on to citizens through direct or indirect taxes and fees,” as he put it in a letter to his state’s junior Senator.

So in addition to abortion restrictions, Mr. Nelson won the concession that Congress will pay for 100% of Nebraska Medicaid expansions into perpetuity. His capitulation ought to cost him his political career, but more to the point, what about the other states that don’t have a Senator who’s the 60th vote for ObamaCare?

“After a nearly century-long struggle we are on the cusp of making health-care reform a reality in the United States of America,” Mr. Obama said on Saturday. He’s forced to claim the mandate of “history” because he can’t claim the mandate of voters. Some 51% of the public is now opposed, according to National Journal’s composite of all health polling. The more people know about ObamaCare, the more unpopular it becomes.

The tragedy is that Mr. Obama inherited a consensus that the health-care status quo needs serious reform, and a popular President might have crafted a durable compromise that blended the best ideas from both parties. A more honest and more thoughtful approach might have even done some good. But as Mr. Obama suggested, the Democratic old guard sees this plan as the culmination of 20th-century liberalism.

So instead we have this vast expansion of federal control. Never in our memory has so unpopular a bill been on the verge of passing Congress, never has social and economic legislation of this magnitude been forced through on a purely partisan vote, and never has a party exhibited more sheer political willfulness that is reckless even for Washington or had more warning about the consequences of its actions.

These 60 Democrats are creating a future of epic increases in spending, taxes and command-and-control regulation, in which bureaucracy trumps innovation and transfer payments are more important than private investment and individual decisions. In short, the Obama Democrats have chosen change nobody believes in—outside of themselves—and when it passes America will be paying for it for decades to come.

EXHIBIT 2

CONSERVATIVE ACTION PROJECT

The Conservative Action Project, chaired by former Attorney General Edwin Meese, is

designed to facilitate conservative leaders working together on behalf of common goals. Participation is extended to leaders of groups representing all major elements of the conservative movement—economic, social and national security.

Edwin Meese, former Attorney General; Steven G. Calabresi, Professor, Northwestern Law School; Mathew D. Staver, Founder & Chairman, Liberty Counsel; Curt Levey, Executive Director, Committee for Justice; Marion Edwyn Harrison, Past President, Free Congress Foundation; Kenneth Klukowski, Senior Legal Analyst, American Civil Rights Union; Wendy Wright, President, Concerned Women for America; J. Kenneth Blackwell, Visiting Professor, Liberty School of Law; Grover Norquist, President, Americans for Tax Reform; William Wilson, President, Americans for Limited Government; Matt Kibbe, President, Freedom Works; Jim Martin, President, 60 Plus Association; David McIntosh, former Member of Congress, Indiana; Colin A. Hanna, President, Let Freedom Ring; Tony Perkins, President, Family Research Council; Brent Bozell, President, Media Research Center; Brian McManus, Council for Affordable Health Insurance; Karen Kerrigan, President, Small Business & Entrepreneurship Council; T. Kenneth Cribb, former Counselor to the U.S. Attorney General; Richard Viguerie, Chairman, ConservativeHQ.com; Alfred Regnery, Publisher, American Spectator.

MEMO FOR THE MOVEMENT

The Individual Mandate in “Obamacare” is Unconstitutional

Re: The mandate under the Obama-Pelosi-Reid healthcare legislation requiring American citizens to purchase health insurance violates the U.S. Constitution.

Action: We urge you to make this point to members of the U.S. Senate—and if a bill passes the Senate to impress upon members of both chambers of Congress—that the key provision in the healthcare legislation violates the U.S. Constitution.

Issue: Mandating that individuals must obtain health insurance, and imposing any penalty—civil or criminal—on any private citizen for not purchasing health insurance is not authorized by any provision of the U.S. Constitution. As such, it is unconstitutional, and should not survive a court challenge on that issue. Supporters of the legislation have incorrectly contended that the legal justification for the mandate is authorized by the Commerce Clause, the General Welfare Clause, or the Taxing and Spending Clause. Given that this mandate provision is essential to Obamacare; its unconstitutionality renders the entire program untenable.

The individual mandate is unconstitutional unless there is a specific constitutional provision that authorizes it. The federal government is a government of limited jurisdiction. It has only enumerated powers. Therefore unless a specific provision of the Constitution empowers a particular law, then that law is unconstitutional. There is no such authorization for the mandate.

The individual mandate is not authorized by the Commerce Clause. Most of those advocating the Democrats’ bill say that Congress can pass this legislation pursuant to its power to regulate interstate commerce. That argument is incorrect, because there is no interstate commerce when private citizens do not purchase health insurance.

The Commerce Clause only covers matters where citizens engage in economic activity. The last time the Supreme Court struck down a law for violating the Commerce

Clause, in *United States v. Morrison* (2000), the Court did so on the grounds that the activity in question was not an economic activity.

The Commerce Clause only extends to persons or organizations voluntarily engaging in commercial activity. Government can only regulate economic action; it cannot coerce action on the part of private citizens who do not wish to participate in commerce. In the most expansive case for Congress' power to regulate interstate commerce, *Wickard v. Filburn* (1942), the Court upheld the agricultural regulation in question against a wheat farmer who earned his entire living from growing and selling wheat, making him a willing participant in interstate commerce.

The Commerce Clause requires an actual economic effect, not merely a congressional finding of an economic effect. When the Court struck down the Violence Against Women Act in *United States v. Morrison* (2000), the Court noted that although the statute made numerous findings regarding the link between such violence and interstate commerce, it held that those findings did not actually establish an economic effect. Therefore the various interstate-commerce findings in the Senate version of the "Obamacare" legislation do not make the bill constitutional.

The individual mandate is not authorized under the General Welfare Clause. The Supreme Court made clear in *United States v. Butler* (1936) and *Helvering v. Davis* (1937) that the General Welfare Clause only applies to congressional spending. It applies to money going out from the government; it does not confer or concern any government power to take in money, such as would happen with the individual mandate. Therefore the mandate is outside the scope of the General Welfare Clause.

The individual mandate is not authorized under the Taxing and Spending Clause or Income Tax. The Constitution only allows certain types of taxation from the federal government.

The Article I Taxing and Spending Clause permits duties, imposts, excises and capitation taxes—duties, imposts and excises are taxes on purchases. A capitation tax is a tax that every person must pay, and the Constitution's apportionment rule requires that every person in each state must pay exactly the same amount. The Obamacare mandate is imposed on people who are making no purchase, and is a tax that some people in a state would pay, but others do not.

The Sixteenth Amendment allows an income tax. An income tax is imposed only on earnings, but people would have to pay this tax even if they had no income.

Therefore it cannot be any of these constitutionally-permitted taxes.

The individual mandate is unconstitutional regardless of whether there are criminal penalties involved. There is no distinction between criminal and civil penalties for determining the constitutionality of legislation, and the penalty imposed in *Wickard v. Filburn* (1942) was not a criminal penalty. Therefore even if the criminal sanctions were removed from the legislation, the imposition of any penalty or consequence for not purchasing insurance renders the mandate unconstitutional.

The individual mandate cannot be properly compared to requiring auto insurance. President Obama said in a Nov. 9 interview on ABC television that requiring people to buy health insurance and penalizing those that do not buy is acceptable because people are

required to buy car insurance. That statement is untrue.

Only state governments can require people to get car insurance. While the federal government is limited to the powers enumerated in the Constitution, the states have a general police power. The police power enables state governments to pass laws for public safety and public health. The federal government has no general police power, and therefore could not require car insurance.

States do not require people to purchase car insurance. Driving a car is a privilege, not a right. States require people to get insurance only as a condition for those people who voluntarily choose to drive on the public roads. If a person chooses to use public transportation, or use a bicycle instead of a car, or operate a car only on their own property, they are not required to have car insurance, and cannot be penalized for lacking insurance.

FOR ADDITIONAL INFORMATION ON THE UNCONSTITUTIONALITY OF THE HEALTH CARE MANDATE, PLEASE VISIT THESE WEBSITES

<http://www.washingtonpost.com/wpdyn/content/article/2009/08/21/AR2009082103033.html>

<http://www.politico.com/news/stories/1009/28463.html>

<http://www.politico.com/news/stories/1009/28620.html>

<http://www.politico.com/news/stories/1009/28787.html>

<http://www.foxnews.com/opinion/2009/10/30/ken-klukowski-open-letter-pelosi-gibbs-constitution-individual-mandate/>

<http://www.washingtontimes.com/news/2009/nov/02/beware-the-health-insurance-police/>

<http://www.heritage.org/Research/LegalIssues/lm0049.cfm>

<http://blogs.abcnews.com/politicalpunch/2009/11/interview-with-the-president-jail-time-for-those-without-health-care-insurance.html>

http://hatch.senate.gov/public/index.cfm?FuseAction=PressReleases.Detail&PressRelease_id=097a758af3-1b78-be3e-e03a-c0eea6d515c.5

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. ENSIGN. Mr. President, I know we are waiting for the chairman of the Finance Committee to come. I ask unanimous consent to speak in the meantime, in these few seconds.

I thank the senior Senator from Utah. He is one of the best constitutional scholars we have here in the Senate. I appreciate his words and analysis on why this bill is unconstitutional. I think his words this morning were eloquent. I appreciate his support as I raise this constitutional point of order.

I yield to the Senator from Montana, the chairman of the Finance Committee.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I have a unanimous consent request that I understand has been cleared by both sides.

I ask unanimous consent that after Senator ENSIGN raises the point of order that the Reid substitute amendment No. 2786 is in violation of the Constitution, the point of order be set aside to recur on Wednesday, December

23, at a time to be determined by the majority and Republican leaders.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The Senator from Nevada is recognized.

Mr. ENSIGN. Mr. President, I rise to make a constitutional point of order against this bill on the grounds that it violates Congress' enumerated powers in article I, section 8 and that it violates the fifth amendment of the Constitution. I ask for the yeas and nays.

The PRESIDING OFFICER. Pursuant to the unanimous consent, the point of order shall be set aside until a time tomorrow to be determined by the majority leader and the minority leader.

Is there a sufficient second? There appears to be a sufficient second. The yeas and nays are ordered on the point of order.

Mr. ENSIGN. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. SESSIONS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SESSIONS. Mr. President, I would like to share some thoughts on a central issue to this health care reform legislation. It is something that has gotten away from us. I do not believe we fully comprehended it. It is a critical issue.

It seems to me we are double-counting the money. We are counting money twice—maybe the largest amount of money ever having been counted twice in the history of the world. It is very dangerous with regard to the financial viability of the legislation we are looking at today.

It was promised by the President that this legislation would not add one dime to the national debt. He said yesterday that this legislation would strengthen Medicare. This is his quote: . . . and Medicare will be stronger and its solvency extended by nearly a decade.

I don't think that is accurate. We have had other Members of the Democratic leadership say that.

What we know is we have, I think it is about \$460 billion in tax increases and \$490 billion in tax increases and a little less than that, \$400-and-some-odd billion in savings to Medicare, and that accounts for the \$871 billion the bill is supposed to cost in the first 10 years. Of course, that is not an accurate ultimate cost since most of the benefits in the bill do not start until the fifth year. So when you go the first full 10 years of the bill, it costs \$2.5 trillion. But, regardless, let's take this first 10 years. The assertion is that Medicare can be improved and that we can take money from it and that this is going to

make Medicare stronger and that somehow this is going to extend the solvency of Medicare, which is going insolvent by 2017. That is because more and more people are retiring and people are living longer, among other reasons. So the cost of Medicare goes up.

I guess what I am framing now is what I believe to be a matter of the greatest importance. The argument is that somehow, by cutting benefits in Medicare by almost $\frac{3}{2}$ trillion, we are somehow strengthening Medicare. That would be true if the money that was taken out of Medicare Programs and benefits and providers who are providing the benefits—if that money were maintained in Medicare.

They go to the CMS, the institution that keeps up with Medicare costs, the Center for Medicare and Medicaid Services, the Chief Actuary there, Mr. Richard Foster, and they ask him: Won't these reductions in Medicare expenses extend the life of Medicare? And he said yes. OK. He said yes. He writes this:

We estimate that the aggregate net savings to the Part A trust fund under the PPACA—

That is the health care reform bill—would postpone the exhaustion of the trust fund assets by 9 years—that is from 2017 under current law to 2026 under the proposed legislation.

Great. That is not a bad result. But then he goes on. I think he was simply asked: If you reduce spending in Medicare by effecting these cuts and reductions in Medicare, will it extend the life? And he said it would. However, I think he felt he might have been used, and so he didn't leave it right there. I think he believed there was something else afoot in this deal. He goes on to say this:

In practice, the improved Part A financing—

That is what he is talking about, these cuts—

... the improved Part A financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions under the PPACA)—

The health care bill—

and to extend the trust fund, despite the appearance of this result from the respective accounting conventions.

Maybe I am wrong about this. I am happy to have a lot of people look at it. Wait a minute, we have the President of the United States yesterday saying that Medicare will be stronger and its solvency extended for nearly a decade. We have Senator DURBIN and I think Senator BAUCUS and others saying the same thing. We are talking about \$400 billion.

So I would think this Congress can get a straight answer somewhere. Don't you? Well, I have been asking staff, and they say it is double counting.

I said: What do you mean it is double counting?

Well, Senator GREGG, the ranking Republican on the Budget Committee—former chairman of the Budget Committee—said it is double accounting. He offered an amendment, a simple amendment that said any money that is saved in Medicare stays in Medicare. Did that pass? No. They voted that down. That should be a signal, I submit. That should be a red flag.

So now I am looking at this really, really hard because the way I see the financial accounting of the bill, perhaps the largest bogus part of it is to say that the money that is being saved from Medicare is going to create this new program and, at the same time, saying the savings in Medicare are going to be used to extend the life of Medicare. You cannot do both.

That is what Mr. FOSTER said in his letter of December 10:

In practice, the improved Part A financing—

He is talking about the improved Part A financing of Medicare by these cuts—

the improved Part A financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions under the PPACA) and to extend the trust fund. . . .

All right. You got it? Let's go back and leave out the parentheses:

... the improved Part A financing cannot be simultaneously used to finance other Federal outlays . . . and to extend the trust fund, despite the appearance of this result from the respective accounting conventions.

So they got CBO to score it as if the money is going into the new health care reform, and they got CMS to score it as if it is saving Medicare.

Now, I was a Federal prosecutor for a long time. I know the responsibilities placed on presidents of corporations. If the president of a corporation were to issue a prospectus and ask people to invest money in his company and support his program, his agenda, and he said: I have \$400 billion or \$400,000 I am going to spend in it, and he knew the money was being spent on something else and he did not really have that money, that is a criminal offense, and people would go to jail for it.

I am worried about it; I really am. This is unbelievable. So we are going to get to the bottom of this. If I am wrong, I would like to see where the money is coming from. So my question to my colleagues is—and apparently this has been asked by staff for weeks and they have never gotten a straight answer—where do you get this \$871 billion? How much of that are you counting coming from savings in Medicare; and where, precisely, are you getting it from Medicare? If you are going to spend it on the new program, how are you going to say it is going to strengthen Medicare as to its insolvency problem?

You cannot count the money twice, and I believe that is what Mr. FOSTER

was suggesting; that you cannot simultaneously count the money "despite the appearance of this result from the respective accounting conventions." What he is saying is, CBO is following proper accounting conventions for their scoring and CMS is doing it their way and it gives the appearance that you have some money that can be spent twice. But he said you cannot simultaneously use the same money. Now, isn't that true? But in this body, I do not know.

What is another fundamental matter of budgetary importance that goes with it? The President has repeatedly said that not one dime will be added to the national debt, and it should not be. We cannot continue to do that. So when this legislation started, the idea was we needed to reform a lot of problems in our health care situation.

One of the problems everybody recognized was that the doctors are not getting paid in a proper fashion for the work they do. Under the Balanced Budget Act of 1997, we effected rules on how much doctors should be paid, and if those rules went into effect today, doctors would have a 21-percent pay cut on all Medicare work. Already Medicare physicians are leaving the practice because they get paid much less from the Federal Medicare Program than they do from private health insurance. So they would rather do private work than Medicare. But they do Medicare—most doctors do—but if you took them another 21 percent down, they would not.

Every year, they come here and ask the Congress to waive this cut, and Congress—as part of the duplicity of this body that has gone on under both parties, but each year it gets worse and worse—we fix it, and we do not execute the cut. But we only do it for 1 year. So when we have a budget, it assumes a 10-year budget. As President Obama submitted it to us, it assumes in the first year you pay the physicians and you do not cut their pay. Then for 9 years you assume they get a 21-percent reduction. It is a gimmick because you cannot cut the physicians 21 percent; and we know that. If we budgeted for the full amount, we are going to have to pay physicians, and we are going to pay physicians, then there would be a big hole because we do not have the money and we either have to cut something else, raise taxes, or raise the debt. What we have been doing is paying for it with more debt.

Well, each year, the doctors get all upset because they are staring at a 21-percent pay cut. All their representatives in the AMA and everybody come up every year and tell us: Don't cut our pay, and we do not—1 year at a time.

This is a misrepresentation. It hides the financial precariousness of our position. It is not good. It should never continue. It needs to be permanently fixed, and that was supposed to be part

of health care reform from the beginning. The President said that is what he was going to do. The leadership on the other side said that is what they were going to do.

But what happened—when they met in their secret rooms, and they all wheeled and dealt and tried to add up these numbers and see how they could manipulate numbers and scores and accounting to make it add up so they could say it would not add one penny to the debt—they could not get around the \$250 billion it takes to pay the doctors. They could not do it.

They say, under this bill, there is a \$130 billion surplus over the first 10 years. But it does not fix the doctor payments for Medicare in health care work, Medicaid. It does not fix it. So when you fix it, it costs \$250 billion. There is no dispute about that. We have analyzed that. The accounting numbers are clear: \$250 billion.

So what the Democrats tried to do—it was a clever—Senator ENSIGN referred to it the other day as a shell game. They moved the doctor fix out of the health care reform—just took it out—and so, therefore, you do not have the \$250 billion hole and you just put it over here. They thought they would be clever, they would just pass it, and we would add it all to the debt. They tried to do so, so they could tell the doctors they tried to vote to have a permanent fix of their payments. “Doctors, we are going to take care of it. We’ll just pass it, and every penny of this will add to the debt.”

Well, 13 Democrats would not swallow that, and I think every Republican opposed it, and it went down. So now I think we have a 2-month fix. Two months is where we are working from today, so we would not have a slashing of payments to physicians by failure to fix it.

So they just took it out, and I assume we are going to have some other gimmick to hide that \$250 billion. So if you put the \$250 billion cost into health care reform, you end up with a \$120 billion deficit right off the bat. Then, when you get into this double accounting of \$450 billion, you have really got a mess. They are estimating \$871 billion in income for the first 10 years of this plan. As I analyze it, you have a \$250 billion hole from not paying the doctors, and then you have a \$400-plus billion double accounting—the savings from Medicare.

So it is just not good. I am telling you, we only have one President. He has a lot of things on his mind, and it is very frustrating. But I will say one more thing he said at that press conference. He said, and he has repeatedly stated: It is going to reduce health care premiums for your insurance. Right? This was yesterday, after this bill passed. He says he is tired of people carping about the cost of the bill. Remember him saying that—tired of

these carpers? I guess he is talking about me because I have been carping about the cost of it for some time because the numbers do not add up.

All right. They claim the legislation will reduce insurance costs. This is the score of the CBO about small businesses. What about insurance premiums? If you are small businesses, the average premiums today for a family is \$13,300. If the Reid bill passes, by 2016 the premiums will be \$19,200. Is that cutting premiums? Well, yes, it is because under the Reid bill it would increase, on average, 5.38 percent. But if we did not pass any bill at all, it would increase it 5.46 percent. So it saved money; it reduced your premium. It will be \$19,200 instead of \$19,300. That is for small businesses.

What about for large businesses? Does it cut insurance premiums there? For large business plans, under the Reid bill, the increase, if we pass this legislation, would be 5.41 percent per year in your premiums. If you do not pass the bill at all, it would be 5.56 percent. Is that a savings? Very little. Instead of \$21,100, under the Reid bill you would pay \$20,300.

Then, finally, the individual market—this is the people who already are the ones who are getting hurt because they are not in group plans; they don’t have employers paying a third, a half, or whatever, for insurance; they don’t get the same tax breaks. They are getting killed. Barbers, individual people who can’t get into group plans, it is horrible for them. What happens to the individual market? Under the Reid bill, their premiums would go up 7.77 percent per year. They would go up more than the others. What about if we didn’t do anything? How much would their bills go up then, their insurance bills? Only 5.51 percent. Theirs go up more than 2 percent.

So I am just saying this legislation may have a great vision, it may have a great idea about trying to make the system work better, but it doesn’t. These are huge costs. It is not financially sound. It is not going to reduce our premiums. It is going to increase the percentage of wealth in America going to health care instead of reducing it as I thought we were supposed to do from the beginning.

I see my colleague, Senator KYL, here. I would just leave it at that. I thank my colleagues. But if I am correct about these numbers, we shouldn’t vote for the bill. People should change their vote. If I am in error, I would like to be informed of how I am in error.

I yield the floor.

The PRESIDING OFFICER (Mr. BURRIS). The Senator from Arizona.

Mr. KYL. Mr. President, I listened carefully to what my colleague said, and as a member of the Finance Committee, I can tell him that he is not in error. What he said about premiums going up under this legislation is true.

The promise was that premiums would not go up. Well, they continue to go up. In fact, in the case of the individual market, the legislation itself causes them to go up between 10 and 13 percent. My colleague is not in error.

If the Reid bill has a motto, it is “in government we trust.” With the turn of every page, it is no exaggeration to say the Reid bill creates a Washington takeover of health care, to wit, \$2.5 trillion in new government spending; \$494 billion in new taxes; \$465 billion in Medicare cuts; 70 new government programs; and higher health insurance premiums for individuals, families, and businesses. It is packed with new Federal requirements and mandates that amount to a stunning assault on liberty. Even in the absence of a government-run insurance plan, this bill would give the government virtually total control over health care. The bill itself is the government option.

Michael Cannon, a health policy expert at the Cato Institute, warns that the bill’s linchpin, the requirement that all individuals buy a government-approved insurance plan, would be “the most sweeping and dangerous measure in any of the bills before Congress.”

Of course, if Congress mandates that every American purchase health insurance, then Congress gets to define exactly what that health insurance entails. Welcome to the future, where bureaucrats and politicians know what is best for families, small businesses, and seniors. For example, under this legislation the government would set new Federal rating rules. Rating rules dictate how insurers may calculate premiums, which experts estimate would increase premiums by a whopping 72 percent in my home State of Arizona. They would determine the coverage benefits for all plans regardless of consumer preferences or health care needs. The government would limit insurers to offering only four plans. You have to offer two; you can’t offer any more than four. They would prohibit individuals over the age of 30 from enrolling in a catastrophic health care plan. And to highlight the magnitude of government interference and micromanagement, the bill even dictates the number of pages—by the way, it is no more than 4—and the font size—no smaller than 12 point—of the summary of benefits. These are just a few examples of the heavyhanded government controls. Indeed, the word “shall” appears 3,607 times in the Reid bill. I haven’t had a chance yet to count how many more times it appears in the almost 400-page amendment that has been now filed.

In my view, however, the most dangerous consequence of the Washington takeover of health care is the inevitable rationing that will result in the delay and denial of care. Ensuring access to the highest quality care and protecting the sacred doctor-patient relationship should be the fundamental

goals of any health reform effort. These intangibles are the cornerstones of U.S. health care, the very things Americans value most, that the Reid bill puts in jeopardy. Don't look for the words "ration" or "withhold coverage" or "delay access to care" in the bill. Obviously, they are not there. Instead, contemplate the inevitable result of new Federal rules that aim to reduce health care costs but will inevitably result in delayed or denied tests, treatments, and procedures deemed to be too expensive. For example, the Reid bill would establish a Medicare Commission. This is an unelected body of bureaucrats with the task of finding, and I am quoting here, "sources of excess cost growth," meaning, of course, tests and treatments that are allegedly too expensive or whose coverage would mean too much government spending on seniors. The Commission's decisions will result in the delay and denial of care.

Medicare already delays more medical claims than private insurers do, but this bill would redistribute Medicare payments to physicians based on how much they spend treating seniors. It would rely on recommendations from the U.S. Preventive Services Task Force—the entity, by the way, that recently recommended against mammograms for women under the age of 50—to set preventive health care benefits, and it would authorize the Federal Government to use comparative effectiveness research when making coverage determinations. It is this last issue—comparative effectiveness research—that I wish to discuss in more detail.

The Reid bill would create a new entity called the Patient-Centered Outcomes Research Institute to conduct comparative effectiveness research. This research, which is already done in the private sector, compares the effectiveness of two or more health care services or treatments, and, of course, it is used to provide doctors with information as to what works best in most cases. The goal is to provide patients and doctors with better information regarding the risks and benefits of a drug, let's say, for example, versus surgery in a particular kind of case. The question before us is not as to the merits of the research but, rather, whether the research should be used by the government to determine the treatments and services covered by insurance.

In a recent interview, President Obama said:

What I think the government could do effectively is to be an honest broker in assessing and evaluating treatment options.

The President believes the government should assess and evaluate health care treatments, and certainly that is how health care works in other countries such as Great Britain. For example, there, they have the National Institute for Health and Clinical Excel-

lence; the acronym is NIHCE. NIHCE routinely uses comparative effectiveness research to make cost-benefit calculations. They don't even attempt to hide it. On its Web site, NIHCE says:

With the rapid advancement in modern medicine, most people accept that no publicly funded health care system, including the National Health Service, can possibly pay for every new medical treatment which becomes available. The enormous costs involved mean that choices have to be made.

Choices are made, and this is the key: They are made by the government, not by patients and doctors.

The National Health Service, which runs Britain's health care system, has issued guidance known as the Liverpool Care Pathway whereby a doctor can withdraw fluids and drugs from a patient if the medical team diagnoses that the patient is close to death. Many are then put on continuous sedation so that they die free of pain. Doctors warn that some patients are being wrongly put on the pathway, which is creating a self-fulfilling prophecy that they would die because sedation often masks the signs of improvement.

Also, due to excessively long waiting periods, the National Health Service launched what they call an End Waiting, Change Lives campaign. The goal here was to reduce patients' waiting times to 18 weeks from referral to treatment—18 weeks. That is supposed to be a good thing? That is 4½ months for an appointment. This is why many Europeans and Canadians visit the United States each year, places such as the Mayo Clinic in Arizona, for access to the treatments that are denied to them in their own countries.

These are the dangers of a government-run health care system. The government, not the patients and doctors, makes the health care decisions. The government decides if your health care is an effective use of government resources, and the government inevitably interferes in your ability to access care. That is rationing, and it is wrong. This is not what Americans want or expected from health care reform. Yet it is precisely the path Congress is taking. Perhaps that is why 61 percent of Americans disapprove of this bill.

Nothing in the Reid bill would prohibit the Federal Government from using comparative effectiveness research, just as it has done in Britain, as a tool to delay or deny coverage of a health care treatment or service. The bill actually empowers the Secretary of Health and Human Services to use comparative effectiveness research when making coverage determinations. For example, on page 1,684 of the original bill, it says:

The Secretary may only use evidence and findings from research conducted under section 1181 to make a determination regarding coverage . . .

And so on.

As the Washington Examiner notes:

Health and Human Services Secretary Kathleen Sebelius would be awarded unprecedented new powers under the proposal, including the authority to decide what medical care should be covered by insurers as well as the terms and conditions of coverage and who should receive it. The Reid legislation lists 1,697 times where the Secretary is given the authority to create, determine, or define things in the bill.

I know my colleagues will point to language that says: Well, the Secretary can't make these decisions on rationing care solely on the basis of comparative effectiveness research. Whoopee. I am not sure if that is a word we can use on the Senate floor, but big deal. You can't make it solely on that basis, but you can use comparative effectiveness research to ration care. That is wrong, and that is what this bill permits. And despite numerous times to get a simple amendment I offered to say no comparative effectiveness research can be used by a Federal agency to deny care or treatment—simple—the other side says: No, we already have it covered. It is good enough. Our language is fine. You don't need that simple statement that would prevent this research from being used in that fashion. I think it is pretty clear that the attempt here is to be able to do it.

During the Finance Committee, I asked the majority counsel why they didn't bar the Federal Government from using comparative effectiveness research as a tool to ration care. The staff replied:

The reason why we did not include an express prohibition is we did not want to limit the institute from considering areas of science that have a budgetary impact, if you will.

That is, of course, precisely the problem. Americans do not want the Federal Government using this research as a cost-cutting tool.

Regina Herzlinger, a professor at Harvard Business School, warns: CER could easily morph into an instrument of health care rationing by the Federal Government without the appropriate safeguards.

That is why earlier this year I joined Senator MCCONNELL and Senator ROBERTS and Senator CRAPO in introducing the PATIENTS Act, and it creates this firewall to prevent the use of research for rationing. We filed it as an amendment, but, of course, we are not going to be able to vote on it now that cloture has been invoked. This is the third time this year we have tried to institute this pro-patient firewall, but obviously we are not going to be able to vote on it, as I said.

From the very beginning of the health care reform debate, I have believed that any bill should be rooted in a simple yet fundamental principle: that very American should be able to choose the doctor, hospital, and health plan of his or her choice. No Washington bureaucrat should interfere

with that right or substitute the government's judgment for that of a physician. There is nothing more important to Americans, other than maybe their freedom, than the health of their family—and that does, by the way, include an element of freedom, obviously, the freedom to do what you think is best for your family. We would all do anything we could to help a loved one. We don't want Washington impeding our ability to do so.

Maybe that is why this new Washington Post-ABC poll "finds the public generally fearful that a revamped system would bring higher costs while worsening the quality of their care." Even, they say, those without insurance are evenly divided on the question of whether their care would be better if the system were overhauled.

The American people get it. The bill itself is the government option, but in government, they do not trust.

The PRESIDING OFFICER. The Senator from Louisiana is recognized.

Ms. LANDRIEU. Mr. President, I come to the floor today in support of the Patient Protection and Affordability Act, and I wish to give some of the reasons why I am supporting this important piece of legislation.

Before my colleague leaves the floor, I would like to respond to his last comment. One of the reasons the American people are having difficulty believing the government can do anything right is that he and his colleagues have spent the last several decades convincing them that the government is the problem and that the government can't do anything right.

Even in the face of strong evidence that suggests otherwise, they continue that worn-out, tired mantra. People in my State and around the Nation are getting tired of it because they know that government must stand sometimes to protect them from abusive practices in the private marketplace, abusive practices of insurance companies, to try to level the playing field and set the rules. Of course, those on the other side don't believe in a level playing field and rules. They believe citizens in our country should be at the whim and mercy of the private market. That has been their philosophy for decades. That is not the philosophy of the Democratic Party. We believe in a public-private partnership. We believe in a level playing field. We believe in giving people the opportunity to earn their way, with fair rules in place. That party has never believed that, and that is at great issue in the underlying debate. They can continue to fabricate myths and lies about this bill, but those of us who support it will proudly continue to tell the truth about it.

I have served in public office for 30 years as a State legislator, State treasurer, and now as a United States Senator. But it doesn't take 30 years to know the health care system our citi-

zens live under and live with today is expensive, wasteful, and painfully inefficient.

From my visits with doctors and nurses, to seniors on Medicare, to recent college graduates struggling to afford coverage, to dozens and dozens of small business owners who are frightened to death that they are not going to be able to continue in their business because of the rising cost of health care, it has become clear to me that the time for reform is now.

In Louisiana, the average family spends more than \$12,000 each year for health insurance. That is almost 100 percent of the earnings of a person who is working 40 hours a week at the minimum wage. Think about that. Only in one developed country in the world would we have a system that says if you go to work 40 or 50 hours a week, you have the privilege of taking all that money and having to purchase health care in the system that my colleagues on the other side want to advocate for. That is wrong. We must drive down the cost to the government, to businesses, and to families. This bill will begin to do that.

Since 2000, the amount that working families are charged for health insurance has increased by 91 percent. That doesn't seem to concern my colleagues on the other side of the aisle. If this Congress stood by and did nothing, those costs would nearly double in the next 6 years, with economists predicting that families in my State will pay a whopping \$23,000 for insurance in 2016—an 85-percent increase. To say that a different way, that means that if we do nothing, the average family in Louisiana will be paying 60 percent of their income for health care—if they can find it and if they can get around a preexisting condition—leaving only 40 percent of their wages to cover food, education, children, housing, transportation, and everything else families need their funds for.

These skyrocketing costs are burdening families not just in Louisiana but in every State. We don't have a choice but to change. We cannot continue to rely just on the private market without reform, without guidelines, and without incentives to change. Our people will be priced out of the market. Maybe that is what my colleagues on the other side of the aisle want. That is not what I want.

Small businesses are struggling to remain competitive and to turn a profit. In the face of highly unstable and unpredictable health care costs this is getting harder and harder. As chair of the Small Business Committee, I have held 23 hearings and roundtables just this year, and several of them have been focused on how the current health care system and volatile health care costs are hurting our Nation's small businesses.

Today, small businesses are seeing their health care costs increase faster

than the prices of the products and services they sell four times faster than the rate of inflation since 2001. Premiums for single policies increased by 74 percent for small businesses in the last eight years, according to a 2009 Kaiser Family Foundation survey. Nationally, 40 percent of small businesses say that health care costs have had a negative impact on other parts of their business.

What are we supposed to do, stand here and do nothing? No—that is why acting now is so important. That is why this bill is so important, because the status quo is unsustainable. It is unsustainable for our government and it is unsustainable for small businesses.

Even though families, businesses, and government budgets are being squeezed by unsustainable costs, Senate Republicans are doing everything they can to argue for the status quo. Why? I don't know. Each day, they find a new excuse for their obstruction. I wish they had put the same amount of passion, energy, and creative thinking into contributing policies and ideas to this debate as they have into their delaying tactics. Every amendment they offered was to send the bill backward, not forward. They seem hell-bent on defeating and not improving this bill, contrary to their statements on the floor.

The Republicans have charged that we are rushing in to vote for this bill. That is simply not true. We have been debating this issue on and off for the last 87 years.

Republican President, Theodore Roosevelt, made national health insurance a plank in his party platform when he sought the Presidency in 1912. President Harry Truman, in 1945 and then again in 1948, called on Congress to pass reform legislation to expand quality health care coverage to more Americans. President Truman believed we needed a stronger system and that the federal government must play a role in establishing a more robust system of care. His critics called his approach "socialized medicine." Sound familiar?

Only in Washington would 87 years be considered rushing!

This has been a debate that has gone on with particular intensity for the last 2 years, as our Presidential candidates took to the airwaves in debate after debate—Republican and Democratic—outlining their ideas for reform. This hasn't sprung up in the last 2 weeks. This hasn't sprung up in the last 2 months.

Millions of Americans went to the polls, understanding, in large measure, what we needed to do to change the system. Despite the rhetoric from the other side, that is the reality, and the record will reflect that. Instead of coming to the table and working with Democrats to write a bipartisan bill, Republicans chose to put partisan party politics first. I listened to my

friend, MAX BAUCUS, this morning. I, myself, who thought I had followed carefully the work of the Senate Finance Committee, was actually moved to hear the number of meetings—dozens and dozens, maybe hundreds and hundreds of meetings—he attempted to have in a bipartisan way months ago, years ago, with Republicans. Then, at some point, they decided they thought that politics was more important than policy. I think they made the wrong choice.

They fabricated death panels, distorted Medicare cuts, and undermined and disrespected the role of government in protecting its citizens. They have engaged in a relentless misinformation campaign, aimed solely at using fear to sway public opinion against this bill.

Recently—just yesterday—Senator JOHN MCCAIN, our colleague from Arizona, claimed that the American people are opposed to reform, and he speaks about the will of the majority. I remind my colleague from Arizona that the will of the majority spoke loud and clear last year when they elected President Obama to be President and decided not to elect him. The President is carrying out the will of the majority of the people by trying to provide for them hope and opportunity in an area that has eluded us for 87 years.

This is a good effort, a strong effort, and I most certainly believe that the will of the American people is being heard. The other side has tried to paint a picture of a nation opposed to health care reform. Recent polls show otherwise. When we cut through the misinformation and scare tactics, when Americans hear what is in the bill, they overwhelmingly support it.

According to a recent CNN poll, 73 percent of Americans support expanding Medicaid for the poor. Americans know what most of us know: Most people on Medicaid are the working poor. These are people who wake up early in the morning, work hard all day, and they go back home at night, often by taking public transportation because they don't have an automobile. They work hard. They are American citizens. But they don't have enough money to spend 60 percent or 80 percent of their income on health insurance in a broken, unbridled, unfixed private market. So we join together with our States to provide them access to care through the Medicaid system. I support that. And in this bill, the Federal Government will pick up a large share of the cost of expanding coverage.

That same poll showed that providing subsidies for families that make up to \$88,000 a year is favored by 67 percent of Americans. Additional regulations on insurance companies, such as banning denial of coverage for those with preexisting conditions are favored by 60 percent of the American people.

I am one of the Democrats who didn't want to eliminate insurance companies. I believe in private markets. But there have to be certain rules and regulations in order for the private market to work for everyone, and not just for those with wealth or those with the inside scoop on how private markets work.

So we are incentivizing a healthier insurance industry—not coddling it but encouraging it to be competitive and to provide services and coverage for more people in our country.

A recent poll by the Mellman Group shows that support for this bill exists in all States. In my home State of Louisiana, when the provisions of the bill were actually read to voters, 57 percent of Louisianians supported the bill, with 43 percent strongly supporting the reform effort. And most importantly, 62 percent of Louisianians oppose using the filibuster to stop health care reform.

I will read the language used in the poll because people say you can say anything in polls, which is true. If pollsters are not reputable, they can twist and distort. I will read the language used by the poll to describe the plan:

The plan would require every American citizen to have health insurance and require large employers to provide coverage to their employees. It would require insurance companies to cover those with pre-existing conditions and prevent them from dropping coverage for people who get sick, while providing incentives for affordable preventive care. Individuals and small businesses that do not have coverage would be able to select a private insurance plan from a range of options sold on a National Insurance Exchange. Lower and middle income people would receive subsidies to help them afford this insurance, while those individuals who like the coverage they already have will be able to keep their current plan.

This is a very accurate description of this bill before us—the Patient Protection and Affordable Care Act. It is not a government takeover. There is no public option. There is a national plan available now to every American, just like the Members of Congress and the Federal employees have. There will be exchanges—similar to shopping centers—and Americans will be able to go to the exchanges and choose from a number of insurance options. The prices will be more transparent. Administrative costs will be lowered. You will not need a Ph.D. to be able to read these policies—they will be written in plain English.

Again, this is not a government takeover, as the other side claims. That is why 57 percent of people in Louisiana, when given the right information, without the rhetoric, without the railing, without the distortions, say: Absolutely, I am for a public-private partnership.

The American people elected President Obama to bring about change. A big part of the change President Obama and Democrats promised during the

campaign was improving health care for all Americans. Thanks to the President's leadership and the leadership of Senator REID and many others, we are taking several meaningful steps toward fulfilling that promise.

With the exception of two colleagues, Republicans have failed to negotiate in good faith. I want to say how much I respect our two colleagues from Maine, Senator SNOWE and Senator COLLINS. I have been in dozens of meetings with both of them and know that they struggled mightily to find a way to work with us and to support this bill. I have not spoken with them in the last few days, so I will not discuss their reasons for withholding their support. I am sure they will express those on the floor. But I can say that they are the exception to the rule. I know Senator GRASSLEY, Senator GRAHAM, Senator BENNETT, and a few others engaged early on. I want to acknowledge them and I appreciate their good will. But, unfortunately, the leadership of the Republican Party chose politics over policy. I am disappointed that not a single Republican could support an end to the filibuster. I suppose it is easy to stay unified when the only word in your vocabulary is NO. Although Democrats did not initially agree on exactly how to get there, we were united in saying yes to the common goal of delivering meaningful health care reform to America's families and small businesses. It has been difficult. Some of us come from very conservative States. Some of us come from liberal States. We have diverse populations in our States that have different needs and different views. It has not been pretty, but it has been a practical and hopefully a positive exercise that will bring comfort, support, and strength to the American people and to our economy.

I do hold out hope that when we take our vote on final passage, Republicans will recognize this historic opportunity and vote in favor of this bill that will reduce costs and increase access to health care for millions of Americans.

Last month, I stood here on the floor of the Senate to announce my intention to vote in favor of bringing Senator REID's melded bill to the floor. At the time, I was very clear that my vote was not an indication that I supported that particular version of the bill. My vote was to bring that bill to the floor so that we could do the legislative work the American people sent us here to do.

After weeks of floor debate and amendments and round-the-clock negotiations, that work has been completed. We produced a health care bill that is significantly improved from the one that came to the floor. I would like to share a few thoughts about why, in my view, it is improved.

Through tough negotiations, Senate Democrats have developed a consensus

that blends the best of public and private approaches to reduce costs, expand coverage, and increase choice and competition for Americans and have done so without a government-run public option.

Since I continue to hear distortions from my colleagues on the other side, let me be clear: there is no government-run public option in this bill. Instead, we reached an agreement to provide private health insurance plans to be sold nationwide. The Office of Personnel Management will negotiate lower premiums, just as they negotiate the plans currently available to Federal employees and to Members of Congress. Importantly, we ensured that at least one nonprofit plan will be offered in every State exchange and that the States cannot opt out at the whim of every Governor and legislature. For the first time in our Nation's history, Americans will have an opportunity to have the same kind of insurance that federal employees, including Members of Congress, have.

In addition, there has been a lot of talk about the cost of this bill to the government and to taxpayers. There have been a number of false claims about how this bill will add to the deficit and be a burden to our children and grandchildren. The fact is, this bill is completely paid for and it will reduce the deficit by \$132 billion over the next 10 years and as much as \$1.3 trillion in the following 10 years.

Based on our efforts, the Congressional Budget Office and the Nation's premier economists have confirmed that premiums will go down over time or remain stable so that wages for millions of Americans can increase. When this bill is passed, 31 million uninsured Americans will have access to quality health coverage.

This bill is a big step toward fiscal responsibility and a stronger economy. It aims to achieve these goals by streamlining the health insurance market, ensuring efficiency, and limiting insurance company administrative costs, and to some degree, their profits.

It also imposes an excise tax on insurance companies with high-cost plans. This will encourage employers to be more value-conscious purchasers of health insurance. Employers are expected to choose cheaper plans, and as less capital is spent on health care, wages will go up for hard-working families. Economists predict that this could give American workers a \$223 billion pay raise, amounting to \$660 per household.

I strongly urge that this provision be included in the final legislation. I know that there is fierce opposition to this on the House side. But—and the President has said this publicly and privately to us—this is one of the most significant provisions that will help drive down costs for the entire health care system. It cannot be jettisoned at

this point in the debate. This provision must be in the bill for me to give my final support.

We have also created administrative savings through insurance exchanges, and during Senate consideration of the bill we strengthened the Independent Medicare Advisory Board to find more ways to reduce cost growth and improve quality.

The final Senate bill includes a substantial investment in community health centers and will provide funding to expand access to health care in rural communities and under-served urban areas as well. In Louisiana, federally-supported health clinics have saved the state over \$354 million in emergency room visits by the uninsured. The legislation also expands access by increasing funding for rural health care providers and training programs for physician and other health care providers.

There are many parts of the current bill that I am proud to have fought for. The bill creates health insurance exchanges that will provide individuals, families, and small businesses with a wide variety of affordable choices and ensure that they will always have coverage, whether they change jobs, lose a job, move or get sick. These state-based exchanges will enable consumers to comparison shop online for health insurance which will drive down costs by increasing choice and competition.

The exchange will help the uninsured obtain needed coverage and will also help the more than 200,000 Louisiana residents who currently do not have insurance through their employer to get quality coverage at an affordable price. Many of these Louisianians in the exchange will qualify for a tax credit to help them purchase the insurance of their choice.

For example, in Calcasieu Parish, the median household income is \$39,713. In the exchange created by this bill, the average family in Calcasieu would receive an affordability credit that limits what they spend on their premium to around 5.6% of their income or \$2,225. Considering, right now the average Louisiana family is spending up to 28% of their income on health care, this is a huge improvement.

This version of the bill that we improved on the Senate floor now includes additional much-needed help for small business owners, led by Senator LINCOLN, Senator STABENOW, myself, and other members of my committee. Senator SHAHEEN, Senator CARDIN, Senator HAGAN, Senator BAYH, and others worked very diligently on these provisions.

While small businesses make up 74 percent of Louisiana's businesses, only 37 percent of them offered health coverage benefits in 2008. Of those, 62 percent say they are struggling to do so. Of the 64 percent who don't provide insurance, 87 percent say they can't afford it.

I worked closely with Senator STABENOW to improve affordability and choices for small businesses and amended the bill to make the bridge credit available immediately to help small businesses afford health insurance for their employees, and improve the tax credits for small businesses. This means that small businesses who want to offer quality health insurance to their employees will get tax breaks right away, rather than waiting until 2011. I also worked with Senator LINCOLN to expand the number of small businesses that will be eligible for tax credits so that more small businesses get help in offering health insurance coverage for their employees—allowing more small business workers to benefit. In all, these changes bring an additional \$13 billion in tax relief—on top of the \$27 billion already in the bill—to small businesses.

If you own a small business of 25 or less employees here is how reform will help you: Businesses with 25 or less employees whose average annual wages are less than \$50,000 will get immediate help through a three-year bridge credit. The creation of exchanges and a 2 year exchange tax credit will lift the burden of excessive paperwork administrative costs. The exchanges will create more stable, secure choices for your employees

In Louisiana, more than 50,000 small businesses could be helped by this small business tax credit proposal!

This will help small business owners such as Mary Noel Black and her husband, who own a UPS franchise store in Baton Rouge. They offer their four employees group coverage and are willing to pay half the cost, but the premium rates have gone up so much that neither the workers nor the business can afford to pay the \$3,600 a year per employee for insurance. To help Mary pay for the health insurance of each employee, beginning in 2011, Mary could get a \$1,260 bridge credit per employee under this bill for 3 years. Then, in 2014, if she purchases coverage through the exchange, her business is eligible for an exchange credit of \$1,800 per employee for an even more generous tax credit for another 2 years. This savings could mean the difference between offering insurance or dropping coverage because instead of costing her business \$14,400 a year now for her four employees—a cost that is just unaffordable—the tax credit could initially bring her cost down to \$9,360 and later to \$7,200.

Through our work on the Senate floor during this public debate, we have made this good bill better for small business. Not only have we extended and expanded the small business tax credits, the legislation includes several amendments I authored to ensure small businesses continue to have a seat at the table once this bill is implemented.

The bill requires that small businesses receive information regarding

reinsurance for early retirees, small business tax credits, and other issues specifically for small businesses regarding affordable health care options.

It lists Small Business Administration resource partners as eligible recipients of exchange public awareness grants and will include all Small Business Administration partners in the program, including Women's Business Centers, SCORE, Minority Business Centers, Veteran Business Centers, and others.

The bill now requires the Government Accountability Office to specifically review the impact of exchanges on access to affordable health care for small businesses to ensure that exchanges are indeed making a difference for small business owners.

It also clearly states that agencies cannot waive the Federal acquisition regulation, which requires them to report small business contracting numbers and meet small business contracting goals of 23 percent.

There is a provision that modifies the definition of a full-time employee to take into account fluctuation in employee hours, and reduce the impact of employer responsibility requirements for industries with high turnover and that rely on part-time employees.

The bill eliminates penalties for businesses that wait up to 60 days to provide health insurance to their full-time employees.

Finally, the Patient Protection and Affordable Care Act establishes a national workforce commission to gather information on the health care workforce and better coordinate and implement workforce planning and analysis. The managers' amendment ensures that small businesses and the self-employed will be represented on the commission.

These are important considerations for small businesses and I was proud to ensure these concerns were addressed through the amendment process.

Despite claims from opponents of the bill, we have taken important steps to strengthen Medicare, not weaken it. The Senate health care reform bill creates an independent Medicare advisory board to find ways to reduce cost growth and improve quality and moves to a system that rewards quality over quantity. It reduces payments for preventable hospital readmissions in Medicare, and cuts waste, fraud and abuse by enhancing oversight, identifying areas prone to fraud and requiring Medicare and Medicaid providers and suppliers to establish compliance programs.

As much as our Republican colleagues have tried to scare seniors into opposing this bill, the fact is that Louisiana's 650,000 Medicare beneficiaries stand to gain from this health care reform bill. The AARP and many seniors' organizations are continuing to support this bill because they know it improves care for our seniors.

The bill lowers premiums by reducing Medicare's overpayments to private plans. All Medicare beneficiaries pay the price of excessive overpayments through higher premiums—even the 78 percent of seniors in Louisiana who are not enrolled in a Medicare Advantage plan. Without reform a typical couple in traditional Medicare would pay nearly \$90 in additional Medicare premiums next year to subsidize these private plans.

Our bill extends the life of the Medicare Trust Fund by 9 years and lays the groundwork for a more sustainable health system. Thanks to these reform efforts, there will be no additional cost for preventive services under the Medicare program. This includes a free wellness visit and personalized prevention plan designed to help give beneficiaries the resources they need to take better care of themselves in these important years.

This legislation puts taxpayers' dollars above insurance company profits by forcing insurers to bid competitively for the business of Medicare beneficiaries and makes changes to the Medicare Advantage payment structure that will give insurers an incentive to deliver more value.

Another critical aspect of the bill is that it increases the amount of coverage Medicare Part D beneficiaries receive before they begin to pay out of pocket for their prescriptions. Right now, roughly 116,000 Medicare beneficiaries in Louisiana hit a wall in Medicare Part D drug coverage that will cost some of them an average of \$4,080 per year. This reform legislation will provide a 50 percent discount for brand-name drugs.

Some of the bill's most important provisions will benefit the most important population—children.

The underlying bill includes a provision allowing children to remain on their parents' plans up until the age of 26. I have children. I would like to think that by 22 or 23, they will be on their own, they will be gainfully employed and off my payroll. But any of us who have raised children know that sometimes it takes a little more time to launch our children. I see Senator SHAHEEN, who is nodding. She has done this herself. It takes a little time to launch them. According to the latest data from the Census Bureau, in 2007 there were an estimated 13.2 million uninsured young adults. So the bill includes this important provision to allow kids to stay on their parents' insurance for a bit longer as they transition into adulthood.

But my question was, where do the young people who age out of the foster care system sign up, because they do not have parents? I was proud to work on a provision that Leader REID included in this bill to ensure that every young person who ages out of the foster care system will be able to stay on

Medicaid until the age of 26 starting in 2014. Almost 30,000 young people age out of the foster care system every year, having never been adopted or reunified with their birth parents. The fact that they aged out is our failure as government. We have failed them once and we just can't fail them twice. We must support their transition to adulthood, and guaranteeing access to quality health care will help with that transition.

When this legislation is signed into law, insurance companies will not be able to drop children for preexisting conditions beginning immediately. This is crucial for families with children who have battled cancer or diabetes. When a parent loses a job, they may struggle to get insurance when they find new employment. Once this bill becomes law, no insurance company will be able to deny a child with preexisting conditions.

This health care reform bill holds insurance companies' feet to the fire to ensure they are accountable to their customers. By 2014, insurers will not be able to deny coverage due to preexisting conditions. That means they will not be allowed to drop you from coverage if you get sick or are in an accident.

Because of the good work of my colleagues Senator ROCKEFELLER and Senator BEN NELSON, this bill requires insurance companies to disclose the pricing of their benefits to ensure that premiums are spent on health benefits not profits and gives consumers rebates, putting the insurance companies' excessive profits back into your pockets. It contains new requirements ensuring that insurers and health care providers report on their performance, empowering patients to make the best possible decisions. Under this bill, a health insurer's participation in the exchanges will depend on its performance. Insurers that jack up their premiums before the exchanges begin will be excluded—a powerful incentive to keep premiums affordable.

Finally, I was also proud to work with Leader REID and Finance Committee Chairman MAX BAUCUS to address an inequity in the formula that determines the federal match of Medicaid dollars. As we all know, in 2005 Hurricanes Katrina and Rita ravaged the Gulf Coast and destroyed homes, neighborhoods, and even full communities throughout South Louisiana. In an effort to aid the recovery, Congress approved a much-needed aid package for Louisianians that infused grant dollars and direct assistance to speed our recovery.

Some of the necessary one-time recovery dollars were calculated into our state's per capita income. In addition, labor and wage costs increased because there was heightened recovery activity

and a constriction in the market. Consequently, Louisiana's per capita income was abnormally inflated and put us in a category with richer states.

The result is that our federal match for Medicaid is scheduled to drop pretty dramatically. I worked with my colleagues to correct this formula. I never asked for special treatment for Louisiana, but only for understanding of our state's unique situation. We only wanted to be treated fairly and not to get penalized because we have been forced to rebuild following the worst natural disaster in the United States' history. Our federal Medicaid match rates should reflect that the reality on the ground in Louisiana, not the cold calculations of inflexible federal formulas.

An important note is that this Medicaid funding fix was supported by every Member of our Congressional Delegation, and specifically and repeatedly requested by our Republican Governor Bobby Jindal. Some politicians in my state may run and hide when the heat gets turned up, but that's not the way I was raised. I never have and never will run from what I think is right. I was sent here to fight for my state and that is exactly what I'm doing.

Those who have dubbed this provision the "Louisiana Purchase" know little about lawmaking and even less about my views on health care reform. This Medicaid fix alone would not have been enough to earn my vote on this legislation. This was one of literally a dozen priorities I had as the Senate considered health care reform. I am voting for this bill because it achieves the goals I laid out at the beginning of this debate: it drives down costs and expands affordable health care choices for millions of families and small businesses in Louisiana and around the nation. Any claim to the contrary, is a pathetic lie meant to derail this bill, a tactic that was all too common during this debate.

Today, we stand on the verge of history, with an opportunity to support a bill that will provide health insurance to 31 million more Americans, reducing the deficit by \$132 billion over the next ten years.

The bill is not perfect. It is not the exact health care bill that I would have written. I think the same could be said for each of my colleagues. It was a long, difficult process and during the course of completing this landmark bill there were a lot of twists and turns. But, as former President Clinton was fond of saying, we should never let the perfect become the enemy of the good.

And through hard work and good faith and tough negotiations and keeping our eye on the ball, Senate Democrats have actually crafted, in my view, an extraordinary piece of legislation that will go a long way to pro-

viding comfort and security to the American people who elected us to do so.

It will provide comfort and security for the local grocery store owner in Jennings, the 22-year-old in Lake Charles who has just left the foster care system, the single mother of three in Monroe, the 9-year-old boy in Natchitoches who was just diagnosed with diabetes, and the 70-year-old Medicare beneficiary in Houma who worked for three decades in the offshore oil industry.

The Patient Protection and Affordable Care Act will make a difference in these lives and millions more across America, and I urge my colleagues to support it.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mrs. SHAHEEN. Mr. President, I ask unanimous consent that the remaining Democratic time be divided equally between myself, Senator STABENOW, and Senator BINGAMAN.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. SHAHEEN. Mr. President, I wish to begin by congratulating Senator LANDRIEU and thanking her for all the hard work she has done on this bill—first of all for small business. I think we have significantly, with her leadership, improved this legislation for small business so that many of the small businesses in this country—many in my home State of New Hampshire—will now be able to get help as they try to cover their employees for health care. I also wish to congratulate her for all her good work to help children in the foster system. It is significant they will be able to get health insurance once they age out of the foster system and, of course, to help those, as she has pointed out, who have children who are in their early twenties and who are still trying to get settled in a profession.

My daughter was fortunate enough to have health insurance last year in her first job out of college. But now she is going to a new job that doesn't have health insurance, and so she will be able to be covered once this legislation is passed under our plan. As Senator LANDRIEU points out, it is going to make a real difference for families and for small business.

I am very pleased to be here today to support this legislation and also to try to dispel some of the myths we have heard from our colleagues on the other side of the aisle about what is actually in this legislation. Despite what many of our colleagues may want us to believe, passing this bill is the fiscally responsible thing to do. Our current health care system is a threat to the security of our families, our small businesses, and the entire economy of this Nation. The costs of health care in America make up almost 18 percent of

our economy—our gross domestic product. That is more than any other industrialized country. Health care costs are rising three times faster than wages. The leading cause of about two-thirds of the bankruptcies in America is medical bills. Our current health care system is simply not sustainable.

The Patient Protection and Affordable Care Act moves us in a new direction—a direction that is fiscally responsible because this bill is fully paid for. In fact, according to the Congressional Budget Office, the Patient Protection and Affordable Care Act would reduce our Federal deficit by \$132 billion over the next 10 years. In fact, this legislation represents one of the largest deficit-reduction measures we have seen certainly in many years and possibly ever.

Small businesses in my home State of New Hampshire and across this country are going to benefit from this legislation. We heard Senator LANDRIEU talk about many of the provisions she worked on—and many of which I cosponsored—to help improve the legislation for small business. The fact is, the steep annual increases in the cost of health insurance have been forcing more and more businesses to make the very difficult decision to either drop coverage for their workers or to increase their employees' contribution to the point that too many workers have had to decline coverage.

I have heard from a number of businesspeople in New Hampshire, and I wish to read what a couple of them have said.

A young woman named Adria Bagshaw testified this summer at a Small Business Committee field hearing we held in New Hampshire. Adria and her husband Aaron own the W.H. Bagshaw Company. It is a fifth-generation small manufacturing company in Nashua, NH. There aren't a lot of those fifth-generation companies left that are owned by the same family. They offer health insurance to their 18 employees and cover anywhere between 10 to 25 percent of their monthly premium. But now the premiums are \$1,100 per month per family, and Adria is afraid she will have to cut back on the quality of their health insurance plan or the amount the company covers to make ends meet. The sad thing is that she says right now they are spending more on health insurance than they are for raw materials to make their products.

I also heard from a man named John Colony, who is a small business owner in the small, very picturesque town of Harrisville, NH. He e-mailed me saying:

The cost of health insurance is the biggest problem that our small business faces.

He has 24 employees. He went on to say:

The present system is expensive, inefficient and broken. I can't tell you how the 20

to 35 percent annual rate increases depress us all and there is no end in sight. Over the past five years, most of our employees have had to drop coverage because they simply can't afford to pay their share of the premium. I really believe that the time has come to put the existing system out of its misery.

Well, I am happy to tell John we are about to do that, because under this legislation, beginning next year, we provide significant tax credits for small businesses to help them pay for the cost of coverage for their workers. This bill contains a number of significant measures to rein in runaway health care costs—measures such as creating a new pathway for biologic drugs so we can get biologic generic drugs to the market and help lower costs for people. There are measures in this bill that will eliminate waste, fraud, and abuse—something that takes too big a chunk out of our health care dollar. There are also measures in here that will get rid of the subsidies the government pays to insurance companies for Medicare Advantage plans. These are all commonsense actions that will save the government and health care consumers money over time.

In addition, this bill makes significant improvements to our health care delivery system. That is the way we provide health care for people. It injects more competition into the health care marketplace. Controlling health care spending is critical to address the fiscal health of this Nation—no pun intended. This legislation takes a very important first step in slowing down the growth.

I am sure every Member of the Senate—Republican and Democratic alike—has heard heartbreaking stories from our constituents about health care—stories about being denied health insurance, about having to stay at a job they do not like because of the fear of losing coverage, about frustration over the lack of choice and who provides their health insurance or a lack of understanding about their plan's limits until it is too late and they are facing financial peril. Well, this bill will, I am happy to say, change that. Not only do we ensure coverage for an additional 31 million people—

The PRESIDING OFFICER. The Senator's time has expired.

Mrs. SHAHEEN.—but we eliminate the abuses of the insurance companies.

I will be back to talk about some of these other areas.

I thank the Chair, and I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, first, I wish to thank my friend from New Hampshire for her advocacy on health care reform in general, but specifically working together on the areas that affect small business, I very much appreciate, and we are so pleased to have her in the Senate.

I come to the floor to join my colleagues. I know the chair of the Small Business Committee, Senator LANDRIEU, has been here and others will be here—Senator LINCOLN, who has played such a critical role in putting together the small business provisions in the bill.

I am very pleased to have authored one of the provisions in the managers' amendment that will guarantee that small businesses get immediate help starting next year—tax cuts to help them pay for the cost of health insurance. Michigan has close to 200,000 small employers that represent about 96 percent of the employers in our State.

Most folks who think of Michigan think of large employers, large manufacturers. But, in fact, the majority of our employers, as in the majority of each of our States, are small businesses. That is where the majority of the new jobs are being created. We have just 41 percent of our firms that have fewer than 50 employees who actually are able to offer health insurance. So less than half our small businesses are able to offer health insurance, which is why we are focused on small businesses in this reform bill.

The majority of people in this country who don't have insurance are actually working. The majority of us—about 60 percent—have insurance through our employers. We have about another 20 percent or so who receive their insurance through Medicare or Medicaid or the Veterans' Administration or some other public entity and then 15 to 20 percent of the people overall in America who don't have insurance are predominantly small businesses—people working for small businesses or they are self-employed or they are working one, two, or three part-time jobs just to try to hold things together. So that is a major focus of the health care reforms that are in the legislation that is before us.

I am very pleased we have been able to put together a package that has \$40 billion in direct tax cuts—\$40 billion in direct tax cuts—for small businesses across America to help them afford health insurance going forward, rather than waiting for the new insurance pooling—the exchange—which will provide additional help for small businesses. This help, this tax cut, starts right away. We will see 3.6 million small businesses that could qualify for the tax cuts in this bill that will begin next year.

In my State, that means over 109,000 small businesses that could be helped by the small business tax cuts that will make premiums more affordable. So I am very pleased to be part of a group of Members who came together and worked very hard to focus on the fastest growing part of the economy, which are our small businesses.

I will just share one story, and this was from Crain's Detroit, a highly re-

spected business publication in Michigan. Mark Hodesh, who is the owner of an Ann Arbor home and garden store, said he has seen his health insurance premiums go up more than 300 percent since 1997. In 1996, he paid \$132 in health care premiums a month per employee; and this year, regular premium increases have led him to pay upward of \$375 per month for each employee. So that is a 300-percent increase. He says:

I have been in small business for 40 years, and my conclusion is that without health care reform, these increasing costs will put me out of business.

That is the reality for businesses across this country. I do believe health care reform is directly tied to jobs, whether it is large businesses competing internationally that make a determination to move their facility because of health care costs, whether it is small businesses going out of business or having to decide if they keep people working or pay for health insurance or whether it is the self-employed person out on their own, in their own enterprise—maybe it is local realtor. We know realtors have struggled for years because they haven't been able to buy through a large insurance pool. That is what this reform is all about. That is what this legislation is all about, to help small businesses, people who are working out of their homes, who are self-employed, as well as people who have lost their job and then lost their insurance. That is what this is all about.

When we look at this legislation, according to the Small Business Majority, without health insurance reform that is in this legislation the annual costs of health benefits will more than double in less than a decade. They will more than double. We know, because we have seen the statistics, that when we talk about doubling health care costs for businesses in the next 10 years, it is estimated to equal another 3.5 million jobs.

We cannot afford to lose another 3.5 million jobs because of the doubling of health care costs in America. We are focused on creating more jobs. We need to be laser focused—certainly, I am, coming from Michigan—on creating jobs not losing jobs. According to the economic analysis of the Small Business Majority, health insurance reform could save up to 72 percent of small business jobs otherwise lost to a continuing rise in health care costs. We need those jobs.

Again, health insurance reform is all about saving lives, saving money, saving Medicare, and it is certainly about saving jobs. That is why I am so pleased we have made small businesses a major priority in this legislation—both through \$40 billion in tax cuts for small businesses, creating the new insurance pool through which small businesses can get the same kind of deal,

have the same kind of clout as a large business today in being able to negotiate with private companies, and other provisions that are in the bill as well.

There are many reasons to support health insurance reform. Standing up for small businesses is certainly at the top of the list.

I yield the floor.

The PRESIDING OFFICER (Mrs. GILLIBRAND). The Senator from New Mexico is recognized.

Mr. BINGAMAN. Madam President, over the past few weeks we have heard a lot of heated debate about this health care proposal. Much of it has concentrated on a few key issues: whether there should be a public option, whether there should not be. Of course, much of that debate was on the Democratic side among Members with strongly held views on both sides of the issue.

The question of whether we should try to allow people 55 and older to buy into Medicare was also debated. There were strongly held views on that issue.

It is clear now we have a bill before us that will do neither one of those things but which I think will accomplish very major health care reform for the country. I want to just concentrate for a few minutes on some of the other policies that are contained in this legislation that have received much less attention but which clearly are very constructive proposals that will dramatically improve the health care delivery system in the country.

I can remember when we started these discussions early in the spring and summer and had many meetings and hearings and workshops both in the HELP Committee and in the Finance Committee, there were statements made that—on the Democratic and Republican side—we can agree upon maybe 80, maybe 85 percent of the changes we ought to embrace in health care reform. The question is, What about the other 15 to 20 percent? I think we need to spend more time focused on that 80 to 85 percent, and let me do that for just a minute.

This Patient Protection and Affordable Care Act which Senator REID and others have introduced and is in the House legislation as well, both pieces of legislation do contain very important policies. Let me talk a minute about some of those.

First, this act before us includes long overdue reforms to increase the efficiency and the quality of the U.S. health care system while holding down the growth in costs. For example, the legislation includes payment reforms—I have championed those for a long time; others in this body have championed them as well—to shift from a fee-for-service payments system to a bundled payments system. This will reshape our health care reimbursement system to reward better care and not simply more care as the system currently does.

The legislation also includes broad expansion of quality reporting and pay-for-performance reforms that will further incentivize quality and efficiency. The legislation also puts in place the framework for a national quality strategy and several new key Federal oversight bodies to allow both providers and consumers to have unbiased information about whether health care treatments and devices and pharmaceuticals are effective and efficient.

We have heard a lot of charges made that trying to find out what is effective and efficient is objectionable somehow because it might lead to rationing of care. There is no rationing of care contemplated in this legislation. But how anyone could come to the Senate floor and argue against providing good, scientifically based information both to providers and the consumers about which treatments, which devices, which pharmaceuticals are effective and useful is hard for me to understand.

Second, this Patient Protection and Affordable Care Act includes a broad new framework to ensure that all Americans have access to quality and affordable health insurance. It includes the creation of new health insurance exchanges which will provide Americans a centralized source of meaningful private insurance, as well as refundable tax credits to ensure that the coverage they need is affordable. These new health insurance exchanges will help improve the choices that are available to Americans by allowing families and businesses to easily compare insurance plans and prices and the performance of those plans. This will put families rather than insurance companies or insurance bureaucrats or government bureaucrats in charge of health care. These exchanges will help people to decide which quality, affordable insurance option is right for them.

On the issue of cost, the nonpartisan Congressional Budget Office forecasts that this legislation would not add to the Federal deficit. In fact, the latest estimate they have given us is that it would reduce the deficit by \$132 billion by 2019 and well over \$1 trillion in the second 10-year period; that is, the period from 2020 to 2029.

On the subject of premium costs, which all of us care about, all Americans care about, CBO has also found that in the individual market the amount that subsidized enrollees would pay for coverage would be roughly 56 percent to 59 percent lower, on average, than the premiums they are expected to be charged when this law takes effect in the individual market under current law.

Among enrollees in the individual market who would not receive new subsidies, average premiums would increase by less than 10 to 13 percent—this, again, according to the Congressional Budget Office. The legislation

would have smaller effects on premiums for employment-based coverage. Its greatest impact would be on smaller employers qualifying for new health insurance tax credits. For these businesses and their employees, the Congressional Budget Office predicts that premiums would decrease by somewhere between 8 and 11 percent, compared with the costs that they would have to pay under current law.

These estimates by the Congressional Budget Office are consistent with the estimates of the impact in my home State of New Mexico, where average families may see a decrease in premiums of as much as 60 percent from what they might otherwise have to pay. This is families, I am talking about, who would be eligible for these advance refundable tax credits.

In addition, about two-thirds of the people in my State of New Mexico would potentially be able to qualify for subsidies or for Medicaid. In fact, a quarter of our population in New Mexico is at an income level that would allow them to qualify for near full subsidies if they bought insurance through an insurance exchange or for Medicaid itself.

An overall decrease in premium costs also is consistent with the experience that the State of Massachusetts had after they enacted similar reform to what is now being considered in the Senate. There has been a substantial reduction in the cost of nongroup insurance in that State. In fact, the average individual premium in Massachusetts fell from \$8,537 at the end of 2006 to \$5,142 in mid-2009. That is a 40-percent reduction in premium for that coverage. This was at a time when the rest of the Nation was seeing a 14-percent increase.

Finally, much of the debate on health care reform has focused on insurance coverage. It is important to recognize that as we expand coverage to include more Americans, the demand for health care services is going to increase as well. A strong health care workforce is, therefore, essential for successful health reform. Within this country, approximately 25 percent of the counties are designated as health professional shortage areas. That is a measure that indicates that there are insufficient medical staff to properly serve that geographic area.

This problem is even more apparent in rural States such as mine, such as New Mexico. For example, 32 out of the 33 counties in our State—we have just 33 counties—32 of those counties have this shortage designation—health professional shortage area designation. As a result, New Mexico ranks dead last compared to all other States with regard to both access to health care and the ability to utilize preventive medicine.

This Patient Protection and Affordable Care Act also contains key provisions to improve access and delivery of

health services throughout the Nation. These provisions include increasing the supply of physicians and nurses and other health care providers, enhancing workforce education and training, providing support for the existing workforce—health care workforce, increasing the support for community health centers.

I applaud Senator REID and Senator BAUCUS and Senator DODD and Senator HARKIN and many other colleagues in the Senate who worked so hard on this bill. The legislation represents major health care reform. It is time for the Senate to enact this critical and long overdue legislation. There will be chances and opportunities to improve on this legislation in the future. I hope to participate in some of those.

Nothing that is passed into law in this Congress or any Congress that I have served in is what it should be in all respects. But this legislation is extremely important and significant health care legislation. It will do a tremendous amount of good for a vast number of Americans and it will do that “good” in a very responsible way.

I urge my colleagues to support passage of this legislation so we can get on with a conference with the House of Representatives and finally settle on a bill that could be sent to President Obama for his signature.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Madam President, I know our leader is coming to speak, but prior to him coming, I will take a portion of my time that has been allotted to me by my side.

I sat here with great interest listening to the Senator from New Mexico. He referenced the State of Massachusetts. I entered into the RECORD yesterday the 21 percent of the people under the plan who could not get care in Massachusetts because they could not afford the copay and the deductible. This is basically a copy or model off of that.

He also discussed the fact that this shows a \$132 billion savings over the next 10 years. That is provided you do not think you are going to allow any increase in doctor payments and you are not going to reverse the 21-percent cut.

Madam President, my leader is here, and I will be happy to yield to him at this time.

The PRESIDING OFFICER. The Republican leader is recognized.

Mr. MCCONNELL. Madam President, I thank my friend from Oklahoma. I will be very brief.

Madam President, Americans woke up yesterday stunned to read that Democrats had voted to end debate on the latest version of this massive bill while they were sleeping. They will be stunned again when they learn about this second early-morning vote to advance a bill that most of them oppose.

Americans are right to be stunned because this bill is a mess. And so was the process that was used to get it over the finish line.

Americans are outraged by the last-minute, closed-door, sweetheart deals that were made to gain the slimmest margin for passage of a bill that is all about their health care. Once the Sun came up, Americans could see all the deals that were tucked inside this grab bag, and they do not like what they are finding. After all, common sense dictates that anytime Congress rushes, Congress stumbles. It is whether Senator so-and-so got a sweet enough deal to sign off on it. Well, Senator so-and-so might have gotten his deal, but the American people have not signed off.

Public opinion is clear. What have we become as a body if we are not even listening to the people we serve? What have we become if we are more concerned about a political victory or some hollow call to history than we are about actually solving the problems the American people sent us here to address? This bill was supposed to make health care less expensive. It does not. Incredibly, it makes it more expensive.

Few people could have imagined that this is how this debate would end—with a couple of cheap deals hidden in the folds of this 2,700-page bill and rushed early-morning votes. But that is where we are. Americans are asking themselves: How did this happen? How did a great national debate that was supposed to lead to a major bipartisan reform lead to a bag full of cheap legislative tricks inside a \$2.3 trillion, 2,733-page bill that actually makes health care costs go up?

This legislation will reshape our Nation in ways its supporters will come to regret. But they cannot say they were not warned. The verdict of the American people has been clear for months: They do not want it.

Madam President, I thank my friend from Oklahoma, and I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Madam President, I would just follow with one comment to my leader as far as his comments.

In 2007, we passed a bill called the Honest Leadership and Open Government Act of 2007. That act requires the posting of any earmarks or direct benefits for Senators in any bill. It has to be posted. We have not seen that with this bill, though we know there are numerous and sundry specific earmarks for Members.

So my hope is that sometime during this process, we will take up the violation of this very law by the leader of this Chamber in terms of ignoring it and flaunting it. What he said, when we passed it, was it was a needed change, and now we see it ignored as they bring this bill to the floor.

Mr. MCCONNELL. I thank my friend from Oklahoma.

One thing about rushing, not only is there a potential violation of the provision the Senator from Oklahoma mentioned, but we are learning more about this bill every day as we scrub it and try to understand it and figure out what all is in it. All of that, of course, is made more possible by rushing things through in sort of an expedited, hurried fashion to get it by the American people before Christmas in the hopes they will not notice.

Mr. COBURN. I thank the leader.

I want to spend my time this morning kind of talking about how you control health care costs in our country. My experience, just from my qualifications—I have 9 years of experience in manufacturing medical devices. I did that as a young man, had hundreds of employees and a fairly large business. I left that business to become a physician. The call of my life was to help people directly rather than indirectly through my medical device association.

So I want to lay out the two different ways, the two different arguments for how we control health care costs because everybody in this Chamber wants to control health care costs. All the Democrats and all the Republicans do. We have 11 studies that say premiums are going to rise and one that says they are not under this bill. So that is not going to control costs.

But I want to read a story that a lady from my district wrote me because I think it is very important in us considering which way we go.

Dr. COBURN.

I hope you don't mind a personal story, but as I listen to the health care debate, I can't help but think constantly of my middle daughter. I am convinced that Chloe would have lost her chance for a normal life, had these policies—

In this new health care bill—

been in effect two years ago. No government agency could possibly have understood Chloe's unique needs or her extremely rare condition.

After a perfectly healthy childhood, my seventeen-year-old showed me that her left arm was twitching and wouldn't stop. Within weeks, the entire left side of her body was jerking constantly, every waking moment of every day. Her MRI revealed more than one periventricular heterotrophic nodule—

That is a growth around the ventricular system, the fluid system of the brain—

but her first two neurologists weren't sure there was a connection between the [changes in her movement and the movement disorder and the symptoms and the nodules]. They certainly had nothing useful to offer in terms of treatment. But I made the rash promise to my daughter that someone, somewhere, knew what to do, and that we would not stop looking until we found that person. Unlike mothers in a government run system, I was free to research the options and apply where I wanted. Our search took less than three months.

Chloe's pediatric movement disorder specialist at Mayo Clinic called her condition “unique” and unclassifiable. He had to debate her case with his neurology team, but

in the end they were willing to try an unprecedented series of brain surgeries. Chloe was desperate to live a normal life again, so my husband and I agreed, though perhaps you can imagine what an excruciating decision that was. Today, Chloe twitches a little, but anyone who didn't know her history would think she is just fidgeting. She is an honors linguistics student at OU, and she even takes dance lessons. She recently started driving again. She said once, "Mom, without the surgery, I would be strapped into a wheelchair now."

I know that Chloe would never have had the unique care she needed, if we had been required to petition a government agency for permission. A less dedicated person than her subspecialist would have tried to classify her condition and restrict her to known treatments. In fact, other subspecialists wanted to make those same restrictions. Chloe's doctor learned how to treat her by spending a great deal of time with her, by talking to her and to us for hours at a time, and by observing her in multiple contexts. I fear for the next mother whose child has an unclassifiable condition, and whose treatment is planned by a faraway committee with a diagnostic manual open on the table. Chloe won't be in that manual.

The thing that keeps people from getting health care in America today is the cost of health care. We have had all sorts of attempts of, how do we do that? We have had the Massachusetts model, and, as entered into the RECORD yesterday, they have insurance reform. Almost everybody in Massachusetts is covered. Yet last year 21 percent of those people who were covered could not get care because they could not afford the deductibles and copays. So expanding insurance and expanding the model does not solve it.

So you can either approach controlling costs or you can ration care. What has happened in this bill, as it comes through, is we have chosen to ration care. My colleagues are going to dispute that, but I want to offer significant evidence to offset that and discuss what is in the bill and to also discuss what is not in the bill.

What is not in the bill is a prohibition against rationing, which all of my colleagues on both the Finance Committee and the HELP Committee voted against, which means you are for rationing if you vote against, a prohibition. The leader denied an amendment on the floor of the Senate to eliminate rationing, so we do not get to see where everybody stands. But we understand the intent. So there is no question that the way we are going to control costs is to limit your access by rationing health care.

The other side of controlling costs is to incentivize the prevention of disease and incentivize payments for good outcomes when we manage chronic disease that is there in an efficient and effective way. That is not in the bill. That is not anywhere in the bill. What we have to do is incentivize an insurance company to invest in the management of chronic disease rather than to pay for the consequences of the chronic disease. That is not in the bill either.

So we get two choices.

Now, what do we find in this bill? We find a Medicare advisory commission. They actually dropped the name "Medicare" from it, but we find an advisory commission that is going to tell us how much money we have to cut from Medicare, and we either have to cut that amount or make some cuts somewhere else.

We have the U.S. Preventive Services Task Force, and we have already seen during the debate on this bill when they do something that is based on cost alone—not clinical; breast cancer screening for women between the ages 40 to 50—when they do something on the basis of cost instead of clinical, we run in and jump and say no, but we are going to pass a bill that is going to totally empower that. Seventeen times in this bill is the U.S. Preventive Services Task Force referenced in what it is going to tell us what to do, and it is not going to tell us just in Medicare and Medicaid, it is going to tell us in every area what we are going to do. But because there was such a reaction to the first recommendation based on cost—and let me explain what that was. They said that if you are age 50 and over, the incidence of finding somebody with breast cancer is 1 in 1,470 people, but if you are between the ages of 40 and 50, it is only 1 in 1,910 people; therefore, it is not cost-effective. So it does not matter if you have breast cancer between the ages of 40 and 50, we do not think the government ought to be paying for your mammogram and we do not think anybody ought to have one. Well, that is fine for all those people who do not have breast cancer. It is terrible for the people who do have breast cancer and it could be found early with a mammogram.

So we rushed in here and we offset what that task force did. But they are going to be doing it time and time again. And is the Congress going to truly—every time they make a decision based on cost-effectiveness, not clinical effectiveness, are we going to reverse it? We are not. So there is another proof that we are, in fact, going to use the rationing of care to control costs.

Mr. BURR. Madam President, will my colleague yield for a question?

Mr. COBURN. I would be happy to.

Mr. BURR. If, in fact, the Congress did reverse the decision of an advisory board, what does that do to the budget deficit? And what does it do to the claims that this current bill being considered is paid for?

Mr. COBURN. I am not sure I can answer the question. But it would make it less effective in terms of supposed claims.

Mr. BURR. So if the authors of this bill never intended to make cuts, then it blows the budget neutrality that is portrayed in this bill. But if they use all the mechanisms that are in place to make sure reimbursements are cut or

the scope of coverage is affected by a decision to limit one's care, then we could see prevention cut, wellness programs cut, or even the preventive diagnosis such as for breast cancer limited to a much smaller group.

Mr. COBURN. I think the Senator from North Carolina is really going to where I am going to get to later; that is, what is the motivation for the decisionmaking? I think my colleagues on the other side of the aisle are well intended, but I don't think they are well informed about the consequences of their intentions.

So if you set up the Task Force for Preventive Health Services and say you are going to rely on it, but we know they are going to make the decisions based on cost-effectiveness, not clinical effectiveness, what we are going to see is the American Cancer Society coming again and again and again because what we are going to do is we are going to cover those where it is cost-effective but not clinically effective. For 80 percent of Americans, they are not going to notice the difference, but one out of five Americans is going to notice the difference.

The second area, which I wish to spend some time on because we have actually modeled it after England, is cost comparative effectiveness. We ought to talk about what is comparative effectiveness research because there is nothing wrong with the research. It is health care research comparing various drugs, devices, and treatments head to head, and the whole goal of that is to find out what works best and what costs the least.

The assumption in this bill is, we can have 24 or 36 people in Washington decide that. In the Framingham studies they have been running for over 50 years on heart disease, we still don't have the answers and we have been studying it for 50 years. But we are going to be making decisions on cost, not on clinical effectiveness, which is going to limit your ability to have what you and your doctor think you need.

So we are going to pull out clinical experience of individual physicians. We are going to eliminate the heart of medicine, which is the combination of vast experience, gray hair, long years of training, family history, clinical history and physical exam and we are going to say: No, it doesn't matter. We are going to say: Here is the way you are going to do it.

Who uses comparative effectiveness research? Well, several countries do. When I share with my colleagues the stories about how it is used, you are going to get a real vision of what is coming with this bill—a real vision.

This bill creates a new agency called the Patient-Centered Outcomes Research Institute to perform comparative effectiveness research. I have already said the idea behind it is good. I

strongly support medical research. I strongly support helping doctors and their patients choose the best research and the best treatment. The problem is, this bill doesn't do that. On the contrary, this bill will empower the government to decide which treatments you can have and which ones you cannot have. That is what this does. This removes the judgment of the doctor and replaces it with the judgment of the bureaucracy in Washington. It is not a hypothetical concern, it is a real-world problem.

In Britain, they control health care costs by denying or delaying access to expensive therapies. That is one of the reasons this country has one-third better survival for every cancer you can imagine over Great Britain because we don't do that. As a two-time cancer survivor I am acutely aware as a patient, not as a doctor, in that I want to make sure for my family and my patients they have the best alternatives, not the cheapest, because the cheapest alternatives are the ones that take years away from your life.

I am going to go through some examples. Nobody can dispute this is what is happening now and what will happen under our program. To Senator BAUCUS's credit, he had a bill that wasn't cost comparative effectiveness; he had one based on clinical comparative effectiveness. That is not in here. What is in here is cost comparative effectiveness. Senator BAUCUS knew you don't want to use cost as the main thing; you want to use clinical outcomes as the No. 1 deciding agent in how we approach health care—not cost—because if you only look at cost, nobody in this country would get a mammogram between 40 and 50. But this bill is different from what Senator BAUCUS had offered in his Finance Committee markup.

There is an agency in Great Britain called the National Institutes for Health and Clinical Excellence. It is pronounced NIHCE. Here are some of the decisions of NIHCE in the most recent years. They have a problem in England with cost, too, and they have a single-payer, government-run system. They have the government running it, but they still can't control their costs, so what have they done? They have repeatedly denied breast cancer patients breakthrough drugs. They have forced patients with multiple sclerosis to wait 2½ years to receive new innovative treatments that people in this country are getting as soon as they are available. They have denied early stage Alzheimer's patients medication, requiring their condition to worsen before they give them the medicine. What do we know about the medicine? It works best when you have the slightest symptoms of Alzheimer's, not when you get worse. But that is the bureaucratic thinking: We will save money rather than practice good medicine.

They deny life-prolonging treatments to kidney cancer patients. They denied new medicine to all but a small percentage of patients with osteoporosis and then only as a last resort. In other words, you have to about have your bones breaking by standing before you get medicine for osteoporosis in Great Britain. In this country, we have prevented millions of hip fractures through effective medicines to restore the calcium and bone matrix in seniors' bones. But we have Medicare now saying you are doing too many tests to check on that, so you can only do it every 2 years. So we are going to use rationing, and we are.

They denied access to the only drugs available to treat aggressive brain tumors. They denied effective drugs to bowel cancer patients, colon cancer.

Macular degeneration is something that affects a large number of people in this country. That is where the macula—the area that actually allows you to see and concentrate your vision—as we age, we have what is called cystoid macular degeneration or dry degeneration. That is a disease of the eye where it causes vision loss. NIHCE required patients suffering from macular degeneration to go blind in one eye before they could have the medicine that almost every American who has macular degeneration in this country has. She had to go blind first in one eye before you could ever get the medicine. That is a bureaucrat making this decision or a bureaucratic committee because it was cost-effective to allow you to live with one eye. Elderly patients went to court to fight for drugs to keep them from going blind. Twenty-two thousand Britains became totally blind through that ruling by the NIHCE. In one case, an 88-year-old World War II veteran and former Air Force pilot sold his house to pay for the drug after the government said they weren't going to pay for it. The Royal National Institute of Blind People said that as a result of NIHCE's decision, countless people have either been stripped of their sight or stripped of their life savings to pay for private treatment.

For Alzheimer's, they ruled that three drugs, common to many people who are listening today—Aricept, Reminyl, and Exelon—were not cost-effective for patients with early Alzheimer's disease. Well, those are the only ones they work effectively on. One hundred thousand Alzheimer's patients a year were denied treatment that could have slowed the progress of their disease. The British Alzheimer's Society said this decision was disgraceful and victimized the most vulnerable in our society.

Brain cancer. Gliadel and Temodal were not cost-effective for treating brain tumors and severely restricted their access to them. A 47-year-old woman sold her house to buy the drug

the government refused to provide. They have been held as the biggest breakthroughs in treating brain tumors in the last 30 years. Finally, in April of the year before last, they finally relented and allowed brain cancer patients to have the drugs that were available on the market.

Erbix, very effective in resistant colon cancers. In 2006, denied. Seventeen thousand Britons a year get the sort of advanced colon cancer that Erbix is designed for. Yet they can't have it.

Mr. BURR. May I ask a question of my colleague? Listening to this list of products that have been denied people in Great Britain, and certainly this is true in some other countries, makes me look at the Medicare population in this country with the realization that the way Medicare was constructed, a senior can't pay out of pocket because no provider can receive a payment from a senior. If for some reason this bill were passed and you took part of the arsenal of drugs away from seniors or procedures away from seniors, how can a senior get a benefit if no provider can receive an out-of-pocket payment from a senior?

Mr. COBURN. That is the problem with our system today. What we are going to hear them say is the insurance companies do this now. At first, for new treatments, until they are proven effective, most insurance companies don't cover them, but they cover them much sooner than Medicare does today. Today, Medicare is the last to approve the drugs.

We are going to hear that is not any different than the limitations from insurance. That is true. We need to change that. But the fact is, we are getting ready to put all these people into insurance programs, and then we are going to have the Federal Government, which is just as bad or worse than the insurance company, making those decisions.

I wish to finish my point on cost. We get two ways for fixing cost because that is what is keeping people from getting access. We can either ration it—and there are three methods to rationing in this bill which will be used—or we can incentivize outcomes and we can incentivize prevention and we can pay, based on the transparency of outcomes and quality. We haven't done any of that in this bill. We have said we have, but when you look at how do you prevent it—and the model is the 200,000 employees at Safeway and what they have been able to do in using their incentive systems to pay for prevention, to use competitive purchasing to reconnect the employee with the purchase of health care.

I understand my colleague from Nebraska is here, and I will yield to him because I understand he was a unanimous consent request.

The PRESIDING OFFICER. The Senator from Nebraska is recognized.

Mr. JOHANNIS. Madam President, I appreciate the courtesy extended by the Senator from Oklahoma.

I ask unanimous consent that the pending substitute amendment be modified to delete the following special carve-outs: eliminating or reducing the Medicaid unfunded mandate on Nebraska, Vermont, Massachusetts; exempting certain health insurance companies in Nebraska and Michigan from taxes and fees; providing automatic Medicare coverage for anyone in Libby, MT; earmarking \$100 million for a health care facility, reportedly, in Connecticut; giving special treatment to Hawaii's disproportionate share of hospitals; boosting reimbursement rates for certain hospitals in Michigan and Connecticut; and mandating special treatment for hospitals in frontier States such as Montana, South Dakota, North Dakota, and Wyoming.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Madam President, I appreciate the Senator's desire to want to cut the payments to his own State, but I object.

The PRESIDING OFFICER. Objection is heard.

Mr. JOHANNIS. Thank you. I yield to the Senator from Iowa.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, we had a very early vote, and it brings the health care reform bill obviously one step closer to final passage—at least it looks obvious that is going to happen. Regardless of whether the other side has 60 votes, my friends on the other side still have a problem they want to not have the public concentrate on; that is, that the pending bill still raises taxes on middle-income Americans. The Reid modification did nothing to reverse this fact.

I will take a few moments to illustrate the winners and losers under the bill. We start with a question: If a person is not receiving a subsidy for health insurance under the bill, then how can the person receive a tax cut? This is a relevant question because the White House and the majority leadership continue to proclaim that the bill is a "net tax cut" for middle-class Americans. For example, on Wednesday, December 16, a senior White House aide wrote:

The bill being considered represents a substantial net tax cut for middle income families.

So I think that statement begs more questions. Who do you believe? The White House, on the one hand, or on the other hand, the nonpartisan independent experts upon whom we on Capitol Hill rely for judgment—the people who are not political, the Joint Committee on Taxation?

This committee tells us that in 2019, a little more than 13 million individual families and single parents would re-

ceive the government subsidy for helping people under 400 percent of poverty buy health insurance. The Joint Committee also tells us that the number of tax filers in 2019 will be 176 million people. If people are wondering why we talk about 2019, it is the budget window from now until the end of the 10-year period of time that we call a "budget window." That means out of—comparing this 13 million to the 176 million taxpayers, 13 million people receiving the subsidy and 176 million tax filers—that means out of that 176 million individuals, families, and single parents, only 13 million of them would receive a government subsidy for health insurance. That is only 7 percent of the tax filers. It is pretty important to understand that only 7 percent of Americans will benefit from the subsidy for health insurance.

We have a pie chart so people can see exactly what I am talking about. This says 176 million taxpayers, with 13 million receiving the subsidy. This means 163 million families, individuals, and single parents—or 93 percent of all taxpayers—will receive no government benefit under the Reid bill. What does that mean? It means there is a small beneficiary class under the Reid bill—7 percent. Thirteen million people will receive benefits under the Reid bill. A very large nonbeneficiary class—93 percent—will not benefit.

This nonbeneficiary class is affected in other ways. Yes, while one group of Americans in this class would be unaffected, another group of Americans will see their taxes go up. This group would not have a tax benefit to offset the new tax liability. That means these Americans will be worse off under the Reid bill.

It is legitimate to ask, for these 93 percent of the people, what happened to their net tax cut? What they will see instead is a net tax increase. Based on the Joint Committee's data, in 2019 42 million individuals, families, and single parents with incomes under \$200,000 will see their taxes go up. This is even after taking into account the subsidy for health insurance. Again, this is on a net basis.

If we were to identify those Americans who are not eligible to receive the tax credit and those whose taxes go up before they see some type of tax reduction from the subsidy, this number will climb to 73 million Americans. The first bar on the chart illustrates what we have already established but looks at Americans earning less than \$200,000. Right here, 13 million families and single parents and individuals would receive the subsidy.

The middle bar on the chart shows the net tax increase number of 42 million Americans under \$200,000-a-year income. Finally, when we identify those Americans who get no benefit under this bill, and those Americans who see a tax increase, we find that

there are 73 million individuals, families, and single parents under the \$200,000 category. That is this group.

I want to close by referring to a final chart that illustrates the winners and losers under the Reid bill. What we see is that there is a group of Americans who clearly benefit under the bill from the government subsidy for health insurance. This group, however, is relatively small—8 percent of Americans, if you look at those earning less than \$200,000.

There is another much larger group of Americans who are seeing their taxes go up. This group is not benefiting from the government subsidy, this group on the chart. There is another group of taxpayers who are generally unaffected, this 82 million here. The Joint Committee on Taxation tells us this group may be affected by tax increases that are not included in this study, like the cap on flexible savings accounts and the individual mandate tax that people are going to pay if they don't buy health insurance.

The bottom line is this: My friends on the other side of the aisle, first, cannot say that all taxpayers receive a tax cut; two, they cannot say the Reid bill does not raise taxes on middle-income Americans because we have the professionals who are nonpolitical at the Joint Committee telling us differently. No one can dispute that data.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Madam President, my friends on the other side of the aisle continue to argue that the Reid bill eliminates the so-called hidden tax. They argue that this would reduce the cost of health care. For example, on Wednesday, December 16, a senior White House aide wrote:

Even if you believe that some of the tax on insurance companies is passed along, it would be more than outweighed by the benefits middle-class families would get from reducing the hidden tax they currently pay for the uninsured.

I don't believe the fees on health insurance companies will be passed through to the policyholders. I think it is just idiotic not to think they would not be passed through.

I want to flatout state I know they are going to be passed through. My authority for this is the Congressional Budget Office and the Joint Committee on Taxation telling us that fact. The CBO and the Joint Committee on Taxation told us that these fees will actually increase health insurance premiums. Premiums will go up because

the companies are paying increased taxes under this bill. For insurance premiums to go up, under a title of a bill that encompasses health care reform, that is going in the wrong direction. Also, for argument's sake, let's assume my Democratic colleagues are correct and this so-called hidden tax that results from uncompensated care equals \$1,000. The pending health care reform bill still leaves a large number of Americans uninsured. Specifically, the Reid bill leaves 23 million out of 54 million without health insurance at the end of this budget window, 2019. So, at best, the Democrats' reform cuts the hidden tax in half—in this case, to about \$500 a family.

To add insult to injury, however, the bill adds new hidden taxes. These taxes are the fees imposed on health insurance. CBO and the Joint Committee on Taxation—two respected organizations—say this will increase costs. If you check the report, no one can dispute that. These fees go into effect in 2011—still 3 years before any of the major reforms under the pending bill kick in.

That means this hidden tax will increase premiums in 2011, 2012, and 2013. That is before there is any government assistance for health insurance being provided to families that need it. The new hidden tax is also created as a result of the Medicaid expansion on the one hand, and Medicare cuts on the other hand, a major cost shift in health care derived from government programs—Medicare and Medicaid—which reimburse providers at rates roughly 20 percent to 40 percent lower than private providers.

President Obama understands that paying doctors below market rates leads to cost shift. This is what he said at a townhall meeting on health care reform:

If they are only collecting 80 cents on the dollar, they have to make that up someplace else, and they end up getting it from people who have private insurance.

The Medicare and Medicaid cost shift will be increased significantly under the pending health care reform bill. According to the CBO estimate, Medicaid will be increased by more than 40 percent, from 35 million to 50 million people. Additionally, the bill includes almost \$½ trillion in Medicare cuts that will result in lower payments to providers.

Increasing the current Medicare and Medicaid cost shift as a result of the Democrats' health reforms would add even more costs to a family's health insurance policy. The easier cost shift to address would be the \$1,700 cost shift from defensive medicine. The Democrats do not address the cost shift from defensive medicine which former CMS Director Mark McClellan has estimated adds \$1,700 in additional cost per average family.

Addressing this reform alone could save more than covering all of the uninsured in America.

So, you see, my friends on the other side say their bill will eliminate the so-called hidden tax. My friends seem to come up short on that one. Also, they add new hidden taxes that will burden middle-class Americans.

I think in the present situation, the legislation before us and the language used by debaters on the other side, they should be transparent when they are talking about getting rid of the hidden tax. The pending health care reform bill makes things from these three perspectives work.

Madam President, I will be happy to yield the floor for a minute for the purpose of a colloquy with Senator BAUCUS on another subject.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Madam President, I would like to address a colloquy with Senator GRASSLEY, as he said, on another subject that is not related to this bill.

The PRESIDING OFFICER. Without objection, it is so ordered.

EXPIRING TAX PROVISIONS

Mr. BAUCUS. Madam President, the Senate is wrapping up legislative business shortly, but there are a few expiring tax provisions that have unfortunately not been extended. These provisions include tax benefits for individuals and businesses. These provisions would help teachers who purchase supplies for their classrooms and families with college students.

Further, a great number of U.S. businesses rely on important tax benefits, such as the research and development tax credit and the active financing exception, both of which expire at the end of this year. The energy industry also relies on several provisions that expire on December 31. Unfortunately, this is not the first time we have allowed important tax benefits to expire. As soon as the Senate reconvenes next year, my intention is that we take up legislation to extend these important provisions.

That is why Senator GRASSLEY and I have written a letter to the Senate leadership. I ask unanimous consent to have this letter printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC, December 22, 2009.

Hon. HARRY REID,
Majority Leader, U.S. Senate, Washington, DC.
Hon. MITCH MCCONNELL,
Republican Leader, U.S. Senate, Washington, DC.

DEAR MAJORITY LEADER REID AND REPUBLICAN LEADER MCCONNELL: We write to inform you that early in the next year, we intend to address the extension of various tax provisions expiring on or before December 31, 2009. We intend to extend the provisions

without a gap in coverage, just as the House did on December 9th of this year. The legislation will extend several important tax benefits to individuals and businesses. The legislation will also extend a number of energy tax provisions, including the biodiesel tax credit, and natural disaster relief.

These provisions are important to our economy—not only because they help create jobs, but also because they are used to address pressing national concerns. We understand that the expiration of these provisions creates uncertainty and complexity in the tax law.

Taxpayers need notice of the availability of these provisions to fully and effectively utilize the intended benefits. We hope to address this issue as soon as possible to cause the fewest disruptions and administrative problems for taxpayers and also generate the greatest economic and social benefit.

Sincerely,

MAX BAUCUS,
Chairman, Senate
Committee on Finance.

CHUCK GRASSLEY,
Ranking Member, Senate
Committee on Finance

Mr. BAUCUS. Madam President, the letter states our intention to work together to get the extenders done as quickly as possible in the new year.

Senator GRASSLEY and I both understand that expiration of these provisions creates uncertainty and complexity in the tax law. Taxpayers need notice of the availability of these provisions to fully and effectively utilize their intended benefits. Finally, we must act quickly to cause the least disruptions and administrative problems for the Internal Revenue Service.

I hope when the Senate convenes early in 2010, we can address these expiring provisions as soon as possible. I wonder if that is also the intention of the my good friend from Iowa, Senator GRASSLEY.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, I would like to add to what Senator BAUCUS said by speaking positively on this issue and to remind my colleagues who maybe have been watching in the last 3 weeks and have seen Senator BAUCUS and I on opposite sides of the issue of health care reform—it is uncharacteristic for us to have different points of view on legislation. In the 10 years he and I have been leaders of the Finance Committee, most of the issues coming out of our committee have been very bipartisan. What he just talked about and what I am going to respond to is one of those issues.

I agree with Chairman BAUCUS that we should retroactively extend the expiring tax provisions as soon as possible after Congress reconvenes in 2010.

As chairman of the Finance Committee in 2005, I worked with then-Ranking Member BAUCUS, and we authored the biodiesel tax credit.

The biodiesel tax credit is a tax credit that is needed to be extended before

the end of the year to prevent the U.S. biodiesel market from grinding to a halt on January 1, 2010. This tax credit differs from other tax provisions in that the price of biodiesel will be \$1 higher on January 1, 2010, as a result of the tax credit not being extended before that date. That means people will simply buy petroleum diesel rather than biodiesel come January 1, 2010.

I point out that support in Congress for extending the biodiesel tax credit, I think, has been and still is robust, bipartisan, and bicameral, and that it has not been extended prior to January 1, 2010, due solely to issues unrelated to the merits of the biodiesel tax credit.

I want everybody to know that I agree with Chairman BAUCUS that the expiration of these tax provisions creates uncertainty and complexity in the tax law. I also agree that the taxpayers need notice that these tax provisions will be in place so they can plan their personal and business affairs to fully and efficiently use the intended tax incentives.

In addition, extending the tax provisions as early as possible in 2010, as we intend to do, will minimize the administrative problems created for the Internal Revenue Service.

I look forward to working with Chairman BAUCUS to retroactively extend these provisions as soon as possible when the Senate reconvenes in 2010.

Mr. BAUCUS. Madam President, I thank the Senator for his statement. I look forward to working with him and other Senators so we can pass this legislation as soon as possible next year.

Again, I commend my colleague and friend. It is true that much more often than not we are working on the same side of an issue. Even on the few occasions when we are on the opposite side, I do say we do it agreeably. I wish more of the Senate would act the same way.

Mr. HARKIN. Madam President, I thank the Senators. The delay in the passage of the Tax Extenders Act of 2009 will cause problems for a wide variety of groups, as the distinguished Senators from Montana and Iowa have outlined. I believe the negative impact of our failure to act this year will be felt first, and felt most strongly, by manufacturers of biodiesel. Without the immediate passage of legislation to extend the biodiesel tax credit, a large number of biodiesel manufacturing plants are likely to close down because they do not have the resources to operate without the financial benefit of the credit.

Biodiesel is a key part of our Nation's success in biofuels. These biofuels, produced here in our own country, are helping to reverse our near-total dependence on petroleum for transportation in this country. The hard truth is that we get about 70 percent of our petroleum from other countries, and many of those countries are

unstable or are unfriendly to the United States or both. So biodiesel is helping us restore national energy security.

Biodiesel is made from vegetable oils or animal fats. The biodiesel industry employed over 50,000 workers and added over 600 million gallons of biobased fuel last year to help power the diesel engines across our Nation and throughout the economy.

However, this is still a very small and struggling industry. It is absolutely dependent on continuation of the biodiesel tax credit. Without this credit, most of the biodiesel plants in this country will simply be forced to shut down, thus idling important domestic fuels production capacity as well as putting as many as 20,000 employees out of work. We can't let that happen. And, if for any reason the credit was not made retroactive, bankruptcy would in a good number of instances be a quick result.

I do appreciate the efforts by the chairman and ranking member to move forward with this badly needed legislation at the first opportunity.

Ms. STABENOW. Madam President, as we work toward economic recovery, it is imperative that we act quickly to extend critical tax provisions scheduled to expire this year that promote research and development, spur community development, support the deployment of alternative vehicles and fuels, and provide certainty for businesses and families.

Knowing these tax provisions are in place allows Americans to plan for the upcoming year. The longer we wait to pass this legislation, the more uncertainty we place on businesses during a time when they are starting to recover. Many of these tax provisions encourage investment, the development of new technologies, and business growth, which allow our companies to be competitive in a global marketplace.

Delaying the extension of the research credit could put more than 100,000 jobs and billions of dollars in economic activity and Treasury revenue expected in 2010 in jeopardy, according to estimates from TechAmerica. If the credit is renewed, the association estimates that 120,000 jobs would be generated and/or sustained, there would be an additional \$16 billion in additional research and development and other economic activity and \$13 billion in Federal tax revenue over the course of 2010. However, for every day that the credit is left expired, there is the potential to lose 331 jobs, \$45 million in economic activity, and \$37 million in tax revenue.

Another important tax provision set to expire this year allows businesses to write off the expenses of cleaning up brownfields, industrial land that would otherwise continue to be a blight on our communities and harm our environment. In my home State of Michi-

gan, these credits will be needed more than ever to address the brownfields that have been left behind as a result of the restructuring of the automotive industry. Revitalization of these brownfields will be critically important to communities throughout the State and the Midwest.

It is also imperative that we restore the estate tax retroactively to January 1, 2010. I am extremely disappointed that an extension was blocked and that the estate tax will be allowed to expire in 2010. Contrary to Republicans' claims, more heirs of farm and business estates will be hit with a tax increase than if we extended the estate tax at current levels. If the 2009 rules are retroactively applied, then only approximately 6,000 estates would pay the estate tax each year; however, if the estate tax expires, then it is estimated that 61,000 estates could be hit with the capital gains tax. It is critical that we extend the estate tax under the 2009 parameters to protect small businesses and family-owned farms, continue the incentive that the estate tax provides for charitable giving, and provide certainty for the heirs of farm and business estates.

During one of the most challenging economic times our country has faced, dragging our feet on these tax extensions could have a substantial impact on our Nation's businesses and families at a time when we should be doing all we can to help them succeed. I look forward to working with Chairman BAUCUS and Ranking Member GRASSLEY to retroactively extend expiring tax credits expeditiously when we return next year.

Mr. GRASSLEY. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

Mr. GRASSLEY. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Madam President, there was a report released recently by the Chief Actuary, Rick Foster. I hope this report will once and for all put an end to any serious consideration of the CLASS Act. The CLASS Act is going to be in the bill, if this bill passes Congress. But it should not be in it, and we should have had a long discussion on this provision because it is simply fiscally unsustainable.

The information the Chief Actuary's letter provides is ample evidence of why the CLASS part of this bill cannot work. Quoting from page 13 of the Chief Actuary's letter:

We estimate that an initial average premium level of about \$240 per month would be required to adequately fund CLASS program costs for this level of enrollment, antiselection, and premium inadequacy for students and low income participants.

So who would enroll in the CLASS program? An American making 300 percent of poverty has a gross income of

\$32,490. If the CLASS premium is, as the Chief Actuary predicts, \$240 per month—that is \$2,880 per year—and an individual at 300 percent of poverty would have to commit 8.9 percent of their income to join the program. That is simply not possible, nor is it plausible to argue that young, healthy persons will commit almost 9 percent of their income to long-term care insurance policy.

The people who will enroll then are those who have real expectations of using the long-term care benefit. People who join the CLASS program with the expectation of needing the benefit become the Bernie Madoffs of the CLASS Act Ponzi scheme.

An individual becomes eligible for the CLASS program after paying premiums for just 5 years. If a person pays premiums of \$2,880 per year for 5 years, they would have paid a total of \$14,400 in premiums for that program. That person can then begin collecting a benefit of \$1,500 per month. In 10 months, the person will have recouped their 5 years' worth of premiums.

This simple explanation should make it crystal clear why the CLASS Act is a fiscal disaster waiting to happen, not based on our determination but based on the determination of the Chief Actuary. The premium will be too expensive to entice young, healthy people to participate. The benefit payout is very enticing for people who know they will need the benefit. Healthy people do not participate; sicker people will. This adverse selection problem will send the program into the classic insurance death spiral.

The Chief Actuary concluded on page 14 of his report with this one sentence:

There is a very serious risk that the problem of adverse selection would make the CLASS program unsustainable.

If the CLASS Act becomes law, the Federal taxpayers are at very serious risk of paying a price to clean up the fiscal disaster when the CLASS Act fails.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BAUCUS. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. Madam President, this chart shows very graphically—this is data put together by the Joint Committee on Tax, combining all the various provisions in the bill. Basically, it shows that in 2015—that is the bar on the far left—there will be a \$26.8 billion net tax cut for individuals—net tax cut. Two years later in 2017—that is the middle vertical bar—there is a net tax cut of \$40 billion for all Americans—a net tax cut. Not for all Americans.

Some will not get it, but most Americans by far will. Then, of course, 2 years later in 2019, there is a net tax cut of \$40.8 billion.

I wanted to make it clear that there is a net tax cut in this bill, according to Joint Tax. This is the distribution over 3 different years—2015, 2017, and 2019. That is information prepared by the Joint Committee on Tax. I want Americans to know there are tax cuts in this bill, and they are very significant.

Madam President, I yield the floor.

RECESS

The PRESIDING OFFICER. Under the previous order, the Senate stands in recess until 2:30 p.m.

Thereupon, the Senate, at 12:30 p.m., recessed until 2:30 p.m. and reassembled when called to order by the Presiding Officer (Mr. WEBB).

SERVICE MEMBERS HOME OWNERSHIP TAX ACT—Continued

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I have control of the Democratic block of time, and I yield 25 minutes to the good Senator from Rhode Island.

Mr. REED. Mr. President, I thank the chairman for yielding me the time and also thank him for his great effort on this legislation.

It is a profound privilege to have the opportunity to serve the people of Rhode Island and in that capacity to support the legislation before us. This effort has been decades in the making. Every year that passes without health insurance reform has made the task more difficult and, the need for reform, more essential.

Rhode Islanders have seen their health care costs double in just the last decade. In 2000, the average employer-sponsored family health insurance policy cost about \$6,700. In 2008, the same plan cost nearly \$12,700. Without reform, by 2016, that family will pay over \$24,000 in premiums, consuming 45 percent of their projected median income. Such a course is unsustainable by the families of Rhode Island.

Soaring health care costs are hurting family budgets, small businesses, and the national economy. In 1980, Americans spent \$253 billion on medical bills. Today, we are paying \$2.5 trillion on medical bills. That pressure is pushing Medicare toward collapse and 750,000 Americans into bankruptcy each year.

This legislation will help contain health costs, extend insurance to millions, and give health consumers more protection against discriminatory insurance practices. By shifting the balance of power from insurance companies to consumers, we will make health care more affordable for individuals and businesses and provide families

with greater health care access and stability.

This bill is fiscally responsible. It is fully paid for. We trimmed wasteful programmatic spending and imposed new fees on drugmakers, reined in entitlement spending, and imposed taxes on things such as tanning beds, which lead to health care costs. But we also provided every American family with greater health care stability and extended affordable health insurance to 30 million more of our fellow citizens.

The nonpartisan, independent Congressional Budget Office—the CBO—estimates this bill will reduce the deficit by \$132 billion over the next decade and \$1.2 trillion over the following 10 years.

We need urgent action. The delay tactics and the procedural obstacles employed by the other side are hurting our fellow citizens. Every day, 14,000 more Americans lose their health coverage, and every day we remain here delaying this measure, 14,000 more Americans will lose their coverage. We have to, I think, reverse that trend and begin to fix our broken health care system.

Since 1999, Rhode Island's uninsured population has nearly doubled, growing from 6.1 percent to 11.8 percent in 2008, and it has soared up to about 15 percent today in the wake of unprecedented economic issues. But while some of us have made this debate about trying to fix a broken health care system, others have made it clear their real intention was to use this issue to "break President Obama" and make health reform his "Waterloo." Partisanship must not come before providing access to life-saving health care to children, families, and seniors.

I also don't understand how some party loyalists who spent the past 8 years helping George W. Bush drive our economy into the ground and inflate the deficit to record levels are now obstructing every reasonable effort to fix these problems. How could they help George W. Bush double our national deficit, running it up more in 8 years than all 42 Presidents before him, and then turn around and claim President Obama isn't doing enough to control it?

How could they say this \$800 billion insurance reform bill—which is fully paid for and reduces costs to consumers—is too expensive, but the \$1.2 trillion prescription drug bill they passed—which was financed through deficit spending and amounted, in many respects, to a giveaway to drug companies—was somehow good policy?

How can they rail against health care reform right after overseeing the largest expansion of our government in decades? How will they change their approach when, through hard work, we do, in fact, extend coverage and reduce cost and begin to deal with the deficit that has to be dealt with in the years ahead?

Health insurance reform hasn't always been this partisan. Indeed, many Republicans have said they support a great deal of what is in this bill but, for whatever reason, they refuse to support it. Indeed, by my count, this bill increases competition, which Republicans said they wanted. Indeed, by my count, this bill lowers cost, which Republicans said they wanted. Indeed, by my count, this bill does not contain a public option. I regret that, but that is the position I think most of the Republicans—not all—supported. And, indeed, this bill provides Americans with tax credits to purchase insurance, which Republicans said they wanted.

So the bill we will pass seeks to tear down the inefficiencies in the current system, curb the cost, and reduce the waste and abuse Rhode Islanders and Americans experience every day.

It is our responsibility to enact meaningful health reform. Just saying no may be a powerful political weapon, but this country is built on hope and a better future, not fear.

Health insurance reform will offer Rhode Islanders access to stable and affordable health insurance coverage. Here are some of the changes that will happen immediately with the enactment of this bill:

Insurance coverage for the uninsured with preexisting conditions will be provided through a high-risk pool within 6 months of this bill being signed into law. In my State, one plan already acts as the insurer of last resort and provides coverage for those who have preexisting conditions. This bill will support their efforts. And, all insurers will be prevented from denying coverage to children immediately due to a preexisting condition.

There will be no lifetime limits on coverage for all new policies. This means no one will exhaust their coverage plan, no matter how sick they become.

There will be restrictions on annual limits for all new policies. Insurance companies will have more difficulty denying care in the middle of treatment.

All new policies sold will cover children up to the age of 26. This is particularly helpful since graduates from college often—particularly in this economy—have a hard time finding employment with health care benefits.

Insurers will no longer be able to rescind coverage upon illness—when treatments, checkups, screenings, and medication are absolutely critical.

Insurance companies will be required to cover—free of charge—preventive care for new policyholders.

Beginning next year, in 2011, small businesses will be eligible for a tax credit to purchase insurance for employees.

Then, in 2014, after allowing the States a time to design and develop and prepare themselves, our bill will extend affordable coverage to over 30

million uninsured Americans through a new health insurance exchange which promises to expand choice, increase competition, and rein in cost.

Rhode Islanders without a job will be able to purchase insurance on a newly established and government-regulated health insurance market. Many will receive Federal support for the purchase of coverage.

Rhode Islanders employed by a company that does not provide insurance—or inadequate insurance—will be able to purchase insurance on this new market exchange.

Small business owners will be able to easily compare the cost of insurance coverage offered by a multitude of plans through a new health insurance exchange, and it will allow small business owners to pick the coverage that fits the needs and budget of their employees.

Rhode Islanders on Medicare will no longer have to pay out of pocket for important preventive services and no longer spend portions of the year in the so-called doughnut hole without paid drug coverage.

Low-income adults, without children, will have access to Medicaid, which will provide them with insurance at reasonable costs.

Having access to health insurance is important. Individuals, employers, employees, and families will have access to new insurance options after reform, which is important. However, affordability—the amount a family has to pay—is also critically important.

We have examples of States that have already enacted insurance reform that covers their entire population, and what we found is, premiums have gone down significantly since this reform was enacted. We have learned a lot from their efforts, and Federal reform will improve upon those efforts for the rest of the country.

As I suggested before, the average premium for a Rhode Island family is \$12,700. If we don't do something, experts predict this premium will double in just 6 or 7 years. Rhode Islanders will be looking at health insurance bills—just the bills of annual premiums—of over \$25,000. Again, that is not sustainable. It will literally bankrupt the families of Rhode Island, and they will make a very difficult choice: paying this much money—which for many, if not most, is extraordinarily difficult—or not having insurance or doing other things, such as limiting the access their children have for college or not saving for their retirement. We can change that today by moving forward with this legislation.

The Congressional Budget Office has also analyzed the effect of this bill on the premiums that Rhode Islanders pay, and they expect premiums to decrease anywhere from 14 to 20 percent. CBO found these decreases will result from an influx of enrollees with below-average spending for health care.

One of the problems we have in the health care system today is, healthy, young people—unless they are offered health insurance through their employer—don't typically purchase it. They are the classic free riders. If they get hurt in an accident, they will go to the emergency room and be treated for free. They will not have paid into the system that cares for them. The whole principle of insurance is spreading risk across the largest population to reduce cost. That is precisely what we are doing. This is fundamental to any insurance program.

So this approach will actually lower the cost, as the CBO has reported. Additionally, the bill will provide permanent tax credits for Rhode Islanders to purchase insurance.

Depending on income, individual Rhode Islanders can expect a \$500 to \$3,000 break on their insurance costs because of these tax credits. Rhode Island families can expect to save much more—\$1,400 to \$8,500—on their insurance through these credits. Everyone should recognize the insurance reforms in this bill will mean people will get better coverage at lower costs.

The bill also mitigates the costs facing small businesses, which in my State accounts for 95 percent of all businesses. Every year, these business owners face increasing premiums of 15 to 20 percent. They do not have much choice. Two companies control 80 percent of the market in Rhode Island, and you either accept what is offered or you go without insurance. Every year, they see double-digit increases. Again, this is not sustainable, not only over the long term but over the next several years.

Starting a business and finding the right personnel is a challenging and expensive proposition. Innovation and entrepreneurship is risky. Often startup companies have difficulty hiring qualified individuals because the business owners can't face these increasing costs of health insurance. In Rhode Island, these kinds of pressures have led to the loss of employer-sponsored health care or reduction in premium assistance from employers.

What has happened over the last several years is, real wages have been flat because health care has been taking all the extra money that in other times would have gone to increased wages. As a result, if you are a middle-income American and you look around through all the struggle and all the work you are doing and you have this sense that you haven't made a lot of real progress in terms of additional wealth or additional money put aside, it is no wonder. You have been paying the indirect costs of an ineffective, inefficient health care system. The money is going into health care. The money is going into—in many respects—health care that is not efficient or effective and it is not going into the paycheck of working Americans.

The reforms set forth in the Patient Protection and Affordable Care Act will strengthen the employer-sponsored health insurance market. There has been some suggestion that this is going to create no opportunities or options for employers to continue to provide health insurance for their workers. But, according to the CBO, 83 percent of the privately insured Americans will be insured through their employers. That is a dramatic change, nearly double the total of Americans insured through their employer today.

What we are going to see is not a decrease in employer insurance but an increase. I think this is something that will match the best aspects of our economy—individual business men and women making judgments about what plan is best for them and providing that benefit in a cost-effective way to their employees. It will occur because of a few simple changes:

First, as I mentioned, small business owners will actually receive a tax credit to purchase insurance for employees, should they choose, beginning next year, 2011. I will repeat, small businesses will get a tax credit, a tax break which they are not getting now, to help provide insurance for their workers.

Second, individuals will have the option of finding affordable insurance on their own with increased competition to drive down costs, as more people shop effectively for health care insurance.

Third, there will be lower administrative overhead and greater simplification of insurance as a result of this legislation.

Under the proposal we are considering, premiums for small businesses will stop the never-ending trend of increase after increase and will begin to come down. Making health insurance more affordable for small business owners will help them by defraying their startup costs and ensuring individuals can seek employment regardless of the benefit options.

It will foster innovation and put companies in a situation where they have an edge over foreign competitors and can win in the global marketplace. American companies today are competing against nations around the globe that either have a national system, which does not directly affect their balance sheet in terms of health insurance costs, or they have no health insurance at all, and as a result, that is not on the balance sheet of these companies. Every one of our businesses is, in some way or another, competing against other countries that heavily subsidize their insurance, that provide an advantage, a competitive advantage. We want to in some small way diminish—in fact, in a large way at least begin to diminish that advantage.

While there have been many ill-founded claims about the reform package, the simple fact is that the tax

credits provided in this bill is the largest health tax credit bill that has ever been considered in Congress. Over \$400 billion in tax credits will be provided to Americans in order to increase affordability.

Since health insurance reform will provide Rhode Islanders access to affordable health coverage, our providers should no longer face the financial pressure from uncompensated care. Hospitals will care for patients with insurance, and doctors will be able to prescribe preventive measures to patients so they do not become ill. Today, it is estimated that of all the private insurance premiums we pay in Rhode Island, at least \$1,000 dollars of those premiums is to pay for uncompensated care in our hospitals, in our clinics throughout the State. When we have a significant number—95, 94-plus percent—of Rhode Islanders covered, those uncompensated costs won't be uncompensated. There will be an insurance program behind these individuals, so they can seek preventive care and they can pay for emergency care and pay for regular care.

Each one of the hospitals in my state is contributing in our efforts to insure more Americans and doing so with the knowledge that they can potentially benefit from the fact that people will not be showing up in their emergency rooms without insurance but will bring their insurance card, and the support their card ensures, to the emergency room.

In addition, the safety net providers throughout the country, our community health centers, will find great support in this legislation.

There will be direct improvements for physicians in Rhode Island. The looming 21 percent Medicare payment reduction will be eliminated, as it is impending. We will continue to look for permanent solutions, not only to this issue of Medicare payments but also a payment formula used to pay doctors in a more equitable and more appropriate way.

I am also pleased that we have taken steps to improve and enhance training of a new generation of primary care physicians who will be necessary to fill the increased demand. These improvements will help our overall efficiency.

This bill will also provide seniors with an improved Medicare Program. Nearly one-fifth of my State is on Medicare; over 180,000 Rhode Islanders rely on Medicare. Seniors have paid into Medicare during their lifetime. They deserve a program that will provide comprehensive coverage at the lowest cost without risk of coverage being terminated. However, that is not the Medicare coverage Rhode Islanders always receive today. Here is what Medicare does today. Medicare frequently allows the same test for the same complaint to be performed multiple times. This costs money, but it

doesn't necessarily improve patient care. Medicare leaves over 31,000 Rhode Islanders without prescription drug coverage for parts of the year. This costs them money. And Medicare today is on the path toward insolvency in just 8 short years, which will affect every senior in Rhode Island.

Instead of allowing Medicare to go bankrupt, the comprehensive health reform bill we are currently debating would extend Medicare solvency for at least 5 additional years. Some predict it will be extended for nearly a decade. This is important for seniors enrolled in the program today and those who will soon enroll in the program.

Solvency is extended by reforming the system. Seniors in my State will not have to make multiple trips to their doctors' offices for the same test for the same complaint because we will eliminate unnecessary duplication and tests and services. They will not fear being readmitted to a hospital after discharge because we will encourage care coordination after discharge. And they will not put off important preventive care because the out-of-pocket costs are just too great because the cost-sharing component for preventive care will be eliminated.

Many of my seniors are on the Medicare Advantage Program, which is a privatized version of traditional Medicare. Over 65,000 seniors in my State have elected to enroll in this option, and there has been an effort to characterize the changes to this program as undermining that program. The private insurance companies have been saying that for over a month now. Why? Because they profit very handsomely from Medicare Advantage. They spent months telling seniors health reform will take away their coverage. These claims are inaccurate.

We will eliminate excessive overpayments to private insurance companies. In my State, Medicare Advantage plans are paid over 20 percent more per beneficiary than traditional Medicare fee-for-service. This overpayment is particularly astounding given the fact that the Government Accountability Office found that 19 percent of Medicare Advantage beneficiaries pay more than traditional Medicare for home health care and 16 percent pay more for inpatient services. Seniors should be angry and upset at insurance companies, that they continue to profit from the Medicare system while simultaneously taking more money from seniors' pocketbooks as they charge extra for these services. This was not the intent of the program. In fact, the intent of the program—the argument the insurance companies made is: Give us the flexibility to manage Medicare patients, and we will lower costs. Very shortly after that, it became clear that they were not managing the costs that well.

Of course, the bill is going to target waste, fraud, and abuse. For every \$1

we spend in this effort—and you have to invest in this fraud detection—we expect to recover \$17.

Our efforts will improve health care of seniors and will stabilize Medicare.

Also, we should note that we will be doing significant amounts with respect to children. I particularly applaud Senator BOB CASEY's amendment to ensure that Rhode Islanders on Rite Care will not have to fear losing their safety net coverage.

Finally, it is important to note, as I mentioned before, that these reforms are paid for. This is a stark contrast to others. We voted on the Medicare prescription bill in 2003, which I opposed. It was unpaid for, and it was more costly than the amendment which was originally presented to us.

We voted on countless measures outside the normal process of budgeting to fund the wars in Iraq. We voted tax cut after tax cut for the wealthy, which has left my State not prosperous and wealthy but 13 percent of my State unemployed and 15 percent of my neighbors are uninsured.

We are moving forward to reduce the deficit with this bill, to provide valuable coverage, to ensure the promise of health care in the United States is fulfilled, not denied.

I yield the floor.

Mr. BAUCUS. Mr. President, pending a potential unanimous consent request by the two leaders, I now yield such time as the Senator from Massachusetts desires.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KIRK. I ask unanimous consent to speak as in morning business, the time to be counted postcloture.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The remarks of Mr. KIRK are printed in today's RECORD under "Morning Business.")

Mr. REID. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. UDALL of Colorado). The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, I ask unanimous consent that all postcloture time be considered expired on H.R. 3590 at 8 a.m., Thursday, December 24, if cloture is invoked, and that immediately the bill, as amended, be read a third time, and the Senate vote on passage; that after passage of H.R. 3590, as amended, the Senate then proceed to the immediate consideration of Calendar No. 245, H.R. 4314, an act to permit continued financing of government operations; that no amendments be in order; that the bill be read a third

time, and the Senate then proceed to vote on passage; that passage require an affirmative 60-vote threshold; and if that threshold is achieved, then the motion to reconsider be considered made and laid upon the table; further, that on Wednesday, January 20, 2010, at a time to be determined by the majority leader, following consultation with the Republican leader, the Finance Committee be discharged of H.J. Res. 45, increasing the statutory limit on the public debt and the Senate then proceed to the measure; that immediately after the joint resolution is reported, the majority leader or his designee be recognized to offer a substitute amendment and that the following be the only first-degree amendments in order to the joint resolution: Thune, TARP; Murkowski, endangerment EPA regs; Coburn, rescissions package; Sessions, spending caps; McConnell, relevant to any on the list; Reid, one relevant to any on the list; Reid, pay-go; Baucus, three relevant to any on the list; Conrad-Gregg, fiscal task force; that each of the listed amendments be subject to an affirmative 60-vote threshold and that if any achieve that threshold, then they be agreed to and the motion to reconsider be laid upon the table; that if they do not achieve the 60-vote threshold, then they be withdrawn; that upon disposition of all amendments, the substitute amendment, as amended, if amended, be agreed to, the joint resolution, as amended, be read a third time and the Senate then proceed to vote on passage; further, that passage also be subject to an affirmative 60-vote threshold; further, as in executive session, I ask unanimous consent that on Wednesday, January 20, 2010, after a period of morning business, the Senate proceed to executive session to consider Calendar No. 421, the nomination of Beverly Martin to be a U.S. circuit judge for the Eleventh Circuit; that there be 60 minutes of debate with respect to the nomination, with the time equally divided and controlled between Senators LEAHY and SESSIONS or their designees; that upon the use or yielding back of time, the Senate then proceed to vote on confirmation of the nomination; that upon confirmation, the motion to reconsider be considered made and laid upon the table, no further motions be in order, the President be immediately notified of the Senate's action, and the Senate then resume legislative session.

The PRESIDING OFFICER. Is there objection?

The Republican leader is recognized.

Mr. MCCONNELL. Mr. President, reserving the right to object, and I will not be objecting, I wish to make sure the Senate is aware of an understanding the majority leader and I have that the substitute amendment referred to in paragraph 1 will be limited to an actual amount when it is offered.

Mr. REID. That is right. And if there are any amendments here that pass, of course, they would automatically be part of it.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, reserving the right to object, I wish to inquire whether, under that consent request that is being propounded, secondary amendments would be in order to any of the first-degree amendments on that list.

Mr. REID. No.

Mr. BAUCUS. I do not object.

The PRESIDING OFFICER. Hearing no objection, without objection, it is so ordered.

The Republican leader is recognized.

THANKING SENATE PAGES MARTIN CHARBONEAU AND MIKHAILA FOGEL

Mr. MCCONNELL. Mr. President, I wish to recognize two young pages who are actually on the floor with us today. Martin Charboneau and Mikhaila Fogel are the pages who energetically volunteered to stay until the Senate adjourns and actually have sacrificed some of their Christmas vacation. Also, they both volunteered their service over the weekend before the Thanksgiving break.

We typically have seven pages at a time on each of the sides, the Democratic side and the Republican side, but both Martin and Mikhaila marvelously have worked hard and dutifully, on both sides of the floor—both the Democratic side and the Republican side—to make a 14-person job work with just two people.

One can imagine how hard a task it must be for just two individuals to prepare for the numerous speeches we have had over the course of the past week. I know Senator REID joins me in thanking them for their gracious and impeccable service to the Senate.

The PRESIDING OFFICER. The Senator from North Dakota is recognized.

Mr. CONRAD. Mr. President, I wish to begin by recognizing the work on this legislation of Leader REID, Chairman BAUCUS, Chairman HARKIN, and Chairman DODD.

I believe, when the history of this bill is written, it will be recognized what a remarkable job of leadership Senator REID has provided, bringing together a disparate caucus around extraordinarily complex issues to accomplish something that will be seen in the future as a leap forward for America in reforming the health care system in this country.

Chairman BAUCUS—no one has made a deeper, more committed, personal sacrifice than Senator BAUCUS in advancing this legislation. His commitment to getting this bill done and getting it done right will stand the test of history.

Chairman HARKIN, who succeeded Chairman Kennedy, made major contributions on the wellness provisions.

Chairman DODD, who filled in for Chairman Kennedy and continued in the role of handling this legislation, even while being chairman of the Banking Committee, provided an example of legislative leadership that is unmatched.

The four of them have done a superb job in putting together the pieces of the bill that I believe will lead the way to a dramatically improved health care system in our country.

If we reflect, objectively, on the package before us, it is an entirely reasonable and responsible approach. There is no government takeover of health care, no rationing, no cuts to guaranteed Medicare benefits, no benefits for illegal immigrants, and the bill sets a goal of no taxpayer funding for abortion beyond the Hyde amendment provisions in current law.

In fact, this bill does much of what Republicans said they want in a health care plan. It is fully paid for, and it reduces deficits in both the short and the long term. It expands coverage and provides assistance to help families and small businesses afford health insurance. It sets new rules to stop insurance company abuses. It reforms the delivery system to control costs and improve quality. It allows for the sale of insurance across State lines. It supports medical malpractice reforms.

Those are facts. Every one of those elements is in this bill. This is an approach that Senators on both sides of the aisle, who want solutions rather than slogans, should embrace.

The need to act is clear. The status quo is simply unsustainable. Health care costs are crushing families, businesses, and even the government. The premiums for individuals and families are rising three times as fast as wages. You can see where we are headed. It is as clear as it can be.

Without action, families will see average health care premiums rise to \$22,000 a family by 2019—\$22,000, on average, for family health care premiums in 2019, unless we act.

It does not stop there. Premiums, as I have indicated, are skyrocketing, and national health care costs are skyrocketing right along with them. Without action, total health care spending will equal 38 percent of the gross domestic product of the country by 2050. Thirty-eight percent of the gross domestic product for health care? That would be one in every two and half dollars in this economy. Already, we are consuming one in every six in this economy on health care, and that is an unsustainable course. These costs are driving our long-term fiscal imbalances, threatening our future economic prosperity.

Without action, Federal spending on Medicare and Medicaid will reach 12.7 percent of GDP by 2050. This chart I have in the Chamber makes it very clear. In 1980, the two programs were

consuming 2 percent of gross domestic product, but on the current trend line, by 2050, these two—Medicare and Medicaid—will consume more than 12 percent of our GDP—one in every eight dollars in our economy.

The growth in health care costs threatens to bankrupt Medicare. Medicare went cash negative last year. Without action, Medicare will be bankrupt in 2017. The trustees have just told us that will happen. That is 2 years earlier than forecast just last year. Again, Medicare went cash negative already. That means more money is going out than is coming in, in the Medicare accounts, and it will be insolvent—broke—in 8 years. This legislation extends its life by 9 years.

These health care costs are hurting our competitive position in the world. We are spending far more than other countries on health care, leaving less money for research and development, investment, and higher wages for Americans. In fact, as a percentage of our gross domestic product, we spend twice as much as most other advanced countries.

Here it is, as shown on this chart. We are now even higher than 16 percent of our GDP. The latest numbers indicate we have gone to 17 percent of our GDP for health care. That is one in every six dollars. Look at other countries. Japan and the United Kingdom are half as much; Belgium, Germany, Switzerland, France, a little over half as much as we are paying.

But even with the fact that we are spending more, we are actually performing worse on virtually every metric on health care outcomes. We are ranked 19th in preventable deaths, 22nd in infant mortality, 24th in life expectancy; and we still leave 46 million people without insurance.

Continuing the status quo is not an option. America can do better, and this bill proves it. The bill before us is fiscally responsible. The nonpartisan Congressional Budget Office—the official scorekeeper, relied on by both sides of the aisle—tells us the bill reduces the deficit by \$130 billion over the first 10 years.

Now, those aren't my numbers, those aren't the numbers of the chairman of the Finance Committee, those aren't the Democratic leader's numbers. Those are the numbers of the nonpartisan Congressional Budget Office. They say this bill will reduce the deficit by \$130 billion over the first 10 years.

The savings in the following decade are even more impressive: between \$650 billion and \$1.3 trillion. The Congressional Budget Office says:

All told, CBO expects that the legislation, if enacted, would reduce Federal budget deficits over the decade after 2019 relative to those projected under current law—with a total effect during that decade that is in a broad range between one-quarter percent and one-half percent of gross domestic product.

One-quarter and one-half percent of GDP for that second 10 years is \$650 billion to \$1.3 trillion. Shame on those who get up on the other side and say this is going to increase the deficit. Where is their evidence, other than claims, other than assertions? We are talking about the considered judgment of the Congressional Budget Office that is nonpartisan and is the official scorekeeper for the Congress of the United States.

The bill bends the cost curve for the Federal commitment to health care in the long term. In its December 19 estimate, CBO reports that the proposal would generate a reduction in the Federal budgetary commitment to health care during the decade following the 10-year budget window. So, yes, it bends the cost curve for the Federal expenditure during that period.

This legislation also reforms the insurance market. We have all heard the horror stories. I have loads of letters in my office from constituents telling me about what has happened to them: being dropped because they got sick, even after paying years of premiums; being denied coverage because of pre-existing conditions, in many cases pre-existing conditions that had nothing to do with the illness for which they now need assistance; and being denied even though they have paid the premiums. This is serious business.

This bill puts a stop to these abuses. It prohibits insurers from denying coverage for preexisting conditions on new policies. It prohibits insurers from rescinding coverage when people become sick after they have paid premiums for years on new plans. It bans insurers from lifetime caps and annual limits on health care benefits, and it prevents insurers from charging more based on health status.

It also expands choice and competition. The bill before us builds on our current market-based system and makes it better. It is not government-run health care. Instead, it embraces choice and competition. It sets up a new health exchange where consumers can shop for the best value. It creates consumer-run, co-op health plans not government-run plans but plans run by the members. It allows for insurance sales across State lines to further increase competition.

The managers' amendment also creates a new national plan. The Office of Personnel Management, the same agency that currently oversees health plans for all Federal employees, including Members of Congress, would select private health insurance carriers to offer plans that would be available nationwide. These plans would provide new competition for State-based health plans, particularly in areas where just one or two insurers currently dominate the market. At least one multistate plan would have to be a not-for-profit

insurer, such as one of the newly created co-ops. I am particularly excited by this development.

When we look around the world at the countries with the best outcomes and the lowest cost, one feature stands out: these countries rely on primarily not-for-profit insurance. Germany, France, Switzerland, Belgium, Japan, all have adopted this model. They don't have government-run health care, but they do have universal coverage. They do have extremely high-quality health care outcomes and much lower costs than we do. So I believe the not-for-profit national plans and the co-op option may, in the long run, play a key role in transforming our system into a more efficient, higher quality system.

This legislation also expands coverage. According to the Congressional Budget Office, it covers 94 percent of the American people. It creates State-based exchanges for individuals and small businesses. It provides \$476 billion in tax credits to help working Americans and small businesses buy coverage. You don't hear that much from the other side about this \$467 billion of tax assistance for people to afford better health care coverage. It also reforms the delivery system to focus on quality and not quantity. The bill before us slows cost growth while improving quality. The sad fact is that 30 percent of current health care spending does nothing to improve health care outcomes. We are wasting about \$750 billion a year on unnecessary and counterproductive procedures. Again, that is not a congressional estimate; that comes from a Dartmouth nationwide survey that concluded 30 percent of health care expenditure in this country is wasted. This bill reforms the delivery system in a fundamental way. It contains every delivery system reform health care experts believe is needed to provide better care while slowing cost growth.

This proposal also extends the solvency of Medicare. Medicare's actuary says the Senate bill extends the life of Medicare by 9 years. Some on the other side say that because Medicare is heading toward insolvency, we can't have Medicare savings. What? What are they talking about?

Perhaps the oddest thing I have seen in this debate is the contrast with the last year of the Bush administration. The previous administration sent up a proposal to have nearly \$500 billion in savings under Medicare, and we didn't hear one peep from the other side, not one. In fact, they all said it was critically important to do. Now all of a sudden it is the death of Medicare.

What is even more bizarre about their argument is that now there is an offset for the savings from Medicare providers. The offset is they are going to get 30 million new customers, 30 million Americans who haven't had insurance who will now have it so their un-

compensated care costs will go down, making it more affordable for providers to provide these savings.

Most of these savings have been negotiated with providers. Why have they been willing to agree to savings—hospitals, nursing homes, and home health care? It is because they know they are going to get substantially expanded business—30 million customers with insurance who previously did not.

This is important legislation. These Medicare reforms don't hurt seniors. Some on the other side have said you can't reduce the growth in Medicare costs without taking benefits away from seniors. That is just scare tactics. The Medicare savings provisions lower cost growth without harming beneficiaries.

This legislation also helps my State. I am proud to say it. Some have said the Medicare changes will hurt North Dakota providers. Clearly, they haven't read the bill. Right now, we get paid way below the average for Medicare reimbursement. In fact, we are the second or third lowest State in the country in Medicare reimbursement. North Dakota providers get \$5,000 a year per Medicare beneficiary.

In Miami, they get three times as much, more than \$16,000 a year to take care of seniors there. Now I would be the first to say it may cost more to provide medicine in Miami than it does in Minot, but it doesn't cost three times as much. The fact is, moving to a system that is based on outcomes rather than procedures will benefit, not hurt, a State such as North Dakota.

In addition, this legislation includes the frontier States provision that Senator DORGAN and I offered as an amendment. Our provision puts a floor under payments to North Dakota providers and in other States like ours that are rural States that have not received fair levels of reimbursement. It will mean an additional \$66 million a year in Medicare payments to my State.

Overall, this bill is a win for North Dakota, a win for the Nation. It reduces the deficit, it controls costs, it saves Medicare—or at least extends its life for at least 9 years—it embraces choice for American consumers and competition and expands coverage. It reforms the insurance industry, and it rewards quality and efficiency.

This legislation is an excellent start. I urge my colleagues to allow it to continue because we all know this isn't the last step. Next we go to the conference committee where we will have a chance to write the final legislation. No doubt this bill will be further improved as it has been at every step of the process.

Again, let me conclude as I began by thanking the leadership who has made this bill a possibility: Senator REID, who has done a remarkable job of bringing people together; Senator BAUCUS, who has spent more than a year

and a half in as dedicated an effort as I have ever seen by a committee chairman in this body to bring major legislation to conclusion; Senator DODD, who filled in for Senator Kennedy on a pinch hit basis but worked so hard to produce a result in that committee; and Senator HARKIN, the new chairman of the committee, for all of his assistance in getting the job done.

When the history of this legislation is written, those four will be recognized as producing something that was critically important for this country. We should salute them.

I thank the Chair and yield the floor.

Mr. BAUCUS. Mr. President, I very much thank my good friend from North Dakota for his generous statements. As he knows, this is all teamwork. We are all in this together, all Senators, especially on this side of the aisle, with the President, to get health care reform finally passed for all Americans. Teddy Roosevelt started this many years ago, and many Presidents since have been unable to get health care reform passed. I think finally this time we are going to do it, and it is a moment of which we are all very proud.

Mr. President, I yield the remainder of my time to the Senator from Washington. I don't know how much that is, but whatever it is, it is all hers.

The PRESIDING OFFICER. The Senator from Montana has 7½ minutes remaining.

The Senator from Washington is recognized.

Mrs. MURRAY. Mr. President, I thank my colleague from Montana, the chairman of the Finance Committee, who, I remember, months ago, with a smile on his face, said we can get this done. We are on the verge, and we owe him a huge debt of gratitude. So I thank the Senator very much.

As this debate now moves forward, it has become apparent that some of our colleagues are losing sight of what we are working on. What should be a robust debate about a critical issue that is facing all of our families and businesses is being bogged down by distractions and political gimmicks and obstructions and a lot of delay while American families watch and wait and wonder where they exactly fit into this conversation. So I want to be clear with my colleagues and with Americans across the country today: This bill is about you. It is about your loved ones. It is about the people just like you across the country to bring down your premiums, expand your options, and increase your stability.

It is about helping our economy and creating jobs by reducing the drag that has been created by the skyrocketing premiums and unlocking the potential for new health care careers. It is about supporting the doctors and the nurses, the hospitals and the clinics that work every day to take care of you. It is about helping you or your father or

your mother, your grandfather or your grandmother, by increasing benefits, cutting waste, and strengthening the Medicare on which you depend. And it is about Katerina.

Katerina is a woman from Redmond, WA, and she is one of my more than 10,000 constituents from my home State who have sent me their stories about their experiences with our broken health care system. Katerina is a single mom. She has a good education, she told me, and she has a good job and a solid middle-class lifestyle. But like a lot of Americans this year, struggling in the toughest economy since the Great Depression, she was laid off from her job, and she lost her employer-provided health care. She was able to scrape enough money together to pay for COBRA coverage, but she told me she didn't dare go to the doctor because she knew she wouldn't be able to afford the copays. So though she was technically covered right now, in practice, neither she nor her child have access to true health care or preventive services. She found that living that way had some real consequences.

Last month she told me she got an eye infection and eventually had to go to the doctor for treatment. She said after all of her out-of-pocket costs and still with no job and no income, she had to make some very serious and very tough choices about her family's food and clothing budget. Who knows what would have happened if Katerina or her child got seriously ill.

Our broken health insurance system is failing Katerina, and she is not alone. Millions of people have lost jobs in this current recession.

Millions of families have been tossed out of their employers' plans—families who had health care, who felt secure, all of a sudden understand how broken the system really is and how few options they actually have today for affordable care. That is why we need health insurance reform for Katerina and millions of Americans in similar situations and the hundreds of millions of Americans who may switch jobs or move or start small businesses or who just want more options for high-quality affordable health care.

Mr. President, let me talk for a minute about how this bill will specifically help Katerina and many others. Our plan sets up a market where people can shop for and purchase insurance, where insurance companies would have to compete for your business, and where people such as Katerina would be able to choose a plan that fits her family best from among a range of options in an open marketplace.

It would inject competition into the insurance market, it will lower costs, and it will give families, such as Katerina's, more choices. That means instead of just having one choice when she is laid off, which was to purchase high-priced COBRA, Katerina will be

able to compare the price and performance of plans and make a decision for her family with the benefit of true options.

That will increase stability and keep insurance companies accountable. Never again will insurance companies be able to drop a family's plan simply because somebody got sick. No longer will losing your job mean losing access to affordable coverage, and no longer will people such as Katerina have to choose between food, clothing, and health care for herself and her child.

It will also keep families secure by ensuring that all insurance plans offer an adequate level of coverage, including free preventive care that will keep them healthy and ensure that minor, inexpensive medical issues can be treated before they become major, expensive medical problems.

Our plan will increase options, enhance security and stability, and it will reduce costs for people such as Katerina by providing credits and premium assistance. So families will no longer have to worry about their coverage if they lose a job, switch jobs, move, or get sick.

Mr. President, that is what this plan is about. It is about Katerina, it is about her child, and it is about the millions of Americans in similar situations.

If the status quo wins out, things will only get worse. If some of my colleagues continue to play politics with this issue, Katerina will continue to struggle.

If we continue to have delay and distraction and obstruction, families will pay more for less, they will lose coverage, and they will be denied treatment and continue to have to fight insurance company redtape to get the care they deserve.

That is what this is all about. I am going to continue to stand up and tell the stories of families and small business owners from Washington because they are counting on us to fix this broken system. I urge my colleagues to focus on their States' families and join with us to pass true health insurance reform.

Before I yield, I want to take this opportunity to make an additional point. As everybody knows, we have been working incredibly demanding schedules in recent weeks. Senators have seen this floor at every conceivable hour—late at night, early in the morning, in the face of a blizzard. Far too frequently, we forget that every time we are here, there are literally hundreds of staff forced to be here along with us. In fact, they are often here long before we arrive and long after we leave. This body could not function without the tireless dedication of these men and women.

Many of them are here now: the clerks, Parliamentarians, cloakroom staff, doorkeepers, Capitol Police offi-

cers, and the maintenance workers. They work very long hours, nights, mornings, and weekends—with no regard to a government closure, dangerous snowstorms, or the need to complete their holiday shopping. If we are here, they are here. They deserve our thanks.

I want to express my gratitude to every one of them and to my own staff as well. It hasn't been an easy time. You should all know we are deeply appreciative of your service.

I, for one, am strongly supportive of bringing this debate to a close so that each one of you can be home with your families enjoying some well-deserved time off for the holidays.

I yield the floor.

FURTHER CHANGES TO S. CON. RES. 13 PURSUANT

Mr. CONRAD. Mr. President, section 301(a) of S. Con. Res. 13, the 2010 budget resolution, permits the chairman of the Senate Budget Committee to adjust the allocations of a committee or committees, aggregates, and other appropriate levels and limits in the resolution, and make adjustments to the pay-as-you-go scorecard, for legislation that is deficit-neutral over 11 years, reduces excess cost growth in health care spending, is fiscally responsible over the long term, and fulfills at least one of eight other conditions listed in the reserve fund.

I have already made two adjustments pursuant to section 301(a). The first adjustment was on November 21, for S.A. 2786, the Patient Protection and Affordable Care Act, an amendment in the nature of a substitute to H.R. 3590. The second adjustment was on December 1, for S.A. 2791, an amendment to S.A. 2786 to clarify provisions relating to first dollar coverage for preventive services for women.

The Senate today adopted S.A. 3276, an amendment to S.A. 2786 to improve the bill. I find that in conjunction with S.A. 2786, as modified, that this amendment also satisfies the conditions of the deficit-neutral reserve fund to transform and modernize American's health care system. Therefore, pursuant to section 301(a), I am further revising the aggregates in the 2010 budget resolution, as well as the allocation to the Senate Finance Committee. Along with those adjustments, I have also adjusted the aggregates and committee allocation to reflect changes to the original score of S.A. 2786 as a result of a provision included in H.R. 3326, the Department of Defense Appropriations Act, 2010. That provision uses savings also counted in the score of S.A. 2786. In total, as a result of Congress clearing H.R. 3326 on December 19, the amount of savings in S.A. 2786 is \$1 billion lower over the 2010–2014 period.

I ask unanimous consent to have printed in the RECORD the following revisions to S. Con. Res. 13.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 301(a) DEFICIT-NEUTRAL RESERVE FUND TO TRANSFORM AND MODERNIZE AMERICA'S HEALTH CARE SYSTEM

(In billions of dollars)

Section 101	
(1)(A) Federal Revenues:	
FY 2009	1,532.579
FY 2010	1,614.258
FY 2011	1,936.811
FY 2012	2,140.785
FY 2013	2,321.087
FY 2014	2,563.018
(1)(B) Change in Federal Revenues:	
FY 2009	0.008
FY 2010	-51.728
FY 2011	-151.820
FY 2012	-219.608
FY 2013	-194.250
FY 2014	-70.640
(2) New Budget Authority:	
FY 2009	3,675.736
FY 2010	2,905.487
FY 2011	2,845.236
FY 2012	2,835.568
FY 2013	2,988.308
FY 2014	3,206.647
(3) Budget Outlays:	
FY 2009	3,358.952
FY 2010	3,017.021
FY 2011	2,965.551
FY 2012	2,867.235
FY 2013	2,993.112
FY 2014	3,184.357

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 301(a) DEFICIT-NEUTRAL RESERVE FUND TO TRANSFORM AND MODERNIZE AMERICA'S HEALTH CARE SYSTEM

(In millions of dollars)

Current Allocation to Senate Finance Committee:	
FY 2009 Budget Authority	1,178,757
FY 2009 Outlays	1,166,970
FY 2010 Budget Authority	1,249,836
FY 2010 Outlays	1,249,342
FY 2010–2014 Budget Authority	6,824,817
FY 2010–2014 Outlays	6,818,925
Adjustments:	
FY 2009 Budget Authority	0
FY 2009 Outlays	0
FY 2010 Budget Authority	-5,220
FY 2010 Outlays	-6,670
FY 2010–2014 Budget Authority	20,950
FY 2010–2014 Outlays	3,720
Revised Allocation to Senate Finance Committee:	
FY 2009 Budget Authority	1,178,757
FY 2009 Outlays	1,166,970
FY 2010 Budget Authority	1,244,616
FY 2010 Outlays	1,242,672
FY 2010–2014 Budget Authority	6,845,767
FY 2010–2014 Outlays	6,822,645

Mr. LEAHY. Mr. President, the urgent need for comprehensive reform of our health care system has not stopped opponents from launching spurious attacks. I understand that the junior Senator from Nevada recently raised a constitutional point of order against the pending health care reform bill. As chairman of the Senate Judiciary Committee, I would like to respond to those who have called into question whether Congress has the authority under the Constitution to enact health insurance reform legislation. The authority of

Congress to act is well-established by the text and the spirit of the Constitution, by the long-standing precedent established by our courts, by prior acts of Congress and by the history of American democracy. The legislative history of this important measure should leave no doubt with respect to the constitutionality of our actions.

The Constitution of the United States begins with a preamble that sets forth the purposes for which "We the People of the United States" ordained and established it. Among the six purposes set forth by the Founders was that the Constitution was established to "promote the general Welfare." It is hard to imagine an issue more fundamental to the general welfare of all Americans than their health.

The authority and responsibility for taking actions to further this purpose is vested in Congress by article I of the Constitution. In particular article I, section 8, sets forth several of the core powers of Congress, including the "general welfare clause," the "commerce clause" and the "necessary and proper clause." These clauses form the basis for Congress's power, and include authority to reform health care by containing spiraling costs and ensuring its availability for all Americans. The necessary and proper clause of the Constitution provides that "The Congress shall have Power . . . To make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers, and all other Powers vested by this Constitution in the Government of the United States or in any Department or Officer thereof."

Any serious questions about congressional power to take comprehensive action to build and secure the social safety net have been settled over the past century. According to article I, section 8, "The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defense and general Welfare of the United States." This clause has been the basis for actions by Congress to provide for Americans' social and economic security by passing Social Security, Medicare and Medicaid. Those landmark laws provide the well-established foundation on which Congress builds today by seeking to provide all Americans with access to quality, affordable health care.

The Supreme Court settled the debate on the constitutionality of Social Security more than 70 years ago in three 1937 decisions. In one of those decisions, *Helvering v. Davis*, Justice Cardozo wrote that the discretion to determine whether a matter impacts the general welfare "is not confided in the courts" but falls "within the wide range of discretion permitted to the Congress." Turning then to the "nation-wide calamity that began in 1929" of unemployment spreading from State to State throughout the Nation, leav-

ing older Americans without jobs and security, Justice Cardozo wrote of the Social Security Act: "The hope behind this statute is to save men and women from the rigors of the poor house as well as from the haunting fear that such a lot awaits them when journey's end is near."

The Supreme Court reached its decisions upholding Social Security after the first Justice Roberts—Justice Owen Roberts—in the exercise of good judgment and judicial restraint began voting to uphold the key New Deal legislation. He was not alone. It was Chief Justice Hughes who wrote the Supreme Court's opinion in *West Coast Hotel v. Parrish* upholding minimum wage requirements as reasonable regulation. The Supreme Court also upheld a Federal farm bankruptcy law, railroad labor legislation, a regulatory tax on firearms and the Wagner Act on labor relations in *National Labor Relations Board v. Jones & Laughlin Steel Corporation*. The Supreme Court abandoned its judicially created veto over congressional action with which it disagreed on policy grounds and rightfully deferred to Congress's constitutional authority.

Congress has woven America's social safety net over the last three score and 12 years. Congress's authority to use its power and its judgment to promote the general welfare cannot now be in doubt. America and all Americans are the better for it. Growing old no longer means growing poor. Being older or poor no longer means being without medical care. These developments are all due to congressional action.

These Supreme Court decisions and the principles underlying them are not in question. As dean Erwin Chemerinsky of the University of California Irvine School of Law wrote in a recent op-ed in *The Los Angeles Times*: "Congress has broad power to tax and spend for the general welfare. In the last 70 years, no federal taxing or spending program has been declared to exceed the scope of Congress' power. The ability in particular of Congress to tax people to spend money for health coverage has been long established with programs such as Medicare and Medicaid." I will ask that this article be printed in the RECORD following my remarks.

The right-wing opponents of health care reform are so intent on partisan warfare that they are even calling into question the constitutionality of America's established social safety net. They would leave American workers without the protections their lifetime of hard work have earned them. They would turn back the clock to the hardships of the Great Depression, and thrust modern American back into the conditions of Dickens' novels. That is what some extremists will be urging another Justice Roberts—Chief Justice John Roberts—to do. That path should

be rejected now, just as it was when another inspiring President led the effort to confront the economic challenges facing Americans. To strike down principles that have been settled for nearly three quarters of a century would be wrong and damaging to the Nation.

For months now, we have been debating whether or not to pass health care reform. We can debate whether to control costs by having all Americans be covered by health insurance. In fact, we have been having that debate for months and months in this Congress, through extensive public markups in two committees in the Senate, as well as in the House of Representatives, and now for weeks on the Senate floor. We have considered untold numbers of amendments in committees and several before the Senate. That is what Congress is supposed to do. We consider legislation, debate it, vote on it and act in our best collective judgment to promote the general welfare. Some Senators will agree and some will disagree, but it is a matter for the full Senate to decide. I wish we could do so by a majority but Senate Republicans abhor majority rule now that they are not in control. So it will take an extraordinary majority for the Senate's will to be done.

Tomorrow, we will vote on a point of order challenging the pending bill's constitutionality. The fact that Senate Republicans disagree with the majority's effort to help hardworking Americans obtain access to affordable health care does not make it unconstitutional. As Justice Cardozo wrote in upholding Social Security, "whether wisdom or unwisdom resides in the scheme of benefits set forth . . . it is not for us to say. The answer to such inquiries must come from Congress, not the courts." I agree. Justice Cardozo understood the separation of powers enshrined in the Constitution and the Supreme Court's precedent. In 1803, our greatest Chief Justice, John Marshall, upheld the constitutionality of the Judiciary Act in *Stuart v. Laird* noted that "there are no words in the Constitution to prohibit or restrain the exercise of legislation power." That is true here, where Congress is acting to provide for the general welfare of all Americans.

I believe that Congress can and should decide whether the problems of the lack of availability and affordability of health care, and the rising health care costs that burden the American people, is a problem, "plainly national in area and dimensions," as Justice Cardozo wrote of the widespread crisis of unemployment and insecurity during the Great Depression. I believe that it is right for this Congress to determine that it is in the general welfare of the Nation to ensure that all Americans have access to affordable quality health care. But whether other Senators agree or dis-

agree with me, none should argue that we should take steps that turn back to clock to the Great Depression when conservative activist judges prevented Congress from exercising its powers to make that determination. As Chief Justice Marshall wrote in his landmark decision in *McCulloch v. Maryland*: "Let the end be legitimate, let it be within the scope of the Constitution, and all means which are appropriate, which are plainly adopted to that end, which are not prohibited, but consistent with the letter and spirit of the Constitution, are constitutional."

In seeking to discredit health care reform, the other side relies on a resurrection of long-discredited legal doctrines used by courts a century ago to tie Congress's hands by substituting their own views of property to strike down laws such as those guaranteeing a minimum wage and outlawing child labor. They have to rely on such cases of unbridled conservative judicial activism as *Lochner v. New York*, *Shechter Poultry Corporation v. United States*, *Reagan v. Farmers Loan and Trust* and the infamous *Dred Scott* case. Those dark days are long gone and better left behind. The Constitution, Supreme Court precedent, our history and congressional action all stand on the side of Congress's authority to enact health care legislation including health insurance reform.

Under article I, section 8, Congress has the power "to regulate Commerce with foreign Nations, and among the several States." Since at least the time of the Great Depression and the New Deal, Congress has been understood and acknowledged by the Supreme Court to have power pursuant to the commerce clause to regulate matters with a substantial effect on interstate commerce. The Supreme Court has long since upheld laws like the Fair Labor Standards Act against commerce clause challenges, ruling that Congress had the authority to outlaw child labor. The days when women and children could not be protected, when the public could not be protected from sick chickens infecting them, when farmers could not be protected and when any regulation that did not guarantee profits to corporations are long past. The reach of Congress's commerce clause authority has been long established and well settled.

Even recent decisions by a Supreme Court dominated by Republican-appointed justices have affirmed this rule of law. In 2005, the Supreme Court ruled in *Gonzales v. Raich* that Congress had the power under the commerce clause to prohibit the use of medical marijuana even though it was grown and consumed at home, because of its impact on the national market for marijuana. Surely if that law passes constitutional muster, Congress's actions to regulate the health care market that makes up one-

sixth of the American economy meets the test of substantially affecting commerce. Conservatives cannot have it both ways. They cannot ignore the settled meaning of the Constitution as well as the authority of the American people's elected representatives in Congress.

The regulation of health insurance clearly meets the test from *Raich*, whether the activities "taken in the aggregate, substantially affect interstate commerce." Addressing these problems is at the core of Congress's powers under the commerce clause. In fact, the Supreme Court expressly addressed this issue 65 years ago, ruling in 1944 that insurance was interstate commerce and subject to Federal regulation. Congress responded to this decision in 1945 with the McCarran-Ferguson Act, which gave insurance companies an exemption from antitrust laws unless Federal regulation was made explicit under Federal law. It is the immunity from Federal antitrust law enacted in McCarran-Ferguson that I have been working to overcome with my Health Insurance Industry Antitrust Enforcement Act of 2009 and the amendment I have sought to offer to the current health insurance reform legislation. Why would this exemption have been necessary if insurance was not interstate commerce? I strongly believe that the exemption in McCarran-Ferguson is wrongheaded but would anyone seriously contend that it is unconstitutional? Of course not. That is why I am working so hard to pass legislation to repeal it.

The legislation and amendment I have sponsored will prohibit the most egregious anticompetitive conduct—price fixing, bid rigging and market allocations—conduct that harms consumers, raises health care costs, and for which there is no justification. Subjecting health and medical malpractice insurance providers to the Federal antitrust laws will enable customers to feel confident that the price they are being quoted is the product of a fair marketplace. The lack of affordable health insurance plagues families throughout our country, and my amendment would take a step toward ensuring competition among health insurers and medical malpractice insurers. The need for Congress to repeal the out of date Federal antitrust law exemption only further demonstrates the tremendous impact of health care on our economy and congressional power to act.

The third clause of article I, section 8, to which I have referred, is the necessary and proper clause, as a basis for congressional action. This clause gives Congress the power "to make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers and all other Powers vested by this Constitution in the United States." The Supreme Court settled

the meaning of the necessary and proper clause 190 years ago in Justice Marshall landmark decision in *McCullough v. Maryland*, during the dispute over the National Bank. Justice Marshall wrote that “the clause is placed among the powers of Congress, not among the limitations on those powers.” The necessary and proper clause goes hand in hand with the commerce clause to ensure congressional authority to regulate activity with a significant economic impact.

We face a health care crisis, with millions of Americans uninsured and with uncertainty and high costs for Americans who are insured. We need to ensure that Americans not risk bankruptcy and disaster with every illness. Americans who work hard their whole life should not be robbed of their family's security because health care is too expensive. During the New Deal we charted a path for America where growing old did not mean being poor, or being without health care. Americans should not lose their life savings because they have the misfortune of losing a job or getting sick. That is not America.

The success of the last century was the establishment of a social safety net for which all Americans can be grateful and proud. Through Social Security, Medicare and Medicaid, Congress established some of the cornerstones of American security. They are within the constitutional authority of the Congress just as health insurance reform is. No conservative activist court should overstep the judiciary's role by seeking to turn back the clock and deny a century of progress. The authority of Congress is well settled and well established by the Constitution, judicial precedent, and our history of legislation promoting the general welfare and protecting the economic security and health of Americans.

The cumulative economic effects on the Nation of the rising costs of health care are significant, with those costs making up a large percentage of our economy and with American businesses struggling to provide benefits to their employees. As set forth in a paper by Georgetown University and the O'Neill Institute for National and Global Health Law, the requirement for individuals to purchase health insurance would address the problem of free riders, millions of Americans who refuse to buy health insurance and then rely on expensive emergency health care when faced with medical problems. This shifts the costs of their health care to people who do have insurance, which in turn has a significant effect on the costs of insurance premiums for covered Americans and on the economy as a whole. A requirement that all Americans have health insurance—like requirements to be vaccinated or to have car insurance or to register for the draft or to pay taxes—is within

congressional power if Congress determines it to be essential to controlling spiraling health care costs. Requiring that all Americans have health insurance coverage, and preventing some from depending on expensive emergency services in place of regular health care, can and will help reduce the cost of health insurance premiums for those who already have insurance.

Whether Senators agree or not on the necessity to reform our health care system and health insurance, I trust that all Senators, Republican, Democratic and Independent, agree that it is our responsibility to act and within Congress's constitutional authority to legislate for the general welfare of all Americans.

Mr. President, I ask unanimous consent to have printed in the RECORD the Los Angeles Times op-ed to which I referred.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Los Angeles Times, Oct. 6, 2009]

THE CONSTITUTIONALITY OF HEALTHCARE
(By Erwin Chemerinsky)

Are the healthcare bills pending in the House and Senate unconstitutional?

That's what some of the bills' critics have alleged. Their argument focuses on the fact that most of the major proposals would require all Americans to obtain healthcare coverage or pay a tax if they don't. Those too poor to afford insurance would have their health coverage provided by the state.

Although the desirability of this approach can be debated, it unquestionably would be constitutional.

Those who claim otherwise make two arguments. First, they say the requirement is beyond the scope of Congress' powers. And second, they say that people have a right to be uninsured and that requiring them to buy health insurance violates individual liberty. Neither argument has the slightest merit from a constitutional perspective.

Congress has broad power to tax and spend for the general welfare. In the last 70 years, no federal taxing or spending program has been declared to exceed the scope of Congress' power. The ability in particular of Congress to tax people to spend money for health coverage has been long established with programs such as Medicare and Medicaid.

Congress has every right to create either a broad new tax to pay for a national healthcare program or to impose a tax only on those who have no health insurance.

The reality is that virtually everyone will, at some point, need medical care. And, if a person has certain kinds of communicable diseases, the government will insist that he or she be treated whether they are insured or not. A tax on the uninsured is a way of paying for the costs of their likely future medical care.

Another basis for the power of Congress to impose a health insurance mandate is that the legislature is charged with regulating commerce among the states. The Supreme Court has held that this means Congress has the ability to regulate activities that have a substantial effect on interstate commerce. A few years ago, for example, the court held that Congress could prohibit individuals from cultivating and possessing small

amounts of marijuana for personal medicinal use because marijuana is bought and sold in interstate commerce.

The relationship between healthcare coverage and the national economy is even clearer. In 2007, healthcare expenditures amounted to \$2.2 trillion, or \$7,421 a person, and accounted for 16.2% of the gross domestic product.

The claim that individuals have a constitutional “right” to not have health insurance is no stronger than the objection that this would exceed Congress' powers. It is hard to even articulate the constitutional right that would be violated by requiring individuals to have health insurance or pay a tax.

Since the 19th century, the Supreme Court has consistently held that a tax cannot be challenged as an impermissible taking of private property for public use without just compensation. All taxes, of course, are a taking of private property for public use, and a tax to pay for health coverage—whether imposed on all Americans or just the uninsured—is certainly something Congress could impose.

The claim that an insurance mandate would violate the due process clause is also specious. Most states have a requirement for mandatory car insurance, and every challenge to such mandates has been rejected. More important, since 1937, the Supreme Court has constantly held that government regulations of property and the economy will be upheld as long as they are reasonable. Virtually every economic regulation and tax has been found to meet this requirement. A mandate for health coverage would meet this standard, which is so deferential to the government.

Finally, those who object to having health coverage on freedom-of-religion grounds also have no case. The Supreme Court has expressly rejected objections to paying Social Security and other taxes on religious grounds. More generally, the Supreme Court has ruled that individuals do not have a right to an exemption from a general law on the ground that it burdens their religion.

There is much to debate over healthcare reform and how to achieve it. But those who object on constitutional grounds are making a faulty argument that should have no place in the debate over this important public issue.

Mrs. FEINSTEIN. Mr. President, I rise to discuss an amendment to create a medical insurance rate authority and rate review process that I filed to the Patient Care and Affordable Choice Act.

Unfortunately, because of the objections of one of my colleagues, my amendment was not included in the final bill before us today.

I am profoundly disappointed. I would like to take a few minutes to discuss why I believe this proposal is so important and why, without it, we can expect to see skyrocketing health insurance premiums.

I am very concerned that health insurance companies will seek to exploit the time between passage of the bill, and 2014, when reforms are fully in place.

Credit card companies provide a useful example. Earlier this year, Congress approved major credit card reform legislation. However, the consumer protections it contains will not be fully effective until February 2010.

Credit card companies have taken full advantage of this interim period to raise rates, with many card interest rates increasing 20 percent over the last year.

I am very worried that health insurance companies will do the very same thing. And I believe the rate authority amendment is essential to stopping them.

In some States, insurance commissioners have the authority to review rates and increases and block rates that are found to be unjustified. According to a 2008 Families USA report, 33 States have some form of a prior approval process for premium increases.

The same report describes several notable successes among States that use this process, including . . . regulators in North Dakota were able to reduce 37 percent of the proposed rate increases filed by insurers. Maryland used their State laws to block a 46-percent premium increase after a company charged artificially low rates for 2 years. The decision was upheld in court. New Hampshire regulators were able to reduce a proposed 100 percent rate increase to 12.5 percent.

But in other States, including California, insurance commissioners do not have this ability.

And some states have laws like this on the books, but do not have sufficient resources to review all the rate changes that insurance companies propose.

Consumers deserve full protection from unfair rate increases, no matter where they live.

The amendment I have proposed would ensure that all Americans have some level of basic protection. The amendment will strengthen a provision included in the underlying bill, which already requires insurance companies to submit justifications and explain increases in premiums. They must submit these justifications to the Secretary of Health and Human Services, and they must make these justifications available on their Web site.

I believe we must do more.

The amendment asks the National Association of Insurance Commissioners to produce a report detailing the rate review laws and capabilities in all 50 States. The Secretary of HHS will then use these findings to determine which States have the authority and capability to undertake sufficient rate reviews to protect consumers.

In States where insurance commissioners have authority to review rates, they will continue to do so.

In States without sufficient authority or resources, the Secretary of HHS will review rates and take any appropriate action to deny unfair requests.

This could mean blocking unjustified rate increases, or requiring rebates, if an unfair increase is already in effect.

This will provide all American consumers with another layer of protection from an unfair premium increase.

The amendment would also require the Secretary of Health and Human Services to establish a medical insurance rate authority as part of the process in the bill that enables her to monitor premium costs.

The rate authority would advise the Secretary on insurance rate review and would be composed of seven officials that represent the full scope of the health care system including: at least two consumers; at least one medical professional; and one representative of the medical insurance industry.

The remaining members would be experts in health economics, actuarial science, or other sectors of the health care system.

The rate authority will also issue an annual report, providing American consumers with basic information about how insurance companies are behaving in the market. It will examine premium increases, by plan and by State, as well as medical loss ratios, reserves and solvency of companies, and other relevant behaviors.

This data will give consumers better information. But more importantly, it will give the newly created insurance exchanges better information.

Under the amendment, the Secretary of Health and Human Services, and the relevant insurance commissioner, will recommend to exchanges whether a company should be permitted to participate in the exchanges.

So companies should be put on notice: unfair premium increases and other unfair behaviors will come with a price. Millions of Americans will receive tax credits to purchase coverage in the exchange beginning in 2014. Insurance companies will need to demonstrate that they are worthy of participating in this new market, and receiving Federal money to cover uninsured Americans.

This concern about premium increases stems from the fact that we are the only industrialized nation that relies heavily on a for-profit medical insurance industry to provide basic health care. I believe, fundamentally, that all medical insurance should be not for profit.

The industry is focused on profits, not patients. And it is heavily concentrated, leaving consumers with few alternatives when their premiums do increase.

As of 2007, just two carriers—WellPoint and UnitedHealth Group—had gained control of 36 percent of the national market for commercial health insurance.

Since 1998, there have been more than 400 mergers of health insurance companies, as larger carriers have purchased, absorbed, and enveloped smaller competitors.

In 2004 and 2005 alone, this industry had 28 mergers, valued at more than \$53 billion. That is more merger activity in health insurance than in the 8 previous years combined.

Today, according to a study by the American Medical Association, more than 94 percent of American health insurance markets are highly concentrated, as characterized by U.S. Department of Justice guidelines. This means these companies could raise premiums or reduce benefits with little fear that consumers will end their contracts and move to a more competitive carrier.

In my State of California just two companies, WellPoint and Kaiser Permanente, control more than 58 percent of the market. In Los Angeles, the top two carriers controlled 51 percent of the market.

Record levels of market concentration have helped generate a record level of profit increases.

Between 2000 and 2007, profits at 10 of the largest publicly traded health insurance companies soared 428 percent from—\$2.4 billion in 2000 to \$12.9 billion in 2007. This is Health Care for America Now, Premiums Soaring in Consolidated Health Insurance Market, May 2009, citing U.S. Securities and Exchange Commission filings.

The CEOs at these companies took in record earnings. In 2007, these 10 CEOs made a combined \$118.6 million. The CEO of CIGNA took home \$25.8 million; The CEO of Aetna took home \$23 million; The CEO of UnitedHealth took home \$13.2 million; and the CEO of WellPoint took home \$9.1 million.

I am very concerned that this profit seeking behavior will only worsen, now that insurance companies know that health reform will change their business model.

Insurers know that come 2014, they will be playing by new rules: No discriminating based on preexisting conditions. No cherry picking and choosing to cover only the healthy. No charging women or older people astronomical rates. No dropping coverage once someone gets sick.

Insurers know these changes are coming. Listen to a comment made by Michael A. Turpin, a former senior executive for UnitedHealth. He is now a top official at an insurance brokerage firm, and he said that insurers were “under so much pressure to post earnings, they’re going to make hay while the sun is shining.”

“Make hay while the sun is shining.” That means these companies will try to make as much money as they possibly can, for as long as they can.

That is why a rate review amendment is so important.

Frankly, I wish the health reform bill before us would go further and eliminate the for-profit health insurance industry.

But since this bill chooses to maintain a for-profit industry, we must do the next best thing and ensure that it is thoroughly regulated. Insurance companies should not be able to take advantage of the fact that affordable

health care is a basic life need. In effect, they have the power to increase their prices at will, knowing that people will continue to pay as long as they can afford to do so.

This amendment certainly will not fix all of the ills of a for-profit insurance industry, but I believe it makes a needed improvement in the underlying bill and will help protect consumers from unfair increases. Without it, I worry that consumers in far too many States will see major premium increases.

I will continue to work to see that this amendment is included in the final version of health reform legislation. Without it, too many Americans will still lack protection from unfair rate increases.

I ask unanimous consent that a copy of a support letter from California organizations be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

DECEMBER 17, 2009.

Hon. HARRY REID,
Majority Leader of the U.S. Senate, Hart Office
Building, Washington, DC.

Re Support of amendment to HR. 3590 to improve rate review of increases in health insurance premiums.

DEAR SENATOR REID: Thank you for your leadership in advancing health reform this year. We, the undersigned organizations, support a proposed amendment by Senators Feinstein, Rockefeller and others that would provide greater specificity in terms of rate review of increases in health insurance premiums.

The proposed amendment:

Creates a rate review authority that could deny or modify unjustified rate increases or order rebates to consumers,

Defines potentially unjustified rate increases as increases which exceed market averages,

Gives priority to rate increases that impact large numbers of consumers,

Creates market conduct studies of health insurance rate increases,

Exclude from State Exchanges insurers that have a pattern of excessive premium increase, low medical loss ratios or other market conduct,

Allows a State to conduct the rate reviews.

We support the provisions of health reform which make health insurance more affordable for individuals and businesses. This amendment is consistent with the stated intention of the "Patient Protection and Affordable Care Act" and provides greater specificity to the provisions on "ensuring that consumers get value for their dollars."

The proposed amendment prevents anticipatory price increases by health insurers in advance of full implementation of health reform. Scrutiny of rate increases will have a deterrent effect on increases in premiums that are out of line.

For these reasons, we support the proposed amendment.

Sincerely,

ANGIE WEI,
Legislative Director,
California Labor
Federation.

MARTY MARTINEZ,
Policy Director, California
Pan-Ethnic
Health Network.

MICHAEL RUSSO,
Health Care Advocate
and Staff Attorney,
California Public
Research Interest
Group (CALPIRG).

SONYA VASQUEZ,
Policy Director, Community
Health
Councils, Inc.

GARY PASSMORE,
Director, Congress of
California Seniors.

ANTHONY WRIGHT,
Executive Director,
Health Access California.

BILL A. LLOYD,
Executive Director,
Service Employees
International Union
California State
Council.

REV. LINDI RAMSDEN,
Executive Director,
Unitarian Universalist
Legislative
Ministry Action Network—California.

The PRESIDING OFFICER. The Senator from Mississippi is recognized.

Mr. WICKER. Mr. President, I ask unanimous consent that several Republican colleagues and I be allowed to engage in a colloquy for the next hour.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WICKER. Mr. President, I thank my friend from Washington for commending and complimenting the staff. That is a bipartisan sentiment for this Christmas season. I am sure every Senator on the floor feels the same way and expresses that appreciation to the hard-working staff.

I want to start off by saying there is still an opportunity for this bill to be amended to change some of the very harmful ways that this will affect our people back home and, particularly, our State governments.

I was on the Senate floor several days ago pointing out the objections that most of the State Governors have with regard to the Medicaid mandates. I want to read from a letter dated December 10, from my Governor, Haley Barbour of Mississippi, who reminds Senators that:

This bill continues to place a huge unfunded mandate on States, while harming our small businesses and seniors through budget gimmicks and increased taxes.

And he says this:

If the current bill, which would expand Medicaid up to 133 percent of the Federal poverty level, were enacted into law, the number of Mississippians on Medicaid would increase to 1,037,606, or 1 in 3 citizens, in Mississippi. Over 10 years, this bill would cost Mississippi taxpayers \$1.3 billion.

I was on the Senate floor a few days ago also with this map, which shows in red the number of States that are facing this unfunded mandate because of the increased Federal mandate for Medicare coverage coming from this bill, should it be enacted into law. I

was pointing out that only the two States—Vermont and Massachusetts—because of a formula that has been worked out, would be exempt. Every other State will have to come up with the extra money either through cutting education programs, cutting mental health programs or other vital services or by raising taxes. They will have to come up with the extra money under this legislation so that half of the people covered by this new act will be covered by Medicaid.

I want to make an amendment to that chart today and add one other State. I think it has become quite a well-known fact that we need to put one other State up there in yellow, and that is the State of Nebraska.

We know pursuant to an agreement that was made before Senator NELSON announced his support as the 60th vote for cloture on this very important legislation, a deal was cut—the minority leader said a cheap deal, and I agree—that the State of Nebraska would be exempt in perpetuity from its requirement to pay the State match. The Federal Government, according to this legislation that we will be asked to vote on in the next 2 days, will pick up all of the extra expenditures for the State of Nebraska.

The poverty level in Nebraska is not quite as bad. I don't know how the powers that be felt they should or could justify this expenditure, but I will tell you the people in the State of Mississippi are going to have to come up with another \$1.3 billion over the next 10 years to pay for what we are going to be required to do by Congress—in its wisdom.

How is it fair that one Senator from Nebraska goes behind closed doors with the majority leader and cuts this deal so that his citizens don't have to pay this extra tax, and they don't have to do without services in other State programs to come up with the money? No one in this building—nobody within the sound of my voice—can come in here and explain why that is fair.

The fact is, the majority leader needed that vote, and that was part of the deal that was cut. Now citizens in Arizona, citizens in Wyoming, citizens in Mississippi, in Arkansas, and in Louisiana—we will have to come up with the extra Federal tax money on our part, but the Federal Government can cover all of the additional costs—State and Federal—in Nebraska.

Mr. MCCAIN. If the Senator will yield, on that map, I wonder should there not be a sticker for the State of Florida? According to a published report by one of my favorite columnists, Dana Milbank, of the Washington Post:

Gator Aid: Senator Bill Nelson inserted a grandfather clause that would allow Floridians to preserve their pricey Medicare Advantage program.

So maybe we should have one of those stickers for Florida there. By the

way, that will cost my constituents more money because they will not have that same deal. Should there be a sticker for Montana?

Again, according to Dana Milbank:

Handout Montana: Senator Max Baucus secured Medicare coverage for anybody exposed to asbestos—as long as they worked in a mine in Libby, Montana.

Should there be a sticker there?

Continuing, Dana Milbank says:

Iowa pork and Omaha Prime Cuts: Senator Tom Harkin won more Medicare money for low-volume hospitals of the sort commonly found in Iowa. . . .

Maybe there should be a sticker for that. I don't know if you have North Dakota in there. Dana Milbank says:

Meanwhile, Senators Byron Dorgan and Kent Conrad, both North Dakota Democrats, would enjoy a provision that would bring higher Medicaid payments to hospitals and doctors in "frontier counties" of states such as—let's see here—North Dakota!

Should there be one for Hawaii? Mr. Milbank goes on to say:

Hawaii, with two Democratic senators, would get richer payments to hospitals that treat many uninsured people.

Should there be a sticker there for Michigan? Mr. Milbank says:

Michigan, home of two other Democrats, would earn higher Medicare payments for some reduced fees for Blue Cross/Blue Shield. Vermont's Senator Bernie Sanders held out for larger Medicaid payments for his state. (neighboring Massachusetts would get one, too).

I guess there are a number of States that maybe should have stickers on them so that the American people can see where these special deals were cut out, and the majority of the population of this country can see where they were not. They are going to pay while those States pay less because of not just their location but because they happen to have been behind closed doors and cut special deals.

Mr. BAUCUS. I wonder if the Senator would yield briefly.

Mr. MCCAIN. Sure. I ask that Senator BAUCUS be recognized.

Mr. BAUCUS. I am pointing out, as the Senators know, for example, under this legislation, the Federal Government pays all the costs of eligible enrollees through 2016. In this legislation, we are talking about the so-called expansion population. That is those between 100 percent of poverty on Medicaid and 133 percent of poverty, and under the underlying statute—

Mr. MCCAIN. Does that mean all these States are being treated the same?

Mr. BAUCUS. In 2016, all States are treated the same.

Mr. MCCAIN. This happens to be 2009. What happens between now and 2016?

Mr. BAUCUS. Beginning next year, when this goes into effect, 2010 through 2016, all States will get 100 percent payments for that expansion coverage.

Mr. WICKER. What would happen, then, after 2016 under current legislation?

Mr. BAUCUS. Afterward, under current legislation—one sentence of background. Today, as the Senator well knows, different States receive different Federal contributions to Medicaid. It varies according to States. The average is about 57 percent Federal. The average for all States on average is 57 percent of the cost of Medicaid is paid for—

Mr. MCCAIN. If that is the case—

Mr. BAUCUS. Let me finish.

Mr. MCCAIN. If that is the case, we will be glad to have the same provision inserted for the State of Arizona that was inserted for the State of Florida. You don't have a problem with that, do you?

Mr. BAUCUS. Let me answer the question.

Mr. MCCAIN. Do you have a problem with that?

Mr. BAUCUS. I can answer only one question at a time. The first question is from the Senator from Mississippi. Then, after 2017, all States get 90 percent—we are talking about expansion of population.

Mr. WICKER. The Senator yielded to me the other day, and I appreciate that. We have a number of Republicans who want to speak during our hour.

The fact is, after 2016, every State in red has to tax their own citizens and pay their State share, except Vermont, Massachusetts, and Nebraska. And I still challenge any colleague in this Senate to come before this body and say that is fair. I do not believe they will say that is fair.

Mr. MCCAIN. My question to the Senator from Montana is this: Would the Senator from Montana be willing to have the same provision that Senator NELSON, according to these reports, inserted, a grandfather clause that would allow Floridians to reserve their price in the Medicare Advantage Program? Would he accept a unanimous consent request right now that same provision apply to every State in America?

I ask unanimous consent that the same provision that was put in for the State of Florida by Senator NELSON would apply to every State in America.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Reserving the right to object, I think it would be highly imprudent for me not to object, so I will object to that request. I also point out that on average, Uncle Sam pays 90 percent of the Medicaid payments for this expansion of population after the year 2016.

The PRESIDING OFFICER. Objection is heard.

Mr. MCCAIN. I think the fact that an objection was heard resolves the case. Those are comforting words on the part of the Senator from Montana, whom I appreciate, but the fact is, there are special deals for special people. It is well known. It is very well known.

May I mention to my colleagues—sort of a personal privilege here—the

Senator from Louisiana came to the floor this morning and said:

Recently, just yesterday, Senator John McCain, our colleague from Arizona, has claimed that the American people are opposed to reform and he speaks about the will of the majority. I would like to remind, respectfully, my colleague from Arizona that the will of the majority spoke last year when they elected President Obama to be President and they decided not to elect him, and the President is carrying out the will of the majority of the people to try to provide them hope and opportunity.

I say in response to that, I really did not need to be reminded. I had not forgotten. Sometimes I would very much like to. But I appreciate the reminder.

The fact is that the Senator from Louisiana and other Senators should know that poll after poll, public opinion, partially because of what the Senator from Mississippi is pointing out—the latest being "U.S. Voters Oppose Health Care Plan by Wide Margin." A Quinnipiac poll finds 3 to 1 that the plan should not pay for abortion. And it says American voters mostly disapprove of the plan 53-36 and disapprove 56-38 percent President Obama's handling of the health care issue.

If I can remind my friend and colleague from Louisiana, I did carry her State.

Mr. BAUCUS. The Senator carried my State too.

Mr. MCCAIN. And the State of the Senator from Montana.

Mr. JOHANNES. If I may jump in here, probably like every Senator here, I read the newspapers back home every morning as I start my day. There was an editorial in the Lincoln Journal Star on December 21 that speaks to this issue of special deals. I thought it was excellent. The Lincoln Journal Star has covered me for a long time. Sometimes I agree with them, sometimes I do not. Sometimes they agree with me, sometimes they do not. But I have always respected the work they do.

Here is what they said in their editorial:

Since when has Nebraska become synonymous for cynical "what's in it for me"-type politics?

The term "Cornhusker kickback" is already a favorite of television's talking heads.

They go on to say:

That's how the rest of the country sees [this] deal.

The editorial continues:

Under its provisions, the federal government would pay all additional Medicaid costs for Nebraska "in perpetuity." The Congressional Budget Office has estimated the deal may be worth \$100 million over 10 years.

They go on to say I think in very powerful language:

The deal is the embodiment of what is wrong in Washington.

Instead of thoughtful, careful work on real problems, Washington lawmakers cobble together special deals, dubious financial accounting and experimentation on a grandiose scale.

They devote a paragraph to the many special deals cut, and the Senator's chart illustrates one.

Mr. MCCAIN. If the Senator will—

Mr. JOHANNIS. If I may finish, I say to Senator MCCAIN, and then you can ask me.

They say this:

It's time to push the reset button on health care reform.

The effort has gone awry.

Mr. MCCAIN. But also, doesn't this bring up a larger issue—I ask all my colleagues to comment on this—whether our job here is to do whatever we can to just simply help our State, even if it is at the expense of other States, as the Senator from Mississippi pointed out, or is our title U.S. Senator, Arizona, Nebraska, Mississippi, et cetera? My title is not Arizona Senator, U.S.; it is U.S. Senator, Arizona. So of course I am here to represent the people of my State. But is a U.S. Senator's job to go out and do something which would then be at the expense of the citizens of another State simply by virtue of their clout and influence? Is that what we were sent here by our constituents to do?

Is it true what the majority leader said yesterday:

"I don't know if there is a Senator that doesn't have something in this bill that was important to them," Senate Majority Leader HARRY REID reasoned when asked at a news conference Monday about the cash-for-cloture accusation. "And if they don't have something important in it to them, then it doesn't speak well of them."

Does it speak well of us when we do something like the Senator from Mississippi pointed out, that favors Libby, MT, and not the rest of the country, that helps the seniors in Medicare Advantage in Florida and not in Arizona? Is that what we were sent here to do? That has never been my view of what our obligations to our citizens are, but also to the citizens of this country.

I ask my colleagues to comment.

The PRESIDING OFFICER. The Senator from Idaho.

Mr. RISCH. Mr. President, here is what this has come to. In the next 48 hours, this 2,400-some page bill is going to pass the Senate. But how did we get there? Was it done the way things are usually done in this body? Not at all. One party has been able to gather 60 votes for this. Not one person from the other party is going to vote for it. How did they get those 60 votes? Did they get it by arguing this out? They did not do that. They have bluntly, boldly, and on the front of virtually every newspaper in this country bought the votes to pass this bill, to get to the 60. They bought the last handful of votes, and they did not even buy it with their money, they bought it with the American people's money. Now, that is wrong.

The explanation I heard from the majority leader the other day is: Well,

that is the way this is done. That may be the way this is done in banana republics, that may be the way this is done in Third World countries, but this is America. The American people are outraged over this. The other party ought to be outraged.

I heard one Member quoted as saying: Well, I was too stupid to get any money for my State in there. I heard the majority leader say: You are not doing your job if you don't have something in there for you. Where is the outrage from the other side, not only about the process but how they are getting snookered by some other members of their party? Where is the outrage?

I watched the debate on the other side and have seen Members come down and say: The American people want this. Are they living in a cave? Sure, there are a handful of American people who want this. Let me tell you who does not. The U.S. Conference of Bishops does not want it. The National Right to Life people do not want this. Not one Republican wants this. The Democrats do not want it.

Listen to what Howard Dean, the former leader of the Democratic Party, said:

At this point, the bill does more harm than good.

Ask any Democratic Governor in America. This bill transfers \$25 billion in costs in unfunded mandates to the Governors and to their taxpayers. They have to come up with \$25 billion. They don't want it.

I have stood here and listened to the other side say: This is wonderful for small business. Small business is going to come out so well on this. Then why does the National Federation of Independent Business—small businesses—say:

The Senate bill fails small businesses.

The National Association of Wholesale Distributors. The Small Business Entrepreneurship Council says:

Small business group say Reid health bill more of the same—more taxes, mandates, big spending, and nothing to help lower insurance costs.

Associated Builders and Contractors is against it. The National Association of Manufacturers is against it, the Independent Electrical Contractors, the International Franchise Association. Even the labor unions have said: Don't tax our health care benefits. We agree with them. We are on the side of the labor unions. We should not be taxing health care benefits.

But set all that stuff aside. These are all people who have an ax to grind. The American people do not want this bill. These people who are coming out here saying the American people want this bill, I don't know whether they are not reading the newspapers, whether they are not reading their own e-mails at their office. The Quinnipiac poll that was out this morning, Tuesday through Sunday, says: 36 percent of the Amer-

ican public support the health care spending bill; 53 percent oppose. That is an 18-percent difference. Gallup says 61 percent of the American people don't want this bill.

Stop coming out here saying the American people want this bill. The American people do not want it. You want it, but the American people do not want it. Leaders in your own party do not want it. The labor unions do not want it. Nobody wants this thing, and most of all small business does not want this bill.

I have listened to anecdote after anecdote from the other side. There are some very touching stories, and everybody over here is empathetic with them. But you don't legislate using anecdotes because you are only hearing one side of the story, you are not hearing all the facts dealing with the anecdotes, and to then pat this 2,400-page bill and say this will solve that, that is not the way you legislate, and it is certainly not the way you argue a point.

I heard the other side come out here and pat the bill and say: When we pass this bill, 94 percent of American people will have insurance, will be covered by health insurance. In court, they say you have to tell the truth, the whole truth, and nothing but the truth, and that is exactly why. You cannot pat this bill and say now 94 percent of the American people are going to be covered.

Somebody listening to that will say: Gosh, what a wonderful bill. What is it going to cost? It costs \$2.5 trillion to cover 94 percent of the American people. But they don't say the bill only adds another 7 percent. The fact is, they don't tell you that 87 percent of Americans are already covered by some kind of health insurance. So don't say this is a grand and glorious victory because we are now going to cover 94 percent when 87 percent are already covered.

This is gimmickry at its worst, to tax for 4 years without giving any major benefits. Giving some minor benefits but holding off the major benefits until later is plain gimmickry. They say: Oh, look how wonderful this is. It is not going to add to the national deficits because we are going to collect taxes for 4 years, and only then are we going to start the benefits.

What do we have here? When all is said and done and you strip it away, you have \$2.5 trillion and 2,400 pages that most people do not understand, higher taxes, and higher insurance premiums.

I can give you one fact that is the best reason to vote against this bill; that is, it cuts \$½ trillion out of Medicare benefits. If you are a senior watching, \$½ trillion of Medicare benefits is going to disappear. I heard the President say and I heard my friends on the other side say: Look, if you like your program, if you like your insurance

plan, you are going to be able to keep it. Try to tell that to the people who are on Medicare Advantage. It is being stripped. It is being eliminated under this bill. Indeed, if you read the rules and regulations under this bill, the plan you have will not even exist when it is done.

You know, I have heard the other side say: Oh, you Republicans are just playing on fears of the American people. Let me tell you something. The American people are frightened. They are afraid. It isn't just this health care bill, they have sat here for the last year, and they have watched stimulus packages costing \$1 trillion. They have watched multibillion-dollar bailouts. They have seen buyouts. They have seen trillion-dollar deficits running up. They have seen the national debt now running into the trillions. And, yes, they are afraid.

But it isn't us that is doing it to them, it is you that have done it to them. It is you that have committed the actions that have put the fear into the hearts of the American people. Don't do this. Stop this nonsense. You have the opportunity still to stop this. You can do it. The American people don't want this. Stop the insanity.

I yield the floor.

Mr. WICKER. I will say to my friend, I am afraid. I am afraid for my country. We are going to have a vote sometime between now and Christmas Eve on raising the debt limit. It will just be a short-term thing. I doubt if a single Republican will vote for that. Then we will have to come back again in February and do the same thing.

The debt that is piling up on our country is something to be frightened about. It is something we need to fight against and be resolute about. We are not shedding crocodile tears, but I am frightened by this debt, and we should be, if we want our economy to stay strong. The fact we are adding \$2.5 trillion in an entitlement program, which apparently the majority has the votes for, is simply going to add to this enormous debt.

So it is no wonder, when you add the Medicare cuts, the taxes that most States are going to have to pay—unless they cut a special deal—on top of the tremendous national debt that we are facing, the American people are frightened. They have a right to be frightened and worried.

Mr. BARRASSO. I don't know how many of my colleagues have seen the editorial in today's *Investors Business Daily*.

Mr. President, I ask unanimous consent to have printed in the *RECORD* the article to which I am going to refer.

There being no objection, the material was ordered to be printed in the *RECORD*, as follows:

LOUISIANA PURCHASE AND OMAHA STAKES

Politics: Mary Landrieu's payoff was the new "Louisiana Purchase." Ben Nelson got

Uncle Sam to pick up Nebraska's future Medicaid tab. Maybe we should just put Senate votes up on eBay.

Nelson, the 60th vote in the middle-of-the-night Senate party line vote on health care reform, will go down in American political history as the inventor of the permanent earmark. His seemingly principled stand against including federal funding for abortion evaporated like the morning dew as he decided to take what was behind door No. 1.

The deal for Nelson includes special Medicaid funding for Nebraska, along with Vermont and Massachusetts, which has a special election to fill the seat of the late Sen. Ted Kennedy coming up in January. Under the Senate bill every state is equal, but some are more equal than others. The other states and their taxpayers—that means you—will pick up this tab.

This came just three days after Sen. Bernie Sanders, I-Vt., said on Neil Cavuto's Fox Business show that he was prepared to vote against the bill after the recent decision to strip the public option and the Medicare buy-in provision from the legislation to get the vote of Sen. Joe Lieberman, I-Conn.

Nelson won a permanent exemption from the state share of Medicaid expansion for Nebraska. Uncle Sam will take the hit for 100% of the Medicaid expansion for Nebraska—forever. The world's greatest deliberative body has now become the most corrupt.

The Congressional Budget Office (CBO) informed lawmakers Sunday night that this section of the manager's amendment to the Senate's health bill would cost \$1.2 billion over 10 years.

Nebraska actually receives the least of the three, some \$100 million over the first 10 years. Vermont will receive \$600 million over 10 years, while Massachusetts will get \$500 million.

Nelson, like most other senators, doesn't know what's really in this bill or what it costs, except for the scoring that involves comparing a decade of taxes with six or seven years of "benefits."

This includes gutting Medicare by half a trillion dollars. The abortion language he accepted may not survive conference or the Stupak amendment supporters in the House. The Medicaid bribe he accepted will.

Senate Majority Leader Harry Reid, the Boss Tweed of our time, defended how this sausage was made. "You'll find a number of states that are treated differently than other states. That's what legislating is all about. It's about compromise," he said.

On the contrary, sir, it's about bribery—about what has been dubbed the "Cornhusker kickback," and about politics done the "Chicago Way."

A \$100 million item for construction of a university hospital was inserted in the Senate health care bill at the request of Sen. Christopher Dodd, D-Conn., who faces a difficult re-election campaign.

Presumably there's a wing where taxpayers can go to get their wallets removed.

The Democrats insist that their Medicare cuts will not lead to rationing. So why did, as HotAir.com reports, Sen. Bill Nelson, D-Fla., insist on language that exempted three heavily Democratic counties in his home state from the cuts? If those massive cuts to the program won't hurt people on Medicare Advantage, why did Nelson fight to get exemptions for Palm Beach, Dade and Broward counties?

After all this wheeling and dealing, we will still have a cost-raising tax-increasing, Frankenstein monster of a bill hurriedly stitched together behind closed doors that

will lead to doctor shortages and rationed care.

Mr. BARRASSO. The article is headlined: "Louisiana Purchase and Omaha Stakes." The editorial says:

Politics: Mary Landrieu was the new "Louisiana Purchase." Ben Nelson got the federal government to pick up his state's future Medicaid tab.

And the article continues:

Maybe we should just put Senate votes up on eBay. . . . Nelson won a permanent exemption from the state share of Medicaid expansion for Nebraska—forever. The world's greatest deliberative body has now become the most corrupt.

So Uncle Sam is taking the hit for 100 percent of the Medicaid expansion for Nebraska forever. That is what this says. It goes on to say this is not what legislating is about; that this is not compromise, rather, it is about bribery.

Mr. President, this is horrible for us as a nation to have these things written about this institution, when we should be way above any of these sorts of claims.

I look at that map that my colleague from Mississippi has up, with just Nebraska on there as the special deal, and I do not believe that is the way legislation should be written. We should be looking at ways to improve health care for all Americans, improve the quality, make it more affordable, make it more available to people, and give them the access they need.

I brought four amendments the other day, after Senator REID brought his massive amendment to the floor, and each was rejected. They were things that would actually improve this bill and make it better for Americans.

So I stand here, looking at this, and reading headline after headline and editorial after editorial about just how very bad is the way this bill is being pushed forward. We certainly wouldn't want any young child to know how this is happening in their country, as we try to get them involved in this process and learn and study and feel that maybe they should become involved in this. This isn't what legislating in America is all about. We are better than this.

If you have to do these sorts of things to get a 60th vote, then the bill isn't good enough to pass. If the ideas aren't good enough to get the votes, then it shouldn't pass. In this country, we look for bipartisan solutions to the big issues of the day. That is what we did in the Wyoming Legislature. Major issues passed with overwhelming numbers. That is what has happened in this country throughout the course of history. The big bills have come forth with large numbers of supporters, and that is how you get the country to follow you, not by trying to force through a vote, buying a vote here and buying a vote there to just squeak by with the minimum amount of support. That is

not the way to change policy that is going to affect everyone in the United States personally and affect one-sixth of our economy. That is not the way to do it.

It has not been the way, it shouldn't be the way, and it should never be the way again. I am looking for some Democrat to stand up and say: This isn't the way, and I am going to not vote for this bill.

Mr. MCCAIN. A Senator from Colorado came to the floor and proudly stated that he had not asked for anything or gotten anything, and I will ask the Senator from Nebraska a question because his State seems to be at the center of a lot of attention. But, first of all, there is a little booklet that is put out by the Government Printing Office that talks about how our laws are made. We give it to our constituents and send it to schools all over America. I have never seen anything in that little booklet—it is a very interesting booklet—that says you get behind closed doors and you cut deals.

I know we are all a little cynical about politics and campaign promises, but the negotiating behind closed doors is especially so, particularly after your President says during the campaign, time after time: I am going to have all the negotiations around a big table. We will have doctors and nurses, hospital administrators, insurance companies, drug companies, they will get a seat at the table. They just would not be able to buy every chair. But what we will do, we will have negotiations televised on C-SPAN so that people can see who is making arguments on behalf of their constituents and who is making arguments on behalf of the drug companies.

Of all people he recognized, the drug companies—who got the best deal of all? PhRMA. Who has spent the most money lobbying? Who has spent the most money on advertising? PhRMA. Who is going to cost the American consumer \$100 billion, that could have been saved by the consumer if we had been able to reimport prescription drugs?

But I would ask my friend from Nebraska because along with the "Louisiana purchase" and probably the Florida deal this Nebraska deal has probably gotten the most publicity and visibility. Maybe because it was the 60th vote. I don't know if it is the biggest or not, in terms of money, because we will be finding deals in this 2,700-page bill for months. For months, we will be finding provisions, even though our staffs have carefully read it. It is not 2,700 pages for nothing.

So I would ask the Senator from Nebraska: How does this go over in the heartland of America? How do the people in Nebraska, who see that they have gotten some kind of special deal, a special provision—certainly reported as so in the media—that would come at

the expense of other taxpayers in America? I am curious about the reaction the Senator from Nebraska gets.

Mr. JOHANNES. It doesn't go over. It just simply doesn't. In every way possible, over the last 4 or 5 days, I have been asked: Do you support this special deal for Nebraska? I don't. I think it is wrong.

I could read through all the special deals because we have all got the list—it is Florida, Louisiana, and Montana, and on and on and on. But I came to the floor this morning and I asked unanimous consent that all the special deals be taken out, and I listed a long list of them. Of course, there was an objection to that request for unanimous consent. Why? Why would we want to try to pass legislation with all of this? It makes no sense to me.

But let me take a step back. We all remember a few months ago there was a big story that Nevada was going to get a special Medicaid deal. It was right about that time that we took a few days off. I went back home, and I did townhall meetings, as I have done for years and years and years. But we really invested time and effort, and we identified six principles of health care which are on my Web site for people to look at. I literally had a PowerPoint presentation. I did four townhall meetings—Carnie, Grand Island, Lexington, and Lincoln. I put up these principles.

One of the principles was no carve-out. No backroom deals. No special deals. I presented that to the people who were at those townhall meetings. I did tons of interviews. I explained why I felt the way I did. People were so irate at the possibility that Nevada was going to get this special deal.

Since then, I think that has fallen by the wayside, but all these other things have come along. That is why I read the Lincoln Journal Star editorial. This is an editorial page that sometimes likes what I am doing and sometimes it does not. Over the years, they have not hesitated to take me to task. They looked at this and they said:

Since when has Nebraska become synonymous for cynical "what's in it for me"-type politics?

They said it is time to hit the reset button. We are not getting this right at all. We simply aren't getting it right. They talked about the issues of cost containment, they talked about the Actuary's report, which I had spent a little time talking to them about, and other folks around the State. After looking at all of that, they just said: Look, this isn't going the way it needs to go for the American people.

Here is what I would say to all of my colleagues in the Senate. I love my State. I love the people there. They are such honest, decent people. In many parts of our State, people believe you seal a contract not by putting things in writing but by shaking hands and giving your word. They don't want this

kind of attention. They don't want to be on the evening news every night with the talking heads talking about the "cornhusker kickback" or whatever the latest terminology is. They just want to be treated fairly.

They asked me to come here and represent them as fervently as I can, to try to do all I can to get fair treatment for them. But not a single person at any townhall I have ever had stood up and said: MIKE, I disagree with that principle. I want you to go back there and give me a special deal or get our State a special deal.

So I appreciate Senator MCCAIN asking me the question. I feel very strongly about this. I wish the other side would consider my request for a unanimous consent agreement that just says: Time out, everybody. Let's pull out the special deals, whether it is Nebraska or Montana or whatever. It doesn't matter to me. Let's pull those out and let's take a step back and let's work for what Senator RISCH talks about and the rest of us have talked about. We can get 80 votes on a health care reform bill. I guarantee you. But not on this bill.

Mr. WICKER. I would echo what the Senator from Nebraska has just said. I know my friend from Arizona has been one of the most outspoken critics of special deals and special earmarks. This is not some catchall appropriations bill to get us through the end of the year. This is one of the most major pieces of legislation on which any Member of this Senate currently serving will ever vote. This is one-sixth of the American economy, and the American people are learning about these special carve-outs where the citizens of one State will be treated differently not because of a formula, not because of the poverty level, but because of political power.

It would just seem to me that one Member of the majority party, in these next 2 days, might step forward and say: You are right, and I will not be a party to this.

Mr. MCCAIN. Let me make one additional comment. I have seen reform go through the Congress of the United States. The first one I saw was when we saved Social Security—a major reform of Social Security. There was no backroom dealing. It was a straightforward proposal as to how to fix Social Security. We fixed welfare, it was welfare reform—again, open, honest, bipartisan negotiations and bipartisan agreement. Welfare reform, Social Security reform, the efforts we made at tobacco reform, at campaign finance reform, at immigration reform and many others—the Patients' Bill of Rights. Every reform I have ever been involved in has had two major and sole components: No. 1, it is bipartisan; No. 2, there were no special favors or deals cut, provisions in thousands of pages of legislation.

Again, we know where the train is headed. We know what is going to happen a short time from now, but they will make history. You will make history. You will have rammed through "reform" on a strictly partisan basis, without the participation of the other party, over the objections of a majority of the American people, done in closed negotiations, with results that are announced to the American people without debate or discussion and to this side without debate or discussion.

The American people do not like it. They do not like for us to do business that way. I am sure this peaceful revolution that is going on out there already—because as the Senator from Idaho pointed out, because of the involvement of the car companies, the stimulus, the bonus, the generational theft we are committing, this, all on top of that, is going to give great fuel to the fire that is already burning out there, where they want real change, real change which they were promised in the last Presidential campaign and certainly did not get.

Mr. RISCH. I say to Senator MCCAIN, probably one of the great ironies of all this is going to be at 8 o'clock on December 24—when this bill passes with the 60 votes, all Democrats—immediately following that vote is going to be a vote, again all 60 Democrats and only Democrats, raising the national debt. What an irony, to put \$2.5 trillion in spending of a new social entitlement program, adding it to the three already huge entitlement programs that are in the process of bankrupting America, adding this to it and then turning right around and increasing the debt ceiling. When they increase it, it is going to be—nobody knows exactly how much it is going to be, hundreds of billions. But that is only in the last 2 months. They are going to have to come back again in February and increase the national debt ceiling again. What irony.

Mr. MCCAIN. Of course, this legislation turns everything we know about budgeting on its head, although it has been done before and it has been done by Republicans, to our shame. Today, if you go out and buy an automobile, you can drive it for a year before you have to pay for it. Under this bill, it is the opposite. You pay the taxes, you have the reductions in benefits, and then 4 years later you start having whatever benefits would accrue from this legislation. So for 4 years small businesspeople, people all over America, will see their health care costs increased before there is a single, tangible result from it—remarkable.

Mr. WICKER. The Senator mentioned the Florida carve-out. Perhaps I should have it on my map. The reason I did not is it involves Medicare Advantage and not Medicaid. The map was about Medicaid, but he makes a good point about the Florida carve-out.

I had a discussion with some of the leadership on the Democratic side on

the floor of the Senate the other day about Medicare Advantage. The strong assertion over on that side is, Medicare Advantage is not Medicare. As a matter of fact, some of the leadership in this very body said the booklet the Government puts out that says Medicare Advantage is part of Medicare should be changed. Those words should be stricken from the handout because it is not part of Medicare. The Web site the Federal Government has saying Medicare Advantage is part of Medicare, that should be changed because it is just an insurance company masquerading as Medicare.

Let me just take a second. This is Betty. Betty represents—she is from Louisiana. I don't know if she was one of the 60 percent of Louisianans who voted for Senator MCCAIN in Louisiana, but she enjoys Medicare Advantage. She was told during the election that if you like your coverage, under any plan that the Obama administration would approve, you get to keep that coverage. She gets hearing aids, vision coverage, dental care, and she likes her Medicare Advantage.

If Betty is 1 of the 150,000 seniors in the State of Louisiana who enjoy this benefit, she is at risk of losing it. But if she happens to be in the State of Florida, in any of these counties with the \$100 million carve-out, she is fortunate enough to be able to keep her Medicare Advantage.

In other words, it may not be guaranteed, but she sure likes it. Obviously, one of the Senators from Florida believes his constituents like it—again, a carve-out so this nonguaranteed, non-Medicare benefit that is not very good, they can keep it in Florida. That is in the bill and no one can deny that special treatment is given to that one State under Medicare Advantage. Again, I challenge any American to come onto the floor of this Senate and tell me how that is fair.

Mr. BARRASSO. It is not. There have been a number of references to our friend and colleague, the late Senator Ted Kennedy. Let's take a look at the book his brother, John Kennedy, wrote, "Profiles in Courage." As we have seen all this, it is time for one courageous Democrat to stand and say: This is about our country. This is about our country, not about a kickback. This is about health care, not about a hand in the cookie jar.

That is what we need. We need one courageous Democrat to stand and say: I don't want to be part of this editorial that talks about the Louisiana Purchase and Omaha Stakes. I don't want to be a part of this that says this, the world's greatest deliberative body, has now become corrupt. I don't want to be a part of this that says this is about bribery.

It needs one courageous Democrat, 1 out of 60, to stand and say: I am going to vote no; we need to back up; we need

to think about this. We have 100 Members of the Senate who want to reform health care in this country, who want to get the costs under control, who want to improve quality, who want to improve access—100 Senators want to do that. That is the goal of each and every one of us here.

We need one courageous Senator to say it is time, time now, to take a step back, let us go home over Christmas, let us think about this, let us talk to our constituents at home, let us hear what they have to say about this looking out for No. 1—\$100 million. Dana Milbank's column in the Washington Post today, that is what we need now in the Senate. We need the kind of courage John Kennedy wrote about in "Profiles in Courage."

Mr. RISCH. I say to Senator BARRASSO, you know there are already some courageous Democrats stepping up. I hope every Democrat on the other side calls their Governor and says: Governor, what do you think about this? Help me out here. I am in caucus, they bought enough votes to get to the 60. But I have to tell you I don't like the way they did it, No. 1; and, No. 2, what about the rest of us? We didn't get the \$300 million. We didn't get the X number of million. Help me out, Governor. They say they are going to shift \$25 billion to the States that you are going to have to come up with. What do you think? Do you think I ought to vote for this—or maybe if one of us steps forward and says I am going to vote no and I want to set the reset button and I want to put people back to the table and say let's do this right, we can do this right.

We are Americans. We know how to do this. We are the most innovative people in the world. All we have to do is get together and do it. But to jam this down the throats of the American people—and make no doubt about it, this is being jammed down the throats of the American people on the eve of Christmas, in the middle of the night, in the face of poll after poll that says don't do this to us.

That is what is happening. There are courageous Democrats out there. Not one of them is sitting here.

Mr. WICKER. Let me tell my friend from Idaho about some courageous Democrats. When the House version of this was being considered at the other end of this building, a number of Democrats stepped forward and said: I can't vote for this. It was very close. They have a huge majority, 40 votes over there. As a matter of fact, one Member of the House today basically said: I can't take any more. He switched parties. A Member from Alabama is now joining the Republican conference. But there are a number of loyal Democrats who have no intention of switching parties and they have stepped forward and said: I can't vote for it. Don't count me in on this.

BART STUPAK is a Representative, a courageous pro-life Representative from Michigan. He did vote for the bill. I do not impugn his motives. He did what he thought was right. But before he voted for it, he made sure legislation was included in the House version to make sure the Hyde language, which has been the law of the land for almost two decades, was included.

Here is what Representative STUPAK said yesterday or the day before yesterday about this so-called pro-life compromise that was included in the version we will have to vote on in the Senate. He said it is "not acceptable . . . a dramatic shift in Federal policy that would allow the Federal Government to subsidize insurance policies with abortion coverage."

That is a release actually on December 19.

I appreciate the courage of someone from a Democratic State, from a district that has long been Democratic, who is a member—chairman of a committee and a member of the leadership over there—stepping forward and saying: I can't go this far. Unless this language is changed—and we are told by Members of the Senate there better not be much of a conference. What we vote on, on Christmas Eve, it better sort of stay like it is or it will not be passed by the Senate when it comes out of conference.

BART STUPAK is stepping forward and saying, if that is the case, then I am switching from a yes to a no. I appreciate that kind of courageous Democrat.

Mr. MCCAIN. Can I say, I appreciate the Senator from Mississippi bringing this important aspect to this issue and continuing to do so.

I would like to pick up on what Dr. BARRASSO mentioned about the Kennedy family. It is well known I had a very close relationship, developed over the years, with Senator Ted Kennedy and that we worked together on a variety of issues. So there is a great irony in the constant, over there on the other side of the aisle, references to Senator Kennedy, who always began legislation by getting bipartisan, by getting Members of the other side of the aisle committed and working together—whether it be on immigration reform, whether it be on health care reform, whether it be on one of the great achievements of President Bush 2, No Child Left Behind.

In other words, every dealing I ever had with Senator Kennedy was to reach out, establish a fundamental base for agreement, and then move forward with legislation in a bipartisan fashion, which I think was one of the major reasons why he had such an impressive legislative record.

How did the other side do it? Without a bit of serious negotiation, without bringing anyone on board before moving forward—no one—which ends up,

now, with a 60-to-40 vote, which is a pure partisan vote and outcome when there has never been, in history, a single reform that was not bipartisan. That is why the American people are rejecting this. That is why the American people are seeing through it. To hear the constant refrain that the American people want this: Read any poll. It is just a matter of difference because the American people have figured this out. It is going to be one of the great historic mistakes—not historic—but historic mistakes made by the Congress of the United States.

Mr. MCCONNELL. If I may say to my friend from Arizona, he is absolutely right. I have had an opportunity to observe Senator Kennedy over the years. That is exactly the way he operated.

If I may, just to make a point with regard to the observation of the Senator from Mississippi about Congressman STUPAK, as I understand it, Congressman STUPAK was not asking for some special deal for Michigan in return for his vote. He was, rather, trying to establish a principle that would apply to all Americans. Is that not the case?

Mr. WICKER. That is exactly correct. I commend my former House colleague for taking that principled stand.

Mr. MCCONNELL. Could not be same thing be said for our colleague, Senator LIEBERMAN from Connecticut? I am sorry he ended up voting for this 2,700-page monstrosity, but you have to stay, as I understood his position—and Senator MCCAIN certainly knows him very well—his position was, if the government goes into the insurance business, I can't support this bill, not: I am open for business and what you can you do for Connecticut.

Mr. MCCAIN. There may be on the floor a unanimous consent request to remove the Nebraska Medicaid deal. I would hope, if there is any unanimous consent agreement at any time, that the whole bill will be fixed, which means every special provision would be removed, whether it be from Nebraska or any other State. We still have the Louisiana Purchase of \$300 million. We still have the Florida Medicare grandfather clause, \$25 to \$30 billion. The list goes on and on. The Connecticut hospital—I guess it is the Connecticut hospital. It is always in legislation, so you have to do research to see who qualifies. I would hope we could have, again, agreement that all these special provisions that affect certain specific States would be removed as well. That would go over rather well with the American people.

I want to say to my colleagues, thank you for your passion. I know a lot of people don't watch our proceedings on the floor. It has played a role in educating the American people as to what we are facing. The media played a role, advocacy groups, grassroots organizations all over America.

But I have had the great privilege of engaging in these colloquies with my colleagues. To me, it has been both helpful to my constituents, and, frankly, it has also been helpful to me to work with people who have been involved in these issues, former Governors and others. We have made some kind of contribution, which I think is what we are all sent here for.

Mr. WICKER. How much time remains?

The PRESIDING OFFICER (Mr. ROCKEFELLER). The Senator has 2 minutes.

Mr. WICKER. Unless my colleagues want to join in, I thank them for joining us and certainly thank Senator MCCAIN, one of the most distinguished public servants, someone who sacrificed for his country and who has been on this floor hour after hour.

The bill we will be asked to vote for on Christmas Eve by the administration's own Chief Actuary increases health care costs, threatens access to care for seniors, forces people off their current coverage, and actually increases the amount of the gross domestic product that will be spent on health care rather than decreasing it. These are not statements I have made; these are assessments made by the Chief Actuary for the Obama administration.

There is still time. Even if this bill passes, we will go home for Christmas, for the holidays. We will hear from our constituents. I hope we listen to that over 60 percent of Americans who say: We advise you not to vote for this legislation.

Mr. BARRASSO. It is time for a new chapter to be written in "Profiles in Courage." One of the Members of this body can be that profile. All they have to do is stand up and say: No, I will not be part of what has been called corruption in the Senate. I will not be part of what has been called, in the editorials, bribery in the Senate. I will be that courageous person and vote no. It is time for a new chapter in "Profiles in Courage."

I yield the floor.

The PRESIDING OFFICER. It is the understanding of the Chair that the Senator from Mississippi had the floor.

Mr. WICKER. I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I have several points to make. First, as a matter of personal privilege, on behalf of the people of Libby, MT, the Senator from Arizona made it sound as if the folks in Libby were getting some kind of a sweetheart deal. I wish the Senator would not leave so he can hear what is actually going on. I think the Senator from Arizona would agree with me that he would not want his constituents to suffer an environmental calamity. He would not want his constituents to not get some redress because of a declaration of public emergency due to contamination of asbestos. I assume the Senator from Arizona

would very much stand up for his constituents.

Let me explain. Congress passed a law in 1980 called CERCLA. That legislation said that whenever there was a declaration of a public emergency because of contamination at a Superfund site, the government has an opportunity to declare a public emergency and help those people get medical care because of contamination of asbestos; in this case especially, something called tremolite, which causes even greater damage than ordinary asbestos. I would assume the Senator from Arizona would want his constituents to get some help from contamination from asbestos.

Mr. MCCAIN. May I respond?

Mr. BAUCUS. Absolutely.

Mr. MCCAIN. All the Senator had to do was have it authorized, bring it up on the floor as an appropriation, and I am sure the Senator's arguments would have been far more cogent than jamming it into a bill which has to do with health care reform, the policy of health care reform.

This legislation and this cause of the Senator from Montana has been turned back several times on other grounds.

Mr. BAUCUS. This is health care. Reclaiming my right to the floor.

Mr. MCCAIN. I am responding.

Mr. BAUCUS. I reclaim my right to the floor because he doesn't want to deal in good faith with this issue.

My second point. It is disrespectful, it is unseemly for Senators in this body to invoke the names of Ted Kennedy and Jack Kennedy in opposition to this bill. It is disrespectful and unseemly. I, frankly, am very much surprised that Senators would go to that level and invoke the names of Ted Kennedy and Jack Kennedy in opposition to this legislation. Talk about profiles in courage. I hear Senators on the other side say: Where is the courage of one Senator to stand up and vote against health care reform? That is what I keep hearing. Where is the courage? Where is the courage of one Senator on the Democratic side to stand up and vote against health care reform?

Mr. President, I want to turn that around. "Profiles in Courage"—Jack Kennedy and Ted Kennedy were Senators who worked to try to find resolutions to agreements. They wanted to compromise. They wanted to work together to get just results.

I ask, where is the Senator on that side of the aisle who has the courage to break from their leadership, break from the partisanship they are exercising on their side of the aisle to work together to pass health care reform? I ask, where is the courage? Where are the Senators who have the courage on that side of the aisle to stand up and work together on a bipartisan basis to get health care reform passed? Where?

We on this side reached out our hands for bipartisan agreement on

health care reform, probably to a fault. I say "to a fault" because for months and months this Senator, anyway, extended the hand to work with other Senators on a bipartisan basis. I know the current occupant of the chair knows that. He watched this. He saw it happen in the Finance Committee.

Senator GRASSLEY and I worked very hard to get Senators on both sides of the aisle to work to pass health care reform, very hard. Then after a while we had to work toward another approach. The Group of 6—3 Republicans, 3 Democrats—worked for months on a bipartisan basis to get health care reform passed. Do you know what happened? I watched it happen. Those Senators in the room were acting in good faith. They were in good faith. They wanted to mutually work together to pass health care reform. They asked good questions. Senator ENZI from Wyoming, for example, asked very good questions. Senator SNOWE asked very good questions. Senator GRASSLEY asked very good questions. We worked to get health care reform.

But do you know what happened? I could feel it happening. One by one by one, they started to drift away. They wanted to pass health care reform. They wanted to act in a bipartisan basis. But they were pressured—pressured from their political party not to do it, not to do it, not to do it. Why were they pressured not to do it? Unfortunately, they gave in to the pressure because their leadership wanted to make a political statement. One of the Senators on the floor here said: Let's make health care Obama's Waterloo. They did not want to work with us, that side of the aisle. They did not want to work with us because they thought it was better to make a political statement: Attack the bill, attack the bill, attack the bill in order to make political points for the 2010 election. That is what they were trying to do.

I ask, where is the courage? Where is the courage? Where is the Republican Senator who will stand up and say: Boy, let's work together to pass health care reform. Where is the Senator who will stand up and say: We want to work together to pass health care reform.

This Senator tried mightily to get bipartisan support. Ask Senator GRASSLEY from Iowa, with whom I have been working for a long, long time. They were pulled away. Senator GRASSLEY—I don't want to speak for him, but I know he wanted to get health care reform passed on a bipartisan basis. I know that is the case. Frankly, he got pressured, pressured, and he just couldn't do it. I have the highest respect and regard for him, but he just couldn't do it.

Mr. WICKER. Will the Senator yield briefly?

Mr. BAUCUS. Absolutely.

Mr. WICKER. I think the Senator has really answered his own question. As a

matter of fact, Senator GRASSLEY and Senator ENZI met for hours and hours, weeks upon weeks with my friend from Montana in good faith, hoping to come up with a program that could get that 80-vote support we usually get on matters of—

Mr. BAUCUS. That is how they started out, that is true.

Mr. WICKER. And then eventually, it dawned on them that my friends on the other side of the aisle wanted to Europeanize the health care system of the United States of America.

Mr. BAUCUS. Reclaiming my time.

The PRESIDING OFFICER. The Senator from Montana has the floor.

Mr. WICKER. I thank the Senator for yielding.

Mr. BAUCUS. That is not what happened. I was in the room constantly. I talked to those Senators many times. That is not what happened. I will tell you what did happen. Your leadership pressured them, pressured them, pressured them not to work together. There was no European-style effort in that room. That is a totally untruthful statement—a totally untruthful statement. None whatsoever. We are passing a bill here that is a uniquely American solution. It provides competition. It helps the doctor-patient relationship. That assertion of working toward a European solution is entirely untrue. It is entirely false.

The fact is, those Senators did not want to work with us. It is regrettable. It is highly regrettable. One of the biggest travesties here is there was not a good-faith effort on that side of the aisle to come up with a constructive, comprehensive alternative to the Democratic version of health care reform. If there had been a constructive, honest, alternative health care reform, we could have had a really good debate. What is the better approach to solving the health care problem? That did not ever happen. It did not ever happen at all. Rather, they didn't have anything. They didn't have a health care bill. None whatsoever.

The only one that came up a little bit was over in the House. Because of all the criticism about Republicans not having an alternative, finally the Republicans in the House came up with an alternative. It was very small. There wasn't much to it. To be honest, the CBO said it would hardly increase any coverage whatsoever. It was not really a comprehensive health care reform bill. And there has been none in the U.S. Senate on the Republican side, no alternative for a comprehensive health care reform bill.

I want the public to know we worked very hard to get a bipartisan bill. That side of the aisle started without working with us, but gradually they began to believe that politically they would have a better chance in the 2010 elections by just not working with us but just attack, attack, attack, attack,

trying to score political points to defeat any honest effort to get health care reform.

I now yield such time as he would like to the Senator from Nebraska.

The PRESIDING OFFICER. The Senator from Nebraska is recognized.

Mr. NELSON of Nebraska. Thank you, Mr. President.

Well, this has been quite an enlightening experience on the floor this past 30 or 40 minutes. It shows how emotionally charged this body has become over this issue and perhaps other issues as well. But the challenge is, we are all entitled to our own opinions. We are just not entitled to our own set of facts.

I would like to take a moment to explain the so-called Medicaid fix for the State of Nebraska. Now, it has been described as the "Omaha Stakes fix." I take issue—and I only wish my colleague from Nebraska had stayed on the floor to hear this. I take issue with one of the premier businesses in the State of Nebraska used in a manner of derision to outline something that is factually incorrect on the basis of how they are presenting it.

You can twist and you can turn and you can try to distort what happens, but it does not change the underlying facts. The underlying facts are, this was pursued initially as an opt-in or opt-out for all States. It was impossible to do that at the present time, and so as a matter of fix, there was, in fact, the extension of the Federal dollars from the year 2017 on, well into the future, as a marker to lay down so that every State could object to this manner of unfunded mandates.

As a Governor—and my colleague is a former Governor—we fought against Federal unfunded mandates. As a Senator back here, I have also fought against unfunded and underfunded Federal mandates. This was, in fact, exactly that. While we were not able to get in this legislation an actual opt-out or opt-in for a State-based decision, what we did get is at least a line, if you will, so that in the future other States are going to be able to come forward and say: Hey, either the Federal Government pays for that into the future or the State will have the opportunity to decide not to continue that so that we do not have an unfunded Federal mandate.

So I am surprised. I am shocked. Well, actually, I am not shocked. I am disappointed this would be used and misused in this fashion, not only derisively against a great company in Nebraska—the Nebraska Steaks—I am also surprised my colleague would participate in a colloquy that would use the name of that company in such a manner.

I am surprised this colloquy went on without understanding the facts of what this so-called carve-out—which is not a carve-out—truly consisted of.

There is no carve-out. Each State between now and 2017—two-thirds-plus of a decade—will have an opportunity to come back in and get this bill changed.

Governors asked for relief. As Governors, we asked for relief against these continuing unfunded mandates. Time and time again, we fought against them. This was one more opportunity to fight. As a matter of fact, the Governor of Nebraska spotted this and wrote me a letter on December 16 and said, among other things:

The State of Nebraska cannot afford an unfunded mandate and uncontrolled spending of this magnitude.

He goes on to say a number of other things about the bill. But he makes the point that this is an unfunded Federal mandate and wanted me to do something about it.

So I sent him back a letter on the same date, saying:

Thank you. . . .

Please be advised that I have proposed that the Senate bill be modified to include an "opt-in" mechanism to allow states to avoid the issues you have raised. Under my proposal, if Nebraska prefers not to opt in to a reformed health care system, it would have that right.

My colleague and others know this is the case. They know this is the case, but they choose to ignore it. They choose to ignore the facts.

On December 20, I again wrote to the Governor and shared with him my concern about this unfunded mandate, and I pointed out that:

Within hours after the amendment was filed, [my colleague from Nebraska] objected to the inclusion of these funds. As a result, I am prepared to ask that this provision be removed from the amendment in conference if it is [the Governor's] desire.

I got a letter back on the day after, on December 21, talking about this as a special deal. It is not a special deal for Nebraska. It is, in fact, an opportunity to get rid of an unfunded Federal mandate for all the States. Let me repeat that: for all the States. There is nothing special about it, and it is fair.

What we have done is we have drawn a line in the sand and said: This is unacceptable, and it is unacceptable for all States as well. I cannot believe that this sort of a situation would continue. There is no misunderstanding here. I think it is just an opportunity to mislead, distort, and, unfortunately, confuse the American public all the more, and to use the State of Nebraska and the name of a good company for partisan political purposes on the other side of the aisle.

My colleagues know I am not a deeply partisan person and that I rarely come to the floor to speak, and that when I come to the floor, it is for something like this, to take exception with the misuse of information for partisan purposes. That is exactly what has been done with this situation.

I am prepared to fight for the State of Nebraska, and I hope my colleague is

as well. Obviously, the Governor was prepared to fight for the State of Nebraska by bringing it to my attention. But I am not prepared to fight to get a special deal for the State of Nebraska. I did not, and I refuse to accept that kind of responsibility or that kind of a suggestion from anyone on that side of the aisle or anyone else.

Then, as it relates to abortion, I think my colleagues know that we introduced legislation that is comparable to the Stupak legislation in the House dealing with barring the use of Federal funds for elective abortions. We introduced it over here, and it was bipartisan. It was Nelson-Hatch-Casey, and it did not pass. So I began the process of trying to find other solutions that I thought equally walled off the use of Federal funds and made it clear that no Federal funds would be used.

Now, apparently I did not say "mother may I" in the process of writing that language because others took issue with it, even though they cannot constructively point out how it does not prohibit the use of Federal funds or wall off those funds or keep them totally segregated. They just did not like the language.

Well, if in the conference the Stupak-Nelson-Hatch-Casey language passes, I will be happy, and so will Congressman STUPAK, and so would, I would imagine, those who signed on to that legislation. It is unfortunate, though, to continue to distort and misrepresent what happens in the body of the Senate. It is difficult enough to have comity. It is difficult enough to have cooperation. It is difficult enough to have collegiality. When politics are put above policy and productivity, this is what we get.

Mr. President, I am very disappointed, somewhat disillusioned, by the use of this method and this approach that would undermine the good name of a company in Nebraska, as well as the name of the State of Nebraska, by associating it with something that has not been done, was not intended, and did not result.

Mr. President, with that, I yield the floor.

The PRESIDING OFFICER. Who seeks recognition?

Mr. BAUCUS. Mr. President, I yield 15 minutes to the Senator from Delaware.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. CARPER. Mr. President, let me just express my thanks for those 17 minutes.

I would ask the Chair to please advise me when I have used 15 of those minutes.

The PRESIDING OFFICER. The Chair will do so.

Mr. CARPER. Mr. President, listening to the debate today reminds me of, among others, a famous quotation from Winston Churchill, who, I believe, said: "The worst system devised by wit of

man”—he was talking about democracy. He said it was the worst form of government devised by wit of man, and then he added “except for all the rest.”

We like to sort of lecture the Iraqis and Afghans on how to run a democracy, and we still struggle with it after more than 200 years. In the 8 or 9 years I have been here, I have never seen us struggle as much as we have on the issue of health care. Part of the reason is because it is just enormously complex, and it is just confusing.

As to the people who are following the debate, if you listen to folks on the political left, mostly in our party, what you hear is: No public option, no Medicare buy-in, we are not doing enough to make health care affordable. What you hear from the right, mostly on the other side of the aisle, is, this is government run, this is government funded, this is a government takeover.

So you have the two extremes out here trying to take shots at one another. Those of us in the middle are sort of collateral damage or road kill. But at the end of the day, a lot of times when you find neither the left nor the right are entirely pleased with the outcome, sometimes that suggests that the outcome is not all that bad.

I am not saying this is a perfect balance, but it is not a bad balance. For those, especially in our party, who feel as though we should have done more, I am sure in 1965, when Lyndon Johnson signed into law the Medicare legislation, there were probably some who did not vote for it—and I am told it was mostly Democrats who voted for it, not so much our Republican friends—but I am not sure how many Democrats who voted for Medicare at the time said: It does not do enough for our senior citizens. It does not provide for hospice care. It does not provide for home health care. It does not provide for disability benefits for those who are under the age of 65. There is no prescription drug program. There is nothing for outpatient surgery. None of those things were in the original Medicare legislation. Over time, they have been added, and I think the Medicare legislation, the Medicare law, has been improved to make it a better program.

Now we face a day when the Medicare Program is literally running out of money. One of the less-told secrets in the legislation that is before us is that the life of the Medicare trust fund—life that has been down to about 7 or 8 years—I understand, thanks to the reforms that are in this legislation, should be pretty much doubled. That is not good enough, but we are going to stretch by about 100 percent the useful remaining life of the Medicare Program.

Another fact that is sort of lost in all the debate, all the tumult, is what this does with respect to our budget deficits. I am told by—not us, not Democrats or Republicans—the neutral Con-

gressional Budget Office, which is neither Democratic nor Republican—nonpartisan—that the legislation, if we adopt it in its current form, will reduce the deficit over the next 10 years by about \$130 billion, and by as much as maybe \$1 trillion, \$1.3 trillion in the second 10 years beyond that.

In terms of what is going to happen as to the cost of premiums, we are told, again, by the nonpartisan Congressional Budget Office that rather than spiking premiums, we are actually going to see people get somewhat better coverage for, frankly, not more money in terms of their premiums.

In terms of those of us who just love the health insurance we have—we are delighted with the coverage and the amount we pay for it—I would just remind all of us of a couple things: One, we have spent more money by far than any nation on Earth for health care—about 1½ times more than the next closest country. We do not get better results. In many cases, we get worse results.

We have about 14,000 people who woke up with health care coverage who will wake up tomorrow morning and they will not have it; they will have lost it. Over 40 million people in our country have no health care coverage at all.

Finally, we have big companies such as GM and Chrysler that have gone bankrupt because they cannot compete with foreign competitors because of the price of our health care; and that is true with a lot of smaller companies as well.

The idea of doing nothing is, to my mind, not a very smart thing to do. We have to do a number of things to accomplish three goals: No. 1, rein in the growth of health care costs. This idea of two, three times the rate of inflation in the growth of health care costs is not sustainable. Frankly, if we do not rein in the growth of health care costs, neither will be sustainable the coverage we extend to people who do not have it today.

The third thing we try to work on in this legislation, to the extent we can—a lot of interesting things are going on in the private sector, very interesting things going on in the private sector, regarding how to instill personal responsibility in employees, and how to get better transparency and better costs through the health care delivery system. That is going to be a part of this as well. But we have to figure out a way to get better outcomes, and there are a lot of good examples for doing that.

I want to take the remaining time I have today to just mention some things that are in the legislation that I think make sense because they are based and founded on what works. And as an old Governor—and Senator NELSON has already spoken from Nebraska—we are used to focusing on

what works and trying to replicate what works, steal ideas from other States and try to work them in our own State. I want to mention a couple things we have taken that work. We are trying to grow them and, in some cases, on a national level.

One of things Senator BAUCUS and his staff in the Finance Committee focused on, I think, is maybe the best idea in the health care legislation, something called an exchange.

When I was a naval flight officer, we used to go to the exchange on the base which was a place to buy stuff. It was like a little department store. The exchange in health care delivery, which will open in January 2014—I hope we can actually stand up the exchanges and open the exchanges sooner—but that is going to be a place for people to go and buy health care coverage. When people do that, they will become part of a purchasing pool in their State or maybe in a couple of States to sort of band together and form a regional purchasing pool.

Why is a purchasing pool important? Well, because we are part of one, and we know that with 8 million people in our purchasing pool—Federal employees, Federal retirees, all of our dependents—we get a lot of competition. A lot of private sector companies want to offer us products to choose from. We don't get cheap insurance, but we get pretty good prices. With 8 million people in a purchasing pool, we really drive down administrative costs to about 3 percent for every premium dollar. That is a lot lower than folks who try to go out and buy it on their own in the open market. They may pay 33 percent of their premium dollar for their administrative costs. They are not paying 3 percent. We are going to try to replicate that. We do it in the exchange.

There may be 50 exchanges throughout the country, some regional exchanges as well. So we do exchanges as well. When States create interstate compacts across State lines, such as Delaware with New Jersey or maybe Delaware and Maryland or Delaware and Pennsylvania, maybe all four of us, insurance sold in any of those four States can be sold across State lines and introduce new competition, additional competition for business and for the folks looking for coverage for those two or three or four States.

Another thing that works is the delivery system, delivery of health care in outfits such as the Cleveland Clinic and the Mayo Clinic, Geisinger in Pennsylvania, not far from where we are in Delaware, Intermountain Health out in Utah, and Kaiser Permanente in California.

I actually went with Rachael Russell, a member of my staff, to the Cleveland Clinic about 3 months ago. What we found was the Cleveland Clinic and the Mayo Clinic and Geisinger and all

these others pretty much all have the same template. They focus on primary care. They focus on prevention and wellness. They coordinate the care of folks who are receiving treatment. All of their patients have electronic health records.

Medical malpractice coverage is provided by the entity itself, the Mayo Clinic, Cleveland Clinic, and all the docs are on salary. They have gone after what we call not just defensive medicine but fee-for-service, and they have done a very good job reducing the problems that flow out of fee-for-service which lead to more utilization and unnecessary utilization of time, tests, technology. They get better outcomes and they spend less money.

What we are trying to do with this legislation is to take those health care delivery ideas from those nonprofits and instill them into the delivery of health care, particularly through Medicare but also in other ways too.

I like to shop for groceries. We have a bunch of good grocery stores in Delaware. One of the places I shop for groceries occasionally when I am in my State is a place called Safeway, in Dover. A guy named Steve Burd is the CEO of the company, and they have really helped inform our decision-making in this debate in ways that are pretty remarkable by virtue of the way they provide coverage to their employees. It is not just Safeway. It is not just Pitney Bowes. There are a number of companies that are figuring out how to get better results for less money, and we are borrowing some of their ideas.

One of the ways we are borrowing is to say, how does Safeway provide—literally flattening out for the last 4 or 5 years—health care coverage for their employees? They haven't reduced their benefits. One of the things they have done is to incentivize their employees, use financial incentives to get employees to—if they are overweight, to control their weight, get their weight down, and if they do that, their payments are reduced. If they are smokers, they get rewarded for stopping smoking. If they have high cholesterol or high blood pressure, they get rewarded by reduced premiums for reducing their cholesterol and blood pressure.

What we have done with our legislation—and I thank the chairman and my colleagues for their support, Democratic and Republican, for supporting an amendment by Senator ENSIGN and myself where employers would be able to provide a 30-percent discount to employees who do the right thing for their own health. By doing that, they will reduce health care costs for not just their employer but for others in the group in which they are covered.

There is another piece in the legislation that really borrows from an idea that is popping up in a couple of cities and maybe a State or two around the

country, and that is, Why don't we better inform people? We are interested in personal responsibility, people taking charge of their own health and reducing their health care liability. Why don't we do a better job of ensuring that—when I go into a restaurant or anybody goes into a restaurant, we look at the menu board of a chain restaurant and we know right then and there what the calories are in what we are drinking or eating, for an entree, for a salad or dessert. I know it right there by looking at the menu board if it is a chain restaurant. If it is a menu, not a board, they have to have that information on the menu. They have to have on site additional information on 10 other items, including fats, trans fats, cholesterol, sodium, and on and on.

The idea is to make us better informed consumers. As we try to fight obesity in this country—about a third of our country is obese or overweight, and adults are worse than kids. Kids are catching up with their parents, unfortunately. That is one of the things that is in the legislation. We call it the Lean Act. The idea is to try to provide personal information so people can assume personal responsibility.

Speaking of what we should eat or not eat, I wish to mention doughnuts, and I will do it in the context of something called the doughnut hole. Folks who are Medicare eligible have probably heard this term before because under the Medicare prescription drug program, when people's out-of-pocket costs reach about—when their cost for medicines, their prescription medicines, reach about \$2,500, the first \$2,500, Medicare pays 75 percent of the cost and the individual pays 25 percent of the cost. But once a person's prescription costs reach \$2,500 up to about \$5,500, for most people Medicare doesn't pay anything and the individual pays it all. That \$2,500 to \$5,500 gap is called the doughnut hole. It has nothing to do with doughnuts, but that is the name we have given to it.

In the legislation that is before us—again, I give a lot of credit to our chairman and others who have negotiated this—we are going to fill the doughnut hole. We are going to basically cover people who are in that gap of the \$2,500 to \$5,500 so that people will be able to continue to take the medicine they need to take. They won't stop. They will have the availability to medicine.

They will also have access to something called primary care. I am at the tender age of 62, and I think my Presiding Officer, also from Delaware, is just about the same age as I. When people in this country end up being old enough for Medicare, they get a one-time-only Medicare physical. That is it—one time. If they live to be 105, they never get another one, at least not paid for by Medicare.

In terms of borrowing good ideas from the nonprofits, the Cleveland Clinics and the Mayo Clinics, we are going to say you get more than just one physical. You get it when you are 65 and 66 and 67 and 68, and if you live to be 105, God bless you, you will get it every year up until then; finding out what is right with people, what is wrong with people, and what they need to do more of or less of. That is a smart idea, and it is part of the reforms in the legislation.

In terms of going back to medicine, we want to make sure people have good access to primary care, annual physicals if they are on Medicare, so their doctor can find out what is wrong with them, if they need to exercise, stop smoking, control their weight, whatever that might be, but also to learn if there are some medicines they ought to be taking, and second, to make sure they can afford them. Third, our legislation actually improves their lives in terms of if medicines are prescribed, they will actually be taken and used the way they are prescribed.

There is a little piece in this legislation that Senator RON WYDEN deserves a lot of credit for called personalized medicine. The idea is that if there are certain people who, because of their genetic makeup, the way God made them, they have a particular condition and the medicine is not going to help them—if the same group of people have the same problem—or if a different group of people have a different genetic makeup and the medicine will help one group and not the other, we want to make sure we spend the money on the folks who will be helped and not waste money on the folks who will never be helped because of their genetic makeup—literally, the way the Good Lord made them. That is called personalized medicine, and it is in this legislation. I think in the future it will be a very important addition.

Lastly, I want to build on a proposal offered again by Senator BAUCUS with Senator ENZI, and the issue is defensive medicine.

The ACTING PRESIDENT pro tempore. The Senator has used 15 minutes.

Mr. CARPER. Thank you.

The issue is defensive medicine. The issue is medical malpractice. There have been a couple of amendments offered by friends across the aisle for us to try to deal with the incidence of medical malpractice lawsuits, the defensive medicine that sort of flows from there where doctors prescribe really too many tests and too many procedures and maybe too many of the wrong kinds of medicine just in an effort to reduce the likelihood they are going to be sued. What we have done here is to take an idea from the States.

The States have done some very interesting stuff with respect to trying to make sure we reduce the incidence of medical malpractice lawsuits, that

we reduce the incidence of defensive medicine, and we actually improve health care outcomes. We are going to take those ideas, one called Sorry Works that they were using up in Michigan where people have an opportunity—doctors have an opportunity to apologize and offer a financial settlement to people and patients who have been harmed by that doctor; an idea called panels of certification like we have in Delaware where before I can sue my doctor I have to go before a panel to find out if my suit has any basis in fact. We are going to take ideas like safe harbor. If a doctor does all the things by the book, everything by the book, should that doctor receive some kind of expectation that maybe they are safe from lawsuits or reduced exposures to lawsuits? We think there should be some of that. There is the idea of health courts, where there are folks on the court, like the bankruptcy courts, folks who are the experts, and before a suit can actually go into a court, that health court would actually sit in determination of whether a doctor or a hospital or a nurse has really messed up. Those are all ideas that are being talked about, experimented with.

We are going to make sure they are robustly tested. States are going to apply for grants to test those ideas and maybe others to accomplish three things: one, reducing medical malpractice lawsuits; two, reducing the incidence of defensive medicine; and three, and most importantly, improving health care outcomes.

Those ideas build on what works. They are not Democratic ideas. They are not Republican ideas. I think they are just smart ideas for the most part. They are ideas that, as time goes by, people will find out if they really do the trick in helping to rein in health care costs so the coverage we extend can be sustained.

I will just close with this, if I could. For the folks in this country who are totally confused by all this, for the people who are scared that we are doing something really foolish and it is going to be a disaster for our country, let me just say that when all the negative ads sort of stop being funded, when folks have actually had a chance to understand some of the things I have talked about here today and a lot of the aspects of the bill that really will improve outcomes, that really will rein in the growth of cost, that really will extend coverage, I think they really will be pleasantly surprised.

In closing, I am the guy who came here always believing that Democrats and Republicans should work together. I know our chairman tried mightily in the Finance Committee to do that, and I commend him and others for their effort. When we come back, we can't have another 12 months of this or 12 years of this. Our country is in trouble if this is the way we are going to be

doing business in the future. Our country is in trouble.

My hope is that we will get this done, we will get it behind us, we will improve the bill in conference, and the President will provide a signature for us, and we will go back to work on implementing this. Just like Medicare. Just like Medicare. The key isn't just to stop; the key is to make it better and to build on this as a foundation. I am committed to doing that. I know my colleagues on this side of the aisle are committed to doing that. My hope and prayer is that our friends on the other side will want to join us in that effort.

Again, I commend our chairman of the Finance Committee, our leadership, Senator REID, and others. I commend my friend OLYMPIA SNOWE, who showed a lot of courage during the course of this debate in committee and here on the floor. She was under enormous pressure, as were some of our Republican colleagues on the Finance Committee whom I am convinced would like to have been with us, and I believe we would have had an even better bill if the pressure from within their own party had allowed them to be more fully participative. But that wasn't the case this time. It has to be the next.

On that happy note, I say to my colleagues, we will gather again after the holidays and get this job done and look forward to working on a host of other issues. None will be more important than this one. None will be more important than this one.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, I want to begin by saying I agree with my colleague from Delaware. This partisanship has to stop. It is just too much. It is ironic, it is bittersweet that we are reaching a high point because we are going to pass health care reform legislation, but we are reaching a low point, too, in terms of partisanship. It is very unfortunate. Many of us over the last several days have been scratching our heads just trying to figure out what we can do to avoid this next year. Hope springs eternal.

I know this Senator and I know the occupant of the chair want to try to find ways for this body to be much more civil. We are not just blowing smoke here. We really mean it. I thank very much the Senator from Delaware for raising that point. It is needed, and I do think this country is in trouble if we don't find some solution to handle this excessive partisanship which is certainly hurting our country.

On another matter, some of my colleagues on the other side of the aisle have asserted that the penalty that is proposed under the bill before us for failing to maintain health coverage is unconstitutional. One Senator has

raised a point of order—Senator ENSIGN—on that subject, and that is now pending.

Those of us who voted to proceed to the health reform bill and who voted for cloture on the substitute amendment take seriously our oath to defend the Constitution. Every Senator here takes that oath of office very seriously.

We have seriously looked at this question as well and have concluded that the penalty in the bill is constitutional.

Those who study constitutional law as a line of work have drawn that same conclusion. Most legal scholars who have considered the question of a requirement for individuals to purchase health care coverage argue forcefully that the requirement is within Congress's power to regulate interstate commerce.

Take Professor Erin Chemerinsky, a renowned constitutional law scholar, author of four popular treatises and casebooks on constitutional law and the dean of the University of California Irvine School of Law. Professor Chemerinsky has gone so far as to say that those arguing on the other side of the issue do not have "the slightest merit from a constitutional perspective."

In arguing that a requirement to have health care coverage falls within Congress's power to regulate interstate commerce, Professor Chemerinsky compares health care reform to the case of *Gonzales v. Raich*—often cited by the other side. In that case, the Supreme Court held that the Federal Government's commerce clause powers extend to the cultivation and possession of small amounts of marijuana for personal use. Professor Chemerinsky notes that the relationship between health care coverage and the national economy is even clearer than the cultivation and possession involved in *Gonzalez v. Raich*.

Mr. President, I ask unanimous consent that Professor Chemerinsky's Los Angeles Times article be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[FROM THE LOS ANGELES TIMES, OCT. 6, 2009]

THE CONSTITUTIONALITY OF HEALTHCARE

(By Erwin Chemerinsky)

Are the healthcare bills pending in the House and Senate unconstitutional?

That's what some of the bills' critics have alleged. Their argument focuses on the fact that most of the major proposals would require all Americans to obtain healthcare coverage or pay a tax if they don't. Those too poor to afford insurance would have their health coverage provided by the state.

Although the desirability of this approach can be debated, it unquestionably would be constitutional.

Those who claim otherwise make two arguments. First, they say the requirement is beyond the scope of Congress' powers. And second, they say that people have a right to be

uninsured and that requiring them to buy health insurance violates individual liberty. Neither argument has the slightest merit from a constitutional perspective.

Congress has broad power to tax and spend for the general welfare. In the last 70 years, no federal taxing or spending program has been declared to exceed the scope of Congress' power. The ability in particular of Congress to tax people to spend money for health coverage has been long established with programs such as Medicare and Medicaid.

Congress has every right to create either a broad new tax to pay for a national healthcare program or to impose a tax only on those who have no health insurance.

The reality is that virtually everyone will, at some point, need medical care. And, if a person has certain kinds of communicable diseases, the government will insist that he or she be treated whether they are insured or not. A tax on the uninsured is a way of paying for the costs of their likely future medical care.

Another basis for the power of Congress to impose a health insurance mandate is that the legislature is charged with regulating commerce among the states. The Supreme Court has held that this means Congress has the ability to regulate activities that have a substantial effect on interstate commerce. A few years ago, for example, the court held that Congress could prohibit individuals from cultivating and possessing small amounts of marijuana for personal medicinal use because marijuana is bought and sold in interstate commerce.

The relationship between healthcare coverage and the national economy is even clearer. In 2007, healthcare expenditures amounted to \$2.2 trillion, or \$7,421 a person, and accounted for 16.2% of the gross domestic product.

The claim that individuals have a constitutional "right" to not have health insurance is no stronger than the objection that this would exceed Congress' powers. It is hard to even articulate the constitutional right that would be violated by requiring individuals to have health insurance or pay a tax.

Since the 19th century, the Supreme Court has consistently held that a tax cannot be challenged as an impermissible taking of private property for public use without just compensation. All taxes, of course, are a taking of private property for public use, and a tax to pay for health coverage—whether imposed on all Americans or just the uninsured—is certainly something Congress could impose.

The claim that an insurance mandate would violate the due process clause is also specious. Most states have a requirement for mandatory car insurance, and every challenge to such mandates has been rejected. More important, since 1937, the Supreme Court has constantly held that government regulations of property and the economy will be upheld as long as they are reasonable. Virtually every economic regulation and tax has been found to meet this requirement. A mandate for health coverage would meet this standard, which is so deferential to the government.

Finally, those who object to having health coverage on freedom-of-religion grounds also have no case. The Supreme Court has expressly rejected objections to paying Social Security and other taxes on religious grounds. More generally, the Supreme Court has ruled that individuals do not have a right to an exemption from a general law on the ground that it burdens their religion.

There is much to debate over healthcare reform and how to achieve it. But those who object on constitutional grounds are making a faulty argument that should have no place in the debate over this important public issue.

Mr. BAUCUS. Mr. President, as a second example, I refer my colleagues to an article by Mark Hall, a law professor at Wake Forest University. His article is a comprehensive peer-reviewed analysis of the constitutionality of a Federal individual responsibility requirement.

In this article, Professor Hall concludes that there are no plausible 10th amendment or States' rights issues arising from the imposition by Congress of an individual responsibility to maintain health coverage.

Professor Hall notes further that health care and health insurance both affect and are distributed through interstate commerce, and that gives Congress the power to legislate a coverage requirement using its commerce clause powers.

Professor Hall notes that the Supreme Court indicated in its decision in *U.S. v. Morrison* and *U.S. v. Lopez*—two other cases relied on by the other side—that the noneconomic, criminal nature of the conduct in those cases were central to the Court's decisions in those cases that the government had not appropriately exercised power under the commerce clause.

Health insurance, on the other hand, does not deal with criminal conduct. Health insurance is commercial and economic in nature and, to reiterate, substantially affects interstate commerce.

Health insurance and health care services are a significant part of the national economy. National health spending is 17.6 percent of the economy, and it is projected to increase from \$2.5 trillion in 2009 to \$4.7 trillion in 2019.

Private health insurance spending is projected to be \$854 billion in 2009. It covers things such as medical supplies, drugs, and equipment that are shipped in interstate commerce.

Health insurance is sold by national or regional health insurance carriers. Thus, health insurance is sold in interstate commerce. As well, claims payments flow through interstate commerce.

The individual responsibility requirements, together with other provisions in the act, will add millions of new consumers to the health insurance market, increasing the supply and demand for health care services.

Under existing health and labor laws, the Federal Government has a significant role in regulating health insurance.

Other prominent legal scholars have also said that Congress has the constitutional authority to impose a requirement on individuals to maintain health coverage.

Jonathan Adler, a professor of law at Case Western Reserve University School of Law, stated:

In this case, the overall scheme would involve the regulation of "commerce" as the Supreme Court has defined it for several decades, as it would involve the regulation of health care markets. And the success of such a regulatory scheme would depend upon requiring all to participate.

Doug Kendall of the Constitutional Accountability Center similarly concluded:

The fundamental point behind pushing people into the private insurance market is to make sure that uninsured individuals who can pay for health insurance don't impose costs on other taxpayers.

Professor Michael Dorf of the Cornell University Law School also noted:

[T]he individual mandate is "plainly adapted" to the undoubtedly legitimate end of regulating the enormous and enormously important health care sector of the national economy. It is therefore constitutional.

Robert Shapiro, a professor of law at Emory University School of Law, stated:

When everyone thinks of the wisdom of an individual mandate, or of health care reform generally, it would be surprising if the Constitution prohibited a democratic resolution of the issue. Happily, it does not.

Thus, Mr. President, the weight of authority is that health care and insurance represent interstate commerce. The individual responsibility requirement to maintain coverage would be within Congress's power to regulate interstate commerce.

Mr. President, in the last hour, several Senators on the other side listed many organizations they claim oppose the bill before us. I will indicate many organizations that favor the health care reform bill.

I will begin with the American Medical Association. That is the major doctors association that supports this legislation. In fact, the incoming president, the president-elect of AMA, at a press conference yesterday, made that statement very clear.

In addition, the American Heart Association supports the legislation. They believe the many patient-centered provisions are a significant step toward meaningful health care.

The American Hospital Association supports passage of the legislation.

The American Cancer Society Action Network supports it.

The Federation of American Hospitals also supports it.

The National Puerto Rican Coalition supports this legislation.

Mr. President, it would be unfair to say that these are all totally 100 percent endorsements. Rather, these are statements of support from these organizations. Some totally support it, and some say there are very good features in it. As far as I know, none of these groups totally oppose this legislation. Some would like to see some changes, but they favor the legislation.

The American Association of Retired People supports this legislation. That is the largest seniors group. They think this is good—I am sure for a lot of reasons, but it extends the solvency to the Medicare trust fund for another 5 years.

The Business Roundtable supports this legislation. They say:

On behalf of the members of Business Roundtable, I want to commend you for your efforts to improve the health care reform legislation currently being considered by the United States Senate. The proposed legislation is a step toward our shared goal of providing high quality, affordable health care for all Americans. . . . As we understand it, the proposed legislation now will include provisions to accelerate and enhance the process for delivery reform for the Medicare system. . . . It strengthens the match between the insurance reforms and the individual obligation. . . . We will continue to work with you, the Congress and the Administration to ensure we achieve the goals we all set when this process began.

The American Diabetes Association also supports this bill. They say it is “long overdue improvements to our broken health care system.”

The Small Business Majority also believes the managers’ amendment “includes new provisions essential for small business protection and survival.”

Doctors for America supports passage of this bill.

The National Hospice and Palliative Care Organization strongly supports this legislation. There has been confusion as to whether they did. But they strongly support it, saying:

On behalf of hospice and palliative care providers and the more than 1.5 million patients, and their families . . . would like to express our strong support for the national effort to enact health care reform. We acknowledge the enormity and complexity . . . and we applaud your recognition of the importance of various provisions. . . .

Families USA supports this legislation. I already mentioned AARP, which also supports it. Community Catalyst is another organization that supports it. U.S. PIRG supports it. The Center for American Progress supports it. Medco Health, Microsoft, a big company in the United States, makes a strong statement approving the measure we are considering here.

Many organizations support this legislation. I am sure there are more, but this is an example of a few.

How much time remains on our side? The ACTING PRESIDENT pro tempore. There is 10 minutes remaining.

Mr. BAUCUS. Mr. President, I yield 10 minutes to the Senator from Pennsylvania.

The ACTING PRESIDENT pro tempore. The Senator from Pennsylvania is recognized.

Mr. CASEY. Mr. President, I commend the work of our Finance Committee chairman, MAX BAUCUS, for so many things in this debate. First, for helping us get health care legislation

moving in 2009 and now at the point of getting close to passing the bill. I am grateful for his leadership. There are some highlights of the bill I want to note in the remaining moments of our time.

First, there has been a lot of debate over the last couple of days and weeks—but even over months—about cost and care. Fortunately, we are able to report that with this bill coming out of the Senate, we will have more care and less costs. The deficit will be cut by \$132 billion over 10 years as a result of this bill; \$1.3 trillion will be cut in the deficit in the second decade.

It will provide coverage for 94 percent of the American people. This has not been talked about much, but the bill is a net tax cut for the American people. We are going to crack down on insurers’ practices that have gone on too long, were allowed to go on for too many years: ending preexisting condition discrimination, and discrimination based upon gender, providing protection from exorbitant out-of-pocket costs, something we hear about all the time.

Just with regard to older citizens across our country, one, the bill will extend the solvency of Medicare; two, it makes prescription drugs more affordable by filling the so-called doughnut hole and helping people with those costs; cutting waste, fraud, and abuse in Medicare; ensuring Medicare funding to improving care for seniors not to insurance companies.

Small businesses—if there was one sector of our economy we have heard from over and over about the crushing burden of health care costs, it is small businesses. I know that tens of thousands of small businesses in Pennsylvania, for example, will benefit from this legislation.

There are two points with regard to the bill and small business. First, the bill provides tax credits to small businesses to make employee coverage more affordable.

Second, tax credits of up to 50 percent of premiums will be available to eligible firms that choose to offer coverage—a tremendous breakthrough for people out there who are creating most of the jobs in Pennsylvania and most of the jobs nationally.

One of the more unreported or underreported aspects of the bill is what happens immediately. A lot of folks say: We like your bill. We like what is going to happen. But a lot of it won’t take effect for at least several years, until 2014.

A good part of the bill takes effect in 2010. A quick summary of those provisions: First, it provides affordable coverage to the uninsured with preexisting conditions. If there is an insurance company that excludes you because of a preexisting condition, you can go into a high-risk pool to get help right away.

It improves care to older citizens, as I mentioned, and lowers prescription drug costs.

It reduces costs for small businesses through tax credits.

Fourth, it extends coverage for young adults—young adults 25, 26 years old, who may be living under difficult circumstances and don’t have insurance coverage. Preventive care—we preached and talked about that for years, and we point to studies and good practices, but we have never made it part of our overall health care bill. This bill does it.

We eliminate lifetime limits on the amount of coverage a person may receive—a terrible problem for families. The message from our system has been that we can cure you, but we have to limit the kind of care we are going to provide for you.

Three more points in this area: What are the immediate benefits in 2010? It prohibits discrimination based upon salary, gender, or illness. We make insurance plans more transparent and competitive.

Finally—and this is a rather new change—it prohibits insurance companies from denying children coverage due to a preexisting condition.

That has moved up in the bill, so to speak, to an immediate benefit for children. So at least in the short term for children, there will be no more denying them coverage due to a preexisting condition—a tremendous breakthrough for a child, for his or her family, and for our economy and for our health care system, to protect children in a very substantial way. Whether it is cutting the deficit, providing better quality of care, providing opportunities for great prevention which will lead to a healthier outcome, protecting people so they do not have to go bankrupt to get the care they need, and especially for protecting older citizens and children, this bill moves forward in a way we have never had an opportunity to move our system forward in a very positive way.

I again commend Chairman BAUCUS on his work and our majority leader, HARRY REID, and all those who made it possible to move this bill forward and to have it passed through the Senate and move it to enactment.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, I see no Senator seeking recognition. I ask unanimous consent that the next block of time begin immediately.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The Senator from Florida.

Mr. LEMIEUX. Mr. President, I thank the chairman of the Senate Finance Committee for his courtesy. I appreciate the opportunity to be here.

I understand, Mr. President, I have a certain allotment of time. If I can be

notified when I have 2 minutes remaining, I would appreciate that.

The ACTING PRESIDENT pro tempore. The Chair is unaware of any restrictions. There is 1 hour for the Senator's side.

Mr. LEMIEUX. OK. If I can be notified when I have spoken for 20 minutes.

The ACTING PRESIDENT pro tempore. The Chair will so notify the Senator.

Mr. LEMIEUX. Mr. President, I rise today to talk about this health care bill. I have spoken about it before. I feel obligated on behalf of my State of Florida to explain why I, unfortunately, will not be able to support this bill on final passage. I think, in doing so, it is important to talk about why we are here and how we got here.

I am sure the American people think that in this process of debating health care over the past weeks and months, this has been a process where both sides, Republicans and Democrats, have worked together, sat in an open room and gave ideas back and forth; that there has been give-and-take and compromise so that we could come to the plan that is before us today. I am sure the American people believe that amendments were offered, that each Senator could come to the floor and offer amendments and that his and her colleagues were allowed to hear about those amendments and vote them up or down. I also believe the American people think we do not just come to this Chamber and give monologs. They probably think this room is not empty and that there are just two of my distinguished colleagues here but that we all sit here and listen to each others' arguments and decide what is best for the American people.

Unfortunately, that is not the case with this bill. This bill was designed and crafted by the Democratic leadership, without the input of the colleagues from this side of the aisle. There was no give-and-take. There was no back-and-forth in a conference room with C-SPAN in the room, as the President told us he would ensure when he ran for the Office of the Presidency. And we did not have the opportunity to offer amendments to make this bill better.

I know that seems hard to believe, that we would not have the ability to offer amendments to make this bill better, but I can prove it to you.

I have an amendment at the desk. It is amendment No. 3225. What this amendment does is it takes a piece of legislation I filed shortly after coming to the Senate in September of this year—the legislation is called the Prevent Health Care Fraud Act of 2009. This legislation has 11 cosponsors. It has bipartisan support.

What the bill does is basically three things:

First, it creates the chief health care fraud prevention officer of the United

States. It would be the No. 2 person at Health and Human Services. Their only job would be to ferret out health care fraud.

Second, it would use and take a page from the private sector to go after fraud. There is an industry out there right now that does an excellent job of stopping fraud. That industry is about the same size as the health care industry. It is the credit card business. It is about a \$2 trillion business. Health care is about a \$2 trillion business. In health care and in Medicare alone, estimates are that \$1 out of every \$7 in Medicare is fraud. In the credit card business, it is pennies on the hundreds of dollars.

How does the credit card business do it? We have all had this experience. You go to purchase something in a store, and when you leave, you get an e-mail or a phone call and your credit card company says to you: Did you really mean to purchase that good or service? Guess what. If you say no, they don't pay. The way we do things in Medicare and Medicaid is we do pay-and-chase. We pay, and then when we think there is fraud, we try to go after it.

This model stops the fraud before it starts. A group here in Washington, DC, has evaluated this legislation and says that it might save as much as \$20 billion a year in Medicare alone. We think there is \$60 billion in fraud in Medicare—\$1 out of every \$7.

This proposal that we put forward also would require background checks for every health care provider in America to make sure they are not a criminal. Florida, my State, unfortunately is ground zero for health care fraud. We have the worst health care fraud in America. Just this past weekend, and I sent this letter around to my colleagues—a \$61 million Medicare fraud scheme out of Florida and some other States.

My bill, this proposal which has bipartisan support, could save \$20 billion a year. We have fashioned this bill into an amendment to this health care bill.

Mr. President, I ask unanimous consent that the pending amendment be set aside to call up my amendment. It is amendment No. 3225.

The ACTING PRESIDENT pro tempore. Is there objection?

Mr. BAUCUS. Reserving the right to object, and I hope my colleague will let me say a word or two in my reservation, the underlying bill, while certainly objective, was crafted with the guidance of CMS, the Office of the Inspector General, HHS, and the Justice Department for stronger antifraud. It would give CMS new screening authority to provide resources to CMS for new screening authority. It also limits providers in other ways but more oversight when fraud is suspected, such as limiting durable medical equipment providers because we know it is fraught

with fraud. We also require providers to have compliance programs, make sure providers know the rules. There are increased penalties for fraudulent activity in the bill as well. Most importantly, we will give CMS, HHS, OIG, and DOJ more tools at their disposal to preserve and protect the program's integrity. The bill does a lot to protect fraud.

I might say, I know this is on his time, but this procedure has been unusual. I appreciate the indulgence of the Chair, as well as the indulgence of the Senator from Florida.

You will not believe the number of amendments that were offered on a bipartisan basis in the Finance Committee, as well as in the HELP Committee. They were adopted in both committees. It was very transparent, open, bipartisan. Unfortunately, by the time the bill got to the floor, it became apparent we were facing less than the nature of legitimate amendments, more message amendments. So the majority leader resorted to a procedure to move this bill expeditiously.

I am taking advantage of the Senator's time to explain all this. That is not the proper procedure. There are strong antifraud provisions in this legislation, and very respectfully I must object.

The ACTING PRESIDENT pro tempore. Objection is heard.

Mr. LEMIEUX. Mr. President, I thank the distinguished chairman of the Finance Committee. Sure, there are things in this bill that he pointed out to go after fraud. But I would like to inform the Senate of a report that came out evaluating this new bill, the managers' amendment.

I have a table which evaluates how much will be saved from the waste, fraud, and abuse provisions which are in this bill. It is \$9 billion. The proposal that I have, one group—and, again, it is not the CBO—one group has said it might save \$20 billion a year.

Putting aside our differences, I sure wish we could talk about my amendment today, I say to my colleague. I hope we can revisit it after this is over because we should be able to agree, and it does have bipartisan support. I wish we could amend the bill today. I hear the objection, and I will move on. I hope we can talk about this.

Mr. BAUCUS. I ask the Senator if he might yield using time on our side. I fully agree with the Senator. It is unfortunate we cannot proceed at this moment. But I pledge my support next year to work aggressively with very strong oversight to boost our antifraud measures even more than they are in this bill.

There will be an awful lot of oversight necessary when the bill is passed to make sure all the provisions that are intended come true. In fact, we think we are working hard to get it passed; frankly, I think we have to

work harder next year to make sure the provisions work. I pledge my support to work aggressively in that area.

Mr. LEMIEUX. I thank the chairman. I wish we could do it before we had to rush to judgment on this bill. I wish we had more time. I wish we did not have to be backed up against a wall before Christmas. I understand colleagues on the other side have a desire to get this bill done. But it is my concern with this measure and with the other measures in the bill that we could have worked together.

Mr. President, I say to the chairman, I am new to the Chamber. But this is not the way businesses work. It is not the way American families work. It is not the way even State legislators work, which I have experience with in Florida.

I wish we could have talked about that amendment and offered it. I wish my colleagues were here to debate it up or down. Let's talk about where we are instead. Let's talk about what this bill does and why I cannot, unfortunately, support it as a Senator from Florida.

We know this bill cuts Medicare by nearly \$½ trillion. We know this bill raises taxes by nearly \$½ trillion. And we know it does not accomplish the fundamental goal the President put forward when we embarked on this debate about health care reform.

The American people are beginning to realize and if they have not realized yet will be shocked to hear that this bill is not going to cut the cost of health care for people who have insurance already. That is the very reason this debate was embarked upon, not just access for people who do not have health care insurance but to bring the costs down. Health care has gone up 130 percent in the past 10 years. This bill will not address that. In fact, estimates show that for some folks, the cost of health care will go up.

There are basically five reasons why I cannot support this measure as a Senator from Florida.

I am concerned, first of all, about access and quality of care for our seniors. When you take \$½ trillion out of Medicare, my fear is that it is going to diminish the quality of care for seniors in Florida.

It is said on the other side that we are not going to take away benefits, that we are just going to take money away from providers. It was said on the other side that the new insurance will take care of uncompensated care, so that the cuts to hospitals and to other providers will not really hurt seniors in the end. I think that is a tremendously risky experiment.

I cannot believe, at the end of the day, when we pay providers less, it is not going to affect benefits. Right now, studies show that 24 percent of seniors on Medicare trying to find primary care physicians cannot find one. I get letters from seniors in Florida who say

they cannot find a doctor who will take their Medicare. We know in Medicaid it is worse. We know in Medicaid that if you are just going into the program and trying to find a physician, almost 40 percent of the physicians will not take you. In metropolitan areas for specialists, it is up to 50 percent who will not take Medicaid.

I fear that if we take nearly \$½ trillion out of a program that is already in financial trouble, a program that in the next 7 years is going to be in serious financial trouble and not be able to meet its obligations, that it is going to hurt seniors.

I have heard this discussion about how we are prolonging the life of Medicare. The distinguished chairman just spoke about it. But when you look at what the Actuary at HHS has said about that assumption, the assumption is that we are not going to restore the 21-percent decrease in physician payments which, of course, as soon as we get back in the new year, we are going to have before us.

You cannot take money out of Medicare and pay for a new program and shore up Medicare. You do not need an actuary or an evaluation or an analyst to tell you that. It is common sense. You cannot get blood from a stone. If the doctor is not in, it is not health care reform.

I have received a letter, as many of my colleagues have, from an organization called 60 Plus which represents 5.5 million seniors. James Martin, the president of 60 Plus, writes:

Cutting half a trillion dollars from Medicare while adding 31 million more to the health care rolls is an outrage.

60 Plus strongly supports health care reform but first we should do no harm to a system serving so many so well. . . . Make incremental changes that do not bankrupt a system already teetering on insolvency.

I want to talk a minute about Medicare Advantage. There are more Floridians in Medicare Advantage than any other State. A lot has been said about this program. We have had amendments to try to stop the cuts. Mr. President, 950,000 Floridians—Medicare Advantage is a great program, and people in Florida enjoy it. Seniors enjoy it because they get more than regular care; they get eye care, hearing care, wellness, diabetic supplies, and other things that add to the quality of life of seniors and help their entire health care. These Medicare Advantage providers are actually working hard to make sure their senior customers are happy, not a concept you hear a lot about when the government is in charge.

There is a fix for Florida, as has been talked about, but I wish to talk about what that fix is, as I understand it. It is an off-ramp. For the rest of the country, it is going to be somewhat of an exit. For Florida, it is an off-ramp.

First of all, we don't know what will happen in conference. The Senate cuts

\$120 billion; the House cuts \$170 billion. I don't know if the Florida fix will still be there. But in talking to experts and reading the bill myself—specifically around page 895 through about 901 of the original Reid bill—there is this grandfathering in for folks in Florida, and other areas, but part of Florida is covered. Of the 950,000 people, the experts think 150,000 to maybe as many as 250,000 will not get this grandfathering in. They are going to get the cuts to Medicare Advantage. So this is not good for them. Then, for the others, say, 700,000 people or so, every year, starting in 2013, their benefits—or the payments to the providers for benefits—are going to decline 5 percent a year. That is on pages 895 through 897. So it is an off-ramp. Every year, less payments. Every year, less benefits.

I talked to one provider down in Miami that many Senators in this Chamber have visited. He runs a very successful Medicare Advantage Program. He said these cuts would be devastating. So while it might not be an exit for Florida right away, it is certainly going to be an off-ramp that one day ends up being an exit.

Let's remember that many of the folks on the other side of the aisle who are proposing these cuts to Medicare Advantage didn't vote for Medicare Advantage to start with. They don't like it. They don't like the private sector being involved. They don't like these extra benefits being provided. It goes against what they philosophically believe. But I know Floridians like it. Because this bill cuts it, I can't be for it. No one can guarantee to me that in the next 10 years Medicare Advantage in Florida will be as robust as it is today.

I am concerned also about the home health care payments. I am concerned about what it is going to do to the small business home health care providers in Florida. I talked to the largest provider of home health care services in Florida, and he said: We will be fine, but the small businesses—the mom and pops who do this—will go out of business. That is disconcerting in a State with 11½ percent unemployment.

The second reason I can't support this bill is this is going to have a devastating effect on our State budget in Florida. We talked today to the head of the Florida health care system, the Agency for Health Care Administration, and these increases in Medicaid, raising Medicaid from 100 percent of poverty to 133 percent, are going to cost Florida an estimated \$3½ billion over the next 10 years. That is \$3½ billion Florida can't afford to pay.

Our budget has gone from \$73 billion to \$66 billion in a short period of time with the economic decline. Unlike this Chamber, which spends money it doesn't have, Florida has to balance its budget. So what happens when you have less money? You have to cut programs. But when you have a Federal

mandate, you can't cut that. So what do you cut? You cut education and teachers. You cut law enforcement—not good for Florida. This is a burden Florida can't afford to pay. That is why all the Governors in the country—virtually Republican and Democratic alike—including our Governor, Charlie Crist, are against this unfunded mandate.

The third reason I can't support this bill is because it raises taxes—\$518 billion. What happens when the drug company that makes your medicine or the medical device company that makes the lifesaving implement for you gets taxed? They are going to pass it along to you. They are going to put it right in the bill. That is the way it is going to work. That is why health care costs aren't going down for the 170 million Americans who have health insurance. In fact, for some, they are going to go up. That is not health care reform.

Fourth, this is a budget-busting bill. It is not deficit neutral. Let me explain why. You will hear reports this is going to cut more than \$100 billion from the deficit over the next 10 years. Only in Washington, DC, could you come to this calculation. It is funny math. We have this Congressional Budget Office, which is sort of the arbiter of all things financial here in Washington. You send them a proposal and they give you an answer. But it is not a thinking answer; it is an analytical answer, and it gets gamed. What you send them determines what you get back. They only look at a 10-year period—what it is going to cost in the next 10 years. If you bring in more money than you spend in the next 10 years, then it will cut the budget. It will cut the deficit. That is what they say back to you.

So what was done in this bill in order to get something that would fulfill the President's promise to be a budget cut or at least deficit neutral? We have 10 years of taxes and 6 years of benefits. Most of the benefits don't start until 2014, yet the taxes start in 2 weeks—in January. That is akin to you going to buy a home and saying: I am going to live here for 10 years, and they say: That is great, start paying today and you can move in in 2014.

It is funny math. This is a \$2.5 trillion new entitlement program we can't afford. We can't afford the programs we have, let alone the programs the majority in this Chamber want. We have a \$12 trillion deficit. We have \$30-some trillion in unfunded entitlement deficit. We have hundreds of thousands of dollars of debt for every family in America, and no plan to pay for it. We spend more than we take in. We spent \$1.4 trillion—we have a \$1.4 trillion deficit this year—just the debt this year. That is more than the past 4 years combined.

The American people are on to this and they are angry about it and they should be.

The ACTING PRESIDENT pro tempore. The Senator has used 20 minutes.

Mr. LEMIEUX. Fifth and finally, the reason I can't support this bill is it doesn't lower the cost of health insurance for Americans.

The Congressional Budget Office has said the majority of Americans would see the same increases as they currently get under the current system. For some people, individual policies, for example, they will receive a 10- to 13-percent increase.

I am going to conclude by saying this, and this will probably be the final time I will speak before we have final passage on this bill. I long for what could have been. We could have worked together. We could have had an 80-vote bill. We could have had a bill that would say insurance companies can't drop you if you are sick, insurance companies can't deny you if you have a preexisting condition, insurance companies can compete across State lines, set up an exchange, give a tax credit to the American people, put money in their pocket, let them be consumers who go out and buy health insurance and drive the cost down because the market economy would, once again, work in health care.

This bill doesn't solve the problem. It perpetuates it and makes it worse. At the same time, it cuts health care for seniors and doesn't lower the cost of health insurance for most Americans. For more and more seniors, the doctor will not be in. That is not reform. For those reasons, respectfully, for that lost opportunity, I will not be able to support this bill.

I yield the remainder of my time to my friend and colleague from Alaska.

The ACTING PRESIDENT pro tempore. The Senator from Alaska is recognized.

Ms. MURKOWSKI. Mr. President, I wish to acknowledge the very eloquent and articulate comments of my friend from Florida. We recognize that his time in the Senate has been relatively short, but in terms of an individual jumping in with both feet and embracing the challenges we clearly have in front of us and representing the constituents of the State of Florida in the manner he has, I think that deserves public recognition, and I thank the Senator for his leadership.

We have had occasion to talk about the similarities between Alaska and Florida. You might not think there would be much in relationship there—my being from the North and the cold versus the sunny South in Florida. But when it comes to our senior populations, this is where we truly have a shared interest. Florida has probably the largest number of seniors per capita, and in my State of Alaska, we are the State that has the fastest growing population of seniors per capita.

One might not think of Alaska as being a retirement haven, but more

and more we are becoming so, and we share the same problems when it comes to access. When you can't get in to see a provider, when that insurance card is all we have given you, then we haven't done anything to provide for a level of care to improve the situation for the residents of Florida or the residents of Alaska. So what we are doing today—as we move toward final passage on legislation that I would concur with the Senator from Florida does not fix the problem—we are not dealing with how we appropriately and adequately provide for access to quality health care. We have much work remaining before us.

We have had some time these past couple days—actually these past couple weeks—as we have spent a considerable amount of time in our offices waiting for votes at 1 in the morning or votes at 7 o'clock in the morning, and I have had a chance to go through some things on my desk, but I have also had an opportunity to spend a lot of time checking to see what people are saying when they are contacting our office. The volume of correspondence, whether in e-mails or faxes or phone calls, coming in from Alaskans during this time has been absolutely unprecedented.

I think, typically, in the legislative calendar about this time—several days before Christmas—you don't see constituents contacting their Senators and pounding the drum. Well, let me tell you, the people in Alaska are pounding the drum. In just the past 24 hours, we have gotten probably close to about 500 health care e-mails that have come in. Overwhelmingly these are e-mails from constituents saying: No, this is not good. You must do what you can to prevent this reform package, as you call it, from moving forward.

It seems the longer the people from Alaska, the longer the people from around this country have to look at what is contained in this 2,000-plus page bill, the more they realize the negative impacts, the consequences to them and their families and their businesses and they are no longer silent. I have had so many calls and letters coming from people saying: I have never weighed in with you before, never weighed in with my delegation, but this is something I can't keep silent on.

When you look at some of the ones that have come in, these are just today's. This is one from a woman in Anchorage who says: Yesterday on the TV news I heard about the sweetheart deal Senator NELSON made regarding the rest of us paying Nebraska's Medicare bill forever. To say I am angry is putting it mildly.

There is a gentleman in Fairbanks who writes in: I am very skeptical about this mandatory health insurance that apparently everyone will have to buy in.

Here is one from a fellow in Anchorage also. He says: You are moving a

health care bill that can't be understood unless a person has a law degree.

Another individual, and this is an interesting one. He and his family apparently own four indoor tanning businesses in Alaska. We need to get a little sunshine, even if it is not what God has provided us. But these are good businesses, and he says: When did this go from a 5-percent tax increase for cosmetic surgery to 10 percent for indoor tanning anyway? And he adds: Adding another 10-percent tax hike on small businesses, like indoor tanning, will likely drive many families, just like mine, into bankruptcy.

I could go on and on in terms of the stacks of correspondence and phone calls we have gotten, but suffice it to say, the more people understand what is in this legislation, the greater their concerns are and the greater their outrage as they learn what is contained in it.

One of the things I learned just yesterday, which I don't think we have gotten the focus or the attention on—and this is a concern that was raised by the Anchorage homebuilders and the Alaska State Home Building Association. They have pointed out that as an industry, the homebuilders industry, they are being unfairly singled out in this bill.

We have talked about the employer mandate that is contained in this legislation, and that mandate applies to those businesses with 50 or more employees. But there is a zing in this legislation to homebuilders who are now responsible for providing federally approved health benefits if they have five or more employees.

Look at what is going on throughout this country in terms of industries that have taken a real hit with this economic downturn and this recession. The homebuilding industry has suffered incredibly during this downturn. On top of depressed house prices and increases in home foreclosures, now we are now going to punish them with an employer mandate that treats them worse than any other employer. In other words, if you have five or more employees as a homebuilder, you need to know that your industry is the one, the only one that will be subject to the employer mandate of \$750 per employee.

In Alaska, we checked to see how many individuals are homebuilders within the State. We have about 250 homebuilders in Alaska. But when you look to see how many individuals they employ, that is about 3,078 employees, it is about 12 employees to every builder. So the total homebuilding industry that would be impacted is about 800 employers in my State.

Yesterday, there was a letter sent to Members of the Senate. This is from the homebuilding industry as well as many other associated industries—the air-conditioning contractors, the build-

ers and contractors, the electrical contractors. I wish to mention some of the statements that are contained in this letter. Again, it is written yesterday. They say:

We are writing to express our strong opposition to language contained in the managers' amendment which excludes the construction industry from the small business exemption contained in the bill. The fact that the managers' amendment was made public less than 2 days before the first vote on the matter has increased the difficulty of playing a constructive role in the legislative process.

I will take a little detour from the letter. This is part of the problem. You have these organizations and groups, and there is a list of about a dozen of them here, that have signed on to this letter. They had literally hours before we were forced to vote on the managers' amendment. They did not know what was in the bill and how it impacted them. They go on to say:

The managers' amendment singles out the construction industry by altering the exemption so it applies only to firms with fewer than 5 employees. This is an unprecedented assault on our industry. It is unreasonable to presume that small business owners can bear the increased costs of these new benefits simply because Congress mandates that they do so.

They go on to conclude in the letter:

We are unaware of any data or evidence that suggests that the needs and struggles of a construction contractor with fewer than 50 employees are so different from those of small business owners in other industries, and absent such convincing evidence, we are left to assume that this specific provision is merely a political payoff to satisfy the desires of a small constituency.

Those are some pretty strong words there toward the end. But it does cause you to wonder why, in this legislation, we are going to require that businesses—only businesses in excess of 50 employees are going to be subject to this mandate. Why this unprecedented assault on the homebuilders? I don't get it. But what it does cause me to get is that there is a heck of a lot more out there that, the more we read it, the more we sit down and we connect the dots, the more we realize this fish we have set out on the front porch is going to continue to stink.

It stuns me. We have the homebuilders up in Alaska who are beside themselves, saying: Can you take a look at this and let me know how the Senators feel. What are you going to do about this, LISA, is the question I have received.

This is something we all have to reckon with.

Madam President, at the conclusion of my remarks, I ask unanimous consent that a copy of the letter be printed in the RECORD.

The PRESIDING OFFICER (Mrs. SHAHEEN). Without objection, it is so ordered.

(See exhibit 1.)

Ms. MURKOWSKI. I am going to speak a little bit about how aspects of

this legislation have impact specifically on my State. As a rural State, sometimes the impacts we see are different than you have in more urban States. Our geography is different, our lack of providers, our high senior population, our extremely expensive costs, there are a lot of dynamics at play that cause real issues and real concerns.

There have been many words that have been exchanged on this floor about what this bill doesn't do or what it does do. I find it helpful to go to the experts, the think tank in my State, and ask them flat out. We have an institution at the University of Alaska called the Institute of Social Economic Research. I take what they have to say very seriously.

I also take very seriously what our Congressional Budget Office has to say, what the CMS Actuary has to say, because, as my colleague from Florida pointed out, these are the independent arbiters. These are the guys whose job it is to work the numbers. I would like to discuss some of the findings from the University of Alaska and also try to inject a little bit of common sense into the debate as to what it means for Alaska, how it increases their premiums, how it raises that cost curve on the Federal health care expenses, the taxes on small businesses for the individuals, the families, the health benefits of the police, the firefighters, other public protective service people who put their lives on the line for so many. These are the things about which, unfortunately, we might not be getting the full picture.

Our colleagues on the other side have claimed that health care coverage will be expanded. Again, let's go to our non-partisan entities—the CBO and the Joint Committee on Taxation. The average premium per person, if you purchase in the individual market, is going to be 10 to 13 percent higher in 2016 than the average premium under current law. That tells you if these Federal scorekeepers are correct, your premiums are going to go up under this health bill if you buy insurance yourself.

In Alaska, according to ISER—again, the Institute for Social and Economic Research—you have about 28,000 Alaskans who would pay 12 percent more for their premiums. It is going to cost an individual in my State an extra \$1,100 per year and a family in my State nearly \$3,000 more per year for the coverage by 2016.

Again, you have to ask the question: Is health care expanding? This bill forces you to purchase federally approved health care; otherwise, you have to pay the penalty of \$750 or 2 percent of your income if you earn more than \$37,500.

If you look at Alaska's population, this is going to bring in more than 50 percent of Alaska's population who are going to be penalized if they fail to

have health insurance. Again, you ask the question: Is health care coverage going to be expanded?

Since the law we are advancing is going to require that you buy federally approved health insurance, and then we are going to penalize you if you do not buy it, then what you have is the heavy hand of the Federal Government that forces you to buy health insurance, which is going to cost about 12 percent more once this bill is enacted—12 percent more than it would today.

The Democrats will also talk about the hidden tax on families and how that will go away because once this bill passes, under this bill, everyone is going to have coverage. Alaskans and all Americans who do not get federally approved health insurance that the Federal Government is going to require that you have, they are going to be fined \$750, 2 percent of your taxable income, and what the Democrats will not tell you when they say health care coverage is going to be expanded or the hidden tax is going to go away is, those with income greater than \$37,500—again, affecting over 50 percent of the people in my State—are going to be taxed a full 2 percent of their household income, once the bill is fully phased in, if they do not get health insurance. It is this penalty that is going to raise \$15 billion to help pay for this bill. This is how we are paying for the bill.

CBO and CMS told us the taxes on medical devices—whether they are tongue depressors or x-rays or blood sugar meters—these are going to be passed on to the individuals so you are going to be taxed for vital medications and other health products. The question you then have to ask yourself: OK, so do these hidden costs actually go away?

I suppose they do because they are no longer hidden. What we will have done is we will have raised your premiums, we will have increased the penalties on those earning more than \$37,500 who did not buy into health insurance, and we will have taxed your tongue depressors and x-rays to pay for the bill.

In addition, the smallest of the small businesses are going to be taxed if they do not provide insurance for their employees, and individuals and couples earning over \$200,000, they are going to be penalized because they are the higher income earners.

The Democrats are also telling you that as Medicare patients, they are going to get some good, positive things. They will get free preventive services. This is good. This is absolutely great. We should be encouraging preventive services.

But as my colleague from Florida was explaining, as I mentioned, after this bill passes, are any of the 13—I think we are down to only 12 now—primary care doctors in Alaska, in the Anchorage area anyway, accepting new

Medicare patients? We are saying we are going to provide this service to you at no cost. But, again, if you can't get anybody who will take you as a patient, how are we helping you? We have heard from a doctor in Anchorage. In fact, I have an opinion piece that was published just this week in the Anchorage Daily News. She indicates she is dropping out of Medicare and she is doing it because of this legislation.

I ask unanimous consent that be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Anchorage Daily News, Dec. 18, 2009]

OPINION: DOCTORS AND PATIENTS, NOT FEDS, KNOW BEST

(By Ilona Farr, M.D.)

I have made the heart-wrenching decision as a physician to opt out of Medicare. I do so after working with Sen. Stevens, Sen. Murkowski and Rep. Young for a decade in hopes we could ensure seniors would be able to continue to receive medical services in Alaska.

On a visit costing \$115, Medicare pays \$40, secondary insurance pays \$7, and the rest—\$68—is a loss, not a tax write-off. It takes six insurance paying patient visits to offset losses from one Medicare or Medicaid patient.

The House health care bills, HR3590/HR3962, increase the number of people not paying their share of the costs and will lead doctors to opt out of Medicare or retire early.

Anchorage has 75 family physicians, down from 180. Physician shortages like these are caused by government interference in the free market. Government artificially keeps reimbursement rates low, forcing other patients, and insurance companies, to pick up the additional costs. Family practice residencies are filled with foreign medical graduates because of high costs (more than \$200,000) associated with medical school. Low physician reimbursement rates make it difficult to repay loans.

Medicare and Medicaid auditors are paid on commission, can fine us \$2,000 to \$50,000 for one charting mistake or billing error, and then extrapolate this over the practice and drive us out of business . . . all for one minor mistake. There is fraud, but this system that penalizes us severely for simple errors is untenable.

In these bills malpractice reform is restricted, health savings accounts (which help reduce costs and fraud) are essentially eliminated, and taxes and fees on insurance and medical services are increased. There are no Medicare/Medicaid rate, rule, or audit reforms, or tax write-offs for business losses.

One section in Sen. Harry Reid's bill says Medicare will no longer pay for home health services, durable medical goods, and possibly labs, X-rays, prescriptions or other services written by providers who have opted out of Medicare. Many talented physicians have had to opt out of Medicare (and by this law must opt out of Medicaid and the military's Tricare also) to stay in business. People will no longer be able to see these physicians because of government financial restrictions or will be forced to pay all medical bills associated with these visits themselves.

Bills under consideration cut Medicare spending by \$460 billion, raise fees on medical services, increase physicians' adminis-

trative burdens, promote electronic medical records with mandated reporting of outcomes data, and increase business costs so it will be impossible for small practices to survive.

My decision to withdraw from Medicare was also precipitated by U.S. Preventive Services Task Force's recommendation that breast cancer screening mammograms should only be done on women between age 50 and 74. Approximately 48 percent of my patients with breast cancer developed it before age 50. Up to 1.2 percent of my practice, mostly young mothers, could have died if this were a national guideline.

The Senate bill has this task force and other committees determining what tests will be covered for patients. I am concerned that penalties may be imposed on insurance companies, and maybe providers, for going against these guidelines. The Hippocratic Oath compels us to protect the health of all humans throughout life, and many provisions in these health care bills would cause us to violate that oath.

Physicians and patients (not government) should decide the best, most cost-effective medical treatment for patients. Government should not dictate to insurance companies or providers which tests can or cannot be covered. Medicine is changing too rapidly for guidelines to be made at a national level.

I have worked in government medical facilities and in private practice for the last 26 years. Physicians provide timelier, less costly and more patient-oriented care if not overseen by hordes of non-producing government administrators.

I am in favor of reform, but current bills before Congress will collapse our health care system and work against the freedoms we are guaranteed under the Constitution. Government should not be allowed to force people to purchase health insurance, mandate what health care services you are allowed, or increase our taxes astronomically to support a huge government health care bureaucracy that will bankrupt us as individuals and as a nation.

Ms. MURKOWSKI. It is no secret, in my State of Alaska and in far too many States around this country, we do not have enough providers that will take these individuals. ISER has said seniors in low payment Medicare States will be forced to wait in line. Alaska is one of two States—we are, I think, second to last in terms of Medicare payments and where we stack up in relation to the reimbursement. ISER goes on to state:

Independent of the doc fix, in Alaska the remainder of seniors are at risk of long lines to see a primary care doctor and overflowing to community health center and hospital emergency rooms where existing capacity is highly likely to be quickly overwhelmed and long wait times become increasingly common.

ISER has also said that additional new insured patients are going to hurt Medicare beneficiaries, and they state:

Federal healthcare reform applied to Alaska likely will exacerbate an already very challenging situation for Alaska's seniors as baby boomers age into Medicare and finding themselves waiting in line behind a rapidly expanding line of better paying private plans.

We are told 5 years from now our Medicare population is going to increase by 50 percent. We cannot accommodate those who are Medicare-eligible now. Our boom is not sustainable.

The CMS Actuary has said:

The Reid bill reduces payments to health care providers, which is unlikely to be sustainable on a permanent basis. As a result, providers could find it difficult to remain profitable and absent legislative intervention, might end their participation in the Medicare program.

It is happening. Doctors, providers, physicians are making those decisions as we speak. They are opting out. So this is not some theoretical approach to the problem. This is happening.

Madam President, how much time do we have on our side?

THE PRESIDING OFFICER. The Senator has 17 minutes.

Ms. MURKOWSKI. If I may ask my colleague from Kansas, do I understand the Senator is seeking about 10 minutes?

Mr. BROWNBACK. Yes.

Ms. MURKOWSKI. Madam President, I want to speak about small businesses because we have all been talking about the impact to small businesses. Under this bill, as we know, small businesses are going to be penalized \$750 per employee if even one of their employees seeks governmental health care through Medicaid or through Federal subsidies. So if you have 50 or more employees, you can be expected to pay fines in an amount of \$750 per employee, which amounts to over \$37,000 or \$3,000 for that individual employee.

I think we need to put it into perspective in terms of who these businesses are. These are the solo-practitioners, like the one-lawyer office or the small doctor's office. If these individuals purchase health care in the individual market, they are going to see their premiums go up an extra \$1,160 per year for a family—nearly \$3,000 more in 2016.

Alaska is defined as a high-cost State. If you are a small business that can afford to pay good health and dental benefits for your employees and those benefits amount to \$8,500 per individual or \$23,000 per family, in a high-cost State such as Alaska, you look to be hit with a 40-percent excise tax because you basically want to provide your employees with good benefits.

Again, according to ISER:

Alaska is a high cost state and thus, roughly 50 percent of health plans in Alaska will be subject to the tax by 2016, compared to only 19 percent average in the Lower 48.

Again, by 2016, 50 percent of the plans in my State will be subject to this 40-percent excise tax.

I ask unanimous consent to have printed in the RECORD a letter we received from the municipality of Anchorage, Police and Fire Retiree Medical Trust.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MUNICIPALITY OF ANCHORAGE, POLICE & FIRE RETIREE MEDICAL TRUST,

December 15, 2009.

PLAN ADMINISTRATOR REPORT

At the November 24, 2009 PFRMT board meeting I brought to your attention a health care bill, HR 3590as—Patient Protection and Affordable Care Act, being considered in the US Senate that contains provisions that if implemented into law would require that the Municipality of Anchorage (MOA) and the Trust to make changes to their current business practices. S 1796—America's Healthy Future Act of 2009 also contains these changes and could become effective January 1, 2010.

Three provisions in the bill that are of particular concern are:

1. Inclusion of health care benefits as taxable income to employees. Not only will this increase the employee's taxable income but the MOA's payroll taxes will also increase.

SEC. 9002. INCLUSION OF COST OF EMPLOYER-SPONSORED HEALTH COVERAGE ON W-2. (p. 1996)

(b) EFFECTIVE DATE—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

2. Taxation of MOA health care plans. This tax will be imposed on the employer. The current MOA health plan design is apt to be considered to have an "excess benefit". This would make it subject to a 40% excise tax. There is also an aggregation rule for the value of employee coverage with multiple employers or retiree medical (example, veterans and rehired police officers and fire fighters). If a retiree would purchase MOA Health Insurance that is considered excessive, the 40% excise tax would be incurred by the general fund of the Medical Trust. One may argue that the tax is a tax to the employer. The argument can also be made that the Trust is an integral part of the Municipality. This was a conclusion determined in IRS PLR-06164-96. Thus the tax would be payable from the Trust general fund assets.

SEC. 9001. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE. (P. 1979)

"any excess benefit with respect to coverage, there is hereby imposed a tax equal to 40% of the excess benefit."

(d) (1) (E) GOVERNMENTAL PLANS INCLUDED

IRS PLR-06164-96 Because the Trust is an integral part of the Municipality, it is not required to file an annual federal income tax return. (p.5)

3. Current Municipal employees are able to be reimbursed tax free from money that they have placed in their flexible spending account for over the counter (OTC) medicine. Retired police officers and fire fighters also currently are allowed this reimbursement as part of their medical benefit. Under the rules of this bill, these reimbursements would no longer be allowed. This is a reduction in employee benefits. It is also likely to encourage an increase the utilization of more expensive non-OTC prescriptions, as they are a covered expense.

SEC. 9003. DISTRIBUTIONS FOR MEDICINE QUALIFIED ONLY IF FOR PRESCRIBED DRUG OR INSULIN. (p. 1997)

This bill contains expenses that should be considered and planned for accordingly. A December 2009 press release from Mercer, an HR consultancy stated,

Nearly two-thirds (63 percent) of employers in a recent survey by Mercer say they would cut health benefits to avoid paying an excise tax included in the Senate's Patient Protec-

tion and Affordable Care Act, unveiled November 18. Mercer estimates that one in five employers offer health coverage that would be deemed "too generous" and thus be subject to the Act's 40 percent non-deductible tax on the excess value.

Two letters have been sent to the MOA informing them of these matters. The dates of these letters were November 25 and December 5, 2009. Since then, Larry Baker, Senior Policy Advisor, in the Mayor's Office informed me that the MOA's benefit consultant, The Wilson Agency, affirmed that the current MOA health plans are going to be subject to the 40% excise tax. They are contacting Senator Begich but beyond that he did not specify what the course of action was going to be.

I recommend two points of action. Bring the PFRMT membership up to date of this situation. And contact Senator Begich to inform him of the negative impact that these bills will have on our retired police officers' and fire fighters' medical benefit.

Sincerely,

LORNE BRETZ,
Plan Administrator.

Ms. MURKOWSKI. The city of Anchorage is the largest city in Alaska. We received this letter last week. In the letter, they cite specifically three provisions in the bill that are of particular concern—No. 1, inclusion of health care benefits as taxable income to employees.

It states:

Not only will this increase the employee's taxable income but the [Municipality of Anchorage's] payroll tax will also increase.

The second point is the taxation of the municipality's health care plans.

This tax will be imposed on the employer. The current [municipality] health plan design is apt to be considered to have "an excess benefit." This would make it subject to a 40% excise tax.

They go on to say:

There is also an aggregation rule for the value of employee coverage with multiple employers or retiree medical. If a retiree would purchase [the municipality's] Health Insurance that is considered excessive, the 40% excise tax would be incurred.

One may argue that the tax is a tax to the employer. The argument can also be made that the Trust is an integral part of the Municipality. Thus the tax would be payable from the Trust general fund assets.

Their third point is:

Current municipal employees are able to be reimbursed tax free from money they have placed in their flexible spending account for over the counter medicine. Retired police officers and firefighters also currently are allowed this reimbursement as part of their medical benefit. Under the rules of this bill, these reimbursements would no longer be allowed. This is a reduction in employee benefits. It is also likely to encourage an increase [in] the utilization of more expensive non-OTC prescriptions, as they are a covered expense.

There are about 400 members that are part of the Police and Fire Retiree Medical Trust. When they find out, as I am sure they will, that essentially they are going to be taxed on their plan—I think most of these firefighters and police officers don't view themselves as having access to a Cadillac

plan. They are just firefighters and police officers. But this is coming from their trust fund, expressing great concern over what we have in front of us.

I have mentioned that we have received a copy of an opinion piece from a primary care provider in Anchorage who has outlined why she is opting out of the Medicare system in Alaska.

I ask unanimous consent to have her letter printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Anchorage Daily News, Dec. 18, 2009]

OPINION: DOCTORS AND PATIENTS, NOT FEDS, KNOW BEST

(By Ilona Farr, M.D.)

I have made the heart-wrenching decision as a physician to opt out of Medicare. I do so after working with Sen. Stevens, Sen. Murkowski and Rep. Young for a decade in hopes we could ensure seniors would be able to continue to receive medical services in Alaska.

On a visit costing \$115, Medicare pays \$40, secondary insurance pays \$7, and the rest—\$68—is a loss, not a tax write-off. It takes six insurance paying patient visits to offset losses from one Medicare or Medicaid patient.

The House health care bills, HR3590/HR3962, increase the number of people not paying their share of the costs and will lead doctors to opt out of Medicare or retire early.

Anchorage has 75 family physicians, down from 180. Physician shortages like these are caused by government interference in the free market. Government artificially keeps reimbursement rates low, forcing other patients, and insurance companies, to pick up the additional costs. Family practice residencies are filled with foreign medical graduates because of high costs (more than \$200,000) associated with medical school. Low physician reimbursement rates make it difficult to repay loans.

Medicare and Medicaid auditors are paid on commission, can fine us \$2,000 to \$50,000 for one charting mistake or billing error, and then extrapolate this over the practice and drive us out of business . . . all for one minor mistake. There is fraud, but this system that penalizes us severely for simple errors is untenable.

In these bills malpractice reform is restricted, health savings accounts (which help reduce costs and fraud) are essentially eliminated, and taxes and fees on insurance and medical services are increased. There are no Medicare/Medicaid rate, rule, or audit reforms, or tax write-offs for business losses.

One section in Sen. Harry Reid's bill says Medicare will no longer pay for home health services, durable medical goods, and possibly labs, X-rays, prescriptions or other services written by providers who have opted out of Medicare. Many talented physicians have had to opt out of Medicare (and by this law must opt out of Medicaid and the military's Tricare also) to stay in business. People will no longer be able to see these physicians because of government financial restrictions or will be forced to pay all medical bills associated with these visits themselves.

Bills under consideration cut Medicare spending by \$460 billion, raise fees on medical services, increase physicians' administrative burdens, promote electronic medical records with mandated reporting of outcomes data, and increase business costs so it

will be impossible for small practices to survive.

My decision to withdraw from Medicare was also precipitated by U.S. Preventive Services Task Force's recommendation that breast cancer screening mammograms should only be done on women between age 50 and 74. Approximately 48 percent of my patients with breast cancer developed it before age 50. Up to 1.2 percent of my practice, mostly young mothers, could have died if this were a national guideline.

The Senate bill has this task force and other committees determining what tests will be covered for patients. I am concerned that penalties may be imposed on insurance companies, and maybe providers, for going against these guidelines. The Hippocratic Oath compels us to protect the health of all humans throughout life, and many provisions in these health care bills would cause us to violate that oath.

Physicians and patients (not government) should decide the best, most cost-effective medical treatment for patients. Government should not dictate to insurance companies or providers which tests can or cannot be covered. Medicine is changing too rapidly for guidelines to be made at a national level.

I have worked in government medical facilities and in private practice for the last 26 years. Physicians provide timelier, less costly and more patient-oriented care if not overseen by hordes of non-producing government administrators.

I am in favor of reform, but current bills before Congress will collapse our health care system and work against the freedoms we are guaranteed under the Constitution. Government should not be allowed to force people to purchase health insurance, mandate what health care services you are allowed, or increase our taxes astronomically to support a huge government health care bureaucracy that will bankrupt us as individuals and as a nation.

Ms. MURKOWSKI. One of the things we don't have in this legislation is a provision that relates to medical malpractice. It has been stated that, in Alaska, you tried medical malpractice reform and we haven't seen the positive impacts.

I ask unanimous consent to have printed in the RECORD a statement from the Alaska State Medical Association, along with an article that was published in Alaska Medicine in September of 2009 entitled "Malpractice Relief, Lower Premiums, Tort Reform Add to Alaska's Appeal."

There being no objection, the material was ordered to be printed in the RECORD, as follows:

ALASKA PHYSICIANS' GROUP: SENATOR ERRED ON TORT REFORM

ANCHORAGE, ALASKA (Dec. 21, 2009)—The Alaska State Medical Association (ASMA), which represents physicians throughout Alaska and is primarily concerned with the health of all Alaskans, is taking issue with Sen. Mark Begich's stance on medical liability reform.

In an interview with Fox News on Dec. 7, 2009, Alaska's junior senator opined that tort reform in his home state has not worked. ASMA asserts that Begich did not accurately portray the facts in that nationally broadcast interview and that medical liability reform in Alaska serves as a shining example for the other 49 states.

"Alaska's physicians have worked hard for at least the last 35 years to achieve meaningful and equitable liability reform measures," ASMA President Brion J. Beerle, MD, wrote today in a letter to Sen. Begich. "Those efforts have resulted in a stable marketplace for insurers that provide medical professional liability coverage to Alaska's physicians at rates that are competitive."

More than 90% of medical liability coverage in Alaska is provided by two, not-for-profit insurers—MIEC and NORCAL—that are owned by their policyholders (mutual insurers) and overseen by boards of governors, all of whom are physicians, with representation on those boards by Alaska physicians.

"The cumulative result of the Alaska physicians' advocacy has been a success for physicians and their patients," Beerle wrote. "For example, according to the Medical Liability Monitor Survey, 2008 premiums paid by Alaska's internists average just 24% of those paid by the interests in the five most expensive states; general surgeons pay about 25%; and obstetricians/gynecologists pay about 31%. According to that same 2008 survey, the premiums for those same specialties are in the lowest quartile of all states plus the District of Columbia."

"MIEC also has returned excess earnings to its policyholders in 16 of the last 19 years; and NORCAL policyholders received dividends in 12 of the last 18 years. MIEC has, in addition, reduced its rates by 5% in 2009 and also for 2010," the ASMA president added.

Writing on behalf of the association he leads, Beerle noted that because of tort reform, premiums Alaska's physicians pay for liability coverage is generally not significant in the cost of operating a medical practice.

"The factor that does have a material effect is the cost of practicing defensive medicine," he wrote.

The American Medical Association has estimated that the annual cost of the practice of defensive medicine in the United States ranges from \$99 billion to \$179 billion.

"Until medical liability reforms similar to those enacted in Alaska are adopted nationwide, the additional costs of the practice of defensive medicine will continue to be a driver in the cost of health care in Alaska and throughout the country," Beerle concluded.

[From Alaska Medicine, Sept. 2009]

MALPRACTICE RELIEF

(By Andrew Firth and Roger Holmes)

It is seemingly a universal truth that wherever one practices in the United States, malpractice insurance costs too much. But in Alaska, the average medical malpractice premiums are lower than at least 35 other states, a national survey shows.

Physicians in Alaska pay much less than their colleagues in the nation's five most costly states, according to the Medical Liability Monitor Survey, 2008. Premiums paid by Alaska's internists average 24 percent of those paid by internists in the five highest states; surgeons here pay roughly 25 percent, and obstetrician/gynecologists pay about 31 percent. (The top five states vary by specialty.) Some of the difference in cost may be societal, but part of it has to do with the tort reforms that have passed, or not passed, in each state.

In Alaska, our history is similar to many states where the costs are lower. It's a state with an active medical society (the Alaska State Medical Association), an engaged membership, a broad coalition of providers and an enlightened legislative body that recognizes the connection between malpractice costs and access to care.

In 1975, Alaskan physicians suddenly were confronted with a disappearing market for medical malpractice insurance. The Legislature stepped in and created the Medical Indemnity Corporation of Alaska (MICA), a quasi-state agency funded with state money but run by a private board of directors appointed by the governor. At the same time, the Legislature modified the law governing medical malpractice claims. Among the key changes:

The burden of proof was codified, making it clear that a practitioner could only be judged against those in the same field or specialty.

Res ipso loquitur, a legal doctrine that switched the burden of proof to the health-care provider in certain instances, was abolished.

The law required that juries be told that injury alone does not raise a presumption of negligence or misconduct.

Plaintiffs were prohibited from filing inflammatory pleadings asking for millions of dollars.

The law of informed consent was codified. The law prohibited claims that a health-care provider had orally agreed to achieve a specific medical result.

Plaintiffs were prohibited from obtaining a recovery for sums that had been paid by collateral sources, except for a select few federal programs that must, by law, seek reimbursement.

During the 1970s and '80s physicians encountered rising and falling malpractice costs as the insurance cycle reacted to changing claim experience in Alaska and elsewhere, culminating in the departure of several medical professional liability (MPL) insurers in the late 1990s.

In the mid-1990s, the Alaska State Medical Association and several MPL insurers joined with the Alaska State Hospital and Nursing Home Association, Providence Hospital and the business community to press for additional tort reforms. The result was the 1997 Tort Reform Act.

Among its achievements was a cap on non-economic damages of \$400,000 except in cases of severe disfigurement or severe permanent impairment, in which the cap rises to \$1 million.

Punitive damages were limited, and the standards for awarding them were tightened. Prejudgment interest was tied to the federal discount rate—Alaska's current rate is 3.25 percent. Joint and several liability was abolished in favor of comparative fault, in which each party is responsible only for its percentage share of the total fault. And parties were prohibited from using experts in medical malpractice cases unless the expert is licensed, trained and experienced in the same discipline or school of practice as the physician and certified by a recognized board.

A coalition called Alaskans for Access to Health Care—comprising ASMA, Alaska Physicians & Surgeons, the hospital association and Providence—went back to the Legislature in 2005 and argued for an even lower non-economic damage cap for health-care providers. The result was a limit of \$250,000 in all cases except when damages are awarded for wrongful death or a severe permanent physical impairment that is more than 70 percent disabling. For those, the limit is \$400,000.

Since then, Alaska has enjoyed a stable malpractice climate, with both of its major insurance carriers reducing rates and/or returning profits through dividend distributions.

The caps make a big difference. For example, NORCAL Mutual, which writes policies

in Alaska and California, also does business in Rhode Island, which does not limit non-economic damages in malpractice cases.

"Most rates for physicians with at least three years' practice experience (mature rates) in Rhode Island are at least double the mature rates for physicians in Alaska," NORCAL Marketing and Communications Manager Brent Samodurov wrote in an e-mail to Alaska Medicine. "For several medical specialties NORCAL Mutual's rates for Rhode Island are nearly triple those for Alaska."

MPL CARRIERS

There are two major MPL insurers in Alaska: MIEC and NORCAL. Both companies are owned by their policyholders (mutual insurers) and are overseen by a board of governors consisting of physicians.

MIEC came to Alaska in 1978 and is sponsored by ASMA. NORCAL became active in 1991 after it purchased MICA.

According to data published by the National Association of Insurance Commissioners, MIEC wrote 69.7 percent of all medical malpractice premiums for physicians in the state during 2008 and NORCAL wrote 23.4 percent. Ten other carriers shared the remaining 6.9 percent of the market.

Typical of these types of policyholder-owned companies, both MIEC and NORCAL have a long history of returning profits to policyholders through dividend distributions:

NORCAL's Alaska clients have received dividends in 12 of the past 18 years, the most recent amounting to 12 percent of each eligible policyholder's premium as of Sept. 30, 2008, according to Samodurov. He noted: "Dividends declared are directly related to the company's loss experience in each state."

MIEC has a similar record of returning profits to its Alaska members. MIEC policyholders have received dividends in 16 of the past 19 years in amounts that average 28.8 percent of basic premiums (for \$1 million/\$3 million limits) in each one of the past 19 years.

Ms. MURKOWSKI. The bottom line is from the Alaska State Medical Association:

The cumulative result of Alaska physicians' advocacy has been a success for physicians and their patients.

Again, we have seen the positive impact in Alaska because of the laws we have passed. It is unfortunate that we didn't take that opportunity as we dealt with health care reform these past many months.

I yield the floor.

EXHIBIT 1

DECEMBER 21, 2009.

*U.S. Senate,
Washington, DC.*

DEAR SENATOR: We are writing to express our strong opposition to language contained in the Manager's Amendment to H.R. 3590, which excludes the construction industry from the small business exemption contained in the bill. We regret that this is our first opportunity to address this issue, though the fact that the Manager's Amendment was made public less than two days before the first vote on the matter has increased the difficulty of playing a constructive role in the legislative process.

In recognition of the negative impact that a mandate to provide health insurance will have on employers, H.R. 3590 exempts employers with fewer than 50 employees from

the fines levied on those who cannot afford to provide their employees with the federal minimum standard of health insurance. However, the Manager's Amendment singles out the construction industry by altering the exemption so that it applies to only those firms with fewer than 5 employees.

This narrowly focused provision is an unprecedented assault on our industry, and the men and women who every day make the bold decision to strike out on their own by starting a business. Our members' benefit packages reflect the reality of their business models, and they proudly offer the best health insurance coverage that they can afford. It is unreasonable to presume that small business owners can bear the increased cost of these new benefits simply because Congress mandates that they do so.

In the real world, where the rhetoric surrounding this legislation will meet the stark reality of the employer struggling to make payroll, this special interest carve out is simply another bill to pay in an industry that, with an unemployment rate exceeding 18% and more than \$200 billion in economic activity lost in the past year, already is struggling to survive.

And, we would be remiss if we failed to question the justification for singling out the construction industry to bear such a burden. We are unaware of any data or evidence that suggests that the needs and struggles of a construction contractor with fewer than 50 employees are so different from those of small business owners in other industries, and absent such convincing evidence, we are left to assume that this specific provision is merely a political payoff to satisfy the desires of a small constituency.

As Congress moves forward in the legislative process for H.R. 3590, we strongly encourage you to address this onerous provision that needlessly singles out small construction industry employers.

Sincerely,

Air Conditioning Contractors of America, American Institute of Architects, Associated Builders and Contractors, Associated Equipment Distributors, Associated General Contractors, Association of Equipment Manufacturers, Independent Electrical Contractors, National Association of Home Builders, National Federation of Independent Business, National Lumber and Building Material Dealers Association, National Ready-Mixed Concrete Association, National Roofing Contractors Association, National Utility Contractors Association, Plumbing-Heating-Cooling Contractors-National Association, Small Business & Entrepreneurship Council, U.S. Chamber of Commerce.

The PRESIDING OFFICER. The Senator from Kansas.

Mr. BROWNBACK. Madam President, I am glad to join my colleagues in talking about the health care bill. If you looked in the New York Times today, there was a full-page ad describing the bill. I am putting it up here, the same thing that was in the New York Times today. It starts with the question, I want to receive care from my doctor. This, on one page, puts the 2,600 pages in kind of what you are going to see with this bill. It is convoluted. It is difficult. It is expensive. This is what you are going to get. This was in the New York Times today. This is where I sit or this is what is going to happen to me in this overall system. It is no wonder the American public

doesn't want this. They are not excited about this. They are not excited about what it is going to do to the budget—\$2.5 trillion. That is about \$700 million a day, if you are counting in millions a day as one way to look at it.

There are some interesting things hidden within the bill. One of the things I want to point out is the transfer of wealth from young people to old. One of the things that has really bugged me about what we have done in so many of the government systems here—it has been a wealth transfer from younger people to older.

Several of my children are students and working part-time jobs, and they are paying payroll taxes. They say: What is this payroll tax going to? I say: Well, talk to your grandparents and tell them to say thank you to you. These are funds collected that are going to pay for their retirement funds. They do, and the grandparents say thank you. But it doesn't seem to be satisfying to them because they are saying: Why aren't I putting this in something I am saving money for me so that I can have something later on instead of this sort of, OK, I am paying and they are getting. What is going to be there when I get there?

That sort of wealth transfer from young people to old people continues in this bill. Look at this wealth transfer. Younger workers will pay more for health insurance premiums so that older workers can pay less. Their cost at age 25 will go up 25 percent for health insurance premiums. If you are 64, it will go down 20 percent for health care. This is another one of the wealth transfers that take place. It isn't right. It is taking from the kids. It is taking from the grandkids. It should not be continued. It is continued in this bill.

You can look at it another way: Subsidies in this bill go disproportionately to older Americans. Average subsidies for the 55-year-olds are nearly 10 times that of a 25-year-old. A 25-year-old gets a subsidy of \$458, a 55-year-old gets a subsidy of \$4,427—another wealth transfer from younger to older.

Then you can look at the claims in this bill that there are going to be tax cuts for the middle class. That is if you are in the lucky group. For every low-to-middle-income family with a tax cut, three low-to-middle-income families have a tax increase in this bill by the structure of this bill, by this structure, this convoluted, difficult-to-navigate, hard-to-understand, expensive, \$2.5 trillion structure.

That is where we stand. Likely to pass this body and then go to the House of Representatives where there is a major issue that is still brewing, difficult, and must be dealt with, and that is the issue of public funding of abortion that is in this bill.

If you want to cut some of the cost out of this thing, why don't you take some of those expenses out of this.

That would be one way to cut back some of the expenses. But in the House bill, they included Stupak language which continued the Hyde tradition and law of the land that the government will not pay for abortions other than cases of rape, incest, and life of the mother. Except now buried in the Senate bill, in the Reid amendment, is the public funding of abortion, which we haven't done for years.

Yesterday I talked to both Congressman STUPAK and Senator NELSON. They both agree that the Stupak language is far superior. It doesn't publicly fund abortions, whereas what is in this bill now does. You don't need to take my word. Here is what others have said. The U.S. Conference of Catholic Bishops, who want a health care bill but are opposed to the public funding of abortion and opposed to abortion, say:

The bill is morally unacceptable unless and until it complies with longstanding current laws on abortion funding such as the Hyde amendment.

We voted on this floor for the Nelson-Hatch amendment which is now not in the bill.

You don't have to take that. You can take BART STUPAK, Democrat from Michigan, who voted for the bill in the House. He says:

It is now not acceptable. A dramatic shift in Federal policy that would allow the Federal Government to subsidize insurance policies with abortion coverage.

The American public doesn't want that either. The latest poll of December 22 shows that 72 percent of Americans oppose using any public money in the health care overhaul to pay for abortion, including 54 percent of Democrats and 74 percent of Independents. That is where they are. That is where the public is.

National Right to Life, which is the gold standard on standing up for life, says:

The Reid managers amendment requires that all enrollees in an abortion covering plan make a separate payment into an account that will pay for abortions. The bill also contains language that is intended to prevent or discourage any insurer from explaining what this surcharge is to be used for. Moreover, there is nothing in the language to suggest that payment of the abortion charge is optional for any enrollee.

This base bill has another thing in it: It takes the individual opt-out and moves to it a State opt-out. So while let's say Kansas may opt out of the abortion funding in the bill, they still have to pay their taxes that go to another State to pay for abortions there which are equally offensive to my people or other States that don't want to see this funding take place.

It doesn't address the issue of having preventive services include abortion. There was discussion that we are not going to include preventive services in it, but that is not in the language. There was discussion. We tried an

amendment. That is not there. It can still be defined. Now it may ultimately unwind the entire bill based upon the funding of abortion that is in the Senate bill. It will be up to House Members, a number of whom are very concerned and quite fired up about this particular piece, to take this out. I know Congressman STUPAK is working to do that, wants to see that done, agrees with Senator NELSON that his language is far superior, actually does that. It is supported by the Catholic Bishops, the National Right to Life, and other pro-life groups that say the way to go is the Stupak language.

It is not what is in the Senate bill. The Senate bill will actually fund abortions. Then we go through the specifics, as I have in here, of the various places that it has. I met with Senator NELSON about those specifics. I have addressed a number of those concerns. I know he continues to work on it, but at the end of the day this is one of those babies you cannot split. You need to have the Stupak language in this bill. I am afraid at the end of the day that is not going to be in there. I know Congressman STUPAK is pushing very hard for its inclusion, and I wish him all the best.

If this legislation passes this body, it is going to be up to the House of Representatives to put in that Stupak language. And they can do it. It is my hope they will do it. I do not think the overall bill should be passed, but certainly you should not have this piece of funding in this bill, in breaking the longstanding work we have had in the Hyde agreement, in the Hyde language.

Thank you very much, Madam President. How much time do we have remaining on our side?

The PRESIDING OFFICER. One minute.

Mr. BROWNBACK. Madam President, in that concluding minute, what I would like to briefly speak about is the overall process.

I think there are people in this body who did not want to include things such as abortion funding in the bill. But when you operate in a closed process like this, these sorts of things end up happening because the people who work on these issues are excluded. I certainly was not consulted. I am not saying anyone said: Well, look, we are not going to get your vote anyway, so we do not need to have it. But if you do not want to have abortion funding in it, one should look past that and say: Let's get the people who understand and work on this issue—and we agree, we should not have it in there; that is what President Obama said; it should not be in there—and let's see what language passes by their muster.

That was not done. Unfortunately, that is part of what has happened in this process. I think it is tragic that it has happened that way in this process. I think it is wrong. I think it builds a

bill that then people are not satisfied with, and certainly a process they do not agree with that takes place in this overall bill.

It is still not too late. There is still time to address these issues, now that we have the bill to be able to look at. If people of good faith on the other side want to get these addressed, there are ways, and we have the language on how to address it. It is called the Stupak language. It has already passed the House of Representatives. It is called the Nelson-Hatch amendment that was debated here, although it was not passed. We can do that. It is important that it get done.

This bill is not supported by the American public, and particularly this funding piece that is so offensive to so many Americans. We can debate about abortion, but the government should not be funding it, and that is agreed to by over 70 percent of the American public.

I just ask my colleagues on the other side, as you move on forward with this—if this bill passes here—take this piece out. We know what language is agreed to and works. This piece can be taken out. It can be taken out yet. And I think the whole bill may unwind if it is not taken out—unwind because of a number of Democrats who voted for the bill on the House side who want the Stupak language, and they do not want the inferior language that was put in on the Senate side that will actually allow and start the funding of abortion, that we have not done for 30 years.

Madam President, I thank my colleagues and yield the floor.

Mr. GRASSLEY. Madam President, My Friend, Senator CASEY, just a few moments ago repeated the frequent claim made by members on the other side of the aisle that the health care bill provides a \$40 billion net tax cut.

As I demonstrated in a speech earlier today, this claim is inaccurate and does nothing to address the fact that millions of middle-class Americans will see a tax increase.

I have consistently given my Democratic friends credit for providing a significant benefit to help people buy insurance.

This beneficiary class, however, is small.

At the same time there are 78 million individuals, families, and single parents who will see a tax increase.

Seventy-three million of them are below \$200,000.

It is only because the subsidy for this small group is so large—and refundable—that there is a net tax benefit.

For example, the average subsidy is close to \$8,000. Around 13.2 million individuals and families receive this subsidy.

But the data also shows that there is a group of 73 million middle-class Americans who will pay on average \$710 more in taxes.

My Democratic colleagues want to say that since the cost of providing an average tax benefit of \$8,000 to 13.2 million individuals and families is greater than the revenue raised by raising the taxes on 73 million individuals and families by \$710 there is a net tax decrease.

The truth is individuals who are seeing a tax increase are not actually benefiting from the very large subsidy. This is because, in general, this group isn't even eligible for the subsidy.

It comes back to this: a small group of Americans benefit under this bill. Another group of Americans pay higher taxes. These Americans include middle-income individuals and families.

Mr. HATCH. Madam President, I rise to speak on my amendment to the Reid health care bill that would add an expedited judicial review provision to the legislation. It would provide a mechanism for the courts expeditiously to handle any future constitutional challenges to this legislation.

Make no mistake. I strongly oppose this Federal takeover of our health care system. I do so for a host of important and serious policy reasons. I believe it is bad for our country, but I also oppose it because I believe some of its core provisions are unconstitutional, undermining the Constitution and the liberty that it makes possible.

I have argued for months that the constitutional problems with this legislation include the requirement that individuals obtain a certain level of health insurance and the differential State-by-State taxation of high cost insurance plans. Other scholars and commentators have argued that restrictions on the ability of insurance providers to make risk-adjusted decisions about coverage and premiums amount to a taking of private property in violation of the fifth amendment. Others have said that requiring States to pass legislation creating health benefit exchanges exceeds Congress's power in our Federal-State system.

I do not necessarily believe that each of these constitutional arguments is as substantive or as persuasive as the next. Some may agree with this one or that one, all of them, or none at all. These and other arguments, however, are real, substantive, and many of them are as yet untested by the courts because this legislation goes so far beyond anything the Federal Government has ever attempted. These and other issues very well may be the basis for litigation against this legislation. Therefore, I think it is in everyone's interest to provide a mechanism for future constitutional challenges to be handled expeditiously by the courts.

The supporters of this legislation, those who are so confident that no conceivable constitutional argument has any merit whatsoever, should be the strongest supporters of this amendment. More than anyone, they would

want to eliminate as quickly as possible anything that could delay or prevent full implementation of this legislation. Frankly, I am surprised that they are not the ones offering this amendment and I hope they will support it.

Madam President, I now wish to speak about my amendment No. 3294. My amendment would ensure that all Americans would be able to keep the health care coverage they already have.

My amendment is simple. If adopted, it would ensure that the implementation of the Democrat's health care bill shall be conditioned on the Secretary of Health and Human Services certifying to Congress that this legislation would not cause more than 1,000,000 Americans to see higher premiums as compared to projections under current law.

This amendment would ensure that this \$2.5 trillion tax-and-spend bill would not go into effect if the Secretary of Health and Human Services finds that it would actually raise health insurance premiums for more than 1 million Americans compared to projections under current law contrary to the promise made by President Obama that health care reform would result in average savings of \$2,500 per family.

One of the major reasons for enacting health care reform is to ensure that we control rising health care costs that continue to put increasing pressure on American families and small businesses. However, according to the non-partisan Congressional Budget Office, the premiums under this bill would actually rise for Americans purchasing insurance on their own by as much as 13 percent and will continue to rise at double the rate of inflation for both the small group and large group markets.

Spending \$2.5 trillion of hard-earned taxpayer dollars on a system that already spends almost \$2.2 trillion a year without any impact on controlling health care premiums should be unacceptable to every American.

Madam President, I also wish to speak to my amendment No. 3296 to H.R. 3590, the health care reform legislation. This amendment isn't complicated. It would prevent the provisions of the bill from taking effect in the event that it imposes unfunded mandates on the States. As we all know, this legislation imposes significant new burdens on the States and the proposed funding for this program is, in some cases, likely to fall short. Simply put, the Congress should not impose upon the States new Federal policy requirements without ensuring they are adequately reimbursed. In the event that Congress does not provide full funding for these programs, my amendment would ensure that none of the new mandates will be binding on the States.

MEDICAID PHARMACY REIMBURSEMENT

Mrs. LINCOLN. I would like to engage my colleague, the distinguished Senate Finance Committee chairman, in a short colloquy regarding the Medicaid pharmacy reimbursement provisions in the Senate health care reform bill.

Mr. BAUCUS. I would be happy to engage Senator LINCOLN in a colloquy. I commend her for all her leadership over the years on this issue, because she recognizes that it is important to reimburse pharmacies adequately for the generic medications they dispense to Medicaid patients. In rural States like ours, Medicaid patients need access to their community pharmacies to obtain their medications. Sometimes community pharmacies are the only health care providers for many miles. So, it is important that we permanently fix in this health care reform bill the problems for pharmacies caused by the severe reimbursement cuts from the Deficit Reduction Act of 2005.

Mrs. LINCOLN. I thank my colleague and agree with him. That is why I ask him the purpose behind the language in the bill that would establish the Federal upper limit for generics at no less than 175 percent of the weighted-average average manufacturer price. I know this amount is less than the chairman originally proposed in the Medicaid Fair Drug Payment Act from last Congress, which I cosponsored. However, in what cases would it be the intent of the intent of the chairman that the Federal upper limit would be set at more than 175 percent? I am particularly concerned about my small independent pharmacies in Arkansas that fill a significant number of Medicaid prescriptions. Would it be the intent to set a higher rate for these pharmacies? Would it be the intent to set a higher rate for generics that might be in short supply or for which there are availability problems to encourage more manufacturers to make them?

Mr. BAUCUS. I would say to my colleague that the language indicating that the Secretary could set the Federal upper limit at no less than 175 percent the weighted average average manufacturer price could be used in those types of circumstances. It would give the Secretary flexibility to set the Federal upper limits in cases where there is a need to provide states with a higher match in order to assure that appropriate payment is made to pharmacies to encourage the use of generic drugs.

Mrs. LINCOLN. I thank the chairman for his insights into this provision and his work on behalf of our Nation's community pharmacies.

WISCONSIN'S MEDICAID PROGRAM

Mr. KOHL. Madam President, I rise to discuss language in the Reid substitute amendment to H.R. 3590 that would have a dramatic effect on Wis-

consin's Medicaid Program. I would like to converse about this with two of my distinguished colleagues—the other Senator from my home State of Wisconsin, Senator FEINGOLD, and Senator BAUCUS, chairman of the Senate Finance Committee.

I commend Senator BAUCUS's long and hard work in crafting this historical piece of legislation, and today, I seek clarification of one piece of this bill.

Mr. FEINGOLD. I also seek clarification of this piece of the Patient Protection and Affordable Care Act, specifically in section 2001, regarding the definition of individuals that would be considered newly eligible under Medicaid.

Mr. BAUCUS. I thank the Senator. I would be pleased to enter into a colloquy with the Senators from Wisconsin on this subject.

Mr. KOHL. I thank the Senator. Section 2001 of the legislation describes which individuals in each State will be deemed “newly eligible” for Medicaid. It is my understanding that the Federal Government will provide 100 percent of the funds to cover this group of newly eligibles from 2014 to 2016 and that States will be provided with their current law FMAP rates, which are below 100 percent, for individuals already covered. Is this correct?

Mr. BAUCUS. I thank the Senator for the question. Yes, that is correct, and it is my understanding of the legislation as well.

Mr. FEINGOLD. I thank the Senator. As the Senator knows, to be considered “newly eligible” under this bill, individuals must not be eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage as described in section 1937 of the Social Security Act. Two of the benefits that must be incorporated into benchmark coverage under section 1937 of the Social Security Act are mental health and substance use disorder services, and prescription drug coverage. If these two benefits are not offered at all, then the coverage will not count as benchmark coverage.

Mr. KOHL. As my two colleagues are aware, Wisconsin currently provides coverage for a number of individuals under a Medicaid waiver, but this coverage does not meet the requirements for benchmark or benchmark-equivalent coverage under the Social Security Act. The Centers for Medicare & Medicaid Services, the Federal agency that oversees Medicaid, has confirmed this for us. Senator FEINGOLD and I understand that, because of this, the individuals in Wisconsin who do not receive benchmark or benchmark-equivalent coverage will be considered newly eligible, and therefore Wisconsin will receive 100 percent Federal funds for those individuals in 2014, 2015, and 2016. Is this the Senator's understanding of the legislation as well?

Mr. BAUCUS. Yes. I thank the Senator.

RELIGIOUS CONSCIENCE EXEMPTION

Mr. CASEY. May I ask the Senator from Iowa to yield for a question about the managers' amendment, amendment 3276, to amendment 2786 to H.R. 3590?

Mr. HARKIN. Of course.

Mr. CASEY. Chairman HARKIN, the managers' amendment includes a religious conscience exemption from the individual requirement to maintain minimum essential coverage in section 1501. Is it the intent of the managers that this exemption apply to an individual who is a member of recognized religious sect described in Internal Revenue Code section 1402(g) regardless of employment status?

Mr. HARKIN. Yes, the intent of the religious exemption is to focus on an individual who is a member of a religious sect described in 1402(g) and who is an adherent of the teachings of that sect notwithstanding his or her employment status.

Mr. CASEY. I thank the chairman. So, for example, an Amish person working in a factory or store for a non-Amish employer and meeting the 1402(g) requirements would not be required to obtain insurance coverage against his or her religious convictions?

Mr. HARKIN. The Senator is correct. The managers' amendment creates a clear bright line exemption for individuals described in 1402(g). This religious conscience exemption applies whether one is unemployed, a self-employed Amish person, an Amish person working for an Amish employer, or an Amish person working for a non-Amish employer.

Mr. CASEY. I thank the Senator for that clarification.

The PRESIDING OFFICER. The majority leader is recognized.

ORDERS FOR WEDNESDAY,
DECEMBER 23, 2009

Mr. REID. Madam President, I ask unanimous consent that when the Senate completes its business today it adjourn until 9:45 a.m., Wednesday, December 23; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 3590, the health care reform legislation, with the time following any leader remarks and until 10 a.m. equally divided and controlled between the two leaders or their designees; that at 10 a.m. and until 2 p.m. the time be controlled in alternating 1-hour blocks of time, with the majority controlling the first hour; further that the remaining time until 2:13 p.m. be equally divided and controlled between the two leaders, with the majority leader controlling the final half.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. REID. Madam President, Senators should expect a series of rollcall votes, maybe as many as five, to begin at approximately 2:13 tomorrow afternoon.

ORDER FOR ADJOURNMENT

Mr. REID. Madam President, if there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the previous order, following the remarks of Senator DODD of Connecticut.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DODD. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. DODD. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE REFORM

Mr. DODD. Madam President, I want to take a few minutes, if I may, this evening to speak about what this health care bill means to my constituents in Connecticut. I say to the Presiding Officer, the benefits to our States are very similar in many ways, but, obviously, we like to point out what this particularly means in our own respective jurisdictions that we represent.

But before doing so, I want to take a few minutes, if I could, because, again, tomorrow will be a short day, and then there are the votes, apparently, that we are going to have Thursday, and then we will be leaving the Senate for a number of weeks before we return in mid-January, and it might not be possible tomorrow or in the very early hours of Christmas Eve to say a special thanks to the people who work with our offices in this Chamber, both on the minority side and the majority side, who rarely get the kind of recognition they deserve.

I have tried periodically over the years to make sure that as to the consideration of every major bill we talk about the staff and what they have done. So I want to take a couple minutes and identify people with whom I have worked. This not an inclusive list. There are many more people who work for individual Senators who have done outstanding work. Our floor staff here, both on the majority side and the minority side, do a remarkable job and have great patience with all of us. I am very grateful to them, as well as for the jobs they perform.

I want to take a few minutes and recognize the people I have worked very

closely with over the last—well, intensely—over the last almost year now on this issue.

Certainly in Senator REID's office, the majority leader's office, Kate Leone, Carolyn Gluck, Jacqueline Lampert and Randy Devalk deserve a great deal of credit. All of us know them and how much they have been involved in this issue.

And for those of us who serve in our caucus, we have listened to Kate Leone on numerous occasions go over the details of these bills, answer the questions Members have raised about the importance of the legislation. So to the members of Senator REID's staff—and, obviously, there are a lot more people in his office who deserve recognition—but I want to particularly recognize these four individuals with whom we have worked very closely.

Senator Kennedy, as we all know, was such a lion of this institution and cared so deeply about this issue. Over the years, he attracted some wonderful people to work with him, as he fought year in and year out to bring us to the moment we are about to enjoy; and that is, to see some national health care legislation adopted for the very first time.

Michael Myers had worked on this issue for a number of years for Senator Kennedy, and still is here working with Senator HARKIN now as part of the Health, Education, Labor, and Pensions Committee.

Mark Childress, again, worked for the majority leader, worked for Tom Daschle, has worked for others in this body, and has just done a fantastic job. He stayed on at my request and the request of Leader REID to help us work on this issue. He was involved with the White House as well, and really understood the substance of this bill as well as the political navigation that was necessary to bring us to this moment.

I thank Pam Smith as well for her fine work for Senator HARKIN. Jenelle Krishnamoorthy made a wonderful contribution. She worked closely with Senator HARKIN, and I want to thank her. Connie Garner was responsible, for many years, working on the CLASS Act, which is a part of our bill. Portia Wu and David Bowen did a remarkable job. John McDonough and Topher Spiro, as well, are individuals who certainly made a significant contribution to our product here.

Senator BAUCUS's staff: Liz Fowler, Bill Dauster, Russ Sullivan, Cathy Koch, Yvette Fontenot, David Schwartz, Neleen Eisinger, Chris Dawe, Shawn Bishop, and Kelly Whitener—I want to thank them for their efforts as well.

Again, we could give separate remarks about each of these individuals and their contributions.

In my office, again, like others, I have been blessed with some wonderful people. Jim Fenton is my legislative

director and has done a terrific job. Tamar Magarik Haro, who is sitting with me on the floor this evening—I know we are not supposed to recognize people other than Members—along with Jeremy Sharp, they have just done a wonderful, wonderful job, and I know all of my colleagues have gotten to know both of them because of their work.

Monica Feit, Joe Caldwell, Bryan DeAngelis, Andy Barr, Lia Lopez, Daniel Barlava, and Rachael Holt all have made wonderful contributions as well.

Senate legislative counsel, with special thanks to Bill Baird, who was present throughout the entire HELP Committee consideration, has gone way above and beyond. And legislative counsel never gets the kind of recognition they deserve.

They do a tremendous job in drafting the actual legislation. Once these ideas are developed, then they require legislative language to be written.

From the administration, Nancy Ann DeParle, whom all of us have gotten to know very well; Jeanne Lambrew—I want to give a special thanks to Jeanne. She has been just incredible in terms of her encyclopedic knowledge of the issues, working very closely with our staffs. Again, individuals who may not be well known to the public, but when this bill becomes law, these are the individuals who deserve special credit for their tremendous work.

Mike Hash, Lauren Aronson, Secretary Sebelius, Kathleen Sebelius, who left the governorship of Kansas to come here to be head of the Health and Human Services agency and has done a magnificent job in her new capacity; Jim Messina, who worked with MAX BAUCUS for years up here and has been the Deputy Chief of Staff at the White House and has done a tremendous job. Phil Schilliro and Shawn Maher both worked to represent the administration and their Legislative Affairs Office and they do a great job; Dana Singiser as well, for her work.

We will make this list available for the RECORD. I wanted to thank these individuals again for their fine work.

I wish to speak, if I can today, not in my capacity as a senior member of the Health, Education, Labor, and Pensions Committee nor in my capacity as one of the coauthors of the underlying legislation, but rather in my capacity, as I said at the outset, as a Senator representing 3.5 million residents of the State of Connecticut. Our neighboring State, my good friend and colleague, the Senator from New Hampshire, the Presiding Officer, represents New England.

If you travel my State, you will meet some of the world's most talented and dedicated health care professionals. You will tour some of the Nation's finest hospitals where patients get world-class treatment. But you will also hear some heartbreaking stories from people in my State who come from middle-

class families who have lost everything—their homes, their life's savings, their hope for the future—just because someone in their family got sick. They needed special care. You will meet hard-working men and women who have seen their insurance premiums skyrocket over the last decade from around \$6,000 for a family of four to over \$12,000 annually for that same family, and they wonder how much longer they will be able to continue to afford the coverage they have. You will meet small business owners facing an impossible choice between cutting off health care benefits to their employees or laying off those workers.

I have talked specifically about constituents of mine, small businesspeople who literally have been faced with that choice or who have had employees who dreaded having to leave the job they had because there were no health care benefits. They took reductions in pay because they just couldn't stay given the health conditions of their family. Having to leave a job they had for 20 years or more to find new work where there was health care coverage; leaving a job they loved for less pay because they weren't able to get that health care coverage—not because their employer didn't want to give it to them but because that small employer just could not afford to do so and stay in business. Even those who are healthy in my State, who have insurance, there is that worry as well.

What I have described is not an irrational fear they have that someone in their family will lose their job that provides the coverage as I just described, worrying about that child who may develop an illness not covered by their policies, or worrying about no matter how much they pay in premiums their insurance doesn't allow them to be sure of anything at all.

The residents of my State understand the status quo is no longer sustainable because the so-called status quo threatens the basic economic security of every family in my State, as it does across this country. They and their fellow Americans in all 50 States sent us here to take action, and it is action that we shall take.

When this bill becomes law, the people of my State will begin to reap the benefits right away. One in four of my constituents have high blood pressure. One in four teens suffers from diabetes in Connecticut. Today, insurance companies can use these preexisting conditions, along with many others, as an excuse to deny these people coverage. Immediately, young people in our State and across the country will be protected against these preexisting conditions to receive the coverage they need. Beginning 90 days after this bill becomes law, every uninsured resident of my State who has been denied coverage because of a preexisting condition will be able to find the affordable

coverage they need to treat that condition.

Small businesses make up more than three and four businesses in the State of Connecticut, but today only one-half of them are able to offer health benefits to their workers. Beginning in 2010, next year, some 37,000 small businesses in my State, as well as others across the nation, will be eligible for tax credits to make those benefits more affordable. A 50-percent tax break, \$40 billion in this bill, is provided specifically for that purpose: to assist the 37,000 small businesses in Connecticut, and others across the country, to get a tax credit, as much as 50 percent, to allow them to defer or reduce the cost of health insurance for their employees.

Small business owners throughout Connecticut have experienced persistent annual increases in premiums. In recent years—and this is true across the country, but certainly true in my State—it is not uncommon for small business owners to be told they have to pay 20 percent or more for the same insurance they had the previous year.

So the bill we are about to pass will empower the State insurance exchanges such as the one we will have in Connecticut in 2014 to deny insurers access to the exchange if they engage in consumer price gouging in the next few years. That is going to be critically important. For the more than half million seniors in Connecticut, this bill protects Medicare, keeping it solid into the future. Nearly 100,000 seniors in my State hit what is called the doughnut hole in the prescription drug benefit area, costing them an average of more than \$4,000 annually.

This bill we are about to adopt takes the first critical step toward closing that doughnut hole, and Connecticut seniors should know that I and Chairman BAUCUS, along with majority leader HARRY REID, have committed to completing that job in conference, and we will do so.

Meanwhile, in Connecticut, seniors will see their Medicare premiums go down. They will see major improvements in the quality of care they receive, resulting in as many as 29,000 hospital readmissions being prevented. In my State of Connecticut, 3 in 10 Connecticut residents have not had a colorectal cancer screening.

One in six women over the age of 50 have not had a mammogram in the past 2 years. These are important screenings. They and other wellness programs will be provided at no cost to people in my State as well as others across the country. Beginning in 2011, seniors will be able to get a free annual checkup so they can stay well instead of simply receiving care when they get sick. That annual free checkup can make such a difference. I am a living example of that where—because under our health care plan, I can have a free medical checkup once a year. As a re-

sult of that, I discovered that I had prostate cancer, and what a difference that made to be able to discover that, to get through the surgery, and to know that I have a bright future ahead of me, not one that I would discover later on when the kind of surgery I received might have been worthless and pointless.

So these are the kinds of annual physicals Members of Congress get under our health care plans, and our fellow citizens ought to be able to as well, particularly our seniors.

In addition, there are some 255,000 Connecticut residents between the ages of 55 and 64 who will need home health services after they turn 65 because of an illness or an injury. These services, whether they involve installing a handicap shower or hiring a home health care aide, will help these older Americans live in their homes in dignity and with independence. But today these services are not always covered by Medicare or private insurance. Rather than having to impoverish themselves so they can qualify for Medicaid by transferring all of their wealth and assets to a family member or rely on the full-time help of loved ones, these seniors will be able to take advantage of a new voluntary program called the CLASS Act—authored by Senator Kennedy years ago and which is now a part of this bill—that will provide a cash benefit to be used on these services and supports, totally paid for by the individual themselves. Not a nickel, not a penny of Federal money is in that program. It is totally based on the contribution that people make to that program.

So when I hear people talk about this as if it was some great robbery from the Federal Treasury, it doesn't involve the Federal Treasury at all. As the bill takes effect, the health insurance exchanges are set up and health insurance will become a buyer's market for people in my State as well. More than 350,000 Connecticut residents who today do not have insurance will finally have affordable options to choose from. Nearly a quarter of a million people in my State would be eligible for premium credits to help take care of the cost of insurance. That doesn't go into effect until 2014, but in 2010, next year, insurance companies will be prohibited from imposing lifetime caps on the amount of care you can receive.

Insurance companies will be prohibited next year from taking away your coverage, and they will be prohibited from discriminating based on gender or income in the year 2014. The insurance industry will be forced to spend more of your premium dollars on your health care, not on bureaucrats hired to come up with reasons to deny you the care you need. This is called the so-called medical loss ratios which require that resources be spent on patient care and

needs of the policyholder rather than on profits or administrative costs.

The industry will also be required to offer an appeal if your claim is denied, and each State will set up its own independent appeals process to keep the industry honest. Next year the industry will be forced to provide more details about their policies so that you can shop for health insurance the same way you shop for anything else, armed with enough information to be a smart consumer.

All of these insurance items will take effect at least by 2014, many of them next year, as I have just mentioned.

It is not just consumers who will benefit. Connecticut's 15,000 physicians will also benefit. Today these physicians spend, on average, 140 hours and \$68,000 every year just dealing with bureaucrats at the health insurance companies. Let me repeat that: 140 hours and roughly \$68,000 every year just dealing with bureaucrats at the insurance companies. That is 2.1 million hours and \$1 billion in costs overall, time and money wasted in my State alone. That is going to end.

This bill cuts down on bureaucratic redtape and needless paperwork. Doctors will be able to spend their time caring for patients, not fighting with the insurance industry. Meanwhile, more than 5,000 Connecticut primary care physicians will qualify for the new 5- to 10-percent payment bonus. That happens next year in 2010. New programs will incentivize many more young doctors to stay in primary care, which we all know is critically important.

Today, 9 percent of Connecticut residents can't access a primary care physician because there aren't enough doctors to go around. This bill makes an investment in our medical workforce and a \$10 billion investment in community health centers and the National Health Service Corps, which begins taking effect immediately in 2010. It will be phased in over 5 years. That is going to expand dramatically the availability of patient care with our community health care system.

As more uninsured people gain coverage, Connecticut will no longer have to subsidize the \$383 million it spends in uncompensated care our providers deliver each year—important at a time when my State is already, like every State—almost every State—in serious budget trouble.

I have just recited a long list of statistics showing how my State will benefit from this bill—in many instances, benefit immediately. Some will take a little longer, but many of these provisions go into effect in the next year. More important than any statistic will be what you will see when you tour my State, or any other State for that matter, after this bill takes effect—or more accurately, what you will not see. You will not see 100 people losing their in-

surance, their health insurance every single day, finding themselves cast into uncertainty and fear—100 people every day—that will no longer be the case. You will not see families paying an extra \$1,100 a year in health insurance premiums, the so-called hidden tax paid by everyone with insurance as a result of the nearly 50 million uninsured Americans. You will not see seniors facing the loss of their Medicare benefits because overpayments to private insurance companies have rendered the program insolvent. You will not see parents laying awake at night praying that their child's cough goes away because they can't afford to take him or her to see a doctor. You will not see people losing their homes, their life's savings, losing their economic security, all because they got sick or a child or a spouse did. You will not see people dying, as 45,000 do every year in our country, because they couldn't afford access to the health care system.

So as a senior member of the Health, Education, Labor and Pensions Committee, and a close and dear friend of our departed colleague, Senator Ted Kennedy, who led this fight for so long, it will be my honor—a deep honor indeed, one of the highest honors I would have had in the 30 years I have served here—to cast a vote in favor of this landmark legislation.

As one of two Senators whose job it is to look out for the people of my home State of Connecticut, supporting this bill is nothing short of my duty, and I intend to fulfill it with great pride at 8 a.m. on Christmas Eve. What better gift could I give to my folks at home than to cast my vote as 1 of 100 in this body for health care reform in our Nation, so long overdue, so long waited for. And on this Christmas Eve it will become an accomplished feat of the U.S. Senate.

With that, I yield the floor and note the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. DODD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. UDALL of Colorado). Without objection, it is so ordered.

Mr. DODD. Mr. President, there were a number of other people I wished to mention. I will not go through the list of all the staff involved in this effort in the Senate. I am sure I would miss some people. It is a lengthy list of those who played such an important role. I was fearful I wouldn't have a chance between now and the actual vote on Thursday morning, Christmas Eve, to express my deep gratitude as one Member who benefited tremendously from the participation of my staff, two of whom are seated with me this evening. I know that is probably a

violation of Senate rules to recognize them, but I want my constituents at home and the American public to know how many dedicated people there are whose names they never know, faces they will never see.

I ask unanimous consent that a list of staff be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

REID

Kate Leone, Carolyn Gluck, and Randy DeValck.

HARKIN/KENNEDY

Michael Myers, Mark Childress, Pam Smith, Jenelle Krishnamoorthy, Connie Garner, Portia Wu, David Bowen, John McDonough, Topher Spiro, Stacey Sachs, Tom Kraus, Terri Roney, Craig Martinez, Taryn Morrissey, Andrea Harris, Sara Selgrade, Lee Perselay, Caya Lewis, Stephanie Hammonds, Andrew Garrett, Joe Hutter, Lauren McFerran, Jeff Teitz, Kate Cyrul, Dan Goldberg, Caroline Fichtenberg, Bill McConagha, Lory Yudin, and Evan Griffis.

BAUCUS

Liz Fowler, Bill Dauster, Russ Sullivan, Cathy Koch, Yvette Fontenot, David Schwartz, Neleen Eisinger, Chris Dawe, Shawn Bishop, Kelly Whitener, Tony Clapsis, Diedra Henry-Spires, Tom Reeder, Bridget Mallon, Tiffany Smith, and Catherine Dratz.

DODD

Jim Fenton, Tamar Magarik Haro, Jeremy Sharp, Monica Feit, Joe Caldwell, Bryan DeAngelis, Andy Barr, Lia Lopez, Daniel Barlava, and Rachael Holt.

Senate Legislative Counsel, with special thanks to Bill Baird, who, along with Stacy Kern-Scheerer, was present throughout the entire HELP Committee and has gone above and beyond.

OBAMA ADMINISTRATION

NancyAnn DeParle, Jeanne Lambrew, Mike Hash, Lauren Aronson, Secretary Sebelius, Jim Messina, Phil Schilliro, Shawn Maher, and Dana Singiser.

Mr. DODD. Mr. President, let me say this to the minority staff as well. While we have disagreed, and while they didn't vote for the bill, there are people I admire immensely on the minority staff. On our committee, there were wonderful suggestions and contributions that came from the Republican side of the aisle. While they didn't support the bill, I think they made it a better bill because of their contributions. I want to add their names as well. MIKE ENZI of Wyoming, the ranking member—and I worked with every Republican minority member of the HELP Committee—offered amendments that were included. While they may not want to admit it or acknowledge it, they made a contribution to this bill that makes it stronger and a better piece of legislation. I add their names as well for their efforts.

MORNING BUSINESS

Mr. DODD. Mr. President, I ask unanimous consent that the Senate proceed

to a period of morning business, with Senators permitted to speak therein for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

TRIBUTE TO BARBARA A. SOULIOTIS

Mr. KIRK. Mr. President, I know all my colleagues share an indebtedness to the many staff members who work so (skillfully and) tirelessly behind the scenes each day. They assist us in serving the public and responding to the needs of our constituents. Today, I am honored to pay particular tribute to the contributions of one truly outstanding member of the Senate staff. She will retire at the end of this session of Congress after 47 years of impressive service to the citizens of Massachusetts.

Barbara Souliotis worked on Senator Edward M. Kennedy's first campaign for the Senate in 1962. She was the first employee in Senator Kennedy's office in November of that year. And from the moment he joined this body until the end of his life, Barbara served as a member of his staff and for the last 23 years, she was the State director of his Boston office.

"Barbs" recalls that on her first day at work here in Washington, she spilled a glass of Coca Cola on Senator Kennedy. When she started to apologize, he smiled his iconic smile and said "Barbara, you and I are going to get along just fine."

And they did. She served him brilliantly throughout his entire Senate career—the only member to run the full race as a "staffer", though many of us have reported back in whenever Barbara sent out the call.

Senator Kennedy considered "Barbs" to be his most indispensable assistant. If anyone ever had a question relating to the Massachusetts people whom he loved, he would inevitably ask; "Have you checked with Barbs?" I know how proud Ted would be that this tribute honoring Barbara's extraordinary example of public service to our Senate, our Commonwealth and our country is taking place this day.

I first met Barbara Souliotis when I joined Senator Kennedy's staff in 1969—40 years ago. I could see right away that behind Barbara's modest demeanor was a remarkable woman who would never let Senator Kennedy down. Why?

Because she had learned that his values and his commitment to making a positive difference in peoples lives was the very reason she wanted to work for him in the first place. As I have thought about public service through the years, it has become clear that the best of our Nation was built on the labors of loyalty and love of unsung public heroines like Barbara Souliotis.

It was once said that "Loyalty means nothing unless it has at its heart—the

absolute principle of self sacrifice". If that is the standard of loyalty, I can tell you this,—there is no more loyal United States Senate staffer than Senator Kennedy's own "Barbara Souliotis".

She embodies the admirable quality of loyalty no matter the circumstances. Barbs planned to retire years ago, but her loyalty to Senator Kennedy and her leadership position on his staff kept her with him to the end. Just as she had throughout his storied career, she worked unfailingly for Senator Kennedy through the difficult months of his illness and during his final days.

After Senator Kennedy passed away in August, Barbara continued her remarkable life's work of service as the director of my Boston office. This woman I had known as a colleague came, once again, to the aid of a friend. As one who was appointed to, among other things, continue constituent services for the people of Massachusetts, I knew I could keep that pledge—because Barbara Souliotis volunteered to stay on to lead the Kennedy team during these last few months.

Barb's loyalty, integrity and commitment are legendary. She is the true noble public servant, the tireless and compassionate friend, the unassuming aid to all around her.

If public service is Barb's vocation, sports is her avocation. There is no more avid fan of the Boston Red Sox, the Boston Bruins, the Boston Celtics, and the New England Patriots than Barbara Souliotis.

And she's also an outstanding golfer who plays without a handicap and who has at least one hole-in-one on her score card. In Massachusetts, sports and politics are our passion. And Barbs has scored literally thousands of holes-in-one for the constituents of Massachusetts. A lifelong resident of Haverhill, she has travelled tens of thousands of miles through the years serving the people of our Commonwealth.

In acknowledging Barbara's years of All-Star service to Senator Kennedy for 47 years and to me for these few important and historic months, I add my own personal heartfelt thanks to her, especially for the blessings of her friendship, support, and counsel over the many decades, and I wish her a well-deserved happy and healthy retirement in the many years to come. Thank you, Barbs. We love you. Hit 'em long and hit 'em straight!

NOMINATION OF ERROLL SOUTHERS

Mr. DURBIN. Mr. President, it is only fitting that during this travel-heavy holiday season, we urge our colleagues on the other side of the aisle to work with us in confirming the nomination of Erroll Southers as Assistant Secretary for the Transportation Security Administration.

The Transportation Security Administration is tasked with ensuring the security and safety of travelers using our transportation network. Most often associated with security at airports, TSA responsibilities also include highway, rail, port, bus, and mass transit security. The agency grew out of the aftermath of 9/11, a somber reminder of the need for vigilant attention to transportation security.

Erroll Southers is the chief of homeland security and intelligence for the Los Angeles International Airport police force. He is ready for this job. He has nearly three decades working in public safety, homeland security, and intelligence. Chief Southers has worked as a Santa Monica police officer, special agent for the Federal Bureau of Investigation, and as a top officer with the Los Angeles International Airport, assisting in the management of the largest U.S. airport police force.

Unfortunately, without Chief Southers in the position he has been nominated to, TSA is without the leadership necessary to move forward. The President nominated Chief Southers in September, and the nomination has been reported favorably to the Senate by both the Homeland Security and Commerce Committees, it is being held up by Senate Republicans.

At the same time Senate Republicans are insisting on expanding the role and responsibility of TSA by requiring guns to be allowed on Amtrak, they block and delay the permanent leadership necessary to implement these new policies.

And what is the justification for delaying Chief Southers' confirmation? It is not his qualifications, his past actions or experience. These are generally accepted to be outstanding. No, it is instead an unreasonable demand that he predetermine if TSA employees should be allowed to form unions. Instead of bending to political pressure, Chief Southers has taken the stance that this decision should be made with the input of all stakeholders, using good information, to find the best solution that does not jeopardize safety and security.

The Senate must move past these disagreements and provide the administration with the leadership agencies need to implement congressionally mandated duties. Chief Southers is an excellent candidate to lead the Transportation Security Administration, and he should be in place at the agency today. In the midst of the heaviest travel period of the year, it is irresponsible that the Senate has left this post unfilled. I urge my colleagues to support the confirmation of Chief Southers.

BIODIESEL TAX CREDIT

Mr. GRASSLEY. Mr. President, the biodiesel tax credit will expire on December 31, 2009. I am speaking today to

set the record straight about why the biodiesel tax credit will not be extended before the end of the year.

Some have suggested that Republicans are to blame for not getting the biodiesel tax credit extended before the end of the year. This is simply inaccurate.

The bottom line is that the Senate Democratic leadership decided they were going to attach the tax extender package to a controversial estate tax bill in an attempt to get moderate Democrats and Republicans to vote for an estate tax bill that does not provide sufficient estate tax relief.

If the Senate Democratic leadership had not chosen to hold the tax extender package hostage in an attempt to force moderate Democrats and Republicans to vote for an estate tax bill that lacks support, the tax extender package would have easily passed separately.

The tax extenders bill could have passed as a stand-alone bill easily at any time during this whole year. In fact, the Senate Democratic leadership could simply bring up a noncontroversial version of the tax extenders bill and pass it by unanimous consent like we have done in the past. We wouldn't even need to be talking about the tax extenders package in relation to the Department of Defense funding bill.

However, because the Senate Democratic leadership failed to act on the tax extenders package this entire year, one of the only legislative vehicles left to pass the tax extenders package was the Department of Defense funding bill.

Instead of just adding to the Defense bill a noncontroversial tax extenders package that both Republicans and Democrats could agree on, the Senate Democratic leadership instead decided that they would also try to attach the controversial estate tax bill and a controversial increase in the debt limit.

They could have instead just included a noncontroversial tax extenders package with the Defense bill, and it would have easily passed. Again, they did not do this because they wanted to use the tax extenders package as leverage to get moderate Democrats and Republicans to vote for an estate tax bill that lacks support.

It is also worth noting that there are 60 Senators that caucus with the Democrats, so they can pass anything if they vote together. It rings hollow to place the blame on Republicans for failing to enact the tax extenders package before the end of the year when the Democrats hold a supermajority of 60 Senators, an overwhelming majority in the House, and the Presidency.

The House, waiting until the last month of the year, finally passed a tax extenders bill. However, the House usually passes an extenders bill prior to the last month of the year.

For example, in 2008 the House passed a tax extenders bill on September 26,

2008, and in 2007 the House passed a tax extenders bill on November 9, 2007. This year, the House passed an extenders bill that they knew the Senate would not accept. And then they left town for the year. This is called a dump and run.

The House dumped a tax extenders bill that they knew the Senate would not agree to, and left town before the Senate could have any chance to negotiate a tax extenders bill that both the House and Senate could agree to.

The House also had a choice to make regarding whether they wanted to pass a tax extenders bill this year by simply attaching a noncontroversial version of the tax extenders bill, which both the House and Senate could agree on, to the House Department of Defense bill, without attaching either the controversial estate tax bill or the increase of the debt limit on the Defense bill. However, the House chose not to do so.

Therefore, this should set the record straight. The Democratic leadership in the House and the Senate, and not Republicans, are responsible for the failure to pass a tax extenders bill before the end of this year.

This failure has very serious consequences to the U.S. biodiesel industry, which will grind to a halt as of January 1, 2010. I remind my colleagues of the economic challenges faced by this industry. In 2008, the biodiesel industry supported more than 52,000 green jobs.

Because of the downturn in the economy, the biodiesel industry has already lost 29,000 green jobs in 2009. The industry is poised to lose another 23,000 jobs if nothing is done on the tax incentive or regulatory delays at the Environmental Protection Agency.

So where are these jobs? Some might think they are all in the Midwest, but they are not. These green jobs are in 44 of the 50 States. I would like to list the 13 largest biodiesel-producing States in the country.

There are 24 facilities in Texas. There are 15 facilities in Iowa. There are 6 facilities in Illinois and 6 in Missouri. There are 4 facilities in Washington. Ohio has 11 facilities. There are 5 facilities in Indiana. There are 3 facilities each in Mississippi and South Carolina. There are 7 facilities in Pennsylvania and 4 in Arkansas. New Jersey has 2 facilities. There is 1 facility in North Dakota.

Only 6 of the 50 States do not have some biodiesel production. They are Alaska, Delaware, Maine, New Hampshire, Vermont, and Wyoming. The other 44 States have some biodiesel presence.

So workers in 44 States will be negatively affected by the inaction of this Congress to extend the tax credit.

You don't have to take my word for it. On November 25, I received a letter from the Iowa Renewable Fuels Association.

The letter outlined the economic and job ramifications of allowing the tax credit to expire, even if it is a short-term expiration. I would like to read directly from that letter.

It states in part:

Simply put, if the biodiesel tax incentive is allowed to expire—even for a brief period of time—the Iowa biodiesel industry will cease production and many plants will likely not reopen under current ownership.

If the biodiesel tax incentive expires, biodiesel blends will be priced out of the marketplace and our customers—the oil companies—will stop purchasing biodiesel. In reality, we already cannot book any first quarter sales for next year.

No retroactive action on the tax credit sometime next year will undo the harm caused by the lost sales and shuttered plants over the holidays.

Quite frankly, the biodiesel industry is facing shutdowns that would certainly lead to a much longer—and unpaid—Christmas break than anticipated for the hundreds of workers at Iowa biodiesel plants.

But there are long-term impacts potentially even more far-reaching. After more than a year of mainly breakeven or negative margins, most of Iowa's biodiesel plants simply do not have the cash reserves to withstand even a two or three month shutdown.

So, even if the biodiesel blenders' tax credit is retroactively enacted, several of Iowa's biodiesel plants are unlikely to reopen under the current local-ownership. Please do not let the Iowa-owned biodiesel industry disappear on your watch.

I would ask unanimous consent that the entire letter from the Iowa Renewable Fuels Association to which I referred be printed in the RECORD.

The dire situation reflected in this letter applies to all 173 biodiesel plants around the country. The expiration of this tax credit on December 31, 2009, will affect all 23,000 workers in this green energy sector.

It is unfortunate that we have to be faced with the loss of 23,000 green jobs because of inaction on the extension of the biodiesel tax credit. I hope this explanation makes clear who is responsible for this terrible situation.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

IOWA RENEWABLE FUELS ASSOCIATION,
November 25, 2009.

Hon. CHARLES E. GRASSLEY,
Hart Senate Office Building,
Washington, DC.

DEAR SENATOR GRASSLEY: First, thank you for taking the time to meet with Iowa Renewable Fuels Association members on November 17, 2009. At that meeting, we discussed the absolute necessity of extending the biodiesel blenders' tax credit prior to the end of this year. With this letter, we want to reinforce the economic and job ramifications of allowing the tax credit to expire—even for a couple of months.

As a longtime supporter of Iowa biodiesel, you know that the biodiesel tax incentive, which allows blenders to claim a \$1 excise tax credit for each gallon of biodiesel blended with diesel, is set to expire on December 31, 2009. Simply put, if the biodiesel tax incentive is allowed to expire—even for a brief period of time—the Iowa biodiesel industry will cease production and many plants will likely not reopen under current ownership.

With the tax credit, biodiesel blends are very competitive in today's marketplace. However, if the biodiesel tax incentive expires, biodiesel blends will be priced out of the marketplace and our customers—the oil companies—will stop purchasing biodiesel. In reality, we already cannot book any first quarter sales for next year. Therefore, biodiesel plants are unable to purchase feedstocks for the beginning of 2010 because there is no guarantee that a market for biodiesel will exist come January 1, 2010. As a result, many plants will likely begin to stop operations in mid-December.

No "retroactive" action on the tax credit sometime next year will undo the harm caused by the lost sales and shuttered plants over the holidays. Quite frankly, the biodiesel industry is facing shutdowns that would certainly lead to a much longer—and unpaid—Christmas break than anticipated for the hundreds of workers at Iowa biodiesel plants.

That is a prospect that any industry hopes to avoid. But there are long-term impacts potentially even more far-reaching. While 2009 has been a rough economic year for many industries, the biodiesel industry has been hit harder than most. In fact, of Iowa's fifteen biodiesel refineries, only nine are currently operating—and most of those at a severely reduced capacity. After more than a year of mainly breakeven or negative margins, most of Iowa's biodiesel plants simply do not have the cash reserves to withstand even a two or three month shutdown.

So even if the biodiesel blenders' tax credit is retroactively enacted, several of Iowa's biodiesel plants are unlikely to reopen under the current local-ownership. In fact, if recent history from the ethanol industry is any indication, Big Oil companies may swoop in, buy the closed plants for pennies on the dollar and then reopen them as part of their multi-national, vertically-integrated business plan. While this would be better than having the doors of these plants closed for good, keeping these plants in the hands of Iowa investors provides the most benefits to the local communities.

During our meeting, there was discussion of using a tax extenders package or estate tax bill as a vehicle to extend the biodiesel tax credit this year. That type of decision is best left to you—we just know the extension needs to happen this year. We have also increasingly heard of the need for a "jobs bill" this year in response to U.S. unemployment surpassing ten percent. We urge you to consider the extension of the tax credit as part of any "jobs bill" that Congress may consider. After all, extending the tax credit—something most people believe will happen "eventually"—is an easy way to maintain hundreds of jobs in Iowa and thousands around the country. Failure to extend the biodiesel tax credit will undoubtedly add to the jobless rolls.

We thank you for your support of the Iowa biodiesel industry, and we encourage you to do all you can to ensure that the biodiesel tax incentive is extended as soon as possible. We are not trying to be alarmist. Rather, we want you to have a clear picture of the prospects facing the Iowa biodiesel industry as the tax credit expiration comes closer each day. Please do not let the Iowa-owned biodiesel industry disappear on your watch.

Sincerely,

MONTE SHAW,
Executive Director.

THANKING STAFF

Mr. NELSON of Nebraska. Mr. President, I want to take a few minutes in the midst of this debate to acknowledge some individuals who work for us here in the Senate. As chairman of the Legislative Branch Appropriations subcommittee that funds these agencies, I have had the opportunity to get to know these staffs and have a good understanding of the work they do for us here in the Senate. These folks work tirelessly behind the scenes at all times to keep this institution running safe and sound under any circumstances.

We have been in session every week-end since Thanksgiving, including during the largest December snowstorm in Washington's history, and we have worked uninterrupted thanks to the dedication and hard work of these individuals. It is easy to take for granted the hard work they perform on a daily basis—and we often do, but today, on behalf of the entire Senate I would like to say a heartfelt thank you to all of them.

I want to start by thanking the U.S. Capitol Police Force, led by Chief Philip Morse and Assistant Chief Dan Nichols. This force of 1800 officers put their lives on the line every day to protect us and this institution, and they have all worked a tremendous amount of overtime lately. I want to particularly mention the terrific work of Inspector Sandra Coffman and her staff in the Capitol Division for all the extra hours they have worked in securing and protecting the Capitol and the Chamber. They have gone above and beyond their normal duty, and we are extremely grateful for their dedication to our safety and protection.

Next I want to thank the staff of the Senate Sergeant at Arms, led by Sergeant at Arms Terry Gainer and Deputy Sergeant at Arms Drew Willison. The SAA staff of nearly 900 people includes the doorkeepers who have worked nonstop through the last month keeping access to the Senate available for staff and visitors who have traveled to Washington to witness this historic debate firsthand. They have kept our computer systems and overstretched telephone systems running, kept the mail moving, and the recording studio functioning, not to mention the facilities staff who have kept the Capitol Building clean and warm, replenishing wood for the fireplaces nonstop.

I want to thank the staff of the Architect of the Capitol, led by Acting Architect Stephen Ayers, and the many, many folks who have worked around the clock from Ted Bechtel and the Capitol Grounds crew who have been removing snow from the road, sidewalks, and parking lots of the Capitol Complex, to Robin Morey and his staff who have kept the Senate buildings clean and warm throughout these

long, long weeks. I truly appreciate the extra hours of work provided by these individuals.

I want to thank the Secretary of the Senate, Nancy Erickson, and her staff, including the legislative clerks, the bill clerks, the enrolling clerks, the executive clerks, Parliamentarians, official reporters of debates, captioning services, journal clerks, and the staff of the Daily Digest. These folks have been here around the clock, under some very tiring circumstances, to deliver the services that are needed to keep this institution running.

Last but not least, I want to thank Lula Davis and David Schiappa, our floor leaders, for their tireless guidance in keeping us—the Members—where we need to be when we need to be there. We are in your debt.

Mr. President, I have undoubtedly left out many people in the Senate who deserve to be thanked, and I hope they know who they are and how much we appreciate them.

ADDITIONAL STATEMENTS

100TH ANNIVERSARY OF THE HOUSE OF JACOB

• Mr. VOINOVICH. Mr. President, today I am pleased to extend my warmest congratulations to the Supreme Council of the House of Jacob of the United States of America as it celebrates its 100th anniversary with delegates from 41 locations from around the United States travelling to Coshocton, OH, for services in the church's newly constructed Mount Zion Tabernacle.

For 100 years, the Supreme Council of the House of Jacob of the United States of America has invited men and women of diverse backgrounds to worship God according to the teachings of Jesus Christ, advocating strong family ties, a high standard of moral values and civic participation.

I would like to recognize Supreme Bishop, Father J. Daniel Israel, J.O.G., and the Board of Directors of the House of Jacob of the United States of America, which make up the leadership of this church. I commend the ministries and the good works under their supervision within Ohio, and across our Nation.

I encourage my fellow Ohioans, my colleagues in the Senate and the entire Nation to recognize this memorable anniversary celebration and to congratulate the Supreme Council of the House of Jacob of the United States of America on its 100-year anniversary on the 1st day in January 2010. Also, may God continue to bless this Church, its leaders and its faithful members.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to

the Senate by Mrs. Neiman, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC-4144. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Update to Notice 2009-38" (Notice No. 2010-2) received in the Office of the President of the Senate on December 17, 2009; to the Committee on Finance.

EC-4145. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Extension of Notice 2008-55" (Notice No. 2010-3) received in the Office of the President of the Senate on December 17, 2009; to the Committee on Finance.

EC-4146. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Guidance Under Section 409A(a) Regarding Complying with Opinions Issued By the Special Master Under the EESA" (Notice No. 2009-92) received in the Office of the President of the Senate on December 17, 2009; to the Committee on Finance.

EC-4147. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Extension of Deadline to Adopt Certain Retirement Plan Amendments" (Notice No. 2009-97) received in the Office of the President of the Senate on December 17, 2009; to the Committee on Finance.

EC-4148. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "2009 Cumulative List of Changes in Plan Qualification Requirements" (Notice No. 2009-98) received in the Office of the President of the Senate on December 17, 2009; to the Committee on Finance.

EC-4149. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Arbitrage Treatment of Certain Guarantee Funds" (Notice No. 2010-5) received in the Office of the President of the Senate on December 17, 2009; to the Committee on Finance.

EC-4150. A communication from the Chief of the Publications and Regulations Branch,

Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Reduction in Taxable Income for Housing Hurricane Katrina Displaced Individuals" ((TD 9474)(RIN1545-BF14)) received in the Office of the President of the Senate on December 17, 2009; to the Committee on Finance.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. ROCKEFELLER, from the Committee on Commerce, Science, and Transportation, without amendment:

H.R. 3819. A bill to extend the commercial space transportation liability regime.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. HATCH:

S. 2922. A bill to amend the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to extend the Rural Community Hospital Demonstration Program; to the Committee on Finance.

By Mrs. MURRAY:

S. 2923. A bill to provide funding for summer and year-round youth jobs and training programs; to the Committee on Health, Education, Labor, and Pensions.

By Mr. LEAHY (for himself, Mr. HATCH, Mr. KOHL, and Mr. SESSIONS):

S. 2924. A bill to reauthorize the Boys & Girls Clubs of America, in the wake of its Centennial, and its programs and activities; to the Committee on the Judiciary.

By Mr. WYDEN (for himself and Mr. CORNYN):

S. 2925. A bill to establish a grant program to benefit victims of sex trafficking, and for other purposes; to the Committee on the Judiciary.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. BURR (for himself and Mrs. HAGAN):

S. Res. 384. A resolution honoring United States Army Special Operations Command on their 20th anniversary; to the Committee on Armed Services.

By Mr. LUGAR:

S. Res. 385. A resolution recognizing the great progress made by the people of Ukraine in the establishment of democratic institutions, and supporting a free and transparent presidential election on January 17, 2010; to the Committee on Foreign Relations.

By Mr. KAUFMAN (for himself, Mr. LIEBERMAN, Mr. MCCAIN, Mr. DODD, Mr. KYL, Mr. CASEY, Mr. GRAHAM, Mr. LEVIN, Mr. BROWNBACK, and Mr. HATCH):

S. Res. 386. A resolution condemning the Government of Iran for restricting and suppressing freedom of the press, freedom of speech, freedom of expression, and freedom of assembly, and for its human rights abuses, and for other purposes; considered and agreed to.

ADDITIONAL COSPONSORS

S. 619

At the request of Mr. SPECTER, his name was added as a cosponsor of S. 619, a bill to amend the Federal Food, Drug, and Cosmetic Act to preserve the effectiveness of medically important antibiotics used in the treatment of human and animal diseases.

S. 891

At the request of Mr. DURBIN, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 891, a bill to require annual disclosure to the Securities and Exchange Commission of activities involving columbite-tantalite, cassiterite, and wolframite from the Democratic Republic of Congo, and for other purposes.

S. 987

At the request of Mr. DURBIN, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of S. 987, a bill to protect girls in developing countries through the prevention of child marriage, and for other purposes.

S. 1076

At the request of Mr. SPECTER, his name was added as a cosponsor of S. 1076, a bill to improve the accuracy of fur product labeling, and for other purposes.

S. 1297

At the request of Mr. CONRAD, the name of the Senator from Georgia (Mr. ISAKSON) was added as a cosponsor of S. 1297, a bill to amend the Internal Revenue Code of 1986 to encourage guaranteed lifetime income payments from annuities and similar payments of life insurance proceeds at dates later than death by excluding from income a portion of such payments.

S. 1927

At the request of Mr. DODD, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 1927, a bill to establish a moratorium on credit card interest rate increases, and for other purposes.

S. 1939

At the request of Mrs. GILLIBRAND, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of S. 1939, a bill to amend title 38, United States Code, to clarify presumptions relating to the exposure of certain veterans who served in the vicinity of the Republic of Vietnam, and for other purposes.

S. 2781

At the request of Ms. MIKULSKI, the names of the Senator from New Jersey (Mr. LAUTENBERG) and the Senator from Massachusetts (Mr. KIRK) were added as cosponsors of S. 2781, a bill to change references in Federal law to mental retardation to references to an intellectual disability, and to change references to a mentally retarded individual to references to an individual with an intellectual disability.

S. 2787

At the request of Mr. THUNE, the name of the Senator from Florida (Mr. LEMIEUX) was added as a cosponsor of S. 2787, a bill to repeal the authority of the Secretary of the Treasury to extend the Troubled Asset Relief Program.

S. 2847

At the request of Mr. NELSON of Florida, his name was added as a cosponsor of S. 2847, a bill to regulate the volume of audio on commercials.

S. 2862

At the request of Ms. SNOWE, the name of the Senator from Maryland (Mr. CARDIN) was added as a cosponsor of S. 2862, a bill to amend the Small Business Act to improve the Office of International Trade, and for other purposes.

S. 2917

At the request of Mr. BAUCUS, the names of the Senator from Arkansas (Mrs. LINCOLN) and the Senator from Nebraska (Mr. JOHANNIS) were added as cosponsors of S. 2917, a bill to amend the Internal Revenue Code of 1986 to modify the penalty for failure to disclose certain reportable transactions and the penalty for submitting a bad check to the Internal Revenue Service, to modify certain rules relating to Federal vendors, and for other purposes.

S. CON. RES. 39

At the request of Mr. MENENDEZ, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of S. Con. Res. 39, a concurrent resolution expressing the sense of the Congress that stable and affordable housing is an essential component of an effective strategy for the prevention, treatment, and care of human immunodeficiency virus, and that the United States should make a commitment to providing adequate funding for the development of housing as a response to the acquired immunodeficiency syndrome pandemic.

S. RES. 158

At the request of Mr. KERRY, the name of the Senator from South Carolina (Mr. GRAHAM) was added as a cosponsor of S. Res. 158, a resolution to commend the American Sail Training Association for advancing international goodwill and character building under sail.

AMENDMENT NO. 2995

At the request of Mr. SCHUMER, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of amendment No. 2995 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3218

At the request of Mr. DORGAN, the name of the Senator from Connecticut (Mr. DODD) was added as a cosponsor of

amendment No. 3218 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mrs. MURRAY:

S. 2923. A bill to provide funding for summer and year-round youth jobs and training programs; to the Committee on Health, Education, Labor, and Pensions.

Mrs. MURRAY. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2923

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Youth Jobs Act of 2010".

SEC. 2. SUMMER AND YEAR-ROUND YOUTH JOBS.

(a) FINDINGS.—Congress finds that—

(1) a \$1,500,000,000 investment in summer and year-round employment for youth, through the program supported under this section, can create up to 450,000 temporary jobs and meaningful work experiences for economically disadvantaged youth and stimulate local economies;

(2) there is a serious and growing need for employment opportunities for economically disadvantaged youth (including young adults), as demonstrated by statistics from the Bureau of Labor Statistics stating that, in November 2009—

(A) the unemployment rate increased to 10 percent, as compared to 6.8 percent in November 2008;

(B) the unemployment rate for 16- to 19-year-olds rose to 26.7 percent, as compared to 20.4 percent in November 2008; and

(C) the unemployment rate for African-American 16- to 19-year-olds increased to 49.4 percent, as compared to 32.2 percent in November 2008;

(3) research from Northwestern University has shown that every \$1 a youth earns has an accelerator effect of \$3 on the local economy;

(4) summer and year-round jobs for youth help supplement the income of families living in poverty;

(5) summer and year-round jobs for youth provide valuable work experience for economically disadvantaged youth;

(6) often, a summer or year-round job provided under the Workforce Investment Act of 1998 is an economically disadvantaged youth's introduction to the world of work;

(7) according to the Center for Labor Market Studies at Northeastern University, early work experience is a very powerful predictor of success and earnings in the labor market, and early work experience raises earnings over a lifetime by 10 to 20 percent;

(8) participation in a youth jobs program can contribute to a reduction in criminal and high-risk behavior for youth; and

(9)(A) youth jobs programs benefit both youth and communities when designed around principles that promote mutually beneficial programs;

(B) youth benefit from jobs that provide them with work readiness skills and that help them make the connection between responsibility on the job and success in adulthood; and

(C) communities benefit when youth are engaged productively, providing much-needed services that meet real community needs.

(b) REFERENCES.—

(1) CERTIFICATE; CREDENTIAL.—In subsection (d), references to the terms "certificate" and "credential" have the meanings prescribed by the Secretary of Labor.

(2) YOUTH-RELATED REFERENCES.—In this Act, and in the provisions referred to in subsections (c) and (d) for purposes of this Act—

(A) a reference to a youth refers to an individual who is not younger than age 14 and not older than age 24, and meets any other requirements for that type of youth; and

(B) a reference to a youth activity refers to an activity covered in subsection (d)(1) that is carried out for a youth described in subparagraph (A).

(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary of Labor for youth activities under the Workforce Investment Act of 1998 (29 U.S.C. 2801 et seq.), \$1,500,000,000, which shall be available for the period of January 1, 2010 through June 30, 2011, under the conditions described in subsection (d).

(d) CONDITIONS.—

(1) USE OF FUNDS.—The funds made available under subsection (c) shall be used for youth jobs and training programs, to provide opportunities referred to in subparagraphs (C), (D), (E), and (F) of section 129(c)(2) of such Act (29 U.S.C. 2854(c)(2)) and, as appropriate, opportunities referred to in subparagraphs (A) and (G) of such section, except that no such funds shall be spent on unpaid work experiences and the opportunities may include learning described in paragraph (3)(B).

(2) LIMITATION.—Such funds shall be distributed in accordance with sections 127 and 128 of such Act (29 U.S.C. 2852, 2853), except that no portion of such funds shall be reserved to carry out 128(a) or 169 of such Act (29 U.S.C. 2853(a), 2914).

(3) PRIORITY.—In using funds made available under subsection (c), a local area (as defined in section 101 of such Act (29 U.S.C. 2801))—

(A) shall give priority to providing—

(i) work experiences in viable, emerging, or demand industries, or work experiences in the public or nonprofit sector that fulfill a community need; and

(ii) job referral services for youth to work experiences described in clause (i) in the private sector, for which the employer involved agrees to pay the wages and benefits, consistent with Federal and State child labor laws; and

(B) may give priority to providing—

(i) work experiences combined with linkages to academic and occupational learning, so that the experiences and learning provide opportunities for youth to earn a short-term certificate or credential that has value in the labor market; and

(ii) work experiences combined with learning that are designed to encourage and maximize the likelihood of a participant's return to, or completion of, a program of study leading to a recognized secondary or postsecondary degree, certificate, or credential.

(4) MEASURE OF EFFECTIVENESS.—The effectiveness of the activities carried out with such funds shall be measured, under section 136 of such Act (29 U.S.C. 2871), only with performance measures based on the core indicators of performance described in section

136(b)(2)(A)(ii)(I) of such Act (29 U.S.C. 2871(b)(2)(A)(ii)(I)), applied to all youth served through the activities.

By Mr. LEAHY (for himself, Mr. HATCH, Mr. KOHL, and Mr. SESSIONS):

S. 2924. A bill to reauthorize the Boys & Girls Clubs of America, in the wake of its Centennial, and its programs and activities; to the Committee on the Judiciary.

Mr. LEAHY. Mr. President, I am pleased today to introduce legislation to reauthorize the Department of Justice grant program for Boys & Girls Clubs. I thank Senator HATCH, Senator KOHL and Senator SESSIONS for joining me in this effort.

I have partnered with Senator HATCH for many years on issues concerning the Boys & Girls Clubs, and this bipartisan bill shows the commitment of both Democrats and Republicans to the good work done by Boys & Girls Clubs across the Nation.

Children are the future of our country, and we have a responsibility to make sure they are safe and secure. I know firsthand how well Boys & Girls Clubs work, and the real impact they have in our communities. In my home State of Vermont, we are fortunate to have 6 Boys & Girls Clubs operating in 25 locations. These clubs serve more than 14,000 youth in the State. I often hear from parents, educators, law enforcement officers and others in Vermont about just how successful these Clubs are, and how they inspire youth to reach their full potential.

As a senior member of the Senate Appropriations Committee, I have pushed for more Federal funding for Boys & Girls Clubs. This year, I recommended additional funding for youth mentoring programs, so that youth-serving organizations like the Boys & Girls Clubs of America are able to continue making a substantial and real difference in the lives of vulnerable children. I was pleased that Congress included \$100 million for competitive youth mentoring grants in the recently passed consolidated appropriations bill.

The current recession has hit many organizations around the country, threatening their financial health, and the Boys & Girls Clubs are no different. At the same time, participation in these clubs has never been higher, and it continues to increase. I believe funding is well spent at the community level, however, where the positive impact on our youth is felt most directly.

In the 108th Congress, Senator HATCH and I worked together to pass a bill to reauthorize and extend the programs of the Boys & Girls Clubs of America through fiscal year 2009. Due in part to the support of Congress, there now exist over 4,300 Boys & Girls Clubs in all 50 states, serving more than 4.8 million young people. The bill we introduce today will help us continue to support these important programs by

authorizing Justice Department grants through 2015.

We need safe havens where our youth—the future of our country—can learn and grow up free from the influences of drugs, gangs and crime. That is why Boys & Girls Clubs are so important to our children.

I hope all Senators will support this bipartisan bill to provide Federal support for the Boys & Girls Clubs of America. Our greatest responsibility is to our children, and supporting Boys & Girls Clubs is just one way in which we can show our commitment to their future.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2924

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Boys & Girls Clubs Centennial Reauthorization Act of 2009”.

SEC. 2. BOYS & GIRLS CLUBS OF AMERICA.

Section 401 of the Economic Espionage Act of 1966 (42 U.S.C. 13751 note) is amended—

(1) in subsection (a), by striking paragraph (1) and inserting the following:

“(1) FINDINGS.—Congress finds that—

“(A) for over 100 years, the Boys & Girls Clubs of America, a national organization chartered by an Act of Congress, has proven itself as a positive force in the communities it serves;

“(B) Boys & Girls Clubs and the programs and services implemented therein by over 50,000 professional staff, and 194,000 volunteers promote and enhance the development of boys and girls by instilling a sense of competence, usefulness, belonging and influence thereby making Boys & Girls Clubs a safe place to learn and grow;

“(C) the purpose of the program established by this section has been to provide adequate resources in the form of seed money for the Boys & Girls Clubs of America to assist local communities to form partnerships in a collaborative manner so education, youth development and prevention programs could be available for the youth in those communities;

“(D) in 1990 there were 1,810 Boys and Girls Clubs facilities throughout the United States, Puerto Rico, and the United States Virgin Islands, serving 2,400,000 youths nationwide;

“(E) due to the public investment via the program established pursuant to this section, resulting congressional appropriations, and private partnership support, there are now 4,387 Boys & Girls Clubs facilities throughout the United States, Puerto Rico, and the United States Virgin Islands, serving 4,500,000 youths nationwide;

“(F) with the assistance of the Federal Government, local communities have collaborated to establish and operate the Clubs in schools, parks, parks and recreation facilities, libraries, and community centers;

“(G) these new partnerships have resulted in 33 percent of the Boys & Girls Clubs located in or on school campuses where Club programs enhance and enrich the learning opportunities for youth;

“(H) the growth of Boys & Girls Clubs also includes an increase in Clubs located in public housing sites across the Nation, having grown from 289 in 1990 to 440 in 2009;

“(I) the growth of Boys and Girls Clubs also includes the growth of Boys & Girls Clubs on Native American land, having grown from 0 in 1990 to 225 in 2009 serving 140,000 Native American youth;

“(J) investment in our school partnerships has positively impacted graduation rates as demonstrated in recent survey of Clubs conducted by BGCA’s CareerLaunch career preparation program, in which 96.68 percent of participants progressed successfully to the next grade level at the end of the 2008-2009 school year;

“(K) public housing projects and Native American land in which there is an active Boys and Girls Club have experienced a reduction in the presence of crack cocaine, and a reduction in juvenile crime and gang violence;

“(L) Boys & Girls Clubs are locally run and have been exceptionally successful in balancing public funds with private sector donations and maximizing community involvement as evidenced by collaborations and partnerships with schools, cities, counties, Sea Research, other youth providers such as Big Brothers Big Sisters, Police Athletic League (PAL), Cal Ripken Sr. Foundation, Boy Scouts, Girl Scouts, 4-H, and public libraries; and

“(M) further investment in Boys & Girls Clubs, which celebrated 100 years of service in 2006 will—

“(i) inure to our collective national benefit;

“(ii) continue to assist in the effort to reduce crime and drug use among our Nation’s youth by teaching young people how to avoid gangs, resist alcohol, tobacco, and other drug use;

“(iii) continue to assist in improving educational opportunities and create centers of learning in and with schools thereby reducing the drop out rate and helping to improve the economy (if the national male graduation rate were increased by only 5 percent, the Nation would see an annual savings of \$4,900,000,000 in crime related costs);

“(iv) continue in the efforts of reducing childhood obesity by teaching young people about the benefits of healthy habits such as eating right and being physically active;

“(v) continue to serve youth in rural communities including Native American land, by engaging and creating partnerships in those communities;

“(vi) continue to serve youth in urban and suburban communities including Public Housing by engaging and creating partnerships in those communities;

“(vii) continue to provide outdoor and environmental education programs for kids that would otherwise not have those educational and enriching opportunities;

“(viii) continue to develop job training programs for teens; and

“(ix) better equip communities to continue to sustain and improve the quality of these programs through effective use of existing resources, merging operations, and working collaboratively within communities to provide the highest quality programs for the youth in the Boys & Girls Clubs.”;

(2) in subsection (c)(1)—

(A) by striking “2006, 2007, 2008, 2009, and 2010” and inserting “2011, 2012, 2013, 2014, and 2015”; and

(B) by striking “establishing and extending Boys & Girls Clubs facilities where needed, with particular emphasis placed on establishing clubs in and extending services to

public housing projects and distressed areas" and inserting "improving the quality of youth development and educational programs, health, physical fitness, and prevention services for youth at existing and new Boys & Girls Clubs facilities with special emphasis on reducing high school drop out rates";

(3) in subsection (c)(2)—

(A) by striking subparagraphs (A) and (B); and

(B) by redesignating subparagraphs (C) and (D) as subparagraphs (A) and (B), respectively; and

(4) by amending subsection (e) to read as follows:

"(e) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There are authorized to be appropriated to carry out this section—

"(A) \$85,000,000 for fiscal year 2011;

"(B) \$85,000,000 for fiscal year 2012;

"(C) \$85,000,000 for fiscal year 2013;

"(D) \$85,000,000 for fiscal year 2014; and

"(E) \$85,000,000 for fiscal year 2015.".

By Mr. WYDEN (for himself and Mr. CORNYN):

S. 2925. A bill to establish a grant program to benefit victims of sex trafficking, and for other purposes; to the Committee on the Judiciary.

Mr. WYDEN. Mr. President, I am pleased to join today with my colleague from Texas, Senator CORNYN, to introduce the Trafficking Deterrence and Victims Support Act of 2009.

This bill addresses a serious problem that is modern day slavery, pure and simple—human sex trafficking. You could almost call it a war, where all too often, children are the casualties.

The statistics on minors involved in sex trafficking are shocking. Experts estimate that over 100,000 children in the U.S. are at risk for prostitution. The average age of entry into prostitution is 12. The children at greatest risk of becoming involved in sex trafficking are what they call "repeat runaways"—kids who have run away over and over again. They need help right away if they are going to avoid being caught by pimps. One third of runaway children are lured into prostitution within 48 hours of leaving home and 75 percent of minors caught in this web of prostitution have a pimp.

This problem is on the rise because criminal gang members are increasingly turning to pimping. Gang members have discovered that they are less likely to get prosecuted for trafficking a person than trafficking drugs. While drugs can only be sold once, a pimp can sell a person over and over. It is just as lucrative. A pimp can make \$200,000 a year on one trafficking victim.

This situation is horrifying and totally unacceptable. The bill I am introducing today will bring a smart strategy that will give some teeth to the efforts law enforcement across the country have made to combat sex trafficking. It will give them additional resources they need to lock up pimps and sex traffickers. It will also help victims break away from their abusers and get the treatment and services they need to take their lives back.

Let us be absolutely clear about this—the pimps who prey upon vulnerable young people are criminals, and they should be put behind bars. The young women, girls, and sometimes boys who are trafficked are not criminals—they are victims of crime. They don't need to be prosecuted. They need all the help they can get to escape the clutches of pimps.

Unfortunately, until now, the government has been a step behind. Right now, it is very difficult for law enforcement officers and prosecutors to build criminal cases and crack down on pimps. The Trafficking Deterrence and Victims Support Act would change that.

Here is how it would work: The bill would establish a pilot project of 6 block grants in locations in different regions of the country with significant sex trafficking activity. The block grants would be awarded by the Department of Justice to State or local government applicants that have developed a workable, comprehensive plan to combat sex trafficking. The grants would require a comprehensive, multi-disciplinary approach to addressing trafficking problems. Applicants for the grants would have to demonstrate they can work together with local, State, and Federal law enforcement agencies, prosecutors, and social service providers to achieve the goals the bill would set out for them.

Government agencies that get the grants would be required to create shelters where trafficking victims would be safe from their pimps, and where they could start getting treatment for the trauma they have suffered. The shelters would provide counseling, legal services, and mental and physical health services, including treatment for substance abuse, sexual abuse, and trauma-informed care. The shelters would also provide food, clothing, and other necessities, as well as education and training to help victims get their lives on track.

It is going to take this kind of comprehensive plan to finally turn the tables on pimps who, right now, just wait for their victims to be released from jail so they can put them back out on the streets to make money for them. Once those girls are out, they don't come back to testify against their pimps—they're just gone.

This bill fixes that problem by giving the young victims a safe haven. It is only by addressing the needs of these victims that law enforcement officers will be able to work with them to build criminal cases against their pimps. The block grants will also provide for specialized training for law enforcement officers and prosecutors to help them learn how to handle trafficking victims and build trafficking cases.

This bill would also strengthen reporting requirements for runaway or missing children, and authorize fund-

ing to the FBI to enhance the National Crime Information Center, NCIC, database, which is where missing child reports are filed. This would give law enforcement officers better information on the children at greatest risk of being lured in to sex trafficking by being able to show a tally of how many times a child has run away, and can flag them as "repeat runaways" who are at high risk of being lured into prostitution.

Sex trafficking is a complex issue that requires the comprehensive, wrap-around approach that this bill would deliver. As daunting as this problem is, there are bright examples of how to address the challenge, such as the achievements of Sergeant Byron Fassett of the Dallas Police Department. Just listening to Sergeant Fassett, who spoke at a recent congressional briefing that I hosted, is an education in how to do this right. The lessons he has learned in over 20 years of combating sex trafficking are a primer for how to get victims out of the clutches of pimps and build cases to put pimps away. Sergeant Fassett is not the only officer out there who's attacking this challenge the right way. In my home town of Portland, the officers on the human trafficking task force are doing excellent work. But right now, they simply don't have the resources to crack this problem. The Trafficking Deterrence and Victims Support Act would deliver the training and resources they need.

I want to also thank the many individuals and organizations who attended the briefing and participated in efforts to craft this legislation. I particularly want to acknowledge the Polaris Project and the National Center for Missing & Exploited Children, for their instrumental roles in this effort.

I look forward to working with Senator CORNYN and other colleagues to move this important legislation forward. There are children out on the streets tonight who shouldn't have to wait for the help this bill can give. Let us end this appalling war on those kids. Let us give them the help they need by passing this piece of legislation with all the speed possible.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2925

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Trafficking Deterrence and Victims Support Act of 2009".

SEC. 2. FINDINGS.

Congress finds the following:

(1) Human trafficking is modern day slavery. It is the fastest-growing, and second largest, criminal enterprise in the world.

Human trafficking generates an estimated profit of \$32,000,000,000 per year, world wide.

(2) In the United States, human trafficking is an increasing problem. This criminal enterprise includes citizens of the United States, many of them children, who are forced into prostitution, and foreigners brought into the country, often under false pretenses, who are coerced into forced labor or commercial sexual exploitation.

(3) Sex trafficking is one of the most lucrative areas of human trafficking. Criminal gang members in the United States are increasingly involved in recruiting young women and girls into sex trafficking. Interviews with gang members indicate that the gang members regard working as an individual who solicits customers for a prostitute (commonly known as a "pimp") to being as lucrative as trafficking in drugs, but with a much lower chance of being criminally convicted.

(4) Minors in the United States are highly vulnerable for sexual exploitation and sex trafficking. As many as 2,800,000 children live on the streets. Of the estimated 1,600,000 children who run away each year, 77 percent return home within 1 week. However, 33 percent of children who run away are lured into prostitution within 48 hours of leaving home.

(5) National Incidence Studies of Missing, Abducted, Runaway and Throwaway Children, the definitive study of episodes of missing children, found that of the children who are victims of non-family abduction, runaway or throwaway children, the police are alerted by family or guardians in only 21 percent of the cases. In 79 percent of cases there is no report and no police involvement, and therefore no official attempt to find the child.

(6) In 2007, the Administration of Children and Families, Department of Health and Human Services, reported to the Federal Government 265,000 cases of serious physical, sexual, or psychological abuse of children.

(7) Experts estimate that over 100,000 children in the United States are at risk for prostitution.

(8) Children who have run away from home are at a high risk of becoming involved in sex trafficking. Children who have run away multiple times are at much higher risk of not returning home and of engaging in prostitution.

(9) The vast majority of children involved in sex trafficking have suffered previous sexual or physical abuse, live in poverty, or have no stable home or family life. These children require a comprehensive framework of specialized treatment and mental health counseling that addresses post-traumatic stress, depression, and sexual exploitation.

(10) The average age of entry into prostitution is 12. Seventy-five percent of minors engaged in prostitution have a pimp. A pimp can earn \$200,000 per year prostituting 1 trafficking victim.

(11) Sex trafficking is a complex and varied criminal problem that requires a multi-disciplinary, cooperative solution. Reducing trafficking will require the government to address victims, pimps, and johns; and to provide training specific to sex trafficking for law enforcement officers and prosecutors, and child welfare, public health, and other social service providers. A good model for this type of approach is the Internet Crimes Against Children task force program.

(12) Human trafficking is a criminal enterprise that imposes significant costs on the economy of the United States. Government and non-profit resources used to address trafficking include those of law enforcement, the

judicial and penal systems, and social service providers. Without a range of appropriate treatments to help trafficking victims overcome the trauma they have experienced, victims will continue to be involved in crime, unable to support themselves, and continue to require government resources rather than being productive contributors to the legitimate economy.

(13) Many domestic minor sex trafficking victims are younger than 18 years old and are below the age of consent. Because trafficking victims have been forced to engage in prostitution rather than willfully to committing a crime, these victims should not be charged as criminal defendants. Instead, these victims of trafficking should have access to treatment and services to help them escape and overcome being sexually exploited, and should also be allowed to seek appropriate remuneration from crime victims' compensation funds.

(14) The State of New York has adopted a safe harbor law that establishes a presumption a minor charged with a prostitution offense is a severely trafficked person. This law allows the child to avoid criminal charges of prostitution and instead be considered a "person in need of supervision." The statute also provides support and services to sexually exploited youth who are under the age of 18 years old. These services include safe houses, crisis intervention programs, community-based programs, and law-enforcement training to help officers identify sexually exploited youth.

(15) Sex trafficking is not a problem that occurs only in urban settings. This crime exists also in rural areas and on Indian reservations. Efforts to address sex trafficking should include partnerships with organizations that seek to address the needs of such under-served communities.

SEC. 3. SENSE OF THE SENATE.

It is the sense of the Senate that—

(1) the Attorney General should implement changes to the National Crime Information Center database in order to ensure that—

(A) a child entered into the database will be automatically designated as an endangered juvenile if the child has been reported missing not less than 3 times in a 1 year period;

(B) the database be programmed to cross-reference newly entered reports with historical records already in the database; and

(C) the database be programmed to include a visual cue on the record of a child designated as an endangered juvenile in order to assist law enforcement officers in recognizing the child and providing the child with appropriate care and services; and

(2) funds awarded under subpart 1 of part E of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3750 et seq.) (commonly known as Byrne Grants) should be used to provide programs relating to sex trafficking education, training, deterrence, and prevention.

SEC. 4. SEX TRAFFICKING BLOCK GRANTS.

(a) DEFINITIONS.—In this section—

(1) the term "Assistant Attorney General" means the Assistant Attorney General for the Office of Justice Programs of the Department of Justice;

(2) the term "domestic minor" means an individual who is—

(A) a citizen of the United States or a lawful permanent resident of the United States; and

(B) under the age of 18 years old; and

(3) the term "eligible entity" means a State or unit of local government that—

(A) has significant sex trafficking activity;

(B) has demonstrated cooperation between State and local law enforcement agencies, prosecutors, and social service providers in addressing sex trafficking; and

(C) has developed a workable, multi-disciplinary plan to combat sex trafficking, including—

(i) the establishment of a shelter for sex trafficking victims;

(ii) the provision of comprehensive services to domestic minor victims;

(iii) the provision of specialized training for law enforcement officers and social service providers; and

(iv) deterrence and prosecution of sex trafficking offenses.

(b) GRANTS AUTHORIZED.—

(1) IN GENERAL.—The Assistant Attorney General is authorized to award 6 block grants to eligible entities in different regions of the United States to combat sex trafficking, and not less than 1 of the block grants shall be awarded to an eligible entity with a State population of less than 5,000,000.

(2) GRANT AMOUNT.—Each grant awarded under this section shall be in the amount of \$2,500,000.

(3) DURATION.—

(A) IN GENERAL.—A grant awarded under this section shall be for a period of 1 year.

(B) RENEWAL.—The Secretary may renew a grant under this section for 2 1-year periods.

(c) USE OF FUNDS.—

(1) ALLOCATION.—For each grant awarded under subsection (b)—

(A) not less than 25 percent of the funds shall be used to provide shelter and services to victims of sex trafficking; and

(B) not less than 10 percent of the funds shall be awarded by the eligible entity to a subcontractor with annual revenues of less than \$750,000, to provide services to victims of sex trafficking or training for law enforcement and social service providers.

(2) OTHER ACTIVITIES.—Grants awarded pursuant to subsection (b) may be used for activities such as—

(A) providing shelter to domestic minor trafficking victims, including temporary or long-term placement as appropriate;

(B) providing trafficking victims with clothing and other daily necessities needed to keep the trafficking victims from returning to living on the street;

(C) counseling and legal services for victims of sex trafficking, including substance abuse treatment, trauma-informed care, and sexual abuse or other mental health counseling;

(D) specialized training for law enforcement personnel and social service providers, specific to sex trafficking issues;

(E) funding salaries, in whole or in part, for law enforcement officers, including patrol officers; detectives; and investigators; provided that the percentage of the salary of the law enforcement officer paid for by funds from a grant awarded under subsection (b) shall be no less than the percentage of the time dedicated to working on sex trafficking cases by the law enforcement officer;

(F) funding salaries for State and local prosecutors, including assisting in paying trial expenses for prosecution of sex trafficking law offenders;

(G) investigation expenses, including—

(i) wire taps;

(ii) consultants with expertise specific to sex trafficking cases;

(iii) travel; and

(iv) any other technical assistance expenditures; and

(H) outreach and education programs to provide information about deterrence and

prevention of sex trafficking, including programs to provide treatment to men charged with solicitation of prostitution in cases where—

(i) a treatment program is an appropriate alternative to criminal prosecution; and

(ii) the men were not charged with solicitation of sex with a minor.

(d) APPLICATION.—

(1) IN GENERAL.—Each eligible entity desiring a grant under this Act shall submit an application to the Assistant Attorney General at such time, in such manner, and accompanied by such information as the Assistant Attorney General may reasonably require.

(2) CONTENTS.—Each application submitted pursuant to paragraph (1) shall—

(A) describe the activities for which assistance under this section is sought; and

(B) provide such additional assurances as the Secretary determines to be essential to ensure compliance with the requirements of this Act.

(e) EVALUATION.—The Assistant Attorney General shall, in consultation with the Comptroller General of the United States, enter into a contract with an academic or non-profit organization that has experience in sex trafficking issues and evaluation of grant programs to conduct an annual evaluation of grants made under this section to determine the impact and effectiveness of programs funded with grants awarded under subsection (b).

(f) AUTHORIZATION OF APPROPRIATIONS.—For fiscal years 2011 through 2014, there are authorized to be appropriated, to carry out the provisions of this section, the following sums:

(1) \$45,000,000 to fund grants awarded under subsection (b).

(2) \$1,500,000 to conduct the evaluation under subsection (e).

(3) \$3,500,000 to the Attorney General, to design and implement improvements to the NCIC database.

SEC. 5. REPORTING REQUIREMENTS.

(a) REPORTING REQUIREMENT FOR STATE CHILD WELFARE AGENCIES.—

(1) REQUIREMENT FOR STATE CHILD WELFARE AGENCIES TO REPORT CHILDREN MISSING OR ABDUCTED.—Section 471(a) of the Social Security Act (42 U.S.C. 671(a)) is amended—

(A) in paragraph (32), by striking “and” after the semicolon;

(B) in paragraph (33), by striking the period and inserting “; and”; and

(C) by inserting after paragraph (33) the following:

“(34) provides that the State has in effect procedures that require the State agency to promptly report information on missing or abducted children to the law enforcement authorities for entry into the National Crime Information Center (NCIC) database.”.

(2) REGULATIONS.—The Secretary of Health and Human Services shall promulgate regulations implementing the amendment made by paragraph (1). The regulations promulgated under this subsection shall include provisions to withhold federal funds to any State that fails to substantially comply with the requirement imposed under the amendment made by paragraph (1).

(3) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2010, without regard to whether final regulations required under paragraph (2) have been promulgated by that date.

(b) ANNUAL STATISTICAL SUMMARY.—Section 3701(c) of the Crime Control Act of 1990 (42 U.S.C. 5779(c)) is amended by inserting “, that includes the total number of reports re-

ceived and the total number of entries made to the National Crime Information Center (NCIC) database” after “of this title”.

(c) STATE REPORTING.—Section 3702 of the Crime Control Act of 1990 (42 U.S.C. 5780) is amended in paragraph (4)—

(1) by striking “(2)” and inserting “(3)”;

(2) in subparagraph (A), by inserting “, and a photograph taken within the previous 180 days” after “dental records”;

(3) in subparagraph (B), by striking the “and” after the semicolon;

(4) by redesignating subparagraph (C) as subparagraph (D); and

(5) by inserting after subparagraph (B) the following:

“(C) notify the National Center for Missing and Exploited Children of each report received relating to a child reported missing from a foster care family home or childcare institution; and”.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 384—HONORING UNITED STATES ARMY SPECIAL OPERATIONS COMMAND ON THEIR 20TH ANNIVERSARY

Mr. BURR (for himself and Mrs. HAGAN) submitted the following resolution; which was referred to the Committee on Armed Services:

S. RES. 384

Whereas since the establishment of United States Army Special Operations Command (USASOC) on December 1, 1989, its personnel have operated in some of the most remote and hostile regions of the world;

Whereas the 7 components of USASOC consist of the John F. Kennedy Special Warfare Center and School, the United States Army Special Forces Command, the 75th Ranger Regiment, the 160th Special Operations Aviation Regiment, the 4th Psychological Operations Group, the 95th Civil Affairs Brigade, and the 528th Sustainment Brigade;

Whereas USASOC provides 70 percent of special operations personnel in Central Command's theater and approximately 63 percent of the total overseas military commitments of the United States;

Whereas in the 8 years since the start of Operation Enduring Freedom and Operation Iraqi Freedom, 245 USASOC soldiers have made the ultimate sacrifice; and

Whereas Master Sergeant Brendan O'Connor, Chief Warrant Officer David Cooper, Colonel Mark Mitchell, Master Sergeant Donald Hollenbaugh, and Master Sergeant Daniel Briggs, all of whom have served this Nation as soldiers assigned to USASOC, received the Distinguished Service Cross for actions in support of the Global War on Terrorism: Now, therefore, be it

Resolved, That the Senate—

(1) commends the United States Army Special Operations Command for more than 20 years of dedicated service to our Nation;

(2) honors the more than 27,000 personnel who serve in the United States Army Special Operations Command; and

(3) pledges its continued support for the men and women of the United States Armed Forces.

SENATE RESOLUTION 385—RECOGNIZING THE GREAT PROGRESS MADE BY THE PEOPLE OF UKRAINE IN THE ESTABLISHMENT OF DEMOCRATIC INSTITUTIONS, AND SUPPORTING A FREE AND TRANSPARENT PRESIDENTIAL ELECTION ON JANUARY 17, 2010

Mr. LUGAR submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 385

Whereas adherence by Ukraine to democratic, transparent, and fair election standards has been necessary for full integration into the community of democracies;

Whereas steps undertaken by Ukraine in recent years, including reform of election laws and regulations, the development of a free and independent press, and the establishment of public institutions that respect human rights and the rule of law, have enhanced Ukraine's progress toward democracy and enhanced prosperity;

Whereas elections in Ukraine in 2004, 2006, and 2007 were determined by the Organization for Security and Cooperation in Europe (OSCE) to have been consistent with international election standards;

Whereas the United States has closely supported the people of Ukraine in their bold efforts to pursue a free and democratic future following the declaration of their independence in 1991;

Whereas the NATO Freedom Consolidation Act of 2007 (Public Law 110-17; 22 U.S.C. 1928 note), signed into law by President George W. Bush on April 9, 2007, recognized the progress made by Ukraine toward meeting the responsibilities and obligations for membership in the North Atlantic Treaty Organization (NATO) and designated Ukraine as eligible to receive assistance under the NATO Participation Act of 1994 (title II of Public Law 103-447; 22 U.S.C. 1928 note);

Whereas Ukraine has made steps toward integration within European institutions through a joint European Union-Ukraine Action Plan, as part of the European Neighbourhood Policy; and

Whereas the United States-Ukraine Strategic Partnership Commission was inaugurated by Secretary of State Hillary Clinton and Ukrainian Foreign Minister Petro Poroshenko on December 9, 2009: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes the great progress made by the people of Ukraine in establishing democratic institutions and carrying out peaceful election processes in 2004, 2006, and 2007;

(2) supports a free and transparent election process in the presidential election in Ukraine on January 17, 2010, that comports with the international election standards of the Organization for Security and Cooperation in Europe;

(3) encourages all parties to respect the independence and territorial integrity of Ukraine, as well as the full integration of Ukraine into the international community of democracies; and

(4) pledges support for the creation of a prosperous free market economy and the strengthening of a free and open democratic system in Ukraine.

**SENATE RESOLUTION 386—CON-
DEMNING THE GOVERNMENT OF
IRAN FOR RESTRICTING AND
SUPPRESSING FREEDOM OF THE
PRESS, FREEDOM OF SPEECH,
FREEDOM OF EXPRESSION, AND
FREEDOM OF ASSEMBLY, AND
FOR ITS HUMAN RIGHTS
ABUSES, AND FOR OTHER PUR-
POSES**

Mr. KAUFMAN (for himself, Mr. LIEBERMAN, Mr. MCCAIN, Mr. DODD, Mr. KYL, Mr. CASEY, Mr. GRAHAM, Mr. LEVIN, Mr. BROWBACK, and Mr. HATCH) submitted the following resolution; which was considered and agreed to:

S. RES. 386

Whereas hundreds of thousands of Iranian citizens have engaged in peaceful protest since the June 12, 2009, presidential election in Iran;

Whereas the Government of Iran has responded to these protests with a concerted campaign of intimidation, repression, and violence, including human rights abuses against Iranian citizens;

Whereas there have been numerous allegations of torture, rape, imprisonment, and violence perpetrated against Iranian citizens by the Government of Iran since the June 12 elections;

Whereas the Government of Iran has sought to restrict and suppress the legitimate right of the people of Iran to exercise freedom of speech, freedom of expression, freedom of assembly, and freedom of the press;

Whereas the Government of Iran has monitored, controlled, and censored access to the Internet, and has conducted a campaign of harassment and intimidation through the electronic media;

Whereas Freedom House assesses Internet and digital media in Iran as "Not Free," and characterizes the Government of Iran as wielding "one of the world's most sophisticated apparatuses for controlling the internet and other digital technologies";

Whereas the Government of Iran is engaged in a range of activities that interfere with, or infringe upon, the right of the people of Iran to access accurate, independent news and information;

Whereas, according to Amnesty International, the Government of Iran has banned several newspapers, including Farhang-e Ashti, Arman-e Ravabet-e Omomi, Tahlil-e Rooz, and Sarmayeh;

Whereas the Government of Iran has harassed, arrested, detained, imprisoned, and assaulted numerous Iranian and foreign journalists, publishers, editors, photographers, cameramen, and bloggers;

Whereas the Government of Iran has prohibited Iranian and non-Iranian news services from distributing reports in Farsi;

Whereas the Government of Iran has revoked and temporarily suspended the accreditation of foreign journalists to report on current events and news developments in Iran;

Whereas the Government of Iran has interrupted short message service (SMS), preventing text message communications and blocking Internet sites that utilize such services;

Whereas the Government of Iran has partially jammed shortwave and medium wave transmissions of Radio Farda, the Persian language service of Radio Free Europe/Radio Liberty;

Whereas the Government of Iran has intermittently jammed satellite broadcasts by Radio Farda, the Voice of America's Persian News Network (PNN), the British Broadcasting Corporation (BBC), and other non-Iranian government news services;

Whereas the Government of Iran has blocked Web sites and blogs, including social networking, content-sharing, and blogging sites, such as Facebook, Twitter, YouTube, Orkut, Blogger, and Persianblog;

Whereas the Government of Iran has targeted, blocked, and limited Internet connections and mobile network access to thwart communication in advance of planned demonstrations, and has seized mobile phones that were used to film or document the demonstrations;

Whereas the Government of Iran has monitored online activities of Iranians and threatened them and their families with punitive action, including citizens of Iran and Iranian-Americans living in the United States and elsewhere overseas;

Whereas, in November 2009, the police forces of the Government of Iran formed a special unit to monitor websites and "Internet crimes," including political offenses;

Whereas the Victims of Iranian Censorship Act (subtitle D of title XII of Public Law 111-84), which was signed into law on October 28, 2009, stipulates that "it shall be the policy of the United States to encourage the development of technologies, including Internet Web sites, that facilitate the efforts of the Iranian people to gain access to and share accurate information and exercise freedom of speech, freedom of expressions, freedom of assembly, and freedom of the press, through the Internet or other electronic media";

Whereas on December 10, 2009, President Barack Obama affirmed in his statement accepting the Nobel Peace Prize, "We will bear witness to the quiet dignity of reformers... to the hundreds of thousands who have marched silently through the streets of Iran. It is telling that the leaders of these governments fear the aspirations of their own people more than the power of any other nation. And it is the responsibility of all free people and free nations to make clear to these movements that hope and history are on their side."

Whereas, on December 18, 2009, the United Nations General Assembly passed a resolution calling on the Government of Iran to respect its human rights obligations, including its obligations under its own constitution as well as those of international human rights law; and

Whereas, on December 18, 2009, the Department of State issued a statement welcoming the passage of the United Nations resolution which stated, "The resolution, first adopted last month by the UN Third Committee, expresses deep concern over the brutal response of Iranian authorities to peaceful demonstrations in the wake of the June 12 election... Those in Iran who are trying to exercise their universal rights should know that their voices are being heard." Now, therefore, be it

Resolved, That the Senate—

(1) supports the right of the people of Iran to peacefully express their voices, opinions, and aspirations, despite intimidation, repression, and violence;

(2) condemns the human rights abuses committed by the Government of Iran against Iranian citizens;

(3) condemns the efforts of the Government of Iran to restrict and suppress freedom of the press, freedom of speech, freedom of expression, and freedom of assembly;

(4) condemns online censorship, monitoring, intimidation, and harassment con-

ducted by the Government of Iran, including threats against citizens of Iran and Iranian-Americans living in the United States;

(5) condemns an atmosphere of impunity in Iran for those who employ censorship, intimidation, harassment, or violence to restrict and suppress freedom of speech, freedom of expression, freedom of assembly, and freedom of the press;

(6) condemns the Government of Iran for violating the International Covenant on Civil and Political Rights, done at New York December 16, 1966, and entered into force March 23, 1976, which has been ratified by Iran and states, "Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.";

(7) welcomes the decision made by the Department of State on December 15, 2009, to foster and support the free flow of information to Iranian citizens by recommending that the Department of the Treasury's Office of Foreign Assets Control (OFAC) issue a general license that would authorize downloads of free mass market software to Iran necessary for the exchange of personal communications or sharing of information or both over the Internet as deemed "essential to the national interest of the United States"; and

(8) urges the implementation of the Victims of Iranian Censorship Act (subtitle D of title XII of Public Law 111-84).

**AMENDMENTS SUBMITTED AND
PROPOSED**

SA 3294. Mr. HATCH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 3295. Mr. HATCH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3296. Mr. HATCH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3297. Mr. DEMINT submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 3294. Mr. HATCH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other

purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. ____ . ENSURING THE AFFORDABILITY OF COVERAGE.

Notwithstanding any other provision of this Act, this Act (and the amendment made by this Act) shall not take effect until the date on which the Secretary of Health and Human Services certifies to Congress that the implementation of this Act (and amendments) will not result in a greater increase in health insurance premiums than the increase that is otherwise projected under current law for more than 1,000,000 Americans.

SA 3295. Mr. HATCH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ____ . CIVIL ACTIONS BROUGHT ON CONSTITUTIONAL GROUNDS.

(a) SPECIAL RULES FOR ACTIONS BROUGHT ON CONSTITUTIONAL GROUNDS.—If any action is brought for declaratory or injunctive relief to challenge the constitutionality of any provision of this Act or any amendment made by this Act, the following rules shall apply:

(1) The action shall be filed in any United States District Court and shall be heard by a 3-judge court convened pursuant to section 2284 of title 28, United States Code.

(2) A copy of the complaint shall be delivered promptly to the Secretary of the Senate and the Clerk of the House of Representatives.

(3) A final decision in the action shall be reviewable only by appeal directly to the Supreme Court of the United States. Such appeal shall be taken by the filing of a notice of appeal within 10 days, and the filing of a jurisdictional statement within 30 days, of the entry of the final decision.

(4) It shall be the duty of the United States District Court in which the action is brought and the Supreme Court of the United States to advance on the docket and to expedite to the greatest possible extent the disposition of the action and appeal.

(b) APPLICABILITY.—

(1) INITIAL CLAIMS.—With respect to any action initially filed on or before July 31, 2010, the provisions of subsection (a) shall apply with respect to each action described in such section.

(2) SUBSEQUENT ACTIONS.—With respect to any action initially filed after July 31, 2010, the provisions of subsection (a) shall not apply to any action described in such section unless the person filing such action elects such provisions to apply to the action.

SA 3296. Mr. HATCH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time

homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. ____ . PROHIBITION ON UNFUNDED MANDATES.

Notwithstanding any other provision of this title (or an amendment made by this title), no State or locality shall be required to comply with a requirement of this title (or amendment) prior to the date on which funds are appropriated at the full authorized level as provided for in this Act (or an amendment made by this Act).

SA 3297. Mr. DEMINT submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ____ . POINT OF ORDER.

(a) IN GENERAL.—It shall not be in order in the Senate to consider a congressionally directed spending item, a limited tax benefit, or a limited tariff benefit, if a Senator, Member, Delegate, or Resident Commissioner has conditioned the inclusion of language to provide funding for a congressional directed spending item, a limited tax benefit, or a limited tariff benefit in any amendment, bill, or joint resolution (or an accompanying report) or in any conference report on a bill or joint resolution (including an accompanying joint explanatory statement of managers) on any vote cast by any Senator, Member, Delegate, or Resident Commissioner.

(b) WAIVER.—The provisions of this section be waived or suspended only by the affirmative vote of two-thirds of the Members, present and voting.

(c) APPEALS.—Appeals from the decisions of the Chair relating to any provision of this section shall be limited to 1 hour, to be equally divided between, and controlled by, the appellant and the manager of the measure. An affirmative vote of two-thirds of the Members of the Senate, present and voting, shall be required to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

NOTICE OF INTENT TO SUSPEND THE RULES

Mr. DEMINT. Mr. President, I submit the following notice in writing: In accordance with Rule V of the Standing Rules of the Senate, I hereby give notice in writing that it is my intention to move to suspend Rule XXII, Paragraph 2, for the purpose of proposing and considering the following amendment, including germaneness requirements:

At the appropriate place, insert the following:

SEC. ____ . POINT OF ORDER.

(a) IN GENERAL.—It shall not be in order in the Senate to consider a congressionally directed spending item, a limited tax benefit, or a limited tariff benefit, if a Senator, Member, Delegate, or Resident Commissioner has conditioned the inclusion of language to provide funding for a congressional directed spending item, a limited tax benefit, or a limited tariff benefit in any amendment, bill, or joint resolution (or an accompanying report) or in any conference report on a bill or joint resolution (including an accompanying joint explanatory statement of managers) on any vote cast by any Senator, Member, Delegate, or Resident Commissioner.

(b) WAIVER.—The provisions of this section be waived or suspended only by the affirmative vote of two-thirds of the Members, present and voting.

(c) APPEALS.—Appeals from the decisions of the Chair relating to any provision of this section shall be limited to 1 hour, to be equally divided between, and controlled by, the appellant and the manager of the measure. An affirmative vote of two-thirds of the Members of the Senate, present and voting, shall be required to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

EXTENDING GENERALIZED SYSTEM OF PREFERENCES AND THE ANDEAN PREFERENCE ACT

Mr. DODD. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of H.R. 4284, received from the House and at the desk.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will state the bill by title. The bill clerk read as follows:

A bill (H.R. 4284) to extend the Generalized System of Preferences and the Andean Trade Preference Act, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. DODD. Mr. President, I ask unanimous consent that the bill be read the third time, passed, the motion to reconsider be laid upon the table, and that any statements on the bill be printed in the RECORD, with no intervening action.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 4284) was ordered to a third reading, read the third time, and passed.

COMMENDING THE SOLDIERS AND CIVILIAN PERSONNEL AT FORT GORDON

Mr. DODD. Mr. President, I ask unanimous consent that the Committee on Armed Services be discharged from further consideration and the Senate now proceed to H. Con. Res. 206.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The bill clerk read as follows:

A concurrent resolution (H. Con. Res. 206) commending the soldiers and civilian personnel stationed at Fort Gordon and their

families for their service and dedication to the United States and recognizing the contributions of Fort Gordon to Operation Iraqi Freedom and Operation Enduring Freedom and its role as a pivotal communications training installation.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mr. DODD. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, and the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The concurrent resolution was agreed to.

The preamble was agreed to.

CONDEMNING THE GOVERNMENT OF IRAN

Mr. DODD. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 386, submitted earlier today.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The clerk will report.

The bill clerk read as follows:

A resolution (S. Res. 386) condemning the Government of Iran for restricting and suppressing freedom of the press, freedom of speech, freedom of expression, and freedom of assembly, and for its human rights abuses, and for other purposes.

There being no objection, the Senate proceeded to consider the resolution.

Mr. DODD. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and that any statements related to the resolution be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 386) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 386

Whereas hundreds of thousands of Iranian citizens have engaged in peaceful protest since the June 12, 2009, presidential election in Iran;

Whereas the Government of Iran has responded to these protests with a concerted campaign of intimidation, repression, and violence, including human rights abuses against Iranian citizens;

Whereas there have been numerous allegations of torture, rape, imprisonment, and violence perpetrated against Iranian citizens by the Government of Iran since the June 12 elections;

Whereas the Government of Iran has sought to restrict and suppress the legitimate right of the people of Iran to exercise freedom of speech, freedom of expression, freedom of assembly, and freedom of the press;

Whereas the Government of Iran has monitored, controlled, and censored access to the

Internet, and has conducted a campaign of harassment and intimidation through the electronic media;

Whereas Freedom House assesses Internet and digital media in Iran as "Not Free," and characterizes the Government of Iran as wielding "one of the world's most sophisticated apparatuses for controlling the internet and other digital technologies";

Whereas the Government of Iran is engaged in a range of activities that interfere with, or infringe upon, the right of the people of Iran to access accurate, independent news and information;

Whereas, according to Amnesty International, the Government of Iran has banned several newspapers, including Farhang-e Ashti, Arman-e Ravabet-e Omomi, Tahlil-e Rooz, and Sarmayeh;

Whereas the Government of Iran has harassed, arrested, detained, imprisoned, and assaulted numerous Iranian and foreign journalists, publishers, editors, photographers, cameramen, and bloggers;

Whereas the Government of Iran has prohibited Iranian and non-Iranian news services from distributing reports in Farsi;

Whereas the Government of Iran has revoked and temporarily suspended the accreditation of foreign journalists to report on current events and news developments in Iran;

Whereas the Government of Iran has interrupted short message service (SMS), preventing text message communications and blocking Internet sites that utilize such services;

Whereas the Government of Iran has partially jammed shortwave and medium wave transmissions of Radio Farda, the Persian language service of Radio Free Europe/Radio Liberty;

Whereas the Government of Iran has intermittently jammed satellite broadcasts by Radio Farda, the Voice of America's Persian News Network (PNN), the British Broadcasting Corporation (BBC), and other non-Iranian government news services;

Whereas the Government of Iran has blocked Web sites and blogs, including social networking, content-sharing, and blogging sites, such as Facebook, Twitter, YouTube, Orkut, Blogger, and Persianblog;

Whereas the Government of Iran has targeted, blocked, and limited Internet connections and mobile network access to thwart communication in advance of planned demonstrations, and has seized mobile phones that were used to film or document the demonstrations;

Whereas the Government of Iran has monitored online activities of Iranians and threatened them and their families with punitive action, including citizens of Iran and Iranian-Americans living in the United States and elsewhere overseas;

Whereas, in November 2009, the police forces of the Government of Iran formed a special unit to monitor websites and "Internet crimes," including political offenses;

Whereas the Victims of Iranian Censorship Act (subtitle D of title XII of Public Law 111-84), which was signed into law on October 28, 2009, stipulates that "it shall be the policy of the United States to encourage the development of technologies, including Internet Web sites, that facilitate the efforts of the Iranian people to gain access to and share accurate information and exercise freedom of speech, freedom of expressions, freedom of assembly, and freedom of the press, through the Internet or other electronic media";

Whereas on December 10, 2009, President Barack Obama affirmed in his statement ac-

cepting the Nobel Peace Prize, "We will bear witness to the quiet dignity of reformers...to the hundreds of thousands who have marched silently through the streets of Iran. It is telling that the leaders of these governments fear the aspirations of their own people more than the power of any other nation. And it is the responsibility of all free people and free nations to make clear to these movements that hope and history are on their side."

Whereas, on December 18, 2009, the United Nations General Assembly passed a resolution calling on the Government of Iran to respect its human rights obligations, including its obligations under its own constitution as well as those of international human rights law; and

Whereas, on December 18, 2009, the Department of State issued a statement welcoming the passage of the United Nations resolution which stated, "The resolution, first adopted last month by the UN Third Committee, expresses deep concern over the brutal response of Iranian authorities to peaceful demonstrations in the wake of the June 12 election...Those in Iran who are trying to exercise their universal rights should know that their voices are being heard." Now, therefore, be it

Resolved, That the Senate—

(1) supports the right of the people of Iran to peacefully express their voices, opinions, and aspirations, despite intimidation, repression, and violence;

(2) condemns the human rights abuses committed by the Government of Iran against Iranian citizens;

(3) condemns the efforts of the Government of Iran to restrict and suppress freedom of the press, freedom of speech, freedom of expression, and freedom of assembly;

(4) condemns online censorship, monitoring, intimidation, and harassment conducted by the Government of Iran, including threats against citizens of Iran and Iranian-Americans living in the United States;

(5) condemns an atmosphere of impunity in Iran for those who employ censorship, intimidation, harassment, or violence to restrict and suppress freedom of speech, freedom of expression, freedom of assembly, and freedom of the press;

(6) condemns the Government of Iran for violating the International Covenant on Civil and Political Rights, done at New York December 16, 1966, and entered into force March 23, 1976, which has been ratified by Iran and states, "Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.";

(7) welcomes the decision made by the Department of State on December 15, 2009, to foster and support the free flow of information to Iranian citizens by recommending that the Department of the Treasury's Office of Foreign Assets Control (OFAC) issue a general license that would authorize downloads of free mass market software to Iran necessary for the exchange of personal communications or sharing of information or both over the Internet as deemed "essential to the national interest of the United States"; and

(8) urges the implementation of the Victims of Iranian Censorship Act (subtitle D of title XII of Public Law 111-84).

APPOINTMENTS

The PRESIDING OFFICER. The Chair, on behalf of the President pro tempore, pursuant to 22 U.S.C. 276n, as amended, appoints the following Senator as a delegate of the U.S.-China Interparliamentary Group conference during the 111th Congress: The Honorable MICHAEL ENZI of Wyoming.

The Chair, on behalf of the President pro tempore, pursuant to 22 U.S.C. 276n, as amended, appoints the following Senator as a delegate of the U.S.-China Interparliamentary Group conference during the 111th Congress: the Honorable ROLAND BURRIS of Illinois.

Mr. DODD. Mr. President, I yield the floor.

ADJOURNMENT UNTIL 9:45 A.M.
TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 9:45 a.m. tomorrow.

There being no objection, the Senate, at 7:06 p.m., adjourned until Wednesday, December 23, 2009, at 9:45 a.m.

NOMINATIONS

Executive nominations received by the Senate:

THE JUDICIARY

J. MICHELLE CHILDS, OF SOUTH CAROLINA, TO BE UNITED STATES DISTRICT JUDGE FOR THE DISTRICT OF SOUTH CAROLINA, VICE GEORGE ROSS ANDERSON, JR., RETIRED.

RICHARD MARK GERGEL, OF SOUTH CAROLINA, TO BE UNITED STATES DISTRICT JUDGE FOR THE DISTRICT OF

SOUTH CAROLINA, VICE HENRY M. HERLONG, JR., RETIRED.

DEPARTMENT OF JUSTICE

WILLIAM N. NETTLES, OF SOUTH CAROLINA, TO BE UNITED STATES ATTORNEY FOR THE DISTRICT OF SOUTH CAROLINA FOR THE TERM OF FOUR YEARS, VICE WILLIAM WALTER WILKINS, III.

KELVIN CORNELIUS WASHINGTON, OF SOUTH CAROLINA, TO BE UNITED STATES MARSHAL FOR THE DISTRICT OF SOUTH CAROLINA FOR THE TERM OF FOUR YEARS, VICE JOHNNY MACK BROWN.

IN THE COAST GUARD

THE FOLLOWING NAMED INDIVIDUAL FOR APPOINTMENT AS COMMANDANT OF THE UNITED STATES COAST GUARD AND TO THE GRADE INDICATED UNDER TITLE 14, U.S.C., SECTION 44:

To be admiral

VICE ADM. ROBERT J. PAPP, JR.

HOUSE OF REPRESENTATIVES—Wednesday, December 23, 2009

The House met at noon and was called to order by the Speaker pro tempore (Mr. MORAN of Virginia).

DESIGNATION OF THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

WASHINGTON, DC,
December 23, 2009.

I hereby appoint the Honorable JAMES P. MORAN to act as Speaker pro tempore on this day.

NANCY PELOSI,
Speaker of the House of Representatives.

PRAYER

The Reverend Gene Hemrick, Washington Theological Union, Washington, D.C., offered the following prayer:

In the Old Testament, the Canticle of the prophet Daniel rings with the exaltation of God's Mother Nature:

Cold and Chill bless the Lord
Ice and Snow bless the Lord
Nights and Days bless the Lord
Light and Darkness bless the Lord
Lightning and Clouds bless the Lord

O Lord, the recent snowstorm in our Nation's capital reminds us of this canticle and of the wise means You employ in maintaining the order and rhythms of nature with which You bless this world.

Bless this Congress with the heavenly wisdom that is needed to be prudent stewards of Your ecological systems. Endow it with Your divine counsel and understanding as it seeks the most efficient and effective means for preserving their God-given order and balance. Amen.

THE JOURNAL

The SPEAKER pro tempore. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

PLEDGE OF ALLEGIANCE

The SPEAKER pro tempore. The Chair will lead the House in the Pledge of Allegiance.

The SPEAKER pro tempore led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

COMMUNICATION FROM THE HON. JOHN B. LARSON, CHAIRMAN, DEMOCRATIC CAUCUS

The SPEAKER pro tempore laid before the House the following communication from the Honorable JOHN B. LARSON, Chairman, Democratic Caucus:

DEMOCRATIC CAUCUS,
HOUSE OF REPRESENTATIVES,
Washington, DC, December 23, 2009.

Hon. NANCY PELOSI,
Speaker of the House, U.S. Capitol, Washington DC.

DEAR MADAM SPEAKER: This is to notify you that the Honorable Parker Griffith of Alabama has resigned as a Member of the Democratic Caucus.
Sincerely,

JOHN B. LARSON,
Chairman.

COMMUNICATION FROM THE SPEAKER

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

HOUSE OF REPRESENTATIVES,
December 23, 2009.

Hon. JAMES L. OBERSTAR,
Chairman, Committee on Transportation and Infrastructure, Rayburn House Office Building, Washington, DC.

DEAR MR. CHAIR: This is to advise you that Representative Parker Griffith's election to the Committee on Transportation and Infrastructure has been automatically vacated pursuant to clause 5(b) of rule X effective today.

Best regards,

NANCY PELOSI,
Speaker of the House.

COMMUNICATION FROM THE SPEAKER

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

HOUSE OF REPRESENTATIVES,
December 23, 2009.

Hon. NYDIA M. VELÁZQUEZ,
Chairman, Committee on Small Business, Rayburn House Office Building, Washington, DC.

DEAR MADAM CHAIR: This is to advise you that Representative Parker Griffith's election to the Committee on Small Business has been automatically vacated pursuant to clause 5(b) of rule X effective today.

NANCY PELOSI,
Speaker of the House.

COMMUNICATION FROM THE SPEAKER

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

HOUSE OF REPRESENTATIVES,
December 23, 2009.

Hon. BART GORDON,
Chairman, Committee on Science and Technology, Rayburn House Office Building, Washington, DC.

DEAR MR. CHAIR: This is to advise you that Representative Parker Griffith's election to the Committee on Science and Technology has been automatically vacated pursuant to clause 5(b) of rule X effective today.

Best regards,

NANCY PELOSI,
Speaker of the House.

ADJOURNMENT

The SPEAKER pro tempore. Pursuant to section 11(b) of House Resolution 976, the House shall stand adjourned until 10 a.m. on Saturday, December 26, 2009, unless the conditions specified in section 11(c) of that resolution have been met, in which case the House shall stand adjourned sine die pursuant to House Concurrent Resolution 223.

Accordingly (at 12 o'clock and 4 minutes p.m.), the House adjourned.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

5189. A letter from the Assistant to the Board, Board of Governors of the Federal Reserve System, transmitting the System's final rule — Truth in Lending [Regulation Z; Docket No. R1378] received December 1, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

5190. A letter from the Chief Counsel, Department of Homeland Security, transmitting the Department's final rule — Final Flood Elevation Determinations [Docket ID: FEMA-2008-0020] received December 1, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

5191. A letter from the Chief Counsel, Department of Homeland Security, transmitting the Department's final rule — Changes in Flood Elevation Determinations [Docket ID: FEMA-2008-0020; Internal Agency Docket No. FEMA-B-1063] received December 1, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

5192. A letter from the Chief Counsel, Department of Homeland Security, transmitting the Department's final rule — Final Flood Elevation Determinations [Docket ID: FEMA-2008-0020] received December 1, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

5193. A letter from the Chief Counsel, Department of Homeland Security, transmitting the Department's final rule — Final Flood Elevation Determinations [Docket ID: FEMA-2008-0020] received December 1, 2009,

□ This symbol represents the time of day during the House proceedings, e.g., □ 1407 is 2:07 p.m.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

5194. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Reef Fish Fishery of the Gulf of Mexico; Closure of the 2009 Commercial Harvest of Gulf of Mexico Greater Amberjack [Docket No.: 040205043-4043-01] (RIN: 0648-XP56) received December 8, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

5195. A letter from the Deputy Assistant Administrator For Regulatory Programs, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Pacific Halibut Fish-

eries; Subsistence Fishing [Docket No.: 0812191631-91238-03] (RIN: 0648-AX53) received December 1, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

5196. A letter from the Acting Assistant Administrator for Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Central Gulf of Alaska Rockfish Program; Amendment 85 [Docket No.: 0811201490-91372-03] (RIN: 0648-AX42) received December 1, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

5197. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administra-

tion, transmitting the Administration's final rule — Fisheries of the Exclusive Economic Zone Off Alaska; Reallocation of Pacific cod in the Bering Sea and Aleutian Islands Management Area [Docket No. 0801041351-9087-02] (RIN: 0648-XS69) received December 1, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

5198. A letter from the Deputy Assistant Administrator For Regulatory Programs, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Fisheries of the United States Exclusive Economic Zone Off Alaska; Fisheries of the Arctic Management Area; Bering Sea Subarea [Docket No.: 090218204-91211-04] (RIN: 0648-AX71) received December 1, 2009, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Natural Resources.

SENATE—Wednesday, December 23, 2009

The Senate met at 9:45 a.m. and was called to order by the Honorable TOM UDALL, a Senator from the State of New Mexico.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Eternal God, the source of peace on Earth, good will toward humanity, we feel delight because You are sovereign, causing all things to work together for good to those who love You, who are called according to Your purpose.

Help our lawmakers to see that each difficulty is an opportunity to see You work and that in Your time You will bring them to a place of abundance. May they face waiting tasks and challenges with Your gifts of understanding, kindness, civility, and self-control. Lord, astound them with new insight and fresh vision they could not conceive without Your blessings. Give them the faith to believe that if they listen to You, You will give them answers they cannot find by themselves.

We pray in Your powerful Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable TOM UDALL led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The assistant legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 23, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable TOM UDALL, a Senator from the State of New Mexico, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. UDALL of New Mexico thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. REID. Mr. President, following leader remarks, the Senate will resume consideration of the health reform legislation. The time until 10 a.m. is equally divided between the two leaders or their designees. From 9 a.m. until 2 p.m. today, there will be 1-hour alternating blocks of time, with the majority controlling the first hour. The time between 2 p.m. and 2:13 p.m. will be equally divided and controlled between the two leaders, with the majority leader controlling the final half. The Senate will then proceed to a series of five or six rollcall votes in relation to the health care bill.

I note the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. REID. Mr. President, I note the absence of a quorum. No one is here.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. SESSIONS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of H.R. 3590, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid amendment No. 2786, in the nature of a substitute.

REID (for CARDIN) amendment No. 2878 (to amendment No. 2786), to provide for the establishment of Offices of Minority Health.

Reid amendment No. 3292 (to amendment No. 2878), to change the effective date.

The ACTING PRESIDENT pro tempore. Under the previous order, the time until 10 a.m. will be equally divided between the two leaders.

The Senator from Alabama is recognized.

Mr. SESSIONS. Mr. President, I just received this morning—and I am sure it is on the CBO Web site, the Congressional Budget Office Web site—an analysis of the health care bill we are considering today. That analysis is crystal-clear and confirms what CMS has told us; that is, the proponents of the legislation before us have been double-counting—double-counting—the savings from Medicare, and as a result, it cannot be said that this bill is going to create a surplus in the Treasury but, in fact, will put us in a deficit.

I think every Member of this body needs to read this communication before they cast their vote. I know a lot of Members of the Senate who voted for the bill did so under the belief that it would be deficit neutral. They have said so publicly. The President has repeatedly stated—and he did to the Joint Session of Congress—that not one dime will be added to the national debt, and that is not so.

I will reveal what we were told by CBO this morning in their report. This is what the CBO said to us, and it is very simple. It is actually stunning that we have been confused about this issue when we are talking about hundreds of billions of dollars. It is absolutely an amazing event that the U.S. Congress can't get its act together when we are talking about hundreds of billions of dollars.

They say this:

The key point is that the savings to the HI trust fund—

Talking about Medicare—
under the PPACA—

That is the health care bill we are considering—

would be received by the government only once, so they cannot be set aside to pay for future Medicare spending and, at the same time, pay for current spending on other parts of the legislation or on other programs.

That is exactly what this bill proposes to do.

Just 2 days ago at this press conference, the President said:

Medicare will be stronger and its solvency extended by nearly a decade.

Then he goes on to say this:

The Congressional Budget Office now reports that this bill will reduce our deficit by \$132 billion over the first decade.

That is counting the money twice. It cannot be done. That is wrong, and it must not be allowed to occur.

Senator GREGG, the former chairman of the Budget Committee and ranking Republican on that committee, proposed an amendment that said any savings in Medicare stay in Medicare, and our colleague who voted it down—Senator HARKIN said: You have to vote it down—to our colleagues in his speech on the floor—you have to vote it down because it will kill the bill. Why would it kill the bill? Because they are planning to use the money both ways, and it cannot be done and ought not to be done.

This is very much consistent, entirely consistent with the communication from the Chief Actuary, Richard S. Foster, of the Center for Medicare and Medicaid Services. Mr. Foster laid it out. We should have seen this back on December 10. It is really what piqued my interest in this whole matter because I was wondering how this could be done. It didn't make sense to me. And I read his letter, and he says this:

The combination of lower Part A costs—

And that is Part A of Medicare, the hospital part—

and higher tax revenues results in a lower Federal deficit based on budget accounting rules.

He goes on to say:

However, trust fund accounting considers the same lower expenditures and additional revenues as extending the exhaustion date of the Part A trust fund.

They are running out of money, and if you cut the cost to Part A, you would extend, according to the trust fund accounting, the lifetime of the trust fund before it goes broke.

He adds:

In practice, the improved Part A financing cannot be simultaneously used to finance other Federal outlays.

Then he put in parentheses:

such as the covered expansions under the PPACA—

Which is the health care bill—

and to extend the trust fund, despite the appearance of this result from the respective accounting conventions.

So there are two different accountings. The one from CMS says one thing. The one from CBO, which is a unified accounting, a different process of accounting for Federal expenditures—both say good things. But both can't be accurate. Both Members say, CBO says you can't count it twice, and CMS also says that.

The ACTING PRESIDENT pro tempore. The Senator's time has expired.

Mr. SESSIONS. I thank the Chair and urge my colleagues to access this information on the CBO Web site and mine if they would like.

The ACTING PRESIDENT pro tempore. Under the previous order, the time until 2 p.m. will be controlled in alternating 1-hour blocks of time, with the majority controlling the first hour.

The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, it has been nearly 5 weeks since the majority leader moved to proceed to the health care reform bill before us today. And it has been more than 2 months since the Finance Committee reported its bill, a great deal of which is reflected in the bill before us today.

It has been 3 months since the Finance Committee publicly posted the 564 amendments that Senators filed for consideration in the committee.

It has been 7 months since the Finance Committee convened three bipartisan roundtable discussions on each of the three major areas of reform: delivery system reform, insurance coverage, and options for financing reform.

It has been 7 months since the Finance Committee issued three bipartisan policy papers detailing the options from which the committee chose to craft its bill.

It has been 18 months since the Finance Committee convened a bipartisan, day-long health care summit at the Library of Congress.

It has been 19 months since the Finance Committee began holding open hearings to prepare for the bill before us today.

It has been more than 15 long years since the last time that the Senate took on this fight to enact comprehensive health care reform.

It has been 38 years since our late Colleague, Ted Kennedy, proposed a plan to extend health insurance coverage to all.

It has been 44 years since Congress created Medicare, providing health care for America's seniors, and Medicaid, providing health care for the poorest among us.

It has been 64 years since President Harry Truman asked the Congress to enact a national insurance program "to assure the right to adequate medical care and protection from the economic fears of sickness."

It has been 97 years since President Theodore Roosevelt ran on a platform that called for "the protection of home life against the hazards of sickness . . . through the adoption of a system of social insurance adapted to American use."

And it is now only hours until this Senate will pass meaningful health care reform.

It will not be long now until the law will prohibit insurance companies from cancelling insurance policies when people get sick.

It will not be long now until people with preexisting conditions will have access to health care.

It will not be long now until the law will prohibit insurance companies from imposing lifetime or annual limits on benefits.

It will not be long now until parents will be able to include their children up to age 26 on their insurance policies.

It will not be long now until the law will require insurance companies to report on the share of premium dollars that goes to pay medical care, and the share that doesn't.

It will not be long now until consumers will be able to shop for quality insurance in new Internet Web sites, where insurance companies will compete for their business.

It will not be too long now until millions of uninsured Americans will be able to buy insurance on new exchanges with tax credits to help make it affordable.

It will not be too long now until the law will prohibit insurance companies from discriminating against women in setting premiums.

It will not be too long now until the law will limit insurance companies in how much more they can charge when people get older.

It will not be too long now until more than 30 million Americans who otherwise would not have health care coverage will finally get that peace of mind.

It will not be too long now until more than 30 million Americans will have a better chance to live longer, healthier, less pain-ridden lives.

It will not be too long now until more than 30 million Americans will be able to share their family Christmas free of the fears of medical bankruptcy.

Mr. President, it will not be long now. It has been a long time coming.

I thank God that I have lived to see this day. I thank God for sustaining us and for enabling us to reach this time. Let us now, at long last, pass this historic legislation.

Mr. President, I yield 20 minutes to the Senator from Maryland.

The ACTING PRESIDENT pro tempore. The Senator from Maryland is recognized.

Mr. CARDIN. Mr. President, first, it will not be long now until we achieve universal health care coverage affordable care for all Americans. I thank Senator BAUCUS for making this moment possible. I know how hard he has worked for so many weeks, so many months, so that we could bring very different views together but all focused on the goal of achieving affordable health care for every American.

Senator BAUCUS never lost sight of that goal. As a result, we are now just hours away from the last procedural hurdle until we will have a chance in the Senate to vote on a bill that for the 23 years I have been in Congress I have told the people of the Third Congressional District and the people of Maryland that I am going to fight to change our health care system so that every American has access to affordable, quality health care.

We are going to take a giant step forward to reaching that goal in the legislation we have before us today. Through the Chair, I thank Senator

BAUCUS very much for his extraordinary patience and leadership to bring us to this moment.

Mr. President, there is a lot of discussion on both sides as to what the facts of the bill are. I am going to use the CBO because that is what we agreed to. That is the objective scorekeeper. They are not partisan. Everybody agrees to that.

The CBO tells us that for the under-65 group we are going to increase the number of insured from 83 percent to 94 percent. For all Americans, we are going to have 98 percent covered by health insurance. That is universal. We are going to have a framework so that at long last America joins every other industrialized nation in the world with a health care system where everyone is included.

To me, this is a moral issue. It is an issue of whether health care is a privilege or a right. I believe the values of America teach us that health care should be a right for all Americans.

The bill we will be voting on will take us very much in the direction of achieving that goal. Today in America too many people fall through the cracks. Too many families are literally destroyed because they cannot afford access to health care. Therefore, they don't get the tests they need, and perhaps a disease that could have been caught early or prevented is lost, and a person has to go through tremendous health care treatment; perhaps even losing their life.

We have seen too many families go through bankruptcy because they cannot afford the health care they need. We see too many literally cutting their prescription pills in half in the hopes of being able to keep their medicine for a longer period of time because they cannot afford it, knowing full well they are compromising their health.

I have mentioned the case of Deamonte Driver which, to me, is representative of so many tragedies in our community that could be avoided. Deamonte Driver, a 12-year-old in Prince George's County, MD, very close to here, had a tooth ache. His mom tried to get him to a dentist, but he had no insurance, and they couldn't find a dentist. They went to a social worker and made dozens of calls and still couldn't find a dentist. Deamonte was complaining of severe headaches. After weeks of not being able to get to a dentist, he went to the emergency room—the only option that was still available. They found out the tooth had become abscessed, which went into his brain. He had emergency surgery. He lost his life because our health care system didn't provide access to affordable, quality care for all Americans.

Mr. President, that is about to change. I am proud to be a part of it. I have been asked by many in recent days as to what is in it for the people of Maryland. The people of Maryland

are going to get a national health care system that makes a lot more sense, a rational system for care in America. With the current system, too many people are being left out. Small employers have a hard time finding affordable products.

I have gotten many letters from constituents that I have read. I must tell you about the letter I received from a small business owner in Montgomery County. She and her husband had to take out two separate policies to cover their family of four. The private insurance companies discriminated and said each has preexisting conditions, and the only way to have full coverage is to have two policies with two separate deductibles—which the family cannot afford—two separate premiums that the family cannot afford.

There is not competition to provide coverage to small businesses in America. Small businesses in Maryland want to have the opportunity to cover their employees, and they know competition will work, and this bill provides for a lot more competition.

This bill will help those who are losing coverage today. Many people in Maryland are losing their health care coverage every day. Hundreds lose their health insurance in my State every day. We live in the wealthiest Nation in the world, and Maryland is the wealthiest State, and we are still losing health coverage today.

Our Medicare beneficiaries are finding their program under attack. They want to have the stability of knowing Medicare will be there not just this year but for decades to come. This bill starts to reform Medicare by reforming health care so we can sustain it and fill in the prescription drug doughnut hole under which so many seniors are finding it very difficult to afford their medicine.

For the people of Maryland, this bill will provide a rational way in which they can maintain their existing coverage, find it more affordable, and certainly sustain coverage for our Medicare population and provide competition for small business owners to find affordable health care. It ought to bring down health care costs. Marylanders are very interested in that.

Again, let me use the CBO, the objective scorekeeper. They say for the overwhelming majority of Americans, their health premiums will go down because health care costs are coming down. This legislation invests in prevention and wellness. We know prevention and wellness works. We know if you can detect a disease early, you cannot only save lives, but you can save health care costs because the preventive services only cost a couple hundred dollars, and an operation you can avoid is tens of thousands of dollars. Screening and early detection works. Management of diseases works.

Most of our health care costs in America are spent on the leading dis-

eases such as cardiac care and diabetes. We know we spend a lot of money, but we can manage those diseases more effectively, and this bill takes us down that path. We can save money by investing in health information technology. Think about that—about how much paper we receive every year from our health care system. Think about our own medical records and how that could be used to help us each manage our own health care and take more responsibility. We are not doing that today. We know that we can use a card to go anywhere in the world, and they can track our financial records. But for health care, that is not true today.

By investing in health information technology, we can reduce a significant amount of administrative costs in health care and better manage each of our own health care needs. That is what this bill does.

This bill will cover 31 million more Americans. That is not what I am saying as a Democratic Senator from Maryland; that is what the CBO is saying this bill will achieve—31 million more Americans that will not have to go to an emergency room to get their primary care needs met.

Think about how much it costs each one of us when that person whose only option is to go to an emergency room, how much that costs us. You see, many of those individuals cannot afford those hospital charges, so it becomes uncompensated care. It is added to the rates at the hospital that you and I pay—those of us who have health insurance.

The people in Maryland who have health insurance have a hidden tax of \$1,100 every year. It is not only a waste of money that we have to pay, it is an efficient way to work the system. There should be facilities available so that everybody can get care in a much more cost-effective way. This bill moves us toward those goals. It provides competition so we can bring down the cost of health insurance through the local exchanges.

Another provision in the bill that I am very excited about is that we can cross State lines for competition, so if you are an employer in Maryland and you hire workers in Maryland and Virginia and Pennsylvania, you are able to get the regional and national competition so you have more choice on the health insurance companies. That will also bring down costs but also increase quality, which is what we are trying to do.

For Marylanders, this bill is important. This bill will help reduce the Federal deficit. How many of us have talked about that? I know that people who watch us say: Gee, I hear a Republican Senator and then a Democratic Senator; is this the same bill they are talking about?

Let's talk about the Congressional Budget Office, the objective scorekeeper. The Congressional Budget Office says this bill will reduce the Federal deficit by \$132 billion—billion, that is a B, billion. That is quite an accomplishment when you realize that to get everyone covered, the Federal Government is providing subsidies which will cost us some additional investments. To make sure small businesses can afford it, we provide tax credits. That costs revenues—people insured, they have tax preferences. Yet the Congressional Budget Office has confirmed that this bill brings down the deficit by \$132 billion in the first 10 years.

Let's look at the second 10 years because a lot of us want to look at the long-term impact. The Congressional Budget Office, the objective scorekeepers, tell us it will reduce the deficit by one-half of 1 percent of the GDP or about \$1.3 trillion. It is quite an accomplishment to get everybody covered and reduce the deficit and have that confirmed by the Congressional Budget Office. That helps the people of Maryland, and that is why the people of Maryland benefit from this bill, as do the citizens of every State in the Nation.

I wish to talk about protecting consumers. Senator BAUCUS talked about this. I wish to make sure people understand what is involved. Senator BAUCUS mentioned a lot of the provisions that are in the bill about preexisting conditions and pediatrics for children take effect immediately, the caps we bring in, the lifetime caps we deal with covering children under the age of 26, the reinsurance program for 55- to 64-year-olds, the loss ratios that were added to the bill by the managers' amendment to make sure insurance companies are using your premium dollar to pay for benefits, the independent review of a decision made by an insurance company whether to cover a charge.

But I wish to talk about the Patients' Bill of Rights because I think the people of this Nation would be surprised to find out we have not yet enacted the Patients' Bill of Rights.

It was 1997 when we started talking about a Patients' Bill of Rights, about enacting it so we had national protection against the arbitrary practices of private insurance companies. In 1998, President Clinton, by Executive order, applied the Patients' Bill of Rights to the government insurance programs. But today there is still no protection against private insurance companies with a Patients' Bill of Rights.

I am very pleased the managers' amendment has added four very important provisions I authored by an amendment, that I have been working with Democrats and Republicans over the last decade to get into Federal law.

Access to emergency care—let me talk about that for a moment because

today there are people who live in New Mexico and live in Montana and live in Maryland who go to their emergency rooms. They read the fine print of their insurance plan. It says: Before you go to an emergency room, you have to call for preauthorization or you need to go to the emergency room that is in network or we may second-guess whether you needed to go to that emergency room, if, in fact, your final diagnosis was you did not have an emergency need or condition. You may have sweating, the traditional chest pains, the traditional symptoms for a heart attack. You did exactly what a prudent layperson would do: get to that emergency room as quickly as possible. Then you find out it was not a heart attack. Today the insurance companies can second-guess your coverage.

Thanks to the managers' amendment Senator BAUCUS helped us put together, we now are going to cover access to emergency care as a requirement for every private insurance company. Prudent layperson standards, no preauthorizations, get to the closest emergency room as quickly as you can—those are important protections to get into Federal law.

Then there is the ability to choose your primary care doctor. Your primary care doctor is the person you have to have confidence in. If you are a woman, if you want it to be OB/GYN, you should have that right. Many insurance companies deny you that today. If you are a parent and you want a pediatrician for your child, you should be able to have a pediatrician as a primary physician for your child. It is not guaranteed to today. Many insurance plans deny it. This will make sure it is in law.

I am pleased, and I know the people of Maryland will be glad to know, at long last, we get the Patients' Bill of Rights protected.

There are a lot of groups that supported this over the years. I wish to acknowledge the long list of people, the long list of groups, bipartisan groups, that have worked on this issue, from AARP to the Consumers Union to the NAACP to the SEIU, YMCA—the list goes on and on of groups that have supported the Patients' Bill of Rights against private insurance companies. At long last, we have the ability, with the passage of this bill on the Senate floor, to move it one step closer to passage and to be the law of the land.

I wish to talk about minority health. The reasons I wish to talk about minority health are twofold. First, I know my colleagues are interested to know that the amendment that is currently pending that the leader filed, technically on my behalf, which establishes the minority health protections within the different Federal agencies—I wish to assure my colleagues that it is in the underlying bill. It is in the package. It is in the managers' package which has been adopted.

I am going to suggest to the body that we withdraw the amendment because we do not need it to pass; it is already in the underlying bill. This was the original amendment I submitted. I wished to explain that because the amendment I filed to establish the Minority Health Office at the Department of Health and Human Services and also within NIH will be in the underlying bill because of the managers' package.

This is an important moment because there are huge disparities in our health care delivery systems in America, bringing about huge disparities among different ethnic communities. The life expectancy of African Americans, for example, is 5.3 years lower than Whites. When we look at diabetes in America, the incidence of diabetes is two times greater among minorities than the general population. That means we need to have a strategy to deal with it. We need to know how can we reach out to minority communities to deal with their special needs. Unless you have a focus within the Department of Health and Human Services, unless you have a focus within NIH and the other agencies, you will not deal with it as effectively as we should. I, again, thank Senator BAUCUS, Senator DODD, Senator REID, and the rest who understood this and put it into the managers' package because we can then develop a national strategy to help deal with the issues of the minorities.

I also will mention heart disease. African Americans have a 33-percent higher death rate due to heart disease. The list goes on and on. That is why this bill codifies the Office of Minority Health in the Office of the Secretary of Health and Human Services, establishes individual Offices of Minority Health at the Centers for Disease Control and Prevention, Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration, Agency for Health Care Research and Quality, Food and Drug Administration, the Centers for Medicare & Medicaid Services, and it elevates the current Center on Minority Health and Health Disparities at NIH into an institute. That is good news for this Nation in dealing with this issue.

I, again, thank those who helped me get this into the managers' package—and it is now in the bill—that we will be taking up for a vote tomorrow.

I also compliment Senator SANDERS—I have done this before—on the community health centers. I mention that because as we deal with the disparities in health care in America, we deal with minority health care issues, yes, we have to get people health insurance, we have to get people the financial wherewithal to provide health care, but you also have to have the facilities in place if you are going to deal with health care needs. It is one thing

to say we will cover the costs, it is another thing to say we will have the doctors available.

I met with one of the leaders at Johns Hopkins University, which is located in the urban part of Baltimore city. He said: We need help. We need more community health centers. We need more primary care doctors. We need more nurses. We need help with more people seeking care through traditional channels rather than using emergency rooms. That is great news. With them being able to afford insurance, that is great news, but let us have the facilities.

There are many underserved in Maryland and around the Nation who just need facilities. Thanks to the Sanders amendment, of which I am proud to be a cosponsor and worked with him, that is in this bill. We are going to see \$10 billion to expand community health centers and 25 million more Americans will be able to get access to care through our community health centers. That is good news and that will help and we invest in creating more primary care doctors, which is a very valuable part of this bill. I applaud all those.

Let me point out this bill will help families in America. The choice is whether we pass this bill which sets up the framework for America to finally become a nation that provides universal coverage or we maintain the status quo. Let me tell you what happens if we maintain the status quo. These are the numbers. Right now, the average cost for a family for health insurance is \$13,244. If we do not take action, by 2016—that is not too many years away—it is going to be \$24,291.

The ACTING PRESIDENT pro tempore. The Senator has consumed the 20 minutes he was yielded.

Mr. CARDIN. May I have 2 more minutes, if that is possible?

Mr. BAUCUS. I yield the Senator 2 more minutes.

Mr. CARDIN. Mr. President, if people are going to be able to maintain their existing coverage, we have to act, and this bill will allow us to act. That is why the American Medical Association supports the bill. This bill will help our Medicare population because it strengthens Medicare, as I pointed out before. That is why the AARP supports it. We will be able to provide preventive services, such as annual physicals, for our seniors. This bill is important for small business owners who no longer will be discriminated against by paying 20 percent more than comparable large companies pay for the same type of insurance product.

This bill is good for Marylanders. It is good for every American. It moves us toward universal coverage. The bill is not perfect. I am disappointed with some of the things in the bill and some of the things that did not make it into the bill. But this bill establishes the

framework for universal, affordable, quality care for every American. It speaks to the values of our Nation.

I am proud to support this legislation, and I know we will look back at this day as being one of the bright moments for America, where we said to the people of our Nation that, indeed, we will provide affordable, quality health care for every American.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana is recognized.

Mr. BAUCUS. I yield 15 minutes to the Senator from Delaware, Mr. KAUFMAN.

The ACTING PRESIDENT pro tempore. The Senator from Delaware is recognized.

Mr. KAUFMAN. Mr. President, I thank the manager not just for this but for the many things he has done to make this bill a possibility. It is truly historic, transformational. To a large degree, it is because of his hard work. I appreciate that.

Also, I yield him 30 minutes of my postcloture time.

The ACTING PRESIDENT pro tempore. The time will be so yielded.

Mr. KAUFMAN. Mr. President, I rise, once again, to express my support for this historic health care legislation before us. After more than a year of debate and months and months of negotiations, I welcome the extraordinary opportunity finally to enact meaningful health care reform. Yes, I mean years and months, since this reform effort has been a long and deliberative process, not the rush job opponents of this effort have been claiming.

I must admit, however, there were times during this debate when I was not sure if we were ever going to reach this point. In fact, I was convinced we were not. But I found in my life that when you think things are never going to happen, as with every important thing I have ever done, you reach a point when you say this is never going to happen, and this is another example. There are many times I never thought this would happen.

From the bogus charge of death panels—which was just named *politifact.com's* "Lie of the Year"—to the tension over whether the bill will contain a public option, which I supported, there were some long days where it was hard to see how we were going to get to the end point.

But thanks to the hard work of the majority leader, as well as Senators BAUCUS, DODD and HARKIN and their staffs, we are finally here.

As many of you know, I have worked in and around the Congress for more than 36 years. I have learned quite a bit about how things operate in the Senate.

The Senate is commonly referred to as the most deliberative body in the world. But such deliberations are not

always pretty. Sometimes tempers flare, sometimes debate does not reach the level we aspire to or the American people deserve. Sometimes the most important legislation actually fails to get the votes necessary to pass.

We all know what happened to health care reform the last time we attempted a major overhaul 15 years ago when President Clinton tried to pass his version of health care reform. The debate was just as passionate with charges and countercharges on both sides of the aisle. Because of the coarseness of that debate, because of the seemingly intractable opposition to health care reform, Congress has been wary in the intervening 15 years to take up this cause again, and it is understandable.

But over the past 15 years, our health care system has gotten more expensive. Rising medical costs, skyrocketing premiums, increasing numbers of the uninsured and the strain on both business and providers have brought the critical need for health reform back to the Senate this year.

Make no mistake, we need health care reform now. The status quo—what I call the present health care system—is simply unsustainable.

Medical costs account for one-sixth of domestic spending and are headed upward. In 1979, we spent approximately \$220 billion as a nation on health care. In 1992, we spent close to \$850 billion. In 2009, we will spend \$2.5 trillion on health care. Listen to this: \$220 billion in 1979, \$850 billion in 1992, and \$2.5 trillion in 2009. How can anyone argue it is not time to deal with health care reform and that the need is urgent? The trajectory of our national health care expenditures is out of control.

In addition, one of the biggest—if not the biggest—forces behind our Federal deficit, which we hear so much about on this floor, are the skyrocketing costs of Medicare and Medicaid. In 1996, Medicare and Medicaid accounted for only 1 percent of all government expenditures; they now account for 20 percent. If we do nothing to start bending the cost curve down for Medicare and Medicaid, we will eventually spend more on these two programs than on all other Federal programs combined. We must slow the level of growth in the Medicare and Medicaid Programs if we are to ever get our budget situation under control.

In addition to the fiscal pressures crushing our Federal and State governments, the present health care system is also crushing families and workers. Just look at the rise in the insurance premiums in my home State of Delaware. In 2000, the average premium for family health coverage was just over \$7,500. That is \$7,500. By 2008, the number had jumped to \$14,900—that is \$14,900—almost doubling in just 8 years. If we fail to enact the pending

health care reform legislation, the same premium for family coverage is expected in Delaware to reach \$29,000 in 2016.

Let me repeat that: \$29,000 for family coverage in Delaware in 2016 if we don't pass health care reform now.

States around the country will see similar increases, which are simply unaffordable. Too many people are going bankrupt paying for their medical care. Today, the inability to pay for skyrocketing medical bills accounts for more than 60 percent of U.S. personal bankruptcies, a rate of 1½ times what it was just 6 years ago. Keep this in mind: More than 75 percent of families entering bankruptcy due to health care costs actually have health insurance.

Let me repeat this because it is a critical point: Three-quarters of all Americans filing for bankruptcy because of medical bills already have insurance. We also need reform to stop the worst abuses in the health insurance industry. In my year as serving as the Senator from Delaware, I have heard from far too many constituents who have been refused an insurance policy because they have a preexisting condition.

I have heard from fathers who were denied family insurance coverage because they were told their children had preexisting conditions too expensive to cover. Much to my shock—and I have talked about this on the Senate floor—I have received letters from women who have been turned down for coverage because their pregnancy was considered a preexisting condition. Pregnancy a preexisting condition? That is simply intolerable. Even worse, however—if that is possible—is the practice of rescission, where insurance companies drop coverage for individuals the moment they get sick and need their insurance the most. Being denied coverage after you have already paid your premiums is just plain cruel.

For all those reasons and more, we must reform the present health care system. Thankfully, we now have the opportunity to bring about meaningful health care reform through the Patient Protection and Affordable Care Act, and I would like to take just a couple more minutes to discuss why this legislation has earned my support.

First off, it is fiscally responsible. President Obama laid down a marker that any health care reform legislation that landed on his desk could not add to our Nation's debt. I am happy to say this legislation passes this test.

According to the Congressional Budget Office, the Patient Protection and Affordable Care Act will reduce the deficit by \$132 billion over the first 10 years. This bill is fully paid for.

Second, the bill helps stabilize Medicare and Medicare Programs. In the absence of this legislation, the Medicare trust fund is expected to go bankrupt

in 2017. According to the head actuary at the Centers for Medicare and Medicaid Services, passing this bill would extend the solvency of the trust fund for an additional 9 years—9 years. Medicare is a sacred trust with Americans, and this bill ensures this trust is preserved.

In addition to reducing the deficit and shoring up the Medicare Program, this bill contains numerous provisions that will help Americans afford their premiums and prevent them from filing for bankruptcy protection. Starting next year, insurers will no longer be able to place lifetime caps on health care benefits. For the next several years, insurers will also be restricted in the annual limits they can place on benefits, and then these will be eliminated altogether in 2014.

These are huge changes for people with debilitating diseases and those who experience unexpected catastrophic events costing millions of dollars in treatment.

In addition, premium subsidies for families with incomes under 400 percent of the poverty level—or \$88,000 for a family of four—will be available to help them afford their premiums once the new insurance exchange is up and running. There will also be annual limits on out-of-pocket costs for individuals, and dependents will be able to be covered under their parents' insurance policies until the age of 26.

All of these are meaningful reforms that will dramatically lower the rate of bankruptcies associated with medical costs.

The bill also contains some other great consumer protections that don't currently exist in our present health care system. I have already highlighted the problems in the current system with insurers denying coverage for people with preexisting conditions and rescinding coverage when people get sick. Under this bill, Americans will finally be freed from the shackles of preexisting clauses that have kept so many from obtaining much needed health insurance.

Starting next year, insurers will no longer be able to deny coverage to children with preexisting medical conditions. This ban on not covering preexisting conditions will be extended to all Americans in 2014.

The bill also forbids insurers from rescinding health insurance after Americans have already paid their premiums. Americans will no longer lose their coverage when they get sick and need it most.

In addition, the bill dramatically expands coverage of prevention and wellness services. It provides incentives for employers to implement wellness programs and offers a new annual wellness checkup for seniors enrolled in Medicare.

These are all good, positive reforms to our health care system.

Now that we are close to finishing this debate, the media has focused its attention on particular deals that benefit certain Senators and specific States, but I want to point out that all the benefits I have talked about—all of them—are available to every American in every State.

Most every Senator has brought something to this debate and to this bill. I am very pleased that the managers' package includes the health care fraud enforcement amendment, which I introduced, along with Senators LEAHY, SPECTER, KLOBUCHAR, and SCHUMER as cosponsors. Again, this benefits all Americans not just Delawareans.

The National Health Care Anti-Fraud Association conservatively estimates that 3 percent of all health care spending—some \$72 billion—is lost to health care fraud in both public and private health care plans. That is \$72 billion lost in health care fraud in both public and private health care plans. Other estimates place the figure as high as 10 percent over \$220 billion.

Fraud hits every one of us in every corner of our Nation where we can least afford it—our health care premiums—while simultaneously driving down the quality of, and our trust in, the health care system. This amendment increases funding for fighting fraud in public programs.

It improves screening of providers and suppliers and requires implementation of meaningful compliance programs. This section tightens requirements for claims submissions and provides new tools to deter fraud and abuse in the private insurance market.

It also strengthens criminal investigations and prosecution. Today, outdated laws and punishments insufficient to provide effective deterrence hamper prosecutors and agents. This may seem incredible, but many criminals have told law enforcement officers that they switched to health care fraud from the drug trade because the reward-to-risk ratio is so much higher. Can you imagine that? There is actually an incentive for crooks in the present health care system to commit health care fraud.

This antifraud amendment can begin to reverse this trend. Significantly reducing costs attributable to fraud will go a long way toward bending the cost curve down. What this bill does is it increases the sentencing requirements for people who commit health care fraud to make it much less attractive for them to get into the health care fraud business. It gives us the prosecutors and the agents we need—just like we did in the financial regulatory reform—to go after these folks and catch them, then put them in jail. With these new sentencing guidelines, we can put them there for a longer time, discouraging people from getting into the health care fraud business to begin with.

In addition, the package of amendments I cosponsored with my fellow freshman Democrats will also improve the bill and benefit all Americans.

I am lucky to be a member of a dynamic freshman class, including the Presiding Officer, and I have enjoyed teaming up with them in our morning speeches and colloquies to push the health care reform effort forward. I am pleased that our amendment package was accepted by the bill's managers and that it provides commonsense, practical solutions that help further contain costs, improve value, and increase quality.

For example, it quickens the implementation of uniform administrative standards, allowing for more efficient exchange of information among patients, doctors, and insurers. It provides more flexibility in establishing accountable care organizations that realign financial incentives and help ensure that Americans receive high-quality care. It provides greater incentives to insurers in the exchange to reduce health care disparities affecting underserved minority communities.

For all the reasons listed above, from the original text to the additions added to the managers' package, this bill should and must be passed. It brings quality, affordable health care within the reach of all Americans, including more than 30 million Americans who are currently uninsured. It strengthens the Medicare Program, extending its insolvency for 9 years. It helps restore fiscal order by reducing the deficit by approximately \$132 billion over 10 years and more than \$1 trillion over 20 years. It offers much needed consumer protections that provide stable coverage at an affordable cost.

In closing, I again want to acknowledge the hard work of Senators BAUCUS, REID, DODD, HARKIN, as well as their staffs—especially their staffs—because the staff has done incredible work on this piece of legislation. They have enabled us to reach this historic legislative moment.

I have ended many speeches by noting that it is time to gather our collective will and do the right thing to join this historic opportunity by passing health care reform. I think we may have finally reached that goal. We certainly can't afford to wait any longer. We need to act now. We can do no less. The American people deserve no less.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. KIRK). The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I yield the remainder of the time we have in our hour to the Senator from North Dakota, Mr. CONRAD.

Mr. CONRAD. Mr. President, I rise this morning not to talk about health care but to talk about the other critical matter that faces this body before we leave this session for the holidays

and that is the matter of extending the debt limit of the United States. Let me start by saying it is imperative that we extend the debt limit. If we do not, the United States would default on its debt. The consequences for this country and the global economy would be nothing short of catastrophic.

If you think about the problems created in world markets by the fact that Dubai defaulted on \$40 billion of debt, think of what it would mean to global markets if the United States were to default on \$12 trillion of debt.

For those who say this is Obama's fault—no. This is not Obama's fault. He has been in office 11 months. I remind everyone that he walked into the biggest mess in 70 years—deficits and debt exploding, joblessness skyrocketing, economic growth plummeting. All that was happening before Barack Obama became President of the United States. He did not create the economic mess, he inherited it. He did not create the fiscal mess, he inherited it. Those are things he had to take on as the new President.

There were record deficits and a doubling of the national debt, there was the worst recession since the Great Depression, financial market and housing crises, ongoing wars in Iraq and Afghanistan, and an unsustainable long-term budget outlook with everything going in the wrong direction.

This is what was happening to deficits before President Obama took office. The deficits were skyrocketing. In fact, we have never held Presidents responsible for the fiscal affairs during the first year of their term of office because everybody here knows they inherit a budget from the previous President for the first year. That is not Barack Obama's responsibility, that is the responsibility of the previous administration.

For those who say President Obama made things worse—no, he didn't make things worse, he made things better. Yes, he added short term to the deficit, about \$300 billion in 2009 because of the economic recovery package, but I remind people the difference the economic recovery package has made. We have gone from private-sector job losses of 749,000 jobs a month when he came in—this is January of 2009, the month he came in. Job losses had mounted to 749,000 jobs a month. Look at the trend. Because of the recovery package and other measures that were put in place, the changes in private nonfarm payrolls have improved dramatically, from losses of over 700,000 a month in January to losses of 18,000 last month. We now believe that, in the first quarter of next year, those job losses will have become job gains.

The same thing happened on economic growth. Economic growth was sharply negative when President Obama came into office. In the last quarter, we now know the economy ac-

tually grew at a rate of 2.2 percent. That is a dramatic change. The fact is President Obama made things better. He inherited a disaster and he went to work to get America back on track.

Let's look for a moment at the debt. This is what happened under the previous administration. The gross debt of the United States skyrocketed, more than doubling under the previous administration. So this is what the current President inherited. He did not create it. He wasn't the architect of it. He didn't produce these deficits and debt. He inherited them.

It is true we are still on a course for long-term debt that is unsustainable. This was the cover of Newsweek on December 7, Pearl Harbor day. The Newsweek cover said this: "How great powers fall; steep debt, slow growth, and high spending kill empires—and America could be next."

When you went inside to the story, it said this:

This is how empires decline. It begins with a debt explosion. It ends with an inexorable reduction in the resources available for the Army, Navy, and the Air Force . . . If the United States doesn't come up soon with a credible plan to restore the Federal budget to balance over the next 5 to 10 years, the danger is very real that a debt crisis could lead to a major weakening of American power.

I don't know what could be more clear than that. Here is what has happened since 2001. Again, most of this is on the shoulders, the responsibility of the previous administration, because the debt absolutely skyrocketed under their watch. But it is continuing to grow and we must face up to that.

What is even more alarming is the longer term outlook. On the trend we are on, the debt, which will reach over 100 percent of the gross domestic product by 2019, is projected to hit 400 percent of gross domestic product by 2050. That is the trendline we are on. That is the trendline we have been on since 2001, a trendline of massively growing debt. The question is, can we face up to it? Do we have the strength, do we have the will to take on the burgeoning debt?

This is what the National Journal wrote on November 7 of this year:

The debt problem is worse than you think. Simply put, even alarmists may be underestimating the size of the (debt) problem, how quickly it will become unbearable and how poorly prepared our political system is to deal with it.

The reality we confront tomorrow morning is whether we will extend the debt limit of the United States. We have no choice. If we fail to pay the debts we have already accrued, the United States and other markets around the world would collapse. That is just the fact. We cannot permit that to happen.

How we got to this point is very clear to me. The previous administration put forward a fiscal policy that doubled the

debt of the United States and put us on track to continue doubling it every 8 years. The current administration has taken action to get the economy moving and growing again. Had they not taken those steps, which add to the deficit in the short term, the long-term debt outlook would be even worse. That does not take away from the fact that we have to deal with the reality that confronts us now. That reality is we are on a trendline that is absolutely unsustainable.

To those who say if you deal with the debt, you are going to have to do something about Social Security and Medicare and revenue—I say yes. That is true. We are going to have to do something about all of those. To those who say dealing with the debt means facing up to the hard reality that confronts this country and the fact that we are on a course that is unsustainable—I say yes. That is true. We are going to have to make changes in the entitlement programs. We are going to have to make changes in the revenue system.

When I say that, I don't mean by that the first thing we do is raise taxes. The first thing we ought to do is collect the taxes that are already owed but are not being paid because of these offshore tax havens and abusive tax shelters and all the rest. We can get more revenue. We do not need to raise taxes to get more revenue. We need to collect the revenue that is currently owed and we need to get it from the people who are cheating all the rest of us by engaging in these tax schemes—offshore tax havens, abusive tax shelters. We even have companies now that are leasing sewer systems, buying them from European cities in order to depreciate them on the books in the United States to reduce their taxes here, then leasing those same sewer systems back to the European cities that built them in the first place. That is happening right now.

If you doubt we are losing money to offshore tax havens, Google “offshore tax havens” and see how many hits you get. You get over a million. Those sites describe a life of luxury, living offshore, tax free, on income received in this country, income on which taxes are owed in this country but not paid. That is the kind of thing that has to be stopped.

Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. The Senator has 5½ minutes.

Mr. CONRAD. Let me talk for a minute about what Senator GREGG and I have proposed: a bipartisan task force to deal with this long-term debt threat. Our proposal has 35 cosponsors now. The idea is to give a group of our colleagues and members of the administration the responsibility to come up with a plan to reduce the deficits and debt. If a plan enjoyed a supermajority

among the group of 18 who would be given the responsibility to come up with such a plan—if 14 of the 18 could agree on a plan—it would have to come here for a vote. It would come here for a vote. Every Senator would retain their rights to vote up or down. Every Senator would retain their rights. And it would require 60 votes in the Senate to pass, it would require 60 percent of the House to pass and the President would be able to veto it if he didn't like it.

I think it is clear that we have a real challenge facing our country and it is going to take some special process to deal with it. What we have outlined would put everything on the table with 18 Members, 10 Democrats, 2 from the administration, and 8 Republicans. All task force Members would need to be currently serving in Congress or the administration. If 14 of the 18 could agree, that report would have to come to the Congress for a vote. The report would be submitted after the 2010 election and there would be fast-track consideration in the Senate and the House. There would be a final vote before the 111th Congress adjourned.

To those who say that is going to shred Social Security and Medicare—I say no. What threatens Social Security and Medicare is our doing nothing. Both of those programs are already cash negative. The trustees of Medicare tell us the program will be insolvent by 2017 if we do nothing. The answer can not be to do nothing. I believe this is a challenge that requires us to come together now, Republicans and Democrats, House, Senate, the administration, as we came together to deal with fiscal crises in the past. The Social Security Commission in the 1980s, the Andrews Air Force Base Summit in the 1990s—those were special procedures to deal with a special challenge and that is what is required now. We are on a course that is absolutely and utterly unsustainable.

Let me go back to the vote tomorrow, because a group of us have said we are not going to vote for any long-term extension of the debt without consideration of a special process to deal with the debt, but we are also prepared to extend the debt on a short-term basis. That is absolutely essential. That is the responsible thing to do. A failure to extend the debt tomorrow would send a message to markets around the globe that the United States is not going to pay its debt. The United States cannot renege on its commitment to pay the \$12 trillion of debt that has already been run up. Those are not future debts but debts that have already been incurred. Those are debts that are due now and will be due in the weeks to come.

The United States has never defaulted on its debt and it never can without grave consequences to our economy and to the world economy.

Let me say again as clearly as I can: for those who want to blame President Obama, that won't wash. He has been in office only 11 months. He walked into the biggest mess in over 70 years—deficits and debt exploding, job losses skyrocketing, economic growth plummeting. President Obama didn't create that economic mess, he inherited it. He did not create the fiscal mess, he inherited it.

Tomorrow will be a key vote for this country. Those of us who are concerned about the growing debt and are willing to take it on must also be responsible about making certain that the United States does not default on its already accrued debts. To do otherwise would be disastrous for this country.

How much time do I have remaining?

The PRESIDING OFFICER. The Senator has 10 seconds.

Mr. CONRAD. Perfect. Merry Christmas.

I yield the floor.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. CORKER. Mr. President, I would inquire how much time is allotted to me?

The PRESIDING OFFICER. The minority has 60 minutes.

Mr. CORKER. I have 10 minutes. I wonder if the Presiding Officer might let me know when I have 2 minutes remaining.

The PRESIDING OFFICER. The Chair will do so.

Mr. CORKER. I thank the Chair.

Mr. President, I have watched this body over the last period we have been discussing health care. The body itself, the integrity of this body has been challenged. I have watched as individuals have challenged each other's integrity as it relates to this bill. I choose not to do that today.

I wish to say, as I do constantly in my State, that I consider it a privilege to wake up each day and come to work in this body. Obviously, things don't always go as one might expect, but I do consider it a privilege. I thank the folks back home for allowing me to serve and to deal with these important issues.

I don't think I will ever quite understand why this bill was put together the way it was. I certainly understand there are differences of opinion and differences of interest, but I don't think I will ever understand why Medicare moneys, from an insolvent program, were used to fund a new entitlement.

CBO has come out this morning clearly stating what we have been saying for over 6 months. The fact is, taking Medicare savings and using them to create another entitlement does not work. It takes away from the solvency of Medicare itself. It is kind of late, but I am glad CBO has actually come out and said today, finally, after months of debate, what we have been saying from day one, that you could not take Medicare savings and use them to create a

new entitlement without challenging the solvency of Medicare itself.

I will never understand why that building block, a flawed building block, was used to create this bill. Everybody knows it was that use of inappropriate funding that began this whole partisan divide. My guess is, we might have ended up with a bill that would stand the test of time had we not utilized that basic flawed building block in the bill.

There has been one, though, that I have found equally problematic; that is, the whole issue of creating an unfunded mandate for the State of Tennessee and for States across the country. The challenge to people's personal integrity has been centered more around this issue than anything else, as various Senators trying to protect their States from an unfunded mandate have been challenged in that regard.

Many people who serve in this body used to be mayors, they used to be Governors, people who had to deal with budgets in their own States. Years ago, in a bipartisan effort, a bill was passed to ensure that we in Washington didn't pass laws that increased costs for cities. I was a mayor of a city. I was commissioner of finance for a State. In those capacities, there was nothing that was more offensive than for the Federal Government to pass a law and send down a mandate to a city or a State that costs money and yet not send the money that went with it. There was nothing more infuriating. We had to actually balance our budgets. We didn't have the ability to borrow money from overseas and to continue to operate in the red.

Back in 1995, a law was passed called the Unfunded Mandates Reform Act. It was done to do away with the arrogance that existed up until that time—and unfortunately, continues to exist—where the Federal Government would create laws that would increase costs on cities and States. It was passed in a bipartisan way. As a matter of fact, 15 Members from the other side of the aisle supported this law, voted for this law, and put this law in place. Many of the people who made this bill, created this bill participated. The chairman of the Finance Committee voted for this law. The majority leader voted for this law. The distinguished chairman of the Budget Committee voted for this law. The chairman of the HELP Committee who drafted a big part of this bill voted for this law. What this law said was that we could not pass legislation out of this body, out of Congress, that placed an unfunded mandate on States, on cities, and caused them to have to do things that raised expenses by laws we created without sending the money themselves.

Our Governor of Tennessee is a Democrat. He is on the other side of the aisle. We have worked closely on a number of economic development

issues. I have talked with him all the way through this process. He actually had hoped to work with this administration on health care and on health care legislation. He has been involved in health care all of his life. He has managed our State well. He has dealt with many challenging health care issues. Much has been documented about the travails our State has had as it relates to Medicaid and our desire to try to fix that. He has called this bill, which appears to be ready to pass this body, the mother of unfunded mandates. He has talked about the more than \$750 million in cost this bill is going to cause the State of Tennessee to deal with at a time when they are hoping their State's revenues will be at 2008 levels by the year 2014.

Again, I will never understand why we have raided an insolvent entitlement to create a new entitlement, weakening Medicare. I will never understand why we have done that to create this bill. I will never understand why this body chose to create such a large unfunded mandate for States through the provisions we have put in place as it relates to Medicaid, telling States they have to raise the levels at which they insure citizens across their State to 133 percent of federal poverty.

There is no question this bill violates the law put in place in 1995.

The PRESIDING OFFICER. The Senator has 2 minutes remaining.

Mr. CORKER. I thank the Chair.

I talked about the fact that it is a privilege to serve in this body. Generally speaking, people try to live up to the standards this body has set for all of us and that citizens across the country expect us to live up to. For that reason, I am going to raise a budget point of order. There is no question, per what CBO has said, the fact that this bill is going to cause cities and States to pay more for the health insurance of their employees—CBO has stated that clearly. There is no question this bill is going to cause States to have to utilize dollars that otherwise might be used for education or public safety.

I raise a point of order. Section 425(a)(2) of the Congressional Budget Act of 1974 makes it out of order to consider any legislation that contains an unfunded intergovernmental mandate in excess of the statutory limit unless the bill provides new direct spending authority or includes an authorization for appropriations in an amount equal to or exceeding the direct cost of such mandate in the Senate.

The pending bill includes an unfunded intergovernmental mandate in excess of the annual statutory limit of \$69 million within the next 5 years. Therefore, I raise a point of order against the substitute amendment pursuant to section 425(a)(2) of the Congressional Budget Act of 1974.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I move to waive the point of order for consideration of the pending legislation and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The yeas and nays are ordered.

The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I ask my friend from Montana, Senator BAUCUS, to be alert because I want to raise a similar request to set aside. But before I do that, I want to explain why I am doing this. I worked for 6 years to pass the Congressional Accountability Act, which was signed into law by President Clinton in 1995. I worked so hard because I strongly believed there should only be one set of laws in this country.

Prior to 1995, there were two sets of laws—one for Capitol Hill and one for the rest of the country because Congress exempted itself. That is why, following on that practice of 1995, I offered an amendment during the Finance Committee markup to require that Members of Congress and congressional staff get their employer-based health insurance through the same exchanges as our constituents. That is something for which I also heard complaints from the grassroots of Iowa during my town meetings. I did offer that amendment, and it was adopted without objection.

But then after careful consideration and examination of the bill Senator REID put together—and this was done by the Congressional Research Service—it was revealed that my amendment was changed under this closed-door merger process. Something cute happened. Under the bill we now have before us, this requirement would not apply to staff for committees of the Congress or leadership offices, it would apply to Members and their personal staff but not leadership. That is a real cute thing, to give exemptions for some people on Capitol Hill but not for others.

I ask unanimous consent to have printed in the RECORD an analysis from the Congressional Research Service.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CONGRESSIONAL RESEARCH SERVICE,
Washington, DC, Dec. 2, 2009.

MEMORANDUM

To: Senate Finance Committee. Attention: Andrew McKechnie.

From: Ida Brudnick, Analyst on the Congress, Government and Finance Division; Todd B. Tatelman, Legislative Attorney, American Law Division.

Subject: Potential Statutory Interpretation of 1312(d)(2)(D)(ii)(II) of H.R. 3590, The Patient Protection and Affordable Care Act.

This memorandum responds to your request for a review and potential statutory

interpretation of 1312(d)(2)(D)(ii)(II) of H.R. 3590, The Patient Protection and Affordable Care Act.¹ Specifically, you have asked whether the definition of the term “congressional staff” could be interpreted to exclude committee staff, leadership staff, or other employees of the Congress. The definition used by the bill covers “all full-time and part-time employees employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.”² In addition, you have asked CRS to review the language used by S. 1796, America’s Healthy Future Act of 2009, which was reported from the Senate Finance Committee.³ S. 1796 used the term “congressional employee,” which it defined as “an employee whose pay is disbursed by the Secretary of the Senate or the Clerk of the House of Representatives.”⁴ Finally, you have requested that CRS examine what, if any, other Legislative Branch employees might be covered should language similar to that in S. 1796 ultimately be adopted.

Based on our review of the financial practices of the Congress with respect to payment of employees, the bill language, and applicable canons of statutory construction, it appears possible to argue that the definition of “congressional staff” used by 1312(d)(2)(D)(ii)(II) excludes any staff not directly affiliated with a Member’s individual or personal office. Should this interpretation be adopted by an implementing body or a court, it would appear that it would exclude professional committee staff, joint committee staff, some shared staff, as well as potentially those staff employed by leadership offices including, but not limited to, the Speaker of the House, Majority Leader of the Senate, Minority Leader of the House, Minority Leader of the Senate, as well as the Whip offices in both the House and Senate. Moreover, this interpretation would arguably exclude other congressional employees, for example, those employed by the Office of the House Clerk, House Parliamentarian, House Historian, Secretary of the Senate, Senate Legal Counsel, House and Senate Legislative Counsel offices.

LEGISLATIVE BRANCH APPROPRIATIONS ACCOUNTS

The legislative branch appropriations acts funds the: Senate; House of Representatives; Joint Items;⁵ Capitol Police; Office of Compliance; Congressional Budget Office; Architect of the Capitol, including the Capitol Visitor Center; Library of Congress, including the Congressional Research Service; Government Printing Office; Government Accountability Office; and Open World Leadership Program.

Both the House and Senate portions of the annual legislative branch appropriations bills contain one line item that provides for salaries and expenses within Member offices. The House and Senate sections contain additional line items for employees of leadership offices, committees, and officers.

In the Senate, the Senators’ Official Personnel and Office Expense Account provides each Senator with funds to administer a personal office. It consists of an administrative and clerical assistance allowance, a legislative assistance allowance, and an official office expense allowance. The funds may be interchanged by the Senator, subject to limitations on official mail. The FY2010 legislative branch appropriations act provided \$422 million.

The Senate portion of the bill includes the following additional headings: Expense Allowances and Representation; Salaries, Officers, and Employees; Office of Legislative

Counsel; Office of Legal Counsel; Expense Allowances for Secretary of Senate, Sergeant at Arms and Doorkeeper of the Senate, and Secretaries for the Majority and Minority of the Senate; and Contingent Expenses. The “Contingent Expenses” account includes funding for Inquiries and Investigations; Expenses of the United States Senate Caucus on International Narcotics Control; Secretary of the Senate; Sergeant at Arms and Doorkeeper of the Senate; Miscellaneous Items; and, Official Mail Costs.

Staff in personal offices in the House of Representatives are paid through funding provided for Members’ Representational Allowances (MRA). The MRA, which was preceded by multiple allowances for each Member covering different categories of spending, was first established in 1996.⁶ The FY2010 legislative branch appropriations act provided \$660.0 million for MRAs.

The House “Salaries and Expenses” account provides funding under the following additional headings: House Leadership Offices; Committee Employees; Salaries, Officers And Employees; And Allowances And Expenses. Many of these categories include multiple line items. In FY2010, the “House Leadership Offices” heading provided funding for the: Office of the Speaker; Office of the Majority Floor Leader; Office of the Minority Floor Leader; Office of the Majority Whip; Office of the Minority Whip; Speaker’s Office for Legislative Floor Activities; Republican Steering Committee; Republican Conference Committee; Democratic Steering and Policy Committee; Democratic Caucus; Nine Minority employees; training and program development—majority; training and program development—minority; Cloakroom Personnel—majority; and Cloakroom Personnel—minority. “Committee Employees” provides funding in separate headings for “Standing Committees, Special And Select,” and “Committee on Appropriations.” Funding for “Salaries, Officers And Employees” is divided among various financial, administrative, legal, ceremonial, and security offices, including, for example, the offices of the Clerk of the House, Chief Administrative Office, Sergeant at Arms, Inspector General, and General Counsel.

POTENTIAL STATUTORY INTERPRETATION

When interpreting the meaning of legislative language, courts will often use methods of statutory construction commonly referred to as “canons,” or general principles for drawing inferences about language. Perhaps the most common “canon of construction” is the plain meaning rule, which assumes that the legislative body meant what it said when it adopted the language in the statute. Phrased another way, if the meaning of the statutory language is “plain,” the court will simply apply that meaning and end its inquiry.⁷ As the United States Supreme Court stated in *Connecticut National Bank v. Germain*:

[I]n interpreting a statute a court should always turn first to one, cardinal canon before all others. We have stated time and again that courts must presume that a legislature says in a statute what it means and means in a statute what it says there When the words of a statute are unambiguous, then, this first canon is also the last: judicial inquiry is complete.⁸

Applying the plain meaning canon to the language in H.R. 3590, it appears possible to argue that the phrase “official office of a Member of Congress” most naturally refers to Member’s personal offices and, therefore, excludes other employees that a Member

may utilize for other purposes. For example, Members who serve as committee chairman or ranking members may have staff affiliated with their service on a given committee. While the Member may have control over hiring, promotion, and even termination, those staff are paid by the committee and not the Member. Moreover, the Member’s position on the committee is not commonly considered their “official office,” as committee assignments may change during a Congress and are determined by the chamber caucuses. Furthermore, it is worth noting that CRS has been unable to locate any previous use of the phrase “official office of a Member of Congress” in statute or appropriations laws.

Alternatively, applying the plain meaning canon to the language used in S. 1796, it appears possible to argue that this language includes committee staff, leadership staff and most other congressional employees. The language, unlike that in H.R. 3590, turns on who the disbursing agent of the funds is, rather than who the employer is. As a result, the language in S. 1796 appears to be much broader, as most “congressional employees” have their pay disbursed from either the Secretary of the Senate or the Chief Administrative Office (CAO) of the House, regardless of whether they are employed in a Member’s personal office, by a committee, leadership official, or in another capacity by the Congress. Moreover, unlike the language in H.R. 3590, similar text to that in S. 1796 has been used previously to categorize congressional staff for salary and benefits purposes.⁹

OTHER POTENTIAL ISSUES

The language in H.R. 3590 raises additional possible concerns in light of the way that the House and Senate conduct business. For example, one potential issue with proposing different standards for employees in Member office accounts and employees paid through other House and Senate accounts arises from the use of shared staff. Although the House and Senate have different rules regarding shared staff, both chambers allow types of shared staffing arrangements that could result in an employee being both on the payroll of a Member office and another type of office.

In the Senate, 2 U.S.C. 61-1a authorizes limited sharing of staff:

Notwithstanding any other provision of law, appropriated funds are available for payment to an individual of pay from more than one position, each of which is either in the office of a Senator and the pay of which is disbursed by the Secretary of the Senate or is in another office and the pay of which is disbursed by the Secretary of the Senate out of an appropriation under the heading “Salaries, Officers, and Employees”, if the aggregate gross pay from those positions does not exceed the maximum rate specified in section 61-1(d)(2) of this title.

The Senate Handbook summarizes these laws, stating:¹⁰

An employee may be on the payroll of more than one Senator’s office or on the payroll of a Senator’s office and a leadership or administrative office, providing the aggregate pay received does not exceed the maximum annual salary for a Senator’s office (2 U.S.C. 61-1a). An employee can only be shared between offices which are funded through the appropriations, “Senators’ Official Personnel and Office Expense Account” (Senators’ personal staff), and “Salaries, Officers, and Employees”.

The House Member’s Handbook, as compiled by the Committee on House Administration, states the following about shared employees:¹¹

The term shared employee means an employee who is paid by more than one employing authority of the House of Representatives.

Two or more employing authorities of the House may employ an individual.

Such shared employees must work out of the office of an employing authority, but are not required to work in the office of each employing authority. The pay from each employing authority shall reflect the duties actually performed for each employing authority. The name, title, and pay of such an individual will appear on each employing authority's Payroll Certification. Such employees may not receive pay totaling more than the highest rate of basic pay in the Speaker's Pay Order applicable to the positions they occupy.

Employees may not be shared between a Member or Committee office and the office of an Officer of the House if the employee, in the course of duties for an Officer, has access to the financial information, payroll information, equipment account information, or information systems of either Member, Committee, or Leadership offices.

Applying the interpretation of H.R. 3590 suggested above, it is possible that certain shared staff could be covered by the provision, while other shared staff, even in the same office, would not be covered.

Because the bill does not propose a standard for determining coverage, it is potentially left to the implementing authority to establish such a standard. The implementing authority would appear to arguably have wide discretion in setting such a standard. As a result, it is not unreasonable to assume that an implementing authority could use a majority time or similar standard in making coverage determinations. In other words, shared employees would need to declare whom they spent a majority of time working for. If the staffer's declaration was the Member's official office, they could arguably be covered. On the other hand, if the majority of a staffer's time was spent on committee or leadership work, they may arguably not be covered. It is important to note that this is but one possible standard and that unless otherwise stated in the bill, it will up to the implementing authority to determine the standard.

The language of S. 1793 arguably avoids this problem as it appears to encompass all shared employees because they all receive salaries through either the CAO or Secretary of the Senate.

Another potential issue is the scope of the disbursing authority of the CAO of the House and the Secretary of the Senate. The CAO has served as the disbursing officer for the House of Representatives since 1995. The Secretary of the Senate serves as the disbursing officer for the Senate. Both of these officers are required to publish reports on disbursement.¹² Pursuant to the FY2010 legislative branch appropriations act, the Secretary and CAO are each responsible for the disbursements for two accounts included as "joint items." Additional disbursements by the Secretary include salaries and expenses of the Joint Economic Committee and Office of Congressional Accessibility Services.¹³ The CAO serves as the disbursing officer for the Joint Committee on Taxation and the Office of Attending Physician. In addition, the CAO and Secretary also have disbursing authority for a number of House and Senate revolving funds.¹⁴ Thus, it appears possible to argue that, should the language of H.R. 3590 be interpreted as suggested above, these employ-

ees would be excluded from coverage. Conversely, should the language from S. 1793 be utilized, it would appear that employees of these committees would be covered as they are paid by the CAO or Secretary of the Senate.

Finally, there is the issue of what, if any, other entities or employees of the Legislative Branch the CAO and/or Secretary of the Senate may serve as the disbursing officers. Our research indicates that although the CAO and Secretary of the Senate served as the disbursing officers for the U.S. Capitol Police (USCP) prior to 2003, the Chief of the Capitol Police currently serves as the disbursing officer for the USCP.¹⁵ Moreover, it appears that other Legislative Branch agencies such as the Architect of the Capitol and the Congressional Budget Office each have their own disbursing agents and do not use either the CAO or the Secretary of the Senate. In addition, it appears that the CAO and/or Secretary of the Senate may serve as the disbursing agent for some, but not all, congressional commissions. Thus, some employees of such commissions may be covered by the language used in S. 1793, however, none would appear to be covered by the language used in H.R. 3590.

ENDNOTES

¹Patient Protection and Affordable Care Act, H.R. 3590, §1312(d)(2)(D)(ii)(II), 111th Cong. (2009).

²See id.

³America's Healthy Future Act of 2009, S. 1796, §2231(3)(C), 111th Cong. (2009).

⁴Id.

⁵In the FY2010 legislative branch appropriations act, these included the: Joint Economic Committee, Joint Committee on Taxation, Office of the Attending Physician, Office of Congressional Accessibility Services.

⁶Committee Order No. 41, effective September 1, 1995, in notes to 2 U.S.C. §57; P.L. 104-53, 109 Stat. 519 (Nov. 19, 1995); U.S. Congress, House Committee on Appropriations, Legislative Branch Appropriations Bill, 1996, report to accompany H.R. 1854, 104th Cong., 1st sess., H. Rept. 104-141 (Washington: GPO, 1995), p. 10; P.L. 104-186, 110 Stat. 1719 (Aug. 20, 1996); 2 U.S.C. §57b; P.L. 106-57, 113 Stat. 415 (Sept. 29, 1999).

⁷See Hartford Underwriters Insurance Co. v. Union Planters Bank, N.A., 530 U.S. 1 (2000); see also Robinson v. Shell Oil Co., 519 U.S. 337 (1997); Connecticut National Bank v. Germain, 503 U.S. 249 (1992); Mallard v. United States District Court for the Southern District of Iowa, 490 U.S. 296, 300 (1989).

⁸Connecticut National Bank, 503 U.S. at 253-54 (citations and quotation marks omitted).

⁹See, e.g., 2 U.S.C. §60a-1 (2006); 2 U.S.C. §60j (2006); 2 U.S.C. §130b (2006); 2 U.S.C. §1301 (2006); 2 U.S.C. §1977 (2006); 5 U.S.C. §5306 (2006); 5 U.S.C. §5515 (2006); 18 U.S.C. §207 (2006).

¹⁰U.S. Senate, Committee on Rules and Administration, Senate Handbook, version of Nov. 2006, 1V-31.

¹¹U.S. House of Representatives, Member's Handbook, available at, <http://cha.house.gov/staff.aspx>.

¹²2 U.S.C. §§104a and 104b.

¹³P.L. 111-68, 123 Stat. 2030, Oct. 1, 2009.

¹⁴For additional information, see: CRS Report R40939, Legislative Branch Revolving Funds, by Ida A. Brudnick and Jacob R. Straus.

¹⁵P.L. 108-7, Feb. 20, 2003, 117 Stat. 366; 2 U.S.C. 1907.

Mr. GRASSLEY. This carve-out creates a double standard and is totally

unacceptable. This amendment goes beyond just going where my original amendment went to cover all people on Capitol Hill. The amendment I am asking consent for would also include the President, Vice President, political appointees, and senior-level staff of the executive branch. It is only fair that if this bill becomes law, these leaders should themselves be subject to the reforms that make our constituents go through the exchange.

I ask unanimous consent to set aside the pending amendment in order to offer amendment No. 3178 which is at the desk.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. GRASSLEY. Mr. President, Democratic leadership and the White House have spent months talking about accountability. With this objection, the majority will not even consider an amendment to make sure the White House and all Members employed on Capitol Hill, not just those in our personal offices, live under the same new health care system the rest of the country lives under. That sure doesn't sound like accountability to me.

There is widespread agreement that the health care system in this country has serious problems. Costs are rising at three times the rate of inflation. Many Americans are uninsured. Millions more fear losing their insurance in a weak economy or because of pre-existing conditions. Doctors are ready to close their doors over high malpractice costs and lower government reimbursements, and we do not do anything in this bill about high malpractice costs.

Something has to be done, everyone seems to agree. But tomorrow the Senate will vote on a bill that makes a bad situation worse. It is unfortunate that we are voting on a bill that a significant majority—61 percent—of Americans oppose. The American people, providers, advocacy groups as well, are simply reacting to the fact that this bill slid rapidly down the slippery slope to more and more government control of health care.

It contains the biggest expansion of Medicaid since 1965. It creates a long-term care insurance program called the CLASS Act that the CMS Actuary says runs a significant risk of being unsustainable, and one of the most significant Members of this body referred to it as a Ponzi scheme similar to what Madoff did. It imposes an unprecedented Federal mandate for coverage backed by the enforcement authority of the Internal Revenue Service. It increases the size of government by \$2.5 trillion when fully implemented. It creates dozens of new Federal bureaucracies and programs to increase the

scope of the Federal role in health care. That is a lot of power over people's lives concentrated in the Federal Government, and there are 1,697 delegations of authority to the Secretary of HHS to do things beyond authorities specifically given in this legislation.

The excesses of this bill appear willfully ignorant of what is going on in the rest of the economy outside of health care. These excesses make it far worse than doing nothing.

At this point in our Nation's history, we are facing very challenging economic times. We have seen the auto industry go into bankruptcy. We have seen banks shutter their doors. The chart behind me shows how the Federal debt has increased by \$1.4 trillion since inauguration. The chart also shows the growing amount of debt the Federal Government is taking on. The amount of increased debt added just since inauguration puts \$11,000 more of debt on each household, and that total debt now exceeds \$12 trillion for the first time in history.

At the beginning of this debate, one of the key promises of health care reform was that it would bring down health care costs. This needs to be done before health spending sinks the Federal budget and saddles taxpayers. I have a chart that illustrates the upward expenditures of health care costs by \$160 billion over the next decade, and that comes from this bill. The red area on this chart is the net additional Federal health spending according to not this Senator but the Congressional Budget Office.

Americans have rightly lost faith when, in the face of the current economic crisis, Congress thinks this \$2.5 trillion restructuring of the health care system is a good idea. From rationing care to infringing on the doctor-patient relationship, this government-run system will guarantee U.S. taxpayers a staggering tax burden for generations to come.

When the debate began last year, interested legislators of both parties set forth benchmarks that were at the time no-brainers and still are. But this bill does not conform. Health care reform should lower the cost of premiums. It should reduce the deficit. Now, this bill does over the 10-year window, but if you look at when the program really starts, 4 years from now, and look ahead 10 years at that time, you will find it does not. It should bend the cost curve of health care the right way, but it does not do that. The Reid bill does not do any of these things we set out to do at the beginning of the debate.

As we end this debate, I urge my colleagues to listen to the American people. The Reid bill is the wrong direction.

Mr. President, with widespread agreement that our health care system has serious problems, why do we have a partisan debate?

There is a column from the *Financial Times* by a commentator, Clive Crook, that sheds some light on the cause of the partisanship.

Mr. Crook, a Brit, is sympathetic to the goals and methods of my friends on the other side. But, as one who knows a system of the universal coverage our friends on the other side seek, he is sober about the consequences.

I ask unanimous consent that a copy of Mr. Crook's article entitled "The Honest Case for a Bungled Health Care Reform," be printed in the *RECORD*.

There being no objection, the material was ordered to be printed in the *RECORD*, as follows:

[From the *Financial Times*, Dec. 20, 2009]

THE HONEST CASE FOR A BUNGLED
HEALTHCARE REFORM
(By Clive Crook)

The US system of government has a lot in its favour, in my view, but if you wanted to argue the opposite, the fiasco of healthcare reform has it all.

The measure being fought over in the Senate—if a bill gets passed, ordeal by House-Senate conference comes next—is detested with equal passion by left and right. A majority of the public is now opposed as well. Even its supporters do not like it all that much. Yet if the system fails to spit this thing up for the president's signature, the country will be deemed ungovernable and the Obama administration will be pronounced dead. Expect the rending of garments either way.

It does not matter that conservatives oppose this reform. Of course they do. Conservatives are unmoved by the plight of the uninsured, want to block this administration's domestic initiatives regardless, and are incapable of uniting behind an alternative proposal. They have nothing to offer on the issue.

It does not matter that the loony left of the Democratic party opposes this reform either. In fact, that is a plus. Progressives who want to kill the most far-reaching US social reform in decades because it would send more customers, public subsidy in hand, to private insurance companies are as stone-hearted on this matter—and as far from understanding the concerns of most voters—as their hard-right enemies. Their opposition is an endorsement.

What matters is the failure to rally the country behind an initiative that, at the outset, voters strongly supported. A telling instance of the administration's ineffectiveness as a spokesman for its own project came just last week. Howard Dean, speaking for the progressive wing of the Democratic party, said the reform would do more harm than good—that this was the policy the insurance companies had dreamed of. White House spokesmen rushed to explain that, on the contrary, the insurance companies hate the bill.

Think about that. At the beginning Barack Obama promised people that if they liked their existing insurance arrangements—which are mostly private, of course—nothing would change. This entire effort is based on preserving, by popular demand, a mostly private model of insurance. And here is the administration endorsing the progressives' view that private insurers are evil, and citing the companies' opposition to the reform as an argument in its favour.

The White House cannot have it both ways. If progressives are right about the wicked-

ness of private insurance, they are right that the whole reform is misconceived. The administration cannot appease leftist opinion and also make the strongest possible case for this reform to the middle of the electorate. Since it cannot appease leftist opinion in any case, why even try? Make a virtue of opposition from that quarter. Mr Obama's reluctance to cross that line has hobbled his administration from the start.

Be that as it may, the healthcare bill in its current form is a mess—and an unpopular mess to boot. Popular fears that the bill will drive up insurance premiums and add to public borrowing are probably justified. The measure is timid about changing incentives to promote efficiency: it proposes lots of experiments, but little compulsion.

Adverse selection is likely to be a bigger problem than the reformers say: new rules would stop insurance companies denying coverage to the sick, and the quid pro quo of mandatory insurance may be insufficient to offset this. If the insurers' risk pools deteriorate, premiums will rise. Deep cuts in Medicare, the public insurance programme for the elderly, are needed to balance the books, but are unlikely to materialise in full. Higher taxes as well as higher premiums are the likely result of this reform.

Would it therefore be better to abandon the effort altogether and start again? One can think of simpler, better blueprints, but the politics that led the country here would still be the same—and so would the economic constraints. It is delusional to suppose that you can significantly widen access to healthcare at no net public cost. You cannot both transform a system and leave its basic structure unaltered. Trying to squirm around these unavoidable realities has brought the effort to its current pass. Why expect things to be different next time?

In the end, I think, everything depends on the weight one attaches to achieving security of coverage as quickly as possible. In my view, this is the overriding consideration. Abandoning the effort now might postpone that goal for another decade or more. The country should regard this as unacceptable. Once the reform is law, though, the real work begins. Getting a grip on costs will be even more urgent than it is already—especially when you recall the broader fiscal calamity that awaits the country during the next decade.

The honest case for reform along the lines of the Senate bill is not that it fixes US healthcare; still less that, as the White House blithely maintains, it alleviates the country's fiscal distress. The truth is, it will create more problems than it solves. But the one big thing it gets right—the assurance of affordable health insurance for all Americans—is of surpassing importance.

Enacting this reform is not the end of the healthcare argument, but the beginning. If it does pass, it may well be looked back on as a mistake once its financial implications sink in. Yet the principle of universal coverage will have been accepted, and with luck there will be no going back. The price will be high, but is worth it.

Mr. GRASSLEY. I am going to try and break through the partisan wall and connect with my friends on the other side.

Costs are rising at three times the rate of inflation.

Many Americans are uninsured, millions more fear losing their insurance in a weak economy or because of pre-existing conditions.

Doctors are ready to close their doors over high malpractice costs and low government reimbursement rates.

Something has to be done. Everyone agrees on that much.

But tomorrow, the Senate will vote on a bill that makes a bad situation worse. Mr. Crook describes the state of play well:

[t]he health care bill in its current state is a mess—and an unpopular mess to boot.

It is unfortunate that we are voting on a bill that a significant majority—61 percent—of Americans oppose.

The American people, providers, and advocacy groups are simply reacting to the fact that this bill slid rapidly down the slippery slope to more and more government control of health care.

Mr. Crook states:

Popular fears that the bill will drive up insurance premiums and add to public borrowing are probably justified. The measure is timid about changing incentives to promote efficiency: it proposes lots of experiments, but little compulsion.

All through this process, it is as if Republicans and Democrats have been living in parallel universes. Republicans have focused on the elements of the policy and asked tough questions about the cost of the change.

Mr. Clive captures that sobering reality:

Adverse selection is likely to be a bigger problem than reformers say: new rules would stop insurance companies denying coverage to the sick, and the quid pro quo of mandatory insurance may be insufficient to offset this. If the insurers' risk pools deteriorate, premiums will rise. . . . Higher taxes as well as higher premiums are the likely result of this reform.

Members on this side of the aisle, at each stage of the process, have focused on this reality. While recognizing the worthy goal of expanding coverage, we have been concerned about the effect on the currently insured.

This bill contains the biggest expansion of Medicaid since it was created in 1965.

It cuts Medicare by a staggering half a trillion dollars over the next decade.

It creates a long-term care insurance program called the CLASS Act that the CMS Actuary says runs a significant risk of being unsustainable.

It imposes an unprecedented Federal mandate for coverage backed by the enforcement authority of the Internal Revenue Service.

It increases the size of the government by \$2.5 trillion when fully implemented.

It creates dozens of new Federal bureaucracies and programs to increase the scope of the Federal role in health care.

That is a lot of power over people's lives concentrated in the Federal Government.

And the excesses of this bill appear willfully ignorant of what is going on in the rest of the economy outside of health care.

The cost of these excesses make this bill far worse than doing nothing.

This summer, official scorekeepers fleshed out the size of this cost of achieving the other side's noble, but costly goal of expanded coverage. As on who agrees with the goal of universal coverage, Mr. Crook acknowledges it:

It is delusional to suppose that you can significantly widen access to healthcare at no net public cost. You cannot both transform a system and leave its basic structure unaltered. Trying to squirm around these unavoidable realities has brought the effort to its current pass.

And yet, despite these cold hard facts, our Democratic friends continue to quest for the Holy Grail of expanded coverage. Mr. Crook captures that sentiment:

In the end, I think, everything depends on the weight one attaches to achieving security of coverage as quickly as possible. In my view, this is the overriding consideration. Abandoning the effort now might postpone that goal for another decade or more. The country should regard this as unacceptable.

Does anyone doubt this is where our Members on the other side are coming from? Some are explicit about it, like my friend, the majority whip. I recognize that transparency. But to them the price—for everyone else, the insured, businesses, Federal and State taxpayers, and Medicare patients—is secondary.

Go back and look at the many pages in the RECORD and you will see two themes prove my point. One is the Democratic theme. Most of the debate from those on the other side has been about what they want this bill to do. They want it to expand the role of the Federal Government in health care. Hence, the prideful references to past efforts, successful and unsuccessful, in that regard. They want it to solve all problems the uninsured face. They recite case after case of uninsured and underinsured. The stories they tell are compelling. On our side, we see the point the other side is making.

Go look at all those pages of debate again. You will see another theme. It is the Republican theme. That theme is not about what we want the bill to do for the uninsured. It is about understanding and explaining what the costs and benefits of this bill are to all Americans: Insured and uninsured, young, middle-aged, and elderly, suburban, and rural. In this regard, Republicans reflect where the vast majority of Americans are right now.

Mr. Crook, again, firmly where our friends on the other side are, captures the polarity of the debate:

Once the reform is law . . . the real work begins. Getting a grip on costs will be even more urgent than it is already—especially when you recall the broader fiscal calamity that awaits the country during the next decade.

Mr. Crook is correct. At this point in our Nation's history, we are a Nation facing very challenging economic

times. We have seen the auto industry go into bankruptcy. We have seen banks shutter their doors.

The Federal debt has increased by \$1.4 trillion since inauguration. This chart shows the growing amount of debt that the Federal Government is taking on. Just the amount of increased debt added just since the inauguration is \$11,535 per household.

It now exceeds \$12 trillion for the first time in history.

In these perilous times, Mr. Crook notes the public is extremely sensitive to the fiscal consequences of the bill before the Senate. And that is where Republicans have focused all along. Mr. Crook describes the tension between the goal he shares with our Democratic Members and the public's focus on the questions Republicans have asked for almost a year now. On one side of that tension are the answers to Republican inquiries:

The honest case for reform along the lines of the Senate bill is not that it fixes U.S. healthcare; still less that, as the White House blithely maintains, it alleviates the country's fiscal distress. The truth is, it will create more problems than it solves.

On the other side of that tension is the goal Democratic Members seek. Their goal of trying to achieve "universal coverage" overrides all other considerations. As Crook puts it "of surpassing importance."

And, if the other side prevails, what does it mean for the future. From Mr. Crook, who shares my Democratic friends' goals, I quote:

Enacting this reform is not the end of the healthcare argument, but the beginning. If it does pass, it may well be looked back on as a mistake once its financial implications sink in. Yet the principle of universal coverage will have been accepted, and with luck there will be no going back. The price will be high, but is it worth it?

What is that price, Mr. President? To a certain extent, what we do know is that it is high for everyone, but the uninsured population. To the extent we don't and cannot know, it is likely to be higher.

From rationing care to infringing on the doctor-patient relationship, this government-run system will guarantee U.S. taxpayers a staggering tax burden for generations to come.

When the debate began last year, interested legislators of both parties set forth benchmarks that were no-brainers. Health care reform should lower the cost of premiums. It should reduce the deficit. It should bend the growth curve in health care the right way.

How does the Reid bill measure up?

CBO tells us premiums rise.

What about health spending? As this chart here illustrates, this bill bends the Federal spending curve further upward by \$160 billion over the next decade. The red area on this chart is that net additional Federal health spending according to the Congressional Budget Office.

How about deficit reduction? Americans have rightly lost faith when in the face of the current economic crisis, Congress thinks this \$2.5 trillion restructuring of the health care system is a good idea.

The Reid bill doesn't measure up on any of those things.

The unfortunate state of this partisan floor debate goes to the tension Mr. Crook identified:

I was raised by FDR Democrats. From a lifetime of public service, I know a little bit about my Democratic friends' political DNA. A big part of that political DNA is one principle. It is this. Expanding health insurance trumps everything else.

I respect and understand that view.

Where we, on our side, differ, is whether it is an absolute or relative principle. Does the principle of universal coverage trump everything else? Does it trump cost containment? Does it trump the tax burden it brings with higher Federal and State taxes?

Does it trump the financial burden it places on small businesses and other employers? Does it trump the financial burden related premium cost increases will bring? Does it trump the negative impact it will have on the Medicare Program that our seniors count on?

For those of us, on this side, expanding coverage is a worthy goal. But it is not an absolute goal. We prefer to expand coverage through better access and affordability. But that goal of expanded coverage must be balanced with other goals.

We view it as relative to those other goals. It is relative to whether the related Federal and State tax burden is bearable. It is relative to realistic cost containment reforms. It is relative to whether the cost burden on employers, especially small businesses, is bearable. It is relative to whether the impact on Medicare services and solvency is bearable.

The American people have tuned into this debate. They don't like the partisanship. They agree with all of us that reform is needed. They have been telling us that expanding coverage is important, but not absolute.

I urge the other side to make the honest case for reform to the American people. That will lead to a bipartisan response, process, and product. Americans don't want bungled health care reform.

I yield the floor.

THE PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Mr. President, I want to associate myself with the comments of the Senator from Iowa. In fact, I would like to incorporate them by reference in my comments because they were so on point on the issue of substance as to what this bill does not do and what it does do. In both instances, he is absolutely right. The bill does not accomplish what we set out to do, which was cover all Americans, which was to bend

health care costs down, which was to let you keep your insurance if you had it and not have your premiums go up. It does just the opposite.

It is a \$2.3 trillion increase in health care spending—\$2.3 trillion. That is how much it grows the government. Health care costs go up by over \$230 billion in the first 10 years. We know premiums are going up.

Now we have this interesting issue involving Medicare. We have heard a lot of talk from the other side of the aisle about how Medicare is not being cut, and if it is being cut, it is just being used to help a new entitlement, and therefore it should be counted as part of the basic effort to bring fiscal responsibility to this bill. Well, that is hokum, just pure unadulterated hokum. Medicare is being cut by \$500 billion the next 10 years, \$1 trillion over the first 10 years of full implementation, and \$3 trillion over the first 20 years. And then the money is being spent not to make Medicare more solvent, not to make Medicare stronger so it does not have a huge unfunded liability, it is being spent to create this brandnew entitlement—an entitlement that is massively going to expand the size of government by \$2.3 trillion.

The American people understand this does not work. Common sense kicks in with the American people. They know—they know—from common sense that you cannot possibly cut Medicare by \$3 trillion, spend it on a new entitlement, and have fiscal responsibility around here and claim Medicare is better off for it. And they do not have to know it through common sense; all they have to do now is listen to the CBO, which has now written us a letter. Let me quote from this letter because it is a devastating letter. I just wish this bill was going to be on the floor long enough for it to actually be open to public view and have some sunshine on it. It is being rushed through here just before Christmas so nobody can see what is actually in it. But here is what CBO says:

The key point is that the savings to the HI trust fund—

That is the Medicare trust fund—under the [bill]—

They use the acronym for it—would be received by the government only once, so they cannot be set aside to pay for future Medicare spending and, at the same time, pay for current spending on other parts of the legislation or on other programs.

Exactly what this bill does: It spends the Medicare money on other programs.

They go on to say—and this is CBO speaking, not me:

To describe the full amount of the [Medicare] trust fund—

Again, they use “HI trust fund”—savings as both improving the government's ability to pay future Medicare benefits and financing new spending outside of Medicare would essentially double-count—

I repeat: “double count”—

a large share of those savings and thus overstate the improvement in the government's fiscal position.

The simple fact is, what is happening here is a scam, a pure and simple scam on the American people and especially on the seniors in this country because Medicare is being cut by billions of dollars in order to create a new entitlement, and it is going to have a massively negative effect on the fiscal health of this Nation because we know that new entitlement will not be fully funded and we know Medicare has \$35 trillion of unfunded liability out there.

If you are going to cut Medicare by \$3 trillion, as the other side of the aisle is proposing, if you are going to eliminate Medicare Advantage for a large number of seniors—except those who live in southern Florida—then that money ought to be used to reduce the debt so that the Medicare system becomes more solvent. It is that simple in the long run. It is not being done here. CBO has pulled the curtain back from this game and made it very clear that it is not going to be done. Of course, nobody is going to learn this because they are going to pass this bill through here before anybody can figure that out and even listen to CBO.

It is just an outrage the way this bill was put together. We all know that. Dark of night, back rooms, deals everywhere, only a few people in the room; those people who really drafted the bill, very small crowd. Nobody else was allowed in. No cameras, no information about what was going on. And then you would bring in a Senator here and a Senator there and say: What do you need from me to get your vote, and something would appear in the bill, I guess. Then the bill arrived here.

It is not unusual around here to have earmarks in bills. If they were within the budget and the budget was reasonable, I would even ask for earmarks. But this goes way beyond the concept of earmarks—this bill. This bill fundamentally changes policy—that has never happened around here—for one part of the country versus another part of the country. In other words, all of America—all American seniors—will have to live by massive cuts in Medicare Advantage. That is a pretty good health insurance program for a lot of seniors; I think there are 11 million seniors on that program. All of America has to live by that policy except for three counties in southern Florida. All of America has to live by an insurance situation where insurance companies are taxed at a certain rate, except insurance companies in Nebraska. All of America has to live by Medicaid reimbursement rates, which are going to cost the States billions of dollars—New Hampshire, \$120 million over 10 years—except for Vermont and Massachusetts. And then there is a special exemption in here for New York and a couple of

other States—Louisiana, \$300 million. That is a total corruption of the concept of policy. Policy in America is supposed to cover everyone. When the Federal Government acts, it is supposed to be a policy that affects everyone equally. You are not supposed to have little cadres of exceptions for those policies.

This bill has been called historic—historic—by my colleagues on the other side of the aisle. Well, the most historic thing about this bill is the fundamental damage it has done to the concept of open, thorough, and public debate that was at the heart of the thought process of Adams and Madison, our Founding Fathers, when they created the checks and balances system, with the Senate at the center. The Senate was supposed to be the place where bills come to the floor, they are open to debate, there are amendments, and you have a process where things get aired and there is sunshine. No sunshine here—no, not at all. This is not majority rule, as conceived by our Founding Fathers in Philadelphia. This is closer to the single-party state system we see in Europe—or have seen in Europe. The minority is ignored, and there are no checks in this process on the autocratic rule of the majority. The irony, of course, is that the bill never went through the public's consideration, never went through committee, and was drafted behind closed doors and has been on the floor for less than 72 hours. As a result, we are delivered a health care bill that has been corrupted by special interests, especially on the issue of policy, that is extraordinarily expensive and has a massive expansion in the Federal bureaucracy, to which, if you applied the word "reform," you would have to call Bernie Madoff "honest." The terms just simply do not apply here.

Unfortunately, this bill in its present form, I believe, will lead to fundamental harm to the fiscal health of this Nation. There is no question in my mind but that if we load \$2.3 trillion of cost onto our government, expand our government in this manner, our children are going to be passed a nation where they have less opportunity than our generation had. Further, I do not think it is going to help the Nation's people, our people relative to their health care. I think it will lead to a significant contraction of the quality of health care, especially for seniors but for all Americans, as we lose the innovation, the energy for innovation, and the resources for innovation. As a result, this bill, in my opinion, should be sent back to the drawing boards and should be reconsidered.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. KAUFMAN). The Senator from Texas.

Mr. CORNYN. Mr. President, over the last few days, as we have dug into this bill and the process by which it was

written behind closed doors, we have discovered the bill is chock-full of sweetheart deals.

When Americans voted to change Washington last year, they did not think it would be politics as usual here, but unfortunately it has sunk to a whole new level. It is painful for me to read the editorials in hometown newspapers back in Texas and elsewhere around the country to see what editorial opinion and other opinion leaders are saying about the process by which this bill was written, but let me read a couple of lines from the Fort Worth Star-Telegram:

The tawdry use of earmarks to bury the doubts of recalcitrant moderate Democrats was a cynical display of ends-justifies-the-means horse-trading that President Barack Obama campaigned against as a Senator and a candidate.

This was an administration that was elected on the campaign slogan: "Change You Can Believe In."

But when David Axelrod, one of the masterminds of the campaign, one of the advisers to the President, was asked about that, he said:

Well, this is just the way it is. This is the way Washington works.

I, for one, want to stand up and say this is not the way it should work. I know Presidents campaign for office saying they are going to change Washington, but the truth is the hardest fight is to keep Washington from changing you. Unfortunately, it seems as though that is what has happened here.

Rather than listening to the American people, the creators of this health care bill started with the special interests first. That is where the meetings behind closed doors started—with the pharmaceutical industry, to cut a deal with them; with the insurance industry, to cut a deal with them. The insurance industry will get \$476 billion worth of tax credits from this bill alone, and the hospital industry, and the list goes on and on.

Colleagues will stand up and tout the endorsement of organizations such as AARP that has backed nearly $\frac{1}{2}$ trillion in cuts out of Medicare because, as it turns out, they are in the insurance business and they can sell more Medigap policies when they cut Medicare Advantage, as this bill does.

In order to get the 60 votes for cloture on the motion to proceed, we didn't hear high-minded and idealistic debates about what is the right policy for this country when it comes to reforming our health care system. If this bill could have passed or mustered 60 votes because it was such great policy and the American people were embracing it, you wouldn't need to make all the sweetheart deals that were made behind closed doors to induce recalcitrant Senators to vote for cloture, not because they think it is the right policy but because their State got a special deal.

We know well about what happened in Louisiana and now in Nebraska, but of course there were special deals for Vermont that included \$600 million in the managers' package. We know that in California, the so-called "Botax" has been replaced now by another tax on tanning beds at the insistence of one of the businesses named Allergan out in California which led the lobbying campaign to defeat the cosmetic surgery tax.

We have heard this is all about keeping insurance companies honest, but the fact is there were special deals here for insurance companies in Nebraska—what has been coined the "Omaha Prime Cuts," the carve-out from new fees for Mutual of Omaha and other insurance companies doing business in Nebraska that no other insurance company in the Nation is going to benefit from.

Then there is the so-called "Gator Aid" special deal for insurance companies in Florida.

There is a \$100 million hospital deal in Connecticut—something called "U Con."

And, of course, there were deals for Montana that were slipped in the bill. Although, you know what, no one actually had the courage to mention the name of the State. You had to start to dig into it, like the Louisiana deal. At least the Senator from Nebraska was brazen enough to actually have Nebraska listed by name. The rest of them you have to dig out by trying to figure out: Who benefits from this deal and who doesn't?

I want to ask: What about the other States? My State, under this unfunded mandate in this legislation, will have to pay the State taxpayers \$21 billion in unfunded Medicaid liabilities over the next 10 years. We didn't make a sweetheart deal to vote for bad policy because my State could get some extra money, because I think that is unprincipled. I wouldn't do it. But what about the other States that voted for the bill without getting the sweetheart money, such as Arkansas, which faces an unfunded Medicaid mandate of \$335 million; Colorado, \$624 million; California, \$3.5 billion—a State that is already nearly bankrupt. This is going to make their situation enormously worse, as Governor Schwarzenegger has acknowledged.

I am not saying other States should somehow get the sweetheart deals that were negotiated for these other votes, but I am saying this entire bill is a bad deal and we need to kill it and start over, strip out all the earmarks, and bring the kind of transparency the President campaigned on and that I think the American people have a right to expect.

These sweetheart deals are egregious in and of themselves. What is worse—and I have been on the telephone talking to constituents back in Texas—

there are some people who paint with such a broad brush, they say, Well, we think all of you are corrupt, because this verifies some of the most cynical suspicions that people have about government. I, for one, resent it. We have many honest and honorable people who serve in public life, and this taints us all with a broad brush and, simply stated, makes me furious. I resent it. I resent those who brought us to this position, because I think it sullies the reputation of the Senate.

In a moment I am going to offer a point of order, but let me first note that one of Senator REID's first acts as majority leader was to pass the Honest Leadership and Open Government Act. Let me tell my colleagues the name of that again. It is called the Honest Leadership and Open Government Act.

In 2007, President Obama, then Senator, said:

To earn back the trust to show people that we are working for them and looking out for their interests, we have to start acting like it.

Unfortunately, for the American people, Washington has not yet started to act like it.

This landmark ethics reform legislation required Senators to publicly disclose earmarks and who requested them. Senator GRASSLEY and I have both made parliamentary inquiries about whether this provision has been complied with, which is now contained in rule LXIV of the Senate Standing Rules, and we found that the majority leader has so far not complied with these public disclosure rules that he himself championed. Since my friends on the other side of the aisle don't seem to care a lot about this, we have to insist that this provision be complied with. In a moment I will raise a point of order about this violation of the Senate rules. We need to force the Members of this body to be honest about who has required special favors and earmarks, tax treatments and benefits in this bill.

I have a parliamentary inquiry.

According to rule XLIV, paragraph 4(a) of the Standing Rules of the Senate states:

If during the consideration of a bill or joint resolution, a Senator proposes an amendment containing a congressionally directed spending item, limited tax benefit, or limited tariff benefit which was not included in the bill or joint resolution as placed on the calendar or as reported by any committee, in a committee report on such bill or joint resolution, or a committee report of the Senate on a companion measure, then as soon as practicable, the Senator shall ensure that a list of such items (and the name of any Senator who submitted a request to the Senate for each respective item included in the list) is printed in the CONGRESSIONAL RECORD.

I would simply inquire of the Chair: Is the Chair aware whether this list of congressionally directed spending items and their Senate sponsors has been printed in the CONGRESSIONAL RECORD?

The PRESIDING OFFICER. The Chair is not aware if such a disclosure has been made.

Mr. CORNYN. Mr. President, under those circumstances, I raise a point of order that the amendment is not in order since it violates the provisions of Senate rule XLIV, paragraph 4(a).

The PRESIDING OFFICER. Paragraph 4(a) of rule XLIV requires that the Senator who proposes an amendment containing any congressionally directed spending item ensure as soon as practicable that the list of such items be printed in the CONGRESSIONAL RECORD. The provision is not enforceable and no point of order lies.

Mr. CORNYN. Mr. President, I appeal the ruling of the Chair and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The yeas and nays were ordered.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I move to table the appeal of the ruling of the Chair and I ask that the vote occur upon the expiration of all postcloture time.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BAUCUS. I ask for the yeas and nays on the motion to table.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The yeas and nays are ordered.

The Senator from Missouri is recognized.

Mr. BOND. Mr. President, last week I had a little fun with an old holiday classic: Clemente Clark Moore's "The Night Before Christmas" which you can still find on YouTube, by the way. While I meant this parody to bring some much needed levity to the process, the points I made are very serious. For the American people, there is nothing more serious than the reform bill we are considering today.

The majority's so-called reform package will restructure one-sixth of our struggling economy, drive health care costs higher, force millions off their current plan, put health care decisions in the hands of bureaucrats, cut seniors' Medicare, raise taxes, and hurt small businesses and cost jobs.

There is nothing funny about this health care bill. Americans faced with rising premiums asked for bipartisan reform to make health care costs affordable. But the Democratic bill fails to give the American people what they want, which is why Senator REID has written bill after bill behind closed doors with no Republicans. The majority party doesn't want Americans to know they are getting a lump of coal for Christmas until it is too late.

But Leader REID has outdone himself on the latest deal he cut. His is Chi-

cago-style politics at its worst: a 2,700-page backroom deal written behind closed doors, full of political payoffs, vampire votes in the dead of night, all to pass a health care bill before Christmas that the American people don't want, that will increase health care costs, raise taxes, and cut Medicare for seniors, operating under an arbitrary deadline which seems designed to minimize transparency, understanding, and public involvement.

But I want the American people to know what they are getting from the majority this holiday season. I don't want my good friend from Nevada to be known as Hurry-up-and-Reid, so let's talk about what is in this bill.

Under the majority's latest backroom deal, Americans are getting more taxes. This deal imposes about \$500 billion in fees and taxes on individuals, families, and businesses.

Under the majority's latest backroom deal, Americans who own small businesses—the backbone of our economy—are getting more taxes and costly regulation. For small businesses who employ a large number of those currently uninsured, this bill does nothing to help make insurance more affordable or accessible.

The bill contains a costly employer mandate which destroys job creation opportunities for employers. It doesn't take a rocket scientist or an economist to figure out that the multiple penalties small businesses will pay for full-time workers will result in these companies forcing workers from full time to part time and discouraging new hiring. Companies are going to have to think twice before hiring new full-time workers if it is going to cost them a pretty penny, at a time when the companies are trying to pinch pennies.

There is also a paperwork mandate which is a new administrative burden on small business which, according to the National Federation of Independent Business, will impose a direct \$17 billion burden on businesses.

Unfortunately for small businesses, unlike larger businesses or unions, the news gets even worse. Unlike large businesses, most small businesses can only find and purchase health insurance in the private insurance marketplace. That means to insure their employees, small businesses have to go to the big insurance companies on which the Reid bill is placing hefty new fees. Most folks don't have a problem with putting more fees on insurance companies. It seems to be politically popular, but it is economics 101 that these insurance companies are not going to suck it up and swallow all of these new fees themselves. CBO has stated so explicitly. Instead, they will pass the fees on to small businesses that will have no choice but to purchase their services.

One of the gimmicks the majority is using to hide the cost of the bill is a

weak tax credit that is supposed to help small businesses in purchasing health insurance.

The hitch is that small businesses will only receive the full tax benefits if they have less than 10 employees. If they hire that 11th employee, the tax credit is reduced. At 25 employees the tax credit is no longer available.

In addition, a small business can only get full credit if it pays its employees an average of \$25,000 a year or less. So no salary increase, no wage increases.

In other words, in what is already a horrible economic situation, where businesses are shuttering their doors and workers are being laid off, we are actually going to punish small businesses for hiring new employees and paying workers more.

This tax credit is also a case of bait and switch. If your small business happens to fit in the narrow qualifications, it is only temporary—after 6 years the credit goes away—but the mandates and burdens on small businesses stay.

That is why the National Federation of Independent Businesses, in their strong opposition to the majority's plan, stated that it:

will not only fail to reduce and control the constantly climbing healthcare costs small business owners face, but it will result in new and greater costs on their businesses. Reform that was supposed to be all about small business has turned out to be more about big business and other late-night dealmakers, all at the expense of our nation's job creators.

That is not the kind of reform small businesses can afford.

Under the majority's latest backroom deal, Americans are getting hundreds of millions of dollars in cuts to critical health care programs, such as \$118 billion in cuts to Medicare Advantage, as well as cuts to hospitals, nursing homes, home health agencies, and hospices.

When government forced through massive cuts to home health in the late 1990s, the unintended consequences were costly and tragic in Missouri. A significant number of agencies closed, forcing patients into more expensive care.

One example is in one county in Missouri, the county's only home health agency closed. The provider had 40 patients they served in homes at a cost of \$400,000 a year. When those patients were cut off, 30 were forced into hospitals or nursing homes. The cost skyrocketed for these patients to a staggering \$1.4 million on the government tab or a \$1 million larger hit to taxpayers. We don't even know what happened to the other 10 patients who lost this critical care.

This is not the kind of reform Americans can afford. Under the majority's latest backroom deal, States are also getting hit hard. For example, the majority's big plan is to expand Medicaid, but their big plan for paying for it is to put the burden on the States; that is,

unless you were able to cut a backroom deal like Nebraska, which leaves other States holding the bag for their costs.

That brings me to my next point. Under the majority's latest backroom deal, Americans are forced to fund a number of political payoffs. There are such a large number of political payoffs, which is why this bill is starting to be dubbed "cash for cloture."

There is a carve-out for the insurance industry in Michigan and Nebraska. There is an extra \$300 million in Medicaid funding for Louisiana, now known as the "Louisiana purchase." What was the mysterious \$100 million for a "health care facility" turns out to be a hospital in Connecticut.

Sadly, this isn't even the entire list of sweetheart deals in REID's latest backroom deal. That is not the kind of reform Americans want.

With Chicago politics and backroom deals such as this, it is no surprise that poll after poll makes clear the American people are saying no to the Democrats' proposals.

The latest poll released by Quinnipiac University found that American voters "mostly disapprove" of the plan—53 to 36 percent.

A recent Washington Post/ABC News poll, detailed in a Post article, found the American public generally fearful that a revamped system would bring higher costs while worsening the quality of their care.

The American public is absolutely right. Americans don't want this bill. In the classic tale called "The Christmas Carol," Scrooge is given the opportunity to see the ghosts of Christmas past, present, and future. While the Democrats are trying to paint the GOP as "Scrooge," they would do well to look at what the Christmas future would look like if their bill were to pass.

We don't want to wake up next Christmas and have Americans paying more for health care or being unable to get it or losing their jobs. But under the majority's latest backroom deal, that is the future.

Next Christmas, we don't want to see small businesses that still cannot afford to offer health insurance to employees or, worse, small businesses struggling to keep their doors open because of the costly new burdens in this bill. Under the majority's latest backroom deal, that is the future. A year from now we don't want to hear that seniors have lost access to services and care. Unfortunately, that is the Christmas future we face if the bill passes. Christmas future—several years from now—could look even worse.

That is why in my "The Night Before Christmas" parody it was not funny as much as it was scary and true when I said:

But I could not catch the holiday spirit myself; how far away from common sense we've been led, our kids and our grandkids have their futures to dread.

In the last year, my colleagues on this side of the aisle watched with dismay as the wheels have come off Federal spending; a trillion dollars of taxpayer money here and a trillion dollars there. Got a problem? Throw money at it. Will historians look back and say the 111th Congress is where the decline of American economic power began in earnest? I don't want that on my watch. We can reform health care without spending trillions of our children's and grandchildren's money.

If the majority were to bring up a bill that made health insurance more affordable for small business owners to purchase for their employees, that eliminated frivolous lawsuits, that emphasized wellness and prevention programs, they could go a long way to solving the problems of the uninsured and underinsured, and they could probably get 80 or 90 truly bipartisan votes. Instead, what they want, apparently, is to take over health care, at a tremendous cost to individuals, families, and businesses, and to increase the dependency on the Federal Government. That is not a Christmas present I want, and I don't want to give it to the American people.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. ENZI. I thank the Senator from Missouri for his comments. He has been chairman of the Small Business Committee. Small business plays a huge role, the biggest role, in the economy of the United States.

We could have, and we should have, spent the last 4 weeks talking about what needed to be done with small business. It is a big issue and it is important. I appreciate the emphasis the Senator from Missouri has put on it through the years.

I want to talk about the whole bill today, because a quote I ran into was that "absolute power corrupts—absolutely."

The Democrats have absolute power right now. Under the biggest requirement for votes, it only takes 60 in the Senate. The Democrats have 60 votes. In the House, they have a clear majority of the votes, and that is all that is required to pass a bill there. They are under the impression that they won the election, so they get to write the bills. Never before has that happened on a major piece of legislation.

Everyone in this country should be upset when the majority refers to bills like ending slavery and civil rights and Medicare and welfare reform and paint the Republicans as the opposition. Substantial numbers on both sides of the aisle made those bills possible. I am pretty sure people remember that it was Lincoln, a Republican, who led the fight to abolish slavery. Leader Mansfield gives Everett Dirksen, a Republican from Illinois, credit for the leadership that made the civil rights bill

possible. In every instance, until now, Republicans have had a leadership role and both sides have substantially participated in making and voting for those laws. In politics, that is how it has to work for our country to be successful.

Only one party, and especially one person, "gains" from this so-called health care reform bill. The President will be able to show how he was able to accomplish something against all odds. Why against all odds? Because the Democrats of the Senate wrote off the 40 votes of the Republicans. That is right, we were written off from the start. Oh, yes, we were allowed to participate to see if we couldn't be persuaded to take what the Democrats wanted to write and foist on America. Anything short of buying the whole Democratic plan and we could be and would be thrown overboard because our votes aren't needed. We were thrown overboard with the excuse of phony time deadlines, when it was needing to do just the Democratic ideas.

Senator Kennedy and I were able to work through an incredible number of bills because we recognized that both sides had good ideas and both sides had bad ideas. The trick was to take as many of the good ideas as possible and have the courage to tell some on both sides that their idea wasn't ready for prime time. With evenhandedness and both leaders promoting the surviving ideas, many of the bills were unanimous on both ends of the building. Were there flaws in some of the bills? Yes. No bill is perfect. On the simplest solutions, nobody, particularly those who have never been involved in that business or that area, can comprehend all of the unintended consequences. But when it is both parties acting in concert, when problems come up, solutions are sought. When bills are done by one party—and no all-encompassing bill has been done this way ever before—when the bills are done by one party, those inevitable flaws result in justified finger pointing.

You can't change such a basic part of the economy—something that affects every single person—by ignoring many who have experience in the business and in the area and not expect major flaws. The American people even recognize the flaws—already. Of course, everybody has some knowledge of health care, since it affects us all. When those flaws develop, and they will, in an avalanche, everybody will point to one party, the Democratic party, and say why did you have to prove your power? Why didn't you work to get it right? Why did you have to polarize the issue to show you were the only ones concerned about people?

Of course, the Republicans will be compelled to pull out the proof that we warned about the flaws but were ignored, because the Democrats are focused on proving that they won the

election. Normally, there is plenty of blame to go around, but not on this one.

The Republicans were thrown overboard. That only left the 60 votes needed to pass the bill. Well, you cannot get 60 people to agree on 100 percent of anything. You could not get 60 people to agree on a place to eat dinner. But all 60 had to agree. That is where you have to move away from legislating and into dealmaking. That is when you have to start playing games like "Let's Make a Deal" or "The Price is Right." I don't want to downplay how masterful the leader was. Everyone has to be in awe of his ability to give much to a few and none to many and get 100 percent to stay on what they can see from the polls is a sinking ship. How can a person discriminate between Members, between States? Usually, we do earmarks in appropriations bills. Now we are starting to do them in policy bills. Why? To buy votes. The leader is buying votes with taxpayer money for things the majority of the taxpayers will never benefit from.

I don't have time to go into the way the groups have made hidden deals for this bill, such as the American Medical Association and big pharmaceuticals.

I don't have time to talk about how taxes will go up and premiums will be up. As an accountant in the Senate, you are going to be shocked by the numbers—but not until it is too late. I don't have time to explain to you how the Democrats are planning to spend the same money twice. That is a pretty neat trick, too.

I don't have time to explain how the government will tell you what the minimum amount of insurance is. It is more insurance than most Americans have right now. If you don't find a way to buy this better package, there will be fines for you to pay. If the government can force you to buy insurance and force you to buy what Washington thinks is the best, what is next? Will they be able to tell you what kind of car to buy? Remember, the government now owns a car company.

I hope I have time to remind you we all agree that Medicare is going broke. But this bill takes almost \$500 billion of Medicare money and uses it to do new programs—new programs outside of Medicare—that will go on forever and need money forever, even after Medicare is broke. They even recognize the problem and form a commission to tell us where to cut Medicare. That is so they can shift the blame to a commission. But the difficulty is they have made special deals that take away the commission's ability to make cuts—except to the benefits of seniors. They are the only ones left standing. There will have to be cuts—real cuts.

They made a deal. I saw a letter from those who said they support the bill. For a while, they had a whole year's worth of change in their pay. Now they

have 2 months where they will be paid what they think is less than adequate but OK to stay in business. Evidently, they think that even though the Senate turned it down, because they couldn't afford to pay for it, \$250 billion in adjustments to what they get paid because it wasn't paid for, and we are going to come back and do that without it being paid for. It could have been paid for out of the Medicare money if they were using it for Medicare only.

I ask unanimous consent to have printed in the RECORD the Effects of the Patient Protection and Affordable Care Act on the Federal Budget and the Balance in the Hospital Insurance Trust Fund.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CBO has been asked for additional information about the projected effects of the Patient Protection and Affordable Care Act (PPACA), incorporating the manager's amendment, on the Federal budget and on the balance in the Hospital Insurance (HI) trust fund, from which Medicare Part A benefits are paid. Specifically, CBO has been asked whether the reductions in projected Part A outlays and increases in projected HI revenues under the legislation can provide additional resources to pay future Medicare benefits while simultaneously providing resources to pay for new programs outside of Medicare.

HOW THE HI TRUST FUND WORKS

The HI trust fund, like other Federal trust funds, is essentially an accounting mechanism. In a given year, the sum of specified HI receipts and the interest that is credited on the previous trust fund balance, less spending for Medicare Part A benefits, represents the surplus (or deficit, if the latter is greater) in the trust fund for that year. Any cash generated when there is an excess of receipts over spending is not retained by the trust fund; rather, it is turned over to the Treasury, which provides government bonds to the trust fund in exchange and uses the cash to finance the government's ongoing activities. This same description applies to the Social Security trust funds; those funds have run cash surpluses for many years, and those surpluses have reduced the government's need to borrow to fund other federal activities. The HI trust fund is not currently running an annual surplus.

The HI trust fund is part of the Federal government, so transactions between the trust fund and the Treasury are intragovernmental and leave no imprint on the unified budget. From a unified budget perspective, any increase in revenues or decrease in outlays in the HI trust fund represents cash that can be used to finance other government activities without requiring new government borrowing from the public. Similarly, any increase in outlays or decrease in revenues in the HI trust fund in some future year represents a draw on the government's cash in that year. Thus, the resources to redeem government bonds in the HI trust fund and thereby pay for Medicare benefits in some future year will have to be generated from taxes, other government income, or government borrowing in that year.

Reports on HI trust fund balances from the Medicare trustees and others show the extent of prefunding of benefits that theoretically is occurring in the trust fund. However,

because the government has used the cash from the trust fund surpluses to finance other current activities rather than saving the cash by running unified budget surpluses, the government as a whole has not been truly prefunding Medicare benefits. The nature of trust fund accounting within a unified budget framework implies that trust fund balances convey little information about the extent to which the Federal government has prepared for future financial burdens, and therefore that trust funds have important legal meaning but little economic meaning.

THE IMPACT OF THE PPACA ON THE HI TRUST FUND AND ON THE BUDGET AS A WHOLE

Several weeks ago CBO analyzed the effect of the PPACA as originally proposed on the HI trust fund (http://www.cbo.gov/ftpdocs/107xx/doc10731/Estimated_Effects_of_PPACA_on_HI_TF.pdf). CBO and the staff of the Joint Committee on Taxation (JCT) estimated that the act would reduce Part A outlays by \$246 billion and increase HI revenues by \$69 billion during the 2010-2019 period. Those changes would increase the trust fund's balances sufficiently to postpone exhaustion for several years beyond 2017, when the fund's balance would have fallen to zero under the assumptions used for CBO's March 2009 baseline projections.

The improvement in Medicare's finances would not be matched by a corresponding improvement in the Federal government's overall finances. CBO and JCT estimated that the PPACA as originally proposed would add more than \$300 billion (\$246 billion + \$69 billion + interest) to the balance of the HI trust fund by 2019, while reducing Federal budget deficits by a total of \$130 billion by 2019. Thus, the trust fund would be recording additional saving of more than \$300 billion during the next 10 years, but the government as a whole would be doing much less additional saving.

CBO has not undertaken a comparable quantitative analysis for the PPACA incorporating the manager's amendment, but the results would be qualitatively similar. The reductions in projected Part A outlays and increases in projected HI revenues would significantly raise balances in the HI trust fund and create the appearance that significant additional resources had been set aside to pay for future Medicare benefits. However, the additional savings by the government as a whole—which represent the true increase in the ability to pay for future Medicare benefits or other programs—would be a good deal smaller.

The key point is that the savings to the HI trust fund under the PPACA would be received by the government only once, so they cannot be set aside to pay for future Medicare spending and, at the same time, pay for current spending on other parts of the legislation or on other programs. Trust fund accounting shows the magnitude of the savings within the trust fund, and those savings indeed improve the solvency of that fund; however, that accounting ignores the burden that would be faced by the rest of the government later in redeeming the bonds held by the trust fund. Unified budget accounting shows that the majority of the HI trust fund savings would be used to pay for other spending under the PPACA and would not enhance the ability of the government to redeem the bonds credited to the trust fund to pay for future Medicare benefits. To describe the full amount of HI trust fund savings as both improving the government's ability to pay future Medicare benefits and financing new spending outside of Medicare would essen-

tially double-count a large share of those savings and thus overstate the improvement in the government's fiscal position.

Mr. ENZI. Mr. President, I ask unanimous consent to have printed in the CONGRESSIONAL RECORD a December 22 article from the Casper Star Tribune, by nationally syndicated columnist Cal Thomas.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Casper Star Tribune, Dec. 22, 2009]

SNOW JOBS

(By Cal Thomas)

There were two snow jobs in Washington over the weekend. One came from the sky as a record December snowfall blanketed the city. The other came from Capitol Hill where the Senate labored to cover up the real effects of its massive "health care reform" bill.

All you need to know about this monstrosity is contained in a paragraph from page four of the Congressional Budget Office's 21-page letter to Senate Majority Leader Harry Reid: "According to CBO and (the Joint Committee on Taxation's) assessment, enacting the Patient Protection and Affordable Care Act with the manager's amendment would result in a net reduction in federal budget deficits of \$132 billion over the 2010-2019 period. In the subsequent decade, the collective effect of its provisions would probably be continued reductions in federal budget deficits if all of the provisions continued to be fully implemented. Those estimates are subject to substantial uncertainty."

So uncertain are they that the CBO later noticed an error in its calculations and a day later on Sunday, Dec. 20 delivered another letter to Senate leaders that said: "Correcting that error has no impact on the estimated effects of the legislation during the 2010-2019 period. However, the correction reduces the degree to which the legislation would lower federal deficits in the decade after 2019."

The public is being asked to swallow a bill that most senators haven't read, contains cost projections that are substantially uncertain, and touts outcomes that can be reasonably predicted to be nothing that resembles what Democrats are promising.

Senator Ben Nelson, Nebraska Democrat and a supposedly staunch pro-lifer, agreed to vote for the bill after, as the Washington Post put it, he got "abortion language" he wanted and "also secured other favors for his home state." That's what it's ultimately about: getting favors for your home state so you can be re-elected. Re-election trumps the Constitution and the will of the people, most of whom oppose the Senate and House health care "reform" bills.

Even one's stand on a moral issue like abortion can be compromised for the right deal. Inserting language that supposedly restricts federal funding of abortion in order to provide political cover to Sen. Nelson turns out to be a sham. According to House Minority Leader John Boehner, whose office wrote a critique of Reid's 383-page Manager's Amendment, "Everyone enrolled in these (health) plans must pay a monthly abortion premium and these funds will be used to pay for the elective abortion services. The Reid amendment directs insurance companies to assess the cost of elective abortion coverage and charge a minimum of \$1 per enrollee every month."

Some defenders of this deal argue that federal money will be magically segregated when it comes to abortion and that money going to abortion providers will be for other "services." Even if this were true—and there is little truth coming out of Washington these days—that is like saying the government won't pay for the actual procedure, but it will subsidize other costs, such as the electric bill and the rent on the clinic's office space.

Republicans have done a good job highlighting the multiple flaws in the Senate bill (and the similarly long House bill). Most importantly for seniors, the Senate bill slashes hundreds of billions of dollars from Medicare to pay for a new-government program. It includes massive tax increases on individuals businesses, which means businesses are unlikely to hire workers at a time of double-digit unemployment. It includes a massive new entitlement program—the CLASS Act (short for Community Living Assistance and Support Services)—which Budget Committee Chairman Kent Conrad has described as "a Ponzi scheme of the first order" and which was recently opposed by a bipartisan majority, including 11 Democrats.

To their credit, Republicans have stood together in opposition to this health care fiasco. Their pledge to voters in the November 2010, election should be to repeal the measure and to offer real insurance and health care reform that will not include an abortion provision, new taxes, more entitlements and a bigger bureaucracy.

Yes, it can be done.

He says:

There were two snow jobs in Washington over the weekend. One came from the sky as a record December snowfall blanketed the city. The other came from Capitol Hill where the Senate labored to cover up the real effects of its massive "health care reform" bill.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. ENZI. Mr. President, I ask unanimous consent to have printed in the RECORD a Wall Street Journal article called "ObamaCare's Longshoremen Rules."

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Wall Street Journal]

OBAMACARE'S LONGSHOREMEN RULES

President Obama praised the Senate yesterday for clearing a 60-40 procedural vote on his health plan in the dead of night and "standing up to the special interests who've prevented reform for decades and who are furiously lobbying against it now." They're furiously lobbying all right—not against ObamaCare but for the sundry preferences in the Senate bill.

Start with the special tax carve-outs included in the "manager's amendment" that Harry Reid dropped Saturday morning. White House budget director Peter Orszag has claimed that the bill's 40% excise tax on high-cost insurance plans is key to reducing health costs. Yet the Senate Majority Leader's new version specifically exempts "individuals whose primary work is longshore work." That would be the longshoremen's union, which has negotiated very costly insurance benefits. The well-connected dock workers join other union interests such as miners, electrical linemen, EMTs, construction workers, some farmers, fishermen, foresters, early retirees and others who are absolved from this tax.

In other words, controlling insurance costs is enormously important, unless your very costly insurance is provided by an important Democratic constituency.

The Reid bill also gives a pass on the excise tax to the 17 states with the highest health costs. This provision applied to only 10 states in a prior version, but other Senators made a fuss. So controlling health costs is enormously important, except in the places where health costs need the most control.

Naturally, the Secretary of Health and Human Services will decide how to measure "costs" and therefore which 17 states qualify. (Prediction: Swing states that voted for Mr. Obama in 2008 or have powerful Democratic Senators.)

These 11th-hour indulgences make a hash of Mr. Orszag's cost-control theories and Mr. Obama's cost-control claims. Their spin has been that wise men would convene and make benevolent decisions about everyone's health care based only on evidence and the public good. But as the Reid bill shows, politics will always dominate when Washington is directing a U.S. health industry that is larger than the economy of France.

Or take a separate \$6.7 billion annual "fee" on insurance companies that is supposed to be divvied up by market share. This beaut doesn't claim to be anything more than a revenue grab, but at the behest of Michigan Senator CARL LEVIN Democrats chose to apply it to some insurers and not others. Select companies incorporated as nonprofits will be exempt, even though nonprofits typically have net income exceeding for-profit companies because they pay no taxes.

Since this new tax will merely be passed through as higher premiums, the carve-outs mean that cost increases will be even higher for workers whose employer contracts with a nonfavored insurer. These gyrations to tax law are so complex that it still isn't clear which nonprofits would qualify, but the protections are sure to apply to certain insurers in Michigan, Illinois and California. The poor saps stuck with higher premiums everywhere else can thank Mr. Levin and Senators Debbie Stabenow, Dick Durbin, Barbara Boxer and Dianne Feinstein.

The press corps is passing this favoritism off as sausage-making necessary to "make history," but that's an insult to sausages. What this special-interest discrimination illustrates in how all health-care choices will soon be made as Washington expands its political control over one-seventh of the U.S. economy.

Mr. ENZI. It points out how there will be an excise tax in 17 States with the highest costs, but yet we made an exception for a number of unions, particularly the longshoremen's union not being subject to some of the taxes in the bill.

Mr. President, I ask unanimous consent to have printed in the RECORD a letter from a number of contractors.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

DECEMBER 21, 2009.

U.S. SENATE,
Washington, DC.

DEAR SENATOR: We are writing to express our strong opposition to language contained in the Manager's Amendment to H.R. 3590, which excludes the construction industry from the small business exemption contained in the bill. We regret that this is our first op-

portunity to address this issue, though the fact that the Manager's Amendment was made public less than two days before the first vote on the matter has increased the difficulty of playing a constructive role in the legislative process.

In recognition of the negative impact that a mandate to provide health insurance will have on employers, H.R. 3590 exempts employers with fewer than 50 employees from the fines levied on those who cannot afford to provide their employees with the federal minimum standard of health insurance. However, the Manager's Amendment singles out the construction industry by altering the exemption so that it applies to only those firms with fewer than 5 employees.

This narrowly focused provision is an unprecedented assault on our industry, and the men and women who every day make the bold decision to strike out on their own by starting a business. Our members' benefit packages reflect the reality of their business models, and they proudly offer the best health insurance coverage that they can afford. It is unreasonable to presume that small business owners can bear the increased cost of these new benefits simply because Congress mandates that they do so.

In the real world, where the rhetoric surrounding this legislation will meet the stark reality of the employer struggling to make payroll, this special interest carve out is simply another bill to pay in an industry that, with an unemployment rate exceeding 18% and more than \$200 billion in economic activity lost in the past year, already is struggling to survive.

And, we would be remiss if we failed to question the justification for singling out the construction industry to bear such a burden. We are unaware of any data or evidence that suggests that the needs and struggles of a construction contractor with fewer than 50 employees are so different from those of small business owners in other industries, and absent such convincing evidence, we are left to assume that this specific provision is merely a political payoff to satisfy the desires of a small constituency.

As Congress moves forward in the legislative process for H.R. 3590, we strongly encourage you to address this onerous provision that needlessly single out small construction industry employers.

Sincerely,

Air Conditioning Contractors of America, American Institute of Architects, Associated Builders and Contractors, Associated Equipment Distributors, Associated General Contractors, Association of Equipment Manufacturers, Independent Electrical Contractors, National Association of Home Builders, National Federation of Independent Business, National Lumber and Building Material Dealers Association, National Ready-Mixed Concrete Association, National Roofing Contractors Association, National Utility Contractors Association, Plumbing-Heating-Cooling Contractors—National Association, Small Business & Entrepreneurship Council U.S. Chamber of Commerce.

Mr. ENZI. It points out how most businesses have an exclusion of 50 employees or less, but they have singled out the construction industry with an exemption of 5 employees.

Mr. President, I ask unanimous consent to have printed in the RECORD a Wall Street Journal article that covers that same topic.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From The Wall Street Journal, Dec. 22, 2009].

SENATE HEALTH BILL UNFAIR TO CONSTRUCTION INDUSTRY—NAHB

"In their rush to pass massive health care reform before Christmas, Senate Democrats included a last-minute provision overtly targeting the construction industry, including home builders," the National Association of Home Builders said in an e-mail alert to its 200,000 members Monday. "In order to find the 60 votes needed to pass health-care reform, a provision was slipped into the health-care bill to exclude the construction industry from the small business health-care exemption contained in the bill."

Employers with more than 50 employees would be required to offer insurance or pay a fine of up to \$750 per employee if any employee obtains federal subsidies for coverage. But the builder group says the bill singles out the construction industry by "only giving construction firms an exemption from the bill's employer mandates if a firm employs less than five people. Every other industry is granted an exemption if they have fewer than 50 employees."

Many home builders are small, private organizations working to survive the worst downturn in decades. More than half of the NAHB's members have fewer than five employees. "You might as well take an industry that has been a cornerstone of the economy and kick it while it's down," said Jerry Howard, the Washington-based group's chief executive. "It makes no sense . . . and it's really bad public policy."

The NAHB is urging its members to quickly contact their senators to derail the measure. The Senate, however, is marching toward a Christmas Eve vote. The Senate version needs to be reconciled with a House-passed bill, but is likely to form the core of any final legislation presented to President Barack Obama for his signature.

If the Senate bill passes and goes to a conference committee with the House, as expected, the House is likely to do most of the reconciling. That's because Senate Majority Leader Harry Reid—after battling for weeks to get the minimum number of votes needed to avert a Republican filibuster—has little room to maneuver. The House passed its version on Nov. 7 on a 220-215 vote.

President Obama hopes to sign a final bill before his State of the Union address after the first of the year so he can turn to other issues, in particular the economy and jobs.

Mr. ENZI. Mr. President, the Department of Labor recently reported that our Nation's unemployment rate is 10 percent. In States such as Michigan, California, Rhode Island, and Nevada, the average rate is over 12 percent.

Millions of Americans have lost their jobs and millions more go to work every day worried about keeping the job they have. Businesses of all sizes are struggling to keep their doors open and are finding it harder and harder to make ends meet.

Unfortunately, the policies in the Reid health care reform bill will only make matters worse for America's businesses and the workers they employ.

When I am home in Wyoming, which is nearly every weekend, my constituents ask me: What does health care reform mean for me? Unfortunately I have to tell them that if the Reid bill is passed, their jobs and their paychecks will be in danger.

The bill being pushed through the Senate imposes \$28 billion of new taxes on businesses that will eliminate jobs and reduce wages.

Many business owners cannot provide health insurance. They cannot afford insurance for their workers or for their own families. They have looked at their bottom lines and understand that they cannot afford to buy insurance and continue to stay in business—health insurance simply costs too much.

Rather than addressing the issue and enacting reforms that would lower health insurance costs, the majority's health care bill instead increase the taxes that these businesses will have to pay.

These are the same businesses that are already barely making it. These are the same businesses that are laying off workers to try to survive.

We know what the new employer taxes in the Reid bill will do, and who will ultimately have to pay the price for this misguided policy. These taxes will eliminate jobs and be paid for on the backs of American workers.

The Congressional Budget Office has told us that the new job killing taxes in the Reid bill will lower wages across this country by \$28 billion.

We have shed 3.5 million jobs since January of this year and the average workweek is now down to 33 hours for the American worker. Yet the bill before us today will actually make that situation worse.

The workers who will be the hardest hit by the job killing tax in the Reid bill are those already making the lowest wages and with the fewest job opportunities. According to the Congressional Budget Office, employer mandates like those included in the Reid bill would quote "reduce the hiring of low-wage workers."

Low-income workers are already hit hard by the current economic conditions. These low-income workers typically have less formal education and find it even more difficult to find work. Workers without a high school diploma have a 50 percent higher unemployment rate than workers with higher education levels.

Harvard Professor Kate Baicker reported that an employer mandate, like the one in this bill, will mean that "workers who would lose their jobs are disproportionately likely to be high school dropouts, minority and women".

This is in part due to the fact that many of these workers are only making minimum wage. Their employers cannot reduce their wages, so consequently they will either have to re-

duce the number of hours these employees work or simply get rid of them to make up for the costs of the next tax.

Employer mandates and the job killing taxes that go with them are paid on the backs of low-income workers. The job killing taxes in this bill fall disproportionately on the people who struggle the most—putting the jobs they have at risk and making it even more difficult to find a new one.

At a time when Americans across this country are looking for signs of an economic recovery, the Senate should be debating a bill that helps the situation, rather than a bill that makes it worse.

The job killing tax in the Reid bill will also discourage employers from hiring new workers and growing their business. Any small business that currently has 50 or fewer employees will do everything they can to avoid hiring that 51st employee in order to avoid these new taxes.

I filed an amendment to the Reid bill that would protect businesses and their workers from the worst effects of the job killing tax. My amendment would simply suspend the employer mandate any time the unemployment rate goes above 6 percent.

Between 1999 and 2008, the unemployment rate was about 5 percent. But when our economy began to struggle, we saw the unemployment rate rise to a point that now we are seeing more than 10 percent unemployment.

It seems only logical to me that if our economy is struggling and people are losing their jobs, we would want to protect workers from having their wages cut and even losing their jobs because of the job killing tax in the Reid bill.

I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I now yield to Senator MURRAY from Washington—I suggest she be recognized to speak for 7 minutes.

The PRESIDING OFFICER. The Senator from Washington.

Mrs. MURRAY. Mr. President, the health insurance system in our country has been broken for a very long time. For far too long, families and businesses across my home State of Washington have been forced to make some tough decisions, spending nights struggling or whispering after their kids go to bed about how to pay the bills and praying they do not get sick.

I am proud to say that is about to change. Over the course of months of work on this issue, I have noticed it is very easy for this debate to tip into the realm of abstractions, to focus on numbers and charts—to devolve into petty partisanship or ideological inflexibility. Too often real people get left out of this conversation—mothers and fathers who are scared they are going

to lose their jobs; families scared they are going to lose their insurance; people with preexisting conditions who cannot get coverage and who know they are one hospital visit away from bankruptcy; small business owners who cannot afford another premium increase and who want to cover their employees but they cannot keep up with the rising costs; senior citizens who are forced to cut their pills in half to make them last twice as long; people who pay their premiums and like their doctors, but when they get sick they find out that some of the most personal choices in their lives are being made by their insurance companies.

These are the real people who need real health insurance reform. Most Americans seem to fall into one of those categories.

Over the past few months, I have tried to ensure that the struggles of people in my home State are represented in this debate. I told my colleagues the stories that I have received in over 10,000 letters and e-mails and at roundtables and on the phone, stories told to me too often by men and women with tears in their eyes or a quiver in their voice, people who are not looking for a handout or a free ride but who are pleading for a fair system—a system that works for families or businesses like theirs.

I shared the story of Janet from Seattle. She lost her job, lost her insurance, and succumbed to cancer after being forced to wait 6 weeks to see a specialist after her throat began to hurt. Janet's story is why we need to reform the health insurance system.

I told my colleagues the story of Joseph and his wife who was denied an MRI after complaining of pain in her chest, and only after 3 years of fighting her insurance company were they able to determine she had breast cancer and begin the treatment she desperately needed. Their story is why we need real health insurance reform.

I told the story of Mark Peters from Port Townsend who owns a small technology company. He told me he is being crushed by skyrocketing premiums. He offers health insurance to his employees. He does the right thing. But he told me he just got a letter from his insurance company raising his rates by 25 percent. Mark told me his small business cannot sustain increases such as that; no business can. But in our current health insurance system, small businesses are often at the mercy of the insurance companies. This company's story is why we need to reform the health insurance system.

I told the story of Patricia Jackson from Woodinville who has private insurance but cannot keep up with the rising premiums. To provide care for her family of four, Patricia told me she paid \$840 a month in 2007. The next year it was \$900 a month, and then \$1,186 a month, and again her rates

were raised recently to a hike of \$1,400 a month. That is an increase of over 66 percent in just 3 years. Patricia and her family's story is why we need to reform the health insurance system.

I told my colleagues the story of Marcelas Owens. Marcelas Owens is a young man I have thought about every single day since I actually met him back in June. Marcelas is only 10 years old. He has two younger siblings whom you can see in the photo with him. This is his grandmother. He and his siblings have been through a lot. Two years ago, their mother Tiffany lost her life because she was uninsured. She was 27 years old. Tiffany was a single mom who worked as an assistant manager in a fast food restaurant. She had health care coverage through her job. But in September of 2006, Marcelas told me that she got sick, she lost her job, she lost her insurance, and ultimately she lost her life. Marcelas and his sisters lost their mom.

Health insurance reform is coming too late for Tiffany. But her story and the story Marcelas tells me why we need to reform health insurance.

Real people, real stories, real needs—that is why we are here now and that is why we have to get this done. When we pass this bill, Americans will be able to shop for coverage that meets their needs. For the first time, insurance companies will have to compete for our business, for the business of the American people.

When we pass this bill, we will end discrimination based on preexisting conditions and make it illegal to drop people when they get sick.

When we pass this bill, we are going to give tax credits to small businesses and help the self-employed afford care.

When we pass this bill, we are going to make preventive services free, end lifetime coverage limits, and cap out-of-pocket fees. We are going to extend the life of Medicare without cutting guaranteed benefits while shrinking the doughnut hole gap in drug coverage for our seniors.

When we pass this bill, people such as Mark and Patricia and Joseph and his wife will be helped. The memories of people such as Janet and Tiffany will be honored. That is why we need to reform the health insurance system.

I thank the more than 10,000 people in my home State of Washington who sent me their personal health care stories. Their input has helped guide me as I worked on this bill and served as a constant and welcome reminder about who I am here to represent.

I urge my colleagues to stand with these families and with the families of the small business owners in their States and across the country who desperately need this reform.

Health insurance reform has been a long time coming. But today we stand closer than ever to making it a reality.

I yield the floor.

Mr. BAUCUS. Mr. President, I yield 18 minutes to the Senator from Minnesota, Mr. FRANKEN.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. FRANKEN. Mr. President, we have been working on this bill for a long time, and I am proud of what we are doing here. Every Senator has had his or her chance to speak up and help make this a better bill or to make their case against the bill.

Unfortunately, it has been a bit ramorous, and I think that is too bad. There have been accusations flying back and forth. Umbrage has been taken. This place has become an umbrage factory. I even took umbrage once, and I feel badly about that. My colleagues across the aisle have taken great umbrage because we have accused them of using scare tactics.

May I point out that the title of the op-ed of my friend from Oklahoma in last Wednesday's Wall Street Journal is "The Health Bill Is Scary." Exhibit A in our case that the other side has, indeed, used scare tactics—the op-ed entitled "The Health Bill Is Scary."

Seriously, when you are talking about people's health, there is more than enough fear to go around. Instead of scaring people, we should be debating the merits of the proposal in front of us. We have heard a lot of stories. We all know our health care system is screwed up. We can all agree on that. The most important things to know about the bill are what is actually in it and will it help.

You see, this bill is too important for us to hide it from our bosses, the American people. We have a duty to let the American people know exactly what we are doing on their behalf. That is why I have been so disappointed when my friends and colleagues have said—and I actually agree with them—that Americans are confused about what is in this bill. They would not be so confused if everyone was being honest and forthright about what is in the bill.

I have heard a lot of misinformation over the last several weeks: some on the airwaves and, unfortunately, some right here on the Senate floor. Very early Monday morning, I heard a colleague on the floor say this bill is going to add \$2.5 trillion to our deficit. That is simply made up. The nonpartisan Congressional Budget Office, the official scorekeeper of Congress, said the bill reduces the debt by \$132 billion in the next 10 years. They estimate the bill lowers the debt by at least five times that amount in the following decade.

CBO is like a referee, and we all agree to let the referee make the call about what things will cost. It is completely possible we will disagree on different calls the referee makes during the game. I do not always agree with CBO. For example, I do not think they

score prevention as saving enough. I may be wrong or I may be right, but I accept the CBO score because the CBO is the ref. We would not walk away from a basketball game saying we won if the other team scored more points and just say: It is bad refereeing, we really won.

So we may not like how CBO scores certain provisions, but it is all we can go by. These are the rules of the games to which we agreed. So if you are talking on the Senate floor, you cannot just say this bill will add \$2.5 trillion to the debt when it is not at all what the CBO says.

No wonder people are confused. People who are trying to kill health reform are deliberately confusing Americans, and it is working. A recent study found that more than half of respondents to health care polls say they do not know enough about the bill to give a hard opinion. Then opponents use the fact that people are confused as a reason to draw out this process.

The American people are confused and opponents of this bill want more time to confuse them even more.

I have heard a colleague on this floor say this bill would not add one day—he said "not one day"—to the solvency of Medicare. That is simply not what the nonpartisan Chief Medicare Actuary found. This is the same Actuary who is often cited by opponents of the bill. He has determined that it keeps Medicare solvent for an extra 9 years.

Colleagues on my side are often making statements that might come under the heading of overselling, saying that for most people premiums will go down. It is true for many Americans, the out-of-pocket costs for better, more secure health insurance will go down. But it is also true that most health care premiums will continue to go up. It is just that they will go up at a slower rate than they would have if this bill were not adopted. That is a really good thing.

This bill is going to pass. So we want people to understand what is happening. We are slowing the growth and the cost of health care. I want to be crystal clear because I do not want to confuse people either. So today I am going to try to cut through all this rhetoric and tell you about what is actually in the bill and how it will affect you.

When I first spoke on this floor on health reform, I related three questions that I hear from most Minnesotans. I heard them when I was at the State fair, when I spoke with tea-partyers. I heard them in Minneapolis and St. Paul. I heard them in Willmar—all across the State—and on the Iron Range.

First, they say health care costs too much; what are we going to do about that.

Second, they ask: What am I going to do if I get sick or my spouse or one of

my kids get sick and then someone in my family has a preexisting condition and then I lose my job? How am I going to get health insurance then?

Third, they ask: If something bad happens to me, am I going to lose everything; am I going to go bankrupt?

Well, now that we are about to pass this bill, let me take each question and tell you how this will affect you; what this bill will do and what it will not do. Remember, this legislation is an important first step but not the final word.

First, what does this bill do about health care costing so much? Let's take a look at a point Dr. Atul Gawande, a Harvard physician, makes. He points out that almost half this bill comprises programs to try out different ways to lower costs and improve quality. Some have criticized this as a weakness in the bill, but I think it is a strength. Gawande makes the point that when a system is as complex as ours, there is no one-time fix. There is not one simple solution. As much as I wish it were true, the whole country probably can't be like the Mayo Clinic or HealthPartners or other insurance companies in my State or Intermountain in Utah or Geisinger in Pennsylvania. So one size may not fit all.

But these projects and pilots will generate solutions to fix the biggest problems in health care, such as paying doctors fee for service, which rewards volume and not value. For example, thanks to the efforts of MARIA CANTWELL and my colleague, AMY KLOBUCHAR, and others, for the first time ever we will include what is called the value index in the Medicare payment structure. Doctors and States that provide high-quality care at a reasonable cost will no longer be punished for that. Instead, they will be rewarded for being effective partners in their patients' care.

The bill also calls for all health insurance companies to use a single uniform standard for claims, as we do in Minnesota now, which will save our State \$60 million just this year. There are lots of ideas, and we don't know which ones yet will work the best. But the point is, all the key elements are in this bill.

One program in the bill I am particularly proud of is the Diabetes Prevention Program at CDC. I worked on these provisions with my Republican colleague, DICK LUGAR from Indiana, who is a hero of mine. The Diabetes Prevention Program is based on what we have learned in Minnesota and in Indiana—prediabetics can avoid becoming diabetic if they get access to community services such as nutritional counseling and gym memberships. These are proven to cut the risk of developing diabetes in half, so people can live healthier lives and their health care costs less. We will replicate this program across the country.

We will also guarantee routine checkups and recommended preventive care, such as colonoscopies and mammograms, are covered by all insurance plans at no cost. No copays for preventive care.

I am also happy the bill requires a minimum medical loss ratio, something I have been fighting for with Senator ROCKEFELLER. This is going to make health insurance companies put at least 85 percent of their premiums toward actual health services, not administrative costs, marketing campaigns or profits or bloated CEO salaries. Advocates have been trying to get these profit restrictions in place in many States, but it is usually too hard to fight these companies on a local level. So while I am disappointed we don't have the public option, the minimum medical loss ratio is a potent measure that will limit insurers' profits and put the brakes on skyrocketing premiums.

Diabetes prevention, minimum medical loss ratio, incentivizing value over volume—these are just a few of the innovative ways this bill will bring down costs. All the basic ingredients for success are here. Dr. John Gruber, professor of economics at MIT, agrees. He says this about our bill:

It's really hard to figure out how to bend the cost curve, but I can't think of a thing to try that they didn't try. They really make the best effort anyone has ever made. Everything is in here. I can't think of anything I'd do that they are not doing in the bill.

So when two of my colleagues said 2 days ago: There is no health care reform in this bill, well, that is confusing.

The next question I hear from Minnesotans is: What if I get sick and lose my job, what will I do?

This bill reforms the insurance markets, guaranteeing that having health insurance equals security. Some of these reforms will kick in when the bill passes, others will kick in 4 years from now.

I wish we could do everything at once, but we are making a complex set of reforms and it will take time to implement them and generate the cost savings necessary to pay for the benefits you will receive.

For the Minnesotans who can't afford the coverage they have because they are sick or have a preexisting condition, what will this bill do for them?

Well, 6 months after this bill is passed, we will get rid of all preexisting condition exclusions for kids, and young adults will be able to stay on their parents' insurance until they turn 27. That is big.

Within 90 days, families who get turned down because of preexisting conditions will have access to non-profit insurance coverage designed to cover people who can't pay for insurance on their own. These are called high-risk pools, and many States, as

well as Minnesota, have these plans in some form. The good thing is, this bill will invest \$5 billion to help people afford premiums in the high-risk pools.

In 2014, anybody who doesn't have an affordable plan through work or has been denied coverage will be able to go to a Web site and purchase coverage through a new insurance marketplace called the exchange. No one will be turned away or charged more because of their health status or because they happen to be a woman. It will let you compare plans and prices. What you pay will be based on your income. No one will pay more than 10.2 percent of their income toward premiums in the exchange. Lower income families will pay significantly less. If the coverage you are offered through your employer costs you more than 8 percent of your income, you can go to the exchange.

There are millions of people who have insurance and are worried about losing what they have; for instance, Minnesotans who work for small businesses that are squeezed by growing health care costs. Beginning in 2010, this bill will give small businesses tax credits to pay up to 35 percent of their employees' premiums.

More small businesses will be able to cover more employees more affordably. Then, in 2014, once the exchanges are up and running, small businesses can choose to go into the exchange so they can pool their risk with other small businesses.

These reforms will bring coverage to an additional 295,000 Minnesotans by 2019. There should be no confusion. This is real reform.

Lastly, Minnesotans ask me: Will I go bankrupt from health care costs? I hear from a lot of Minnesotans who have maxed out their health insurance or who are getting uncomfortably close to their annual or lifetime limits. These arbitrary limits let insurance companies off the hook and leave you holding the bill when you are sick and need help the most.

Fifty percent of personal bankruptcies in this country are due to a health care crisis. The good news is, within 6 months of passing this bill, new plans will not have lifetime limits on benefits and will stop companies from imposing annual limits on needed care. When the exchanges are operational, the use of annual limits will be banned entirely.

I would like to ban all limits on all plans, new and existing, right away. But this is an example of how we have had to compromise in order to keep the cost of the bill down so we are being fiscally responsible and not adding to the debt. I wish to be very clear on that. When this bill is fully implemented, it will give Americans access to affordable health care so they can avoid going bankrupt when they get very sick. That is very good.

There is more. We will start closing the Medicare prescription doughnut

hole in 2010. We will invest in home visits for new mothers, more loan forgiveness for primary care providers and for doctors who practice in rural areas, the Public Health Investment Fund, stronger antifraud laws, support for people with disabilities to stay out of nursing homes, and funding for community health centers.

I said at the beginning of this debate there would be amendments that make it an even better bill and there would be amendments that make it less to my liking and, therefore, a less good bill from my point of view. But I also said I would only support a bill if it makes quality health care available to tens of thousands of additional Minnesotans and tens of millions more Americans. We have all compromised on many fronts, but the bill we have before us is real reform and deserves our support.

The bill deserves our support because Minnesotans and Americans can't wait any longer. As Martin Luther King, Jr., once said: "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." We have the opportunity to express our humanity today, to make our country healthier and more secure for generations to come.

I would like to conclude by sharing a letter I received from John Goldfine in Duluth, MN. John operates a business on the shores of Lake Superior and wrote to share the requests he had received to donate money to fellow community members facing financial crises because of health care costs.

John was asked to donate to a cancer benefit for a woman who has melanoma.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. FRANKEN. I ask unanimous consent for 2 more minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FRANKEN. John was asked to donate to a cancer benefit for a woman who has melanoma, to attend a spaghetti dinner for an 11-year-old with brain cancer, a bake sale for a woman in need of a new kidney, and a pancake breakfast for a burn survivor. This is what John says:

As a business owner in Duluth, these are just a few of the requests that we have received these last few years. We have given a donation towards these fundraisers to help people pay for their medical expenses. As I travel the country and go into grocery stores, restaurants and convenience stores, I always take a minute to look at what is going on in the area. Rare is the time that I do not see a fundraiser to help someone with their health care bills and expenses. I know you know how wrong this is, but I am left wondering what some of your fellow Congressmen and Senators are thinking. Maybe they need to go home and look at some of these community bulletin boards. Every time I look at one of these I want to cry. I know how hard this battle is. I know there will be more compromises, but please do not

leave empty handed. There are so many people out there that really need some help.

I am proud I am voting for this bill to provide help for the people who need it.

I thank the Presiding Officer for the extra time, and I yield the floor.

The PRESIDING OFFICER. The deputy majority leader is recognized.

Mr. DURBIN. Mr. President, I wish to thank my colleague. That letter from his constituent is heartfelt and should be an inspiration to all of us to get this job done. We have sacrificed. This is the 24th day debating this bill. Some of these sessions have been early in the morning and late at night, but I think the time has been well spent. People have come to the floor and spoken at great length but no one more eloquently than your constituent who sent you that letter.

Come tomorrow morning, we will have the official vote—very early in the morning. I would like to say to my colleagues from West Virginia and Minnesota that we have a piece of news. A lot of what has been said on the floor has been said by others and said before, but this is a piece of news worth reporting. Our bill—the health care reform bill—has been endorsed by the American Medical Association, the largest physician organization in this country; endorsed by the American Hospital Association, the largest organization representing our hospitals; it has been endorsed by the American Association of Retired Persons, the largest senior citizens organization, which focuses intensely on the future of Medicare; and today we have received the endorsement of what is regarded by most as the most highly respected medical organization in America. If you ask most Americans whom do you respect the most, it is the nurses. You know why. Because when you are in a hospital with someone you love or in the care of a doctor, it is the nurse who is with you in those moments that make a lifetime. The nurses today have issued their formal endorsement of this health care reform bill.

The nurses today have Rose Gonzalez, director of government affairs for the American Nurses Association, who writes:

Nurses across this country have waited decades for this historic moment and the time is at hand.

Once again, the need for fundamental reform of the U.S. health care system is critical. ANA and nurses around the country are ready to work with you toward enactment of the strongest possible health care reform legislation.

For all of our critics from the other side of the aisle, the simple fact is this: The people who are on the front line of health care, the people to whom we turn every day for critical care and critical treatment of the people we love, endorse this measure. They have come out foursquare for it. I would rather have their endorsement than

any political endorsement we might find.

Now let me tell you how this is significant. This bill will change many things. Some on the other side have criticized the bill because it is too big; they want a small bill. I want a bill that is large enough to treat the problem. It is like saying to a doctor: You can give me a prescription but only give me one; I can only take one prescription at a time.

In this bill we address problems existing in our health care system that go to the heart of the challenge that faces our Nation. We have great doctors and hospitals and nurses. But we spend more than twice as much as any other nation on Earth per person for health care in some areas. Many countries spend a fraction of what we spend and get much better results.

We know the cost of health care is getting beyond us. We know a family of four with a health insurance plan now through their employer pays, on average, \$12,000 a year for premiums. Ten years ago it was \$6,000. It is projected to double again in just 8 years. People would be working to earn \$2,000 a month just to pay for health insurance. That is before you take the first penny home for your family. That is unsustainable.

The first thing we do is address affordability, start bringing down the increase in cost in health care. That is our first responsibility, and this bill does it. The second thing it does is extend the reach of health insurance protection.

As I stand here, one out of every six Americans has no health insurance. These are not lazy, shiftless people. These are people who can't afford it, who work at a place that doesn't offer it, or happen to be unemployed. At the end of the day, 60 percent of those people, 30 million, will have the protection of health insurance. That is critically important.

This bill provides protections needed by the people who have health insurance. How many times have you heard about a friend or a family member who has to fight an insurance company for the payment for critical care that the doctor has ordered, or over a prescription which the doctor believes will keep a person healthy or make that person well? Those battles are now going to tip to the side of the consumers of America. Health insurance companies will not be able to discriminate based on preexisting conditions or put caps on lifetime policies or tell kids that at age 24 they can no longer be covered by the family health care plans. All of those things are changed in this bill, giving consumers across America a fighting chance when it comes to health insurance.

Last night I met with several of my colleagues. We talked over dinner about how America is going to react to

this. It is hard enough to digest the contents of this bill, to expect the average American who has so many other concerns to digest it may be too much to ask. But I asked my staff to give me a list of the things that most Americans can expect to see, the changes they can expect to see on a timely basis—not the long-term changes where 94 percent of people have health insurance or would have a better standing to fight health insurance companies when they complain, but what will we be able to see. My staff came up with a convenient top 10 list which most of us are familiar with from late night television shows.

Within 6 months or a year after this bill is enacted into law, here are the top 10 things Americans will notice changing when they buy a new health plan: No. 1, if you own a small business you will start receiving within 6 months tax credits to help your business pay for health insurance for your employees beginning with tax year 2010. Mr. President, 144,000 small businesses in my State of Illinois will be eligible for the small business tax credit so that small businesses can afford to offer health insurance for the owners of the business and for their employees. That is No. 1—and this is all within 90 days of enactment.

No. 2, we are going to create immediate options for people who can't get health insurance today. We estimate that 8 percent of the people in my State have diabetes; 28 percent have high blood pressure, and all of them could be denied coverage because of this so-called preexisting condition. We are going to put in place high-risk pools so these people who can't buy health insurance today because of these preexisting conditions, have an option, a place to turn to, to buy health insurance. That is No. 2.

No. 3, and this is good news for every family and every parent: Within 6 months after the enactment of this bill, the parents of loved ones—3.6 million kids in my State—will sleep better knowing that whatever health insurance they have will be required to cover their child regardless of any preexisting condition. Any child under the age of 18 with a diagnosis of diabetes or a history of cancer or asthma or whatever it may be cannot be denied coverage under the family plan, within 6 months of this bill being enacted.

No. 4, you will no longer need to fear an insurance company dropping you from coverage once you get sick. It is called rescission, and it means as soon as you need the health insurance, the health insurance companies run away and say: We are not covering you anymore. Hire a lawyer and fight us if you don't like that. That comes to an end within 6 months after this bill passes.

No. 5, you will no longer need to worry if you get sick or get in an accident because you are out of town and

out of the network of hospitals and doctors your insurance policy provides. This bill ensures access to emergency care in-network and out-of-network without additional cost sharing beginning 6 months after the date of enactment.

No. 6, you will have the freedom to choose your doctor, the person you think is right for you and your family. This bill protects your choice by allowing plan members to pick any participating primary care provider and prohibit insurers from requiring prior authorization before a woman, for example, goes in for a gynecological examination.

No. 7, you will no longer fear losing your home or going bankrupt because of a bad car accident or a serious illness such as cancer. This bill, when it becomes law, will bar insurance companies from limiting lifetime benefits and severely restricting annual benefits under health insurance policy.

No. 8, this bill will require providing preventive services and immunizations without copay. Mr. President, 41 percent of the people in my State have not had a colorectal cancer screening; 22 percent of women in Illinois over the age of 50 have not had a mammogram in the past 2 years. Health insurance reform will ensure that people can access preventive services for free through the health care plans. It makes sense. It is an ounce of prevention and built into the law 6 months after it passes.

No. 9, senior citizens are going to notice the difference within 6 months. They will have access to dramatic discounts in the purchase of name-brand prescription drugs under Medicare Part D beginning July 1, 2010. Roughly 314,000 Medicare beneficiaries in Illinois hit the so-called doughnut hole, the gap in coverage. They are going to have protection. It is going to be provided by this bill.

No. 10, seniors across America will be eligible for one free wellness visit each year without charge. Think about that: the peace of mind which it brings to you and to your family to know that you have had a checkup, and the doctor said you are doing fine and takes care of a problem before it becomes major.

Those are the top 10 things to expect in the first 6 months or a year, and more to follow. This is a bill worth voting for. This is a bill which finally puts us on record as a Nation that health care is not just the privilege of the lucky and the wealthy. It is a privilege of living in this great Nation. It is a right that comes to all of us. If we truly want to enshrine that guarantee of life, let's enshrine in this bill guaranteed access to quality health care.

We have had a long debate. Those on the other side have been critical of this bill. They have never offered an alternative—not one substitute comprehensive alternative. They just can't do it,

and they won't. But we know we have the responsibility to do it.

With votes this afternoon, in just a couple of hours and again tomorrow morning, we are going to make this bill a bill that is passed by the Senate, on its way to conference with the House, and by the first of this new coming year, we will be able to offer that promise of quality care which the American people are asking for.

Madam President, I yield the floor.

The PRESIDING OFFICER (Mrs. HAGEN). The Senator from West Virginia.

Mr. ROCKEFELLER. Madam President, I thank you. I rise today to join with my colleagues, in fact, to stand very proudly with my colleagues, in support of the Senate passage of groundbreaking comprehensive health care reform. I have wanted to say that for decades. It has taken not just the better part of a year but, in fact, the better part of a generation.

The story of health care reform over the last 50 years has been one of narrow incremental change, some quite meaningful—the Children's Health Insurance Program, for example—but none truly comprehensive in the way the Americans want to have their health care.

It is a history of big ideas left unrealized for lack of political will, for lack of time—whatever—of leaders and lawmakers and the medical profession all trying boldly yet all failing badly; failing fundamentally to take away the fear of so many, the terror of living and getting sick in America today; the terror of becoming sick in a country that holds itself out as a beacon of hope, a beacon of fairness, yet denies men, women, and children access to doctors and nurses, tests and medicines that we know will prevent illness or will make them well; a country that allows people, especially low-income people, but not only low-income people, however, to suffer or watch a beloved family member suffer alone and outside the health care system—all at great cost to our national economy and our national productivity and our national sense of self-esteem but, even more importantly, to our national soul, to our moral compass, to our conscience.

Now in the final days of 2009 we have a profound opportunity to deliver on years and years of unmet promises and to begin a new decade by building a strong, new foundation for the American people, for all of them; to wit, a more secure and reliable health care system that works for virtually all Americans, where those who are uninsured finally have some place to go for health care; where those with insurance know that the coverage they count on and pay for will be there when they need it—they will know that—and where a profit-driven health insurance industry does not play mercilessly with people's lives or steal their hope so

that the health insurance company can have a very prosperous future, a very gloomy chapter in our Nation's business history.

Each of us brings to this moment shared stories about the tragic and trying personal experiences of our friends and neighbors back home. We are all motivated by this bill. We are all moved by this bill. I know that West Virginia's struggles with the health care system are not unique in America, but they are unique to me because I represent them. They are what drive me to work so hard to make things better. That never changes.

I talked about the Bord family. The Bords are two dedicated schoolteachers with health insurance through their employer whose son Samuel had leukemia and needed treatment well beyond the onerous annual insurance limits imposed upon him, without his knowledge, and, therefore, his health insurance stopped producing any care for him at all at 8 years old. What was he to know?

Samuel's parents were desperate, and they feared for the worst. When he hit his \$1 million cap on annual insurance, my office helped his parents to find some more resources, but those ran out too. So the Bords were left with two gut-wrenching suggestions: consider getting a divorce so that Samuel would qualify for Medicaid, or stop taking their other two children to the doctor and giving them health care so they could spend the money that they had been spending in part on Samuel—take it all away from the other two children to help with Samuel as best they could. When people are desperate, they try anything. The choices are all cruel.

So you get a device or you choose one child's health care needs over another's—that is not what parents want to be like. Those are the choices our Nation offered to these caring, hard-working parents with a sick child. How can that be? How can we allow that to be? The answer is, of course, that we cannot.

They did everything in their power, but this fall Samuel passed away. There are no words. It breaks my heart to think of what his parents went through, not only the pain of watching their son fight a terrible disease but also the uncertainty of paying for his treatment as best as they could and then have the coverage they counted on and paid for suddenly cease to exist.

I say to my colleagues, when do we say collectively that enough is enough? When do we finally step in and try to solve such an enormous set of problems? So much is at stake, so many people's needs and expectations are so high, and so are mine and so are yours, I say to the Presiding Officer. I know all too well that reform is not about shying away from the tough issues or the tough decisions. Reform is not about reaching perfect agreements on a

perfect piece of legislation. Reform is making things better for people, as much as you can for as long as you can, with as much money as you can possibly collect to pay for it.

There are real and serious differences of opinion among us, among our esteemed colleagues in the House of Representatives as well—the Senate, the House, there are differences. Within the Senate—one side of the aisle, the other side—there are differences. Within the Democratic Party, there are differences. We have struggled to find solutions that will make a difference, that we can afford. We have had to negotiate and compromise.

Now we vote in a few short hours. It is an extraordinary moment in history. There is nothing like it that I have ever seen. We vote, I believe, to improve access to affordable and meaningful coverage; to control runaway costs—we have to do that so the Medicare trust fund doesn't run out; and to rein in the health insurance industry's rapacious and, to me, lugubrious practices. I don't like them, and they don't like taking care of us, and they don't.

Am I disappointed that this legislation does not include a strong public option, like the one I first introduced, to keep private companies honest? Am I disappointed it does not include a sensible Medicare buy-in provision that should be a right for millions of Americans? Of course I am. Does that mean I turn my back and walk away from all of this because I didn't get everything I wanted? Of course not. I am a public official. I represent people, I represent their interests, even as they, maybe in the majority, oppose what we are doing here because they know not yet entirely what is in this bill. But when they do, they will feel differently. Am I disappointed that we were unable to expand Medicaid even more for our most vulnerable Americans? Yes, of course I am. I live in a State where, in the average hospital, 85 percent of all patients are either under Medicaid or Medicare. As my colleagues on the Finance Committee heard me say often, 50 percent of all babies born in West Virginia are born under Medicaid. That is the way it is there for the people I represent. Yes, of course I am disappointed that we do not have more, but I still believe those are among the best and right solutions in this bill for our health care system. They are the best we can do at this particular time, and it is a great deal that we are doing. It is an unavoidable fact that this bill does not do everything I had hoped for but, again, that would not justify turning my back on what the bill does achieve.

Why is it that we always seek out the negative and avoid the positive? It is because the negative is easier to talk about. It is easier to criticize than to do, than to collect people together under an umbrella.

The ultimate question cannot be what the bill does not do. It cannot end there because in so many ways what this bill does do is make good on the powerful promise of meaningful reform that millions of people have dreamt of, have prayed for, have fought for, for so long.

Passing health care reform will mean 31 million previously uninsured Americans will now get health care coverage. Excuse me, 31 million people—extraordinary. It is in the bill.

Passing health care reform will extend Medicaid so that vulnerable populations can get the health care they need.

Passing health care reform will close, almost, the doughnut hole that hurts 3.4 million seniors enrolled in the Medicare prescription drug program. Mr. President, 3.4 million seniors is a lot. So we close at least half the doughnut hole, and then we give people a bonus for this coming year. But by closing half, we are signaling that we are going to close it all. Health care now will be done each year, every year, to make things better.

Passing health care reform will mean the elimination of preexisting condition exclusions right away for our children. As soon as the exchanges are up and running, that will also apply to adults.

Passing health care reform will mean it is illegal for insurance companies to impose arbitrary limits, as they did annually on Samuel, or lifetime benefits, such as the Bord family faced so courageously.

Passing health care reform will mean insurance companies are required to spend more of their money—which comes from premiums we give them—on medical care, not fancy offices and executive salaries. They will be required to achieve a medical loss ratio of 85 to 90 percent. We shall see. They will have to prove it. We already have the numbers. We know where to go to get the numbers. Nobody has done it. So they can play in their shifty darkness and deprive people of things, take things away. People do not know where to go to complain, and they just get referred somewhere else. This will be the very first time they are held accountable—and they will be held accountable. They will be held accountable by the law, by congressional oversight, by a ferocity of attention on what health insurance has done to hurt so many people and how, now, they are going to behave in a very different manner whether they like it or whether they don't.

Passing health care reform will mean family coverage must include dependent children up to the age of 26. That is exciting. It is also immediate. But it is exciting because young people don't tend to get health insurance because they think nothing will happen to them. It actually doesn't work out like

that, and when they get hurt, somebody else has to pay. They should have their own health insurance, and so they are going to get it. They will not be outside the health care system; they will be inside the health care system.

Passing health care reform will mean protecting the Children's Health Insurance Program, or CHIP, which John Chafee and I wrote back in the mid-1990s and Ted Kennedy and ORRIN HATCH first established through the HELP Committee in 1997 in a show of bipartisanship—which, frankly, I am nostalgic for these days—which will cover more than 14 million children by the year 2013. Today, CHIP covers 7 million, but you see it has run out of its 10 years, so it has to be reauthorized. Then we add on 2 more years, and the program will keep going on and on, and children will have health insurance forever.

Passing health care reform will mean guaranteed prevention and wellness benefits for seniors so they can get the regular checkups that are so important. It is a big deal. Somebody told me once that there are about 9 million American seniors who live alone. In West Virginia, it might be on the tops of hills or it might be on some dusty plain, but they are basically alone, by themselves. They are aged, they have problems. Does anybody check in on them? Does anybody call them? Do they have a telephone? Have you eaten your food today? Do you have food? Are you OK? Did you fall down? Did you break your hip? Is there somebody to check? We have to do a lot better than that. Through this bill, we will.

Passing health care reform will mean we finally begin to get politics and lobbyists out of the business of deciding Medicare payments. That is very important for me because we can create new hope—perhaps our only hope—for keeping Medicare stable and solvent for the long term.

The list goes on and on—real, meaningful, life-changing and in some cases lifesaving new laws and new policies that will become law. Not since the creation of Medicare and Medicaid nearly 45 years ago has this body or the other body attempted to make a commitment as fundamental to our future in health care as we are doing here.

Fortunately, this commitment will not end with the passage of this legislation. We will not have to wait another 15 to 20 years to take up the cause of reform. Because of the intensity of the experience, the passion of the experience, the depth of the feeling in discussing the experience as we have talked back and forth with each other, this now becomes an annual commitment. We will be doing health care every single year until we get it exactly right. We have not gotten here by accident or by chance, and we will not get all the way across the finish line without more hard work and, hopefully, good will.

To those on the left who are disappointed in what this bill does not do—and in some cases, those folks are even calling for its demise—I implore you to reconsider, to be a part of this solution even as we keep working on others, which I promise you I will do, and I think you know that I mean what I say when I say it. To those on the right who in all these years somehow have not seen fit to accept any of the various options and ideas that are put on tables for comprehensive reform, I ask you to seek the facts, find the truth, follow the facts, follow the truth. There are legitimate disagreements between us about how best to solve the problems plaguing our health care system and hurting our people. But the status quo is unacceptable. Claims that we are rushing this process or have operated in secret are absurd. Claims that we will hurt seniors, close hospitals, take away people's choices are reckless and disingenuous.

Our work in this institution affects people's lives every single day in all the work we do for good or for ill. In public life, really, there is nothing neutral: you either do something that helps or you do something that hurts. We have a solemn responsibility to help our people in their hour of need, and that is the reason we are here. It is the only reason we are here—to achieve meaningful reform, not just in health care but in all other needs.

As somebody who has been involved in this debate from the very beginning and fought for strong reforms in the Senate Finance Committee, I know how far we have come to get here. And I, for one, am not going to allow this moment and its great promise to end in failure. The progress will be real. The greatly improved quality of life for millions of Americans will be its measure.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Madam President, I ask unanimous consent that after Senator HUTCHISON raises a point of order that the Reid substitute amendment No. 2786 is a violation of the Constitution, the point of order be set aside until after all postcloture time expires.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Texas.

Mrs. HUTCHISON. Madam President, I ask the distinguished Senator from Montana if, following the postcloture time, my point of order will be put in the queue for the votes if I ask for the yeas and nays?

Mr. BAUCUS. That is my understanding.

Mrs. HUTCHISON. Madam President, we truly are in uncharted waters. This bill has been written by the majority under a veil of secrecy. We are expected to vote on its final passage less than 2 days before families across the

country will be sitting down for holiday celebrations. Over the last weeks, my colleagues and I have spoken about some of the things we know to be problematic, ranging from unsustainable cuts to Medicare that will result in catastrophic reductions in care—make no mistake about that—to oppressive new taxes on individuals, medical devices, prescription drugs, and insurance companies that will clearly raise costs to consumers and stifle innovation, to taxes on small businesses at a time when we know our economy is on the brink. We are in a recession. We are asking businesses to hire people. Yet we are forcing burdens on them, taxes on them that would have the opposite effect. It would cause them not to take a chance to hire someone who will have the result of new mandates that go beyond all the expenses of an employee today. We have talked about that for the last 3 weeks.

Today I wish to talk about the concerns we have been able to have about 3 days to find on the constitutionality of parts of this bill. We have not had too much time to consider this. Certainly, constitutional issues will take much thought. But we do believe some of the bill's provisions do violence to our constitutional protections. Members, staff, and legal experts are scrambling by the majority's decision to draft a bill that we didn't have a chance to look at in detail because it only was released on Saturday, and we haven't had very much debate time on these legal issues.

I commend many of my colleagues for identifying one of my biggest concerns. The majority claims the commerce clause of the Constitution gives Congress the authority to adopt much of what it is we are looking at in this substitute before us. What I disagree with and what I don't think has been mentioned is, the power to regulate interstate commerce has not been the basis for a robust role in insurance regulation. Our States have the experience, the infrastructure in place to carry out this important regulatory role. In comparison, the Federal role in regulating private insurance has been limited. In fact, following the decision by Congress to exclude Federal agencies from any antitrust role in the insurance market, it is our States that have been charged with providing this regulatory oversight during the last 60 years. Yet usurping the role of the States in regulating health insurance is precisely what the substitute that has been put forward will do.

Creating a big role for the Federal Government in health care will also usurp States, rights that have been in place for over 60 years. Consider, for a moment, that the commerce clause is being suggested to allow Congress to not only regulate a channel of commerce that historically has been addressed by States but for Congress to

actually direct the American people to purchase a specific product or service. Everyone within the sound of my voice should be alarmed that Members of Congress actually believe our Constitution, which enumerates and protects our liberties and choices, can be perverted to require Americans to purchase something they may not want and may feel they do not need. Such a view is totally at odds with our Constitution. I believe strongly the individual insurance mandates in this bill are unconstitutional.

The person who has raised the point of order is also on the floor with me, Senator ENSIGN from Nevada. He is going to cover that area. It is essential we address it.

I wish to raise another area where I think we also have transgressed over the Constitution. That is the trampling of the rights of our States under the 10th amendment. I taught constitutional law. I have studied the background of the Constitution. I have looked at many facets of it. I can't say I am a constitutional scholar. I am a lawyer. I have taught this subject.

I wish to read the very clear and simple 10th amendment. The 10th amendment has made clear the following:

The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively or to the people.

That is it. The beauty of our Constitution is, it is a very limiting document. That is why it is short. Everything not specifically given to the Federal Government in the Constitution is reserved to the States or to the people. That is the beauty of our Constitution. The reason it is short is because the powers were meant to be limited. What was reserved to the Federal Government was meant to be limited because our Founders knew the government closest to the people and the people should be responsible for most of the laws of the country.

Today, in the bill we have before us, we have a State, such as my State of Texas and many States across the country, which have taken full responsibility for creating, maintaining, and providing oversight for a health insurance plan and will now have to justify changes to the terms of the insurance plan to the Federal bureaucrats.

My State of Texas has created a fully self-insured plan for State employees and for our teachers so creation, administration, and oversight will be within the realm of the State. I believe it is very important, when we look at the bill before us, to see that the States now are going to be required, similar to every insurance provider, to justify with the Federal Government changes in premiums. The States are going to have to now put forward all the background, what they are doing in their self-insured plans, and justify it before the States, apparently, will be able to go forward.

Of course, there is going to be a book written on the meaning of "justify." I can see it coming. What exactly does justify mean? I don't think we have to go that far to write the book on what justify means because this is an encroachment on the rights of the States guaranteed by the 10th amendment. Not only does it walk away from the words themselves of the 10th amendment but walks away from what the Founding Fathers intended; that is, that it is the prerogative of the States to make the laws that affect the people. Even Congress, for the last 60 years, has kept the Federal Government restrained pretty much—not completely but pretty much—from mandates and regulation of insurance plans. There are some, but it has largely been left to the States. The States have provided the infrastructure for what can be offered in a State. But here we go. In what is supposed to be the reform of our health care system, we are taking away the rights, the prerogatives of the States, and also the expertise the States have come to have put together and formed through the years. The big Federal Government takeover is going to begin.

Let me mention a 1992 case by the Supreme Court, which stated, in *New York v. United States*:

The Framers explicitly chose a Constitution that confers upon Congress the power to regulate individuals, not States.

I have asked the attorney general of Texas to use every resource at his disposal to investigate the provisions in this legislation and to challenge any unconstitutional attempt to limit the authority of Texas to carry out its regulatory responsibilities in the insurance market or to provide for the insurance needs of its employees and the teachers of Texas through the State health insurance plans. The attorney general of Texas has already said he is going to challenge the constitutionality of treating one State differently from all the other 49 and the taxation of our residents in Texas because of the exemption of the State of Nebraska from the Medicaid responsibilities that every other State is going to have. Of course, every other State will pick up the tab for this Nebraska exemption. The attorney general of Texas is on it, just like the attorney general of South Carolina and probably many more by the time we will end this day.

It is important we also stand on 10th amendment grounds for the States to be able to put forward a self-insurance plan for its employees without the permission of the Federal Government, and I feel-duty bound to question the constitutionality of this bill on 10th amendment grounds.

Therefore, Madam President, I make a constitutional point of order against the substitute amendment on the grounds that it violates the 10th

amendment of the Constitution, and I ask for the yeas and nays.

The PRESIDING OFFICER. Under the precedents and practices of the Senate, the Chair has no power or authority to pass on such a point of order. The Chair, therefore, under the precedents of the Senate, submits the question to the Senate. Is the point of order well taken?

The yeas and nays have been requested.

Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. Under the previous order, the vote on this question will occur after all postcloture time expires.

Mrs. HUTCHISON. Thank you, Madam President. That is my understanding. I very much appreciate the opportunity to bring this forward.

I think now that we are finally beginning to digest this bill, we are seeing several areas where points of order have been raised, and I hope some of these will send this bill back to the drawing board, where it belongs, to have health care reform that will do what we intended to do when we started; that is, bring down the cost of health care, make more affordable health care possible for more people in this country. If we could do that, on a bipartisan basis, I think the people of America, as they sit down for their holiday celebrations with their families, would have been well served.

I implore my colleagues to look at the points of order that will be voted on postcloture today and think about the consequences of passing this monstrous piece of legislation that is going to alter the quality of life for every individual, every family, every small business in this country.

Let's start again and do it right. Doing it fast should not be the goal. Doing it right is what we should pursue. I hope my colleagues, before we finish this process, will come back with something we can all be proud of and not something that is going to pass on a strictly partisan vote.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Madam President, I wish to first compliment the Senator from Texas on her raising a different constitutional point of order. There are several ways in which this bill violates the Constitution. I have raised a constitutional point of order, where I believe this bill violates the enumerated powers under article I, section 8 of the Constitution, as well as the fifth amendment takings clause of the Constitution.

I see the senior Senator from Utah is in the Chamber. He is going to talk about several other problematic provisions in the bill that is before us today.

This is the Constitution of the United States, which I hold in my hand. There are several other documents in here, but that is how short the Constitution of the United States is—this short, concise document that limits the powers of the Federal Government. Our Founders were afraid of a powerful central government, so they put down on paper the powers they granted to this body, the House of Representatives, and the rest of the Federal Government.

When each one of us comes to this floor, after we are elected, we raise our right hand, put our hand on the Bible, and take an oath to defend and protect the Constitution of the United States. We do not take an oath to reform health care or to do anything else that we may think is good to do. Anything on health care or any other good provision we want to enact has to fit within the limited powers that are listed within the Constitution of the United States.

That is the oath, the solemn oath, each and every Senator takes. That is what each and every one of us needs to think about when we are voting on this constitutional point of order.

I wish to make a couple points very briefly in one area where I think, on the individual mandate, this bill violates the U.S. Constitution. Nowhere, at no time, has this government, this Federal Government, ever passed a law that requires people who do nothing to engage in economic activity. In other words, if this bill passes and then you choose not to buy health insurance, this bill requires you to purchase health insurance. If you do not do that, it charges you up to 2 percent of your income. So this bill is telling you, just because you exist as a citizen of the United States, you must do something.

The United States has never, in its history, ever passed something such as this. This will dramatically expand the powers of the Federal Government, if this bill is passed, and if, God forbid, the Supreme Court upholds this piece of legislation.

I have read a lot of articles—and I submitted several of them yesterday—by constitutional scholars, who believe this bill is unconstitutional. Even folks who believe it is constitutional, some folks on the left, concede that there are legitimate arguments against the bill's constitutionality. They also recognize that there is potential that it is unconstitutional. So this is not some wild-eyed radical debate. This is a legitimate debate about what this document, this Constitution of the United States, actually means.

I am not a lawyer similar to a lot of the other Members of the Senate, but I understand the importance of a pretty plain reading of the Constitution's text.

Within the enumerated powers, and within the fifth amendment, there are

limitations on what this Congress can do. The Supreme Court has held that the interstate commerce clause, for instance—gives this body certain power to regulate commercial activity. Even activity of an individual that is intrastate in nature can be regulated if it has the potential to somehow substantially affect interstate commerce.

Unfortunately, this bill goes beyond even regulating any kind of commercial activity. It goes to regulating non-economic inactivity. It says: If you choose not to do something, we are going to regulate you and we are going to tax you if you do not behave. This is a very dangerous precedent for the Congress to set. I made the point yesterday; others have made this point—if we could just require citizens to purchase certain things, why did we need a cash-for-clunkers bill? The reality is we lack the power to just tell people: Go out and buy a car.

The government is allowed to provide certain incentives for people to do activity that maybe they were not going to do. But Congress does not have the power to actually tell citizens what to do, in that case, to regulate inactivity.

There are all kinds of things this government could tell people what to do if something such as this precedent is upheld today. This is incredibly dangerous, and the people of America need to wake up and the people who are voting for this bill need to analyze the unintended consequences and the massive expansion of power this bill will provide for, if this bill passes, and if the Supreme Court does not strike it down.

I am going to yield because I have listened to the senior Senator from Utah talk eloquently about the provisions that are unconstitutional. He is much more of a constitutional scholar than I would ever dream to be. I hope everybody pays close attention to what he is saying and thinks about that oath each one of us made when we raised our right hand to defend and uphold the Constitution. Are we doing that if we vote for this bill?

I yield the floor.

THE PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Madam President, I thank my gracious colleague, and I am grateful for his kind words.

Each Member of this body has taken an oath to support and defend the Constitution of the United States. Not any Constitution, not their own personal Constitution, not a fake or pretend Constitution, but the real Constitution of the United States. That means that there will come times when politics says yes, but the Constitution says no. There will come times when the grand plans and good intentions of politicians meet the limits of the Constitution. I submit that this is one of those times, and the constitutional point of order raised by the Senator from Nevada presents each of us with the choice of

whether politics or the Constitution will win the day. I choose the Constitution and will vote to support the point of order.

America's founders gave us a written Constitution that delegates certain powers to the Federal Government, separates those powers among three branches, and enumerates the powers given to Congress. They did all of that writing, delegating, separating, and enumerating for one overriding reason, to set limits on Federal Government power because liberty cannot survive without such limits. As Justice Sandra Day O'Connor reaffirmed in 1991 when writing the Supreme Court's opinion in *Gregory v. Ashcroft*, our system of federalism and the separation of powers "was adopted by the Framers to ensure the protection of our fundamental liberties." Liberty requires limits on government power, it always has and it always will. The question for us today is whether liberty is still more important than power.

The Members of this body have our own, independent responsibility to ensure that the actions we take are consistent with the Constitution we have sworn to support and defend. We cannot simply assume that the Constitution necessarily allows us to do whatever we may want to do. And we cannot ignore this question by simply punting it to the courts. Litigation is likely, to be sure, which means that the courts will be asked to decide certain legal questions, including whether this legislation is constitutional. Judges also take an oath to support and defend the Constitution and must exercise the powers it grants to them. Speculating about how courts may decide a hypothetical case in the future, however, is no substitute for Senators making a decision about an actual piece of legislation today.

The Constitution cannot limit government if government controls the Constitution. If the Constitution means whatever we want it to mean, then we might as well take an oath to support and defend ourselves. Frankly, that is what it seems like we do sometimes. But we cannot take the power the Constitution provides without the limits the Constitution sets.

Turning to the legislation before us, we all want to see a higher percentage of Americans covered by health insurance. That is a desirable goal, but my friends on the other side of the aisle would achieve that goal with a very blunt instrument, an order that Americans purchase health insurance. That is a means that the Constitution does not permit. While the Constitution gives Congress power to regulate interstate commerce, that power does not mean anything and everything we want to mean. Those words are not infinitely malleable. I agree with the 75 percent of Americans who say that this mandate to purchase health insurance is

unconstitutional because Congress's power to regulate interstate commerce does not include telling Americans what they must buy.

When President Franklin D. Roosevelt chose Frances Perkins as his Secretary of Labor, they discussed social policy legislation including health insurance. As Secretary Perkins later described it, they agreed that such legislation would pose "very severe constitutional problems," including fundamentally altering Federal-State relationships. That is why the Social Security Act uses the payroll tax. Even the Roosevelt administration, which oversaw the most dramatic expansion of federal power in our Nation's history, would not go as far as the legislation before us today would go. Even they knew that the Constitution put certain means off limits.

The goal of raising the percentage of Americans with health insurance could be achieved by constitutionally permissible means. My friends on the other side of the aisle know as well as I do, however, that those means are politically impossible. And so they have chosen politics over the Constitution, and that is why I will support the constitutional point of order.

In 1995, the Supreme Court reaffirmed that there are indeed limits on the means Congress may use to achieve its goals. The Court rejected a version of the power to regulate interstate commerce that would make it hard to imagine any activity by individuals that Congress could not regulate. The legislation before us would not only regulate economic transactions in which individuals choose to engage, it would require that they engage in those transactions. This is the first time that Congress has ever ordered Americans to use their own money to purchase a particular good or service. Crossing that line would do exactly what the Supreme Court said we may not do, and would virtually eliminate whatever limits remain on federal government power. That would deprive the Constitution not only of its meaning, but of its function as a guardian of liberty. I urge my colleagues to put the Constitution ahead of politics and support this point of order.

There is a lot of talk from the majority about why passing this bill is the right thing to do for the American people. It is a decision of conscience for them. Well, let us take a closer look at these decisions of conscience.

After weeks of closed-door, clandestine negotiations, Senator REID finally emerged with a 383-page Christmas list. This bill is a dark example of everything that is wrong with Washington today. Despite all the promises of accountability and transparency, this bill is a grab bag of Chicago-style, backroom buyoffs. It is nothing more than a private game of "Let's Make A Deal" with the special interest groups financed by American taxpayers.

So who won and who lost in this game? Well, let's take a closer look. The AARP issued a strong statement of support for this bill. The Reid bill slashes Medicare by almost a \$½ trillion to finance additional government spending. So why would the Nation's largest lobbying organization, avowed to protect the interests of seniors, support this legislation? To find the answer, similar to anything else in Washington, follow the money.

AARP takes in more than half its \$1.1 billion budget in royalty fees from health insurers and other vendors. The sale of supplementary Medicare policies, called Medigap plans, make up a major share of this \$1.1 billion royalty revenue. AARP has a direct interest in selling more Medigap plans. However, there is a strong competitor to Medigap policies, and that happens to be the Medicare Advantage plans.

These private plans provide comprehensive coverage, including vision and dental care, at lower premiums for nearly 11 million seniors across the country. Seniors enrolled in Medicare Advantage do not need Medigap policies. So what happens when the Reid bill slashes this program by almost \$120 billion? That is with a "b."

Look at the Washington Post front-page story from October 27, questioning whether AARP has a conflict of interest. I quote:

Democratic proposals to slash reimbursements for . . . Medicare Advantage are widely expected to drive up demand for private Medigap policies like the ones offered by AARP, according to health-care experts, legislative aides and documents.

One of the most disturbing developments in the Reid bill has been the perpetuation and even the doubling of the unconstitutional mandate tax from \$8 billion to \$15 billion. You heard me right. This unconstitutional mandate tax actually doubled behind closed doors. I have long argued that forcing Americans to either buy a Washington-defined level of coverage or face a tax penalty collected through the Internal Revenue Service is highly unconstitutional.

We hear a lot of rhetoric from the other side about Republicans defending the big, evil insurance companies while they are the defenders of American families. The insurance mandate is a clear example of this partisan hypocrisy. Let me ask one simple question. Who would benefit the most from this unprecedented, unconstitutional mandate to purchase insurance or face a stiff penalty enforced by our friends at the Internal Revenue Service?

The answer is pretty simple. There are two clear winners under this draconian policy—and neither is the American family. The first winner is the Federal Government, which could easily use this authority to increase the penalty—or impose similar ones—to create new streams of revenue to fund more out-of-control spending.

Second, the insurance companies are the most direct winners under this individual insurance mandate because it would force millions of Americans who would not otherwise do so to become their customers. I cannot think of a bigger giveaway for insurance companies than the Federal Government ordering Americans to buy their insurance products. If you do not believe me, then just look at the stock prices of the insurance companies that have recently shot to their 52-week highs.

Jane Hamsher, the publisher of the very liberal blog Firedoglake, said the following in a recent posting:

Having to pay 2 percent of their income in annual fines for refusing to comply with the IRS acting as the collection agency just might wind up being the most widely hated legislation of the decade. Barack Obama just might achieve the bipartisan unity on health care he always wanted—Democrats and Republicans are coming together to say "kill this bill."

Now that we clearly understand the huge windfalls the Reid bill provides AARP and insurance companies, let me take a moment to talk about the winners and losers in the so-called abortion compromise.

The language to prevent taxpayer dollars from being used to fund abortions is completely unacceptable. The new abortion provisions are significantly weaker than the amendment I introduced with Senator BEN NELSON to ensure that the Hyde amendment, which prohibits use of Federal dollars for elective abortions, applies to any new Federal health programs created in this bill. The Hyde amendment has been public law since 1976.

The so-called abortion compromise does not stop there. The Reid bill creates a State opt-out charade. However, this provision does nothing about one State's tax dollars paying for abortions in other States. Tax dollars from Nebraska can pay for abortions in California or New York.

This bill also creates a new public option run by the Office of Personnel Management that will, for the first time, create a federally funded and managed plan that will cover elective abortions.

When you have Senator BOXER, the distinguished Senator from California, and Speaker PELOSI, the distinguished Speaker of the House of Representatives—two of the largest pro-abortion advocates in the Congress—supporting this sham so-called compromise and everyone from the U.S. Conference of Catholic Bishops to the National Right to Life Committee and the Family Research Council opposing it, there is only one clear loser, and that is the majority of Americans who believe in the sanctity of life and oppose the use of Federal dollars for elective abortions.

Last, but not least, I wish to spend a couple of minutes talking about the numerous special deals conferred on States in this \$2.5 trillion spending bill.

How hefty are the price tags for decisions of conscience? Here are some highlights: \$300 million for Louisiana, \$600 million for Vermont, \$500 million for Massachusetts, \$100 million for Nebraska, and that is just the beginning.

At a recent news conference, when the authors of this legislation were asked about the Nebraska earmark for Medicaid funding, the majority leader simply replied:

A number of States are treated differently than other States. That's what legislation is all about. That's compromise.

The next logical question is pretty straightforward: Who will pay for these special deals? The answer is simple: Every other State in the Union will pay for these special deals, including my home State of Utah. All of these States that are collectively facing \$200 billion in deficits and are cutting jobs and educational services to survive will now pay to support these special deals.

According to the Congressional Budget Office, the Medicaid expansion in the Reid bill creates a \$26 billion unfunded mandate on our cash-strapped States.

Coincidentally, only one State avoids this unfunded mandate; that is, the State of Nebraska.

Of course, let's not forget about the biggest loser in this bill: the hard-working American taxpayer. This bill imposes over $\$1\frac{1}{2}$ trillion worth of new taxes, fees, and penalties on individuals, families, and businesses. The new fees begin in 2010, while the major coverage provisions do not start until 2014. Almost \$57 billion in new taxes are collected before any American sees the major benefits of this bill, which are largely delayed until 2014, assuming they are benefits at all.

It is also no coincidence that through the use of these budget gimmicks, the majority can claim this bill reduces our national deficit when we all know these reductions will never, ever be realized.

Based on data from the Joint Committee on Taxation, the nonpartisan congressional scorekeeper, this bill would break another one of President Obama's campaign promises by increasing taxes on 42 million individuals and families making less than \$250,000 a year. At a time when we are struggling to fight a double-digit unemployment rate, the Reid bill not only increases payroll taxes by nearly \$87 billion but also imposes \$28 billion in new taxes on employers that do not provide government-approved health plans. These new taxes will ultimately be paid by American workers in the form of reduced wages and lost jobs.

However, it is hard to say we didn't see these new taxes coming. For years now, many of us have warned that the out-of-control spending in Washington would eventually have to be repaid on the backs of American families. In this bill, the repayment comes in the form

of stifled economic growth, lost jobs, and new and increasing taxes—and they are just the first installment of what will be a long and painful extortion of taxpayers if Congress doesn't stand up and stop these terrible bills. According to a recent study of similar proposals by the Heritage Foundation, these new job-killing taxes will place approximately 5.2 million low-income workers at risk of losing their jobs or having their hours reduced and an additional 10.2 million workers would see lower wages and reduced benefits.

Poll after poll tells us about the growing opposition against this tax-and-spend health care bill. The latest Rasmussen poll shows that 55 percent of Americans are now opposed to this bill. The CNN poll is an even higher 61 percent. Among senior citizens, the group most likely to use the health care system, only 33 percent are in favor while 60 percent are opposed. Independent voters are also opposed 2 to 1. Opposition in certain State polls such as Nebraska is even higher at 67 percent.

So what is the majority doing to address these concerns? Nothing. In fact, despite the efforts by many of us here on this side of the aisle to express our substantive policy disagreements for months, one Senator recently said the following:

They are desperate to break this President. They have ardent supporters who are nearly hysterical at the very election of President Barack Obama. The birthers, the fanatics, the people running around in right-wing militia and Aryan support groups, it is unbearable to them that President Barack Obama should exist.

That statement is outrageous. It was made by a very dear friend of mine, and I know he probably didn't mean it the way it comes out, but it is outrageous.

Instead of listening to the policy concerns of a majority of Americans, the other side is simply dismissing them as rants from the far right. If the majority refuses to listen to what Americans are telling them now, I am sure they are going to have a rude wake-up call later. It should come as no surprise that this kind of arrogance and power has led to congressional approval ratings rivaling the most hated institutions on the planet at a dismal 22 percent and falling.

One of the biggest tragedies of letting this bill move forward is that it will do nothing to address the fundamental issue of rising health care costs in this country. According to the Congressional Budget Office, CBO, this bill will actually raise our national health care costs by \$200 billion. The administration's own Actuary at the Centers for Medicare and Medicaid Services, CMS, agrees with this assessment.

When this bill fails to work, Americans will no longer have anything in Congress to effectively address the issue of health care reform. The opportunity to save Medicare and Medicaid

from their impending financial collapse will be lost for another generation.

The historic blizzard in Washington earlier this month was the perfect symbol of the anger and frustration brewing in the hearts of the American people against this bill. I urge the majority once again to listen to the voices of the American people. Every vote for this bill is the 60th vote. Let me repeat that again. Every vote for this bill is the 60th vote. My Republican colleagues and I are united with the American people in our fight against this \$2.5 trillion tax-and-spend bill. I implore my colleagues not to do this to the American people. Don't foreclose on their futures. Don't stick them with even more government spending and more government intrusion.

We can fix health care. Many of us have been working to do just that for many years. A truly bipartisan bill that would garner 75 to 80 votes, which has always been the case in the past on these major pieces of legislation in the Senate, would be fiscally sound and provide the American people with the fixes they are asking for in the health care marketplace, and it would be easily achievable if we would just open our hearts and work together. Many of us are standing at the ready, and have been for months, to step forward and pass meaningful health care reform that truly would help American families and please American taxpayers. To date, we have been rebuffed by an unfailing determination by a few to pursue a nearly Socialist agenda.

I would ask my colleagues on the other side of the aisle who do not believe in the Europeanization of America, who believe in doing truly bipartisan work here in the Senate, to step forward and vote against advancing this bill and work with those of us on this side of the aisle who are committed to making a difference to craft a health care reform bill they can be proud to support.

Having said that, I do praise my colleague and friend from Montana, Senator BAUCUS, who literally did try for months in many meetings with first the Gang of 7—I was in that and then finally decided I could not support what they were going to come up with and expressed to my colleagues that I would have to in good conscience leave the negotiations. He tried, but he was too restricted in what he really could do, so that in the end no Republican supported what was done. We had a totally Democratic bill in the HELP Committee, a totally Democratic bill with the Pelosi bill in the House, and the Reid bill has been done in back rooms here with the White House, with very few even Democrats involved, and many of the things some of my friends worked so hard to get in the bill were no longer in it.

Let me just say there are good people in this body on both sides of the floor,

but I have suggested in times past and I suggest it again: If you can't get 75 or 80 votes for a bill that affects every American, that is one-sixth of the American economy, then you know that bill is a lousy bill.

There are many on our side of the aisle who have stood ready, willing, and able to try to do something in a bipartisan way. I have spent 33 years here, and I have participated in a bipartisan way to help bring both sides together on all kinds of health care bills that work. This one would work, too, if we would just work in a bipartisan way.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Madam President, I wish to make a couple of points regarding the constitutional point of order I raised on the individual mandate.

Some folks have said that States mandate car insurance, that is require people who drive to carry car insurance; therefore, the Federal Government can mandate the purchasing of health insurance to individuals. Well, I think that should be pretty obvious that States can do things that the Federal Government cannot. The Constitution limits the Federal Government as to what it can do and it reserves the power for the States and/or the people. Senator HUTCHISON raised this exact point in her constitutional point of order relating to the 10th amendment.

So this mandate of buying car insurance—comparing it to the mandate to buy health insurance from the Federal Government is a false comparison. The Federal Government cannot mandate you to buy car insurance, nor can it mandate you to buy health insurance. It is not within the enumerated powers given to this body and to this Federal Government in the Constitution.

This bill is a real threat to liberty because of the precedent it sets on the Federal Government being able to tell individuals what to do.

I wish to quote from a couple of articles that have been written. This one was written by David Rivkin and Lee Casey. I am quoting:

But Congress cannot so simply avoid the constitutional limits on its power. Taxation can favor one industry or course of action over another, but a "tax" that falls exclusively on anyone who is uninsured is a penalty beyond Congress's authority. If the rule were otherwise, Congress could evade all constitutional limits by "taxing" anyone who doesn't follow an order of any kind—whether to obtain health-care insurance [in this case] . . . or even to eat your vegetables.

It literally sets the precedent to dramatically expand the powers of the Federal Government far beyond anything our Founders wrote and limited this Congress to doing in the Constitution.

I see the Republican whip here, and I wish to yield to him because of his expertise on the Constitution.

I want to make a real quick point reading from another article. I commend this article to our colleagues by Randy Barnett and Nathaniel Stewart and Todd Gaziano. It said:

Never in the nation's history has the commerce power been used to require a person who does nothing to engage in economic activity.

There are constitutional experts out there telling us this bill is doing something the Federal Government has never done in its history. So I go back to this United States Constitution.

When we take an oath to defend the Constitution, we better take that as a solemn oath and think about whether we are violating that oath we swore to uphold and defend when we are voting on this bill.

You must uphold this constitutional point of order. It is not just up to the Supreme Court; it is up to us. We don't just say we will pass anything, whether it is constitutional or not, and let the Supreme Court decide. That is the oath we take. It is our responsibility to uphold and defend the Constitution. We must think about that when we are passing something here. That is the reason we have this authority to bring a constitutional point of order, so that this body considers whether it is constitutional. That is why we must consider the consequences of greatly expanding the powers of the Federal Government in this bill, which are so dramatic that the threat to liberty is very real.

I yield the floor to the Republican whip so he can make some comments.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. KYL. Madam President, I compliment my colleague who has raised a most important constitutional point. It is true, as Senators, we have an obligation not just to throw questions to the Supreme Court but to use our best judgment as to whether we would be violating the Constitution by adopting them.

I think the point of order he raises with respect to the 10th amendment is a very important question and should be carefully considered by our colleagues. I think you can only come to one conclusion. I support what he is trying to do.

I also want to make another point, which is that around the country people are calling in and raising questions about other aspects of the bill, also raising similar questions—the imposition of a supermajority rule, for example. Can one Congress bind another in that regard? We are only now learning of all of these things, and our constituents are only learning of them because the most recent amendment was filed just a few days ago.

As we read through it and begin to realize its implications, a lot of questions are being raised. The question I want to raise today goes right to the

heart of the claim that supporters have made for this legislation; that is, that it reduces the Federal budget deficit. Many colleagues on the other side of the aisle have said: I could not vote for this bill if it did not reduce the Federal budget deficit, or at least if it were not deficit neutral.

It turns out that from information received today from the CBO, it is not deficit neutral. In fact, it adds at least \$170 billion to the deficit, which, of course, is very important since tomorrow we are going to be asked to increase the temporary debt ceiling. This legislation will add to our Federal debt, not make the situation better, as many of our colleagues have claimed.

I will describe why that is so. I heard another colleague on the other side on a talk show this morning say that we are going to extend the fiscal life of Medicare by 9 years. That is a claim that directly conflicts with the claim that the bill is budget neutral.

What both the CMS Actuary and the CBO have now said is, no; both are not true. There is only one sum of money. You can either extend the life of Medicare with that money, or you can buy a new entitlement under the bill with that money. But you cannot do both.

So if that money is spent on the new entitlement, for example, it cannot extend the life of Medicare. It cannot show a budget surplus of \$130 billion.

In effect, they are saying you can't sell the same pony twice. Here is exactly what the Congressional Budget Office had to say about it this morning. Incidentally, we were tipped off to this by a comment that was in the body of a letter from the CMS Actuary last week, or December 10, and as we read through it and tried to analyze the new amendment that was just filed, it became clear that, in effect, that is precisely what is being done by the other side.

I am not suggesting duplicity. What I am suggesting is that they, too, have been misled by the arcane accounting language, and until it became crystal clear with the language today, I can understand why there would be confusion—but no longer. You cannot vote for this bill this afternoon and claim not to have known that it both buys an extension of the trust fund for Medicare and claims to buy a surplus of \$130 billion.

Here is what the CBO says today, December 23, which is posted on their Web site:

The key point is that the savings to the HI trust fund under this bill would be received by the government only once, so they cannot be set aside to pay for future Medicare spending and at the same time pay for current spending on other parts of the legislation.

In other words, the new entitlements that are allegedly paid for under the bill. Here is the last sentence:

To describe the full amount of the HI trust fund savings as both improving the government's ability to pay future Medicare benefits and financing new spending outside of Medicare would essentially double-count a large share of those savings and thus overstate the improvement in the government's fiscal position.

It would essentially double-count the money. That is the point Senator GREGG and Senator SESSIONS and I tried to make earlier this morning.

This is new information, I grant you. But it is an illustration of why we should not try to force this bill to a vote before Christmas, when we haven't tried to figure out what this all means and the American people haven't had an opportunity to react to it.

I quoted to you from the CBO, the nonpartisan office that tells us what the fiscal impact is. Here is what tipped us off: Richard Foster, the CMS Chief Actuary, had sent a letter. This phrase caught our attention. He said:

In practice, the improved part A financing cannot be simultaneously used to finance other Federal outlays, such as the coverage expansion under this bill and to extend the trust fund. Despite the appearance of this result from the respective accounting conventions.

Despite the fact, in other words, that it appears you can do both because of the way the government accounting is, it is only one pot of money. You cannot use it to extend the life of Medicare on one hand and buy new entitlements and show a budget surplus on the other.

This is what happens when you try to rush a bill through like this too quickly. Many colleagues on the other side of the aisle have said: I will not vote for a bill that is not budget neutral or creates a budget deficit. Then they cannot vote for this legislation now that CBO has said what it has said. Some of them won't realize that. That is why I came to the floor.

I compliment Senator SESSIONS for talking to the Director of the Budget Office last night and confirming this, asking him if he would put it in writing, which he did.

I think this is a game changer, my friends. If, now that you have this knowledge, you still go forward and vote for the legislation, those of you who have made the pledge not to do so will be violating that pledge. You can't use the same pot of money to do two separate things, as the CBO said. They describe it this way: You can't do both of these things. You would essentially double-count a large share of that savings and thus overstate the situation.

Mr. SESSIONS. Will the Senator yield for a question?

Mr. KYL. Yes.

Mr. SESSIONS. The earlier statement from CBO was that the legislation would result in reducing the deficit by \$132 billion, which was cited several times. Well, that was obviously

before the statement that was issued today. In boiling it down—and the Senator is an accomplished lawyer—doesn't this say there is a misimpression created by that previous statement and that this statement today clarifies it, making absolutely clear that it is not creating a surplus or reducing the debt but, in fact, increasing the debt?

Mr. KYL. Madam President, that is exactly right. The title of the document is "Effects of the Patient Protection and Affordable Care Act on the Federal Budget and the Balance in the Hospital Insurance Trust Fund." He starts out by saying CBO has been—

Mr. BAUCUS. Will the Senator yield for a question?

Mr. KYL. Madam President, I will be happy to in a moment. I ask unanimous consent that the CMS report, dated December 10, be printed in the RECORD following the colloquy so that people can follow what we have done.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

DEPARTMENT OF HEALTH & HUMAN
SERVICES, CENTERS FOR MEDICARE
& MEDICAID SERVICES,
Security Boulevard, Baltimore, MD.
OFFICE OF THE ACTUARY

Date: December 10, 2009.

From: Richard S. Foster, F.S.A., *Chief Actuary.*

Subject: Estimated Effects of the "Patient Protection and Affordable Care Act" on the Year of Exhaustion for the Part A Trust Fund, Part B Premiums, and Part A and Part B Coinsurance Amounts.

In addition to proposals to expand health insurance coverage, the "Patient Protection and Affordable Care Act of 2009" (PPACA) includes numerous provisions that would reduce Medicare costs and one that would increase the Hospital Insurance payroll tax rate for high-income individuals and families. This memorandum describes the estimated impacts of the PPACA, as proposed by Senate Majority Leader Harry Reid on November 18, 2009, on the date of exhaustion for the Medicare Hospital Insurance (Part A) trust fund, on Part B beneficiary premiums, and on the average level of Part A and Part B beneficiary coinsurance.

We estimate that the aggregate net savings to the Part A trust fund under the PPACA would postpone the exhaustion of trust fund assets by 9 years—that is, from 2017 under current law to 2026 under the proposed legislation.

The combination of lower Part A costs and higher tax revenues results in a lower Federal deficit based on budget accounting rules. However, trust fund accounting considers the same lower expenditures and additional revenues as extending the exhaustion date of the Part A trust fund. In practice, the improved Part A financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions under the PPACA) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions.

The estimated postponement of asset exhaustion for the Part A trust fund does not reflect the relatively small impact on HI payroll taxes due to economic effects of the legislation or the small increase in adminis-

trative expenses under the legislation. As noted in our December 10, 2009 memorandum on the estimated financial and other effects of the PPACA, reductions in Medicare payment updates to Part A providers, based on economy-wide productivity gains, are unlikely to be sustainable on a permanent annual basis. If such reductions were to prove unworkable within the period 2010–2026, then the actual HI savings from these provisions would be less than estimated, and the postponement in the trust fund exhaustion date would be reduced.

The Medicare expenditure reductions under the PPACA would also affect the level of Part B premiums paid by enrollees and the Part A and Part B beneficiary coinsurance amounts. The following table presents these estimated impacts:

CY	Part B Premium Impact (change in monthly premium amount)	Coinsurance Impact (change in yearly per capita amount)	
		Part A	Part B
2010	\$0.00	\$0	\$90
2011	1.80	–1	22
2012	–3.10	–4	–37
2013	–4.60	–8	–55
2014	–5.30	–13	–64
2015	–7.20	–18	–86
2016	–9.00	–23	–108
2017	–10.80	–28	–129
2018	–12.50	–34	–151

As indicated, Part B premiums and average coinsurance payments would initially increase, reflecting higher overall Part B costs under the PPACA in 2010 as a result of the provision to postpone the 21.3-percent reduction in physician payment rates that would be required for 2010 under current law. Thereafter, there would be steadily increasing savings to Part B and associated reductions in the Part B premium and coinsurance averages. Similarly, the Part A savings under the PPACA would result in lower beneficiary coinsurance payments for inpatient hospital and skilled nursing care. As before, all of these results are conditional on the continued application of the productivity adjustments to the Medicare "market basket" payment updates.

Expenditure reductions under Part B translate directly to lower financing requirements from general revenues and beneficiary premiums, since financing is re-established annually to match program costs. Thus, in the case of Part B, the savings under the PPACA are not needed to help pay for future Part B benefit costs, and the full reduction in Federal general revenues attributable to such savings can be used to offset other Federal costs, such as those arising under the PPACA coverage expansions.

Mr. KYL. I am now happy to yield.

Mr. BAUCUS. I ask my good friend from Arizona, is it not true that the last statement from CBO, on the degree to which the underlying legislation does or does not reduce the deficit, stated that the legislation reduces the deficit by \$132 billion—that is the last statement after addressing the deficit—and also stating that at the end of the decade, the deficit will be reduced between \$630 billion and \$1.3 trillion? Isn't that the last statement from CBO addressing the question on whether this legislation reduces or increases the deficit. Isn't that true?

Mr. KYL. Madam President, I don't know the document that my friend is referring to as "the last document." I

think that document, dated December 23, today, is the last document.

Mr. BAUCUS. This is from a day or two ago. It is the CBO letter commenting on the modification.

Mr. KYL. I don't know. I am not aware of that. My point is this: The document released today, in order to clarify the situation again, said the key point is that you can't do both. The government only gets the money once. Therefore, they say, to describe the full amount as both providing a savings to Medicare and providing a surplus essentially double-counts the money and thus overstates the improvement in the government's position.

Mr. BAUCUS. Will the Senator further yield?

Mr. KYL. I will not yield now. I have a unanimous consent request.

I ask unanimous consent that a Washington Post op-ed by Michael Gerson, dated December 23, be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Washington Post, Dec. 23, 2009]

FOR SALE: ONE SENATOR (D-NEB.); NO PRINCIPLES, LOW PRICE

(By Michael Gerson)

Sometimes there is a fine ethical line between legislative maneuvering and bribery. At other times, that line is crossed by a speeding, honking tractor-trailer, with outlines of shapely women on mud flaps bouncing as it rumbles past.

Such was the case in the final hours of Senate Majority Leader Harry Reid's successful attempt to get cloture on health-care reform. Sen. Ben Nelson of Nebraska, the last Democratic holdout, was offered and accepted a permanent exemption from his state's share of Medicaid expansion, amounting to \$100 million over 10 years.

Afterward, Reid was unapologetic. "You'll find," he said, "a number of states that are treated differently than other states. That's what legislating is all about."

But legislating, presumably, is also about giving public reasons for the expenditure of public funds. Are Cornhuskers particularly sickly and fragile? Is there a malaria outbreak in Grand Island? Ebola detected in Lincoln?

Reid didn't even attempt to offer a reason why Medicaid in Nebraska should be treated differently from, say, Medicaid across the Missouri River in Iowa. The majority leader bought a vote with someone else's money. Does this conclusion sound harsh? Listen to Sen. Lindsey Graham of South Carolina, who accused the Senate leadership and the administration of "backroom deals that amount to bribes" and "seedy Chicago politics" that "personifies the worst of Washington."

This special deal for Nebraska raises an immediate question: Why doesn't every Democratic senator demand the same treatment for his or her state? Eventually, they will. After the Nelson deal was announced, Sen. Tom Harkin of Iowa enthused, "When you look at it, I thought well, God, good, it is going to be the impetus for all the states to stay at 100 percent (coverage by the federal government). So he might have done all of us a favor." In a single concession, Reid

undermined the theory of Medicaid—designed as a shared burden between states and the federal government—and added to future federal deficits.

Unless this little sweetener is stripped from the final bill by a House-Senate conference committee in January, which would leave Nelson with a choice. He could enrage his party by blocking health reform for the sake of \$100 million—making the narrowness of his interests clear to everyone. Or he could give in—looking not only venal but also foolish.

How did Nelson gain such leverage in the legislative process in the first place? Because many assumed that his objections to abortion coverage in the health bill were serious—not a cover, but a conviction. Even though Nelson, a rare pro-life Democrat, joked in an interview that he might be considered a "cheap date," Republican leadership staffers in the Senate thought he might insist on language in the health-care bill preventing public funds from going to insurance plans that cover abortion on demand, as Democratic Rep. Bart Stupak had done in the House.

Instead, Nelson caved. The "compromise" he accepted allows states to prohibit the coverage of elective abortions in their insurance exchanges. Which means that Nebraska taxpayers may not be forced to subsidize insurance plans that cover abortions in Nebraska. But they will certainly be required to subsidize such plans in California, New York and many other states.

In the end, Nelson not only surrendered his beliefs, he also betrayed the principle of the Hyde Amendment, which since 1976 has prevented the coverage of elective abortion in federally funded insurance. Nelson not only violated his pro-life convictions, he also may force millions of Americans to violate theirs as well.

I can respect those who are pro-life out of conviction and those who are pro-choice out of conviction. It is more difficult to respect politicians willing to use their deepest beliefs—and the deepest beliefs of others—as bargaining chips.

In a single evening, Nelson managed to undermine the logic of Medicaid, abandon three decades of protections under the Hyde Amendment and increase the public stock of cynicism. For what? For the sake of legislation that greatly expands a health entitlement without reforming the health system; that siphons hundreds of billions of dollars out of Medicare instead of using that money to reform Medicare; that imposes seven taxes on Americans making less than \$250,000 a year, in direct violation of a presidential pledge; that employs Enron-style accounting methods to inflate future cost savings; that pretends to tame the insurance companies while making insurance companies the largest beneficiaries of reform.

And, yes, for \$100 million. It is the cheap date equivalent of Taco Bell.

Mr. SESSIONS. The leader's time is up at 6 minutes after the hour; is that correct?

The PRESIDING OFFICER. The Republican leader has 6½ minutes reserved.

Mr. SESSIONS. I ask Senator KYL this: The CBO report this morning essentially says you cannot count the same money twice; correct?

Mr. KYL. Madam President, it doesn't say you cannot. It just says that is what would happen if you attempted to apply the money both to

the trust fund and to the additional spending. It says it "would essentially double count and thus overstate."

What I am saying is that it doesn't say you can't do it, but they are saying you only have one pot of money to pay for two things and, obviously, you cannot do that and be honest about the accounting. That is my interpretation of what it says.

Mr. SESSIONS. I think that is correct. The Senator may not know this. I understand that at the request of our Democratic colleagues, they have returned to CBO and gotten another statement this morning, perhaps so they can continue to make the argument that somehow this creates a surplus. But staff having examined that, I am informed that it in no way refutes this morning's statement that this cannot simultaneously fund a new program and strengthen Medicare at the same time.

I think it is a matter, will Senator KYL not agree—I am not afraid to talk about it—if we need to slow down before we vote, so be it. First of all, is the Senator convinced, as Senator GREGG indicated this morning and CBO does, that we are, in fact, passing a bill that would, if it passes, add to the debt approximately \$170 billion, as staff has calculated based on this letter, and would not reduce the debt by \$132 billion?

Mr. KYL. Mr. President, I am absolutely convinced of that, yes.

Mr. SESSIONS. I do not think there is any dispute about it. I think that is the fact. It has been exposed. The President looked us in the eye in a joint session of Congress, did he not, and said this legislation would not add one dime or one dollar to the debt of the United States?

Mr. KYL. Mr. President, it is my recollection that is pretty close to what the President said. I guess maybe this would not be such a big deal unless you are trying to do two things with the same pot of money. As long as the other side is also claiming we are actually extending the life of Medicare, which I heard one of my colleagues do on television this morning, then you cannot make this other claim. You can claim one or the other but you cannot claim both. That is precisely what the head of CBO said:

To describe the full amount of HI trust fund savings as both improving the government's ability to pay future Medicare benefits and financing new spending outside of Medicare would essentially double-count a large share of those savings and thus overstate the improvement in the government's fiscal position.

Mr. SESSIONS. To follow up on that, is it not true—and President Obama Monday flatly stated in one press conference that it would reduce our deficit over 10 years by \$130 billion and extend the Medicare Program by 9 years, which is patently false, it would appear. I am not sure he understood the

complexities of all this accounting, but, in fact, I think he misspoke at that point. Would the Senator from Arizona not agree?

Mr. KYL. Mr. President, I obviously cannot get into the President's mind, but I must say that all of us had missed this point. I said before I ascribe no ill will to anybody on the other side. This is hard to understand. Accounting can be arcane. That is why this statement from the CMS was a little troubling to us when we first read it. They said:

Despite the appearance of this result from the respective accounting conventions—

Which is a fancy way of saying accountants have their way of showing things and that might have confused you—

in practice, improved party financing cannot be simultaneously used to finance other Federal outlays.

You cannot use the same pot of money of \$10 to buy two different \$10 benefits. You can buy one or the other or half of each, but you cannot buy both. As the old saying goes, you cannot sell the same pony twice.

Mr. SESSIONS. It said, did it not, in that CMS letter that was a fact “despite the appearance of this result from the respective accounting conventions”? Were they not warning us that it might appear this way but it cannot be that way?

Mr. KYL. Mr. President, our colleague Senator GREGG, a respected member of the Budget Committee, pointed out this morning why that is so, and my colleague from Alabama can do that as well.

There are two different systems of accounting by two different parts of the government. The only way they can do this is by sending an IOU back to the Social Security trust fund, but, of course, the IOU comes out of the pocket of the taxpayers where we have to borrow it and it is still an obligation even though it shows up on accounting books as obligation satisfied.

Mr. BAUCUS. Will the Senator yield for a simple question?

Mr. KYL. Sure.

Mr. BAUCUS. I wonder if the Senator is aware that CBO this morning at 9:57 sent an e-mail to all relevant staff that its estimates with regard to budget deficit reduction still stand, still hold. CBO still estimates this legislation results in a \$132 billion deficit reduction. That was an e-mail sent today. Is the Senator aware of that e-mail?

Mr. KYL. I did not see that e-mail. I assume that is the same communicate about which the Senator from Alabama is talking. It shows you exactly why this is so confusing and why I am a little bit concerned about the politicization of the CBO.

Last night and again this morning, we have a memo that says you cannot pay twice. If after that he says I still show that as a surplus, then what he has to also be saying is, and therefore

it does not extend the life of the Social Security trust fund. As I said, you can do one or the other, or roughly half of each, but you cannot do both. If he is choosing to say it is applied to one, then our colleagues cannot continue to say that it applies to the other.

Mr. President, Americans' biggest complaint about the current healthcare system is the increasing cost of health insurance premiums.

President Obama promised that his healthcare reform bill would address this problem. As he said during his campaign, “I have made a solemn pledge that I will sign a universal healthcare bill into law . . . that will . . . cut the cost of a typical family's premium by up to \$2,500 a year.”

By the President's own yardstick, this bill is a failure, since it actually increases premiums for many Americans and fails to restrain growths for the rest.”

Recently, the nonpartisan Congressional Budget Office (CBO) concluded that, under this bill, those in the individual market—that is, those without employer-sponsored insurance—will face premium increases between 10 and 13 percent. That's approximately \$2,100 per family by 2016.

A second study, from the actuarial firm Oliver Wyman, also concluded premiums will rise under this legislation, thanks to burdensome new Federal mandates and requirements and several new taxes.

In the individual market, this study predicts, premiums will rise by \$3,300 per year for family coverage and \$1,500 for individuals. In my home State of Arizona premiums could rise by as much as 72 percent in the individual market.

This study also tells us that the small group market would see premium increases. Small employers purchasing new policies in the reformed market would experience premiums up to 20 percent higher in 2019 than they would under current law.

Oliver Wyman also estimates that, if this bill is enacted, 2.9 million fewer Americans would have insurance through small-employer policies.

So what this bill does is raise the cost of insurance for many Americans and then force everyone to buy a policy—and not just any policy, one that is been approved by Washington!

Our friends on the other side of the aisle argue that many families will receive government subsidies to help with the increased cost of insurance brought on by new mandates, taxes, and Federal requirements.

There are a few problems with this argument.

First, not every family will qualify for such subsidies. Indeed, 14 million Americans who buy their own coverage would earn too much to get a subsidy, according to the Congressional Budget Office.

So 14 million Americans will be required, by Washington, to purchase unsubsidized insurance that is more expensive than they could get under current law. And this is being called reform?

Second, those who do receive a subsidy may find the subsidy does not begin to cover the total cost of the increase. So, those families, too, will actually be worse off.

And, finally, the heart of this debate is a basic question: What is the point of raising the price of insurance and then subsidizing a portion of the increase? You are still raising premiums and someone has to pay for subsidies.

Americans have asked us to lower healthcare costs, not raise them and then provide subsidies to those who qualify. And they certainly don't want to pay more in taxes to subsidize their own insurance—but that is what the Democrats' bill would have them do.

As the Wall Street Journal recently editorialized, “The [Reid] bill will increase costs, but it will then disguise those costs by transferring them to taxpayers from individuals.”

Not surprisingly, small business associations, whose members would be overwhelmingly impacted by this legislation, are disappointed.

The Small Business Coalition for Affordable Healthcare, for one, opposes this bill.

Their name says it all. This organization believes, as all of us do here in the Senate, that the status quo is not acceptable and not sustainable. But they disapprove of this legislation because, as they wrote in a letter to Congress, “it costs too much and delivers too little.”

Here are just a few of the dozens of businesses represented by this organization: The Americans Hotel and Lodging Association; American Bakers Association; the Independent Electrical Contractors; the National Association of Convenience Stores; the National Automobile Dealers Association; Printing Industries of America; the Society of American Florists. The list goes on and on.

These businesses wrote a letter to Congress expressing disapproval of the bill's huge costs and failure to bring down premiums, among other provisions that hurt small businesses. They believe that increased premiums have a domino effect, hurting both the employer and the employee, resulting in fewer jobs, depressed wages, and fewer choices.

I will share some excerpts from their letter, with regard to increased premiums and costs:

They write:

The bill does little to make insurance more affordable and the [small business] tax credit is so limited, few will be able to obtain affordable insurance.

They go on:

The impact on non-group premiums is . . . devastating, as they are expected to increase

an average of 10–13 percent per person. Those estimates, in addition to the financing provisions in the bill, slam the “savings” door shut.

Another organization, the National Federation of Independent Business, has also raised major objections to this bill with regard to increased premiums.

Here is a telling excerpt from a letter they wrote to the two Senate party leaders:

H.R. 3590 fails the small business test, and, therefore, fails small business. The most recent CBO study detailing the effect [this bill] will have on insurance premiums reinforces that, despite claims by its supporters, the bill will not deliver the widely-promised help to the small business community.

Bruce Josten of the U.S. Chamber of Commerce concurs. He recently said:

The fundamental failure of the Senate bill is its failure to address cost containment. We have a bill that raises taxes on pretty much everything that moves in the healthcare space. And successful cost containment practices that are in the marketplace, like health savings accounts or flexible spending accounts, are dramatically weakened in this . . . Healthcare cost increases are going to crowd out the compensation pool.

The majority leader recently disagreed with the notion that this bill increases costs, citing a prediction by the President's Council of Economic Advisers that the bill before us would bring down costs.

This is the same council that told us unemployment would peak at 8 percent if only Congress would pass the stimulus. As Americans know, Congress passed the stimulus, and we are now at 10 percent unemployment.

Moreover, if the Council of Economic Advisors is supposed to be the Bible of economic analysis and administration officials know best, why is it that on the same day the President's top economic advisor Larry Summers declared on *This Week*, “the recession is over,” the Council's chair, Christina Romer, told *Meet the Press* viewers that “of course” the recession is not over? So, who should we believe on costs?

I submit that small business owners and their representatives have the most intimate knowledge of which policies will benefit them and which stand to hurt them. They are telling us this bill will hurt them.

Finally, I would like to point out that this bill does not even guarantee that all Americans have insurance. This bill leaves 24 million Americans uninsured.

We are going to spend \$2.5 trillion to raise the price of insurance for millions of Americans and keep affordable insurance out of reach for millions more.

There are much better ways to give access to affordable healthcare to all Americans.

We should start with serious medical liability reform, which has been proven in Texas, Arizona, and Missouri to bring down costs for patients and doctors.

We need to allow Americans to buy insurance across State lines. This is one of the most commonsense reforms out there. Why should Americans be denied access to lower-cost policies just because they are being sold in other states?

We should also allow small businesses to band together to pool their risk and purchase insurance at the same rates large corporations get.

Enacting these simple reforms would cost little, if anything, and would be sure to bring down costs. That is the kind of reform Americans would be sure to support.

The ACTING PRESIDENT pro tempore. The Senator's time has expired. The majority leader is recognized.

Mr. REID. Mr. President, I ask unanimous consent that the Baucus motion to waive be set aside.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. REID. Mr. President, I want to take a moment to talk about the motion to table the appeal by Senator CORNYN and the ruling of the Chair that no point of order lies under rule XLIV.

Senator CORNYN's appeal is not about transparency and certainly not about disclosure. It is about delay and obstruction. That is what the whole tenor of all the Republican statements has been regarding this legislation.

The vote is whether we create a whole new point of order even though Senate rules at this stage do not allow a point of order. They want to rewrite the rules at a whim, not for purpose of disclosure and transparency but for the purpose of delay and obstruction.

The legislative history of the Honest Leadership and Government Act specifically addresses the issue of whether a point of order lies in this instance:

If rule XLIV does not expressly provide for a point of order with respect to a provision, then no point of order shall lie under the provision.

We open a Pandora's box if we reverse the ruling of the Chair on appeal. What would be the new rule? How would the new rules be implemented? What happens to the health care bill? Who decides the answers to these questions?

Moreover, if we overrule the Chair, we would be setting a dangerous precedent that points of order lie even if not provided for in Senate rules, standing orders, or procedures.

It is clear the purpose of this is to obstruct and delay. I urge my colleagues to vote to table the Cornyn appeal of the ruling of the Chair when that comes.

Mr. CORNYN. Will the Senator yield for a question?

Mr. REID. No, I will not. The health care votes we have held this week have been procedural in nature. Each has been a party-line vote and much of this

debate is focused on politics. But health reform is not about procedure or partisanship or politics. It is about people—people like the thousands who write us every day.

At my desk, we have a few of the letters we have picked up in the last day or so. Sorry, staff has had to lift that and I didn't. This is a few we have gotten. Look at this. They are all basically the same. Each of these letters right here represents a story, a tragedy, a life, a death, but most of all, a person—a person, people who wake up every morning and struggle to get health care or struggle to hold on to what they have, people who lie awake every night second-guessing the agonizing decisions they have to make about what to sacrifice just to stay healthy.

Here is a letter that was written to Senator BOB CASEY of Pennsylvania. Listen to what this woman said:

Dear Senator CASEY. In a country like the United States, we shouldn't need a tip jar in an ice cream shop to raise money for a kid with leukemia. Jennifer Wood.

Here is another one of those letters. This one is from a father in North Las Vegas, NV:

Can you imagine what it is like to have a doctor look you in your eye when you hold your 1-year-old child and be told that you will likely outlive your son?

He goes on to say:

I am certain my story is not unique, but it is real. Stop forcing Americans to use the most expensive point of service, the emergency room, to get what the system won't give them. Let's make all Americans equal in the eyes of health care, please.

This legislation is not about the number of pages of this bill. It is about the number of people—people such as the man whose letter I just read who was told by a doctor that he would likely outlive his son. It is about the number of people whom this bill will help. That is what this is all about. It is about fairness. So when people are hurt or sick, they can go see somebody who can help them and not lie awake at night wondering if they will outlive their 1-year-old son.

Mr. President, how much time remains?

The ACTING PRESIDENT pro tempore. There is 1½ minutes remaining.

Mr. REID. I yield back that time and ask the vote start earlier.

I withdraw that request.

I ask unanimous consent that prior to each vote today there be 2 minutes of debate equally divided and controlled in the usual form.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

There is now 2 minutes equally divided.

The majority leader.

Mr. REID. Mr. President, stop the 2 minutes from running. I do want to explain. We will shortly have a series of

up to seven votes. As we noted in the last few days, if Members remain at their desks, the votes can be concluded much earlier.

ENSIGN POINT OF ORDER

The ACTING PRESIDENT pro tempore. There is now 2 minutes of debate equally divided prior to a vote on the constitutional point of order offered by the Senator from Nevada, Mr. ENSIGN.

Who yields time?

The majority leader.

Mr. REID. Mr. President, the vote sequence will be as follows: Ensign constitutional point of order; Corker unfunded mandates point of order; Baucus motion to table the Cornyn appeal ruling of the Chair; Hutchison constitutional point of order. I have been advised that a Republican Member will move to suspend the rules so he can offer his amendment under rule XXII. He is going to be allowed 10 minutes. This will require 67 votes because it is an effort to change the rules. Following that we will have adoption of the substitute amendment and cloture on H.R. 3590. So there is a series of seven votes.

The ACTING PRESIDENT pro tempore. Who yields time?

The Senator from Nevada is recognized.

Mr. ENSIGN. Mr. President, I raise a constitutional point of order because I am concerned that the health reform bill violate's Congress's enumerated powers under article I, section 8 and the fifth amendment takings clause of the Constitution.

Each one of us takes an oath to defend the Constitution of the United States. We do not take an oath to reform health care. We do not take an oath to do anything else here but to defend the Constitution of these United States.

Health care reform needs to fit within the Constitution. The Constitution limits the powers we have. The Congress, the U.S. Government has never enacted anything that would regulate someone's inactivity in the way the individual mandate in this health care bill would. Anything we have ever done, somebody actually had to have an action before we could tax or regulate it. In this case, if you choose to not do something—in other words, if you do not choose health insurance—this bill will actually tax you. It will act as an onerous tax. So for the first time in the history of the United States this bill will do something the Federal Government has never done before. This bill would do something that is beyond Congress's powers to authorize. This bill is unconstitutional and I urge all Members to vote in support of the constitutional point of order.

The ACTING PRESIDENT pro tempore. The Senator's time has expired.

The Senator from Montana.

Mr. BAUCUS. Mr. President, our committee and the HELP Committee

have given a lot of thought to the provisions in this legislation. We also gave a lot of thought to the constitutionality of the provisions—how they work and the interrelationship between the power of Congress and the States and what States will be doing, particularly under the commerce clause and the tax-and-spending powers of the Constitution.

It is very strongly our considered judgment, and that of many constitutional scholars who have looked at these provisions—and many articles have been put in the Record—that clearly these provisions are constitutional. The commerce clause is constitutional, the tax-and-spending clause, and the provisions clearly are constitutional.

I yield back my time.

The ACTING PRESIDENT pro tempore. The question is on agreeing to the constitutional point of order made by the Senator from Nevada, Mr. ENSIGN, that the amendment violates article I, section 8 of the Constitution, and the fifth amendment.

The question is, Is the point of order well taken?

The yeas and nays have been ordered.

The clerk will call the roll.

The bill clerk called the roll.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted "yea."

The ACTING PRESIDENT pro tempore. Are there any other Senators in the Chamber desiring to vote?

The yeas and nays resulted—yeas 39, nays 60, as follows:

[Rollcall Vote No. 389 Leg.]

YEAS—39

Alexander	DeMint	Lugar
Barrasso	Ensign	McCain
Bennett	Enzi	McConnell
Bond	Graham	Murkowski
Brownback	Grassley	Risch
Burr	Gregg	Roberts
Chambliss	Hatch	Sessions
Coburn	Hutchison	Shelby
Cochran	Inhofe	Snowe
Collins	Isakson	Thune
Corker	Johanns	Vitter
Cornyn	Kyl	Voinovich
Crapo	LeMieux	Wicker

NAYS—60

Akaka	Franken	Mikulski
Baucus	Gillibrand	Murray
Bayh	Hagan	Nelson (NE)
Begich	Harkin	Nelson (FL)
Bennet	Inouye	Pryor
Bingaman	Johnson	Reed
Boxer	Kaufman	Reid
Brown	Kerry	Rockefeller
Burr	Kirk	Sanders
Byrd	Klobuchar	Schumer
Cantwell	Kohl	Shaheen
Cardin	Landrieu	Specter
Carper	Lautenberg	Stabenow
Casey	Leahy	Tester
Conrad	Levin	Udall (CO)
Dodd	Lieberman	Udall (NM)
Dorgan	Lincoln	Warner
Durbin	McCaskill	Webb
Feingold	Menendez	Whitehouse
Feinstein	Merkley	Wyden

NOT VOTING—1

Bunning

The ACTING PRESIDENT pro tempore. The point of order is not well-taken.

CORKER POINT OF ORDER

The ACTING PRESIDENT pro tempore. There is now 2 minutes equally divided prior to the vote on the motion to waive the point of order raised by the Senator from Tennessee, Mr. CORKER.

Who yields time?

The Senator from Tennessee is recognized.

Mr. CORKER. Mr. President, thank you so much.

There is almost nothing held in lower esteem than for the Senate to pass laws in this body that cause mayors and Governors to have budgetary problems because we create unfunded mandates.

Many of you have been mayors and Governors, and for that reason, in 1995, in a bipartisan way, a law was created—15 Senators on the other side of the aisle who are now serving supported this law—to keep us from passing unfunded mandates. CBO has stated without a doubt that this bill violates that.

I urge Members to vote against this motion to waive that. It is important. It says everything about the way we do business here in Washington. Please, let's not pass another huge unfunded mandate to the States at a time when they all are having budgetary problems. This speaks to the essence of who we are and the arrogance many people perceive us to have here in Washington.

The ACTING PRESIDENT pro tempore. The Senator from Montana is recognized.

Mr. BAUCUS. This point of order calls for legislation to impose an obligation on States to extend their coverage on Medicaid. Under existing law, on average, the Federal Government pays about 57 cents on the dollar for every dollar spent under Medicaid. Under this legislation, the Federal Government will pay 100 percent of that obligation for newly enrolled beneficiaries up through the year 2016. Afterward, the Federal Government will pay on average 90 percent of the cost of new enrollees. Therefore, I think this is a very fair deal for States, and I urge my colleagues to waive the point of order.

Mr. President, I also ask consent that this vote and all subsequent votes in this sequence be 10-minute votes.

The PRESIDING OFFICER (Mr. SANDERS). The question is on agreeing to the motion to waive the Budget Act point of order raised under section 425(a)(2).

The yeas and nays were previously ordered.

The clerk will call the roll.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted "nay."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 55, nays 44, as follows:

[Rollcall Vote No. 390 Leg.]

YEAS—55

Akaka	Franken	Merkley
Baucus	Gillibrand	Mikulski
Begich	Hagan	Murray
Bennet	Harkin	Nelson (FL)
Bingaman	Inouye	Pryor
Boxer	Johnson	Reed
Brown	Kaufman	Reid
Burris	Kerry	Rockefeller
Byrd	Kirk	Sanders
Cantwell	Klobuchar	Schumer
Cardin	Kohl	Specter
Carper	Landrieu	Stabenow
Casey	Lautenberg	Tester
Conrad	Leahy	Udall (CO)
Dodd	Levin	Udall (NM)
Dorgan	Lieberman	Whitehouse
Durbin	Lincoln	Wyden
Feingold	McCaskey	
Feinstein	Menendez	

NAYS—44

Alexander	Ensign	Murkowski
Barrasso	Enzi	Nelson (NE)
Bayh	Graham	Risch
Bennett	Grassley	Roberts
Bond	Gregg	Sessions
Brownback	Hatch	Shaheen
Burr	Hutchison	Shelby
Chambliss	Inhofe	Snowe
Coburn	Isakson	Thune
Cochran	Johanns	Vitter
Collins	Kyl	Voinovich
Corker	LeMieux	Warner
Cornyn	McCain	Webb
Crapo	McConnell	Wicker
DeMint		

NOT VOTING—1

Bunning

The PRESIDING OFFICER. The motion to waive section 425(a)(2) requiring a simple majority is agreed to.

The point of order falls.

The majority leader is recognized.

Mr. REID. Mr. President, I have spoken to the Republican leader. Senators on both sides feel that it would be to their advantage if we had the vote on Christmas Eve at 7 a.m. rather than 8 a.m. That being the case, I ask unanimous consent that the vote start at 7 a.m. on Christmas Eve.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LEAHY. May I address a question to the distinguished majority leader.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. LEAHY. Mr. President, it will not affect my travel plans because I long ago decided—

Mr. REID. If I could interrupt my friend, quit while you are ahead.

Mr. LEAHY. You have your agreement on this. But is there any possibility that our friends on the other side, knowing that those who are traveling to the Midwest are going to face horrendous problems, that we could have that vote this evening? It will not

affect the Senator from Vermont one way or the other, but it will affect a lot of Senators, Republicans and Democrats alike, who have to fly through the Midwest to get where they are going.

Mr. MCCONNELL. Regular order.

CORNYN APPEAL OF THE RULING OF THE CHAIR

The PRESIDING OFFICER. Regular order has been called for.

There is now 2 minutes equally divided prior to a vote on the motion to table the appeal of the ruling of the Chair.

The Senator from Texas.

Mr. CORNYN. Mr. President, upon passage of the Honest Leadership and Open Government Act, the majority leader said:

I believe last November Americans . . . asked us to make Government honest. We have done that . . . This is the toughest reform bill in the history of this body as it relates to ethics and lawmaking.

This is an appeal to the ruling of the Chair that that provision of rule XLIV is unenforceable. Why would anybody who voted overwhelmingly to make this the toughest reform bill in the history of the body render this rule toothless by agreeing with the attempt to set this aside and to waive its effect?

I ask my colleagues to make sure we vote for transparency, for honesty, for open government. Vote no on this motion to waive.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, the plain text of the language in rule XLIV provides that no point of order lies against amendments. That is the way the drafters intended it. That is the way they wrote rule XLIV. That is why the Presiding Officer ruled that way on the advice of the Parliamentarian. We should support the Chair and the Parliamentarian and vote for the motion to table the appeal of the ruling of the Chair.

I yield back the remainder of my time.

Mr. CORNYN. Do I have time remaining?

The PRESIDING OFFICER. One second.

Mr. CORNYN. I ask my colleagues to vote no on the motion to waive.

The PRESIDING OFFICER. The question is on agreeing to the motion to table the appeal of the ruling of the Chair that there is no point of order under rule XLIV, paragraph 4(a).

The yeas and nays were previously ordered.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted "nay."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 57, nays 42, as follows:

[Rollcall Vote No. 391 Leg.]

YEAS—57

Akaka	Gillibrand	Murray
Baucus	Hagan	Nelson (NE)
Begich	Harkin	Nelson (FL)
Bingaman	Inouye	Pryor
Boxer	Johnson	Reed
Brown	Kaufman	Reid
Burris	Kerry	Rockefeller
Byrd	Kirk	Sanders
Cantwell	Klobuchar	Schumer
Cardin	Kohl	Shaheen
Carper	Landrieu	Specter
Casey	Lautenberg	Stabenow
Conrad	Leahy	Tester
Dodd	Levin	Udall (CO)
Dorgan	Lieberman	Udall (NM)
Durbin	Lincoln	Warner
Feingold	Menendez	Webb
Feinstein	Merkley	Whitehouse
Franken	Mikulski	Wyden

NAYS—42

Alexander	Crapo	Lugar
Barrasso	DeMint	McCain
Bayh	Ensign	McCaskill
Bennet	Enzi	McConnell
Bennett	Graham	Murkowski
Bond	Grassley	Risch
Brownback	Gregg	Roberts
Burr	Hatch	Sessions
Chambliss	Hutchison	Shelby
Coburn	Inhofe	Snowe
Cochran	Isakson	Thune
Collins	Johanns	Vitter
Corker	Kyl	Voinovich
Cornyn	LeMieux	Wicker

NOT VOTING—1

Bunning

The motion was agreed to.

Mr. REID. I move to reconsider the vote.

Mr. DURBIN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

HUTCHISON POINT OF ORDER

The PRESIDING OFFICER. There is now 2 minutes, equally divided, prior to a vote on the constitutional point of order made by the Senator from Texas, Mrs. HUTCHISON.

The Senator from Texas.

Mrs. HUTCHISON. Mr. President, the 10th amendment says:

The powers not delegated to the United States by the Constitution . . . are reserved to the States. . . .

In this bill, a State such as Texas and many other States that have taken full responsibility for insurance plans for their employees and teachers will have to justify any change in those terms to the Federal Government.

The majority claims the commerce clause gives them the power to do what is in this bill. But what they fail to mention is the power to regulate interstate commerce has not been the basis for a robust role in insurance regulation.

This is an encroachment of the Federal Government into a role left to the States in the Constitution. The 10th amendment is being eroded by an activist Congress, and it is time to stop it now.

I urge a vote to uphold this point of order.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, the bill before us is clearly an appropriate exercise of the commerce clause. We further believe Congress has power to enact this legislation pursuant to the taxing and spending powers. This bill does not violate the 10th amendment because it is an appropriate exercise of powers delegated to the United States, and because our bill fundamentally gives States the choice to participate in the exchanges themselves or, if they do not choose to do so, to allow the Federal Government to set up the exchanges fully within the provisions as interpreted by the Supreme Court of the 10th amendment.

I urge my colleagues to vote against the point of order.

The PRESIDING OFFICER. The question is on the constitutional point of order made by the Senator from Texas, Mrs. HUTCHISON, that the amendment violates the 10th amendment.

The question is, Is the point of order well taken?

The yeas and nays have been ordered.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted "yea."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 39, nays 60, as follows:

[Rollcall Vote No. 392 Leg.]

YEAS—39

Alexander	DeMint	Lugar
Barrasso	Ensign	McCain
Bennett	Enzi	McConnell
Bond	Graham	Murkowski
Brownback	Grassley	Risch
Burr	Gregg	Roberts
Chambliss	Hatch	Sessions
Coburn	Hutchison	Shelby
Cochran	Inhofe	Snowe
Collins	Isakson	Thune
Corker	Johanns	Vitter
Cornyn	Kyl	Voinovich
Crapo	LeMieux	Wicker

NAYS—60

Akaka	Franken	Mikulski
Baucus	Gillibrand	Murray
Bayh	Nelson	Nelson (NE)
Begich	Harkin	Nelson (FL)
Bennet	Inouye	Pryor
Bingaman	Johnson	Reed
Boxer	Kaufman	Reid
Brown	Kerry	Rockefeller
Burris	Kirk	Sanders
Byrd	Klobuchar	Schumer
Cantwell	Kohl	Shaheen
Cardin	Landrieu	Specter
Carper	Lautenberg	Stabenow
Casey	Leahy	Tester
Conrad	Levin	Udall (CO)
Dodd	Lieberman	Udall (NM)
Dorgan	Lincoln	Warner
Durbin	McCaskill	Webb
Feingold	Menendez	Whitehouse
Feinstein	Merkley	Wyden

NOT VOTING—1

Bunning

The PRESIDING OFFICER. The point of order is not agreed to.

The Senator from South Carolina.

Mr. DEMINT. Mr. President, since I have not used or yielded 10 minutes, I ask to be recognized for up to 10 minutes under rule XXII, paragraph 2.

The PRESIDING OFFICER. The Senator has that right.

The Senator from South Carolina.

DEMINT MOTION TO SUSPEND

Mr. DEMINT. Mr. President, in just a moment I will move to suspend the rules for the purpose of offering an amendment that would ban the practice of trading earmarks for votes.

While I want to be careful not to suggest wrongdoing by any Member, there has been growing public concern that earmarks were used to buy votes for this legislation. It has been argued by some that this practice is acceptable because it is necessary to get things done in the Senate. I reject that argument, and I urge my colleagues to put an end to business as usual here in the Senate.

The House of Representatives has a rule prohibiting the use of earmarks to buy votes for legislation. If we were in the House considering this bill, vote trading would be a direct violation of the ethics rules. Unfortunately, a vote-trading rule does not exist in the Senate.

During the debate on the lobbying and ethics reform bill in the 110th Congress, the senior Senator from Illinois, Mr. DURBIN, and I offered an earmark reform amendment which contained the following language:

A Member may not condition the inclusion of language to provide funding for a congressional earmark . . . on any vote cast by another Member.

The Durbin-DeMint amendment was written to mirror Speaker PELOSI's earmark reforms in the House. The Durbin-DeMint amendment passed the Senate by a vote of 98 to 0 and was included in S. 1, the Honest Leadership and Open Government Act, which passed the Senate by a vote of 96 to 2.

The rule against trading votes for earmarks was in the bill when it left the Senate, but then the bill moved to a closed-door negotiation. Somehow, at some point in those closed-door negotiations, someone dropped the earmark-for-vote language. I have no idea who it was, and we may never know. Remember, this bill was called the Honest Leadership and Open Government Act. In any case, the vote-trading rule was dropped from the bill, which then passed the Senate and was signed by the President.

Just to confirm all of this, I wish to make a parliamentary inquiry to the Chair. Is the Chair aware of any prohibition in the Standing Rules of the Senate such as the previously referenced rule contained in the Durbin-

DeMint amendment or in the Rules of the House of Representatives?

The PRESIDING OFFICER. No such rule exists in the Senate.

Mr. DEMINT. No such rule exists.

I have an amendment which would correct this error. It mirrors the Durbin-DeMint language which passed the Senate 98 to 0, and I will read the relevant parts. I quote:

It shall not be in order in the Senate to consider a congressionally directed spending item . . . if a Senator . . . has conditioned the inclusion of the language . . . on any vote cast by any Senator.

This language had unanimous bipartisan support in 2007, and it should be part of the rules today. This rule would provide needed accountability and allow any Senator to raise a point of order to strike any earmark that has been used to buy votes. This point of order could be waived and the ruling of the Chair could be appealed with the support of two-thirds of Senators present and voting.

Before I make this motion and we vote on this amendment, I wish to make a few things absolutely clear. First, this rule already won a unanimous vote in the Senate in 2007, so it is not controversial. Second, this rule only applies to earmarks used to buy votes in the future. It will not, unfortunately, apply to the earmarks in this bill. Third, this vote is not a trick. The amendment is written as a "standing order," so it will not increase the number of votes required to pass this legislation. It will not slow down the health care bill in any way.

The only reason for Senators to oppose this amendment is if they want to use earmarks to buy votes for legislation. It is that simple. If you support business as usual, then oppose this motion. But if you want to start to clean this place up and bring some integrity back to the legislative process, then please support the motion.

Mr. President, I move to suspend the provisions of rule XXII, including germaneness requirements, for the purpose of proposing and considering my amendment No. 3297, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

It appears there is a sufficient second.

The yeas and nays were ordered.

The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, this proposed new point of order may sound good in theory, but it has many flaws, in fact, when you stop and think about it. If you think the Senate is tied up in knots now, if this were in effect, the current situation would pale in comparison to what the effect of this amendment would be.

The amendment is written in a way to become an endless source of delay. Senators could make one point of order

after another under this provision, pointing to different provisions or indicating the integrity of different Senators.

The amendment provides no way for determining how to rule on a point of order raised under it. A point of order cannot be decided without solid guidance. Points of order make the most sense when they are based on objective criteria.

The proposed amendment to rule XXII would ask the Chair and the Parliamentarian to sort through purely subjective concepts such as the basis for a Senator's vote or the intent behind inclusion of a provision. How would the Chair be able to rule on such a point of order? Would the Parliamentarian have to question the chairman of a committee or a Senator who offers the amendment, under oath? Would the Parliamentarian have to question every Senator who requested a directed spending item, under oath, to ensure they did not condition their support on inclusion of the item?

The rule may sound good in theory, but it is totally unworkable as a practical matter.

I move to table the DeMint motion and ask for the yeas and nays.

The PRESIDING OFFICER. There is 1 minute left for those who favor the motion. Who yields time?

The Senator from South Carolina, 1 minute.

Mr. DEMINT. Mr. President, I would answer the questions of the Senator by suggesting that Senator DURBIN, who wrote the amendment, perhaps may wish to make a couple of comments about it because this is the mirror—

Mr. DURBIN. Are you yielding time?

Mr. DEMINT. Yes, I sure will.

Mr. DURBIN. I don't understand how this amendment would work. If the Senator happens to have a hurricane in his State and needs disaster aid and we put money in the bill, then would we have to question the Senator's motive for voting for the bill? I think it goes entirely too far, and I support this effort to table.

Mr. DEMINT. This a DeMint-Durbin amendment. It is mirrored after Speaker PELOSI's bill. They have this rule in the House. They can make it workable. Certainly, the integrity of this body is worth considering.

I would encourage my colleagues, at this point, when the public is looking at us, asking for some trust and integrity, we can make this bill work. I ask my colleagues to support my amendment and oppose the tabling motion.

Mr. BAUCUS. I move to table the motion and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion to table the motion to suspend the rules.

The clerk will call the roll.

The PRESIDING OFFICER (Mr. AKAKA). Are there any other Senators in the Chamber desiring to vote?

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted "nay."

The result was announced—yeas 53, nays 46, as follows:

[Rollcall Vote No. 393 Leg.]

YEAS—53

Akaka	Franken	Mikulski
Baucus	Gillibrand	Murray
Begich	Hagan	Nelson (FL)
Bennet	Harkin	Pryor
Bingaman	Inouye	Reed
Boxer	Johnson	Reid
Brown	Kaufman	Rockefeller
Burris	Kerry	Sanders
Byrd	Kirk	Schumer
Cantwell	Klobuchar	Shaheen
Cardin	Kohl	Specter
Carper	Landrieu	Stabenow
Casey	Lautenberg	Tester
Conrad	Leahy	Udall (CO)
Dodd	Levin	Udall (NM)
Dorgan	Lieberman	Whitehouse
Durbin	Lincoln	Wyden
Feinstein	Menendez	

NAYS—46

Alexander	Enzi	Merkley
Barrasso	Feingold	Murkowski
Bayh	Graham	Nelson (NE)
Bennett	Grassley	Risch
Bond	Gregg	Roberts
Brownback	Hatch	Sessions
Burr	Hutchison	Shelby
Chambliss	Inhofe	Snowe
Coburn	Isakson	Thune
Cochran	Johanns	Vitter
Collins	Kyl	Voinovich
Corker	LeMieux	Warner
Cornyn	Lugar	Webb
Crapo	McCain	Wicker
DeMint	McCaskill	
Ensign	McConnell	

NOT VOTING—1

Bunning

The motion was agreed to.

Mr. REID. I move to reconsider the vote, and I move to lay that motion on the table.

The motion to table was agreed to.

AMENDMENT NO. 2878 WITHDRAWN

Mr. REID. Mr. President, I ask unanimous consent that amendment No. 2878 be withdrawn.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 2786, AS AMENDED

Mr. REID. Mr. President, what then is the pending business?

The PRESIDING OFFICER. There is now 2 minutes of debate prior to a vote on amendment No. 2786, as amended.

The Senator from Montana.

Mr. BAUCUS. Mr. President, this is a vote to adopt the substitute. This is another vote on whether we wish to reform health care.

I urge my colleagues to vote aye and move this process forward.

I yield back my time.

Mr. REID. I ask for the yeas and nays.

The PRESIDING OFFICER. The yeas and nays have been ordered.

Who yields time in opposition?

Mr. REID. I yield back the time on behalf of my Republican colleague.

The PRESIDING OFFICER. Without objection, it is so ordered.

The question is on agreeing to amendment No. 2786, as amended.

The yeas and nays have been ordered.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted "no."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 60, nays 39, as follows:

[Rollcall Vote No. 394 Leg.]

YEAS—60

Akaka	Franken	Mikulski
Baucus	Gillibrand	Murray
Bayh	Hagan	Nelson (NE)
Begich	Harkin	Nelson (FL)
Bennet	Inouye	Pryor
Bingaman	Johnson	Reed
Boxer	Kaufman	Reid
Brown	Kerry	Rockefeller
Burris	Kirk	Sanders
Byrd	Klobuchar	Schumer
Cantwell	Kohl	Shaheen
Cardin	Landrieu	Specter
Carper	Lautenberg	Stabenow
Casey	Leahy	Tester
Conrad	Levin	Udall (CO)
Dodd	Lieberman	Udall (NM)
Dorgan	Lincoln	Warner
Durbin	McCaskill	Webb
Feingold	Menendez	Whitehouse
Feinstein	Merkley	Wyden

NAYS—39

Alexander	DeMint	Lugar
Barrasso	Ensign	McCain
Bennett	Enzi	McConnell
Bond	Graham	Murkowski
Brownback	Grassley	Risch
Burr	Gregg	Roberts
Chambliss	Hatch	Sessions
Coburn	Hutchison	Shelby
Cochran	Inhofe	Snowe
Collins	Isakson	Thune
Corker	Johanns	Vitter
Cornyn	Kyl	Voinovich
Crapo	LeMieux	Wicker

NOT VOTING—1

Bunning

The amendment (No. 2786), as amended, was agreed to.

Mr. REID. Mr. President, I move to reconsider the vote, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

CLOTURE MOTION

The PRESIDING OFFICER. Under the previous order and pursuant to rule XXII, the Chair lays before the Senate the pending cloture motion, which the clerk will report.

The legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on H.R. 3590, the Service Members Home Ownership Tax Act of 2009.

Christopher Dodd, Richard Durbin, Mark Begich, Paul G. Kirk, Sheldon Whitehouse, Roland W. Burris, Max Baucus, Sherrod Brown, Claire McCaskill, Jon Tester, Barbara A. Mikulski, Bill Nelson, Maria Cantwell, Mark Udall, Arlen Specter, Kirsten E. Gillibrand, and Ron Wyden.

The PRESIDING OFFICER. By unanimous consent, the mandatory quorum call has been waived.

The question is, Is it the sense of the Senate that debate on H.R. 3590, the Service Members Home Ownership Tax Act of 2009, shall be brought to a close?

The yeas and nays are mandatory under the rule.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted "nay."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The yeas and nays resulted—yeas 60, nays 39, as follows:

[Rollcall Vote No. 395 Leg.]

YEAS—60

Akaka	Franken	Mikulski
Baucus	Gillibrand	Murray
Bayh	Hagan	Nelson (NE)
Begich	Harkin	Nelson (FL)
Bennet	Inouye	Pryor
Bingaman	Johnson	Reed
Boxer	Kaufman	Reid
Brown	Kerry	Rockefeller
Burris	Kirk	Sanders
Byrd	Klobuchar	Schumer
Cantwell	Kohl	Shaheen
Cardin	Landrieu	Specter
Carper	Lautenberg	Stabenow
Casey	Leahy	Tester
Conrad	Levin	Udall (CO)
Dodd	Lieberman	Udall (NM)
Dorgan	Lincoln	Warner
Durbin	McCaskill	Webb
Feingold	Menendez	Whitehouse
Feinstein	Merkley	Wyden

NAYS—39

Alexander	DeMint	Lugar
Barrasso	Ensign	McCain
Bennett	Enzi	McConnell
Bond	Graham	Murkowski
Brownback	Grassley	Risch
Burr	Gregg	Roberts
Chambliss	Hatch	Sessions
Coburn	Hutchison	Shelby
Cochran	Inhofe	Snowe
Collins	Isakson	Thune
Corker	Johanns	Vitter
Cornyn	Kyl	Voinovich
Crapo	LeMieux	Wicker

NOT VOTING—1

Bunning

The PRESIDING OFFICER. On this vote, the yeas are 60, the nays are 39. Three-fifths of the Senators duly chosen and sworn having voted in the affirmative, the motion to invoke cloture on the underlying bill is agreed to.

Mr. REID. Mr. President, I think we all recognize that things have gotten pretty tense around the Senate as we have worked three weekends in a row, long hours, and approach the Christmas holiday. Sometimes the tension

has boiled over into what has been said on and off the floor, and the way we treat each other, and that is very regrettable.

Two nights ago there was an unfortunate incident that deserves special mention, though. One of our colleagues, the Senator from South Carolina, attacked the office of the Senate Parliamentarian. We all know that the Senate Parliamentarian is a non-partisan referee. The Office of the Parliamentarian does their best to enforce the rules and procedures of the Senate in an impartial manner.

We have all come across situations when we were frustrated by the Parliamentarian's ruling because we were hoping that a given amendment was or was not germane, or that a given point of order was or was not well taken. But, we have all taken comfort in the fact that whatever the ruling in the instant case, the Parliamentarian was calling it straight and the same ruling would apply to similar amendments by other Senators and similar facts in the future.

So, it is simply not right and not fair to attack the Parliamentarians for doing their job. This is especially so when the issue is not a close call. Our colleague from South Carolina attacked the Parliamentarian over a ruling relating to the difference between amendments to the Standing Rules of the Senate and procedural changes adopted in less formal ways. The former requires a 2/3rds vote to achieve cloture; the latter is treated like any other piece of legislation. The distinction is an interesting quirk of Senate rules. But it is a venerable and well-established distinction. The Senate Manual includes 70 pages of Standing Orders. The Budget Act process—which the minority used to make a point of order just today—is almost entirely dependent on procedures that are not part of the Standing Rules of the Senate. In fact, in the last two Congresses, the Senator from South Carolina has authored or co-sponsored at least 17 bills or amendments that implicate the distinction. For the Parliamentarian to be accused of "redefin[ing] words," "ignoring a rule" of the Senate, and a "truly historic" and unconstitutional "subvert[sion of] the principle we have operated under" for re-stating this longstanding distinction is completely unwarranted.

As I noted, tensions are running high and Senators are tired and, according to one recent article, cranky. But I hope that the body will do its best to ensure proper decorum as we proceed for the remainder of the year and the remainder of the Congress. We need to treat each other with respect. And we certainly need to treat the institution of the Senate and its hard-working employees with respect.

Mr. President, I ask unanimous consent there now be alternating blocks of

time as follows: The first hour under the control of the Republicans; further, that after the first 2 hours, then there be alternating blocks of 30 minutes, with the Republicans controlling the first 30 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HARKIN. Mr. President, there have been a lot of conversations on this floor in the last couple hours. There are a lot of people who are facing tough timetables tomorrow. I know of one Senator—

Mr. VITTER. Mr. President, regular order. Regular order, Mr. President.

Mr. HARKIN. Mr. President, I ask consent I be given 2 minutes.

The PRESIDING OFFICER. Is there objection?

Mr. VITTER. Mr. President, reserving the right to object. I would be happy for those 2 minutes to come out of the Democrats' 1 hour without asking for regular order.

Mr. HARKIN. That is fine.

The PRESIDING OFFICER. Without objection.

Mr. HARKIN. Mr. President, I know one Senator whose family is with their in-laws. The husband is from England and the kids are over there and cannot make it for Christmas dinner tomorrow night. I know another person who has to get out to the West and there are a lot of storms out there. If they can get that early flight, they can make two legs and get home. If they have to go later in the day, they have to do three legs and they may not make it. There are a lot of people around here who are having a lot of problems that we are all here. There is no reason to hold over the vote so I am going to ask unanimous consent that the vote on the passage of the bill and the vote on the debt limit bill occur at 6 p.m. this evening.

The PRESIDING OFFICER. Is there objection?

Mr. VITTER. Addressed the Chair.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. VITTER. Mr. President, that request has not been cleared on this side. On behalf of my colleagues, I object. If the Senator would like to talk to all his colleagues about it, that would be fine, but in the meantime, I would object.

Mr. HARKIN. Mr. President, then I would further ask unanimous consent that the votes that are going to occur at 7 a.m. tomorrow occur at 12:15 a.m., in the morning.

The PRESIDING OFFICER. Is there objection?

Mr. VITTER. Mr. President, my response would be the same and I would object in the same vein.

The PRESIDING OFFICER. The objection is heard.

Mr. HARKIN. I want Members to know who is keeping us here.

Mr. RISCH. Mr. President?

The PRESIDING OFFICER. The Senator from Idaho.

Mr. RISCH. Mr. President, I ask unanimous consent that the vote referred to by Senator HARKIN take place at 2 p.m. on January 20, 2010, when we return.

The PRESIDING OFFICER. Is there objection?

Mr. HARKIN. I object.

The PRESIDING OFFICER. There are objections.

The Senator from Louisiana is recognized.

Mr. VITTER. Mr. President, I ask unanimous consent that this first block of time on the minority side be divided equally between the following Senators: myself, Senators COBURN, THUNE, SESSIONS, KYL, and ENSIGN.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. VITTER. I thank the Chair. Mr. President, I ask for order on the floor.

The PRESIDING OFFICER. The Senate will be in order.

Mr. VITTER. Mr. President, I ask that time not be counted against me until the floor is in order.

The PRESIDING OFFICER. The Senator will not be charged. The Senator from Louisiana is recognized.

Mr. VITTER. Mr. President, I rise to talk about this important health care issue but also to talk about another vitally important issue directly connected, which is spending and debt because we will also have an enormously important vote tomorrow morning on increasing the debt limit. It is already over \$12 trillion, but the proposal is to increase it further.

In starting, let me refer back to a couple comments and parts of the debate yesterday because I think it will provide a good segue into this important debate. First, yesterday, as we were debating health care, my colleague from Louisiana, the distinguished senior Senator, Ms. LANDRIEU, was on C-SPAN's "Washington Journal." In discussing the health care bill, my participation came up. She said: "Senator VITTER has not lifted a finger to pass this bill."

I wish to say that is a very kind and positive and generous comment of the Senator and I take it as a nice Christmas overture and I accept it in that vein. I wish her all the best this Christmas season as well. It is obviously very true, and I take it as a very positive comment.

I would go further. I fought hard against this bill. I fought hard for alternative reforms, focused reforms, reforms focused like a laser beam on real solutions in health care to real problems such as preexisting conditions. I would simply add, I don't think this fight is over by a long shot. I will continue fighting and I will continue offering those alternatives.

With regard to the bill and this enormously important issue of spending

and debt, as I was leaving the floor to go to meetings in my office after speaking yesterday, Senator BAUCUS took issue, apparently, with some of my comments—specifically, my comments about Medicare. I had suggested that this bill cuts Medicare by \$467 billion, almost $\frac{3}{2}$ trillion. Although I needed to go to meetings, I think Senator BAUCUS took issue with that and characterized that as actually extending the life of Medicare.

The Congressional Budget Office answered that debate far better than I could have. They answered that debate in the last 24 hours with their report. They outline very clearly and we have been talking about it earlier today that, in fact, Medicare money and other pools of money are double counted in this analysis about the health care bill. "The key point is that the savings to the HI trust fund under the health care bill would be received by the government only once so they cannot be set aside to pay for future Medicare spending and, at the same time, pay for current spending on other parts of the legislation or on other programs."

The same Congressional Budget Office report says "to describe the full amount of HI trust fund savings and both improving the Government's ability to pay future Medicare benefits and financing new spending outside of Medicare would essentially double count a large share of those savings."

So this answers the Senator's comments directly. You can't have it both ways. You can't say we have a bill that is paid for and also a bill that strengthens Medicare and extends solvency for additional years. That is double counting. That is exactly what the CBO is saying. The American people, in a much more basic, commonsense way, know better. They know this bill isn't paid for. They know this bill is going to expand the deficit and put us on an even worse fiscal road. They know that in their gut. They know that with their common sense. Of course, that gets us to the other big vote tomorrow extending the debt limit, yet again, well beyond \$12 trillion.

These issues are connected. They are connected in the technical way I just suggested, and these issues are certainly connected in the hearts and minds of the American people. The American people have responded to this debate because health care is so vitally important and the health care issue is so personal.

There is even an overarching, larger reason the American people have responded so much to this debate. It is because they are connecting the dots. They are putting this as part of a larger pattern, and they are connecting the dots between bailing out and taking over insurance companies and financial companies and car companies, hiring and firing the CEO from the Oval Office

to potentially one-sixth of the U.S. economy in health care. They are connecting those dots in terms of spending and debt, as well, because that has been the dominant trend over the last 12 months at least.

We have a debt limit today. It is over \$12 trillion. The motion tomorrow suggests that is not enough. We need to go higher. The American people are connecting the dots, particularly in the last year, and they are scared to death about where it leads. How did we get this way? How did we come to this \$12 trillion-plus point? Well, in July, 2008, Fannie Mae and Freddie Mac were given an unlimited line of credit from the Treasury that, so far, has been \$400 billion, and that bill increased the debt limit from \$9.8 trillion to \$10.6 trillion. But that wasn't enough. Only 3 months later, in October, 2008, came the Wall Street bailouts, the \$700 billion TARP that will raise the debt limit. That did raise the debt limit even further, to \$11.3 trillion, but we weren't done yet. Only a few months after that, in February of this year, we passed the so-called stimulus bill. That will cost over \$1 trillion before it is all over, and then the debt limit was raised to \$12.1 trillion. Then we passed an omnibus spending bill earlier this year that increased spending about 8 percent over the previous fiscal year.

This month, we passed another omnibus spending bill that increased spending another 12 percent on top of that. That is what is leading to tomorrow's debt limit vote. That is what is leading to the statement that our debt limit is now above \$12 trillion. But that is not enough. Apparently, we need to go further.

The American people are connecting the dots. They see this trend, which has accelerated dramatically over the last 12 months, and they are truly scared for our collective future—for their kids' and their grandkids' future. All these things I mentioned plus this health care bill are part of that.

The American people know in their gut—they may not understand all of the Congressional Budget Office technicalities, but they know in their gut that you cannot have it both ways. You cannot count \$467 billion of Medicare cuts as both helping pay for the other spending in the bill and strengthening Medicare. It is one or the other. It cannot be both. It is the same thing in the health care bill with regard to Social Security—\$52 billion double-counted. But you cannot have that both ways. It is the same thing in this health care bill with regard to the CLASS Act—\$72 billion double-counted. You can't have that both ways. Those factors alone put this bill out of balance, adding to the deficit, adding to the debt.

What about the doc fix, the fix of reimbursement rates under Medicare to health care professionals such as doctors, which is clearly needed. That was

taken out of the health care bill. Why? Because that would cost money. It was taken out. It was just pushed down the road, the can was kicked down the road. That has to be revisited by March 1 of next year. If a real 10-year-or-more doc fix is passed, that will be another \$200 billion unpaid for—more deficit and more debt.

The American people get it. They know in their hearts, in their gut, that we are on an unsustainable course. They know all these bailouts and so-called stimulus acts, all these spending bills and now this enormous health care bill, are part of that unsustainable course, and they are crying out. They are saying we must reverse course, we must save our Nation. I hope we do that starting here, starting now.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma, Mr. COBURN, is recognized.

Mr. COBURN. Mr. President, I ask consent to have 3 minutes outside of the time allotted to make a point of personal privilege, and I ask unanimous consent for that. I would say the reason is today is my 41st wedding anniversary, and I was going to discuss that.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

HONORING MY WIFE ON MY 41ST ANNIVERSARY

Mr. COBURN. In 1953, I met a young lady—actually, it was 1954—a young lady when she was 6 years of age. Her name was Carolyn. I went through grade school with this young lady. I went through junior high with this young lady. I went through high school with this young lady. The only serious dating relationship I ever had in my life was with this young girl named Carolyn Denton. She became one of my best friends in high school. It just so happened that one weekend I couldn't get a date, she didn't have one, and I asked her out. From that point forward, I fell in love with somebody I have been married to for 41 years, my wife Carolyn Coburn.

On this day of significant votes in the Senate, and tomorrow, I wanted to take a moment to say how much I appreciate what she has meant to me the past 41 years, how much stronger she has made me as a man, how she has completed every aspect of my life being my partner as we walk through life, and the gift she gave me of three wonderful daughters.

So to my wife Carolyn, in front of the body, I tell you thank you and happy anniversary.

I would like to go to my prepared remarks.

The PRESIDING OFFICER. The Senator is recognized.

Mr. COBURN. Mr. President, I have spent 5 years in the Senate talking to my colleagues about spending. We find in front of us another opportunity to

do the wrong thing. We have a debt limit increase. Yet, in those 5 years, after hundreds and hundreds of amendments the body has refused to agree to that would cut spending, we are going to increase the debt limit but we are not going to make any effort to cut the spending.

I have given seven complete speeches on the floor about the significant amount of waste in the Federal Government. I will not repeat those now. But that number is now annualized to \$380 billion a year—every year, \$380 billion worth of waste. Part of it is fraud, but a large part of it is duplication. Let me give some examples of the duplication because I think when Americans hear this they do not understand why.

The Government Accountability Office found that there are 13 Federal agencies that spend \$3 billion to fund 207 Federal programs, 207 different programs, to encourage student standards in the fields of math and science—13 different agencies, 207 different programs. We could have spent one-tenth that amount of money and had exactly the same results and saved \$2.7 trillion. But we will not do it.

Another example, according to GAO, to the tune of \$30 billion, the Federal Government funded more than 44 job-training programs administered by 9 different Federal agencies across the Federal bureaucracy. According to the Catalog of Federal Domestic Assistance, we have 14 departments within the Federal Government and 49 independent agencies that operate exchange and study-abroad programs. We have 49 programs instead of 1. I have tons of other examples just like that.

We have failed to do our job, and the easiest thing in the world is to spend somebody else's money. Increasing the debt limit without having a rescission to get rid of programs just like this and have one program that is effective and efficient, that has metrics on it, that measures its goals and is accountable, instead of 49 or 72 or 64 across a large number of different agencies—we can do that, but there is no will here to do that. As a consequence, what we do, instead of making the Federal Government more efficient, we just raise the debt limit. I am not about to be a part of that anymore.

I know my colleagues get upset with me as I come to the floor year after year talking about what we do and the fact that we do not fix the real problems. I have been rather hard to get along with, by my colleagues, in terms of them advancing new programs when we do not eliminate the programs that are already doing the same thing.

I think at this time of Christmas, one of the things we ought to be doing is telling the American public that we will change. Next year, instead of creating new programs, we are going to look at all the programs and consolidate them and have one that does math

and science, one that is for work-study programs abroad, not the numerous numbers we have for which we have no accountability.

America recognizes our incompetence, but we are going to spell it out. In this new year that comes forward, there is not going to be a week that comes by that I do not come to the floor and show another example to the American people of how we are not doing our work. It grieves me—not for me but for my children and everybody else's children, for my grandchildren and everybody else's grandchildren—that we fail to treat the real symptoms of our debt; that is, we will not do the hard work of oversight. We should be condemned for that. We are failing the American people. It ought not to be.

I yield the floor.

The PRESIDING OFFICER. The Senator from South Dakota, Mr. THUNE, is recognized.

Mr. THUNE. Mr. President, I appreciate the comments of both my colleagues from Louisiana and Oklahoma touching on an issue that I think is becoming increasingly important to a lot of Americans.

I was listening this morning to one of my colleagues on the other side as he came down here and talked about how all the spending problems and all these debt problems were all inherited from the previous administration. There is sort of a Bush-phobia or something around here among Members on the other side because they do not want to own up for the decisions they have made.

Granted, I would be the first one to admit that when Republicans were in control of the Congress, we didn't do it right all the time and we lost our way a little bit with regard to spending.

But having said that, we now have—since 2006—a Democratic Congress. I need to remind my colleagues that the President doesn't spend a dime under our Constitution. Congress has the power of the purse. Congress appropriates funds. So if you look at the last several years in terms of appropriations, going back to the last couple of years that the Republicans were in control of the Congress, the amount of spending in the nondefense part of the budget was a negative 1 percent in 2007, 5 percent in 2006, and 8 percent in 2005. That is nondefense discretionary spending in our annual appropriations. If you go to total growth, which includes defense, you are talking about 8 percent in 2005, 5 percent in 2006, and 2 percent in 2007—more than most people would argue we needed to be spending in annual appropriations bills.

But the Democrats took control of the Congress after the 2006 election, so they started writing the budgets. We have ownership for the 2007 budget, but the Democrats have ownership for 2008, 2009, and 2010. The 2008 budget grew at 9 percent total growth. Nondefense discretionary spending grew at 6 percent.

If you look at nondefense discretionary spending in 2009, the last fiscal year, it was 12 percent. In this fiscal year, 2010, the estimate is that we will spend 17 percent over the previous year. So year-over-year spending in nondefense discretionary appropriations here in the Congress will have grown almost 30 percent in the last 2 years. That is not a problem that was created by the Bush administration. That is not a problem, obviously, for which the Republican majority was responsible. That is the Democrats, when they took control of the Congress after the 2006 elections, beginning in 2007. They write the budgets, they approve the appropriations bills. Obviously, as you can see, the numbers have gone up dramatically—12 percent in the 2009 budget year, and the 2010 estimate for which we are now funding appropriations bills—and we have funded most of them now with the omnibus or with the smaller appropriations bills, the six bills that were passed just a week or two ago—looking at 17 percent year-over-year spending in appropriations. So that is almost 30 percent in the last 2 budget years. That is not a problem the other side can hold the previous administration responsible for or attack them for.

I will also mention that the \$1 trillion approved earlier this year in the stimulus funding was approved on almost party lines. There were a couple of Republicans who supported that, but for the most part that was something approved by the Democratic majority. It was proposed by the President of the United States. That is not spending for which the former President is responsible.

At some point around here, people have to own up and take responsibility for their own decisions. You cannot blame the past administration. You cannot blame inherited problems for all the spending that is going on right here, right now. The last year, as I said, appropriations spending—and this year again—was by any stretch way above anything we have seen or should see at a time when we have an economy in recession and most Americans are having to tighten their budgets—12 percent nondiscretionary increase in 2009 and 17 percent increase in spending in 2010.

With that and the stimulus spending, it brings us to where we are today, which is this massive expansion of the Federal Government—\$2.5 trillion in new spending for a new entitlement program. That, too, is not something for which the previous administration is responsible. That is something this administration, the majority here in the Congress, has decided they want to push through. They want to finish it before the Christmas holiday. They want to get this in the rearview mirror before the American people have an opportunity to see what is in it, particu-

larly in the last hurried rush here over the weekend where we got the 400-page amendment that included all the special last-minute deals that were made to try to get that elusive 60th vote. What we have seen is now the \$2.5 trillion in new spending is filled with all kinds of goodies that are going to favor individual Senators and individual States.

The American people are starting to react.

The point I want to make about this is, the one thing that the President and a lot of our colleagues on the other side have been talking about is how this reduces the deficit. This saves \$132 billion over the next 10 years. Just remember that is \$132 billion over 10 years. If you look at what the deficit was for the month of October, if any of my colleagues know what the deficit was for the month of October, 1 month alone, this last October, it was \$176 billion—in 1 month. They are crowing about \$132 billion in savings over a 10-year period.

What is interesting about that \$132 billion, if you take away all the gimmicks and you look at all the phony accounting that has been done to get to that number, it goes down in a real hurry.

For example, the SGR fix, the physician reimbursement issue is a \$200 billion-plus item. Let's say they are saying they got \$132 billion in savings over the next 10 years. But at some point you have to deal with that \$200 billion SGR. If you take that away, you end up with a negative \$68 billion already. Then you add in this CLASS Act, which everybody who has any sense, any actuary has absolutely denounced, including even the Washington Post. But if you look at what the CLASS Act does, they are using the revenues in the first early years that come from the premiums paid in. That money will be spent.

So when it comes time to pay out benefits, there isn't going to be any money there. But they are showing a \$72 billion savings or addition to their so-called savings in that first 10 years from the CLASS Act. The chairman of the Budget Committee has called the CLASS Act a Ponzi scheme of the first order, something that Bernie Madoff would be proud of.

You take that \$72 billion out, which the Congressional Budget Office says is going to add huge deficits in the out-years, you take out that \$72 billion, and you are already at a \$130 billion deficit. We haven't even dealt with the fact that because of the way they have set this up, by front end loading the tax increases and back end loading spending, that understates the total cost.

In the first 10 years, if you take those first 4 years when you have \$56 billion of revenue coming in and only \$9 billion of spending going out, that is another \$47 billion that you could add to

the deficit. So you have gone from \$132 billion in savings to a \$177 billion deficit. That is before you even get to the more important issue, which is what the CBO came out with today in response to a question by the Senator from Alabama asking: How can you count money that is going to come from these Medicare cuts, count that as revenue that will save and extend the life of Medicare, and still spend it for a new entitlement program on health care?

The CBO basically said that is double counting. In fact, I want to read what they said:

To describe the full amount of HI trust fund savings as both improving the government's ability to pay future Medicare benefits and financing new spending outside of Medicare would essentially double-count a share of those savings and thus overstate the improvement in the government's fiscal position.

Every American knows you can't spend the same money twice. That is what this does. They are going to cut \$1 trillion over 10 years, when fully implemented, out of Medicare, but they will spend that money on a new entitlement program and still count the savings in Medicare. You can't have it both ways. The American people have figured out this shell game.

When you take a \$177 billion deficit after you take out all these accounting gimmicks, you are already running a significant deficit. Then when you add in the fact that what the CBO now says, what most of us have believed to be true and have been arguing, that you can't spend the same money twice, you cannot double-count that revenue, the Medicare trust fund is going to take a significantly big hit. I know the Senator from Alabama is going to talk more extensively about that. I want to point that out because we are going into a big debate about raising the debt limit. Everybody, now that the horse is out of the barn, wants to shut the gate. But you can't spend \$2.5 trillion on a new entitlement program and then claim to be fiscally responsible or say that you are doing something to reduce the deficit.

Interestingly enough, the CMS Actuary said these Medicare cuts are unlikely to be sustainable on a permanent basis. We all know we are not going to cut \$1 trillion out of Medicare over the first 10 years. That just doesn't happen here. All that money is going to get borrowed and put on the debt or they will have to raise taxes to pay for it. You can't have it both ways.

As we get into the debate about the debt limit, it is important to put things into context. I want to say again that \$132 billion in savings, which is what they are saying they get by this health care reform bill with all the tax increases and the Medicare cuts, is suspicious in the first place, given the fact that the SGR, the \$200 billion is not included, the \$72 billion

CLASS Act, and the \$47 billion that they achieve by front end loading tax increases and back end loading spending brings you to a \$177 billion deficit in the first 10 years. That does not even include the funky accounting being used with regard to the Medicare trust fund. We will get into this debate about the debt limit, but nothing bears on that more heavily than what we do with health care.

We need to defeat this. I hope we will still see some courage by a few of my colleagues to help us take this health care bill down, to go back to the drawing board, to do it right and to actually put in place solutions that will meaningfully reduce the cost of health care for people in this country, not increase their premiums, and not add to the deficit and saddle future generations with an enormous debt they don't deserve. Remember, \$176 billion was the deficit in the month of October alone. We are talking about, under their numbers, \$132 billion in savings over 10 years which, when you sit down and figure it out, it just doesn't add up.

I yield the floor.

The PRESIDING OFFICER (Mr. NELSON of Florida). The Senator from Arizona.

Mr. KYL. Mr. President, when the recession hit last fall, many Americans had been living beyond their means and had to quickly scale back. Families all across America have been tightening their belts. They have been forgoing vacations, meals in restaurants, extra Christmas presents, cutting back wherever they can. The government needs to take a lesson from those families. It is time that Congress and the administration get serious about cutting spending in a meaningful way. Spending during President Obama's first year in office, to put it charitably, has not been what most would describe as responsible. Government spending grew by \$705 billion in fiscal year 2009, an increase of 24 percent. Appropriations legislation enacted this year will increase spending by another 8 percent in the year 2010. All of this spending, of course, has an impact on both the Federal deficit and the Federal debt.

Let me clarify the difference between those two numbers. The deficit is the amount of total spending not covered by revenues in a given year. The debt is the sum of all of the Nation's yearly deficits. The 2009 deficit made history and not in a good way. It exceeded \$1.4 trillion in the last fiscal year. That is the highest amount in history and more than three times as much as the highest deficit during the last administration. The budget President Obama submitted to Congress doubles the deficit in 5 years and triples it in 10. It also creates more debt than the combined debt under every President since George Washington. That seems almost impossible, but it is true.

The President's budget creates more debt than all of the debt ever combined

throughout the history of the country, from George Washington all the way up through George Bush, more debt under President Obama's budget than all of that combined.

Even Management and Budget Director Peter Orszag has said that is not sustainable. The debt has reached an almost unimaginable sum of \$12 trillion. To pay the Federal Government's bills for the next 2 months, tomorrow we are going to consider passing a roughly \$300 billion increase in the allowable U.S. national debt known as the debt ceiling. That means our debt ceiling, now \$12.1 trillion, will be \$12.4 trillion. After those 2 months, we will need to add another \$1.5 trillion to the debt ceiling to pay for the remaining spending in the year 2010.

Early next year our debt ceiling will be a whopping \$13.9 trillion. Of the massive national debt, a paper by the Heritage Foundation tells us:

The recession and excessive spending have caused the debt held by the public to grow sharply to 56 percent of the economy, topping the historic average of 36 percent. To make matters worse, entitlement programs will double in size over the next few decades and cause the national debt to reach 320 percent of the economy.

That is so obviously unsustainable that it has to be of great concern to us. It is like the size of a credit card being several times more than our income, such that we can never pay the debt on the credit card. That is even to ignore the interest payments. Let's not forget about that. That is another tab we have to pick up. I have only been talking about the principle. But in 2009 alone, interest payments were \$209 billion. By the year 2019, interest payments are expected to reach \$800 billion a year. That is just the interest on the debt.

How are we going to afford that? By the way, who do we pay that to? We pay it to all the people we borrow money from, one of which is the nation of China. Chinese officials have indicated that they are very nervous about the amount of debt the United States is taking on.

In mid-March, Chinese Premier Wen Jiabao voiced concerns about U.S. Government bond holdings:

We have lent huge amounts of money to the United States. Of course we are concerned about the safety of our assets. To be honest, I am a little bit worried, and I would like to . . . call on the United States to honor its word and remain a credible nation and ensure the safety of Chinese assets.

What can a lender do when he or a nation becomes concerned that the borrower is going to have trouble paying back, when the borrower keeps coming back for more and more lending? What you do is you raise the interest rate to reflect the greater risk in the lending of the money. That is what is going to happen to us. That greater interest rate is going to be manifest in payments that we have to make by our

productivity and the taxes we pay. That will decrease our standard of living and create an additional obligation on the American people.

President Obama has acknowledged the problem. He said:

We can't keep on just borrowing from China. We have to pay interest on that debt, and that means we are mortgaging our children's future with more and more debt.

He is right. So why does he propose more spending and more borrowing and more than any other President in the history of the world?

It is time for words and actions to match. It is time for Congress and the President to start reining in this out-of-control spending and debt. I stand with my colleague from Alabama in support of his amendment to reinstate statutory spending caps. While this is not a panacea for solving the fiscal problems the Nation faces, it is a good way to start on the path to responsibility. I will bet that most of our colleagues on the other side of the aisle will vote against it. It is wrong for them to expect Republicans to extend the debt ceiling as long as they are unwilling to do anything to get spending under control.

Americans expect us to get this spending and debt under control. When we return to the Senate in January, our first item of business will be a long-term debt ceiling extension, including consideration of the Sessions amendment and others. After pushing the stimulus, the auto bailout, cash for clunkers, the massive \$2.5 trillion health care bill, and others, I would hope our Democratic colleagues are ready to take a breather from their big spending and support a more reasonable course so that we don't have to continue to extend the Nation's debt ceiling.

The PRESIDING OFFICER. The Senator from Alabama.

Mr. SESSIONS. Mr. President, I thank Senator KYL for his consistent performance over his entire career in the Senate of trying to maintain financial responsibility in this body, and I respect him highly on that and many other issues.

There is so much we could say at this point on the debt limit, on which we expect the vote tomorrow. I am not going to vote on a debt limit increase until we accompany it with some action that will actually reduce the incredibly irresponsible path we are on. That is going to be one of my positions, and I think others will take the same view.

Saying we have to increase the debt—well, we have to do something about reckless government spending. We really do. We have to do something about it. They always say: Next year. So I say: When? I believe we should condition any increase in the debt limit on the passage of legislation that would renew what has expired, spending caps on the discretionary spending

accounts. I thank Senator KYL for supporting the legislation.

In other words, we can do that. We did it in 1990. You can see, as shown on this chart, the declining expenditures that resulted in those numbers. We passed it in 1990. As shown on this chart, those yellow lines represent the deficit—up to \$300 billion, and it began to shrink. In late 2000, 2001, we had surpluses in our accounts. It is odd to show a surplus, shown below the line on this chart, but we accomplished that.

President Clinton liked to claim credit for it. I have a vague memory that Republicans shut the government down to contain President Clinton's spending. But there were battles over containing spending, and it worked. A big key to it was the spending limits, the spending caps. Those expired in 2002, and, look, we began to show the increases in deficits again. So I think as a condition of voting for a debt increase we should have a fix of the restoring of the caps.

Senator KYL made reference to the fact that under President Obama's 10-year budget he submitted earlier this year, which was scored by the Congressional Budget Office, a nonpartisan group, but the leaders were picked by the Democratic majority. What would it do to our deficit, I ask? He has a budget for 10 years. He shows what he expects to have in revenues during those 10 years and what he expects to spend. He does not show, however, what is spent in the health care legislation because that was not in law at the time the budget was submitted. So in truth it will be worse than this.

But let's look at this. In 2008, the debt was \$5.8 trillion; in 2013 it doubles to \$11.8 trillion; and by 2019, it triples to \$17.3 trillion. That is a stunning tripling of the public debt of the United States of America. It is an unsustainable path. One of the most grim parts of the scoring of this deficit expansion is it is not getting better. In years 8, 9, 10, the deficit is going up to almost \$1 trillion a year; in 2019—the 10th year—going up. They are not projecting during that 10 years any recession. In fact, they projected that we would come out of the recession we are in now faster than we are coming out of it. So the numbers probably will be worse there.

This is not made up. This is the President's budget. It is scored by this Congress's CBO, and it is the best numbers we have. It is a stunning development. We cannot continue. That is why people say it is unsustainable.

Senator KYL made reference to this. I made a chart on it some time ago. I just could not believe it. In 2009, the total interest this government paid on the debt we owe was \$170 billion. You can see, this chart shows the annual interest payments we make that are surging year after year. It is the result of several things.

CBO is cautious, but they are acknowledging that interest rates are going to go up. We have virtually zero interest rates in short-term Treasuries today. That is not going to continue. So you have more debt and higher interest rates. You get surging interest payments.

In 2017, we have interest payments over \$600 billion. It goes over, in 2019—1 year's interest—\$799 billion. As I recall, the supplementals we have used to fund the war in Iraq represented about \$70 billion a year. A couple years ago, our highway spending was about \$40 billion a year. Aid to education is about \$100 billion a year. In 2019, in 1 year, we will pay \$799 billion, I think, at a minimum, just in interest. You see how huge those numbers are? It is unsustainable. We cannot continue to do this.

The American people understand it. CNN did a poll last month. They asked this question of the American people:

Which of the following comes closer to your view of the budget deficit—the government should run a deficit if necessary when the country is in a recession and at war or the government should balance the budget even when the country is in a recession and is at war?

What do you favor? Sixty-seven percent say: "Balance the budget."

Well, what is Congress doing? Running the most incredible series of deficits we have ever seen, tripling the national debt in 10 years—all in furtherance, basically, of President Obama's budget, which calls for this.

Sure, President Bush was not as frugal and fiscally responsible as he should have been. Most, however, of his debt was driven by war costs. But regardless, he could have been more frugal and spent less. But the deficits he had would come in at half or less than half of the deficits we are going to see on average over the next 10 years. So I have to say, we are losing our perspective.

This health care reform bill is a serious matter. We have a report this morning from the Congressional Budget Office that clarifies what has been pretty obvious to us for some time, but it was difficult to get an official accounting of how these numbers are scored or added up by the Congressional Budget Office.

But, basically, what they say is pretty simple. They are saying that proposals in this bill that raise the payroll tax on Medicare and reduce expenditures within Medicare—cutting Medicare—saves money. It puts more money in the pot. But it is part of the Medicare trust fund pot. As to that savings, it is said: Well, we will just spend it over here and pay for this new health care program that was just voted on earlier today.

So we are going to take this savings and increased revenue to Medicare, and we are going to spend it over here. This

is a chart I just put together to try to show that. As shown on this chart, here is Medicare. You raise Medicare income and you cut their costs and you create an extra surplus. We have some surplus still in Medicare. If we do not do something about it, Medicare will be in deficit in 2017—8 years. So this transfer of money then goes to the U.S. Treasury, and: Oh, we have extra money, let's spend it on a new health care reform that has never before been passed, creating benefits for people who have never received these kinds of benefits before because we want to be helpful to those people, create more insured people in America.

But as the CBO said, you cannot count this money twice. What about the people who are paying into Medicare, who have been paying into it for 40 years? They have not received a dime of benefit—until they get to age 65—and it is their money they are putting into Medicare. They are not just giving it over here to the U.S. Treasury.

As one of them wrote me: You are taking my money. I am 67. I am just now beginning to draw Medicare. You are taking my money and giving it to somebody else. I have never received any benefits from Medicare until now, and you are taking it from me.

So as a matter of the way our accounting occurs, the U.S. Treasury cannot take that money just free and clear. It is not extra, free money.

I see my colleague. I want Senator BAUCUS to recognize that according to the CBO Director—he told me last night, there are bonds issued. Treasury has to give a bond to Medicare, a Treasury note, an IOU. So when Medicare starts running in default—as it will within the next 15 years if this bill were to pass—when Medicare starts running into default, they are going to have the Treasury pay for it. So, in effect, this bond causes the U.S. Treasury to pay interest to Medicare.

During this first 10 years, the U.S. Treasury will pay interest to Medicare of \$69 billion on the money they borrowed—this IOU here. Then, when it goes into default—as it is inevitably heading into default—the Treasury will have to pay those bonds. So it increases the debt.

What CBO says, without any equivocation, is—it is not disputable—the debt of the United States will be increased by this bill, not decreased. It will not be a \$132 billion surplus in reality but will be a \$170 billion deficit, just on that. Then, when you get to what Senator THUNE talked about, other gimmicks in the bill, it makes that even worse.

You say, well, the CBO has a score that says it is a \$132 billion surplus. It reduces our debt \$132 billion. Well, the way they are doing this, and the way that accounting is done, with trust funds and nontrust funds in a unified

government budget, they do not score this IOU because they seem to think it is all one government, and so what is one is not the other, and it is not debt. But it is a debt, and they said it explicitly. You cannot count the money over here as adding to the life of Medicare and at the same time score this as free money to be spent over here on this program.

President Obama, Monday, at a press conference, said it is going to reduce our deficit \$132 billion, and it is going to extend the life of Medicare by 9 years. Well, you cannot do both, as they have explicitly stated in the letter we got from CBO, and it is just a matter of absolute fact.

They say:

To describe the full amount of HI trust fund savings—

Over here in Medicare—

as both improving the government's ability to pay future Medicare benefits and financing new spending outside of Medicare would essentially double-count a large share of those savings. . . .

Well, these kinds of gimmicks and manipulations have been done before, but it is time to end it. I think the American people have said: In a time of war, in a time of recession, we need to get busy about the budget—by a two-thirds vote.

They are right. We are going to work our way out of this recession. This American economy will respond sooner or later and, hopefully, sooner for the people of the United States.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. SESSIONS. Mr. President, is that the 10 minutes on this side? And is there time left on this side? I ask unanimous consent to have 3 additional minutes.

Mr. THUNE. Mr. President, I think our side has another 10 minutes or so, with which I would perhaps enter into a colloquy with the Senator from Alabama.

I would ask the Senator, on the point he made—and I give the Senator great credit for raising that question to the CBO—because I think it is intuitive to most people that you cannot spend money twice; that you cannot somehow double-count it. That is essentially what the CBO said in their letter. I think the Senator quoted from it.

They went on to say—CBO has written “that the savings to the HI trust fund . . . would be received by the government only once, so they cannot be set aside to pay for future Medicare spending and, at the same time, pay for current spending on other parts of the legislation or on other programs.” That is the argument we have been making all along. I guess finally it dawned on the CBO, evidently, and it took the Senator's question, I think, to get them to respond this way.

But the way the Senator explained the interaction between government

trust funds, the unified budget, and the IOUs the government writes to itself, perhaps gives some explanation to how they came up with this actually achieving a savings. But the Senator made it very clear: \$170 billion actually to the deficit. As I mentioned earlier, the accounting gimmicks that have been used have understated the 10-year cost of this. By the way, my staff corrected me. The off-the-top-of-my-head calculation was \$177 billion in deficit; it is actually \$187 billion. So you add that to what you mentioned, pretty soon you have what they are claiming is a \$170 billion savings turns into a very sizable deficit.

So I would ask the Senator from Alabama—again, I give him great credit for bringing this to light, raising this issue with the CBO—what does that mean for this piece of legislation we are going to be voting on tomorrow, a \$2½ trillion expansion of the government financed through tax increases and Medicare cuts. Yet even with all that, the assumption is, this is not going to meet the requirement the President set out; that is, that it doesn't add a single dime to the deficit.

What does that mean to that commitment made by the President and to this legislation's sort of fiscal situation as we move forward and to these negotiations or discussions, if this passes tomorrow, with the House of Representatives?

Mr. SESSIONS. This is a huge issue. I remember a few months ago, in a joint session of Congress, President Obama spoke to us. He looked out at the crowd and said: This bill will not add one dollar—or one dime—to the national debt. It was a firm commitment to all the American people who were listening, all the Congressmen and Senators in that room—it will not add to the debt. So what we now know is that this bill is going to add to the debt. There is no doubt about it. The debt of the United States will increase. It is a dangerous trend that happens in a lot of different ways that has put us onto this course.

I think he recognized you shouldn't increase the debt. He recognized, if he is going to create an entirely new health care program over here, it ought to be paid for, and he promised to do that. We have Members of this body, Members of the House who supported the bill, based on the promise it would not increase the debt. But we have now, conclusive proof, in any number of different ways but particularly with the CBO score, that it will increase the debt. It is a decisive issue as far as I can see.

Mr. THUNE. If the Senator will further yield, in addition to this revelation from the CBO, which I think does change the game and the whole debate about whether this is a budget buster, which it has been described as, in spite of the fact that our colleagues on the

other side have been arguing it extends the life of Medicare, I think this statement by the CBO certainly shreds the notion that you can have it both ways; that you can double count this money; that you can spend it twice. You can't do that. I think the American people get that, which is why they believe it will add to the deficit as well.

But there are other things in this bill—

Mr. SESSIONS. I would just say my understanding, having looked at this at some length and given it thought, is the legislation will extend Medicare because it increases the Medicare tax, and that will bring in more money. It pretends we will slash provider payments on health care and others and save money that way. So, on paper, it definitely should extend the life of Medicare.

What do we do with the money? Well, the money that is saved is not staying in Medicare. It is being borrowed by the U.S. Treasury to spend on a new program, and the U.S. Treasury owes it to Medicare. We can see in the trends in Medicare it will not be too many years before Medicare is going to want that money. That is going to leave us over here, and that is why we have a debt. It increases our debt, and we are going to have to pay that back—our children, our grandchildren—sooner than that. Hopefully, we will be around to pay some of that back.

So that is the problem we have. It is a misrepresentation to say this creates money that can fund a program on a permanent basis. It does not. It is just an internal debt situation.

Mr. THUNE. If the Senator will further yield, a couple other items that are being used to get us to where this argument can be made, which is that there are savings from this, this \$132 billion savings and deficit reduction the majority has talked about also includes the creation of an entirely new program called this CLASS Act.

There were eight Democratic Senators who wrote a letter, basically, asking that the CLASS Act not be included in this bill, recognizing what many have; that is, that the CBO has recognized that while it may show some savings in the early years, when people are paying premiums, it is similar to everything else. That money, when it gets spent on other things, isn't there to pay out benefits when the time comes to pay out benefits. So we get this artificial \$72 billion infusion of cash in the early years, which is being used to, again, understate the cost of this and to demonstrate—or to make the argument that there is, in fact, \$132 billion in savings here or deficit reduction.

There is \$72 billion that this CLASS Act represents in that first 10-year window which, as I described earlier, our colleague on the other side has described it as a Ponzi scheme. But it

does create an entirely new program, not unlike some of the entitlement programs that already exist, where payments are coming in now that are being used to spend for other purposes that someday, when the chickens come home to roost, there is going to be another reckoning. Again, I think it is another example of a program of a way in which this financial picture, with regard to this health care bill, is understating its true costs and its impact on deficits in the long run.

I would ask my colleague from Alabama, having looked at that particular program, if he would agree that too is something that is going to cost us significantly in the outyears and whether that is something that ought to be included as counted toward the whole calculation on deficit reduction in this legislation.

Mr. SESSIONS. I thank Senator THUNE for his leadership in exposing this. The way I believe this operates—and you correct me if I am wrong—but the way I believe it operates is it requires a certain number of premiums now, and the actuaries who score these things say that in the years to come, there will be claims on those policies and people will claim more and more as they get older and the years go by and it becomes actuarially unsound. But in the first few years, on paper—on paper—for the first 2 years, it looks good because you have more coming in than going out. So they are scoring this short-term surplus—correct me if I am wrong—they are scoring this as an asset, as income to the Treasury, when the contracts people have when they start paying this money in protects them for years and years to come, and in the future they will be making more claims than are paid out.

That is why it is actuarially unsound and will increase the debt in the long run. Would the Senator describe it that way?

Mr. THUNE. Well, I think that is exactly how it would work. Again, it is another gimmick, if you will; another accounting tool.

Mr. SESSIONS. So it is dishonest. When you know a program is not actuarially sound and it is going to take additional Federal Government revenue to honor the contracts in the years to come, to count that today as an asset is wrong. It is improper to do that. We ought not to propose a plan that has a Ponzi scheme-type nature to it.

Mr. THUNE. Well, I don't disagree, and I think the American people agree with that.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. SESSIONS. I thank the Chair and yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, this has been an interesting discussion we have

heard in the last 15, 20 minutes. One can do anything with figures, numbers. I am not going to cite the often-used phrase that some category of people can figure, another category of people can do something else. But anyway, one can do anything with numbers, anything whatsoever. Frankly, this is an effort to confuse by pulling different figures out from one document and then another and concocting—they can put a board up here. It is just an effort to confuse. One can do anything with numbers.

The real question is, What are the facts?

Mr. SESSIONS. Will the Senator yield?

Mr. BAUCUS. I wish to first make a point, and I will yield later to the Senator.

The Congressional Budget Office stands by its analysis. I have before me an e-mail sent today, dated today's date, 2:56 p.m., and let me read it, from the Congressional Budget Office:

The Congressional Budget Office has been asked whether our memo this morning discussing the effect of [this legislation] incorporating the manager's amendment, on the federal budget and on the balance in the Hospital Insurance trust fund alters CBO's earlier findings about the budgetary impact of the legislation. It does not. In particular, as described in our December 19 and December 20 letters to Senator Reid—

Let me continue reading and, hopefully, Senators are listening to this because this is a letter today, actually it is an e-mail today, at 2:56 p.m. CBO says:

CBO and the staff of the Joint Committee on Taxation estimate that the legislation would reduce federal budget deficits by \$132 billion during the 2010–2019 period.

Next:

CBO expects that the legislation would reduce federal budget deficits during the decade beyond 2019 relative to those projected under current law—with a total effect during that decade that is in a broad range between one-quarter percent and one-half percent of GDP.

Of course, we know that is about \$650 billion to \$1.3 trillion. That is CBO today.

Third:

CBO expects that the legislation would generate a reduction in the federal budgetary commitment to health care during the decade beyond 2019.

So what everyone says—and I might say to my good friend from Alabama, part of that chart he had before us today is accurate, I mean the flow of Medicare and the IOUs and so forth. The part that is inaccurate is the increasing debt and the double accounting part. There is no double accounting here. There are separate accounting regimes and procedures that are used for all trust funds, including Medicare. The Medicare trust fund issues dollars that are in surplus in the outyears, as the Senator said, that have been held by the trust fund—by the trustees—and

dollars that are used in any way the Federal Government decides to spend dollars, either pursuant to legislation or maybe the administration on its own may be spending some dollars in one place or another.

This is not double accounting. Nobody has claimed there is double accounting. There are two different regimes and that is how—the Senator accurately described how the Medicare trust fund is accounted for. But it is also true that under our budget rules, we have a unified budget, there is one government—U.S. Government—there is Medicare and the rest of the government, and under that unified budget regime, the CBO still reaches the same conclusion it has always reached. I would like that to be on the RECORD.

The Senator has a question.

Mr. SESSIONS. Mr. Chairman, I would agree that—

The PRESIDING OFFICER. The Senator will address the other Senator through the Chair.

Mr. SESSIONS. Mr. President, will the Senator yield for a question?

Mr. BAUCUS. Mr. President, I yield for a question.

Mr. SESSIONS. I think that CBO's second statement is correct. I think the statement they did earlier about the \$132 billion surplus reducing the debt over 10 years is technically accurate. But I think the statement they issued early this morning that this is—to count it in both places is a double count of the money, in effect.

My question to the Senator is, we are going to be talking about voting on the debt limit tomorrow.

Mr. BAUCUS. That is correct.

Mr. SESSIONS. The debt limit is the gross debt of the country.

Isn't it true the passage of this health care bill will increase the gross debt of the country, the gross debt being both the public debt and the intergovernmental debt?

Mr. BAUCUS. No, that is not—

Mr. SESSIONS. Will not the bill increase the gross debt of the United States?

Mr. BAUCUS. If I might respond and answer the question—no; the exact opposite. CBO says so. CBO says it actually reduces the debt by \$1 billion.

Mr. SESSIONS. I am asking the difference. The question is gross debt. Does it reduce or increase the gross debt?

Mr. BAUCUS. If I might, Mr. President, as the Senator knows, the debt is the accumulation of deficits, and by definition, if a deficit is reduced, therefore, the national debt is also reduced. That is a mathematical truism. If the deficit is reduced, automatically the debt is reduced. That is mathematics.

The next point I want to make, there was substantial debate today about the constitutionality of this bill. As I have discussed before, we have confidence that the health care plan we have

crafted is an appropriate exercise of the commerce clause and does not violate the 10th amendment. We further believe that ample power is available under the takings and spending power, as well.

I ask unanimous consent to have printed in the RECORD two articles by Prof. Erwin Chemerinsky and Prof. Michael Dorf.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From *Politico*, Oct. 23, 2009]

HEALTH CARE REFORM IS CONSTITUTIONAL

(By Erwin Chemerinsky)

Those opposing health care reform are increasingly relying on an argument that has no legal merit: that the health care reform legislation would be unconstitutional. There is, of course, much to debate about how to best reform America's health care system. But there is no doubt that bills passed by House and Senate committees are constitutional.

Some who object to the health care proposals claim that they are beyond the scope of congressional powers. Specifically, they argue that Congress lacks the authority to compel people to purchase health insurance or pay a tax or a fine.

Congress clearly could do this under its power pursuant to Article I, Section 8 of the Constitution to regulate commerce among the states. The Supreme Court has held that this includes authority to regulate activities that have a substantial effect on interstate commerce. In the area of economic activities, "substantial effect" can be found based on the cumulative impact of the activity across the country. For example, a few years ago, the Supreme Court held that Congress could use its commerce clause authority to prohibit individuals from cultivating and possessing small amounts of marijuana for personal medicinal use because marijuana is bought and sold in interstate commerce.

The relationship between health care coverage and the national economy is even stronger and more readily apparent. In 2007, health care expenditures amounted to \$2.2 trillion, or \$7,421 per person, and accounted for 16.2 percent of the gross domestic product.

Ken Klukowski, writing in *POLITICO*, argued that "people who declined to purchase government-mandated insurance would not be engaging in commercial activity, so there's no interstate commerce." Klukowski's argument is flawed because the Supreme Court never has said that the commerce power is limited to regulating those who are engaged in commercial activity.

Quite the contrary: The court has said that Congress can use its commerce power to forbid hotels and restaurants from discriminating based on race, even though their conduct was refusing to engage in commercial activity. Likewise, the court has said that Congress can regulate the growing of marijuana for personal medicinal use, even if the person being punished never engaged in any commercial activity.

Under an unbroken line of precedents stretching back 70 years, Congress has the power to regulate activities that, taken cumulatively, have a substantial effect on interstate commerce. People not purchasing health insurance unquestionably has this effect.

There is a substantial likelihood that everyone will need medical care at some point.

A person with a communicable disease will be treated whether or not he or she is insured. A person in an automobile accident will be rushed to the hospital for treatment, whether or not he or she is insured. Congress would simply be requiring everyone to be insured to cover their potential costs to the system.

Congress also could justify this as an exercise of its taxing and spending power. Congress can require the purchase of health insurance and then tax those who do not do so in order to pay their costs to the system. This is similar to Social Security taxes, which everyone pays to cover the costs of the Social Security system. Since the 1930s, the Supreme Court has accorded Congress broad powers to tax and spend for the general welfare and has left it to Congress to determine this.

Nor is there any basis for arguing that an insurance requirement violates individual liberties. No constitutionally protected freedom is infringed. There is no right to not have insurance. Most states now require automobile insurance as a condition for driving.

Since the 19th century, the Supreme Court has consistently held that a tax cannot be challenged as an impermissible take of private property for public use without just compensation. All taxes are a taking of private property for public use, but no tax has ever been invalidated on that basis.

Since the late 1930s, the Supreme Court has ruled that government economic regulations, including taxes, are to be upheld as long as they are reasonable. Virtually all economic regulations and taxes have been found to meet this standard for more than 70 years. There is thus no realistic chance that the mandate for health insurance would be invalidated for denying due process or equal protection.

Those who object to the health care proposals on constitutional grounds are making an argument that has no basis in the law. They are invoking the rhetorical power of the Constitution to support their opposition to health care reform, but the law is clear that Congress constitutionally has the power to do so. There is much to argue about in the debate over health care reform, but constitutionality is not among the hard questions to consider.

[From *FindLaw Legal News*, Nov. 2, 2009]

THE CONSTITUTIONALITY OF HEALTH INSURANCE REFORM, PART II: CONGRESSIONAL POWER

(By Michael C. Dorf)

Although many key details remain to be negotiated, Congress appears poised to enact some substantial reform of American health care that will build on, rather than replace, our patchwork of government, private, and non-profit insurance. The bill that the President signs will likely contain, among other things, an "individual mandate" requiring that everyone obtain health insurance or face a financial penalty. Would such a mandate be constitutional?

In my last column and an accompanying blog entry, I considered and rejected the objection that an individual mandate would be an unprecedented burden on liberty because it would affirmatively direct conduct, rather than either forbidding conduct or imposing affirmative obligations on only those who engage in conduct that the government has the power to forbid. As I explained, there are substantial precedents for such affirmative obligations and even if there were not, there is no reason in principle why an affirmative

duty is a greater restriction on liberty than a prohibition or condition.

In this column, I consider a different objection to the individual mandate: the claim that the federal government lacks the authority under the Constitution to impose the mandate or to penalize those who do not comply. As I explain, this objection is also unsound as a matter of constitutional law. I conclude, however, that individual members of Congress ought to decide for themselves whether regulating health care in the manner of the proposed bills is an appropriate job for the federal government, or instead should be left to state regulation or the market.

IS A REGULATION OF HEALTH CARE A REGULATION OF INTERSTATE COMMERCE?

Under the Tenth Amendment, Congress may only enact legislation that falls within one or more of its enumerated powers. Most of those powers—and all of the powers that are potentially relevant in the health insurance reform debate—are found in Article I, Section 8. From the very earliest days of the Republic, there has been controversy about the scope of those powers.

Consider, for instance, that the Constitution does not expressly grant Congress the power to charter a bank. Accordingly, President George Washington asked two of his Cabinet members to prepare memoranda on whether that power could nonetheless be inferred from the powers that are enumerated in the Constitution—including the powers to regulate interstate and foreign commerce, to coin money, to lay and collect taxes, to spend money for the general welfare, and to enact such laws as are "necessary and proper for carrying into execution the" specifically enumerated powers.

Arguing for a position that would today be called "states' rights," Thomas Jefferson said no. The enumerated powers had to be construed narrowly, he said, or else the federal government would completely overshadow the states. Alexander Hamilton disagreed, however. He explained that in order to carry out the powers it was expressly granted, Congress must have implied powers. Washington sided with Hamilton and, years later, in the landmark 1819 case of *McCulloch v. Maryland*, so did the Supreme Court.

At various points in American history, politicians and judges have flirted with the Jeffersonian view, but for the most part, the Hamiltonian position has prevailed, especially with respect to laws purporting to regulate interstate commerce. Thus, under the Supreme Court's 1942 decision in *Wickard v. Filburn*, Congress can forbid a farmer from growing more wheat than his federal quota allows on the theory that if he does not grow wheat, he will purchase it, which will affect the interstate market.

Likewise, in the 2005 case of *Gonzales v. Raich*, the Court said that in the course of regulating the national illegal market in marijuana, Congress could forbid the intrastate, noncommercial production and consumption of medical marijuana, even if it is legal under state law. The Court explained that Congress legitimately worried that making an exception to the general prohibition on marijuana use for medical marijuana use that is authorized by state law could substantially undermine the government's ability to police other marijuana production, distribution, and possession.

That same logic applies to the individual mandate in the health insurance context. As I explained in my last column, the main point of the individual mandate is to ensure that insurance companies cover people even though they have pre-existing conditions.

Without the individual mandate, however, many young, healthy people would decline insurance until they got sick, creating a severe adverse selection problem. Thus, the individual mandate is closely connected with the regulation of health insurance, just as the Court said in *Raich* that the regulation of marijuana that is used for medical purposes is closely related to the regulation of the broader market for marijuana.

Health care is an enormous interstate business. It therefore counts as interstate commerce, regulable by Congress. Just as, in *Raich*, Congress acted constitutionally by declining to exempt individual acts of non-commercial intrastate marijuana possession from the Controlled Substances Act, so too Congress would act constitutionally by including an individual mandate within the ambit of its regulation of health care.

IS EXISTENCE AN "ECONOMIC ACTIVITY"?
THAT'S THE WRONG QUESTION

Skeptics nonetheless point to two Supreme Court cases—the 1995 ruling in *United States v. Lopez* and the 2000 decision in *United States v. Morrison*—as grounds for the conclusion that the individual mandate would be beyond the power of Congress under the Commerce Clause. In *Lopez*, the Court invalidated a federal criminal law forbidding possession of a firearm near a schoolyard. In *Morrison*, the Court rejected a federal law providing victims of gender-motivated violence with a right to sue their attackers. Both decisions reasoned that Congress typically cannot regulate "noneconomic" intrastate activities on the ground that they affect interstate commerce.

Accordingly, lawyers David Casey and Lee Rivkin, writing in *The Washington Post* in August, concluded that *Lopez* and *Morrison* make the Commerce Clause unavailable as a source of congressional power for the individual mandate because a human being's mere existence is not a form of economic activity. Indeed, they might have added, existence is not an activity at all.

Although the issue is not entirely free from doubt, I do not think that Casey and Rivkin have correctly read the precedents. In *Lopez* and *Morrison*, Congress sought to prohibit activities—firearms possession near schools and gender-motivated violence, respectively—that were not, according to the Court, "economic." In those two cases, it was only by several logical inferences of the handbone-connected-to-the-wristbone-wristbone-connected-to-the-elbow-bone sort that one could move from the regulated activity to an effect on commerce. For example, in *Lopez*, the theory went as follows: Guns near schools intimidate children; intimidated children have a hard time concentrating on their studies; they learn less; they then grow up to be less productive members of society; and thus the national economy suffers. Even though each link in this chain is plausible, the *Lopez* majority reasoned that if the Court were to allow this sort of inferential process, then virtually anything would count as a regulation of interstate commerce. Acknowledging that congressional power under the Commerce Clause is very broad, the Court in *Lopez* and *Morrison* nonetheless insisted that it is not infinitely broad.

By contrast with the laws that were invalidated in *Lopez* and *Morrison*, the individual mandate is quite close to the core of the Commerce Clause. Treating the mere existence of a human being as the predicate of regulation in the health care bills would miss the point. Whereas the Gun Free School Zones Act in *Lopez* and the civil remedy provision of the Violence Against Women Act in

Morrison sought to discourage certain conduct, the point of the individual mandate is to encourage certain conduct. And crucially, the conduct the individual mandate seeks to encourage is quintessentially economic: It is the purchase of a service, namely health insurance.

Does Congress have the power to encourage people to engage in market transactions? Of course it does. That, after all, was the whole point of the law upheld in *Filburn*: By limiting the amount of wheat that farmer *Filburn* could grow, the government sought to encourage him to buy compensating amounts on the market. As the unanimous Court explained in a ruling that the more recent cases expressly reaffirm: "The stimulation of commerce is a use of the regulatory function quite as definitely as prohibitions or restrictions thereon."

In the end, then, the argument of Casey, Rivkin, and others who oppose the individual mandate on Article I grounds amounts to no more than the assertion that the Constitution forbids Congress from using the most direct means of encouraging market activity: a mandate that individuals do so. But there is nothing in the text or history of the Constitution to support that conclusion.

Indeed, the *Ur*-decision about Article I power, *McCulloch*, says the exact opposite: "Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional."

As we have seen, the individual mandate is "plainly adapted" to the undoubtedly legitimate end of regulating the enormous and enormously important health-care sector of the national economy. It is therefore constitutional.

THE TAXATION POWER

In light of the broad interpretation the Supreme Court has given to the enumerated powers of Congress, an Act may be justified on more than one constitutional ground. Thus, the individual mandate could alternatively be upheld as a valid exercise of the Article I power to "lay and collect taxes, duties, imposts and excises," as bolstered by the Sixteenth Amendment's authorization of an income tax. After all, in most versions of the individual mandate, Americans are not literally required to purchase health insurance: Instead, they are told to pay a tax from which they can be exempted if they have health insurance.

To be sure, as Casey and Rivkin observe, a 1922 case, *Bailey v. Drexel Furniture Co.*, holds that Congress may not use taxation as a pretext for accomplishing a regulatory objective that it could not accomplish directly. But subsequent cases upholding "occupational taxes" on businesses that Congress clearly intended to discourage, have made clear that a tax that serves a revenue-raising purpose is not invalid simply because it also serves a regulatory purpose. And there is no doubt that the tax on uninsured income earners would serve a valid revenue-raising purpose—namely, to defray the costs of subsidizing health insurance for those who could not otherwise afford it.

Thus, even if Congress lacked the power to adopt the individual mandate under the Commerce Clause, the taxing power would separately authorize a properly-worded tax on the uninsured, despite its regulatory impact.

FEDERALISM IN CONGRESS: ITS MEMBERS, TOO,
CAN CONSIDER THE CONSTITUTIONAL DIMENSIONS OF LEGISLATION

The foregoing analysis shows why an individual mandate would be upheld against a court challenge, so long as the courts faithfully apply the current Supreme Court precedents. Nonetheless, members of Congress are entitled—indeed, some might say they are obligated—to reach their own constitutional judgment about any bill that comes before them. And that is especially true when there is a question about the proper role of the federal government and the states.

In its cases involving challenges to congressional power, the Supreme Court has sometimes said that the broad deference given to Congress arises out of institutional concerns: Except in extreme cases, the Justices lack the fact-finding capacity and democratic legitimacy to make all of the fine-grained judgments about what matters should be federalized and what matters should be best left to the states. In the words of the late constitutional law scholar Herbert Wechsler, the Court relies on "the political safeguards of federalism" to do most of the work of ensuring a constitutional balance between national and state regulation.

Wechsler pointed to a variety of ways in which the interests of the states are represented in Congress itself. Chief among these are the facts that each state has two Senators, and that electoral districts respect state lines. In addition, as Stanford Law School Dean Larry Kramer has noted in more recent scholarship, the national political parties tie members of a state's congressional delegation to state politicians. Taken together, these and other mechanisms ensure that Congress will not simply federalize everything, leaving no area of regulatory discretion to the states.

Wechsler's point was mostly descriptive: Congress, he said, would in fact take account of state interests. But we might add a normative dimension: Congress should take its constitutional role seriously in matters of federalism, because judges are going to be highly deferential in such matters if and when federal statutes are constitutionality tested.

Accordingly, it would be perfectly appropriate for one or more members of Congress to vote against the individual mandate or health care reform more broadly on the ground that they think such matters should be left to state regulation or to private decision makers. But it would be equally appropriate for Congress to conclude otherwise and thereby join the ranks of the other industrialized countries—including those, like Canada and Germany, with robust commitments to federalism—that have comprehensive national health care systems. Properly understood, the constitutional case law is no obstacle.

DEBT LIMIT

Mr. BAUCUS. Mr. President, tomorrow morning, the Senate will have to vote on legislation to increase the statutory limit on the United States debt. The measure that will be before us will increase the limit by \$290 billion.

The debt limit sets a ceiling on the amount of money the U.S. Treasury can borrow. If we pass this bill, then the Treasury can continue to borrow money until about February 11 of next year. If we do not pass this bill, then at least two very bad things will happen:

First, the United States would default on the interest payments on this

debt for the first time in the history of this country. Second, the Federal Government would be unable to borrow the money it will need to pay Social Security benefits that beneficiaries are entitled to receive.

The bottom line is we have no choice. We have to approve it. The law limits how much money the Treasury can borrow. One might ask: How did we reach the current limit? The answer is simple and it is, frankly—I am trying to give a very fair answer, fair to both sides of the aisle and not be political about this but just be fair and explain how we got to where we are.

The financial crisis and the deep recession the new administration inherited has resulted in record borrowing this year. Let me be specific.

First, the Bush administration asked for and then used authority to spend unprecedented sums of money to help banks, auto companies, insurance firms, Fannie Mae, and Freddie Mac to weather the financial crisis. The prior administration enacted and used these authorities before the current administration even took office. That ran up a huge number, a huge addition to our deficits and debt.

Second, the new administration inherited the great recession. The recession has lowered revenues. To compensate for reduced revenues, the Treasury has had to borrow more.

In addition, the recession has increased the need for Federal spending on things such as unemployment insurance and Medicaid costs for folks who can no longer afford health care. To compensate for these increased outlays, Treasury has had to borrow more as well.

Finally, to keep the recession from becoming a lot worse than it has, the Obama administration had no choice but to enact a vigorous stimulus package, and the Treasury had to borrow the money to make up for this shortfall as well.

Without enactment of this stimulus, the economy could have well descended into a depression. We would have been in far worse economic shape had we not passed the stimulus legislation.

To cover the costs of all these measures—that is those in the Bush administration and those in the Obama administration—the Treasury Department has had to borrow record amounts of money. Unfortunate as it is, we had to do it. Had we not, we would be in much worse shape today.

As a result of this unprecedented borrowing, the Treasury is about to reach the current limit. It is clear that we have no choice but to raise the ceiling on the debt the Treasury can borrow.

We have spent the money. We have to raise the debt limit so bills can be paid. If we do not, the United States will default on its interest payments for the first time in its 220-year history. We cannot let that happen. We will not be

able to pay all the monthly Social Security benefits to which people are entitled. That would be unthinkable.

It is true we have to work harder to reduce these deficits—we have no choice—also, therefore, to reduce our national debt, certainly as a percent of gross domestic product. We have no choice. The point is we are beginning to reach a crisis in the accumulation of deficits and therefore debt. That is clear. We must as a country, as a Congress, working with the President, reduce those deficits in national debt. However, we have to pay our bills. If we do not pay our bills, we default. That would cause catastrophic consequences.

To prevent those catastrophic consequences—that is, other countries having less confidence in the government, less confidence in the ability of the United States to pay its debt, less confidence in the U.S. dollar—we must increase the Treasury's borrowing limit and, for a short period of time, I think it is appropriate and prudent.

I urge my colleagues to vote for this legislation. There is no way around it. It is a necessity. We simply have no choice. We have to pay our debts, but in the future, let's work harder to get our deficits under control.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Mr. President, I am not a member of the Finance Committee and do not have the responsibility Senator BAUCUS does in dealing with these debt ceiling issues. But let me corroborate what he has been saying. Someone once drew the analogy that this is like going out to dinner, ordering a good meal, and then refusing to pay the bill at the end of it. We have a meal in front of us—tragically a meal that got too large because, frankly, the previous administration accumulated a debt without ever asking the American people to pay for it, including the war in Iraq and other items that left us in a hole larger than created by all administrations combined over 225 years of our history—a remarkable achievement. It is not just the deficit of one administration but all 43 Presidents combined had never accumulated what one administration did in 8 years.

I commend my colleague from Montana. This is no easy task. It is a painful vote for anyone to cast, but it is obviously critical. This is more than just a vote in this Chamber. It goes to the very stability of the global economy.

We have to meet our obligations. I, for one, am certainly glad to cast a vote. I do not think it is a difficult vote. It is a hard vote considering what is at stake. But the implications of refusing to support this would be catastrophic to our country.

I thank my colleague.

Mr. President, 10 minutes short of 12 hours from now, we are going to cast our final vote on the national health

care proposal. I have some closing remarks on this historic debate.

Before I do so, I wish to thank once again our staffs who have been involved in all of this. I know my dear friend and colleague from Iowa will talk about this more specifically. I have already announced the names of the majority staff who have made a contribution to this effort.

I think it is fairly clear that tomorrow morning at 7 a.m., when we cast our votes on this proposal, this is going to be a very divided Chamber. Sadly, we are going to end up on a very partisan vote. I suspect something along the lines of 60–40, although obviously we need less than 60 votes to pass the bill at this point. But I suspect the vote will be something like that. I regret that deeply. It saddens me we have come to that moment. But it is what it is.

While last evening I mentioned the members of the staff who are part of the majority staff who made such a contribution—and I thank them once again for their efforts—I want to also mention the minority staff who served their Members well and admirably in this effort, certainly during the markup of our bill in the Health, Education, Labor, and Pensions Committee that Senator Kennedy chaired for so many years, that I had the honor of taking over for him during his period of illness, and is now chaired by my friend from Iowa, Senator HARKIN.

The Senator from Wyoming, MIKE ENZI, is the ranking minority member of that committee. We ultimately had a divided, partisan vote in that committee. But as my colleagues have heard me say over and over again during these days and weeks of debate, a good part of our bill, even though it ended up with a partisan vote, included 161 amendments offered by the minority in that markup session. More than half of all the amendments considered were offered by the Republicans on that committee, on my committee at the time that were adopted almost unanimously in most cases.

I wish to mention the minority staff tonight who made that possible. They strengthened our bill and made it a stronger one. Beginning with Frank Macchiarola, Chuck Clapton, Katy Barr, Todd Spangler, Hayden Rhudy, Keith Flanagan, Amy Muhlberg. They work for Senator ENZI.

Liz Wroe and Jeff Gonzales work for JUDD GREGG of New Hampshire.

Jay Khosla, Patty DeLoatsche—I may have mispronounced that last name; I apologize if I did—along with Paul Williams of Senator HATCH's staff made a significant contribution to the bill.

While, again, there was division on a partisan basis, I thank them for their efforts. They put in long hours as well.

On that note, let me say before getting to the substance of my remarks, I

chair the Senate Banking, Housing, and Urban Affairs Committee. We have been working diligently. In fact, today my good friend and colleague from Alabama, RICHARD SHELBY, and I spent about an hour or so together and then about five or six members, Republicans and Democrats on that committee, spent another hour together, as we have every day almost over the last several weeks trying to fashion a bill on financial services reform that we hope to present to our colleagues on our return in January and February that will deal with the catastrophe that has occurred economically in our Nation.

My hope is as a Chamber—I know my colleagues have heard me say this—I arrived in this Chamber as an employee of the Senate about 50 years ago. I sat on these steps right over here. Lyndon Johnson sat in the Presiding Officer chair. John Kennedy was the President of the United States. I was a Senate page and listened to the all-night debates in the early 1960s on civil rights and got to witness history. I got to watch the Members of this Chamber, some of the historic figures—Hubert Humphrey, Lyndon Johnson, Everett Dirksen—remarkable people who served here. Barry Goldwater, of course. We served together in this Chamber for a period of time when I arrived in the Senate.

Thirty-five years ago on January 3 of next month, I arrived as a 30-year-old Member of the House of Representatives, and 6 years later I arrived here as a freshman Senator 30 years ago. Going back to the sixties, I had a lot to do with this Chamber and watched it over the years.

The best moments occur when we work together. This has been a bitter and difficult battle over the last number of months. But as someone who takes great pride in having been part of this Chamber, as my father was before me, for more than a quarter of the life of our country, I want to see us once again return to the days when we have our partisan debates, which we should because it has built the country.

Partisanship—there is nothing wrong with that. It is our ability to act civilly with each other. I have been deeply disturbed by some of the debate I have heard, usually from newer Members, usually those who have been here 1, 2, 3 years, who do not have an appreciation of what this Chamber means and how we work together.

While we have our differences, the ability to walk away from differences and forge those relationships over the next day is critically important. It is always the newest Members who fail to understand how the Senate has worked for more than two centuries. We need to get back to that sense of civility once again.

I hope when we return in January to deal with new issues that we will get

back to that comity that is important. Not the disagreements. The disagreements are important, but the ability to deal with each other and forge the kind of proposals that serve all of our constituents and serve all of our country is going to be critically important.

I wanted to share that thought with my colleagues this evening as someone who now at the ripe old age of 65 has spent well more than half of my life deeply involved in this institution. It saddens me when we end up being divided and engaged in the ad hominem arguments that I think ridicule the institution, belittle and demean the contributions that each and every Member wants to make.

Even though we have had very strong disagreements, I never once in my life in this Chamber ever questioned the patriotic intentions of any Member. We may have strong disagreements on how to best achieve that more perfect Union, but the idea you challenge another's patriotism, honesty, their integrity, does a great disservice to this institution, in my view.

Again, I regret sometimes the newer Members who fail to understand the importance of maintaining that which our Founders envisioned when they created this institution.

This evening I rise to express once and for all and lastly in this debate my strong support for this bill, our Patient Protection and Affordable Care Act of 2009. In a little over a week, this decade, the first decade of the 21st century will come to a close, and it has been a turbulent one for our country. We have been tested by the acts of God and the acts of evil men in this decade. We have entered two wars and have been through a profound recession, almost a depression. Our financial markets have failed. Middle-class families have lost their footing. The American dream is fading for far too many of our families in this Nation.

We wear these 10 years heavily. We have seen deep division in our country, bitter debates within the walls of this Chamber in which all of us are so proud to serve.

We do not have the luxury of tackling only those challenges that can be solved easily. But as Thomas Paine wrote:

The harder the conflict, the more glorious the triumph.

Those words come from a pamphlet called "The American Crisis." It was published 233 years ago this very week at another very uncertain moment in American history. That pamphlet begins with these words:

These are times that try men's souls; the summer soldier and the sunshine patriot will, in this crisis, shrink from the service of his country; but he that stands it now, deserves the love and thanks of man and woman.

GEN George Washington, outmanned, outgunned, and sensing that morale

was flagging in light of recent setbacks, ordered that this pamphlet and these words be read to his deeply troubled and impoverished troops. And on Christmas Eve, 1776, he gathered his officers at McKonkey's Ferry to plan the crossing of the Delaware.

This body has been in session on Christmas Eve only once since 1963—and we will tomorrow—when in the wake of President Kennedy's assassination, the Senate met to consider a bill to fund our operations in Vietnam. We will be in session tomorrow morning, embroiled again in times that certainly try men's souls. Like GEN George Washington, we have an opportunity to meet history's gaze, to steel ourselves to the difficult work of making our Union more perfect.

The journey we complete tomorrow has been a long and difficult one. But I, for one, would not trade it for anything. We who will have the privilege to cast our votes at 7 a.m. tomorrow morning for health care reform will never cast a more important vote in our Senate careers. History will judge harshly those who have chosen to shrink from this moment, but those of us who stand up to make this country more secure, to make our Union more perfect, we will never forget this Christmas Eve. For this Christmas Eve, we have given an incredible gift. We have been granted a rare opportunity to deliver an enormous victory for the American people for generations to come. We have a chance to alleviate tremendous burdens of anxiety and fear and suffering, to make our country stronger and healthier, to deliver the leadership our constituents have demanded—and rightfully so—and the real and meaningful change they voted for 13 months ago. So in the last week of a decade in which so much has been asked of the American people, that is what history now asks of us in this Chamber.

Over the past weeks and months, I have come to this floor to talk about what this bill will do for the citizens of my State and my country. I have talked about how reform will guarantee every American will have access to quality, affordable care when they need it, from the doctor they choose. I have talked about how reform will reduce our national deficit by finally getting health care costs under control. I have talked, as others have, about what reform will do for small businesses—giving them access to health insurance exchanges where they can find the best deals for their workers and a tax credit to help them pay for it. And I have talked, as others have, about how reform will help our older citizens, our seniors, by strengthening Medicare and closing the so-called doughnut hole for prescription drugs and creating a new, voluntary program to pay for long-term care. I, along with others, have talked about how reform

will help doctors and health care providers spend more time caring for their patients, which they want to do, and less time fighting with insurance company bureaucrats. I and so many others have talked about how reform will finally make insurance accessible and affordable for the 350,000 residents of my State and the 31 million people across our Nation who today don't have it, whether it is because they can't afford it or because they have been denied coverage due to a preexisting condition. I have also talked, along with my colleagues, about how reform will finally make insurance a buyer's market, ending a wide variety of abusive insurance industry practices and empowering consumers to make smart decisions.

As has been said so many times, this bill is far from perfect, and we all know that. It represents not the end but, as my friend and colleague from Iowa has said so many times, the beginning of our work. Long after all of us have left this Chamber, however we depart, those who come after us will work on our product. They will make it better, they will make it stronger, they will find our shortcomings in this bill, they will add to it, and they will subtract from it. But they can never engage in those efforts if we do not do the job I am confident we will do tomorrow morning at 7 a.m. on Christmas Eve, and that is to renew the American dream, revive our middle class, and rebuild the foundation upon which future generations will stand.

I am very proud of this legislation, with all its shortcomings. I am proud to have had a role in bringing it to a vote—an accidental role, as all of us know. I wouldn't be standing here talking about it in this context, other than as a Member of this Chamber, were it not for the tragic death of my great friend and colleague from Massachusetts.

President Teddy Roosevelt famously said:

It is not the critic who counts; not the man [or woman] who points out how the strong man stumbles, or whether the doer of deeds could have done them better. The credit belongs to the man who [or woman] is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errs; who comes short again and again, because there is no effort without error and shortcoming; but who does actually strive to do the deeds; who knows great enthusiasms, the great devotions; who spends himself [or herself] in a worthy cause; who at the best knows in the end the triumph of high achievement, and who at the worst, if he [or she] fails, at least fails while daring greatly, so that his [or her] place shall never be with those cold and timid souls who neither know victory nor defeat.

So we happy few, the 60 of us who stand in the arena today, who have fought and argued and compromised and organized so that we might cast this historic vote at 7 a.m. on Christmas Eve, we would not trade this opportunity for anything.

This last year has proven that progress is not easy. Tomorrow, we will prove that it is not impossible. May the next decade in our country's history be shaped by that spirit—by the promise of a brighter tomorrow, by the unshakable desire to rise to the challenges that fate places in our path, by the quest to make our great Nation a more perfect one.

I yield the floor.

The PRESIDING OFFICER (Ms. CANTWELL). The Senator from Iowa is recognized.

Mr. HARKIN. Madam President, I ask unanimous consent that the remainder of the time used on the bill today be for debate only.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HARKIN. Madam President, first of all, before he leaves the floor, I want to thank my dear friend, my colleague, my classmate from 1975, for all his great leadership on this bill. We were all saddened by the fact that our leader, Senator Kennedy, could not be with us over the last year to guide and direct and to see the fulfillment of his lifetime dream of health care reform. It fell upon CHRIS DODD's shoulders to take it through. Madam President, he did it superbly. He kept our committee together.

Again, I just want to say that Senator DODD bent over backward, extended every consideration to the other side to amend and to be involved in the shaping of this bill. As my friend said, we adopted 161 of their amendments out of 220 or so they offered. Not all of them were accepted. Not all of the Democratic amendments were accepted, by the way, in the committee. So I thought Senator DODD went the extra mile to accommodate the other side. He did. I am just sorry that not one Republican saw fit to support the bill when it came out of the committee, but so be it. Because of Senator DODD's dedication and his leadership, we have a great bill here today.

I have been watching the debate, and most of the things people are talking about are items that were in the bill Senator DODD crafted, things that are going to make a big difference in people's lives. I will talk about a few of those in my formal remarks—things such as doing away with preexisting conditions; stopping rescissions, where they cut off your policy when you get sick; keeping kids on their parents' policies longer, and all of the things we fought so hard for regarding prevention and wellness. All of that is in our bill. It is in the bill Senator DODD brought forward out of our committee. So I am proud to have him not only as a friend but as our great leader on this health care bill. Tomorrow morning, when we finally pass it, it will be in no small part because of the great leadership of Senator DODD. So I wanted to thank him on the floor before he leaves to go

home to be with his two great kids and his wonderful wife.

Appreciate it very much, CHRIS.

Mr. DODD. I thank my colleague from Iowa, and we couldn't have done it without him as well. I appreciate it.

Mr. HARKIN. I thank the Senator very much.

Madam President, I also want to thank my good friend from Illinois, Senator BURRIS, for allowing me to go first here, in front of him.

You know, I was kind of feeling bad for myself because I didn't know if I was going to make Christmas Eve with my wife and family for the first time in 41 years. But I think, because of moving up the vote to 7 a.m., I might be able to do that.

But I just found out that today is Senator BURRIS's 48th wedding anniversary. Congratulations, Senator BURRIS. So he is here today and his lovely wife is out in Illinois, but he sent her flowers today. I am sure she appreciated that, but she would much rather be with Roland on this day. My goodness, 48 years—in this day and age, it is hard to find people married that long. So I congratulate Senator BURRIS, who is a great friend of mine personally and a valuable Member of the Senate. I think it shows what people are giving up here to make sure they are here to get health reform passed. Senator BURRIS gave up being with his spouse of 48 years. That is quite a sacrifice.

Thank you very much, Senator BURRIS.

Madam President, as we approach the final vote, again I wish to thank both Senator DODD and Senator BAUCUS for a masterful job of shepherding this legislation through the Finance and HELP Committees.

There is no way we would be here today without the great work of our majority leader. To put it in Biblical terms, Leader REID has the patience of Job, the wisdom of Solomon, and the stamina of Sampson. Senator REID is on the verge of achieving what majority leaders going back nearly a century have failed to accomplish. Make no mistake about it, when this final vote is cast tomorrow morning, Majority Leader REID will have earned his place in the Senate's history.

As we approach the final vote, we have reached a momentous crossroad, just as Senators did in 1935 when they passed the Social Security Act and in 1965 when they created Medicare. Each of those bills marked a giant step forward for the American people. Each was stridently opposed by defenders of the status quo. But in the end, a critical mass of Senators rose to the historic occasion. They voted their hopes, not their fears. As we know now, in retrospect, they passed laws that transformed America in profoundly positive ways.

The Senate has now arrived at another one of those rare historic crossroads. This time, we are going to pass

comprehensive health reform—a great goal that has eluded Congresses and Presidents going back to Theodore Roosevelt.

I make no bones about my enthusiasm for the reforms in this great bill. Is it perfect? Is it what I would write if I could dictate everything? No. There have been genuine compromises made, and that is the art of legislating.

There are a lot of things not in this bill for which I fought very hard, such as a public option or getting a Medicare buy-in at age 55. But I understand the art of compromise. Beyond that, this bill will be the biggest expansion of health coverage since the creation of Medicare.

It cracks down on abusive practices by health insurance companies, abuses that currently leave most Americans one serious illness away from bankruptcy. It includes an array of provisions, including wellness and prevention and public health. Our aim in this bill is to change our current sick care system to a true health care system that keeps people out of the hospital in the first place.

Madam President, I was struck by something that the distinguished minority leader, Senator MCCONNELL, said early Monday morning prior to the first critical cloture vote. Addressing Democratic Senators, the minority leader turned and faced us and said: It's not too late, it's not too late. All it takes is one, just one. Gesturing to this side of the aisle, he said: One can stop this bill; one can stop it, for every single one will own it.

He was talking about Democrats. I say to the minority leader, we Democrats are proud to own this bill. Just as we are proud of our ownership of Social Security and Medicare and the Elementary and Secondary Education Act and so many other reforms, progressive reforms, that have made America the great Nation we are today.

For the record, let me point out exactly what it is that Democrats will "own" by passing this bill. We will own the fact that this bill is fully paid for. Indeed, this bill will reduce the Federal debt by \$132 billion in the first decade and by at least \$650 billion in the second decade. We will own the fact that some 30 million additional Americans will in coming years have access to quality, affordable health care.

Let me mention just a few of the things in the bill that Democrats will own next year as soon as President Obama signs this into law. We will own the fact that next year insurance companies will be required to cover the preexisting conditions of children. We will own that. Think about that. There will be a program to extend coverage to uninsured Americans with preexisting conditions later.

We will own the fact that this bill provides immediate support to health coverage for early retirees. We will

own the fact that this bill will immediately shrink the size of the doughnut hole by raising the ceiling on the initial coverage period by \$500 next year.

We will own the immediate guarantee of this bill of 50 percent price discounts on brand-name drugs and biologics purchased by low- and middle-income Medicare beneficiaries who are in the doughnut hole. We will own the fact that this bill will provide tax credits to small businesses to make employees' coverage more affordable. Tax credits of up to 35 percent of the cost of premiums will be available to small businesses next year.

In addition, we will own the fact that this bill requires health insurance companies to allow children to stay on their family's policies until age 26. Democrats will own the fact that this bill prohibits health insurers from imposing lifetime limits on the benefits consumers believe they are paying for and will tightly restrict the use of any annual limits.

Let me mention one other extremely important thing that, in the minority leader's word, Democrats will own. Our bill, immediately, will stop insurers from the devastating practice of rescinding or cancelling health insurance coverage when a policyholder is seriously ill.

All of those things I mention will happen right away, Madam President, as soon as the bill is signed into law. Taken together, this is a breathtaking catalog of reforms that will benefit the American people immediately. So, we Democrats are very proud, I say to the minority leader, to own these reforms.

We had hoped that our Republican colleagues would also be proud to own them. But let's remember William F. Buckley's conservative model. He is sort of the father of the conservative movement in America. He said the role of conservatives is "to stand athwart history yelling 'stop'." That is exactly what our Republican colleagues have been doing by filibustering and trying to kill health care. They are "athwart history, yelling 'stop'." My friends on the Republican side will be on the wrong side of history, the wrong side of reform, and the wrong side of progress.

I have been saying this bill, the Patient Protection and Affordable Care Act, is like a starter home. It is not the mansion of our dreams. It doesn't have every bell and whistle we would all like, but it has a solid foundation giving every American access to quality, affordable coverage. It has an excellent protective roof which will shelter Americans from the worst abuses of the health insurance companies, and this starter home has plenty of room for additions and improvements.

We Democratic Senators are proud to own this starter home. We are proud of the fact that this starter home is fully paid for. It is a starter home without a mortgage.

Indeed, as I said earlier, this bill will reduce the Federal deficit by \$132 billion in the first decade and by at least \$650 billion in the second decade. So, Madam President, even at this late date before the vote tomorrow morning, I say to our Republican colleagues, Democrats are proud to own this legislation and this starter home. We are proud to own the many reforms and benefits in this bill and we would be very pleased to share ownership with as many of our Republican colleagues who care to join us.

With all due respect to William F. Buckley, it is not written in stone that conservatives have to say no to history. I urge every Senator to say yes.

This bill has many authors. But in a very real sense this is Senator Ted Kennedy's bill. Our late beloved colleague would be so proud to see the Senate on the cusp of passing landmark health care reform. For decades, from his first days in the Senate, this was his highest priority and fondest win. As his friends on both sides of the aisle know, his great dream was of an America where quality affordable care is a right not a privilege for every citizen.

Today, we are on the verge of making that dream a reality. So often Senator Kennedy talked about the moral imperative of health reform. Too often in the debates of recent weeks we have lost sense of this moral imperative. We have heard speeches. We have had charts, back and forth and back and forth on some of the small stuff; who wins, who loses, because of this or that minor provision in the bill.

Today, on the eve of this historic vote, we should refocus on the big stuff, the moral imperative that drove Senator Kennedy. With this bill we will get rid of the shameful dividing line that has excluded millions of Americans for too long. For too long, tens of millions of Americans have been on the wrong side of that divide, without health insurance, without regular medical care for their children, just one serious illness away from bankruptcy. With this landmark legislation we erase that shameful divide within our American family. With this bill we say for every American, for every member of our American family, access to quality affordable care will be a right, not a privilege. It is a monumental achievement.

I urge all of our colleagues to vote yes on this bill.

Now, Madam President, a lot has been said about those of us who have been the leadership on this bill: Senator REID, Senator BAUCUS, Senator DODD, myself, and so many others. It is important to etch in history in our CONGRESSIONAL RECORD the names of those individuals on our staffs, who have done so much to get us to this point. I said earlier there is an old saying that Senators are a constitutional

impediment to the smooth functioning of staff. We kind of laugh at that, but we know there is great truth to that. Were it not for the staff who spent so many hours and so much time away from their families that we would not be here.

I was talking with Senator REID's office. Kate Leone did a magnificent job. Carolyn Gluck, Jacqueline Lampert, Bruce King, David Krone, Rodell Molineaux, and Randy DeValk.

Senator DODD's staff: Jim Fenton, Tamar Magarik Haro, Monica Feit, Brian DeAngelis.

Senator BAUCUS's staff: Liz Fowler, Bill Dauster, Russ Sullivan, John Sullivan, Scott Mulhauser, Kelly Whitener, Cathy Koch, Yvette Fontenot, David Schwartz, Neleen Eisinger, Chris Dawe.

On our HELP committee: Michael Myers, our great staff director, who for more than a decade has led this staff and for almost 20 years has worked for Senator Kennedy. We are all sorry that Senator Kennedy could not be here for this. I can say honestly that Mike Myers carries on the torch as his staff director. He did a magnificent job of getting us through this. And David Bowen—David Bowen, if there is one person who knows more about what is in this bill than anyone else, it is David Bowen. I have never asked him about anything in this bill that he didn't know where it was and what it does. He has been at every meeting, I don't care how early in the morning, how late at night. I know he has been apart from his family and his children. I wish David the best in terms of being with his family tomorrow and over Christmas. David Bowen has done such a magnificent job of guiding and directing this bill and making sure it was all put together.

Connie Garner, who worked so hard, so hard; Portia Wu, John McDonough, Topher Spiro, Stacey Sachs, Tom Kraus, Terri Roney, Craig Martinez, Taryn Morrissey, Andrea Harris, Sara Selgrade, Dan Stevens, Caroline Fichtenberg, Lory Yudin, Evan Griffis.

Now I want to mention one other person who has been on my staff but now is on the HELP Committee staff, Jenelle Krishnamoorthy. I have for many years been advocating that we have to change our focus in America from a sick care society to a health care society. I mentioned that earlier. This bill contains more for wellness and prevention and public health than any bill ever passed by Congress—ever passed—and it is not talked about much, you don't hear too much debate about it. But it is significant that we are going to change this paradigm. We are going to start putting more up front, keeping people healthy in the first place.

One person who has done more than anyone else to make this happen is Jenelle Krishnamoorthy. I want to

thank her for just focusing laser-like the last couple of years or so on this and making sure it became a big part of our health care reform bill.

On my personal staff, Jim Whitmire, Beth Stein, Jenny Wing, Rosemary Gutierrez, and Lee Perselay. Let me mention Lee. Lee does all my work on disability issues. As many people know, it is my name on the Americans With Disabilities Act. Nineteen years ago we passed that. Lee Perselay does all my work on the disability issue.

There is another part of the bill not too many talk about, but it is so profoundly important to people with disabilities. In this bill there is a provision that will have the Federal Government give a 6 percent increase in the amount of money that the Federal Government gives to a State for Medicaid, 6 percent increase for a State that will enact legislation to put in place the provisions of the Olmstead decision by the Supreme Court over 10 years ago; that is, that every person with a disability has a right to a least restrictive environment. That means living in their own communities and their own homes with personal assistant services, support so they can live at home rather than going to a nursing home.

This has been a dream of the disability community since we passed the Americans With Disability Act in 1990. We have never been able to get it done. Now we have it in this bill. It is not talked about much, didn't hear much about it. But this will have more of a profound effect on people with disabilities than any other single thing in this bill or anything that we have done, literally, since 1990. Now people with disabilities can live at home and live in their own communities and the State will get money from the Federal Government to enable them to do that. Lee Perselay.

Lee Perselay; thank you very much, Lee.

Kate Cyrul of my staff, Dan Goldberg, and the Senate legislative counsel. A special thanks to Bill Baird, along with Stacy Kern-Scheerer and Ruth Ernst, who was present throughout the entire HELP Committee, and they have gone above and beyond.

To all the floor staff here, too, we forget about all they have done—Mike Spahn and Anne Wall and Stacy Rich and Tim Mitchell and Tricia Engle and Lula Davis, wonderful floor staff working with us to get us to this point, where we have a final vote on this tomorrow morning.

I wished to particularly mention these individuals. In many ways, they are the unsung heroes and heroines of what we have done. They can be content in knowing, as they go through life, they did a big thing here. They did something so important to help transform our society. I, personally, thank each and every one of them and wish

them the best of the holiday season, Christmas, New Year. We will come back next year, and we will start implementing this bill. As the chairman of the HELP Committee, we will start looking at building those additions and those expansions.

I yield the floor and thank my friend from Illinois for letting me go.

The PRESIDING OFFICER (Mr. BEGICH). The Senator from Illinois is recognized.

Mr. BURRIS. Mr. President, how much time do I have?

The PRESIDING OFFICER. The Senator has 6 minutes.

Mr. BURRIS. Mr. President, the Senate has long been a forum for great debate.

This institution is equipped to handle the most difficult questions our Nation faces.

Since we took up the issue of health care reform, the debate has been fierce, and our differences of opinion have played out in dramatic fashion on the national stage.

Over the last several months, I have said time and again that this health reform bill must accomplish the three distinct goals of a public option in order to win my support:

It must create real competition in the health care system.

It must provide significant cost savings to the American people.

And it must restore accountability to the insurance industry.

For months I have told my colleagues that I would not be able to support a final bill that fails to meet these three goals.

I believe they are the keys to comprehensive health reform in America, and without them, our legislation would be ineffective and incomplete.

I expressed my concerns about the compromise bill, and I asked tough questions.

I have reviewed the CBO score and the final legislative language as soon as it became available.

I believe the way forward is clear.

This bill is not perfect. It does not include everything I had hoped for.

But I am convinced that it can meet the three goals of a public option.

I believe it represents a monumental step forward—a strong foundation we can improve upon in the months and years to come.

This is not the end of health care reform in America—it is the beginning.

That is why we need to take the next step in this process. Although this is not the bill I had hoped I might be voting on, I am confident enough to pass this legislation on to the next step.

Let us send the Patient Protection and Affordable Care Act to a conference committee, where it will be merged with the House bill.

There, I have every hope that the conferees will have the opportunity to strengthen some of these provisions and make this legislation better.

We must not let the perfect stand in the way of the good. While it is not everything I had hoped it would be, it is far more than we have now.

And while this bill will not satisfy many of us, it would be a mistake to overlook all the good it will do for tens of millions of Americans.

So let me explain exactly why I am convinced that this bill will satisfy the three goals of a public option:

According to the nonpartisan Congressional Budget Office, the exchanges that will be created under this legislation will dramatically enhance competition in the insurance market.

This will drive premiums down, allowing consumers to shop around for the plan that is best for them, their family, or their small business.

CBO projections show that this would force providers to compete for the first time in many years, reducing costs and bringing everyone's premiums under control.

As a result, many more people would be able to get better coverage for less money.

This bill will enhance the choices that are available for individuals and small businesses.

Everyone will have the choice to keep their current insurance coverage if they are happy with it, but if they are not, they will have real options for the first time in many years.

This bill will give consumers the tools they need to hold insurance companies accountable.

It includes strong consumer protections—many of which take effect immediately—and it contains significant insurance reforms designed to put ordinary folks back in the driver's seat.

This bill will eliminate annual and lifetime caps on coverage, prohibit companies from dropping patients who get sick, and prevent discrimination against people who have preexisting conditions.

It will also require insurance providers to cover essential health benefits and recommended preventive care, so more people can get the treatment they need.

Based on these provisions, it is quite clear that this measure will provide immediate and lasting improvements in the health care system for everyone in this country.

It will extend quality coverage to 31 million Americans who are currently uninsured, and increase access to preventive care.

This will reduce emergency room visits, allow more people to treat preventable and chronic diseases, and help to bring health care costs under control.

In fact, the Congressional Budget Office projects that this legislation will cut the deficit by more than \$130 billion in just the first decade, and will save nearly \$1 trillion over the next several decades.

That is why I am confident that this bill will meet the three goals of a pub-

lic option: competition, cost savings, and accountability.

It may not be the legislation I would have written at the beginning of this process, but after nearly a century of debate about health care reform, under the leadership of 11 Presidents and countless Members of Congress, this legislation represents a strong consensus.

So it is time to take the next step in this process—to send this bill to conference and keep building upon this foundation.

This is not a perfect bill, but it contains a number of fundamentally good components.

Most importantly, it will ensure that 94 percent of Americans can get the health coverage they need.

After decades of inaction, the Patient Protection and Affordable Care Act is a monumental step in the right direction.

There were many competing ideas that gave rise to this bill.

There were many voices, inside this Chamber and outside of it, shouting to be heard on these issues.

There were concessions and compromises.

But, out of a century of dissent—out of decades of discussion and debate—we have arrived at a basis for comprehensive reform.

It is time to put aside our differences and move forward as one Congress, and one Nation.

There is much work left to do on this and a host of other issues. But in the messy process of debate and compromise, along the path that has led us to this point, this body has reaffirmed the enduring truth of the motto inscribed in this Chamber, just above the Vice President's chair: "E pluribus unum." It is there, Madam President, right over your head. It means "Out of many, one."

For our entire history, it has been the creed that binds us to one another and to our common identity as Americans. It is the principle that drives us to assemble in this august Chamber to debate the toughest issues we will ever face.

Although we come from every section of this country, from many States, we are one country, and together, we can create a health care system that will be worthy of the people we represent.

It is time to make good on the promise of the last century and move forward with the Patient Protection and Affordable Care Act.

Let's take the next step, and send this bill to conference.

I yield the floor.

MEDICARE GEOGRAPHIC INEQUITIES IN REIMBURSEMENT

Mr. HARKIN. Mr. President, I am pleased to support the legislation pending before the Senate today, which will ensure that 31 million Americans will finally have access to affordable, qual-

ity health coverage, which will crack down on outrageous abuses by the insurance industry, and which will, at long last, put prevention and wellness at the heart of our health care system. I rise today, however, to signal that there is an area of this legislation that remains of concern and that I will be working to fix as we head to conference; namely, provisions to rectify the geographic inequities in the low Medicare reimbursement rates.

Across the country, Americans pay equal premiums to support Medicare. Yet there is a substantial geographic disparity in physician reimbursement levels in the Medicare Part B Program. The degree of this disparity is unjustified and inherently unfair—and it is having an increasingly negative impact on the number of providers that are accepting Medicare and magnifying the workforce shortage problem—especially in rural areas. The unfairness in this disparity in reimbursement rates is compounded by the fact that the States with the lowest reimbursement rates are often those that deliver the highest quality of care. The system must change and reward the quality of service delivered instead of the volume of care served.

I see that my colleague from Oregon, Senator MERKLEY, is here on the floor. He and I have often discussed this issue, as his State is also one that provides outstanding care and yet suffers from unduly low reimbursement rates. I wonder if my distinguished colleague shares my view that this is something we must continue to work on before this bill is finalized?

Mr. MERKLEY. I thank my distinguished colleague for raising this issue, which has also been a concern of mine. I agree with him that my State consistently lags behind other States on Medicare reimbursement and per capita spending. I strongly believe that a fundamental way to achieve the goal of more efficiency in Medicare is to realign the Medicare payment system to reward health care providers for the quality of care they deliver, not simply the quantity of services they provide. Medicare is spending over one-third more for each Medicare beneficiary in some States compared to Oregon, to Iowa, or to the home State of my good friends from Minnesota, Senators KLOBUCHAR and FRANKEN, who are also here on the floor with us today.

The simple fact is, this antiquated payment formula penalizes rural providers and penalizes medical efficiency, and I know in Oregon it has forced many physicians to stop accepting Medicare patients or limit the number of Medicare patients they serve, and that is why I feel so strongly that we must fix it once and for all in the final health reform bill. I wonder if the Senators from Minnesota have had a similar experience in their state.

Ms. KLOBUCHAR. I want to thank you, Senator MERKLEY and Senator

HARKIN, for your work on this issue. I have observed the same problems with Medicare reimbursement in my home State. We represent States and regions that have demonstrated true leadership in lowering costs to Medicare while increasing the quality of care patients receive. The high-efficiency areas we represent are known for utilizing integrated health delivery systems and innovative quality measures to provide Medicare beneficiaries with better value. Research shows that these efficient delivery practices can save the Medicare Program upwards of \$100 billion a year while also providing beneficiaries better access to the care they need. Unfortunately, the current Medicare payment structure penalizes those who provide efficient care while rewarding those who order unnecessary tests and services. It is critical that this is addressed in conference, and it will be a priority as we move forward through this process.

Mr. FRANKEN. Thank you, Senator HARKIN, for your leadership, and also thanks to my other colleagues for working on this issue. I agree with all that has been said, and I would like to reiterate that our States have some of the best health care in the country. And it just doesn't make sense that under the current Medicare reimbursement system, the good care in our States gets punished and the less effective, more expensive care gets rewarded. The result is that we are not providing health care in this country; we are providing sick care. We need incentives for providers for high-value care, and the best way to do this is through Medicare payment reform.

These geographic disparities in Medicare payments are unfair, and they are not good for patient care. We are forcing excellent providers out of business because reimbursement rates are low and they just can't make ends meet. This is counterproductive to the goal that I know we all share—to increase access to high-quality health care for all Americans. It is a top priority for me that in conference we make some changes so high quality care that is provided at a reasonable cost will no longer be punished. Instead, we need to make sure that the bill rewards providers for being effective partners in their patients' care. I appreciate the opportunity to share these concerns and discuss these issues with my colleagues.

Mr. HARKIN. I couldn't agree with my colleagues more. It is long past time to take action to fix this system. I appreciate the commitment of the Senator from Oregon and the Senators from Minnesota to fixing this problem once and for all.

DEFINITION OF FULL TIME WORK

Mrs. MURRAY. Mr. President, I would like to engage my friends, the Senator from Iowa and Chairman of the Health, Education, Labor and Pen-

sions Committee, and the Senator from Montana and Chairman of the Finance Committee, in a conversation about how "full time" is defined in the Patient Protection and Affordable Care Act and clarify any misunderstandings about how the legislation resolves the potential for exclusion of certain work group such as flight crews and rail workers due to the definition of "full time" work and the unique way their work hours are calculated.

Is it the Senators' understanding that the Patient Protection and Affordable Care Act resolves a potential problem of excluding from employer incentives to provide coverage for employees who work in professions that use unique calculations for hours worked, such as flight crews and rail workers? And that it does this by indicating that the Secretary of HHS, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for employees who are not compensated on an hourly basis?

Mr. HARKIN. Yes, the Senator is correct. The Patient Protection and Affordable Care Act is designed to expand access to high quality and affordable health coverage for all workers. Because of the nature of work, some industries uniquely calculate total daily and monthly working time to determine full-time schedules. That is why this legislation gives the Secretaries of Health and Human Services and Labor discretion to establish rules and regulations for the hours of service for workers outside of standard hours. This provision is meant to be construed broadly.

Mr. BAUCUS. I would concur with my friend, the Senator of Iowa, in his understanding of the act. This provision is meant to be construed broadly, and to expand access to high quality and affordable health coverage for all workers.

Mrs. MURRAY. Of particular concern to me are groups such as pilots and flight attendants, cabin crews who, under "full time" contracts, "work" on average only 70 hours per month due to the unique way their hours are calculated. For obvious safety reasons, a pilot is limited, through Federal regulations, to flying 100 hours per month, or 1,200 hours annually, even though he or she contributes many more hours of service outside of the time spent flying planes. This unusual work schedule, however, raises the potential that a pilot might not be considered a full-time employee for purposes of this legislation under a rule that defined full time status as simply "working" upwards of 30 or 40 hours per week. The same is true of other flight-crew employees.

Additionally, railroad hours-of-service employees, who work by the mile or

by the day, could also find it difficult to meet the definition of full-time employee under a strict "hours worked" standard. Many train and engine service railroad employees are paid by the mile and or by the day or paid for time available to work, and are not paid by the hour. Although these workers are undoubtedly full-time employees within their profession, the annual or weekly hours they are calculated to work might not satisfy a narrow minimum hour component that did not take into account a more flexible hours of service concept for certain types of jobs.

Currently all flight and cabin crew members employed by Part 121 commercial air carriers and train and engine service railroad employees paid by the mile or by the day are full-time employees and receive the same benefits afforded other full-time workers. Is it the Senators' understanding that this bill is intended to allow these working groups to be encompassed in the definition of "full-time employee" for purposes of the employer incentives to provide quality health care coverage?

Mr. HARKIN. Yes, that is my understanding, that the Secretaries of Health and Human Services and Labor will establish standards to govern workers in these industries so they are fully entitled to the protections under this bill. It is not the intent of Congress to exclude or prevent workers with unique work schedules from the benefits under the Patient Protection and Affordable Care Act or from incentives for employers to provide these workers with quality healthcare coverage.

Mr. BAUCUS. Again, I am pleased to concur with the Senator from Iowa in his understanding. The Secretaries of Health and Human Services and Labor will establish standards to govern workers in these industries so they are fully entitled to the protections under this bill.

Mrs. MURRAY. Mr. President, I would like to thank the Senators from Iowa and Montana for their time and clarification on this issue.

Mr. DURBIN. The Patient Protection and Affordable Care Act offers community health workers some overdue recognition, and more importantly, authorizes grants to help support and expand their work.

Community health workers are from the communities they serve. From rural small towns to the urban inner city, community health workers reach out to underserved communities in ways that the current health care system cannot, providing culturally and linguistically appropriate health information in a more familiar and welcoming manner. Their work helps to bridge the healthcare gap and diminish disparities.

Nowhere is this more evident than in the community-based doula program.

Community-based doulas support pregnant women during the months of pregnancy, birth, and the immediate postpartum period. They provide parent education, logistical and emotional support. They help new mothers make better lifestyle choices and deliver healthier babies. What makes these programs work is the culturally sensitive mentoring within the community.

In Chicago, the community-doula model has made a big difference in the lives of these young moms and their babies. The Chicago Health Connection came up with this model. They trained mentors from the community to work with at-risk moms, many of whom didn't know where else to turn. These mentors spend time in the neighborhood, finding and befriending pregnant women who need help.

With the guidance of the doula, the Chicago Health Connection found that more young mothers were going to their prenatal care appointments, making better lifestyle choices, and—not surprisingly—delivering healthier babies. The doulas stay with the moms through the early months, encouraging breastfeeding, cuddling, and interactive play.

Bina Holland is a community-based doula at the Easter Seals Children's Development Center in Rockford, IL. Bina has had a powerful impact on one of her clients—a 14 year old girl who was 5 months pregnant and severely underweight. Bina taught her about healthy nutrition habits to strengthen her body to carry a baby. Bina also encouraged the young woman to visit her doctor regularly and to openly talk with the doctor about the health status of the baby.

The girl delivered her baby early at 2.5 lbs, and Bina was there to explain the health benefits of breastfeeding. The young mom agreed to nurse her child, and each week the mother monitored the baby's growth. The child was nursed to health, and the mother successfully graduated from the doula program. Thanks to Bina.

Community-based doulas are a powerful resource for maternal and child health, and the model is effective. In communities that have employed it, outcomes include better prenatal care, higher birth weight, higher breastfeeding rates, better parenting skills, fewer preterm births and c-section deliveries, and delays in subsequent pregnancy for teenages.

With Chicago Health Connection's success, they took on the challenge of working with other communities to build their own community-based doula program. Today, they have transformed into Health Connect One, a training organization for communities nationwide interested in starting their own community based doula programs. The need is everywhere, and these women are working hard to make

these important services available everywhere for all moms.

I am encouraged by the language in Section 5313 of the Patient Protection and Affordable Care Act, Grants to Promote the Community Health Workforce and want to ensure that the definition of community health worker includes community-based doulas. The Federal Government currently funds community-based doula programs through the Maternal and Child Health Bureau's Special Projects of Regional and National Significance. Expanding the definition of community health workers in the reform bill will give these evidence-based programs greater support to meet the needs of families in underserved communities.

Community-based doula programs are a proven example of the health outcomes that education, prevention and health literacy can bring. With grants to promote the community health workforce, doulas will continue to promote positive health behaviors in pregnant women and improve the lives of families nationwide.

Mr. FEINGOLD. Mr. President, I will vote for the comprehensive health reform bill being considered in the U.S. Senate, but I will also work to improve its flaws. There is much that is good about this legislation. It will, over the course of 10 years, help ensure that nearly every American has access to good and affordable health insurance. It will put Medicaid and Medicare spending on a more sustainable and stable path. It will increase access to home and community-based long term care services, increase our medical workforce, and end some of the worst abuses by the private insurance. But there are serious deficiencies—like the failure to establish a public health insurance option—that we know of, and there will be undoubtedly be some gaps in the bill that we will discover during implementation. The commitment that is made with this legislation is ongoing, and will require diligent oversight and improvements in the years to come.

I am pleased that many of the priorities I laid out at the start of this process have been addressed in this bill. The bill includes provisions I fought for that help make sure Wisconsin is treated fairly. Those provisions include fixes to a flawed Medicare formula that denies our state fair reimbursement, financial incentives for the kind of low-cost, high-value care practiced in Wisconsin, and hundreds of millions of dollars in additional Medicaid assistance for Wisconsin to account for the State's leadership in expanding coverage to its citizens. But I also recognize that this bill does not do as much as I would like to reform our current health care system, and I will work to try to make sure the final version fixes these flaws.

I receive countless letters and emails and phone calls from my constituents

on health care reform. Some of the most heartbreaking letters I receive are from people who are sick or caring for a sick loved one and do not have health insurance. Some of these people are recently laid off due to the recession, and have lost their health insurance. Some people had health insurance, but were dropped from their coverage because they became sick and actually needed health care. And some people were denied health insurance altogether, either because it was priced out of their reach, or because they had a preexisting condition. In far too many cases, these people have been forced to declare bankruptcy because of their medical bills. Two thirds of all personal bankruptcy cases in the United States are due to medical debt, and over 80 percent of those individuals had health insurance. And in the most egregious cases, sick children in Wisconsin and around the country have reached lifetime limits on care that are set by an insurance bureaucrat, and are denied coverage for further medical treatment.

Because of this bill, lifetime and annual limits on coverage will be prohibited. Premiums cannot increase due to medical needs or illness. Insurers cannot charge women more than men for the same insurance policy. Restricting or denying coverage based on preexisting conditions is prohibited for all Americans, beginning with children effective 6 months after final passage of this bill. A recent study found that 36 percent of currently uninsured adults were unable to get health insurance because of a preexisting condition. Preexisting conditions can be anything from serious, chronic diseases like diabetes or cancer to medical episodes like acne or even pregnancy. In nine States, being a victim of domestic violence can be a preexisting condition. This bill will end these consumer abuses.

People will be guaranteed the ability to renew their health insurance year after year. If a claim is denied, policy holders have a guaranteed right to appeal. And group insurers are required to spend at least 85 percent of every premium dollar on actual health care; if they are found to be spending less, they are required to refund the difference to the customer. This policy, along with others, will require an unprecedented level of transparency in the sale of health insurance policies.

One of the strongest points of this bill for me, and perhaps one of the most underappreciated, is the commitment made to realign Medicare spending to reward our doctors and hospitals for the quality of care they provide to their patients, rather than the quantity of care. Moving to a value-based system is one of the single most effective ways to reduce health care spending and improve the quality of care. Wisconsin is a national leader in value-

based delivery of health care. If every health care provider operated like those in Wisconsin, over \$100 billion a year in taxpayer dollars could be saved. Just last year, the Congressional Budget Office estimated that nearly 30 percent of Medicare spending could be avoided by integrating and coordinating care, in the manner of high-value providers.

As a result of this bill, Medicare reimbursement for certain health care providers will be based, in part, on the quality of care they deliver to their patients. Health providers will now have the opportunity to voluntarily join together as Accountable Care Organizations to coordinate the care they deliver to their patients, and to share in the savings they generate for Medicare. They will be given numerous opportunities and incentives to change the way they deliver health care, and will, for the first time, be penalized for delivering low-quality care. For example, if a hospital demonstrates high rates of readmissions or hospital acquired infections, they will receive less reimbursement from Medicare. Not only will patients receive smarter care from their physicians, these policies will help ensure that taxpayer dollars are going to pay for the value of care Medicare patients receive, as opposed to the volume of care.

In addition to these positive changes to the way Medicare pays for health care, there is language to finally address the historic inequity in Medicare reimbursement that Wisconsin and other rural States have faced. Thanks to the leadership of Senator CHUCK GRASSLEY in the Senate Finance Committee, this bill includes language that will increase Medicare reimbursement for Wisconsin physicians and directs the Secretary of Health and Human Services to analyze and adjust the current formula to ensure more accurate payments for rural providers in the future. Fixing the flawed Medicare formula so that Wisconsin receives its fair share of Medicare reimbursements has long been a priority of mine.

I am pleased that this bill more fairly reimburses Wisconsin for the leadership my state has demonstrated in extending coverage to low-income residents through BadgerCare, our State Medicaid program. I was concerned that the Senate Finance Committee bill would have denied Wisconsin much-deserved Medicaid dollars, and I worked hard to try to ensure the bill before the Senate fixed this problem. As a result, relative to the bill that the Senate Finance Committee reported, this bill will bring hundreds of millions more in Medicaid assistance back to Wisconsin. I appreciate the willingness of my fellow Wisconsin Senator, HERB KOHL, the Chairman of the Finance Committee, Senator MAX BAUCUS, and Senator REID in working with me to ensure that Wisconsin's investment is acknowledged in this legislation.

I am also pleased by the attention to long-term care reform in this bill. Modern medicine has turned fatal diseases into chronic diseases, and enabled individuals to live much longer. These are tremendous accomplishments. But the reality is that these individuals need even more assistance because of medical advancements—from their families, communities, and government.

Long-term care reform is inextricably linked to overall health reform, and one cannot truly succeed without the other. While this bill does not include a comprehensive strategy to reform our long-term care system as I had hoped, it does include a number of critical building blocks to assist reform efforts in the future. One of these critical pieces is the Community Living Assistance Services and Supports Act, or CLASS Act. The CLASS Act would create an optional insurance program to help pay for home care and other assistance for adults who become disabled. Those choosing to participate would pay monthly premiums into an insurance trust, and after 5 years, could access a cash benefit if they become disabled and need assistance.

Another critical component of this bill is the attention paid to expanding home and community-based care options. Again, Wisconsin has been a national leader in increasing access to home and community-based care, beginning with the Community Options Program almost 30 years ago. As a State Senator, I worked to help expand Wisconsin's Community Options Program, known as COP, which provided flexible, consumer-oriented and consumer-directed long-term care services in community-based settings, enabling thousands of people needing long-term care to remain in their own homes rather than going to a nursing home. Over time, the COP program turned into Wisconsin's FamilyCare program, which is our newest State entitlement program for low-income and disabled adults to receive necessary care, supports, and services in their homes and communities.

The progressive vision that is the driving force behind Family Care is also the driving force behind the long-term care provisions in this bill. This bill will establish the Community First Choice Option, which gives States the option to create a new Medicaid benefit through which States could offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require the level of care offered in a hospital, nursing facility, or intermediate care facility.

This bill also removes barriers to expanding home and community-based services; protects recipients of home and community-based services from spousal impoverishment; and increases appropriations by \$40 million to help fund Aging and Disability Resource Centers.

And finally, as a result of Senator REID's amendment, the bill provides new financial incentives for States to shift Medicaid beneficiaries out of nursing homes and into home and community-based services.

Over 10 million Americans are currently in need of long-term care, and that number is expected to rise to 15 million in the next 10 years. These individuals struggle to remain independent with limited assistance. Policies like those included in this bill, which increase options for home and community-based care so that nursing homes are not the only choice, are smart changes that will benefit consumers of long-term care and save taxpayers money.

One of my most important priorities for the bill was that it be fiscally responsible. Based on the most current projections, the Congressional Budget Office expects this legislation to reduce the deficit by \$132 billion by 2019 and roughly \$1 trillion by 2029. While the bill does not go as far as I would like to rein in health care spending, the \$871 billion price tag on the bill is fully offset and will not add a penny to the deficit.

Deficit reduction is achieved through a number of policies, three of which are included in legislation I introduced to bring down the deficit, the Control Spending Now Act. These policies, which make prescription drugs more affordable and require wealthy individuals to pay their fair share of Medicare premiums, generate \$24.6 billion in savings.

For all the positive aspects of this bill, I am deeply disappointed by the lack of a public option. I have been fighting all year for a strong public option to compete with the insurance industry and bring health care costs down. I continued that fight during recent negotiations, and I refused to sign onto a deal to drop the public option from the Senate bill.

Removing the public option from the Senate bill is the wrong move. I am concerned that without a public option, there will be no true competition for the insurance industry. We have included mechanisms to protect against egregious year-to-year increases in private insurance premiums from this point on, but we have no mechanism to force insurance companies to decrease premiums as they are set today. A strong public health insurance option would provide a powerful incentive for less responsible insurers to re-evaluate their own cost-sharing and benefit plans to ensure they are an attractive option for consumers.

The public option would give consumers a strong voice in the marketplace. If the private market was not meeting their needs, they would have an alternative. Competition is how we can reduce our health care costs, but there is no real competition in the private market. Private insurers compete

to generate the most profit, and the best return on investment for their shareholders. There is at most a secondary motivation to compete to give the best value to consumers. A public option serves as an outside factor to force private insurers to consider more than just shareholder interests.

The Congressional Budget Office estimated that the public option in the bill that was brought to the floor could save up to \$25 billion. The CBO's analysis of Senator REID's amendment, which strikes the public option and replaces it with multi-state plans, says the following about the new policy:

Whether insurers would be interested in offering such plans is unclear, and establishing a nationwide plan comprising only of non-profit insurers might be particularly difficult. Even if such plans were arranged, the insurers offering them would probably have participated in the insurance exchanges anyway, so the inclusion of this provision did not have a significant effect on the estimates of federal costs or enrollment in the exchanges.

Removing the public option gives up a huge opportunity to reduce costs for American families and the government, and I will work to try to ensure the final bill fixes this serious mistake.

I also am concerned about the excise tax on high cost health plans. Under this bill, health insurers will be taxed on the value of any health care plan sold that is valued above \$8,500 for an individual and \$23,000 for a family. Improvements have been made to this policy during Senate consideration, and the thresholds for the tax, along with exemptions for high-risk professions, have been expanded. But I have heard from so many in my State who have traded wage increases for solid health insurance benefits in the past years. I have heard from teachers and laborers and union members who are worried they may lose the health benefits they have fought for, and can't reclaim the wages they have already lost. While this policy is often referred to as the "Cadillac" health care tax, they will be the first to tell you that they hardly live the Cadillac lifestyle. I urge my colleagues in the Senate and the House to consider the real-life impact that this policy could have on working Americans and their families.

I am concerned about the cuts to home health and hospice providers under this bill. Home health and hospice providers offer a truly valuable service to our communities. But under this bill, their reimbursements will be drastically cut and I am concerned that access will decrease as a result. Improvements have been made under Senator REID's amendment, but we must do better for home health and hospice providers.

I am disappointed that the bill does not permit the safe importation of prescription drugs, which would reduce health care spending for consumers and the Federal Government. I will keep

fighting to enact this common-sense reform.

Lastly, I oppose the sweetheart deals that some Senators and interest groups apparently cut. These deals weaken the bill by subsidizing States or interest groups at taxpayer expense. They are unjustified, and they should be eliminated.

Mr. WYDEN. Mr. President, the Patient Protection and Affordable Care Act is a fundamental first step toward providing all Americans with affordable, quality health care. The health care system is complex, and that is why this Senate and two of its committees, including the Senate Finance Committee of which I am a member, have taken the better part of this past year crafting this legislation. I believe several provisions of this bill are transformational for American health care and will begin to move America toward more competition, choice, and quality.

The first provision is in the managers' amendment, and it is called free choice vouchers. This section creates something that has never existed before in the American health care system: a concrete way for middle-income Americans who cannot afford their health care to actually push back against the insurance lobby and force insurance companies to compete for their business in the insurance exchanges. Unlike today, where if a hard-working, middle-class American can't afford just the one health insurance policy available to him at his job, with this new provision, there will be a different health care marketplace, with free enterprise choices that can actually drive down costs for the middle class while ensuring those choices are of good quality. And in that new marketplace, a worker who cannot afford his employer's health plan can get a tax-free voucher for the same amount the employer contributes under the health plan and use that voucher to buy a more affordable plan in the insurance exchange.

I have been an advocate for consumer empowerment and choice my entire career in public service. Exchanges are a new pathway to creating a competitive marketplace for the first time for health care in this country. Massachusetts led the way, opening the door to showing Federal legislators the potential for insurance exchanges when Massachusetts enacted its own health reform law. Many other States lead the way with innovation in health care, including States like Oregon and Vermont. That is why I have authored and championed in the Senate Finance Committee section 1332, the waiver for State innovation. If States think they can do health reform better than under this bill, and they cover the same number of people with the same comprehensive coverage, they can get a waiver exempting them from the legislation and still get the Federal money

that would have been provided under the bill. To me, this provision is a safety valve, if certain provisions in this bill will not work as intended in a given State. This provision will give States a way to tailor health reform to best meet the needs of their citizens. I intend to work with Senator SANDERS and other colleagues to make sure that State waivers will be available even sooner than they are under the current bill.

The waiver for State innovation and free choice vouchers will improve the number of choices in the bill, for states, for employers and for employees. The Patient Protection and Affordable Care Act will also increase quality of care, particularly in the Medicare Program. I worked in the Finance Committee to increase bonus payments to high quality plans in the Medicare Advantage Program. In Oregon, Medicare Advantage is a lifeline given the low traditional Medicare reimbursement rates in the State. This amendment will reward the high quality plans that exist in Oregon, but will also encourage other plans across the country to increase the quality of the care they provide. By boosting payments to the highest quality plans—the four and five star plans—the Federal Government will be incentivizing plans that provide preventive care, manage chronic diseases well, and have high levels of consumer satisfaction.

Another provision that will add quality to the Medicare Program is Independence at Home, IAH, section 3024 of the bill, that I won approval for in the Finance Committee. This provision stems from legislation that I introduced with 11 other Members on both sides of the aisle. As the name indicates, the Independence at Home program will provide a way for seniors with chronic medical conditions to get medical treatment at home. The IAH program is based on a house call team approach that has proven successful in reducing costs and improving the quality of care for high cost patients with multiple chronic illnesses, patients who account for 66 percent—85 percent of Medicare spending. The Independence at Home program requires providers to achieve minimum savings on health care provided to the highest cost Medicare beneficiaries as a condition of participating in the program.

Providing care at home makes sense, and is the right direction for the future of health care delivery. But there is another aspect of the future of health care that I think holds much promise: personalized medicine. I won approval in the Finance Committee, along with Senator CARPER, for including section 3113 in the bill. This provision will increase access to innovative molecular diagnostic tests that provide the foundation for the application of personalized medicine for individuals suffering from life threatening diseases such as

cancer and heart disease. These tests hold the promise of getting patients the right type of chemotherapy for their specific case of cancer. Personalized medicine is the future, and I am thrilled that the Patient Protection and Affordable Care Act takes steps to move toward 21st century medicine.

I have spent the better part of my career trying to make the health care marketplace more competitive and trying to improve the quality of care for all Americans. I take many lessons from my home State of Oregon, and have tried to apply the innovation that Oregon is known for as an example for how other States can provide higher quality care at a lower cost. Through free choice vouchers, State waivers, Medicare Advantage bonus payments, Independence at Home, and personalized medicine, I believe this bill improves competition, choice and quality across the entire country.

Mr. INOUE. Mr. President, I am pleased that this bill will extend basic health care to more than 30 million Americans who were previously unable to afford the costs associated with seeing a medical professional. Not since former President Harry S. Truman enrolled as Medicare's first participant in July of 1965 has our health care system undergone such a complete overhaul. The reform brought about by this bill is needed and long overdue. For too long millions of Americans have struggled to see health professionals while health insurance providers have raised premiums and executives have reaped multimillion-dollar bonuses. That is no longer the case. This bill also ensures that Hawaii, a State long ahead of the curve in terms of providing health insurance and affordable access to medical professionals, maintains its high level of health care while expanding the reach of existing Federal programs. The State Prepaid Health Care Act of 1975 ensures that every employee in Hawaii working at least 20 hours a week receive health insurance from their employer. Hawaii received an exemption to ensure Hawaii's employer mandated health care law would not be rolled back. The health care reform bill also includes tremendous cost savings and subsidy incentives for the State. Hawaii is one of two States in the country who are not permanently enrolled in the Federal disproportionate share hospital, DSH, program which reimburses hospitals that care for the uninsured. Currently Hawaii's temporary enrollment expires in 2012 but the new bill will make DSH permanent resulting in more than \$100 million for Hawaii's health care industry over the next 10 years. I am also pleased that we were able to include the reauthorization of the Wakefield Pediatric-Emergency Medical Services for Children program, at the suggestion of my two colleagues from North Dakota, Senator KENT CONRAD and Senator BYRON DOR-

GAN. This program works to ensure that emergency rooms across the country are equipped with the resources necessary to treat young children. A civilized, democratic society like ours should help maintain the health and welfare of all our citizens. No one should be denied medical care or lose coverage because they can't afford to pay to see a medical professional. Like that July afternoon in 1965 when President Lyndon Johnson signed Medicare into law I am especially pleased to see that our great Nation once again has recognized and worked to meet the basic needs of our citizens.

Mr. LEVIN. Mr. President, at a handful of moments, Members of the U.S. Senate have faced choices that could fairly be described as historic. Each of these choices was between progress—sometimes incomplete progress—and an intolerable status quo. In our finest hours, we have overcome fear and doubt and stood for the principle that our Nation, though great, could aspire to do better. When our ambition has weakened, we have taken the timid path. That is an easier journey and less laden with fear or political peril, but it has not served our own time well or passed the test of history.

We have come to another of those times. We can vote, now, to address decades of frustration and anguish over a health care system most Americans know is broken. Or we can destroy the hopes of millions of Americans whose modest ambition is not a perfect system, but an improved one. We cannot vote to end every problem in health care; this bill will not do that. But we can make life safer, more secure, less costly, for most Americans, because we can give them a better health care system.

Briefly, here is some of what this legislation will accomplish:

People with preexisting conditions who are currently left out of the system will be able to get access to health care in the future. Within 6 months of enactment, this legislation will allow those not covered at work and who are unable to find insurance in the individual market because of preexisting conditions to buy a plan that will remain in place if they get sick. And it will offer free preventive services and immunizations.

This bill has provisions to help strengthen Medicare by giving seniors access to important preventive services that they may otherwise not be able to afford. And also for seniors, this bill reduces the Medicare doughnut hole, a gap in prescription drug coverage that I hope we are able to eventually close altogether.

After 2014, new plans will be barred from imposing annual limits on coverage, and sliding tax credits will be available to make insurance more affordable for those earning below \$88,000 for a family of four, or earning below

\$43,000 for an individual. The credits that will be offered to make coverage more affordable will bring millions of Americans under the umbrella of health insurance, an important improvement for those families now without insurance and a step toward reducing burdens and inefficiencies that make health care more expensive for all of us. State-based exchanges will offer those seeking individual coverage both the purchasing power of belonging to a larger group, and a transparent marketplace in which benefits are standardized and costs are clear.

The bill also helps small businesses that are struggling to get a handle on ever-increasing health care insurance costs. Beginning in 2010, small businesses will receive a tax credit of up to 35 percent of their costs for insuring their employees and their employees' families. In 2014 and beyond, the tax credit can be as much as 50 percent of an employer's costs for covering employees. These credits will encourage these employers, which are the backbone of our economy, to provide health care insurance coverage.

The bill also includes some major insurance company reforms. Beginning in 2011, plans that do not spend a high percentage of their revenue for patient care—85 percent of revenue for large-group programs, and 80 percent in the individual and small-group market—will have to provide rebates to their enrollees.

One of the benefits of this new requirement on insurance companies is reversing the troublesome trend that has seen more and more of our health care dollars spent on administration. Since 1970, the number of administrative positions in our health care system has increased by nearly 3,000 percent, far outstripping the growth in the number of physicians over the same period. It is long past time to ensure that we are spending precious health care dollars on care and not on paperwork and bureaucracy. Hospitals will become more transparent as well—every hospital in the Nation will publish a list of standard charges for the items and services it provides.

The bill includes incentives to boost the availability of primary care, including financial incentives under Medicare to increase the number of primary care physicians. And it also promotes standardizing health information technology in an effort to reduce costly administrative overhead.

This is not everything I hoped for. But it is what we can get done. It is what we should do.

The minority has offered no alternatives, just apocalyptic rhetoric. Some of them stood before rallies, leading chants about socialism. They claimed it is a big government takeover. "Kill the bill" was their slogan. Before television cameras our efforts to produce reform were compared to

the activities of financial fraudsters like Bernie Madoff.

For those familiar with the facts, these notions are rightly seen as falsehoods. One of these falsehoods—the notion that health care reform would mean “death panels” voting to end the lives of senior citizens—has just been named by an independent fact-checking organization its “Lie of the Year.” That’s quite a distinction. When discussing the scare tactics being used by opponents of health reform, the policy director of AARP said, “The opponents of health reform have targeted (seniors) and have . . . misrepresented the facts, and have consciously tried to scare seniors who depend on health care. So no surprise that they feel anxious, because they’re hearing messages every day designed to scare the bejesus out of them.”

The extreme rhetoric of the minority is a repeat of similar rhetoric which was used when Social Security and Medicare were being considered by the Congress.

In 1935, as Social Security was being debated, one Republican warned the program would “enslave workers,” and another declared “the lash of the dictator will be felt” if it passed. Three decades later, as the Congress debated the Medicare Program, one Republican Member of Congress said, “Let me tell you here and now, it is socialized medicine.” A future Republican President of the United States warned that if Medicare passed, “you and I are going to spend our sunset years telling our children and our children’s children what it was like in America when men were free.”

Incredibly, the same Republican Party that once equated Medicare with socialism would now have the public believe they are defending Medicare from the threat of socialism. The mental gymnastics this requires is breathtaking. If this bill is such a threat to seniors, why does AARP support its passage? If it will destroy our health care system, why do so many of the groups that know health care firsthand, from the American Medical Association to the American Heart Association to the American Cancer Society, and dozens of others support passage of this bill? If this bill will explode the deficit, why does the nonpartisan Congressional Budget Office tell us it will reduce the deficit by \$132 billion over the first decade after enactment, and up to \$1.3 trillion in the second?

Are all these organizations, the nonpartisan CBO, independent fact-checkers, scores of economists and health care experts—are they all engaged in a conspiracy to engineer a socialist government takeover of medicine? I am afraid that some of our Republican colleagues have latched onto any argument at hand to justify their opposition to health care reform.

Let me ask one final question: What do opponents say to our constituents

who speak to us every day of their belief that the time for health reform has come? That today is not the time? The man from Kalamazoo, MI, who went bankrupt because his health insurance would not cover \$40,000 in costs for a life-saving heart operation—will they tell him this is not the time? The woman from Jackson, Michigan, who spent months fighting to get coverage because insurance companies considered her pregnancy a preexisting condition—will they tell her this is not the time? The worried mother who wrote my office to say, “We will lose too many bright young people—if something is not done”—will they tell her this is not the time?

No, this is the time. Now is the time to embrace the same call of history that led our predecessors to ignore the apocalyptic rhetoric and establish Social Security and Medicare. We must pass this bill, so that generations after us do not look back on a broken health care system and say, “Here was another lost moment when it could all have changed.” We must pass this bill. Now is the time. Just as we are ploughing the roads of record snow to get to work, our work now is to plough through the endless filibusters to get our job done.

Mr. REID. On behalf of Senator BAUCUS, Senator DODD, and myself, I submit this statement under the spirit of rule XLIV of the Standing Rules of the Senate. We hereby certify that, to the best of our knowledge and belief, the managers’ amendment to the substitute amendment to H.R. 3590 does not contain any congressionally directed spending item as defined in rule XLIV.

Rule XLIV defines a congressionally directed spending item as “a provision or report language included primarily at the request of a Senator providing, authorizing, or recommending a specific amount of discretionary budget authority, credit authority, or other spending authority for a contract, loan, loan guarantee, grant, loan authority, or other expenditure with or to an entity, or targeted to a specific State, locality or Congressional district, other than through a statutory or administrative formula-driven or competitive award process.” To the best of our belief, no item meets this definition. There are numerous items that affect one or more States or localities differently than others, but none of these meet the definition because of one or more of the following reasons—(A) no specific amount is associated with the provision, (B) the provision involves distribution through “a statutory . . . formula-driven . . . or competitive award process” or (C) the criteria are such that more than one State or locality will or may benefit. It is quite common in legislation for formulas and programs to make adjustments to affect State- or locality-specific needs.

The rule defines a “limited tax benefit” as “any revenue provision that (A) provides a Federal tax deduction, credit, exclusion, or preference to a particular beneficiary or limited group of beneficiaries under the Internal Revenue Code of 1986; and (B) contains eligibility criteria that are not uniform in application with respect to potential beneficiaries of such provision.”

Section 10905 provides exceptions to the annual fee on health insurance providers for certain insurers. One of these exceptions is provided to any entity that meets the following criteria—a mutual insurance company with market share in a State for 2008 between 40 percent and 60 percent and whose medical loss ratio for all markets—individual, small group and large group—in 2008 was 90 percent or higher. The performance-based exception is available if the entity has an average medical loss ratio for years after 2011 for the previous 3 years for all markets of 89 percent or higher—prior year for 2012 fee and prior two years for 2013 fee. It may be argued that this provision could be considered a “limited tax benefit” as defined in rule XLIV; at the same time, the Joint Committee of Taxation has indicated that the universe of potential beneficiaries depends in part on how “medical loss ratio” is ultimately determined under the statute. In the interest of transparency, the provision was included at the request of Senator BEN NELSON so that nonprofit Blue Cross Blue Shield of Nebraska would not be excluded from the exemption of nonprofit insurers from the fee. In keeping with the spirit of rule XLIV, Senator NELSON has provided Senator BAUCUS with a certification that neither he nor his family has a financial interest in the provision.

Mr. President, I ask unanimous consent to have printed in the RECORD the letter from Senator NELSON of Nebraska dated December 21, 2009.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. SENATE,

Washington, DC, December 21, 2009.

Chairman MAX BAUCUS,
Ranking Member CHARLES GRASSLEY,
U.S. Senate Committee on Finance, Dirksen
Senate Office Building, Washington, DC.

DEAR CHAIRMAN BAUCUS AND RANKING MEMBER GRASSLEY: Consistent with the provisions of Rule XLIV of the Standing Rules of the Senate, I am submitting this letter with regard to Section 10905 of Senate Amendment 3276.

Section 10905 of the amendment creates a limited exemption from the annual fee on health insurance providers established by Section 9010 of Amendment No. 2786 to H.R. 3590, the Patient Protection and Affordable Care Act of 2009. The exemption from the fee is created for certain non-profit insurers with a high medical loss ratio. Among other exemptions provided for under this section, an exemption from the fee is available to any entity which is a non-profit mutual insurance company with market share in a

State for 2008 between 40% and 60% and whose medical loss ratio for all markets (individual, small group, and large group) in 2008 was 90% or higher. The exception is available only if the entity has an average medical loss ratio for years after 2011 for the previous three years for all markets of 89% or higher (prior year for 2012 fee and prior two years for 2013 fee).

This provision could be considered a "limited tax benefit" as defined in Rule XLIV, and I anticipate that Blue Cross Blue Shield of Nebraska may benefit from this provision, provided that they maintain the high medical loss ratio called for under the provision. My purpose for requesting this provision was so that Nebraska's sole non-profit insurer would not be excluded from the exceptions to the insurance fee as set forth in Section 10905.

Consistent with the requirements of paragraph 9 of Rule XLIV, neither I nor my immediate family have any pecuniary interest in this item.

Sincerely,

E. BENJAMIN NELSON.

Mr. REID. Mr. President, as we finish this session, there are many people who have worked to get us to this point. From the staff in the Senate to the Capitol Police, many employees have given their time to make sure that the Senate could complete its work on health care.

In particular, I would like to recognize the work of the employees of the Government Printing Office, GPO. Each day, the GPO works with the Secretary of the Senate to meet the needs of the Senate and we appreciate their efforts. Nearly all of the documents we have used for the health care debate have been printed and delivered by the employees of the GPO.

This past weekend, when the heavy snow blanketed the city and shut down most government agencies and operations, the men and women of the GPO came to work and remained at their posts. Some GPO employees spent the night to ensure that the Senate was able to get the documents we needed. Their performance throughout the health care debate was commendable and I would like to ask my colleagues to join me in thanking the GPO for a job well done.

The PRESIDING OFFICER. The Senator from Idaho is recognized.

Mr. CRAPO. Mr. President, as we approach the vote tomorrow morning, I know a lot of people are calling it a historic vote. In some contexts, I guess it is. However, many of us are concerned it is a historic mistake rather than a history-making opportunity.

We have had a lot of debate about whether this legislation is the right or wrong way to improve health care for all Americans. We have had hours and hours, in fact, days and weeks of committee hearings and meetings with good bipartisan discussion on options and ways to accomplish this. But now, apparently, we have a mandate by the majority demanding we have a final vote in the Senate before Christmas.

While we debate this, let me say I believe we need to hear more from the

people who are going to be most affected, the American people, because the final details of this bill were not crafted in front of the American public. I think most people in America know the President pledged that this legislation would be crafted around a table that is public, where, in fact, he said C-SPAN cameras could be present—in his words: So people could see the deals people were making and who was working for the American people and who was cutting deals.

The C-SPAN camera was not present, the table was not open, the room was closed, and the bill was negotiated in secret. But we are starting to find out what the deals were, and the deals are outraging the American people as they see specific exemptions from certain burdens in the bill being given to certain States in order to get the votes from the Senators for those States.

We heard about different proposals dealing with the State of Louisiana, the State of Florida, the State of Connecticut, the State of Nebraska, and the list is growing as we have an opportunity to deeply delve into the bill and determine exactly what is in it.

But we will not have time to know all the details of these deals. We will not have time to even know all the details of how the bill works because this 2,700-page bill, 400 pages of which were only disclosed last Saturday, will be voted on at 7 o'clock in the morning.

Three days ago, I asked Idahoans who, similar to most Americans—in fact, all Americans—want health care reform, to sign a petition on the Internet asking the Senate to:

... defeat H.R. 3590 ... because we need reform that will lower costs while increasing quality ... and keeping health care decisions between a patient and their doctor.

The response to this request has been remarkable. In fact, I suspect that, as I am speaking, we have already gotten over 20,000 signatures on the petition on the Internet. I asked people to go to my Internet site, mikecrapo.com, and simply sign the petition. Here is a partial stack. We are still printing out the rest of the names of the people who signed the petition, but somewhere between 19,000 and 20,000—and growing—people signed the petition.

Here is the remarkable thing about it. When I asked the people of Idaho to sign this petition, I asked them to do two things. I asked them, first, to go to the Web site and sign the petition. Then, second, I asked them to contact everyone within their circle of influence—people on their Christmas card list, people on their e-mail contacts list, people on their Facebook, their Facebook friends, everyone who is within their circle of influence—and ask them to also sign the petition and, if they didn't live in Idaho, to contact their Senator and encourage their Senator to oppose this legislation, if they agreed with me that it is not the path our Nation should follow.

Remarkably, more than half the people who have so far signed the petition did not get that information from me. They got the request or encouragement to sign the petition from the friend or relative. A huge proportion of them do not live in Idaho. In fact, we have had people from all over America, in every one of the 50 States, sign this petition.

Why is this happening? By the way, the number is growing. It is happening because the more Americans know about this bill, the more they know it is not the path they want us to take for health care reform. Health care is personal, private, and a sensitive matter among individuals and their doctors and their family. This bill makes health care a public policy decision controlled by a government bureaucracy. Americans don't want that kind of government control over our health care economy. Yet instead Americans see an administration and a congressional majority forcing this bill down their throats in a rush to pass it before public opposition legitimately overwhelms this wrongheaded monstrosity. Thousands are signing this petition because they desperately want Congress to listen, but they know that their collective voice has been ignored. The petition is one way they can make themselves heard in hopes that this Congress will pass needed and sensible reform but not this bill.

In fact, another point about this petition is in addition to getting on the Web site and signing the petition, I have individuals calling my offices and saying: Thank you for giving us an avenue to try to reach out to the Senate and tell the Senate to stop. I think thousands of Idahoans and people from all over America are eager to have an avenue to speak out, and we need to stop and listen. I thank the thousands of Idahoans and Americans across the country for being willing to get involved as citizens and petition their government to respect our rights and to honor our values and to reform health care sensibly. The national polls indicate people oppose this bill. They want commonsense, lower cost action that will reduce the cost of premiums and doctor visits.

This legislation instead raises taxes on the middle class, increases premium costs for many people now carrying insurance, cuts senior programs, and fails to lower health care costs. Simply put, there has not been a piece of legislation this decade that has come forward to meet more opposition than this health care reform bill. The more Idahoans and Americans know about the bill, the more they dislike it. Health care is a personal, private, and sensitive matter, and this bill goes the opposite direction. But the majority is moving full steam ahead in hope that they can pass it before the public can understand what it is and register their opposition. If we will take the time, we

can improve the health care system—without the tax increases, without the massive increase in the growth of government, without the porkbarrel spending and the sweetheart deals, without the Medicare cuts and the unconstitutional burdens on State governments this bill presents.

Among the steps many of us are trying to see enacted are things such as allowing insurance companies to compete across State lines, allowing small businesses to band together to negotiate group rates for insurance, requiring pricing disclosures from health care providers to promote a competitive, consumer-driven health care market, and offering incentives for patients and the private sector to create wellness programs and other efficiencies in health care delivery. In fact, when a bill similar to this was presented as the Republican alternative in the House, with the provisions the House Republicans proposed, it was scored, contrary to the bill we will be voting on, by CBO that it would actually reduce the cost of health care in America by significant percentages. Yet we are now continuing to plow full steam ahead with a vote at 7 o'clock in the morning on a bill that will increase the cost of health care.

The petition I brought forward asks Congress to listen. It registers the fears of many Americans that they are being ignored by the administration and by the majority in Congress. I am going to continue to aggressively push for their wishes on the floor of the Senate.

I wish to take an opportunity now to go ahead and get into a little bit more of the detail we do know about this bill. Why do I say it is the wrong direction for America? To start, let's ask what Americans want in health care reform. If you asked most Americans—and there have actually been a number of polls that have shown this—do they want health care reform, they say yes. When they are asked what they mean by that and what they want, the overwhelming answer is that they want to stop the skyrocketing increases in the cost of their health care insurance, they want to control the skyrocketing increases in the cost of medical care. They also say they want to see increased access for those who don't now have access to quality insurance, both because they are compassionate and want to see that kind of health care for everyone and because they know they are paying for it in their insurance premiums, for those who have insurance, and in their taxes, those who pay taxes. They want to assure that we continue to have the highest quality of health care possible. That is what we are supposed to be doing. That is what this bill should be working on. That is the objective we should be achieving.

Yet what are we achieving? In an earlier discussion of the House bill, I be-

lieve the Wall Street Journal said it was the worst bill ever. We now have a different bill in the Senate, but it is still falls into the same category. Why? Because it drives up the cost of health care. It raises taxes by hundreds of billions of dollars. It cuts Medicare by hundreds of billions of dollars. It grows the government by \$2.5 trillion. It forces the needy uninsured not into a program where most of them can get insurance but into a failing and less robust medical system, Medicaid. It imposes damaging unfunded mandates on our State governments that are already sharing the burden of Medicaid and facing difficult troubled economic times. It means increased taxes not just at the Federal level but at the State level with unfunded mandates. It leaves millions of Americans uninsured, and it establishes massive government controls over our health care economy.

Let me go through a few of those to give more specifics. First, I don't think most Americans, when they talk about health care reform, think that means we need to grow the size of our government by \$2.5 trillion. Although there is some smoke and mirrors in the way this bill is put together, because the first 4 years of its costs are not started until 4 years into the bill, so when you try to count the first 10 years, you only see a smaller number, when you take the first true 10 years of spending in this bill, it increases the cost of this government's health care expenditures by \$2.5 trillion. As we can see on this chart, look at the first 4 years. The spending is basically deferred. Why would that happen? I will explain that when I talk about deficit issues. But what it does is hide the true cost of the bill. If you measure the true cost of the bill in the first full 10 years of spending, it is \$2.5 trillion rather than the \$1.2 trillion it would be if you counted it otherwise.

What we see is a massive growth of the Federal Government. That is not what people were asking for and, frankly, it makes them kind of do a doubletake when you explain to them that we are increasing the size of our government by such massive amounts with health care reform. Those proposing that we adopt this bill often say: Our objective and what the American people want is to drive the cost curve down. I often ask, what cost curve are they talking about? If they are talking about the cost of health care or the cost of health care premiums, they are going up. If they are talking about the size of the Federal Government and the level of Federal Government spending, that is going up.

There is one that they talk about. It is called the deficit. That is whether we are spending more than we are taxing and cutting. They argue that the deficit is going down. There is only one way you can argue that this bill does

not increase the deficit, and that is if you assume that we don't have nearly $\frac{1}{2}$ trillion of Medicare cuts, that we don't have $\frac{1}{2}$ trillion worth of taxes in the first year and \$1.28 trillion of taxes in the first full 10 years of implementation and that we don't have several budget gimmicks.

What are the gimmicks? The first and biggest is the one I showed on the previous chart. They don't count the first 4 years of spending. They stop the spending and don't let it start happening for 4 years so that we have 10 years of taxes, 10 years of Medicare cuts, and 6 years of spending. When you balance that out, you can claim it doesn't increase the deficit because you don't have a full 10 years of spending.

There are other budget gimmicks. We have something called the SGR fix, the adjustments in compensation rates for physicians that we all know on both sides we must do. We must keep the physician compensation comparable and moving up with inflation. That is going to cost \$245 billion, approximately, over the next 10 years. That \$245 billion cost to reform and adjust the Medicare compensation system is absent from the bill. Why? Because they are going to do it in a separate bill and probably not pay for it; in other words, not have offsets. We will see whether they have offsets, but it is not in this bill. If it were, it would drive the deficit numbers by \$245 billion in the wrong direction.

There are other types of gimmicks. For example, there is double counting of the Medicare cuts. The CBO came out with a report today that said that if you cut Medicare by \$465 billion, claiming that you are going to use that \$465 billion to help make the financial situation for Medicare more stable, you can't then take that same \$465 billion and use it to establish a massive new government program, yet a third major government health care entitlement system. You can't spend it on a new one and claim you are saving one that is already facing fiscal collapse. It is these kinds of budget gimmicks that make many of us object to the bill. If you didn't have those budget gimmicks, if you didn't have those tax increases, if you didn't have those Medicare cuts, there is no way you could say this bill is deficit neutral.

One of the things CBO does report—I want to move to the question of the cost of insurance—is that the premiums in the individual market will go up, not down. What does that mean? CBO breaks the insurance market into three categories: the individual market, the small group market, and the large group market. The individual market is the one that is primarily there for small businesses that don't have a large or a small group opportunity or individuals who don't get their insurance through their employer. It represents about 17 percent

or almost 1 in 5 of all insured people in the country. Their insurance rates under this bill—17 percent of all Americans—are going to go up. The amount by which they will go up is about 10 to 13 percent, according to CBO.

The next group is the small group market. They represent about another 13 percent. Again, CBO says under this bill their rates are going to go up, not quite as badly, between 1 and 3 percent, but up, not down.

That brings us to the large group market. The large group market actually fares a little better. This is the remaining 70 percent of those insured in the United States. Basically, the CBO report says that for them there is a chance theirs may go down by a percent or two, but basically, it could be stable, a zero-percent change as well. Because individuals in the large group market, those who get their insurance from larger employers, have less liability of a harmful impact because they have that large group that can continue to negotiate to control their health care costs.

So what do we see? Even under the best scenario—and there have been nine or ten studies of this and the CBO report is the one that is the most favorable toward the bill; most of the other reports have said that the rates are going to go up for everybody—but even if we take CBO's numbers, 30 percent of the people will see their insurance rates go up, not down. The other 70 percent can expect basically the status quo; in other words, not any change at all, maybe a slight decrease.

Is that what Americans were asking for robust health care reform system? No. Americans are asking for true, solid, significant control of the cost of their premiums and their health care costs.

I wish to move next to the question of taxes. This bill increases taxes by about $\frac{1}{2}$ trillion. The President has pledged he wouldn't sign a bill that involved tax increases on the middle class. He defined the middle class to be people who as individuals make less than \$200,000 a year or as a family or a couple making less than \$250,000 a year. Here is the President's pledge:

I can make a firm pledge. No family making less than \$250,000 will see their taxes increase.

He was pushed on this pledge and he clarified it. He said not your income taxes, not your payroll taxes, not your capital gains taxes, not any of your taxes. You will not see any of your taxes increase one single dime.

That is the President's pledge. But what do we have? In the first 10 years, \$493 billion in new taxes. The question is: Do those taxes all fall on the so-called wealthy, those making more than \$250,000? Well, CBO and the Joint Tax Committee have analyzed it, and the answer is clearly no.

But before I get to that, let's see what the taxes do in the first full 10

years of implementation. Remember, the first 4 years are kind of a slow start with the spending, but if you compare the taxes and the spending, count the total amount of taxes starting on the day when the spending kicks into gear, it is not \$493 billion, or whatever the number was, it is \$1.28 trillion in new taxes. That is not what the American people are asking for.

The next question you might ask yourself is: OK, how much of those taxes are going to be paid by people who the President pledged would not be hit? Well, the Joint Tax Committee has analyzed the bill, and by 2019—and the reason they use the year 2019 is that is the end of the first full 10 years of implementation—by the year 2019, at least 73 million American households earning below \$200,000 will face a tax increase. That is not just people making \$200,000, that is everybody who pays taxes who makes any kind of income less than \$200,000 in America. Seventy-three million—not individuals—households will pay taxes under this bill.

One of the things that is interesting, in response to this argument, some of my colleagues on the other side have said: Wait a minute. That is not true. This bill is actually a tax cut. Wait a minute, you have me saying this bill increases taxes and someone on the other side saying this bill cuts taxes. How could that be?

Well, there is a subsidy in this bill for those who are at lower income categories and are provided government dollars or subsidies in order to purchase insurance—the ones who are fortunate enough not to have been pushed into the Medicaid system. That subsidy is about \$400 billion or \$500 billion in the bill, and it is administered by the IRS, so it is claimed to be a tax cut. If you offset that subsidy against tax increases in other parts of the bill, then you can say: Well, there is a tax cut in this bill.

First of all, that is not what the President said. The President did not say: I will not increase your taxes more than I will cut somebody else's taxes. That is not what he said. What he said was: Your taxes will not go up if you are making under \$250,000 as a couple or \$200,000 as an individual.

But even if you accept that argument, 73 percent or \$288 billion of this tax subsidy goes to taxpayers who do not pay any taxes. Their income levels are so low they do not hit the thresholds for incurring a tax liability. They get a pure, straightforward subsidy. The Congressional Budget Office acknowledges this and scores it as Federal spending, not as tax relief.

But either way you want to look at it, let's say you agree it is tax cuts and agree to offset it—which I think is wrong—you still come up with 42 million American households earning less than \$200,000 a year who will face a net tax increase, and the tax increases are not small for these families.

The bill grows the Federal Government. It pushes up every cost curve you could think of. It increases taxes. It increases the cost of health insurance. It increases the cost of health care.

What does it do to Medicare? It cuts Medicare by \$465 billion in the first year and, again, if you want to look at the first full 10 years, by \$953 billion in Medicare cuts. Basically, what we have here in this part of the bill is an absolute transfer—an absolute transfer—from America's senior citizens right over to the new government entitlement program and a redistribution of that wealth to other people.

Senior citizens who have throughout their life paid the Medicare tax, the Medicare payroll tax, will now see the Medicare they thought they were going to get cut. What kinds of cuts are we talking about that we may be dealing with here? The biggest one is Medicare Advantage—\$120 billion of cuts.

About one in four American seniors has Medicare Advantage insurance. This is insurance that was provided in a contract relationship with the private sector. In other words, it was an experiment to see if we could let the private sector deliver Medicare and how they would do at it. They found they can actually, through the Medicare Advantage Program, increase the benefits seniors get.

This is probably the most popular part of the Medicare Program. It is growing rapidly. The reason it is growing rapidly is because it provides better coverage. Those in the Medicare Advantage Program are going to see their benefits cut.

Another pledge the President made was: If you like what you have, you can keep it. Well, not if you have Medicare Advantage. It is also not true about a lot of people who have their insurance through their employers these days because that is going to be lost to millions of Americans too.

But in addition to the Medicare Advantage cuts, you are going to see hospital reimbursements, skilled nursing facilities, home health agencies, hospice, and others cuts to the tune of \$465 billion in the first 10 years. The experts have all told us, what that is going to do is to make impossible for many health care providers in these categories to keep their doors open, or it will cause them to reduce the amount and quality of services they provide.

So senior citizens are going to see their Medicare, particularly their Medicare Advantage, benefits cut and their access to care restricted and reduced under this bill.

In summary, there has been a lot of talk again about how Americans want health care reform. But we need to do it in a smart and sensible way. Many have argued there are no alternatives being put forward by our side. As I indicated earlier in my remarks, that is

simply not true. In fact, the alternative that was put forward in the House and the alternative many of us have been talking about here have been scored to actually achieve the results Americans are asking for.

We do not need to rush this bill through in a claim that we are making history but in a way that will be a huge historical mistake. The American people, in huge numbers, are asking us to slow down and stop it and start working together in ways that do not create a government takeover of health care, that do not drive up the size and reach of the Federal Government, that do not drive up taxes but instead provide the right kind of approaches to medical savings, that do not slash Medicare benefits to our seniors, that do not put massive burdens on our States, and that do not force the neediest of our uninsured into a failing health care system, Medicaid.

We are simply going to have to be back at this in the future if we do not get it right now. Only then we will be facing much worse fiscal circumstances and very difficult problems with sustaining the fiscal stability of the two programs we are now dealing with trying to sustain: Medicare and Medicaid.

I urge my colleagues to listen to the people who signed this petition—people all across this Nation in every one of the 50 States—who are saying: Wait. Do not do this now. Do some sensible reform, but do not make this mistake.

I encourage all my colleagues, as we are literally on the eve of the vote that will determine whether this bill makes it through the Senate, to step back and take a deep breath and evaluate whether it will not be better for all of America for us to move a little slower and start trying to build a bipartisan solution that can have true benefits for the American people.

With that, Mr. President, I yield the remainder of my time.

Mr. HATCH. Mr. President, there is a lot of talk from the majority about why passing this bill is the right thing to do for the American people. It is a decision of conscience for them. Well, let us take a closer look at these decisions of conscience.

After weeks of closed-door clandestine negotiations, Senator REID finally emerged with a 383-page Christmas list. This bill is a dark example of everything that is wrong with Washington today. Despite all the promises of accountability and transparency, this bill is a grab bag of Chicago-style, back-room buy-offs. It is nothing more than the Democratic leadership's own private game of "Let's Make A Deal" with special interest groups financed by American taxpayers.

So who won and who lost in this game? Well let us take a closer look.

AARP issued a strong statement of support for this bill. The Reid bill slashes Medicare by almost \$½ trillion

to finance additional government spending. So, why would the Nation's largest lobbying organization, avowed to protect the interests of seniors, support this legislation? To find the answer, like anything else in Washington, just follow the money.

AARP takes in more than half of its \$1.1 billion budget in royalty fees from health insurers and other vendors. The sale of supplementary Medicare policies, called Medigap plans, make up a major share of this royalty revenue. AARP has a direct interest in selling more Medigap plans. However, there is a strong competitor to Medigap policies—Medicare Advantage plans.

These private plans provide comprehensive coverage, including vision and dental care, at lower premiums for nearly 11 million seniors across the country. Seniors enrolled in Medicare Advantage do not need Medigap policies. So what happens when the Reid bill slashes this program by almost \$120 billion? Just look at the Washington Post front-page story from October 27 questioning whether AARP has a conflict of interest:

Democratic proposals to slash reimbursements for . . . Medicare Advantage are widely expected to drive up demand for private Medigap policies like the ones offered by AARP, according to health-care experts, legislative aides and documents.

One of the most disturbing developments in the Reid bill has been the perpetuation and even doubling of the unconstitutional individual mandate tax from \$8 billion to \$15 billion. You heard me right—this unconstitutional mandate tax actually doubled behind closed doors. I have long argued that forcing Americans to either buy a Washington-defined level of coverage or face a tax penalty collected through the Internal Revenue Service is highly unconstitutional.

We hear a lot of rhetoric from the other side about Republicans defending the big, evil insurance companies while Democrats are the defenders of American families. The insurance mandate is a clear example of this partisan hypocrisy. Let me ask one simple question: Who would benefit the most from this unprecedented mandate to purchase insurance or face a stiff penalty enforced by our friends at the Internal Revenue Service?

The answer is simple. There are two clear winners under this Draconian policy—and neither is the American family. The first winner is the Federal Government, which could easily use this authority to increase the penalty, or impose similar ones, to create new streams of revenue to fund more out-of-control spending. Second, the insurance companies are the most direct winners under this individual insurance mandate because it would force millions of Americans who would not otherwise do so to become their customers. I cannot think of a bigger give-

away for insurance companies than the Federal Government ordering Americans to buy their products. If you do not believe me then just look at the stock prices of the insurance companies that have recently shot to their 52-week highs.

Jane Hamsher, the publisher of the very liberal blog Firedoglake, said the following in a recent posting: "Having to pay 2 percent of their income in annual fines for refusing to comply—with the IRS acting as the collection agency—just might wind up being the most widely hated legislation of the decade. Barack Obama just might achieve the bipartisan unity on health care he always wanted—Democrats and Republicans are coming together to say kill this bill."

Now that we clearly understand the huge windfalls the Reid bill provides AARP and insurance companies, let me take a moment to talk about the winners and losers in the so-called abortion compromise. The language to prevent taxpayer dollars from being used to fund elective abortions is completely unacceptable. The new abortion provisions are significantly weaker than the amendment I introduced with Senator BEN NELSON to ensure that the Hyde amendment, which prohibits use of federal dollars for elective abortions, applies to any new federal health programs created in this bill. The Hyde amendment has been public law since 1976.

The so-called abortion compromise does not stop there. The Reid bill creates a State opt-out charade. However, this provision does nothing about one state's tax dollars from paying for abortions in other states. Tax dollars from Nebraska can pay for abortions in California or New York. This bill also creates a new public option run by the Office of Personnel Management, OPM, that will, for the first time, create a federally funded and managed plan that will cover elective abortions.

When you have Senator BOXER and Speaker PELOSI, two of the largest pro-choice advocates in the Congress, supporting this sham so-called compromise and everyone from the U.S. Conference of Catholic Bishops to the National Right to Life Committee and the Family Research Council opposing it, there is only one clear loser—the majority of Americans who believe in the sanctity of life and oppose the use of federal dollars for elective abortions.

Last but not least, I would like to spend a couple of minutes to talk about the numerous special deals conferred on States in this \$2.5 trillion spending bill. How hefty are the pricetags for decisions of conscience? Here are some highlights: \$300 million for Louisiana; \$600 million for Vermont; \$500 million for Massachusetts; \$100 million for Nebraska.

At a recent news conference, when the authors of this legislation were

asked about the Nebraska earmark for Medicaid funding, the majority leader simply replied, "A number of states are treated differently than other states. That's what legislation is all about. That's compromise."

The next logical question is pretty straightforward—Who will pay for these special deals? The answer is simple. Every other State in the Union, including Utah, who are collectively facing \$200 billion in deficits and are cutting jobs and educational services to survive, will now pay to support these special deals.

According to the Congressional Budget Office, the Medicaid expansion in the Reid bill creates a \$26 billion unfunded mandate on our cash-strapped States. Coincidentally, only one state avoids this unfunded mandate—Nebraska.

Of course, let us not forget about the biggest loser in this bill—the hard-working American taxpayer. This bill imposes over a \$½ trillion worth of new taxes, fees, and penalties on individuals, families, and businesses. The new fees begin in 2010, while the major coverage provisions do not start until 2014. Almost \$57 billion in new taxes are collected before any American sees the major benefits of this bill, which are largely delayed until 2014. It is also no coincidence that through the use of these budget gimmicks the majority can claim this bill reduces our national deficit when we all know these reductions will never be realized.

Based on data from the Joint Committee on Taxation—the nonpartisan congressional scorekeeper—this bill would break another one of President Obama's campaign promises by increasing taxes on 42 million individuals and families making less than \$250,000 a year.

At a time, when we are struggling to fight a double-digit unemployment rate, the Reid bill not only increases payroll taxes by nearly \$87 billion but also imposes \$28 billion in new taxes on employers that do not provide government-approved health plans. These new taxes will ultimately be paid by American workers in the form of reduced wages and lost jobs.

However, it is hard to say we didn't see these new taxes coming. For years now, many of us have warned that the out-of-control spending in Washington will eventually have to be repaid on the backs of American families. In this bill, the repayment comes in the form of stifled economic growth, lost jobs, and new and increasing taxes—and they are just the first installment of what will be a long and painful extortion of taxpayers if Congress doesn't stand up and stop these terrible bills.

According to a recent study of similar proposals by the Heritage Foundation, these new job-killing taxes will place approximately 5.2 million low income workers at risk of losing their

jobs or having their hours reduced and an additional 10.2 million workers could see lower wages and reduced benefits.

Poll after poll tells us about the growing opposition against this tax-and-spend health care bill. The latest Rasmussen poll shows that 55 percent of Americans are now opposed to this bill. The CNN poll has it even higher at 61 percent. Among senior citizens, the group most likely to use the health care system, only 33 percent are in favor while 60 percent are opposed. Independent voters are also opposed almost 2 to 1. Opposition in certain state polls, like Nebraska, is even higher at 67 percent.

So what is the majority doing to address these concerns? Nothing. In fact, despite the efforts by many of us here on this side of the aisle to express our substantive policy disagreements for months, one Senator recently said the following: "They are desperate to break this president. They have ardent supporters who are nearly hysterical at the very election of President Barack Obama. The birthers, the fanatics, the people running around in right-wing militia and Aryan support groups, it is unbearable to them that President Barack Obama should exist."

This statement is outrageous. Instead of listening to the policy concerns of a majority of Americans, the other side is simply dismissing them as rants from the far right. If the majority refuses to listen to what Americans are telling them now—I am sure they will have a rude wake-up call waiting for them later. It should come as no surprise to anyone that this kind of arrogance of power has led to congressional approval ratings rivaling the most hated institutions on the planet at a dismal 22 percent and falling.

One of the biggest tragedies of letting this bill move forward is that it will do nothing to address the fundamental issue of rising health care costs in this country. According to the Congressional Budget Office, this bill will actually raise our national health care costs by \$200 billion. The administration's own actuary at the Centers for Medicare and Medicaid Services, CMS, agrees with this assessment. When this bill fails to work, Americans will no longer have any faith in Congress to effectively address the issue of health care reform. The opportunity to save Medicare and Medicaid from their impending financial collapse will be lost for another generation.

The historic blizzard in Washington earlier this month was a perfect symbol of the anger and frustration brewing in the hearts of the American people against this bill. I urge the majority once again to listen to the voices of the American people. Every vote for this bill is the 60th vote. Let me repeat that again—every vote for this bill is the 60th vote. My Republican col-

leagues and I are united with the American people in our fight against this \$2.5 trillion tax-and-spend bill. I implore my colleagues not to do this to the American people. Don't foreclose on their futures. Don't stick them with even more government spending and government intrusion.

We can fix health care. Many of us have been working to do just that for many years. A truly bipartisan bill that would garner 75 to 80 votes in the Senate, would be fiscally sound and provide the American people with the fixes they are asking for in the health care marketplace is easily achievable. Many of us are standing at the ready, and have been for months, to step forward and pass meaningful health care reform that truly would help American families and please American taxpayers. To date, we have been rebuffed by an unfailing determination by a few to pursue a nearly Socialist agenda. I would ask my colleagues on the other side of the aisle who do not believe in the Europeanization of America, who believe in doing truly bipartisan work here in the Senate, to step forward, vote against advancing this bill and work with those of us on this side of the aisle who are committed to making a difference to craft a health care reform bill they can be proud to support.

THE PRESIDING OFFICER. The Senator from New York.

MR. SCHUMER. Mr. President, it is truly my honor to be here on this historic evening and speak in support of the bill which we will vote on early tomorrow morning, Christmas Eve morning. It is an honor because anyone who looks at this country knows the problems we have, and that two problems caused by the health care system are at the top of the list. One represents a more conservative point of view and one represents a more liberal point of view. But I am proud to say the bill we will pass tomorrow morning, God willing, deals with both.

The more conservative issue is controlling costs. The health care system costs this country a whole lot of money. By and large, we get good health care—not everybody but most people. But it is so expensive, and that has been documented.

What does that mean? It means small businesses cannot grow and actually have less money to pay for wages. It means our large businesses are less competitive globally. We have seen that in the auto industry. It means individuals often have to pay a fortune for health care. It means our government runs deficits that are perilous to the economy. Health care costs are more the cause of our deficits than anything else.

On the other hand, we run a real problem because many people are not covered or covered adequately. The heartwrenching stories told by our fine leader—and I cannot give him enough

kudos for the job he has done here; and I will talk about that in a minute—but the people who are not covered or covered poorly suffer in many ways. They become not only less happy citizens—that is most important—but less productive citizens. The heartwrenching stories of people who do not have coverage for them or their children we all know about. It also, by the way, increases costs because when people delay coverage, when they are ill, it inevitably costs more.

This bill addresses both. I wish to, in my brief amount of time here—and I do not know how much time I have—address both. I wish to talk on the cost side first.

Why do health care costs go up so much more than any other product? Two main reasons. First, we do not have perfect knowledge, as the economists would say. We basically do not know what we are buying. When we go to the doctor, and the doctor says: You need this test, we do not know if we need it. Is the doctor genuinely prescribing a test we need or is there some element that he makes enough money on this test that why not? can't hurt because we do not need it?

In my family, my relatives have all had prostate cancer, and I watch very carefully. But when I go to the doctor and he says I need this kind of a test or this kind of a scan, I say: Of course. If it were a car or a house, I might investigate to see if I needed it.

The second reason costs are so expensive is because fundamentally health care deals with God's most precious gift to us, which is life. Who would not beg, borrow, or steal to find \$100,000—who would not give their right arm if we were told our husband, our wife, our mother, our father, our son, or our daughter was ill and \$100,000 would give them a 25-percent greater chance of living better, of healing? We would do it. But because most of us do not have that \$100,000, we buy insurance. That is the reason there is health care insurance. It is not because it is health care; it is because it is so vital and so expensive. So we are willing to pay \$5,000 a year, so that, God forbid, if that time comes when we need that \$100,000 to cover a loved one, it is there because we have insurance.

So when I go to the doctor and he says I need this special test, special scan, special procedure, not only do I not know whether I need it—because the training is difficult; and you can go online, but you cannot really figure these things out—but, second, I am not paying for it. You put those things together, and the costs go through the roof. We have tried in this bill to finally get a handle on the costs. Most other countries have. In America, we haven't. We must. I believe very deeply in covering everybody, but unless we get a handle on the costs, we will not be able to afford to cover everybody.

Even if we cover them today, we will run out of money in 5 years. We do it in four ways, and I am going to be very brief about them because my time is somewhat limited.

First, we deal with efficiencies. There is one form. If there is IT, as we put in the stimulus bill—information technology—we can save hundreds of billions of dollars. Just one form. You go to a doctor's office, there is a nurse, a doctor, and there are four people filling out forms. If you had one form, you wouldn't need that.

Second, prevention. Early intervention and prevention saves billions, and in this bill that is what we encourage, early intervention and prevention. Right now, amazingly enough, if you get diabetes in the later stages, Medicare or private insurance will pay for dialysis. God forbid someone needs a leg amputation, one of those serious retina operations, they pay. They don't pay for the early stages. They don't pay for the nutrition therapy, the exercise therapy that could arrest diabetes in the early stages. We do that.

The third thing we try to do in this bill is provide competition in the insurance industry, and we do provide competition in the exchanges. We do put some limits on the insurance companies with the medical loss ratio provisions that Senator ROCKEFELLER, Senator FRANKEN, and Senator NELSON helped craft. If we could have had a public option, it would have created more competition. That is one of my great regrets, that we don't. I worked hard for it, but we don't. Nonetheless, we still get some limitation on insurance companies and create more competition.

The fourth is the hardest: fee for service. The fee-for-service system is what drives up the costs. This bill, more than any other provision ever passed in America, begins to grapple with that most difficult issue.

You do those four things, and you will bring costs down.

It is no wonder that CBO has said that in the first 10 years, we save \$127 billion, even though we are covering 31 million more people, and in the second decade, we are going to save over \$1 trillion. I forget the number. I think it is \$1.3 trillion. We are doing whoever becomes President in 2020 a huge favor because with the cost-control provisions in this bill, should they become law, we will get a great handle on costs. It will take a while, but it will do the job. On the other side, we don't cover everybody, but 94 percent of all people will be covered, so it is an amazing feat to both cover many more people and reduce costs, and that is what this bill does.

I wish to say, for my home State of New York, there are lots of good things in this bill. We have 800,000 seniors who would be cut from Medicare who will not be because of provisions we were able to get in the Finance Committee.

Graduate medical education, intermediate medical education—a lifeblood for jobs in New York because training doctors is probably our second biggest industry in New York City—is not cut even though it was proposed to be cut. Money for neighborhood national health services and community health centers will provide physicians in inner cities and in rural areas where they don't have health care. They will get really good health care.

This bill is far from perfect. Had I written it, I would have written it a different way. Had Senator CANTWELL or Senator CASEY or Senator KLOBUCHAR written it, they would have written it differently from me. But if every one of us in this Senate insisted that the bill had to be written exactly our way, we would have 100 bills, each with 1 vote, and no progress. So great progress has been made, and this is a proud moment.

There are many people I wish to thank.

My staff—I do want to mention Meghan Taira, Katie Beirne, and all of the others who worked so hard; Jeff Hamond, who worked so hard and so diligently on this bill.

I thank MAX BAUCUS. He soldiered on and on when things looked bleak and pursued his dream of a bipartisan bill, which would have been a better product. It wasn't to be but not because of lack of his efforts.

Thanks go to Senator DODD and Senator HARKIN on the HELP Committee and my colleagues on the Finance Committee, but at the top of the list is just one person, and I was proud to be one of his lieutenants on this, and that is HARRY REID. I was up close. What an amazing job that man did, modestly, without complaining, without looking to what was good for him. He had a mission, a job: get us 60 votes on this very difficult, complicated proposal. And he did it. He will never get the credit he deserves because he is such a modest man, but I wanted to share that with my colleagues and with the country as I am sure others have done before.

So this bill is a very good bill on both sides of the ledger. It will reduce costs rather significantly and in a smart way, without hurting patient care. It gets rid of the fraud and the waste and the abuse and duplication. At the same time, it will cover many more people.

This is a very fine day for this country, this Senate, and Leader REID. Tomorrow morning, I will be very proud to vote for this piece of legislation, certainly one of the most important I have ever voted on in my 35 years as a legislator.

I yield the floor.

The PRESIDING OFFICER. The Senator from Washington.

Ms. CANTWELL. Mr. President, I am proud to be out on the floor tonight with my colleagues.

I thank the Senator from New York for his comments and his work in the Finance Committee. He literally did work night and day in that committee and then worked with Leader REID on trying to get consensus within our caucus on this legislation. So I appreciate his strong, active support in making reform.

I, too, wish to add my congratulations tonight because we are here to talk about controlling health care costs and what we are going to do to help the American people. I too wish to thank my colleagues, Senator BAUCUS and Senator REID, for their active leadership, as well as Senator DODD and Senator HARKIN.

I add my thanks to the whole Finance Committee staff. I don't think people realize they have worked from January until December, many weekends as well as during the week, many late nights as well as early mornings, and they deserve a lot of credit for the details behind this legislation and making sure the i's are dotted and the t's are crossed.

I wish to thank my staff, all of my staff but in particular Mark Iozzi, who worked on this legislation, as did the rest of the Finance Committee members of the staff, for about the last 11½ months. I was glad to send him off on a plane today to reach his family, and hopefully he will be watching the vote tomorrow morning by television. It should be a proud moment for him.

I also wish to add a particular thanks to President Obama. I wish to say to the President that he started this year with the dedication that this was going to be a year where we got health care reform. He stated that at the beginning of his Presidency and held steady to that during the very raucous debate that happened in the early months regarding the budget and whether we would have the money to do health care reform. He remained committed as we went home over the summer and many things happened at town meetings. He came back and was determined that we would forge ahead. He, as we got legislation out of the Finance Committee and had to combine bills, remained active and intent about this legislation.

It reminds me of a saying my father used to make to me because he was a Navy man and always came up with nautical terms to kind of describe the direction in which he would want his children to go. The President's actions on health care policy for this year remind me of the saying "steady as she goes" because that is what the President has done for the last many months—steady as she goes so that we can get health care reform.

So I wish to add my thanks and congratulations to him and to his administration and to the many members of that administration who were down here on the Hill, including Mr.

Messina, who made many frequent visits, I think, to Members to talk about some of the details.

I am glad I am following my colleague from Idaho, from the Northwest, who spoke earlier, because I think it shows you can be from the same region of the country and have the very same interests but look at this legislation differently—not that I don't share some of his concerns, and I am going to fight to make changes and add to the legislation as it continues to move into conference and in the years after its implementation. I think the Senator has brought up some good points that we need to follow up on.

Controlling health care costs in general is what is driving us to take action tomorrow morning on Christmas Eve. We know we have already seen a 120-percent increase in insurance premiums for the last 10 years; that is, from 1999 to 2009, we have seen a 120-percent increase for Americans and their premium costs. That is something the American people can't afford. And when my colleague from Idaho talks about the increase we are going to see in the next 10 years, he is right. Insurance premiums are going to go up again. This debate is about what we are going to do to try to control those costs, whether this legislation we are discussing today will have an impact in reducing those costs so that maybe premiums aren't going to go up another 120 percent in the next 10 years and make insurance even more unaffordable for the American people.

We know there are organizations that have done multiple studies. We know there is at least \$700 billion in waste each year in our health care system. That is according to the Robert Wood Johnson Foundation. We know that is the kind of money that, if we are smarter about our health care choices, we can reduce the costs of health care and improve the system.

Part of this is reforming Medicare and the cost of Medicare because Medicare dollars are one in every five health care dollars today. The more expensive Medicare is, the end result is the more expensive insurance is in general. So it is very important for us to reform the Medicare system, to have provider reform, which this legislation has, and to change the system.

But we also have to deal with the cost of the uninsured because we know that Americans right now who don't have insurance and who go to the emergency room are adding something like \$43 billion a year in higher premium costs. That is \$1,000 for each family in their premium increases.

I know we can do nothing and have these same costs on the backs of the American people or we can try to change the system, as we are with this legislation, to improve the quality of care and access and to lower the costs for Americans. That is why one of the

main reforms I fought for in this legislation was about paying for value, not for volume; that is, to change the fee-for-service system that rewards physicians for how many procedures they do or how many patients they have seen a day but not for the value of the system. So I know that because of the change we have in this legislation, we are going to reward physicians, starting several years from now—something that has worked in my State and many States in the Pacific Northwest that are more efficient at lowering the costs—by increasing efficiency and thereby rewarding those States with better Medicare payments.

What it actually means for individuals is that they are going to get shorter waiting times, they are going to get better access to doctors, they are going to get more coordinated care, and they are going to get better outcomes. Why? Because that is what we are going to incent in these reforms. That is the kind of system that is working in many parts of the country that are cost-effective, that yield better results for individual patients at lower cost.

I wish to thank my colleague from Minnesota, Senator KLOBUCHAR, because it was her legislation that she introduced early this year that really catalyzed this effort to focus on many of the things done at the Mayo Clinic and things that had been done in Minnesota and things we had done in Washington State that said: Let's change this process and save dollars for everybody in America by getting off the fee-for-service systems and going to a system that will be more cost-effective. So I wish to thank her and her State for that leadership and to thank those in my State who have performed the same way on efficiency to deliver this kind of health care reform.

A second cost control of this legislation that I supported that I think will do well for many people in this country is in the area of long-term care reform.

Some people may know that my colleague, Senator HARKIN, was on the floor and was talking about long-term care in the insurance sector, but part of what we are doing in this bill is also to incent States to move off of nursing home care and on to community-based care.

Home care juxtaposed to nursing home care is 70 percent cheaper and better meets the needs of individuals. I say that because my State implemented this policy to focus on long-term, community-based care decades ago. The end result is that kind of care has been more cost-effective, less expensive, personalized care, and individuals get to stay in their communities.

I do not know any senior in America who would choose to go to a nursing home over staying in their home or in their community. But they have had very little choice up until now on this

legislation to be able to do that because we continue to incentivize nursing home care.

There are some who need nursing home care because they need a higher level of delivery of care, and those people will still go to those facilities. But we will save a lot in our Federal budget, as we look at our Medicare and Medicaid budgets, for the future if we simply take this one action. This bill alone would be worth passing just for this one provision because of how much money it is going to save the Federal Government.

The Basic Health Plan. Many of my colleagues may have heard me talk about the Basic Health Plan as a basis of this legislation that we added in this country. Many people across the country may not understand the Basic Health Plan because they do not have something similar to the Basic Health Plan in their States.

Nearly 20 years ago, the Washington State Legislature passed the Basic Health Plan because it allowed States to negotiate for lower rates. Essentially, it is a public-private partnership. Some people call it a public option. Some people call it a public plan. I call it cost-effective health care delivery. It is cost-effective because we have proven for 20 years that we get 35 to 40 percent lower rates for individuals by grouping into this kind of plan and having the State negotiate the rates. We have been able to have that plan now for 20 years.

This provision of allowing States to do something similar to the Basic Health Plan is a provision we added in the Finance Committee that now will allow every State in America to take money they would get instead for tax credits and use that money in the delivery of negotiated rates for their States. This will allow 70 percent of the uninsured to have full coverage.

What does that mean from a cost-effective perspective? Let's take an example. If this legislation is not passed and we have the current system in America, an individual in 2016 trying to get access to the individual market would have to pay over \$5,850, and the individual would pay everything. The government would be paying nothing; that is, if this bill does not pass. That is what would happen.

Let's look at what will happen if, in fact, this bill does pass. You will have the option of going into the exchange. The estimates are by CBO that you will be able to reduce from where we normally would be, about 11 percent, the cost of health care. In that exchange, an individual who would be covered at 200 percent of poverty would end up paying \$1,200, and the Federal Government would end up paying \$4,000. Already somebody is coming out ahead. They say that sounds good. That sounds like a better deal than me being able to afford this current rate. That

would be \$5,850. It means I would be uninsured.

The Basic Health Plan has been in operation for 20 years, driving down costs through negotiated rates, as I said, by 35 and 40 percent, and it is a far different picture for the individual.

In our State, the individual only pays \$400—\$400—versus \$1,200. Look at the government. The government rate adds to that, \$3,700, but it is cheaper. Why? Because the State has negotiated with insurers and driven down the cost. That is what is missing in the exchange.

While some of my colleagues, I know, think the exchange is going to deliver great clout through the Office of Personnel Management, I hope they are right. I am anxious to see the results of that. But I am unapologetic about the fact that I know the State of Washington has delivered these kinds of savings through negotiated rates and that many States in our country have been the most cost-effective tools for delivering new and efficient health care models, while we at the Federal level still struggle to try to drive those policies.

I know this legislation has cost controls. I know my colleague from Idaho is very concerned about this, and he is right to be concerned. We will be judged by how much we are going to drive down the costs. But the American people should understand that rates are going to go up another 120 percent in the next 10 years if we do nothing. So this legislation is about bending the cost curve. It is about looking at the projected growth, looking at general inflation, and trying to drive health care costs somewhere below what they would be on an annual basis. That is our objective.

We are going to have a challenge in monitoring this legislation, but that is why I am going to fight and cheerlead for the Basic Health Plan and hope that every State in the country takes the option of delivering health care through that kind of negotiated public plan that will allow them to drive down insurance costs.

I hope we can expand the Basic Health Plan in conference to an even more robust plan that would cover more people. It does not make sense to me to continue to subsidize expensive insurance by giving Federal tax credits when I know the bill to the Federal Government and to the individual taxpayer can be cheaper by implementing negotiated rates.

While we have not been able to fully implement that at the Federal level, let's not hold States back. Let States do what they have done best for the last several decades; that is, innovate—innovate more quickly, more effectively, not without a Federal partnership but in a partnership with the Federal Government and in a partnership with a public-private mechanism that I

think has been cost-effective for the last 20 years.

Tomorrow, I will be voting in support of this legislation because I believe in the innovation this legislation enables. I know when we passed the Basic Health Plan in the mid eighties people said the same thing. There were concerns about whether we were going to be able to implement the cost-effectiveness. In fact, at that time, it was said that some stakeholders believed it would be an entitlement. Others saw it as essentially a cost-containment measure that would reduce uncompensated care. Some others thought it would demonstrate the viability of government-subsidized health care. Advocates wanted to implement something quickly so they could develop constituencies.

All these things are similar arguments to what we are hearing today and what this debate has been about. But I know that what happened after 20 years of us putting a plan in place is that hundreds of thousands of Washingtonians got more affordable health care. It has been a plan that has worked effectively. No one has tried to dismantle the program from a political perspective. I think working together with the Federal Government we can show more cost containment for the American public.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Ms. KLOBUCHAR. Mr. President, I ask to speak for 12 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Ms. KLOBUCHAR. Mr. President, I come to the floor in support of the Patient Protection and Affordable Care Act. It is an honor to follow my friend from Washington, Senator CANTWELL, who has been such a leader on the Finance Committee in focusing on the very issue that is key in my State; that is, cost reform, delivery system reform, because for too long the people in cost-efficient States, such as Minnesota, Washington, and Wisconsin, have been seeing other States not quite offering that kind of quality care we would like to see all over the country.

I think it always shocks people. If you go to a hotel and you say you want to get a room, usually if you spend more money you have a bigger room and you have a better view. That is not true with health care.

Time and again, we see studies across this country—academic, bipartisan studies—showing, in fact, some of the highest quality health care comes with some of the lowest costs.

As the Senator from Washington talked about how we can save that \$700 billion year that is wasted in our system, a lot of it comes not at the cost of care but actually at getting better care, because if you reduce unnecessary waste, if you stop having people running around to 20 different specialists

who are giving them conflicting advice and not conferring and not knowing about the medications they are taking, when you have those disorganized systems, they not only cost too much money for everyone, they also give worse care. That is why the Mayo model, an integrated care model with one primary care doctor working with a team of specialists is a model we would like to see all across this country.

We cannot simply keep pushing our problems to another day. Rising health care costs are unsustainable, busting the budget of families and businesses alike. If we do not act, these costs are going to break the backs of the American people.

This country spends \$2.4 trillion on health care alone. That is \$1 out of every \$6 in the American economy. It is projected to be 20 percent of our whole economy in 2020 if we do not act. Despite spending 1½ times more per person on health care than any other country, we all know there are many problems in our health care system.

Wages simply do not keep pace with premiums. Peoples' wages have been stagnant or maybe gone up a little, gone down some or they lost their jobs, but health care costs continue to skyrocket.

I always tell the people in my State there are three numbers we need to remember—6, 12, and 24. Ten years ago, the average American family was spending \$6,000 a year on their health care. Now they are spending \$12,000, with many people spending a lot more. What will they be spending in 10 years if we do not act? Mr. President, \$24,000, up to \$36,000 a year on their health care premiums.

When I go around my State, I hear these stories all the time. Granite Gear, a little backpack company up in Two Harbors, MN, makes backpacks for our soldiers. They have done well. They built their business. The guy in charge of it said he would not have started that business if he knew then what he knows now; that is, for his family of four, a small little business in Two Harbors, MN, he is spending \$24,000 a year on his health care.

I have heard from doctors at Gunder-son Lutheran in La Crescent, MN. They told me the story of how at one of their hospitals in their region they had three patients in a 1-month period come into the emergency room with severe stomach problems. They had ruptured appendixes. Do you know what they said as to why it got to that point? For two of them, they worked at small businesses and they were afraid it was going to blow up the premiums for health care coverage for that little company. The third one could not afford the copays. They waited and waited and waited. They got a doctor and that doctor was the emergency room, some of the most expensive care in this country.

I heard from a mom in Bemidji, MN, who has a daughter named Micki. The mom's name is Sheryl. She wrote me a letter. She said:

I just got off the phone with my daughter Micki. At first, I couldn't understand her because she was sobbing so hard. Her husband had just been told by his boss that they wouldn't be carrying health insurance on their employees any longer. They are a small company and it was costing them \$13,000 a month. For her, this is a matter of life and death. She has cystic fibrosis. Her medications can run anywhere from \$7,000 to \$13,000 a month. Because it is a preexisting condition, the insurance companies won't touch her unless it is under a group plan like the one her husband just lost.

She went on to say in her letter:

You need to stand and be my voice, be Micki's voice. Micki is a fighter but she can't keep fighting a system that is so against her. Micki has already lived longer than any of her doctors expected. We need you to be her voice.

That is why this bill is so important. The status quo is simply not sustainable, not for families, not for small businesses, not for big businesses that are trying to compete internationally against other companies and countries that have more efficient health care systems.

Despite claims from my friends on the other side of the aisle, we have spent months debating this issue. The C-SPAN viewers know what I am talking about. If you look at the input the Republicans have had on this bill, you can see that over 160 amendments were accepted in the HELP Committee. Dozens of bipartisan meetings and roundtable discussions were held in the Senate Finance Committee.

They have engaged across this country—so many people, sadly—in a campaign of misinformation. I know a lot of people in Minnesota and across the country are left trying to wade through all the ads, misinformation, and scare tactics to find out what this bill is about. Well, this bill is not perfect, as so many of my colleagues have said. We will work to make changes and work forward. I would like to see more cost reform in this bill. But what we do with this bill is a beginning not an end. We work to reduce cost, we work to expand coverage and increase choice and competition for American consumers.

First, and very important to me and to my mother—who is 82 years old—this bill protects Medicare and our seniors. Medicare is one of the most valued social programs our country has produced in the last half century. Yet it is also a program in dire need of reform if it is to survive on sound financial footing and continue to provide the fine medical care our seniors have come to expect.

By 2011, the first baby boomers will enter the Medicare system. Without action, if we sit and put our heads in the sand, it will go in the red by 2017. So

think of people such as my mom—82 years old. She wants to live well into her 90s and beyond. Think of people who are 55 and who want to be on Medicare when they are 65. It is going to go in the red by 2017 if we don't do something to make sure it is on strong financial footing.

With this bill, we start to do that. We extend Medicare solvency by 10 years. I am encouraged that my legislation can create a value index, which the Senator from Washington discussed, as part of the formula that is used to determine Medicare's fee schedule. That was included in the Senate's bill. This indexing will help reduce unnecessary procedures because those who produce more volume will also need to improve care or the increased volume will negatively impact fees. Doctors will have a financial incentive to maximize the quality and the value of their services instead of just the quantity.

My favorite story along these lines is not from Minnesota but from Geisinger, PA. They were trying to figure out: How do we best treat diabetes. We are not happy with the results. They realized with the routine cases, those were the people they wanted someone to see more often, to check in on them. So they had them assigned to nurses and the more difficult cases to the endocrinologists. The endocrinologists would review the nurses' work and make sure there was proper followup if there had to be adjustments. At the end of year, they had much happier patients. The quality of care went way up, and they saved \$200 per month per patient.

What does our system in America do now? What does the Medicare system do? It punishes them for that good work. So that is what we are talking about, actually getting that higher quality. You can save money if you have the right incentives in place.

With this legislation, we also stop paying for care that doesn't result in quality patient outcomes. Who wants to go into the hospital to be treated and get sick from something else during that hospitalization? When you have to go back again, that is called a hospital readmission. In 1 year, hospital readmissions cost Medicare \$17.4 billion. A 2007 report by the Medicare Payment Advisory Commission found Medicare paid an average of \$7,200 per readmission that was likely preventable. This practice must stop. This isn't good care for patients, and it is not a good investment for taxpayers.

The bill also establishes an independent, 15-member Medicare Commission tasked with presenting Congress with comprehensive proposals to reduce health care costs and improve quality of care for Medicare benefits. The current Medicare payment policies are not working well for patients, doctors, and hospitals. We have to control costs and we have to get that high-

quality care we see in Minnesota throughout the country.

In this bill, we also work to stop fraud and abuse. Law enforcement authorities estimate that Medicare fraud costs taxpayers more than \$60 billion every year—\$60 billion going to con men, \$60 billion going to storefronts that say they are a doctor's office, when all that is behind it is a bunch of fraudsters and rip-off artists who are getting checks meant to go to providers of care to our seniors—\$60 billion a year. Finally, we have a bill that puts the tools in place—enhanced criminal penalties—that allows for direct deposit of those payments from the government to those providers, so we don't have people ripping us off with an antiquated system of bad and false checks. With this change, we put a stop to criminals running phony businesses to steal Medicare checks from our seniors.

We are also working to help our seniors with the cost of their prescription drugs. Millions of Americans depend on prescription drugs to help them manage chronic disease or other illnesses. But drug prices continue to skyrocket. That is why I voted for reimportation, to allow these safe drugs to come in from places such as Canada. We are not afraid of getting our medications from Canada. Canadians come to shop and to vacation and to fish in Minnesota, and we go to Canada to shop and to work and to fish. We don't have a problem with their drugs. Sadly, that proposal did not pass the Senate, but I will continue to advocate for that.

What does this bill do so far? What it does is to help fill that doughnut hole, that point where seniors who had been getting help with paying for their prescription drugs stop getting that help. That doughnut hole is now filled.

This legislation provides relief for our small businesses. Right now, small businesses pay 20 percent more than large businesses for the cost of care. In a recent national survey, nearly three-quarters of small businesses that did not offer benefits cited high premiums as a reason. Beginning in 2011, with this legislation, small businesses will be eligible for tax credits worth up to 35 percent of their contribution to their employees' health insurance plans. In 2014, these tax credits will even increase more.

This legislation, as we all know, also creates insurance exchanges known as small business health option programs—or SHOP programs—where small businesses can finally pool their numbers and do what big businesses do—negotiate for better rates for their insurance.

Beginning with the passage of this bill—and this is one of my favorite parts—kids can't be denied coverage due to preexisting conditions. So if your son or daughter gets sick, an insurance company can't look at you and

say: I am sorry your kid got sick, you don't have any insurance.

Look at the story I just read with Micki, the woman whose husband lost her insurance. She has cystic fibrosis, and she is not sure if she is going to be able to get insurance. This puts an end to that and for kids it does it the minute the bill gets signed into law.

Insurance companies will be barred from limiting the total benefits Americans can use over the course of a year or over their lifetime. Affordable insurance coverage options will also be made immediately available through a high-risk pool for Americans who have been uninsured and have been denied coverage because they have a pre-existing condition.

With this bill, insurance companies immediately must fully cover regular checkups and tests that help prevent illness, such as mammograms or eye and foot exams for diabetics.

In addition, children would continue to be eligible for family coverage through the age of 26.

I see my friend, the Senator from Pennsylvania, is here. Maybe he has four children who will soon be 26. I know many people are glad this bill has contained in it a provision that says you can keep your kids on your insurance until they are 26.

We know this bill isn't perfect, no big piece of legislation ever is. There is still work that needs to be done in conference committee. There are still negotiations that will take place. There are still things that need to be fixed. We know this is only the beginning of reform, not the end, but we must keep looking to the future. For too long, health care costs have been spiraling out of control. That is why we can't afford to hold off any longer on reforming health care.

I am going to close by reading something Vicki Kennedy—Ted Kennedy's widow—wrote for the Washington Post. This is what she wrote this weekend:

The bill before Congress will finally deliver on the urgent need of all Americans. It would make their lives better and do so much good for this country. That, in the end, must be the test of reform. That was always the test for Ted Kennedy. He's not here to urge us not to let this chance slip through our fingers. So I humbly ask his colleagues to finish the work of his life, the work of generations, to allow the vote to go forward and to pass health-care reform now. As Ted always said, "When it's finally done, the people will wonder what took so long."

After all the work and debate that has gone into this bill over the past year, we are finally having the votes the American people deserve. Tomorrow morning, Christmas Eve, will be the vote.

I yield the floor.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. CASEY. Mr. President, I ask unanimous consent to speak for up to 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. CASEY. Mr. President, I wish to commend my colleague from Minnesota, Senator KLOBUCHAR, for the outline of the bill and the important priorities we are here to debate. This is the last night, the last couple of hours, before we vote on the bill tomorrow morning, and I wish to do two things. One is to highlight, in very brief fashion, some of the main benefits of this bill to the American people—and especially to our families—and then to speak of one particular family from Pennsylvania who I will talk about in a moment.

By way of overview, what we tried to do in this bill, and I believe we have accomplished it, is not only to meet the goals President Obama set forth in the early part of this year as he assumed the Presidency and began to make health care reform a priority, but I also believe we are trying to meet the goals and the objectives of the American people. I think we have reached that point.

This legislation to reform health care will, first, not only be deficit neutral, but over the first 10 years of the bill it will save \$132 billion—reduce the deficit \$132 billion.

Something we haven't talked enough about, although we have had a lot of important debates, but in terms of covering those who don't have any coverage today, this bill will cover 31 million Americans. We know, for example, the Medicaid Program, which is more than 40 years old, covers 61 million Americans, and Medicare covers 45 million. So in this one piece of legislation, not after 10 or 20 or 30 years but once it is fully implemented over the next couple years, it will cover 31 million Americans. That will not only be beneficial to those individuals and their families, but I would argue it is good for our economy. They will be more productive workers and our economy will be stronger because we covered them.

The bill extends Medicare solvency. That is something we hear a lot about. We have heard a lot of discussion about Medicare but what about making sure it is solvent. Our bill does that.

Prescription drugs. A lot of families have benefited from our prescription drug program, but then they fall into a time period where they are paying the whole freight. It has been referred to as the "doughnut hole," but that doesn't capture the gravity of the problem for a family and for an individual, older citizen. When they fall into that so-called doughnut hole, they are in big trouble because they have to carry the whole burden. They have to pay for those prescription drugs all by themselves. This bill addresses that, something that has gone unaddressed for a number of years.

The number of children in our country who are covered by the children's

health insurance and other initiatives has grown, thankfully. We will be growing from 7 million kids covered under the prior legislation to 14 million under the children's health insurance. But a lot of those children who don't have the benefit of the Children's Health Insurance Program might be caught in the preexisting condition problem. Their ability to have coverage will be limited because they have a preexisting condition. What our bill does is to say that upon passage of this bill, within months of the passage of this bill, in 2010, children will be fully protected in this sense: Any kind of act by an insurance company to deny them coverage because of a preexisting condition will be illegal in 2010.

We also, over a number of years, will make it illegal for an insurance company to deny someone coverage due to a preexisting condition for adults. For those who are discriminated against, even before the bill is implemented, we provide a high-risk pool for them.

We protect consumers in other ways. I was holding a copy of the first half of the bill here. Sometimes bills get real complicated, and I know our colleagues on the other side have complained about the size of the bill. But to get it right, you have to put in a lot of detail. On page 78 of the bill, it is very clear. On page 78, the bill deals directly with the preexisting condition problem. Millions of Americans have been denied coverage over the last couple of years because of this one problem—millions of Americans. Here is what it says, very simply, on page 78:

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such a plan or coverage.

It is not long or complicated. It is one sentence—one sentence that, at long last, provides the kind of protection insurance companies have refused to provide to adults and children, and the protection for children goes into effect within a matter of months after enactment.

Let me make two more points, and then I wish to talk about an individual and her family. The Children's Health Insurance Program, as I said, has been extended. But what happened in the earlier versions of the bill was the full funding of it would cut off in 2013. In the bill, we now have added to that. So now the children's health insurance funding will be extended 2 more years. So at least through the end of September 2015, the Children's Health Insurance Program is fully funded.

We need to do more than that. We will have to get to that as we move forward, but we have extended it 2 more years.

We also have done some things in this bill that didn't get a lot of attention.

When we were in the early stages of this bill way back in the summer, in

the Health, Education, Labor, and Pensions Committee, Senator DODD and I and others included provisions in the bill long before it was amended in the original bill we put before our committee this summer.

For example, mandating prevention and screenings for children. No. 2, ensuring pediatric benefits as well as pediatric input into the formation of benefits; vision and oral health care for children, and, finally, in this section, strengthening the pediatric workforce. If we are going to give children the kind of expert help they have a right to expect and we have a right to expect for their care, we have got to make sure we have the workforce, the high-skilled work force, the doctors, who are, in fact, pediatricians; so all kinds of benefits for our children and for our families.

But this isn't just a debate about policy and the provisions of the bill. That is, obviously, part of what we are here to do. What we are here to do is meet the needs of real families in America. I have met a number of them in Pennsylvania, and every Member here, whether they are for or against the bill, whether they are trying to kill the bill on the other side or whether they are trying to support and pass the bill on this side, could tell a story. Each of those Senators could tell a story about many families in their State.

One story is to remain an inspiration for me from day one, going way back in February when I received a letter. This woman in Pennsylvania who wrote to me remains an inspiration. Her name is Trisha Urban, from Berks County, PA, right near Reading and the eastern side of our State. She wrote this letter. I will quote major portions of the letter. She talked about herself and her husband. She said her husband had to leave his job for 1 year to complete an internship requirement to complete his doctorate in psychology. "The internship was unpaid and we could not afford COBRA." She goes on to say that because of preexisting conditions neither her husband's health issues nor her pregnancy—Trisha talked about her pregnancy in the letter—"nor my pregnancy would be covered under private insurance. I worked four part-time jobs and was not eligible for any health benefits. We ended up with a second-rate insurance plan through my husband's university.

"When medical bills started to add up, the health insurance company decided to drop our coverage," stating that the internship didn't qualify us for benefits. It didn't stop there for a second. So within the space of two sentences, she has highlighted at least two, if not three, of the major problems we have heard so much about: the preexisting condition problem that I pointed to in the bill and we have heard about from so many others, and also dropping of coverage, arbitrary ac-

tions by an insurance company to drop coverage when they believe it is in their best interests and not in the interests of the family.

Let me pick up with the letter. I am quoting here again from the letter from Trisha Urban:

We are left with close to \$100,000 worth of medical bills. Concerned with the upcoming financial responsibility of the birth of our daughter and the burden of current medical expenses, my husband missed his last doctor's appointment less than one month ago.

Less than 1 month from February of 2009.

Here is her story, the tragic part of her story, in addition to all of the problems she had with her health insurance company and all of the challenges she and her husband faced getting coverage for her family, her husband's heart condition and in her coverage, as well as her pregnancy, she talks about that night in early 2009 when she was ready to deliver her daughter. She said:

My water broke the night before. We were anxiously awaiting the birth of our first child. A half hour later, two ambulances were in my driveway. As the paramedics were assessing the health of my baby and me the paramedic from the other ambulance told me that my husband could not be revived.

Here's Trisha Urban, having lived through all of those difficulties with her own insurance and her problems with insurance and worrying about her pregnancy and worrying about her husband. She walks up to her driveway the exact day that her baby was born and she finds her husband dead in the driveway.

The chart depicts the headline from the Reading Eagle dated February of this year: "Tilden Township Woman Tends to Baby Born Hours After Her Husband's Death."

I will cite a few facts from the story:

Just after noon, Thursday, Trisha A. Urban's husband, Andrew D. Urban, died. Less than nine hours later, she gave birth to their first child, Cora Catherine.

Because of that tragedy and maybe only because of that tragedy I met Trisha Urban months after she wrote a letter to me, and I met her daughter. They came down to hear the President's speech to a joint session of Congress. I held her daughter Cora. I probably never would have met that beautiful child were it not for this tragedy, were it not for this story.

I am not sure what I would do if I were in her case. I am not sure if I would have remained so saddened by it and so frustrated by what the insurance companies did to her or didn't do for her. Anyone would understand that, if she or I or anyone else who suffers that tragedy would look within themselves and suffer alone with their family. Patricia Urban didn't do that. She didn't just tell us about the problems she had with her insurance company; she didn't just tell us about the tragic death of her husband; she did more than that. She wrote to me.

For those who say, well, we don't need to do anything about this health insurance problem, I would ask them to listen to Trisha Urban. She said at the end of her letter:

I am a working class American and do not have the money or the insight to legally fight the health insurance company. We had no life insurance. I will probably lose my home, my car, and everything we worked so hard to accumulate in our life will be gone in an instant.

But then she says this:

If my story is heard, if legislation can be changed to help other uninsured Americans in a similar situation, I am willing to pay the price of losing everything. I'm asking you to share my story with others in Congress and I'm willing to speak on behalf of my husband so that his death will not be in vain.

So says Trisha Urban in this letter. She challenged me with that letter, or at least I took it as a kind of challenge I wanted to accept. I think she challenges all of us. If Trisha Urban, who lived through all of those problems with the health insurance company, denied coverage because of preexisting condition, dropped coverage, medical bills going through the roof, and then the ultimate tragedy, the death of her husband, if she can endure all that and still stand up and say, I am willing to pay the price of losing everything I need, I am going to do that to try to help pass a health care bill—if she can do that, the least we can do is to do what a lot of us have tried to do over many months, which is to work on this, to debate it, and to fight hard to pass it. So tomorrow morning in the early hours of the morning, when it might still be dark out, it is my hope and prayer there will be a little light in that darkness in the early morning tomorrow when we pass this bill, and we can say that we did our best.

I know we are not done yet to get this bill out of the Senate. I know we are not done yet. We can at least say we did our best, that we tried as best we could to be responsive to, to answer the plea for help and the invocation of hope that Trisha Urban has in her letter.

I have remained ever inspired by her courage, by her willingness to speak up, and by her willingness to be a witness not just to what has been going wrong with our system and not just giving testimony about her husband's death but the way Trisha Urban has been a witness to the hope and the promise of change that will come with this bill. I know tomorrow morning isn't the end of the road. But tomorrow morning is at least the beginning of the end of a lot of these tragedies and a lot of these stories.

So on Trisha's behalf as we say on behalf of so many others, we need to get this legislation passed tomorrow morning and to move forward in a positive new direction in terms of what happens to our health care system.

With that, Mr. President, I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. CASEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

MORNING BUSINESS

Mr. CASEY. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

NATIVE AMERICAN APOLOGY

Mr. INOUE. Mr. President, I wish today to discuss the Native American apology resolution that was recently passed as part of the fiscal year 2010 Defense appropriations bill.

I believe that it is well known to most Members of this body that the original inhabitants of the lands that now constitute the United States, the aboriginal, indigenous, native people of America, occupied and exercised sovereignty over more than 550 million acres of land prior to the first European contact.

In the early days of our history, well before our Nation was formed, the native people fought alongside our soldiers in the Revolutionary War. The Indian tribes enabled the survival of General George Washington and his troops during the harsh winter at Valley Forge by providing food to the troops.

A few years later, as our Founding Fathers were engaged in the challenge of forming a new nation, they drew upon the democratic model of government that they learned from the Six Nations of the Iroquois Confederacy. There they found the well-institutionalized practice of the fundamental principles of freedom of speech and a system of governmental checks and balances provided through the separation of governmental powers.

In our early days as a nation, we entered into treaties with Native Americans pursuant to the provisions of the U.S. Constitution that recognize them as sovereigns. But later, we abandoned the path of an honorable course of dealings, and turned to war. Thousands lost their lives through these battles and horrific massacres. The native population everywhere was decimated.

Forced marches to relocate the native people from their traditional homelands to areas west of the Mississippi in the dead of winter cost thousands of more lives. Few Americans know that there was not one Trail of Tears—but many.

The treaties could have signaled a return to a course of honorable dealings with the native people had the United States not proceeded to break provisions in every single one of the treaties that were ratified by the United States Senate.

Amazingly, notwithstanding these appalling deeds, the native people of the United States have always been and continue to be staunchly patriotic and loyal to this country. They have volunteered to serve in the defense of our Nation in every military action and war in which we have been engaged and on a per capita basis, more Native Americans have put themselves in harm's way and given their lives to protect the United States than any other ethnic group of Americans. They have made the greatest sacrifice, but their contributions do not end there.

We know that the native people of the United States have made significant contributions to our society in every walk of life, in every profession, in medicine and agriculture and as stewards of the lands and resources we all hold dear. There have been great men and women who have led their native nations out of war, poverty, and despair. Throughout the generations, they have shown us the true meaning of courage in the face of the greatest odds, and the quiet strength to persevere.

This provision signifies a new day, brings a message of hope, and provides a foundation for the future.

Mr. President, I would like to thank Senator BROWNBACK for his leadership on this measure.

LEGISLATIVE WORK OF COMMITTEE ON THE JUDICIARY

Mr. LEAHY. Mr. President, this has been an extraordinary year in the history of the Senate Committee on the Judiciary. Thanks to the members and their work through 87 hearings and 33 business meetings this year we have been productive. Here are some of the legislative highlights:

We have considered and reported to the Senate several important legislative initiatives: We successfully considered and reported to the Senate the Fraud Enforcement and Recovery Act that President Obama signed into law in May. We reported the important Patent Reform Act, which can help our economic recovery and lead to additional American jobs. We reported significant cyber security legislation, including the Personal Data Privacy and Security Act.

We also reported the Improving Assistance to Domestic Violence Victims Act; Public Corruption Prosecution Improvements Act; the Crime Victims Fund Preservation Act; and the Performance Rights Act. We reported the Railroad Antitrust Enforcement Act; the PACT Act on cigarette smuggling;

and the Preserve Access to Affordable Generics Act, to end anticompetitive pay-for-delay schemes in the drug industry.

Mindful of the end of the year deadlines, we worked hard to report with bipartisan support the USA PATRIOT Act Sunset Extension Act and the Satellite Television Modernization Act.

We reported the Juvenile Justice and Delinquency Prevention Reauthorization Act just last week. And after many working sessions, we were finally able to report the historic Free Flow of Information Act to establish a qualified privilege in Federal law for journalists to protect their confidential sources and the public's right to know.

Through the course of the year Senators on this Committee contributed to enactment of the Lilly Ledbetter Fair Pay Act, Matthew Shepard and James Byrd, Jr. Hate Crimes Prevention Act, the Fraud Enforcement and Recovery Act, the OPEN FOIA Act, the Human Rights Enforcement Act, the Webcasters Settlement Act, an extension of the EB-5 program for three years, an end to the "widow penalty" in immigration law, the Judicial Survivors Protection Act, the Reserve Officers Modernization Act, the charter for the Military Officers Association of America, as well as legislation to keep the Patent Office on a financial footing, and legislation to clarify statutory time periods for litigation. We worked to include in the American Recovery and Reinvestment Act provisions to provide needed funding to state and local law enforcement and to protect privacy as we improve healthcare information technology.

Many of us worked for Senate passage of the District of Columbia House Voting Rights Act.

Within the health insurance reform legislation being passed by the Senate this week are provisions we worked on to improve our anti-fraud efforts and to provide recourse for those harmed by health services.

I thank the members of the Senate Judiciary Committee for their contributions and cooperation.

JUDICIAL AND EXECUTIVE NOMINATIONS

Mr. LEAHY. Mr. President, I have been calling on the Republican leadership to end the delays and obstruction of judicial nominations and join with us to make progress in filling some of the many vacancies on Federal circuit and district courts. I have done so repeatedly for most of the year, and several times over this last month. Regrettably, as we head into the winter recess and the end of the first session of the 111th Congress, Republican obstruction is setting a new low for the Senate in our consideration of judicial nominations.

The Senate has been allowed to confirm only one judicial nominee all

month. It is now December 23. By this date in President Bush's first year in office, the Senate with a Democratic majority confirmed 10 nominations just in December to reach a total of 28 confirmed Federal circuit and district court nominees in the first session of the 107th Congress. That is 10 times as many nominations as the Senate has considered and confirmed this month. During the first year of President Bush's tumultuous administration, with the Senate majority changing in the middle of the year and Democrats then in the majority, we worked from July through December to confirm 28 judicial nominees. That was, of course, the year of the September 11 attacks and the anthrax attacks in the Senate, but we continued our work. The Senate proceeded to confirm 6 judicial nominees by voice vote in December 2001, a total of 10 judicial nominees that month, a total of 28 in the last 6 months of that year, and 100 in the 17 months I served as chairman of the Senate Judiciary Committee during President Bush's first term.

By contrast, thus far this month, with 12 judicial nominees now available to the Senate for final consideration, Senate Republicans have only allowed a vote on Judge Jacqueline Nguyen to the Central District of California. She was confirmed unanimously after been delayed 6 weeks. They have even refused to consider the nomination of Beverly Martin of Georgia to the Eleventh Circuit, despite strong support from her home state Senators, both Republicans. Instead of acting of her nomination, which has been awaiting final action since September 10, and that of Judge Greenaway of New Jersey, who has been nominated to the Third Circuit and was reported on October 1, they insist on delaying debate on that nomination for at least a month. I hope we will be able to turn to that nomination when the Senate returns in late January.

The refusal by the Republican minority to enter into customary time agreements to consider non-controversial nominees has led us to fall well short of the confirmations achieved in the first years of other Presidents. On the eve of the end of the session, the Senate has confirmed little more than one-third as many of President Obama's circuit and district court nominees as it confirmed of President George W. Bush's—28—or of President Clinton's—27—in their first years. In fact, President Obama is on pace to have the fewest judicial nominees confirmed by a President in his first year since President Eisenhower, who only made nine nominations in 1953. Of course, all nine were confirmed. The total this year stands to be the fewest confirmed in any President's first year in more than 50 years, and the fewest in any year since the Republican majority confirmed only 17 in the 1996 session, a Presidential election year.

The unprecedented obstruction we have seen by Senate Republicans on issue after issue—over 100 filibusters this year alone, by some calculations, which have affected 70 percent of all Senate action—have ground Senate consideration of judicial nominations to a crawl. Instead of time agreements and the will of the majority, the Senate is faced with filibusters, and anonymous and Republican leadership holds. Those who just a short time ago said that a majority vote is all that should be needed to confirm a nomination, and that filibusters of nominations are unconstitutional, have hypocritically reversed themselves and now employ any delaying tactic they can.

Judicial nominees have been and are available for consideration. This lack of Senate action is attributable to Senate Republicans and no one else. The President has reached across the aisle to consult and has made quality nominations. We have held the hearings, and the Senate Judiciary Committee has favorably reported 12 judicial nominees to the Senate on which action has not been permitted. There are now more judicial nominations stalled on the Senate Executive Calendar—12—than the number that have been confirmed all year. One has been ready for Senate consideration for more than 13 weeks, another more than 10 weeks, and the list goes on. Nor are these controversial nominees. Eight of the 12 were reported from the Judiciary Committee without a single dissenting vote. The majority leader and all Democratic Senators have been ready to proceed. The Republican Senate leadership is not. It has stalled and delayed and obstructed.

Unlike his predecessor, President Obama has reached out and across the aisle to work with Republican Senators in making his judicial nominations. The nomination of Judge Hamilton, which the Republican leadership filibustered, was supported by the most senior Republican in the U.S. Senate, my respected friend from Indiana, Senator LUGAR. Other examples are the nominees to vacancies in Alabama supported by Senators SESSIONS and SHELBY, in South Dakota supported by Senator THUNE, and in Florida, supported by Senators MARTINEZ and LAMIEUX. Still others are the President's nomination to the Eleventh Circuit from Georgia, supported by Senators ISAKSON and CHAMBLISS, which the Senate will not consider until the end of January because of Republican objection, and his nomination to the Sixth Circuit from Tennessee, supported by Senator ALEXANDER.

Last week we held a confirmation hearing for two more well-respected and well-qualified nominees that were the result of President Obama's effort to reach out and consult with home state Senators from both sides of the aisle, Judge James Wynn and Judge Albert Diaz. Judge Wynn and Judge Diaz

have been nominated to fill two long-standing vacancies on the U.S. Court of Appeals for the Fourth Circuit. Both are from North Carolina. Senator BURR and Senator HAGAN worked with each other and with the White House on these nominations. I thank them both for their testimony before the committee last week in strong support of these nominees.

These nominations are just the most recent examples of this President reaching out to home State Senators from both parties to consult before making nominations. Just as I worked last year to end a decade-long impasse on the Sixth Circuit with the confirmations of Judge Helene White and Ray Kethledge of Michigan, I will work to see that these nominations from North Carolina are considered fairly and confirmed expeditiously. With the support of the senior Senator from North Carolina, a Republican, and the determined efforts of Senator HAGAN, a Democrat, North Carolina will finally have the representation on the Fourth Circuit that it deserves.

Instead of praising the President for consulting with Republican Senators, the Republican leadership has doubled back on what they demanded when a Republican was in the White House. No more do they talk about each nominee being entitled to an up-or-down vote. That position is abandoned and forgotten. Instead, they now seek to filibuster and delay judicial nominations. They have also walked back from their position at the start of this Congress, when they threatened to filibuster nominees on which home state Senators were not consulted. We saw with Judge Hamilton that they filibustered a nominee supported by Senator LUGAR.

When President Bush worked with Senators across the aisle, I praised him and expedited consideration of his nominees. When President Obama reaches across the aisle, the Senate Republican leadership delays and obstructs his qualified nominees. It is clear that the Republican leadership has returned to their practices in the 1990s, which resulted in more than doubling circuit court vacancies, and led to the pocket filibuster of more than 60 of President Clinton's nominees. The crisis they created eventually led even to public criticism of their actions by Chief Justice Rehnquist during those years.

The Republican obstruction and delay in considering well-qualified non-controversial nominees comes at a tremendous cost to the ability of our Federal courts to provide justice for all Americans. We have seen a tremendous spike in judicial vacancies. Although there have been nearly 110 judicial vacancies this year on our Federal circuit and district courts around the country, only 10 vacancies have been filled. That is wrong. The American people deserve better.

In only 5 months of President Bush's first year in office when I served as Senate Judiciary Committee chairman and with a Democratic Senate majority, we confirmed 28 judicial nominees. During 17 months of President Bush's first 2 years in office, we confirmed 100 of his judicial nominees. Although two Republicans chaired the Senate Judiciary Committee and Senate Republicans held the Senate majority for more than half of President Bush's time in office, more judges nominated by President Bush were confirmed by the Senate Democratic majority and when I served as Senate Judiciary Committee chairman. During President Bush's last year in office, we had reduced judicial vacancies to as low as 34, even though it was a Presidential election year. When President Bush left office, we had reduced vacancies in 9 of the 13 circuits since President Clinton left office.

As matters stand today, judicial vacancies have spiked and are being left unfilled. We will start 2010 with the highest number of vacancies on article III courts since 1994, when the vacancies created by the last comprehensive judgeship bill were still being filled. While it has been nearly 20 years since we enacted a Federal judgeship bill, judicial vacancies are nearing record levels, with 97 current vacancies and another 23 already announced. If we had proceeded on the judgeship bill recommended by the Judicial Conference to address the growing burden on our Federal judiciary, as we did in 1984 and 1990, in order to provide the resources the courts need, current vacancies would stand at 160 today. That is the true measure of how far behind we have fallen. I know we can do better. Justice should not be delayed or denied to any American because of overburdened courts and the lack of Federal judges.

I, again, urge the Republican minority to allow Senate action on the 12 judicial nominees on the Senate Executive Calendar before the end of the session. We have now wasted weeks having to seek time agreements in order to consider even nominations that were reported by the Judiciary Committee unanimously and confirmed unanimously by the Senate when finally allowed to be considered. The 12 judicial nominees are Beverly Martin of Georgia, nominated to the Eleventh Circuit; Joseph Greenaway of New Jersey, nominated to the Third Circuit; Edward Chen, nominated to the District Court for the Northern District of California; Dolly Gee, nominated to the District Court for the Central District of California; Richard Seeborg, nominated to the District Court for the Northern District of California; Barbara Keenan of Virginia, nominated to the Fourth Circuit; Jane Stranch of Tennessee, nominated to the Sixth Circuit; Thomas Vanaskie of Pennsylvania, nominated to the Third Circuit; Louis Butler, nominated to the District Court for

the Western District of Wisconsin; Denny Chin of New York, nominated to the Second Circuit; Rosanna Malouf Peterson, nominated to the District Court for the Eastern District of Washington; and William Conley, nominated to the District Court for the Western District of Wisconsin.

At the end of the Senate's 2001 session, only four judicial nominations were left on the Senate Executive Calendar, all of which were confirmed soon after the Senate returned in 2002. At the end of the first session of Congress during President Clinton's first term, just one judicial nominee was left on the Senate Executive Calendar. At the end of the President George H.W. Bush's first year in office, a Democratic Senate majority left just two judicial nominations pending on the Senate Executive Calendar. At the end of the first year of President Reagan's first term—a year in which the Senate confirmed 41 of his Federal circuit and district court nominees—not a single judicial nomination was left on the Senate Executive Calendar.

In stark contrast, there are now 12 judicial nominees on the Senate Executive Calendar, and unless there is a burst of cooperation from Republicans, they will remain on the calendar awaiting Senate consideration beyond the end of this session and into next year. That is a significant change from our history and tradition of confirming judicial nominations that have been reported favorably by the Senate Judiciary Committee by the end of a session.

The record of obstruction of the Senate Republicans is just as disappointing when we consider the executive nominations that have been reported by the Judiciary Committee. There are currently an incredible 20 executive nominations that have been reported favorably by the Senate Judiciary Committee pending on the Senate Executive Calendar, including nominations for Assistant Attorneys General to run three of the 11 divisions at the Department of Justice. Each of these nominations has been pending 4 months or longer. An editorial in today's Washington Post entitled "Nominees in Limbo" and subtitled "The Senate should do its job before taking a vacation" describes the Republican obstruction of the nomination of Dawn Johnson to head the Office of Legal Counsel, which has been stalled on the Senate Executive Calendar since March, as "[p]erhaps the greatest nominations travesty." The editorial concludes: "[T]he president should be given deference in choosing executive-branch officials who share his views. Ms. Johnson is highly qualified and should be confirmed. At the very least, senators should have the decency to give her an up-or-down vote."

Senate Democrats treated President Bush's first nominations for these same posts quite differently than Senate Republicans are now treating

President Obama's nominees. We promptly reported the President's nominees to head the Office of Legal Counsel, the Office of Legal Policy, and the Tax Division, and they each received Senate consideration in a matter of days or weeks after they were reported by the committee. We still have heard no explanation for the five months of Republican obstruction of the nomination of Chris Schroeder to head the Office of Legal Policy after his nomination was reported by the committee in July by voice vote without dissent. The Washington Post editorial rightfully calls for Mr. Schroeder's confirmation as well as for the confirmation of the long-pending nomination of Mary Smith to run the Tax Division.

As with the judicial nominations, the Republicans have employed new standards of demanding a supermajority and floor time and delays to consider even nominations that could be confirmed easily, grinding our progress to a halt. I hope that the Republican Senators and leadership will relent and end the year by making progress on these important nominations to put us on a better path for the next session.

THE TORTURE VICTIMS PROTECTION ACT

Mr. LEAHY. Mr. President, the U.S. Supreme Court recently granted certiorari in a case involving the Torture Victim Protection Act of 1991, TVPA, a law I supported from the earliest days following its introduction by Senator SPECTER in the summer of 1986. Senator SPECTER and I worked for years to see this historic human rights bill become law in 1991. Yet today I am concerned that the TVPA's crucial role in protecting human rights may be weakened or even rendered meaningless. The Supreme Court case, *Samantar v. Yousuf*, may decide the fate of this landmark law.

The TVPA provides a Federal cause of action against any individual who subjects any person to torture or extrajudicial killing. This cause of action is available where the individual acts under actual or apparent authority, or under color of law of any foreign nation. Congress passed the TVPA in response to widespread use of official torture and summary executions that took place around the world, despite the universal consensus condemning such practices. Congress recognized that neither Federal nor international law was strong enough to curb such egregious human rights abuses. We enacted the TVPA to ensure accountability for those who commit atrocious violations of human rights.

The case currently before the Supreme Court, *Samantar v. Yousuf*, raises the question of whether the Foreign Sovereign Immunities Act, FSIA, allows an action filed under the TVPA

to be brought against a former government official of a foreign country who is now living in the United States. The answer is clear in the TVPA and its legislative history. The answer is yes. Congress expressly intended the TVPA to apply against former government officials. In enacting the TVPA, Congress made it explicit that the FSIA would almost never provide a defense to such persons. They can be sued under the TVPA to recoup damages caused by their torturous actions.

The Senate clearly stated its intention to ensure that the TVPA operated in concert with existing law, specifically taking into account the FSIA, the Alien Tort Claims Act, and the United Nations Convention Against Torture, which the United States signed in 1988. This point was discussed extensively as we drafted and refined the legislation. The operation of the TVPA was considered in a hearing held by the Judiciary Committee's Subcommittee on Immigration and Refugee Affairs in June 1990. The committee was not oblivious to the concerns raised at the time by the executive branch regarding sovereign immunity. We were cognizant of the role of the executive to manage foreign policy. We addressed each of these concerns in turn, but we were not persuaded that they outweighed the importance of creating a private cause of action under the TVPA. The full Congress agreed when it enacted the TVPA in March 1992.

The TVPA was drafted, in part, in response to gaps in two existing laws: the Alien Tort Claims Act and the Convention Against Torture. In deciding whether the Alien Tort Claims Act could be used by victims of torture committed abroad, one Federal judge expressed concern that separation of powers principles required an explicit grant by Congress of a private right of action for lawsuits that affect foreign relations. The Alien Tort Claims Act did not have such an explicit grant. Congress responded by enacting the TVPA with an unambiguous basis for a cause of action.

Similarly, the United States signature on the Convention Against Torture was an important and symbolic step in the prevention of torture, but the Convention fell short of the TVPA in at least two important respects. First, the Convention required that signatories open their courts to suits for damages caused by torture in their own countries. That policy was welcome but insufficient. The TVPA allows torture victims to sue their abuser without returning to the country of abuse. Congress took this step because it believed that governments that had allowed torture to occur within their jurisdiction would not necessarily provide meaningful redress to victims. Furthermore, torture victims who escaped from the country of abuse

would not eagerly return to that country to file suit. Congress designed the TVPA specifically to respond to that situation by opening U.S. courts to these cases and providing a civil cause of action here in the United States for torture committed abroad.

Second, by creating a Federal cause of action in our own courts, Congress ensured that torturers would no longer have a safe haven in the United States. The legislation served notice to individuals engaged in human rights violations that their actions were anathema to American values and they would not find shelter from accountability here.

Congress explicitly drafted the TVPA to strengthen and expand the scope of action that victims of torture could take in our courts, but Congress was nonetheless conscious of the bill's limits. The TVPA was not meant to override traditional diplomatic immunities or the FSIA's grant of immunity to foreign governments. The act struck a balance. It protected well established notions of sovereign and diplomatic immunities for current political actors without creating a safe haven for the perpetrators of horrible acts after they left their official positions and settled in, or fled to, the United States.

For example, Congress carefully created the cause of action against an "individual" to ensure that foreign states or their entities could not be sued under the act under any circumstances. Similarly, we discussed at length the fact that the legislation would not permit a suit against a former leader of a country merely because an isolated act of torture occurred somewhere in that country. But Congress neither intended nor imagined that the FSIA would provide former officials with a defense to a lawsuit brought under the TVPA. Such an interpretation would undermine the purpose of the law. The TVPA was not intended to cover the torturous acts of private individuals. To the contrary, in order for a defendant to be liable under the TVPA, the torture must have been taken "under actual or apparent authority or under the color of law of a foreign nation." The Judiciary Committee explicitly stated in its report on the bill that, "the FSIA should normally provide no defense to an action taken under the TVPA against a former official."

I hope that the Supreme Court studies this definitive and comprehensive history as it considers the case of *Samantar v. Yousuf*. Congress clearly intended the TVPA to extend to former officials of foreign countries if they choose to come to the United States after leaving their positions of authority. Congress also stated that the FSIA does not extend immunity to such individuals. Claims that a suit brought against a former official would undermine the FSIA and endanger foreign relations are simply inaccurate. Congress properly weighed the foreign policy concerns when it passed the TVPA.

The Supreme Court should not overrule the well-considered judgment of Congress.

DETERIORATING SITUATION IN NEPAL

Mr. LEAHY. Mr. President, over the years, both during and since the end of the monarchy in Nepal, I have urged the Nepal Army to respect human rights and cooperate with civilian judicial authorities in investigations of its members who abuse human rights. I spoke on this subject a few days ago in relation to the horrific case of Maina Sunuwar, a 15-year-old Nepali girl who was tortured to death by Nepal Army officers who then sought to cover up the crime.

I have also, similarly, urged the Maoists to stop committing acts of violence and extortion against civilians, respect human rights, and work to improve the lives of the Nepali people through the political process. The fact that the Maoists laid down their arms and entered into a peace agreement gave the Nepali people the first chance in Nepal's history to build a democratic government that is responsive to their needs.

It is therefore disheartening that the Maoists continue to engage in tactics that serve little purpose but to make the lives of the Nepali people, already difficult, even harder. They have just staged their latest general strike, which for the past 3 days crippled Nepal's economy.

For 3 days, Nepal, already a poor country, neither imported nor exported goods through its land entry points, causing a significant loss of revenue. Tourism, one of Nepal's most important sources of income for hotels, shops, transport, restaurants, and guide services, has been damaged. The garment industry, also among Nepal's largest, was brought to a halt. And there is the risk that foreign companies will decide that Nepal is still too unstable, and look elsewhere to invest.

What possible good does this kind of protest do? It angers and hurts the very people whose interests the Maoists claim to serve. In fact, it hurts poor people the most, because they and their children do not have savings, and go hungry. And it can hardly make other political parties more likely to accede to the Maoists' demands.

The latest news is that the Maoist leaders have threatened an indefinite national strike unless the government puts in place within a month a unity government headed by the Maoists. This kind of ultimatum, which has no place in a democracy, would be disturbing enough if it were not for the fact that the Maoists headed a coalition government last year after winning national elections, only to leave the government in May when it failed to replace the then army chief of staff.

I also felt that Nepal needed a new army chief who was not tainted by past abuses, but for the Maoists to quit the government and then accuse the President of forcing them to do so when their demands were not met, was irresponsible. Today, in fact, Nepal has a new army chief. Time will tell if he is the right person for the job.

As an observer of developments in Nepal, I have been encouraged by the positive steps the country has taken since the events that led to the end of the monarchy. But the desires that led to that courageous demonstration of popular will remain unfulfilled. The institutions of democracy are barely functioning and the political situation continues to deteriorate. Only 5 months remain until the deadline for drafting a new constitution, and growing distrust between the political parties threatens to derail the peace process. Indeed, the political parties have often seemed more concerned with promoting their own interests than with addressing the needs of the Nepali people. The army has yet to reform. Thousands of Maoist ex-combatants need to be demobilized and trained for jobs in the civilian workplace. Unless the political parties take decisive steps to work together to address these issues, the situation will go from bad to worse, and at some point the Nepali people may again take matters into their own hands.

In the meantime, the periodic economic shutdowns and acts of violence and intimidation perpetrated by the Young Communist League, cause one to question whether the Maoist leaders understand or accept the responsibilities that are inherent in a democracy. Rather than orchestrating acts of collective punishment to try to force a result, the Maoists need to earn the public's trust and respect. There is also the responsibility to exercise power in a manner that strengthens, not erodes, popular support. So far, the Maoists have failed to demonstrate a capacity for either.

The Communist Party of Nepal—Maoist—today remains a designated foreign terrorist organization under U.S. law. I am among those who would like to see that designation lifted, as I believe the U.S. could, through technical assistance and exchange programs, help the Maoist leaders to better understand the benefits of working constructively within the democratic process on behalf of the Nepali people. But the fact remains that having engaged in acts that got them onto the list in the first place, they need to demonstrate that they have abandoned those tactics and are accountable to the people. Organizing harmful strikes that serve no logical or legitimate purpose, encouraging acts of violence, refusing to punish its own members who committed atrocities, and making threats, are not consistent with a responsible political organization.

Mr. President, poverty and injustice have been a fact of life in Nepal for centuries. Three and a half years ago the Nepali people rose up against a corrupt, abusive monarchy and demanded something better. They are still waiting, but they will not wait forever. Like Nepal's other political parties, the Maoists will be judged by what they deliver.

FATE OF HMONG REFUGEES

Mr. LEAHY. Mr. President, I want to speak briefly about a worrisome humanitarian situation that is developing in Thailand, which could cause problems for our relations with the Thai military.

Thailand and the United States are longtime friends and allies, and our Armed Forces have developed a cooperative relationship. Many Thai military officers have been trained in the United States, and Thai soldiers have participated in joint U.S.-Thai training exercises such as Operation Cobra Gold. I expect this relationship to continue. But I am very concerned, as I know are other Senators, that the Thai Government may be on the verge of deporting roughly 4,000 ethnic Hmong back to Laos where many fear persecution.

Thailand has a long history of generosity towards refugees from Burma, Laos, Cambodia and Vietnam. It is a history to be proud of. But the Thai Government, which insists that the Hmong are economic migrants who should be repatriated, has reportedly deployed additional troops to Phetchabun province where most of the Hmong are in camps. There is a growing concern that the Thai military may expel the Hmong before the end of the year. There is also concern that a group of 158 Hmong in Nongkhai province, who have been screened and granted United Nations refugee status, could be sent back to Laos. I understand that the United States and several countries have told the U.N. High Commissioner for Refugees and the Thai Government they are prepared to consider this group of refugees for resettlement. Potential resettlement countries should be given an opportunity to interview these individuals in Thailand.

It may be that some of the 4,000 Hmong are economic migrants. It is also likely that some are refugees who have a credible fear of persecution if they were returned to Laos. I am aware that many Hmong fought alongside the U.S. military during the Vietnam war. The U.N. High Commissioner for Refugees, working with Thai authorities, needs to determine who has a legitimate claim for asylum and who does not, in accordance with long-standing principles of refugee law and practice. No one with a valid claim should be returned to Laos except on a voluntary basis. The United States, and other

countries, can help resettle those who do have valid claims but need access and the opportunity to consider relevant cases.

I mention this because I cannot overstate the consternation it would cause here if the Thai Government were to forcibly return the Hmong to Laos in violation of international practice and requirements. The image of Laotian refugees including many who the United Nations and the Thai Government itself have stated are in need of protection being rounded up by Thai soldiers and sent back against their will during the Christmas season, and the possible violence that could result, is very worrisome. On December 17 I joined other Senators in a letter to the Thai Prime Minister about this, and I will ask that a copy be printed in the RECORD at the end of my remarks.

As chairman of the Department of State, Foreign Operations, and Related Programs Subcommittee of the Appropriations Committee which funds international assistance programs, I have supported U.S. military training programs and other assistance to the Thai military. We share common interests and want to continue to work together. But after the deplorable forced repatriation to China of Uighur refugees by Cambodian authorities last week, we expect better of the Thai Government. Should the Hmong be treated similarly it could badly damage the Thai military's reputation, and put our military collaboration at risk.

Mr. President, I ask unanimous consent to have printed in the RECORD the December 17, 2009 letter to which I referred.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. SENATE,
Washington, DC, December 17, 2009.

MR. ABHISIT VEJAJIVA,
Prime Minister, Kingdom of Thailand, Wisconsin Ave., N.W., Washington, DC.

DEAR MR. PRIME MINISTER, We are writing to express our concern regarding reports of a possible repatriation to Laos of Lao Hmong from the Huay Nam Khao camp and Nong Khai detention center in Thailand. While we recognize that the Kingdom of Thailand is burdened by the large number of refugees it hosts on its territory, we encourage you to not take steps to repatriate any individuals to Laos at this time. Thailand is a strong ally of the U.S., and the cooperation between our governments, including a history of working together on Laotian and Burmese refugee issues, is greatly valued.

We understand that your government has conducted screenings in the Phetchabun camp in Huay Nam Khao to identify and separate refugees meriting protection from those migrating for primarily economic reasons. We remain concerned, however, regarding the lack of transparency in this screening process, and the absence of a civilian entity to lead it. In July of this year, a group of Senators sent a letter to General Songkitti Jaggabatarat requesting more information about the criteria and methods used in screening Laotian Hmong in the

Phetchabun camp, but a response to this inquiry has not yet been received.

We acknowledge the difficulty that this issue has posed for both your country as well as the inhabitants of the camps. However, we believe that the lack of transparency in the screening and repatriation process only exacerbates these difficulties and heightens international concern regarding these populations. A process that adheres to the core tenets of the refugee convention, and is conducted by an independent third party organization, could resolve much of this concern by helping to ensure that the Lao Hmong are able to provide a full and accurate account that can serve as the basis for an appropriate status determination.

Before repatriating any individuals to Laos, we strongly urge your government to work with an independent third-party organization to conduct a transparent screening process consistent with international standards. Once such a process is in place, we hope that any Hmong determined to have refugee status will be provided opportunities for third country resettlement. This includes the individuals at the Nong Khai center, who have already been screened by the United Nations High Commissioner for Refugees. For those who are not judged to require protection, we encourage you to work with international organizations and the governments of the U.S. and Laos to establish a repatriation process that includes effective third party monitoring.

We also understand that Assistant Secretary of State Eric Schwartz will be visiting Thailand in the very near future. We hope that the U.S. and Thailand can work closely to find a solution that alleviates the burden of this situation on Thailand, as well as the concerns about the repatriation of those in need of protection, and we would be happy to consult with you on this process.

We appreciate your efforts to ensure a transparent process and just resolution to this issue. The Kingdom of Thailand remains a close ally of the United States and we look forward to working with your government to strengthen this important relationship.

Sincerely,

Russell D. Feingold, United States Senator; Barbara Boxer, United States Senator; Sheldon Whitehouse, United States Senator; Richard G. Lugar, United States Senator; Patrick J. Leahy, United States Senator; Lisa Murkowski, United States Senator; Amy Klobuchar, United States Senator; Mark Begich, United States Senator; Al Franken, United States Senator.

TRIBUTE TO LEWIS K. BILLINGS

Mr. HATCH. Mr. President, today I express my deep appreciation to a great Utahn and friend, Provo City Mayor Lewis K. Billings, whose tenure as mayor will soon come to an end. It has been my distinct pleasure to work with Mayor Billings over the past 12 years.

Nestled at the base of the Rocky Mountains, Provo was founded by rugged pioneers in 1849 and is one of the oldest cities in the West. Today, Provo is one of largest cities in the State of Utah. Mayor Billings and his beautiful wife Patti are longtime residents of Provo and raised eight wonderful children there.

Mayor Billings was elected Provo City Mayor in November 1997, after completing 3 years as chief administrative officer and director of community and government relations for the city of Provo. He and I share many of the same conservative values and principles and his service as mayor is a strong reflection of his dedication to those ideals. Mayor Billings will long be remembered for focusing on effective public safety and law enforcement, fiscal responsibility, economic development and job creation, neighborhood and downtown revitalization, the arts, emergency readiness, and a host of other local, regional, and national public policy issues. During his tenure, Provo City has consistently received national recognition for low crime rates, high quality of life, and positive business development.

Mayor Billings has accomplished a great deal during his tenure as Mayor of Provo. His dedicated public service and determination to shape Provo into the wonderful city it is today will be remembered for years to come. I ask my colleagues to join me and the citizens of the great State of Utah in thanking Mayor Billings for his many years of dedicated service. We all appreciate his efforts and service, but none so more than me.

GUN OWNERS SUPPORT GUN SAFETY LAWS

Mr. LEVIN. Mr. President, the debate surrounding gun legislation is often an acrimonious one, creating the perception that Americans are hopelessly divided on this policy issue. After listening to the positions of the National Rifle Association, NRA, a person could conclude that progress toward a national consensus on sensible gun legislation is a long way off. This perception, however, is just that: merely a perception. In reality, Americans of all political stripes share much common ground when it comes to issues of gun safety, and I am hopeful that this consensus will produce tangible legislative results.

In a recent poll conducted by well-known pollster Frank Luntz, NRA members and non-NRA gun owners expressed strong support for a number of proposed gun safety laws. These gun-owning Americans did not see a contradiction between supporting legislative efforts to reduce gun violence and their right to bear arms. Specifically, 85 percent of non-NRA gun owners and 69 percent of NRA gun owners supported closing the "gun show loophole" by requiring all gun sellers at gun shows to conduct a Brady criminal background check on prospective purchasers. In addition, 86 percent of non-NRA gun owners and 82 percent of NRA members favored a proposal to prevent individuals listed on a terrorist watch list from purchasing firearms. Seventy-

four percent of non-NRA gun owners and 69 percent of NRA members also agreed with this statement: “the federal government should not restrict the police’s ability to access, use, and share data that helps them enforce federal, state, and local gun laws.”

At first glance, these polling numbers may not seem very surprising. After all, these gun safety proposals are founded on common sense and are crafted to keep firearms out of the hands of criminals and terrorists. Unfortunately though, the NRA leadership continues to oppose three Federal gun safety bills that, according to the recent poll, their own members support: the Gun Show Background Check Act, S. 843, which would close the “gun show loophole;” the Denying Firearms and Explosives to Dangerous Terrorists Act, S. 1317, which would prevent individuals listed on terrorist watch lists from purchasing a gun; and the Preserving Records of Terrorist and Criminal Transactions Act, S. 2820, which would improve the ability of law enforcement agencies to prevent gun violence by increasing the amount of time gun background check records are kept.

I support these sensible gun safety measures, and as the polling indicates, so do a majority of American gun owners, including NRA members. The NRA is not only out of touch with mainstream America, they also are out of touch with their own members. It is time to set aside the false claims that too often cloud the debate surrounding gun safety. There is an overwhelming consensus in America: the time to pass commonsense gun safety legislation is now.

SMALL BUSINESS LENDING ENHANCEMENT ACT OF 2009

Mr. UDALL of Colorado. Mr. President, as our Nation begins its economic recovery, our unemployment numbers still remain far too high. Too many Americans are unable to find work, which only slows the pace of our emergence from recession. As part of my continuing effort to support tailored, fiscally responsible methods to getting our economy back on track, I am proud to discuss a bipartisan bill that I introduced this week with several of my Senate colleagues from both sides of the aisle.

The bill is the Small Business Lending Enhancement Act of 2009, which is cosponsored by Senator SCHUMER, Senator LIEBERMAN, Senator SNOWE, Senator BOXER, Senator COLLINS, and Senator GILLIBRAND. If enacted, this legislation would immediately allow increased lending for small businesses to the tune of billions of dollars. It would do so in a safe and fiscally responsible way, without calling on the Federal Government to spend a dime. And best of all, it could lead to large-scale job

creation in my home State of Colorado and around the country. For these reasons, I hope that our Senate colleagues join us in urging swift passage of this common-sense legislation.

Small businesses are the engine of our Nation’s economy. In the last 15 years, small businesses have generated nearly two-thirds of all new jobs created in the United States, and they currently employ more than half of the American workforce.

However, small businesses continue to struggle accessing credit, as large banks have significantly cut back on Main Street lending. According to a recent Treasury Department report, the 22 banks that have received the most funding through the Troubled Asset Relief Program, TARP, cut their collective small business loan balances by \$11.6 billion from April through October of this year.

America’s community banks, which by-and-large did not receive Federal bailout funds, are doing all they can to fill the Main Street credit vacuum created by these large financial institutions. While this legislation I have authored is aimed at helping credit unions ramp up their small business lending, I have also joined with many of my colleagues this year in support of a number of initiatives that will help community banks increase lending to small businesses.

The Small Business Lending Enhancement Act will further these efforts to free up credit for small business. Under current statute, credit unions are required to limit member business lending to 12.25 percent of the credit union’s total assets. This bill would raise that cap to 25 percent of total assets, and increase the minimum business loans subject to the cap from \$50,000 to \$250,000. These provisions would increase the amount that credit unions already offering business loans could provide to small businesses, while also encouraging more credit unions to enter the business loan market. Under current law, many credit unions find it difficult to start member business lending programs because the cost of meeting high regulatory and staffing requirements is too expensive relative to the cap. Raising the member business lending cap would make it easier for credit unions to recover costs, and therefore would increase the number of credit unions able to start small business loan programs.

The Credit Union National Association estimates that these sensible reforms would increase small business lending by \$10 billion within the first year of their enactment, including an increase of nearly \$200 million in my home State of Colorado. This new access to credit would likely produce more than 100,000 new jobs nationwide within the first year of the bill’s enactment. That is the sort of pro-business, pro-jobs policy that we need.

Mr. President, these simple statutory changes would not increase Federal outlays one cent, but they would dramatically increase the amount of private capital available to small businesses to help make payroll, buy inventory, and expand and innovate. Moreover, these proposed statutory changes are safe and fully supported by the National Credit Union Administration, the independent Federal regulator with oversight of our Nation’s credit unions. To further ensure the safety and soundness of credit unions, this bill requires the NCUA to submit a semiannual report to Congress on the status of credit union member business lending, including any recommendations for legislative changes. In sum, this is a responsibly drafted bill that could help spur much-needed economic growth and job production.

Mr. President, we have to do all we can to responsibly unlock credit markets for small businesses in Colorado and throughout the country. I believe this legislation is an important piece of that effort. I look forward to working with my colleagues on both sides of the aisle to quickly pass the Small Business Lending Enhancement Act, and allow our nation’s small businesses to again set our country on a path toward job growth and further prosperity.

TAX EXTENDERS

Ms. LANDRIEU. Mr. President, as the Senate moves forward toward ending the debate on health care reform and recessing until the New Year, we leave some important legislation unfinished, including legislation that would extend a number of tax provisions that are set to expire on December 31 of this year. The House has already acted to extend a number of these expiring tax provisions, and I urge my colleagues on the Senate Finance Committee to work with Senator BAUCUS and Senator GRASSLEY to take up this legislation immediately when we come back from recess.

As part of this effort, I urge my colleagues to extend tax provisions, some of which are set to expire this year, that were enacted by Congress to aid the recovery of the gulf coast after the 2005 hurricane season. Hurricane Katrina devastated the gulf coast and recovery efforts to date have been delayed because of a continuing shortage of skilled construction workers, limited financing, and sustained increases in construction and insurance costs. These challenges have been compounded by the current economic crisis.

By extending a number of the tax provisions that were enacted as part of the Gulf Opportunity Zone legislation that Congress passed in 2005, a number of important projects, including low-income housing projects, will have adequate time to overcome development

challenges, and create more opportunities for displaced residents looking to return after the 2005 storms. This will result in more jobs and a faster recovery for the gulf coast. If Congress fails to act to extend the tax provisions of the GO Zone legislation, including the placed-in-service provision of the GO Zone low-income housing tax credit, at least 77 low-income housing projects in the Gulf Coast are at risk of not being completed.

Mr. President, I ask unanimous consent that a letter I wrote requesting an extension of the placed-in-service provision of the GO Zone low-income housing tax credit be included in any tax extenders legislation be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. SENATE,

Washington, DC, December 9, 2009.

Hon. MAX BAUCUS,

Chair, Senate Committee on Finance, Washington, DC.

Hon. CHARLES GRASSLEY,

Ranking Member, Senate Committee on Finance, Washington, DC.

DEAR CHAIRMAN BAUCUS AND RANKING MEMBER GRASSLEY: We write to request your support for extending the placed-in-service date for affordable housing developments in the Gulf Opportunity Zone.

As you know, GO Zone low income housing tax credits have been vital in our effort to restoring the number of affordable housing units along the Gulf Coast. Tough economic conditions, however, have prevented many of these projects from moving forward at the pace necessary to meet the placed-in-service deadline of January 1, 2011.

Together this bipartisan group of Gulf Coast senators has been working to extend this deadline for two years, to allow 77 low income housing projects in Louisiana, Mississippi, and Alabama to move forward and creating more than 13,000 construction-related jobs. This legislation would not allocate any new credits—it would merely provide additional time to take full advantage of the credits that were issued in the aftermath of the 2005 hurricanes.

Extending the place-in-service deadline is critical to improving the availability of affordable housing along the Gulf Coast. FEMA estimates that the 2005 storms destroyed or heavily damaged 82,000 rental units, of which 54,000 served low-income populations. During his August 27 visit to New Orleans, HUD Secretary Shaun Donovan emphasized the need to revitalize this housing and highlighted the importance of a placed-in-service extension.

With an extension, developers will be able to attract investors to their proposed developments, have adequate time to overcome financial barriers triggered by the current economic crisis, and create more opportunities for residents displaced by the 2005 hurricanes to return home. Without an extension, more than 6,000 units are unlikely to be completed. The loss of more than \$1 billion in economic activity—to the construction industry, suppliers, professionals, developers and others—would be a major blow to our states and the region.

Your initiative in helping the Gulf Coast to recover has been invaluable. It is our hope that the Senate Finance Committee will continue this leadership by including a

placed-in-service extension in a tax extenders bill or other legislation this year. We appreciate your consideration of this request.

Sincerely,

MARY L. LANDRIEU,

United States Senator.

DAVID B. VITTER,

United States Senator.

ROGER F. WICKER,

United States Senator.

THAD COCHRAN,

United States Senator.

CHRISTMAS OVERSEAS

Mr. JOHANNIS. Mr. President, I rise today to speak about those Nebraskans who will be overseas, in harm's way, this Christmas.

The job our young men and women in uniform do to protect our safety every day is magnificent. I have met with many of these young service men and women throughout my years of public service, and I know they represent the very best of America. During my time as Governor, it was truly an honor to command Nebraska's National Guard forces. They serve our country with immense valor, at the risk of their own lives. To them, we are all deeply grateful.

Christmas in wartime has always been a difficult time for troops and their families. The contrast is very great between Americans at home celebrating holiday cheer, and those on the front lines going about their regular day of danger. It is a contrast that we should be mindful of this season. I, and many of my fellow Nebraskans, will pause tomorrow to give thanks for the sacrifice of our troops, and pray that they get home safely. Their mission is just, and they are the most capable military in the world. Their presence is missed at this time more than any other but our pride, in them and their friends, is even greater than our sorrow at their absence.

So to those Nebraskans who are in harm's way this Christmas, and to all American forces, those who serve abroad to protect us here at home, I truly thank you. I hope it will be, in some small measure, a comfort on Christmas, to know that so many of your friends, family, and fellow Americans are safe and secure due to your service, and praying for you.

So today, as always, I wish you all a safe return, and a very Merry Christmas.

AMERICAN HIKERS DETAINED BY IRAN

Mrs. BOXER. Mr. President, I rise today to renew my appeal to the Government of Iran to immediately release the three American hikers—Shane Bauer, Sarah Shourd, and Josh Fattal—who were detained by Iranian authorities in July.

According to available information, the three young adults, who are all

graduates of the University of California, Berkeley, inadvertently crossed an unmarked border into Iran while hiking in the Kurdistan region of northern Iraq.

Shane, Sarah and Josh have now been held in semi-isolation for over 140 days without charge, access to legal representation, or information on the current status of their case and future proceedings. This is deeply troubling and incredibly difficult for their families.

I recently spoke to the Iranian Ambassador to the United Nations on behalf of the hikers to reiterate my call for their release. I also asked that they be able to call their families and continue to be visited by Swiss consular officials.

During this holiday season, Americans from all walks of life are celebrating and renewing ties of family, friendship, and good will.

The extended absence of these young Americans from their families is particularly painful during such a festive time. As such, I call upon the Iranian authorities to immediately release Shane, Sarah and Josh so that their families can welcome them home.

20TH ANNIVERSARY OF THE U.S. ARMY SPECIAL OPERATIONS COMMAND

Mrs. HAGAN. Mr. President, this month, the U.S. Army Special Operations Command, USASOC, celebrates 20 years of service to the Army and Nation. Having been at war for over one-third of that time, the men and women of USASOC continue to make great contributions worldwide with an operations tempo that has never been greater. USASOC remains committed to maintaining the world's finest ground special operations force. Its personnel take quiet professional pride in executing each mission with excellence, honor and valor.

I am proud that USASOC's headquarters are in North Carolina. USASOC Commander LTG John Mulholland has done a tremendous job in training, organizing, and equipping Army Special Forces units, capable of conducting global Special Operations missions. Army Special Forces units perform a variety of missions, including special reconnaissance, psychological, civil affairs, unconventional warfare, foreign internal defense, direct action, counterterrorism, and counterinsurgency.

The principle units that make up today's USASOC include the John F. Kennedy Special Warfare Center and School, U.S. Army Special Forces Command, 75th Ranger Regiment, 160th Special Operations Aviation Regiment, 3rd and 7th Special Forces Group, 4th Psychological Operations Group, 95th Civil Affairs Brigade and the 528th Sustainment Brigade.

Since its inception on December 1, 1989, the pace of USASOC's operations has been extraordinary; operating around the world, often behind-the-lines, in some of the most remote and hostile regions on the planet.

At more than 27,000 personnel, USASOC is only 5 percent of the U.S. Army. However, USASOC is the largest of the service components that make up U.S. Special Operations Command, USSOCOM, and provides approximately 70 percent of the special operations personnel in Central Command's theater and approximately 63 percent of America's total overseas military commitments. USASOC provides trained and ready Army special operations forces to support the Geographic Combatant Commanders, GCC, the Theater Special Operations Commands, TSOC, and Ambassadors throughout the world.

Today the operations tempo for Army Special Operations has never been greater, and is unlikely to decrease in the near future. USASOC currently has soldiers deployed on 103 Missions in 56 countries around the world, and is operating across the spectrum of operations.

Currently 222 of the Army's 228 Continental United States-based Special Forces operational detachments "A"—ODA—are committed to supporting operations worldwide, either deployed or preparing for deployment. USASOC's ability to manage the high operations tempo is directly attributable to the caliber of its personnel. The range of skills within USASOC is embraced by a spectrum of Army unconventional units.

I would like to take this opportunity to highlight the great contributions of USASOC units currently in theater, particularly the 3rd and 7th Special Forces Groups in Afghanistan, the 95th Civil Affairs Brigade and the 4th Psychological Operations Group in Iraq and Afghanistan.

President Obama has stated in his agenda for defense, "We must build up our special operations forces, civil affairs, information operations and other units and capabilities." The demand for special operations personnel, skills and training remain high. Faced with often desperate, unconventional enemies, our approaches for defeating them involve unwavering commitment combined with unique unconventional skills.

USASOC's expertise ensures the Army's special operations forces can execute the most lethal, highly complex and sensitive special operations, wage unconventional warfare, conduct high risk helicopter operations, or prosecute civil military and influence operations.

For those in today's USASOC, the pace is fast, the challenges great, but morale and job satisfaction have seldom been greater. The command's motto, "Without Equal", captures the

spirit of its personnel and their commitment to maintaining the world's finest ground special operations force.

The command's missions, however, have not come without a sizable cost in lives lost. In the 8 years since the start of Operation Enduring Freedom and Operation Iraqi Freedom, 244 of USASOC's personnel have made the ultimate sacrifice. Their names are cast in bronze on a wall in USASOC's Memorial Plaza at Fort Bragg, NC.

In closing, the performance and contributions of Army Special Operations Forces in the Central Command theater of operations and around the world have been nothing short of magnificent. Whether in Iraq and Afghanistan, the Philippines, Trans-Sahara Africa or wherever friends and partners find themselves challenged by the forces of disintegration, oppression and extremism, Army Special Operators from across the Command's formations are unquestionably among America's most relevant answer to the threats our Nation faces.

TRIBUTE TO JIM PITCOCK

Mr. PRYOR. Mr. President, today I rise to honor the career of Jim Pitcock, a valuable staff member and more importantly a valuable part of the Arkansas community. Jim has been faithful and selfless in his service to the State of Arkansas, and his contributions will be sorely missed by me, my staff, and the many Arkansans who have had the great fortune of working with this wonderful public servant.

Jim has served on my staff from the very first day of my tenure as a Member of the U.S. Senate. His knowledge of the State of Arkansas and government has guided some of my most important decisions and for that I will be forever grateful. His wise, steady counsel is always held in high esteem. Jim has served several roles on my staff. His most recent role as senior caseworker has benefitted the people of Arkansas by assisting individuals, businesses and organizations that are experiencing difficulties with Federal agencies. Jim's leadership has set an expectation of excellence in constituent services.

Prior his work in the U.S. Senate, Jim was already a legend in Arkansas. He served as news director at Channel 7 in Little Rock for more than 30 years. During this time, Jim established an unprecedented system of archiving news coverage for historical purposes. Jim has witnessed and archived news from Governors Faubus to Huckabee and Presidents Johnson to Clinton. He also provided critical coverage of major events in our State, such as the Damascus missile explosion, the Cuban refugee crisis and the great Arkansas Texas shootout football game of 1969. Following his departure from television, I was privileged to have Jim

join my staff in the Arkansas attorney general's office in 2001 serving as the public information officer.

After so many years of faithful service to the people of Arkansas, Jim Pitcock has made a decision to retire from the Senate and his presence will be missed. He will continue to be a friend and adviser to me and I wish him all the best of luck as he begins this new chapter in his life.

Mr. President, I ask my colleagues to join me in celebrating the outstanding career and service of Jim Pitcock to the U.S. Senate and the State of Arkansas.

THREE SISTERS SCENIC BIKEWAY

Mr. WYDEN. Mr. President, too many of our communities are hemorrhaging jobs. That is especially true in rural areas, where industries have suffered and companies have had to let lots of people go. In Oregon, for example, changes in forest policy have hit rural communities particularly hard in recent years. I am constantly working to find solutions that will help those communities not just survive but thrive.

It is indisputable that many rural communities and small towns in Oregon contain some of the most beautiful scenery in America. When I look at their future, I see that the scenic beauty and solitude of beautiful places like Sisters, OR, which sits in the shadow of the Cascade Mountains, can be a big engine to drive the economy. Investments in amenities like parks and scenic bikeways can be valuable for communities because they aren't fleeting. They build infrastructure that lasts for generations. The beauty of nature, especially out in the countryside, attracts tourists—particularly bicyclists.

The League of American Bicyclists estimates that biking contributes \$133 billion per year to our national economy, provides 1.1 million jobs, and generates \$17.7 billion in Federal, State, and local taxes. They estimate that another \$46.9 billion is spent on meals, transportation, lodging, gifts, and entertainment during bike trips and tours.

Savvy entrepreneurs in Oregon have come together to capitalize on the benefits that being a destination for bicyclists can bring to a community. Cycle Oregon—called "the best bike ride in America"—attracted 2,200 people from 44 States and 11 foreign countries to its 2008 ride, which took hardy bicyclists through some of Oregon's most beautiful sites. But it is not just Oregon entrepreneurs who have figured this out. It is a nationwide phenomenon. Bloomington, Indiana's "Hilly 100 ride," for example, draws 5,000 riders and over \$1 million in lodging and food sales. And in Iowa, the week-long Register's Annual Great Bicycle Ride Across Iowa has become so

popular that last year, they had to turn people away after more than 9,000 applied to cycle across the State.

It is often through outdoor events like bike races that you will find a CEO or company leader visiting Central Oregon on a vacation and having the brainstorm that it would make a great place to locate a new enterprise. Many high-tech companies, for example, are locating in places with unique, scenic beauty to set them apart from their competition in the big cities and to give them an added bonus to attract the talent they need to succeed.

I thought there must be a way to tap the full recreation potential of central Oregon and create a model that could be replicated in other parts of the country. So, 2 years ago I asked recreation leaders in Deschutes County to look at how recreation could add value to its recreation assets, creating the strongest possible engine for economic development.

Since then, the Sisters area has decided that much of its economy is tied to broadening the set of recreation experiences they can offer to visitors. They have developed many miles of new, spectacular mountain bike trails in the cascade foothills of Peterson Ridge as part of that effort. They see the development of a better cycling route to Bend as a vital addition to the menu of recreation opportunities in the area.

Community and business leaders from across Deschutes County have worked for the past two years on ideas like those developed in Sisters. They came together recently to formally launch an effort to create the Three Sisters Scenic Bikeway—a scenic bike route connecting each of the cities in that county, via cycling-friendly routes that take you past spectacular scenery.

Government officials are pitching in too. The Oregon Department of Transportation and the U.S. Forest Service are working together to implement the committee's vision of a paved bike path connecting Bend to Sunriver. The Forest Service is about halfway through their decision making process on a paved path from Sunriver out to Lava Lands Visitors Center, and ODOT is pursuing a variety of funding options to get the work done while crews are still working on the major reconstruction of Highway 97 nearby.

As we rebuild our country's infrastructure and seek new ways to create jobs, we would do well to follow the lesson of Deschutes County and The Three Sisters Scenic Bikeway. It was an idea that was first proposed by concerned members of the community. It answers local needs and they have a lot of confidence it will work. And as representatives of those communities, my colleagues and I have the ability to help water the seeds of those ideas when government can help out.

This kind of collaborative effort by local groups can be the kind of national model other struggling rural communities should consider as they work to rebuild their infrastructure and economies. Cities across America are realizing that investing in outdoor recreation options like bikeways is an affordable way to significantly improve their quality of life and, in the process, improve their competitiveness to attract new businesses and jobs.

It is time to remember that our infrastructure can't just be focused on ways to bring more cars onto our already stressed roads. Fixing highways and bridges is critically important, but for better health, relaxation, and the economic benefits they can bring, bikeways can also be part of the solution to fix our infrastructure and help revive struggling communities back home.

RESPONSE TO SLATE ARTICLE BY JACOB WEISBERG

Mr. GRASSLEY. Mr. President, I would like to address an article written by Jacob Weisberg for Slate magazine on December 12, 2009. This article is entitled, "Are Republicans Serious About Fixing Health Care? No, and here's the proof." In this article, Mr. Weisberg unfairly and misleadingly takes aim at my position in the current health reform debate.

The author reports that I have criticized the Reid bill for creating an "indefensible new entitlement" and that it "expands the deficit, threatens Medicare, and does too little to restrain health care inflation."

I don't dispute Mr. Weisberg attributing these criticisms of the Reid bill to me. But, Mr. Weisberg can't dispute these serious shortcomings of the Reid bill that I and other Members on this side of the aisle have been discussing on the Senate floor for the past weeks. In fact, both the nonpartisan Congressional Budget Office, CBO, and the independent Department of Health and Human Services, HHS, Chief Actuary have confirmed that the Reid bill would not only establish this indefensible new entitlement, but also represent the largest expansion of government-run health care in history. But let me go through each criticism of the Reid bill that Mr. Weisberg has correctly reported.

The Reid bill will expand the deficit. Mr. Weisberg identifies the 10-year CBO score of the bill to be \$848 billion, but that is comprised of 10 years of Medicare cuts and tax increases and only 6 years of outlays. So if he were intellectually honest, Mr. Weisberg would have used the cost of 10 years of outlays, which budget analysts assume to be closer to \$2.5 trillion. But the use of budget gimmickry does not end there when supporters of the Reid bill claim that it is deficit neutral.

One of the biggest problems in Medicare that we have to address in Con-

gress every year is the Medicare physician payment formula or the sustainable growth rate, SGR. Comprehensively fixing the SGR costs well over \$200 billion. Only providing a two-month temporary patch for the problem will result in a more than 20-percent drop in Medicare physician payments beginning in March of next year. To me and many other Members of Congress, health care reform includes fixing the SGR so that physicians can be assured of not facing drastic Medicare payment cuts year after year and so that beneficiaries can be assured of having access to physicians. But there is no SGR fix in the Reid bill. Do the math and you will see why. A comprehensive SGR fix of over \$200 billion would wipe away the \$132 billion in budgetary savings that the Reid bill is currently reported to have.

In fact, the Congressional Budget Office noted that the estimated cost of repealing the SGR and replacing it with a permanent freeze would be about \$207 billion once physician-administered drugs were removed from the calculation of the SGR formula. That was done in the physician rule that CMS finalized on October 30, 2009. However, according to CBO, the removal of those drugs from the SGR formula will increase Medicare's spending for physician services, as well as federal spending under TRICARE by \$78 billion over the 2010-2019 period. The net impact on the budget would be close to \$300 billion over 10 years, none of which is reflected in the Reid bill.

And let's take a look at what is in the bill. I certainly hope Mr. Weisberg did when he wrote his article. A good portion of the budgetary savings in the Reid bill is from the CLASS Act. This program apparently produces budgetary savings during the first 10 years, but only because no benefits pay out for the first 5 years. This makes the revenues outpace the program's outlays. But CBO has stated that outlays will outpace revenues after the first 10 years. This means that the CLASS act will result in deficit spending over the long run. In fact, the chairman of the Budget Committee, a Democrat, called the CLASS Act a massive government ponzi scheme. So this casts serious doubt on those who tout that the Reid bill is deficit neutral or saves money.

The Reid bill also threatens Medicare. I don't think Mr. Weisberg can argue that close to $\frac{1}{2}$ trillion in Medicare cuts won't jeopardize beneficiary access to care. Even the White House's own Chief Actuary confirmed that the Reid bill jeopardizes beneficiary access to care. He raised concerns in particular about two categories of these Medicare cuts. First, the Chief Actuary warned about the permanent productivity adjustments to annual payment updates. Under the Reid bill, these productivity adjustments automatically cut annual Medicare payment updates

based on productivity measures of the entire economy. Referring to these cuts, he wrote that “the estimated savings . . . may be unrealistic.” In his analysis of these provisions, Medicare’s own Chief Actuary stated, “it is doubtful that many could improve their own productivity to the degree achieved by the economy at large,” and that they “are not aware of any empirical evidence demonstrating the medical community’s ability to achieve productivity improvements equal to those of the overall economy.” In fact, the Chief Actuary’s conclusion is that it would be difficult for providers to even remain profitable over time as Medicare payments fail to keep up with the costs of caring for beneficiaries. Ultimately, the Chief Actuary’s conclusion is that providers who rely on Medicare might end their participation in Medicare, “possibly jeopardizing access to care for beneficiaries.”

The Chief Actuary even has numbers to back up these statements. His office ran simulations of the effects of these drastic and permanent cuts. And based on these simulations, the Chief Actuary found that during the first 10 years, “20 percent of Medicare Part A providers would become unprofitable as a result of the productivity adjustments.” That’s one out of five hospitals, nursing homes and hospices. It is for this reason that the Chief Actuary found, “reductions in payment updates based on economy-wide productivity gains, are unlikely to be sustainable on a permanent annual basis.”

The second category of Medicare cuts that the Chief Actuary raised concerns about would be imposed by the new Independent Payment Advisory Board created in the Reid bill. This is the new body of unelected officials that would have broad authority to make even further cuts in Medicare. These additional cuts in Medicare would be driven by arbitrary cost growth targets. This board would have the authority to impose further automatic Medicare cuts even absent any Congressional action. The Chief Actuary gave a reality check to this proposal. He showed how tall an order the Reid bill’s target for health care cost growth actually is. According to the HHS Chief Actuary, limiting cost growth to a level below medical price inflation “would represent an exceedingly difficult challenge.” He pointed out in this analysis that Medicare cost growth was below this target in only 4 of the last 25 years.

The HHS Chief Actuary also pointed out that the backroom deals that carved out certain types of providers would complicate this board’s efforts to cut Medicare cost growth. According to the analysis, “[t]he necessary savings would have to be achieved primarily through changes affecting physician services, Medicare Advantage payments and Part D.” So providers like hospitals will escape from this

board’s cuts at the expenses of doctors, seniors enrolled in Medicare Advantage plans and seniors who will pay higher premiums for their Medicare drug coverage. If we surveyed the nation’s seniors, I doubt very much they would say that raising their premiums for Medicare drug coverage or limiting preventive benefits in Medicare Advantage is what they would call health care reform.

And this board is guaranteed to have to impose these additional Medicare cuts. According to the Chief Actuary’s analysis of the Medicare cuts in the Reid bill, even though the Medicare cuts already in the Reid bill are “quite substantial” they “would not be sufficient to meet the growth rate targets.” So this means the board will be required by law to impose even more Medicare cuts in addition to the massive Medicare cuts already in the Reid bill. And this will make it even harder for our seniors to find providers who will treat them.

Not only does the Reid bill “[do] too little to restrain health care inflation,” it actually increases health care inflation. According to the HHS Chief Actuary, the Reid bill would bend the health care cost curve the wrong way. Over the next 10 years, the Administration’s own Actuary stated that “total national health expenditures under this bill would increase by an estimated total of \$234 billion.” As a result of that increase, health care would then be projected to grow from 17 percent to 20.9 percent of the gross domestic product in 2019. So using the Reid bill to curb health care cost growth would be like putting out a fire with gasoline.

The Chief Actuary also found that a good portion of the increase in national health expenditures would be caused by the so-called fees in this bill on medical devices, on prescription drugs and on health insurance premiums. He stated, that these “fees would be passed through to health consumers in the form of higher drug and device prices and higher insurance premiums.” This would result in, “an associated increase of approximately 11 billion dollars per year in overall national health expenditures.”

Higher premiums from the Reid bill are no trifling matter. In fact, one estimate concluded that the Senate bill would increase premiums by about 50 percent on average for individuals without employer-based coverage, and more than 20 percent for small businesses. And even the Congressional Budget Office’s more conservative analysis predicts that premiums will increase 10 to 13 percent for 14 million Americans as a result of the Reid bill.

But that is where my agreement with Mr. Weisberg ends. He then proceeds to lob several troubling and incorrect claims at me in his attempt to portray me as “incoherent.”

Mr. Weisberg distorts what I said in response to a constituent’s question at a town hall meeting in Iowa last August when he accuses me of playing the “age card.” This is what Mr. Weisberg claims that I said: “There is some fear, because in the House bill, there is counseling at the end of life. And from that standpoint, you have every right to fear.”

But this is what was actually said at that meeting:

Question from Iowan: “Thank you, Senator GRASSLEY, for coming. The Democrats tell us all the time that it’s a right of every American to have health care. Yet it seems this Obama plan will systematically deny those rights to certain groups like the elderly. And I, as a person in my 60’s I’m getting very concerned about the health care that I might be able to have if this bill passes. . . .”

Iowan Restating the Question: “Ok . . . [the question] involves limited coverage because of a person’s background and age, race, physical condition such as that. Basically it was on the lady’s age.”

Senator GRASSLEY: “[V]ery recently in things that we’ve been talking about in our negotiations has been just exactly what you brought up. I won’t name people in Congress or people in Washington, but there’s some people that think that it’s a terrible problem that Grandma’s laying in the hospital bed with tubes in her, and think that there ought to be some government policy that enters into that. I’m just on the opposite. I think that’s a family and a religious and or ethical thing that needs to be dealt with and there’s some fear because in the House bill there’s counseling for end of life. And from that standpoint, you have every right to fear. You shouldn’t have counseling at the end of life. You ought to have counseling 20 years before you’re going to die. You ought to plan these things out. And, you know, I don’t have any problem with things like living wills, but they ought to be done within the family. We should not have a government program that determines you’re going to pull the plug on Grandma. Thank you all very much for coming.”

Mr. Weisberg is not the first who has taken what I said during this exchange and twisted it to attempt to portray me as a fearmonger. And unfortunately he probably won’t be the last. What’s even more unfortunate is that Mr. Weisberg and those like him fail to see the legitimate cause for concern when you have a combination of the expanded role of government in health care generally plus funding for advance care planning consultations alongside cost containment proposals. Some commentators took my comments and twisted them and even quoted me as saying the House health care reform bill would establish death panels, and this was blatantly incorrect. As you can see from what was said at the town meeting, I said no such thing. As I said then, putting end-of-life consultations alongside cost containment and government-run health care causes legitimate concern.

And to address another point that Mr. Weisberg makes, a provision that provided for the option of advance care planning was in a bill I supported. In

2003, Congress enacted a narrow provision to offer coverage for hospice consultation services for Medicare beneficiaries who have been diagnosed as terminally ill. Under this provision, this consultation would be covered only when provided by a health care provider with expertise in end-of-life issues such as a hospice physician. The covered services include a pain and care management evaluation, counseling about hospice care and other optional services such as advice on advance care planning. This provision was designed to assure that advice on advance care planning in this context is only offered by qualified professionals and done in an appropriate manner.

In his article, Mr. Weisberg misses the point. The core of this issue is when it comes to advance care planning, what role, if any, the government should play. When the government attempts to influence these sensitive decisions, it raises the possibility that the government's interests may be different and potentially incompatible with the patient's interests.

When provisions to increase the government role in advance care planning are included alongside cost containment provisions, it raises the concern that the purpose for the proposal is to save money rather than to ensure appropriate care at the end of life. And that is in fact what has already happened. This idea of encouraging living wills was originally proposed by the Carter administration in 1977 as an option to produce both federal and system-wide savings in health expenditures. More recently, the Urban Institute published a paper in July 2009 that identified proposals like advance care planning consultations as a way to help cut costs to offset spending for health care reform. Compassion and Choices, formerly known as the Hemlock Society, has also advocated for the inclusion of advance care planning consultations in health care reform legislation. Minimizing such an important issue or trying to turn it into an amusing story as Mr. Weisberg has done debases the important discussion that needs to occur on this sensitive and personal issue.

Mr. Weisberg then criticizes Medicare Part D, which I championed, in his attempt to question my opposition to the Reid bill. In 2003, Medicare was 37 years old and functioning a lot like it had on day one. It emphasized treatment, not prevention, not disease management. It was a horse-and-buggy version of health care compared with the kind of coverage that other Americans received through their employers. Then, as now, employer-based health plans often covered prescription drugs. Employers realized it was cost-effective to pay for a relatively cheap cholesterol-lowering drug if it meant avoiding a triple bypass down the road.

But Medicare beneficiaries were stuck in 1965 when prescription drugs were less vital than they are today. And because Medicare didn't cover prescription drugs, they often were forced to forgo medications, pay out of pocket, try to find an affordable supplemental policy, or take a bus to Canada to get their medicines.

Republicans and Democrats alike agreed Medicare beneficiaries deserved 21st century health care coverage, including prescription drug coverage. However, there were still differences on how much the government could afford to spend on providing this new benefit. In May of 2002, Republicans put forth a \$350 billion proposal to provide comprehensive drug coverage to America's seniors. The Democrats thought this was insufficient and put forth their own proposal totaling close to \$600 billion. At the end of the day, the fiscal year 2004 budget resolution included a \$400 billion reserve fund for the creation of the drug benefit.

While there was bipartisan support for the drug benefit, Democrats nevertheless continued to argue that Congress should be spending more. For example, former Senator Bob Graham of Florida said, "Some would argue that this budget includes \$400 billion for a Medicare prescription drug benefit. They know full well that \$400 billion is inadequate to provide an affordable, comprehensive, universal prescription drug benefit for America's seniors." The late Senator Edward Kennedy stated, "This budget has far less funding than is necessary to provide a meaningful prescription drug benefit for all seniors." And Senator TOM HARKIN stated, "We need a budget that is balanced, that takes the approach that we need to reduce the debt to take care of the baby boomers and provide for a decent drug benefit for the elderly. Clearly, the \$400 billion proposed for prescription drugs and other medical reforms is far too low for that purpose." Congress eventually passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Medicare Modernization Act, Public Law 108-173, on a bipartisan basis and created the drug benefit that year. In contrast to the process we are witnessing this year on health care reform, the final conference report from the MMA passed the Senate with the support of 11 Democrats and one Independent. And yet I can't help but think that if the Democrats had their way on the total amount of spending almost twice as much on the drug benefit, then far more than this responsible bipartisan amount would have been spent. And certainly despite the criticism that the new drug benefit is often subjected to from the left, not even the most staunch opponents of Part D have proposed repealing the drug benefit for our Nation's seniors.

Now in addition to the bipartisan support for the creation of the benefit,

the vast majority of Medicare beneficiaries also like their prescription drug coverage. Survey after survey consistently shows that the benefit enjoys broad support from beneficiaries. According to Medicare Today, 88 percent of Part D enrollees are satisfied with the program. And the program has come in \$239 billion under budget. When was the last time you could say that about a government program? Furthermore, the fact that Medicare beneficiaries are able to obtain their prescription drugs and afford them means fewer hospitalization and emergency room visits when diseases like diabetes, heart disease, and pulmonary disease are properly managed with modern prescription drug therapy.

How is adding prescription drug coverage to Medicare different from the current health care debate?

Medicare was already 37 years old when Congress added prescription drug coverage. The Medicare structure was well-established. Congress worked in a bipartisan way to set aside the funding to improve the program and do so without disrupting the parts that already worked for tens of millions of people. Don't forget that 76 senators voted in favor of the Senate bill for the drug benefit including 35 Democrats and one Independent. We certainly can't say the same for the current health care reform effort in the Senate.

One key difference is the fact that the prescription drug benefit is purely voluntary, unlike the mandatory system of insurance coverage for everyone proposed in the current health reform bills that is backed up with the imposition of stiff fines on those who don't comply. Under the Medicare benefit, seniors who don't need prescription coverage or who don't see it is a good value for the premium don't have to get it. The drug benefit is provided and administered by private entities, which compete for beneficiaries' business. And this competition between plans has kept the overall cost of the program down.

And let's not forget what we were trying to do back in 2003 compared to what is happening in Congress now. Back in 2003, we were operating on a budget surplus, and there was bipartisan support to address a need by creating the Medicare drug benefit. The Medicare Modernization Act met this need.

The situation is totally different in 2009. We are now operating on record budget deficits. So the goal of any health reform legislation should be to bend the cost curve. But as the HHS Chief Actuary has established, the Reid bill fails to do so.

In response to those who say the drug benefit only added to Medicare's expenses, the Medicare Modernization

Act also expanded coverage of preventive services to emphasize less expensive prevention over more costly treatment. The law created a specific process for overall program review if general revenue spending exceeded a specified threshold. And it took the politically bold step of introducing the concept of income testing into Medicare, with higher income people paying larger Part B premiums beginning in 2007.

Also, Mr. Weisberg makes several additional points about Medicare Part D that are simply wrong. For example, he states that the government prohibition from negotiating drug prices with manufacturers only raises the Medicare Part D pricetag. CBO, the Chief Actuary, and noted economists have all found the exact opposite to be true. The Chief Actuary stated that "direct price negotiation by the Secretary would be unlikely to achieve prescription drug discounts of greater magnitude than those negotiated by Medicare prescription drug plans responding to competitive forces." And CBO has concluded that "the Secretary would be unable to negotiate prices across the broad range of covered Part D drugs that are more favorable than those obtained by PDPs under current law." Even the Washington Post editorial page has stated that "governments are notoriously bad at setting prices, and the U.S. government is notoriously bad at setting prices in the medical realm." What's more, the idea of private negotiation on drug costs originated with none other than President Bill Clinton. Under President Clinton's plan, he proposed that "[p]rices would be determined through negotiations between the private benefit administrators and drug manufacturers." President Clinton's plan was introduced on April 4, 2000 as S. 2342 by the late Senator Moynihan by request.

Mr. Weisberg also uses incorrect data to compare the 10-year cost of Medicare Part D and the Reid bill. Medicare Part D costs do not "dwarf" the Reid bill costs as Mr. Weisberg claims because the true 10-year cost of the Reid bill, as acknowledged by supporters of the bill on the Senate floor, is \$2.5 trillion and not the \$848 billion figure that he uses.

So attempting to portray me as being "incoherent" for opposing the Reid bill even though I championed the Medicare Modernization Act is absolute nonsense.

The Medicare Modernization Act did not impose a \$2½ trillion tab on Americans. It did not kill jobs with taxes and fees that go into effect 4 years before the reforms kick in. It did not kill jobs and lower wages with an employer mandate. It did not impose a half a trillion in higher taxes on premiums, on medical devices, on prescription drugs, and more. It did not jeopardize access to care with massive Medicare cuts. It did not impose higher health

care costs. And it did not raise health premiums for millions of Americans like the Reid bill will do.

Mr. President, I ask unanimous consent to have printed in the RECORD the December 12, 2009, Slate article by Jacob Weisberg.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Slate, Dec. 12, 2009]

ARE REPUBLICANS SERIOUS ABOUT FIXING HEALTH CARE?

(By Jacob Weisberg)

Iowa Sen. Charles Grassley, the top Republican on the Senate finance committee, has emerged as one of the harshest critics of what the right likes to call "Obamacare." After spending the first half of the year working with Democrats to find a bipartisan compromise, Grassley has spent the second half trying to prevent one. He attacks the bill now being debated on the Senate floor as an indefensible new entitlement. He complains that it expands the deficit, threatens Medicare, and does too little to restrain health care inflation. At a town hall meeting in August, the 76-year-old Iowan played the age card. "There is some fear, because in the House bill, there is counseling for end of life. And from that standpoint, you have every right to fear," he told an audience in John Wayne's hometown of Winterset.

One might credit the sincerity, if not the validity, of such concerns were it not for an inconvenient bit of history. Not so long ago, when Republicans controlled the Senate, Grassley was the chief architect of a bill that actually did most of the bad things he now accuses the Democrats of wanting. As chairman of the finance committee, Grassley championed the legislation that created a prescription-drug benefit under Medicare. The contrast between what he and his colleagues said during that debate in 2003 and what they're saying in 2009 exposes the disingenuousness of their current complaints.

Today the Medicare prescription-drug debate is remembered mainly for the political shenanigans Republicans used to get their bill through. Bush officials lied about the numbers and threatened to fire Medicare's chief actuary if he shared honest cost estimates with Congress. House Republicans cut off C-SPAN and kept the roll call open for three hours—as opposed to the requisite 15 minutes—while cajoling the last few votes they needed for passage. Former Majority Leader Tom DeLay was admonished by the House ethics committee for winning the eleventh-hour support of Nick Smith, a Michigan Republican, by threatening to vaporize Smith's son in an upcoming election. It's worth remembering these moments when Republicans criticize Democratic Majority Leader Harry Reid for his hardball tactics.

The real significance of that episode, however, is not their bad manners, but what Republicans ordered the last time health care was on the menu. Their bill, which stands as the biggest expansion of government's role in health care since the creation of Medicare and Medicaid in 1965, created an entitlement for seniors to purchase low-cost drug coverage. Grassleycare, also known as Medicare Part D, employs a complicated structure of deductibles, co-pays, and coverage limits. Thanks to something called the "doughnut hole," drug coverage disappears when out-of-pocket costs reach \$2,400, returning only when they hit \$3,850. Simply stated, the bill cost a fortune, wasn't paid for, is com-

plicated as hell, and doesn't do all that much—though it does include coverage for end-of-life-counseling, or what Grassley now calls "pulling the plug on grandma."

In their 2009 report to Congress, the Medicare trustees estimate the 10-year cost of Medicare D as high as \$1.2 trillion. That figure—just for prescription-drug coverage that people over 65 still have to pay a lot of money for—dwarfs the \$848 billion cost of the Senate bill. The Medicare D price tag continues to escalate because the bill explicitly bars the government from using its market power to negotiate drug prices with manufacturers or establishing a formulary with approved medications.

And unlike the Democratic bills, which won't add to the deficit, the bill George W. Bush signed was financed entirely through deficit spending. While Grassley and his colleagues accuse Democrats of harming Medicare through cost cuts, it is their bill that has done the most to hasten Medicare's coming insolvency. Between now and 2083, Medicare D's unfunded obligations amount to \$7.2 trillion according to the trustees. Numbers like these prompted former Comptroller General David M. Walker to call it "... probably the most fiscally irresponsible piece of legislation since the 1960s."

Grassley is not alone in his incoherence. Of 28 current Republican senators who were in the Senate back in 2003, 24 voted for the Medicare prescription-drug benefit. Of 122 Republicans still in the House, 108 voted for it. There is not space here to fully review this hall of shame, which includes Lamar Alexander of Tennessee, Mike Enzi of Wyoming, Kay Bailey Hutchison of Texas, and Orrin Hatch of Utah, among many others. Here is Kansas Republican Sam Brownback in 2003: "The passage of the Medicare bill fulfills a promise that we made to my parents' generation and keeps a promise to my kids' generation." Here is Brownback in 2009: "This hugely expensive bill will not lower costs and will not cover all uninsured." Here is Jon Kyl of Arizona: "As a member of the bipartisan team that crafted the Part D legislation, I am committed to ensuring its successful implementation. I will fight attempts to erode Part D coverage." Kyl now calls Harry Reid's legislation: "a trillion-dollar bill that raises premiums, increases taxes, and raids Medicare."

The explanation for this vast collective flip-flop is—have you guessed?—politics. Medicare recipients are much more likely to vote Republican than the uninsured who would benefit most from the Democratic bills. In 2003, Karl Rove was pushing the traditional liberal tactic of solidifying senior support with a big new federal benefit, don't worry about how to pay for it. Today, GOP incumbents are more worried about fending off primary challenges from the right, like the one Grassley may face in 2010, or being called traitors by Rush Limbaugh. But what happened the last time they were in charge gives the lie to their claim that they object to expanding government. They only object to expanding government in a way that doesn't help them get re-elected.

JUDICIAL NOMINATIONS

Mr. SESSIONS. Mr. President, as the first session of the 111th Congress comes to a close, I believe it is important to correct the record regarding the Senate's processing of judicial nominations. Despite the statements of some of my Democrat colleagues to the

contrary, the fact is we have been moving nominees at a fair and reasonable pace. The Judiciary Committee has held hearings for every one of President Obama's circuit court nominees and all of his district court nominees that are ripe for a hearing. At this point in President Bush's administration, 30 nominees had yet to even receive a hearing. As the numbers bear out, President Obama's nominees have fared far better.

Allegations that Republicans are delaying confirmation votes ring hollow. Democrats control 60 votes in the Senate and set the agenda for the floor. If my Democrat colleagues are dissatisfied with the pace of nominations, I suggest that they look to their leader. On Tuesday, the majority and minority leaders announced that we will vote on Judge Beverly Martin's nomination to the Eleventh Circuit Court of Appeals on January 20. As I have said many times before, Republicans have been ready and willing to proceed to a roll call vote on this nomination for months. I do not know the majority leader's reasons for not calling up the nomination sooner. Indeed, I do not claim to know the majority leader's reasons for not calling up a number of nominations. Perhaps in some cases it is because my Democrat colleagues do not want to have a debate on the merits and expose to the American people just what types of individuals the President has nominated to serve on the Federal bench and in crucial positions at the Justice Department. Or perhaps, and I sincerely hope that this is not the case, Democrats have been purposefully delaying nominees in order to create the illusion that Republicans are obstructing.

It bears mention that the average time from nomination to confirmation for nominees to the Circuit Courts of Appeal under President Bush was 350 days. And that was just the average. The majority of President Bush's first nominees to the circuit courts waited years for confirmation votes and some of them never even received a hearing, despite being highly qualified, outstanding nominees.

It has been suggested by some that roll call votes should not be required for judicial nominees, as if this is something that has never been done before. In fact, rollcall votes and time agreements for noncontroversial judicial nominees became routine in 2001, at the insistence of Chairman LEAHY and former Majority Leader Daschle. During the Bush administration, of the 327 article III judges confirmed by the Senate, 59 percent were by rollcall vote. The vast majority of those—86 percent—were consensus, noncontroversial nominees who were unanimously approved. In short, in 2001 the Democrats adopted a new standard: a presumption that all lifetime appointments receive a formal recorded

vote. There is no reason that presumption should change now simply because a Democrat is in the White House. Notwithstanding that new standard, I would be remiss if I did not point out that four of the last five judicial nominees that we have confirmed have been confirmed without rollcall votes.

Over the past month, the Senate has been consumed in a debate on a healthcare bill that would create an enormous entitlement program, the likes of which we have never before seen in this country. Tomorrow morning, the Senate will proceed to a vote on this monumental piece of legislation. It can hardly be said that it has been "business as usual" in the Senate. While Senators have been focused on health care, as they should be, Democrats have seen fit to slip through lifetime appointments to the Federal judiciary. Just last week, Chairman LEAHY scheduled a hearing for two Fourth Circuit nominees in the middle of this historic debate. Both Judge Diaz and Judge Wynn were nominated by the President on November 4, 2009. This is a quick turnaround for any circuit court nominee, and it is especially quick for a nominee to the Fourth Circuit. During the 110th Congress, despite the 33 percent vacancy rate and overwhelming need for judges, four nominees to that court were needlessly delayed: Mr. Steve Matthews, Judge Robert Conrad, Judge Glen Conrad, and Mr. Rod Rosenstein.

President Bush nominated Steve Matthews on September 6, 2007, to the same seat on the Fourth Circuit for which Judge Diaz has been nominated. Mr. Matthews had the support of his home state senators and received an ABA rating of Substantial Majority Qualified. He was a graduate of Yale Law School and had a distinguished career in private practice in South Carolina. Despite his exemplary qualifications, Mr. Matthews waited 485 days for a hearing that never came. His nomination was returned on January 2, 2009.

Another of President Bush's nominees, Chief Judge Robert Conrad, was nominated to the seat for which Judge Wynn is now nominated. He had the support of his home state senators and received an ABA rating of Unanimous Well-Qualified. Further, Judge Conrad met Chairman LEAHY's standard for a noncontroversial, consensus nominee because he previously received bipartisan approval by the Judiciary Committee and the Senate when he was confirmed by voice vote to be a U.S. Attorney in North Carolina and later to the District Court for the Western District of North Carolina. On October 2, 2007, Senators BURR and Dole sent a letter to Senator LEAHY requesting a hearing for Judge Conrad, and they spoke on his behalf at a press conference on June 19 that featured a number of Judge Conrad's friends and colleagues who had traveled all the

way from North Carolina to show their support for his nomination. That request was ignored. On April 15, 2008, Senators BURR, Dole, GRAHAM, and DEMINT sent a letter to Senator LEAHY asking for a hearing for Judge Conrad and Mr. Matthews. Despite overwhelming support and exceptional qualifications, Judge Conrad, who was nominated on July 17, 2007, waited 585 days for a hearing that never came. His nomination was returned on January 2, 2009.

Judge Glen Conrad also had the support of his home State Senators—including Democrat Senator JIM WEBB—and received an ABA rating of Majority Well-Qualified. He too met Chairman LEAHY's standard because he was confirmed to the District Court for the Western District of Virginia by a unanimous, bipartisan vote of 89-0 in September 2003. Despite his extensive qualifications, Judge Conrad, who was nominated on May 8, 2008, waited 240 days for a hearing that never came. His nomination was returned on January 2, 2009.

Earlier this year, we confirmed Judge Andre Davis to the "Maryland" seat on the Fourth Circuit. A brief history of that seat bears mention. President Bush nominated Rod Rosenstein to fill this vacancy on November 15, 2007. The ABA rated Mr. Rosenstein Unanimous Well Qualified, and in 2005, he was confirmed by a noncontroversial voice vote to be the United States attorney for the District of Maryland. Prior to his service as U.S. attorney, he held several positions in the Department of Justice under both Republican and Democrat administrations. Despite his stellar qualifications, Mr. Rosenstein waited 414 days for a hearing that never came. His nomination was returned on January 2, 2009. The reason given by his home state senators for why his nomination was blocked was that he was "doing a good job as the U.S. attorney in Maryland and that's where we need him." I think that a 2008 Washington Post editorial painted a more accurate picture: "blocking Mr. Rosenstein's confirmation hearing . . . would elevate ideology and ego above substance and merit, and it would unfairly penalize a man who people on both sides of this question agree is well qualified for a judgeship."

It was only when President Obama nominated Judge Davis to this seat that we heard Democrats' outrage over the fact that the seat had been vacant for 9 years. Ironically, however, Judge Davis fared far better than President Bush's nominees to the Fourth Circuit. He received a hearing a mere 27 days after his nomination, a committee vote just 36 days later, and, finally, confirmation earlier this year. There are other examples of Democrats' unreasonable delay and obstruction but I will not detail them here. Suffice it to

say that Democrats are now capitalizing on their eight years of obstruction by seeking to pack the Fourth Circuit Court of Appeals.

It has been said that the overall federal judiciary vacancy rate is higher than it was when President Bush was in office and therefore we need to confirm more judicial nominees. But, as the story of the Fourth Circuit obstructionism illustrates, that is a specious argument. During the Bush administration, Democrats held up qualified judicial nominees—for years in some cases—denying them an up-or-down vote even though the majority of Senators were ready and willing to confirm them. And, in any event, the need to fill vacancies should not undercut the responsibility of the Senate to properly vet these lifetime appointments. As the minority party, we have a duty and a right to ask the important questions that may not be asked by those who agree with the President's point of view.

In that regard, we can only process nominees that we have before us. President Obama has nominated only 12 circuit court nominees, all of whom have had hearings; there are currently 20 circuit court vacancies. Similarly, President Obama has nominated only 19 district court nominees, all but 6 of whom have had hearings; there are currently 78 district court vacancies. These numbers stand in stark contrast to the 65 nominees President Bush put forth during his first year in office.

I have said many times that I do not wish to engage in a back and forth on this issue but I will not stand by while some in this body attempt to rewrite history in their favor. Facts are stubborn things and despite the statements by some to the contrary, they cannot alter the state of the facts and the evidence.

NOMINATION HOLDS

Mr. GRASSLEY. Mr. President, I, Senator CHUCK GRASSLEY, intend to object to proceeding to the nominations of Lael Brainard to be Under Secretary of the Treasury, Michael Mundaca to be an Assistant Secretary of the Treasury, Mary Miller to be an Assistant Secretary of the Treasury, and Charles Collins to be an Assistant Secretary of the Treasury.

My support for the final confirmation of these nominees will rest on the response to concerns I have with respect to Internal Revenue Code section 6707A. A letter outlining these concerns was sent to both Secretary Geithner and Commissioner Shulman on December 22, 2009, and I ask unanimous consent that my letter be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC, December 22, 2009.

Hon. TIMOTHY F. GEITHNER, Secretary,
U.S. Department of Treasury, Pennsylvania Avenue, NW, Washington, DC.

Hon. DOUGLAS SHULMAN, Commissioner,
Internal Revenue Service, Constitution Avenue, NW, Washington, DC.

DEAR SECRETARY GEITHNER AND COMMISSIONER SHULMAN: I am writing to express my disappointment with actions taken by both the Department of the Treasury (Treasury) and the Internal Revenue Service (IRS) with respect to Internal Revenue Code (IRC) sections 382 and 6707A.

On November 18, 2008, I wrote to then Secretary Paulson regarding Notice 2008-83, which changed the rules governing the deductibility of losses under IRC section 382(h). The facts and circumstances surrounding the issuance of that Notice raised concerns about the independence and merits of the decision.

Treasury's most recent guidance on this same issue, Notice 2010-2, raises the same concerns. Accordingly, I request that you provide the Finance Committee with all records relating to communications pertaining to the issuance of Notice 2010-2 between Treasury officials, Citigroup, Inc., or other Troubled Asset Relief Program (TARP) participants and/or their representatives. Please also provide a timeline for, and documentation of, Treasury and IRS discussions and approvals for Notice 2010-2 as well as any discussions about the impact this notice would have on the tax gap. In cooperating with the Committee's review, no documents, records, data, or other information related to these matters, either directly or indirectly, shall be destroyed, modified, removed, or otherwise made inaccessible to the Committee.

I understand that Treasury believes that Notice 2010-2 was justified, in part, because it would help protect the government's interest in Citigroup, Inc. Yet, it appears that Notice 2010-2 may generate billions of dollars of tax savings for Citigroup, Inc. Please provide documentation of any discussions of impact on the tax gap resulting from Notice 2010-2.

The quick and immediate relief provided to Citigroup, Inc. stands in stark contrast to Treasury and IRS's position on providing relief to small business owners who have been assessed penalties under IRC section 6707A. As you know, Chairman Baucus and I have been working throughout this year with our counterparts in the House of Representatives to provide relief that can only be accomplished through legislation and we expect that legislation to be enacted very soon. As a supporter of closing the tax gap, I very much appreciate the IRS's difficult position with respect to protecting the government's interest in collecting taxes and penalties due and appreciate the IRS's moratorium on collection enforcement activity.

However, according to Commissioner Shulman's letter to Chairman Baucus dated July 17, 2009, 72% of section 6707A penalty assessments were imposed on small businesses and small business owners. The penalty is clearly being assessed disproportionately on small businesses compared to larger taxpayers. In addition, the placement of liens on these taxpayers, even though they are not yet being enforced, is a significant threat to their operations. Many small businesses use business assets or mortgage personal residences to secure lines of credit for the businesses. Imposing liens has significant negative implications for a small business that has limited access to capital.

I discussed this issue with Commissioner Shulman last month. I understand my staff has also discussed this again with IRS staff since then but that the IRS insists that placement of liens is necessary to protect the government's interest. I am troubled and frustrated by this position. It is inconsistent with the administration's publicly expressed concern about the difficulties facing small businesses in accessing capital.

I am also concerned that there is a disconnect between what Treasury and IRS staff in Washington, DC think is happening and what is actually happening in the field. For example, when my staff discussed with your staff the issue of IRC section 6723 being used to justify the placement of liens, your staff denied this was happening. Yet, after providing the name of a specific taxpayer who was subject to such a lien, my staff was informed that there may be a systemic issue in either the Automated Lien System or the Integrated Collection System.

My staff has also informed me that some of the assessments and liens are the result of Treasury and IRS regulations and procedures, such as the decision to disallow disclosures on amended returns and the decision to pursue 6707A assessments while other examination issues remain unresolved. Until Treasury regulations and IRS procedures can be revised to clear up the confusion, I request that IRS remove all liens on small businesses resulting from 6707A assessments unless there is a known risk that the taxpayer will evade payment of the penalties. Since the pending legislation will significantly reduce the 6707A assessment amount, liens may no longer be necessary.

As a supporter of closing the tax gap, I very much appreciate the IRS's difficult position with respect to protecting the government's interest in collecting taxes and penalties. If the IRS believes that removal of a lien would result in the IRS being unable to collect the penalty amount as revised by the pending legislation, please provide a description of these situations. However, I ask you to consider using your discretion as was done for big financial corporate TARP participants who will benefit from Notice 2010-2.

I appreciate your prompt attention to this matter. Please contact my staff with any questions or concerns.

Sincerely,

CHUCK GRASSLEY,
Ranking Member.

Mr. GRASSLEY. Mr. President, I want to explain my position on the nomination of Lael Brainard to be Under Secretary of the Treasury for International Affairs. I voted against Dr. Brainard in the Finance Committee, and I want the record to show that I am opposed to her nomination in the full Senate.

Dr. Brainard was nominated on March 23 of this year, and the Finance Committee's routine vetting began shortly after that. For the past 9 months Dr. Brainard has given evasive, incomplete, and inconsistent answers to questions asked by the Committee minority and majority. I have said this before, but every nominee who passes through the Finance Committee has been treated the same for the nearly 9 years I have been either chairman or ranking member. Dr. Brainard was treated in a manner consistent with how past nominees have been treated,

but she did not respond in a consistent manner. On November 18, the Finance Committee released a memo covering three basic issues that arose during the vetting of Dr. Brainard. The nominee had a chance to review and make comments on this memo before it was released.

The first issue covered in the memo involves responses to questions on the Finance Committee questionnaire pertaining to previous late payments of taxes and whether or not the nominee is current on taxes owed. The nominee had to submit four separate responses to one question as the committee came to gradually discover that Rappahannock County, VA, property taxes had been paid late in 2005, 2006, 2007, and 2008. The issue is not that someone forgot to pay their property taxes on time; the issue here is the difficulty the Finance Committee had in getting complete, accurate, and correct answers out of Dr. Brainard. Committee staff spent most of 2009 attempting to get straight answers from Dr. Brainard, and the whole time this was going on the nominee had not paid her 2008 property taxes. The nominee finally disclosed the late payment of the 2008 property taxes on October 12, 2009, though the taxes had actually been paid in September. Answers on this specific issue from the nominee reflect a troubling aspect that is characteristic of many of Dr. Brainard's answers. Though Dr. Brainard owns the Rappahannock County property with her husband, she has consistently avoided taking any responsibility for the payment of taxes owed.

As I said before, the issue is not that someone forgot to pay county property taxes on time. Though a chronic inability to pay taxes timely is a serious concern, the real problem here is the inability of the nominee to be straight with myself, our staff, and the committee as a whole.

The second issue discussed in the November 18 memo involves the completion of several forms I-9, employment eligibility verification, which is required to document that a new employee is authorized to work in the United States. The nominee will tell you that all of her employees are eligible to work in the United States, and I do not dispute that. As before the issue here is the inability of the nominee to respond in a straightforward manner to questions. Additionally, the number of forms I-9 produced by the nominee with significant irregularities was very unusual. The committee released six different forms I-9 with irregularities. The committee memo discusses each of these, but possibly the most problematic is one form where it appears that dates have been written over to change the year. When questioned by committee staff about these forms I-9 in a meeting with the nominee and her accountant, the accountant asked to

speak to the nominee alone, without committee staff in the room. The nominee sent a letter to myself and Chairman BAUCUS apologizing for the irregularities but offering no substantive explanation for many of them.

The third issue discussed in the Finance Committee memo involves the nominee's deduction of one-sixth of her household expenses from partnership income as an office-in-home deduction. Committee staff simply asked the nominee to show how she determined that one-sixth was the appropriate percentage, and the nominee has provided many different answers to this question. The Finance Committee memo summarizes Dr. Brainard's attempts to explain her office-in-home deduction with a variety of formulas adding up to a variety of answers. As before, the real issue here is not what percentage the nominee should have used to calculate her office-in-home deduction; the issue is the inability of the nominee to respond to what should be simple questions in a straightforward way.

As the committee memo notes, on her 2008 partnership return, the nominee reduced the size of her office-in-home deduction by half from one-sixth to one-twelfth. Dr. Brainard said that this change was made because committee staff had been asking questions regarding her earlier use of the office-in-home deduction. The nominee did not amend her partnership returns for 2005, 2006, and 2007 where an office-in-home deduction of one-sixth was taken. I am not able to say that either number is correct or incorrect because the nominee provided several contradictory answers to this question.

As I have been saying, the larger issue here is not that someone was late in paying county property taxes, or the appropriate size of an office-in-home deduction. The larger issue is the apparent unwillingness or inability of a person, nominated by the President, to answer questions asked by a standing committee of the Senate in a straightforward manner. The reason Dr. Brainard's nomination took a full 9 months to the day to be discharged by the Finance Committee is that she spent 9 months giving evasive, incomplete, and inconsistent answers to committee staff in response to what are generally routine questions.

The only thing that is perhaps even more troubling than a nominee who doesn't seem to take the vetting done by a Senate Committee seriously is the reaction we have seen by others, including some who serve in this body. Some apparently see the due diligence and vetting done on nominees as an assembly line that produces a guaranteed outcome.

We have seen what I believe to be political operatives from outside the Senate selectively leak information in a effort to target the Finance Committee's process of vetting nominees and

even the specific staffers who carry out this work. These political operatives have had a lot of work to do, as Dr. Brainard is the fifth nominee from the current administration to run into significant problems during the Finance Committee vetting process. The Finance Committee vetting process has not changed in the nearly 9 years I have been chairman or ranking member. What has changed are the specific nominees and the apparent willingness of some to tolerate and excuse issues that would have disqualified nominees from the previous administration.

Nominees in the previous administration would have had trouble garnering support if they had these sorts of problems, and I made it clear my job was not to defend a problematic nominee. Most people do not know about these problematic nominees from the past because in some cases they did not get a hearing and in others they were not nominated in the first place.

There is only one person who could tell us why the vetting process for this nominee took so long, and that person is Lael Brainard.

I have been trying to ask her questions for 9 months now without much success, so now my questions are for the critics of the Finance Committee process and those determined to see this nominee confirmed no matter what.

How long should we allow a nominee to provide incomplete and contradictory answers before we simply decide that person ought to be confirmed anyway?

Who is important enough not to be obligated to follow the same rules and obligations as all other nominees?

What high government official is so important that they ought to be exempt from the burden of routine Congressional oversight?

Is knowing the right people a substitute for simple honesty and strength of character?

As for myself, I am going to answer these questions by reiterating my opposition to the nomination.

I, Senator CHUCK GRASSLEY, do not object to proceeding to the nominations of Lael Brainard to be Under Secretary of the Treasury, Michael Mundaca to be an Assistant Secretary of the Treasury, Mary Miller to be an Assistant Secretary of the Treasury, and Charles Collins to be an Assistant Secretary of the Treasury.

ADDITIONAL STATEMENTS

TRIBUTE TO TARAS G. SZMAGALA

• Mr. VOINOVICH. Mr. President, today I wish to recognize Taras G. "Tary" Szmagala, on the occasion of his retirement from the Greater Cleveland Regional Transit Authority in Cleveland, OH. Tary has dedicated his

life to public service and has worked tirelessly to improve the quality of life for the citizens of our community. His career demonstrates a commitment to excellence and exemplary leadership, and has earned him the respect and admiration of his friends and associates.

For 23 years, Tary has served the Greater Cleveland Regional Transit Authority, during which time he has held a number of positions, including: director of governmental relations, manager of communications, deputy general manager, interim general manager, and executive director of external affairs. He has made significant contributions towards procuring Federal and State capital improvement funds for the RTA's major projects, including, but not limited to, the Euclid Corridor Project and the extension of the Waterfront Line, and the Walkway from Tower City to Gateway.

Additionally, Tary's distinguished career in public service includes serving as special assistant to U.S. Senator Robert Taft, teacher and administrator for the Parma Board of Education, and public and personnel coordinator for the Cleveland Regional Sewer District. Moreover, he has served numerous governmental leaders and organizations, and has devoted countless hours to civic organizations, including the Stella Maris Board of Directors, the National Highway Safety Advisory Committee, the Ohio Public Transit Association, St. Ignatius High School and several colleges.

Tary has worked tirelessly to provide many Americans with a tangible connection to their Ukrainian heritage by serving on the Ukrainian Museum Archives Board of Directors, the Ukrainian National Association Board of Directors and as a representative of the Ukrainian-American community in many official capacities, including as Member of Presidential Delegation to Ukraine in 1991.

It is my privilege to recognize Tary for his diligent commitment and dedicated service to the Greater Cleveland Regional Transit Authority, and to the community that he has served for over three decades.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mrs. Neiman, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations and a withdrawal which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

NOTIFICATION OF THE PRESIDENT'S INTENTION TO DESIGNATE THE REPUBLIC OF MALDIVES AS A BENEFICIARY DEVELOPING COUNTRY AND TO TERMINATE THE DESIGNATIONS OF CROATIA AND EQUATORIAL NEW GUINEA AS BENEFICIARY DEVELOPING PROGRAMS UNDER THE GENERALIZED SYSTEM OF PREFERENCES PROGRAM—PM 39

The PRESIDING OFFICER laid before the Senate the following message from the President of the United States, together with an accompanying report and papers; which was referred to the Committee on Finance:

To the Congress of the United States:

The Generalized System of Preferences (GSP) offers duty-free treatment to specified products that are imported from designated beneficiary developing countries. The GSP is authorized by title V of the Trade Act of 1974, as amended (the "Act").

In accordance with sections 502(f)(1)(A) and 502(f)(2) of the Act, I am providing notification of my intent to add the Republic of Maldives to the list of beneficiary developing countries under the GSP program and my intent to terminate the designations of Croatia and Equatorial Guinea as beneficiary developing countries under the GSP program.

In Proclamation 6813 of July 28, 1995, the designation of Maldives as a beneficiary developing country for purposes of the GSP program was suspended. After considering the criteria set forth in sections 501 and 502 of the Act, I have determined that the suspension of the designation of Maldives as a GSP beneficiary developing country should be ended.

In addition, I have determined that Croatia and Equatorial Guinea have each become a "high income" country, as defined by the official statistics of the International Bank for Reconstruction and Development. In accordance with section 502(e) of the Act, I have determined that the designations of Croatia and Equatorial Guinea as beneficiary developing countries under the GSP program should be terminated, effective January 1, 2011.

BARACK OBAMA.

THE WHITE HOUSE, December 23, 2009.

MESSAGE FROM THE HOUSE

ENROLLED BILL SIGNED

At 1:42 p.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the Speaker pro tempore (Mr. VAN HOLLEN) has signed the following enrolled bill:

H.R. 4284. An act to extend the Generalized System of Preferences and the Andean Trade Preference Act, and for other purposes.

The enrolled bill was subsequently signed by the President pro tempore (Mr. BYRD).

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 1242. An act to amend the Emergency Economic Stabilization Act of 2008 to provide for additional monitoring and accountability of the Troubled Asset Relief Program; to the Committee on Banking, Housing, and Urban Affairs.

H.R. 3639. An act to amend the Credit Card Accountability Responsibility and Disclosure Act of 2009 to establish an earlier effective date for various consumer protections, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC-4151. A communication from the Under Secretary of Defense (Comptroller), transmitting, pursuant to law, the report of a violation of the Antideficiency Act that occurred within the National Geospatial-Intelligence Agency in fiscal year 2003, and has been assigned National Geospatial-Intelligence Agency case number 08-03; to the Committee on Appropriations.

EC-4152. A communication from the Deputy Secretary, Division of Corporation Finance, Securities and Exchange Commission, transmitting, pursuant to law, the report of a rule entitled "Proxy Disclosure Enhancements" (RIN3235-AK28) received in the Office of the President of the Senate on December 17, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-4153. A communication from the Director of Environmental Policy and Compliance, Office of the Secretary, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled "Implementation of the National Environmental Policy Act (NEPA) of 1969" received in the Office of the President of the Senate on December 17, 2009; to the Committee on Environment and Public Works.

EC-4154. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "Tier II Issue: Cost Sharing Stock Based Compensation Directive No. 2" (LMSB-4-1109-040) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC-4155. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, the report of a petition to add workers from Oak Ridge Hospital in Oak Ridge, Tennessee, to the Special Exposure Cohort; to the Committee on Health, Education, Labor, and Pensions.

EC-4156. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, the report of a petition to add workers from Piqua Organic Moderated Reactor in Piqua, Ohio, to the Special Exposure Cohort; to the Committee on Health, Education, Labor, and Pensions.

EC-4157. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, the report of a petition to add workers from the Hanford site in Richland, Washington, to the Special Exposure Cohort; to the Committee on Health, Education, Labor, and Pensions.

EC-4158. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, the report of a petition to add workers from the Metals and Controls Corporation in Attleboro, Massachusetts, to the Special Exposure Cohort; to the Committee on Health, Education, Labor, and Pensions.

EC-4159. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, the report of a petition to add workers from the Brookhaven National Laboratory in Upton, New York, to the Special Exposure Cohort; to the Committee on Health, Education, Labor, and Pensions.

EC-4160. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, a report relative to the Community Services Block Act Discretionary Activities: Community Economic Development and Rural Facilities Programs; to the Committee on Health, Education, Labor, and Pensions.

EC-4161. A communication from the Director, Strategic Human Resources Policy Division, Office of Personnel Management, transmitting, pursuant to law, the report of a rule entitled "Adverse Actions" (RIN3206-AL39) received in the Office of the President of the Senate on December 17, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC-4162. A communication from the Director, Strategic Human Resources Policy Division, Office of Personnel Management, transmitting, pursuant to law, the report of a rule entitled "Training; Supervisory, Management, and Executive Development" (RIN3206-AK75) received in the Office of the President of the Senate on December 17, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC-4163. A communication from the Director, Strategic Human Resources Policy Division, Office of Personnel Management, transmitting, pursuant to law, the report of a rule entitled "Examining System" (RIN3206-AL51) received in the Office of the President of the Senate on December 17, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC-4164. A communication from the Chief of the Border Security Regulations Branch, Customs and Border Protection, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Importer Security Filing and Additional Carrier Requirements; Correction" (RIN1651-AA70) received in the Office of the President of the Senate on December 17, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC-4165. A communication from the Assistant Secretary, Bureau of Political-Military Affairs, Department of State, transmitting, pursuant to law, the Uniform Resource Locator (URL) for a report relative to the FY2009 Agency Financial Report; to the Committee on Homeland Security and Governmental Affairs.

EC-4166. A communication from the Secretary of the Department of Energy, transmitting, pursuant to law, a report entitled "Fiscal Year 2009 Agency Financial Report"; to the Committee on Homeland Security and Governmental Affairs.

EC-4167. A communication from the US-VISIT Program Director, National Protection and Programs Directorate, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "United States Visitor and Immigrant Status Indicator Technology Program ("US-

VISIT"); Enrollment of Additional Aliens in US-VISIT; Authority to Collect Biometric Data From Additional Travelers and Expansion to the 50 Most Highly Trafficked Land Border Ports of Entry" (RIN1601-AA35; RIN1600-AA00) received in the Office of the President of the Senate on December 17, 2009; to the Committee on the Judiciary.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. LIEBERMAN, from the Committee on Homeland Security and Governmental Affairs, without amendment:

S. 69. A bill to establish a fact-finding Commission to extend the study of a prior Commission to investigate and determine facts and circumstances surrounding the relocation, internment, and deportation to Axis countries of Latin Americans of Japanese descent from December 1941 through February 1948, and the impact of those actions by the United States, and to recommend appropriate remedies, and for other purposes (Rept. No. 111-112).

By Mr. DORGAN, from the Committee on Indian Affairs, with amendments:

S. 1178. A bill to extend Federal recognition to the Chickahominy Indian Tribe, the Chickahominy Indian Tribe-Eastern Division, the Upper Mattaponi Tribe, the Rappahannock Tribe, Inc., the Monacan Indian Nation, and the Nansemond Indian Tribe (Rept. No. 111-113).

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of nominations were submitted:

By Mr. BAUCUS for the Committee on Finance.

*Lael Brainard, of the District of Columbia, to be an Under Secretary of the Treasury.

*Ellen Gloninger Murray, of Virginia, to be an Assistant Secretary of Health and Human Services.

*Bryan Hayes Samuels, of Illinois, to be Commissioner on Children, Youth, and Families, Department of Health and Human Services.

*Jim R. Esquea, of New York, to be an Assistant Secretary of Health and Human Services.

*Michael W. Punke, of Montana, to be a Deputy United States Trade Representative, with the rank of Ambassador.

*Islam A. Siddiqui, of Virginia, to be Chief Agricultural Negotiator, Office of the United States Trade Representative, with the rank of Ambassador.

*Charles Collins, of Maryland, to be a Deputy Under Secretary of the Treasury.

*Mary John Miller, of Maryland, to be an Assistant Secretary of the Treasury.

*Michael F. Mundaca, of New York, to be an Assistant Secretary of the Treasury.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first

and second times by unanimous consent, and referred as indicated:

By Mrs. LINCOLN (for herself and Mr. SANDERS):

S. 2926. A bill to amend the XVIII of the Social Security Act to provide for the application of a consistent Medicare part B premium for all Medicare beneficiaries in a budget neutral manner for 2010, to provide an additional round of economic recovery payments to certain beneficiaries, and to assess the need for a consumer price index for elderly consumers to compute cost-of-living increases for certain governmental benefits; to the Committee on Finance.

By Mr. HARKIN (for himself, Mr. SANDERS, Mr. WHITEHOUSE, and Mr. BROWN):

S. 2927. A bill to amend the Internal Revenue Code of 1986 to impose a tax on certain securities transactions to fund job creation and deficit reduction, and for other purposes; to the Committee on Finance.

By Mr. GRASSLEY:

S. 2928. A bill to amend the Internal Revenue Code of 1986 to extend certain disaster tax relief provisions, and for other purposes; to the Committee on Finance.

By Mr. FEINGOLD (for himself and Mr. WHITEHOUSE):

S. 2929. A bill to prohibit secret modifications and revocations of the law, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

By Mr. SPECTER (for himself, Mr. SCHUMER, and Mr. GRAHAM):

S. 2930. A bill to deter terrorism, provide justice for victims, and for other purposes; to the Committee on the Judiciary.

ADDITIONAL COSPONSORS

S. 624

At the request of Mr. DURBIN, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 624, a bill to provide 100,000,000 people with first-time access to safe drinking water and sanitation on a sustainable basis by 2015 by improving the capacity of the United States Government to fully implement the Senator Paul Simon Water for the Poor Act of 2005.

S. 891

At the request of Mr. BROWNBACK, the name of the Senator from Ohio (Mr. BROWN) was added as a cosponsor of S. 891, a bill to require annual disclosure to the Securities and Exchange Commission of activities involving columbite-tantalite, cassiterite, and wolframite from the Democratic Republic of Congo, and for other purposes.

S. 1402

At the request of Mr. SPECTER, his name was added as a cosponsor of S. 1402, a bill to amend the Internal Revenue Code of 1986 to increase the amount allowed as a deduction for start-up expenditures.

S. 2824

At the request of Mr. KOHL, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 2824, a bill to establish a small dollar loan-loss guarantee fund, and for other purposes.

S. 2854

At the request of Mr. KOHL, the name of the Senator from Missouri (Mr. BOND) was added as a cosponsor of S. 2854, a bill to amend the Internal Revenue Code of 1986 to extend and modify the credit for new qualified hybrid motor vehicles, and for other purposes.

S. 2925

At the request of Mr. WYDEN, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of S. 2925, a bill to establish a grant program to benefit victims of sex trafficking, and for other purposes.

AMENDMENT NO. 2995

At the request of Mr. SCHUMER, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of amendment No. 2995 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3264

At the request of Mr. WYDEN, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of amendment No. 3264 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. GRASSLEY:

S. 2928. A bill to amend the Internal Revenue Code of 1986 to extend certain disaster tax relief provisions, and for other purposes; to the Committee on Finance.

Mr. GRASSLEY. Mr. President, today I have introduced a bill to extend deadlines for a number of provisions in the Heartland Disaster Tax Relief Act of 2008, as well as a number of national disaster tax relief provisions, through 2010.

The Heartland Disaster Tax Relief Act has been critical in rebuilding the lives and communities of those affected by the terrible floods and tornadoes from last year.

Because of delays in Federal funding and tighter credit conditions, many individuals, families, and businesses affected by the 2008 floods and storms will be unable to meet the deadline for the tax relief intended to help with recovery.

Louisiana is still rebuilding from Hurricane Katrina in 2005. Congress extended tax incentives for that disaster twice, and might even extend them a third time. I am just proposing a second year of the same kind of tax incentives that have been in effect for Hurricane Katrina victims for over 4 years.

This is especially important when small businesses are struggling to recover, and small businesses create 70 percent of all net new jobs.

It is only fair to extend the deadlines and give these individuals, families, and businesses the chance to recover and rebuild.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2928

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Heartland Disaster Tax Relief Extension Act of 2009".

TITLE I—HEARTLAND DISASTER AREAS

SEC. 101. CREDIT TO HOLDERS OF TAX CREDIT BONDS.

Section 702(d)(7)(C) of the Heartland Disaster Tax Relief Act of 2008 (Public Law 110-343; 122 Stat. 3918) is amended by striking "January 1, 2010" and inserting "January 1, 2011".

SEC. 102. EDUCATION TAX BENEFITS.

Section 702(d)(8) of the Heartland Disaster Tax Relief Act of 2008 (Public Law 110-343; 122 Stat. 3918) is amended by striking "or 2009" and inserting "2009, or 2010".

SEC. 103. SPECIAL RULES FOR USE OF RETIREMENT FUNDS.

Section 702(d)(10) of the Heartland Disaster Tax Relief Act of 2008 (Public Law 110-343; 122 Stat. 3918) is amended—

(1) by striking "January 1, 2010" both places it appears and inserting "January 1, 2011", and

(2) by striking "December 31, 2009" both places it appears and inserting "December 31, 2010".

SEC. 104. ADJUSTMENTS REGARDING TAXPAYER AND DEPENDENCY STATUS.

Section 702(d)(15) of the Heartland Disaster Tax Relief Act of 2008 (Public Law 110-343; 122 Stat. 3918) is amended by striking "or 2009" and inserting "2009, or 2010".

SEC. 105. EFFECTIVE DATE.

The amendments made by this title shall take effect as if included in the enactment of section 702 of the Heartland Disaster Tax Relief Act of 2008.

TITLE II—NATIONAL DISASTER AREAS

SEC. 201. LOSSES ATTRIBUTABLE TO FEDERALLY DECLARED DISASTERS.

(a) NO LIMIT FOR 2010.—Paragraph (1) of section 165(h) of the Internal Revenue Code of 1986 is amended by striking "\$500 (\$100 for taxable years beginning after December 31, 2009)" and inserting "\$100 (\$0 for taxable years beginning after December 31, 2009, and before January 1, 2011)".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.

SEC. 202. EXPENSING OF QUALIFIED DISASTER EXPENSES.

(a) IN GENERAL.—Subparagraph (A) of section 198A(b)(2) of the Internal Revenue Code of 1986 is amended by striking "January 1, 2010" and inserting "January 1, 2011".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to disasters occurring after December 31, 2009.

SEC. 203. NET OPERATING LOSSES ATTRIBUTABLE TO FEDERALLY DECLARED DISASTERS.

(a) IN GENERAL.—Subclause (I) of section 172(j)(1)(A)(i) of the Internal Revenue Code of

1986 is amended by striking "January 1, 2010" and inserting "January 1, 2011".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to disasters occurring after December 31, 2009.

SEC. 204. WAIVER OF CERTAIN MORTGAGE REVENUE BOND REQUIREMENTS.

(a) IN GENERAL.—Paragraph (11) of section 143(k) of the Internal Revenue Code of 1986 is amended by striking "January 1, 2010" and inserting "January 1, 2011".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to bonds issued after December 31, 2009.

SEC. 205. SPECIAL DEPRECIATION ALLOWANCE FOR QUALIFIED DISASTER PROPERTY.

(a) IN GENERAL.—Subclause (I) of section 168(n)(2)(A)(ii) of the Internal Revenue Code of 1986 is amended by striking "January 1, 2010" and inserting "January 1, 2011".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to disasters occurring after December 31, 2009.

By Mr. FEINGOLD (for himself and Mr. WHITEHOUSE):

S. 2929. A bill to prohibit secret modifications and revocations of the law, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

Mr. FEINGOLD. Mr. President, today Senator WHITEHOUSE and I will introduce the Executive Order Integrity Act of 2009. The bill prevents secret changes to published Executive Orders by requiring the President to place a notice in the Federal Register when he has modified or revoked a published Order. Through this simple measure, the bill takes an important step toward reversing the growth of secret law in the executive branch.

The principle behind this bill is straightforward. It is a basic tenet of democracy that the people have a right to know the law. Indeed, the notion of "secret law" has been described in court opinions and law treatises as "repugnant" and "an abomination." That's why the laws passed by Congress have historically been matters of public record.

But the law that applies in this country includes more than just statutes. It includes regulations, the controlling legal interpretations of courts and the executive branch, and certain Presidential directives. As we learned at a hearing of the Judiciary Committee's Constitution Subcommittee that I chaired last year, some of this body of executive and judicial law was increasingly kept secret from the public, and too often from Congress as well, under the Bush administration. The administration concealed Department of Justice legal opinions and interpretations of the Foreign Intelligence Surveillance Court.

The shroud of secrecy extended to Executive Orders and other Presidential directives that carry the force of law. The Federal Register Act requires the President to publish any Executive Orders that have general applicability and legal effect. But through

the diligent efforts of my colleague Senator WHITEHOUSE, we learned in late 2007 that the Department of Justice took the position that a President can “waive” or “modify” any Executive Order without any notice to the public or Congress—simply by not following it. In other words, even in cases where the President is required to make the public, the President can change the law in secret.

The Office of Legal Counsel memorandum that contains this position is still classified, but Senator WHITEHOUSE convinced the Department of Justice to declassify certain propositions in the memorandum. Among them is the proposition that “[w]henver [the President] wishes to depart from the terms of a previous executive order,” he may do so, because “an executive order cannot limit a President.” And he doesn’t have to change the executive order, or give notice that he is violating it, because by “depart[ing] from the executive order,” the President “has instead modified or waived it.”

Now, no one disputes that a President can withdraw or revise an Executive Order at any time; that is every President’s prerogative. But abrogating a published Executive Order without any public notice works a secret change in the law. Worse, because the published Order stays on the books, it actively misleads Congress and the public as to what the law is.

This is not just a hypothetical problem dreamed up by the Office of Legal Counsel. It has happened, and it could happen again. To list just one example, the Bush administration’s warrantless wiretapping program not only violated the Foreign Intelligence Surveillance Act; it was inconsistent with several provisions of Executive Order 12333, the longstanding executive order governing electronic surveillance and other intelligence activities. Apparently, the administration believed its actions constituted a tacit amendment of that Executive Order. Who knows how many other Executive Orders were secretly revoked or amended by the conduct of the administration over the past 8 years.

The bill that Senator WHITEHOUSE and I are introducing provides a simple solution to this problem. If the President revokes, modifies, waives, or suspends a published Executive Order or similar directive, notice of this change in the law must be placed in the Federal Register within 30 days. The notice must specify the Order or the provision that has been affected; whether the change is a revocation, a modification, a waiver, or a suspension; and the nature and circumstances of the change. If information about the nature and circumstances of the change is classified, it is exempt from the publication requirement, but the information still must be provided to Congress

so that we, as legislators, know how the law has been changed.

That is what our bill does; now let me talk briefly about what our bill does not do. First, it does not expand the existing legal requirements, under the Federal Register Act, that determine which Executive Orders must be published. To the extent the Federal Register Act permits a certain amount of “secret law” in the form of unpublished Executive Orders, our bill leaves that framework in place.

Second, our bill does not require public notice when the President revokes or modifies an unpublished Executive Order—even if the substance of the unpublished order is well-known to Congress and even the American people. This bill is narrowly aimed at the situation in which the American people have been given official notice of one version of the law, but a different version is being implemented.

Third, the bill does not require the President to adhere to the terms of an Executive Order. Many scholars have argued that a President must adhere to a formally promulgated Executive Order unless or until the Order is formally withdrawn or amended, just as the head of an agency must adhere to the agency’s regulations. I happen to agree. But this bill does not take issue with the Bush administration’s assertion that any deviation from the Executive Order by the President is a permissible amendment of that Order. It simply requires public notice that the amendment has occurred.

Fourth, the bill does not require the publication of classified information about intelligence sources and methods or similar information. The basic fact that the published law is no longer in effect, however, cannot be classified. On rare occasions, national security can justify elected officials keeping some information secret, but it can never justify lying to the American people about what the law is. Maintaining two different sets of laws, one public and one secret, is just that—deceiving the American people about what law applies to the Government’s conduct.

It is my hope and my expectation that the Obama administration will not continue the previous administration’s practice of purporting to amend the law in secret. But even if the administration agrees to end this practice, that will not end the need for this legislation. At last year’s Secret Law hearing, the Deputy Assistant Attorney General for OLC testified that during the Iran-Contra scandal in the 1980s, the Reagan Department of Justice took the same position: that the President could secretly modify executive orders simply by not complying with them. We can safely assume that the ability to modify the law in secret will hold as much appeal for a future administration as it did for at least

two administrations in the past. We can’t wait for this to happen in order to act, because we won’t know that it has happened—the entire point of the practice, after all, is to keep Congress and the public in the dark. The time to prevent this eventuality is now.

I commend Senator WHITEHOUSE for his tireless work to bring this issue to light, and I urge all of my colleagues in the Senate to support this modest effort to ensure the integrity of our published laws.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2929

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Executive Order Integrity Act of 2009”.

SEC. 2. REVOCATIONS, MODIFICATIONS, WAIVERS, AND SUSPENSIONS OF PRESIDENTIAL PROCLAMATIONS AND EXECUTIVE ORDERS.

Section 1505 of title 44, United States Code, is amended by adding at the end the following:

“(d) REVOCATIONS, MODIFICATIONS, WAIVERS, AND SUSPENSIONS OF PRESIDENTIAL PROCLAMATIONS AND EXECUTIVE ORDERS.—

“(1) NOTICE REQUIRED.—If the President, whether formally or informally, and whether through express order, conduct, or other means—

“(A) revokes, modifies, waives, or suspends any portion of a Presidential proclamation, Executive Order, or other Presidential directive that was published in the Federal Register; or

“(B) authorizes the revocation, modification, waiver, or suspension of any portion of such Presidential proclamation, Executive Order, or other Presidential directive; notice of such revocation, modification, waiver, or suspension shall be published in the Federal Register within 30 days after the revocation, modification, waiver, or suspension, in accordance with the terms under paragraph (2).

“(2) CONTENT OF NOTICE.—

“(A) IN GENERAL.—Except as provided under subparagraph (B), the notice required under paragraph (1) shall specify—

“(i) the Presidential proclamation, Executive Order, or other Presidential directive, and any particular portion thereof that is affected;

“(ii) for each affected directive or portion thereof, whether that directive or portion thereof was revoked, modified, waived, or suspended; and

“(iii) except where such information is classified, the specific nature and circumstances of the revocation, modification, waiver, or suspension.

“(B) REVISED EXECUTIVE ORDER.—Where the revocation, modification, waiver, or suspension of a Presidential proclamation, Executive Order, or other Presidential directive is accomplished through the publication in the Federal Register of a revised Presidential proclamation, Executive Order, or other Presidential directive that replaces or amends the one that was revoked, modified, waived, or suspended, that revised Presidential proclamation, Executive Order, or

other Presidential directive shall constitute notice for purposes of paragraph (1).

“(3) CLASSIFIED INFORMATION.—If the information specified under paragraph (2)(A)(iii) is classified, such information shall be provided to Congress, using the security procedures established under section 501(d) of the National Security Act of 1947 (50 U.S.C. 413(d)), in the form of a classified annex delivered to—

“(A) the majority and minority leader of the Senate;

“(B) the Speaker, majority leader, and minority leader of the House of Representatives;

“(C) the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives; and

“(D) if the information pertains to national security matters, the Select Committee on Intelligence of the Senate and the Permanent Select Committee on Intelligence of the House of Representatives.

“(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as either authorizing or prohibiting the revocation, modification, waiver, or suspension of any Presidential proclamation, Executive Order, or other Presidential directive that was published in the Federal Register through means other than a formal directive issued by the President and published in the Federal Register.”.

By Mr. SPECTER (for himself, Mr. SCHUMER, and Mr. GRAMHAM):

S. 2930. A bill to deter terrorism, provide justice for victims, and for other purposes; to the Committee on the Judiciary.

Mr. SPECTER. Mr. President, I have sought recognition to urge support for the legislation I have just introduced, the Justice Against Sponsors of Terrorism Act. The legislation would amend the Foreign Sovereign Immunities Act, FSIA, and the Anti-Terrorism Act, ATA, to ensure that foreign sponsors of terrorism are held accountable to their American victims in our courts. These amendments are necessary because some lower-court decisions have deprived victims of terrorism, including most recently 9/11's victims, of the legal remedies Congress intended to confer on them when it enacted the FSIA and ATA, and thereby removed a critical deterrent to the financing and sponsorship of terrorism. Congressional inaction would leave the victims of 9/11 without recourse against the sponsors of al-Qaeda and, more importantly perhaps, render the FSIA and the ATA ineffective deterrents to future terrorist attacks.

Recent news reports serve as a reminder that al-Qaeda and other foreign terrorist organizations remain dedicated to their declared goal of carrying out large-scale terrorist attacks within the U.S. In our continuous efforts to prevent such attacks, we have appropriately focused our attention on stemming the flow of money to terrorists through deterrence. As the Treasury Department's Undersecretary for Terrorism and Financial Intelligence has observed, “the terrorist operative who

is willing to strap on a suicide belt is not susceptible to deterrence, but the individual donor who wants to support violent jihad may well be.” Testimony of Stuart Levey, Under Secretary for Terrorism and Financial Intelligence, before the Senate Committee on Finance, April 1, 2008. Holding them liable for civil damages in courts may be the most effective—and, given the absence of effective criminal sanctions, often only—way to deter them from sponsoring terrorist attacks. “Suits against financiers of terrorism can,” as renowned federal judge Richard Posner recently emphasized, “cut the terrorist's lifeline.” *Boim v. Holy Land Foundation for Relief and Development*, 549 F. 3d 685 (7th Cir. 2008).

As carefully written by Congress, the FSIA abrogates the sovereign immunity of foreign countries and permits suit against them in Federal court when, among other things, a foreign country commits terrorists acts or other tortious conduct that results in injury on our soil. The ATA authorizes suit in Federal court by any U.S. national injured “by reason of an act of international terrorism” and permits the recovery of “threefold the damages he or she sustains”, that is, treble damages, as well the costs of suit and attorneys' fees. “18 U.S.C. §2333(a).

But a number of lower Federal courts have frustrated Congress's intent by erecting unfounded jurisdictional barriers to suit. No such decision is more significant in its effect than the Court of Appeals for the Second Circuit's *In re Terrorist Attacks* on September 11, 2001, 538 F. 3d 71 (2d Cir. 2009). That decision arose from litigation brought by the victims of the 9/11 attacks, including family members of the nearly 3,000 innocent people killed and commercial entities that suffered in excess of \$10 billion in damage to their property. The plaintiffs sought damages against, among other defendants, the Kingdom of Saudi Arabia, several Saudi officials, and a purported charity under the control of the Kingdom known as the Saudi High Commission for Relief of Bosnia and Herzegovina. Substantial evidence establishes that these defendants had provided funding and sponsorship to al-Qaeda without which it could not have carried out the 9/11 attacks. Even the Second Circuit acknowledged that plaintiffs had offered a “wealth of detail, conscientiously cited to published and unpublished sources,” as to the defendants' sponsorship of al-Qaeda.

None of the plaintiffs had their day in court, however, for the Second Circuit ruled that the Federal courts have no jurisdiction over the principal defendants. As for Saudi Arabia and its official state agencies, the Second Circuit held that they were not subject to suit under the FSIA's tort exception because, having not been designated by the United States as a state sponsor of

terrorism, Saudi Arabia was not covered by a separate FSIA exception for suits against designated state sponsors of terrorism. Suits arising from terrorist activities, the court concluded, can only be brought under the FSIA's exception governing designated state sponsors of terrorism. As for the Saudi princes, the Second Circuit held that the courts lacked personal jurisdiction over them because, though they “could and did foresee [that] the recipients of their donations would attack targets in the United States,” they did not themselves “direct” any terrorist attacks or “command” any “agent” to “commit them.”

Both conclusions are wrong. The former is especially troubling because it establishes an immunity from suit under the FSIA that Congress did not intend. A foreign state is subject to suit for its terrorist activities under the FSIA's tort exception without regard to whether it is subject to suit under the separate exception for designated state sponsors of terrorism—that is, without regard to whether the United States has designated it as a state sponsor of terrorism. The Second Circuit effectively read into the tort exception an exception for terrorist-related torts. Even the Solicitor General, who has adopted an unduly restrictive interpretation of the FSIA's exceptions, concluded that the Second Circuit misread the statute on this critical point.

The Second Circuit's and other lower courts' decisions on these seemingly technical jurisdictional points not only deprive the victims of terrorism the compensation to which they are entitled but also remove a powerful weapon in our arsenal against foreign terrorism. We can no longer wait for the Supreme Court to correct these errant decisions. The Court's refusal earlier this year to hear the plaintiffs' appeal of the Second Circuit's decision in *In re Terrorist Attacks*, despite the importance of the case and the conflicts among the lower courts on the key issues it presents, suggests that the Court may well never do so.

That is why I have introduced the Justice Against Sponsors of Terrorism Act. The act's main provisions would amend FSIA to make clear that, as Congress originally intended, a foreign state may be sued under the torts exception if it sponsors terrorists who commit terrorist attacks on our soil, without regard to whether it is a state-designated sponsor of terrorism, and amend the ATA to ensure that its anti-terrorism provisions, like FSIA's, are given the meaning Congress intended. I urge my colleagues to support these modest, but critical, amendments.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON FINANCE

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session of the Senate on December 23, 2009, at 2 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGES OF THE FLOOR

Mr. CRAPO. Mr. President, I ask unanimous consent that Marques Chavez be granted the privilege of the floor for the remainder of today's session.

The PRESIDING OFFICER. Without objection, it is so ordered.

NUCLEAR FORENSICS AND ATTRIBUTION ACT

Mr. CASEY. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 244, H.R. 730.

The PRESIDING OFFICER. The clerk will report the bill by title.

The bill clerk read as follows:

A bill (H.R. 730) to strengthen efforts in the Department of Homeland Security to develop nuclear forensics capabilities to permit attribution of the source of nuclear material, and for other purposes.

There being no objection, the Senate proceeded to consider the bill, which had been reported from the Committee on Homeland Security and Governmental Affairs with an amendment to strike all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Nuclear Forensics and Attribution Act".

SEC. 2. FINDINGS.

Congress finds the following:

(1) The threat of a nuclear terrorist attack on American interests, both domestic and abroad, is one of the most serious threats to the national security of the United States. In the wake of an attack, attribution of responsibility would be of utmost importance. Because of the destructive power of a nuclear weapon, there could be little forensic evidence except the radioactive material in the weapon itself.

(2) Through advanced nuclear forensics, using both existing techniques and those under development, it may be possible to identify the source and pathway of a weapon or material after it is interdicted or detonated. Though identifying intercepted smuggled material is now possible in some cases, pre-detonation forensics is a relatively undeveloped field. The post-detonation nuclear forensics field is also immature, and the challenges are compounded by the pressures and time constraints of performing forensics after a nuclear or radiological attack.

(3) A robust and well-known capability to identify the source of nuclear or radiological material intended for or used in an act of terror could also deter prospective proliferators. Furthermore, the threat of effective attribution could compel improved security at material storage facilities, preventing the unwitting transfer of nuclear or radiological materials.

(4)(A) In order to identify special nuclear material and other radioactive materials con-

fidently, it is necessary to have a robust capability to acquire samples in a timely manner, analyze and characterize samples, and compare samples against known signatures of nuclear and radiological material.

(B) Many of the radioisotopes produced in the detonation of a nuclear device have short half-lives, so the timely acquisition of samples is of the utmost importance. Over the past several decades, the ability of the United States to gather atmospheric samples—often the preferred method of sample acquisition—has diminished. This ability must be restored and modern techniques that could complement or replace existing techniques should be pursued.

(C) The discipline of pre-detonation forensics is a relatively undeveloped field. The radiation associated with a nuclear or radiological device may affect traditional forensics techniques in unknown ways. In a post-detonation scenario, radiochemistry may provide the most useful tools for analysis and characterization of samples. The number of radiochemistry programs and radiochemists in United States National Laboratories and universities has dramatically declined over the past several decades. The narrowing pipeline of qualified people into this critical field is a serious impediment to maintaining a robust and credible nuclear forensics program.

(5) Once samples have been acquired and characterized, it is necessary to compare the results against samples of known material from reactors, weapons, and enrichment facilities, and from medical, academic, commercial, and other facilities containing such materials, throughout the world. Some of these samples are available to the International Atomic Energy Agency through safeguards agreements, and some countries maintain internal sample databases. Access to samples in many countries is limited by national security concerns.

(6) In order to create a sufficient deterrent, it is necessary to have the capability to positively identify the source of nuclear or radiological material, and potential traffickers in nuclear or radiological material must be aware of that capability. International cooperation may be essential to catalogue all existing sources of nuclear or radiological material.

SEC. 3. SENSE OF CONGRESS ON INTERNATIONAL AGREEMENTS FOR FORENSICS COOPERATION.

It is the sense of the Congress that the President should—

(1) pursue bilateral and multilateral international agreements to establish, or seek to establish under the auspices of existing bilateral or multilateral agreements, an international framework for determining the source of any confiscated nuclear or radiological material or weapon, as well as the source of any detonated weapon and the nuclear or radiological material used in such a weapon;

(2) develop protocols for the data exchange and dissemination of sensitive information relating to nuclear or radiological materials and samples of controlled nuclear or radiological materials, to the extent required by the agreements entered into under paragraph (1); and

(3) develop expedited protocols for the data exchange and dissemination of sensitive information needed to publicly identify the source of a nuclear detonation.

SEC. 4. RESPONSIBILITIES OF DOMESTIC NUCLEAR DETECTION OFFICE.

(a) ADDITIONAL RESPONSIBILITIES.—Section 1902 of the Homeland Security Act of 2002 (as redesignated by Public Law 110-53; 6 U.S.C. 592) is amended—

(1) in subsection (a)—

(A) in paragraph (9), by striking "and" after the semicolon;

(B) by redesignating paragraph (10) as paragraph (14); and

(C) by inserting after paragraph (9) the following:

"(10) lead the development and implementation of the national strategic five-year plan for improving the nuclear forensic and attribution capabilities of the United States required under section 1036 of the National Defense Authorization Act for Fiscal Year 2010;

"(11) establish, within the Domestic Nuclear Detection Office, the National Technical Nuclear Forensics Center to provide centralized stewardship, planning, assessment, gap analysis, exercises, improvement, and integration for all Federal nuclear forensics and attribution activities—

"(A) to ensure an enduring national technical nuclear forensics capability to strengthen the collective response of the United States to nuclear terrorism or other nuclear attacks; and

"(B) to coordinate and implement the national strategic five-year plan referred to in paragraph (10);

"(12) establish a National Nuclear Forensics Expertise Development Program, which—

"(A) is devoted to developing and maintaining a vibrant and enduring academic pathway from undergraduate to post-doctorate study in nuclear and geochemical science specialties directly relevant to technical nuclear forensics, including radiochemistry, geochemistry, nuclear physics, nuclear engineering, materials science, and analytical chemistry;

"(B) shall—

"(i) make available for undergraduate study student scholarships, with a duration of up to 4 years per student, which shall include, if possible, at least 1 summer internship at a national laboratory or appropriate Federal agency in the field of technical nuclear forensics during the course of the student's undergraduate career;

"(ii) make available for doctoral study student fellowships, with a duration of up to 5 years per student, which shall—

"(I) include, if possible, at least 2 summer internships at a national laboratory or appropriate Federal agency in the field of technical nuclear forensics during the course of the student's graduate career; and

"(II) require each recipient to commit to serve for 2 years in a post-doctoral position in a technical nuclear forensics-related specialty at a national laboratory or appropriate Federal agency after graduation;

"(iii) make available to faculty awards, with a duration of 3 to 5 years each, to ensure faculty and their graduate students have a sustained funding stream; and

"(iv) place a particular emphasis on reinvigorating technical nuclear forensics programs while encouraging the participation of undergraduate students, graduate students, and university faculty from historically Black colleges and universities, Hispanic-serving institutions, Tribal Colleges and Universities, Asian American and Native American Pacific Islander-serving institutions, Alaska Native-serving institutions, and Hawaiian Native-serving institutions; and

"(C) shall—

"(i) provide for the selection of individuals to receive scholarships or fellowships under this section through a competitive process primarily on the basis of academic merit and the nuclear forensics and attribution needs of the United States Government;

"(ii) provide for the setting aside of up to 10 percent of the scholarships or fellowships awarded under this section for individuals who are Federal employees to enhance the education of such employees in areas of critical nuclear forensics and attribution needs of the United States Government, for doctoral education under the scholarship on a full-time or part-time basis;

“(iii) provide that the Secretary may enter into a contractual agreement with an institution of higher education under which the amounts provided for a scholarship under this section for tuition, fees, and other authorized expenses are paid directly to the institution with respect to which such scholarship is awarded;

“(iv) require scholarship recipients to maintain satisfactory academic progress; and

“(v) require that—

“(I) a scholarship recipient who fails to maintain a high level of academic standing, as defined by the Secretary, who is dismissed for disciplinary reasons from the educational institution such recipient is attending, or who voluntarily terminates academic training before graduation from the educational program for which the scholarship was awarded shall be liable to the United States for repayment within 1 year after the date of such default of all scholarship funds paid to such recipient and to the institution of higher education on the behalf of such recipient, provided that the repayment period may be extended by the Secretary if the Secretary determines it necessary, as established by regulation; and

“(II) a scholarship recipient who, for any reason except death or disability, fails to begin or complete the post-doctoral service requirements in a technical nuclear forensics-related specialty at a national laboratory or appropriate Federal agency after completion of academic training shall be liable to the United States for an amount equal to—

“(aa) the total amount of the scholarship received by such recipient under this section; and

“(bb) the interest on such amounts which would be payable if at the time the scholarship was received such scholarship was a loan bearing interest at the maximum legally prevailing rate;

“(13) provide an annual report to Congress on the activities carried out under paragraphs (10), (11), and (12); and”;

(2) by adding at the end the following new subsection:

“(b) DEFINITIONS.—In this section:

“(1) ALASKA NATIVE-SERVING INSTITUTION.—The term ‘Alaska Native-serving institution’ has the meaning given the term in section 317 of the Higher Education Act of 1965 (20 U.S.C. 1059d).

“(2) ASIAN AMERICAN AND NATIVE AMERICAN PACIFIC ISLANDER-SERVING INSTITUTION.—The term ‘Asian American and Native American Pacific Islander-serving institution’ has the meaning given the term in section 320 of the Higher Education Act of 1965 (20 U.S.C. 1059g).

“(3) HAWAIIAN NATIVE-SERVING INSTITUTION.—The term ‘Hawaiian native-serving institution’ has the meaning given the term in section 317 of the Higher Education Act of 1965 (20 U.S.C. 1059d).

“(4) HISPANIC-SERVING INSTITUTION.—The term ‘Hispanic-serving institution’ has the meaning given that term in section 502 of the Higher Education Act of 1965 (20 U.S.C. 1101a).

“(5) HISTORICALLY BLACK COLLEGE OR UNIVERSITY.—The term ‘historically Black college or university’ has the meaning given the term ‘part B institution’ in section 322(2) of the Higher Education Act of 1965 (20 U.S.C. 1061(2)).

“(6) TRIBAL COLLEGE OR UNIVERSITY.—The term ‘Tribal College or University’ has the meaning given that term in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1059c(b)).”.

(b) JOINT INTERAGENCY ANNUAL REPORTING REQUIREMENT TO CONGRESS AND THE PRESIDENT.—

(1) IN GENERAL.—Section 1907(a)(1) of the Homeland Security Act of 2002 (6 U.S.C. 596a(a)(1)) is amended—

(A) in subparagraph (A)(ii), by striking “; and” and inserting a semicolon;

(B) in subparagraph (B)(iii), by striking the period at the end and inserting “; and”; and

(C) by adding at the end the following new subparagraph:

“(C) the Director of the Domestic Nuclear Detection Office and each of the relevant departments that are partners in the National Technical Forensics Center—

“(i) include, as part of the assessments, evaluations, and reviews required under this paragraph, each office’s or department’s activities and investments in support of nuclear forensics and attribution activities and specific goals and objectives accomplished during the previous year pursuant to the national strategic five-year plan for improving the nuclear forensic and attribution capabilities of the United States required under section 1036 of the National Defense Authorization Act for Fiscal Year 2010;

“(ii) attaches, as an appendix to the Joint Interagency Annual Review, the most current version of such strategy and plan; and

“(iii) includes a description of new or amended bilateral and multilateral agreements and efforts in support of nuclear forensics and attribution activities accomplished during the previous year.”.

Mr. CASEY. I ask unanimous consent that the committee substitute amendment be agreed to, the bill, as amended, be read a third time and passed, the motions to reconsider be laid upon the table, with no intervening action or debate, and any statements be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The committee amendment in the nature of a substitute was agreed to.

The amendment was ordered to be engrossed and the bill to be read a third time.

The bill (H.R. 730), as amended, was read the third time and passed.

EXTENDING THE COMMERCIAL SPACE TRANSPORTATION LIABILITY REGIME

Mr. CASEY. Mr. President, I ask unanimous consent that the Senate proceed to the consideration of Calendar No. 249, H.R. 3819, an act to extend the commercial space transportation liability regime.

The PRESIDING OFFICER. The clerk will report the bill by title.

The bill clerk read as follows:

A bill (H.R. 3819) to extend the commercial space transportation liability regime.

There being no objection, the Senate proceeded to consider the bill.

Mr. CASEY. Mr. President, I ask unanimous consent that the bill be read a third time, passed, and the motion to reconsider be laid upon the table and any statements be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 3819) was ordered to be read a third time, was read the third time, and passed.

DISCHARGE AND REFERRAL—EXECUTIVE NOMINATION

Mr. CASEY. Mr. President, as in executive session, I ask unanimous con-

sent that the Committee on Environment and Public Works be discharged from further consideration of the following nomination and that the nomination be referred to the Committee on Commerce, Science, and Transportation:

Timothy McGee, of Louisiana, to be an Assistant Secretary of Commerce.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDERS FOR THURSDAY, DECEMBER 24, 2009

Mr. CASEY. I ask unanimous consent that when the Senate completes its business today, it adjourn until 6:45 a.m., Thursday, December 24; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 3590, with the time until 7 a.m. equally divided and controlled between the two leaders or their designees, and the Senate proceed to vote on passage of the bill at 7 a.m., as provided for under the previous order.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. CASEY. Mr. President, there will be two rollcall votes beginning at 7 a.m. tomorrow. The first vote will be on passage of H.R. 3590. The second vote will be on passage of H.R. 4314. Senators are encouraged to be in the Chamber at the beginning of the first vote and to vote from their desks.

ADJOURNMENT UNTIL 6:45 A.M. TOMORROW

Mr. CASEY. If there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the previous order.

There being no objection, the Senate, at 8:15 p.m., adjourned until Thursday, December 24, 2009, at 6:45 a.m.

NOMINATIONS

Executive nominations received by the Senate:

STATE JUSTICE INSTITUTE

DANIEL J. BECKER, OF UTAH, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE STATE JUSTICE INSTITUTE FOR A TERM EXPIRING SEPTEMBER 17, 2010, VICE ROBERT NELSON BALDWIN, TERM EXPIRED.

JAMES R. HANNAH, OF ARKANSAS, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE STATE JUSTICE INSTITUTE FOR A TERM EXPIRING SEPTEMBER 17, 2010, VICE JOSEPH FRANCIS BACA, TERM EXPIRED.

GAYLE A. NACHTIGAL, OF OREGON, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE STATE JUSTICE INSTITUTE FOR A TERM EXPIRING SEPTEMBER 17, 2012, VICE SOPHIA H. HALL, TERM EXPIRED.

JOHN B. NALBANDIAN, OF KENTUCKY, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE STATE JUSTICE INSTITUTE FOR A TERM EXPIRING SEPTEMBER 17, 2010, VICE KEITH MCNAMARA, TERM EXPIRED.

DEPARTMENT OF JUSTICE

ANDRE BIROTTE, JR., OF CALIFORNIA, TO BE UNITED STATES ATTORNEY FOR THE CENTRAL DISTRICT OF

CALIFORNIA FOR THE TERM OF FOUR YEARS, VICE THOMAS P. O'BRIEN.

DAVID A. CAPP, OF INDIANA, TO BE UNITED STATES ATTORNEY FOR THE NORTHERN DISTRICT OF INDIANA FOR THE TERM OF FOUR YEARS, VICE JOSEPH S. VAN BOKKELEN, RESIGNED.

RICHARD S. HARTUNIAN, OF NEW YORK, TO BE UNITED STATES ATTORNEY FOR THE NORTHERN DISTRICT OF NEW YORK FOR THE TERM OF FOUR YEARS, VICE GLENN T. SUDDABY, RESIGNED.

WILLIAM JOSEPH HOCHUL, JR., OF NEW YORK, TO BE UNITED STATES ATTORNEY FOR THE WESTERN DISTRICT OF NEW YORK FOR THE TERM OF FOUR YEARS, VICE TERRANCE P. FLYNN, RESIGNED.

RONALD C. MACHEN, JR., OF THE DISTRICT OF COLUMBIA, TO BE UNITED STATES ATTORNEY FOR THE DISTRICT OF COLUMBIA FOR THE TERM OF FOUR YEARS, VICE KENNETH L. WAINSTEIN, RESIGNED.

ANNE M. TOMPKINS, OF NORTH CAROLINA, TO BE UNITED STATES ATTORNEY FOR THE WESTERN DISTRICT OF NORTH CAROLINA FOR THE TERM OF FOUR YEARS, VICE GRETCHEN C.F. SHAPPERT, RESIGNED.

SALLY QUILLIAN YATES, OF GEORGIA, TO BE UNITED STATES ATTORNEY FOR THE NORTHERN DISTRICT OF GEORGIA FOR THE TERM OF FOUR YEARS, VICE DAVID E. NAHMIA, RESIGNED.

NOEL CULVER MARCH, OF MAINE, TO BE UNITED STATES MARSHAL FOR THE DISTRICT OF MAINE FOR THE TERM OF FOUR YEARS, VICE DAVID DONALD VILES.

GEORGE WHITE, OF MISSISSIPPI, TO BE UNITED STATES MARSHAL FOR THE SOUTHERN DISTRICT OF MISSISSIPPI FOR THE TERM OF FOUR YEARS, VICE NEHEMIAH FLOWERS.

BEATRICE A. HANSON, OF NEW YORK, TO BE DIRECTOR OF THE OFFICE FOR VICTIMS OF CRIME, VICE JOHN W. GILLIS.

DISCHARGED NOMINATION

The Senate Committee on Environment and Public Works was discharged from further consideration of the following nomination by unanimous consent to be re-referred to the Committee on Commerce, Science, and Transportation and the nomination was referred to the Committee on Commerce,

Science, and Transportation by unanimous consent under authority of the order of the Senate of 12/23/2009:

TIMOTHY MCGEE, OF LOUISIANA, TO BE AN ASSISTANT SECRETARY OF COMMERCE.

WITHDRAWAL

Executive Message transmitted by the President to the Senate on December 23, 2009 withdrawing from further Senate consideration the following nomination:

SUEDEEN G. KELLY, OF NEW MEXICO, TO BE A MEMBER OF THE FEDERAL ENERGY REGULATORY COMMISSION FOR THE TERM EXPIRING JUNE 30, 2014, (REAPPOINTMENT), WHICH WAS SENT TO THE SENATE ON JULY 28, 2009.

EXTENSIONS OF REMARKS

HONORING THE LIFE OF JIM CLARKE

HON. FRANK R. WOLF

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 23, 2009

Mr. WOLF. Madam Speaker, I rise to share with our colleagues today the recent passing of Jim Clarke. He died on December 21, 2009 at his home in Annandale, Virginia, at the age of 75.

In 1962 Jim joined WMAL, the predecessor of WJLA (ABC Channel 7), where he served as a dedicated television journalist for more than 40 years. Jim did an outstanding job for Channel 7 and served our region well before retiring just a few years ago. Jim was a man of integrity and will be sorely missed by all who had the pleasure of knowing him. My thoughts and prayers go out to his wife, Lizbe, and the rest of his family during these difficult times.

I would like to share an obituary for Jim that ran in the Washington Post on December 22.

[From the Washington Post, Dec. 22, 2009]

JIM CLARKE, EMMY-WINNING WJLA ANCHOR AND REPORTER, DIES

(By T. Rees Shapiro)

Jim Clarke, 75, an Emmy Award-winning television journalist for more than 40 years at what became WJLA (Channel 7), died Dec. 21 at his home in Annandale. Mr. Clarke had a heart attack in his sleep after shoveling snow for most of the day before.

In 1962, Mr. Clarke joined WMAL, the predecessor to WJLA, as an evening news anchor and reporter. During his career at the ABC News affiliate, his work included covering the race riots after the assassination of the Rev. Martin Luther King, Jr., the trial of the failed presidential assassin John Hinckley, Jr., and the Iran-Contra hearings.

Mr. Clarke focused many of his investigations on consumer advocacy stories and government corruption. He won numerous awards for his work, including nine local Emmy Awards, the Ted Yates award for courageous journalism and the National Headliner Award for an investigative report on abuses at St. Elizabeths Hospital, where several psychiatric patients died from neglect.

Mr. Clarke was in Norway when the news broke in 1998 about the sex scandal surrounding President Bill Clinton and former White House intern Monica Lewinsky, and he caught the first flight back to begin his coverage. To get a head start during the plane ride home, he wrote his script for the next newscast on the back of an airsickness bag.

James Davis Clarke, a native of Auxier, Ky., was a 1956 communication arts graduate of Fordham University in New York. One of his earliest jobs in the news business was as a copyboy for NBC newscaster John Cameron Swayze.

Mr. Clarke's big break came in the early 1960s as a radio reporter for WGH radio in Newport News, Va. He secured a taped inter-

view at the home of Francis Gary Powers, the U-2 spy plane pilot who had been shot down over Russia. The report made news across the country as a rare first-person account of the crash and eventually reached the ears of the WMAL newsman Ed Meyer, who recruited Mr. Clarke to join the ABC affiliate in Washington.

Mr. Clarke retired from WJLA in 2003 as a national affairs reporter.

Survivors include his wife of 48 years, Lizbe Schuster Clarke of Annandale; four children, Christopher Clarke of Washington, Kimberly Allen of Albuquerque, Katie Adamson of Arlington County and Suzanne Sprague of Portland, Ore.; and eight grandchildren.

Among colleagues, Mr. Clarke was known to be intrepid. One evening during the 1970s, Mr. Clarke had been out late in Virginia covering a story that was in danger of not making the 6 o'clock evening news.

According to his co-worker John Corcoran, rather than not make the broadcast, Mr. Clarke hopped a ride on the station's helicopter and ordered an assignment editor and intern to pick up an emergency blanket and meet him on the roof of the station. The problem was, there was no helicopter landing pad.

Leaning outside the hovering helicopter, Mr. Clarke dropped the tape from his report into the outstretched blanket below, and the segment made it into the editing bays for that evening's news.

INTRODUCING DECABROMINE ELIMINATION AND CONTROL ACT

HON. CHELLIE PINGREE

OF MAINE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 23, 2009

Ms. PINGREE of Maine. Madam Speaker, I am very proud to introduce the Decabromine Elimination and Control Act today.

Since 2005 there have been 44 state-based initiatives to ban brominated flame retardants (PBDEs), but only four have been signed into law, including one in my home state of Maine. That bill was sponsored by my daughter, Maine Speaker of the House Hannah Pingree, and passed by the Maine legislature.

Today, I am honored to continue the long tradition of bringing good ideas from Maine to Washington.

PBDEs are known endocrine disruptors, interfering with the transmission and regulation of thyroid and reproductive hormones. Exposure of infants to PBDEs is of particular concern because these chemicals have produced developmental neurotoxicity in laboratory animals, impairing memory, learning and behavior. Even more worrisome is the fact that breastfeeding infants are exposed to higher concentrations of PBDEs because of the presence of these chemicals in mother's milk. The time has come to remove this chemical from our children's toys and clothing. We must take

immediate steps to ban this toxic and dangerous chemical.

This bill phases out, and ultimately bans, the last hazardous type of PBDE, Decabromine, by 2013. It mandates disclosure of products containing Decabromine to the Environmental Protection Agency and requires safer alternatives to be created to replace this toxic chemical. I have worked closely with the International Association of Fire Fighters, the Environmental Working Group, Maine Department of Environmental Protection and Environmental Health Strategy Center to develop this important piece of legislation, and I greatly appreciate the contributions of each of these groups in getting us to this critical point.

I look forward to working with my colleagues in the 111th Congress to pass this vital legislation and finally enact a long overdue ban on Decabromine.

RECOGNIZING THE MIRAMAR HIGH SCHOOL PATRIOTS

HON. ALCEE L. HASTINGS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 23, 2009

Mr. HASTINGS of Florida. Madam Speaker, I rise today to honor the Miramar High School Patriots' football team of my hometown, Miramar, Florida. On Friday, December 18, 2009, Miramar beat the DeLand Bulldogs 42-20 to become the first team from Broward County to win a 6A championship. Their 14-1 record and their convincing win in the title game are two things of which all Broward County citizens and all true football fans can be proud.

I congratulate Coach Damon Cogdell and the entire team for a job well done. I especially want to praise quarterback Ryan Williams, who passed for five touchdowns in the game, and receiver Ivan McCartney, who caught three of them. I am delighted to laud a team that has achieved great success.

The Miramar High School Patriots are fine examples of young men who have excelled at athletics and academics. By working hard and focusing on the tasks at hand, they have reached the pinnacle of their sport. They are people of whom their peers and everyone can be justifiably proud. I look forward to more championships from them in future years.

CELEBRATING THE NEVADA COUNTY ASSOCIATION OF REALTORS' 75TH ANNIVERSARY

HON. TOM McCLINTOCK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 23, 2009

Mr. McCLINTOCK. Madam Speaker, I rise to honor the Nevada County Association of

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

Realtors' 75th anniversary. For 75 years the Nevada County Association of Realtors has been dedicated to helping protect the investment Americans place in their homes.

In 1935, a group of local real estate agents established the Nevada County Association of Realtors with the goal of offering clients and their families the highest level of professional real estate service.

The Nevada County Association of Realtors seeks to maintain and enhance programs, products and volunteer participation as well as develop new services and relationships to meet the demands of its members, clients and the community. The Association promotes the preservation of real property rights and is a tremendous asset to its community.

Madam Speaker, I would like to thank the Nevada County Association of Realtors and also ask my colleagues to join me in recognizing its 75 years of continued service to its community as well as the State of California.

SENATE COMMITTEE MEETINGS

Title IV of Senate Resolution 4, agreed to by the Senate on February 4, 1977, calls for establishment of a system for a computerized schedule of all meetings and hearings of Senate committees, subcommittees, joint committees, and committees of conference. This title requires all such committees

to notify the Office of the Senate Daily Digest—designated by the Rules Committee—of the time, place, and purpose of the meetings, when scheduled, and any cancellations or changes in the meetings as they occur.

As an additional procedure along with the computerization of this information, the Office of the Senate Daily Digest will prepare this information for printing in the Extensions of Remarks section of the CONGRESSIONAL RECORD on Monday and Wednesday of each week.

Meetings scheduled for Thursday, December 24, 2009 may be found in the Daily Digest of today's RECORD.

SENATE—Thursday, December 24, 2009

The Senate met at 6:45 a.m. and was called to order by the Vice President.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

O Lord our Heavenly Father, source of light, truth, and goodness, on this Christmas Eve, transform this time of decision into a season of vision and inspiration. Continue to show our lawmakers Your mercy as You shed light on their thoughts and offer them Your salvation. Lord, give them strength, understanding, and humility as they seek to honor You by serving their Nation. Provide them with the power to match great needs with great deeds. Today, tune their hearts to the infinite that perplexity may be removed by Your wisdom and peace. As You protect them from vanity and pride, give them the strength to concentrate, to think objectively, and to see Your will clearly. Remind us all this is the day that You have made so we should rejoice and be glad in it. We pray in Your great Name. Amen.

RESERVATION OF LEADER TIME

The VICE PRESIDENT. Under the previous order, the leadership time is reserved.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The VICE PRESIDENT. Under the previous order, the Senate will resume consideration of H.R. 3590 which the clerk will report.

The legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

The VICE PRESIDENT. The majority leader is recognized.

Mr. REID. Mr. President, first let me take a minute to express my appreciation on behalf of the entire Senate to a number of people, not the least of which is ADM Barry Black who every morning leads this institution in prayer. His prayers are meaningful. They are beautiful. He is a brilliant man and adds so much to the Senate family.

I wish to offer my appreciation to the Parliamentarians who have been through a very intense, difficult decisionmaking time the last several months. Alan Frumin, Elizabeth MacDonough, Peter Robinson, and Leigh Hildebrand, we all appreciate you very much.

To the journal clerks led by Scott Sanborn, we appreciate your work. The legislative clerk, Kathie Alvarez, and all of her assistants; very difficult, tense times, and we appreciate what you do for us every day.

I also wish to express my appreciation to the court reporters, the doorkeepers, and the Sergeant at Arms. Chief Gainer is a good person. He does a wonderful job with the many responsibilities he has. But I do say this—and there is a lot of personal pride in this—as good as he is, he is better as a result of one of my former staffers, Drew Willison, who we all know is the Assistant Sergeant at Arms and does a remarkable job at protecting this institution.

Nancy Erickson, a wonderful person, is the Secretary of the Senate. She is someone I have great admiration and respect for. But again, with some personal pride, I suggest that one reason she has done such a good job is because of her assistant, the Assistant Secretary of the Senate, Sheila Dwyer, who again is one of my protégés.

I say with pride the tremendous, terrific, powerful work that has been done by Lula Davis, the Secretary of the Majority. There have been, as with all of us, a lot of difficult times, and she has held up remarkably well, giving me and the entire Senate the information they ask for constantly. She is assisted by Tim Mitchell. Of course, this place would not run as well without her working with the Secretary of the Minority, David Schiappa and his entire crew. They are wonderful people to work with. Even though sometimes this place becomes very partisan, the work done by Lula Davis and David Schiappa is never partisan as it appears to the American public.

Finally, Mr. President, I wish to say a word about the people who work in the cloakrooms. They are the people who are unseen but instrumental to the operation of the Senate. I say finally, but I have to say with a lot of pride, having been one of them, how much I appreciate and acknowledge the attention and the protection of the Capitol Police. They are throughout this building. Some are in uniform, some aren't. But with all of the evil in the world, they have a very difficult job and they do extremely well.

Mr. President, we are happy to see the Vice President of the United States here in his capacity as President of the U.S. Senate. For 36 years you have graced these halls with your brilliance and I think it is fair to say that we miss you very much, but we are glad you are where you are.

Mr. President, following any leader remarks, the time until we finish our remarks will be divided between my counterpart and my friend from Kentucky, the senior Senator from Kentucky, and after we complete our remarks, we will proceed to a series of two rollcall votes in relation to the following items: passage of H.R. 3590, the health care reform legislation; and passage of H.R. 4314, an act to permit continued financing of government operations.

The VICE PRESIDENT. The Republican leader is recognized.

Mr. MCCONNELL. Mr. President, I want to associate myself with the entirely appropriate remarks the majority leader has made about all of the people who work here at the Capitol at this difficult and intense time that we have been through. We thank you very much for your outstanding service.

It is early and I will be brief. The most obvious problem with the bill before us is that it doesn't do what it was supposed to do. The one test for any bill is whether it will lower costs. This bill fails that test. It is also clear that even many of the people on this side who are going to support this bill don't like it; otherwise, the Democratic leaders wouldn't have had such a tough time rounding up the votes; otherwise, Democratic leaders would not have had to have votes in the middle of the night or at the crack of dawn or over the weekend or even during a blizzard; otherwise, they wouldn't be rushing it through Congress on Christmas Eve, the first time this body has had a vote the day before Christmas in more than a century.

This debate was supposed to produce a bill that reformed health care in America. Instead, we are left with party-line votes in the middle of the night, a couple of sweetheart deals to get it over the finish line, and a truly outraged public. A problem they were told would be fixed wasn't. I guarantee you that the people who voted for this bill are going to get an earful when they finally get home for the first time since Thanksgiving. They know there is widespread opposition to this monstrosity.

I want to assure you, Mr. President, this fight isn't over. In fact, this fight is long from over. My colleagues and I will work to stop this bill from becoming law. That is the clear will of the American people and we are going to continue to fight on their behalf.

The VICE PRESIDENT. The majority leader is recognized.

Mr. REID. Mr. President, like so many endeavors that have benefited so

many Americans, making health insurance more affordable and health insurance companies more accountable is a process. It is one that has required us to find common ground, as we should. That is why we have a piece of legislation that over the next decade will reduce the deficit by \$132 billion and, over the next decade, as much as \$1.3 trillion.

Everyone knows we have had votes in the middle of the night and on Christmas Eve because the Republicans wouldn't allow us to have votes at any other hour. It is true when we go home we are going to hear an earful. I am going to hear an earful I bet from young Caleb, a boy who was born with legs that stopped here, right above his knees, who has needed a set of new prosthetic devices because the rest of his body is growing, but the insurance company says no because he had a pre-existing disability. I will get an earful from Caleb and especially his parents—an earful of joy and happiness. Because, you see, from this day forward, insurance companies will not be able to deny coverage because of a preexisting disability. For people such as Caleb and parents who have children with diabetes and other problems, it is over. So, yes, we will hear an earful, but it is going to be an earful of wonderment and happiness that people have waited for for a long time.

This morning is not the end of the process. It is merely the beginning. We will continue to build on this success to improve our health system even more and to further ease the terrible burdens on American families and businesses.

But that process cannot begin unless we start today. The American people and the American economy cannot afford for us to wait for the next time because, you see, there may not be a next time.

Nearly 65 years ago, Harry Truman condemned a system that condemns its citizens to the devastating economic side effects of sickness. Nearly 65 years later, we still suffer from the same. Just months after World War II came to a close, President Harry S. Truman wrote in a letter to Congress to this body:

We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all of its citizens deserves the help of all the Nation.

Decades have passed and these financial barriers have grown taller, but we will never solve the problem unless we find the resolve which we haven't found until today.

This is how long we have waited. Think of those who were 1 year old in 1945, the day Truman issued his call to this body for action, of those—and there are many, far too many—who have lived their entire lives without the ability to afford any type of health

care—any type of health care. Coverage got more and more expensive each year. Insurance companies found more and more excuses to leave them out in the cold. For those who worked in a small business or owned one or moved from job to job, the peace of mind health care can provide was merely a dream.

Today, on the verge of the year 2010, those Americans are finally just months away from qualifying for Medicare. That is a long time for a citizen to wait for health care in the greatest and richest Nation the world has ever known. How much longer? How much longer can we afford to put this off or ask the uninsured for their patience? Until health care costs consume not just a sixth of our economy, but a third, or a half? Until premiums consume more than half of a family's income?

We certainly don't have the luxury of waiting until America becomes the only developed Nation on Earth where you can die for lack of health insurance. We already bear that blemish. That is why we are bringing security and stability to millions who have health insurance and bringing health insurance to millions who have none.

What we will do is ensure consumers have more choices and insurance companies face more competition.

We will stand up to those greedy insurance companies that deny health care to the sick and drive millions into bankruptcy, foreclosure, and sometimes even worse.

We will add years to the life of Medicare, which will add years to the life of our seniors.

We will trade a system that demands you pay more and get less for one in which you will pay less and get more.

As we do all this, we will slash our children's deficit in dramatic fashion. We may not completely cure this crisis today or tomorrow, but we must start toward that end. We must strive for progress and not surrender for want of purity. Our charge is to move forward. This is a tradition as old as this Republic, one that has always comprised interests and opinions as diverse as the people who populate it. Our Founding Fathers did not promise to form an infallible new Nation; they promised instead to promote the general welfare as we move toward a more perfect Union. They valued progress.

Our Nation's earliest leaders promised not absolute happiness but only the pursuit of that goal. They valued opportunity. Similar to other new programs that improve the lives of many and were since strengthened to improve even more—programs such as Medicare, Medicaid, and Social Security—progress and opportunity are what this historic bill represents.

To those who so admirably care so much for their fellow man that they demand more, I say: This is just the be-

ginning. With Senator Ted Kennedy's voice booming in our ears—with his passion in our hearts—we say as he said: The work goes on, the cause endures.

Opponents of this bill have used every trick in the book to delay this day, this moment. Yet here we are, minutes away from doing what many have tried but none have ever achieved.

We are here because facts will always defeat fear. Although one might slow the progress, they can't stop it, and although one might slow the speed of progress, its force cannot be stopped.

I am sorry to say that, for the first time in American history, a political party has chosen to stand on the sidelines rather than participate in great—and greatly needed—social change.

I am sorry to see that many on the other side have resorted to myths and misinformation and continue to rely on them long after they were debunked.

It is regrettable they view our citizens' health care crisis through a political lens, because affording to live a healthy life isn't about politics or partisanship or polling.

It is about people. It is about life and death in America. It is a question of morality, of right and wrong. It is about human suffering. Given the chance to relieve this suffering, we must take this chance and deliver on a promise the American people have deserved for six and a half decades.

The VICE PRESIDENT. The question is on the engrossment of the amendment and third reading of the bill.

The amendment was ordered to be engrossed and the bill to be read the third time.

The bill was read the third time.

Mr. DURBIN. Mr. President, I ask for the yeas and nays.

The VICE PRESIDENT. Is there a sufficient second?

There is a sufficient second.

The bill having been read the third time, the question is, Shall the bill pass?

The clerk will call the roll.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted "nay."

The VICE PRESIDENT. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 60, nays 39, as follows:

[Rollcall Vote No. 396 Leg.]

YEAS—60

Akaka	Cantwell	Franken
Baucus	Cardin	Gillibrand
Bayh	Carper	Hagan
Begich	Casey	Harkin
Bennet	Conrad	Inouye
Bingaman	Dodd	Johnson
Boxer	Dorgan	Kaufman
Brown	Durbin	Kerry
Burris	Feingold	Kirk
Byrd	Feinstein	Klobuchar

Kohl	Mikulski	Shaheen
Landrieu	Murray	Specter
Lautenberg	Nelson (NE)	Stabenow
Leahy	Nelson (FL)	Tester
Levin	Pryor	Udall (CO)
Lieberman	Reed	Udall (NM)
Lincoln	Reid	Warner
McCaskill	Rockefeller	Webb
Menendez	Sanders	Whitehouse
Merkley	Schumer	Wyden

NAYS—39

Alexander	DeMint	Lugar
Barrasso	Ensign	McCain
Bennett	Enzi	McConnell
Bond	Graham	Murkowski
Brownback	Grassley	Risch
Burr	Gregg	Roberts
Chambliss	Hatch	Sessions
Coburn	Hutchison	Shelby
Cochran	Inhofe	Snowe
Collins	Isakson	Thune
Corker	Johanns	Vitter
Cornyn	Kyl	Voivovich
Crapo	LeMieux	Wicker

NOT VOTING—1

Bunning

The bill (H.R. 3590), as amended, was passed, as follows:

H.R. 3590

In the Senate of the United States, December 24, 2009.

Resolved, That the bill from the House of Representatives (H.R. 3590) entitled “An Act to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.”, do pass with the following amendments:

Strike out all after the enacting clause and insert:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Patient Protection and Affordable Care Act”.

(b) **TABLE OF CONTENTS.**—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

Sec. 1001. Amendments to the Public Health Service Act.

“PART A—INDIVIDUAL AND GROUP MARKET REFORMS**“SUBPART II—IMPROVING COVERAGE**

“Sec. 2711. No lifetime or annual limits.

“Sec. 2712. Prohibition on rescissions.

“Sec. 2713. Coverage of preventive health services.

“Sec. 2714. Extension of dependent coverage.

“Sec. 2715. Development and utilization of uniform explanation of coverage documents and standardized definitions.

“Sec. 2716. Prohibition of discrimination based on salary.

“Sec. 2717. Ensuring the quality of care.

“Sec. 2718. Bringing down the cost of health care coverage.

“Sec. 2719. Appeals process.

Sec. 1002. Health insurance consumer information.

Sec. 1003. Ensuring that consumers get value for their dollars.

Sec. 1004. Effective dates.

Subtitle B—Immediate Actions to Preserve and Expand Coverage

Sec. 1101. Immediate access to insurance for uninsured individuals with a pre-existing condition.

Sec. 1102. Reinsurance for early retirees.

Sec. 1103. Immediate information that allows consumers to identify affordable coverage options.

Sec. 1104. Administrative simplification.

Sec. 1105. Effective date.

Subtitle C—Quality Health Insurance Coverage for All Americans**PART I—HEALTH INSURANCE MARKET REFORMS**

Sec. 1201. Amendment to the Public Health Service Act.

“SUBPART I—GENERAL REFORM

“Sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status.

“Sec. 2701. Fair health insurance premiums.

“Sec. 2702. Guaranteed availability of coverage.

“Sec. 2703. Guaranteed renewability of coverage.

“Sec. 2705. Prohibiting discrimination against individual participants and beneficiaries based on health status.

“Sec. 2706. Non-discrimination in health care.

“Sec. 2707. Comprehensive health insurance coverage.

“Sec. 2708. Prohibition on excessive waiting periods.

PART II—OTHER PROVISIONS

Sec. 1251. Preservation of right to maintain existing coverage.

Sec. 1252. Rating reforms must apply uniformly to all health insurance issuers and group health plans.

Sec. 1253. Effective dates.

Subtitle D—Available Coverage Choices for All Americans**PART I—ESTABLISHMENT OF QUALIFIED HEALTH PLANS**

Sec. 1301. Qualified health plan defined.

Sec. 1302. Essential health benefits requirements.

Sec. 1303. Special rules.

Sec. 1304. Related definitions.

PART II—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

Sec. 1311. Affordable choices of health benefit plans.

Sec. 1312. Consumer choice.

Sec. 1313. Financial integrity.

PART III—STATE FLEXIBILITY RELATING TO EXCHANGES

Sec. 1321. State flexibility in operation and enforcement of Exchanges and related requirements.

Sec. 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.

Sec. 1323. Community health insurance option.

Sec. 1324. Level playing field.

PART IV—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS

Sec. 1331. State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid.

Sec. 1332. Waiver for State innovation.

Sec. 1333. Provisions relating to offering of plans in more than one State.

PART V—REINSURANCE AND RISK ADJUSTMENT

Sec. 1341. Transitional reinsurance program for individual and small group markets in each State.

Sec. 1342. Establishment of risk corridors for plans in individual and small group markets.

Sec. 1343. Risk adjustment.

Subtitle E—Affordable Coverage Choices for All Americans**PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS****SUBPART A—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS**

Sec. 1401. Refundable tax credit providing premium assistance for coverage under a qualified health plan.

Sec. 1402. Reduced cost-sharing for individuals enrolling in qualified health plans.

SUBPART B—ELIGIBILITY DETERMINATIONS

Sec. 1411. Procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost-sharing, and individual responsibility exemptions.

Sec. 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.

Sec. 1413. Streamlining of procedures for enrollment through an exchange and State Medicaid, CHIP, and health subsidy programs.

Sec. 1414. Disclosures to carry out eligibility requirements for certain programs.

Sec. 1415. Premium tax credit and cost-sharing reduction payments disregarded for Federal and Federally-assisted programs.

PART II—SMALL BUSINESS TAX CREDIT

Sec. 1421. Credit for employee health insurance expenses of small businesses.

Subtitle F—Shared Responsibility for Health Care**PART I—INDIVIDUAL RESPONSIBILITY**

Sec. 1501. Requirement to maintain minimum essential coverage.

Sec. 1502. Reporting of health insurance coverage.

PART II—EMPLOYER RESPONSIBILITIES

Sec. 1511. Automatic enrollment for employees of large employers.

Sec. 1512. Employer requirement to inform employees of coverage options.

Sec. 1513. Shared responsibility for employers.

Sec. 1514. Reporting of employer health insurance coverage.

Sec. 1515. Offering of Exchange-participating qualified health plans through cafeteria plans.

Subtitle G—Miscellaneous Provisions

Sec. 1551. Definitions.

Sec. 1552. Transparency in government.

Sec. 1553. Prohibition against discrimination on assisted suicide.

Sec. 1554. Access to therapies.

Sec. 1555. Freedom not to participate in Federal health insurance programs.

Sec. 1556. Equity for certain eligible survivors.

Sec. 1557. Nondiscrimination.

Sec. 1558. Protections for employees.

Sec. 1559. Oversight.

Sec. 1560. Rules of construction.

Sec. 1561. Health information technology enrollment standards and protocols.

Sec. 1562. Conforming amendments.

Sec. 1563. Sense of the Senate promoting fiscal responsibility.

TITLE II—ROLE OF PUBLIC PROGRAMS**Subtitle A—Improved Access to Medicaid**

Sec. 2001. Medicaid coverage for the lowest income populations.

Sec. 2002. Income eligibility for nonelderly determined using modified gross income.

Sec. 2003. Requirement to offer premium assistance for employer-sponsored insurance.

- Sec. 2004. Medicaid coverage for former foster care children.
- Sec. 2005. Payments to territories.
- Sec. 2006. Special adjustment to FMAP determination for certain States recovering from a major disaster.
- Sec. 2007. Medicaid Improvement Fund rescission.
- Subtitle B—Enhanced Support for the Children's Health Insurance Program*
- Sec. 2101. Additional federal financial participation for CHIP.
- Sec. 2102. Technical corrections.
- Subtitle C—Medicaid and CHIP Enrollment Simplification*
- Sec. 2201. Enrollment Simplification and coordination with State Health Insurance Exchanges.
- Sec. 2202. Permitting hospitals to make presumptive eligibility determinations for all Medicaid eligible populations.
- Subtitle D—Improvements to Medicaid Services*
- Sec. 2301. Coverage for freestanding birth center services.
- Sec. 2302. Concurrent care for children.
- Sec. 2303. State eligibility option for family planning services.
- Sec. 2304. Clarification of definition of medical assistance.
- Subtitle E—New Options for States to Provide Long-Term Services and Supports*
- Sec. 2401. Community First Choice Option.
- Sec. 2402. Removal of barriers to providing home and community-based services.
- Sec. 2403. Money Follows the Person Rebalancing Demonstration.
- Sec. 2404. Protection for recipients of home and community-based services against spousal impoverishment.
- Sec. 2405. Funding to expand State Aging and Disability Resource Centers.
- Sec. 2406. Sense of the Senate regarding long-term care.
- Subtitle F—Medicaid Prescription Drug Coverage*
- Sec. 2501. Prescription drug rebates.
- Sec. 2502. Elimination of exclusion of coverage of certain drugs.
- Sec. 2503. Providing adequate pharmacy reimbursement.
- Subtitle G—Medicaid Disproportionate Share Hospital (DSH) Payments*
- Sec. 2551. Disproportionate share hospital payments.
- Subtitle H—Improved Coordination for Dual Eligible Beneficiaries*
- Sec. 2601. 5-year period for demonstration projects.
- Sec. 2602. Providing Federal coverage and payment coordination for dual eligible beneficiaries.
- Subtitle I—Improving the Quality of Medicaid for Patients and Providers*
- Sec. 2701. Adult health quality measures.
- Sec. 2702. Payment Adjustment for Health Care-Acquired Conditions.
- Sec. 2703. State option to provide health homes for enrollees with chronic conditions.
- Sec. 2704. Demonstration project to evaluate integrated care around a hospitalization.
- Sec. 2705. Medicaid Global Payment System Demonstration Project.
- Sec. 2706. Pediatric Accountable Care Organization Demonstration Project.
- Sec. 2707. Medicaid emergency psychiatric demonstration project.
- Subtitle J—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)*
- Sec. 2801. MACPAC assessment of policies affecting all Medicaid beneficiaries.
- Subtitle K—Protections for American Indians and Alaska Natives*
- Sec. 2901. Special rules relating to Indians.
- Sec. 2902. Elimination of sunset for reimbursement for all Medicare part B services furnished by certain Indian hospitals and clinics.
- Subtitle L—Maternal and Child Health Services*
- Sec. 2951. Maternal, infant, and early childhood home visiting programs.
- Sec. 2952. Support, education, and research for postpartum depression.
- Sec. 2953. Personal responsibility education.
- Sec. 2954. Restoration of funding for abstinence education.
- Sec. 2955. Inclusion of information about the importance of having a health care power of attorney in transition planning for children aging out of foster care and independent living programs.
- TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE**
- Subtitle A—Transforming the Health Care Delivery System*
- PART I—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM**
- Sec. 3001. Hospital Value-Based purchasing program.
- Sec. 3002. Improvements to the physician quality reporting system.
- Sec. 3003. Improvements to the physician feedback program.
- Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs.
- Sec. 3005. Quality reporting for PPS-exempt cancer hospitals.
- Sec. 3006. Plans for a Value-Based purchasing program for skilled nursing facilities and home health agencies.
- Sec. 3007. Value-based payment modifier under the physician fee schedule.
- Sec. 3008. Payment adjustment for conditions acquired in hospitals.
- PART II—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY**
- Sec. 3011. National strategy.
- Sec. 3012. Interagency Working Group on Health Care Quality.
- Sec. 3013. Quality measure development.
- Sec. 3014. Quality measurement.
- Sec. 3015. Data collection; public reporting.
- PART III—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS**
- Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS.
- Sec. 3022. Medicare shared savings program.
- Sec. 3023. National pilot program on payment bundling.
- Sec. 3024. Independence at home demonstration program.
- Sec. 3025. Hospital readmissions reduction program.
- Sec. 3026. Community-Based Care Transitions Program.
- Sec. 3027. Extension of gainsharing demonstration.
- Subtitle B—Improving Medicare for Patients and Providers*
- PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES**
- Sec. 3101. Increase in the physician payment update.
- Sec. 3102. Extension of the work geographic index floor and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule.
- Sec. 3103. Extension of exceptions process for Medicare therapy caps.
- Sec. 3104. Extension of payment for technical component of certain physician pathology services.
- Sec. 3105. Extension of ambulance add-ons.
- Sec. 3106. Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities.
- Sec. 3107. Extension of physician fee schedule mental health add-on.
- Sec. 3108. Permitting physician assistants to order post-Hospital extended care services.
- Sec. 3109. Exemption of certain pharmacies from accreditation requirements.
- Sec. 3110. Part B special enrollment period for disabled TRICARE beneficiaries.
- Sec. 3111. Payment for bone density tests.
- Sec. 3112. Revision to the Medicare Improvement Fund.
- Sec. 3113. Treatment of certain complex diagnostic laboratory tests.
- Sec. 3114. Improved access for certified nurse-midwife services.
- PART II—RURAL PROTECTIONS**
- Sec. 3121. Extension of outpatient hold harmless provision.
- Sec. 3122. Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas.
- Sec. 3123. Extension of the Rural Community Hospital Demonstration Program.
- Sec. 3124. Extension of the Medicare-dependent hospital (MDH) program.
- Sec. 3125. Temporary improvements to the Medicare inpatient hospital payment adjustment for low-volume hospitals.
- Sec. 3126. Improvements to the demonstration project on community health integration models in certain rural counties.
- Sec. 3127. MedPAC study on adequacy of Medicare payments for health care providers serving in rural areas.
- Sec. 3128. Technical correction related to critical access hospital services.
- Sec. 3129. Extension of and revisions to Medicare rural hospital flexibility program.
- PART III—IMPROVING PAYMENT ACCURACY**
- Sec. 3131. Payment adjustments for home health care.
- Sec. 3132. Hospice reform.
- Sec. 3133. Improvement to Medicare disproportionate share hospital (DSH) payments.
- Sec. 3134. Misvalued codes under the physician fee schedule.
- Sec. 3135. Modification of equipment utilization factor for advanced imaging services.
- Sec. 3136. Revision of payment for power-driven wheelchairs.
- Sec. 3137. Hospital wage index improvement.
- Sec. 3138. Treatment of certain cancer hospitals.
- Sec. 3139. Payment for biosimilar biological products.
- Sec. 3140. Medicare hospice concurrent care demonstration program.
- Sec. 3141. Application of budget neutrality on a national basis in the calculation of the Medicare hospital wage index floor.

Sec. 3142. HHS study on urban Medicare-dependent hospitals.

Sec. 3143. Protecting home health benefits.

Subtitle C—Provisions Relating to Part C

Sec. 3201. Medicare Advantage payment.

Sec. 3202. Benefit protection and simplification.

Sec. 3203. Application of coding intensity adjustment during MA payment transition.

Sec. 3204. Simplification of annual beneficiary election periods.

Sec. 3205. Extension for specialized MA plans for special needs individuals.

Sec. 3206. Extension of reasonable cost contracts.

Sec. 3207. Technical correction to MA private fee-for-service plans.

Sec. 3208. Making senior housing facility demonstration permanent.

Sec. 3209. Authority to deny plan bids.

Sec. 3210. Development of new standards for certain Medigap plans.

Subtitle D—Medicare Part D Improvements for Prescription Drug Plans and MA–PD Plans

Sec. 3301. Medicare coverage gap discount program.

Sec. 3302. Improvement in determination of Medicare part D low-income benchmark premium.

Sec. 3303. Voluntary de minimis policy for subsidy eligible individuals under prescription drug plans and MA–PD plans.

Sec. 3304. Special rule for widows and widowers regarding eligibility for low-income assistance.

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TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

SEC. 1001. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

(1) by striking the part heading and inserting the following:

“PART A—INDIVIDUAL AND GROUP MARKET REFORMS”;

(2) by redesignating sections 2704 through 2707 as sections 2725 through 2728, respectively;

(3) by redesignating sections 2711 through 2713 as sections 2731 through 2733, respectively;

(4) by redesignating sections 2721 through 2723 as sections 2735 through 2737, respectively; and

(5) by inserting after section 2702, the following:

“Subpart II—Improving Coverage

“SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.

“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—

“(1) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

“(2) unreasonable annual limits (within the meaning of section 223 of the Internal Revenue Code of 1986) on the dollar value of benefits for any participant or beneficiary.

“(b) PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage that is not required to provide essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act from placing annual or lifetime per beneficiary limits on specific covered

benefits to the extent that such limits are otherwise permitted under Federal or State law.

“SEC. 2712. PROHIBITION ON RESCISSIONS.

“A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 2702(c) or 2742(b).

“SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.

“(a) *IN GENERAL.*—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

“(1) evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force;

“(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

“(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

“(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

“(5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.

“(b) *INTERVAL.*—

“(1) *IN GENERAL.*—The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.

“(2) *MINIMUM.*—The interval described in paragraph (1) shall not be less than 1 year.

“(c) *VALUE-BASED INSURANCE DESIGN.*—The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.

“SEC. 2714. EXTENSION OF DEPENDENT COVERAGE.

“(a) *IN GENERAL.*—A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child (who is not married) until the child turns 26 years of age. Nothing in this section shall require a health plan or a health insurance issuer

described in the preceding sentence to make coverage available for a child of a child receiving dependent coverage.

“(b) *REGULATIONS.*—The Secretary shall promulgate regulations to define the dependents to which coverage shall be made available under subsection (a).

“(c) *RULE OF CONSTRUCTION.*—Nothing in this section shall be construed to modify the definition of ‘dependent’ as used in the Internal Revenue Code of 1986 with respect to the tax treatment of the cost of coverage.

“SEC. 2715. DEVELOPMENT AND UTILIZATION OF UNIFORM EXPLANATION OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS.

“(a) *IN GENERAL.*—Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to enrollees a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, the Secretary shall consult with the National Association of Insurance Commissioners (referred to in this section as the ‘NAIC’), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.

“(b) *REQUIREMENTS.*—The standards for the summary of benefits and coverage developed under subsection (a) shall provide for the following:

“(1) *APPEARANCE.*—The standards shall ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font.

“(2) *LANGUAGE.*—The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

“(3) *CONTENTS.*—The standards shall ensure that the summary of benefits and coverage includes—

“(A) uniform definitions of standard insurance terms and medical terms (consistent with subsection (g)) so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);

“(B) a description of the coverage, including cost sharing for—

“(i) each of the categories of the essential health benefits described in subparagraphs (A) through (J) of section 1302(b)(1) of the Patient Protection and Affordable Care Act; and

“(ii) other benefits, as identified by the Secretary;

“(C) the exceptions, reductions, and limitations on coverage;

“(D) the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations;

“(E) the renewability and continuation of coverage provisions;

“(F) a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing, such scenarios to be based on recognized clinical practice guidelines;

“(G) a statement of whether the plan or coverage—

“(i) provides minimum essential coverage (as defined under section 5000A(f) of the Internal Revenue Code 1986); and

“(ii) ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs;

“(H) a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and

“(I) a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

“(c) *PERIODIC REVIEW AND UPDATING.*—The Secretary shall periodically review and update, as appropriate, the standards developed under this section.

“(d) *REQUIREMENT TO PROVIDE.*—

“(1) *IN GENERAL.*—Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) to—

“(A) an applicant at the time of application;

“(B) an enrollee prior to the time of enrollment or reenrollment, as applicable; and

“(C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

“(2) *COMPLIANCE.*—An entity described in paragraph (3) is deemed to be in compliance with this section if the summary of benefits and coverage described in subsection (a) is provided in paper or electronic form.

“(3) *ENTITIES IN GENERAL.*—An entity described in this paragraph is—

“(A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or

“(B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of the Employee Retirement Income Security Act of 1974).

“(4) *NOTICE OF MODIFICATIONS.*—If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act of 1974) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

“(e) *PREEMPTION.*—The standards developed under subsection (a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under this section, as determined by the Secretary.

“(f) *FAILURE TO PROVIDE.*—An entity described in subsection (d)(3) that willfully fails to provide the information required under this section shall be subject to a fine of not more than \$1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

“(g) *DEVELOPMENT OF STANDARD DEFINITIONS.*—

“(1) *IN GENERAL.*—The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including the insurance-related terms described in paragraph (2) and the medical terms described in paragraph (3).

“(2) *INSURANCE-RELATED TERMS.*—The insurance-related terms described in this paragraph

are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

“(3) **MEDICAL TERMS.**—The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).

“SEC. 2716. PROHIBITION OF DISCRIMINATION BASED ON SALARY.

“(a) **IN GENERAL.**—The plan sponsor of a group health plan (other than a self-insured plan) may not establish rules relating to the health insurance coverage eligibility (including continued eligibility) of any full-time employee under the terms of the plan that are based on the total hourly or annual salary of the employee or otherwise establish eligibility rules that have the effect of discriminating in favor of higher wage employees.

“(b) **LIMITATION.**—Subsection (a) shall not be construed to prohibit a plan sponsor from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of similarly situated employees with a higher hourly or annual compensation.

“SEC. 2717. ENSURING THE QUALITY OF CARE.

“(a) **QUALITY REPORTING.**—

“(1) **IN GENERAL.**—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

“(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;

“(B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

“(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

“(D) implement wellness and health promotion activities.

“(2) **REPORTING REQUIREMENTS.**—

“(A) **IN GENERAL.**—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees under

the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

“(B) **TIMING OF REPORTS.**—A report under subparagraph (A) shall be made available to an enrollee under the plan or coverage during each open enrollment period.

“(C) **AVAILABILITY OF REPORTS.**—The Secretary shall make reports submitted under subparagraph (A) available to the public through an Internet website.

“(D) **PENALTIES.**—In developing the reporting requirements under paragraph (1), the Secretary may develop and impose appropriate penalties for non-compliance with such requirements.

“(E) **EXCEPTIONS.**—In developing the reporting requirements under paragraph (1), the Secretary may provide for exceptions to such requirements for group health plans and health insurance issuers that substantially meet the goals of this section.

“(b) **WELLNESS AND PREVENTION PROGRAMS.**—For purposes of subsection (a)(1)(D), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants, and which may include the following wellness and prevention efforts:

“(1) Smoking cessation.

“(2) Weight management.

“(3) Stress management.

“(4) Physical fitness.

“(5) Nutrition.

“(6) Heart disease prevention.

“(7) Healthy lifestyle support.

“(8) Diabetes prevention.

“(c) **REGULATIONS.**—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations that provide criteria for determining whether a reimbursement structure is described in subsection (a).

“(d) **STUDY AND REPORT.**—Not later than 180 days after the date on which regulations are promulgated under subsection (c), the Government Accountability Office shall review such regulations and conduct a study and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report regarding the impact the activities under this section have had on the quality and cost of health care.

“SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

“(a) **CLEAR ACCOUNTING FOR COSTS.**—A health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, submit to the Secretary a report concerning the percentage of total premium revenue that such coverage expends—

“(1) on reimbursement for clinical services provided to enrollees under such coverage;

“(2) for activities that improve health care quality; and

“(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

“(b) **ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.**—

“(1) **REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.**—A health insurance issuer

offering group or individual health insurance coverage shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, in an amount that is equal to the amount by which premium revenue expended by the issuer on activities described in subsection (a)(3) exceeds—

“(A) with respect to a health insurance issuer offering coverage in the group market, 20 percent, or such lower percentage as a State may by regulation determine; or

“(B) with respect to a health insurance issuer offering coverage in the individual market, 25 percent, or such lower percentage as a State may by regulation determine, except that such percentage shall be adjusted to the extent the Secretary determines that the application of such percentage with a State may destabilize the existing individual market in such State.

“(2) **CONSIDERATION IN SETTING PERCENTAGES.**—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

“(3) **TERMINATION.**—The provisions of this subsection shall have no force or effect after December 31, 2013.

“(c) **STANDARD HOSPITAL CHARGES.**—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

“(d) **DEFINITIONS.**—The Secretary, in consultation with the National Association of Insurance Commissioners, shall establish uniform definitions for the activities reported under subsection (a).

“SEC. 2719. APPEALS PROCESS.

“A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

“(1) have in effect an internal claims appeal process;

“(2) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes;

“(3) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process; and

“(4) provide an external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans.”.

SEC. 1002. HEALTH INSURANCE CONSUMER INFORMATION.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.) is amended by adding at the end the following:

“SEC. 2793. HEALTH INSURANCE CONSUMER INFORMATION.

“(a) **IN GENERAL.**—The Secretary shall award grants to States to enable such States (or the Exchanges operating in such States) to establish, expand, or provide support for—

“(1) offices of health insurance consumer assistance; or

“(2) health insurance ombudsman programs.

“(b) ELIGIBILITY.—

“(1) IN GENERAL.—To be eligible to receive a grant, a State shall designate an independent office of health insurance consumer assistance, or an ombudsman, that, directly or in coordination with State health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law.

“(2) CRITERIA.—A State that receives a grant under this section shall comply with criteria established by the Secretary for carrying out activities under such grant.

“(c) DUTIES.—The office of health insurance consumer assistance or health insurance ombudsman shall—

“(1) assist with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved and providing information about the external appeal process;

“(2) collect, track, and quantify problems and inquiries encountered by consumers;

“(3) educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage;

“(4) assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance; and

“(5) resolve problems with obtaining premium tax credits under section 36B of the Internal Revenue Code of 1986.

“(d) DATA COLLECTION.—As a condition of receiving a grant under subsection (a), an office of health insurance consumer assistance or ombudsman program shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers. The Secretary shall utilize such data to identify areas where more enforcement action is necessary and shall share such information with State insurance regulators, the Secretary of Labor, and the Secretary of the Treasury for use in the enforcement activities of such agencies.

“(e) FUNDING.—

“(1) INITIAL FUNDING.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, \$30,000,000 for the first fiscal year for which this section applies to carry out this section. Such amount shall remain available without fiscal year limitation.

“(2) AUTHORIZATION FOR SUBSEQUENT YEARS.—There is authorized to be appropriated to the Secretary for each fiscal year following the fiscal year described in paragraph (1), such sums as may be necessary to carry out this section.”

SEC. 1003. ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.), as amended by section 1002, is further amended by adding at the end the following:

“SEC. 2794. ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

“(a) INITIAL PREMIUM REVIEW PROCESS.—

“(1) IN GENERAL.—The Secretary, in conjunction with States, shall establish a process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.

“(2) JUSTIFICATION AND DISCLOSURE.—The process established under paragraph (1) shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers

shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers.

“(b) CONTINUING PREMIUM REVIEW PROCESS.—

“(1) INFORMING SECRETARY OF PREMIUM INCREASE PATTERNS.—As a condition of receiving a grant under subsection (c)(1), a State, through its Commissioner of Insurance, shall—

“(A) provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and

“(B) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.

“(2) MONITORING BY SECRETARY OF PREMIUM INCREASES.—

“(A) IN GENERAL.—Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States and consistent with the provisions of subsection (a)(2), shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

“(B) CONSIDERATION IN OPENING EXCHANGE.—In determining under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act whether to offer qualified health plans in the large group market through an Exchange, the State shall take into account any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

“(c) GRANTS IN SUPPORT OF PROCESS.—

“(1) PREMIUM REVIEW GRANTS DURING 2010 THROUGH 2014.—The Secretary shall carry out a program to award grants to States during the 5-year period beginning with fiscal year 2010 to assist such States in carrying out subsection (a), including—

“(A) in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage; and

“(B) in providing information and recommendations to the Secretary under subsection (b)(1).

“(2) FUNDING.—

“(A) IN GENERAL.—Out of all funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary \$250,000,000, to be available for expenditure for grants under paragraph (1) and subparagraph (B).

“(B) FURTHER AVAILABILITY FOR INSURANCE REFORM AND CONSUMER PROTECTION.—If the amounts appropriated under subparagraph (A) are not fully obligated under grants under paragraph (1) by the end of fiscal year 2014, any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under part A.

“(C) ALLOCATION.—The Secretary shall establish a formula for determining the amount of any grant to a State under this subsection. Under such formula—

“(i) the Secretary shall consider the number of plans of health insurance coverage offered in each State and the population of the State; and

“(ii) no State qualifying for a grant under paragraph (1) shall receive less than \$1,000,000, or more than \$5,000,000 for a grant year.”

SEC. 1004. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided for in subsection (b), this subtitle (and the amendments made by this subtitle) shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act, except that the amendments

made by sections 1002 and 1003 shall become effective for fiscal years beginning with fiscal year 2010.

(b) SPECIAL RULE.—The amendments made by sections 1002 and 1003 shall take effect on the date of enactment of this Act.

Subtitle B—Immediate Actions to Preserve and Expand Coverage

SEC. 1101. IMMEDIATE ACCESS TO INSURANCE FOR UNINSURED INDIVIDUALS WITH A PREEXISTING CONDITION.

(a) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014.

(b) ADMINISTRATION.—

(1) IN GENERAL.—The Secretary may carry out the program under this section directly or through contracts to eligible entities.

(2) ELIGIBLE ENTITIES.—To be eligible for a contract under paragraph (1), an entity shall—

(A) be a State or nonprofit private entity;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

(C) agree to utilize contract funding to establish and administer a qualified high risk pool for eligible individuals.

(3) MAINTENANCE OF EFFORT.—To be eligible to enter into a contract with the Secretary under this subsection, a State shall agree not to reduce the annual amount the State expended for the operation of one or more State high risk pools during the year preceding the year in which such contract is entered into.

(c) QUALIFIED HIGH RISK POOL.—

(1) IN GENERAL.—Amounts made available under this section shall be used to establish a qualified high risk pool that meets the requirements of paragraph (2).

(2) REQUIREMENTS.—A qualified high risk pool meets the requirements of this paragraph if such pool—

(A) provides to all eligible individuals health insurance coverage that does not impose any preexisting condition exclusion with respect to such coverage;

(B) provides health insurance coverage—

(i) in which the issuer's share of the total allowed costs of benefits provided under such coverage is not less than 65 percent of such costs; and

(ii) that has an out of pocket limit not greater than the applicable amount described in section 223(c)(2) of the Internal Revenue Code of 1986 for the year involved, except that the Secretary may modify such limit if necessary to ensure the pool meets the actuarial value limit under clause (i);

(C) ensures that with respect to the premium rate charged for health insurance coverage offered to eligible individuals through the high risk pool, such rate shall—

(i) except as provided in clause (ii), vary only as provided for under section 2701 of the Public Health Service Act (as amended by this Act and notwithstanding the date on which such amendments take effect);

(ii) vary on the basis of age by a factor of not greater than 4 to 1; and

(iii) be established at a standard rate for a standard population; and

(D) meets any other requirements determined appropriate by the Secretary.

(d) ELIGIBLE INDIVIDUAL.—An individual shall be deemed to be an eligible individual for purposes of this section if such individual—

(1) is a citizen or national of the United States or is lawfully present in the United States (as determined in accordance with section 1411);

(2) has not been covered under creditable coverage (as defined in section 2701(c)(1) of the Public Health Service Act as in effect on the date of enactment of this Act) during the 6-month period prior to the date on which such individual is applying for coverage through the high risk pool; and

(3) has a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

(e) **PROTECTION AGAINST DUMPING RISK BY INSURERS.**—

(1) **IN GENERAL.**—The Secretary shall establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual's health status.

(2) **SANCTIONS.**—An issuer or employment-based health plan shall be responsible for reimbursing the program under this section for the medical expenses incurred by the program for an individual who, based on criteria established by the Secretary, the Secretary finds was encouraged by the issuer to disenroll from health benefits coverage prior to enrolling in coverage through the program. The criteria shall include at least the following circumstances:

(A) In the case of prior coverage obtained through an employer, the provision by the employer, group health plan, or the issuer of money or other financial consideration for disenrolling from the coverage.

(B) In the case of prior coverage obtained directly from an issuer or under an employment-based health plan—

(i) the provision by the issuer or plan of money or other financial consideration for disenrolling from the coverage; or

(ii) in the case of an individual whose premium for the prior coverage exceeded the premium required by the program (adjusted based on the age factors applied to the prior coverage)—

(I) the prior coverage is a policy that is no longer being actively marketed (as defined by the Secretary) by the issuer; or

(II) the prior coverage is a policy for which duration of coverage from issue or health status are factors that can be considered in determining premiums at renewal.

(3) **CONSTRUCTION.**—Nothing in this subsection shall be construed as constituting exclusive remedies for violations of criteria established under paragraph (1) or as preventing States from applying or enforcing such paragraph or other provisions under law with respect to health insurance issuers.

(f) **OVERSIGHT.**—The Secretary shall establish—

(1) an appeals process to enable individuals to appeal a determination under this section; and

(2) procedures to protect against waste, fraud, and abuse.

(g) **FUNDING; TERMINATION OF AUTHORITY.**—

(1) **IN GENERAL.**—There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, \$5,000,000,000 to pay claims against (and the administrative costs of) the high risk pool under this section that are in excess of the amount of premiums collected from eligible individuals enrolled in the high risk pool. Such funds shall be available without fiscal year limitation.

(2) **INSUFFICIENT FUNDS.**—If the Secretary estimates for any fiscal year that the aggregate amounts available for the payment of the expenses of the high risk pool will be less than the actual amount of such expenses, the Secretary shall make such adjustments as are necessary to eliminate such deficit.

(3) **TERMINATION OF AUTHORITY.**—

(A) **IN GENERAL.**—Except as provided in subparagraph (B), coverage of eligible individuals

under a high risk pool in a State shall terminate on January 1, 2014.

(B) **TRANSITION TO EXCHANGE.**—The Secretary shall develop procedures to provide for the transition of eligible individuals enrolled in health insurance coverage offered through a high risk pool established under this section into qualified health plans offered through an Exchange. Such procedures shall ensure that there is no lapse in coverage with respect to the individual and may extend coverage after the termination of the risk pool involved, if the Secretary determines necessary to avoid such a lapse.

(4) **LIMITATIONS.**—The Secretary has the authority to stop taking applications for participation in the program under this section to comply with the funding limitation provided for in paragraph (1).

(5) **RELATION TO STATE LAWS.**—The standards established under this section shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to qualified high risk pools which are established in accordance with this section.

SEC. 1102. REINSURANCE FOR EARLY RETIREES.

(a) **ADMINISTRATION.**—

(1) **IN GENERAL.**—Not later than 90 days after the date of enactment of this Act, the Secretary shall establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees (and to the eligible spouses, surviving spouses, and dependents of such retirees) during the period beginning on the date on which such program is established and ending on January 1, 2014.

(2) **REFERENCE.**—In this section:

(A) **HEALTH BENEFITS.**—The term “health benefits” means medical, surgical, hospital, prescription drug, and such other benefits as shall be determined by the Secretary, whether self-funded, or delivered through the purchase of insurance or otherwise.

(B) **EMPLOYMENT-BASED PLAN.**—The term “employment-based plan” means a group health benefits plan that—

(i) is—

(I) maintained by one or more current or former employers (including without limitation any State or local government or political subdivision thereof), employee organization, a voluntary employees' beneficiary association, or a committee or board of individuals appointed to administer such plan; or

(II) a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974); and

(ii) provides health benefits to early retirees.

(C) **EARLY RETIREES.**—The term “early retirees” means individuals who are age 55 and older but are not eligible for coverage under title XVIII of the Social Security Act, and who are not active employees of an employer maintaining, or currently contributing to, the employment-based plan or of any employer that has made substantial contributions to fund such plan.

(b) **PARTICIPATION.**—

(1) **EMPLOYMENT-BASED PLAN ELIGIBILITY.**—A participating employment-based plan is an employment-based plan that—

(A) meets the requirements of paragraph (2) with respect to health benefits provided under the plan; and

(B) submits to the Secretary an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require.

(2) **EMPLOYMENT-BASED HEALTH BENEFITS.**—An employment-based plan meets the requirements of this paragraph if the plan—

(A) implements programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions;

(B) provides documentation of the actual cost of medical claims involved; and

(C) is certified by the Secretary.

(c) **PAYMENTS.**—

(1) **SUBMISSION OF CLAIMS.**—

(A) **IN GENERAL.**—A participating employment-based plan shall submit claims for reimbursement to the Secretary which shall contain documentation of the actual costs of the items and services for which each claim is being submitted.

(B) **BASIS FOR CLAIMS.**—Claims submitted under subparagraph (A) shall be based on the actual amount expended by the participating employment-based plan involved within the plan year for the health benefits provided to an early retiree or the spouse, surviving spouse, or dependent of such retiree. In determining the amount of a claim for purposes of this subsection, the participating employment-based plan shall take into account any negotiated price concessions (such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations) obtained by such plan with respect to such health benefit. For purposes of determining the amount of any such claim, the costs paid by the early retiree or the retiree's spouse, surviving spouse, or dependent in the form of deductibles, co-payments, or co-insurance shall be included in the amounts paid by the participating employment-based plan.

(2) **PROGRAM PAYMENTS.**—If the Secretary determines that a participating employment-based plan has submitted a valid claim under paragraph (1), the Secretary shall reimburse such plan for 80 percent of that portion of the costs attributable to such claim that exceed \$15,000, subject to the limits contained in paragraph (3).

(3) **LIMIT.**—To be eligible for reimbursement under the program, a claim submitted by a participating employment-based plan shall not be less than \$15,000 nor greater than \$90,000. Such amounts shall be adjusted each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index for all urban consumers (rounded to the nearest multiple of \$1,000) for the year involved.

(4) **USE OF PAYMENTS.**—Amounts paid to a participating employment-based plan under this subsection shall be used to lower costs for the plan. Such payments may be used to reduce premium costs for an entity described in subsection (a)(2)(B)(i) or to reduce premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs for plan participants. Such payments shall not be used as general revenues for an entity described in subsection (a)(2)(B)(i). The Secretary shall develop a mechanism to monitor the appropriate use of such payments by such entities.

(5) **PAYMENTS NOT TREATED AS INCOME.**—Payments received under this subsection shall not be included in determining the gross income of an entity described in subsection (a)(2)(B)(i) that is maintaining or currently contributing to a participating employment-based plan.

(6) **APPEALS.**—The Secretary shall establish—

(A) an appeals process to permit participating employment-based plans to appeal a determination of the Secretary with respect to claims submitted under this section; and

(B) procedures to protect against fraud, waste, and abuse under the program.

(d) **AUDITS.**—The Secretary shall conduct annual audits of claims data submitted by participating employment-based plans under this section to ensure that such plans are in compliance with the requirements of this section.

(e) **FUNDING.**—There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, \$5,000,000,000 to carry out the program under this section. Such funds shall be available without fiscal year limitation.

(f) **LIMITATION.**—The Secretary has the authority to stop taking applications for participation in the program based on the availability of funding under subsection (e).

SEC. 1103. IMMEDIATE INFORMATION THAT ALLOWS CONSUMERS TO IDENTIFY AFFORDABLE COVERAGE OPTIONS.

(a) **INTERNET PORTAL TO AFFORDABLE COVERAGE OPTIONS.**—

(1) **IMMEDIATE ESTABLISHMENT.**—Not later than July 1, 2010, the Secretary, in consultation with the States, shall establish a mechanism, including an Internet website, through which a resident of any State may identify affordable health insurance coverage options in that State.

(2) **CONNECTING TO AFFORDABLE COVERAGE.**—An Internet website established under paragraph (1) shall, to the extent practicable, provide ways for residents of any State to receive information on at least the following coverage options:

(A) Health insurance coverage offered by health insurance issuers, other than coverage that provides reimbursement only for the treatment or mitigation of—

(i) a single disease or condition; or
(ii) an unreasonably limited set of diseases or conditions (as determined by the Secretary);

(B) Medicaid coverage under title XIX of the Social Security Act.

(C) Coverage under title XXI of the Social Security Act.

(D) A State health benefits high risk pool, to the extent that such high risk pool is offered in such State; and

(E) Coverage under a high risk pool under section 1101.

(b) **ENHANCING COMPARATIVE PURCHASING OPTIONS.**—

(1) **IN GENERAL.**—Not later than 60 days after the date of enactment of this Act, the Secretary shall develop a standardized format to be used for the presentation of information relating to the coverage options described in subsection (a)(2). Such format shall, at a minimum, require the inclusion of information on the percentage of total premium revenue expended on nonclinical costs (as reported under section 2718(a) of the Public Health Service Act), eligibility, availability, premium rates, and cost sharing with respect to such coverage options and be consistent with the standards adopted for the uniform explanation of coverage as provided for in section 2715 of the Public Health Service Act.

(2) **USE OF FORMAT.**—The Secretary shall utilize the format developed under paragraph (1) in compiling information concerning coverage options on the Internet website established under subsection (a).

(c) **AUTHORITY TO CONTRACT.**—The Secretary may carry out this section through contracts entered into with qualified entities.

SEC. 1104. ADMINISTRATIVE SIMPLIFICATION.

(a) **PURPOSE OF ADMINISTRATIVE SIMPLIFICATION.**—Section 261 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d note) is amended—

(1) by inserting “uniform” before “standards”; and

(2) by inserting “and to reduce the clerical burden on patients, health care providers, and health plans” before the period at the end.

(b) **OPERATING RULES FOR HEALTH INFORMATION TRANSACTIONS.**—

(1) **DEFINITION OF OPERATING RULES.**—Section 1171 of the Social Security Act (42 U.S.C. 1320d) is amended by adding at the end the following:

“(9) **OPERATING RULES.**—The term ‘operating rules’ means the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part.”.

(2) **TRANSACTION STANDARDS; OPERATING RULES AND COMPLIANCE.**—Section 1173 of the So-

cial Security Act (42 U.S.C. 1320d–2) is amended—

(A) in subsection (a)(2), by adding at the end the following new subparagraph:

“(J) Electronic funds transfers.”;

(B) in subsection (a), by adding at the end the following new paragraph:

“(4) **REQUIREMENTS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.**—

“(A) **IN GENERAL.**—The standards and associated operating rules adopted by the Secretary shall—

“(i) to the extent feasible and appropriate, enable determination of an individual’s eligibility and financial responsibility for specific services prior to or at the point of care;

“(ii) be comprehensive, requiring minimal augmentation by paper or other communications;

“(iii) provide for timely acknowledgment, response, and status reporting that supports a transparent claims and denial management process (including adjudication and appeals); and

“(iv) describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be required or conditioned upon set values in other fields, and prohibit additional conditions (except where necessary to implement State or Federal law, or to protect against fraud and abuse).

“(B) **REDUCTION OF CLERICAL BURDEN.**—In adopting standards and operating rules for the transactions referred to under paragraph (1), the Secretary shall seek to reduce the number and complexity of forms (including paper and electronic forms) and data entry required by patients and providers.”; and

(C) by adding at the end the following new subsections:

“(g) **OPERATING RULES.**—

“(1) **IN GENERAL.**—The Secretary shall adopt a single set of operating rules for each transaction referred to under subsection (a)(1) with the goal of creating as much uniformity in the implementation of the electronic standards as possible. Such operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and health care providers and the manner in which they operate pursuant to standards issued under Health Insurance Portability and Accountability Act of 1996.

“(2) **OPERATING RULES DEVELOPMENT.**—In adopting operating rules under this subsection, the Secretary shall consider recommendations for operating rules developed by a qualified nonprofit entity that meets the following requirements:

“(A) The entity focuses its mission on administrative simplification.

“(B) The entity demonstrates a multi-stakeholder and consensus-based process for development of operating rules, including representation by or participation from health plans, health care providers, vendors, relevant Federal agencies, and other standard development organizations.

“(C) The entity has a public set of guiding principles that ensure the operating rules and process are open and transparent, and supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

“(D) The entity builds on the transaction standards issued under Health Insurance Portability and Accountability Act of 1996.

“(E) The entity allows for public review and updates of the operating rules.

“(3) **REVIEW AND RECOMMENDATIONS.**—The National Committee on Vital and Health Statistics shall—

“(A) advise the Secretary as to whether a nonprofit entity meets the requirements under paragraph (2);

“(B) review the operating rules developed and recommended by such nonprofit entity;

“(C) determine whether such operating rules represent a consensus view of the health care stakeholders and are consistent with and do not conflict with other existing standards;

“(D) evaluate whether such operating rules are consistent with electronic standards adopted for health information technology; and

“(E) submit to the Secretary a recommendation as to whether the Secretary should adopt such operating rules.

“(4) **IMPLEMENTATION.**—

“(A) **IN GENERAL.**—The Secretary shall adopt operating rules under this subsection, by regulation in accordance with subparagraph (C), following consideration of the operating rules developed by the non-profit entity described in paragraph (2) and the recommendation submitted by the National Committee on Vital and Health Statistics under paragraph (3)(E) and having ensured consultation with providers.

“(B) **ADOPTION REQUIREMENTS; EFFECTIVE DATES.**—

“(i) **ELIGIBILITY FOR A HEALTH PLAN AND HEALTH CLAIM STATUS.**—The set of operating rules for eligibility for a health plan and health claim status transactions shall be adopted not later than July 1, 2011, in a manner ensuring that such operating rules are effective not later than January 1, 2013, and may allow for the use of a machine readable identification card.

“(ii) **ELECTRONIC FUNDS TRANSFERS AND HEALTH CARE PAYMENT AND REMITTANCE ADVICE.**—The set of operating rules for electronic funds transfers and health care payment and remittance advice transactions shall—

“(I) allow for automated reconciliation of the electronic payment with the remittance advice; and

“(II) be adopted not later than July 1, 2012, in a manner ensuring that such operating rules are effective not later than January 1, 2014.

“(iii) **HEALTH CLAIMS OR EQUIVALENT ENCOUNTER INFORMATION, ENROLLMENT AND DISENROLLMENT IN A HEALTH PLAN, HEALTH PLAN PREMIUM PAYMENTS, REFERRAL CERTIFICATION AND AUTHORIZATION.**—The set of operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization transactions shall be adopted not later than July 1, 2014, in a manner ensuring that such operating rules are effective not later than January 1, 2016.

“(C) **EXPEDITED RULEMAKING.**—The Secretary shall promulgate an interim final rule applying any standard or operating rule recommended by the National Committee on Vital and Health Statistics pursuant to paragraph (3). The Secretary shall accept and consider public comments on any interim final rule published under this subparagraph for 60 days after the date of such publication.

“(h) **COMPLIANCE.**—

“(1) **HEALTH PLAN CERTIFICATION.**—

“(A) **ELIGIBILITY FOR A HEALTH PLAN, HEALTH CLAIM STATUS, ELECTRONIC FUNDS TRANSFERS, HEALTH CARE PAYMENT AND REMITTANCE ADVICE.**—Not later than December 31, 2013, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards (as described under paragraph (7) of section 1171) and associated operating rules (as described under paragraph (9) of such section) for electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice, respectively.

“(B) **HEALTH CLAIMS OR EQUIVALENT ENCOUNTER INFORMATION, ENROLLMENT AND**

DISENROLLMENT IN A HEALTH PLAN, HEALTH PLAN PREMIUM PAYMENTS, HEALTH CLAIMS ATTACHMENTS, REFERRAL CERTIFICATION AND AUTHORIZATION.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards and associated operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, health claims attachments, and referral certification and authorization, respectively. A health plan shall provide the same level of documentation to certify compliance with such transactions as is required to certify compliance with the transactions specified in subparagraph (A).

“(2) DOCUMENTATION OF COMPLIANCE.—A health plan shall provide the Secretary, in such form as the Secretary may require, with adequate documentation of compliance with the standards and operating rules described under paragraph (1). A health plan shall not be considered to have provided adequate documentation and shall not be certified as being in compliance with such standards, unless the health plan—

“(A) demonstrates to the Secretary that the plan conducts the electronic transactions specified in paragraph (1) in a manner that fully complies with the regulations of the Secretary; and

“(B) provides documentation showing that the plan has completed end-to-end testing for such transactions with their partners, such as hospitals and physicians.

“(3) SERVICE CONTRACTS.—A health plan shall be required to ensure that any entities that provide services pursuant to a contract with such health plan shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under this subsection.

“(4) CERTIFICATION BY OUTSIDE ENTITY.—The Secretary may designate independent, outside entities to certify that a health plan has complied with the requirements under this subsection, provided that the certification standards employed by such entities are in accordance with any standards or operating rules issued by the Secretary.

“(5) COMPLIANCE WITH REVISED STANDARDS AND OPERATING RULES.—

“(A) IN GENERAL.—A health plan (including entities described under paragraph (3)) shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable revised standards and associated operating rules under this subsection for any interim final rule promulgated by the Secretary under subsection (i) that—

“(i) amends any standard or operating rule described under paragraph (1) of this subsection; or

“(ii) establishes a standard (as described under subsection (a)(1)(B)) or associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.

“(B) DATE OF COMPLIANCE.—A health plan shall comply with such requirements not later than the effective date of the applicable standard or operating rule.

“(6) AUDITS OF HEALTH PLANS.—The Secretary shall conduct periodic audits to ensure that health plans (including entities described under paragraph (3)) are in compliance with any standards and operating rules that are described under paragraph (1) or subsection (i)(5).

“(i) REVIEW AND AMENDMENT OF STANDARDS AND OPERATING RULES.—

“(1) ESTABLISHMENT.—Not later than January 1, 2014, the Secretary shall establish a review committee (as described under paragraph (4)).

“(2) EVALUATIONS AND REPORTS.—

“(A) HEARINGS.—Not later than April 1, 2014, and not less than biennially thereafter, the Secretary, acting through the review committee, shall conduct hearings to evaluate and review the adopted standards and operating rules established under this section.

“(B) REPORT.—Not later than July 1, 2014, and not less than biennially thereafter, the review committee shall provide recommendations for updating and improving such standards and operating rules. The review committee shall recommend a single set of operating rules per transaction standard and maintain the goal of creating as much uniformity as possible in the implementation of the electronic standards.

“(3) INTERIM FINAL RULEMAKING.—

“(A) IN GENERAL.—Any recommendations to amend adopted standards and operating rules that have been approved by the review committee and reported to the Secretary under paragraph (2)(B) shall be adopted by the Secretary through promulgation of an interim final rule not later than 90 days after receipt of the committee's report.

“(B) PUBLIC COMMENT.—

“(i) PUBLIC COMMENT PERIOD.—The Secretary shall accept and consider public comments on any interim final rule published under this paragraph for 60 days after the date of such publication.

“(ii) EFFECTIVE DATE.—The effective date of any amendment to existing standards or operating rules that is adopted through an interim final rule published under this paragraph shall be 25 months following the close of such public comment period.

“(4) REVIEW COMMITTEE.—

“(A) DEFINITION.—For the purposes of this subsection, the term ‘review committee’ means a committee chartered by or within the Department of Health and Human Services that has been designated by the Secretary to carry out this subsection, including—

“(i) the National Committee on Vital and Health Statistics; or

“(ii) any appropriate committee as determined by the Secretary.

“(B) COORDINATION OF HIT STANDARDS.—In developing recommendations under this subsection, the review committee shall ensure coordination, as appropriate, with the standards that support the certified electronic health record technology approved by the Office of the National Coordinator for Health Information Technology.

“(5) OPERATING RULES FOR OTHER STANDARDS ADOPTED BY THE SECRETARY.—The Secretary shall adopt a single set of operating rules (pursuant to the process described under subsection (g)) for any transaction for which a standard had been adopted pursuant to subsection (a)(1)(B).

“(j) PENALTIES.—

“(1) PENALTY FEE.—

“(A) IN GENERAL.—Not later than April 1, 2014, and annually thereafter, the Secretary shall assess a penalty fee (as determined under subparagraph (B)) against a health plan that has failed to meet the requirements under subsection (h) with respect to certification and documentation of compliance with—

“(i) the standards and associated operating rules described under paragraph (1) of such subsection; and

“(ii) a standard (as described under subsection (a)(1)(B)) and associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.

“(B) FEE AMOUNT.—Subject to subparagraphs (C), (D), and (E), the Secretary shall assess a

penalty fee against a health plan in the amount of \$1 per covered life until certification is complete. The penalty shall be assessed per person covered by the plan for which its data systems for major medical policies are not in compliance and shall be imposed against the health plan for each day that the plan is not in compliance with the requirements under subsection (h).

“(C) ADDITIONAL PENALTY FOR MISREPRESENTATION.—A health plan that knowingly provides inaccurate or incomplete information in a statement of certification or documentation of compliance under subsection (h) shall be subject to a penalty fee that is double the amount that would otherwise be imposed under this subsection.

“(D) ANNUAL FEE INCREASE.—The amount of the penalty fee imposed under this subsection shall be increased on an annual basis by the annual percentage increase in total national health care expenditures, as determined by the Secretary.

“(E) PENALTY LIMIT.—A penalty fee assessed against a health plan under this subsection shall not exceed, on an annual basis—

“(i) an amount equal to \$20 per covered life under such plan; or

“(ii) an amount equal to \$40 per covered life under the plan if such plan has knowingly provided inaccurate or incomplete information (as described under subparagraph (C)).

“(F) DETERMINATION OF COVERED INDIVIDUALS.—The Secretary shall determine the number of covered lives under a health plan based upon the most recent statements and filings that have been submitted by such plan to the Securities and Exchange Commission.

“(2) NOTICE AND DISPUTE PROCEDURE.—The Secretary shall establish a procedure for assessment of penalty fees under this subsection that provides a health plan with reasonable notice and a dispute resolution procedure prior to provision of a notice of assessment by the Secretary of the Treasury (as described under paragraph (4)(B)).

“(3) PENALTY FEE REPORT.—Not later than May 1, 2014, and annually thereafter, the Secretary shall provide the Secretary of the Treasury with a report identifying those health plans that have been assessed a penalty fee under this subsection.

“(4) COLLECTION OF PENALTY FEE.—

“(A) IN GENERAL.—The Secretary of the Treasury, acting through the Financial Management Service, shall administer the collection of penalty fees from health plans that have been identified by the Secretary in the penalty fee report provided under paragraph (3).

“(B) NOTICE.—Not later than August 1, 2014, and annually thereafter, the Secretary of the Treasury shall provide notice to each health plan that has been assessed a penalty fee by the Secretary under this subsection. Such notice shall include the amount of the penalty fee assessed by the Secretary and the due date for payment of such fee to the Secretary of the Treasury (as described in subparagraph (C)).

“(C) PAYMENT DUE DATE.—Payment by a health plan for a penalty fee assessed under this subsection shall be made to the Secretary of the Treasury not later than November 1, 2014, and annually thereafter.

“(D) UNPAID PENALTY FEES.—Any amount of a penalty fee assessed against a health plan under this subsection for which payment has not been made by the due date provided under subparagraph (C) shall be—

“(i) increased by the interest accrued on such amount, as determined pursuant to the underpayment rate established under section 6621 of the Internal Revenue Code of 1986; and

“(ii) treated as a past-due, legally enforceable debt owed to a Federal agency for purposes of section 6402(d) of the Internal Revenue Code of 1986.

“(E) ADMINISTRATIVE FEES.—Any fee charged or allocated for collection activities conducted by the Financial Management Service will be passed on to a health plan on a pro-rata basis and added to any penalty fee collected from the plan.”.

(c) PROMULGATION OF RULES.—

(1) UNIQUE HEALTH PLAN IDENTIFIER.—The Secretary shall promulgate a final rule to establish a unique health plan identifier (as described in section 1173(b) of the Social Security Act (42 U.S.C. 1320d-2(b))) based on the input of the National Committee on Vital and Health Statistics. The Secretary may do so on an interim final basis and such rule shall be effective not later than October 1, 2012.

(2) ELECTRONIC FUNDS TRANSFER.—The Secretary shall promulgate a final rule to establish a standard for electronic funds transfers (as described in section 1173(a)(2)(J) of the Social Security Act, as added by subsection (b)(2)(A)). The Secretary may do so on an interim final basis and shall adopt such standard not later than January 1, 2012, in a manner ensuring that such standard is effective not later than January 1, 2014.

(3) HEALTH CLAIMS ATTACHMENTS.—The Secretary shall promulgate a final rule to establish a transaction standard and a single set of associated operating rules for health claims attachments (as described in section 1173(a)(2)(B) of the Social Security Act (42 U.S.C. 1320d-2(a)(2)(B))) that is consistent with the X12 Version 5010 transaction standards. The Secretary may do so on an interim final basis and shall adopt a transaction standard and a single set of associated operating rules not later than January 1, 2014, in a manner ensuring that such standard is effective not later than January 1, 2016.

(d) EXPANSION OF ELECTRONIC TRANSACTIONS IN MEDICARE.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (23), by striking the “or” at the end;

(2) in paragraph (24), by striking the period and inserting “; or”; and

(3) by inserting after paragraph (24) the following new paragraph:

“(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.”.

SEC. 1105. EFFECTIVE DATE.

This subtitle shall take effect on the date of enactment of this Act.

Subtitle C—Quality Health Insurance Coverage for All Americans

PART I—HEALTH INSURANCE MARKET REFORMS

SEC. 1201. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as amended by section 1001, is further amended—

(1) by striking the heading for subpart 1 and inserting the following:

“Subpart I—General Reform”;

(2)(A) in section 2701 (42 U.S.C. 300gg), by striking the section heading and subsection (a) and inserting the following:

“SEC. 2704. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS.

“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.”; and

(B) by transferring such section (as amended by subparagraph (A)) so as to appear after the section 2703 added by paragraph (4);

(3)(A) in section 2702 (42 U.S.C. 300gg-1)—

(i) by striking the section heading and all that follows through subsection (a);

(ii) in subsection (b)—

(I) by striking “health insurance issuer offering health insurance coverage in connection with a group health plan” each place that such appears and inserting “health insurance issuer offering group or individual health insurance coverage”; and

(II) in paragraph (2)(A)—

(aa) by inserting “or individual” after “employer”; and

(bb) by inserting “or individual health coverage, as the case may be” before the semicolon; and

(iii) in subsection (e)—

(I) by striking “(a)(1)(F)” and inserting “(a)(6)”;

(II) by striking “2701” and inserting “2704”; and

(III) by striking “2721(a)” and inserting “2735(a)”;

(B) by transferring such section (as amended by subparagraph (A)) to appear after section 2705(a) as added by paragraph (4); and

(4) by inserting after the subpart heading (as added by paragraph (1)) the following:

“SEC. 2701. FAIR HEALTH INSURANCE PREMIUMS.

“(a) PROHIBITING DISCRIMINATORY PREMIUM RATES.—

“(1) IN GENERAL.—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

“(A) such rate shall vary with respect to the particular plan or coverage involved only by—

“(i) whether such plan or coverage covers an individual or family;

“(ii) rating area, as established in accordance with paragraph (2);

“(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)); and

“(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

“(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

“(2) RATING AREA.—

“(A) IN GENERAL.—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

“(B) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State’s rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

“(3) PERMISSIBLE AGE BANDS.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

“(4) APPLICATION OF VARIATIONS BASED ON AGE OR TOBACCO USE.—With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

“(5) SPECIAL RULE FOR LARGE GROUP MARKET.—If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all coverage offered in such market in the State.

“SEC. 2702. GUARANTEED AVAILABILITY OF COVERAGE.

“(a) GUARANTEED ISSUANCE OF COVERAGE IN THE INDIVIDUAL AND GROUP MARKET.—Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

“(b) ENROLLMENT.—

“(1) RESTRICTION.—A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

“(2) ESTABLISHMENT.—A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 603 of the Employee Retirement Income Security Act of 1974).

“(3) REGULATIONS.—The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

“SEC. 2703. GUARANTEED RENEWABILITY OF COVERAGE.

“(a) IN GENERAL.—Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

“SEC. 2705. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

“(1) Health status.

“(2) Medical condition (including both physical and mental illnesses).

“(3) Claims experience.

“(4) Receipt of health care.

“(5) Medical history.

“(6) Genetic information.

“(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

“(8) Disability.

“(9) Any other health status-related factor determined appropriate by the Secretary.

“(j) PROGRAMS OF HEALTH PROMOTION OR DISEASE PREVENTION.—

“(1) GENERAL PROVISIONS.—

“(A) GENERAL RULE.—For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a ‘wellness program’) shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

“(B) NO CONDITIONS BASED ON HEALTH STATUS FACTOR.—If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

“(C) CONDITIONS BASED ON HEALTH STATUS FACTOR.—If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

“(2) **WELLNESS PROGRAMS NOT SUBJECT TO REQUIREMENTS.**—If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

“(A) A program that reimburses all or part of the cost for memberships in a fitness center.

“(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

“(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

“(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

“(E) A program that provides a reward to individuals for attending a periodic health education seminar.

“(3) **WELLNESS PROGRAMS SUBJECT TO REQUIREMENTS.**—If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

“(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

“(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

“(C) The plan shall give individuals eligible for the program the opportunity to qualify for

the reward under the program at least once each year.

“(D) The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

“(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows—

“(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

“(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

“(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

“(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

“(K) **EXISTING PROGRAMS.**—Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to the date of enactment of this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

“(L) **WELLNESS PROGRAM DEMONSTRATION PROJECT.**—

“(1) **IN GENERAL.**—Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project under which participating States shall apply the provisions of subsection (j) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

“(2) **EXPANSION OF DEMONSTRATION PROJECT.**—If the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines that the demonstration project described in paragraph (1) is effective, such Secretaries may, beginning on July 1, 2017 expand such demonstration project to include additional participating States.

“(3) **REQUIREMENTS.**—

“(A) **MAINTENANCE OF COVERAGE.**—The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State's project is designed in a manner that—

“(i) will not result in any decrease in coverage; and

“(ii) will not increase the cost to the Federal Government in providing credits under section 36B of the Internal Revenue Code of 1986 or cost-sharing assistance under section 1402 of the Patient Protection and Affordable Care Act.

“(B) **OTHER REQUIREMENTS.**—States that participate in the demonstration project under this subsection—

“(i) may permit premium discounts or rebates or the modification of otherwise applicable co-

payments or deductibles for adherence to, or participation in, a reasonably designed program of health promotion and disease prevention;

“(ii) shall ensure that requirements of consumer protection are met in programs of health promotion in the individual market;

“(iii) shall require verification from health insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts—

“(I) do not create undue burdens for individuals insured in the individual market;

“(II) do not lead to cost shifting; and

“(III) are not a subterfuge for discrimination;

“(iv) shall ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note); and

“(v) shall ensure and demonstrate to the satisfaction of the Secretary that the discounts or other rewards provided under the project reflect the expected level of participation in the wellness program involved and the anticipated effect the program will have on utilization or medical claim costs.

“(M) **REPORT.**—

“(1) **IN GENERAL.**—Not later than 3 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning—

“(A) the effectiveness of wellness programs (as defined in subsection (j)) in promoting health and preventing disease;

“(B) the impact of such wellness programs on the access to care and affordability of coverage for participants and non-participants of such programs;

“(C) the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and

“(D) the effectiveness of different types of rewards.

“(2) **DATA COLLECTION.**—In preparing the report described in paragraph (1), the Secretaries shall gather relevant information from employers who provide employees with access to wellness programs, including State and Federal agencies.

“(N) **REGULATIONS.**—Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection with this section.

“SEC. 2706. NON-DISCRIMINATION IN HEALTH CARE.

“(a) **PROVIDERS.**—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

“(b) **INDIVIDUALS.**—The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.

“SEC. 2707. COMPREHENSIVE HEALTH INSURANCE COVERAGE.

“(a) **COVERAGE FOR ESSENTIAL HEALTH BENEFITS PACKAGE.**—A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.

“(b) **COST-SHARING UNDER GROUP HEALTH PLANS.**—A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of section 1302(c).

“(c) **CHILD-ONLY PLANS.**—If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d) of the Patient Protection and Affordable Care Act, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

“(d) **DENTAL ONLY.**—This section shall not apply to a plan described in section 1302(d)(2)(B)(ii)(I).

“SEC. 2708. PROHIBITION ON EXCESSIVE WAITING PERIODS.

“A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not apply any waiting period (as defined in section 2704(b)(4)) that exceeds 90 days.”.

PART II—OTHER PROVISIONS**SEC. 1251. PRESERVATION OF RIGHT TO MAINTAIN EXISTING COVERAGE.**

(a) **NO CHANGES TO EXISTING COVERAGE.**—

(1) **IN GENERAL.**—Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act.

(2) **CONTINUATION OF COVERAGE.**—With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment.

(b) **ALLOWANCE FOR FAMILY MEMBERS TO JOIN CURRENT COVERAGE.**—With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act and which is renewed after such date, family members of such individual shall be permitted to enroll in such plan or coverage if such enrollment is permitted under the terms of the plan in effect as of such date of enactment.

(c) **ALLOWANCE FOR NEW EMPLOYEES TO JOIN CURRENT PLAN.**—A group health plan that provides coverage on the date of enactment of this Act may provide for the enrolling of new employees (and their families) in such plan, and this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply with respect to such plan and such new employees (and their families).

(d) **EFFECT ON COLLECTIVE BARGAINING AGREEMENTS.**—In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this Act, the provisions of this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the

coverage which amends the coverage solely to conform to any requirement added by this subtitle or subtitle A (or amendments) shall not be treated as a termination of such collective bargaining agreement.

(e) **DEFINITION.**—In this title, the term “grandfathered health plan” means any group health plan or health insurance coverage to which this section applies.

SEC. 1252. RATING REFORMS MUST APPLY UNIFORMLY TO ALL HEALTH INSURANCE ISSUERS AND GROUP HEALTH PLANS.

Any standard or requirement adopted by a State pursuant to this title, or any amendment made by this title, shall be applied uniformly to all health plans in each insurance market to which the standard and requirements apply. The preceding sentence shall also apply to a State standard or requirement relating to the standard or requirement required by this title (or any such amendment) that is not the same as the standard or requirement but that is not preempted under section 1321(d).

SEC. 1253. EFFECTIVE DATES.

This subtitle (and the amendments made by this subtitle) shall become effective for plan years beginning on or after January 1, 2014.

Subtitle D—Available Coverage Choices for All Americans**PART I—ESTABLISHMENT OF QUALIFIED HEALTH PLANS****SEC. 1301. QUALIFIED HEALTH PLAN DEFINED.**

(a) **QUALIFIED HEALTH PLAN.**—In this title:

(1) **IN GENERAL.**—The term “qualified health plan” means a health plan that—

(A) has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 1311(c) issued or recognized by each Exchange through which such plan is offered;

(B) provides the essential health benefits package described in section 1302(a); and

(C) is offered by a health insurance issuer that—

(i) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title;

(ii) agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange;

(iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and

(iv) complies with the regulations developed by the Secretary under section 1311(d) and such other requirements as an applicable Exchange may establish.

(2) **INCLUSION OF CO-OP PLANS AND COMMUNITY HEALTH INSURANCE OPTION.**—Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 1322 or a community health insurance option under section 1323, unless specifically provided for otherwise.

(b) **TERMS RELATING TO HEALTH PLANS.**—In this title:

(1) **HEALTH PLAN.**—

(A) **IN GENERAL.**—The term “health plan” means health insurance coverage and a group health plan.

(B) **EXCEPTION FOR SELF-INSURED PLANS AND MEWAS.**—Except to the extent specifically provided by this title, the term “health plan” shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State in-

surance regulation under section 514 of the Employee Retirement Income Security Act of 1974.

(2) **HEALTH INSURANCE COVERAGE AND ISSUER.**—The terms “health insurance coverage” and “health insurance issuer” have the meanings given such terms by section 2791(b) of the Public Health Service Act.

(3) **GROUP HEALTH PLAN.**—The term “group health plan” has the meaning given such term by section 2791(a) of the Public Health Service Act.

SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

(a) **ESSENTIAL HEALTH BENEFITS PACKAGE.**—In this title, the term “essential health benefits package” means, with respect to any health plan, coverage that—

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) **ESSENTIAL HEALTH BENEFITS.**—

(1) **IN GENERAL.**—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

(2) **LIMITATION.**—

(A) **IN GENERAL.**—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) **CERTIFICATION.**—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) **NOTICE AND HEARING.**—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) **REQUIRED ELEMENTS FOR CONSIDERATION.**—In defining the essential health benefits under paragraph (1), the Secretary shall—

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including

women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) **RULE OF CONSTRUCTION.**—Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) **REQUIREMENTS RELATING TO COST-SHARING.**—

(1) **ANNUAL LIMITATION ON COST-SHARING.**—

(A) 2014.—The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) 2015 AND LATER.—In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium ad-

justment percentage under paragraph (4) for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i).

If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(2) **ANNUAL LIMITATION ON DEDUCTIBLES FOR EMPLOYER-SPONSORED PLANS.**—

(A) **IN GENERAL.**—In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed—

(i) \$2,000 in the case of a plan covering a single individual; and

(ii) \$4,000 in the case of any other plan.

The amounts under clauses (i) and (ii) may be increased by the maximum amount of reimbursement which is reasonably available to a participant under a flexible spending arrangement described in section 106(c)(2) of the Internal Revenue Code of 1986 (determined without regard to any salary reduction arrangement).

(B) **INDEXING OF LIMITS.**—In the case of any plan year beginning in a calendar year after 2014—

(i) the dollar amount under subparagraph (A)(i) shall be increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) the dollar amount under subparagraph (A)(ii) shall be increased to an amount equal to twice the amount in effect under subparagraph (A)(i) for plan years beginning in the calendar year, determined after application of clause (i). If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(C) **ACTUARIAL VALUE.**—The limitation under this paragraph shall be applied in such a manner so as to not affect the actuarial value of any health plan, including a plan in the bronze level.

(D) **COORDINATION WITH PREVENTIVE LIMITS.**—Nothing in this paragraph shall be construed to allow a plan to have a deductible under the plan apply to benefits described in section 2713 of the Public Health Service Act.

(3) **COST-SHARING.**—In this title—

(A) **IN GENERAL.**—The term “cost-sharing” includes—

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to essential health benefits covered under the plan.

(B) **EXCEPTIONS.**—Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(4) **PREMIUM ADJUSTMENT PERCENTAGE.**—For purposes of paragraphs (1)(B)(i) and (2)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(d) **LEVELS OF COVERAGE.**—

(1) **LEVELS OF COVERAGE DEFINED.**—The levels of coverage described in this subsection are as follows:

(A) **BRONZE LEVEL.**—A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(B) **SILVER LEVEL.**—A plan in the silver level shall provide a level of coverage that is designed

to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(C) **GOLD LEVEL.**—A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(D) **PLATINUM LEVEL.**—A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) **ACTUARIAL VALUE.**—

(A) **IN GENERAL.**—Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

(B) **EMPLOYER CONTRIBUTIONS.**—The Secretary may issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of coverage for a plan of the employer.

(C) **APPLICATION.**—In determining under this title, the Public Health Service Act, or the Internal Revenue Code of 1986 the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, the rules contained in the regulations under this paragraph shall apply.

(3) **ALLOWABLE VARIANCE.**—The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

(4) **PLAN REFERENCE.**—In this title, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

(e) **CATASTROPHIC PLAN.**—

(1) **IN GENERAL.**—A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if—

(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(B) the plan provides—

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

(ii) coverage for at least three primary care visits.

(2) **INDIVIDUALS ELIGIBLE FOR ENROLLMENT.**—An individual is described in this paragraph for any plan year if the individual—

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of—

(i) section 5000A(e)(1) of such Code (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such Code (relating to individuals with hardships).

(3) **RESTRICTION TO INDIVIDUAL MARKET.**—If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) **CHILD-ONLY PLANS.**—If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

SEC. 1303. SPECIAL RULES.

(a) **SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.**—

(1) **VOLUNTARY CHOICE OF COVERAGE OF ABORTION SERVICES.**—

(A) **IN GENERAL.**—Notwithstanding any other provision of this title (or any amendment made by this title), and subject to subparagraphs (C) and (D)—

(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(i) or (B)(ii) as part of its essential health benefits for any plan year; and

(ii) the issuer of a qualified health plan shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year.

(B) **ABORTION SERVICES.**—

(i) **ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.**—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(ii) **ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED.**—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(C) **PROHIBITION ON FEDERAL FUNDS FOR ABORTION SERVICES IN COMMUNITY HEALTH INSURANCE OPTION.**—

(i) **DETERMINATION BY SECRETARY.**—The Secretary may not determine, in accordance with subparagraph (A)(ii), that the community health insurance option established under section 1323 shall provide coverage of services described in subparagraph (B)(i) as part of benefits for the plan year unless the Secretary—

(I) assures compliance with the requirements of paragraph (2);

(II) assures, in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office, that no Federal funds are used for such coverage; and

(III) notwithstanding section 1323(e)(1)(C) or any other provision of this title, takes all necessary steps to assure that the United States does not bear the insurance risk for a community health insurance option's coverage of services described in subparagraph (B)(i).

(ii) **STATE REQUIREMENT.**—If a State requires, in addition to the essential health benefits required under section 1323(b)(3) (A), coverage of services described in subparagraph (B)(i) for enrollees of a community health insurance option offered in such State, the State shall assure that no funds flowing through or from the community health insurance option, and no other Federal funds, pay or defray the cost of providing coverage of services described in subparagraph (B)(i). The United States shall not bear the insurance risk for a State's required coverage of services described in subparagraph (B)(i).

(iii) **EXCEPTIONS.**—Nothing in this subparagraph shall apply to coverage of services described in subparagraph (B)(ii) by the community health insurance option. Services described in subparagraph (B)(i) shall be covered to the same extent as such services are covered under title XIX of the Social Security Act.

(D) **ASSURED AVAILABILITY OF VARIED COVERAGE THROUGH EXCHANGES.**—

(i) **IN GENERAL.**—The Secretary shall assure that with respect to qualified health plans offered in any Exchange established pursuant to this title—

(I) there is at least one such plan that provides coverage of services described in clauses (i) and (ii) of subparagraph (B); and

(II) there is at least one such plan that does not provide coverage of services described in subparagraph (B)(i).

(ii) **SPECIAL RULES.**—For purposes of clause (i)—

(I) a plan shall be treated as described in clause (i)(II) if the plan does not provide coverage of services described in either subparagraph (B)(i) or (B)(ii); and

(II) if a State has one Exchange covering more than 1 insurance market, the Secretary shall meet the requirements of clause (i) separately with respect to each such market.

(2) **PROHIBITION ON THE USE OF FEDERAL FUNDS.**—

(A) **IN GENERAL.**—If a qualified health plan provides coverage of services described in paragraph (1)(B)(i), the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services:

(i) The credit under section 36B of the Internal Revenue Code of 1986 (and the amount (if any) of the advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).

(ii) Any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act (and the amount (if any) of the advance payment of the reduction under section 1412 of the Patient Protection and Affordable Care Act).

(B) **SEGREGATION OF FUNDS.**—In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall, out of amounts not described in subparagraph (A), segregate an amount equal to the actuarial amounts determined under subparagraph (C) for all enrollees from the amounts described in subparagraph (A).

(C) **ACTUARIAL VALUE OF OPTIONAL SERVICE COVERAGE.**—

(i) **IN GENERAL.**—The Secretary shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under a qualified health plan of the services described in paragraph (1)(B)(i).

(ii) **CONSIDERATIONS.**—In making such estimate, the Secretary—

(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

(II) shall estimate such costs as if such coverage were included for the entire population covered; and

(III) may not estimate such a cost at less than \$1 per enrollee, per month.

(3) **PROVIDER CONSCIENCE PROTECTIONS.**—No individual health care provider or health care facility may be discriminated against because of a willingness or an unwillingness, if doing so is contrary to the religious or moral beliefs of the provider or facility, to provide, pay for, provide coverage of, or refer for abortions.

(b) **APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.**—

(1) **NO PREEMPTION OF STATE LAWS REGARDING ABORTION.**—Nothing in this Act shall be con-

strued to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

(2) **NO EFFECT ON FEDERAL LAWS REGARDING ABORTION.**—

(A) **IN GENERAL.**—Nothing in this Act shall be construed to have any effect on Federal laws regarding—

(i) conscience protection; (ii) willingness or refusal to provide abortion; and

(iii) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(3) **NO EFFECT ON FEDERAL CIVIL RIGHTS LAW.**—Nothing in this subsection shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964.

(c) **APPLICATION OF EMERGENCY SERVICES LAWS.**—Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as “EMTALA”).

SEC. 1304. RELATED DEFINITIONS.

(a) **DEFINITIONS RELATING TO MARKETS.**—In this title:

(1) **GROUP MARKET.**—The term “group market” means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer.

(2) **INDIVIDUAL MARKET.**—The term “individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(3) **LARGE AND SMALL GROUP MARKETS.**—The terms “large group market” and “small group market” mean the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer (as defined in subsection (b)(1)) or by a small employer (as defined in subsection (b)(2)), respectively.

(b) **EMPLOYERS.**—In this title:

(1) **LARGE EMPLOYER.**—The term “large employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(2) **SMALL EMPLOYER.**—The term “small employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(3) **STATE OPTION TO TREAT 50 EMPLOYEES AS SMALL.**—In the case of plan years beginning before January 1, 2016, a State may elect to apply this subsection by substituting “51 employees” for “101 employees” in paragraph (1) and by substituting “50 employees” for “100 employees” in paragraph (2).

(4) **RULES FOR DETERMINING EMPLOYER SIZE.**—For purposes of this subsection—

(A) **APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.**—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(B) **EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.**—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) **PREDECESSORS.**—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(D) **CONTINUATION OF PARTICIPATION FOR GROWING SMALL EMPLOYERS.**—If—

(i) a qualified employer that is a small employer makes enrollment in qualified health plans offered in the small group market available to its employees through an Exchange; and

(ii) the employer ceases to be a small employer by reason of an increase in the number of employees of such employer;

the employer shall continue to be treated as a small employer for purposes of this subtitle for the period beginning with the increase and ending with the first day on which the employer does not make such enrollment available to its employees.

(c) **SECRETARY.**—In this title, the term “Secretary” means the Secretary of Health and Human Services.

(d) **STATE.**—In this title, the term “State” means each of the 50 States and the District of Columbia.

PART II—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.

(a) **ASSISTANCE TO STATES TO ESTABLISH AMERICAN HEALTH BENEFIT EXCHANGES.**—

(1) **PLANNING AND ESTABLISHMENT GRANTS.**—There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after the date of enactment of this Act, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) **AMOUNT SPECIFIED.**—For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.

(3) **USE OF FUNDS.**—A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).

(4) **RENEWABILITY OF GRANT.**—

(A) **IN GENERAL.**—Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant—

(i) is making progress, as determined by the Secretary, toward—

(I) establishing an Exchange; and

(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and

(ii) is meeting such other benchmarks as the Secretary may establish.

(B) **LIMITATION.**—No grant shall be awarded under this subsection after January 1, 2015.

(5) **TECHNICAL ASSISTANCE TO FACILITATE PARTICIPATION IN SHOP EXCHANGES.**—The Secretary shall provide technical assistance to States to facilitate the participation of qualified small businesses in such States in SHOP Exchanges.

(b) **AMERICAN HEALTH BENEFIT EXCHANGES.**—

(1) **IN GENERAL.**—Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an “Exchange”) for the State that—

(A) facilitates the purchase of qualified health plans;

(B) provides for the establishment of a Small Business Health Options Program (in this title referred to as a “SHOP Exchange”) that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and

(C) meets the requirements of subsection (d).

(2) **MERGER OF INDIVIDUAL AND SHOP EXCHANGES.**—A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.

(c) **RESPONSIBILITIES OF THE SECRETARY.**—

(1) **IN GENERAL.**—The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111–8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1);

(F) utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account criteria that the National Association of Insurance Commissioners develops and submits to the Secretary;

(G) utilize the standard format established for presenting health benefits plan options; and

(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable.

(2) **RULE OF CONSTRUCTION.**—Nothing in paragraph (1)(C) shall be construed to require a

qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

(3) **RATING SYSTEM.**—The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).

(4) **ENROLLEE SATISFACTION SYSTEM.**—The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.

(5) **INTERNET PORTALS.**—The Secretary shall—

(A) continue to operate, maintain, and update the Internet portal developed under section 1103(a) and to assist States in developing and maintaining their own such portal; and

(B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduction, and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices.

Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 2716 of the Public Health Service Act and to a copy of the plan's written policy.

(6) **ENROLLMENT PERIODS.**—The Secretary shall require an Exchange to provide for—

(A) an initial open enrollment, as determined by the Secretary (such determination to be made not later than July 1, 2012);

(B) annual open enrollment periods, as determined by the Secretary for calendar years after the initial enrollment period;

(C) special enrollment periods specified in section 9801 of the Internal Revenue Code of 1986 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act; and

(D) special monthly enrollment periods for Indians (as defined in section 4 of the Indian Health Care Improvement Act).

(d) **REQUIREMENTS.**—

(1) **IN GENERAL.**—An Exchange shall be a governmental agency or nonprofit entity that is established by a State.

(2) **OFFERING OF COVERAGE.**—

(A) **IN GENERAL.**—An Exchange shall make available qualified health plans to qualified individuals and qualified employers.

(B) **LIMITATION.**—

(i) **IN GENERAL.**—An Exchange may not make available any health plan that is not a qualified health plan.

(ii) **OFFERING OF STAND-ALONE DENTAL BENEFITS.**—Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan

provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J).

(3) RULES RELATING TO ADDITIONAL REQUIRED BENEFITS.—

(A) **IN GENERAL.**—Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b).

(B) STATES MAY REQUIRE ADDITIONAL BENEFITS.—

(i) **IN GENERAL.**—Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 1302(b).

(ii) **STATE MUST ASSUME COST.**—A State shall make payments to or on behalf of an individual eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 to defray the cost to the individual of any additional benefits described in clause (i) which are not eligible for such credit or reduction under section 36B(b)(3)(D) of such Code and section 1402(c)(4).

(4) FUNCTIONS.—An Exchange shall, at a minimum—

(A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;

(B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(C) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);

(E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act;

(F) in accordance with section 1413, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the CHIP program under title XXI of such Act, or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

(G) establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402;

(H) subject to section 1411, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by such section because—

(i) there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(I) transfer to the Secretary of the Treasury—

(i) a list of the individuals who are issued a certification under subparagraph (H), including the name and taxpayer identification number of each individual;

(ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because—

(I) the employer did not provide minimum essential coverage; or

(II) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 1411(b)(4) that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation);

(J) provide to each employer the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and

(K) establish the Navigator program described in subsection (i).

(5) FUNDING LIMITATIONS.—

(A) **NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.**—In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.

(B) **PROHIBITING WASTEFUL USE OF FUNDS.**—In carrying out activities under this subsection, an Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.

(6) **CONSULTATION.**—An Exchange shall consult with stakeholders relevant to carrying out the activities under this section, including—

(A) health care consumers who are enrollees in qualified health plans;

(B) individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) representatives of small businesses and self-employed individuals;

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

(7) **PUBLICATION OF COSTS.**—An Exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of such Exchange, on an Internet website to educate consumers on such costs. Such information shall also include monies lost to waste, fraud, and abuse.

(e) CERTIFICATION.—

(I) **IN GENERAL.**—An Exchange may certify a health plan as a qualified health plan if—

(A) such health plan meets the requirements for certification as promulgated by the Secretary under subsection (c)(1); and

(B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan—

(i) on the basis that such plan is a fee-for-service plan;

(ii) through the imposition of premium price controls; or

(iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(2) **PREMIUM CONSIDERATIONS.**—The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange may take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1) of the Public Health Service Act (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

(f) FLEXIBILITY.—

(1) **REGIONAL OR OTHER INTERSTATE EXCHANGES.**—An Exchange may operate in more than one State if—

(A) each State in which such Exchange operates permits such operation; and

(B) the Secretary approves such regional or interstate Exchange.

(2) **SUBSIDIARY EXCHANGES.**—A State may establish one or more subsidiary Exchanges if—

(A) each such Exchange serves a geographically distinct area; and

(B) the area served by each such Exchange is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(3) AUTHORITY TO CONTRACT.—

(A) **IN GENERAL.**—A State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out 1 or more responsibilities of the Exchange.

(B) **ELIGIBLE ENTITY.**—In this paragraph, the term "eligible entity" means—

(i) a person—

(I) incorporated under, and subject to the laws of, 1 or more States;

(II) that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and

(III) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(ii) the State Medicaid agency under title XIX of the Social Security Act.

(g) **REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES.—**

(1) **STRATEGY DESCRIBED.**—A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for—

(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

(D) the implementation of wellness and health promotion activities.

(2) **GUIDELINES.**—The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

(3) **REQUIREMENTS.**—The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).

(h) **QUALITY IMPROVEMENT.**—

(1) **ENHANCING PATIENT SAFETY.**—Beginning on January 1, 2015, a qualified health plan may contract with—

(A) a hospital with greater than 50 beds only if such hospital—

(i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act; and

(ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or

(B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.

(2) **EXCEPTIONS.**—The Secretary may establish reasonable exceptions to the requirements described in paragraph (1).

(3) **ADJUSTMENT.**—The Secretary may by regulation adjust the number of beds described in paragraph (1)(A).

(i) **NAVIGATORS.**—

(1) **IN GENERAL.**—An Exchange shall establish a program under which it awards grants to entities described in paragraph (2) to carry out the duties described in paragraph (3).

(2) **ELIGIBILITY.**—

(A) **IN GENERAL.**—To be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan.

(B) **TYPES.**—Entities described in subparagraph (A) may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, small business development centers, other licensed insurance agents and brokers, and other entities that—

(i) are capable of carrying out the duties described in paragraph (3);

(ii) meet the standards described in paragraph (4); and

(iii) provide information consistent with the standards developed under paragraph (5).

(3) **DUTIES.**—An entity that serves as a navigator under a grant under this subsection shall—

(A) conduct public education activities to raise awareness of the availability of qualified health plans;

(B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;

(C) facilitate enrollment in qualified health plans;

(D) provide referrals to any applicable office of health insurance consumer assistance or

health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and

(E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

(4) **STANDARDS.**—

(A) **IN GENERAL.**—The Secretary shall establish standards for navigators under this subsection, including provisions to ensure that any private or public entity that is selected as a navigator is qualified, and licensed if appropriate, to engage in the navigator activities described in this subsection and to avoid conflicts of interest. Under such standards, a navigator shall not—

(i) be a health insurance issuer; or

(ii) receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

(5) **FAIR AND IMPARTIAL INFORMATION AND SERVICES.**—The Secretary, in collaboration with States, shall develop standards to ensure that information made available by navigators is fair, accurate, and impartial.

(6) **FUNDING.**—Grants under this subsection shall be made from the operational funds of the Exchange and not Federal funds received by the State to establish the Exchange.

(j) **APPLICABILITY OF MENTAL HEALTH PARITY.**—Section 2726 of the Public Health Service Act shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.

(k) **CONFLICT.**—An Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subtitle.

SEC. 1312. CONSUMER CHOICE.

(a) **CHOICE.**—

(1) **QUALIFIED INDIVIDUALS.**—A qualified individual may enroll in any qualified health plan available to such individual.

(2) **QUALIFIED EMPLOYERS.**—

(A) **EMPLOYER MAY SPECIFY LEVEL.**—A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under section 1302(d) to be made available to employees through an Exchange.

(B) **EMPLOYEE MAY CHOOSE PLANS WITHIN A LEVEL.**—Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.

(b) **PAYMENT OF PREMIUMS BY QUALIFIED INDIVIDUALS.**—A qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan.

(c) **SINGLE RISK POOL.**—

(1) **INDIVIDUAL MARKET.**—A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(2) **SMALL GROUP MARKET.**—A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(3) **MERGER OF MARKETS.**—A State may require the individual and small group insurance

markets within a State to be merged if the State determines appropriate.

(4) **STATE LAW.**—A State law requiring grandfathered health plans to be included in a pool described in paragraph (1) or (2) shall not apply.

(d) **EMPOWERING CONSUMER CHOICE.**—

(1) **CONTINUED OPERATION OF MARKET OUTSIDE EXCHANGES.**—Nothing in this title shall be construed to prohibit—

(A) a health insurance issuer from offering outside of an Exchange a health plan to a qualified individual or qualified employer; and

(B) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

(2) **CONTINUED OPERATION OF STATE BENEFIT REQUIREMENTS.**—Nothing in this title shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is offered outside of an Exchange to offer benefits.

(3) **VOLUNTARY NATURE OF AN EXCHANGE.**—

(A) **CHOICE TO ENROLL OR NOT TO ENROLL.**—Nothing in this title shall be construed to restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

(B) **PROHIBITION AGAINST COMPELLED ENROLLMENT.**—Nothing in this title shall be construed to compel an individual to enroll in a qualified health plan or to participate in an Exchange.

(C) **INDIVIDUALS ALLOWED TO ENROLL IN ANY PLAN.**—A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in section 1302(e), a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1302(e)(2).

(D) **MEMBERS OF CONGRESS IN THE EXCHANGE.**—

(i) **REQUIREMENT.**—Notwithstanding any other provision of law, after the effective date of this subtitle, the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are—

(I) created under this Act (or an amendment made by this Act); or

(II) offered through an Exchange established under this Act (or an amendment made by this Act).

(ii) **DEFINITIONS.**—In this section:

(I) **MEMBER OF CONGRESS.**—The term “Member of Congress” means any member of the House of Representatives or the Senate.

(II) **CONGRESSIONAL STAFF.**—The term “congressional staff” means all full-time and part-time employees employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.

(4) **NO PENALTY FOR TRANSFERRING TO MINIMUM ESSENTIAL COVERAGE OUTSIDE EXCHANGE.**—An Exchange, or a qualified health plan offered through an Exchange, shall not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986 without regard to paragraph (1)(C) or (D) thereof) or such coverage becomes affordable (within the meaning of section 36B(c)(2)(C) of such Code).

(e) **ENROLLMENT THROUGH AGENTS OR BROKERS.**—The Secretary shall establish procedures under which a State may allow agents or brokers—

(1) to enroll individuals in any qualified health plans in the individual or small group market as soon as the plan is offered through an Exchange in the State; and

(2) to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange. Such procedures may include the establishment of rate schedules for broker commissions paid by health benefits plans offered through an exchange.

(f) **QUALIFIED INDIVIDUALS AND EMPLOYERS; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS.**—

(1) **QUALIFIED INDIVIDUALS.**—In this title:

(A) **IN GENERAL.**—The term “qualified individual” means, with respect to an Exchange, an individual who—

(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and

(ii) resides in the State that established the Exchange (except with respect to territorial agreements under section 1312(f)).

(B) **INCARCERATED INDIVIDUALS EXCLUDED.**—An individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.

(2) **QUALIFIED EMPLOYER.**—In this title:

(A) **IN GENERAL.**—The term “qualified employer” means a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans.

(B) **EXTENSION TO LARGE GROUPS.**—

(i) **IN GENERAL.**—Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market in the State to offer qualified health plans in such market through an Exchange. Nothing in this subparagraph shall be construed as requiring the issuer to offer such plans through an Exchange.

(ii) **LARGE EMPLOYERS ELIGIBLE.**—If a State under clause (i) allows issuers to offer qualified health plans in the large group market through an Exchange, the term “qualified employer” shall include a large employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the large group market through the Exchange.

(3) **ACCESS LIMITED TO LAWFUL RESIDENTS.**—If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.

SEC. 1313. FINANCIAL INTEGRITY.

(a) **ACCOUNTING FOR EXPENDITURES.**—

(1) **IN GENERAL.**—An Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary a report concerning such accountings.

(2) **INVESTIGATIONS.**—The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, may investigate the affairs of an Exchange, may examine the properties and records of an Exchange, and may require periodic reports in relation to activities undertaken by an Exchange. An Exchange shall fully cooperate in any investigation conducted under this paragraph.

(3) **AUDITS.**—An Exchange shall be subject to annual audits by the Secretary.

(4) **PATTERN OF ABUSE.**—If the Secretary determines that an Exchange or a State has engaged in serious misconduct with respect to compliance with the requirements of, or carrying out of activities required under, this title, the Secretary may rescind from payments otherwise due to such State involved under this or any

other Act administered by the Secretary an amount not to exceed 1 percent of such payments per year until corrective actions are taken by the State that are determined to be adequate by the Secretary.

(5) **PROTECTIONS AGAINST FRAUD AND ABUSE.**—With respect to activities carried out under this title, the Secretary shall provide for the efficient and non-discriminatory administration of Exchange activities and implement any measure or procedure that—

(A) the Secretary determines is appropriate to reduce fraud and abuse in the administration of this title; and

(B) the Secretary has authority to implement under this title or any other Act.

(6) **APPLICATION OF THE FALSE CLAIMS ACT.**—

(A) **IN GENERAL.**—Payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729 et seq.) if those payments include any Federal funds. Compliance with the requirements of this Act concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer's entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange.

(B) **DAMAGES.**—Notwithstanding paragraph (1) of section 3729(a) of title 31, United States Code, and subject to paragraph (2) of such section, the civil penalty assessed under the False Claims Act on any person found liable under such Act as described in subparagraph (A) shall be increased by not less than 3 times and not more than 6 times the amount of damages which the Government sustains because of the act of that person.

(b) **GAO OVERSIGHT.**—Not later than 5 years after the first date on which Exchanges are required to be operational under this title, the Comptroller General shall conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges. Such study shall review—

(1) the operations and administration of Exchanges, including surveys and reports of qualified health plans offered through Exchanges and on the experience of such plans (including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges), the expenses of Exchanges, claims statistics relating to qualified health plans, complaints data relating to such plans, and the manner in which Exchanges meet their goals;

(2) any significant observations regarding the utilization and adoption of Exchanges;

(3) where appropriate, recommendations for improvements in the operations or policies of Exchanges; and

(4) how many physicians, by area and specialty, are not taking or accepting new patients enrolled in Federal Government health care programs, and the adequacy of provider networks of Federal Government health care programs.

PART III—STATE FLEXIBILITY RELATING TO EXCHANGES

SEC. 1321. STATE FLEXIBILITY IN OPERATION AND ENFORCEMENT OF EXCHANGES AND RELATED REQUIREMENTS.

(a) **ESTABLISHMENT OF STANDARDS.**—

(1) **IN GENERAL.**—The Secretary shall, as soon as practicable after the date of enactment of this Act, issue regulations setting standards for meeting the requirements under this title, and the amendments made by this title, with respect to—

(A) the establishment and operation of Exchanges (including SHOP Exchanges);

(B) the offering of qualified health plans through such Exchanges;

(C) the establishment of the reinsurance and risk adjustment programs under part V; and

(D) such other requirements as the Secretary determines appropriate.

The preceding sentence shall not apply to standards for requirements under subtitles A and C (and the amendments made by such subtitles) for which the Secretary issues regulations under the Public Health Service Act.

(2) **CONSULTATION.**—In issuing the regulations under paragraph (1), the Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties.

(b) **STATE ACTION.**—Each State that elects, at such time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect—

(1) the Federal standards established under subsection (a); or

(2) a State law or regulation that the Secretary determines implements the standards within the State.

(c) **FAILURE TO ESTABLISH EXCHANGE OR IMPLEMENT REQUIREMENTS.**—

(1) **IN GENERAL.**—If—

(A) a State is not an electing State under subsection (b); or

(B) the Secretary determines, on or before January 1, 2013, that an electing State—

(i) will not have any required Exchange operational by January 1, 2014; or

(ii) has not taken the actions the Secretary determines necessary to implement—

(I) the other requirements set forth in the standards under subsection (a); or

(II) the requirements set forth in subtitles A and C and the amendments made by such subtitles;

the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.

(2) **ENFORCEMENT AUTHORITY.**—The provisions of section 2736(b) of the Public Health Services Act shall apply to the enforcement under paragraph (1) of requirements of subsection (a)(1) (without regard to any limitation on the application of those provisions to group health plans).

(d) **NO INTERFERENCE WITH STATE REGULATORY AUTHORITY.**—Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

(e) **PRESUMPTION FOR CERTAIN STATE-OPERATED EXCHANGES.**—

(1) **IN GENERAL.**—In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.

(2) **PROCESS.**—The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.

SEC. 1322. FEDERAL PROGRAM TO ASSIST ESTABLISHMENT AND OPERATION OF NON-PROFIT, MEMBER-RUN HEALTH INSURANCE ISSUERS.

(a) **ESTABLISHMENT OF PROGRAM.**—

(1) **IN GENERAL.**—The Secretary shall establish a program to carry out the purposes of this section to be known as the Consumer Operated and Oriented Plan (CO-OP) program.

(2) **PURPOSE.**—It is the purpose of the CO-OP program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans.

(b) **LOANS AND GRANTS UNDER THE CO-OP PROGRAM.**—

(1) **IN GENERAL.**—The Secretary shall provide through the CO-OP program for the awarding to persons applying to become qualified nonprofit health insurance issuers of—

(A) loans to provide assistance to such person in meeting its start-up costs; and

(B) grants to provide assistance to such person in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans.

(2) **REQUIREMENTS FOR AWARDING LOANS AND GRANTS.**—

(A) **IN GENERAL.**—In awarding loans and grants under the CO-OP program, the Secretary shall—

(i) take into account the recommendations of the advisory board established under paragraph (3);

(ii) give priority to applicants that will offer qualified health plans on a Statewide basis, will utilize integrated care models, and have significant private support; and

(iii) ensure that there is sufficient funding to establish at least 1 qualified nonprofit health insurance issuer in each State, except that nothing in this clause shall prohibit the Secretary from funding the establishment of multiple qualified nonprofit health insurance issuers in any State if the funding is sufficient to do so.

(B) **STATES WITHOUT ISSUERS IN PROGRAM.**—If no health insurance issuer applies to be a qualified nonprofit health insurance issuer within a State, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the State or the expansion of a qualified nonprofit health insurance issuer from another State to the State.

(C) **AGREEMENT.**—

(i) **IN GENERAL.**—The Secretary shall require any person receiving a loan or grant under the CO-OP program to enter into an agreement with the Secretary which requires such person to meet (and to continue to meet)—

(I) any requirement under this section for such person to be treated as a qualified nonprofit health insurance issuer; and

(II) any requirements contained in the agreement for such person to receive such loan or grant.

(ii) **RESTRICTIONS ON USE OF FEDERAL FUNDS.**—The agreement shall include a requirement that no portion of the funds made available by any loan or grant under this section may be used—

(I) for carrying on propaganda, or otherwise attempting, to influence legislation; or

(II) for marketing.

Nothing in this clause shall be construed to allow a person to take any action prohibited by section 501(c)(29) of the Internal Revenue Code of 1986.

(iii) **FAILURE TO MEET REQUIREMENTS.**—If the Secretary determines that a person has failed to meet any requirement described in clause (i) or (ii) and has failed to correct such failure within a reasonable period of time of when the person first knows (or reasonably should have known) of such failure, such person shall repay to the Secretary an amount equal to the sum of—

(I) 110 percent of the aggregate amount of loans and grants received under this section; plus

(II) interest on the aggregate amount of loans and grants received under this section for the period the loans or grants were outstanding.

The Secretary shall notify the Secretary of the Treasury of any determination under this section of a failure that results in the termination of an issuer's tax-exempt status under section 501(c)(29) of such Code.

(D) **TIME FOR AWARDING LOANS AND GRANTS.**—The Secretary shall not later than July 1, 2013, award the loans and grants under the CO-OP program and begin the distribution of amounts awarded under such loans and grants.

(3) **ADVISORY BOARD.**—

(A) **IN GENERAL.**—The advisory board under this paragraph shall consist of 15 members appointed by the Comptroller General of the United States from among individuals with qualifications described in section 1805(c)(2) of the Social Security Act.

(B) **RULES RELATING TO APPOINTMENTS.**—

(i) **STANDARDS.**—Any individual appointed under subparagraph (A) shall meet ethics and conflict of interest standards protecting against insurance industry involvement and interference.

(ii) **ORIGINAL APPOINTMENTS.**—The original appointment of board members under subparagraph (A)(ii) shall be made no later than 3 months after the date of enactment of this Act.

(C) **VACANCY.**—Any vacancy on the advisory board shall be filled in the same manner as the original appointment.

(D) **PAY AND REIMBURSEMENT.**—

(i) **NO COMPENSATION FOR MEMBERS OF ADVISORY BOARD.**—Except as provided in clause (ii), a member of the advisory board may not receive pay, allowances, or benefits by reason of their service on the board.

(ii) **TRAVEL EXPENSES.**—Each member shall receive travel expenses, including per diem in lieu of subsistence under subchapter I of chapter 57 of title 5, United States Code.

(E) **APPLICATION OF FACAs.**—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the advisory board, except that section 14 of such Act shall not apply.

(F) **TERMINATION.**—The advisory board shall terminate on the earlier of the date that it completes its duties under this section or December 31, 2015.

(c) **QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER.**—For purposes of this section—

(1) **IN GENERAL.**—The term “qualified nonprofit health insurance issuer” means a health insurance issuer that is an organization—

(A) that is organized under State law as a nonprofit, member corporation;

(B) substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans; and

(C) that meets the other requirements of this subsection.

(2) **CERTAIN ORGANIZATIONS PROHIBITED.**—An organization shall not be treated as a qualified nonprofit health insurance issuer if—

(A) the organization or a related entity (or any predecessor of either) was a health insurance issuer on July 16, 2009; or

(B) the organization is sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision.

(3) **GOVERNANCE REQUIREMENTS.**—An organization shall not be treated as a qualified nonprofit health insurance issuer unless—

(A) the governance of the organization is subject to a majority vote of its members;

(B) its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference; and

(C) as provided in regulations promulgated by the Secretary, the organization is required to operate with a strong consumer focus, including

timeliness, responsiveness, and accountability to members.

(4) **PROFITS INURE TO BENEFIT OF MEMBERS.**—An organization shall not be treated as a qualified nonprofit health insurance issuer unless any profits made by the organization are required to be used to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members.

(5) **COMPLIANCE WITH STATE INSURANCE LAWS.**—An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization meets all the requirements that other issuers of qualified health plans are required to meet in any State where the issuer offers a qualified health plan, including solvency and licensure requirements, rules on payments to providers, and compliance with network adequacy rules, rate and form filing rules, any applicable State premium assessments and any other State law described in section 1324(b).

(6) **COORDINATION WITH STATE INSURANCE REFORMS.**—An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization does not offer a health plan in a State until that State has in effect (or the Secretary has implemented for the State) the market reforms required by part A of title XXVII of the Public Health Service Act (as amended by subtitles A and C of this Act).

(d) **ESTABLISHMENT OF PRIVATE PURCHASING COUNCIL.**—

(1) **IN GENERAL.**—Qualified nonprofit health insurance issuers participating in the CO-OP program under this section may establish a private purchasing council to enter into collective purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, administrative services, health information technology, and actuarial services.

(2) **COUNCIL MAY NOT SET PAYMENT RATES.**—The private purchasing council established under paragraph (1) shall not set payment rates for health care facilities or providers participating in health insurance coverage provided by qualified nonprofit health insurance issuers.

(3) **CONTINUED APPLICATION OF ANTITRUST LAWS.**—

(A) **IN GENERAL.**—Nothing in this section shall be construed to limit the application of the antitrust laws to any private purchasing council (whether or not established under this subsection) or to any qualified nonprofit health insurance issuer participating in such a council.

(B) **ANTITRUST LAWS.**—For purposes of this subparagraph, the term “antitrust laws” has the meaning given the term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)). Such term also includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

(e) **LIMITATION ON PARTICIPATION.**—No representative of any Federal, State, or local government (or of any political subdivision or instrumentality thereof), and no representative of a person described in subsection (c)(2)(A), may serve on the board of directors of a qualified nonprofit health insurance issuer or with a private purchasing council established under subsection (d).

(f) **LIMITATIONS ON SECRETARY.**—

(1) **IN GENERAL.**—The Secretary shall not—

(A) participate in any negotiations between 1 or more qualified nonprofit health insurance issuers (or a private purchasing council established under subsection (d)) and any health care facilities or providers, including any drug manufacturer, pharmacy, or hospital; and

(B) establish or maintain a price structure for reimbursement of any health benefits covered by such issuers.

(2) **COMPETITION.**—Nothing in this section shall be construed as authorizing the Secretary to interfere with the competitive nature of providing health benefits through qualified nonprofit health insurance issuers.

(g) **APPROPRIATIONS.**—There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, \$6,000,000,000 to carry out this section.

(h) **TAX EXEMPTION FOR QUALIFIED NON-PROFIT HEALTH INSURANCE ISSUER.**—

(1) **IN GENERAL.**—Section 501(c) of the Internal Revenue Code of 1986 (relating to list of exempt organizations) is amended by adding at the end the following:

“(29) **CO-OP HEALTH INSURANCE ISSUERS.**—

“(A) **IN GENERAL.**—A qualified nonprofit health insurance issuer (within the meaning of section 1322 of the Patient Protection and Affordable Care Act) which has received a loan or grant under the CO-OP program under such section, but only with respect to periods for which the issuer is in compliance with the requirements of such section and any agreement with respect to the loan or grant.

“(B) **CONDITIONS FOR EXEMPTION.**—Subparagraph (A) shall apply to an organization only if—

“(i) the organization has given notice to the Secretary, in such manner as the Secretary may by regulations prescribe, that it is applying for recognition of its status under this paragraph,

“(ii) except as provided in section 1322(c)(4) of the Patient Protection and Affordable Care Act, no part of the net earnings of which inures to the benefit of any private shareholder or individual,

“(iii) no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and

“(iv) the organization does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.”.

(2) **ADDITIONAL REPORTING REQUIREMENT.**—Section 6033 of such Code (relating to returns by exempt organizations) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following:

“(m) **ADDITIONAL INFORMATION REQUIRED FROM CO-OP INSURERS.**—An organization described in section 501(c)(29) shall include on the return required under subsection (a) the following information:

“(1) The amount of the reserves required by each State in which the organization is licensed to issue qualified health plans.

“(2) The amount of reserves on hand.”.

(3) **APPLICATION OF TAX ON EXCESS BENEFIT TRANSACTIONS.**—Section 4958(e)(1) of such Code (defining applicable tax-exempt organization) is amended by striking “paragraph (3) or (4)” and inserting “paragraph (3), (4), or (29)”.

(i) **GAO STUDY AND REPORT.**—

(1) **STUDY.**—The Comptroller General of the General Accountability Office shall conduct an ongoing study on competition and market concentration in the health insurance market in the United States after the implementation of the reforms in such market under the provisions of, and the amendments made by, this Act. Such study shall include an analysis of new issuers of health insurance in such market.

(2) **REPORT.**—The Comptroller General shall, not later than December 31 of each even-numbered year (beginning with 2014), report to the appropriate committees of the Congress the results of the study conducted under paragraph (1), including any recommendations for administrative or legislative changes the Comptroller General determines necessary or appropriate to increase competition in the health insurance market.

SEC. 1323. COMMUNITY HEALTH INSURANCE OPTION.

(a) **VOLUNTARY NATURE.**—

(1) **NO REQUIREMENT FOR HEALTH CARE PROVIDERS TO PARTICIPATE.**—Nothing in this section shall be construed to require a health care provider to participate in a community health insurance option, or to impose any penalty for non-participation.

(2) **NO REQUIREMENT FOR INDIVIDUALS TO JOIN.**—Nothing in this section shall be construed to require an individual to participate in a community health insurance option, or to impose any penalty for non-participation.

(3) **STATE OPT OUT.**—

(A) **IN GENERAL.**—A State may elect to prohibit Exchanges in such State from offering a community health insurance option if such State enacts a law to provide for such prohibition.

(B) **TERMINATION OF OPT OUT.**—A State may repeal a law described in subparagraph (A) and provide for the offering of such an option through the Exchange.

(b) **ESTABLISHMENT OF COMMUNITY HEALTH INSURANCE OPTION.**—

(1) **ESTABLISHMENT.**—The Secretary shall establish a community health insurance option to offer, through the Exchanges established under this title (other than Exchanges in States that elect to opt out as provided for in subsection (a)(3)), health care coverage that provides value, choice, competition, and stability of affordable, high quality coverage throughout the United States.

(2) **COMMUNITY HEALTH INSURANCE OPTION.**—In this section, the term “community health insurance option” means health insurance coverage that—

(A) except as specifically provided for in this section, complies with the requirements for being a qualified health plan;

(B) provides high value for the premium charged;

(C) reduces administrative costs and promotes administrative simplification for beneficiaries;

(D) promotes high quality clinical care;

(E) provides high quality customer service to beneficiaries;

(F) offers a sufficient choice of providers; and

(G) complies with State laws (if any), except as otherwise provided for in this title, relating to the laws described in section 1324(b).

(3) **ESSENTIAL HEALTH BENEFITS.**—

(A) **GENERAL RULE.**—Except as provided in subparagraph (B), a community health insurance option offered under this section shall provide coverage only for the essential health benefits described in section 1302(b).

(B) **STATES MAY OFFER ADDITIONAL BENEFITS.**—Nothing in this section shall preclude a State from requiring that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option offered in such State.

(C) **CREDITS.**—

(i) **IN GENERAL.**—An individual enrolled in a community health insurance option under this section shall be eligible for credits under section 36B of the Internal Revenue Code of 1986 in the same manner as an individual who is enrolled in a qualified health plan.

(ii) **NO ADDITIONAL FEDERAL COST.**—A requirement by a State under subparagraph (B) that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option shall not affect the amount of a premium tax credit provided under section 36B of the Internal Revenue Code of 1986 with respect to such plan.

(D) **STATE MUST ASSUME COST.**—A State shall make payments to or on behalf of an eligible individual to defray the cost of any additional benefits described in subparagraph (B).

(E) **ENSURING ACCESS TO ALL SERVICES.**—Nothing in this Act shall prohibit an individual enrolled in a community health insurance option from paying out-of-pocket the full cost of any item or service not included as an essential health benefit or otherwise covered as a benefit by a health plan. Nothing in subparagraph (B) shall prohibit any type of medical provider from accepting an out-of-pocket payment from an individual enrolled in a community health insurance option for a service otherwise not included as an essential health benefit.

(F) **PROTECTING ACCESS TO END OF LIFE CARE.**—A community health insurance option offered under this section shall be prohibited from limiting access to end of life care.

(4) **COST SHARING.**—A community health insurance option shall offer coverage at each of the levels of coverage described in section 1302(d).

(5) **PREMIUMS.**—

(A) **PREMIUMS SUFFICIENT TO COVER COSTS.**—The Secretary shall establish geographically adjusted premium rates in an amount sufficient to cover expected costs (including claims and administrative costs) using methods in general use by qualified health plans.

(B) **APPLICABLE RULES.**—The provisions of title XXVII of the Public Health Service Act relating to premiums shall apply to community health insurance options under this section, including modified community rating provisions under section 2701 of such Act.

(C) **COLLECTION OF DATA.**—The Secretary shall collect data as necessary to set premium rates under subparagraph (A).

(D) **NATIONAL POOLING.**—Notwithstanding any other provision of law, the Secretary may treat all enrollees in community health insurance options as members of a single pool.

(E) **CONTINGENCY MARGIN.**—In establishing premium rates under subparagraph (A), the Secretary shall include an appropriate amount for a contingency margin.

(6) **REIMBURSEMENT RATES.**—

(A) **NEGOTIATED RATES.**—The Secretary shall negotiate rates for the reimbursement of health care providers for benefits covered under a community health insurance option.

(B) **LIMITATION.**—The rates described in subparagraph (A) shall not be higher, in aggregate, than the average reimbursement rates paid by health insurance issuers offering qualified health plans through the Exchange.

(C) **INNOVATION.**—Subject to the limits contained in subparagraph (A), a State Advisory Council established or designated under subsection (d) may develop or encourage the use of innovative payment policies that promote quality, efficiency and savings to consumers.

(7) **SOLVENCY AND CONSUMER PROTECTION.**—

(A) **SOLVENCY.**—The Secretary shall establish a Federal solvency standard to be applied with respect to a community health insurance option. A community health insurance option shall also be subject to the solvency standard of each State in which such community health insurance option is offered.

(B) **MINIMUM REQUIRED.**—In establishing the standard described under subparagraph (A), the Secretary shall require a reserve fund that shall be equal to at least the dollar value of the incurred but not reported claims of a community health insurance option.

(C) **CONSUMER PROTECTIONS.**—The consumer protection laws of a State shall apply to a community health insurance option.

(8) **REQUIREMENTS ESTABLISHED IN PARTNERSHIP WITH INSURANCE COMMISSIONERS.**—

(A) **IN GENERAL.**—The Secretary, in collaboration with the National Association of Insurance Commissioners (in this paragraph referred to as the “NAIC”), may promulgate regulations to establish additional requirements for a community health insurance option.

(B) **APPLICABILITY.**—Any requirement promulgated under subparagraph (A) shall be applicable to such option beginning 90 days after the date on which the regulation involved becomes final.

(C) **START-UP FUND.**—

(1) **ESTABLISHMENT OF FUND.**—

(A) **IN GENERAL.**—There is established in the Treasury of the United States a trust fund to be known as the “Health Benefit Plan Start-Up Fund” (referred to in this section as the “Start-Up Fund”), that shall consist of such amounts as may be appropriated or credited to the Start-Up Fund as provided for in this subsection to provide loans for the initial operations of a community health insurance option. Such amounts shall remain available until expended.

(B) **FUNDING.**—There is hereby appropriated to the Start-Up Fund, out of any moneys in the Treasury not otherwise appropriated an amount requested by the Secretary of Health and Human Services as necessary to—

(i) pay the start-up costs associated with the initial operations of a community health insurance option; and

(ii) pay the costs of making payments on claims submitted during the period that is not more than 90 days from the date on which such option is offered.

(2) **USE OF START-UP FUND.**—The Secretary shall use amounts contained in the Start-Up Fund to make payments (subject to the repayment requirements in paragraph (4)) for the purposes described in paragraph (1)(B).

(3) **PASS THROUGH OF REBATES.**—The Secretary may establish procedures for reducing the amount of payments to a contracting administrator to take into account any rebates or price concessions.

(4) **REPAYMENT.**—

(A) **IN GENERAL.**—A community health insurance option shall be required to repay the Secretary of the Treasury (on such terms as the Secretary may require) for any payments made under paragraph (1)(B) by the date that is not later than 9 years after the date on which the payment is made. The Secretary may require the payment of interest with respect to such repayments at rates that do not exceed the market interest rate (as determined by the Secretary).

(B) **SANCTIONS IN CASE OF FOR-PROFIT CONVERSION.**—In any case in which the Secretary enters into a contract with a qualified entity for the offering of a community health insurance option and such entity is determined to be a for-profit entity by the Secretary, such entity shall be—

(i) immediately liable to the Secretary for any payments received by such entity from the Start-Up Fund; and

(ii) permanently ineligible to offer a qualified health plan.

(D) **STATE ADVISORY COUNCIL.**—

(1) **ESTABLISHMENT.**—A State (other than a State that elects to opt out as provided for in subsection (a)(3)) shall establish or designate a public or non-profit private entity to serve as the State Advisory Council to provide recommendations to the Secretary on the operations and policies of a community health insurance option in the State. Such Council shall provide recommendations on at least the following:

(A) policies and procedures to integrate quality improvement and cost containment mechanisms into the health care delivery system;

(B) mechanisms to facilitate public awareness of the availability of a community health insurance option; and

(C) alternative payment structures under a community health insurance option for health care providers that encourage quality improvement and cost control.

(2) **MEMBERS.**—The members of the State Advisory Council shall be representatives of the

public and shall include health care consumers and providers.

(3) **APPLICABILITY OF RECOMMENDATIONS.**—The Secretary may apply the recommendations of a State Advisory Council to a community health insurance option in that State, in any other State, or in all States.

(E) **AUTHORITY TO CONTRACT; TERMS OF CONTRACT.**—

(1) **AUTHORITY.**—

(A) **IN GENERAL.**—The Secretary may enter into a contract or contracts with one or more qualified entities for the purpose of performing administrative functions (including functions described in subsection (a)(4) of section 1874A of the Social Security Act) with respect to a community health insurance option in the same manner as the Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary shall have the same authority with respect to a community health insurance option under this section as the Secretary has under subsections (a)(1) and (b) of section 1874A of the Social Security Act with respect to title XVIII of such Act.

(B) **REQUIREMENTS APPLY.**—If the Secretary enters into a contract with a qualified entity to offer a community health insurance option, under such contract such entity—

(i) shall meet the criteria established under paragraph (2); and

(ii) shall receive an administrative fee under paragraph (7).

(C) **LIMITATION.**—Contracts under this subsection shall not involve the transfer of insurance risk to the contracting administrator.

(D) **REFERENCE.**—An entity with which the Secretary has entered into a contract under this paragraph shall be referred to as a “contracting administrator”.

(2) **QUALIFIED ENTITY.**—To be qualified to be selected by the Secretary to offer a community health insurance option, an entity shall—

(A) meet the criteria established under section 1874A(a)(2) of the Social Security Act;

(B) be a nonprofit entity for purposes of offering such option;

(C) meet the solvency standards applicable under subsection (b)(7);

(D) be eligible to offer health insurance or health benefits coverage;

(E) meet quality standards specified by the Secretary;

(F) have in place effective procedures to control fraud, abuse, and waste; and

(G) meet such other requirements as the Secretary may impose.

Procedures described under subparagraph (F) shall include the implementation of procedures to use beneficiary identifiers to identify individuals entitled to benefits so that such an individual's social security account number is not used, and shall also include procedures for the use of technology (including front-end, prepayment intelligent data-matching technology similar to that used by hedge funds, investment funds, and banks) to provide real-time data analysis of claims for payment under this title to identify and investigate unusual billing or order practices under this title that could indicate fraud or abuse.

(3) **TERM.**—A contract provided for under paragraph (1) shall be for a term of at least 5 years but not more than 10 years, as determined by the Secretary. At the end of each such term, the Secretary shall conduct a competitive bidding process for the purposes of renewing existing contracts or selecting new qualified entities with which to enter into contracts under such paragraph.

(4) **LIMITATION.**—A contract may not be renewed under this subsection unless the Secretary determines that the contracting administrator has met performance requirements estab-

lished by the Secretary in the areas described in paragraph (7)(B).

(5) **AUDITS.**—The Inspector General shall conduct periodic audits with respect to contracting administrators under this subsection to ensure that the administrator involved is in compliance with this section.

(6) **REVOCATION.**—A contract awarded under this subsection shall be revoked by the Secretary, upon the recommendation of the Inspector General, only after notice to the contracting administrator involved and an opportunity for a hearing. The Secretary may revoke such contract if the Secretary determines that such administrator has engaged in fraud, deception, waste, abuse of power, negligence, mismanagement of taxpayer dollars, or gross mismanagement. An entity that has had a contract revoked under this paragraph shall not be qualified to enter into a subsequent contract under this subsection.

(7) **FEE FOR ADMINISTRATION.**—

(A) **IN GENERAL.**—The Secretary shall pay the contracting administrator a fee for the management, administration, and delivery of the benefits under this section.

(B) **REQUIREMENT FOR HIGH QUALITY ADMINISTRATION.**—The Secretary may increase the fee described in subparagraph (A) by not more than 10 percent, or reduce the fee described in subparagraph (A) by not more than 50 percent, based on the extent to which the contracting administrator, in the determination of the Secretary, meets performance requirements established by the Secretary, in at least the following areas:

(i) Maintaining low premium costs and low cost sharing requirements, provided that such requirements are consistent with section 1302.

(ii) Reducing administrative costs and promoting administrative simplification for beneficiaries.

(iii) Promoting high quality clinical care.

(iv) Providing high quality customer service to beneficiaries.

(C) **NON-RENEWAL.**—The Secretary may not renew a contract to offer a community health insurance option under this section with any contracting entity that has been assessed more than one reduction under subparagraph (B) during the contract period.

(8) **LIMITATION.**—Notwithstanding the terms of a contract under this subsection, the Secretary shall negotiate the reimbursement rates for purposes of subsection (b)(6).

(F) **REPORT BY HHS AND INSOLVENCY WARNINGS.**—

(1) **IN GENERAL.**—On an annual basis, the Secretary shall conduct a study on the solvency of a community health insurance option and submit to Congress a report describing the results of such study.

(2) **RESULT.**—If, in any year, the result of the study under paragraph (1) is that a community health insurance option is insolvent, such result shall be treated as a community health insurance option solvency warning.

(3) **SUBMISSION OF PLAN AND PROCEDURE.**—

(A) **IN GENERAL.**—If there is a community health insurance option solvency warning under paragraph (2) made in a year, the President shall submit to Congress, within the 15-day period beginning on the date of the budget submission to Congress under section 1105(a) of title 31, United States Code, for the succeeding year, proposed legislation to respond to such warning.

(B) **PROCEDURE.**—In the case of a legislative proposal submitted by the President pursuant to subparagraph (A), such proposal shall be considered by Congress using the same procedures described under sections 803 and 804 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that shall be used for a medicare funding warning.

(g) **MARKETING PARITY.**—In a facility controlled by the Federal Government, or by a State, where marketing or promotional materials related to a community health insurance option are made available to the public, making available marketing or promotional materials relating to private health insurance plans shall not be prohibited. Such materials include informational pamphlets, guidebooks, enrollment forms, or other materials determined reasonable for display.

(h) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 1324. LEVEL PLAYING FIELD.

(a) **IN GENERAL.**—Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law described in subsection (b) if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, a community health insurance option under section 1323, or a nationwide qualified health plan under section 1333(b), is not subject to such law.

(b) **LAWS DESCRIBED.**—The Federal and State laws described in this subsection are those Federal and State laws relating to—

- (1) guaranteed renewal;
- (2) rating;
- (3) preexisting conditions;
- (4) non-discrimination;
- (5) quality improvement and reporting;
- (6) fraud and abuse;
- (7) solvency and financial requirements;
- (8) market conduct;
- (9) prompt payment;
- (10) appeals and grievances;
- (11) privacy and confidentiality;
- (12) licensure; and
- (13) benefit plan material or information.

PART IV—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS

SEC. 1331. STATE FLEXIBILITY TO ESTABLISH BASIC HEALTH PROGRAMS FOR LOW-INCOME INDIVIDUALS NOT ELIGIBLE FOR MEDICAID.

(a) **ESTABLISHMENT OF PROGRAM.**—

(1) **IN GENERAL.**—The Secretary shall establish a basic health program meeting the requirements of this section under which a State may enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits described in section 1302(b) to eligible individuals in lieu of offering such individuals coverage through an Exchange.

(2) **CERTIFICATIONS AS TO BENEFIT COVERAGE AND COSTS.**—Such program shall provide that a State may not establish a basic health program under this section unless the State establishes to the satisfaction of the Secretary, and the Secretary certifies, that—

(A) in the case of an eligible individual enrolled in a standard health plan offered through the program, the State provides—

(i) that the amount of the monthly premium an eligible individual is required to pay for coverage under the standard health plan for the individual and the individual's dependents does not exceed the amount of the monthly premium that the eligible individual would have been required to pay (in the rating area in which the individual resides) if the individual had enrolled in the applicable second lowest cost silver plan (as defined in section 36B(b)(3)(B) of the Internal Revenue Code of 1986) offered to the individual through an Exchange; and

(ii) that the cost-sharing an eligible individual is required to pay under the standard health plan does not exceed—

(I) the cost-sharing required under a platinum plan in the case of an eligible individual with household income not in excess of 150 percent of

the poverty line for the size of the family involved; and

(II) the cost-sharing required under a gold plan in the case of an eligible individual not described in subclause (I); and

(B) the benefits provided under the standard health plans offered through the program cover at least the essential health benefits described in section 1302(b).

For purposes of subparagraph (A)(i), the amount of the monthly premium an individual is required to pay under either the standard health plan or the applicable second lowest cost silver plan shall be determined after reduction for any premium tax credits and cost-sharing reductions allowable with respect to either plan.

(b) **STANDARD HEALTH PLAN.**—In this section, the term “standard health plan” means a health benefits plan that the State contracts with under this section—

(1) under which the only individuals eligible to enroll are eligible individuals;

(2) that provides at least the essential health benefits described in section 1302(b); and

(3) in the case of a plan that provides health insurance coverage offered by a health insurance issuer, that has a medical loss ratio of at least 85 percent.

(c) **CONTRACTING PROCESS.**—

(1) **IN GENERAL.**—A State basic health program shall establish a competitive process for entering into contracts with standard health plans under subsection (a), including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits described in section 1302(b).

(2) **SPECIFIC ITEMS TO BE CONSIDERED.**—A State shall, as part of its competitive process under paragraph (1), include at least the following:

(A) **INNOVATION.**—Negotiation with offerors of a standard health plan for the inclusion of innovative features in the plan, including—

(i) care coordination and care management for enrollees, especially for those with chronic health conditions;

(ii) incentives for use of preventive services; and

(iii) the establishment of relationships between providers and patients that maximize patient involvement in health care decision-making, including providing incentives for appropriate utilization under the plan.

(B) **HEALTH AND RESOURCE DIFFERENCES.**—Consideration of, and the making of suitable allowances for, differences in health care needs of enrollees and differences in local availability of, and access to, health care providers. Nothing in this subparagraph shall be construed as allowing discrimination on the basis of pre-existing conditions or other health status-related factors.

(C) **MANAGED CARE.**—Contracting with managed care systems, or with systems that offer as many of the attributes of managed care as are feasible in the local health care market.

(D) **PERFORMANCE MEASURES.**—Establishing specific performance measures and standards for issuers of standard health plans that focus on quality of care and improved health outcomes, requiring such plans to report to the State with respect to the measures and standards, and making the performance and quality information available to enrollees in a useful form.

(3) **ENHANCED AVAILABILITY.**—

(A) **MULTIPLE PLANS.**—A State shall, to the maximum extent feasible, seek to make multiple standard health plans available to eligible individuals within a State to ensure individuals have a choice of such plans.

(B) **REGIONAL COMPACTS.**—A State may negotiate a regional compact with other States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans.

(4) **COORDINATION WITH OTHER STATE PROGRAMS.**—A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State Medicaid program under title XIX of the Social Security Act, the State child health plan under title XXI of such Act, and other State-administered health programs to maximize the efficiency of such programs and to improve the continuity of care.

(d) **TRANSFER OF FUNDS TO STATES.**—

(1) **IN GENERAL.**—If the Secretary determines that a State electing the application of this section meets the requirements of the program established under subsection (a), the Secretary shall transfer to the State for each fiscal year for which 1 or more standard health plans are operating within the State the amount determined under paragraph (3).

(2) **USE OF FUNDS.**—A State shall establish a trust for the deposit of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State. Amounts in the trust fund, and expenditures of such amounts, shall not be included in determining the amount of any non-Federal funds for purposes of meeting any matching or expenditure requirement of any federally-funded program.

(3) **AMOUNT OF PAYMENT.**—

(A) **SECRETARIAL DETERMINATION.**—

(i) **IN GENERAL.**—The amount determined under this paragraph for any fiscal year is the amount the Secretary determines is equal to 85 percent of the premium tax credits under section 36B of the Internal Revenue Code of 1986, and the cost-sharing reductions under section 1402, that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the State if such eligible individuals were allowed to enroll in qualified health plans through an Exchange established under this subtitle.

(ii) **SPECIFIC REQUIREMENTS.**—The Secretary shall make the determination under clause (i) on a per enrollee basis and shall take into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided to eligible individuals described in clause (i), including the age and income of the enrollee, whether the enrollment is for self-only or family coverage, geographic differences in average spending for health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan through an Exchange, and whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled. This determination shall take into consideration the experience of other States with respect to participation in an Exchange and such credits and reductions provided to residents of the other States, with a special focus on enrollees with income below 200 percent of poverty.

(iii) **CERTIFICATION.**—The Chief Actuary of the Centers for Medicare & Medicaid Services, in consultation with the Office of Tax Analysis of the Department of the Treasury, shall certify whether the methodology used to make determinations under this subparagraph, and such determinations, meet the requirements of clause (ii). Such certifications shall be based on sufficient data from the State and from comparable States about their experience with programs created by this Act.

(B) **CORRECTIONS.**—The Secretary shall adjust the payment for any fiscal year to reflect any

error in the determinations under subparagraph (A) for any preceding fiscal year.

(4) **APPLICATION OF SPECIAL RULES.**—The provisions of section 1303 shall apply to a State basic health program, and to standard health plans offered through such program, in the same manner as such rules apply to qualified health plans.

(e) **ELIGIBLE INDIVIDUAL.**—

(1) **IN GENERAL.**—In this section, the term “eligible individual” means, with respect to any State, an individual—

(A) who is a resident of the State who is not eligible to enroll in the State’s medicare program under title XIX of the Social Security Act for benefits that at a minimum consist of the essential health benefits described in section 1302(b);

(B) whose household income exceeds 133 percent but does not exceed 200 percent of the poverty line for the size of the family involved;

(C) who is not eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986) or is eligible for an employer-sponsored plan that is not affordable coverage (as determined under section 5000A(e)(2) of such Code); and

(D) who has not attained age 65 as of the beginning of the plan year.

Such term shall not include any individual who is not a qualified individual under section 1312 who is eligible to be covered by a qualified health plan offered through an Exchange.

(2) **ELIGIBLE INDIVIDUALS MAY NOT USE EXCHANGE.**—An eligible individual shall not be treated as a qualified individual under section 1312 eligible for enrollment in a qualified health plan offered through an Exchange established under section 1311.

(f) **SECRETARIAL OVERSIGHT.**—The Secretary shall each year conduct a review of each State program to ensure compliance with the requirements of this section, including ensuring that the State program meets—

(1) eligibility verification requirements for participation in the program;

(2) the requirements for use of Federal funds received by the program; and

(3) the quality and performance standards under this section.

(g) **STANDARD HEALTH PLAN OFFERORS.**—A State may provide that persons eligible to offer standard health plans under a basic health program established under this section may include a licensed health maintenance organization, a licensed health insurance insurer, or a network of health care providers established to offer services under the program.

(h) **DEFINITIONS.**—Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.

SEC. 1332. WAIVER FOR STATE INNOVATION.

(a) **APPLICATION.**—

(1) **IN GENERAL.**—A State may apply to the Secretary for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017. Such application shall—

(A) be filed at such time and in such manner as the Secretary may require;

(B) contain such information as the Secretary may require, including—

(i) a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and

(ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government; and

(C) provide an assurance that the State has enacted the law described in subsection (b)(2).

(2) **REQUIREMENTS.**—The requirements described in this paragraph with respect to health

insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows:

(A) Part I of subtitle D.

(B) Part II of subtitle D.

(C) Section 1402.

(D) Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.

(3) **PASS THROUGH OF FUNDING.**—With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, individuals and small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such waiver, shall be paid to the State for purposes of implementing the State plan under the waiver. Such amount shall be determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States.

(4) **WAIVER CONSIDERATION AND TRANSPARENCY.**—

(A) **IN GENERAL.**—An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).

(B) **REGULATIONS.**—Not later than 180 days after the date of enactment of this Act, the Secretary shall promulgate regulations relating to waivers under this section that provide—

(i) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

(ii) a process for the submission of an application that ensures the disclosure of—

(I) the provisions of law that the State involved seeks to waive; and

(II) the specific plans of the State to ensure that the waiver will be in compliance with subsection (b);

(iii) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance;

(iv) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the program under the waiver; and

(v) a process for the periodic evaluation by the Secretary of the program under the waiver.

(C) **REPORT.**—The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.

(5) **COORDINATED WAIVER PROCESS.**—The Secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under the provisions of this section, and the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act, and any other Federal law relating to the provision of health care items or services. Such process shall permit a State to submit a single application for a waiver under any or all of such provisions.

(6) **DEFINITION.**—In this section, the term “Secretary” means—

(A) the Secretary of Health and Human Services with respect to waivers relating to the pro-

visions described in subparagraph (A) through (C) of paragraph (2); and

(B) the Secretary of the Treasury with respect to waivers relating to the provisions described in paragraph (2)(D).

(b) **GRANTING OF WAIVERS.**—

(1) **IN GENERAL.**—The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan—

(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;

(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and

(D) will not increase the Federal deficit.

(2) **REQUIREMENT TO ENACT A LAW.**—

(A) **IN GENERAL.**—A law described in this paragraph is a State law that provides for State actions under a waiver under this section, including the implementation of the State plan under subsection (a)(1)(B).

(B) **TERMINATION OF OPT OUT.**—A State may repeal a law described in subparagraph (A) and terminate the authority provided under the waiver with respect to the State.

(c) **SCOPE OF WAIVER.**—

(1) **IN GENERAL.**—The Secretary shall determine the scope of a waiver of a requirement described in subsection (a)(2) granted to a State under subsection (a)(1).

(2) **LIMITATION.**—The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.

(d) **DETERMINATIONS BY SECRETARY.**—

(1) **TIME FOR DETERMINATION.**—The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection.

(2) **EFFECT OF DETERMINATION.**—

(A) **GRANTING OF WAIVERS.**—If the Secretary determines to grant a waiver under subsection (a)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

(B) **DENIAL OF WAIVER.**—If the Secretary determines a waiver should not be granted under subsection (a)(1), the Secretary shall notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefor.

(e) **TERM OF WAIVER.**—No waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request.

SEC. 1333. PROVISIONS RELATING TO OFFERING OF PLANS IN MORE THAN ONE STATE.

(a) **HEALTH CARE CHOICE COMPACTS.**—

(1) **IN GENERAL.**—Not later than July 1, 2013, the Secretary shall, in consultation with the National Association of Insurance Commissioners, issue regulations for the creation of health care choice compact under which 2 or more States may enter into an agreement under which—

(A) 1 or more qualified health plans could be offered in the individual markets in all such States but, except as provided in subparagraph (B), only be subject to the laws and regulations of the State in which the plan was written or issued;

(B) the issuer of any qualified health plan to which the compact applies—

(i) would continue to be subject to market conduct, unfair trade practices, network adequacy, and consumer protection standards (including standards relating to rating), including addressing disputes as to the performance of the contract, of the State in which the purchaser resides;

(ii) would be required to be licensed in each State in which it offers the plan under the compact or to submit to the jurisdiction of each such State with regard to the standards described in clause (i) (including allowing access to records as if the insurer were licensed in the State); and

(iii) must clearly notify consumers that the policy may not be subject to all the laws and regulations of the State in which the purchaser resides.

(2) **STATE AUTHORITY.**—A State may not enter into an agreement under this subsection unless the State enacts a law after the date of the enactment of this title that specifically authorizes the State to enter into such agreements.

(3) **APPROVAL OF COMPACTS.**—The Secretary may approve interstate health care choice compacts under paragraph (1) only if the Secretary determines that such health care choice compact—

(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title;

(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide;

(D) will not increase the Federal deficit; and

(E) will not weaken enforcement of laws and regulations described in paragraph (1)(B)(i) in any State that is included in such compact.

(4) **EFFECTIVE DATE.**—A health care choice compact described in paragraph (1) shall not take effect before January 1, 2016.

(b) **AUTHORITY FOR NATIONWIDE PLANS.**—

(1) **IN GENERAL.**—Except as provided in paragraph (2), if an issuer (including a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark) of a qualified health plan in the individual or small group market meets the requirements of this subsection (in this subsection a “nationwide qualified health plan”)—

(A) the issuer of the plan may offer the nationwide qualified health plan in the individual or small group market in more than 1 State; and

(B) with respect to State laws mandating benefit coverage by a health plan, only the State laws of the State in which such plan is written or issued shall apply to the nationwide qualified health plan.

(2) **STATE OPT-OUT.**—A State may, by specific reference in a law enacted after the date of enactment of this title, provide that this subsection shall not apply to that State. Such opt-out shall be effective until such time as the State by law revokes it.

(3) **PLAN REQUIREMENTS.**—An issuer meets the requirements of this subsection with respect to a nationwide qualified health plan if, in the determination of the Secretary—

(A) the plan offers a benefits package that is uniform in each State in which the plan is offered and meets the requirements set forth in paragraphs (4) through (6);

(B) the issuer is licensed in each State in which it offers the plan and is subject to all requirements of State law not inconsistent with this section, including but not limited to, the standards and requirements that a State imposes that do not prevent the application of a requirement of part A of title XXVII of the Public Health Service Act or a requirement of this title;

(C) the issuer meets all requirements of this title with respect to a qualified health plan, including the requirement to offer the silver and gold levels of the plan in each Exchange in the State for the market in which the plan is offered;

(D) the issuer determines the premiums for the plan in any State on the basis of the rating rules in effect in that State for the rating areas in which it is offered;

(E) the issuer offers the nationwide qualified health plan in at least 60 percent of the participating States in the first year in which the plan is offered, 65 percent of such States in the second year, 70 percent of such States in the third year, 75 percent of such States in the fourth year, and 80 percent of such States in the fifth and subsequent years;

(F) the issuer shall offer the plan in participating States across the country, in all geographic regions, and in all States that have adopted adjusted community rating before the date of enactment of this Act; and

(G) the issuer clearly notifies consumers that the policy may not contain some benefits otherwise mandated for plans in the State in which the purchaser resides and provides a detailed statement of the benefits offered and the benefit differences in that State, in accordance with rules promulgated by the Secretary.

(4) **FORM REVIEW FOR NATIONWIDE PLANS.**—Notwithstanding any contrary provision of State law, at least 3 months before any nationwide qualified health plan is offered, the issuer shall file all nationwide qualified health plan forms with the regulator in each participating State in which the plan will be offered. An issuer may appeal the disapproval of a nationwide qualified health plan form to the Secretary.

(5) **APPLICABLE RULES.**—The Secretary shall, in consultation with the National Association of Insurance Commissioners, issue rules for the offering of nationwide qualified health plans under this subsection. Nationwide qualified health plans may be offered only after such rules have taken effect.

(6) **COVERAGE.**—The Secretary shall provide that the health benefits coverage provided to an individual through a nationwide qualified health plan under this subsection shall include at least the essential benefits package described in section 1302.

(7) **STATE LAW MANDATING BENEFIT COVERAGE BY A HEALTH BENEFITS PLAN.**—For the purposes of this subsection, a State law mandating benefit coverage by a health plan is a law that mandates health insurance coverage or the offer of health insurance coverage for specific health services or specific diseases. A law that mandates health insurance coverage or reimbursement for services provided by certain classes of providers of health care services, or a law that mandates that certain classes of individuals must be covered as a group or as dependents, is not a State law mandating benefit coverage by a health benefits plan.

PART V—REINSURANCE AND RISK ADJUSTMENT

SEC. 1341. TRANSITIONAL REINSURANCE PROGRAM FOR INDIVIDUAL AND SMALL GROUP MARKETS IN EACH STATE.

(a) **IN GENERAL.**—Each State shall, not later than January 1, 2014—

(1) include in the Federal standards or State law or regulation the State adopts and has in

effect under section 1321(b) the provisions described in subsection (b); and

(2) establish (or enter into a contract with) 1 or more applicable reinsurance entities to carry out the reinsurance program under this section.

(b) **MODEL REGULATION.**—

(1) **IN GENERAL.**—In establishing the Federal standards under section 1321(a), the Secretary, in consultation with the National Association of Insurance Commissioners (the “NAIC”), shall include provisions that enable States to establish and maintain a program under which—

(A) health insurance issuers, and third party administrators on behalf of group health plans, are required to make payments to an applicable reinsurance entity for any plan year beginning in the 3-year period beginning January 1, 2014 (as specified in paragraph (3)); and

(B) the applicable reinsurance entity collects payments under subparagraph (A) and uses amounts so collected to make reinsurance payments to health insurance issuers described in subparagraph (A) that cover high risk individuals in the individual market (excluding grandfathered health plans) for any plan year beginning in such 3-year period.

(2) **HIGH-RISK INDIVIDUAL; PAYMENT AMOUNTS.**—The Secretary shall include the following in the provisions under paragraph (1):

(A) **DETERMINATION OF HIGH-RISK INDIVIDUALS.**—The method by which individuals will be identified as high risk individuals for purposes of the reinsurance program established under this section. Such method shall provide for identification of individuals as high-risk individuals on the basis of—

(i) a list of at least 50 but not more than 100 medical conditions that are identified as high-risk conditions and that may be based on the identification of diagnostic and procedure codes that are indicative of individuals with pre-existing, high-risk conditions; or

(ii) any other comparable objective method of identification recommended by the American Academy of Actuaries.

(B) **PAYMENT AMOUNT.**—The formula for determining the amount of payments that will be paid to health insurance issuers described in paragraph (1)(A) that insure high-risk individuals. Such formula shall provide for the equitable allocation of available funds through reconciliation and may be designed—

(i) to provide a schedule of payments that specifies the amount that will be paid for each of the conditions identified under subparagraph (A); or

(ii) to use any other comparable method for determining payment amounts that is recommended by the American Academy of Actuaries and that encourages the use of care coordination and care management programs for high risk conditions.

(3) **DETERMINATION OF REQUIRED CONTRIBUTIONS.**—

(A) **IN GENERAL.**—The Secretary shall include in the provisions under paragraph (1) the method for determining the amount each health insurance issuer and group health plan described in paragraph (1)(A) contributing to the reinsurance program under this section is required to contribute under such paragraph for each plan year beginning in the 36-month period beginning January 1, 2014. The contribution amount for any plan year may be based on the percentage of revenue of each issuer and the total costs of providing benefits to enrollees in self-insured plans or on a specified amount per enrollee and may be required to be paid in advance or periodically throughout the plan year.

(B) **SPECIFIC REQUIREMENTS.**—The method under this paragraph shall be designed so that—

(i) the contribution amount for each issuer proportionally reflects each issuer's fully insured commercial book of business for all major

medical products and the total value of all fees charged by the issuer and the costs of coverage administered by the issuer as a third party administrator;

(ii) the contribution amount can include an additional amount to fund the administrative expenses of the applicable reinsurance entity;

(iii) the aggregate contribution amounts for all States shall, based on the best estimates of the NAIC and without regard to amounts described in clause (ii), equal \$10,000,000,000 for plan years beginning in 2014, \$6,000,000,000 for plan years beginning in 2015, and \$4,000,000,000 for plan years beginning in 2016; and

(iv) in addition to the aggregate contribution amounts under clause (iii), each issuer's contribution amount for any calendar year under clause (iii) reflects its proportionate share of an additional \$2,000,000,000 for 2014, an additional \$2,000,000,000 for 2015, and an additional \$1,000,000,000 for 2016.

Nothing in this subparagraph shall be construed to preclude a State from collecting additional amounts from issuers on a voluntary basis.

(4) EXPENDITURE OF FUNDS.—The provisions under paragraph (1) shall provide that—

(A) the contribution amounts collected for any calendar year may be allocated and used in any of the three calendar years for which amounts are collected based on the reinsurance needs of a particular period or to reflect experience in a prior period; and

(B) amounts remaining unexpended as of December, 2016, may be used to make payments under any reinsurance program of a State in the individual market in effect in the 2-year period beginning on January 1, 2017.

Notwithstanding the preceding sentence, any contribution amounts described in paragraph (3)(B)(iv) shall be deposited into the general fund of the Treasury of the United States and may not be used for the program established under this section.

(c) APPLICABLE REINSURANCE ENTITY.—For purposes of this section—

(1) IN GENERAL.—The term “applicable reinsurance entity” means a not-for-profit organization—

(A) the purpose of which is to help stabilize premiums for coverage in the individual and small group markets in a State during the first 3 years of operation of an Exchange for such markets within the State when the risk of adverse selection related to new rating rules and market changes is greatest; and

(B) the duties of which shall be to carry out the reinsurance program under this section by coordinating the funding and operation of the risk-spreading mechanisms designed to implement the reinsurance program.

(2) STATE DISCRETION.—A State may have more than 1 applicable reinsurance entity to carry out the reinsurance program under this section within the State and 2 or more States may enter into agreements to provide for an applicable reinsurance entity to carry out such program in all such States.

(3) ENTITIES ARE TAX-EXEMPT.—An applicable reinsurance entity established under this section shall be exempt from taxation under chapter 1 of the Internal Revenue Code of 1986. The preceding sentence shall not apply to the tax imposed by section 511 such Code (relating to tax on unrelated business taxable income of an exempt organization).

(d) COORDINATION WITH STATE HIGH-RISK POOLS.—The State shall eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program established under this section. The State may coordinate the State high-risk pool with such program to the extent not inconsistent with the provisions of this section.

SEC. 1342. ESTABLISHMENT OF RISK CORRIDORS FOR PLANS IN INDIVIDUAL AND SMALL GROUP MARKETS.

(a) IN GENERAL.—The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act.

(b) PAYMENT METHODOLOGY.—

(1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

(B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(2) PAYMENTS IN.—The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

(B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

(c) DEFINITIONS.—In this section:

(1) ALLOWABLE COSTS.—

(A) IN GENERAL.—The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

(B) REDUCTION FOR RISK ADJUSTMENT AND REINSURANCE PAYMENTS.—Allowable costs shall be reduced by any risk adjustment and reinsurance payments received under section 1341 and 1343.

(2) TARGET AMOUNT.—The target amount of a plan for any year is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.

SEC. 1343. RISK ADJUSTMENT.

(a) IN GENERAL.—

(1) LOW ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subsection (b), each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(2) HIGH ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subsection (b), each State shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is

greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(b) CRITERIA AND METHODS.—The Secretary, in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section. The Secretary may utilize criteria and methods similar to the criteria and methods utilized under part C or D of title XVIII of the Social Security Act. Such criteria and methods shall be included in the standards and requirements the Secretary prescribes under section 1321.

(c) SCOPE.—A health plan or a health insurance issuer is described in this subsection if such health plan or health insurance issuer provides coverage in the individual or small group market within the State. This subsection shall not apply to a grandfathered health plan or the issuer of a grandfathered health plan with respect to that plan.

Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

Subpart A—Premium Tax Credits and Cost-sharing Reductions

SEC. 1401. REFUNDABLE TAX CREDIT PROVIDING PREMIUM ASSISTANCE FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 36A the following new section:

“SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

“(a) IN GENERAL.—In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.

“(b) PREMIUM ASSISTANCE CREDIT AMOUNT.—For purposes of this section—

“(1) IN GENERAL.—The term ‘premium assistance credit amount’ means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

“(2) PREMIUM ASSISTANCE AMOUNT.—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—

“(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act, or

“(B) the excess (if any) of—

“(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over

“(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

“(3) OTHER TERMS AND RULES RELATING TO PREMIUM ASSISTANCE AMOUNTS.—For purposes of paragraph (2)—

“(A) APPLICABLE PERCENTAGE.—

“(i) IN GENERAL.—Except as provided in clause (ii), the applicable percentage with respect to any taxpayer for any taxable year is equal to 2.8 percent, increased by the number of percentage points (not greater than 7) which bears the same ratio to 7 percentage points as—

“(I) the taxpayer’s household income for the taxable year in excess of 100 percent of the poverty line for a family of the size involved, bears to

“(II) an amount equal to 200 percent of the poverty line for a family of the size involved.

“(ii) SPECIAL RULE FOR TAXPAYERS UNDER 133 PERCENT OF POVERTY LINE.—If a taxpayer’s household income for the taxable year is in excess of 100 percent, but not more than 133 percent, of the poverty line for a family of the size involved, the taxpayer’s applicable percentage shall be 2 percent.

“(iii) INDEXING.—In the case of taxable years beginning in any calendar year after 2014, the Secretary shall adjust the initial and final applicable percentages under clause (i), and the 2 percent under clause (ii), for the calendar year to reflect the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

“(B) APPLICABLE SECOND LOWEST COST SILVER PLAN.—The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—

“(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and

“(ii) provides—

“(I) self-only coverage in the case of an applicable taxpayer—

“(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

“(bb) who is not described in item (aa) but who purchases only self-only coverage, and

“(II) family coverage in the case of any other applicable taxpayer.

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent other than either spouse and subsection (e) does not apply to the dependent.

“(C) ADJUSTED MONTHLY PREMIUM.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

“(D) ADDITIONAL BENEFITS.—If—

“(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers benefits in addition to the essential health benefits required to be provided by the plan, or

“(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan,

the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such

additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).

“(E) SPECIAL RULE FOR PEDIATRIC DENTAL COVERAGE.—For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.

“(c) DEFINITION AND RULES RELATING TO APPLICABLE TAXPAYERS, COVERAGE MONTHS, AND QUALIFIED HEALTH PLAN.—For purposes of this section—

“(1) APPLICABLE TAXPAYER.—

“(A) IN GENERAL.—The term ‘applicable taxpayer’ means, with respect to any taxable year, a taxpayer whose household income for the taxable year exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

“(B) SPECIAL RULE FOR CERTAIN INDIVIDUALS LAWFULLY PRESENT IN THE UNITED STATES.—If—

“(i) a taxpayer has a household income which is not greater than 100 percent of an amount equal to the poverty line for a family of the size involved, and

“(ii) the taxpayer is an alien lawfully present in the United States, but is not eligible for the medicaid program under title XIX of the Social Security Act by reason of such alien status,

the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

“(C) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and the taxpayer’s spouse file a joint return for the taxable year.

“(D) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual’s taxable year begins.

“(2) COVERAGE MONTH.—For purposes of this subsection—

“(A) IN GENERAL.—The term ‘coverage month’ means, with respect to an applicable taxpayer, any month if—

“(i) as of the first day of such month the taxpayer, the taxpayer’s spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and

“(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).

“(B) EXCEPTION FOR MINIMUM ESSENTIAL COVERAGE.—

“(i) IN GENERAL.—The term ‘coverage month’ shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in section 500A(f)(1)(C) (relating to coverage in the individual market).

“(ii) MINIMUM ESSENTIAL COVERAGE.—The term ‘minimum essential coverage’ has the meaning given such term by section 5000A(f).

“(C) SPECIAL RULE FOR EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.—For purposes of subparagraph (B)—

“(i) COVERAGE MUST BE AFFORDABLE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage—

“(I) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and

“(II) the employee’s required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.8 percent of the applicable taxpayer’s household income.

This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.

“(ii) COVERAGE MUST PROVIDE MINIMUM VALUE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan’s share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

“(iii) EMPLOYEE OR FAMILY MUST NOT BE COVERED UNDER EMPLOYER PLAN.—Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.

“(iv) INDEXING.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.8 percent under clause (i)(II) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

“(3) DEFINITIONS AND OTHER RULES.—

“(A) QUALIFIED HEALTH PLAN.—The term ‘qualified health plan’ has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

“(B) GRANDFATHERED HEALTH PLAN.—The term ‘grandfathered health plan’ has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.

“(d) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

“(1) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

“(2) HOUSEHOLD INCOME.—

“(A) HOUSEHOLD INCOME.—The term ‘household income’ means, with respect to any taxpayer, an amount equal to the sum of—

“(i) the modified gross income of the taxpayer, plus

“(ii) the aggregate modified gross incomes of all other individuals who—

“(I) were taken into account in determining the taxpayer’s family size under paragraph (1), and

“(II) were required to file a return of tax imposed by section 1 for the taxable year.

“(B) MODIFIED GROSS INCOME.—The term ‘modified gross income’ means gross income—

“(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (10) of section 62(a),

“(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

“(iii) determined without regard to sections 911, 931, and 933.

“(3) POVERTY LINE.—

“(A) IN GENERAL.—The term ‘poverty line’ has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397j(c)(5)).

“(B) POVERTY LINE USED.—In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

“(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

“(1) IN GENERAL.—If 1 or more individuals for whom a taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year (including the taxpayer or his spouse) are individuals who are not lawfully present—

“(A) the aggregate amount of premiums otherwise taken into account under clauses (i) and (ii) of subsection (b)(2)(A) shall be reduced by the portion (if any) of such premiums which is attributable to such individuals, and

“(B) for purposes of applying this section, the determination as to what percentage a taxpayer’s household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

“(i) A method under which—

“(I) the taxpayer’s family size is determined by not taking such individuals into account, and

“(II) the taxpayer’s household income is equal to the product of the taxpayer’s household income (determined without regard to this subsection) and a fraction—

“(aa) the numerator of which is the poverty line for the taxpayer’s family size determined after application of subclause (I), and

“(bb) the denominator of which is the poverty line for the taxpayer’s family size determined without regard to subclause (I).

“(ii) A comparable method reaching the same result as the method under clause (i).

“(2) LAWFULLY PRESENT.—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the credit under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

“(3) SECRETARIAL AUTHORITY.—The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

“(f) RECONCILIATION OF CREDIT AND ADVANCE CREDIT.—

“(1) IN GENERAL.—The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any advance payment of such credit under section 1412 of the Patient Protection and Affordable Care Act.

“(2) EXCESS ADVANCE PAYMENTS.—

“(A) IN GENERAL.—If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

“(B) LIMITATION ON INCREASE WHERE INCOME LESS THAN 400 PERCENT OF POVERTY LINE.—

“(i) IN GENERAL.—In the case of an applicable taxpayer whose household income is less than

400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed \$400 (\$250 in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year).

“(ii) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2014, each of the dollar amounts under clause (i) shall be increased by an amount equal to—

“(I) such dollar amount, multiplied by

“(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting ‘calendar year 2013’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

“(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for—

“(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and

“(2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.”.

(b) DISALLOWANCE OF DEDUCTION.—Section 280C of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

“(g) CREDIT FOR HEALTH INSURANCE PREMIUMS.—No deduction shall be allowed for the portion of the premiums paid by the taxpayer for coverage of 1 or more individuals under a qualified health plan which is equal to the amount of the credit determined for the taxable year under section 36B(a) with respect to such premiums.”.

(c) STUDY ON AFFORDABLE COVERAGE.—

(1) STUDY AND REPORT.—

(A) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Comptroller General shall conduct a study on the affordability of health insurance coverage, including—

(i) the impact of the tax credit for qualified health insurance coverage of individuals under section 36B of the Internal Revenue Code of 1986 and the tax credit for employee health insurance expenses of small employers under section 45R of such Code on maintaining and expanding the health insurance coverage of individuals;

(ii) the availability of affordable health benefits plans, including a study of whether the percentage of household income used for purposes of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 (as added by this section) is the appropriate level for determining whether employer-provided coverage is affordable for an employee and whether such level may be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided coverage; and

(iii) the ability of individuals to maintain essential health benefits coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

(B) REPORT.—The Comptroller General shall submit to the appropriate committees of Congress a report on the study conducted under subparagraph (A), together with legislative recommendations relating to the matters studied under such subparagraph.

(2) APPROPRIATE COMMITTEES OF CONGRESS.—In this subsection, the term “appropriate committees of Congress” means the Committee on Ways and Means, the Committee on Education and Labor, and the Committee on Energy and

Commerce of the House of Representatives and the Committee on Finance and the Committee on Health, Education, Labor and Pensions of the Senate.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting “36B,” after “36A,”.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36A the following new item:

“Sec. 36B. Refundable credit for coverage under a qualified health plan.”.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 1402. REDUCED COST-SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.

(a) IN GENERAL.—In the case of an eligible insured enrolled in a qualified health plan—

(1) the Secretary shall notify the issuer of the plan of such eligibility; and

(2) the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c).

(b) ELIGIBLE INSURED.—In this section, the term “eligible insured” means an individual—

(1) who enrolls in a qualified health plan in the silver level of coverage in the individual market offered through an Exchange; and

(2) whose household income exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved.

In the case of an individual described in section 36B(c)(1)(B) of the Internal Revenue Code of 1986, the individual shall be treated as having household income equal to 100 percent for purposes of applying this section.

(c) DETERMINATION OF REDUCTION IN COST-SHARING.—

(1) REDUCTION IN OUT-OF-POCKET LIMIT.—

(A) IN GENERAL.—The reduction in cost-sharing under this subsection shall first be achieved by reducing the applicable out-of-pocket limit under section 1302(c)(1) in the case of—

(i) an eligible insured whose household income is more than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, by two-thirds;

(ii) an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, by one-half; and

(iii) an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, by one-third.

(B) COORDINATION WITH ACTUARIAL VALUE LIMITS.—

(i) IN GENERAL.—The Secretary shall ensure the reduction under this paragraph shall not result in an increase in the plan’s share of the total allowed costs of benefits provided under the plan above—

(I) 90 percent in the case of an eligible insured described in paragraph (2)(A);

(II) 80 percent in the case of an eligible insured described in paragraph (2)(B); and

(III) 70 percent in the case of an eligible insured described in clause (ii) or (iii) of subparagraph (A).

(ii) ADJUSTMENT.—The Secretary shall adjust the out-of-pocket limits under paragraph (1) if necessary to ensure that such limits do not cause the respective actuarial values to exceed the levels specified in clause (i).

(2) ADDITIONAL REDUCTION FOR LOWER INCOME INSURED.—The Secretary shall establish procedures under which the issuer of a qualified health plan to which this section applies shall further reduce cost-sharing under the plan in a manner sufficient to—

(A) in the case of an eligible insured whose household income is not less than 100 percent but not more than 150 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 90 percent of such costs; and

(B) in the case of an eligible insured whose household income is more than 150 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 80 percent of such costs.

(3) METHODS FOR REDUCING COST-SHARING.—

(A) **IN GENERAL.**—An issuer of a qualified health plan making reductions under this subsection shall notify the Secretary of such reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions.

(B) **CAPITATED PAYMENTS.**—The Secretary may establish a capitated payment system to carry out the payment of cost-sharing reductions under this section. Any such system shall take into account the value of the reductions and make appropriate risk adjustments to such payments.

(4) **ADDITIONAL BENEFITS.**—If a qualified health plan under section 1302(b)(5) offers benefits in addition to the essential health benefits required to be provided by the plan, or a State requires a qualified health plan under section 1311(d)(3)(B) to cover benefits in addition to the essential health benefits required to be provided by the plan, the reductions in cost-sharing under this section shall not apply to such additional benefits.

(5) **SPECIAL RULE FOR PEDIATRIC DENTAL PLANS.**—If an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) for any plan year, subsection (a) shall not apply to that portion of any reduction in cost-sharing under subsection (c) that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J).

(d) SPECIAL RULES FOR INDIANS.—

(1) **INDIANS UNDER 300 PERCENT OF POVERTY.**—If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section—

(A) such individual shall be treated as an eligible insured; and

(B) the issuer of the plan shall eliminate any cost-sharing under the plan.

(2) **ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH PROVIDERS.**—If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and

(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A).

(3) **PAYMENT.**—The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.

(e) **RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—**

(1) **IN GENERAL.**—If an individual who is an eligible insured is not lawfully present—

(A) no cost-sharing reduction under this section shall apply with respect to the individual; and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(i) A method under which—

(I) the taxpayer's family size is determined by not taking such individuals into account, and

(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

(ii) A comparable method reaching the same result as the method under clause (i).

(2) **LAWFULLY PRESENT.**—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the cost-sharing reduction under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) **SECRETARIAL AUTHORITY.**—The Secretary, in consultation with the Secretary of the Treasury, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) **DEFINITIONS AND SPECIAL RULES.**—In this section:

(1) **IN GENERAL.**—Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.

(2) **LIMITATIONS ON REDUCTION.**—No cost-sharing reduction shall be allowed under this section with respect to coverage for any month unless the month is a coverage month with respect to which a credit is allowed to the insured (or an applicable taxpayer on behalf of the insured) under section 36B of such Code.

(3) **DATA USED FOR ELIGIBILITY.**—Any determination under this section shall be made on the basis of the taxable year for which the advance determination is made under section 1412 and not the taxable year for which the credit under section 36B of such Code is allowed.

Subpart B—Eligibility Determinations

SEC. 1411. PROCEDURES FOR DETERMINING ELIGIBILITY FOR EXCHANGE PARTICIPATION, PREMIUM TAX CREDITS AND REDUCED COST-SHARING, AND INDIVIDUAL RESPONSIBILITY EXEMPTIONS.

(a) **ESTABLISHMENT OF PROGRAM.**—The Secretary shall establish a program meeting the requirements of this section for determining—

(1) whether an individual who is to be covered in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, meets the requirements of sections 1312(f)(3), 1402(e), and 1412(d) of this title and section 36B(e) of the Internal Revenue Code of 1986 that the individual be a citizen or national of the United States or an alien lawfully present in the United States;

(2) in the case of an individual claiming a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402—

(A) whether the individual meets the income and coverage requirements of such sections; and

(B) the amount of the tax credit or reduced cost-sharing;

(3) whether an individual's coverage under an employer-sponsored health benefits plan is treated as unaffordable under sections 36B(c)(2)(C) and 5000A(e)(2); and

(4) whether to grant a certification under section 1311(d)(4)(H) attesting that, for purposes of the individual responsibility requirement under section 5000A of the Internal Revenue Code of 1986, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

(b) **INFORMATION REQUIRED TO BE PROVIDED BY APPLICANTS.—**

(1) **IN GENERAL.**—An applicant for enrollment in a qualified health plan offered through an Exchange in the individual market shall provide—

(A) the name, address, and date of birth of each individual who is to be covered by the plan (in this subsection referred to as an "enrollee"); and

(B) the information required by any of the following paragraphs that is applicable to an enrollee.

(2) **CITIZENSHIP OR IMMIGRATION STATUS.**—The following information shall be provided with respect to every enrollee:

(A) In the case of an enrollee whose eligibility is based on an attestation of citizenship of the enrollee, the enrollee's social security number.

(B) In the case of an individual whose eligibility is based on an attestation of the enrollee's immigration status, the enrollee's social security number (if applicable) and such identifying information with respect to the enrollee's immigration status as the Secretary, after consultation with the Secretary of Homeland Security, determines appropriate.

(3) **ELIGIBILITY AND AMOUNT OF TAX CREDIT OR REDUCED COST-SHARING.**—In the case of an enrollee with respect to whom a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402 is being claimed, the following information:

(A) **INFORMATION REGARDING INCOME AND FAMILY SIZE.**—The information described in section 6103(l)(21) for the taxable year ending with or within the second calendar year preceding the calendar year in which the plan year begins.

(B) **CHANGES IN CIRCUMSTANCES.**—The information described in section 1412(b)(2), including information with respect to individuals who were not required to file an income tax return for the taxable year described in subparagraph (A) or individuals who experienced changes in marital status or family size or significant reductions in income.

(4) **EMPLOYER-SPONSORED COVERAGE.**—In the case of an enrollee with respect to whom eligibility for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 is being established on the basis that the enrollee's (or related individual's) employer is not treated under section 36B(c)(2)(C) of such Code as providing minimum essential coverage or affordable minimum essential coverage, the following information:

(A) The name, address, and employer identification number (if available) of the employer.

(B) Whether the enrollee or individual is a full-time employee and whether the employer provides such minimum essential coverage.

(C) If the employer provides such minimum essential coverage, the lowest cost option for the enrollee's or individual's enrollment status and the enrollee's or individual's required contribution (within the meaning of section 5000A(e)(1)(B) of such Code) under the employer-sponsored plan.

(D) If an enrollee claims an employer's minimum essential coverage is unaffordable, the information described in paragraph (3).

If an enrollee changes employment or obtains additional employment while enrolled in a qualified health plan for which such credit or reduction is allowed, the enrollee shall notify the Exchange of such change or additional employment and provide the information described in this paragraph with respect to the new employer.

(5) EXEMPTIONS FROM INDIVIDUAL RESPONSIBILITY REQUIREMENTS.—In the case of an individual who is seeking an exemption certificate under section 1311(d)(4)(H) from any requirement or penalty imposed by section 5000A, the following information:

(A) In the case of an individual seeking exemption based on the individual's status as a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.

(B) In the case of an individual seeking exemption based on the lack of affordable coverage or the individual's status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.

(C) VERIFICATION OF INFORMATION CONTAINED IN RECORDS OF SPECIFIC FEDERAL OFFICIALS.—

(1) INFORMATION TRANSFERRED TO SECRETARY.—An Exchange shall submit the information provided by an applicant under subsection (b) to the Secretary for verification in accordance with the requirements of this subsection and subsection (d).

(2) CITIZENSHIP OR IMMIGRATION STATUS.—

(A) COMMISSIONER OF SOCIAL SECURITY.—The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:

(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).

(ii) The attestation of an individual that the individual is a citizen.

(B) SECRETARY OF HOMELAND SECURITY.—

(i) IN GENERAL.—In the case of an individual—

(I) who attests that the individual is an alien lawfully present in the United States; or

(II) who attests that the individual is a citizen but with respect to whom the Commissioner of Social Security has notified the Secretary under subsection (e)(3) that the attestation is inconsistent with information in the records maintained by the Commissioner;

the Secretary shall submit to the Secretary of Homeland Security the information described in clause (ii) for a determination as to whether the information provided is consistent with the information in the records of the Secretary of Homeland Security.

(ii) INFORMATION.—The information described in clause (ii) is the following:

(I) The name, date of birth, and any identifying information with respect to the individual's immigration status provided under subsection (b)(2).

(II) The attestation that the individual is an alien lawfully present in the United States or in the case of an individual described in clause (i)(II), the attestation that the individual is a citizen.

(3) ELIGIBILITY FOR TAX CREDIT AND COST-SHARING REDUCTION.—The Secretary shall submit the information described in subsection (b)(3)(A) provided under paragraph (3), (4), or (5) of subsection (b) to the Secretary of the

Treasury for verification of household income and family size for purposes of eligibility.

(4) METHODS.—

(A) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall provide that verifications and determinations under this subsection shall be done—

(i) through use of an on-line system or otherwise for the electronic submission of, and response to, the information submitted under this subsection with respect to an applicant; or

(ii) by determining the consistency of the information submitted with the information maintained in the records of the Secretary of the Treasury, the Secretary of Homeland Security, or the Commissioner of Social Security through such other method as is approved by the Secretary.

(B) FLEXIBILITY.—The Secretary may modify the methods used under the program established by this section for the Exchange and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant, including allowing an applicant to request the Secretary of the Treasury to provide the information described in paragraph (3) directly to the Exchange or to the Secretary. The Secretary shall not make any such modification unless the Secretary determines that any applicable requirements under this section and section 6103 of the Internal Revenue Code of 1986 with respect to the confidentiality, disclosure, maintenance, or use of information will be met.

(d) VERIFICATION BY SECRETARY.—In the case of information provided under subsection (b) that is not required under subsection (c) to be submitted to another person for verification, the Secretary shall verify the accuracy of such information in such manner as the Secretary determines appropriate, including delegating responsibility for verification to the Exchange.

(e) ACTIONS RELATING TO VERIFICATION.—

(1) IN GENERAL.—Each person to whom the Secretary provided information under subsection (c) shall report to the Secretary under the method established under subsection (c)(4) the results of its verification and the Secretary shall notify the Exchange of such results. Each person to whom the Secretary provided information under subsection (d) shall report to the Secretary in such manner as the Secretary determines appropriate.

(2) VERIFICATION.—

(A) ELIGIBILITY FOR ENROLLMENT AND PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—If information provided by an applicant under paragraphs (1), (2), (3), and (4) of subsection (b) is verified under subsections (c) and (d)—

(i) the individual's eligibility to enroll through the Exchange and to apply for premium tax credits and cost-sharing reductions shall be satisfied; and

(ii) the Secretary shall, if applicable, notify the Secretary of the Treasury under section 1412(c) of the amount of any advance payment to be made.

(B) EXEMPTION FROM INDIVIDUAL RESPONSIBILITY.—If information provided by an applicant under subsection (b)(5) is verified under subsections (c) and (d), the Secretary shall issue the certification of exemption described in section 1311(d)(4)(H).

(3) INCONSISTENCIES INVOLVING ATTESTATION OF CITIZENSHIP OR LAWFUL PRESENCE.—If the information provided by any applicant under subsection (b)(2) is inconsistent with information in the records maintained by the Commissioner of Social Security or Secretary of Homeland Security, whichever is applicable, the applicant's eligibility will be determined in the same manner

as an individual's eligibility under the medicaid program is determined under section 1902(ee) of the Social Security Act (as in effect on January 1, 2010).

(4) INCONSISTENCIES INVOLVING OTHER INFORMATION.—

(A) IN GENERAL.—If the information provided by an applicant under subsection (b) (other than subsection (b)(2)) is inconsistent with information in the records maintained by persons under subsection (c) or is not verified under subsection (d), the Secretary shall notify the Exchange and the Exchange shall take the following actions:

(i) REASONABLE EFFORT.—The Exchange shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information, and by taking such additional actions as the Secretary, through regulation or other guidance, may identify.

(ii) NOTICE AND OPPORTUNITY TO CORRECT.—In the case the inconsistency or inability to verify is not resolved under subparagraph (A), the Exchange shall—

(I) notify the applicant of such fact;

(II) provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant.

The Secretary may extend the 90-day period under subclause (II) for enrollments occurring during 2014.

(B) SPECIFIC ACTIONS NOT INVOLVING CITIZENSHIP OR LAWFUL PRESENCE.—

(i) IN GENERAL.—Except as provided in paragraph (3), the Exchange shall, during any period before the close of the period under subparagraph (A)(ii)(II), make any determination under paragraphs (2), (3), and (4) of subsection (a) on the basis of the information contained on the application.

(ii) ELIGIBILITY OR AMOUNT OF CREDIT OR REDUCTION.—If an inconsistency involving the eligibility for, or amount of, any premium tax credit or cost-sharing reduction is unresolved under this subsection as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify the applicant of the amount (if any) of the credit or reduction that is determined on the basis of the records maintained by persons under subsection (c).

(iii) EMPLOYER AFFORDABILITY.—If the Secretary notifies an Exchange that an enrollee is eligible for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 because the enrollee's (or related individual's) employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage, the Exchange shall notify the employer of such fact and that the employer may be liable for the payment assessed under section 4980H of such Code.

(iv) EXEMPTION.—In any case where the inconsistency involving, or inability to verify, information provided under subsection (b)(5) is not resolved as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify an applicant that no certification of exemption from any requirement or payment under section 5000A of such Code will be issued.

(C) APPEALS PROCESS.—The Exchange shall also notify each person receiving notice under this paragraph of the appeals processes established under subsection (f).

(f) APPEALS AND REDETERMINATIONS.—

(1) *IN GENERAL.*—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall establish procedures by which the Secretary or one of such other Federal officers—

(A) hears and makes decisions with respect to appeals of any determination under subsection (e); and

(B) redetermines eligibility on a periodic basis in appropriate circumstances.

(2) *EMPLOYER LIABILITY.*—

(A) *IN GENERAL.*—The Secretary shall establish a separate appeals process for employers who are notified under subsection (e)(4)(C) that the employer may be liable for a tax imposed by section 4980H of the Internal Revenue Code of 1986 with respect to an employee because of a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee. Such process shall provide an employer the opportunity to—

(i) present information to the Exchange for review of the determination either by the Exchange or the person making the determination, including evidence of the employer-sponsored plan and employer contributions to the plan; and

(ii) have access to the data used to make the determination to the extent allowable by law.

Such process shall be in addition to any rights of appeal the employer may have under subtitle F of such Code.

(B) *CONFIDENTIALITY.*—Notwithstanding any provision of this title (or the amendments made by this title) or section 6103 of the Internal Revenue Code of 1986, an employer shall not be entitled to any taxpayer return information with respect to an employee for purposes of determining whether the employer is subject to the penalty under section 4980H of such Code with respect to the employee, except that—

(i) the employer may be notified as to the name of an employee and whether or not the employee's income is above or below the threshold by which the affordability of an employer's health insurance coverage is measured; and

(ii) this subparagraph shall not apply to an employee who provides a waiver (at such time and in such manner as the Secretary may prescribe) authorizing an employer to have access to the employee's taxpayer return information.

(g) *CONFIDENTIALITY OF APPLICANT INFORMATION.*—

(1) *IN GENERAL.*—An applicant for insurance coverage or for a premium tax credit or cost-sharing reduction shall be required to provide only the information strictly necessary to authenticate identity, determine eligibility, and determine the amount of the credit or reduction.

(2) *RECEIPT OF INFORMATION.*—Any person who receives information provided by an applicant under subsection (b) (whether directly or by another person at the request of the applicant), or receives information from a Federal agency under subsection (c), (d), or (e), shall—

(A) use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the Exchange, including verifying the eligibility of an individual to enroll through an Exchange or to claim a premium tax credit or cost-sharing reduction or the amount of the credit or reduction; and

(B) not disclose the information to any other person except as provided in this section.

(h) *PENALTIES.*—

(1) *FALSE OR FRAUDULENT INFORMATION.*—

(A) *CIVIL PENALTY.*—

(i) *IN GENERAL.*—If—

(I) any person fails to provide correct information under subsection (b); and

(II) such failure is attributable to negligence or disregard of any rules or regulations of the Secretary,

such person shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$25,000 with respect to any failures involving an application for a plan year. For purposes of this subparagraph, the terms “negligence” and “disregard” shall have the same meanings as when used in section 6662 of the Internal Revenue Code of 1986.

(ii) *REASONABLE CAUSE EXCEPTION.*—No penalty shall be imposed under clause (i) if the Secretary determines that there was a reasonable cause for the failure and that the person acted in good faith.

(B) *KNOWING AND WILLFUL VIOLATIONS.*—Any person who knowingly and willfully provides false or fraudulent information under subsection (b) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$250,000.

(2) *IMPROPER USE OR DISCLOSURE OF INFORMATION.*—Any person who knowingly and willfully uses or discloses information in violation of subsection (g) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$25,000.

(3) *LIMITATIONS ON LIENS AND LEVIES.*—The Secretary (or, if applicable, the Attorney General of the United States) shall not—

(A) file notice of lien with respect to any property of a person by reason of any failure to pay the penalty imposed by this subsection; or

(B) levy on any such property with respect to such failure.

(i) *STUDY OF ADMINISTRATION OF EMPLOYER RESPONSIBILITY.*—

(1) *IN GENERAL.*—The Secretary of Health and Human Services shall, in consultation with the Secretary of the Treasury, conduct a study of the procedures that are necessary to ensure that in the administration of this title and section 4980H of the Internal Revenue Code of 1986 (as added by section 1513) that the following rights are protected:

(A) The rights of employees to preserve their right to confidentiality of their taxpayer return information and their right to enroll in a qualified health plan through an Exchange if an employer does not provide affordable coverage.

(B) The rights of employers to adequate due process and access to information necessary to accurately determine any payment assessed on employers.

(2) *REPORT.*—Not later than January 1, 2013, the Secretary of Health and Human Services shall report the results of the study conducted under paragraph (1), including any recommendations for legislative changes, to the Committees on Finance and Health, Education, Labor and Pensions of the Senate and the Committees of Education and Labor and Ways and Means of the House of Representatives.

SEC. 1412. ADVANCE DETERMINATION AND PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.

(a) *IN GENERAL.*—The Secretary, in consultation with the Secretary of the Treasury, shall establish a program under which—

(1) upon request of an Exchange, advance determinations are made under section 1411 with respect to the income eligibility of individuals enrolling in a qualified health plan in the individual market through the Exchange for the premium tax credit allowable under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402;

(2) the Secretary notifies—

(A) the Exchange and the Secretary of the Treasury of the advance determinations; and

(B) the Secretary of the Treasury of the name and employer identification number of each em-

ployer with respect to whom 1 or more employee of the employer were determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402 because—

(i) the employer did not provide minimum essential coverage; or

(ii) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(3) the Secretary of the Treasury makes advance payments of such credit or reductions to the issuers of the qualified health plans in order to reduce the premiums payable by individuals eligible for such credit.

(b) *ADVANCE DETERMINATIONS.*—

(1) *IN GENERAL.*—The Secretary shall provide under the program established under subsection (a) that advance determination of eligibility with respect to any individual shall be made—

(A) during the annual open enrollment period applicable to the individual (or such other enrollment period as may be specified by the Secretary); and

(B) on the basis of the individual's household income for the most recent taxable year for which the Secretary, after consultation with the Secretary of the Treasury, determines information is available.

(2) *CHANGES IN CIRCUMSTANCES.*—The Secretary shall provide procedures for making advance determinations on the basis of information other than that described in paragraph (1)(B) in cases where information included with an application form demonstrates substantial changes in income, changes in family size or other household circumstances, change in filing status, the filing of an application for unemployment benefits, or other significant changes affecting eligibility, including—

(A) allowing an individual claiming a decrease of 20 percent or more in income, or filing an application for unemployment benefits, to have eligibility for the credit determined on the basis of household income for a later period or on the basis of the individual's estimate of such income for the taxable year; and

(B) the determination of household income in cases where the taxpayer was not required to file a return of tax imposed by this chapter for the second preceding taxable year.

(c) *PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.*—

(1) *IN GENERAL.*—The Secretary shall notify the Secretary of the Treasury and the Exchange through which the individual is enrolling of the advance determination under section 1411.

(2) *PREMIUM TAX CREDIT.*—

(A) *IN GENERAL.*—The Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986 to the issuer of a qualified health plan on a monthly basis (or such other periodic basis as the Secretary may provide).

(B) *ISSUER RESPONSIBILITIES.*—An issuer of a qualified health plan receiving an advance payment with respect to an individual enrolled in the plan shall—

(i) reduce the premium charged the insured for any period by the amount of the advance payment for the period;

(ii) notify the Exchange and the Secretary of such reduction;

(iii) include with each billing statement the amount by which the premium for the plan has been reduced by reason of the advance payment; and

(iv) in the case of any nonpayment of premiums by the insured—

(I) notify the Secretary of such nonpayment; and

(II) allow a 3-month grace period for non-payment of premiums before discontinuing coverage.

(3) **COST-SHARING REDUCTIONS.**—The Secretary shall also notify the Secretary of the Treasury and the Exchange under paragraph (1) if an advance payment of the cost-sharing reductions under section 1402 is to be made to the issuer of any qualified health plan with respect to any individual enrolled in the plan. The Secretary of the Treasury shall make such advance payment at such time and in such amount as the Secretary specifies in the notice.

(d) **NO FEDERAL PAYMENTS FOR INDIVIDUALS NOT LAWFULLY PRESENT.**—Nothing in this subtitle or the amendments made by this subtitle allows Federal payments, credits, or cost-sharing reductions for individuals who are not lawfully present in the United States.

(e) **STATE FLEXIBILITY.**—Nothing in this subtitle or the amendments made by this subtitle shall be construed to prohibit a State from making payments to or on behalf of an individual for coverage under a qualified health plan offered through an Exchange that are in addition to any credits or cost-sharing reductions allowable to the individual under this subtitle and such amendments.

SEC. 1413. STREAMLINING OF PROCEDURES FOR ENROLLMENT THROUGH AN EXCHANGE AND STATE MEDICAID, CHIP, AND HEALTH SUBSIDY PROGRAMS.

(a) **IN GENERAL.**—The Secretary shall establish a system meeting the requirements of this section under which residents of each State may apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. Such system shall ensure that if an individual applying to an Exchange is found through screening to be eligible for medical assistance under the State medicaid plan under title XIX, or eligible for enrollment under a State children's health insurance program (CHIP) under title XXI of such Act, the individual is enrolled for assistance under such plan or program.

(b) **REQUIREMENTS RELATING TO FORMS AND NOTICE.**—

(1) **REQUIREMENTS RELATING TO FORMS.**—

(A) **IN GENERAL.**—The Secretary shall develop and provide to each State a single, streamlined form that—

(i) may be used to apply for all applicable State health subsidy programs within the State;

(ii) may be filed online, in person, by mail, or by telephone;

(iii) may be filed with an Exchange or with State officials operating one of the other applicable State health subsidy programs; and

(iv) is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable State health subsidy programs.

(B) **STATE AUTHORITY TO ESTABLISH FORM.**—A State may develop and use its own single, streamlined form as an alternative to the form developed under subparagraph (A) if the alternative form is consistent with standards promulgated by the Secretary under this section.

(C) **SUPPLEMENTAL ELIGIBILITY FORMS.**—The Secretary may allow a State to use a supplemental or alternative form in the case of individuals who apply for eligibility that is not determined on the basis of the household income (as defined in section 36B of the Internal Revenue Code of 1986).

(2) **NOTICE.**—The Secretary shall provide that an applicant filing a form under paragraph (1) shall receive notice of eligibility for an applicable State health subsidy program without any need to provide additional information or paperwork unless such information or paperwork is

specifically required by law when information provided on the form is inconsistent with data used for the electronic verification under paragraph (3) or is otherwise insufficient to determine eligibility.

(c) **REQUIREMENTS RELATING TO ELIGIBILITY BASED ON DATA EXCHANGES.**—

(1) **DEVELOPMENT OF SECURE INTERFACES.**—Each State shall develop for all applicable State health subsidy programs a secure, electronic interface allowing an exchange of data (including information contained in the application forms described in subsection (b)) that allows a determination of eligibility for all such programs based on a single application. Such interface shall be compatible with the method established for data verification under section 1411(c)(4).

(2) **DATA MATCHING PROGRAM.**—Each applicable State health subsidy program shall participate in a data matching arrangement for determining eligibility for participation in the program under paragraph (3) that—

(A) provides access to data described in paragraph (3);

(B) applies only to individuals who—

(i) receive assistance from an applicable State health subsidy program; or

(ii) apply for such assistance—

(I) by filing a form described in subsection (b); or

(II) by requesting a determination of eligibility and authorizing disclosure of the information described in paragraph (3) to applicable State health coverage subsidy programs for purposes of determining and establishing eligibility; and

(C) consistent with standards promulgated by the Secretary, including the privacy and data security safeguards described in section 1942 of the Social Security Act or that are otherwise applicable to such programs.

(3) **DETERMINATION OF ELIGIBILITY.**—

(A) **IN GENERAL.**—Each applicable State health subsidy program shall, to the maximum extent practicable—

(i) establish, verify, and update eligibility for participation in the program using the data matching arrangement under paragraph (2); and

(ii) determine such eligibility on the basis of reliable, third party data, including information described in sections 1137, 453(i), and 1942(a) of the Social Security Act, obtained through such arrangement.

(B) **EXCEPTION.**—This paragraph shall not apply in circumstances with respect to which the Secretary determines that the administrative and other costs of use of the data matching arrangement under paragraph (2) outweigh its expected gains in accuracy, efficiency, and program participation.

(4) **SECRETARIAL STANDARDS.**—The Secretary shall, after consultation with persons in possession of the data to be matched and representatives of applicable State health subsidy programs, promulgate standards governing the timing, contents, and procedures for data matching described in this subsection. Such standards shall take into account administrative and other costs and the value of data matching to the establishment, verification, and updating of eligibility for applicable State health subsidy programs.

(d) **ADMINISTRATIVE AUTHORITY.**—

(1) **AGREEMENTS.**—Subject to section 1411 and section 6103(l)(21) of the Internal Revenue Code of 1986 and any other requirement providing safeguards of privacy and data integrity, the Secretary may establish model agreements, and enter into agreements, for the sharing of data under this section.

(2) **AUTHORITY OF EXCHANGE TO CONTRACT OUT.**—Nothing in this section shall be construed to—

(A) prohibit contractual arrangements through which a State medicaid agency deter-

mines eligibility for all applicable State health subsidy programs, but only if such agency complies with the Secretary's requirements ensuring reduced administrative costs, eligibility errors, and disruptions in coverage; or

(B) change any requirement under title XIX that eligibility for participation in a State's medicaid program must be determined by a public agency.

(e) **APPLICABLE STATE HEALTH SUBSIDY PROGRAM.**—In this section, the term "applicable State health subsidy program" means—

(1) the program under this title for the enrollment in qualified health plans offered through an Exchange, including the premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;

(2) a State medicaid program under title XIX of the Social Security Act;

(3) a State children's health insurance program (CHIP) under title XXI of such Act; and

(4) a State program under section 1331 establishing qualified basic health plans.

SEC. 1414. DISCLOSURES TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.

(a) **DISCLOSURE OF TAXPAYER RETURN INFORMATION AND SOCIAL SECURITY NUMBERS.**—

(1) **TAXPAYER RETURN INFORMATION.**—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

"(21) **DISCLOSURE OF RETURN INFORMATION TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.**—

"(A) **IN GENERAL.**—The Secretary, upon written request from the Secretary of Health and Human Services, shall disclose to officers, employees, and contractors of the Department of Health and Human Services return information of any taxpayer whose income is relevant in determining any premium tax credit under section 36B or any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act or eligibility for participation in a State medicaid program under title XIX of the Social Security Act, a State's children's health insurance program under title XXI of the Social Security Act, or a basic health program under section 1331 of Patient Protection and Affordable Care Act. Such return information shall be limited to—

"(i) taxpayer identity information with respect to such taxpayer,

"(ii) the filing status of such taxpayer,

"(iii) the number of individuals for whom a deduction is allowed under section 151 with respect to the taxpayer (including the taxpayer and the taxpayer's spouse),

"(iv) the modified gross income (as defined in section 36B) of such taxpayer and each of the other individuals included under clause (iii) who are required to file a return of tax imposed by chapter 1 for the taxable year,

"(v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such credit or reduction (and the amount thereof), and

"(vi) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.

"(B) **INFORMATION TO EXCHANGE AND STATE AGENCIES.**—The Secretary of Health and Human Services may disclose to an Exchange established under the Patient Protection and Affordable Care Act or its contractors, or to a State agency administering a State program described in subparagraph (A) or its contractors, any inconsistency between the information provided by the Exchange or State agency to the Secretary and the information provided to the Secretary under subparagraph (A).

“(C) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) or (B) may be used by officers, employees, and contractors of the Department of Health and Human Services, an Exchange, or a State agency only for the purposes of, and to the extent necessary in—

“(i) establishing eligibility for participation in the Exchange, and verifying the appropriate amount of, any credit or reduction described in subparagraph (A),

“(ii) determining eligibility for participation in the State programs described in subparagraph (A).”.

(2) SOCIAL SECURITY NUMBERS.—Section 205(c)(2)(C) of the Social Security Act is amended by adding at the end the following new clause:

“(x) The Secretary of Health and Human Services, and the Exchanges established under section 1311 of the Patient Protection and Affordable Care Act, are authorized to collect and use the names and social security account numbers of individuals as required to administer the provisions of, and the amendments made by, the such Act.”.

(b) CONFIDENTIALITY AND DISCLOSURE.—Paragraph (3) of section 6103(a) of such Code is amended by striking “or (20)” and inserting “(20), or (21)”.

(c) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Paragraph (4) of section 6103(p) of such Code is amended—

(1) by inserting “, or any entity described in subsection (l)(21),” after “or (20)” in the matter preceding subparagraph (A),

(2) by inserting “or any entity described in subsection (l)(21),” after “or (o)(1)(A)” in subparagraph (F)(ii), and

(3) by inserting “or any entity described in subsection (l)(21),” after “or (20)” both places it appears in the matter after subparagraph (F).

(d) UNAUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking “or (20)” and inserting “(20), or (21)”.

SEC. 1415. PREMIUM TAX CREDIT AND COST-SHARING REDUCTION PAYMENTS DISREGARDED FOR FEDERAL AND FEDERALLY-ASSISTED PROGRAMS.

For purposes of determining the eligibility of any individual for benefits or assistance, or the amount or extent of benefits or assistance, under any Federal program or under any State or local program financed in whole or in part with Federal funds—

(1) any credit or refund allowed or made to any individual by reason of section 36B of the Internal Revenue Code of 1986 (as added by section 1401) shall not be taken into account as income and shall not be taken into account as resources for the month of receipt and the following 2 months; and

(2) any cost-sharing reduction payment or advance payment of the credit allowed under such section 36B that is made under section 1402 or 1412 shall be treated as made to the qualified health plan in which an individual is enrolled and not to that individual.

PART II—SMALL BUSINESS TAX CREDIT

SEC. 1421. CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL BUSINESSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by inserting after section 45Q the following:

“SEC. 45R. EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.

“(a) GENERAL RULE.—For purposes of section 38, in the case of an eligible small employer, the small employer health insurance credit determined under this section for any taxable year in

the credit period is the amount determined under subsection (b).

“(b) HEALTH INSURANCE CREDIT AMOUNT.—Subject to subsection (c), the amount determined under this subsection with respect to any eligible small employer is equal to 50 percent (35 percent in the case of a tax-exempt eligible small employer) of the lesser of—

“(1) the aggregate amount of nonelective contributions the employer made on behalf of its employees during the taxable year under the arrangement described in subsection (d)(4) for premiums for qualified health plans offered by the employer to its employees through an Exchange, or

“(2) the aggregate amount of nonelective contributions which the employer would have made during the taxable year under the arrangement if each employee taken into account under paragraph (1) had enrolled in a qualified health plan which had a premium equal to the average premium (as determined by the Secretary of Health and Human Services) for the small group market in the rating area in which the employee enrolls for coverage.

“(c) PHASEOUT OF CREDIT AMOUNT BASED ON NUMBER OF EMPLOYEES AND AVERAGE WAGES.—The amount of the credit determined under subsection (b) without regard to this subsection shall be reduced (but not below zero) by the sum of the following amounts:

“(1) Such amount multiplied by a fraction the numerator of which is the total number of full-time equivalent employees of the employer in excess of 10 and the denominator of which is 15.

“(2) Such amount multiplied by a fraction the numerator of which is the average annual wages of the employer in excess of the dollar amount in effect under subsection (d)(3)(B) and the denominator of which is such dollar amount.

“(d) ELIGIBLE SMALL EMPLOYER.—For purposes of this section—

“(1) IN GENERAL.—The term ‘eligible small employer’ means, with respect to any taxable year, an employer—

“(A) which has no more than 25 full-time equivalent employees for the taxable year,

“(B) the average annual wages of which do not exceed an amount equal to twice the dollar amount in effect under paragraph (3)(B) for the taxable year, and

“(C) which has in effect an arrangement described in paragraph (4).

“(2) FULL-TIME EQUIVALENT EMPLOYEES.—

“(A) IN GENERAL.—The term ‘full-time equivalent employees’ means a number of employees equal to the number determined by dividing—

“(i) the total number of hours of service for which wages were paid by the employer to employees during the taxable year, by

“(ii) 2,080.

Such number shall be rounded to the next lowest whole number if not otherwise a whole number.

“(B) EXCESS HOURS NOT COUNTED.—If an employee works in excess of 2,080 hours of service during any taxable year, such excess shall not be taken into account under subparagraph (A).

“(C) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

“(3) AVERAGE ANNUAL WAGES.—

“(A) IN GENERAL.—The average annual wages of an eligible small employer for any taxable year is the amount determined by dividing—

“(i) the aggregate amount of wages which were paid by the employer to employees during the taxable year, by

“(ii) the number of full-time equivalent employees of the employee determined under paragraph (2) for the taxable year.

Such amount shall be rounded to the next lowest multiple of \$1,000 if not otherwise such a multiple.

“(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B)—

“(i) 2011, 2012, AND 2013.—The dollar amount in effect under this paragraph for taxable years beginning in 2011, 2012, or 2013 is \$20,000.

“(ii) SUBSEQUENT YEARS.—In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be equal to \$20,000, multiplied by the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting ‘calendar year 2012’ for ‘calendar year 1992’ in subparagraph (B) thereof.

“(4) CONTRIBUTION ARRANGEMENT.—An arrangement is described in this paragraph if it requires an eligible small employer to make a nonelective contribution on behalf of each employee who enrolls in a qualified health plan offered to employees by the employer through an exchange in an amount equal to a uniform percentage (not less than 50 percent) of the premium cost of the qualified health plan.

“(5) SEASONAL WORKER HOURS AND WAGES NOT COUNTED.—For purposes of this subsection—

“(A) IN GENERAL.—The number of hours of service worked by, and wages paid to, a seasonal worker of an employer shall not be taken into account in determining the full-time equivalent employees and average annual wages of the employer unless the worker works for the employer on more than 120 days during the taxable year.

“(B) DEFINITION OF SEASONAL WORKER.—The term ‘seasonal worker’ means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

“(e) OTHER RULES AND DEFINITIONS.—For purposes of this section—

“(1) EMPLOYEE.—

“(A) CERTAIN EMPLOYEES EXCLUDED.—The term ‘employee’ shall not include—

“(i) an employee within the meaning of section 401(c)(1),

“(ii) any 2-percent shareholder (as defined in section 1372(b)) of an eligible small business which is an S corporation,

“(iii) any 5-percent owner (as defined in section 416(i)(1)(B)(i)) of an eligible small business, or

“(iv) any individual who bears any of the relationships described in subparagraphs (A) through (G) of section 152(d)(2) to, or is a dependent described in section 152(d)(2)(H) of, an individual described in clause (i), (ii), or (iii).

“(B) LEASED EMPLOYEES.—The term ‘employee’ shall include a leased employee within the meaning of section 414(n).

“(2) CREDIT PERIOD.—The term ‘credit period’ means, with respect to any eligible small employer, the 2-consecutive-taxable year period beginning with the 1st taxable year in which the employer (or any predecessor) offers 1 or more qualified health plans to its employees through an Exchange.

“(3) NONELECTIVE CONTRIBUTION.—The term ‘nonelective contribution’ means an employer contribution other than an employer contribution pursuant to a salary reduction arrangement.

“(4) WAGES.—The term ‘wages’ has the meaning given such term by section 3121(a) (determined without regard to any dollar limitation contained in such section).

“(5) AGGREGATION AND OTHER RULES MADE APPLICABLE.—

“(A) AGGREGATION RULES.—All employers treated as a single employer under subsection

(b), (c), (m), or (o) of section 414 shall be treated as a single employer for purposes of this section.

“(B) OTHER RULES.—Rules similar to the rules of subsections (c), (d), and (e) of section 52 shall apply.

“(f) CREDIT MADE AVAILABLE TO TAX-EXEMPT ELIGIBLE SMALL EMPLOYERS.—

“(1) IN GENERAL.—In the case of a tax-exempt eligible small employer, there shall be treated as a credit allowable under subpart C (and not allowable under this subpart) the lesser of—

“(A) the amount of the credit determined under this section with respect to such employer, or

“(B) the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins.

“(2) TAX-EXEMPT ELIGIBLE SMALL EMPLOYER.—For purposes of this section, the term ‘tax-exempt eligible small employer’ means an eligible small employer which is any organization described in section 501(c) which is exempt from taxation under section 501(a).

“(3) PAYROLL TAXES.—For purposes of this subsection—

“(A) IN GENERAL.—The term ‘payroll taxes’ means—

“(i) amounts required to be withheld from the employees of the tax-exempt eligible small employer under section 3401(a),

“(ii) amounts required to be withheld from such employees under section 3101(b), and

“(iii) amounts of the taxes imposed on the tax-exempt eligible small employer under section 3111(b).

“(B) SPECIAL RULE.—A rule similar to the rule of section 24(d)(2)(C) shall apply for purposes of subparagraph (A).

“(g) APPLICATION OF SECTION FOR CALENDAR YEARS 2011, 2012, AND 2013.—In the case of any taxable year beginning in 2011, 2012, or 2013, the following modifications to this section shall apply in determining the amount of the credit under subsection (a):

“(1) NO CREDIT PERIOD REQUIRED.—The credit shall be determined without regard to whether the taxable year is in a credit period and for purposes of applying this section to taxable years beginning after 2013, no credit period shall be treated as beginning with a taxable year beginning before 2014.

“(2) AMOUNT OF CREDIT.—The amount of the credit determined under subsection (b) shall be determined—

“(A) by substituting ‘35 percent (25 percent in the case of a tax-exempt eligible small employer)’ for ‘50 percent (35 percent in the case of a tax-exempt eligible small employer)’;

“(B) by reference to an eligible small employer’s nonexclusive contributions for premiums paid for health insurance coverage (within the meaning of section 9832(b)(1)) of an employee, and

“(C) by substituting for the average premium determined under subsection (b)(2) the amount the Secretary of Health and Human Services determines is the average premium for the small group market in the State in which the employer is offering health insurance coverage (or for such area within the State as is specified by the Secretary).

“(3) CONTRIBUTION ARRANGEMENT.—An arrangement shall not fail to meet the requirements of subsection (d)(4) solely because it provides for the offering of insurance outside of an Exchange.

“(h) INSURANCE DEFINITIONS.—Any term used in this section which is also used in the Public Health Service Act or subtitle A of title I of the Patient Protection and Affordable Care Act shall have the meaning given such term by such Act or subtitle.

“(i) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, includ-

ing regulations to prevent the avoidance of the 2-year limit on the credit period through the use of successor entities and the avoidance of the limitations under subsection (c) through the use of multiple entities.”.

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Section 38(b) of the Internal Revenue Code of 1986 (relating to current year business credit) is amended by striking “plus” at the end of paragraph (34), by striking the period at the end of paragraph (35) and inserting “, plus”, and by inserting after paragraph (35) the following:

“(36) the small employer health insurance credit determined under section 45R.”.

(c) CREDIT ALLOWED AGAINST ALTERNATIVE MINIMUM TAX.—Section 38(c)(4)(B) of the Internal Revenue Code of 1986 (defining specified credits) is amended by redesignating clauses (vi), (vii), and (viii) as clauses (vii), (viii), and (ix), respectively, and by inserting after clause (v) the following new clause:

“(vi) the credit determined under section 45R.”.

(d) DISALLOWANCE OF DEDUCTION FOR CERTAIN EXPENSES FOR WHICH CREDIT ALLOWED.—

(1) IN GENERAL.—Section 280C of the Internal Revenue Code of 1986 (relating to disallowance of deduction for certain expenses for which credit allowed), as amended by section 1401(b), is amended by adding at the end the following new subsection:

“(h) CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.—No deduction shall be allowed for that portion of the premiums for qualified health plans (as defined in section 1301(a) of the Patient Protection and Affordable Care Act), or for health insurance coverage in the case of taxable years beginning in 2011, 2012, or 2013, paid by an employer which is equal to the amount of the credit determined under section 45R(a) with respect to the premiums.”.

(2) DEDUCTION FOR EXPIRING CREDITS.—Section 196(c) of such Code is amended by striking “and” at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting “, and”, and by adding at the end the following new paragraph:

“(14) the small employer health insurance credit determined under section 45R(a).”.

(e) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

“Sec. 45R. Employee health insurance expenses of small employers.”.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2010.

(2) MINIMUM TAX.—The amendments made by subsection (c) shall apply to credits determined under section 45R of the Internal Revenue Code of 1986 in taxable years beginning after December 31, 2010, and to carrybacks of such credits.

Subtitle F—Shared Responsibility for Health Care

PART I—INDIVIDUAL RESPONSIBILITY

SEC. 1501. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) FINDINGS.—Congress makes the following findings:

(1) IN GENERAL.—The individual responsibility requirement provided for in this section (in this subsection referred to as the “requirement”) is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) EFFECTS ON THE NATIONAL ECONOMY AND INTERSTATE COMMERCE.—The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from \$2,500,000,000,000, or 17.6 percent of the economy, in 2009 to \$4,700,000,000,000 in 2019. Private health insurance spending is projected to be \$854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services. According to the Congressional Budget Office, the requirement will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) Half of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(F) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance which is in interstate commerce.

(G) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(H) Administrative costs for private health insurance, which were \$90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) SUPREME COURT RULING.—In *United States v. South-Eastern Underwriters Association* (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

(b) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

“CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

“Sec. 5000A. Requirement to maintain minimum essential coverage.

“SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

“(a) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

“(b) SHARED RESPONSIBILITY PAYMENT.—

“(1) IN GENERAL.—If an applicable individual fails to meet the requirement of subsection (a) for 1 or more months during any calendar year beginning after 2013, then, except as provided in subsection (d), there is hereby imposed a penalty with respect to the individual in the amount determined under subsection (c).

“(2) INCLUSION WITH RETURN.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

“(3) PAYMENT OF PENALTY.—If an individual with respect to whom a penalty is imposed by this section for any month—

“(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

“(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

“(c) AMOUNT OF PENALTY.—

“(1) IN GENERAL.—The penalty determined under this subsection for any month with respect to any individual is an amount equal to $\frac{1}{12}$ of the applicable dollar amount for the calendar year.

“(2) DOLLAR LIMITATION.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to all individuals for whom the taxpayer is liable under subsection (b)(3) shall not exceed an amount equal to 300 percent the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

“(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

“(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is \$750.

“(B) PHASE IN.—The applicable dollar amount is \$95 for 2014 and \$350 for 2015.

“(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

“(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to \$750, increased by an amount equal to—

“(i) \$750, multiplied by

“(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting ‘calendar year 2015’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

“(4) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

“(A) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to

the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

“(B) HOUSEHOLD INCOME.—The term ‘household income’ means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

“(i) the modified gross income of the taxpayer, plus

“(ii) the aggregate modified gross incomes of all other individuals who—

“(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

“(II) were required to file a return of tax imposed by section 1 for the taxable year.

“(C) MODIFIED GROSS INCOME.—The term ‘modified gross income’ means gross income—

“(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (10) of section 62(a),

“(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

“(iii) determined without regard to sections 911, 931, and 933.

“(D) POVERTY LINE.—

“(i) IN GENERAL.—The term ‘poverty line’ has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397j(c)(5)).

“(ii) POVERTY LINE USED.—In the case of any taxable year ending with or within a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of such calendar year.

“(d) APPLICABLE INDIVIDUAL.—For purposes of this section—

“(1) IN GENERAL.—The term ‘applicable individual’ means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

“(2) RELIGIOUS EXEMPTIONS.—

“(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in such section.

“(B) HEALTH CARE SHARING MINISTRY.—

“(i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

“(ii) HEALTH CARE SHARING MINISTRY.—The term ‘health care sharing ministry’ means an organization—

“(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

“(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

“(III) members of which retain membership even after they develop a medical condition,

“(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

“(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

“(3) INDIVIDUALS NOT LAWFULLY PRESENT.—Such term shall not include an individual for any month if for the month the individual is not

a citizen or national of the United States or an alien lawfully present in the United States.

“(4) INCARCERATED INDIVIDUALS.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

“(e) EXEMPTIONS.—No penalty shall be imposed under subsection (a) with respect to—

“(1) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—

“(A) IN GENERAL.—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

“(B) REQUIRED CONTRIBUTION.—For purposes of this paragraph, the term ‘required contribution’ means—

“(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

“(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

“(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination shall be made by reference to the affordability of the coverage to the employee.

“(D) INDEXING.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for ‘8 percent’ the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

“(2) TAXPAYERS WITH INCOME UNDER 100 PERCENT OF POVERTY LINE.—Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than 100 percent of the poverty line for the size of the family involved (determined in the same manner as under subsection (b)(4)).

“(3) MEMBERS OF INDIAN TRIBES.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

“(4) MONTHS DURING SHORT COVERAGE GAPS.—

“(A) IN GENERAL.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

“(B) SPECIAL RULES.—For purposes of applying this paragraph—

“(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

“(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

“(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

“(5) **HARDSHIPS.**—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

“(f) **MINIMUM ESSENTIAL COVERAGE.**—For purposes of this section—

“(1) **IN GENERAL.**—The term ‘minimum essential coverage’ means any of the following:

“(A) **GOVERNMENT SPONSORED PROGRAMS.**—Coverage under—

“(i) the Medicare program under part A of title XVIII of the Social Security Act,

“(ii) the Medicaid program under title XIX of the Social Security Act,

“(iii) the CHIP program under title XXI of the Social Security Act,

“(iv) the TRICARE for Life program,

“(v) the veteran’s health care program under chapter 17 of title 38, United States Code, or

“(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers).

“(B) **EMPLOYER-SPONSORED PLAN.**—Coverage under an eligible employer-sponsored plan.

“(C) **PLANS IN THE INDIVIDUAL MARKET.**—Coverage under a health plan offered in the individual market within a State.

“(D) **GRANDFATHERED HEALTH PLAN.**—Coverage under a grandfathered health plan.

“(E) **OTHER COVERAGE.**—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

“(2) **ELIGIBLE EMPLOYER-SPONSORED PLAN.**—The term ‘eligible employer-sponsored plan’ means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

“(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

“(B) any other plan or coverage offered in the small or large group market within a State. Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

“(3) **EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.**—The term ‘minimum essential coverage’ shall not include health insurance coverage which consists of coverage of excepted benefits—

“(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

“(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

“(4) **INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.**—Any applicable individual shall be treated as having minimum essential coverage for any month—

“(A) if such month occurs during any period described in subparagraph (A) or (B) of section

911(d)(1) which is applicable to the individual, or

“(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

“(5) **INSURANCE-RELATED TERMS.**—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

“(g) **ADMINISTRATION AND PROCEDURE.**—

“(1) **IN GENERAL.**—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

“(2) **SPECIAL RULES.**—Notwithstanding any other provision of law—

“(A) **WAIVER OF CRIMINAL PENALTIES.**—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

“(B) **LIMITATIONS ON LIENS AND LEVIES.**—The Secretary shall not—

“(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

“(ii) levy on any such property with respect to such failure.”.

(c) **CLERICAL AMENDMENT.**—The table of chapters for subtitle D of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 47 the following new item:

“CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE.”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 1502. REPORTING OF HEALTH INSURANCE COVERAGE.

(a) **IN GENERAL.**—Part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by inserting after subpart C the following new subpart:

“Subpart D—Information Regarding Health Insurance Coverage

“Sec. 6055. Reporting of health insurance coverage.

“SEC. 6055. REPORTING OF HEALTH INSURANCE COVERAGE.

“(a) **IN GENERAL.**—Every person who provides minimum essential coverage to an individual during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).

“(b) **FORM AND MANNER OF RETURN.**—

“(1) **IN GENERAL.**—A return is described in this subsection if such return—

“(A) is in such form as the Secretary may prescribe, and

“(B) contains—

“(i) the name, address and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy,

“(ii) the dates during which such individual was covered under minimum essential coverage during the calendar year,

“(iii) in the case of minimum essential coverage which consists of health insurance coverage, information concerning—

“(I) whether or not the coverage is a qualified health plan offered through an Exchange established under section 1311 of the Patient Protection and Affordable Care Act, and

“(II) in the case of a qualified health plan, the amount (if any) of any advance payment under section 1412 of the Patient Protection and Affordable Care Act of any cost-sharing reduction under section 1402 of such Act or of any premium tax credit under section 36B with respect to such coverage, and

“(iv) such other information as the Secretary may require.

“(2) **INFORMATION RELATING TO EMPLOYER-PROVIDED COVERAGE.**—If minimum essential coverage provided to an individual under subsection (a) consists of health insurance coverage of a health insurance issuer provided through a group health plan of an employer, a return described in this subsection shall include—

“(A) the name, address, and employer identification number of the employer maintaining the plan,

“(B) the portion of the premium (if any) required to be paid by the employer, and

“(C) if the health insurance coverage is a qualified health plan in the small group market offered through an Exchange, such other information as the Secretary may require for administration of the credit under section 45R (relating to credit for employee health insurance expenses of small employers).

“(c) **STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.**—

“(1) **IN GENERAL.**—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

“(A) the name and address of the person required to make such return and the phone number of the information contact for such person, and

“(B) the information required to be shown on the return with respect to such individual.

“(2) **TIME FOR FURNISHING STATEMENTS.**—The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

“(d) **COVERAGE PROVIDED BY GOVERNMENTAL UNITS.**—In the case of coverage provided by any governmental unit or any agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall make the returns and statements required by this section.

“(e) **MINIMUM ESSENTIAL COVERAGE.**—For purposes of this section, the term ‘minimum essential coverage’ has the meaning given such term by section 5000A(f).”.

(b) **ASSESSABLE PENALTIES.**—

(1) Subparagraph (B) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions) is amended by striking “or” at the end of clause (xii), by striking “and” at the end of clause (xiii) and inserting “or”, and by inserting after clause (xiii) the following new clause:

“(xiv) section 6055 (relating to returns relating to information regarding health insurance coverage), and”.

(2) Paragraph (2) of section 6724(d) of such Code is amended by striking “or” at the end of subparagraph (EE), by striking the period at the end of subparagraph (FF) and inserting “, or” and by inserting after subparagraph (FF) the following new subparagraph:

“(GG) section 6055(c) (relating to statements relating to information regarding health insurance coverage).”.

(c) **NOTIFICATION OF NONENROLLMENT.**—Not later than June 30 of each year, the Secretary of the Treasury, acting through the Internal Revenue Service and in consultation with the Secretary of Health and Human Services, shall send a notification to each individual who files an individual income tax return and who is not enrolled in minimum essential coverage (as defined in section 5000A of the Internal Revenue Code of 1986). Such notification shall contain information on the services available through the Exchange operating in the State in which such individual resides.

(d) **CONFORMING AMENDMENT.**—The table of subparts for part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to subpart C the following new item:

“SUBPART D—INFORMATION REGARDING HEALTH INSURANCE COVERAGE”.

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply to calendar years beginning after 2013.

PART II—EMPLOYER RESPONSIBILITIES

SEC. 1511. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF LARGE EMPLOYERS.

The Fair Labor Standards Act of 1938 is amended by inserting after section 18 (29 U.S.C. 218) the following:

“SEC. 18A. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF LARGE EMPLOYERS.

“In accordance with regulations promulgated by the Secretary, an employer to which this Act applies that has more than 200 full-time employees and that offers employees enrollment in 1 or more health benefits plans shall automatically enroll new full-time employees in one of the plans offered (subject to any waiting period authorized by law) and to continue the enrollment of current employees in a health benefits plan offered through the employer. Any automatic enrollment program shall include adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee were automatically enrolled in. Nothing in this section shall be construed to supersede any State law which establishes, implements, or continues in effect any standard or requirement relating to employers in connection with payroll except to the extent that such standard or requirement prevents an employer from instituting the automatic enrollment program under this section.”

SEC. 1512. EMPLOYER REQUIREMENT TO INFORM EMPLOYEES OF COVERAGE OPTIONS.

The Fair Labor Standards Act of 1938 is amended by inserting after section 18A (as added by section 1513) the following:

“SEC. 18B. NOTICE TO EMPLOYEES.

“(a) **IN GENERAL.**—In accordance with regulations promulgated by the Secretary, an employer to which this Act applies, shall provide to each employee at the time of hiring (or with respect to current employees, not later than March 1, 2013), written notice—

“(1) informing the employee of the existence of an Exchange, including a description of the services provided by such Exchange, and the manner in which the employee may contact the Exchange to request assistance;

“(2) if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code of 1986 and a cost sharing reduction under section 1402 of the Patient Protection and Affordable Care Act if the employee purchases a qualified health plan through the Exchange; and

“(3) if the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

“(b) **EFFECTIVE DATE.**—Subsection (a) shall take effect with respect to employers in a State beginning on March 1, 2013.”

SEC. 1513. SHARED RESPONSIBILITY FOR EMPLOYERS.

(a) **IN GENERAL.**—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

“SEC. 4980H. SHARED RESPONSIBILITY FOR EMPLOYERS REGARDING HEALTH COVERAGE.

“(a) **LARGE EMPLOYERS NOT OFFERING HEALTH COVERAGE.**—If—

“(1) any applicable large employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

“(2) at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee, then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

“(b) **LARGE EMPLOYERS WITH WAITING PERIODS EXCEEDING 30 DAYS.**—

“(1) **IN GENERAL.**—In the case of any applicable large employer which requires an extended waiting period to enroll in any minimum essential coverage under an employer-sponsored plan (as defined in section 5000A(f)(2)), there is hereby imposed on the employer an assessable payment, in the amount specified in paragraph (2), for each full-time employee of the employer to whom the extended waiting period applies.

“(2) **AMOUNT.**—For purposes of paragraph (1), the amount specified in this paragraph for a full-time employee is—

“(A) in the case of an extended waiting period which exceeds 30 days but does not exceed 60 days, \$400, and

“(B) in the case of an extended waiting period which exceeds 60 days, \$600.

“(3) **EXTENDED WAITING PERIOD.**—The term ‘extended waiting period’ means any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) which exceeds 30 days.

“(c) **LARGE EMPLOYERS OFFERING COVERAGE WITH EMPLOYEES WHO QUALIFY FOR PREMIUM TAX CREDITS OR COST-SHARING REDUCTIONS.**—

“(1) **IN GENERAL.**—If—

“(A) an applicable large employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

“(B) 1 or more full-time employees of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee, then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large employer described in subparagraph (B) for such month and 400 percent of the applicable payment amount.

“(2) **OVERALL LIMITATION.**—The aggregate amount of tax determined under paragraph (1) with respect to all employees of an applicable large employer for any month shall not exceed the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

“(d) **DEFINITIONS AND SPECIAL RULES.**—For purposes of this section—

“(1) **APPLICABLE PAYMENT AMOUNT.**—The term ‘applicable payment amount’ means, with respect to any month, $\frac{1}{12}$ of \$750.

“(2) **APPLICABLE LARGE EMPLOYER.**—

“(A) **IN GENERAL.**—The term ‘applicable large employer’ means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.

“(B) **EXEMPTION FOR CERTAIN EMPLOYERS.**—

“(i) **IN GENERAL.**—An employer shall not be considered to employ more than 50 full-time employees if—

“(I) the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year, and

“(II) the employees in excess of 50 employed during such 120-day period were seasonal workers.

“(ii) **DEFINITION OF SEASONAL WORKERS.**—The term ‘seasonal worker’ means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

“(C) **RULES FOR DETERMINING EMPLOYER SIZE.**—For purposes of this paragraph—

“(i) **APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.**—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

“(ii) **EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.**—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is an applicable large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

“(iii) **PREDECESSORS.**—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

“(3) **APPLICABLE PREMIUM TAX CREDIT AND COST-SHARING REDUCTION.**—The term ‘applicable premium tax credit and cost-sharing reduction’ means—

“(A) any premium tax credit allowed under section 36B,

“(B) any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act, and

“(C) any advance payment of such credit or reduction under section 1412 of such Act.

“(4) **FULL-TIME EMPLOYEE.**—

“(A) **IN GENERAL.**—The term ‘full-time employee’ means an employee who is employed on average at least 30 hours of service per week.

“(B) **HOURS OF SERVICE.**—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

“(5) **INFLATION ADJUSTMENT.**—

“(A) **IN GENERAL.**—In the case of any calendar year after 2014, each of the dollar amounts in subsection (b)(2) and (d)(1) shall be increased by an amount equal to the product of—

“(i) such dollar amount, and

“(ii) the premium adjustment percentage (as defined in section 1302(c)(4) of the Patient Protection and Affordable Care Act) for the calendar year.

“(B) **ROUNDING.**—If the amount of any increase under subparagraph (A) is not a multiple of \$10, such increase shall be rounded to the next lowest multiple of \$10.

“(6) **OTHER DEFINITIONS.**—Any term used in this section which is also used in the Patient Protection and Affordable Care Act shall have the same meaning as when used in such Act.

“(7) **TAX NONDEDUCTIBLE.**—For denial of deduction for the tax imposed by this section, see section 275(a)(6).

“(e) ADMINISTRATION AND PROCEDURE.—

“(1) IN GENERAL.—Any assessable payment provided by this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

“(2) TIME FOR PAYMENT.—The Secretary may provide for the payment of any assessable payment provided by this section on an annual, monthly, or other periodic basis as the Secretary may prescribe.

“(3) COORDINATION WITH CREDITS, ETC.—The Secretary shall prescribe rules, regulations, or guidance for the repayment of any assessable payment (including interest) if such payment is based on the allowance or payment of an applicable premium tax credit or cost-sharing reduction with respect to an employee, such allowance or payment is subsequently disallowed, and the assessable payment would not have been required to be made but for such allowance or payment.”.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end the following new item:

“Sec. 4980H. Shared responsibility for employers regarding health coverage.”.

(c) STUDY AND REPORT OF EFFECT OF TAX ON WORKERS' WAGES.—

(1) IN GENERAL.—The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments under section 4980H of the Internal Revenue Code of 1986 (as added by the amendments made by this section). The Secretary shall make such determination on the basis of the National Compensation Survey published by the Bureau of Labor Statistics.

(2) REPORT.—The Secretary shall report the results of the study under paragraph (1) to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2013.

SEC. 1514. REPORTING OF EMPLOYER HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart D of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986, as added by section 1502, is amended by inserting after section 6055 the following new section:

“SEC. 6056. LARGE EMPLOYERS REQUIRED TO REPORT ON HEALTH INSURANCE COVERAGE.

“(a) IN GENERAL.—Every applicable large employer required to meet the requirements of section 4980H with respect to its full-time employees during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).

“(b) FORM AND MANNER OF RETURN.—A return is described in this subsection if such return—

“(1) is in such form as the Secretary may prescribe, and

“(2) contains—

“(A) the name, date, and employer identification number of the employer,

“(B) a certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)),

“(C) if the employer certifies that the employer did offer to its full-time employees (and their dependents) the opportunity to so enroll—

“(i) the length of any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) with respect to such coverage,

“(ii) the months during the calendar year for which coverage under the plan was available,

“(iii) the monthly premium for the lowest cost option in each of the enrollment categories under the plan, and

“(iv) the applicable large employer's share of the total allowed costs of benefits provided under the plan,

“(D) the number of full-time employees for each month during the calendar year,

“(E) the name, address, and TIN of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such health benefits plans, and

“(F) such other information as the Secretary may require.

“(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.—

“(1) IN GENERAL.—Every person required to make a return under subsection (a) shall furnish to each full-time employee whose name is required to be set forth in such return under subsection (b)(2)(E) a written statement showing—

“(A) the name and address of the person required to make such return and the phone number of the information contact for such person, and

“(B) the information required to be shown on the return with respect to such individual.

“(2) TIME FOR FURNISHING STATEMENTS.—The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

“(d) COORDINATION WITH OTHER REQUIREMENTS.—To the maximum extent feasible, the Secretary may provide that—

“(1) any return or statement required to be provided under this section may be provided as part of any return or statement required under section 6051 or 6055, and

“(2) in the case of an applicable large employer offering health insurance coverage of a health insurance issuer, the employer may enter into an agreement with the issuer to include information required under this section with the return and statement required to be provided by the issuer under section 6055.

“(e) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of any applicable large employer which is a governmental unit or any agency or instrumentality thereof, the person appropriately designated for purposes of this section shall make the returns and statements required by this section.

“(f) DEFINITIONS.—For purposes of this section, any term used in this section which is also used in section 4980H shall have the meaning given such term by section 4980H.”.

(b) ASSESSABLE PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions), as amended by section 1502, is amended by striking “or” at the end of clause (xxiii), by striking “and” at the end of clause (xxiv) and inserting “or”, and by inserting after clause (xxiv) the following new clause:

“(xxv) section 6056 (relating to returns relating to large employers required to report on health insurance coverage), and”.

(2) Paragraph (2) of section 6724(d) of such Code, as so amended, is amended by striking “or” at the end of subparagraph (FF), by striking the period at the end of subparagraph (GG) and inserting “, or” and by inserting after subparagraph (GG) the following new subparagraph:

“(HH) section 6056(c) (relating to statements relating to large employers required to report on health insurance coverage).”.

(c) CONFORMING AMENDMENT.—The table of sections for subpart D of part III of subchapter

A of chapter 61 of such Code, as added by section 1502, is amended by adding at the end the following new item:

“Sec. 6056. Large employers required to report on health insurance coverage.”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2013.

SEC. 1515. OFFERING OF EXCHANGE-PARTICIPATING QUALIFIED HEALTH PLANS THROUGH CAFETERIA PLANS.

(a) IN GENERAL.—Subsection (f) of section 125 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

“(3) CERTAIN EXCHANGE-PARTICIPATING QUALIFIED HEALTH PLANS NOT QUALIFIED.—

“(A) IN GENERAL.—The term ‘qualified benefit’ shall not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an Exchange established under section 1311 of such Act.

“(B) EXCEPTION FOR EXCHANGE-ELIGIBLE EMPLOYERS.—Subparagraph (A) shall not apply with respect to any employee if such employee's employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the employee the opportunity to enroll through such an Exchange in a qualified health plan in a group market.”.

(b) CONFORMING AMENDMENTS.—Subsection (f) of section 125 of such Code is amended—

(1) by striking “For purposes of this section, the term” and inserting “For purposes of this section—

“(1) IN GENERAL.—The term”, and

(2) by striking “Such term shall not include” and inserting the following:

“(2) LONG-TERM CARE INSURANCE NOT QUALIFIED.—The term ‘qualified benefit’ shall not include”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

Subtitle G—Miscellaneous Provisions

SEC. 1551. DEFINITIONS.

Unless specifically provided for otherwise, the definitions contained in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91) shall apply with respect to this title.

SEC. 1552. TRANSPARENCY IN GOVERNMENT.

Not later than 30 days after the date of enactment of this Act, the Secretary of Health and Human Services shall publish on the Internet website of the Department of Health and Human Services, a list of all of the authorities provided to the Secretary under this Act (and the amendments made by this Act).

SEC. 1553. PROHIBITION AGAINST DISCRIMINATION ON ASSISTED SUICIDE.

(a) IN GENERAL.—The Federal Government, and any State or local government or health care provider that receives Federal financial assistance under this Act (or under an amendment made by this Act) or any health plan created under this Act (or under an amendment made by this Act), may not subject an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.

(b) DEFINITION.—In this section, the term “health care entity” includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

(c) CONSTRUCTION AND TREATMENT OF CERTAIN SERVICES.—Nothing in subsection (a) shall

be construed to apply to, or to affect, any limitation relating to—

(1) the withholding or withdrawing of medical treatment or medical care;

(2) the withholding or withdrawing of nutrition or hydration;

(3) abortion; or

(4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

(d) **ADMINISTRATION.**—The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on this section.

SEC. 1554. ACCESS TO THERAPIES.

Notwithstanding any other provision of this Act, the Secretary of Health and Human Services shall not promulgate any regulation that—

(1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;

(2) impedes timely access to health care services;

(3) interferes with communications regarding a full range of treatment options between the patient and the provider;

(4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions;

(5) violates the principles of informed consent and the ethical standards of health care professionals; or

(6) limits the availability of health care treatment for the full duration of a patient's medical needs.

SEC. 1555. FREEDOM NOT TO PARTICIPATE IN FEDERAL HEALTH INSURANCE PROGRAMS.

No individual, company, business, nonprofit entity, or health insurance issuer offering group or individual health insurance coverage shall be required to participate in any Federal health insurance program created under this Act (or any amendments made by this Act), or in any Federal health insurance program expanded by this Act (or any such amendments), and there shall be no penalty or fine imposed upon any such issuer for choosing not to participate in such programs.

SEC. 1556. EQUITY FOR CERTAIN ELIGIBLE SURVIVORS.

(a) **REBUTTABLE PRESUMPTION.**—Section 411(c)(4) of the Black Lung Benefits Act (30 U.S.C. 921(c)(4)) is amended by striking the last sentence.

(b) **CONTINUATION OF BENEFITS.**—Section 422(l) of the Black Lung Benefits Act (30 U.S.C. 932(l)) is amended by striking “, except with respect to a claim filed under this part on or after the effective date of the Black Lung Benefits Amendments of 1981”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to claims filed under part B or part C of the Black Lung Benefits Act (30 U.S.C. 921 et seq., 931 et seq.) after January 1, 2005, that are pending on or after the date of enactment of this Act.

SEC. 1557. NONDISCRIMINATION.

(a) **IN GENERAL.**—Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part

of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

(b) **CONTINUED APPLICATION OF LAWS.**—Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (42 U.S.C. 611 et seq.), or to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).

(c) **REGULATIONS.**—The Secretary may promulgate regulations to implement this section.

SEC. 1558. PROTECTIONS FOR EMPLOYEES.

The Fair Labor Standards Act of 1938 is amended by inserting after section 18B (as added by section 1512) the following:

“SEC. 18C. PROTECTIONS FOR EMPLOYEES.

“(a) **PROHIBITION.**—No employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee (or an individual acting at the request of the employee) has—

“(1) received a credit under section 36B of the Internal Revenue Code of 1986 or a subsidy under section 1402 of this Act;

“(2) provided, caused to be provided, or is about to provide or cause to be provided to the employer, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission the employee reasonably believes to be a violation of, any provision of this title (or an amendment made by this title);

“(3) testified or is about to testify in a proceeding concerning such violation;

“(4) assisted or participated, or is about to assist or participate, in such a proceeding; or

“(5) objected to, or refused to participate in, any activity, policy, practice, or assigned task that the employee (or other such person) reasonably believed to be in violation of any provision of this title (or amendment), or any order, rule, regulation, standard, or ban under this title (or amendment).

“(b) **COMPLAINT PROCEDURE.**—

“(1) **IN GENERAL.**—An employee who believes that he or she has been discharged or otherwise discriminated against by any employer in violation of this section may seek relief in accordance with the procedures, notifications, burdens of proof, remedies, and statutes of limitation set forth in section 2087(b) of title 15, United States Code.

“(2) **NO LIMITATION ON RIGHTS.**—Nothing in this section shall be deemed to diminish the rights, privileges, or remedies of any employee under any Federal or State law or under any collective bargaining agreement. The rights and remedies in this section may not be waived by any agreement, policy, form, or condition of employment.”.

SEC. 1559. OVERSIGHT.

The Inspector General of the Department of Health and Human Services shall have oversight authority with respect to the administration and implementation of this title as it relates to such Department.

SEC. 1560. RULES OF CONSTRUCTION.

(a) **NO EFFECT ON ANTITRUST LAWS.**—Nothing in this title (or an amendment made by this title) shall be construed to modify, impair, or supersede the operation of any of the antitrust laws. For the purposes of this section, the term “antitrust laws” has the meaning given such term in subsection (a) of the first section of the Clayton Act, except that such term includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition.

(b) **RULE OF CONSTRUCTION REGARDING HAWAII'S PREPAID HEALTH CARE ACT.**—Nothing in this title (or an amendment made by this title) shall be construed to modify or limit the application of the exemption for Hawaii's Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 et seq.) as provided for under section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)).

(c) **STUDENT HEALTH INSURANCE PLANS.**—Nothing in this title (or an amendment made by this title) shall be construed to prohibit an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965) from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable Federal, State or local law.

(d) **NO EFFECT ON EXISTING REQUIREMENTS.**—Nothing in this title (or an amendment made by this title, unless specified by direct statutory reference) shall be construed to modify any existing Federal requirement concerning the State agency responsible for determining eligibility for programs identified in section 1413.

SEC. 1561. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.

Title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.) is amended by adding at the end the following:

“Subtitle C—Other Provisions

“SEC. 3021. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.

“(a) **IN GENERAL.**—

“(1) **STANDARDS AND PROTOCOLS.**—Not later than 180 days after the date of enactment of this title, the Secretary, in consultation with the HIT Policy Committee and the HIT Standards Committee, shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs, as determined by the Secretary.

“(2) **METHODS.**—The Secretary shall facilitate enrollment in such programs through methods determined appropriate by the Secretary, which shall include providing individuals and third parties authorized by such individuals and their designees notification of eligibility and verification of eligibility required under such programs.

“(b) **CONTENT.**—The standards and protocols for electronic enrollment in the Federal and State programs described in subsection (a) shall allow for the following:

“(1) **Electronic matching against existing Federal and State data,** including vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation.

“(2) **Simplification and submission of electronic documentation,** digitization of documents, and systems verification of eligibility.

“(3) **Reuse of stored eligibility information** (including documentation) to assist with retention of eligible individuals.

“(4) **Capability for individuals to apply, recertify and manage their eligibility information online,** including at home, at points of service, and other community-based locations.

“(5) Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate.

“(6) Notification of eligibility, recertification, and other needed communication regarding eligibility, which may include communication via email and cellular phones.

“(7) Other functionalities necessary to provide eligibles with streamlined enrollment process.

“(c) APPROVAL AND NOTIFICATION.—With respect to any standard or protocol developed under subsection (a) that has been approved by the HIT Policy Committee and the HIT Standards Committee, the Secretary—

“(1) shall notify States of such standards or protocols; and

“(2) may require, as a condition of receiving Federal funds for the health information technology investments, that States or other entities incorporate such standards and protocols into such investments.

“(d) GRANTS FOR IMPLEMENTATION OF APPROPRIATE ENROLLMENT HIT.—

“(1) IN GENERAL.—The Secretary shall award grant to eligible entities to develop new, and adapt existing, technology systems to implement the HIT enrollment standards and protocols developed under subsection (a) (referred to in this subsection as ‘appropriate HIT technology’).

“(2) ELIGIBLE ENTITIES.—To be eligible for a grant under this subsection, an entity shall—

“(A) be a State, political subdivision of a State, or a local governmental entity; and

“(B) submit to the Secretary an application at such time, in such manner, and containing—

“(i) a plan to adopt and implement appropriate enrollment technology that includes—

“(I) proposed reduction in maintenance costs of technology systems;

“(II) elimination or updating of legacy systems; and

“(III) demonstrated collaboration with other entities that may receive a grant under this section that are located in the same State, political subdivision, or locality;

“(ii) an assurance that the entity will share such appropriate enrollment technology in accordance with paragraph (4); and

“(iii) such other information as the Secretary may require.

“(3) SHARING.—

“(A) IN GENERAL.—The Secretary shall ensure that appropriate enrollment HIT adopted under grants under this subsection is made available to other qualified State, qualified political subdivisions of a State, or other appropriate qualified entities (as described in subparagraph (B)) at no cost.

“(B) QUALIFIED ENTITIES.—The Secretary shall determine what entities are qualified to receive enrollment HIT under subparagraph (A), taking into consideration the recommendations of the HIT Policy Committee and the HIT Standards Committee.”

SEC. 1562. CONFORMING AMENDMENTS.

(a) APPLICABILITY.—Section 2735 of the Public Health Service Act (42 U.S.C. 300gg–21), as so redesignated by section 1001(4), is amended—

(1) by striking subsection (a);

(2) in subsection (b)—

(A) in paragraph (1), by striking “1 through 3” and inserting “1 and 2”; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking “subparagraph (D)” and inserting “subparagraph (D) or (E)”; and

(ii) by striking “1 through 3” and inserting “1 and 2”; and

(iii) by adding at the end the following:

“(E) ELECTION NOT APPLICABLE.—The election described in subparagraph (A) shall not be

available with respect to the provisions of subpart 1.”;

(3) in subsection (c), by striking “1 through 3 shall not apply to any group” and inserting “1 and 2 shall not apply to any individual coverage or any group”; and

(4) in subsection (d)—

(A) in paragraph (1), by striking “1 through 3 shall not apply to any group” and inserting “1 and 2 shall not apply to any individual coverage or any group”; and

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by striking “1 through 3 shall not apply to any group” and inserting “1 and 2 shall not apply to any individual coverage or any group”; and

(ii) in subparagraph (C), by inserting “or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer”; and

(C) in paragraph (3), by striking “any group” and inserting “any individual coverage or any group”.

(b) DEFINITIONS.—Section 2791(d) of the Public Health Service Act (42 U.S.C. 300gg–91(d)) is amended by adding at the end the following:

“(20) QUALIFIED HEALTH PLAN.—The term ‘qualified health plan’ has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act.

“(21) EXCHANGE.—The term ‘Exchange’ means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act.”

(c) TECHNICAL AND CONFORMING AMENDMENTS.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

(1) in section 2704 (42 U.S.C. 300gg), as so redesignated by section 1201(2)—

(A) in subsection (c)—

(i) in paragraph (2), by striking “group health plan” each place that such term appears and inserting “group or individual health plan”; and

(ii) in paragraph (3)—

(I) by striking “group health insurance” each place that such term appears and inserting “group or individual health insurance”; and

(II) in subparagraph (D), by striking “small or large” and inserting “individual or group”; and

(B) in subsection (d), by striking “group health insurance” each place that such term appears and inserting “group or individual health insurance”; and

(C) in subsection (e)(1)(A), by striking “group health insurance” and inserting “group or individual health insurance”;

(2) by striking the second heading for subpart 2 of part A (relating to other requirements);

(3) in section 2725 (42 U.S.C. 300gg–4), as so redesignated by section 1001(2)—

(A) in subsection (a), by striking “health insurance issuer offering group health insurance coverage” and inserting “health insurance issuer offering group or individual health insurance coverage”; and

(B) in subsection (b)—

(i) by striking “health insurance issuer offering group health insurance coverage in connection with a group health plan” in the matter preceding paragraph (1) and inserting “health insurance issuer offering group or individual health insurance coverage”; and

(ii) in paragraph (1), by striking “plan” and inserting “plan or coverage”; and

(C) in subsection (c)—

(i) in paragraph (2), by striking “group health insurance coverage offered by a health insurance issuer” and inserting “health insurance issuer offering group or individual health insurance coverage”; and

(ii) in paragraph (3), by striking “issuer” and inserting “health insurance issuer”; and

(D) in subsection (e), by striking “health insurance issuer offering group health insurance

coverage” and inserting “health insurance issuer offering group or individual health insurance coverage”;

(4) in section 2726 (42 U.S.C. 300gg–5), as so redesignated by section 1001(2)—

(A) in subsection (a), by striking “(or health insurance coverage offered in connection with such a plan)” each place that such term appears and inserting “or a health insurance issuer offering group or individual health insurance coverage”;

(B) in subsection (b), by striking “(or health insurance coverage offered in connection with such a plan)” each place that such term appears and inserting “or a health insurance issuer offering group or individual health insurance coverage”; and

(C) in subsection (c)—

(i) in paragraph (1), by striking “(and group health insurance coverage offered in connection with a group health plan)” and inserting “and a health insurance issuer offering group or individual health insurance coverage”; and

(ii) in paragraph (2), by striking “(or health insurance coverage offered in connection with such a plan)” each place that such term appears and inserting “or a health insurance issuer offering group or individual health insurance coverage”;

(5) in section 2727 (42 U.S.C. 300gg–6), as so redesignated by section 1001(2), by striking “health insurance issuers providing health insurance coverage in connection with group health plans” and inserting “and health insurance issuers offering group or individual health insurance coverage”;

(6) in section 2728 (42 U.S.C. 300gg–7), as so redesignated by section 1001(2)—

(A) in subsection (a), by striking “health insurance coverage offered in connection with such plan” and inserting “individual health insurance coverage”;

(B) in subsection (b)—

(i) in paragraph (1), by striking “or a health insurance issuer that provides health insurance coverage in connection with a group health plan” and inserting “or a health insurance issuer that offers group or individual health insurance coverage”; and

(ii) in paragraph (2), by striking “health insurance coverage offered in connection with the plan” and inserting “individual health insurance coverage”; and

(iii) in paragraph (3), by striking “health insurance coverage offered by an issuer in connection with such plan” and inserting “individual health insurance coverage”;

(C) in subsection (c), by striking “health insurance issuer providing health insurance coverage in connection with a group health plan” and inserting “health insurance issuer that offers group or individual health insurance coverage”; and

(D) in subsection (e)(1), by striking “health insurance coverage offered in connection with such a plan” and inserting “individual health insurance coverage”;

(7) by striking the heading for subpart 3;

(8) in section 2731 (42 U.S.C. 300gg–11), as so redesignated by section 1001(3)—

(A) by striking the section heading and all that follows through subsection (b);

(B) in subsection (c)—

(i) in paragraph (1)—

(I) in the matter preceding subparagraph (A), by striking “small group” and inserting “group and individual”; and

(II) in subparagraph (B)—

(aa) in the matter preceding clause (i), by inserting “and individuals” after “employers”; and

(bb) in clause (i), by inserting “or any additional individuals” after “additional groups”; and

(cc) in clause (ii), by striking “without regard to the claims experience of those employers and

their employees (and their dependents) or any health status-related factor relating to such" and inserting "and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals"; and

(ii) in paragraph (2), by striking "small group" and inserting "group or individual";

(C) in subsection (d)—

(i) by striking "small group" each place that such appears and inserting "group or individual"; and

(ii) in paragraph (1)(B)—

(I) by striking "all employers" and inserting "all employers and individuals";

(II) by striking "those employers" and inserting "those individuals, employers"; and

(III) by striking "such employees" and inserting "such individuals, employees";

(D) by striking subsection (e);

(E) by striking subsection (f); and

(F) by transferring such section (as amended by this paragraph) to appear at the end of section 2702 (as added by section 1001(4));

(9) in section 2732 (42 U.S.C. 300gg-12), as so redesignated by section 1001(3)—

(A) by striking the section heading and all that follows through subsection (a);

(B) in subsection (b)—

(i) in the matter preceding paragraph (1), by striking "group health plan in the small or large group market" and inserting "health insurance coverage offered in the group or individual market";

(ii) in paragraph (1), by inserting ", or individual, as applicable," after "plan sponsor";

(iii) in paragraph (2), by inserting ", or individual, as applicable," after "plan sponsor"; and

(iv) by striking paragraph (3) and inserting the following:

"(3) VIOLATION OF PARTICIPATION OR CONTRIBUTION RATES.—In the case of a group health plan, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable State law.";

(C) in subsection (c)—

(i) in paragraph (1)—

(I) in the matter preceding subparagraph (A), by striking "group health insurance coverage offered in the small or large group market" and inserting "group or individual health insurance coverage";

(II) in subparagraph (A), by inserting "or individual, as applicable," after "plan sponsor";

(III) in subparagraph (B)—

(aa) by inserting "or individual, as applicable," after "plan sponsor"; and

(bb) by inserting "or individual health insurance coverage"; and

(IV) in subparagraph (C), by inserting "or individuals, as applicable," after "those sponsors"; and

(ii) in paragraph (2)(A)—

(I) in the matter preceding clause (i), by striking "small group market or the large group market, or both markets," and inserting "individual or group market, or all markets,"; and

(II) in clause (i), by inserting "or individual, as applicable," after "plan sponsor"; and

(D) by transferring such section (as amended by this paragraph) to appear at the end of section 2703 (as added by section 1001(4));

(10) in section 2733 (42 U.S.C. 300gg-13), as so redesignated by section 1001(4)—

(A) in subsection (a)—

(i) in the matter preceding paragraph (1), by striking "small employer" and inserting "small employer or an individual";

(ii) in paragraph (1), by inserting ", or individual, as applicable," after "employer" each place that such appears; and

(iii) in paragraph (2), by striking "small employer" and inserting "employer, or individual, as applicable,";

(B) in subsection (b)—

(i) in paragraph (1)—

(I) in the matter preceding subparagraph (A), by striking "small employer" and inserting "employer, or individual, as applicable,";

(II) in subparagraph (A), by adding "and" at the end;

(III) by striking subparagraphs (B) and (C); and

(IV) in subparagraph (D)—

(aa) by inserting ", or individual, as applicable," after "employer"; and

(bb) by redesignating such subparagraph as subparagraph (B);

(ii) in paragraph (2)—

(I) by striking "small employers" each place that such term appears and inserting "employers, or individuals, as applicable,"; and

(II) by striking "small employer" and inserting "employer, or individual, as applicable,"; and

(C) by redesignating such section (as amended by this paragraph) as section 2709 and transferring such section to appear after section 2708 (as added by section 1001(5));

(11) by redesignating subpart 4 as subpart 2;

(12) in section 2735 (42 U.S.C. 300gg-21), as so redesignated by section 1001(4)—

(A) by striking subsection (a);

(B) by striking "subparts 1 through 3" each place that such appears and inserting "subpart 1";

(C) by redesignating subsections (b) through (e) as subsections (a) through (d), respectively; and

(D) by redesignating such section (as amended by this paragraph) as section 2722;

(13) in section 2736 (42 U.S.C. 300gg-22), as so redesignated by section 1001(4)—

(A) in subsection (a)—

(i) in paragraph (1), by striking "small or large group markets" and inserting "individual or group market"; and

(ii) in paragraph (2), by inserting "or individual health insurance coverage" after "group health plans";

(B) in subsection (b)(1)(B), by inserting "individual health insurance coverage or" after "respect to"; and

(C) by redesignating such section (as amended by this paragraph) as section 2723;

(14) in section 2737(a)(1) (42 U.S.C. 300gg-23), as so redesignated by section 1001(4)—

(A) by inserting "individual or" before "group health insurance"; and

(B) by redesignating such section (as amended by this paragraph) as section 2724;

(15) in section 2762 (42 U.S.C. 300gg-62)—

(A) in the section heading by inserting "**AND APPLICATION**" before the period; and

(B) by adding at the end the following:

"(c) APPLICATION OF PART A PROVISIONS.—

"(1) IN GENERAL.—The provisions of part A shall apply to health insurance issuers providing health insurance coverage in the individual market in a State as provided for in such part.

"(2) CLARIFICATION.—To the extent that any provision of this part conflicts with a provision of part A with respect to health insurance issuers providing health insurance coverage in the individual market in a State, the provisions of such part A shall apply."; and

(16) in section 2791(e) (42 U.S.C. 300gg-91(e))—

(A) in paragraph (2), by striking "51" and inserting "101"; and

(B) in paragraph (4)—

(i) by striking "at least 2" each place that such appears and inserting "at least 1"; and

(ii) by striking "50" and inserting "100".

(d) APPLICATION.—Notwithstanding any other provision of the Patient Protection and Afford-

able Care Act, nothing in such Act (or an amendment made by such Act) shall be construed to—

(1) prohibit (or authorize the Secretary of Health and Human Services to promulgate regulations that prohibit) a group health plan or health insurance issuer from carrying out utilization management techniques that are commonly used as of the date of enactment of this Act; or

(2) restrict the application of the amendments made by this subtitle.

(e) TECHNICAL AMENDMENT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Subpart B of part 7 of subtitle A of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et. seq.) is amended, by adding at the end the following:

"SEC. 715. ADDITIONAL MARKET REFORMS.

"(a) GENERAL RULE.—Except as provided in subsection (b)—

"(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and

"(2) to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

"(b) EXCEPTION.—Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted."

(f) TECHNICAL AMENDMENT TO THE INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"SEC. 9815. ADDITIONAL MARKET REFORMS.

"(a) GENERAL RULE.—Except as provided in subsection (b)—

"(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subchapter; and

"(2) to the extent that any provision of this subchapter conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

"(b) EXCEPTION.—Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this subchapter shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted."

SEC. 1563. SENSE OF THE SENATE PROMOTING FISCAL RESPONSIBILITY.

(a) FINDINGS.—The Senate makes the following findings:

(1) Based on Congressional Budget Office (CBO) estimates, this Act will reduce the Federal deficit between 2010 and 2019.

(2) CBO projects this Act will continue to reduce budget deficits after 2019.

(3) Based on CBO estimates, this Act will extend the solvency of the Medicare HI Trust Fund.

(4) This Act will increase the surplus in the Social Security Trust Fund, which should be reserved to strengthen the finances of Social Security.

(5) The initial net savings generated by the Community Living Assistance Services and Supports (CLASS) program are necessary to ensure the long-term solvency of that program.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the additional surplus in the Social Security Trust Fund generated by this Act should be reserved for Social Security and not spent in this Act for other purposes; and

(2) the net savings generated by the CLASS program should be reserved for the CLASS program and not spent in this Act for other purposes.

TITLE II—ROLE OF PUBLIC PROGRAMS

Subtitle A—Improved Access to Medicaid

SEC. 2001. MEDICAID COVERAGE FOR THE LOW-EST INCOME POPULATIONS.

(a) COVERAGE FOR INDIVIDUALS WITH INCOME AT OR BELOW 133 PERCENT OF THE POVERTY LINE.—

(1) BEGINNING 2014.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by striking “or” at the end of subclause (VI);

(B) by adding “or” at the end of subclause (VII); and

(C) by inserting after subclause (VII) the following:

“(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k);”.

(2) PROVISION OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—

(A) IN GENERAL.—Section 1902 of such Act (42 U.S.C. 1396a) is amended by inserting after subsection (j) the following:

“(k)(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2). Such medical assistance shall be provided subject to the requirements of section 1937, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under subparagraph (B) of section 1937(a)(2), the State may not require enrollment in benchmark coverage described in subsection (b)(1) of section 1937 or benchmark equivalent coverage described in subsection (b)(2) of that section.”.

(B) CONFORMING AMENDMENT.—Section 1903(i) of the Social Security Act, as amended by section 6402(c), is amended—

(i) in paragraph (24), by striking “or” at the end;

(ii) in paragraph (25), by striking the period and inserting “; or”; and

(iii) by adding at the end the following:

“(26) with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i) other than medical assistance provided through benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2).”.

(3) FEDERAL FUNDING FOR COST OF COVERING NEWLY ELIGIBLE INDIVIDUALS.—Section 1905 of

the Social Security Act (42 U.S.C. 1396d), is amended—

(A) in subsection (b), in the first sentence, by inserting “subsection (y) and” before “section 1933(d)”; and

(B) by adding at the end the following new subsection:

“(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

“(1) AMOUNT OF INCREASE.—

“(A) 100 PERCENT FMAP.—During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) shall be equal to 100 percent.

“(B) 2017 AND 2018.—

“(i) IN GENERAL.—During the period that begins on January 1, 2017, and ends on December 31, 2018, notwithstanding subsection (b) and subject to subparagraph (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by the applicable percentage point increase specified in clause (ii) for the quarter and the State.

“(ii) APPLICABLE PERCENTAGE POINT INCREASE.—

“(I) IN GENERAL.—For purposes of clause (i), the applicable percentage point increase for a quarter is the following:

“For any fiscal year quarter occurring in the calendar year:	If the State is an expansion State, the applicable percentage point increase is:	If the State is not an expansion State, the applicable percentage point increase is:
2017	30.3	34.3
2018	31.3	33.3

“(II) EXPANSION STATE DEFINED.—For purposes of the table in subclause (I), a State is an expansion State if, on the date of the enactment of the Patient Protection and Affordable Care Act, the State offers health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1938. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.

“(C) 2019 AND SUCCEEDING YEARS.—Beginning January 1, 2019, notwithstanding subsection (b) but subject to subparagraph (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year quarter occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by 32.3 percentage points.

“(D) LIMITATION.—The Federal medical assistance percentage determined for a State

under subparagraph (B) or (C) shall in no case be more than 95 percent.

“(2) DEFINITIONS.—In this subsection:

“(A) NEWLY ELIGIBLE.—The term ‘newly eligible’ means, with respect to an individual described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, on the date of enactment of the Patient Protection and Affordable Care Act, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

“(B) FULL BENEFITS.—The term ‘full benefits’ means, with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i).”.

(4) STATE OPTIONS TO OFFER COVERAGE EARLIER AND PRESUMPTIVE ELIGIBILITY; CHILDREN REQUIRED TO HAVE COVERAGE FOR PARENTS TO BE ELIGIBLE.—

(A) IN GENERAL.—Subsection (k) of section 1902 of the Social Security Act (as added by paragraph (2)), is amended by inserting after paragraph (1) the following:

“(2) Beginning with the first day of any fiscal year quarter that begins on or after January 1, 2011, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

“(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2), the individual may not be enrolled under the State plan unless the individual’s child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term ‘parent’ includes an individual treated as a caretaker relative for purposes of carrying out section 1931.”.

(B) PRESUMPTIVE ELIGIBILITY.—Section 1920 of the Social Security Act (42 U.S.C. 1396r–1) is amended by adding at the end the following:

“(e) If the State has elected the option to provide a presumptive eligibility period under this section or section 1920A, the State may elect to provide a presumptive eligibility period (as defined in subsection (b)(1)) for individuals who are eligible for medical assistance under clause (i)(VIII) of subsection (a)(10)(A) or section 1931 in the same manner as the State provides for such a period under this section or section 1920A, subject to such guidance as the Secretary shall establish.”.

(5) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G), by striking “and (XIV)” and inserting “(XIV)” and by inserting “and (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1)” before the semicolon.

(B) Section 1902(l)(2)(C) of such Act (42 U.S.C. 1396a(l)(2)(C)) is amended by striking “100” and inserting “133”.

(C) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(i) by striking “or” at the end of clause (xii);

(ii) by inserting “or” at the end of clause (xii); and

(iii) by inserting after clause (xiii) the following:

“(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII).”.

(D) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting “1902(a)(10)(A)(i)(VIII).” after “1902(a)(10)(A)(i)(VII).”.

(E) Section 1937(a)(1)(B) of such Act (42 U.S.C. 1396u-7(a)(1)(B)) is amended by inserting “subclause (VIII) of section 1902(a)(10)(A)(i) or under” after “eligible under”.

(b) MAINTENANCE OF MEDICAID INCOME ELIGIBILITY.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking “and” at the end of paragraph (72);

(B) by striking the period at the end of paragraph (73) and inserting “; and”; and

(C) by inserting after paragraph (73) the following new paragraph:

“(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg).”; and

(2) by adding at the end the following new subsection:

“(gg) MAINTENANCE OF EFFORT.—

“(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS FULLY OPERATIONAL.—Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

“(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

“(3) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan

or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

“(4) DETERMINATION OF COMPLIANCE.—

“(A) STATES SHALL APPLY MODIFIED GROSS INCOME.—A State’s determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

“(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO COVERAGE UNDER THE STATE PLAN.—With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).”.

(c) MEDICAID BENCHMARK BENEFITS MUST CONSIST OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—Section 1937(b) of such Act (42 U.S.C. 1396u-7(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by inserting “subject to paragraphs (5) and (6).” before “each”; and

(2) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by inserting “subject to paragraphs (5) and (6)” after “subsection (a)(1).”; and

(B) in subparagraph (A)—

(i) by redesignating clauses (iv) and (v) as clauses (vi) and (vii), respectively; and

(ii) by inserting after clause (iii), the following:

“(iv) Coverage of prescription drugs.

“(v) Mental health services.”; and

(C) in subparagraph (C)—

(i) by striking clauses (i) and (ii); and

(ii) by redesignating clauses (iii) and (iv) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new paragraph:

“(5) MINIMUM STANDARDS.—Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essen-

tial health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

“(6) MENTAL HEALTH SERVICES PARITY.—

“(A) IN GENERAL.—In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

“(B) DEEMED COMPLIANCE.—Coverage provided with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), shall be deemed to satisfy the requirements of subparagraph (A).”.

(d) ANNUAL REPORTS ON MEDICAID ENROLLMENT.—

(1) STATE REPORTS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (b), is amended—

(A) by striking “and” at the end of paragraph (73);

(B) by striking the period at the end of paragraph (74) and inserting “; and”; and

(C) by inserting after paragraph (74) the following new paragraph:

“(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—

“(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

“(B) a description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and

“(C) any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan.”.

(2) REPORTS TO CONGRESS.—Beginning April 2015, and annually thereafter, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the total enrollment and new enrollment in Medicaid for the fiscal year ending on September 30 of the preceding calendar year on a national and State-by-State basis, and shall include in each such report such recommendations for administrative or legislative changes to improve enrollment in the Medicaid program as the Secretary determines appropriate.

(e) STATE OPTION FOR COVERAGE FOR INDIVIDUALS WITH INCOME THAT EXCEEDS 133 PERCENT OF THE POVERTY LINE.—

(1) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(ii)—

(i) in subclause (XVIII), by striking “or” at the end;

(ii) in subclause (XIX), by adding “or” at the end; and

(iii) by adding at the end the following new subclause:

“(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);” and

(B) by adding at the end the following new subsection:

“(hh)(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

“(2) If an individual described in subclause (XX) of subsection (a)(10)(A)(ii) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan, the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term ‘parent’ includes an individual treated as a caretaker relative for purposes of carrying out section 1931.”

(2) CONFORMING AMENDMENTS.—

(A) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by subsection (a)(5)(C), is amended in the matter preceding paragraph (1)—

(i) by striking “or” at the end of clause (xiii);

(ii) by inserting “or” at the end of clause (xiv); and

(iii) by inserting after clause (xiv) the following:

“(xv) individuals described in section 1902(a)(10)(A)(ii)(XX).”

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting “1902(a)(10)(A)(ii)(XX),” after

“1902(a)(10)(A)(ii)(XIX).”

(C) Section 1920(e) of such Act (42 U.S.C. 1396r-1(e)), as added by subsection (a)(4)(B), is amended by inserting “or clause (ii)(XX)” after “clause (i)(VIII).”

SEC. 2002. INCOME ELIGIBILITY FOR NON-ELDERLY DETERMINED USING MODIFIED GROSS INCOME.

(a) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

“(14) INCOME DETERMINED USING MODIFIED GROSS INCOME.—

“(A) IN GENERAL.—Notwithstanding subsection (r) or any other provision of this title, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified gross income and household income that are not less than the ef-

fective income eligibility levels that applied under the State plan or waiver on the date of enactment of the Patient Protection and Affordable Care Act. For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified gross income and household income, a State shall, working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of this title and title XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

“(B) NO INCOME OR EXPENSE DISREGARDS.—No type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

“(C) NO ASSETS TEST.—A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

“(D) EXCEPTIONS.—

“(i) INDIVIDUALS ELIGIBLE BECAUSE OF OTHER AID OR ASSISTANCE, ELDERLY INDIVIDUALS, MEDICALLY NEEDY INDIVIDUALS, AND INDIVIDUALS ELIGIBLE FOR MEDICARE COST-SHARING.—Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

“(I) Individuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance, individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits under title XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State.

“(II) Individuals who have attained age 65.

“(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).

“(IV) Individuals described in subsection (a)(10)(C).

“(V) Individuals described in any clause of subsection (a)(10)(E).

“(ii) EXPRESS LANE AGENCY FINDINGS.—In the case of a State that elects the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane agency in accordance with that paragraph relating to the income of an individual for purposes of determining the individual's eligibility for medical assistance under the State plan or under a waiver of the plan.

“(iii) MEDICARE PRESCRIPTION DRUG SUBSIDIES DETERMINATIONS.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 made by the State pursuant to section 1935(a)(2).

“(iv) LONG-TERM CARE.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under section 1915 or a waiver under section 1115, and services described in section 1917(c)(1)(C)(ii).

“(v) GRANDFATHER OF CURRENT ENROLLEES UNTIL DATE OF NEXT REGULAR REDETERMINATION.—An individual who, on January 1, 2014, is enrolled in the State plan or under a waiver of the plan and who would be determined ineligible for medical assistance solely because of the application of the modified gross income or household income standard described in subparagraph (A), shall remain eligible for medical assistance under the State plan or waiver (and subject to the same premiums and cost-sharing as applied to the individual on that date) through March 31, 2014, or the date on which the individual's next regularly scheduled redetermination of eligibility is to occur, whichever is later.

“(E) TRANSITION PLANNING AND OVERSIGHT.—Each State shall submit to the Secretary for the Secretary's approval the income eligibility thresholds proposed to be established using modified gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection (a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and procedures for purposes of making such determinations as the State used on the date of enactment of the Patient Protection and Affordable Care Act. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance.

“(F) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B)) under the State plan or under a waiver of the plan and under title XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.

“(G) DEFINITIONS OF MODIFIED GROSS INCOME AND HOUSEHOLD INCOME.—In this paragraph, the terms ‘modified gross income’ and ‘household income’ have the meanings given such terms in section 36B(d)(2) of the Internal Revenue Code of 1986.

“(H) CONTINUED APPLICATION OF MEDICAID RULES REGARDING POINT-IN-TIME INCOME AND SOURCES OF INCOME.—The requirement under this paragraph for States to use modified gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required shall not be construed as affecting or limiting the application of—

“(i) the requirement under this title and under the State plan or a waiver of the plan to determine an individual's income as of the point in

time at which an application for medical assistance under the State plan or a waiver of the plan is processed; or

“(ii) any rules established under this title or under the State plan or a waiver of the plan regarding sources of countable income.”.

(b) **CONFORMING AMENDMENT.**—Section 1902(a)(17) of such Act (42 U.S.C. 1396a(a)(17)) is amended by inserting “(e)(14),” before “(l)(3)”.

(c) **EFFECTIVE DATE.**—The amendments made by subsections (a) and (b) take effect on January 1, 2014.

SEC. 2003. REQUIREMENT TO OFFER PREMIUM ASSISTANCE FOR EMPLOYER-SPONSORED INSURANCE.

(a) **IN GENERAL.**—Section 1906A of such Act (42 U.S.C. 1396e–1) is amended—

(1) in subsection (a)—

(A) by striking “may elect to” and inserting “shall”;

(B) by striking “under age 19”; and

(C) by inserting “, in the case of an individual under age 19,” after “(and)”;

(2) in subsection (c), in the first sentence, by striking “under age 19”; and

(3) in subsection (d)—

(A) in paragraph (2)—

(i) in the first sentence, by striking “under age 19”; and

(ii) by striking the third sentence and inserting “A State may not require, as a condition of an individual (or the individual’s parent) being or remaining eligible for medical assistance under this title, that the individual (or the individual’s parent) apply for enrollment in qualified employer-sponsored coverage under this section.”; and

(B) in paragraph (3), by striking “the parent of an individual under age 19” and inserting “an individual (or the parent of an individual)”;

(4) in subsection (e), by striking “under age 19” each place it appears.

(b) **CONFORMING AMENDMENT.**—The heading for section 1906A of such Act (42 U.S.C. 1396e–1) is amended by striking “OPTION FOR CHILDREN”.

(c) **EFFECTIVE DATE.**—The amendments made by this section take effect on January 1, 2014.

SEC. 2004. MEDICAID COVERAGE FOR FORMER FOSTER CARE CHILDREN.

(a) **IN GENERAL.**—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a), as amended by section 2001(a)(1), is amended—

(1) by striking “or” at the end of subclause (VII);

(2) by adding “or” at the end of subclause (VIII); and

(3) by inserting after subclause (VIII) the following:

“(IX) who were in foster care under the responsibility of a State for more than 6 months (whether or not consecutive) but are no longer in such care, who are not described in any of subclauses (I) through (VII) of this clause, and who are under 25 years of age;”.

(b) **OPTION TO PROVIDE PRESUMPTIVE ELIGIBILITY.**—Section 1920(e) of such Act (42 U.S.C. 1396r–1(e)), as added by section 2001(a)(4)(B) and amended by section 2001(e)(2)(C), is amended by inserting “, clause (i)(IX),” after “clause (i)(VIII)”.

(c) **CONFORMING AMENDMENTS.**—

(1) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)), as amended by section 2001(a)(5)(D), is amended by inserting “1902(a)(10)(A)(i)(IX),” after “1902(a)(10)(A)(i)(VIII),”.

(2) Section 1937(a)(2)(B)(viii) of such Act (42 U.S.C. 1396u–7(a)(2)(B)(viii)) is amended by inserting “, or the individual qualifies for medical assistance on the basis of section 1902(a)(10)(A)(i)(IX)” before the period.

(d) **EFFECTIVE DATE.**—The amendments made by this section take effect on January 1, 2019.

SEC. 2005. PAYMENTS TO TERRITORIES.

(a) **INCREASE IN LIMIT ON PAYMENTS.**—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2), in the matter preceding subparagraph (A), by striking “paragraph (3)” and inserting “paragraphs (3) and (5)”;

(2) in paragraph (4), by striking “and (3)” and inserting “(3), and (4)”;

(3) by adding at the end the following paragraph:

“(5) **FISCAL YEAR 2011 AND THEREAFTER.**—The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for the second, third, and fourth quarters of fiscal year 2011, and for each fiscal year after fiscal year 2011 (after the application of subsection (f) and the preceding paragraphs of this subsection), shall be increased by 30 percent.”.

(b) **DISREGARD OF PAYMENTS FOR MANDATORY EXPANDED ENROLLMENT.**—Section 1108(g)(4) of such Act (42 U.S.C. 1308(g)(4)) is amended—

(1) by striking “to fiscal years beginning” and inserting “to—

“(A) fiscal years beginning”;

(2) by striking the period at the end and inserting “; and”;

(3) by adding at the end the following:

“(B) fiscal years beginning with fiscal year 2014, payments made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa with respect to amounts expended for medical assistance for newly eligible (as defined in section 1905(y)(2)) nonpregnant childless adults who are eligible under subclause (VIII) of section 1902(a)(10)(A)(i) and whose income (as determined under section 1902(e)(14)) does not exceed (in the case of each such commonwealth and territory respectively) the income eligibility level in effect for that population under title XIX or under a waiver on the date of enactment of the Patient Protection and Affordable Care Act, shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), (3), and (5) of this subsection) to such commonwealth or territory for such fiscal year.”.

(c) **INCREASED FMAP.**—

(1) **IN GENERAL.**—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by striking “shall be 50 percent” and inserting “shall be 55 percent”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) takes effect on January 1, 2011.

SEC. 2006. SPECIAL ADJUSTMENT TO FMAP DETERMINATION FOR CERTAIN STATES RECOVERING FROM A MAJOR DISASTER.

Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3) and 2001(b)(2), is amended—

(1) in subsection (b), in the first sentence, by striking “subsection (y)” and inserting “subsections (y) and (aa)”;

(2) by adding at the end the following new subsection:

“(aa)(1) Notwithstanding subsection (b), beginning January 1, 2011, the Federal medical assistance percentage for a fiscal year for a disaster-recovery FMAP adjustment State shall be equal to the following:

“(A) In the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the fiscal year without regard to this subsection and subsection (y), increased by 50 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined

for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111–5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111–5.

“(B) In the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the preceding fiscal year under this subsection for the State, increased by 25 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection.

“(2) In this subsection, the term ‘disaster-recovery FMAP adjustment State’ means a State that is one of the 50 States or the District of Columbia, for which, at any time during the preceding 7 fiscal years, the President has declared a major disaster under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act and determined as a result of such disaster that every county or parish in the State warrant individual and public assistance or public assistance from the Federal Government under such Act and for which—

“(A) in the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111–5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111–5, by at least 3 percentage points; and

“(B) in the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection by at least 3 percentage points.

“(3) The Federal medical assistance percentage determined for a disaster-recovery FMAP adjustment State under paragraph (1) shall apply for purposes of this title (other than with respect to disproportionate share hospital payments described in section 1923 and payments under this title that are based on the enhanced FMAP described in 2105(b)) and shall not apply with respect to payments under title IV (other than under part E of title IV) or payments under title XXI.”.

SEC. 2007. MEDICAID IMPROVEMENT FUND RESCISSION.

(a) **RESCISSION.**—Any amounts available to the Medicaid Improvement Fund established under section 1941 of the Social Security Act (42 U.S.C. 1396w–1) for any of fiscal years 2014 through 2018 that are available for expenditure from the Fund and that are not so obligated as of the date of the enactment of this Act are rescinded.

(b) **CONFORMING AMENDMENTS.**—Section 1941(b)(1) of the Social Security Act (42 U.S.C. 1396w–1(b)(1)) is amended—

(1) in subparagraph (A), by striking “\$100,000,000” and inserting “\$0”; and

(2) in subparagraph (B), by striking “\$150,000,000” and inserting “\$0”.

**Subtitle B—Enhanced Support for the
Children's Health Insurance Program**

SEC. 2101. ADDITIONAL FEDERAL FINANCIAL PARTICIPATION FOR CHIP.

(a) *IN GENERAL.*—Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended by adding at the end the following: “Notwithstanding the preceding sentence, during the period that begins on October 1, 2013, and ends on September 30, 2019, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 23 percentage points, but in no case shall exceed 100 percent. The increase in the enhanced FMAP under the preceding sentence shall not apply with respect to determining the payment to a State under subsection (a)(1) for expenditures described in subparagraph (D)(iv), paragraphs (8), (9), (11) of subsection (c), or clause (4) of the first sentence of section 1905(b).”

(b) MAINTENANCE OF EFFORT.—

(1) *IN GENERAL.*—Section 2105(d) of the Social Security Act (42 U.S.C. 1397ee(d)) is amended by adding at the end the following:

“(3) *CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.*—

“(A) *IN GENERAL.*—During the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on September 30, 2019, a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children (including children provided medical assistance for which payment is made under section 2105(a)(1)(A)) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on the date of enactment of that Act. The preceding sentence shall not be construed as preventing a State during such period from—

“(i) applying eligibility standards, methodologies, or procedures for children under the State child health plan or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, respectively, for children under the plan or waiver that are in effect on the date of enactment of such Act; or

“(ii) imposing a limitation described in section 2112(b)(7) for a fiscal year in order to limit expenditures under the State child health plan to those for which Federal financial participation is available under this section for the fiscal year.

“(B) *ASSURANCE OF EXCHANGE COVERAGE FOR TARGETED LOW-INCOME CHILDREN UNABLE TO BE PROVIDED CHILD HEALTH ASSISTANCE AS A RESULT OF FUNDING SHORTFALLS.*—In the event that allotments provided under section 2104 are insufficient to provide coverage to all children who are eligible to be targeted low-income children under the State child health plan under this title, a State shall establish procedures to ensure that such children are provided coverage through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act.”

(2) *CONFORMING AMENDMENT TO TITLE XXI MEDICAID MAINTENANCE OF EFFORT.*—Section 2105(d)(1) of the Social Security Act (42 U.S.C. 1397ee(d)(1)) is amended by adding before the period “, except as required under section 1902(e)(14)”.

(c) *NO ENROLLMENT BONUS PAYMENTS FOR CHILDREN ENROLLED AFTER FISCAL YEAR 2013.*—Section 2105(a)(3)(F)(iii) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(F)(iii)) is amended by inserting “or any children enrolled on or after October 1, 2013” before the period.

(d) *INCOME ELIGIBILITY DETERMINED USING MODIFIED GROSS INCOME.*—

(1) *STATE PLAN REQUIREMENT.*—Section 2102(b)(1)(B) of the Social Security Act (42 U.S.C. 1397bb(b)(1)(B)) is amended—

(A) in clause (iii), by striking “and” after the semicolon;

(B) in clause (iv), by striking the period and inserting “; and”; and

(C) by adding at the end the following:

“(v) shall, beginning January 1, 2014, use modified gross income and household income (as defined in section 36B(d)(2) of the Internal Revenue Code of 1986) to determine eligibility for child health assistance under the State child health plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, consistent with section 1902(e)(14).”

(2) *CONFORMING AMENDMENT.*—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (E) through (L) as subparagraphs (F) through (M), respectively; and

(B) by inserting after subparagraph (D), the following:

“(E) Section 1902(e)(14) (relating to income determined using modified gross income and household income).”

(e) *APPLICATION OF STREAMLINED ENROLLMENT SYSTEM.*—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by subsection (d)(2), is amended by adding at the end the following:

“(N) Section 1943(b) (relating to coordination with State Exchanges and the State Medicaid agency).”

(f) *CHIP ELIGIBILITY FOR CHILDREN INELIGIBLE FOR MEDICAID AS A RESULT OF ELIMINATION OF DISREGARDS.*—Notwithstanding any other provision of law, a State shall treat any child who is determined to be ineligible for medical assistance under the State Medicaid plan or under a waiver of the plan as a result of the elimination of the application of an income disregard based on expense or type of income, as required under section 1902(e)(14) of the Social Security Act (as added by this Act), as a targeted low-income child under section 2110(b) (unless the child is excluded under paragraph (2) of that section) and shall provide child health assistance to the child under the State child health plan (whether implemented under title XIX or XXI, or both, of the Social Security Act).

SEC. 2102. TECHNICAL CORRECTIONS.

(a) *CHIPRA.*—Effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3) (in this section referred to as “CHIPRA”):

(1) Section 2104(m) of the Social Security Act, as added by section 102 of CHIPRA, is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

“(7) *ADJUSTMENT OF FISCAL YEAR 2010 ALLOTMENTS TO ACCOUNT FOR CHANGES IN PROJECTED SPENDING FOR CERTAIN PREVIOUSLY APPROVED EXPANSION PROGRAMS.*—For purposes of recalculating the fiscal year 2010 allotment, in the case of one of the 50 States or the District of Columbia that has an approved State plan amendment effective January 1, 2006, to provide child health assistance through the provision of benefits under the State plan under title XIX for children from birth through age 5 whose family income does not exceed 200 percent of the poverty line, the Secretary shall increase the allotment by an amount that would be equal to the Federal share of expenditures that would have been

claimed at the enhanced FMAP rate rather than the Federal medical assistance percentage matching rate for such population.”

(2) Section 605 of CHIPRA is amended by striking “legal residents” and insert “lawfully residing in the United States”.

(3) Subclauses (I) and (II) of paragraph (3)(C)(i) of section 2105(a) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(ii)), as added by section 104 of CHIPRA, are each amended by striking “, respectively”.

(4) Section 2105(a)(3)(E)(ii) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(E)(ii)), as added by section 104 of CHIPRA, is amended by striking subclause (IV).

(5) Section 2105(c)(9)(B) of the Social Security Act (42 U.S.C. 1397e(c)(9)(B)), as added by section 211(c)(1) of CHIPRA, is amended by striking “section 1903(a)(3)(F)” and inserting “section 1903(a)(3)(G)”.

(6) Section 2109(b)(2)(B) of the Social Security Act (42 U.S.C. 1397ii(b)(2)(B)), as added by section 602 of CHIPRA, is amended by striking “the child population growth factor under section 2104(m)(5)(B)” and inserting “a high-performing State under section 2111(b)(3)(B)”.

(7) Section 2110(c)(9)(B)(v) of the Social Security Act (42 U.S.C. 1397j(c)(9)(B)(v)), as added by section 505(b) of CHIPRA, is amended by striking “school or school system” and inserting “local educational agency (as defined under section 9101 of the Elementary and Secondary Education Act of 1965)”.

(8) Section 211(a)(1)(B) of CHIPRA is amended—

(A) by striking “is amended” and all that follows through “adding” and inserting “is amended by adding”; and

(B) by redesignating the new subparagraph to be added by such section to section 1903(a)(3) of the Social Security Act as a new subparagraph (H).

(b) *ARRA.*—Effective as if included in the enactment of section 5006(a) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), the second sentence of section 1916A(a)(1) of the Social Security Act (42 U.S.C. 1396o–1(a)(1)) is amended by striking “or (i)” and inserting “, (i), or (j)”.

Subtitle C—Medicaid and CHIP Enrollment Simplification

SEC. 2201. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

Title XIX of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

“SEC. 1943. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

“(a) *CONDITION FOR PARTICIPATION IN MEDICAID.*—As a condition of the State plan under this title and receipt of any Federal financial assistance under section 1903(a) for calendar quarters beginning after January 1, 2014, a State shall ensure that the requirements of subsection (b) is met.

“(b) *ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES AND CHIP.*—

“(1) *IN GENERAL.*—A State shall establish procedures for—

“(A) enabling individuals, through an Internet website that meets the requirements of paragraph (4), to apply for medical assistance under the State plan or under a waiver of the plan, to be enrolled in the State plan or waiver, to renew their enrollment in the plan or waiver, and to consent to enrollment or reenrollment in the State plan through electronic signature;

“(B) enrolling, without any further determination by the State and through such website, individuals who are identified by an Exchange established by the State under section

1311 of the Patient Protection and Affordable Care Act as being eligible for—

“(i) medical assistance under the State plan or under a waiver of the plan; or

“(ii) child health assistance under the State child health plan under title XXI;

“(C) ensuring that individuals who apply for but are determined to be ineligible for medical assistance under the State plan or a waiver or ineligible for child health assistance under the State child health plan under title XXI, are screened for eligibility for enrollment in qualified health plans offered through such an Exchange and, if applicable, premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 1412 of the Patient Protection and Affordable Care Act), and, if eligible, enrolled in such a plan without having to submit an additional or separate application, and that such individuals receive information regarding reduced cost-sharing for eligible individuals under section 1402 of the Patient Protection and Affordable Care Act, and any other assistance or subsidies available for coverage obtained through the Exchange;

“(D) ensuring that the State agency responsible for administering the State plan under this title (in this section referred to as the ‘State Medicaid agency’), the State agency responsible for administering the State child health plan under title XXI (in this section referred to as the ‘State CHIP agency’) and an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act utilize a secure electronic interface sufficient to allow for a determination of an individual’s eligibility for such medical assistance, child health assistance, or premium assistance, and enrollment in the State plan under this title, title XXI, or a qualified health plan, as appropriate;

“(E) coordinating, for individuals who are enrolled in the State plan or under a waiver of the plan and who are also enrolled in a qualified health plan offered through such an Exchange, and for individuals who are enrolled in the State child health plan under title XXI and who are also enrolled in a qualified health plan, the provision of medical assistance or child health assistance to such individuals with the coverage provided under the qualified health plan in which they are enrolled, including services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with the requirements of section 1902(a)(43); and

“(F) conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance under this title XIX or for child health assistance under title XXI, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

“(2) AGREEMENTS WITH STATE HEALTH INSURANCE EXCHANGES.—The State Medicaid agency and the State CHIP agency may enter into an agreement with an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act under which the State Medicaid agency or State CHIP agency may determine whether a State resident is eligible for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 1412 of the Patient Protection and Affordable Care Act), so long as the agreement meets such conditions and requirements as the

Secretary of the Treasury may prescribe to reduce administrative costs and the likelihood of eligibility errors and disruptions in coverage.

“(3) STREAMLINED ENROLLMENT SYSTEM.—The State Medicaid agency and State CHIP agency shall participate in and comply with the requirements for the system established under section 1413 of the Patient Protection and Affordable Care Act (relating to streamlined procedures for enrollment through an Exchange, Medicaid, and CHIP).

“(4) ENROLLMENT WEBSITE REQUIREMENTS.—The procedures established by State under paragraph (1) shall include establishing and having in operation, not later than January 1, 2014, an Internet website that is linked to any website of an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act and to the State CHIP agency (if different from the State Medicaid agency) and allows an individual who is eligible for medical assistance under the State plan or under a waiver of the plan and who is eligible to receive premium credit assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 to compare the benefits, premiums, and cost-sharing applicable to the individual under the State plan or waiver with the benefits, premiums, and cost-sharing available to the individual under a qualified health plan offered through such an Exchange, including, in the case of a child, the coverage that would be provided for the child through the State plan or waiver with the coverage that would be provided to the child through enrollment in family coverage under that plan and as supplemental coverage by the State under the State plan or waiver.

“(5) CONTINUED NEED FOR ASSESSMENT FOR HOME AND COMMUNITY-BASED SERVICES.—Nothing in paragraph (1) shall limit or modify the requirement that the State assess an individual for purposes of providing home and community-based services under the State plan or under any waiver of such plan for individuals described in subsection (a)(10)(A)(ii)(VI).”

SEC. 2202. PERMITTING HOSPITALS TO MAKE PRESUMPTIVE ELIGIBILITY DETERMINATIONS FOR ALL MEDICAID ELIGIBLE POPULATIONS.

(a) IN GENERAL.—Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended—

(1) by striking “at the option of the State, provide” and inserting “provide—

“(A) at the option of the State,”;

(2) by inserting “and” after the semicolon; and

(3) by adding at the end the following:

“(B) that any hospital that is a participating provider under the State plan may elect to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period, in the same manner, and subject to the same requirements, as apply to the State options with respect to populations described in section 1920, 1920A, or 1920B (but without regard to whether the State has elected to provide for a presumptive eligibility period under any such sections), subject to such guidance as the Secretary shall establish.”

(b) CONFORMING AMENDMENT.—Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

(1) by striking “or for” and inserting “for”; and

(2) by inserting before the period at the end the following: “, or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that

elects under section 1902(a)(47)(B) to be a qualified entity for such purpose”.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2014, and apply to services furnished on or after that date.

Subtitle D—Improvements to Medicaid Services

SEC. 2301. COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(1) in subsection (a)—

(A) in paragraph (27), by striking “and” at the end;

(B) by redesignating paragraph (28) as paragraph (29); and

(C) by inserting after paragraph (27) the following new paragraph:

“(28) freestanding birth center services (as defined in subsection (1)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (1)(3)(B)) and that are otherwise included in the plan; and”; and

(2) in subsection (1), by adding at the end the following new paragraph:

“(3)(A) The term ‘freestanding birth center services’ means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)) at such center.

“(B) The term ‘freestanding birth center’ means a health facility—

“(i) that is not a hospital;

“(ii) where childbirth is planned to occur away from the pregnant woman’s residence;

“(iii) that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and

“(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.

“(C) A State shall provide separate payments to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center (as defined in subparagraph (B)), such as nurse midwives and other providers of services such as birth attendants recognized under State law, as determined appropriate by the Secretary. For purposes of the preceding sentence, the term ‘birth attendant’ means an individual who is recognized or registered by the State involved to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a birth attendant.”

(b) CONFORMING AMENDMENT.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)), is amended in the matter preceding clause (i) by striking “and (21)” and inserting “, (21), and (28)”.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to services furnished on or after such date.

(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by

this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 2302. CONCURRENT CARE FOR CHILDREN.

(a) *IN GENERAL.*—Section 1905(o)(1) of the Social Security Act (42 U.S.C. 1396d(o)(1)) is amended—

(1) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B) and (C)”; and

(2) by adding at the end the following new subparagraph:

“(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under this title for, services that are related to the treatment of the child’s condition for which a diagnosis of terminal illness has been made.”.

(b) *APPLICATION TO CHIP.*—Section 2110(a)(23) of the Social Security Act (42 U.S.C. 1397j(a)(23)) is amended by inserting “(concurrent, in the case of an individual who is a child, with care related to the treatment of the child’s condition with respect to which a diagnosis of terminal illness has been made)” after “hospice care”.

SEC. 2303. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) *COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.*—

(1) *IN GENERAL.*—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 2001(e), is amended—

(A) in subclause (XIX), by striking “or” at the end;

(B) in subclause (XX), by adding “or” at the end; and

(C) by adding at the end the following new subclause:

“(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards);”.

(2) *GROUP DESCRIBED.*—Section 1902 of such Act (42 U.S.C. 1396a), as amended by section 2001(d), is amended by adding at the end the following new subsection:

“(ii)(1) Individuals described in this subsection are individuals—

“(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

“(B) who are not pregnant.

“(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XV) of the matter following subparagraph (G) of section subsection (a)(10) pursuant to a waiver granted under section 1115.

“(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.”.

(3) *LIMITATION ON BENEFITS.*—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)), as amended by section

2001(a)(5)(A), is amended in the matter following subparagraph (G)—

(A) by striking “and (XV)” and inserting “(XV)”; and

(B) by inserting “, and (XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting” before the semicolon.

(4) *CONFORMING AMENDMENTS.*—

(A) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as amended by section 2001(e)(2)(A), is amended in the matter preceding paragraph (1)—

(i) in clause (xiv), by striking “or” at the end;

(ii) in clause (xv), by adding “or” at the end; and

(iii) by inserting after clause (xv) the following:

“(xvi) individuals described in section 1902(ii).”.

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)), as amended by section 2001(e)(2)(B), is amended by inserting “1902(a)(10)(A)(ii)(XXI),” after “1902(a)(10)(A)(ii)(XX).”.

(b) *PRESUMPTIVE ELIGIBILITY.*—

(1) *IN GENERAL.*—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920B the following:

“PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

“SEC. 1920C. (a) *STATE OPTION.*—State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(ii) (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1902(ii), such medical assistance shall be limited to family planning services and supplies described in 1905(a)(4)(C) and, at the State’s option, medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting.

“(b) *DEFINITIONS.*—For purposes of this section:

“(1) *PRESUMPTIVE ELIGIBILITY PERIOD.*—The term ‘presumptive eligibility period’ means, with respect to an individual described in subsection (a), the period that—

“(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(ii); and

“(B) ends with (and includes) the earlier of—

“(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

“(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

“(2) *QUALIFIED ENTITY.*—

“(A) *IN GENERAL.*—Subject to subparagraph (B), the term ‘qualified entity’ means any entity that—

“(i) is eligible for payments under a State plan approved under this title; and

“(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

“(B) *RULE OF CONSTRUCTION.*—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

“(c) *ADMINISTRATION.*—

“(1) *IN GENERAL.*—The State agency shall provide qualified entities with—

“(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

“(B) information on how to assist such individuals in completing and filing such forms.

“(2) *NOTIFICATION REQUIREMENTS.*—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

“(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

“(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

“(3) *APPLICATION FOR MEDICAL ASSISTANCE.*—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

“(d) *PAYMENT.*—Notwithstanding any other provision of law, medical assistance that—

“(1) is furnished to an individual described in subsection (a)—

“(A) during a presumptive eligibility period; and

“(B) by a entity that is eligible for payments under the State plan; and

“(2) is included in the care and services covered by the State plan, shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).”.

(2) *CONFORMING AMENDMENTS.*—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)), as amended by section 2202(a), is amended—

(i) in subparagraph (A), by inserting before the semicolon at the end the following: “and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section”; and

(ii) in subparagraph (B), by striking “or 1920B” and inserting “1920B, or 1920C”.

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)), as amended by section 2202(b), is amended by inserting “or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section,” after “1920B during a presumptive eligibility period under such section.”.

(c) *CLARIFICATION OF COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.*—Section 1937(b) of the Social Security Act (42 U.S.C. 1396u-7(b)), as amended by section 2001(c), is amended by adding at the end the following:

“(7) *COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.*—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.”.

(d) *EFFECTIVE DATE.*—The amendments made by this section take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 2304. CLARIFICATION OF DEFINITION OF MEDICAL ASSISTANCE.

Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by inserting “or the

care and services themselves, or both" before "(if provided in or after)".

Subtitle E—New Options for States to Provide Long-Term Services and Supports

SEC. 2401. COMMUNITY FIRST CHOICE OPTION.

Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following:

"(k) STATE PLAN OPTION TO PROVIDE HOME AND COMMUNITY-BASED ATTENDANT SERVICES AND SUPPORTS.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, beginning October 1, 2010, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)) or, if greater, the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan and with respect to whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan, but only if the individual chooses to receive such home and community-based attendant services and supports, and only if the State meets the following requirements:

"(A) AVAILABILITY.—The State shall make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing—

"(i) under a person-centered plan of services and supports that is based on an assessment of functional need and that is agreed to in writing by the individual or, as appropriate, the individual's representative;

"(ii) in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded;

"(iii) under an agency-provider model or other model (as defined in paragraph (6)(C)); and

"(iv) the furnishing of which—

"(I) is selected, managed, and dismissed by the individual, or, as appropriate, with assistance from the individual's representative;

"(II) is controlled, to the maximum extent possible, by the individual or where appropriate, the individual's representative, regardless of who may act as the employer of record; and

"(III) provided by an individual who is qualified to provide such services, including family members (as defined by the Secretary).

"(B) INCLUDED SERVICES AND SUPPORTS.—In addition to assistance in accomplishing activities of daily living, instrumental activities of daily living, and health related tasks, the home and community-based attendant services and supports made available include—

"(i) the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks;

"(ii) back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports; and

"(iii) voluntary training on how to select, manage, and dismiss attendants.

"(C) EXCLUDED SERVICES AND SUPPORTS.—Subject to subparagraph (D), the home and community-based attendant services and supports made available do not include—

"(i) room and board costs for the individual;

"(ii) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

"(iii) assistive technology devices and assistive technology services other than those under (1)(B)(ii);

"(iv) medical supplies and equipment; or

"(v) home modifications.

"(D) PERMISSIBLE SERVICES AND SUPPORTS.—The home and community-based attendant services and supports may include—

"(i) expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides; and

"(ii) expenditures relating to a need identified in an individual's person-centered plan of services that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

"(2) INCREASED FEDERAL FINANCIAL PARTICIPATION.—For purposes of payments to a State under section 1903(a)(1), with respect to amounts expended by the State to provide medical assistance under the State plan for home and community-based attendant services and supports to eligible individuals in accordance with this subsection during a fiscal year quarter occurring during the period described in paragraph (1), the Federal medical assistance percentage applicable to the State (as determined under section 1905(b)) shall be increased by 6 percentage points.

"(3) STATE REQUIREMENTS.—In order for a State plan amendment to be approved under this subsection, the State shall—

"(A) develop and implement such amendment in collaboration with a Development and Implementation Council established by the State that includes a majority of members with disabilities, elderly individuals, and their representatives and consults and collaborates with such individuals;

"(B) provide consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life;

"(C) with respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, maintain or exceed the level of State expenditures for medical assistance that is provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year;

"(D) establish and maintain a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports that—

"(i) includes standards for agency-based and other delivery models with respect to training, appeals for denials and reconsideration procedures of an individual plan, and other factors as determined by the Secretary;

"(ii) incorporates feedback from consumers and their representatives, disability organizations, providers, families of disabled or elderly individuals, members of the community, and

others and maximizes consumer independence and consumer control;

"(iii) monitors the health and well-being of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports; and

"(iv) provides information about the provisions of the quality assurance required under clauses (i) through (iii) to each individual receiving such services; and

"(E) collect and report information, as determined necessary by the Secretary, for the purposes of approving the State plan amendment, providing Federal oversight, and conducting an evaluation under paragraph (5)(A), including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care.

"(4) COMPLIANCE WITH CERTAIN LAWS.—A State shall ensure that, regardless of whether the State uses an agency-provider model or other models to provide home and community-based attendant services and supports under a State plan amendment under this subsection, such services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws regarding—

"(A) withholding and payment of Federal and State income and payroll taxes;

"(B) the provision of unemployment and workers compensation insurance;

"(C) maintenance of general liability insurance; and

"(D) occupational health and safety.

"(5) EVALUATION, DATA COLLECTION, AND REPORT TO CONGRESS.—

"(A) EVALUATION.—The Secretary shall conduct an evaluation of the provision of home and community-based attendant services and supports under this subsection in order to determine the effectiveness of the provision of such services and supports in allowing the individuals receiving such services and supports to lead an independent life to the maximum extent possible; the impact on the physical and emotional health of the individuals who receive such services; and an comparative analysis of the costs of services provided under the State plan amendment under this subsection and those provided under institutional care in a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded.

"(B) DATA COLLECTION.—The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

"(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this subsection during the fiscal year.

"(ii) The number of individuals that received such services and supports during the preceding fiscal year.

"(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.

"(iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a waiver.

"(C) REPORTS.—Not later than—

“(i) December 31, 2013, the Secretary shall submit to Congress and make available to the public an interim report on the findings of the evaluation under subparagraph (A); and

“(ii) December 31, 2015, the Secretary shall submit to Congress and make available to the public a final report on the findings of the evaluation under subparagraph (A).

“(6) DEFINITIONS.—In this subsection:

“(A) ACTIVITIES OF DAILY LIVING.—The term ‘activities of daily living’ includes tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

“(B) CONSUMER CONTROLLED.—The term ‘consumer controlled’ means a method of selecting and providing services and supports that allow the individual, or where appropriate, the individual’s representative, maximum control of the home and community-based attendant services and supports, regardless of who acts as the employer of record.

“(C) DELIVERY MODELS.—

“(i) AGENCY-PROVIDER MODEL.—The term ‘agency-provider model’ means, with respect to the provision of home and community-based attendant services and supports for an individual, subject to paragraph (4), a method of providing consumer controlled services and supports under which entities contract for the provision of such services and supports.

“(ii) OTHER MODELS.—The term ‘other models’ means, subject to paragraph (4), methods, other than an agency-provider model, for the provision of consumer controlled services and supports. Such models may include the provision of vouchers, direct cash payments, or use of a fiscal agent to assist in obtaining services.

“(D) HEALTH-RELATED TASKS.—The term ‘health-related tasks’ means specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

“(E) INDIVIDUAL’S REPRESENTATIVE.—The term ‘individual’s representative’ means a parent, family member, guardian, advocate, or other authorized representative of an individual.

“(F) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term ‘instrumental activities of daily living’ includes (but is not limited to) meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.”

SEC. 2402. REMOVAL OF BARRIERS TO PROVIDING HOME AND COMMUNITY-BASED SERVICES.

(a) OVERSIGHT AND ASSESSMENT OF THE ADMINISTRATION OF HOME AND COMMUNITY-BASED SERVICES.—The Secretary of Health and Human Services shall promulgate regulations to ensure that all States develop service systems that are designed to—

(1) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports (including such services and supports that are provided under programs other than the State Medicaid program), and that provides strategies for beneficiaries receiving such services to maximize their independence, including through the use of client-employed providers;

(2) provide the support and coordination needed for a beneficiary in need of such services (and their family caregivers or representative, if applicable) to design an individualized, self-directed, community-supported life; and

(3) improve coordination among, and the regulation of, all providers of such services under federally and State-funded programs in order to—

(A) achieve a more consistent administration of policies and procedures across programs in relation to the provision of such services; and

(B) oversee and monitor all service system functions to assure—

(i) coordination of, and effectiveness of, eligibility determinations and individual assessments;

(ii) development and service monitoring of a complaint system, a management system, a system to qualify and monitor providers, and systems for role-setting and individual budget determinations; and

(iii) an adequate number of qualified direct care workers to provide self-directed personal assistance services.

(b) ADDITIONAL STATE OPTIONS.—Section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)) is amended by adding at the end the following new paragraphs:

“(6) STATE OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES TO INDIVIDUALS ELIGIBLE FOR SERVICES UNDER A WAIVER.—

“(A) IN GENERAL.—A State that provides home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1115 to provide such services, but only for those individuals whose income does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1).

“(B) APPLICATION OF SAME REQUIREMENTS FOR INDIVIDUALS SATISFYING NEEDS-BASED CRITERIA.—Subject to subparagraph (C), a State shall provide home and community-based services to individuals under this paragraph in the same manner and subject to the same requirements as apply under the other paragraphs of this subsection to the provision of home and community-based services to individuals who satisfy the needs-based criteria established under paragraph (1)(A).

“(C) AUTHORITY TO OFFER DIFFERENT TYPE, AMOUNT, DURATION, OR SCOPE OF HOME AND COMMUNITY-BASED SERVICES.—A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), so long as such services are within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and do not include room or board.

“(7) STATE OPTION TO OFFER HOME AND COMMUNITY-BASED SERVICES TO SPECIFIC, TARGETED POPULATIONS.—

“(A) IN GENERAL.—A State may elect in a State plan amendment under this subsection to target the provision of home and community-based services under this subsection to specific populations and to differ the type, amount, duration, or scope of such services to such specific populations.

“(B) 5-YEAR TERM.—

“(i) IN GENERAL.—An election by a State under this paragraph shall be for a period of 5 years.

“(ii) PHASE-IN OF SERVICES AND ELIGIBILITY PERMITTED DURING INITIAL 5-YEAR PERIOD.—A State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services

to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are provided, before the end of the initial 5-year period.

“(C) RENEWAL.—An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning of each such renewal period, that the State has—

“(i) adhered to the requirements of this subsection and paragraph in providing services under such an election; and

“(ii) met the State’s objectives with respect to quality improvement and beneficiary outcomes.”

(c) REMOVAL OF LIMITATION ON SCOPE OF SERVICES.—Paragraph (1) of section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)), as amended by subsection (a), is amended by striking “or such other services requested by the State as the Secretary may approve”.

(d) OPTIONAL ELIGIBILITY CATEGORY TO PROVIDE FULL MEDICAID BENEFITS TO INDIVIDUALS RECEIVING HOME AND COMMUNITY-BASED SERVICES UNDER A STATE PLAN AMENDMENT.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 2304(a)(1), is amended—

(A) in subclause (XX), by striking “or” at the end;

(B) in subclause (XXI), by adding “or” at the end; and

(C) by inserting after subclause (XXI), the following new subclause:

“(XXII) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;”

(2) CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by section 2304(a)(4)(B), is amended in the matter preceding subparagraph (A), by inserting “1902(a)(10)(A)(ii)(XXII),” after “1902(a)(10)(A)(ii)(XXI),”

(B) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as so amended, is amended in the matter preceding paragraph (1)—

(i) in clause (xv), by striking “or” at the end;

(ii) in clause (xvi), by adding “or” at the end; and

(iii) by inserting after clause (xvi) the following new clause:

“(xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;”

(e) ELIMINATION OF OPTION TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS OR LENGTH OF PERIOD FOR GRANDFATHERED INDIVIDUALS IF ELIGIBILITY CRITERIA IS MODIFIED.—Paragraph (1) of section 1915(i) of such Act (42 U.S.C. 1396n(i)) is amended—

(1) by striking subparagraph (C) and inserting the following:

“(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.”; and

(2) in subclause (II) of subparagraph (D)(ii), by striking “to be eligible for such services for a

period of at least 12 months beginning on the date the individual first received medical assistance for such services" and inserting "to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria".

(f) **ELIMINATION OF OPTION TO WAIVE STATEWIDENESS; ADDITION OF OPTION TO WAIVE COMPARABILITY.**—Paragraph (3) of section 1915(i) of such Act (42 U.S.C. 1396n(3)) is amended by striking "1902(a)(1) (relating to statewideness)" and inserting "1902(a)(10)(B) (relating to comparability)".

(g) **EFFECTIVE DATE.**—The amendments made by subsections (b) through (f) take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act.

SEC. 2403. MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

(a) **EXTENSION OF DEMONSTRATION.**—

(1) **IN GENERAL.**—Section 6071(h) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended—

(A) in paragraph (1)(E), by striking "fiscal year 2011" and inserting "each of fiscal years 2011 through 2016"; and

(B) in paragraph (2), by striking "2011" and inserting "2016".

(2) **EVALUATION.**—Paragraphs (2) and (3) of section 6071(g) of such Act is amended are each amended by striking "2011" and inserting "2016".

(b) **REDUCTION OF INSTITUTIONAL RESIDENCY PERIOD.**—

(1) **IN GENERAL.**—Section 6071(b)(2) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended—

(A) in subparagraph (A)(i), by striking "for a period of not less than 6 months or for such longer minimum period, not to exceed 2 years, as may be specified by the State" and inserting "for a period of not less than 90 consecutive days"; and

(B) by adding at the end the following: "Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day period required under subparagraph (A)(i)."

(2) **EFFECTIVE DATE.**—The amendments made by this subsection take effect 30 days after the date of enactment of this Act.

SEC. 2404. PROTECTION FOR RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES AGAINST SPOUSAL IMPOVERISHMENT.

During the 5-year period that begins on January 1, 2014, section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r-5(h)(1)(A)) shall be applied as though "is eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915, under a waiver approved under section 1115, or who is eligible for such medical assistance by reason of being determined eligible under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k)" were substituted in such section for "(at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI)".

SEC. 2405. FUNDING TO EXPAND STATE AGING AND DISABILITY RESOURCE CENTERS.

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the

Secretary of Health and Human Services, acting through the Assistant Secretary for Aging, \$10,000,000 for each of fiscal years 2010 through 2014, to carry out subsections (a)(20)(B)(iii) and (b)(8) of section 202 of the Older Americans Act of 1965 (42 U.S.C. 3012).

SEC. 2406. SENSE OF THE SENATE REGARDING LONG-TERM CARE.

(a) **FINDINGS.**—The Senate makes the following findings:

(1) Nearly 2 decades have passed since Congress seriously considered long-term care reform. The United States Bipartisan Commission on Comprehensive Health Care, also known as the "Pepper Commission", released its "Call for Action" blueprint for health reform in September 1990. In the 20 years since those recommendations were made, Congress has never acted on the report.

(2) In 1999, under the United States Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), individuals with disabilities have the right to choose to receive their long-term services and supports in the community, rather than in an institutional setting.

(3) Despite the Pepper Commission and *Olmstead* decision, the long-term care provided to our Nation's elderly and disabled has not improved. In fact, for many, it has gotten far worse.

(4) In 2007, 69 percent of Medicaid long-term care spending for elderly individuals and adults with physical disabilities paid for institutional services. Only 6 states spent 50 percent or more of their Medicaid long-term care dollars on home and community-based services for elderly individuals and adults with physical disabilities while ½ of the States spent less than 25 percent. This disparity continues even though, on average, it is estimated that Medicaid dollars can support nearly 3 elderly individuals and adults with physical disabilities in home and community-based services for every individual in a nursing home. Although every State has chosen to provide certain services under home and community-based waivers, these services are unevenly available within and across States, and reach a small percentage of eligible individuals.

(b) **SENSE OF THE SENATE.**—It is the sense of the Senate that—

(1) during the 111th session of Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need; and

(2) long term services and supports should be made available in the community in addition to in institutions.

Subtitle F—Medicaid Prescription Drug Coverage

SEC. 2501. PRESCRIPTION DRUG REBATES.

(a) **INCREASE IN MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.**—

(1) **IN GENERAL.**—Section 1927(c)(1)(B) of the Social Security Act (42 U.S.C. 1396r-8(c)(1)(B)) is amended—

(A) in clause (i)—

(i) in subclause (IV), by striking "and" at the end;

(ii) in subclause (V)—

(I) by inserting "and before January 1, 2010" after "December 31, 1995,"; and

(II) by striking the period at the end and inserting "and"; and

(iii) by adding at the end the following new subclause:

"(VI) except as provided in clause (iii), after December 31, 2009, 23.1 percent."; and

(B) by adding at the end the following new clause:

"(iii) **MINIMUM REBATE PERCENTAGE FOR CERTAIN DRUGS.**—

"(I) **IN GENERAL.**—In the case of a single source drug or an innovator multiple source

drug described in subclause (II), the minimum rebate percentage for rebate periods specified in clause (i)(VI) is 17.1 percent.

"(II) **DRUG DESCRIBED.**—For purposes of subclause (I), a single source drug or an innovator multiple source drug described in this subclause is any of the following drugs:

"(aa) A clotting factor for which a separate furnishing payment is made under section 1842(o)(5) and which is included on a list of such factors specified and updated regularly by the Secretary.

"(bb) A drug approved by the Food and Drug Administration exclusively for pediatric indications."

(2) **RECAPTURE OF TOTAL SAVINGS DUE TO INCREASE.**—Section 1927(b)(1) of such Act (42 U.S.C. 1396r-8(b)(1)) is amended by adding at the end the following new subparagraph:

"(C) **SPECIAL RULE FOR INCREASED MINIMUM REBATE PERCENTAGE.**—

"(i) **IN GENERAL.**—In addition to the amounts applied as a reduction under subparagraph (B), for rebate periods beginning on or after January 1, 2010, during a fiscal year, the Secretary shall reduce payments to a State under section 1903(a) in the manner specified in clause (ii), in an amount equal to the product of—

"(I) 100 percent minus the Federal medical assistance percentage applicable to the rebate period for the State; and

"(II) the amounts received by the State under such subparagraph that are attributable (as estimated by the Secretary based on utilization and other data) to the increase in the minimum rebate percentage effected by the amendments made by subsections (a)(1), (b), and (d) of section 2501 of the Patient Protection and Affordable Care Act, taking into account the additional drugs included under the amendments made by subsection (c) of section 2501 of such Act.

The Secretary shall adjust such payment reduction for a calendar quarter to the extent the Secretary determines, based upon subsequent utilization and other data, that the reduction for such quarter was greater or less than the amount of payment reduction that should have been made.

"(ii) **MANNER OF PAYMENT REDUCTION.**—The amount of the payment reduction under clause (i) for a State for a quarter shall be deemed an overpayment to the State under this title to be disallowed against the State's regular quarterly draw for all Medicaid spending under section 1903(d)(2). Such a disallowance is not subject to a reconsideration under section 1116(d)."

(b) **INCREASE IN REBATE FOR OTHER DRUGS.**—Section 1927(c)(3)(B) of such Act (42 U.S.C. 1396r-8(c)(3)(B)) is amended—

(1) in clause (i), by striking "and" at the end;

(2) in clause (ii)—

(A) by inserting "and before January 1, 2010," after "December 31, 1993,"; and

(B) by striking the period and inserting "and"; and

(3) by adding at the end the following new clause:

"(iii) after December 31, 2009, is 13 percent."

(c) **EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.**—

(1) **IN GENERAL.**—Section 1903(m)(2)(A) of such Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

(A) in clause (xi), by striking "and" at the end;

(B) in clause (xii), by striking the period at the end and inserting "and"; and

(C) by adding at the end the following:

"(xiii) such contract provides that (I) covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to and that the

State shall collect such rebates from manufacturers, (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates, and (III) the entity shall report to the State, on such timely and periodic basis as specified by the Secretary in order to include in the information submitted by the State to a manufacturer and the Secretary under section 1927(b)(2)(A), information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drug under this subsection (other than covered outpatient drugs that under subsection (j)(1) of section 1927 are not subject to the requirements of that section) and such other data as the Secretary determines necessary to carry out this subsection."

(2) CONFORMING AMENDMENTS.—Section 1927 (42 U.S.C. 1396r–8) is amended—

(A) in subsection (b)—

(i) in paragraph (1)(A), in the first sentence, by inserting “, including such drugs distributed to individuals enrolled with a medicaid managed care organization if the organization is responsible for coverage of such drugs” before the period; and

(ii) in paragraph (2)(A), by inserting “including such information reported by each medicaid managed care organization,” after “for which payment was made under the plan during the period.”; and

(B) in subsection (j), by striking paragraph (1) and inserting the following:

“(I) Covered outpatient drugs are not subject to the requirements of this section if such drugs are—

“(A) dispensed by health maintenance organizations, including Medicaid managed care organizations that contract under section 1903(m); and

“(B) subject to discounts under section 340B of the Public Health Service Act.”.

(d) ADDITIONAL REBATE FOR NEW FORMULATIONS OF EXISTING DRUGS.—

(1) IN GENERAL.—Section 1927(c)(2) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)) is amended by adding at the end the following new subparagraph:

“(C) TREATMENT OF NEW FORMULATIONS.—

“(i) IN GENERAL.—Except as provided in clause (ii), in the case of a drug that is a new formulation, such as an extended-release formulation, of a single source drug or an innovator multiple source drug, the rebate obligation with respect to the drug under this section shall be the amount computed under this section for the new formulation of the drug or, if greater, the product of—

“(I) the average manufacturer price for each dosage form and strength of the new formulation of the single source drug or innovator multiple source drug;

“(II) the highest additional rebate (calculated as a percentage of average manufacturer price) under this section for any strength of the original single source drug or innovator multiple source drug; and

“(III) the total number of units of each dosage form and strength of the new formulation paid for under the State plan in the rebate period (as reported by the State).

“(ii) NO APPLICATION TO NEW FORMULATIONS OF ORPHAN DRUGS.—Clause (i) shall not apply to a new formulation of a covered outpatient drug that is or has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition, without regard to whether the period of market exclusivity for the drug under section 527 of

such Act has expired or the specific indication for use of the drug.”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to drugs that are paid for by a State after December 31, 2009.

(e) MAXIMUM REBATE AMOUNT.—Section 1927(c)(2) of such Act (42 U.S.C. 1396r–8(c)(2)), as amended by subsection (d), is amended by adding at the end the following new subparagraph:

“(D) MAXIMUM REBATE AMOUNT.—In no case shall the sum of the amounts applied under paragraph (1)(A)(ii) and this paragraph with respect to each dosage form and strength of a single source drug or an innovator multiple source drug for a rebate period beginning after December 31, 2009, exceed 100 percent of the average manufacturer price of the drug.”.

(f) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(A) in subsection (a)(2)(B)(i), by striking “1927(c)(4)” and inserting “1927(c)(3)”;

(B) by striking subsection (c); and

(C) redesignating subsection (d) as subsection (c).

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2010.

SEC. 2502. ELIMINATION OF EXCLUSION OF COVERAGE OF CERTAIN DRUGS.

(a) IN GENERAL.—Section 1927(d) of the Social Security Act (42 U.S.C. 1397r–8(d)) is amended—

(1) in paragraph (2)—

(A) by striking subparagraphs (E), (I), and (J), respectively; and

(B) by redesignating subparagraphs (F), (G), (H), and (K) as subparagraphs (E), (F), (G), and (H), respectively; and

(2) by adding at the end the following new paragraph:

“(7) NON-EXCLUDABLE DRUGS.—The following drugs or classes of drugs, or their medical uses, shall not be excluded from coverage:

“(A) Agents when used to promote smoking cessation, including agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation.

“(B) Barbiturates.

“(C) Benzodiazepines.”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2014.

SEC. 2503. PROVIDING ADEQUATE PHARMACY REIMBURSEMENT.

(a) PHARMACY REIMBURSEMENT LIMITS.—

(1) IN GENERAL.—Section 1927(e) of the Social Security Act (42 U.S.C. 1396r–8(e)) is amended—

(A) in paragraph (4), by striking “(or, effective January 1, 2007, two or more)”;

(B) by striking paragraph (5) and inserting the following:

“(5) USE OF AMP IN UPPER PAYMENT LIMITS.—The Secretary shall calculate the Federal upper reimbursement limit established under paragraph (4) as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer prices for pharmaceutical and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. The Secretary shall implement a smoothing process for average manufacturer prices. Such process shall be similar to the smoothing process used in determining the average sales price of a drug or biological under section 1847A.”.

(2) DEFINITION OF AMP.—Section 1927(k)(1) of such Act (42 U.S.C. 1396r–8(k)(1)) is amended—

(A) in subparagraph (A), by striking “by” and all that follows through the period and inserting “by—

“(i) wholesalers for drugs distributed to retail community pharmacies; and

“(ii) retail community pharmacies that purchase drugs directly from the manufacturer.”; and

(B) by striking subparagraph (B) and inserting the following:

“(B) EXCLUSION OF CUSTOMARY PROMPT PAY DISCOUNTS AND OTHER PAYMENTS.—

“(i) IN GENERAL.—The average manufacturer price for a covered outpatient drug shall exclude—

“(I) customary prompt pay discounts extended to wholesalers;

“(II) bona fide service fees paid by manufacturers to wholesalers or retail community pharmacies, including (but not limited to) distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs);

“(III) reimbursement by manufacturers for recalled, damaged, expired, or otherwise unsalable returned goods, including (but not limited to) reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction; and

“(IV) payments received from, and rebates or discounts provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, hospitals, clinics, mail order pharmacies, long term care providers, manufacturers, or any other entity that does not conduct business as a wholesaler or a retail community pharmacy.

“(ii) INCLUSION OF OTHER DISCOUNTS AND PAYMENTS.—Notwithstanding clause (i), any other discounts, rebates, payments, or other financial transactions that are received by, paid by, or passed through to, retail community pharmacies shall be included in the average manufacturer price for a covered outpatient drug.”; and

(C) in subparagraph (C), by striking “the retail pharmacy class of trade” and inserting “retail community pharmacies”.

(3) DEFINITION OF MULTIPLE SOURCE DRUG.—Section 1927(k)(7) of such Act (42 U.S.C. 1396r–8(k)(7)) is amended—

(A) in subparagraph (A)(i)(III), by striking “the State” and inserting “the United States”; and

(B) in subparagraph (C)—

(i) in clause (i), by inserting “and” after the semicolon;

(ii) in clause (ii), by striking “; and” and inserting a period; and

(iii) by striking clause (iii).

(4) DEFINITIONS OF RETAIL COMMUNITY PHARMACY; WHOLESALER.—Section 1927(k) of such Act (42 U.S.C. 1396r–8(k)) is amended by adding at the end the following new paragraphs:

“(10) RETAIL COMMUNITY PHARMACY.—The term ‘retail community pharmacy’ means an independent pharmacy, a chain pharmacy, a supermarket pharmacy, or a mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medications to the general public at retail prices. Such term does not include a pharmacy that dispenses prescription medications to patients primarily through the mail, nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or pharmacy benefit managers.

“(11) WHOLESALER.—The term ‘wholesaler’ means a drug wholesaler that is engaged in wholesale distribution of prescription drugs to retail community pharmacies, including (but not

limited to) manufacturers, repackers, distributors, own-label distributors, private-label distributors, jobbers, brokers, warehouses (including manufacturer's and distributor's warehouses, chain drug warehouses, and wholesale drug warehouses) independent wholesale drug traders, and retail community pharmacies that conduct wholesale distributions."

(b) **DISCLOSURE OF PRICE INFORMATION TO THE PUBLIC.**—Section 1927(b)(3) of such Act (42 U.S.C. 1396r–8(b)(3)) is amended—

(1) in subparagraph (A)—

(A) in the first sentence, by inserting after clause (iii) the following:

"(iv) not later than 30 days after the last day of each month of a rebate period under the agreement, on the manufacturer's total number of units that are used to calculate the monthly average manufacturer price for each covered outpatient drug;" and

(B) in the second sentence, by inserting "(relating to the weighted average of the most recently reported monthly average manufacturer prices)" after "(D)(v)"; and

(2) in subparagraph (D)(v), by striking "average manufacturer prices" and inserting "the weighted average of the most recently reported monthly average manufacturer prices and the average retail survey price determined for each multiple source drug in accordance with subsection (f)".

(c) **CLARIFICATION OF APPLICATION OF SURVEY OF RETAIL PRICES.**—Section 1927(f)(1) of such Act (42 U.S.C. 1396r–8(b)(1)) is amended—

(1) in subparagraph (A)(i), by inserting "with respect to a retail community pharmacy," before "the determination"; and

(2) in subparagraph (C)(ii), by striking "retail pharmacies" and inserting "retail community pharmacies".

(d) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

Subtitle G—Medicaid Disproportionate Share Hospital (DSH) Payments

SEC. 2551. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.

(a) **IN GENERAL.**—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (1), by striking "and (3)" and inserting ", (3), and (7)";

(2) in paragraph (3)(A), by striking "paragraph (6)" and inserting "paragraphs (6) and (7)";

(3) by redesignating paragraph (7) as paragraph (8); and

(4) by inserting after paragraph (6) the following new paragraph:

"(7) **REDUCTION OF STATE DSH ALLOTMENTS ONCE REDUCTION IN UNINSURED THRESHOLD REACHED.**—

"(A) **IN GENERAL.**—Subject to subparagraph (E), the DSH allotment for a State for fiscal years beginning with the fiscal year described in subparagraph (C) (with respect to the State), is equal to—

"(i) in the case of the first fiscal year described in subparagraph (C) with respect to a State, the DSH allotment that would be determined under this subsection for the State for the fiscal year without application of this paragraph (but after the application of subparagraph (D)), reduced by the applicable percentage determined for the State for the fiscal year under subparagraph (B)(i); and

"(ii) in the case of any subsequent fiscal year with respect to the State, the DSH allotment determined under this paragraph for the State for the preceding fiscal year, reduced by the applicable percentage determined for the State for the fiscal year under subparagraph (B)(ii).

"(B) **APPLICABLE PERCENTAGE.**—For purposes of subparagraph (A), the applicable percentage for a State for a fiscal year is the following:

"(i) **UNINSURED REDUCTION THRESHOLD FISCAL YEAR.**—In the case of the first fiscal year described in subparagraph (C) with respect to the State—

"(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to 25 percent; and

"(II) if the State is any other State, the applicable percentage is 50 percent.

"(ii) **SUBSEQUENT FISCAL YEARS IN WHICH THE PERCENTAGE OF UNINSURED DECREASES.**—In the case of any fiscal year after the first fiscal year described in subparagraph (C) with respect to a State, if the Secretary determines on the basis of the most recent American Community Survey of the Bureau of the Census, that the percentage of uncovered individuals residing in the State is less than the percentage of such individuals determined for the State for the preceding fiscal year—

"(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 25 percent; and

"(II) if the State is any other State, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 50 percent.

"(C) **FISCAL YEAR DESCRIBED.**—For purposes of subparagraph (A), the fiscal year described in this subparagraph with respect to a State is the first fiscal year that occurs after fiscal year 2012 for which the Secretary determines, on the basis of the most recent American Community Survey of the Bureau of the Census, that the percentage of uncovered individuals residing in the State is at least 45 percent less than the percentage of such individuals determined for the State for fiscal year 2009.

"(D) **EXCLUSION OF PORTIONS DIVERTED FOR COVERAGE EXPANSIONS.**—For purposes of applying the applicable percentage reduction under subparagraph (A) to the DSH allotment for a State for a fiscal year, the DSH allotment for a State that would be determined under this subsection for the State for the fiscal year without the application of this paragraph (and prior to any such reduction) shall not include any portion of the allotment for which the Secretary has approved the State's diversion to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.

"(E) **MINIMUM ALLOTMENT.**—In no event shall the DSH allotment determined for a State in accordance with this paragraph for fiscal year 2013 or any succeeding fiscal year be less than the amount equal to 35 percent of the DSH allotment determined for the State for fiscal year 2012 under this subsection (and after the application of this paragraph, if applicable), increased by the percentage change in the consumer price index for all urban consumers (all items, U.S. city average) for each previous fiscal year occurring before the fiscal year.

"(F) **UNCOVERED INDIVIDUALS.**—In this paragraph, the term 'uncovered individuals' means individuals with no health insurance coverage at any time during a year (as determined by the Secretary based on the most recent data available)."

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) take effect on October 1, 2011.

Subtitle H—Improved Coordination for Dual Eligible Beneficiaries

SEC. 2601. 5-YEAR PERIOD FOR DEMONSTRATION PROJECTS.

(a) **IN GENERAL.**—Section 1915(h) of the Social Security Act (42 U.S.C. 1396n(h)) is amended—

(1) by inserting "(1)" after "(h)";

(2) by inserting "or a waiver described in paragraph (2)" after "(e)"; and

(3) by adding at the end the following new paragraph:

"(2)(A) Notwithstanding subsections (c)(3) and (d) (3), any waiver under subsection (b), (c), or (d), or a waiver under section 1115, that provides medical assistance for dual eligible individuals (including any such waivers under which non dual eligible individuals may be enrolled in addition to dual eligible individuals) may be conducted for a period of 5 years and, upon the request of the State, may be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

"(B) In this paragraph, the term 'dual eligible individual' means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and is eligible for medical assistance under the State plan under this title or under a waiver of such plan."

(b) **CONFORMING AMENDMENTS.**—

(1) Section 1915 of such Act (42 U.S.C. 1396n) is amended—

(A) in subsection (b), by adding at the end the following new sentence: "Subsection (h)(2) shall apply to a waiver under this subsection.";

(B) in subsection (c)(3), in the second sentence, by inserting "(other than a waiver described in subsection (h)(2))" after "A waiver under this subsection";

(C) in subsection (d)(3), in the second sentence, by inserting "(other than a waiver described in subsection (h)(2))" after "A waiver under this subsection".

(2) Section 1115 of such Act (42 U.S.C. 1315) is amended—

(A) in subsection (e)(2), by inserting "(5 years, in the case of a waiver described in section 1915(h)(2))" after "3 years"; and

(B) in subsection (f)(6), by inserting "(5 years, in the case of a waiver described in section 1915(h)(2))" after "3 years".

SEC. 2602. PROVIDING FEDERAL COVERAGE AND PAYMENT COORDINATION FOR DUAL ELIGIBLE BENEFICIARIES.

(a) **ESTABLISHMENT OF FEDERAL COORDINATED HEALTH CARE OFFICE.**—

(1) **IN GENERAL.**—Not later than March 1, 2010, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a Federal Coordinated Health Care Office.

(2) **ESTABLISHMENT AND REPORTING TO CMS ADMINISTRATOR.**—The Federal Coordinated Health Care Office—

(A) shall be established within the Centers for Medicare & Medicaid Services; and

(B) have as the Office a Director who shall be appointed by, and be in direct line of authority to, the Administrator of the Centers for Medicare & Medicaid Services.

(b) **PURPOSE.**—The purpose of the Federal Coordinated Health Care Office is to bring together officers and employees of the Medicare and Medicaid programs at the Centers for Medicare & Medicaid Services in order to—

(1) more effectively integrate benefits under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act; and

(2) improve the coordination between the Federal Government and States for individuals eligible for benefits under both such programs in order to ensure that such individuals get full access to the items and services to which they are entitled under titles XVIII and XIX of the Social Security Act.

(c) **GOALS.**—The goals of the Federal Coordinated Health Care Office are as follows:

(1) Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.

(2) Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.

(3) Improving the quality of health care and long-term services for dual eligible individuals.

(4) Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.

(5) Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.

(6) Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.

(7) Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.

(8) Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

(d) **SPECIFIC RESPONSIBILITIES.**—The specific responsibilities of the Federal Coordinated Health Care Office are as follows:

(1) Providing States, specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of the Social Security Act (42 U.S.C. 1395w-28(b)(6))), physicians and other relevant entities or individuals with the education and tools necessary for developing programs that align benefits under the Medicare and Medicaid programs for dual eligible individuals.

(2) Supporting State efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program.

(3) Providing support for coordination of contracting and oversight by States and the Centers for Medicare & Medicaid Services with respect to the integration of the Medicare and Medicaid programs in a manner that is supportive of the goals described in paragraph (3).

(4) To consult and coordinate with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b-6) and the Medicaid and CHIP Payment and Access Commission established under section 1900 of such Act (42 U.S.C. 1396) with respect to policies relating to the enrollment in, and provision of, benefits to dual eligible individuals under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act.

(5) To study the provision of drug coverage for new full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u-5(c)(6))), as well as to monitor and report annual total expenditures, health outcomes, and access to benefits for all dual eligible individuals.

(e) **REPORT.**—The Secretary shall, as part of the budget transmitted under section 1105(a) of title 31, United States Code, submit to Congress an annual report containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.

(f) **DUAL ELIGIBLE DEFINED.**—In this section, the term "dual eligible individual" means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled for benefits under part B of title XVIII of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan.

Subtitle I—Improving the Quality of Medicaid for Patients and Providers

SEC. 2701. ADULT HEALTH QUALITY MEASURES.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 401 of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3), is amended by inserting after section 1139A the following new section:

"SEC. 1139B. ADULT HEALTH QUALITY MEASURES.

"(a) DEVELOPMENT OF CORE SET OF HEALTH CARE QUALITY MEASURES FOR ADULTS ELIGIBLE FOR BENEFITS UNDER MEDICAID.—The Secretary shall identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults in the same manner as the Secretary identifies and publishes a core set of child health quality measures under section 1139A, including with respect to identifying and publishing existing adult health quality measures that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time, that may be applicable to Medicaid eligible adults.

"(b) DEADLINES.—

"(1) RECOMMENDED MEASURES.—Not later than January 1, 2011, the Secretary shall identify and publish for comment a recommended core set of adult health quality measures for Medicaid eligible adults.

"(2) DISSEMINATION.—Not later than January 1, 2012, the Secretary shall publish an initial core set of adult health quality measures that are applicable to Medicaid eligible adults.

"(3) STANDARDIZED REPORTING.—Not later than January 1, 2013, the Secretary, in consultation with States, shall develop a standardized format for reporting information based on the initial core set of adult health quality measures and create procedures to encourage States to use such measures to voluntarily report information regarding the quality of health care for Medicaid eligible adults.

"(4) REPORTS TO CONGRESS.—Not later than January 1, 2014, and every 3 years thereafter, the Secretary shall include in the report to Congress required under section 1139A(a)(6) information similar to the information required under that section with respect to the measures established under this section.

"(5) ESTABLISHMENT OF MEDICAID QUALITY MEASUREMENT PROGRAM.—

"(A) IN GENERAL.—Not later than 12 months after the release of the recommended core set of adult health quality measures under paragraph (1), the Secretary shall establish a Medicaid Quality Measurement Program in the same manner as the Secretary establishes the pediatric quality measures program under section 1139A(b). The aggregate amount awarded by the Secretary for grants and contracts for the development, testing, and validation of emerging and innovative evidence-based measures under such program shall equal the aggregate amount awarded by the Secretary for grants under section 1139A(b)(4)(A).

"(B) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.—Beginning not later than 24 months after the establishment of the Medicaid Quality Measurement Program, and annually thereafter, the Secretary shall publish recommended changes to the initial core set of adult health quality measures that shall reflect the results of the testing, validation, and consensus process for the development of adult health quality measures.

"(c) CONSTRUCTION.—Nothing in this section shall be construed as supporting the restriction of coverage, under title XIX or XXI or otherwise, to only those services that are evidence-based, or in anyway limiting available services.

"(d) ANNUAL STATE REPORTS REGARDING STATE-SPECIFIC QUALITY OF CARE MEASURES APPLIED UNDER MEDICAID.—

"(1) ANNUAL STATE REPORTS.—Each State with a State plan or waiver approved under title XIX shall annually report (separately or as part of the annual report required under section 1139A(c)), to the Secretary on the—

"(A) State-specific adult health quality measures applied by the State under the such plan, including measures described in subsection (a)(5); and

"(B) State-specific information on the quality of health care furnished to Medicaid eligible adults under such plan, including information collected through external quality reviews of managed care organizations under section 1932 and benchmark plans under section 1937.

"(2) PUBLICATION.—Not later than September 30, 2014, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

"(e) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2010 through 2014, \$60,000,000 for the purpose of carrying out this section. Funds appropriated under this subsection shall remain available until expended."

SEC. 2702. PAYMENT ADJUSTMENT FOR HEALTH CARE-ACQUIRED CONDITIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall identify current State practices that prohibit payment for health care-acquired conditions and shall incorporate the practices identified, or elements of such practices, which the Secretary determines appropriate for application to the Medicaid program in regulations. Such regulations shall be effective as of July 1, 2011, and shall prohibit payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for health care-acquired conditions specified in the regulations. The regulations shall ensure that the prohibition on payment for health care-acquired conditions shall not result in a loss of access to care or services for Medicaid beneficiaries.

(b) HEALTH CARE-ACQUIRED CONDITION.—In this section, the term "health care-acquired condition" means a medical condition for which an individual was diagnosed that could be identified by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)).

(c) MEDICARE PROVISIONS.—In carrying out this section, the Secretary shall apply to State plans (or waivers) under title XIX of the Social Security Act the regulations promulgated pursuant to section 1886(d)(4)(D) of such Act (42 U.S.C. 1395ww(d)(4)(D)) relating to the prohibition of payments based on the presence of a secondary diagnosis code specified by the Secretary in such regulations, as appropriate for the Medicaid program. The Secretary may exclude certain conditions identified under title XVIII of the Social Security Act for non-payment under title XIX of such Act when the Secretary finds the inclusion of such conditions to be inapplicable to beneficiaries under title XIX.

SEC. 2703. STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS.

(a) STATE PLAN AMENDMENT.—Title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), as amended by sections 2201 and 2305, is amended by adding at the end the following new section:

"SEC. 1945. STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR INDIVIDUALS WITH CHRONIC CONDITIONS.—

"(a) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to statewideness), section

1902(a)(10)(B) (relating to comparability), and any other provision of this title for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual's health home for purposes of providing the individual with health home services.

“(b) **HEALTH HOME QUALIFICATION STANDARDS.**—The Secretary shall establish standards for qualification as a designated provider for the purpose of being eligible to be a health home for purposes of this section.

“(c) **PAYMENTS.**—

“(1) **IN GENERAL.**—A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider, team of health care professionals, or health team as the individual's health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1903(a), except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

“(2) **METHODOLOGY.**—

“(A) **IN GENERAL.**—The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

“(i) may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, as well as the severity or number of each such individual's chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

“(ii) shall be established consistent with section 1902(a)(30)(A).

“(B) **ALTERNATE MODELS OF PAYMENT.**—The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

“(3) **PLANNING GRANTS.**—

“(A) **IN GENERAL.**—Beginning January 1, 2011, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

“(B) **STATE CONTRIBUTION.**—A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1905(b) (without regard to section 5001 of Public Law 111–5) for each fiscal year for which the grant is awarded.

“(C) **LIMITATION.**—The total amount of payments made to States under this paragraph shall not exceed \$25,000,000.

“(d) **HOSPITAL REFERRALS.**—A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who

seek or need treatment in a hospital emergency department to designated providers.

“(e) **COORDINATION.**—A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

“(f) **MONITORING.**—A State shall include in the State plan amendment—

“(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and

“(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

“(g) **REPORT ON QUALITY MEASURES.**—As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State, in accordance with such requirements as the Secretary shall specify, on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.

“(h) **DEFINITIONS.**—In this section:

“(1) **ELIGIBLE INDIVIDUAL WITH CHRONIC CONDITIONS.**—

“(A) **IN GENERAL.**—Subject to subparagraph (B), the term ‘eligible individual with chronic conditions’ means an individual who—

“(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

“(ii) has at least—

“(I) 2 chronic conditions;

“(II) 1 chronic condition and is at risk of having a second chronic condition; or

“(III) 1 serious and persistent mental health condition.

“(B) **RULE OF CONSTRUCTION.**—Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

“(2) **CHRONIC CONDITION.**—The term ‘chronic condition’ has the meaning given that term by the Secretary and shall include, but is not limited to, the following:

“(A) A mental health condition.

“(B) Substance use disorder.

“(C) Asthma.

“(D) Diabetes.

“(E) Heart disease.

“(F) Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

“(3) **HEALTH HOME.**—The term ‘health home’ means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.

“(4) **HEALTH HOME SERVICES.**—

“(A) **IN GENERAL.**—The term ‘health home services’ means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

“(B) **SERVICES DESCRIBED.**—The services described in this subparagraph are—

“(i) comprehensive care management;

“(ii) care coordination and health promotion;

“(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

“(iv) patient and family support (including authorized representatives);

“(v) referral to community and social support services, if relevant; and

“(vi) use of health information technology to link services, as feasible and appropriate.

“(5) **DESIGNATED PROVIDER.**—The term ‘designated provider’ means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic—

“(A) has the systems and infrastructure in place to provide health home services; and

“(B) satisfies the qualification standards established by the Secretary under subsection (b).

“(6) **TEAM OF HEALTH CARE PROFESSIONALS.**—The term ‘team of health care professionals’ means a team of health professionals (as described in the State plan amendment) that may—

“(A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and

“(B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

“(7) **HEALTH TEAM.**—The term ‘health team’ has the meaning given such term for purposes of section 3502 of the Patient Protection and Affordable Care Act.”

(b) **EVALUATION.**—

(1) **INDEPENDENT EVALUATION.**—

(A) **IN GENERAL.**—The Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the States that have elected the option to provide coordinated care through a health home for Medicaid beneficiaries with chronic conditions under section 1945 of the Social Security Act (as added by subsection (a)) for the purpose of determining the effect of such option on reducing hospital admissions, emergency room visits, and admissions to skilled nursing facilities.

(B) **EVALUATION REPORT.**—Not later than January 1, 2017, the Secretary shall report to Congress on the evaluation and assessment conducted under subparagraph (A).

(2) **SURVEY AND INTERIM REPORT.**—

(A) **IN GENERAL.**—Not later than January 1, 2014, the Secretary of Health and Human Services shall survey States that have elected the option under section 1945 of the Social Security Act (as added by subsection (a)) and report to Congress on the nature, extent, and use of such option, particularly as it pertains to—

(i) hospital admission rates;

(ii) chronic disease management;

(iii) coordination of care for individuals with chronic conditions;

(iv) assessment of program implementation;

(v) processes and lessons learned (as described in subparagraph (B));

(vi) assessment of quality improvements and clinical outcomes under such option; and

(vii) estimates of cost savings.

(B) **IMPLEMENTATION REPORTING.**—A State that has elected the option under section 1945 of the Social Security Act (as added by subsection (a)) shall report to the Secretary, as necessary, on processes that have been developed and lessons learned regarding provision of coordinated

care through a health home for Medicaid beneficiaries with chronic conditions under such option.

SEC. 2704. DEMONSTRATION PROJECT TO EVALUATE INTEGRATED CARE AROUND A HOSPITALIZATION.

(a) **AUTHORITY TO CONDUCT PROJECT.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish a demonstration project under title XIX of the Social Security Act to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary—

(A) with respect to an episode of care that includes a hospitalization; and

(B) for concurrent physicians services provided during a hospitalization.

(2) **DURATION.**—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

(b) **REQUIREMENTS.**—The demonstration project shall be conducted in accordance with the following:

(1) The demonstration project shall be conducted in up to 8 States, determined by the Secretary based on consideration of the potential to lower costs under the Medicaid program while improving care for Medicaid beneficiaries. A State selected to participate in the demonstration project may target the demonstration project to particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular geographic regions of the State, but the Secretary shall insure that, as a whole, the demonstration project is, to the greatest extent possible, representative of the demographic and geographic composition of Medicaid beneficiaries nationally.

(2) The demonstration project shall focus on conditions where there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished to Medicaid beneficiaries while reducing total expenditures under the State Medicaid programs selected to participate, as determined by the Secretary.

(3) A State selected to participate in the demonstration project shall specify the 1 or more episodes of care the State proposes to address in the project, the services to be included in the bundled payments, and the rationale for the selection of such episodes of care and services. The Secretary may modify the episodes of care as well as the services to be included in the bundled payments prior to or after approving the project. The Secretary may also vary such factors among the different States participating in the demonstration project.

(4) The Secretary shall ensure that payments made under the demonstration project are adjusted for severity of illness and other characteristics of Medicaid beneficiaries within a category or having a diagnosis targeted as part of the demonstration project. States shall ensure that Medicaid beneficiaries are not liable for any additional cost sharing than if their care had not been subject to payment under the demonstration project.

(5) Hospitals participating in the demonstration project shall have or establish robust discharge planning programs to ensure that Medicaid beneficiaries requiring post-acute care are appropriately placed in, or have ready access to, post-acute care settings.

(6) The Secretary and each State selected to participate in the demonstration project shall ensure that the demonstration project does not result in the Medicaid beneficiaries whose care is subject to payment under the demonstration project being provided with less items and services for which medical assistance is provided under the State Medicaid program than the items and services for which medical assistance

would have been provided to such beneficiaries under the State Medicaid program in the absence of the demonstration project.

(c) **WAIVER OF PROVISIONS.**—Notwithstanding section 1115(a) of the Social Security Act (42 U.S.C. 1315(a)), the Secretary may waive such provisions of titles XIX, XVIII, and XI of that Act as may be necessary to accomplish the goals of the demonstration, ensure beneficiary access to acute and post-acute care, and maintain quality of care.

(d) **EVALUATION AND REPORT.**—

(1) **DATA.**—Each State selected to participate in the demonstration project under this section shall provide to the Secretary, in such form and manner as the Secretary shall specify, relevant data necessary to monitor outcomes, costs, and quality, and evaluate the rationales for selection of the episodes of care and services specified by States under subsection (b)(3).

(2) **REPORT.**—Not later than 1 year after the conclusion of the demonstration project, the Secretary shall submit a report to Congress on the results of the demonstration project.

SEC. 2705. MEDICAID GLOBAL PAYMENT SYSTEM DEMONSTRATION PROJECT.

(a) **IN GENERAL.**—The Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall, in coordination with the Center for Medicare and Medicaid Innovation (as established under section 1115A of the Social Security Act, as added by section 3021 of this Act), establish the Medicaid Global Payment System Demonstration Project under which a participating State shall adjust the payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model.

(b) **DURATION AND SCOPE.**—The demonstration project conducted under this section shall operate during a period of fiscal years 2010 through 2012. The Secretary shall select not more than 5 States to participate in the demonstration project.

(c) **ELIGIBLE SAFETY NET HOSPITAL SYSTEM OR NETWORK.**—For purposes of this section, the term “eligible safety net hospital system or network” means a large, safety net hospital system or network (as defined by the Secretary) that operates within a State selected by the Secretary under subsection (b).

(d) **EVALUATION.**—

(1) **TESTING.**—The Innovation Center shall test and evaluate the demonstration project conducted under this section to examine any changes in health care quality outcomes and spending by the eligible safety net hospital systems or networks.

(2) **BUDGET NEUTRALITY.**—During the testing period under paragraph (1), any budget neutrality requirements under section 1115A(b)(3) of the Social Security Act (as so added) shall not be applicable.

(3) **MODIFICATION.**—During the testing period under paragraph (1), the Secretary may, in the Secretary’s discretion, modify or terminate the demonstration project conducted under this section.

(e) **REPORT.**—Not later than 12 months after the date of completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation and testing conducted under subsection (d), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(f) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 2706. PEDIATRIC ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT.

(a) **AUTHORITY TO CONDUCT DEMONSTRATION.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall establish the Pediatric Accountable Care Organization Demonstration Project to authorize a participating State to allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments (as described under subsection (d)), in the same manner as an accountable care organization is recognized and provided with incentive payments under section 1899 of the Social Security Act (as added by section 3022).

(2) **DURATION.**—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

(b) **APPLICATION.**—A State that desires to participate in the demonstration project under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) **REQUIREMENTS.**—

(1) **PERFORMANCE GUIDELINES.**—The Secretary, in consultation with the States and pediatric providers, shall establish guidelines to ensure that the quality of care delivered to individuals by a provider recognized as an accountable care organization under this section is not less than the quality of care that would have otherwise been provided to such individuals.

(2) **SAVINGS REQUIREMENT.**—A participating State, in consultation with the Secretary, shall establish an annual minimal level of savings in expenditures for items and services covered under the Medicaid program under title XIX of the Social Security Act and the CHIP program under title XXI of such Act that must be reached by an accountable care organization in order for such organization to receive an incentive payment under subsection (d).

(3) **MINIMUM PARTICIPATION PERIOD.**—A provider desiring to be recognized as an accountable care organization under the demonstration project shall enter into an agreement with the State to participate in the project for not less than a 3-year period.

(d) **INCENTIVE PAYMENT.**—An accountable care organization that meets the performance guidelines established by the Secretary under subsection (c)(1) and achieves savings greater than the annual minimal savings level established by the State under subsection (c)(2) shall receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount of such excess savings. The Secretary may establish an annual cap on incentive payments for an accountable care organization.

(e) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 2707. MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.

(a) **AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish a demonstration project under which an eligible State (as described in subsection (c)) shall provide payment under the State Medicaid plan under title XIX of the Social Security Act to an institution for mental diseases that is not publicly owned or operated and that is subject to the requirements of section 1867 of the Social Security Act (42 U.S.C. 1395dd) for the provision of medical assistance available under such plan to individuals who—

(1) have attained age 21, but have not attained age 65;

(2) are eligible for medical assistance under such plan; and

(3) require such medical assistance to stabilize an emergency medical condition.

(b) **STABILIZATION REVIEW.**—A State shall specify in its application described in subsection (c)(1) establish a mechanism for how it will ensure that institutions participating in the demonstration will determine whether or not such individuals have been stabilized (as defined in subsection (h)(5)). This mechanism shall commence before the third day of the inpatient stay. States participating in the demonstration project may manage the provision of services for the stabilization of medical emergency conditions through utilization review, authorization, or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health.

(c) **ELIGIBLE STATE DEFINED.**—

(1) **IN GENERAL.**—An eligible State is a State that has made an application and has been selected pursuant to paragraphs (2) and (3).

(2) **APPLICATION.**—A State seeking to participate in the demonstration project under this section shall submit to the Secretary, at such time and in such format as the Secretary requires, an application that includes such information, provisions, and assurances, as the Secretary may require.

(3) **SELECTION.**—A State shall be determined eligible for the demonstration by the Secretary on a competitive basis among States with applications meeting the requirements of paragraph (1). In selecting State applications for the demonstration project, the Secretary shall seek to achieve an appropriate national balance in the geographic distribution of such projects.

(d) **LENGTH OF DEMONSTRATION PROJECT.**—The demonstration project established under this section shall be conducted for a period of 3 consecutive years.

(e) **LIMITATIONS ON FEDERAL FUNDING.**—

(1) **APPROPRIATION.**—

(A) **IN GENERAL.**—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, \$75,000,000 for fiscal year 2011.

(B) **BUDGET AUTHORITY.**—Subparagraph (A) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph.

(2) **5-YEAR AVAILABILITY.**—Funds appropriated under paragraph (1) shall remain available for obligation through December 31, 2015.

(3) **LIMITATION ON PAYMENTS.**—In no case may—

(A) the aggregate amount of payments made by the Secretary to eligible States under this section exceed \$75,000,000; or

(B) payments be provided by the Secretary under this section after December 31, 2015.

(4) **FUNDS ALLOCATED TO STATES.**—Funds shall be allocated to eligible States on the basis of criteria, including a State's application and the availability of funds, as determined by the Secretary.

(5) **PAYMENTS TO STATES.**—The Secretary shall pay to each eligible State, from its allocation under paragraph (4), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance described in subsection (a). As a condition of receiving payment, a State shall collect and report information, as determined necessary by the Secretary, for the purposes of providing Federal oversight and conducting an evaluation under subsection (f)(1).

(f) **EVALUATION AND REPORT TO CONGRESS.**—

(1) **EVALUATION.**—The Secretary shall conduct an evaluation of the demonstration project in order to determine the impact on the functioning of the health and mental health service system and on individuals enrolled in the Medicaid program and shall include the following:

(A) An assessment of access to inpatient mental health services under the Medicaid program;

average lengths of inpatient stays; and emergency room visits.

(B) An assessment of discharge planning by participating hospitals.

(C) An assessment of the impact of the demonstration project on the costs of the full range of mental health services (including inpatient, emergency and ambulatory care).

(D) An analysis of the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the demonstration project as compared to those admitted to these same facilities through other means.

(E) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

(2) **REPORT.**—Not later than December 31, 2013, the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1).

(g) **WAIVER AUTHORITY.**—

(1) **IN GENERAL.**—The Secretary shall waive the limitation of subdivision (B) following paragraph (28) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) (relating to limitations on payments for care or services for individuals under 65 years of age who are patients in an institution for mental diseases) for purposes of carrying out the demonstration project under this section.

(2) **LIMITED OTHER WAIVER AUTHORITY.**—The Secretary may waive other requirements of titles XI and XIX of the Social Security Act (including the requirements of sections 1902(a)(1) (relating to statewideness) and 1902(1)(10)(B) (relating to comparability)) only to extent necessary to carry out the demonstration project under this section.

(h) **DEFINITIONS.**—In this section:

(1) **EMERGENCY MEDICAL CONDITION.**—The term “emergency medical condition” means, with respect to an individual, an individual who expresses suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.

(2) **FEDERAL MEDICAL ASSISTANCE PERCENTAGE.**—The term “Federal medical assistance percentage” has the meaning given that term with respect to a State under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)).

(3) **INSTITUTION FOR MENTAL DISEASES.**—The term “institution for mental diseases” has the meaning given to that term in section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i)).

(4) **MEDICAL ASSISTANCE.**—The term “medical assistance” has the meaning given that term in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

(5) **STABILIZED.**—The term “stabilized” means, with respect to an individual, that the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

(6) **STATE.**—The term “State” has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

Subtitle J—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)

SEC. 2801. MACPAC ASSESSMENT OF POLICIES AFFECTING ALL MEDICAID BENEFICIARIES.

(a) **IN GENERAL.**—Section 1900 of the Social Security Act (42 U.S.C. 1396) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in the paragraph heading, by inserting “FOR ALL STATES” before “AND ANNUAL”; and

(ii) in subparagraph (A), by striking “children’s”;

(iii) in subparagraph (B), by inserting “, the Secretary, and States” after “Congress”;

(iv) in subparagraph (C), by striking “March 1” and inserting “March 15”; and

(v) in subparagraph (D), by striking “June 1” and inserting “June 15”;

(B) in paragraph (2)—

(i) in subparagraph (A)—

(I) in clause (i)—

(aa) by inserting “the efficient provision of” after “expenditures for”; and

(bb) by striking “hospital, skilled nursing facility, physician, Federally-qualified health center, rural health center, and other fees” and inserting “payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services”; and

(II) in clause (iii), by inserting “(including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations)” after “beneficiaries”;

(ii) by redesignating subparagraphs (B) and (C) as subparagraphs (F) and (H), respectively;

(iii) by inserting after subparagraph (A), the following:

“(B) **ELIGIBILITY POLICIES.**—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

“(C) **ENROLLMENT AND RETENTION PROCESSES.**—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

“(D) **COVERAGE POLICIES.**—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

“(E) **QUALITY OF CARE.**—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.”;

(iv) by inserting after subparagraph (F) (as redesignated by clause (ii) of this subparagraph), the following:

“(G) **INTERACTIONS WITH MEDICARE AND MEDICAID.**—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dual eligible individuals.” and

(v) in subparagraph (H) (as so redesignated), by inserting “and preventive, acute, and long-term services and supports” after “barriers”;

(C) by redesignating paragraphs (3) through (9) as paragraphs (4) through (10), respectively;

(D) by inserting after paragraph (2), the following new paragraph:

“(3) **RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.**—MACPAC shall—

“(A) review national and State-specific Medicaid and CHIP data; and

“(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.”;

(E) in paragraph (4), as redesignated by subparagraph (C), by striking “or any other problems” and all that follows through the period and inserting “, as well as other factors that adversely affect, or have the potential to adversely

affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.”;

(F) in paragraph (5), as so redesignated,—

(i) in the paragraph heading, by inserting “AND REGULATIONS” after “REPORTS”; and

(ii) by striking “If” and inserting the following:

“(A) CERTAIN SECRETARIAL REPORTS.—If”; and

(iii) in the second sentence, by inserting “and the Secretary” after “appropriate committees of Congress”; and

(iv) by adding at the end the following:

“(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.”;

(G) in paragraph (10), as so redesignated, by inserting “, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations” before the period; and

(H) by adding at the end the following:

“(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

“(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as ‘MedPAC’) established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

“(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

“(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC’s recommendations and reports.

“(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

“(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC’s authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary’s authority to carry out Federal responsibilities with respect to Medicaid and CHIP.”;

(2) in subsection (c)(2)—

(A) by striking subparagraphs (A) and (B) and inserting the following:

“(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science,

health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

“(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.”.

(3) in subsection (d)(2), by inserting “and State” after “Federal”;

(4) in subsection (e)(1), in the first sentence, by inserting “and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP,” after “United States”; and

(5) in subsection (f)—

(A) in the subsection heading, by striking “AUTHORIZATION OF APPROPRIATIONS” and inserting “FUNDING”;

(B) in paragraph (1), by inserting “(other than for fiscal year 2010)” before “in the same manner”; and

(C) by adding at the end the following:

“(3) FUNDING FOR FISCAL YEAR 2010.—

“(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, \$9,000,000.

“(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, \$2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

“(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.”.

(b) CONFORMING MEDPAC AMENDMENTS.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b-6(b)), is amended—

(1) in paragraph (1)(C), by striking “March 1 of each year (beginning with 1998)” and inserting “March 15”;

(2) in paragraph (1)(D), by inserting “, and (beginning with 2012) containing an examination of the topics described in paragraph (9), to the extent feasible” before the period; and

(3) by adding at the end the following:

“(9) REVIEW AND ANNUAL REPORT ON MEDICAID AND COMMERCIAL TRENDS.—The Commission shall review and report on aggregate trends in spending, utilization, and financial performance under the Medicaid program under title XIX and the private market for health care services with respect to providers for which, on an aggregate national basis, a significant portion of revenue or services is associated with the Medicaid program. Where appropriate, the Commission shall conduct such review in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900 (in this section referred to as ‘MACPAC’).

“(10) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—The Commission shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

“(11) INTERACTION OF MEDICAID AND MEDICARE.—The Commission shall consult with MACPAC in carrying out its duties under this section, as appropriate. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with the Commission. Responsibility for analysis of and recommendations to change Medicaid policy regarding Medicaid beneficiaries, including Medicaid beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MACPAC.”.

Subtitle K—Protections for American Indians and Alaska Natives

SEC. 2901. SPECIAL RULES RELATING TO INDIANS.

(a) NO COST-SHARING FOR INDIANS WITH INCOME AT OR BELOW 300 PERCENT OF POVERTY ENROLLED IN COVERAGE THROUGH A STATE EXCHANGE.—For provisions prohibiting cost sharing for Indians enrolled in any qualified health plan in the individual market through an Exchange, see section 1402(d) of the Patient Protection and Affordable Care Act.

(b) PAYER OF LAST RESORT.—Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.

(c) FACILITATING ENROLLMENT OF INDIANS UNDER THE EXPRESS LANE OPTION.—Section 1902(e)(13)(F)(ii) of the Social Security Act (42 U.S.C. 1396a(e)(13)(F)(ii)) is amended—

(1) in the clause heading, by inserting “AND INDIAN TRIBES AND TRIBAL ORGANIZATIONS” after “AGENCIES”; and

(2) by adding at the end the following:

“(IV) The Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in section 1139(c)).”.

(d) TECHNICAL CORRECTIONS.—Section 1139(c) of the Social Security Act (42 U.S.C. 1320b-9(c)) is amended by striking “In this section” and inserting “For purposes of this section, title XIX, and title XXI”.

SEC. 2902. ELIMINATION OF SUNSET FOR REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.—Section 1880(e)(1)(A) of the Social Security Act (42 U.S.C. 1395qq(e)(1)(A)) is amended by striking “during the 5-year period beginning on” and inserting “on or after”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items or services furnished on or after January 1, 2010.

Subtitle L—Maternal and Child Health Services

SEC. 2951. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

Title V of the Social Security Act (42 U.S.C. 701 et seq.) is amended by adding at the end the following new section:

“SEC. 511. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

“(a) PURPOSES.—The purposes of this section are—

“(1) to strengthen and improve the programs and activities carried out under this title;

“(2) to improve coordination of services for at risk communities; and

“(3) to identify and provide comprehensive services to improve outcomes for families who reside in at risk communities.

“(b) REQUIREMENT FOR ALL STATES TO ASSESS STATEWIDE NEEDS AND IDENTIFY AT RISK COMMUNITIES.—

“(1) IN GENERAL.—Not later than 6 months after the date of enactment of this section, each State shall, as a condition of receiving payments from an allotment for the State under section 502 for fiscal year 2011, conduct a statewide needs assessment (which shall be separate from the statewide needs assessment required under section 505(a)) that identifies—

“(A) communities with concentrations of—

“(i) premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;

“(ii) poverty;

“(iii) crime;

“(iv) domestic violence;

“(v) high rates of high-school drop-outs;

“(vi) substance abuse;

“(vii) unemployment; or

“(viii) child maltreatment;

“(B) the quality and capacity of existing programs or initiatives for early childhood home visitation in the State including—

“(i) the number and types of individuals and families who are receiving services under such programs or initiatives;

“(ii) the gaps in early childhood home visitation in the State; and

“(iii) the extent to which such programs or initiatives are meeting the needs of eligible families described in subsection (k)(2); and

“(C) the State's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

“(2) COORDINATION WITH OTHER ASSESSMENTS.—In conducting the statewide needs assessment required under paragraph (1), the State shall coordinate with, and take into account, other appropriate needs assessments conducted by the State, as determined by the Secretary, including the needs assessment required under section 505(a) (both the most recently completed assessment and any such assessment in progress), the communitywide strategic planning and needs assessments conducted in accordance with section 640(g)(1)(C) of the Head Start Act, and the inventory of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect, and other family resource services operating in the State required under section 205(3) of the Child Abuse Prevention and Treatment Act.

“(3) SUBMISSION TO THE SECRETARY.—Each State shall submit to the Secretary, in such form and manner as the Secretary shall require—

“(A) the results of the statewide needs assessment required under paragraph (1); and

“(B) a description of how the State intends to address needs identified by the assessment, particularly with respect to communities identified under paragraph (1)(A), which may include applying for a grant to conduct an early childhood home visitation program in accordance with the requirements of this section.

“(c) GRANTS FOR EARLY CHILDHOOD HOME VISITATION PROGRAMS.—

“(1) AUTHORITY TO MAKE GRANTS.—In addition to any other payments made under this title to a State, the Secretary shall make grants to eligible entities to enable the entities to deliver services under early childhood home visitation programs that satisfy the requirements of subsection (d) to eligible families in order to promote improvements in maternal and prenatal health, infant health, child health and development, parenting related to child development

outcomes, school readiness, and the socioeconomic status of such families, and reductions in child abuse, neglect, and injuries.

“(2) AUTHORITY TO USE INITIAL GRANT FUNDS FOR PLANNING OR IMPLEMENTATION.—An eligible entity that receives a grant under paragraph (1) may use a portion of the funds made available to the entity during the first 6 months of the period for which the grant is made for planning or implementation activities to assist with the establishment of early childhood home visitation programs that satisfy the requirements of subsection (d).

“(3) GRANT DURATION.—The Secretary shall determine the period of years for which a grant is made to an eligible entity under paragraph (1).

“(4) TECHNICAL ASSISTANCE.—The Secretary shall provide an eligible entity that receives a grant under paragraph (1) with technical assistance in administering programs or activities conducted in whole or in part with grant funds.

“(d) REQUIREMENTS.—The requirements of this subsection for an early childhood home visitation program conducted with a grant made under this section are as follows:

“(1) QUANTIFIABLE, MEASURABLE IMPROVEMENT IN BENCHMARK AREAS.—

“(A) IN GENERAL.—The eligible entity establishes, subject to the approval of the Secretary, quantifiable, measurable 3- and 5-year benchmarks for demonstrating that the program results in improvements for the eligible families participating in the program in each of the following areas:

“(i) Improved maternal and newborn health.

“(ii) Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits.

“(iii) Improvement in school readiness and achievement.

“(iv) Reduction in crime or domestic violence.

“(v) Improvements in family economic self-sufficiency.

“(vi) Improvements in the coordination and referrals for other community resources and supports.

“(B) DEMONSTRATION OF IMPROVEMENTS AFTER 3 YEARS.—

“(i) REPORT TO THE SECRETARY.—Not later than 30 days after the end of the 3rd year in which the eligible entity conducts the program, the entity submits to the Secretary a report demonstrating improvement in at least 4 of the areas specified in subparagraph (A).

“(ii) CORRECTIVE ACTION PLAN.—If the report submitted by the eligible entity under clause (i) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall develop and implement a plan to improve outcomes in each of the areas specified in subparagraph (A), subject to approval by the Secretary. The plan shall include provisions for the Secretary to monitor implementation of the plan and conduct continued oversight of the program, including through submission by the entity of regular reports to the Secretary.

“(iii) TECHNICAL ASSISTANCE.—

“(I) IN GENERAL.—The Secretary shall provide an eligible entity required to develop and implement an improvement plan under clause (ii) with technical assistance to develop and implement the plan. The Secretary may provide the technical assistance directly or through grants, contracts, or cooperative agreements.

“(II) ADVISORY PANEL.—The Secretary shall establish an advisory panel for purposes of obtaining recommendations regarding the technical assistance provided to entities in accordance with subclause (I).

“(iv) NO IMPROVEMENT OR FAILURE TO SUBMIT REPORT.—If the Secretary determines after a period of time specified by the Secretary that an eligible entity implementing an improvement

plan under clause (ii) has failed to demonstrate any improvement in the areas specified in subparagraph (A), or if the Secretary determines that an eligible entity has failed to submit the report required under clause (i), the Secretary shall terminate the entity's grant and may include any unexpended grant funds in grants made to nonprofit organizations under subsection (h)(2)(B).

“(C) FINAL REPORT.—Not later than December 31, 2015, the eligible entity shall submit a report to the Secretary demonstrating improvements (if any) in each of the areas specified in subparagraph (A).

“(2) IMPROVEMENTS IN OUTCOMES FOR INDIVIDUAL FAMILIES.—

“(A) IN GENERAL.—The program is designed, with respect to an eligible family participating in the program, to result in the participant outcomes described in subparagraph (B) that the eligible entity identifies on the basis of an individualized assessment of the family, are relevant for that family.

“(B) PARTICIPANT OUTCOMES.—The participant outcomes described in this subparagraph are the following:

“(i) Improvements in prenatal, maternal, and newborn health, including improved pregnancy outcomes

“(ii) Improvements in child health and development, including the prevention of child injuries and maltreatment and improvements in cognitive, language, social-emotional, and physical developmental indicators.

“(iii) Improvements in parenting skills.

“(iv) Improvements in school readiness and child academic achievement.

“(v) Reductions in crime or domestic violence.

“(vi) Improvements in family economic self-sufficiency.

“(vii) Improvements in the coordination of referrals for, and the provision of, other community resources and supports for eligible families, consistent with State child welfare agency training.

“(3) CORE COMPONENTS.—The program includes the following core components:

“(A) SERVICE DELIVERY MODEL OR MODELS.—

“(i) IN GENERAL.—Subject to clause (ii), the program is conducted using 1 or more of the service delivery models described in item (aa) or (bb) of subclause (I) or in subclause (II) selected by the eligible entity:

“(I) The model conforms to a clear consistent home visitation model that has been in existence for at least 3 years and is research-based, grounded in relevant empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement, and has demonstrated significant, (and in the case of the service delivery model described in item (aa), sustained) positive outcomes, as described in the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), when evaluated using well-designed and rigorous—

“(aa) randomized controlled research designs, and the evaluation results have been published in a peer-reviewed journal; or

“(bb) quasi-experimental research designs.

“(II) The model conforms to a promising and new approach to achieving the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), has been developed or identified by a national organization or institution of higher education, and will be evaluated through well-designed and rigorous process.

“(ii) MAJORITY OF GRANT FUNDS USED FOR EVIDENCE-BASED MODELS.—An eligible entity shall

use not more than 25 percent of the amount of the grant paid to the entity for a fiscal year for purposes of conducting a program using the service delivery model described in clause (i)(II).

“(iii) **CRITERIA FOR EVIDENCE OF EFFECTIVENESS OF MODELS.**—The Secretary shall establish criteria for evidence of effectiveness of the service delivery models and shall ensure that the process for establishing the criteria is transparent and provides the opportunity for public comment.

“(B) **ADDITIONAL REQUIREMENTS.**—

“(i) The program adheres to a clear, consistent model that satisfies the requirements of being grounded in empirically-based knowledge related to home visiting and linked to the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B) related to the purposes of the program.

“(ii) The program employs well-trained and competent staff, as demonstrated by education or training, such as nurses, social workers, educators, child development specialists, or other well-trained and competent staff, and provides ongoing and specific training on the model being delivered.

“(iii) The program maintains high quality supervision to establish home visitor competencies.

“(iv) The program demonstrates strong organizational capacity to implement the activities involved.

“(v) The program establishes appropriate linkages and referral networks to other community resources and supports for eligible families.

“(vi) The program monitors the fidelity of program implementation to ensure that services are delivered pursuant to the specified model.

“(4) **PRIORITY FOR SERVING HIGH-RISK POPULATIONS.**—The eligible entity gives priority to providing services under the program to the following:

“(A) Eligible families who reside in communities in need of such services, as identified in the statewide needs assessment required under subsection (b)(1)(A).

“(B) Low-income eligible families.

“(C) Eligible families who are pregnant women who have not attained age 21.

“(D) Eligible families that have a history of child abuse or neglect or have had interactions with child welfare services.

“(E) Eligible families that have a history of substance abuse or need substance abuse treatment.

“(F) Eligible families that have users of tobacco products in the home.

“(G) Eligible families that are or have children with low student achievement.

“(H) Eligible families with children with developmental delays or disabilities.

“(I) Eligible families who, or that include individuals who, are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.

“(e) **APPLICATION REQUIREMENTS.**—An eligible entity desiring a grant under this section shall submit an application to the Secretary for approval, in such manner as the Secretary may require, that includes the following:

“(1) A description of the populations to be served by the entity, including specific information regarding how the entity will serve high risk populations described in subsection (d)(4).

“(2) An assurance that the entity will give priority to serving low-income eligible families and eligible families who reside in at risk communities identified in the statewide needs assessment required under subsection (b)(1)(A).

“(3) The service delivery model or models described in subsection (d)(3)(A) that the entity will use under the program and the basis for the selection of the model or models.

“(4) A statement identifying how the selection of the populations to be served and the service delivery model or models that the entity will use under the program for such populations is consistent with the results of the statewide needs assessment conducted under subsection (b).

“(5) The quantifiable, measurable benchmarks established by the State to demonstrate that the program contributes to improvements in the areas specified in subsection (d)(1)(A).

“(6) An assurance that the entity will obtain and submit documentation or other appropriate evidence from the organization or entity that developed the service delivery model or models used under the program to verify that the program is implemented and services are delivered according to the model specifications.

“(7) Assurances that the entity will establish procedures to ensure that—

“(A) the participation of each eligible family in the program is voluntary; and

“(B) services are provided to an eligible family in accordance with the individual assessment for that family.

“(8) Assurances that the entity will—

“(A) submit annual reports to the Secretary regarding the program and activities carried out under the program that include such information and data as the Secretary shall require; and

“(B) participate in, and cooperate with, data and information collection necessary for the evaluation required under subsection (g)(2) and other research and evaluation activities carried out under subsection (h)(3).

“(9) A description of other State programs that include home visitation services, including, if applicable to the State, other programs carried out under this title with funds made available from allotments under section 502(c), programs funded under title IV, title II of the Child Abuse Prevention and Treatment Act (relating to community-based grants for the prevention of child abuse and neglect), and section 645A of the Head Start Act (relating to Early Head Start programs).

“(10) Other information as required by the Secretary.

“(f) **MAINTENANCE OF EFFORT.**—Funds provided to an eligible entity receiving a grant under this section shall supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives.

“(g) **EVALUATION.**—

“(1) **INDEPENDENT, EXPERT ADVISORY PANEL.**—The Secretary, in accordance with subsection (h)(1)(A), shall appoint an independent advisory panel consisting of experts in program evaluation and research, education, and early childhood development—

“(A) to review, and make recommendations on, the design and plan for the evaluation required under paragraph (2) within 1 year after the date of enactment of this section;

“(B) to maintain and advise the Secretary regarding the progress of the evaluation; and

“(C) to comment, if the panel so desires, on the report submitted under paragraph (3).

“(2) **AUTHORITY TO CONDUCT EVALUATION.**—On the basis of the recommendations of the advisory panel under paragraph (1), the Secretary shall, by grant, contract, or interagency agreement, conduct an evaluation of the statewide needs assessments submitted under subsection (b) and the grants made under subsections (c) and (h)(3)(B). The evaluation shall include—

“(A) an analysis, on a State-by-State basis, of the results of such assessments, including indicators of maternal and prenatal health and infant health and mortality, and State actions in response to the assessments; and

“(B) an assessment of—

“(i) the effect of early childhood home visitation programs on child and parent outcomes, in-

cluding with respect to each of the benchmark areas specified in subsection (d)(1)(A) and the participant outcomes described in subsection (d)(2)(B);

“(ii) the effectiveness of such programs on different populations, including the extent to which the ability of programs to improve participant outcomes varies across programs and populations; and

“(iii) the potential for the activities conducted under such programs, if scaled broadly, to improve health care practices, eliminate health disparities, and improve health care system quality, efficiencies, and reduce costs.

“(3) **REPORT.**—Not later than March 31, 2015, the Secretary shall submit a report to Congress on the results of the evaluation conducted under paragraph (2) and shall make the report publicly available.

“(h) **OTHER PROVISIONS.**—

“(1) **INTRA-AGENCY COLLABORATION.**—The Secretary shall ensure that the Maternal and Child Health Bureau and the Administration for Children and Families collaborate with respect to carrying out this section, including with respect to—

“(A) reviewing and analyzing the statewide needs assessments required under subsection (b), the awarding and oversight of grants awarded under this section, the establishment of the advisory panels required under subsections (d)(1)(B)(iii)(II) and (g)(1), and the evaluation and report required under subsection (g); and

“(B) consulting with other Federal agencies with responsibility for administering or evaluating programs that serve eligible families to coordinate and collaborate with respect to research related to such programs and families, including the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, the Centers for Disease Control and Prevention, the National Institute of Child Health and Human Development of the National Institutes of Health, the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice, and the Institute of Education Sciences of the Department of Education.

“(2) **GRANTS TO ELIGIBLE ENTITIES THAT ARE NOT STATES.**—

“(A) **INDIAN TRIBES, TRIBAL ORGANIZATIONS, OR URBAN INDIAN ORGANIZATIONS.**—The Secretary shall specify requirements for eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations to apply for and conduct an early childhood home visitation program with a grant under this section. Such requirements shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require an Indian Tribe (or consortium), Tribal Organization, or Urban Indian Organization to—

“(i) conduct a needs assessment similar to the assessment required for all States under subsection (b); and

“(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

“(B) **NONPROFIT ORGANIZATIONS.**—If, as of the beginning of fiscal year 2012, a State has not applied or been approved for a grant under this section, the Secretary may use amounts appropriated under paragraph (1) of subsection (f) that are available for expenditure under paragraph (3) of that subsection to make a grant to an eligible entity that is a nonprofit organization described in subsection (k)(1)(B) to conduct an early childhood home visitation program in the State. The Secretary shall specify the requirements for such an organization to apply for and conduct the program which shall, to the greatest extent practicable, be consistent with

the requirements applicable to eligible entities that are States and shall require the organization to—

“(i) carry out the program based on the needs assessment conducted by the State under subsection (b); and

“(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

“(3) RESEARCH AND OTHER EVALUATION ACTIVITIES.—

“(A) IN GENERAL.—The Secretary shall carry out a continuous program of research and evaluation activities in order to increase knowledge about the implementation and effectiveness of home visiting programs, using random assignment designs to the maximum extent feasible. The Secretary may carry out such activities directly, or through grants, cooperative agreements, or contracts.

“(B) REQUIREMENTS.—The Secretary shall ensure that—

“(i) evaluation of a specific program or project is conducted by persons or individuals not directly involved in the operation of such program or project; and

“(ii) the conduct of research and evaluation activities includes consultation with independent researchers, State officials, and developers and providers of home visiting programs on topics including research design and administrative data matching.

“(4) REPORT AND RECOMMENDATION.—Not later than December 31, 2015, the Secretary shall submit a report to Congress regarding the programs conducted with grants under this section. The report required under this paragraph shall include—

“(A) information regarding the extent to which eligible entities receiving grants under this section demonstrated improvements in each of the areas specified in subsection (d)(1)(A);

“(B) information regarding any technical assistance provided under subsection (d)(1)(B)(iii)(I), including the type of any such assistance provided; and

“(C) recommendations for such legislative or administrative action as the Secretary determines appropriate.

“(i) APPLICATION OF OTHER PROVISIONS OF TITLE.—

“(1) IN GENERAL.—Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

“(2) EXCEPTIONS.—The following provisions of this title shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

“(A) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

“(B) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

“(C) Section 504(d) (relating to a limitation on administrative expenditures).

“(D) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

“(E) Section 507 (relating to penalties for false statements).

“(F) Section 508 (relating to nondiscrimination).

“(G) Section 509(a) (relating to the administration of the grant program).

“(j) APPROPRIATIONS.—

“(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section—

“(A) \$100,000,000 for fiscal year 2010;

“(B) \$250,000,000 for fiscal year 2011;

“(C) \$350,000,000 for fiscal year 2012;

“(D) \$400,000,000 for fiscal year 2013; and

“(E) \$400,000,000 for fiscal year 2014.

“(2) RESERVATIONS.—Of the amount appropriated under this subsection for a fiscal year, the Secretary shall reserve—

“(A) 3 percent of such amount for purposes of making grants to eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations; and

“(B) 3 percent of such amount for purposes of carrying out subsections (d)(1)(B)(iii), (g), and (h)(3).

“(3) AVAILABILITY.—Funds made available to an eligible entity under this section for a fiscal year shall remain available for expenditure by the eligible entity through the end of the second succeeding fiscal year after award. Any funds that are not expended by the eligible entity during the period in which the funds are available under the preceding sentence may be used for grants to nonprofit organizations under subsection (h)(2)(B).

“(k) DEFINITIONS.—In this section:

“(1) ELIGIBLE ENTITY.—

“(A) IN GENERAL.—The term ‘eligible entity’ means a State, an Indian Tribe, Tribal Organization, or Urban Indian Organization, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

“(B) NONPROFIT ORGANIZATIONS.—Only for purposes of awarding grants under subsection (h)(2)(B), such term shall include a nonprofit organization with an established record of providing early childhood home visitation programs or initiatives in a State or several States.

“(2) ELIGIBLE FAMILY.—The term ‘eligible family’ means—

“(A) a woman who is pregnant, and the father of the child if the father is available; or

“(B) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as the child’s primary caregiver from birth to kindergarten entry, and including a noncustodial parent who has an ongoing relationship with, and at times provides physical care for, the child.

“(3) INDIAN TRIBE, TRIBAL ORGANIZATION.—The terms ‘Indian Tribe’ and ‘Tribal Organization’, and ‘Urban Indian Organization’ have the meanings given such terms in section 4 of the Indian Health Care Improvement Act.”.

SEC. 2952. SUPPORT, EDUCATION, AND RESEARCH FOR POSTPARTUM DEPRESSION.

(a) RESEARCH ON POSTPARTUM CONDITIONS.—

(1) EXPANSION AND INTENSIFICATION OF ACTIVITIES.—The Secretary of Health and Human Services (in this subsection and subsection (c) referred to as the “Secretary”) is encouraged to continue activities on postpartum depression or postpartum psychosis (in this subsection and subsection (c) referred to as “postpartum conditions”), including research to expand the understanding of the causes of, and treatments for, postpartum conditions. Activities under this paragraph shall include conducting and supporting the following:

(A) Basic research concerning the etiology and causes of the conditions.

(B) Epidemiological studies to address the frequency and natural history of the conditions and the differences among racial and ethnic groups with respect to the conditions.

(C) The development of improved screening and diagnostic techniques.

(D) Clinical research for the development and evaluation of new treatments.

(E) Information and education programs for health care professionals and the public, which may include a coordinated national campaign to increase the awareness and knowledge of postpartum conditions. Activities under such a national campaign may—

(i) include public service announcements through television, radio, and other means; and

(ii) focus on—

(I) raising awareness about screening;

(II) educating new mothers and their families about postpartum conditions to promote earlier diagnosis and treatment; and

(III) ensuring that such education includes complete information concerning postpartum conditions, including its symptoms, methods of coping with the illness, and treatment resources.

(2) SENSE OF CONGRESS REGARDING LONGITUDINAL STUDY OF RELATIVE MENTAL HEALTH CONSEQUENCES FOR WOMEN OF RESOLVING A PREGNANCY.—

(A) SENSE OF CONGRESS.—It is the sense of Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study (during the period of fiscal years 2010 through 2019) of the relative mental health consequences for women of resolving a pregnancy (intended and unintended) in various ways, including carrying the pregnancy to term and parenting the child, carrying the pregnancy to term and placing the child for adoption, miscarriage, and having an abortion. This study may assess the incidence, timing, magnitude, and duration of the immediate and long-term mental health consequences (positive or negative) of these pregnancy outcomes.

(B) REPORT.—Subject to the completion of the study under subsection (a), beginning not later than 5 years after the date of the enactment of this Act, and periodically thereafter for the duration of the study, such Director may prepare and submit to the Congress reports on the findings of the study.

(b) GRANTS TO PROVIDE SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.—Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by section 2951, is amended by adding at the end the following new section:

“SEC. 512. SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.

“(a) IN GENERAL.—In addition to any other payments made under this title to a State, the Secretary may make grants to eligible entities for projects for the establishment, operation, and coordination of effective and cost-efficient systems for the delivery of essential services to individuals with or at risk for postpartum conditions and their families.

“(b) CERTAIN ACTIVITIES.—To the extent practicable and appropriate, the Secretary shall ensure that projects funded under subsection (a) provide education and services with respect to the diagnosis and management of postpartum conditions for individuals with or at risk for postpartum conditions and their families. The Secretary may allow such projects to include the following:

“(1) Delivering or enhancing outpatient and home-based health and support services, including case management and comprehensive treatment services.

“(2) Delivering or enhancing inpatient care management services that ensure the well-being of the mother and family and the future development of the infant.

“(3) Improving the quality, availability, and organization of health care and support services (including transportation services, attendant care, homemaker services, day or respite care, and providing counseling on financial assistance and insurance).

“(4) Providing education about postpartum conditions to promote earlier diagnosis and treatment. Such education may include—

“(A) providing complete information on postpartum conditions, symptoms, methods of coping with the illness, and treatment resources; and

“(B) in the case of a grantee that is a State, hospital, or birthing facility—

“(i) providing education to new mothers and fathers, and other family members as appropriate, concerning postpartum conditions before new mothers leave the health facility; and

“(ii) ensuring that training programs regarding such education are carried out at the health facility.

“(c) **INTEGRATION WITH OTHER PROGRAMS.**—To the extent practicable and appropriate, the Secretary may integrate the grant program under this section with other grant programs carried out by the Secretary, including the program under section 330 of the Public Health Service Act.

“(d) **REQUIREMENTS.**—The Secretary shall establish requirements for grants made under this section that include a limit on the amount of grants funds that may be used for administration, accounting, reporting, or program oversight functions and a requirement for each eligible entity that receives a grant to submit, for each grant period, a report to the Secretary that describes how grant funds were used during such period.

“(e) **TECHNICAL ASSISTANCE.**—The Secretary may provide technical assistance to entities seeking a grant under this section in order to assist such entities in complying with the requirements of this section.

“(f) **APPLICATION OF OTHER PROVISIONS OF TITLE.**—

“(1) **IN GENERAL.**—Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

“(2) **EXCEPTIONS.**—The following provisions of this title shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

“(A) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

“(B) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

“(C) Section 504(d) (relating to a limitation on administrative expenditures).

“(D) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

“(E) Section 507 (relating to penalties for false statements).

“(F) Section 508 (relating to nondiscrimination).

“(G) Section 509(a) (relating to the administration of the grant program).

“(g) **DEFINITIONS.**—In this section:

“(1) The term ‘eligible entity’—

“(A) means a public or nonprofit private entity; and

“(B) includes a State or local government, public-private partnership, recipient of a grant under section 330H of the Public Health Service Act (relating to the Healthy Start Initiative), public or nonprofit private hospital, community-based organization, hospice, ambulatory care facility, community health center, migrant health center, public housing primary care center, or homeless health center.

“(2) The term ‘postpartum condition’ means postpartum depression or postpartum psychosis.”

(c) **GENERAL PROVISIONS.**—

(1) **AUTHORIZATION OF APPROPRIATIONS.**—To carry out this section and the amendment made by subsection (b), there are authorized to be appropriated, in addition to such other sums as may be available for such purpose—

(A) \$3,000,000 for fiscal year 2010; and

(B) such sums as may be necessary for fiscal years 2011 and 2012.

(2) **REPORT BY THE SECRETARY.**—

(A) **STUDY.**—The Secretary shall conduct a study on the benefits of screening for postpartum conditions.

(B) **REPORT.**—Not later than 2 years after the date of the enactment of this Act, the Secretary shall complete the study required by subparagraph (A) and submit a report to the Congress on the results of such study.

SEC. 2953. PERSONAL RESPONSIBILITY EDUCATION.

Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by sections 2951 and 2952(c), is amended by adding at the end the following:

“SEC. 513. PERSONAL RESPONSIBILITY EDUCATION.

“(a) **ALLOTMENTS TO STATES.**—

“(1) **AMOUNT.**—

“(A) **IN GENERAL.**—For the purpose described in subsection (b), subject to the succeeding provisions of this section, for each of fiscal years 2010 through 2014, the Secretary shall allot to each State an amount equal to the product of—

“(i) the amount appropriated under subsection (f) for the fiscal year and available for allotments to States after the application of subsection (c); and

“(ii) the State youth population percentage determined under paragraph (2).

“(B) **MINIMUM ALLOTMENT.**—

“(i) **IN GENERAL.**—Each State allotment under this paragraph for a fiscal year shall be at least \$250,000.

“(ii) **PRO RATA ADJUSTMENTS.**—The Secretary shall adjust on a pro rata basis the amount of the State allotments determined under this paragraph for a fiscal year to the extent necessary to comply with clause (i).

“(C) **APPLICATION REQUIRED TO ACCESS ALLOTMENTS.**—

“(i) **IN GENERAL.**—A State shall not be paid from its allotment for a fiscal year unless the State submits an application to the Secretary for the fiscal year and the Secretary approves the application (or requires changes to the application that the State satisfies) and meets such additional requirements as the Secretary may specify.

“(ii) **REQUIREMENTS.**—The State application shall contain an assurance that the State has complied with the requirements of this section in preparing and submitting the application and shall include the following as well as such additional information as the Secretary may require:

“(I) Based on data from the Centers for Disease Control and Prevention National Center for Health Statistics, the most recent pregnancy rates for the State for youth ages 10 to 14 and youth ages 15 to 19 for which data are available, the most recent birth rates for such youth populations in the State for which data are available, and trends in those rates for the most recently preceding 5-year period for which such data are available.

“(II) State-established goals for reducing the pregnancy rates and birth rates for such youth populations.

“(III) A description of the State’s plan for using the State allotments provided under this section to achieve such goals, especially among youth populations that are the most high-risk or vulnerable for pregnancies or otherwise have special circumstances, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant youth who are under 21 years of age, mothers who are under 21 years of age, and youth residing in areas with high birth rates for youth.

“(2) **STATE YOUTH POPULATION PERCENTAGE.**—

“(A) **IN GENERAL.**—For purposes of paragraph (1)(A)(ii), the State youth population percentage is, with respect to a State, the proportion (expressed as a percentage) of—

“(i) the number of individuals who have attained age 10 but not attained age 20 in the State; to

“(ii) the number of such individuals in all States.

“(B) **DETERMINATION OF NUMBER OF YOUTH.**—The number of individuals described in clauses (i) and (ii) of subparagraph (A) in a State shall be determined on the basis of the most recent Bureau of the Census data.

“(3) **AVAILABILITY OF STATE ALLOTMENTS.**—Subject to paragraph (4)(A), amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

“(4) **AUTHORITY TO AWARD GRANTS FROM STATE ALLOTMENTS TO LOCAL ORGANIZATIONS AND ENTITIES IN NONPARTICIPATING STATES.**—

“(A) **GRANTS FROM UNEXPENDED ALLOTMENTS.**—If a State does not submit an application under this section for fiscal year 2010 or 2011, the State shall no longer be eligible to submit an application to receive funds from the amounts allotted for the State for each of fiscal years 2010 through 2014 and such amounts shall be used by the Secretary to award grants under this paragraph for each of fiscal years 2012 through 2014. The Secretary also shall use any amounts from the allotments of States that submit applications under this section for a fiscal year that remain unexpended as of the end of the period in which the allotments are available for expenditure under paragraph (3) for awarding grants under this paragraph.

“(B) **3-YEAR GRANTS.**—

“(i) **IN GENERAL.**—The Secretary shall solicit applications to award 3-year grants in each of fiscal years 2012, 2013, and 2014 to local organizations and entities to conduct, consistent with subsection (b), programs and activities in States that do not submit an application for an allotment under this section for fiscal year 2010 or 2011.

“(ii) **FAITH-BASED ORGANIZATIONS OR CONSORTIA.**—The Secretary may solicit and award grants under this paragraph to faith-based organizations or consortia.

“(C) **EVALUATION.**—An organization or entity awarded a grant under this paragraph shall agree to participate in a rigorous Federal evaluation.

“(5) **MAINTENANCE OF EFFORT.**—No payment shall be made to a State from the allotment determined for the State under this subsection or to a local organization or entity awarded a grant under paragraph (4), if the expenditure of non-federal funds by the State, organization, or entity for activities, programs, or initiatives for which amounts from allotments and grants under this subsection may be expended is less than the amount expended by the State, organization, or entity for such programs or initiatives for fiscal year 2009.

“(6) **DATA COLLECTION AND REPORTING.**—A State or local organization or entity receiving funds under this section shall cooperate with such requirements relating to the collection of data and information and reporting on outcomes regarding the programs and activities carried out with such funds, as the Secretary shall specify.

“(b) **PURPOSE.**—

“(1) **IN GENERAL.**—The purpose of an allotment under subsection (a)(1) to a State is to enable the State (or, in the case of grants made under subsection (a)(4)(B), to enable a local organization or entity) to carry out personal responsibility education programs consistent with this subsection.

“(2) **PERSONAL RESPONSIBILITY EDUCATION PROGRAMS.**—

“(A) **IN GENERAL.**—In this section, the term ‘personal responsibility education program’ means a program that is designed to educate adolescents on—

“(i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and

“(ii) at least 3 of the adulthood preparation subjects described in subparagraph (C).

“(B) REQUIREMENTS.—The requirements of this subparagraph are the following:

“(i) The program replicates evidence-based effective programs or substantially incorporates elements of effective programs that have been proven on the basis of rigorous scientific research to change behavior, which means delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth.

“(ii) The program is medically-accurate and complete.

“(iii) The program includes activities to educate youth who are sexually active regarding responsible sexual behavior with respect to both abstinence and the use of contraception.

“(iv) The program places substantial emphasis on both abstinence and contraception for the prevention of pregnancy among youth and sexually transmitted infections.

“(v) The program provides age-appropriate information and activities.

“(vi) The information and activities carried out under the program are provided in the cultural context that is most appropriate for individuals in the particular population group to which they are directed.

“(C) ADULTHOOD PREPARATION SUBJECTS.—The adulthood preparation subjects described in this subparagraph are the following:

“(i) Healthy relationships, such as positive self-esteem and relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions.

“(ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects.

“(iii) Financial literacy.

“(iv) Parent-child communication.

“(v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity.

“(vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management.

“(c) RESERVATIONS OF FUNDS.—

“(1) GRANTS TO IMPLEMENT INNOVATIVE STRATEGIES.—From the amount appropriated under subsection (f) for the fiscal year, the Secretary shall reserve \$10,000,000 of such amount for purposes of awarding grants to entities to implement innovative youth pregnancy prevention strategies and target services to high-risk, vulnerable, and culturally under-represented youth populations, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant women who are under 21 years of age and their partners, mothers who are under 21 years of age and their partners, and youth residing in areas with high birth rates for youth. An entity awarded a grant under this paragraph shall agree to participate in a rigorous Federal evaluation of the activities carried out with grant funds.

“(2) OTHER RESERVATIONS.—From the amount appropriated under subsection (f) for the fiscal year that remains after the application of paragraph (1), the Secretary shall reserve the following amounts:

“(A) GRANTS FOR INDIAN TRIBES OR TRIBAL ORGANIZATIONS.—The Secretary shall reserve 5 percent of such remainder for purposes of awarding grants to Indian tribes and tribal organizations in such manner, and subject to such requirements, as the Secretary, in consultation with Indian tribes and tribal organizations, determines appropriate.

“(B) SECRETARIAL RESPONSIBILITIES.—

“(i) RESERVATION OF FUNDS.—The Secretary shall reserve 10 percent of such remainder for expenditures by the Secretary for the activities described in clauses (ii) and (iii).

“(ii) PROGRAM SUPPORT.—The Secretary shall provide, directly or through a competitive grant process, research, training and technical assistance, including dissemination of research and information regarding effective and promising practices, providing consultation and resources on a broad array of teen pregnancy prevention strategies, including abstinence and contraception, and developing resources and materials to support the activities of recipients of grants and other State, tribal, and community organizations working to reduce teen pregnancy. In carrying out such functions, the Secretary shall collaborate with a variety of entities that have expertise in the prevention of teen pregnancy, HIV and sexually transmitted infections, healthy relationships, financial literacy, and other topics addressed through the personal responsibility education programs.

“(iii) EVALUATION.—The Secretary shall evaluate the programs and activities carried out with funds made available through allotments or grants under this section.

“(d) ADMINISTRATION.—

“(1) IN GENERAL.—The Secretary shall administer this section through the Assistant Secretary for the Administration for Children and Families within the Department of Health and Human Services.

“(2) APPLICATION OF OTHER PROVISIONS OF TITLE.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the other provisions of this title shall not apply to allotments or grants made under this section.

“(B) EXCEPTIONS.—The following provisions of this title shall apply to allotments and grants made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

“(i) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

“(ii) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

“(iii) Section 504(d) (relating to a limitation on administrative expenditures).

“(iv) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

“(v) Section 507 (relating to penalties for false statements).

“(vi) Section 508 (relating to nondiscrimination).

“(e) DEFINITIONS.—In this section:

“(1) AGE-APPROPRIATE.—The term ‘age-appropriate’, with respect to the information in pregnancy prevention, means topics, messages, and teaching methods suitable to particular ages or age groups of children and adolescents, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group.

“(2) MEDICALLY ACCURATE AND COMPLETE.—The term ‘medically accurate and complete’ means verified or supported by the weight of research conducted in compliance with accepted scientific methods and—

“(A) published in peer-reviewed journals, where applicable; or

“(B) comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete.

“(3) INDIAN TRIBES; TRIBAL ORGANIZATIONS.—The terms ‘Indian tribe’ and ‘tribal organization’ have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

“(4) YOUTH.—The term ‘youth’ means an individual who has attained age 10 but has not attained age 20.

“(f) APPROPRIATION.—For the purpose of carrying out this section, there is appropriated, out of any money in the Treasury not otherwise appropriated, \$75,000,000 for each of fiscal years 2010 through 2014. Amounts appropriated under this subsection shall remain available until expended.”.

SEC. 2954. RESTORATION OF FUNDING FOR ABSTINENCE EDUCATION.

Section 510 of the Social Security Act (42 U.S.C. 710) is amended—

(1) in subsection (a), by striking “fiscal year 1998 and each subsequent fiscal year” and inserting “each of fiscal years 2010 through 2014”; and

(2) in subsection (d)—

(A) in the first sentence, by striking “1998 through 2003” and inserting “2010 through 2014”; and

(B) in the second sentence, by inserting “(except that such appropriation shall be made on the date of enactment of the Patient Protection and Affordable Care Act in the case of fiscal year 2010)” before the period.

SEC. 2955. INCLUSION OF INFORMATION ABOUT THE IMPORTANCE OF HAVING A HEALTH CARE POWER OF ATTORNEY IN TRANSITION PLANNING FOR CHILDREN AGING OUT OF FOSTER CARE AND INDEPENDENT LIVING PROGRAMS.

(a) TRANSITION PLANNING.—Section 475(5)(H) of the Social Security Act (42 U.S.C. 675(5)(H)) is amended by inserting “includes information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, and provides the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under State law,” after “employment services.”.

(b) INDEPENDENT LIVING EDUCATION.—Section 477(b)(3) of such Act (42 U.S.C. 677(b)(3)) is amended by adding at the end the following:

“(K) A certification by the chief executive officer of the State that the State will ensure that an adolescent participating in the program under this section are provided with education about the importance of designating another individual to make health care treatment decisions on behalf of the adolescent if the adolescent becomes unable to participate in such decisions and the adolescent does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, whether a health care power of attorney, health care proxy, or other similar document is recognized under State law, and how to execute such a document if the adolescent wants to do so.”.

(c) HEALTH OVERSIGHT AND COORDINATION PLAN.—Section 422(b)(15)(A) of such Act (42 U.S.C. 622(b)(15)(A)) is amended—

(1) in clause (v), by striking “and” at the end; and

(2) by adding at the end the following:

“(vii) steps to ensure that the components of the transition plan development process required under section 475(5)(H) that relate to the health care needs of children aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under State law, and to provide the child with the option to execute such a document, are met; and”.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2010.

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A—Transforming the Health Care Delivery System

PART I—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM

SEC. 3001. HOSPITAL VALUE-BASED PURCHASING PROGRAM.

(a) PROGRAM.—

(1) **IN GENERAL.**—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 4102(a) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new subsection:

“(o) HOSPITAL VALUE-BASED PURCHASING PROGRAM.—

“(1) ESTABLISHMENT.—

“(A) **IN GENERAL.**—Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the ‘Program’) under which value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards under paragraph (3) for the performance period for such fiscal year (as established under paragraph (4)).

“(B) **PROGRAM TO BEGIN IN FISCAL YEAR 2013.**—The Program shall apply to payments for discharges occurring on or after October 1, 2012.

“(C) APPLICABILITY OF PROGRAM TO HOSPITALS.—

“(i) **IN GENERAL.**—For purposes of this subsection, subject to clause (ii), the term ‘hospital’ means a subsection (d) hospital (as defined in subsection (d)(1)(B)).

“(ii) **EXCLUSIONS.**—The term ‘hospital’ shall not include, with respect to a fiscal year, a hospital—

“(I) that is subject to the payment reduction under subsection (b)(3)(B)(viii)(I) for such fiscal year;

“(II) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients;

“(III) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year; or

“(IV) for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year.

“(iii) **INDEPENDENT ANALYSIS.**—For purposes of determining the minimum numbers under subclauses (III) and (IV) of clause (ii), the Secretary shall have conducted an independent analysis of what numbers are appropriate.

“(iv) **EXEMPTION.**—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

“(2) MEASURES.—

“(A) **IN GENERAL.**—The Secretary shall select measures for purposes of the Program. Such measures shall be selected from the measures specified under subsection (b)(3)(B)(viii).

“(B) REQUIREMENTS.—

“(i) **FOR FISCAL YEAR 2013.**—For value-based incentive payments made with respect to discharges occurring during fiscal year 2013, the Secretary shall ensure the following:

“(I) **CONDITIONS OR PROCEDURES.**—Measures are selected under subparagraph (A) that cover at least the following 5 specific conditions or procedures:

“(aa) Acute myocardial infarction (AMI).

“(bb) Heart failure.

“(cc) Pneumonia.

“(dd) Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as ‘Surgical Infection Prevention’ for discharges occurring before July 2006).

“(ee) Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan) of the Department of Health and Human Services.

“(II) **HCAHPS.**—Measures selected under subparagraph (A) shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).

“(ii) **INCLUSION OF EFFICIENCY MEASURES.**—For value-based incentive payments made with respect to discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected under subparagraph (A) include efficiency measures, including measures of ‘Medicare spending per beneficiary’. Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.

“(C) LIMITATIONS.—

“(i) **TIME REQUIREMENT FOR PRIOR REPORTING AND NOTICE.**—The Secretary may not select a measure under subparagraph (A) for use under the Program with respect to a performance period for a fiscal year (as established under paragraph (4)) unless such measure has been specified under subsection (b)(3)(B)(viii) and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of such performance period.

“(ii) **MEASURE NOT APPLICABLE UNLESS HOSPITAL FURNISHES SERVICES APPROPRIATE TO THE MEASURE.**—A measure selected under subparagraph (A) shall not apply to a hospital if such hospital does not furnish services appropriate to such measure.

“(D) **REPLACING MEASURES.**—Subclause (VI) of subsection (b)(3)(B)(viii) shall apply to measures selected under subparagraph (A) in the same manner as such subclause applies to measures selected under such subsection.

“(3) PERFORMANCE STANDARDS.—

“(A) **ESTABLISHMENT.**—The Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period for a fiscal year (as established under paragraph (4)).

“(B) **ACHIEVEMENT AND IMPROVEMENT.**—The performance standards established under subparagraph (A) shall include levels of achievement and improvement.

“(C) **TIMING.**—The Secretary shall establish and announce the performance standards under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

“(D) **CONSIDERATIONS IN ESTABLISHING STANDARDS.**—In establishing performance standards with respect to measures under this paragraph, the Secretary shall take into account appropriate factors, such as—

“(i) practical experience with the measures involved, including whether a significant proportion of hospitals failed to meet the performance standard during previous performance periods;

“(ii) historical performance standards;

“(iii) improvement rates; and

“(iv) the opportunity for continued improvement.

“(4) **PERFORMANCE PERIOD.**—For purposes of the Program, the Secretary shall establish the performance period for a fiscal year. Such performance period shall begin and end prior to the beginning of such fiscal year.

“(5) HOSPITAL PERFORMANCE SCORE.—

“(A) **IN GENERAL.**—Subject to subparagraph (B), the Secretary shall develop a methodology

for assessing the total performance of each hospital based on performance standards with respect to the measures selected under paragraph (2) for a performance period (as established under paragraph (4)). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the ‘hospital performance score’) for each hospital for each performance period.

“(B) APPLICATION.—

“(i) **APPROPRIATE DISTRIBUTION.**—The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in an appropriate distribution of value-based incentive payments under paragraph (6) among hospitals achieving different levels of hospital performance scores, with hospitals achieving the highest hospital performance scores receiving the largest value-based incentive payments.

“(ii) **HIGHER OF ACHIEVEMENT OR IMPROVEMENT.**—The methodology developed under subparagraph (A) shall provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure.

“(iii) **WEIGHTS.**—The methodology developed under subparagraph (A) shall provide for the assignment of weights for categories of measures as the Secretary determines appropriate.

“(iv) **NO MINIMUM PERFORMANCE STANDARD.**—The Secretary shall not set a minimum performance standard in determining the hospital performance score for any hospital.

“(v) **REFLECTION OF MEASURES APPLICABLE TO THE HOSPITAL.**—The hospital performance score for a hospital shall reflect the measures that apply to the hospital.

“(6) CALCULATION OF VALUE-BASED INCENTIVE PAYMENTS.—

“(A) **IN GENERAL.**—In the case of a hospital that the Secretary determines meets (or exceeds) the performance standards under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharge occurring in such fiscal year by the value-based incentive payment amount.

“(B) **VALUE-BASED INCENTIVE PAYMENT AMOUNT.**—The value-based incentive payment amount for each discharge of a hospital in a fiscal year shall be equal to the product of—

“(i) the base operating DRG payment amount (as defined in paragraph (7)(D)) for the discharge for the hospital for such fiscal year; and

“(ii) the value-based incentive payment percentage specified under subparagraph (C) for the hospital for such fiscal year.

“(C) VALUE-BASED INCENTIVE PAYMENT PERCENTAGE.—

“(i) **IN GENERAL.**—The Secretary shall specify a value-based incentive payment percentage for a hospital for a fiscal year.

“(ii) **REQUIREMENTS.**—In specifying the value-based incentive payment percentage for each hospital for a fiscal year under clause (i), the Secretary shall ensure that—

“(I) such percentage is based on the hospital performance score of the hospital under paragraph (5); and

“(II) the total amount of value-based incentive payments under this paragraph to all hospitals in such fiscal year is equal to the total amount available for value-based incentive payments for such fiscal year under paragraph (7)(A), as estimated by the Secretary.

“(7) FUNDING FOR VALUE-BASED INCENTIVE PAYMENTS.—

“(A) **AMOUNT.**—The total amount available for value-based incentive payments under paragraph (6) for all hospitals for a fiscal year shall

be equal to the total amount of reduced payments for all hospitals under subparagraph (B) for such fiscal year, as estimated by the Secretary.

“(B) ADJUSTMENT TO PAYMENTS.—

“(i) IN GENERAL.—The Secretary shall reduce the base operating DRG payment amount (as defined in subparagraph (D)) for a hospital for each discharge in a fiscal year (beginning with fiscal year 2013) by an amount equal to the applicable percent (as defined in subparagraph (C)) of the base operating DRG payment amount for the discharge for the hospital for such fiscal year. The Secretary shall make such reductions for all hospitals in the fiscal year involved, regardless of whether or not the hospital has been determined by the Secretary to have earned a value-based incentive payment under paragraph (6) for such fiscal year.

“(ii) NO EFFECT ON OTHER PAYMENTS.—Payments described in items (aa) and (bb) of subparagraph (D)(i)(II) for a hospital shall be determined as if this subsection had not been enacted.

“(C) APPLICABLE PERCENT DEFINED.—For purposes of subparagraph (B), the term ‘applicable percent’ means—

“(i) with respect to fiscal year 2013, 1.0 percent;

“(ii) with respect to fiscal year 2014, 1.25 percent;

“(iii) with respect to fiscal year 2015, 1.5 percent;

“(iv) with respect to fiscal year 2016, 1.75 percent; and

“(v) with respect to fiscal year 2017 and succeeding fiscal years, 2 percent.

“(D) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—

“(i) IN GENERAL.—Except as provided in clause (ii), in this subsection, the term ‘base operating DRG payment amount’ means, with respect to a hospital for a fiscal year—

“(I) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (q)) for a discharge if this subsection did not apply; reduced by

“(II) any portion of such payment amount that is attributable to—

“(aa) payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d); and

“(bb) such other payments under subsection (d) determined appropriate by the Secretary.

“(ii) SPECIAL RULES FOR CERTAIN HOSPITALS.—

“(I) SOLE COMMUNITY HOSPITALS AND MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal year 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

“(II) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the term ‘base operating DRG payment amount’ means the payment amount under such section.

“(8) ANNOUNCEMENT OF NET RESULT OF ADJUSTMENTS.—Under the Program, the Secretary shall, not later than 60 days prior to the fiscal year involved, inform each hospital of the adjustments to payments to the hospital for discharges occurring in such fiscal year under paragraphs (6) and (7)(B)(i).

“(9) NO EFFECT IN SUBSEQUENT FISCAL YEARS.—The value-based incentive payment under paragraph (6) and the payment reduction under paragraph (7)(B)(i) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment re-

duction in making payments to a hospital under this section in a subsequent fiscal year.

“(10) PUBLIC REPORTING.—

“(A) HOSPITAL SPECIFIC INFORMATION.—

“(i) IN GENERAL.—The Secretary shall make information available to the public regarding the performance of individual hospitals under the Program, including—

“(I) the performance of the hospital with respect to each measure that applies to the hospital;

“(II) the performance of the hospital with respect to each condition or procedure; and

“(III) the hospital performance score assessing the total performance of the hospital.

“(ii) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that a hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under clause (i) prior to such information being made public.

“(iii) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

“(B) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Hospital Compare Internet website aggregate information on the Program, including—

“(i) the number of hospitals receiving value-based incentive payments under paragraph (6) and the range and total amount of such value-based incentive payments; and

“(ii) the number of hospitals receiving less than the maximum value-based incentive payment available to the hospital for the fiscal year involved and the range and amount of such payments.

“(11) IMPLEMENTATION.—

“(A) APPEALS.—The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital’s performance assessment with respect to the performance standards established under paragraph (3)(A) and the hospital performance score under paragraph (5). The Secretary shall ensure that such process provides for resolution of such appeals in a timely manner.

“(B) LIMITATION ON REVIEW.—Except as provided in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

“(i) The methodology used to determine the amount of the value-based incentive payment under paragraph (6) and the determination of such amount.

“(ii) The determination of the amount of funding available for such value-based incentive payments under paragraph (7)(A) and the payment reduction under paragraph (7)(B)(i).

“(iii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

“(iv) The measures specified under subsection (b)(3)(B)(viii) and the measures selected under paragraph (2).

“(v) The methodology developed under paragraph (5) that is used to calculate hospital performance scores and the calculation of such scores.

“(vi) The validation methodology specified in subsection (b)(3)(B)(viii)(XI).

“(C) CONSULTATION WITH SMALL HOSPITALS.—The Secretary shall consult with small rural and urban hospitals on the application of the Program to such hospitals.

“(12) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out the Program, including the selection of measures under paragraph (2), the methodology developed under paragraph (5) that is used to calculate hospital performance scores, and the methodology used to determine the amount of value-based incentive payments under paragraph (6).”.

(2) AMENDMENTS FOR REPORTING OF HOSPITAL QUALITY INFORMATION.—Section

1886(b)(3)(B)(viii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(viii)) is amended—

(A) in subclause (II), by adding at the end the following sentence: “The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under subsection (o).”;

(B) in subclause (V), by striking “beginning with fiscal year 2008” and inserting “for fiscal years 2008 through 2012”;

(C) in subclause (VII), in the first sentence, by striking “data submitted” and inserting “information regarding measures submitted”; and

(D) by adding at the end the following new subclauses:

“(VIII) Effective for payments beginning with fiscal year 2013, with respect to quality measures for outcomes of care, the Secretary shall provide for such risk adjustment as the Secretary determines to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

“(IX)(aa) Subject to item (bb), effective for payments beginning with fiscal year 2013, each measure specified by the Secretary under this clause shall be endorsed by the entity with a contract under section 1890(a).

“(bb) In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

“(X) To the extent practicable, the Secretary shall, with input from consensus organizations and other stakeholders, take steps to ensure that the measures specified by the Secretary under this clause are coordinated and aligned with quality measures applicable to—

“(aa) physicians under section 1848(k); and

“(bb) other providers of services and suppliers under this title.

“(XI) The Secretary shall establish a process to validate measures specified under this clause as appropriate. Such process shall include the auditing of a number of randomly selected hospitals sufficient to ensure validity of the reporting program under this clause as a whole and shall provide a hospital with an opportunity to appeal the validation of measures reported by such hospital.”.

(3) WEBSITE IMPROVEMENTS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended by section 4102(b) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new clause:

“(x)(I) The Secretary shall develop standard Internet website reports tailored to meet the needs of various stakeholders such as hospitals, patients, researchers, and policymakers. The Secretary shall seek input from such stakeholders in determining the type of information that is useful and the formats that best facilitate the use of the information.

“(II) The Secretary shall modify the Hospital Compare Internet website to make the use and navigation of that website readily available to individuals accessing it.”.

(4) GAO STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis of the impact of such program on—

(i) the quality of care furnished to Medicare beneficiaries, including diverse Medicare beneficiary populations (such as diverse in terms of race, ethnicity, and socioeconomic status);

(ii) expenditures under the Medicare program, including any reduced expenditures under Part A of title XVIII of such Act that are attributable to the improvement in the delivery of inpatient hospital services by reason of such hospital value-based purchasing program;

(iii) the quality performance among safety net hospitals and any barriers such hospitals face in meeting the performance standards applicable under such hospital value-based purchasing program; and

(iv) the quality performance among small rural and small urban hospitals and any barriers such hospitals face in meeting the performance standards applicable under such hospital value-based purchasing program.

(B) REPORTS.—

(i) **INTERIM REPORT.**—Not later than October 1, 2015, the Comptroller General of the United States shall submit to Congress an interim report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(ii) **FINAL REPORT.**—Not later than July 1, 2017, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(5) HHS STUDY AND REPORT.—

(A) **STUDY.**—The Secretary of Health and Human Services shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis—

(i) of ways to improve the hospital value-based purchasing program and ways to address any unintended consequences that may occur as a result of such program;

(ii) of whether the hospital value-based purchasing program resulted in lower spending under the Medicare program under title XVIII of such Act or other financial savings to hospitals;

(iii) the appropriateness of the Medicare program sharing in any savings generated through the hospital value-based purchasing program; and

(iv) any other area determined appropriate by the Secretary.

(B) **REPORT.**—Not later than January 1, 2016, the Secretary of Health and Human Services shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(b) VALUE-BASED PURCHASING DEMONSTRATION PROGRAMS.—

(1) **VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR INPATIENT CRITICAL ACCESS HOSPITALS.—**

(A) ESTABLISHMENT.—

(i) **IN GENERAL.**—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for critical access hospitals (as defined in paragraph (1) of section 1861(mm) of such Act (42 U.S.C. 1395x(mm))) with respect to inpatient critical access hospital services (as defined in paragraph (2) of such section) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

(ii) **DURATION.**—The demonstration program under this paragraph shall be conducted for a 3-year period.

(iii) **SITES.**—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of critical access hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(B) **WAIVER AUTHORITY.**—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this paragraph.

(C) **BUDGET NEUTRALITY REQUIREMENT.**—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(D) **REPORT.**—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for critical access hospitals with respect to inpatient critical access hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

(2) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR HOSPITALS EXCLUDED FROM HOSPITAL VALUE-BASED PURCHASING PROGRAM AS A RESULT OF INSUFFICIENT NUMBERS OF MEASURES AND CASES.—

(A) ESTABLISHMENT.—

(i) **IN GENERAL.**—Not later than 2 years after the date of enactment of this Act, the Secretary shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for applicable hospitals (as defined in clause (ii) with respect to inpatient hospital services (as defined in section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b))) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

(ii) **APPLICABLE HOSPITAL DEFINED.**—For purposes of this paragraph, the term “applicable hospital” means a hospital described in subclause (III) or (IV) of section 1886(o)(1)(C)(ii) of the Social Security Act, as added by subsection (a)(1).

(iii) **DURATION.**—The demonstration program under this paragraph shall be conducted for a 3-year period.

(iv) **SITES.**—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of applicable hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(B) **WAIVER AUTHORITY.**—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this paragraph.

(C) **BUDGET NEUTRALITY REQUIREMENT.**—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(D) **REPORT.**—Not later than 18 months after the completion of the demonstration program

under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for applicable hospitals with respect to inpatient hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

SEC. 3002. IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM.

(a) **EXTENSION.**—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w-4(m)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A), in the matter preceding clause (i), by striking “2010” and inserting “2014”; and

(B) in subparagraph (B)—

(i) in clause (i), by striking “and” at the end;

(ii) in clause (ii), by striking the period at the end and inserting a semicolon; and

(iii) by adding at the end the following new clauses:

“(iii) for 2011, 1.0 percent; and

“(iv) for 2012, 2013, and 2014, 0.5 percent.”;

(2) in paragraph (3)—

(A) in subparagraph (A), in the matter preceding clause (i), by inserting “(or, for purposes of subsection (a)(8), for the quality reporting period for the year)” after “reporting period”; and

(B) in subparagraph (C)(i), by inserting “, or, for purposes of subsection (a)(8), for a quality reporting period for the year” after “(a)(5), for a reporting period for a year”;

(3) in paragraph (5)(E)(iv), by striking “subsection (a)(5)(A)” and inserting “paragraphs (5)(A) and (8)(A) of subsection (a)”;

(4) in paragraph (6)(C)—

(A) in clause (i)(II), by striking “, 2009, 2010, and 2011” and inserting “and subsequent years”; and

(B) in clause (iii)—

(i) by inserting “(a)(8)” after “(a)(5)”;

(ii) by striking “under subparagraph (D)(iii) of such subsection” and inserting “under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii), respectively”.

(b) **INCENTIVE PAYMENT ADJUSTMENT FOR QUALITY REPORTING.**—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w-4(a)) is amended by adding at the end the following new paragraph:

“(8) **INCENTIVES FOR QUALITY REPORTING.—**

“(A) **ADJUSTMENT.—**

“(i) **IN GENERAL.**—With respect to covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).

“(ii) **APPLICABLE PERCENT.**—For purposes of clause (i), the term “applicable percent” means—

“(I) for 2015, 98.5 percent; and

“(II) for 2016 and each subsequent year, 98 percent.

“(B) **APPLICATION.—**

“(i) **PHYSICIAN REPORTING SYSTEM RULES.**—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in

the same manner as they apply for purposes of such subsection.

“(ii) INCENTIVE PAYMENT VALIDATION RULES.—Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

“(C) DEFINITIONS.—For purposes of this paragraph:

“(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms ‘eligible professional’ and ‘covered professional services’ have the meanings given such terms in subsection (k)(3).

“(ii) PHYSICIAN REPORTING SYSTEM.—The term ‘physician reporting system’ means the system established under subsection (k).

“(iii) QUALITY REPORTING PERIOD.—The term ‘quality reporting period’ means, with respect to a year, a period specified by the Secretary.”

(c) MAINTENANCE OF CERTIFICATION PROGRAMS.—

(1) IN GENERAL.—Section 1848(k)(4) of the Social Security Act (42 U.S.C. 1395w-4(k)(4)) is amended by inserting “or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry” after “Database”).

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply for years after 2010.

(d) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w-4(m)) is amended by adding at the end the following new paragraph:

“(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

“(A) The selection of measures, the reporting of which would both demonstrate—

“(i) meaningful use of an electronic health record for purposes of subsection (o); and

“(ii) quality of care furnished to an individual.

“(B) Such other activities as specified by the Secretary.”

(e) FEEDBACK.—Section 1848(m)(5) of the Social Security Act (42 U.S.C. 1395w-4(m)(5)) is amended by adding at the end the following new subparagraph:

“(H) FEEDBACK.—The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.”

(f) APPEALS.—Such section is further amended—

(1) in subparagraph (E), by striking “There shall” and inserting “Except as provided in subparagraph (I), there shall”; and

(2) by adding at the end the following new subparagraph:

“(I) INFORMAL APPEALS PROCESS.—The Secretary shall, by not later than January 1, 2011, establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.”

SEC. 3003. IMPROVEMENTS TO THE PHYSICIAN FEEDBACK PROGRAM.

(a) IN GENERAL.—Section 1848(n) of the Social Security Act (42 U.S.C. 1395w-4(n)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)—

(i) by striking “GENERAL.—The Secretary” and inserting “GENERAL.—

“(i) ESTABLISHMENT.—The Secretary”;

(ii) in clause (i), as added by clause (i), by striking “the ‘Program’” and all that follows through the period at the end of the second sentence and inserting “the ‘Program’.”; and

(iii) by adding at the end the following new clauses:

“(ii) REPORTS ON RESOURCES.—The Secretary shall use claims data under this title (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this title.

“(iii) INCLUSION OF CERTAIN INFORMATION.—If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this title by the physician (or group of physicians) in such reports.”; and

(B) in subparagraph (B), by striking “subparagraph (A)” and inserting “subparagraph (A)(ii)”;

(2) in paragraph (4)—

(A) in the heading, by inserting “INITIAL” after “FOCUS”; and

(B) in the matter preceding subparagraph (A), by inserting “initial” after “focus the”.

(3) in paragraph (6), by adding at the end the following new sentence: “For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph.”; and

(4) by adding at the end the following new paragraphs:

“(9) REPORTS ON UTILIZATION.—

“(A) DEVELOPMENT OF EPISODE GROUPE.—

“(i) IN GENERAL.—The Secretary shall develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate.

“(ii) TIMELINE FOR DEVELOPMENT.—The episode grouper described in subparagraph (A) shall be developed by not later than January 1, 2012.

“(iii) PUBLIC AVAILABILITY.—The Secretary shall make the details of the episode grouper described in subparagraph (A) available to the public.

“(iv) ENDORSEMENT.—The Secretary shall seek endorsement of the episode grouper described in subparagraph (A) by the entity with a contract under section 1890(a).

“(B) REPORTS ON UTILIZATION.—Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

“(C) ANALYSIS OF DATA.—The Secretary shall, for purposes of preparing reports under this paragraph, establish methodologies as appropriate, such as to—

“(i) attribute episodes of care, in whole or in part, to physicians;

“(ii) identify appropriate physicians for purposes of comparison under subparagraph (B); and

“(iii) aggregate episodes of care attributed to a physician under clause (i) into a composite measure per individual.

“(D) DATA ADJUSTMENT.—In preparing reports under this paragraph, the Secretary shall make appropriate adjustments, including adjustments—

“(i) to account for differences in socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions); and

“(ii) to eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)).

“(E) PUBLIC AVAILABILITY OF METHODOLOGY.—The Secretary shall make available to the public—

“(i) the methodologies established under subparagraph (C);

“(ii) information regarding any adjustments made to data under subparagraph (D); and

“(iii) aggregate reports with respect to physicians.

“(F) DEFINITION OF PHYSICIAN.—In this paragraph:

“(i) IN GENERAL.—The term ‘physician’ has the meaning given that term in section 1861(r)(1).

“(ii) TREATMENT OF GROUPS.—Such term includes, as the Secretary determines appropriate, a group of physicians.

“(G) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the establishment of the methodology under subparagraph (C), including the determination of an episode of care under such methodology.

“(10) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the Program with the value-based payment modifier established under subsection (p) and, as the Secretary determines appropriate, other similar provisions of this title.”

(b) CONFORMING AMENDMENT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)) is amended by adding at the end the following new paragraph:

“(6) REVIEW AND ENDORSEMENT OF EPISODE GROUPE UNDER THE PHYSICIAN FEEDBACK PROGRAM.—The entity shall provide for the review and, as appropriate, the endorsement of the episode grouper developed by the Secretary under section 1848(n)(9)(A). Such review shall be conducted on an expedited basis.”

SEC. 3004. QUALITY REPORTING FOR LONG-TERM CARE HOSPITALS, INPATIENT REHABILITATION HOSPITALS, AND HOSPICE PROGRAMS.

(a) LONG-TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)), as amended by section 3401(c), is amended by adding at the end the following new paragraph:

“(5) QUALITY REPORTING.—

“(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

“(i) IN GENERAL.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a long-term care hospital that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (3), shall be reduced by 2 percentage points.

“(ii) SPECIAL RULE.—The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

“(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

“(C) SUBMISSION OF QUALITY DATA.—For rate year 2014 and each subsequent rate year, each long-term care hospital shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

“(D) QUALITY MEASURES.—

“(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

“(ii) **EXCEPTION.**—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

“(iii) **TIME FRAME.**—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

“(E) **PUBLIC AVAILABILITY OF DATA SUBMITTED.**—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a long-term care hospital has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in long-term care hospitals on the Internet website of the Centers for Medicare & Medicaid Services.”

(b) **INPATIENT REHABILITATION HOSPITALS.**—Section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)) is amended—

(1) by redesignating paragraph (7) as paragraph (8); and

(2) by inserting after paragraph (6) the following new paragraph:

“(7) **QUALITY REPORTING.**—

“(A) **REDUCTION IN UPDATE FOR FAILURE TO REPORT.**—

“(i) **IN GENERAL.**—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a rehabilitation facility that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the increase factor described in paragraph (3)(C), and after application of paragraph (3)(D), the Secretary shall reduce such increase factor for payments for discharges occurring during such fiscal year by 2 percentage points.

“(ii) **SPECIAL RULE.**—The application of this subparagraph may result in the increase factor described in paragraph (3)(C) being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

“(B) **NONCUMULATIVE APPLICATION.**—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

“(C) **SUBMISSION OF QUALITY DATA.**—For fiscal year 2014 and each subsequent rate year, each rehabilitation facility shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

“(D) **QUALITY MEASURES.**—

“(i) **IN GENERAL.**—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

“(ii) **EXCEPTION.**—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

“(iii) **TIME FRAME.**—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

“(E) **PUBLIC AVAILABILITY OF DATA SUBMITTED.**—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a rehabilitation facility has the opportunity to review the data that is to be made public with respect to the facility prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in rehabilitation facilities on the Internet website of the Centers for Medicare & Medicaid Services.”

(c) **HOSPICE PROGRAMS.**—Section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

“(5) **QUALITY REPORTING.**—

“(A) **REDUCTION IN UPDATE FOR FAILURE TO REPORT.**—

“(i) **IN GENERAL.**—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a hospice program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, and after application of paragraph (1)(C)(iv), with respect to the fiscal year, the Secretary shall reduce such market basket percentage increase by 2 percentage points.

“(ii) **SPECIAL RULE.**—The application of this subparagraph may result in the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

“(B) **NONCUMULATIVE APPLICATION.**—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

“(C) **SUBMISSION OF QUALITY DATA.**—For fiscal year 2014 and each subsequent fiscal year, each hospice program shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

“(D) **QUALITY MEASURES.**—

“(i) **IN GENERAL.**—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

“(ii) **EXCEPTION.**—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

“(iii) **TIME FRAME.**—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

“(E) **PUBLIC AVAILABILITY OF DATA SUBMITTED.**—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such proce-

dures shall ensure that a hospice program has the opportunity to review the data that is to be made public with respect to the hospice program prior to such data being made public. The Secretary shall report quality measures that relate to hospice care provided by hospice programs on the Internet website of the Centers for Medicare & Medicaid Services.”

SEC. 3005. QUALITY REPORTING FOR PPS-EXEMPT CANCER HOSPITALS.

Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (U), by striking “and” at the end;

(B) in subparagraph (V), by striking the period at the end and inserting “, and”; and

(C) by adding at the end the following new subparagraph:

“(W) in the case of a hospital described in section 1886(d)(1)(B)(v), to report quality data to the Secretary in accordance with subsection (k).”; and

(2) by adding at the end the following new subsection:

“(k) **QUALITY REPORTING BY CANCER HOSPITALS.**—

“(1) **IN GENERAL.**—For purposes of fiscal year 2014 and each subsequent fiscal year, a hospital described in section 1886(d)(1)(B)(v) shall submit data to the Secretary in accordance with paragraph (2) with respect to such a fiscal year.

“(2) **SUBMISSION OF QUALITY DATA.**—For fiscal year 2014 and each subsequent fiscal year, each hospital described in such section shall submit to the Secretary data on quality measures specified under paragraph (3). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

“(3) **QUALITY MEASURES.**—

“(A) **IN GENERAL.**—Subject to subparagraph (B), any measure specified by the Secretary under this paragraph must have been endorsed by the entity with a contract under section 1890(a).

“(B) **EXCEPTION.**—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

“(C) **TIME FRAME.**—Not later than October 1, 2012, the Secretary shall publish the measures selected under this paragraph that will be applicable with respect to fiscal year 2014.

“(4) **PUBLIC AVAILABILITY OF DATA SUBMITTED.**—The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1886(d)(1)(B)(v) has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services.”

SEC. 3006. PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.

(a) **SKILLED NURSING FACILITIES.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under

title XVIII of the Social Security Act for skilled nursing facilities (as defined in section 1819(a) of such Act (42 U.S.C. 1395i-3(a))).

(2) **DETAILS.**—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in skilled nursing facilities.

(i) **IN GENERAL.**—Subject to clause (ii), any measure specified by the Secretary under subparagraph (A)(iii) must have been endorsed by the entity with a contract under section 1890(a).

(ii) **EXCEPTION.**—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(B) The reporting, collection, and validation of quality data.

(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of skilled nursing facilities.

(E) Any other issues determined appropriate by the Secretary.

(3) **CONSULTATION.**—In developing the plan under paragraph (1), the Secretary shall—

(A) consult with relevant affected parties; and
(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

(4) **REPORT TO CONGRESS.**—Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

(b) **HOME HEALTH AGENCIES.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for home health agencies (as defined in section 1861(o) of such Act (42 U.S.C. 1395x(o))).

(2) **DETAILS.**—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in home health agencies.

(B) The reporting, collection, and validation of quality data.

(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of home health agencies.

(E) Any other issues determined appropriate by the Secretary.

(3) **CONSULTATION.**—In developing the plan under paragraph (1), the Secretary shall—

(A) consult with relevant affected parties; and

(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

(4) **REPORT TO CONGRESS.**—Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

SEC. 3007. VALUE-BASED PAYMENT MODIFIER UNDER THE PHYSICIAN FEE SCHEDULE.

Section 1848 of the Social Security Act (42 U.S.C. 1395w-4) is amended—

(1) in subsection (b)(1), by inserting “subject to subsection (p),” after “1998,”; and

(2) by adding at the end the following new subsection:

“(p) **ESTABLISHMENT OF VALUE-BASED PAYMENT MODIFIER.**—

“(1) **IN GENERAL.**—The Secretary shall establish a payment modifier that provides for differential payment to a physician or a group of physicians under the fee schedule established under subsection (b) based upon the quality of care furnished compared to cost (as determined under paragraphs (2) and (3), respectively) during a performance period. Such payment modifier shall be separate from the geographic adjustment factors established under subsection (e).

“(2) **QUALITY.**—

“(A) **IN GENERAL.**—For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished (as established by the Secretary under subparagraph (B)).

“(B) **MEASURES.**—

“(i) The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be risk adjusted as determined appropriate by the Secretary.

“(ii) The Secretary shall seek endorsement of the measures established under this subparagraph by the entity with a contract under section 1890(a).

“(3) **COSTS.**—For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary.

“(4) **IMPLEMENTATION.**—

“(A) **PUBLICATION OF MEASURES, DATES OF IMPLEMENTATION, PERFORMANCE PERIOD.**—Not later than January 1, 2012, the Secretary shall publish the following:

“(i) The measures of quality of care and costs established under paragraphs (2) and (3), respectively.

“(ii) The dates for implementation of the payment modifier (as determined under subparagraph (B)).

“(iii) The initial performance period (as specified under subparagraph (B)(ii)).

“(B) **DEADLINES FOR IMPLEMENTATION.**—

“(i) **INITIAL IMPLEMENTATION.**—Subject to the preceding provisions of this subparagraph, the Secretary shall begin implementing the payment modifier established under this subsection through the rulemaking process during 2013 for

the physician fee schedule established under subsection (b).

“(ii) **INITIAL PERFORMANCE PERIOD.**—

“(I) **IN GENERAL.**—The Secretary shall specify an initial performance period for application of the payment modifier established under this subsection with respect to 2015.

“(II) **PROVISION OF INFORMATION DURING INITIAL PERFORMANCE PERIOD.**—During the initial performance period, the Secretary shall, to the extent practicable, provide information to physicians and groups of physicians about the quality of care furnished by the physician or group of physicians to individuals enrolled under this part compared to cost (as determined under paragraphs (2) and (3), respectively) with respect to the performance period.

“(iii) **APPLICATION.**—The Secretary shall apply the payment modifier established under this subsection for items and services furnished—

“(I) beginning on January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate; and

“(II) beginning not later than January 1, 2017, with respect to all physicians and groups of physicians.

“(C) **BUDGET NEUTRALITY.**—The payment modifier established under this subsection shall be implemented in a budget neutral manner.

“(5) **SYSTEMS-BASED CARE.**—The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.

“(6) **CONSIDERATION OF SPECIAL CIRCUMSTANCES OF CERTAIN PROVIDERS.**—In applying the payment modifier under this subsection, the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

“(7) **APPLICATION.**—For purposes of the initial application of the payment modifier established under this subsection during the period beginning on January 1, 2015, and ending on December 31, 2016, the term “physician” has the meaning given such term in section 1861(r). On or after January 1, 2017, the Secretary may apply this subsection to eligible professionals (as defined in subsection (k)(3)(B)) as the Secretary determines appropriate.

“(8) **DEFINITIONS.**—For purposes of this subsection:

“(A) **COSTS.**—The term “costs” means expenditures per individual as determined appropriate by the Secretary. In making the determination under the preceding sentence, the Secretary may take into account the amount of growth in expenditures per individual for a physician compared to the amount of such growth for other physicians.

“(B) **PERFORMANCE PERIOD.**—The term “performance period” means a period specified by the Secretary.

“(9) **COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.**—The Secretary shall coordinate the value-based payment modifier established under this subsection with the Physician Feedback Program under subsection (n) and, as the Secretary determines appropriate, other similar provisions of this title.

“(10) **LIMITATIONS ON REVIEW.**—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

“(A) the establishment of the value-based payment modifier under this subsection;

“(B) the evaluation of quality of care under paragraph (2), including the establishment of appropriate measures of the quality of care under paragraph (2)(B);

“(C) the evaluation of costs under paragraph (3), including the establishment of appropriate measures of costs under such paragraph;

“(D) the dates for implementation of the value-based payment modifier;

“(E) the specification of the initial performance period and any other performance period under paragraphs (4)(B)(ii) and (8)(B), respectively;

“(F) the application of the value-based payment modifier under paragraph (7); and

“(G) the determination of costs under paragraph (8)(A).”.

SEC. 3008. PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS.

(a) **IN GENERAL.**—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 3001, is amended by adding at the end the following new subsection:

“(p) **ADJUSTMENT TO HOSPITAL PAYMENTS FOR HOSPITAL ACQUIRED CONDITIONS.**—

“(1) **IN GENERAL.**—In order to provide an incentive for applicable hospitals to reduce hospital acquired conditions under this title, with respect to discharges from an applicable hospital occurring during fiscal year 2015 or a subsequent fiscal year, the amount of payment under this section or section 1814(b)(3), as applicable, for such discharges during the fiscal year shall be equal to 99 percent of the amount of payment that would otherwise apply to such discharges under this section or section 1814(b)(3) (determined after the application of subsections (o) and (q) and section 1814(l)(4) but without regard to this subsection).

“(2) **APPLICABLE HOSPITALS.**—

“(A) **IN GENERAL.**—For purposes of this subsection, the term ‘applicable hospital’ means a subsection (d) hospital that meets the criteria described in subparagraph (B).

“(B) **CRITERIA DESCRIBED.**—

“(i) **IN GENERAL.**—The criteria described in this subparagraph, with respect to a subsection (d) hospital, is that the subsection (d) hospital is in the top quartile of all subsection (d) hospitals, relative to the national average, of hospital acquired conditions during the applicable period, as determined by the Secretary.

“(ii) **RISK ADJUSTMENT.**—In carrying out clause (i), the Secretary shall establish and apply an appropriate risk adjustment methodology.

“(C) **EXEMPTION.**—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

“(3) **HOSPITAL ACQUIRED CONDITIONS.**—For purposes of this subsection, the term ‘hospital acquired condition’ means a condition identified for purposes of subsection (d)(4)(D)(iv) and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital, as determined by the Secretary.

“(4) **APPLICABLE PERIOD.**—In this subsection, the term ‘applicable period’ means, with respect to a fiscal year, a period specified by the Secretary.

“(5) **REPORTING TO HOSPITALS.**—Prior to fiscal year 2015 and each subsequent fiscal year, the Secretary shall provide confidential reports to applicable hospitals with respect to hospital acquired conditions of the applicable hospital during the applicable period.

“(6) **REPORTING HOSPITAL SPECIFIC INFORMATION.**—

“(A) **IN GENERAL.**—The Secretary shall make information available to the public regarding hospital acquired conditions of each applicable hospital.

“(B) **OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.**—The Secretary shall ensure that an applicable hospital has the opportunity to

review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

“(C) **WEBSITE.**—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

“(7) **LIMITATIONS ON REVIEW.**—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

“(A) The criteria described in paragraph (2)(A).

“(B) The specification of hospital acquired conditions under paragraph (3).

“(C) The specification of the applicable period under paragraph (4).

“(D) The provision of reports to applicable hospitals under paragraph (5) and the information made available to the public under paragraph (6).”.

(b) **STUDY AND REPORT ON EXPANSION OF HEALTHCARE ACQUIRED CONDITIONS POLICY TO OTHER PROVIDERS.**—

(1) **STUDY.**—The Secretary of Health and Human Services shall conduct a study on expanding the healthcare acquired conditions policy under subsection (d)(4)(D) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) to payments made to other facilities under the Medicare program under title XVIII of the Social Security Act, including such payments made to inpatient rehabilitation facilities, long-term care hospitals (as described in subsection(d)(1)(B)(iv) of such section), hospital outpatient departments, and other hospitals excluded from the inpatient prospective payment system under such section, skilled nursing facilities, ambulatory surgical centers, and health clinics. Such study shall include an analysis of how such policies could impact quality of patient care, patient safety, and spending under the Medicare program.

(2) **REPORT.**—Not later than January 1, 2012, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART II—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY

SEC. 3011. NATIONAL STRATEGY.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

“PART S—HEALTH CARE QUALITY PROGRAMS

“Subpart I—National Strategy for Quality Improvement in Health Care

“SEC. 399HH. NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE.

“(a) **ESTABLISHMENT OF NATIONAL STRATEGY AND PRIORITIES.**—

“(1) **NATIONAL STRATEGY.**—The Secretary, through a transparent collaborative process, shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health.

“(2) **IDENTIFICATION OF PRIORITIES.**—

“(A) **IN GENERAL.**—The Secretary shall identify national priorities for improvement in developing the strategy under paragraph (1).

“(B) **REQUIREMENTS.**—The Secretary shall ensure that priorities identified under subparagraph (A) will—

“(i) have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care for all populations, including children and vulnerable populations;

“(ii) identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care;

“(iii) address gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures and data aggregation techniques;

“(iv) improve Federal payment policy to emphasize quality and efficiency;

“(v) enhance the use of health care data to improve quality, efficiency, transparency, and outcomes;

“(vi) address the health care provided to patients with high-cost chronic diseases;

“(vii) improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections;

“(viii) reduce health disparities across health disparity populations (as defined in section 485E) and geographic areas; and

“(ix) address other areas as determined appropriate by the Secretary.

“(C) **CONSIDERATIONS.**—In identifying priorities under subparagraph (A), the Secretary shall take into consideration the recommendations submitted by the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders.

“(D) **COORDINATION WITH STATE AGENCIES.**—The Secretary shall collaborate, coordinate, and consult with State agencies responsible for administering the Medicaid program under title XIX of the Social Security Act and the Children’s Health Insurance Program under title XXI of such Act with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under subparagraph (A).

“(b) **STRATEGIC PLAN.**—

“(1) **IN GENERAL.**—The national strategy shall include a comprehensive strategic plan to achieve the priorities described in subsection (a).

“(2) **REQUIREMENTS.**—The strategic plan shall include provisions for addressing, at a minimum, the following:

“(A) **Coordination among agencies within the Department,** which shall include steps to minimize duplication of efforts and utilization of common quality measures, where available. Such common quality measures shall be measures identified by the Secretary under section 1139A or 1139B of the Social Security Act or endorsed under section 1890 of such Act.

“(B) **Agency-specific strategic plans** to achieve national priorities.

“(C) **Establishment of annual benchmarks** for each relevant agency to achieve national priorities.

“(D) **A process for regular reporting** by the agencies to the Secretary on the implementation of the strategic plan.

“(E) **Strategies to align public and private payers** with regard to quality and patient safety efforts.

“(F) **Incorporating quality improvement and measurement** in the strategic plan for health information technology required by the American Recovery and Reinvestment Act of 2009 (Public Law 111–5).

“(c) **PERIODIC UPDATE OF NATIONAL STRATEGY.**—The Secretary shall update the national strategy not less than annually. Any such update shall include a review of short- and long-term goals.

“(d) **SUBMISSION AND AVAILABILITY OF NATIONAL STRATEGY AND UPDATES.**—

“(1) **DEADLINE FOR INITIAL SUBMISSION OF NATIONAL STRATEGY.**—Not later than January 1, 2011, the Secretary shall submit to the relevant committees of Congress the national strategy described in subsection (a).

“(2) **UPDATES.**—

“(A) **IN GENERAL.**—The Secretary shall submit to the relevant committees of Congress an annual update to the strategy described in paragraph (1).

“(B) INFORMATION SUBMITTED.—Each update submitted under subparagraph (A) shall include—

“(i) a review of the short- and long-term goals of the national strategy and any gaps in such strategy;

“(ii) an analysis of the progress, or lack of progress, in meeting such goals and any barriers to such progress;

“(iii) the information reported under section 1139A of the Social Security Act, consistent with the reporting requirements of such section; and

“(iv) in the case of an update required to be submitted on or after January 1, 2014, the information reported under section 1139B(b)(4) of the Social Security Act, consistent with the reporting requirements of such section.

“(C) SATISFACTION OF OTHER REPORTING REQUIREMENTS.—Compliance with the requirements of clauses (iii) and (iv) of subparagraph (B) shall satisfy the reporting requirements under sections 1139A(a)(6) and 1139B(b)(4), respectively, of the Social Security Act.

“(e) HEALTH CARE QUALITY INTERNET WEBSITE.—Not later than January 1, 2011, the Secretary shall create an Internet website to make public information regarding—

“(1) the national priorities for health care quality improvement established under subsection (a)(2);

“(2) the agency-specific strategic plans for health care quality described in subsection (b)(2)(B); and

“(3) other information, as the Secretary determines to be appropriate.”.

SEC. 3012. INTERAGENCY WORKING GROUP ON HEALTH CARE QUALITY.

(a) IN GENERAL.—The President shall convene a working group to be known as the Interagency Working Group on Health Care Quality (referred to in this section as the “Working Group”).

(b) GOALS.—The goals of the Working Group shall be to achieve the following:

(1) Collaboration, cooperation, and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under section 399HH(a)(2) of the Public Health Service Act (as added by section 3011).

(2) Avoidance of inefficient duplication of quality improvement efforts and resources, where practicable, and a streamlined process for quality reporting and compliance requirements.

(3) Assess alignment of quality efforts in the public sector with private sector initiatives.

(c) COMPOSITION.—

(1) IN GENERAL.—The Working Group shall be composed of senior level representatives of—

(A) the Department of Health and Human Services;

(B) the Centers for Medicare & Medicaid Services;

(C) the National Institutes of Health;

(D) the Centers for Disease Control and Prevention;

(E) the Food and Drug Administration;

(F) the Health Resources and Services Administration;

(G) the Agency for Healthcare Research and Quality;

(H) the Office of the National Coordinator for Health Information Technology;

(I) the Substance Abuse and Mental Health Services Administration;

(J) the Administration for Children and Families;

(K) the Department of Commerce;

(L) the Office of Management and Budget;

(M) the United States Coast Guard;

(N) the Federal Bureau of Prisons;

(O) the National Highway Traffic Safety Administration;

(P) the Federal Trade Commission;

(Q) the Social Security Administration;

(R) the Department of Labor;

(S) the United States Office of Personnel Management;

(T) the Department of Defense;

(U) the Department of Education;

(V) the Department of Veterans Affairs;

(W) the Veterans Health Administration; and

(X) any other Federal agencies and departments with activities relating to improving health care quality and safety, as determined by the President.

(2) CHAIR AND VICE CHAIR.—

(A) CHAIR.—The Working Group shall be chaired by the Secretary of Health and Human Services.

(B) VICE CHAIR.—Members of the Working Group, other than the Secretary of Health and Human Services, shall serve as Vice Chair of the Group on a rotating basis, as determined by the Group.

(d) REPORT TO CONGRESS.—Not later than December 31, 2010, and annually thereafter, the Working Group shall submit to the relevant Committees of Congress, and make public on an Internet website, a report describing the progress and recommendations of the Working Group in meeting the goals described in subsection (b).

SEC. 3013. QUALITY MEASURE DEVELOPMENT.

(a) PUBLIC HEALTH SERVICE ACT.—Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) by redesignating part D as part E;

(2) by redesignating sections 931 through 938 as sections 941 through 948, respectively;

(3) in section 948(1), as so redesignated, by striking “931” and inserting “941”; and

(4) by inserting after section 926 the following:

“PART D—HEALTH CARE QUALITY IMPROVEMENT

“Subpart I—Quality Measure Development

“SEC. 931. QUALITY MEASURE DEVELOPMENT.

“(a) QUALITY MEASURE.—In this subpart, the term ‘quality measure’ means a standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services.

“(b) IDENTIFICATION OF QUALITY MEASURES.—

“(1) IDENTIFICATION.—The Secretary, in consultation with the Director of the Agency for Healthcare Research and Quality and the Administrator of the Centers for Medicare & Medicaid Services, shall identify, not less often than triennially, gaps where no quality measures exist and existing quality measures that need improvement, updating, or expansion, consistent with the national strategy under section 399HH, to the extent available, for use in Federal health programs. In identifying such gaps and existing quality measures that need improvement, the Secretary shall take into consideration—

“(A) the gaps identified by the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders;

“(B) quality measures identified by the pediatric quality measures program under section 1139A of the Social Security Act; and

“(C) quality measures identified through the Medicaid Quality Measurement Program under section 1139B of the Social Security Act.

“(2) PUBLICATION.—The Secretary shall make available to the public on an Internet website a report on any gaps identified under paragraph (1) and the process used to make such identification.

“(c) GRANTS OR CONTRACTS FOR QUALITY MEASURE DEVELOPMENT.—

“(1) IN GENERAL.—The Secretary shall award grants, contracts, or intergovernmental agreements to eligible entities for purposes of devel-

oping, improving, updating, or expanding quality measures identified under subsection (b).

“(2) PRIORITIZATION IN THE DEVELOPMENT OF QUALITY MEASURES.—In awarding grants, contracts, or agreements under this subsection, the Secretary shall give priority to the development of quality measures that allow the assessment of—

“(A) health outcomes and functional status of patients;

“(B) the management and coordination of health care across episodes of care and care transitions for patients across the continuum of providers, health care settings, and health plans;

“(C) the experience, quality, and use of information provided to and used by patients, caregivers, and authorized representatives to inform decisionmaking about treatment options, including the use of shared decisionmaking tools and preference sensitive care (as defined in section 936);

“(D) the meaningful use of health information technology;

“(E) the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care;

“(F) the efficiency of care;

“(G) the equity of health services and health disparities across health disparity populations (as defined in section 485E) and geographic areas;

“(H) patient experience and satisfaction;

“(I) the use of innovative strategies and methodologies identified under section 933; and

“(J) other areas determined appropriate by the Secretary.

“(3) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

“(A) have demonstrated expertise and capacity in the development and evaluation of quality measures;

“(B) have adopted procedures to include in the quality measure development process—

“(i) the views of those providers or payers whose performance will be assessed by the measure; and

“(ii) the views of other parties who also will use the quality measures (such as patients, consumers, and health care purchasers);

“(C) collaborate with the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders, as practicable, and the Secretary so that quality measures developed by the eligible entity will meet the requirements to be considered for endorsement by the entity with a contract under such section 1890(a);

“(D) have transparent policies regarding governance and conflicts of interest; and

“(E) submit an application to the Secretary at such time and in such manner, as the Secretary may require.

“(4) USE OF FUNDS.—An entity that receives a grant, contract, or agreement under this subsection shall use such award to develop quality measures that meet the following requirements:

“(A) Such measures support measures required to be reported under the Social Security Act, where applicable, and in support of gaps and existing quality measures that need improvement, as described in subsection (b)(1)(A).

“(B) Such measures support measures developed under section 1139A of the Social Security Act and the Medicaid Quality Measurement Program under section 1139B of such Act, where applicable.

“(C) To the extent practicable, data on such quality measures is able to be collected using health information technologies.

“(D) Each quality measure is free of charge to users of such measure.

“(E) Each quality measure is publicly available on an Internet website.

“(d) OTHER ACTIVITIES BY THE SECRETARY.—The Secretary may use amounts available under this section to update and test, where applicable, quality measures endorsed by the entity with a contract under section 1890(a) of the Social Security Act or adopted by the Secretary.

“(e) COORDINATION OF GRANTS.—The Secretary shall ensure that grants or contracts awarded under this section are coordinated with grants and contracts awarded under sections 1139A(5) and 1139B(4)(A) of the Social Security Act.”.

(b) SOCIAL SECURITY ACT.—Section 1890A of the Social Security Act, as added by section 3014(b), is amended by adding at the end the following new subsection:

“(e) DEVELOPMENT OF QUALITY MEASURES.—The Administrator of the Center for Medicare & Medicaid Services shall through contracts develop quality measures (as determined appropriate by the Administrator) for use under this Act. In developing such measures, the Administrator shall consult with the Director of the Agency for Healthcare Research and Quality.”.

(c) FUNDING.—There are authorized to be appropriated to the Secretary of Health and Human Services to carry out this section, \$75,000,000 for each of fiscal years 2010 through 2014. Of the amounts appropriated under the preceding sentence in a fiscal year, not less than 50 percent of such amounts shall be used pursuant to subsection (e) of section 1890A of the Social Security Act, as added by subsection (b), with respect to programs under such Act. Amounts appropriated under this subsection for a fiscal year shall remain available until expended.

SEC. 3014. QUALITY MEASUREMENT.

(a) NEW DUTIES FOR CONSENSUS-BASED ENTITY.—

(1) MULTI-STAKEHOLDER GROUP INPUT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)), as amended by section 3003, is amended by adding at the end the following new paragraphs:

“(7) CONVENING MULTI-STAKEHOLDER GROUPS.—

“(A) IN GENERAL.—The entity shall convene multi-stakeholder groups to provide input on—

“(i) the selection of quality measures described in subparagraph (B), from among—

“(I) such measures that have been endorsed by the entity; and

“(II) such measures that have not been considered for endorsement by such entity but are used or proposed to be used by the Secretary for the collection or reporting of quality measures; and

“(ii) national priorities (as identified under section 399HH of the Public Health Service Act) for improvement in population health and in the delivery of health care services for consideration under the national strategy established under section 399HH of the Public Health Service Act.

“(B) QUALITY MEASURES.—

“(i) IN GENERAL.—Subject to clause (ii), the quality measures described in this subparagraph are quality measures—

“(I) for use pursuant to sections 1814(i)(5)(D), 1833(i)(7), 1833(t)(17), 1848(k)(2)(C), 1866(k)(3), 1881(h)(2)(A)(iii), 1886(b)(3)(B)(viii), 1886(j)(7)(D), 1886(m)(5)(D), 1886(o)(2), and 1895(b)(3)(B)(v);

“(II) for use in reporting performance information to the public; and

“(III) for use in health care programs other than for use under this Act.

“(ii) EXCLUSION.—Data sets (such as the outcome and assessment information set for home health services and the minimum data set for skilled nursing facility services) that are used for purposes of classification systems used in establishing payment rates under this title shall not be quality measures described in this subparagraph.

“(C) REQUIREMENT FOR TRANSPARENCY IN PROCESS.—

“(i) IN GENERAL.—In convening multi-stakeholder groups under subparagraph (A) with respect to the selection of quality measures, the entity shall provide for an open and transparent process for the activities conducted pursuant to such convening.

“(ii) SELECTION OF ORGANIZATIONS PARTICIPATING IN MULTI-STAKEHOLDER GROUPS.—The process described in clause (i) shall ensure that the selection of representatives comprising such groups provides for public nominations for, and the opportunity for public comment on, such selection.

“(D) MULTI-STAKEHOLDER GROUP DEFINED.—In this paragraph, the term ‘multi-stakeholder group’ means, with respect to a quality measure, a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of such quality measure.

“(8) TRANSMISSION OF MULTI-STAKEHOLDER INPUT.—Not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups provided under paragraph (7).”.

(2) ANNUAL REPORT.—Section 1890(b)(5)(A) of the Social Security Act (42 U.S.C. 1395aaa(b)(5)(A)) is amended—

(A) in clause (ii), by striking “and” at the end;

(B) in clause (iii), by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following new clauses:

“(iv) gaps in endorsed quality measures, which shall include measures that are within priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act, and where quality measures are unavailable or inadequate to identify or address such gaps;

“(v) areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act and where targeted research may address such gaps; and

“(vi) the matters described in clauses (i) and (ii) of paragraph (7)(A).”.

(b) MULTI-STAKEHOLDER GROUP INPUT INTO SELECTION OF QUALITY MEASURES.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1890 the following:

“QUALITY MEASUREMENT

“SEC. 1890A. (a) MULTI-STAKEHOLDER GROUP INPUT INTO SELECTION OF QUALITY MEASURES.—The Secretary shall establish a pre-rulemaking process under which the following steps occur with respect to the selection of quality measures described in section 1890(b)(7)(B):

“(1) INPUT.—Pursuant to section 1890(b)(7), the entity with a contract under section 1890 shall convene multi-stakeholder groups to provide input to the Secretary on the selection of quality measures described in subparagraph (B) of such paragraph.

“(2) PUBLIC AVAILABILITY OF MEASURES CONSIDERED FOR SELECTION.—Not later than December 1 of each year (beginning with 2011), the Secretary shall make available to the public a list of quality measures described in section 1890(b)(7)(B) that the Secretary is considering under this title.

“(3) TRANSMISSION OF MULTI-STAKEHOLDER INPUT.—Pursuant to section 1890(b)(8), not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups described in paragraph (1).

“(4) CONSIDERATION OF MULTI-STAKEHOLDER INPUT.—The Secretary shall take into consider-

ation the input from multi-stakeholder groups described in paragraph (1) in selecting quality measures described in section 1890(b)(7)(B) that have been endorsed by the entity with a contract under section 1890 and measures that have not been endorsed by such entity.

“(5) RATIONALE FOR USE OF QUALITY MEASURES.—The Secretary shall publish in the Federal Register the rationale for the use of any quality measure described in section 1890(b)(7)(B) that has not been endorsed by the entity with a contract under section 1890.

“(6) ASSESSMENT OF IMPACT.—Not later than March 1, 2012, and at least once every three years thereafter, the Secretary shall—

“(A) conduct an assessment of the quality impact of the use of endorsed measures described in section 1890(b)(7)(B); and

“(B) make such assessment available to the public.

“(b) PROCESS FOR DISSEMINATION OF MEASURES USED BY THE SECRETARY.—

“(1) IN GENERAL.—The Secretary shall establish a process for disseminating quality measures used by the Secretary. Such process shall include the following:

“(A) The incorporation of such measures, where applicable, in workforce programs, training curricula, and any other means of dissemination determined appropriate by the Secretary.

“(B) The dissemination of such quality measures through the national strategy developed under section 399HH of the Public Health Service Act.

“(2) EXISTING METHODS.—To the extent practicable, the Secretary shall utilize and expand existing dissemination methods in disseminating quality measures under the process established under paragraph (1).

“(c) REVIEW OF QUALITY MEASURES USED BY THE SECRETARY.—

“(1) IN GENERAL.—The Secretary shall—

“(A) periodically (but in no case less often than once every 3 years) review quality measures described in section 1890(b)(7)(B); and

“(B) with respect to each such measure, determine whether to—

“(i) maintain the use of such measure; or

“(ii) phase out such measure.

“(2) CONSIDERATIONS.—In conducting the review under paragraph (1), the Secretary shall take steps to—

“(A) seek to avoid duplication of measures used; and

“(B) take into consideration current innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices for such quality improvement and measures endorsed by the entity with a contract under section 1890 since the previous review by the Secretary.

“(d) RULE OF CONSTRUCTION.—Nothing in this section shall preclude a State from using the quality measures identified under sections 1139A and 1139B.”.

(c) FUNDING.—For purposes of carrying out the amendments made by this section, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of \$20,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2010 through 2014. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3015. DATA COLLECTION; PUBLIC REPORTING.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 3011,

is further amended by adding at the end the following:

“SEC. 399II. COLLECTION AND ANALYSIS OF DATA FOR QUALITY AND RESOURCE USE MEASURES.

“(a) **IN GENERAL.**—The Secretary shall collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information, as described in section 399JJ, and may award grants or contracts for this purpose. The Secretary shall ensure that such collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time.

“(b) **GRANTS OR CONTRACTS FOR DATA COLLECTION.**—

“(1) **IN GENERAL.**—The Secretary may award grants or contracts to eligible entities to support new, or improve existing, efforts to collect and aggregate quality and resource use measures described under subsection (c).

“(2) **ELIGIBLE ENTITIES.**—To be eligible for a grant or contract under this subsection, an entity shall—

“(A) be—

“(i) a multi-stakeholder entity that coordinates the development of methods and implementation plans for the consistent reporting of summary quality and cost information;

“(ii) an entity capable of submitting such summary data for a particular population and providers, such as a disease registry, regional collaboration, health plan collaboration, or other population-wide source; or

“(iii) a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act);

“(B) promote the use of the systems that provide data to improve and coordinate patient care;

“(C) support the provision of timely, consistent quality and resource use information to health care providers, and other groups and organizations as appropriate, with an opportunity for providers to correct inaccurate measures; and

“(D) agree to report, as determined by the Secretary, measures on quality and resource use to the public in accordance with the public reporting process established under section 399JJ.

“(c) **CONSISTENT DATA AGGREGATION.**—The Secretary may award grants or contracts under this section only to entities that enable summary data that can be integrated and compared across multiple sources. The Secretary shall provide standards for the protection of the security and privacy of patient data.

“(d) **MATCHING FUNDS.**—The Secretary may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to \$1 for each \$5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

“(e) **AUTHORIZATION OF APPROPRIATIONS.**—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.

“SEC. 399JJ. PUBLIC REPORTING OF PERFORMANCE INFORMATION.

“(a) **DEVELOPMENT OF PERFORMANCE WEBSITES.**—The Secretary shall make available to the public, through standardized Internet websites, performance information summarizing

data on quality measures. Such information shall be tailored to respond to the differing needs of hospitals and other institutional health care providers, physicians and other clinicians, patients, consumers, researchers, policymakers, States, and other stakeholders, as the Secretary may specify.

“(b) **INFORMATION ON CONDITIONS.**—The performance information made publicly available on an Internet website, as described in subsection (a), shall include information regarding clinical conditions to the extent such information is available, and the information shall, where appropriate, be provider-specific and sufficiently disaggregated and specific to meet the needs of patients with different clinical conditions.

“(c) **CONSULTATION.**—

“(1) **IN GENERAL.**—In carrying out this section, the Secretary shall consult with the entity with a contract under section 1890(a) of the Social Security Act, and other entities, as appropriate, to determine the type of information that is useful to stakeholders and the format that best facilitates use of the reports and of performance reporting Internet websites.

“(2) **CONSULTATION WITH STAKEHOLDERS.**—The entity with a contract under section 1890(a) of the Social Security Act shall convene multi-stakeholder groups, as described in such section, to review the design and format of each Internet website made available under subsection (a) and shall transmit to the Secretary the views of such multi-stakeholder groups with respect to each such design and format.

“(d) **COORDINATION.**—Where appropriate, the Secretary shall coordinate the manner in which data are presented through Internet websites described in subsection (a) and for public reporting of other quality measures by the Secretary, including such quality measures under title XVIII of the Social Security Act.

“(e) **AUTHORIZATION OF APPROPRIATIONS.**—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.”.

T2PART III—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS

SEC. 3021. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS.

(a) **IN GENERAL.**—Title XI of the Social Security Act is amended by inserting after section 1115 the following new section:

“CENTER FOR MEDICARE AND MEDICAID INNOVATION

“SEC. 1115A. (a) CENTER FOR MEDICARE AND MEDICAID INNOVATION ESTABLISHED.—

“(1) **IN GENERAL.**—There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the ‘CMI’) to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals defined in paragraph (4)(A).

“(2) **DEADLINE.**—The Secretary shall ensure that the CMI is carrying out the duties described in this section by not later than January 1, 2011.

“(3) **CONSULTATION.**—In carrying out the duties under this section, the CMI shall consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management. The CMI shall use open door forums or other mechanisms to seek input from interested parties.

“(4) **DEFINITIONS.**—In this section:

“(A) **APPLICABLE INDIVIDUAL.**—The term ‘applicable individual’ means—

“(i) an individual who is entitled to, or enrolled for, benefits under part A of title XVIII or enrolled for benefits under part B of such title;

“(ii) an individual who is eligible for medical assistance under title XIX, under a State plan or waiver; or

“(iii) an individual who meets the criteria of both clauses (i) and (ii).

“(B) **APPLICABLE TITLE.**—The term ‘applicable title’ means title XVIII, title XIX, or both.

“(b) **TESTING OF MODELS (PHASE I).**—

“(1) **IN GENERAL.**—The CMI shall test payment and service delivery models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable title (as defined in subsection (a)(4)(B)) on program expenditures under such titles and the quality of care received by individuals receiving benefits under such title.

“(2) **SELECTION OF MODELS TO BE TESTED.**—

“(A) **IN GENERAL.**—The Secretary shall select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The models selected under the preceding sentence may include the models described in subparagraph (B).

“(B) **OPPORTUNITIES.**—The models described in this subparagraph are the following models:

“(i) Promoting broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes that address women’s unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.

“(ii) Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment.

“(iii) Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of applicable individuals with multiple chronic conditions and at least one of the following:

“(I) An inability to perform 2 or more activities of daily living.

“(II) Cognitive impairment, including dementia.

“(iv) Promote care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment.

“(v) Supporting care coordination for chronically-ill applicable individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home tele-health technology.

“(vi) Varying payment to physicians who order advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriateness criteria for the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders.

“(vii) Utilizing medication therapy management services, such as those described in section 935 of the Public Health Service Act.

“(viii) Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management, activities.

“(ix) Assisting applicable individuals in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools, including tools that meet the standards developed and identified under section 936(c)(2)(A) of the Public Health Service Act, that improve applicable individual and caregiver understanding of medical treatment options.

“(x) Allowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals.

“(xi) Allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.

“(xii) Aligning nationally recognized, evidence-based guidelines of cancer care with payment incentives under title XVIII in the areas of treatment planning and follow-up care planning for applicable individuals described in clause (i) or (iii) of subsection (a)(4)(A) with cancer, including the identification of gaps in applicable quality measures.

“(xiii) Improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge.

“(xiv) Funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams.

“(xv) Promoting improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions that is responsible for—

“(I) developing, documenting, and disseminating best practices and proven care methods;

“(II) implementing such best practices and proven care methods within such institutions to demonstrate further improvements in quality and efficiency; and

“(III) providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.

“(xvi) Facilitate inpatient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.

“(xvii) Promoting greater efficiencies and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care for the service, when such service is furnished by a health professional who has the authority to furnish the service under existing State law.

“(xviii) Establishing comprehensive payments to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

“(C) ADDITIONAL FACTORS FOR CONSIDERATION.—In selecting models for testing under subparagraph (A), the CMI may consider the following additional factors:

“(i) Whether the model includes a regular process for monitoring and updating patient care plans in a manner that is consistent with the needs and preferences of applicable individuals.

“(ii) Whether the model places the applicable individual, including family members and other informal caregivers of the applicable individual, at the center of the care team of the applicable individual.

“(iii) Whether the model provides for in-person contact with applicable individuals.

“(iv) Whether the model utilizes technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time and across settings.

“(v) Whether the model provides for the maintenance of a close relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations, and other providers of services and suppliers.

“(vi) Whether the model relies on a team-based approach to interventions, such as comprehensive care assessments, care planning, and self-management coaching.

“(vii) Whether, under the model, providers of services and suppliers are able to share information with patients, caregivers, and other providers of services and suppliers on a real time basis.

“(3) BUDGET NEUTRALITY.—

“(A) INITIAL PERIOD.—The Secretary shall not require, as a condition for testing a model under paragraph (1), that the design of such model ensure that such model is budget neutral initially with respect to expenditures under the applicable title.

“(B) TERMINATION OR MODIFICATION.—The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under the applicable title, certifies), after testing has begun, that the model is expected to—

“(i) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under the applicable title;

“(ii) reduce spending under the applicable title without reducing the quality of care; or

“(iii) improve the quality of care and reduce spending.

Such termination may occur at any time after such testing has begun and before completion of the testing.

“(4) EVALUATION.—

“(A) IN GENERAL.—The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

“(i) the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria determined appropriate by the Secretary; and

“(ii) the changes in spending under the applicable titles by reason of the model.

“(B) INFORMATION.—The Secretary shall make the results of each evaluation under this paragraph available to the public in a timely fashion and may establish requirements for States and other entities participating in the testing of models under this section to collect and report information that the Secretary determines is necessary to monitor and evaluate such models.

“(c) EXPANSION OF MODELS (PHASE II).—Taking into account the evaluation under subsection (b)(4), the Secretary may, through rule-making, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested under subsection (b) or a demonstration project under section 1866C, to the extent determined appropriate by the Secretary, if—

“(1) the Secretary determines that such expansion is expected to—

“(A) reduce spending under applicable title without reducing the quality of care; or

“(B) improve the quality of care and reduce spending; and

“(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under applicable titles.

“(d) IMPLEMENTATION.—

“(1) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b).

“(2) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

“(A) the selection of models for testing or expansion under this section;

“(B) the selection of organizations, sites, or participants to test those models selected;

“(C) the elements, parameters, scope, and duration of such models for testing or dissemination;

“(D) determinations regarding budget neutrality under subsection (b)(3);

“(E) the termination or modification of the design and implementation of a model under subsection (b)(3)(B); and

“(F) determinations about expansion of the duration and scope of a model under subsection (c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.

“(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the testing and evaluation of models or expansion of such models under this section.

“(e) APPLICATION TO CHIP.—The Center may carry out activities under this section with respect to title XXI in the same manner as provided under this section with respect to the program under the applicable titles.

“(f) FUNDING.—

“(1) IN GENERAL.—There are appropriated, from amounts in the Treasury not otherwise appropriated—

“(A) \$5,000,000 for the design, implementation, and evaluation of models under subsection (b) for fiscal year 2010;

“(B) \$10,000,000,000 for the activities initiated under this section for the period of fiscal years 2011 through 2019; and

“(C) the amount described in subparagraph (B) for the activities initiated under this section for each subsequent 10-year fiscal period (beginning with the 10-year fiscal period beginning with fiscal year 2020).

Amounts appropriated under the preceding sentence shall remain available until expended.

“(2) USE OF CERTAIN FUNDS.—Out of amounts appropriated under subparagraphs (B) and (C) of paragraph (1), not less than \$25,000,000 shall be made available each such fiscal year to design, implement, and evaluate models under subsection (b).

“(g) REPORT TO CONGRESS.—Beginning in 2012, and not less than once every other year thereafter, the Secretary shall submit to Congress a report on activities under this section. Each such report shall describe the models tested under subsection (b), including the number of individuals described in subsection (a)(4)(A)(i) and of individuals described in subsection (a)(4)(A)(ii) participating in such models and payments made under applicable titles for services on behalf of such individuals, any models chosen for expansion under subsection (c), and the results from evaluations under subsection (b)(4). In addition, each such report shall provide such recommendations as the Secretary determines are appropriate for legislative action to facilitate the development and expansion of successful payment models.”.

(b) MEDICAID CONFORMING AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C.

1396a(a)), as amended by section 8002(b), is amended—

(1) in paragraph (81), by striking “and” at the end;

(2) in paragraph (82), by striking the period at the end and inserting “; and”; and

(3) by inserting after paragraph (82) the following new paragraph:

“(83) provide for implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State.”.

(c) REVISIONS TO HEALTH CARE QUALITY DEMONSTRATION PROGRAM.—Subsections (b) and (f) of section 1866C of the Social Security Act (42 U.S.C. 1395cc–3) are amended by striking “5-year” each place it appears.

SEC. 3022. MEDICARE SHARED SAVINGS PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

“SHARED SAVINGS PROGRAM

“SEC. 1899. (a) ESTABLISHMENT.—

“(1) IN GENERAL.—Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the ‘program’) that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program—

“(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an ‘ACO’); and

“(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).

“(b) ELIGIBLE ACOs.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, as determined appropriate by the Secretary, the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:

“(A) ACO professionals in group practice arrangements.

“(B) Networks of individual practices of ACO professionals.

“(C) Partnerships or joint venture arrangements between hospitals and ACO professionals.

“(D) Hospitals employing ACO professionals.

“(E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.

“(2) REQUIREMENTS.—An ACO shall meet the following requirements:

“(A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.

“(B) The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to in this section as the ‘agreement period’).

“(C) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participating providers of services and suppliers.

“(D) The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c). At a

minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program.

“(E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements under paragraph (3), and the determination of payments for shared savings under subsection (d)(2).

“(F) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.

“(G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.

“(H) The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

“(3) QUALITY AND OTHER REPORTING REQUIREMENTS.—

“(A) IN GENERAL.—The Secretary shall determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of—

“(i) clinical processes and outcomes;

“(ii) patient and, where practicable, caregiver experience of care; and

“(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

“(B) REPORTING REQUIREMENTS.—An ACO shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by ACO professionals, as the Secretary determines appropriate.

“(C) QUALITY PERFORMANCE STANDARDS.—The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

“(D) OTHER REPORTING REQUIREMENTS.—The Secretary may, as the Secretary determines appropriate, incorporate reporting requirements and incentive payments related to the physician quality reporting initiative (PQRI) under section 1848, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (d).

“(4) NO DUPLICATION IN PARTICIPATION IN SHARED SAVINGS PROGRAMS.—A provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section:

“(A) A model tested or expanded under section 1115A that involves shared savings under this title, or any other program or demonstration project that involves such shared savings.

“(B) The independence at home medical practice pilot program under section 1866E.

“(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES TO ACOs.—The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (h)(1)(A).

“(d) PAYMENTS AND TREATMENT OF SAVINGS.—

“(1) PAYMENTS.—

“(A) IN GENERAL.—Under the program, subject to paragraph (3), payments shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings under paragraph (2) if—

“(i) the ACO meets quality performance standards established by the Secretary under subsection (b)(3); and

“(ii) the ACO meets the requirement under subparagraph (B)(i).

“(B) SAVINGS REQUIREMENT AND BENCHMARK.—

“(i) DETERMINING SAVINGS.—In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings under paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii). The Secretary shall determine the appropriate percent described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

“(ii) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period.

“(2) PAYMENTS FOR SHARED SAVINGS.—Subject to performance with respect to the quality performance standards established by the Secretary under subsection (b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program under this title. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

“(3) MONITORING AVOIDANCE OF AT-RISK PATIENTS.—If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

“(4) TERMINATION.—The Secretary may terminate an agreement with an ACO if it does not meet the quality performance standards established by the Secretary under subsection (b)(3).

“(e) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the program.

“(f) **WAIVER AUTHORITY.**—The Secretary may waive such requirements of sections 1128A and 1128B and title XVIII of this Act as may be necessary to carry out the provisions of this section.

“(g) **LIMITATIONS ON REVIEW.**—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

“(1) the specification of criteria under subsection (a)(1)(B);

“(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);

“(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);

“(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO under subsection (d)(1)(B);

“(5) the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit on the total amount of shared savings established by the Secretary under such subsection; and

“(6) the termination of an ACO under subsection (d)(4).

“(h) **DEFINITIONS.**—In this section:

“(1) **ACO PROFESSIONAL.**—The term ‘ACO professional’ means—

“(A) a physician (as defined in section 1861(r)(1)); and

“(B) a practitioner described in section 1842(b)(18)(C)(i).

“(2) **HOSPITAL.**—The term ‘hospital’ means a subsection (d) hospital (as defined in section 1886(d)(1)(B)).

“(3) **MEDICARE FEE-FOR-SERVICE BENEFICIARY.**—The term ‘Medicare fee-for-service beneficiary’ means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B and is not enrolled in an MA plan under part C, an eligible organization under section 1876, or a PACE program under section 1894.”

SEC. 3023. NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

Title XVIII of the Social Security Act, as amended by section 3021, is amended by inserting after section 1886C the following new section:

“NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING

“SEC. 1866D. (a) **IMPLEMENTATION.**—

“(1) **IN GENERAL.**—The Secretary shall establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services under this title.

“(2) **DEFINITIONS.**—In this section:

“(A) **APPLICABLE BENEFICIARY.**—The term ‘applicable beneficiary’ means an individual who—

“(i) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B of such title, but not enrolled under part C or a PACE program under section 1894; and

“(ii) is admitted to a hospital for an applicable condition.

“(B) **APPLICABLE CONDITION.**—The term ‘applicable condition’ means 1 or more of 8 conditions selected by the Secretary. In selecting conditions under the preceding sentence, the Secretary shall take into consideration the following factors:

“(i) Whether the conditions selected include a mix of chronic and acute conditions.

“(ii) Whether the conditions selected include a mix of surgical and medical conditions.

“(iii) Whether a condition is one for which there is evidence of an opportunity for providers

of services and suppliers to improve the quality of care furnished while reducing total expenditures under this title.

“(iv) Whether a condition has significant variation in—

“(I) the number of readmissions; and

“(II) the amount of expenditures for post-acute care spending under this title.

“(v) Whether a condition is high-volume and has high post-acute care expenditures under this title.

“(vi) Which conditions the Secretary determines are most amenable to bundling across the spectrum of care given practice patterns under this title.

“(C) **APPLICABLE SERVICES.**—The term ‘applicable services’ means the following:

“(i) Acute care inpatient services.

“(ii) Physicians’ services delivered in and outside of an acute care hospital setting.

“(iii) Outpatient hospital services, including emergency department services.

“(iv) Post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital.

“(v) Other services the Secretary determines appropriate.

“(D) **EPISODE OF CARE.**—

“(i) **IN GENERAL.**—Subject to clause (ii), the term ‘episode of care’ means, with respect to an applicable condition and an applicable beneficiary, the period that includes—

“(I) the 3 days prior to the admission of the applicable beneficiary to a hospital for the applicable condition;

“(II) the length of stay of the applicable beneficiary in such hospital; and

“(III) the 30 days following the discharge of the applicable beneficiary from such hospital.

“(ii) **ESTABLISHMENT OF PERIOD BY THE SECRETARY.**—The Secretary, as appropriate, may establish a period (other than the period described in clause (i)) for an episode of care under the pilot program.

“(E) **PHYSICIANS’ SERVICES.**—The term ‘physicians’ services’ has the meaning given such term in section 1861(q).

“(F) **PILOT PROGRAM.**—The term ‘pilot program’ means the pilot program under this section.

“(G) **PROVIDER OF SERVICES.**—The term ‘provider of services’ has the meaning given such term in section 1861(u).

“(H) **READMISSION.**—The term ‘readmission’ has the meaning given such term in section 1886(q)(5)(E).

“(I) **SUPPLIER.**—The term ‘supplier’ has the meaning given such term in section 1861(d).

“(3) **DEADLINE FOR IMPLEMENTATION.**—The Secretary shall establish the pilot program not later than January 1, 2013.

“(b) **DEVELOPMENTAL PHASE.**—

“(1) **DETERMINATION OF PATIENT ASSESSMENT INSTRUMENT.**—The Secretary shall determine which patient assessment instrument (such as the Continuity Assessment Record and Evaluation (CARE) tool) shall be used under the pilot program to evaluate the applicable condition of an applicable beneficiary for purposes of determining the most clinically appropriate site for the provision of post-acute care to the applicable beneficiary.

“(2) **DEVELOPMENT OF QUALITY MEASURES FOR AN EPISODE OF CARE AND FOR POST-ACUTE CARE.**—

“(A) **IN GENERAL.**—The Secretary, in consultation with the Agency for Healthcare Research and Quality and the entity with a contract under section 1890(a) of the Social Security Act, shall develop quality measures for use in the pilot program—

“(i) for episodes of care; and

“(ii) for post-acute care.

“(B) **SITE-NEUTRAL POST-ACUTE CARE QUALITY MEASURES.**—Any quality measures developed under subparagraph (A)(ii) shall be site-neutral.

“(C) **COORDINATION WITH QUALITY MEASURE DEVELOPMENT AND ENDORSEMENT PROCEDURES.**—The Secretary shall ensure that the development of quality measures under subparagraph (A) is done in a manner that is consistent with the measures developed and endorsed under section 1890 and 1890A that are applicable to all post-acute care settings.

“(c) **DETAILS.**—

“(1) **DURATION.**—

“(A) **IN GENERAL.**—Subject to subparagraph (B), the pilot program shall be conducted for a period of 5 years.

“(B) **EXTENSION.**—The Secretary may extend the duration of the pilot program for providers of services and suppliers participating in the pilot program as of the day before the end of the 5-year period described in subparagraph (A), for a period determined appropriate by the Secretary, if the Secretary determines that such extension will result in improving or not reducing the quality of patient care and reducing spending under this title.

“(2) **PARTICIPATING PROVIDERS OF SERVICES AND SUPPLIERS.**—

“(A) **IN GENERAL.**—An entity comprised of providers of services and suppliers, including a hospital, a physician group, a skilled nursing facility, and a home health agency, who are otherwise participating under this title, may submit an application to the Secretary to provide applicable services to applicable individuals under this section.

“(B) **REQUIREMENTS.**—The Secretary shall develop requirements for entities to participate in the pilot program under this section. Such requirements shall ensure that applicable beneficiaries have an adequate choice of providers of services and suppliers under the pilot program.

“(3) **PAYMENT METHODOLOGY.**—

“(A) **IN GENERAL.**—

“(i) **ESTABLISHMENT OF PAYMENT METHODS.**—The Secretary shall develop payment methods for the pilot program for entities participating in the pilot program. Such payment methods may include bundled payments and bids from entities for episodes of care. The Secretary shall make payments to the entity for services covered under this section.

“(ii) **NO ADDITIONAL PROGRAM EXPENDITURES.**—Payments under this section for applicable items and services under this title (including payment for services described in subparagraph (B)) for applicable beneficiaries for a year shall be established in a manner that does not result in spending more for such entity for such beneficiaries than would otherwise be expended for such entity for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

“(B) **INCLUSION OF CERTAIN SERVICES.**—A payment methodology tested under the pilot program shall include payment for the furnishing of applicable services and other appropriate services, such as care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities as determined appropriate by the Secretary.

“(C) **BUNDLED PAYMENTS.**—

“(i) **IN GENERAL.**—A bundled payment under the pilot program shall—

“(I) be comprehensive, covering the costs of applicable services and other appropriate services furnished to an individual during an episode of care (as determined by the Secretary); and

“(II) be made to the entity which is participating in the pilot program.

“(ii) **REQUIREMENT FOR PROVISION OF APPLICABLE SERVICES AND OTHER APPROPRIATE SERVICES.**—Applicable services and other appropriate

services for which payment is made under this subparagraph shall be furnished or directed by the entity which is participating in the pilot program.

“(D) PAYMENT FOR POST-ACUTE CARE SERVICES AFTER THE EPISODE OF CARE.—The Secretary shall establish procedures, in the case where an applicable beneficiary requires continued post-acute care services after the last day of the episode of care, under which payment for such services shall be made.

“(4) QUALITY MEASURES.—

“(A) IN GENERAL.—The Secretary shall establish quality measures (including quality measures of process, outcome, and structure) related to care provided by entities participating in the pilot program. Quality measures established under the preceding sentence shall include measures of the following:

“(i) Functional status improvement.

“(ii) Reducing rates of avoidable hospital readmissions.

“(iii) Rates of discharge to the community.

“(iv) Rates of admission to an emergency room after a hospitalization.

“(v) Incidence of health care acquired infections.

“(vi) Efficiency measures.

“(vii) Measures of patient-centeredness of care.

“(viii) Measures of patient perception of care.

“(ix) Other measures, including measures of patient outcomes, determined appropriate by the Secretary.

“(B) REPORTING ON QUALITY MEASURES.—

“(i) IN GENERAL.—A entity shall submit data to the Secretary on quality measures established under subparagraph (A) during each year of the pilot program (in a form and manner, subject to clause (iii), specified by the Secretary).

“(ii) SUBMISSION OF DATA THROUGH ELECTRONIC HEALTH RECORD.—To the extent practicable, the Secretary shall specify that data on measures be submitted under clause (i) through the use of an qualified electronic health record (as defined in section 3000(13) of the Public Health Service Act (42 U.S.C. 300jj–11(13)) in a manner specified by the Secretary.

“(d) WAIVER.—The Secretary may waive such provisions of this title and title XI as may be necessary to carry out the pilot program.

“(e) INDEPENDENT EVALUATION AND REPORTS ON PILOT PROGRAM.—

“(1) INDEPENDENT EVALUATION.—The Secretary shall conduct an independent evaluation of the pilot program, including the extent to which the pilot program has—

“(A) improved quality measures established under subsection (c)(4)(A);

“(B) improved health outcomes;

“(C) improved applicable beneficiary access to care; and

“(D) reduced spending under this title.

“(2) REPORTS.—

“(A) INTERIM REPORT.—Not later than 2 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the initial results of the independent evaluation conducted under paragraph (1).

“(B) FINAL REPORT.—Not later than 3 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the final results of the independent evaluation conducted under paragraph (1).

“(f) CONSULTATION.—The Secretary shall consult with representatives of small rural hospitals, including critical access hospitals (as defined in section 1861(mm)(1)), regarding their participation in the pilot program. Such consultation shall include consideration of innovative methods of implementing bundled payments in hospitals described in the preceding sentence, taking into consideration any difficulties in doing so as a result of the low volume of services provided by such hospitals.

“(g) IMPLEMENTATION PLAN.—

“(1) IN GENERAL.—Not later than January 1, 2016, the Secretary shall submit a plan for the implementation of an expansion of the pilot program if the Secretary determines that such expansion will result in improving or not reducing the quality of patient care and reducing spending under this title.

“(h) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the selection, testing, and evaluation of models or the expansion of such models under this section.”.

SEC. 3024. INDEPENDENCE AT HOME DEMONSTRATION PROGRAM.

Title XVIII of the Social Security Act is amended by inserting after section 1866D, as inserted by section 3023, the following new section:

“INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM

“SEC. 1866D. (a) ESTABLISHMENT.—

“(1) IN GENERAL.—The Secretary shall conduct a demonstration program (in this section referred to as the ‘demonstration program’) to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)).

“(2) REQUIREMENT.—The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in—

“(A) reducing preventable hospitalizations;

“(B) preventing hospital readmissions;

“(C) reducing emergency room visits;

“(D) improving health outcomes commensurate with the beneficiaries’ stage of chronic illness;

“(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;

“(F) reducing the cost of health care services covered under this title; and

“(G) achieving beneficiary and family caregiver satisfaction.

“(b) INDEPENDENCE AT HOME MEDICAL PRACTICE.—

“(1) INDEPENDENCE AT HOME MEDICAL PRACTICE DEFINED.—In this section:

“(A) IN GENERAL.—The term ‘independence at home medical practice’ means a legal entity that—

“(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary’s chronic conditions and designed to achieve the results in subsection (a);

“(ii) is organized at least in part for the purpose of providing physicians’ services;

“(iii) has documented experience in providing home-based primary care services to high-cost chronically ill beneficiaries, as determined appropriate by the Secretary;

“(iv) furnishes services to at least 200 applicable beneficiaries (as defined in subsection (d)) during each year of the demonstration program;

“(v) has entered into an agreement with the Secretary;

“(vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

“(vii) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program.

The entity shall report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group, for providers of services and suppliers, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.

“(B) PHYSICIAN.—The term ‘physician’ includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians’ services and has the medical training or experience to fulfill the physician’s role described in subparagraph (A)(i).

“(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if—

“(A) all the requirements of this section are met;

“(B) the nurse practitioner or physician assistant, as the case may be, is acting consistent with State law; and

“(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role described in paragraph (1)(A)(i).

“(3) INCLUSION OF PROVIDERS AND PRACTITIONERS.—Nothing in this subsection shall be construed as preventing an independence at home medical practice from including a provider of services or a participating practitioner described in section 1842(b)(18)(C) that is affiliated with the practice under an arrangement structured so that such provider of services or practitioner participates in the demonstration program and shares in any savings under the demonstration program.

“(4) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall develop quality performance standards for independence at home medical practices participating in the demonstration program.

“(c) PAYMENT METHODOLOGY.—

“(1) ESTABLISHMENT OF TARGET SPENDING LEVEL.—The Secretary shall establish an estimated annual spending target, for the amount the Secretary estimates would have been spent in the absence of the demonstration, for items and services covered under parts A and B furnished to applicable beneficiaries for each qualifying independence at home medical practice under this section. Such spending targets shall be determined on a per capita basis. Such spending targets shall include a risk corridor that takes into account normal variation in expenditures for items and services covered under parts A and B furnished to such beneficiaries with the size of the corridor being related to the number of applicable beneficiaries furnished services by each independence at home medical practice. The spending targets may also be adjusted for other factors as the Secretary determines appropriate.

“(2) INCENTIVE PAYMENTS.—Subject to performance on quality measures, a qualifying independence at home medical practice is eligible to receive an incentive payment under this section if actual expenditures for a year for the applicable beneficiaries it enrolls are less than the estimated spending target established under paragraph (1) for such year. An incentive payment for such year shall be equal to a portion (as determined by the Secretary) of the amount by which actual expenditures (including incentive payments under this paragraph) for applicable beneficiaries under parts A and B for such

year are estimated to be less than 5 percent less than the estimated spending target for such year, as determined under paragraph (1).

“(d) APPLICABLE BENEFICIARIES.—

“(1) DEFINITION.—In this section, the term ‘applicable beneficiary’ means, with respect to a qualifying independence at home medical practice, an individual who the practice has determined—

“(A) is entitled to benefits under part A and enrolled for benefits under part B;

“(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894;

“(C) has 2 or more chronic illnesses, such as congestive heart failure, diabetes, other dementias designated by the Secretary, chronic obstructive pulmonary disease, ischemic heart disease, stroke, Alzheimer’s Disease and neurodegenerative diseases, and other diseases and conditions designated by the Secretary which result in high costs under this title;

“(D) within the past 12 months has had a nonelective hospital admission;

“(E) within the past 12 months has received acute or subacute rehabilitation services;

“(F) has 2 or more functional dependencies requiring the assistance of another person (such as bathing, dressing, toileting, walking, or feeding); and

“(G) meets such other criteria as the Secretary determines appropriate.

“(2) PATIENT ELECTION TO PARTICIPATE.—The Secretary shall determine an appropriate method of ensuring that applicable beneficiaries have agreed to enroll in an independence at home medical practice under the demonstration program. Enrollment in the demonstration program shall be voluntary.

“(3) BENEFICIARY ACCESS TO SERVICES.—Nothing in this section shall be construed as encouraging physicians or nurse practitioners to limit applicable beneficiary access to services covered under this title and applicable beneficiaries shall not be required to relinquish access to any benefit under this title as a condition of receiving services from an independence at home medical practice.

“(e) IMPLEMENTATION.—

“(1) STARTING DATE.—The demonstration program shall begin no later than January 1, 2012. An agreement with an independence at home medical practice under the demonstration program may cover not more than a 3-year period.

“(2) NO PHYSICIAN DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall not pay an independence at home medical practice under this section that participates in section 1899.

“(3) NO BENEFICIARY DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall ensure that no applicable beneficiary enrolled in an independence at home medical practice under this section is participating in the programs under section 1899.

“(4) PREFERENCE.—In approving an independence at home medical practice, the Secretary shall give preference to practices that are—

“(A) located in high-cost areas of the country;

“(B) have experience in furnishing health care services to applicable beneficiaries in the home; and

“(C) use electronic medical records, health information technology, and individualized plans of care.

“(5) LIMITATION ON NUMBER OF PRACTICES.—In selecting qualified independence at home medical practices to participate under the demonstration program, the Secretary shall limit the number of such practices so that the number of applicable beneficiaries that may participate in the demonstration program does not exceed 10,000.

“(6) WAIVER.—The Secretary may waive such provisions of this title and title XI as the Sec-

retary determines necessary in order to implement the demonstration program.

“(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

“(f) EVALUATION AND MONITORING.—

“(1) IN GENERAL.—The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

“(2) MONITORING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discontinues receiving services under this title through a qualifying independence at home medical practice.

“(g) REPORTS TO CONGRESS.—The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program. Such report shall include an analysis of the demonstration program on coordination of care, expenditures under this title, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

“(h) FUNDING.—For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this title and incentive payments under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in proportions determined appropriate by the Secretary) \$5,000,000 for each of fiscal years 2010 through 2015. Amounts transferred under this subsection for a fiscal year shall be available until expended.

“(i) TERMINATION.—

“(1) MANDATORY TERMINATION.—The Secretary shall terminate an agreement with an independence at home medical practice if—

“(A) the Secretary estimates or determines that such practice will not receive an incentive payment for the second of 2 consecutive years under the demonstration program; or

“(B) such practice fails to meet quality standards during any year of the demonstration program.

“(2) PERMISSIVE TERMINATION.—The Secretary may terminate an agreement with an independence at home medical practice for such other reasons determined appropriate by the Secretary.”

SEC. 3025. HOSPITAL READMISSIONS REDUCTION PROGRAM.

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001 and 3008, is amended by adding at the end the following new subsection:

“(q) HOSPITAL READMISSIONS REDUCTION PROGRAM.—

“(1) IN GENERAL.—With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2012, in order to account for excess readmissions in the hospital, the Secretary shall reduce the payments that would otherwise be made to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) for such a discharge by an amount equal to the product of—

“(A) the base operating DRG payment amount (as defined in paragraph (2)) for the discharge; and

“(B) the adjustment factor (described in paragraph (3)(A)) for the hospital for the fiscal year.

“(2) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), in this subsection, the term ‘base operating DRG payment amount’ means, with respect to a hospital for a fiscal year—

“(i) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (o)) for a discharge if this subsection did not apply; reduced by

“(ii) any portion of such payment amount that is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d).

“(B) SPECIAL RULES FOR CERTAIN HOSPITALS.—

“(i) SOLE COMMUNITY HOSPITALS AND MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal years 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

“(ii) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospitals provided that States paid under such section submit an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established herein with respect to this section.

“(3) ADJUSTMENT FACTOR.—

“(A) IN GENERAL.—For purposes of paragraph (1), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of—

“(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or

“(ii) the floor adjustment factor specified in subparagraph (C).

“(B) RATIO.—The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—

“(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and

“(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

“(C) FLOOR ADJUSTMENT FACTOR.—For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—

“(i) fiscal year 2013 is 0.99;

“(ii) fiscal year 2014 is 0.98; or

“(iii) fiscal year 2015 and subsequent fiscal years is 0.97.

“(4) AGGREGATE PAYMENTS, EXCESS READMISSION RATIO DEFINED.—For purposes of this subsection:

“(A) AGGREGATE PAYMENTS FOR EXCESS READMISSIONS.—The term ‘aggregate payments for excess readmissions’ means, for a hospital for an applicable period, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—

“(i) the base operating DRG payment amount for such hospital for such applicable period for such condition;

“(ii) the number of admissions for such condition for such hospital for such applicable period; and

“(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for such applicable period minus 1.

“(B) AGGREGATE PAYMENTS FOR ALL DISCHARGES.—The term ‘aggregate payments for all discharges’ means, for a hospital for an applicable period, the sum of the base operating DRG

payment amounts for all discharges for all conditions from such hospital for such applicable period.

“(C) EXCESS READMISSION RATIO.—

“(i) IN GENERAL.—Subject to clause (ii), the term ‘excess readmissions ratio’ means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—

“(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital for such condition with respect to such applicable period; to

“(II) the risk adjusted expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period.

“(ii) EXCLUSION OF CERTAIN READMISSIONS.—For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

“(5) DEFINITIONS.—For purposes of this subsection:

“(A) APPLICABLE CONDITION.—The term ‘applicable condition’ means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

“(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary); and

“(ii) measures of such readmissions—

“(I) have been endorsed by the entity with a contract under section 1890(a); and

“(II) such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

“(B) EXPANSION OF APPLICABLE CONDITIONS.—Beginning with fiscal year 2015, the Secretary shall, to the extent practicable, expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as of the date of the enactment of this subsection to the additional 4 conditions that have been identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

“(C) APPLICABLE HOSPITAL.—The term ‘applicable hospital’ means a subsection (d) hospital or a hospital that is paid under section 1814(b)(3), as the case may be.

“(D) APPLICABLE PERIOD.—The term ‘applicable period’ means, with respect to a fiscal year, such period as the Secretary shall specify.

“(E) READMISSION.—The term ‘readmission’ means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as the discharge relates to an applicable condition for which there is an en-

dorsed measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

“(6) REPORTING HOSPITAL SPECIFIC INFORMATION.—

“(A) IN GENERAL.—The Secretary shall make information available to the public regarding readmission rates of each subsection (d) hospital under the program.

“(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that a subsection (d) hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

“(C) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

“(7) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

“(A) The determination of base operating DRG payment amounts.

“(B) The methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5).

“(C) The measures of readmissions as described in paragraph (5)(A)(ii).

“(8) READMISSION RATES FOR ALL PATIENTS.—

“(A) CALCULATION OF READMISSION.—The Secretary shall calculate readmission rates for all patients (as defined in subparagraph (D)) for a specified hospital (as defined in subparagraph (D)(ii)) for an applicable condition (as defined in paragraph (5)(B)) and other conditions deemed appropriate by the Secretary for an applicable period (as defined in paragraph (5)(D)) in the same manner as used to calculate such readmission rates for hospitals with respect to this title and posted on the CMS Hospital Compare website.

“(B) POSTING OF HOSPITAL SPECIFIC ALL PATIENT READMISSION RATES.—The Secretary shall make information on all patient readmission rates calculated under subparagraph (A) available on the CMS Hospital Compare website in a form and manner determined appropriate by the Secretary. The Secretary may also make other information determined appropriate by the Secretary available on such website.

“(C) HOSPITAL SUBMISSION OF ALL PATIENT DATA.—

“(i) Except as provided for in clause (ii), each specified hospital (as defined in subparagraph (D)(ii)) shall submit to the Secretary, in a form, manner and time specified by the Secretary, data and information determined necessary by the Secretary for the Secretary to calculate the all patient readmission rates described in subparagraph (A).

“(ii) Instead of a specified hospital submitting to the Secretary the data and information described in clause (i), such data and information may be submitted to the Secretary, on behalf of such a specified hospital, by a state or an entity determined appropriate by the Secretary.

“(D) DEFINITIONS.—For purposes of this paragraph:

“(i) The term ‘all patients’ means patients who are treated on an inpatient basis and discharged from a specified hospital (as defined in clause (ii)).

“(ii) The term ‘specified hospital’ means a subsection (d) hospital, hospitals described in clauses (i) through (v) of subsection (d)(1)(B) and, as determined feasible and appropriate by

the Secretary, other hospitals not otherwise described in this subparagraph.”.

(b) QUALITY IMPROVEMENT.—Part S of title III of the Public Health Service Act, as amended by section 3015, is further amended by adding at the end the following:

“SEC. 399KK. QUALITY IMPROVEMENT PROGRAM FOR HOSPITALS WITH A HIGH SEVERITY ADJUSTED READMISSION RATE.

“(a) ESTABLISHMENT.—

“(1) IN GENERAL.—Not later than 2 years after the date of enactment of this section, the Secretary shall make available a program for eligible hospitals to improve their readmission rates through the use of patient safety organizations (as defined in section 921(4)).

“(2) ELIGIBLE HOSPITAL DEFINED.—In this subsection, the term ‘eligible hospital’ means a hospital that the Secretary determines has a high rate of risk adjusted readmissions for the conditions described in section 1886(q)(8)(A) of the Social Security Act and has not taken appropriate steps to reduce such readmissions and improve patient safety as evidenced through historically high rates of readmissions, as determined by the Secretary.

“(3) RISK ADJUSTMENT.—The Secretary shall utilize appropriate risk adjustment measures to determine eligible hospitals.

“(b) REPORT TO THE SECRETARY.—As determined appropriate by the Secretary, eligible hospitals and patient safety organizations working with those hospitals shall report to the Secretary on the processes employed by the hospital to improve readmission rates and the impact of such processes on readmission rates.”.

SEC. 3026. COMMUNITY-BASED CARE TRANSITIONS PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a Community-Based Care Transitions Program under which the Secretary provides funding to eligible entities that furnish improved care transition services to high-risk Medicare beneficiaries.

(b) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term “eligible entity” means the following:

(A) A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) identified by the Secretary as having a high readmission rate, such as under section 1886(q) of the Social Security Act, as added by section 3025.

(B) An appropriate community-based organization that provides care transition services under this section across a continuum of care through arrangements with subsection (d) hospitals (as so defined) to furnish the services described in subsection (c)(2)(B)(i) and whose governing body includes sufficient representation of multiple health care stakeholders (including consumers).

(2) HIGH-RISK MEDICARE BENEFICIARY.—The term “high-risk Medicare beneficiary” means a Medicare beneficiary who has attained a minimum hierarchical condition category score, as determined by the Secretary, based on a diagnosis of multiple chronic conditions or other risk factors associated with a hospital readmission or substandard transition into post-hospitalization care, which may include 1 or more of the following:

(A) Cognitive impairment.

(B) Depression.

(C) A history of multiple readmissions.

(D) Any other chronic disease or risk factor as determined by the Secretary.

(3) MEDICARE BENEFICIARY.—The term “Medicare beneficiary” means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and enrolled under part B of such title, but not enrolled under part C of such title.

(4) **PROGRAM.**—The term “program” means the program conducted under this section.

(5) **READMISSION.**—The term “readmission” has the meaning given such term in section 1886(q)(5)(E) of the Social Security Act, as added by section 3025.

(6) **SECRETARY.**—The term “Secretary” means the Secretary of Health and Human Services.

(c) **REQUIREMENTS.**—

(1) **DURATION.**—

(A) **IN GENERAL.**—The program shall be conducted for a 5-year period, beginning January 1, 2011.

(B) **EXPANSION.**—The Secretary may expand the duration and the scope of the program, to the extent determined appropriate by the Secretary, if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to spending under this title, certifies) that such expansion would reduce spending under this title without reducing quality.

(2) **APPLICATION; PARTICIPATION.**—

(A) **IN GENERAL.**—

(i) **APPLICATION.**—An eligible entity seeking to participate in the program shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(ii) **PARTNERSHIP.**—If an eligible entity is a hospital, such hospital shall enter into a partnership with a community-based organization to participate in the program.

(B) **INTERVENTION PROPOSAL.**—Subject to subparagraph (C), an application submitted under subparagraph (A)(i) shall include a detailed proposal for at least 1 care transition intervention, which may include the following:

(i) Initiating care transition services for a high-risk Medicare beneficiary not later than 24 hours prior to the discharge of the beneficiary from the eligible entity.

(ii) Arranging timely post-discharge follow-up services to the high-risk Medicare beneficiary to provide the beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with information regarding responding to symptoms that may indicate additional health problems or a deteriorating condition.

(iii) Providing the high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with assistance to ensure productive and timely interactions between patients and post-acute and outpatient providers.

(iv) Assessing and actively engaging with a high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) through the provision of self-management support and relevant information that is specific to the beneficiary's condition.

(v) Conducting comprehensive medication review and management (including, if appropriate, counseling and self-management support).

(C) **LIMITATION.**—A care transition intervention proposed under subparagraph (B) may not include payment for services required under the discharge planning process described in section 1861(ee) of the Social Security Act (42 U.S.C. 1395x(e)).

(3) **SELECTION.**—In selecting eligible entities to participate in the program, the Secretary shall give priority to eligible entities that—

(A) participate in a program administered by the Administration on Aging to provide concurrent care transitions interventions with multiple hospitals and practitioners; or

(B) provide services to medically underserved populations, small communities, and rural areas.

(d) **IMPLEMENTATION.**—Notwithstanding any other provision of law, the Secretary may implement the provisions of this section by program instruction or otherwise.

(e) **WAIVER AUTHORITY.**—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the program.

(f) **FUNDING.**—For purposes of carrying out this section, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of \$500,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2011 through 2015. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3027. EXTENSION OF GAINSHARING DEMONSTRATION.

(a) **IN GENERAL.**—Subsection (d)(3) of section 5007 of the Deficit Reduction Act of 2005 (Public Law 109-171) is amended by inserting “(or September 30, 2011, in the case of a demonstration project in operation as of October 1, 2008)” after “December 31, 2009”.

(b) **FUNDING.**—

(1) **IN GENERAL.**—Subsection (f)(1) of such section is amended by inserting “and for fiscal year 2010, \$1,600,000,” after “\$6,000,000.”

(2) **AVAILABILITY.**—Subsection (f)(2) of such section is amended by striking “2010” and inserting “2014 or until expended”.

(c) **REPORTS.**—

(1) **QUALITY IMPROVEMENT AND SAVINGS.**—Subsection (e)(3) of such section is amended by striking “December 1, 2008” and inserting “March 31, 2011”.

(2) **FINAL REPORT.**—Subsection (e)(4) of such section is amended by striking “May 1, 2010” and inserting “March 31, 2013”.

Subtitle B—Improving Medicare for Patients and Providers

PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES

SEC. 3101. INCREASE IN THE PHYSICIAN PAYMENT UPDATE.

Section 1848(d) of the Social Security Act (42 U.S.C. 1395w-4(d)) is amended by adding at the end the following new paragraph:

“(10) **UPDATE FOR 2010.**—

“(A) **IN GENERAL.**—Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010, the update to the single conversion factor shall be 0.5 percent.

“(B) **NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2011 AND SUBSEQUENT YEARS.**—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied.”

SEC. 3102. EXTENSION OF THE WORK GEOGRAPHIC INDEX FLOOR AND REVISIONS TO THE PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) **EXTENSION OF WORK GPCI FLOOR.**—Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(E)) is amended by striking “before January 1, 2010” and inserting “before January 1, 2011”.

(b) **PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.**—Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)) is amended—

(1) in subparagraph (A), by striking “and (G)” and inserting “(G), and (H)”; and

(2) by adding at the end the following new subparagraph:

“(H) **PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.**—

“(i) **FOR 2010.**—Subject to clause (iii), for services furnished during 2010, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect $\frac{3}{4}$ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

“(ii) **FOR 2011.**—Subject to clause (iii), for services furnished during 2011, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect $\frac{1}{2}$ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

“(iii) **HOLD HARMLESS.**—The practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011 shall not, as a result of the application of clause (i) or (ii), be reduced below the practice expense portion of the geographic adjustment factor under subparagraph (A)(i) (as calculated prior to the application of such clause (i) or (ii), respectively) for such area for such year.

“(iv) **ANALYSIS.**—The Secretary shall analyze current methods of establishing practice expense geographic adjustments under subparagraph (A)(i) and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different fee schedule areas. Such analysis shall include an evaluation of the following:

“(I) The feasibility of using actual data or reliable survey data developed by medical organizations on the costs of operating a medical practice, including office rents and non-physician staff wages, in different fee schedule areas.

“(II) The office expense portion of the practice expense geographic adjustment described in subparagraph (A)(i), including the extent to which types of office expenses are determined in local markets instead of national markets.

“(III) The weights assigned to each of the categories within the practice expense geographic adjustment described in subparagraph (A)(i).

“(v) **REVISION FOR 2012 AND SUBSEQUENT YEARS.**—As a result of the analysis described in clause (iv), the Secretary shall, not later than January 1, 2012, make appropriate adjustments to the practice expense geographic adjustment described in subparagraph (A)(i) to ensure accurate geographic adjustments across fee schedule areas, including—

“(I) basing the office rents component and its weight on office expenses that vary among fee schedule areas; and

“(II) considering a representative range of professional and non-professional personnel employed in a medical office based on the use of the American Community Survey data or other reliable data for wage adjustments.

Such adjustments shall be made without regard to adjustments made pursuant to clauses (i) and (ii) and shall be made in a budget neutral manner.”

SEC. 3103. EXTENSION OF EXCEPTIONS PROCESS FOR MEDICARE THERAPY CAPS.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)) is amended by striking “December 31, 2009” and inserting “December 31, 2010”.

SEC. 3104. EXTENSION OF PAYMENT FOR TECHNICAL COMPONENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106-554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42

U.S.C. 1395w-4 note), section 104 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w-4 note), section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173), and section 136 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275), is amended by striking “and 2009” and inserting “2009, and 2010”.

SEC. 3105. EXTENSION OF AMBULANCE ADD-ONS.

(a) **GROUND AMBULANCE.**—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended—

(1) in the matter preceding clause (i)—

(A) by striking “2007, and for” and inserting “2007, for”; and

(B) by striking “2010” and inserting “2010, and for such services furnished on or after April 1, 2010, and before January 1, 2011,”; and

(2) in each of clauses (i) and (ii), by inserting “, and on or after April 1, 2010, and before January 1, 2011” after “January 1, 2010” each place it appears.

(b) **AIR AMBULANCE.**—Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275) is amended by striking “December 31, 2009” and inserting “December 31, 2009, and during the period beginning on April 1, 2010, and ending on January 1, 2011”.

(c) **SUPER RURAL AMBULANCE.**—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)) is amended by striking “2010” and inserting “2010, and on or after April 1, 2010, and before January 1, 2011”.

SEC. 3106. EXTENSION OF CERTAIN PAYMENT RULES FOR LONG-TERM CARE HOSPITAL SERVICES AND OF MORATORIUM ON THE ESTABLISHMENT OF CERTAIN HOSPITALS AND FACILITIES.

(a) **EXTENSION OF CERTAIN PAYMENT RULES.**—Section 114(c) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by section 4302(a) of the American Recovery and Reinvestment Act (Public Law 111-5), is further amended by striking “3-year period” each place it appears and inserting “4-year period”.

(b) **EXTENSION OF MORATORIUM.**—Section 114(d)(1) of such Act (42 U.S.C. 1395ww note), in the matter preceding subparagraph (A), is amended by striking “3-year period” and inserting “4-year period”.

SEC. 3107. EXTENSION OF PHYSICIAN FEE SCHEDULE MENTAL HEALTH ADD-ON.

Section 138(a)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275) is amended by striking “December 31, 2009” and inserting “December 31, 2010”.

SEC. 3108. PERMITTING PHYSICIAN ASSISTANTS TO ORDER POST-HOSPITAL EXTENDED CARE SERVICES.

(a) **ORDERING POST-HOSPITAL EXTENDED CARE SERVICES.**—

(1) **IN GENERAL.**—Section 1814(a)(2) of the Social Security Act (42 U.S.C. 1395f(a)(2)), in the matter preceding subparagraph (A), is amended by striking “or clinical nurse specialist” and inserting “, a clinical nurse specialist, or a physician assistant (as those terms are defined in section 1861(aa)(5))” after “nurse practitioner”.

(2) **CONFORMING AMENDMENT.**—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended, in the second sentence, by striking “or clinical nurse specialist” and inserting “clinical nurse specialist, or physician assistant” after “nurse practitioner”.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 3109. EXEMPTION OF CERTAIN PHARMACIES FROM ACCREDITATION REQUIREMENTS.

(a) **IN GENERAL.**—Section 1834(a)(20) of the Social Security Act (42 U.S.C. 1395m(a)(20)), as added by section 154(b)(1)(A) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275), is amended—

(1) in subparagraph (F)(i)—

(A) by inserting “and subparagraph (G)” after “clause (ii)”;

(B) by inserting “, except that the Secretary shall not require a pharmacy to have submitted to the Secretary such evidence of accreditation prior to January 1, 2011” before the semicolon at the end; and

(2) by adding at the end the following new subparagraph:

“(G) **APPLICATION OF ACCREDITATION REQUIREMENT TO CERTAIN PHARMACIES.**—

“(i) **IN GENERAL.**—With respect to items and services furnished on or after January 1, 2011, in implementing quality standards under this paragraph—

“(I) subject to subclause (II), in applying such standards and the accreditation requirement of subparagraph (F)(i) with respect to pharmacies described in clause (ii) furnishing such items and services, such standards and accreditation requirement shall not apply to such pharmacies; and

“(II) the Secretary may apply to such pharmacies an alternative accreditation requirement established by the Secretary if the Secretary determines such alternative accreditation requirement is more appropriate for such pharmacies.

“(ii) **PHARMACIES DESCRIBED.**—A pharmacy described in this clause is a pharmacy that meets each of the following criteria:

“(I) The total billings by the pharmacy for such items and services under this title are less than 5 percent of total pharmacy sales, as determined based on the average total pharmacy sales for the previous 3 calendar years, 3 fiscal years, or other yearly period specified by the Secretary.

“(II) The pharmacy has been enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies, has been issued (which may include the renewal of) a provider number for at least 5 years, and for which a final adverse action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has not been imposed in the past 5 years.

“(III) The pharmacy submits to the Secretary an attestation, in a form and manner, and at a time, specified by the Secretary, that the pharmacy meets the criteria described in subclauses (I) and (II). Such attestation shall be subject to section 1001 of title 18, United States Code.

“(IV) The pharmacy agrees to submit materials as requested by the Secretary, or during the course of an audit conducted on a random sample of pharmacies selected annually, to verify that the pharmacy meets the criteria described in subclauses (I) and (II). Materials submitted under the preceding sentence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods, as requested by the Secretary.”

(b) **ADMINISTRATION.**—Notwithstanding any other provision of law, the Secretary may implement the amendments made by subsection (a) by program instruction or otherwise.

(c) **RULE OF CONSTRUCTION.**—Nothing in the provisions of or amendments made by this section shall be construed as affecting the application of an accreditation requirement for pharmacies to qualify for bidding in a competitive acquisition area under section 1847 of the Social Security Act (42 U.S.C. 1395w-3).

SEC. 3110. PART B SPECIAL ENROLLMENT PERIOD FOR DISABLED TRICARE BENEFICIARIES.

(a) **IN GENERAL.**—

(1) **IN GENERAL.**—Section 1837 of the Social Security Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

“(1)(I) In the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled to part A under section 226(b) or section 226A and who is eligible to enroll but who has elected not to enroll (or to be deemed enrolled) during the individual’s initial enrollment period, there shall be a special enrollment period described in paragraph (2).

“(2) The special enrollment period described in this paragraph, with respect to an individual, is the 12-month period beginning on the day after the last day of the initial enrollment period of the individual or, if later, the 12-month period beginning with the month the individual is notified of enrollment under this section.

“(3) In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall begin on the first day of the month in which the individual enrolls, or, at the option of the individual, the first month after the end of the individual’s initial enrollment period.

“(4) An individual may only enroll during the special enrollment period provided under paragraph (1) one time during the individual’s lifetime.

“(5) The Secretary shall ensure that the materials relating to coverage under this part that are provided to an individual described in paragraph (1) prior to the individual’s initial enrollment period contain information concerning the impact of not enrolling under this part, including the impact on health care benefits under the TRICARE program under chapter 55 of title 10, United States Code.

“(6) The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to provide for the accurate identification of individuals described in paragraph (1). The Secretary of Defense shall provide such individuals with notification with respect to this subsection. The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to ensure appropriate follow up pursuant to any notification provided under the preceding sentence.”

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to elections made with respect to initial enrollment periods that end after the date of the enactment of this Act.

(b) **WAIVER OF INCREASE OF PREMIUM.**—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)) is amended by striking “section 1837(i)(4)” and inserting “subsection (i)(4) or (l) of section 1837”.

SEC. 3111. PAYMENT FOR BONE DENSITY TESTS.

(a) **PAYMENT.**—

(1) **IN GENERAL.**—Section 1848 of the Social Security Act (42 U.S.C. 1395w-4) is amended—

(A) in subsection (b)—

(i) in paragraph (4)(B), by inserting “, and for 2010 and 2011, dual-energy x-ray absorptiometry services (as described in paragraph (6))” before the period at the end; and

(ii) by adding at the end the following new paragraph:

“(6) **TREATMENT OF BONE MASS SCANS.**—For dual-energy x-ray absorptiometry services (identified in 2006 by HCPCS codes 76075 and 76077 (and any succeeding codes)) furnished during 2010 and 2011, instead of the payment amount that would otherwise be determined under this section for such years, the payment amount shall be equal to 70 percent of the product of—

“(A) the relative value for the service (as determined in subsection (c)(2)) for 2006;

“(B) the conversion factor (established under subsection (d)) for 2006; and

“(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area for 2010 and 2011, respectively.”; and

(B) in subsection (c)(2)(B)(iv)—

(i) in subclause (II), by striking “and” at the end;

(ii) in subclause (III), by striking the period at the end and inserting “; and”; and

(iii) by adding at the end the following new subclause:

“(IV) subsection (b)(6) shall not be taken into account in applying clause (ii)(I) for 2010 or 2011.”.

(2) **IMPLEMENTATION.**—Notwithstanding any other provision of law, the Secretary may implement the amendments made by paragraph (1) by program instruction or otherwise.

(b) **STUDY AND REPORT BY THE INSTITUTE OF MEDICINE.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services is authorized to enter into an agreement with the Institute of Medicine of the National Academies to conduct a study on the ramifications of Medicare payment reductions for dual-energy x-ray absorptiometry (as described in section 1848(b)(6) of the Social Security Act, as added by subsection (a)(1)) during 2007, 2008, and 2009 on beneficiary access to bone mass density tests.

(2) **REPORT.**—An agreement entered into under paragraph (1) shall provide for the Institute of Medicine to submit to the Secretary and to Congress a report containing the results of the study conducted under such paragraph.

SEC. 3112. REVISION TO THE MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1)(A) of the Social Security Act (42 U.S.C. 1395iii) is amended by striking “\$22,290,000,000” and inserting “\$0”.

SEC. 3113. TREATMENT OF CERTAIN COMPLEX DIAGNOSTIC LABORATORY TESTS.

(a) **DEMONSTRATION PROJECT.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct a demonstration project under part B title XVIII of the Social Security Act under which separate payments are made under such part for complex diagnostic laboratory tests provided to individuals under such part. Under the demonstration project, the Secretary shall establish appropriate payment rates for such tests.

(2) **COVERED COMPLEX DIAGNOSTIC LABORATORY TEST DEFINED.**—In this section, the term “complex diagnostic laboratory test” means a diagnostic laboratory test—

(A) that is an analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay;

(B) that is determined by the Secretary to be a laboratory test for which there is not an alternative test having equivalent performance characteristics;

(C) which is billed using a Health Care Procedure Coding System (HCPCS) code other than a not otherwise classified code under such Coding System;

(D) which is approved or cleared by the Food and Drug Administration or is covered under title XVIII of the Social Security Act; and

(E) is described in section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3)).

(3) **SEPARATE PAYMENT DEFINED.**—In this section, the term “separate payment” means direct payment to a laboratory (including a hospital-based or independent laboratory) that performs a complex diagnostic laboratory test with respect to a specimen collected from an individual during a period in which the individual is a pa-

tient of a hospital if the test is performed after such period of hospitalization and if separate payment would not otherwise be made under title XVIII of the Social Security Act by reason of sections 1862(a)(14) and 1866(a)(1)(H)(i) of the such Act (42 U.S.C. 1395y(a)(14); 42 U.S.C. 1395cc(a)(1)(H)(i)).

(b) **DURATION.**—Subject to subsection (c)(2), the Secretary shall conduct the demonstration project under this section for the 2-year period beginning on July 1, 2011.

(c) **PAYMENTS AND LIMITATION.**—Payments under the demonstration project under this section shall—

(1) be made from the Federal Supplemental Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t); and

(2) may not exceed \$100,000,000.

(d) **REPORT.**—Not later than 2 years after the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project. Such report shall include—

(1) an assessment of the impact of the demonstration project on access to care, quality of care, health outcomes, and expenditures under title XVIII of the Social Security Act (including any savings under such title); and

(2) such recommendations as the Secretary determines appropriate.

(e) **IMPLEMENTATION FUNDING.**—For purposes of administering this section (including preparing and submitting the report under subsection (d)), the Secretary shall provide for the transfer, from the Federal Supplemental Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t), to the Centers for Medicare & Medicaid Services Program Management Account, of \$5,000,000. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3114. IMPROVED ACCESS FOR CERTIFIED NURSE-MIDWIFE SERVICES.

Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C. 1395l(a)(1)(K)) is amended by inserting “(or 100 percent for services furnished on or after January 1, 2011)” after “1992, 65 percent”.

PART II—RURAL PROTECTIONS

SEC. 3121. EXTENSION OF OUTPATIENT HOLD HARMLESS PROVISION.

(a) **IN GENERAL.**—Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(1) in subclause (II)—

(A) in the first sentence, by striking “2010” and inserting “2011”; and

(B) in the second sentence, by striking “or 2009” and inserting “, 2009, or 2010”; and

(2) in subclause (III), by striking “January 1, 2010” and inserting “January 1, 2011”.

(b) **PERMITTING ALL SOLE COMMUNITY HOSPITALS TO BE ELIGIBLE FOR HOLD HARMLESS.**—Section 1833(t)(7)(D)(i)(III) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)(III)) is amended by adding at the end the following new sentence: “In the case of covered OPD services furnished on or after January 1, 2010, and before January 1, 2011, the preceding sentence shall be applied without regard to the 100-bed limitation.”.

SEC. 3122. EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL PATIENTS IN CERTAIN RURAL AREAS.

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395l–4), as amended by section 105 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395l note) and section 107 of the Medicare, Medicaid, and SCHIP

Extension Act of 2007 (42 U.S.C. 1395l note), is amended by inserting “or during the 1-year period beginning on July 1, 2010” before the period at the end.

SEC. 3123. EXTENSION OF THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) **ONE-YEAR EXTENSION.**—Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended by adding at the end the following new subsection:

“(g) **ONE-YEAR EXTENSION OF DEMONSTRATION PROGRAM.**—

“(1) **IN GENERAL.**—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 1-year period (in this section referred to as the ‘1-year extension period’) that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

“(2) **EXPANSION OF DEMONSTRATION STATES.**—Notwithstanding subsection (a)(2), during the 1-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 5-year period.

“(3) **INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.**—Notwithstanding subsection (a)(4), during the 1-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

“(4) **NO AFFECT ON HOSPITALS IN DEMONSTRATION PROGRAM ON DATE OF ENACTMENT.**—In the case of a rural community hospital that is participating in the demonstration program under this section as of the last day of the initial 5-year period, the Secretary shall provide for the continued participation of such rural community hospital in the demonstration program during the 1-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may specify, to discontinue such participation.”.

(b) **CONFORMING AMENDMENTS.**—Subsection (a)(5) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended by inserting “(in this section referred to as the ‘initial 5-year period’) and, as provided in subsection (g), for the 1-year extension period” after “5-year period”.

(c) **TECHNICAL AMENDMENTS.**—

(1) Subsection (b) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended—

(A) in paragraph (1)(B)(ii), by striking “(2)” and inserting “(2)”; and

(B) in paragraph (2), by inserting “cost” before “reporting period” the first place such term appears in each of subparagraphs (A) and (B).

(2) Subsection (f)(1) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended—

(A) in subparagraph (A)(ii), by striking “paragraph (2)” and inserting “subparagraph (B)”; and

(B) in subparagraph (B), by striking “paragraph (1)(B)” and inserting “subparagraph (A)(ii)”.

SEC. 3124. EXTENSION OF THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) **EXTENSION OF PAYMENT METHODOLOGY.**—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking “October 1, 2011” and inserting “October 1, 2012”; and

(2) in clause (ii)(II), by striking “October 1, 2011” and inserting “October 1, 2012”.

(b) CONFORMING AMENDMENTS.—

(1) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking “October 1, 2011” and inserting “October 1, 2012”; and

(B) in clause (iv), by striking “through fiscal year 2011” and inserting “through fiscal year 2012”.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking “through fiscal year 2011” and inserting “through fiscal year 2012”.

SEC. 3125. TEMPORARY IMPROVEMENTS TO THE MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (A), by inserting “or (D)” after “subparagraph (B)”;

(2) in subparagraph (B), in the matter preceding clause (i), by striking “The Secretary” and inserting “For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in fiscal year 2013 and subsequent fiscal years, the Secretary”;

(3) in subparagraph (C)(i)—

(A) by inserting “(or, with respect to fiscal years 2011 and 2012, 15 road miles)” after “25 road miles”; and

(B) by inserting “(or, with respect to fiscal years 2011 and 2012, 1,500 discharges of individuals entitled to, or enrolled for, benefits under part A)” after “800 discharges”; and

(4) by adding at the end the following new subparagraph:

“(D) TEMPORARY APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2011 and 2012, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under part A in the fiscal year to 0 percent for low-volume hospitals with greater than 1,500 discharges of such individuals in the fiscal year.”.

SEC. 3126. IMPROVEMENTS TO THE DEMONSTRATION PROJECT ON COMMUNITY HEALTH INTEGRATION MODELS IN CERTAIN RURAL COUNTIES.

(a) REMOVAL OF LIMITATION ON NUMBER OF ELIGIBLE COUNTIES SELECTED.—Subsection (d)(3) of section 123 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395i-4 note) is amended by striking “not more than 6”.

(b) REMOVAL OF REFERENCES TO RURAL HEALTH CLINIC SERVICES AND INCLUSION OF PHYSICIANS’ SERVICES IN SCOPE OF DEMONSTRATION PROJECT.—Such section 123 is amended—

(1) in subsection (d)(4)(B)(i)(3), by striking subclause (III); and

(2) in subsection (j)—

(A) in paragraph (8), by striking subparagraph (B) and inserting the following:

“(B) Physicians’ services (as defined in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q))).”;

(B) by striking paragraph (9); and

(C) by redesignating paragraph (10) as paragraph (9).

SEC. 3127. MEDPAC STUDY ON ADEQUACY OF MEDICARE PAYMENTS FOR HEALTH CARE PROVIDERS SERVING IN RURAL AREAS.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the ade-

quacy of payments for items and services furnished by providers of services and suppliers in rural areas under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such study shall include an analysis of—

(1) any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas;

(2) access by Medicare beneficiaries to items and services in rural areas;

(3) the adequacy of payments to providers of services and suppliers that furnish items and services in rural areas; and

(4) the quality of care furnished in rural areas.

(b) REPORT.—Not later than January 1, 2011, the Medicare Payment Advisory Commission shall submit to Congress a report containing the results of the study conducted under subsection (a). Such report shall include recommendations on appropriate modifications to any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas, together with recommendations for such legislation and administrative action as the Medicare Payment Advisory Commission determines appropriate.

SEC. 3128. TECHNICAL CORRECTION RELATED TO CRITICAL ACCESS HOSPITAL SERVICES.

(a) IN GENERAL.—Subsections (g)(2)(A) and (l)(8) of section 1834 of the Social Security Act (42 U.S.C. 1395m) are each amended by inserting “101 percent of” before “the reasonable costs”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of section 405(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; 117 Stat. 2266).

SEC. 3129. EXTENSION OF AND REVISIONS TO MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) AUTHORIZATION.—Section 1820(j) of the Social Security Act (42 U.S.C. 1395i-4(j)) is amended—

(1) by striking “2010, and for” and inserting “2010, for”; and

(2) by inserting “and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to remain available until expended” before the period at the end.

(b) USE OF FUNDS.—Section 1820(g)(3) of the Social Security Act (42 U.S.C. 1395i-4(g)(3)) is amended—

(1) in subparagraph (A), by inserting “and to assist such hospitals in participating in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary” before the period at the end; and

(2) in subparagraph (E)—

(A) by striking “, and to offset” and inserting “, to offset”; and

(B) by inserting “and to participate in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary” before the period at the end.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to grants made on or after January 1, 2010.

PART III—IMPROVING PAYMENT ACCURACY

SEC. 3131. PAYMENT ADJUSTMENTS FOR HOME HEALTH CARE.

(a) REBASING HOME HEALTH PROSPECTIVE PAYMENT AMOUNT.—

(1) IN GENERAL.—Section 1895(b)(3)(A) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)) is amended—

(A) in clause (i)(III), by striking “For periods” and inserting “Subject to clause (iii), for periods”; and

(B) by adding at the end the following new clause:

“(iii) ADJUSTMENT FOR 2013 AND SUBSEQUENT YEARS.—

“(I) IN GENERAL.—Subject to subclause (II), for 2013 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (i)(III) shall be adjusted by a percentage determined appropriate by the Secretary to reflect such factors as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant. In conducting the analysis under the preceding sentence, the Secretary may consider differences between hospital-based and freestanding agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies. Such adjustment shall be made before the update under subparagraph (B) is applied for the year.

“(II) TRANSITION.—The Secretary shall provide for a 4-year phase-in (in equal increments) of the adjustment under subclause (I), with such adjustment being fully implemented for 2016. During each year of such phase-in, the amount of any adjustment under subclause (I) for the year may not exceed 3.5 percent of the amount (or amounts) applicable under clause (i)(III) as of the date of enactment of the Patient Protection and Affordable Care Act.”.

(2) MEDPAC STUDY AND REPORT.—

(A) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the implementation of the amendments made by paragraph (1). Such study shall include an analysis of the impact of such amendments on—

(i) access to care;

(ii) quality outcomes;

(iii) the number of home health agencies; and

(iv) rural agencies, urban agencies, for-profit agencies, and nonprofit agencies.

(B) REPORT.—Not later than January 1, 2015, the Medicare Payment Advisory Commission shall submit to Congress a report on the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Commission determines appropriate.

(b) PROGRAM-SPECIFIC OUTLIER CAP.—Section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)) is amended—

(1) in paragraph (3)(C), by striking “the aggregate” and all that follows through the period at the end and inserting “5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period.”; and

(2) in paragraph (5)—

(A) by striking “OUTLIERS.—The Secretary” and inserting the following: “OUTLIERS.—

“(A) IN GENERAL.—Subject to subparagraph (B), the Secretary”;

(B) in subparagraph (A), as added by subparagraph (A), by striking “5 percent” and inserting “2.5 percent”; and

(C) by adding at the end the following new subparagraph:

“(B) PROGRAM SPECIFIC OUTLIER CAP.—The estimated total amount of additional payments or payment adjustments made under subparagraph (A) with respect to a home health agency

for a year (beginning with 2011) may not exceed an amount equal to 10 percent of the estimated total amount of payments made under this section (without regard to this paragraph) with respect to the home health agency for the year.”.

(C) APPLICATION OF THE MEDICARE RURAL HOME HEALTH ADD-ON POLICY.—Section 421 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2283), as amended by section 5201(b) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 46), is amended—

(1) in the section heading, by striking “ONE-YEAR” and inserting “TEMPORARY”; and

(2) in subsection (a)—

(A) by striking “, and episodes” and inserting “, episodes”;;

(B) by inserting “and episodes and visits ending on or after April 1, 2010, and before January 1, 2016,” after “January 1, 2007,”; and

(C) by inserting “(or, in the case of episodes and visits ending on or after April 1, 2010, and before January 1, 2016, 3 percent)” before the period at the end.

(d) STUDY AND REPORT ON THE DEVELOPMENT OF HOME HEALTH PAYMENT REFORMS IN ORDER TO ENSURE ACCESS TO CARE AND QUALITY SERVICES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct a study to evaluate the costs and quality of care among efficient home health agencies relative to other such agencies in providing ongoing access to care and in treating Medicare beneficiaries with varying severity levels of illness. Such study shall include an analysis of the following:

(A) Methods to revise the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to more accurately account for the costs related to patient severity of illness or to improving beneficiary access to care, including—

(i) payment adjustments for services that may be under- or over-valued;

(ii) necessary changes to reflect the resource use relative to providing home health services to low-income Medicare beneficiaries or Medicare beneficiaries living in medically underserved areas;

(iii) ways the outlier payment may be improved to more accurately reflect the cost of treating Medicare beneficiaries with high severity levels of illness;

(iv) the role of quality of care incentives and penalties in driving provider and patient behavior;

(v) improvements in the application of a wage index; and

(vi) other areas determined appropriate by the Secretary.

(B) The validity and reliability of responses on the OASIS instrument with particular emphasis on questions that relate to higher payment under the home health prospective payment system and higher outcome scores under Home Care Compare.

(C) Additional research or payment revisions under the home health prospective payment system that may be necessary to set the payment rates for home health services based on costs of high-quality and efficient home health agencies or to improve Medicare beneficiary access to care.

(D) A timetable for implementation of any appropriate changes based on the analysis of the matters described in subparagraphs (A), (B), and (C).

(E) Other areas determined appropriate by the Secretary.

(2) CONSIDERATIONS.—In conducting the study under paragraph (1), the Secretary shall consider whether certain factors should be used to measure patient severity of illness and access to care, such as—

(A) population density and relative patient access to care;

(B) variations in service costs for providing care to individuals who are dually eligible under the Medicare and Medicaid programs;

(C) the presence of severe or chronic diseases, as evidenced by multiple, discontinuous home health episodes;

(D) poverty status, as evidenced by the receipt of Supplemental Security Income under title XVI of the Social Security Act;

(E) the absence of caregivers;

(F) language barriers;

(G) atypical transportation costs;

(H) security costs; and

(I) other factors determined appropriate by the Secretary.

(3) REPORT.—Not later than March 1, 2011, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(4) CONSULTATIONS.—In conducting the study under paragraph (1) and preparing the report under paragraph (3), the Secretary shall consult with—

(A) stakeholders representing home health agencies;

(B) groups representing Medicare beneficiaries;

(C) the Medicare Payment Advisory Commission;

(D) the Inspector General of the Department of Health and Human Services; and

(E) the Comptroller General of the United States.

SEC. 3132. HOSPICE REFORM.

(a) HOSPICE CARE PAYMENT REFORMS.—

(1) IN GENERAL.—Section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)), as amended by section 3004(c), is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

(B) by inserting after paragraph (5) the following new paragraph:

“(6)(A) The Secretary shall collect additional data and information as the Secretary determines appropriate to revise payments for hospice care under this subsection pursuant to subparagraph (D) and for other purposes as determined appropriate by the Secretary. The Secretary shall begin to collect such data by not later than January 1, 2011.

“(B) The additional data and information to be collected under subparagraph (A) may include data and information on—

“(i) charges and payments;

“(ii) the number of days of hospice care which are attributable to individuals who are entitled to, or enrolled for, benefits under part A; and

“(iii) with respect to each type of service included in hospice care—

“(I) the number of days of hospice care attributable to the type of service;

“(II) the cost of the type of service; and

“(III) the amount of payment for the type of service;

“(iv) charitable contributions and other revenue of the hospice program;

“(v) the number of hospice visits;

“(vi) the type of practitioner providing the visit; and

“(vii) the length of the visit and other basic information with respect to the visit.

“(C) The Secretary may collect the additional data and information under subparagraph (A) on cost reports, claims, or other mechanisms as the Secretary determines to be appropriate.

“(D)(i) Notwithstanding the preceding paragraphs of this subsection, not earlier than October 1, 2013, the Secretary shall, by regulation, implement revisions to the methodology for determining the payment rates for routine home

care and other services included in hospice care under this part, as the Secretary determines to be appropriate. Such revisions may be based on an analysis of data and information collected under subparagraph (A). Such revisions may include adjustments to per diem payments that reflect changes in resource intensity in providing such care and services during the course of the entire episode of hospice care.

“(ii) Revisions in payment implemented pursuant to clause (i) shall result in the same estimated amount of aggregate expenditures under this title for hospice care furnished in the fiscal year in which such revisions in payment are implemented as would have been made under this title for such care in such fiscal year if such revisions had not been implemented.

“(E) The Secretary shall consult with hospice programs and the Medicare Payment Advisory Commission regarding the additional data and information to be collected under subparagraph (A) and the payment revisions under subparagraph (D).”.

(2) CONFORMING AMENDMENTS.—Section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) is amended—

(A) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting “(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented)” after “subsequent fiscal year”; and

(ii) in subclause (VII), by inserting “(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented), subject to clause (iv),” after “subsequent fiscal year”; and

(B) by adding at the end the following new clause:

“(iii) With respect to routine home care and other services included in hospice care furnished during fiscal years subsequent to the first fiscal year in which payment revisions described in paragraph (6)(D) are implemented, the payment rates for such care and services shall be the payment rates in effect under this clause during the preceding fiscal year increased by, subject to clause (iv), the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) for the fiscal year.”.

(b) ADOPTION OF MEDPAC HOSPICE PROGRAM ELIGIBILITY RECERTIFICATION RECOMMENDATIONS.—Section 1814(a)(7) of the Social Security Act (42 U.S.C. 1395f(a)(7)) is amended—

(1) in subparagraph (B), by striking “and” at the end; and

(2) by adding at the end the following new subparagraph:

“(D) on and after January 1, 2011—

“(i) a hospice physician or nurse practitioner has a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification under subparagraph (A)(ii) and attests that such visit took place (in accordance with procedures established by the Secretary); and

“(ii) in the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of such cases for all programs under this title, the hospice care provided to such individual is medically reviewed (in accordance with procedures established by the Secretary); and”.

SEC. 3133. IMPROVEMENT TO MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001, 3008, and 3025, is amended—

(1) in subsection (d)(5)(F)(i), by striking “For” and inserting “Subject to subsection (r), for”; and

(2) by adding at the end the following new subsection:

“(r) ADJUSTMENTS TO MEDICARE DSH PAYMENTS.—

“(1) EMPIRICALLY JUSTIFIED DSH PAYMENTS.—For fiscal year 2015 and each subsequent fiscal year, instead of the amount of disproportionate share hospital payment that would otherwise be made under subsection (d)(5)(F) to a subsection (d) hospital for the fiscal year, the Secretary shall pay to the subsection (d) hospital 25 percent of such amount (which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).

“(2) ADDITIONAL PAYMENT.—In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal year 2015 and each subsequent fiscal year, the Secretary shall pay to such subsection (d) hospitals an additional amount equal to the product of the following factors:

“(A) FACTOR ONE.—A factor equal to the difference between—

“(i) the aggregate amount of payments that would be made to subsection (d) hospitals under subsection (d)(5)(F) if this subsection did not apply for such fiscal year (as estimated by the Secretary); and

“(ii) the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1) for such fiscal year (as so estimated).

“(B) FACTOR TWO.—

“(i) FISCAL YEARS 2015, 2016, AND 2017.—For each of fiscal years 2015, 2016, and 2017, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals—

“(I) who are uninsured in 2012, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on such Act that, if determined in the affirmative, would clear such Act for enrollment); and

“(II) who are uninsured in the most recent period for which data is available (as so calculated).

“(ii) 2018 AND SUBSEQUENT YEARS.—For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals who are uninsured, as determined by comparing the percent of individuals—

“(I) who are uninsured in 2012 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and

“(II) who are uninsured in the most recent period for which data is available (as so estimated and certified).

“(C) FACTOR THREE.—A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

“(i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and

“(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

“(3) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under sec-

tion 1869, section 1878, or otherwise of the following:

“(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).

“(B) Any period selected by the Secretary for such purposes.”.

SEC. 3134. MISVALUED CODES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the end the following new subparagraphs:

“(K) POTENTIALLY MISVALUED CODES.—

“(i) IN GENERAL.—The Secretary shall—

“(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

“(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

“(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (as the Secretary determines to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as 3 years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called ‘Harvard-valued codes’); and such other codes determined to be appropriate by the Secretary.

“(iii) REVIEW AND ADJUSTMENTS.—

“(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described in clause (i)(II).

“(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

“(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

“(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

“(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

“(VI) The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(I).

“(L) VALIDATING RELATIVE VALUE UNITS.—

“(i) IN GENERAL.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

“(ii) COMPONENTS AND ELEMENTS OF WORK.—The process described in clause (i) may include validation of work elements (such as time, men-

tal effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work.

“(iii) SCOPE OF CODES.—The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii).

“(iv) METHODS.—The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

“(v) ADJUSTMENTS.—The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(I).”.

(b) IMPLEMENTATION.—

(1) ADMINISTRATION.—

(A) Chapter 35 of title 44, United States Code and the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to this section or the amendment made by this section.

(B) Notwithstanding any other provision of law, the Secretary may implement subparagraphs (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), by program instruction or otherwise.

(C) Section 4505(d) of the Balanced Budget Act of 1997 is repealed.

(D) Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation shall not apply to this section or the amendment made by this section.

(2) FOCUSING CMS RESOURCES ON POTENTIALLY OVERVALUED CODES.—Section 1868(a) of the Social Security Act (42 U.S.C. 1395ee(a)) is repealed.

SEC. 3135. MODIFICATION OF EQUIPMENT UTILIZATION FACTOR FOR ADVANCED IMAGING SERVICES.

(a) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—Section 1848 of the Social Security Act (42 U.S.C. 1395w-4) is amended—

(1) in subsection (b)(4)—

(A) in subparagraph (A), by striking “subparagraph (A)” and inserting “this paragraph”; and

(B) by adding at the end the following new subparagraph:

“(C) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—Consistent with the methodology for computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) furnished on or after January 1, 2010, the Secretary shall adjust such number of units so it reflects—

“(i) in the case of services furnished on or after January 1, 2010, and before January 1, 2013, a 65 percent (rather than 50 percent) presumed rate of utilization of imaging equipment;

“(ii) in the case of services furnished on or after January 1, 2013, and before January 1, 2014, a 70 percent (rather than 50 percent) presumed rate of utilization of imaging equipment; and

“(iii) in the case of services furnished on or after January 1, 2014, a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment.”; and

(2) in subsection (c)(2)(B)(v), by adding at the end the following new subclauses:

“(III) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2010 THROUGH 2012.—Effective

for fee schedules established beginning with 2010 and ending with 2012, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 65 percent under subsection (b)(4)(C)(i) instead of a presumed rate of utilization of such equipment of 50 percent.

“(IV) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2013.—Effective for fee schedules established for 2013, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 70 percent under subsection (b)(4)(C)(ii) instead of a presumed rate of utilization of such equipment of 50 percent.

“(V) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2014 AND SUBSEQUENT YEARS.—Effective for fee schedules established beginning with 2014, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 75 percent under subsection (b)(4)(C)(iii) instead of a presumed rate of utilization of such equipment of 50 percent.”.

(b) ADJUSTMENT IN TECHNICAL COMPONENT “DISCOUNT” ON SINGLE-SESSION IMAGING TO CONSECUTIVE BODY PARTS.—Section 1848 of the Social Security Act (42 U.S.C. 1395w-4), as amended by subsection (a), is amended—

(1) in subsection (b)(4), by adding at the end the following new subparagraph:

“(D) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—For services furnished on or after July 1, 2010, the Secretary shall increase the reduction in payments attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.”; and

(2) in subsection (c)(2)(B)(v), by adding at the end the following new subclause:

“(VI) ADDITIONAL REDUCED PAYMENT FOR MULTIPLE IMAGING PROCEDURES.—Effective for fee schedules established beginning with 2010 (but not applied for services furnished prior to July 1, 2010), reduced expenditures attributable to the increase in the multiple procedure payment reduction from 25 to 50 percent (as described in subsection (b)(4)(D)).”.

(c) ANALYSIS BY THE CHIEF ACTUARY OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—Not later than January 1, 2013, the Chief Actuary of the Centers for Medicare & Medicaid Services shall make publicly available an analysis of whether, for the period of 2010 through 2019, the cumulative expenditure reductions under title XVIII of the Social Security Act that are attributable to the adjustments under the amendments made by this section are projected to exceed \$3,000,000,000.

SEC. 3136. REVISION OF PAYMENT FOR POWER-DRIVEN WHEELCHAIRS.

(a) IN GENERAL.—Section 1834(a)(7)(A) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)) is amended—

(1) in clause (i)—

(A) in subclause (II), by inserting “subclause (III) and” after “Subject to”; and

(B) by adding at the end the following new subclause:

“(III) SPECIAL RULE FOR POWER-DRIVEN WHEELCHAIRS.—For purposes of payment for power-driven wheelchairs, subclause (II) shall be applied by substituting ‘15 percent’ and ‘6 percent’ for ‘10 percent’ and ‘7.5 percent’, respectively.”; and

(2) in clause (iii)—

(A) in the heading, by inserting “COMPLEX, REHABILITATIVE” before “POWER-DRIVEN”; and

(B) by inserting “complex, rehabilitative” before “power-driven”.

(b) TECHNICAL AMENDMENT.—Section 1834(a)(7)(C)(ii)(II) of the Social Security Act (42 U.S.C. 1395m(a)(7)(C)(ii)(II)) is amended by striking “(A)(ii) or”.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsection (a) shall take effect on January 1, 2011, and shall apply to power-driven wheelchairs furnished on or after such date.

(2) APPLICATION TO COMPETITIVE BIDDING.—The amendments made by subsection (a) shall not apply to payment made for items and services furnished pursuant to contracts entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w-3) prior to January 1, 2011, pursuant to the implementation of subsection (a)(1)(B)(i)(I) of such section 1847.

SEC. 3137. HOSPITAL WAGE INDEX IMPROVEMENT.

(a) EXTENSION OF SECTION 508 HOSPITAL RECLASSIFICATIONS.—

(1) IN GENERAL.—Subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note), as amended by section 117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173) and section 124 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275), is amended by striking “September 30, 2009” and inserting “September 30, 2010”.

(2) USE OF PARTICULAR WAGE INDEX IN FISCAL YEAR 2010.—For purposes of implementation of the amendment made by this subsection during fiscal year 2010, the Secretary shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on August 27, 2009 (74 Fed. Reg. 43754), and any subsequent corrections.

(b) PLAN FOR REFORMING THE MEDICARE HOSPITAL WAGE INDEX SYSTEM.—

(1) IN GENERAL.—Not later than December 31, 2011, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall submit to Congress a report that includes a plan to reform the hospital wage index system under section 1886 of the Social Security Act.

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall take into account the goals for reforming such system set forth in the Medicare Payment Advisory Commission June 2007 report entitled “Report to Congress: Promoting Greater Efficiency in Medicare”, including establishing a new hospital compensation index system that—

(A) uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved;

(B) minimizes wage index adjustments between and within metropolitan statistical areas and statewide rural areas;

(C) includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;

(D) takes into account the effect that implementation of the system would have on health care providers and on each region of the country;

(E) addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of the implementation of the system; and

(F) provides for a transition.

(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall consult with relevant affected parties.

(c) USE OF PARTICULAR CRITERIA FOR DETERMINING RECLASSIFICATIONS.—Notwithstanding any other provision of law, in making decisions on applications for reclassification of a sub-

section (d) hospital (as defined in paragraph (1)(B) of section 1886(d) of the Social Security Act (42 U.S.C. 1395w(d))) for the purposes described in paragraph (10)(D)(v) of such section for fiscal year 2011 and each subsequent fiscal year (until the first fiscal year beginning on or after the date that is 1 year after the Secretary of Health and Human Services submits the report to Congress under subsection (b)), the Geographic Classification Review Board established under paragraph (10) of such section shall use the average hourly wage comparison criteria used in making such decisions as of September 30, 2008. The preceding sentence shall be effected in a budget neutral manner.

SEC. 3138. TREATMENT OF CERTAIN CANCER HOSPITALS.

Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) is amended by adding at the end the following new paragraph:

“(18) AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.—

“(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary). In conducting the study under this subparagraph, the Secretary shall take into consideration the cost of drugs and biologicals incurred by such hospitals.

“(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1886(d)(1)(B)(v) exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.”.

SEC. 3139. PAYMENT FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) IN GENERAL.—Section 1847A of the Social Security Act (42 U.S.C. 1395w-3a) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking “or” at the end;

(ii) in subparagraph (B), by striking the period at the end and inserting “; or”; and

(iii) by adding at the end the following new subparagraph:

“(C) in the case of a biosimilar biological product (as defined in subsection (c)(6)(H)), the amount determined under paragraph (8).”; and

(B) by adding at the end the following new paragraph:

“(8) BIOSIMILAR BIOLOGICAL PRODUCT.—The amount specified in this paragraph for a biosimilar biological product described in paragraph (1)(C) is the sum of—

“(A) the average sales price as determined using the methodology described under paragraph (6) applied to a biosimilar biological product for all National Drug Codes assigned to such product in the same manner as such paragraph is applied to drugs described in such paragraph; and

“(B) 6 percent of the amount determined under paragraph (4) for the reference biological product (as defined in subsection (c)(6)(I)).”; and

(2) in subsection (c)(6), by adding at the end the following new subparagraph:

“(H) BIOSIMILAR BIOLOGICAL PRODUCT.—The term ‘biosimilar biological product’ means a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under section 351 of the Public Health Service Act.

“(I) REFERENCE BIOLOGICAL PRODUCT.—The term ‘reference biological product’ means the biological product licensed under such section 351 that is referred to in the application described in subparagraph (H) of the biosimilar biological product.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for biosimilar biological products beginning with the first day of the second calendar quarter after enactment of legislation providing for a biosimilar pathway (as determined by the Secretary).

SEC. 3140. MEDICARE HOSPICE CONCURRENT CARE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish a Medicare Hospice Concurrent Care demonstration program at participating hospice programs under which Medicare beneficiaries are furnished, during the same period, hospice care and any other items or services covered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) from funds otherwise paid under such title to such hospice programs.

(2) DURATION.—The demonstration program under this section shall be conducted for a 3-year period.

(3) SITES.—The Secretary shall select not more than 15 hospice programs at which the demonstration program under this section shall be conducted. Such hospice programs shall be located in urban and rural areas.

(b) INDEPENDENT EVALUATION AND REPORTS.—

(1) INDEPENDENT EVALUATION.—The Secretary shall provide for the conduct of an independent evaluation of the demonstration program under this section. Such independent evaluation shall determine whether the demonstration program has improved patient care, quality of life, and cost-effectiveness for Medicare beneficiaries participating in the demonstration program.

(2) REPORTS.—The Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with such recommendations as the Secretary determines appropriate.

(c) BUDGET NEUTRALITY.—With respect to the 3-year period of the demonstration program under this section, the Secretary shall ensure that the aggregate expenditures under title XVIII for such period shall not exceed the aggregate expenditures that would have been expended under such title if the demonstration program under this section had not been implemented.

SEC. 3141. APPLICATION OF BUDGET NEUTRALITY ON A NATIONAL BASIS IN THE CALCULATION OF THE MEDICARE HOSPITAL WAGE INDEX FLOOR.

In the case of discharges occurring on or after October 1, 2010, for purposes of applying section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note) and paragraph (h)(4) of section 412.64 of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall administer subsection (b) of such section 4410 and paragraph (e) of such section 412.64 in the same manner as the Secretary administered such subsection (b) and paragraph (e) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index).

SEC. 3142. HHS STUDY ON URBAN MEDICARE-DEPENDENT HOSPITALS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct a study on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services under section 1886 of the Social Security

Act (42 U.S.C. 1395ww). Such study shall include an analysis of—

(A) the Medicare inpatient margins of urban Medicare-dependent hospitals, as compared to other hospitals which receive 1 or more additional payments or adjustments under such section (including those payments or adjustments described in paragraph (2)(A)); and

(B) whether payments to medicare-dependent, small rural hospitals under subsection (d)(5)(G) of such section should be applied to urban Medicare-dependent hospitals.

(2) URBAN MEDICARE-DEPENDENT HOSPITAL DEFINED.—For purposes of this section, the term “urban Medicare-dependent hospital” means a subsection (d) hospital (as defined in subsection (d)(1)(B) of such section) that—

(A) does not receive any additional payment or adjustment under such section, such as payments for indirect medical education costs under subsection (d)(5)(B) of such section, disproportionate share payments under subsection (d)(5)(A) of such section, payments to a rural referral center under subsection (d)(5)(C) of such section, payments to a critical access hospital under section 1814(l) of such Act (42 U.S.C. 1395f(l)), payments to a sole community hospital under subsection (d)(5)(D) of such section 1886, or payments to a medicare-dependent, small rural hospital under subsection (d)(5)(G) of such section 1886; and

(B) for which more than 60 percent of its inpatient days or discharges during 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report were attributable to inpatients entitled to benefits under part A of title XVIII of such Act.

(b) REPORT.—Not later than 9 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 3143. PROTECTING HOME HEALTH BENEFITS.

Nothing in the provisions of, or amendments made by, this Act shall result in the reduction of guaranteed home health benefits under title XVIII of the Social Security Act.

Subtitle C—Provisions Relating to Part C

SEC. 3201. MEDICARE ADVANTAGE PAYMENT.

(a) MA BENCHMARK BASED ON PLAN'S COMPETITIVE BIDS.—

(1) IN GENERAL.—Section 1853(j) of the Social Security Act (42 U.S.C. 1395w-23(j)) is amended—

(A) by striking “AMOUNTS.—For purposes” and inserting “AMOUNTS.—

“(1) IN GENERAL.—For purposes”;

(B) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting the subparagraphs appropriately;

(C) in subparagraph (A), as redesignated by subparagraph (B)—

(i) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting the clauses appropriately; and

(ii) in clause (i), as redesignated by clause (i), by striking “an amount equal to” and all that follows through the end and inserting “an amount equal to—

“(I) for years before 2007, $\frac{1}{12}$ of the annual MA capitation rate under section 1853(c)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment;

“(II) for 2007 through 2011, $\frac{1}{12}$ of the applicable amount determined under subsection (k)(1) for the area for the year;

“(III) for 2012, the sum of—

“(aa) $\frac{2}{3}$ of the quotient of—

“(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

“(BB) 12; and

“(bb) $\frac{1}{3}$ of the MA competitive benchmark amount (determined under paragraph (2)) for the area for the month;

“(IV) for 2013, the sum of—

“(aa) $\frac{1}{3}$ of the quotient of—

“(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

“(BB) 12; and

“(bb) $\frac{2}{3}$ of the MA competitive benchmark amount (as so determined) for the area for the month;

“(V) for 2014, the MA competitive benchmark amount for the area for a month in 2013 (as so determined), increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2014, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

“(VI) for 2015 and each subsequent year, the MA competitive benchmark amount (as so determined) for the area for the month; or”;

(iii) in clause (ii), as redesignated by clause (i), by striking “subparagraph (A)” and inserting “clause (i)”;

(D) by adding at the end the following new paragraphs:

“(2) COMPUTATION OF MA COMPETITIVE BENCHMARK AMOUNT.—

“(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (3), for months in each year (beginning with 2012) for each MA payment area the Secretary shall compute an MA competitive benchmark amount equal to the weighted average of the unadjusted MA statutory non-drug monthly bid amount (as defined in section 1854(b)(2)(E)) for each MA plan in the area, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the reference month (as defined in section 1858(f)(4), except that, in applying such definition for purposes of this paragraph, ‘to compute the MA competitive benchmark amount under section 1853(j)(2)’ shall be substituted for ‘to compute the percentage specified in subparagraph (A) and other relevant percentages under this part’).

“(B) WEIGHTING RULES.—

“(i) SINGLE PLAN RULE.—In the case of an MA payment area in which only a single MA plan is being offered, the weight under subparagraph (A) shall be equal to 1.

“(ii) USE OF SIMPLE AVERAGE AMONG MULTIPLE PLANS IF NO PLANS OFFERED IN PREVIOUS YEAR.—In the case of an MA payment area in which no MA plan was offered in the previous year and more than 1 MA plan is offered in the current year, the Secretary shall use a simple average of the unadjusted MA statutory non-drug monthly bid amount (as so defined) for purposes of computing the MA competitive benchmark amount under subparagraph (A).

“(3) CAP ON MA COMPETITIVE BENCHMARK AMOUNT.—In no case shall the MA competitive benchmark amount for an area for a month in a year be greater than the applicable amount that would (but for the application of this subsection) be determined under subsection (k)(1) for the area for the month in the year.”; and

(E) in subsection (k)(2)(B)(ii)(III), by striking “(j)(1)(A)” and inserting “(j)(1)(A)(i)”.

(2) CONFORMING AMENDMENTS.—

(A) Section 1853(k)(2) of the Social Security Act (42 U.S.C. 1395w-23(k)(2)) is amended—

(i) in subparagraph (A), by striking “through 2010” and inserting “and subsequent years”; and

(ii) in subparagraph (C)—

(I) in clause (iii), by striking “and” at the end;

(II) in clause (iv), by striking the period at the end and inserting “; and”; and

(III) by adding at the end the following new clause:

“(v) for 2011 and subsequent years, 0.00.”.

(B) Section 1854(b) of the Social Security Act (42 U.S.C. 1395w-24(b)) is amended—

(i) in paragraph (3)(B)(i), by striking “1853(j)(1)” and inserting “1853(j)(1)(A)”; and

(ii) in paragraph (4)(B)(i), by striking “1853(j)(2)” and inserting “1853(j)(1)(B)”.

(C) Section 1858(f) of the Social Security Act (42 U.S.C. 1395w-27(f)) is amended—

(i) in paragraph (1), by striking “1853(j)(2)” and inserting “1853(j)(1)(B)”; and

(ii) in paragraph (3)(A), by striking “1853(j)(1)(A)” and inserting “1853(j)(1)(A)(i)”.

(D) Section 1860C-1(d)(1)(A) of the Social Security Act (42 U.S.C. 1395w-29(d)(1)(A)) is amended by striking “1853(j)(1)(A)” and inserting “1853(j)(1)(A)(i)”.

(b) REDUCTION OF NATIONAL PER CAPITA GROWTH PERCENTAGE FOR 2011.—Section 1853(c)(6) of the Social Security Act (42 U.S.C. 1395w-23(c)(6)) is amended—

(1) in clause (v), by striking “and” at the end;

(2) in clause (vi)—

(A) by striking “for a year after 2002” and inserting “for 2003 through 2010”; and

(B) by striking the period at the end and inserting a comma; and

(C) by adding at the end the following new clauses:

“(vii) for 2011, 3 percentage points; and

“(viii) for a year after 2011, 0 percentage points.”.

(c) ENHANCEMENT OF BENEFICIARY REBATES.—Section 1854(b)(1)(C)(i) of the Social Security Act (42 U.S.C. 1395w-24(b)(1)(C)(i)) is amended by inserting “(or 100 percent in the case of plan years beginning on or after January 1, 2014)” after “75 percent”.

(d) BIDDING RULES.—

(1) REQUIREMENTS FOR INFORMATION SUBMITTED.—Section 1854(a)(6)(A) of the Social Security Act (42 U.S.C. 1395w-24(a)(6)(A)) is amended, in the flush matter following clause (v), by adding at the end the following sentence: “Information to be submitted under this paragraph shall be certified by a qualified member of the American Academy of Actuaries and shall meet actuarial guidelines and rules established by the Secretary under subparagraph (B)(v).”.

(2) ESTABLISHMENT OF ACTUARIAL GUIDELINES.—Section 1854(a)(6)(B) of the Social Security Act (42 U.S.C. 1395w-24(a)(6)(B)) is amended—

(A) in clause (i), by striking “(iii) and (iv)” and inserting “(iii), (iv), and (v)”; and

(B) by adding at the end the following new clause:

“(v) ESTABLISHMENT OF ACTUARIAL GUIDELINES.—

“(I) IN GENERAL.—In order to establish fair MA competitive benchmarks under section 1853(j)(1)(A)(i), the Secretary, acting through the Chief Actuary of the Centers for Medicare & Medicaid Services (in this clause referred to as the ‘Chief Actuary’), shall establish—

“(aa) actuarial guidelines for the submission of bid information under this paragraph; and

“(bb) bidding rules that are appropriate to ensure accurate bids and fair competition among MA plans.

“(II) DENIAL OF BID AMOUNTS.—The Secretary shall deny monthly bid amounts submitted under subparagraph (A) that do not meet the actuarial guidelines and rules established under subclause (I).

“(III) REFUSAL TO ACCEPT CERTAIN BIDS DUE TO MISREPRESENTATIONS AND FAILURES TO ADEQUATELY MEET REQUIREMENTS.—In the case where the Secretary determines that information submitted by an MA organization under subparagraph (A) contains consistent misrepresentations and failures to adequately meet requirements of the organization, the Secretary may refuse to accept any additional such bid

amounts from the organization for the plan year and the Chief Actuary shall, if the Chief Actuary determines that the actuaries of the organization were complicit in those misrepresentations and failures, report those actuaries to the Actuarial Board for Counseling and Discipline.”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to bid amounts submitted on or after January 1, 2012.

(e) MA LOCAL PLAN SERVICE AREAS.—

(1) IN GENERAL.—Section 1853(d) of the Social Security Act (42 U.S.C. 1395w-23(d)) is amended—

(A) in the subsection heading, by striking “MA REGION” and inserting “MA REGION; MA LOCAL PLAN SERVICE AREA”; and

(B) in paragraph (1), by striking subparagraph (A) and inserting the following:

“(A) with respect to an MA local plan—

“(i) for years before 2012, an MA local area (as defined in paragraph (2)); and

“(ii) for 2012 and succeeding years, a service area that is an entire urban or rural area, as applicable (as described in paragraph (5)); and”;

(C) by adding at the end the following new paragraph:

“(5) MA LOCAL PLAN SERVICE AREA.—For 2012 and succeeding years, the service area for an MA local plan shall be an entire urban or rural area in each State as follows:

“(A) URBAN AREAS.—

“(i) IN GENERAL.—Subject to clause (ii) and subparagraphs (C) and (D), the service area for an MA local plan in an urban area shall be the Core Based Statistical Area (in this paragraph referred to as a ‘CBSA’) or, if applicable, a conceptually similar alternative classification, as defined by the Director of the Office of Management and Budget.

“(ii) CBSA COVERING MORE THAN ONE STATE.—In the case of a CBSA (or alternative classification) that covers more than one State, the Secretary shall divide the CBSA (or alternative classification) into separate service areas with respect to each State covered by the CBSA (or alternative classification).

“(B) RURAL AREAS.—Subject to subparagraphs (C) and (D), the service area for an MA local plan in a rural area shall be a county that does not qualify for inclusion in a CBSA (or alternative classification), as defined by the Director of the Office of Management and Budget.

“(C) REFINEMENTS TO SERVICE AREAS.—For 2015 and succeeding years, in order to reflect actual patterns of health care service utilization, the Secretary may adjust the boundaries of service areas for MA local plans in urban areas and rural areas under subparagraphs (A) and (B), respectively, but may only do so based on recent analyses of actual patterns of care.

“(D) ADDITIONAL AUTHORITY TO MAKE LIMITED EXCEPTIONS TO SERVICE AREA REQUIREMENTS FOR MA LOCAL PLANS.—The Secretary may, in addition to any adjustments under subparagraph (C), make limited exceptions to service area requirements otherwise applicable under this part for MA local plans that have in effect (as of the date of enactment of the Patient Protection and Affordable Care Act)—

“(i) agreements with another MA organization or MA plan that preclude the offering of benefits throughout an entire service area; or

“(ii) limitations in their structural capacity to support adequate networks throughout an entire service area as a result of the delivery system model of the MA local plan.”.

(2) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—

(i) Section 1851(b)(1) of the Social Security Act (42 U.S.C. 1395w-21(b)(1)) is amended by striking subparagraph (C).

(ii) Section 1853(b)(1)(B)(i) of such Act (42 U.S.C. 1395w-23(b)(1)(B)(i))—

(I) in the matter preceding subclause (I), by striking “MA payment area” and inserting “MA local area (as defined in subsection (d)(2))”; and

(II) in subclause (I), by striking “MA payment area” and inserting “MA local area (as so defined)”.

(iii) Section 1853(b)(4) of such Act (42 U.S.C. 1395w-23(b)(4)) is amended by striking “Medicare Advantage payment area” and inserting “MA local area (as so defined)”.

(iv) Section 1853(c)(1) of such Act (42 U.S.C. 1395w-23(c)(1)) is amended—

(I) in the matter preceding subparagraph (A), by striking “a Medicare Advantage payment area that is”; and

(II) in subparagraph (D)(i), by striking “MA payment area” and inserting “MA local area (as defined in subsection (d)(2))”.

(v) Section 1854 of such Act (42 U.S.C. 1395w-24) is amended by striking subsection (h).

(B) EFFECTIVE DATE.—The amendments made by this paragraph shall take effect on January 1, 2012.

(f) PERFORMANCE BONUSES.—

(1) MA PLANS.—

(A) IN GENERAL.—Section 1853 of the Social Security Act (42 U.S.C. 1395w-23) is amended by adding at the end the following new subsection:

“(n) PERFORMANCE BONUSES.—

“(1) CARE COORDINATION AND MANAGEMENT PERFORMANCE BONUS.—

“(A) IN GENERAL.—For years beginning with 2014, subject to subparagraph (B), in the case of an MA plan that conducts 1 or more programs described in subparagraph (C) with respect to the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to the product of—

“(i) 0.5 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original Medicare fee-for-service program for the year; and

“(ii) the total number of programs described in clauses (i) through (ix) of subparagraph (C) that the Secretary determines the plan is conducting for the year under such subparagraph.

“(B) LIMITATION.—In no case may the total amount of payment with respect to a year under subparagraph (A) be greater than 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original Medicare fee-for-service program for the year, as determined prior to the application of risk adjustment under paragraph (4).

“(C) PROGRAMS DESCRIBED.—The following programs are described in this paragraph:

“(i) Care management programs that—

“(I) target individuals with 1 or more chronic conditions;

“(II) identify gaps in care; and

“(III) facilitate improved care by using additional resources like nurses, nurse practitioners, and physician assistants.

“(ii) Programs that focus on patient education and self-management of health conditions, including interventions that—

“(I) help manage chronic conditions;

“(II) reduce declines in health status; and

“(III) foster patient and provider collaboration.

“(iii) Transitional care interventions that focus on care provided around a hospital inpatient episode, including programs that target post-discharge patient care in order to reduce unnecessary health complications and readmissions.

“(iv) Patient safety programs, including provisions for hospital-based patient safety programs in contracts that the Medicare Advantage organization offering the MA plan has with hospitals.

“(v) Financial policies that promote system-atic coordination of care by primary care physi-cians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements, or pay-for-performance pro-grams.

“(vi) Programs that address, identify, and ameliorate health care disparities among prin-cipal at-risk subpopulations.

“(vii) Medication therapy management pro-grams that are more extensive than is required under section 1860D-4(c) (as determined by the Secretary).

“(viii) Health information technology pro-grams, including clinical decision support and other tools to facilitate data collection and en-sure patient-centered, appropriate care.

“(ix) Such other care management and coordi-nation programs as the Secretary determines ap-propriate.

“(D) CONDUCT OF PROGRAM IN URBAN AND RURAL AREAS.—An MA plan may conduct a pro-gram described in subparagraph (C) in a man-ner appropriate for an urban or rural area, as applicable.

“(E) REPORTING OF DATA.—Each Medicare Advantage organization shall provide to the Secretary the information needed to determine whether they are eligible for a care coordination and management performance bonus at a time and in a manner specified by the Secretary.

“(F) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of programs de-scribed in subparagraph (C) for which an MA plan receives a care coordination and manage-ment performance bonus under this paragraph. The Comptroller General shall monitor auditing activities conducted under this subparagraph.

“(2) QUALITY PERFORMANCE BONUSES.—

“(A) QUALITY BONUS.—For years beginning with 2014, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to cov-erage of an individual under this part, to an MA plan that achieves at least a 3 star rating (or comparable rating) on a rating system de-scribed in subparagraph (C) in an amount equal to—

“(i) in the case of a plan that achieves a 3 star rating (or comparable rating) on such sys-tem 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service pro-gram for the year; and

“(ii) in the case of a plan that achieves a 4 or 5 star rating (or comparable rating) on such sys-tem, 4 percent of such national monthly per cap-ita cost for the year.

“(B) IMPROVED QUALITY BONUS.—For years beginning with 2014, in the case of an MA plan that does not receive a quality bonus under sub-paragraph (A) and is an improved quality MA plan with respect to the year (as identified by the Secretary), the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to cov-erage of an individual under this part, to the MA plan in an amount equal to 1 percent of such national monthly per capita cost for the year.

“(C) USE OF RATING SYSTEM.—For purposes of subparagraph (A), a rating system described in this paragraph is—

“(i) a rating system that uses up to 5 stars to rate clinical quality and enrollee satisfaction and performance at the Medicare Advantage contract or MA plan level; or

“(ii) such other system established by the Sec-etary that provides for the determination of a comparable quality performance rating to the rating system described in clause (i).

“(D) DATA USED IN DETERMINING SCORE.—

“(i) IN GENERAL.—The rating of an MA plan under the rating system described in subpara-

graph (C) with respect to a year shall be based on based on the most recent data available.

“(ii) PLANS THAT FAIL TO REPORT DATA.—An MA plan which does not report data that en-ables the Secretary to rate the plan for purposes of subparagraph (A) or identify the plan for purposes of subparagraph (B) shall be counted, for purposes of such rating or identification, as having the lowest plan performance rating and the lowest percentage improvement, respectively.

“(3) QUALITY BONUS FOR NEW AND LOW EN-ROLLMENT MA PLANS.—

“(A) NEW MA PLANS.—For years beginning with 2014, in the case of an MA plan that first submits a bid under section 1854(a)(1)(A) for 2012 or a subsequent year, only receives enroll-ments made during the coverage election periods described in section 1851(e), and is not able to receive a bonus under subparagraph (A) or (B) of paragraph (2) for the year, the Secretary shall, in addition to any other payment pro-vided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 2 percent of national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year. In its fourth year of operation, the MA plan shall be paid in the same manner as other MA plans with comparable enrollment.

“(B) LOW ENROLLMENT PLANS.—For years be-ginning with 2014, in the case of an MA plan that has low enrollment (as defined by the Sec-etary) and would not otherwise be able to re-ceive a bonus under subparagraph (A) or (B) of paragraph (2) or subparagraph (A) of this para-graph for the year (referred to in this subpara-graph as a ‘low enrollment plan’), the Secretary shall use a regional or local mean of the rating of all MA plans in the region or local area, as determined appropriate by the Secretary, on measures used to determine whether MA plans are eligible for a quality or an improved quality bonus, as applicable, to determine whether the low enrollment plan is eligible for a bonus under such a subparagraph.

“(4) RISK ADJUSTMENT.—The Secretary shall risk adjust a performance bonus under this sub-section in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1854(b)(1)(C).

“(5) NOTIFICATION.—The Secretary, in the an-nual announcement required under subsection (b)(1)(B) for 2014 and each succeeding year, shall notify the Medicare Advantage organiza-tion of any performance bonus (including a care coordination and management performance bonus under paragraph (1), a quality perfor-mance bonus under paragraph (2), and a quality bonus for new and low enrollment plans under paragraph (3)) that the organization will receive under this subsection with respect to the year. The Secretary shall provide for the publication of the information described in the previous sen-tence on the Internet website of the Centers for Medicare & Medicaid Services.”

(B) CONFORMING AMENDMENT.—Section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w-23(a)(1)(B)) is amended—

(i) in clause (i), by inserting “and any per-formance bonus under subsection (n)” before the period at the end; and

(ii) in clause (ii), by striking “(G)” and insert-ing “(G), plus the amount (if any) of any per-formance bonus under subsection (n)”.

(2) APPLICATION OF PERFORMANCE BONUSES TO MA REGIONAL PLANS.—Section 1858 of the Social Security Act (42 U.S.C. 1395w-27a) is amended—

(A) in subsection (f)(1), by striking “sub-section (e)” and inserting “subsections (e) and (i)”;

(B) by adding at the end the following new subsection:

“(i) APPLICATION OF PERFORMANCE BONUSES TO MA REGIONAL PLANS.—For years beginning

with 2014, the Secretary shall apply the per-formance bonuses under section 1853(n) (relat-ing to bonuses for care coordination and man-agement, quality performance, and new and low enrollment MA plans) to MA regional plans in a similar manner as such performance bonuses apply to MA plans under such subsection.”

(g) GRANDFATHERING SUPPLEMENTAL BENEFITS FOR CURRENT ENROLLEES AFTER IMPLEMENTA-TION OF COMPETITIVE BIDDING.—Section 1853 of the Social Security Act (42 U.S.C. 1395w-23), as amended by subsection (f), is amended by add-ing at the end the following new subsection:

“(o) GRANDFATHERING SUPPLEMENTAL BENE-FITS FOR CURRENT ENROLLEES AFTER IMPLEMEN-TATION OF COMPETITIVE BIDDING.—

“(1) IDENTIFICATION OF AREAS.—The Secretary shall identify MA local areas in which, with re-spect to 2009, average bids submitted by an MA organization under section 1854(a) for MA local plans in the area are not greater than 75 percent of the adjusted average per capita cost for the year involved, determined under section 1876(a)(4), for the area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attrib-utable to payments under section 1848(o), 1886(n), and 1886(h).

“(2) ELECTION TO PROVIDE REBATES TO GRAND-FATHERED ENROLLEES.—

“(A) IN GENERAL.—For years beginning with 2012, each Medicare Advantage organization of-fering an MA local plan in an area identified by the Secretary under paragraph (1) may elect to provide rebates to grandfathered enrollees under section 1854(b)(1)(C). In the case where an MA organization makes such an election, the monthly per capita dollar amount of such re-bates shall not exceed the applicable amount for the year (as defined in subparagraph (B)).

“(B) APPLICABLE AMOUNT.—For purposes of this subsection, the term ‘applicable amount’ means—

“(i) for 2012, the monthly per capita dollar amount of such rebates provided to enrollees under the MA local plan with respect to 2011; and

“(ii) for a subsequent year, 95 percent of the amount determined under this subparagraph for the preceding year.

(3) SPECIAL RULES FOR PLANS IN IDENTIFIED AREAS.—Notwithstanding any other provision of this part, the following shall apply with respect to each Medicare Advantage organization offer-ing an MA local plan in an area identified by the Secretary under paragraph (1) that makes an election described in paragraph (2):

“(A) PAYMENTS.—The amount of the monthly payment under this section to the Medicare Adv-antage organization, with respect to coverage of a grandfathered enrollee under this part in the area for a month, shall be equal to—

“(i) for 2012 and 2013, the sum of—

“(I) the bid amount under section 1854(a) for the MA local plan; and

“(II) the applicable amount (as defined in paragraph (2)(B)) for the MA local plan for the year.

“(ii) for 2014 and subsequent years, the sum of—

“(I) the MA competitive benchmark amount under subsection (j)(1)(A)(i) for the area for the month, adjusted, only to the extent the Sec-etary determines necessary, to account for in-duced utilization as a result of rebates provided to grandfathered enrollees (except that such ad-justment shall not exceed 0.5 percent of such MA competitive benchmark amount); and

“(II) the applicable amount (as so defined) for the MA local plan for the year.

(B) REQUIREMENT TO SUBMIT BIDS UNDER COMPETITIVE BIDDING.—The Medicare Advan-tage organization shall submit a single bid amount under section 1854(a) for the MA local

plan. The Medicare Advantage organization shall remove from such bid amount any effects of induced demand for care that may result from the higher rebates available to grandfathered enrollees under this subsection.

“(C) NONAPPLICATION OF BONUS PAYMENTS AND ANY OTHER REBATES.—The Medicare Advantage organization offering the MA local plan shall not be eligible for any bonus payment under subsection (n) or any rebate under this part (other than as provided under this subsection) with respect to grandfathered enrollees.

“(D) NONAPPLICATION OF UNIFORM BID AND PREMIUM AMOUNTS TO GRANDFATHERED ENROLLEES.—Section 1854(c) shall not apply with respect to the MA local plan.

“(E) NONAPPLICATION OF LIMITATION ON APPLICATION OF PLAN REBATES TOWARD PAYMENT OF PART B PREMIUM.—Notwithstanding clause (iii) of section 1854(b)(1)(C), in the case of a grandfathered enrollee, a rebate under such section may be used for the purpose described in clause (ii)(III) of such section.

“(F) RISK ADJUSTMENT.—The Secretary shall risk adjust rebates to grandfathered enrollees under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1854(b)(1)(C).

“(4) DEFINITION OF GRANDFATHERED ENROLLEE.—In this subsection, the term ‘grandfathered enrollee’ means an individual who is enrolled (effective as of the date of enactment of this subsection) in an MA local plan in an area that is identified by the Secretary under paragraph (1).”.

(h) TRANSITIONAL EXTRA BENEFITS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w-23), as amended by subsections (f) and (g), is amended by adding at the end the following new subsection:

“(p) TRANSITIONAL EXTRA BENEFITS.—

“(1) IN GENERAL.—For years beginning with 2012, the Secretary shall provide transitional rebates under section 1854(b)(1)(C) for the provision of extra benefits (as specified by the Secretary) to enrollees described in paragraph (2).

“(2) ENROLLEES DESCRIBED.—An enrollee described in this paragraph is an individual who—
“(A) enrolls in an MA local plan in an applicable area; and

“(B) experiences a significant reduction in extra benefits described in clause (ii) of section 1854(b)(1)(C) as a result of competitive bidding under this part (as determined by the Secretary).

“(3) APPLICABLE AREAS.—In this subsection, the term ‘applicable area’ means the following:

“(A) The 2 largest metropolitan statistical areas, if the Secretary determines that the total amount of such extra benefits for each enrollee for the month in those areas is greater than \$100.

“(B) A county where—

“(i) the MA area-specific non-drug monthly benchmark amount for a month in 2011 is equal to the legacy urban floor amount (as described in subsection (c)(1)(B)(iii)), as determined by the Secretary for the area for 2011;

“(ii) the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in an MA plan for 2009 is greater than 30 percent (as determined by the Secretary); and

“(iii) average bids submitted by an MA organization under section 1854(a) for MA local plans in the county for 2011 are not greater than the adjusted average per capita cost for the year involved, determined under section 1876(a)(4), for the county for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1848(o), 1886(n), and 1886(h).

“(C) If the Secretary determines appropriate, a county contiguous to an area or county described in subparagraph (A) or (B), respectively,

“(4) REVIEW OF PLAN BIDS.—In the case of a bid submitted by an MA organization under section 1854(a) for an MA local plan in an applicable area, the Secretary shall review such bid in order to ensure that extra benefits (as specified by the Secretary) are provided to enrollees described in paragraph (2).

“(5) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund established under section 1841, in such proportion as the Secretary determines appropriate, of an amount not to exceed \$5,000,000,000 for the period of fiscal years 2012 through 2019 for the purpose of providing transitional rebates under section 1854(b)(1)(C) for the provision of extra benefits under this subsection.”.

(i) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS AND CLARIFICATION OF MA PAYMENT AREA FOR PACE PROGRAMS.—

(1) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS FOR PACE PROGRAMS.—Section 1894 of the Social Security Act (42 U.S.C. 1395ee) is amended—

(A) by redesignating subsections (h) and (i) as subsections (i) and (j), respectively;

(B) by inserting after subsection (g) the following new subsection:

“(h) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS UNDER PART C.—With respect to a PACE program under this section, the following provisions (and regulations relating to such provisions) shall not apply:

“(1) Section 1853(j)(1)(A)(i), relating to MA area-specific non-drug monthly benchmark amount being based on competitive bids.

“(2) Section 1853(d)(5), relating to the establishment of MA local plan service areas.

“(3) Section 1853(n), relating to the payment of performance bonuses.

“(4) Section 1853(o), relating to grandfathering supplemental benefits for current enrollees after implementation of competitive bidding.

“(5) Section 1853(p), relating to transitional extra benefits.”.

(2) SPECIAL RULE FOR MA PAYMENT AREA FOR PACE PROGRAMS.—Section 1853(d) of the Social Security Act (42 U.S.C. 1395w-23(d)), as amended by subsection (e), is amended by adding at the end the following new paragraph:

“(6) SPECIAL RULE FOR MA PAYMENT AREA FOR PACE PROGRAMS.—For years beginning with 2012, in the case of a PACE program under section 1894, the MA payment area shall be the MA local area (as defined in paragraph (2)).”.

SEC. 3202. BENEFIT PROTECTION AND SIMPLIFICATION.

(a) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—

(1) IN GENERAL.—Section 1852(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w-22(a)(1)(B)) is amended—

(A) in clause (i), by inserting “, subject to clause (ii),” after “and B or”; and

(B) by adding at the end the following new clauses:

“(iii) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—Subject to clause (v), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

“(iv) SERVICES DESCRIBED.—The following services are described in this clause:

“(I) Chemotherapy administration services.

“(II) Renal dialysis services (as defined in section 1881(b)(14)(B)).

“(III) Skilled nursing care.

“(IV) Such other services that the Secretary determines appropriate (including services that the Secretary determines require a high level of

predictability and transparency for beneficiaries).

“(v) EXCEPTION.—In the case of services described in clause (iv) for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i).”.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2011.

(b) APPLICATION OF REBATES, PERFORMANCE BONUSES, AND PREMIUMS.—

(1) APPLICATION OF REBATES.—Section 1854(b)(1)(C) of the Social Security Act (42 U.S.C. 1395w-24(b)(1)(C)) is amended—

(A) in clause (ii), by striking “REBATE.—A rebate” and inserting “REBATE FOR PLAN YEARS BEFORE 2012.—For plan years before 2012, a rebate”;

(B) by redesignating clauses (iii) and (iv) as clauses (iv) and (v); and

(C) by inserting after clause (ii) the following new clause:

“(iii) FORM OF REBATE FOR PLAN YEAR 2012 AND SUBSEQUENT PLAN YEARS.—For plan years beginning on or after January 1, 2012, a rebate required under this subparagraph may not be used for the purpose described in clause (ii)(III) and shall be provided through the application of the amount of the rebate in the following priority order:

“(I) First, to use the most significant share to meaningfully reduce cost-sharing otherwise applicable for benefits under the original medicare fee-for-service program under parts A and B and for qualified prescription drug coverage under part D, including the reduction of any deductibles, copayments, and maximum limitations on out-of-pocket expenses otherwise applicable. Any reduction of maximum limitations on out-of-pocket expenses under the preceding sentence shall apply to all benefits under the original medicare fee-for-service program option. The Secretary may provide guidance on meaningfully reducing cost-sharing under this subclause, except that such guidance may not require a particular amount of cost-sharing or reduction in cost-sharing.

“(II) Second, to use the next most significant share to meaningfully provide coverage of preventive and wellness health care benefits (as defined by the Secretary) which are not benefits under the original medicare fee-for-service program, such as smoking cessation, a free flu shot, and an annual physical examination.

“(III) Third, to use the remaining share to meaningfully provide coverage of other health care benefits which are not benefits under the original medicare fee-for-service program, such as eye examinations and dental coverage, and are not benefits described in subclause (II).”.

(2) APPLICATION OF PERFORMANCE BONUSES.—Section 1853(n) of the Social Security Act, as added by section 3201(f), is amended by adding at the end the following new paragraph:

“(6) APPLICATION OF PERFORMANCE BONUSES.—For plan years beginning on or after January 1, 2014, any performance bonus paid to an MA plan under this subsection shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of section 1854(b)(1)(C)(iii).”.

(3) APPLICATION OF MA MONTHLY SUPPLEMENTARY BENEFICIARY PREMIUM.—Section 1854(b)(2)(C) of the Social Security Act (42 U.S.C. 1395w-24(b)(2)(C)) is amended—

(A) by striking “PREMIUM.—The term” and inserting “PREMIUM.—

“(i) IN GENERAL.—The term”; and

(B) by adding at the end the following new clause:

“(ii) APPLICATION OF MA MONTHLY SUPPLEMENTARY BENEFICIARY PREMIUM.—For plan years beginning on or after January 1, 2012, any

MA monthly supplementary beneficiary premium charged to an individual enrolled in an MA plan shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of paragraph (1)(C)(iii)."

SEC. 3203. APPLICATION OF CODING INTENSITY ADJUSTMENT DURING MA PAYMENT TRANSITION.

Section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395w-23(a)(1)(C)) is amended by adding at the end the following new clause:

"(iii) APPLICATION OF CODING INTENSITY ADJUSTMENT FOR 2011 AND SUBSEQUENT YEARS.—

"(I) REQUIREMENT TO APPLY IN 2011 THROUGH 2013.—In order to ensure payment accuracy, the Secretary shall conduct an analysis of the differences described in clause (ii)(1). The Secretary shall ensure that the results of such analysis are incorporated into the risk scores for 2011, 2012, and 2013.

"(II) AUTHORITY TO APPLY IN 2014 AND SUBSEQUENT YEARS.—The Secretary may, as appropriate, incorporate the results of such analysis into the risk scores for 2014 and subsequent years."

SEC. 3204. SIMPLIFICATION OF ANNUAL BENEFICIARY ELECTION PERIODS.

(a) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—

(I) IN GENERAL.—Section 1851(e)(2)(C) of the Social Security Act (42 U.S.C. 1395w-1(e)(2)(C)) is amended to read as follows:

"(C) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—Subject to subparagraph (D), at any time during the first 45 days of a year (beginning with 2011), an individual who is enrolled in a Medicare Advantage plan may change the election under subsection (a)(1), but only with respect to coverage under the original medicare fee-for-service program under parts A and B, and may elect qualified prescription drug coverage in accordance with section 1860D-1."

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to 2011 and succeeding years.

(b) TIMING OF THE ANNUAL, COORDINATED ELECTION PERIOD UNDER PARTS C AND D.—Section 1851(e)(3)(B) of the Social Security Act (42 U.S.C. 1395w-1(e)(3)(B)) is amended—

(1) in clause (iii), by striking "and" at the end;

(2) in clause (iv)—

(A) by striking "and succeeding years" and inserting "; 2008, 2009, and 2010"; and

(B) by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new clause:

"(v) with respect to 2012 and succeeding years, the period beginning on October 15 and ending on December 7 of the year before such year."

SEC. 3205. EXTENSION FOR SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.

(a) EXTENSION OF SNP AUTHORITY.—Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w-28(f)(1)), as amended by section 164(a) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275), is amended by striking "2011" and inserting "2014".

(b) AUTHORITY TO APPLY FRAILTY ADJUSTMENT UNDER PACE PAYMENT RULES.—Section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w-23(a)(1)(B)) is amended by adding at the end the following new clause:

"(iv) AUTHORITY TO APPLY FRAILTY ADJUSTMENT UNDER PACE PAYMENT RULES FOR CERTAIN

SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

"(I) IN GENERAL.—Notwithstanding the preceding provisions of this paragraph, for plan year 2011 and subsequent plan years, in the case of a plan described in subclause (II), the Secretary may apply the payment rules under section 1894(d) (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

"(II) PLAN DESCRIBED.—A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) that is fully integrated with capitated contracts with States for Medicaid benefits, including long-term care, and that have similar average levels of frailty (as determined by the Secretary) as the PACE program."

(c) TRANSITION AND EXCEPTION REGARDING RESTRICTION ON ENROLLMENT.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w-28(f)) is amended by adding at the end the following new paragraph:

"(6) TRANSITION AND EXCEPTION REGARDING RESTRICTION ON ENROLLMENT.—

"(A) IN GENERAL.—Subject to subparagraph (C), the Secretary shall establish procedures for the transition of applicable individuals to—

"(i) a Medicare Advantage plan that is not a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); or

"(ii) the original medicare fee-for-service program under parts A and B.

"(B) APPLICABLE INDIVIDUALS.—For purposes of clause (i), the term 'applicable individual' means an individual who—

"(i) is enrolled under a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); and

"(ii) is not within the 1 or more of the classes of special needs individuals to which enrollment under the plan is restricted to.

"(C) EXCEPTION.—The Secretary shall provide for an exception to the transition described in subparagraph (A) for a limited period of time for individuals enrolled under a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) who are no longer eligible for medical assistance under title XIX.

"(D) TIMELINE FOR INITIAL TRANSITION.—The Secretary shall ensure that applicable individuals enrolled in a specialized MA plan for special needs individuals (as defined in subsection (b)(6)) prior to January 1, 2010, are transitioned to a plan or the program described in subparagraph (A) by not later than January 1, 2013."

(d) TEMPORARY EXTENSION OF AUTHORITY TO OPERATE BUT NO SERVICE AREA EXPANSION FOR DUAL SPECIAL NEEDS PLANS THAT DO NOT MEET CERTAIN REQUIREMENTS.—Section 164(c)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275) is amended by striking "December 31, 2010" and inserting "December 31, 2012".

(e) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS BE NCQA APPROVED.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w-28(f)), as amended by subsections (a) and (c), is amended—

(1) in paragraph (2), by adding at the end the following new subparagraph:

"(C) If applicable, the plan meets the requirement described in paragraph (7).";

(2) in paragraph (3), by adding at the end the following new subparagraph:

"(E) If applicable, the plan meets the requirement described in paragraph (7).";

(3) in paragraph (4), by adding at the end the following new subparagraph:

"(C) If applicable, the plan meets the requirement described in paragraph (7)."; and

(4) by adding at the end the following new paragraph:

"(7) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS BE NCQA APPROVED.—For 2012 and subsequent years, the Secretary shall require that a Medicare Advantage organization offering a specialized MA plan for special needs individuals be approved by the National Committee for Quality Assurance (based on standards established by the Secretary)."

(f) RISK ADJUSTMENT.—Section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395i-23(a)(1)(C)) is amended by adding at the end the following new clause:

"(iii) IMPROVEMENTS TO RISK ADJUSTMENT FOR SPECIAL NEEDS INDIVIDUALS WITH CHRONIC HEALTH CONDITIONS.—

"(I) IN GENERAL.—For 2011 and subsequent years, for purposes of the adjustment under clause (i) with respect to individuals described in subclause (II), the Secretary shall use a risk score that reflects the known underlying risk profile and chronic health status of similar individuals. Such risk score shall be used instead of the default risk score for new enrollees in Medicare Advantage plans that are not specialized MA plans for special needs individuals (as defined in section 1859(b)(6)).

"(II) INDIVIDUALS DESCRIBED.—An individual described in this subclause is a special needs individual described in subsection (b)(6)(B)(iii) who enrolls in a specialized MA plan for special needs individuals on or after January 1, 2011.

"(III) EVALUATION.—For 2011 and periodically thereafter, the Secretary shall evaluate and revise the risk adjustment system under this subparagraph in order to, as accurately as possible, account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions.

"(IV) PUBLICATION OF EVALUATION AND REVISIONS.—The Secretary shall publish, as part of an announcement under subsection (b), a description of any evaluation conducted under subclause (III) during the preceding year and any revisions made under such subclause as a result of such evaluation."

(g) TECHNICAL CORRECTION.—Section 1859(f)(5) of the Social Security Act (42 U.S.C. 1395w-28(f)(5)) is amended, in the matter preceding subparagraph (A), by striking "described in subsection (b)(6)(B)(i)".

SEC. 3206. EXTENSION OF REASONABLE COST CONTRACTS.

Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter preceding subclause (I), by striking "January 1, 2010" and inserting "January 1, 2013".

SEC. 3207. TECHNICAL CORRECTION TO MA PRIVATE FEE-FOR-SERVICE PLANS.

For plan year 2011 and subsequent plan years, to the extent that the Secretary of Health and Human Services is applying the 2008 service area extension waiver policy (as modified in the April 11, 2008, Centers for Medicare & Medicaid Services' memorandum with the subject "2009 Employer Group Waiver-Modification of the 2008 Service Area Extension Waiver Granted to Certain MA Local Coordinated Care Plans") to Medicare Advantage coordinated care plans, the Secretary shall extend the application of such waiver policy to employers who contract directly with the Secretary as a Medicare Advantage private fee-for-service plan under section 1857(i)(2) of the Social Security Act (42 U.S.C. 1395w-27(i)(2)) and that had enrollment as of October 1, 2009.

SEC. 3208. MAKING SENIOR HOUSING FACILITY DEMONSTRATION PERMANENT.

(a) IN GENERAL.—Section 1859 of the Social Security Act (42 U.S.C. 1395w–28) is amended by adding at the end the following new subsection:

“(g) SPECIAL RULES FOR SENIOR HOUSING FACILITY PLANS.—

“(1) IN GENERAL.—In the case of a Medicare Advantage senior housing facility plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the service area of such plan may be limited to a senior housing facility in a geographic area.

“(2) MEDICARE ADVANTAGE SENIOR HOUSING FACILITY PLAN DESCRIBED.—For purposes of this subsection, a Medicare Advantage senior housing facility plan is a Medicare Advantage plan that—

“(A) restricts enrollment of individuals under this part to individuals who reside in a continuing care retirement community (as defined in section 1852(l)(4)(B));

“(B) provides primary care services onsite and has a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate;

“(C) provides transportation services for beneficiaries to specialty providers outside of the facility; and

“(D) has participated (as of December 31, 2009) in a demonstration project established by the Secretary under which such a plan was offered for not less than 1 year.”.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on January 1, 2010, and shall apply to plan years beginning on or after such date.

SEC. 3209. AUTHORITY TO DENY PLAN BIDS.

(a) IN GENERAL.—Section 1854(a)(5) of the Social Security Act (42 U.S.C. 1395w–24(a)(5)) is amended by adding at the end the following new subparagraph:

“(C) REJECTION OF BIDS.—

“(i) IN GENERAL.—Nothing in this section shall be construed as requiring the Secretary to accept any or every bid submitted by an MA organization under this subsection.

“(ii) AUTHORITY TO DENY BIDS THAT PROPOSE SIGNIFICANT INCREASES IN COST SHARING OR DECREASES IN BENEFITS.—The Secretary may deny a bid submitted by an MA organization for an MA plan if it proposes significant increases in cost sharing or decreases in benefits offered under the plan.”.

(b) APPLICATION UNDER PART D.—Section 1860D–11(d) of such Act (42 U.S.C. 1395w–111(d)) is amended by adding at the end the following new paragraph:

“(3) REJECTION OF BIDS.—Paragraph (5)(C) of section 1854(a) shall apply with respect to bids submitted by a PDP sponsor under subsection (b) in the same manner as such paragraph applies to bids submitted by an MA organization under such section 1854(a).”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bids submitted for contract years beginning on or after January 1, 2011.

SEC. 3210. DEVELOPMENT OF NEW STANDARDS FOR CERTAIN MEDIGAP PLANS.

(a) IN GENERAL.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

“(y) DEVELOPMENT OF NEW STANDARDS FOR CERTAIN MEDICARE SUPPLEMENTAL POLICIES.—

“(1) IN GENERAL.—The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages described in paragraph (2) under subsection (p)(1), to otherwise update standards to include requirements for nominal cost sharing to encourage the use of appropriate physicians' services under part B. Such revisions shall be based on evidence published in peer-reviewed journals or current examples used by integrated delivery systems and made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the '1991 NAIC Model Regulation' deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law and the reference to 'date of enactment of this subsection' deemed a reference to the date of enactment of the Patient Protection and Affordable Care Act. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2015.

“(2) BENEFIT PACKAGES DESCRIBED.—The benefit packages described in this paragraph are benefit packages classified as 'C' and 'F'.”.

(b) CONFORMING AMENDMENT.—Section 1882(o)(1) of the Social Security Act (42 U.S.C. 1395ss(o)(1)) is amended by striking “, and (w)” and inserting “(w), and (y)”.

Subtitle D—Medicare Part D Improvements for Prescription Drug Plans and MA-PD Plans**SEC. 3301. MEDICARE COVERAGE GAP DISCOUNT PROGRAM.**

(a) CONDITION FOR COVERAGE OF DRUGS UNDER PART D.—Part D of Title XVIII of the Social Security Act (42 U.S.C. 1395w–101 et seq.), is amended by adding at the end the following new section:

“CONDITION FOR COVERAGE OF DRUGS UNDER THIS PART

“SEC. 1860D–43. (a) IN GENERAL.—In order for coverage to be available under this part for covered part D drugs (as defined in section 1860D–2(e)) of a manufacturer, the manufacturer must—

“(1) participate in the Medicare coverage gap discount program under section 1860D–14A;

“(2) have entered into and have in effect an agreement described in subsection (b) of such section with the Secretary; and

“(3) have entered into and have in effect, under terms and conditions specified by the Secretary, a contract with a third party that the Secretary has entered into a contract with under subsection (d)(3) of such section.

“(b) EFFECTIVE DATE.—Subsection (a) shall apply to covered part D drugs dispensed under this part on or after July 1, 2010.

“(c) AUTHORIZING COVERAGE FOR DRUGS NOT COVERED UNDER AGREEMENTS.—Subsection (a) shall not apply to the dispensing of a covered part D drug if—

“(1) the Secretary has made a determination that the availability of the drug is essential to the health of beneficiaries under this part; or

“(2) the Secretary determines that in the period beginning on July 1, 2010, and ending on December 31, 2010, there were extenuating circumstances.

“(d) DEFINITION OF MANUFACTURER.—In this section, the term ‘manufacturer’ has the meaning given such term in section 1860D–14A(g)(5).”.

(b) MEDICARE COVERAGE GAP DISCOUNT PROGRAM.—Part D of title XVIII of the Social Security Act (42 U.S.C. 1395w–101) is amended by inserting after section 1860D–14 the following new section:

“MEDICARE COVERAGE GAP DISCOUNT PROGRAM

“SEC. 1860D–14A. (a) ESTABLISHMENT.—The Secretary shall establish a Medicare coverage gap discount program (in this section referred to as the ‘program’) by not later than July 1, 2010. Under the program, the Secretary shall enter into agreements described in subsection (b) with manufacturers and provide for the performance of the duties described in subsection (c)(1). The

Secretary shall establish a model agreement for use under the program by not later than April 1, 2010, in consultation with manufacturers, and allow for comment on such model agreement.

“(b) TERMS OF AGREEMENT.—

“(1) IN GENERAL.—

“(A) AGREEMENT.—An agreement under this section shall require the manufacturer to provide applicable beneficiaries access to discounted prices for applicable drugs of the manufacturer.

“(B) PROVISION OF DISCOUNTED PRICES AT THE POINT-OF-SALE.—Except as provided in subsection (c)(1)(A)(iii), such discounted prices shall be provided to the applicable beneficiary at the pharmacy or by the mail order service at the point-of-sale of an applicable drug.

“(C) TIMING OF AGREEMENT.—

“(i) SPECIAL RULE FOR 2010 AND 2011.—In order for an agreement with a manufacturer to be in effect under this section with respect to the period beginning on July 1, 2010, and ending on December 31, 2011, the manufacturer shall enter into such agreement not later than May 1, 2010.

“(ii) 2012 AND SUBSEQUENT YEARS.—In order for an agreement with a manufacturer to be in effect under this section with respect to plan year 2012 or a subsequent plan year, the manufacturer shall enter into such agreement (or such agreement shall be renewed under paragraph (4)(A)) not later than January 30 of the preceding year.

“(2) PROVISION OF APPROPRIATE DATA.—Each manufacturer with an agreement in effect under this section shall collect and have available appropriate data, as determined by the Secretary, to ensure that it can demonstrate to the Secretary compliance with the requirements under the program.

“(3) COMPLIANCE WITH REQUIREMENTS FOR ADMINISTRATION OF PROGRAM.—Each manufacturer with an agreement in effect under this section shall comply with requirements imposed by the Secretary or a third party with a contract under subsection (d)(3), as applicable, for purposes of administering the program, including any determination under clause (i) of subsection (c)(1)(A) or procedures established under such subsection (c)(1)(A).

“(4) LENGTH OF AGREEMENT.—

“(A) IN GENERAL.—An agreement under this section shall be effective for an initial period of not less than 18 months and shall be automatically renewed for a period of not less than 1 year unless terminated under subparagraph (B).

“(B) TERMINATION.—

“(i) BY THE SECRETARY.—The Secretary may provide for termination of an agreement under this section for a knowing and willful violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 30 days after the date of notice to the manufacturer of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, and such hearing shall take place prior to the effective date of the termination with sufficient time for such effective date to be repealed if the Secretary determines appropriate.

“(ii) BY A MANUFACTURER.—A manufacturer may terminate an agreement under this section for any reason. Any such termination shall be effective, with respect to a plan year—

“(I) if the termination occurs before January 30 of a plan year, as of the day after the end of the plan year; and

“(II) if the termination occurs on or after January 30 of a plan year, as of the day after the end of the succeeding plan year.

“(iii) EFFECTIVENESS OF TERMINATION.—Any termination under this subparagraph shall not affect discounts for applicable drugs of the manufacturer that are due under the agreement before the effective date of its termination.

“(iv) NOTICE TO THIRD PARTY.—The Secretary shall provide notice of such termination to a third party with a contract under subsection (d)(3) within not less than 30 days before the effective date of such termination.

“(c) DUTIES DESCRIBED AND SPECIAL RULE FOR SUPPLEMENTAL BENEFITS.—

“(1) DUTIES DESCRIBED.—The duties described in this subsection are the following:

“(A) ADMINISTRATION OF PROGRAM.—Administering the program, including—

“(i) the determination of the amount of the discounted price of an applicable drug of a manufacturer;

“(ii) except as provided in clause (iii), the establishment of procedures under which discounted prices are provided to applicable beneficiaries at pharmacies or by mail order service at the point-of-sale of an applicable drug;

“(iii) in the case where, during the period beginning on July 1, 2010, and ending on December 31, 2011, it is not practicable to provide such discounted prices at the point-of-sale (as described in clause (ii)), the establishment of procedures to provide such discounted prices as soon as practicable after the point-of-sale;

“(iv) the establishment of procedures to ensure that, not later than the applicable number of calendar days after the dispensing of an applicable drug by a pharmacy or mail order service, the pharmacy or mail order service is reimbursed for an amount equal to the difference between—

“(I) the negotiated price of the applicable drug; and

“(II) the discounted price of the applicable drug;

“(v) the establishment of procedures to ensure that the discounted price for an applicable drug under this section is applied before any coverage or financial assistance under other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of applicable beneficiaries as the Secretary may specify;

“(vi) the establishment of procedures to implement the special rule for supplemental benefits under paragraph (2); and

“(vii) providing a reasonable dispute resolution mechanism to resolve disagreements between manufacturers, applicable beneficiaries, and the third party with a contract under subsection (d)(3).

“(B) MONITORING COMPLIANCE.—

“(i) IN GENERAL.—The Secretary shall monitor compliance by a manufacturer with the terms of an agreement under this section.

“(ii) NOTIFICATION.—If a third party with a contract under subsection (d)(3) determines that the manufacturer is not in compliance with such agreement, the third party shall notify the Secretary of such noncompliance for appropriate enforcement under subsection (e).

“(C) COLLECTION OF DATA FROM PRESCRIPTION DRUG PLANS AND MA-PD PLANS.—The Secretary may collect appropriate data from prescription drug plans and MA-PD plans in a timeframe that allows for discounted prices to be provided for applicable drugs under this section.

“(2) SPECIAL RULE FOR SUPPLEMENTAL BENEFITS.—For plan year 2010 and each subsequent plan year, in the case where an applicable beneficiary has supplemental benefits with respect to applicable drugs under the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in, the applicable beneficiary shall not be provided a discounted price for an applicable drug under this section until after such supplemental benefits have been applied with respect to the applicable drug.

“(d) ADMINISTRATION.—

“(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for the implementa-

tion of this section, including the performance of the duties described in subsection (c)(1).

“(2) LIMITATION.—

“(A) IN GENERAL.—Subject to subparagraph (B), in providing for such implementation, the Secretary shall not receive or distribute any funds of a manufacturer under the program.

“(B) EXCEPTION.—The limitation under subparagraph (A) shall not apply to the Secretary with respect to drugs dispensed during the period beginning on July 1, 2010, and ending on December 31, 2010, but only if the Secretary determines that the exception to such limitation under this subparagraph is necessary in order for the Secretary to begin implementation of this section and provide applicable beneficiaries timely access to discounted prices during such period.

“(3) CONTRACT WITH THIRD PARTIES.—The Secretary shall enter into a contract with 1 or more third parties to administer the requirements established by the Secretary in order to carry out this section. At a minimum, the contract with a third party under the preceding sentence shall require that the third party—

“(A) receive and transmit information between the Secretary, manufacturers, and other individuals or entities the Secretary determines appropriate;

“(B) receive, distribute, or facilitate the distribution of funds of manufacturers to appropriate individuals or entities in order to meet the obligations of manufacturers under agreements under this section;

“(C) provide adequate and timely information to manufacturers, consistent with the agreement with the manufacturer under this section, as necessary for the manufacturer to fulfill its obligations under this section; and

“(D) permit manufacturers to conduct periodic audits, directly or through contracts, of the data and information used by the third party to determine discounts for applicable drugs of the manufacturer under the program.

“(4) PERFORMANCE REQUIREMENTS.—The Secretary shall establish performance requirements for a third party with a contract under paragraph (3) and safeguards to protect the independence and integrity of the activities carried out by the third party under the program under this section.

“(5) IMPLEMENTATION.—The Secretary may implement the program under this section by program instruction or otherwise.

“(6) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the program under this section.

“(e) ENFORCEMENT.—

“(1) AUDITS.—Each manufacturer with an agreement in effect under this section shall be subject to periodic audit by the Secretary.

“(2) CIVIL MONEY PENALTY.—

“(A) IN GENERAL.—The Secretary shall impose a civil money penalty on a manufacturer that fails to provide applicable beneficiaries discounts for applicable drugs of the manufacturer in accordance with such agreement for each such failure in an amount the Secretary determines is commensurate with the sum of—

“(i) the amount that the manufacturer would have paid with respect to such discounts under the agreement, which will then be used to pay the discounts which the manufacturer had failed to provide; and

“(ii) 25 percent of such amount.

“(B) APPLICATION.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(f) CLARIFICATION REGARDING AVAILABILITY OF OTHER COVERED PART D DRUGS.—Nothing in this section shall prevent an applicable bene-

ficiary from purchasing a covered part D drug that is not an applicable drug (including a generic drug or a drug that is not on the formulary of the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in).

“(g) DEFINITIONS.—In this section:

“(1) APPLICABLE BENEFICIARY.—The term ‘applicable beneficiary’ means an individual who, on the date of dispensing an applicable drug—

“(A) is enrolled in a prescription drug plan or an MA-PD plan;

“(B) is not enrolled in a qualified retiree prescription drug plan;

“(C) is not entitled to an income-related subsidy under section 1860D-14(a);

“(D) is not subject to a reduction in premium subsidy under section 1839(i); and

“(E) who—

“(i) has reached or exceeded the initial coverage limit under section 1860D-2(b)(3) during the year; and

“(ii) has not incurred costs for covered part D drugs in the year equal to the annual out-of-pocket threshold specified in section 1860D-2(b)(4)(B).

“(2) APPLICABLE DRUG.—The term ‘applicable drug’ means, with respect to an applicable beneficiary, a covered part D drug—

“(A) approved under a new drug application under section 505(b) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biologic product, licensed under section 351 of the Public Health Service Act (other than a product licensed under subsection (k) of such section 351); and

“(B)(i) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA-PD plan uses a formulary, which is on the formulary of the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in;

“(ii) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA-PD plan does not use a formulary, for which benefits are available under the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in; or

“(iii) is provided through an exception or appeal.

“(3) APPLICABLE NUMBER OF CALENDAR DAYS.—The term ‘applicable number of calendar days’ means—

“(A) with respect to claims for reimbursement submitted electronically, 14 days; and

“(B) with respect to claims for reimbursement submitted otherwise, 30 days.

“(4) DISCOUNTED PRICE.—

“(A) IN GENERAL.—The term ‘discounted price’ means 50 percent of the negotiated price of the applicable drug of a manufacturer.

“(B) CLARIFICATION.—Nothing in this section shall be construed as affecting the responsibility of an applicable beneficiary for payment of a dispensing fee for an applicable drug.

“(C) SPECIAL CASE FOR CERTAIN CLAIMS.—In the case where the entire amount of the negotiated price of an individual claim for an applicable drug with respect to an applicable beneficiary does not fall at or above the initial coverage limit under section 1860D-2(b)(3) and below the annual out-of-pocket threshold specified in section 1860D-2(b)(4)(B) for the year, the manufacturer of the applicable drug shall provide the discounted price under this section on only the portion of the negotiated price of the applicable drug that falls at or above such initial coverage limit and below such annual out-of-pocket threshold.

“(5) MANUFACTURER.—The term ‘manufacturer’ means any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural

origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis. Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

“(6) **NEGOTIATED PRICE.**—The term ‘negotiated price’ has the meaning given such term in section 423.100 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this section), except that such negotiated price shall not include any dispensing fee for the applicable drug.

“(7) **QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.**—The term ‘qualified retiree prescription drug plan’ has the meaning given such term in section 1860D–22(a)(2).”.

(c) **INCLUSION IN INCURRED COSTS.**—

(1) **IN GENERAL.**—Section 1860D–2(b)(4) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)) is amended—

(A) in subparagraph (C), in the matter preceding clause (i), by striking “In applying” and inserting “Except as provided in subparagraph (E), in applying”; and

(B) by adding at the end the following new subparagraph:

“(E) **INCLUSION OF COSTS OF APPLICABLE DRUGS UNDER MEDICARE COVERAGE GAP DISCOUNT PROGRAM.**—In applying subparagraph (A), incurred costs shall include the negotiated price (as defined in paragraph (6) of section 1860D–14A(g)) of an applicable drug (as defined in paragraph (2) of such section) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1860D–14A, regardless of whether part of such costs were paid by a manufacturer under such program.”.

(2) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply to costs incurred on or after July 1, 2010.

(d) **CONFORMING AMENDMENT PERMITTING PRESCRIPTION DRUG DISCOUNTS.**—

(1) **IN GENERAL.**—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended—

(A) by striking “and” at the end of subparagraph (G);

(B) in the subparagraph (H) added by section 237(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2213)—

(i) by moving such subparagraph 2 ems to the left; and

(ii) by striking the period at the end and inserting a semicolon;

(C) in the subparagraph (H) added by section 431(a) of such Act (117 Stat. 2287)—

(i) by redesignating such subparagraph as subparagraph (I);

(ii) by moving such subparagraph 2 ems to the left; and

(iii) by striking the period at the end and inserting “; and”; and

(D) by adding at the end the following new subparagraph:

“(J) a discount in the price of an applicable drug (as defined in paragraph (2) of section 1860D–14A(g)) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount program under section 1860D–14A.”.

(2) **CONFORMING AMENDMENT TO DEFINITION OF BEST PRICE UNDER MEDICAID.**—Section 1927(c)(1)(C)(i)(VI) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)(i)(VI)) is amended by inserting “, or any discounts provided by manufacturers under the Medicare coverage gap discount program under section 1860D–14A” before the period at the end.

(3) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply to drugs dispensed on or after July 1, 2010.

SEC. 3302. IMPROVEMENT IN DETERMINATION OF MEDICARE PART D LOW-INCOME BENCHMARK PREMIUM.

(a) **IN GENERAL.**—Section 1860D–14(b)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–114(b)(2)(B)(iii)) is amended by inserting “, determined without regard to any reduction in such premium as a result of any beneficiary rebate under section 1854(b)(1)(C) or bonus payment under section 1853(n)” before the period at the end.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to premiums for months beginning on or after January 1, 2011.

SEC. 3303. VOLUNTARY DE MINIMIS POLICY FOR SUBSIDY ELIGIBLE INDIVIDUALS UNDER PRESCRIPTION DRUG PLANS AND MA-PD PLANS.

(a) **IN GENERAL.**—Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended by adding at the end the following new paragraph:

“(5) **WAIVER OF DE MINIMIS PREMIUMS.**—The Secretary shall, under procedures established by the Secretary, permit a prescription drug plan or an MA-PD plan to waive the monthly beneficiary premium for a subsidy eligible individual if the amount of such premium is de minimis. If such premium is waived under the plan, the Secretary shall not reassign subsidy eligible individuals enrolled in the plan to other plans based on the fact that the monthly beneficiary premium under the plan was greater than the low-income benchmark premium amount.”.

(b) **AUTHORIZING THE SECRETARY TO AUTO-ENROLL SUBSIDY ELIGIBLE INDIVIDUALS IN PLANS THAT WAIVE DE MINIMIS PREMIUMS.**—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)) is amended—

(1) in subparagraph (C), by inserting “except as provided in subparagraph (D),” after “shall include,”

(2) by adding at the end the following new subparagraph:

“(D) **SPECIAL RULE FOR PLANS THAT WAIVE DE MINIMIS PREMIUMS.**—The process established under subparagraph (A) may include, in the case of a part D eligible individual who is a subsidy eligible individual (as defined in section 1860D–14(a)(3)) who has failed to enroll in a prescription drug plan or an MA-PD plan, for the enrollment in a prescription drug plan or MA-PD plan that has waived the monthly beneficiary premium for such subsidy eligible individual under section 1860D–14(a)(5). If there is more than one such plan available, the Secretary shall enroll such an individual under the preceding sentence on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.”.

(c) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply to premiums for months, and enrollments for plan years, beginning on or after January 1, 2011.

SEC. 3304. SPECIAL RULE FOR WIDOWS AND WIDOWERS REGARDING ELIGIBILITY FOR LOW-INCOME ASSISTANCE.

(a) **IN GENERAL.**—Section 1860D–14(a)(3)(B) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(B)) is amended by adding at the end the following new clause:

“(vi) **SPECIAL RULE FOR WIDOWS AND WIDOWERS.**—Notwithstanding the preceding provisions of this subparagraph, in the case of an individual whose spouse dies during the effective period for a determination or redetermination that has been made under this subparagraph, such effective period shall be extended through the date that is 1 year after the date on which the determination or redetermination would (but for the application of this clause) otherwise cease to be effective.”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on January 1, 2011.

SEC. 3305. IMPROVED INFORMATION FOR SUBSIDY ELIGIBLE INDIVIDUALS REASSIGNED TO PRESCRIPTION DRUG PLANS AND MA-PD PLANS.

Section 1860D–14 of the Social Security Act (42 U.S.C. 1395w–114) is amended—

(1) by redesignating subsection (d) as subsection (e); and

(2) by inserting after subsection (c) the following new subsection:

“(d) **FACILITATION OF REASSIGNMENTS.**—Beginning not later than January 1, 2011, the Secretary shall, in the case of a subsidy eligible individual who is enrolled in one prescription drug plan and is subsequently reassigned by the Secretary to a new prescription drug plan, provide the individual, within 30 days of such reassignment, with—

“(1) information on formulary differences between the individual’s former plan and the plan to which the individual is reassigned with respect to the individual’s drug regimens; and

“(2) a description of the individual’s right to request a coverage determination, exception, or reconsideration under section 1860D–4(g), bring an appeal under section 1860D–4(h), or resolve a grievance under section 1860D–4(f).”.

SEC. 3306. FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) **ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PROGRAMS.**—Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note) is amended by striking “(42 U.S.C. 1395w–23(f))” and all that follows through the period at the end and inserting “(42 U.S.C. 1395w–23(f)), to the Centers for Medicare & Medicaid Services Program Management Account—

“(i) for fiscal year 2009, of \$7,500,000; and

“(ii) for the period of fiscal years 2010 through 2012, of \$15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.”.

(b) **ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.**—Subsection (b)(1)(B) of such section 119 is amended by striking “(42 U.S.C. 1395w–23(f))” and all that follows through the period at the end and inserting “(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

“(i) for fiscal year 2009, of \$7,500,000; and

“(ii) for the period of fiscal years 2010 through 2012, of \$15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.”.

(c) **ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.**—Subsection (c)(1)(B) of such section 119 is amended by striking “(42 U.S.C. 1395w–23(f))” and all that follows through the period at the end and inserting “(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

“(i) for fiscal year 2009, of \$5,000,000; and

“(ii) for the period of fiscal years 2010 through 2012, of \$10,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.”.

(d) **ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.**—Subsection (d)(2) of such section 119 is amended by striking “(42 U.S.C. 1395w–23(f))” and all that follows through the period at the end and inserting “(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

“(i) for fiscal year 2009, of \$5,000,000; and

“(ii) for the period of fiscal years 2010 through 2012, of \$5,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.”.

(e) **SECRETARIAL AUTHORITY TO ENLIST SUPPORT IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.**—Such section 119 is amended by adding at the end the following new subsection:

“(g) SECRETARIAL AUTHORITY TO ENLIST SUPPORT IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—The Secretary may request that an entity awarded a grant under this section support the conduct of outreach activities aimed at preventing disease and promoting wellness. Notwithstanding any other provision of this section, an entity may use a grant awarded under this subsection to support the conduct of activities described in the preceding sentence.”.

SEC. 3307. IMPROVING FORMULARY REQUIREMENTS FOR PRESCRIPTION DRUG PLANS AND MA-PD PLANS WITH RESPECT TO CERTAIN CATEGORIES OR CLASSES OF DRUGS.

(a) IMPROVING FORMULARY REQUIREMENTS.—Section 1860D–4(b)(3)(G) of the Social Security Act is amended to read as follows:

“(G) REQUIRED INCLUSION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

“(i) FORMULARY REQUIREMENTS.—

“(I) IN GENERAL.—Subject to subclause (II), a PDP sponsor offering a prescription drug plan shall be required to include all covered part D drugs in the categories and classes identified by the Secretary under clause (ii)(I).

“(II) EXCEPTIONS.—The Secretary may establish exceptions that permit a PDP sponsor offering a prescription drug plan to exclude from its formulary a particular covered part D drug in a category or class that is otherwise required to be included in the formulary under subclause (I) (or to otherwise limit access to such a drug, including through prior authorization or utilization management).

“(ii) IDENTIFICATION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

“(I) IN GENERAL.—Subject to clause (iv), the Secretary shall identify, as appropriate, categories and classes of drugs for which the Secretary determines are of clinical concern.

“(II) CRITERIA.—The Secretary shall use criteria established by the Secretary in making any determination under subclause (I).

“(iii) IMPLEMENTATION.—The Secretary shall establish the criteria under clause (ii)(II) and any exceptions under clause (i)(II) through the promulgation of a regulation which includes a public notice and comment period.

“(iv) REQUIREMENT FOR CERTAIN CATEGORIES AND CLASSES UNTIL CRITERIA ESTABLISHED.—Until such time as the Secretary establishes the criteria under clause (ii)(II) the following categories and classes of drugs shall be identified under clause (ii)(I):

“(I) Anticonvulsants.

“(II) Antidepressants.

“(III) Antineoplastics.

“(IV) Antipsychotics.

“(V) Antiretrovirals.

“(VI) Immunosuppressants for the treatment of transplant rejection.”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to plan year 2011 and subsequent plan years.

SEC. 3308. REDUCING PART D PREMIUM SUBSIDY FOR HIGH-INCOME BENEFICIARIES.

(a) INCOME-RELATED INCREASE IN PART D PREMIUM.—

(1) IN GENERAL.—Section 1860D–13(a) of the Social Security Act (42 U.S.C. 1395w–113(a)) is amended by adding at the end the following new paragraph:

“(7) INCREASE IN BASE BENEFICIARY PREMIUM BASED ON INCOME.—

“(A) IN GENERAL.—In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section) for the calendar year, the monthly amount of the beneficiary premium applicable under this section for a month after December 2010 shall be increased by the monthly adjustment amount specified in subparagraph (B).

“(B) MONTHLY ADJUSTMENT AMOUNT.—The monthly adjustment amount specified in this subparagraph for an individual for a month in a year is equal to the product of—

“(i) the quotient obtained by dividing—

“(I) the applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section) for the individual for the calendar year reduced by 25.5 percent; by

“(II) 25.5 percent; and

“(ii) the base beneficiary premium (as computed under paragraph (2)).

“(C) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this paragraph, the term ‘modified adjusted gross income’ has the meaning given such term in subparagraph (A) of section 1839(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

“(D) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall make any determination necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

“(E) PROCEDURES TO ASSURE CORRECT INCOME-RELATED INCREASE IN BASE BENEFICIARY PREMIUM.—

“(i) DISCLOSURE OF BASE BENEFICIARY PREMIUM.—Not later than September 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as computed under paragraph (2)) for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year.

“(ii) ADDITIONAL DISCLOSURE.—Not later than October 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year:

“(I) The modified adjusted gross income threshold applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section).

“(II) The applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section).

“(III) The monthly adjustment amount specified in subparagraph (B).

“(IV) Any other information the Commissioner of Social Security determines necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

“(F) RULE OF CONSTRUCTION.—The formula used to determine the monthly adjustment amount specified under subparagraph (B) shall only be used for the purpose of determining such monthly adjustment amount under such subparagraph.”.

(2) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—Section 1860D–13(c) of the Social Security Act (42 U.S.C. 1395w–113(c)) is amended—

(A) in paragraph (1), by striking “(2) and (3)” and inserting “(2), (3), and (4)”; and

(B) by adding at the end the following new paragraph:

“(4) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—

“(A) IN GENERAL.—Notwithstanding any provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related increase in the base beneficiary premium for an individual for a month (as determined under subsection (a)(7)) shall be paid through withholding from benefit payments in the manner provided under section 1840.

“(B) AGREEMENTS.—In the case where the monthly benefit payments of an individual that

are withheld under subparagraph (A) are insufficient to pay the amount described in such subparagraph, the Commissioner of Social Security shall enter into agreements with the Secretary, the Director of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in subparagraph (A) that was not withheld under such subparagraph.”.

(b) CONFORMING AMENDMENTS.—

(1) MEDICARE.—Section 1860D–13(a)(1) of the Social Security Act (42 U.S.C. 1395w–113(a)(1)) is amended—

(A) by redesignating subparagraph (F) as subparagraph (G);

(B) in subparagraph (G), as redesignated by subparagraph (A), by striking “(D) and (E)” and inserting “(D), (E), and (F)”; and

(C) by inserting after subparagraph (E) the following new subparagraph:

“(F) INCREASE BASED ON INCOME.—The monthly beneficiary premium shall be increased pursuant to paragraph (7).”.

(2) INTERNAL REVENUE CODE.—Section 6103(l)(20) of the Internal Revenue Code of 1986 (relating to disclosure of return information to carry out Medicare part B premium subsidy adjustment) is amended—

(A) in the heading, by inserting “AND PART D BASE BENEFICIARY PREMIUM INCREASE” after “PART B PREMIUM SUBSIDY ADJUSTMENT”; and

(B) in subparagraph (A)—

(i) in the matter preceding clause (i), by inserting “or increase under section 1860D–13(a)(7)” after “1839(i)”; and

(ii) in clause (vii), by inserting after “subsection (i) of such section” the following: “or increase under section 1860D–13(a)(7) of such Act”; and

(C) in subparagraph (B)—

(i) by striking “Return information” and inserting the following:

“(i) IN GENERAL.—Return information”;

(ii) by inserting “or increase under such section 1860D–13(a)(7)” before the period at the end;

(iii) as amended by clause (i), by inserting “or for the purpose of resolving taxpayer appeals with respect to any such premium adjustment or increase” before the period at the end; and

(iv) by adding at the end the following new clause:

“(ii) DISCLOSURE TO OTHER AGENCIES.—Officers, employees, and contractors of the Social Security Administration may disclose—

“(I) the taxpayer identity information and the amount of the premium subsidy adjustment or premium increase with respect to a taxpayer described in subparagraph (A) to officers, employees, and contractors of the Centers for Medicare and Medicaid Services, to the extent that such disclosure is necessary for the collection of the premium subsidy amount or the increased premium amount,

“(II) the taxpayer identity information and the amount of the premium subsidy adjustment or the increased premium amount with respect to a taxpayer described in subparagraph (A) to officers and employees of the Office of Personnel Management and the Railroad Retirement Board, to the extent that such disclosure is necessary for the collection of the premium subsidy amount or the increased premium amount,

“(III) return information with respect to a taxpayer described in subparagraph (A) to officers and employees of the Department of Health and Human Services to the extent necessary to resolve administrative appeals of such premium subsidy adjustment or increased premium, and

“(IV) return information with respect to a taxpayer described in subparagraph (A) to officers and employees of the Department of Justice for use in judicial proceedings to the extent necessary to carry out the purposes described in clause (i).”.

SEC. 3309. ELIMINATION OF COST SHARING FOR CERTAIN DUAL ELIGIBLE INDIVIDUALS.

Section 1860D-14(a)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w-114(a)(1)(D)(i)) is amended by inserting “or, effective on a date specified by the Secretary (but in no case earlier than January 1, 2012), who would be such an institutionalized individual or couple, if the full-benefit dual eligible individual were not receiving services under a home and community-based waiver authorized for a State under section 1115 or subsection (c) or (d) of section 1915 or under a State plan amendment under subsection (i) of such section or services provided through enrollment in a medicaid managed care organization with a contract under section 1903(m) or under section 1932” after “1902(q)(1)(B))”.

SEC. 3310. REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES UNDER PRESCRIPTION DRUG PLANS AND MA-PD PLANS.

(a) IN GENERAL.—Section 1860D-4(c) of the Social Security Act (42 U.S.C. 1395w-104(c)) is amended by adding at the end the following new paragraph:

“(3) REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES.—The Secretary shall require PDP sponsors of prescription drug plans to utilize specific, uniform dispensing techniques, as determined by the Secretary, in consultation with relevant stakeholders (including representatives of nursing facilities, residents of nursing facilities, pharmacists, the pharmacy industry (including retail and long-term care pharmacy), prescription drug plans, MA-PD plans, and any other stakeholders the Secretary determines appropriate), such as weekly, daily, or automated dose dispensing, when dispensing covered part D drugs to enrollees who reside in a long-term care facility in order to reduce waste associated with 30-day fills.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to plan years beginning on or after January 1, 2012.

SEC. 3311. IMPROVED MEDICARE PRESCRIPTION DRUG PLAN AND MA-PD PLAN COMPLAINT SYSTEM.

(a) IN GENERAL.—The Secretary shall develop and maintain a complaint system, that is widely known and easy to use, to collect and maintain information on MA-PD plan and prescription drug plan complaints that are received (including by telephone, letter, e-mail, or any other means) by the Secretary (including by a regional office of the Department of Health and Human Services, the Medicare Beneficiary Ombudsman, a subcontractor, a carrier, a fiscal intermediary, and a Medicare administrative contractor under section 1874A of the Social Security Act (42 U.S.C. 1395kk)) through the date on which the complaint is resolved. The system shall be able to report and initiate appropriate interventions and monitoring based on substantial complaints and to guide quality improvement.

(b) MODEL ELECTRONIC COMPLAINT FORM.—The Secretary shall develop a model electronic complaint form to be used for reporting plan complaints under the system. Such form shall be prominently displayed on the front page of the Medicare.gov Internet website and on the Internet website of the Medicare Beneficiary Ombudsman.

(c) ANNUAL REPORTS BY THE SECRETARY.—The Secretary shall submit to Congress annual reports on the system. Such reports shall include an analysis of the number and types of complaints reported in the system, geographic variations in such complaints, the timeliness of agency or plan responses to such complaints, and the resolution of such complaints.

(d) DEFINITIONS.—In this section:

(1) MA-PD PLAN.—The term “MA-PD plan” has the meaning given such term in section 1860D-41(a)(9) of such Act (42 U.S.C. 1395w-151(a)(9)).

(2) PRESCRIPTION DRUG PLAN.—The term “prescription drug plan” has the meaning given such term in section 1860D-41(a)(14) of such Act (42 U.S.C. 1395w-151(a)(14)).

(3) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(4) SYSTEM.—The term “system” means the plan complaint system developed and maintained under subsection (a).

SEC. 3312. UNIFORM EXCEPTIONS AND APPEALS PROCESS FOR PRESCRIPTION DRUG PLANS AND MA-PD PLANS.

(a) IN GENERAL.—Section 1860D-4(b)(3) of the Social Security Act (42 U.S.C. 1395w-104(b)(3)) is amended by adding at the end the following new subparagraph:

“(H) USE OF SINGLE, UNIFORM EXCEPTIONS AND APPEALS PROCESS.—Notwithstanding any other provision of this part, each PDP sponsor of a prescription drug plan shall—

“(i) use a single, uniform exceptions and appeals process (including, to the extent the Secretary determines feasible, a single, uniform model form for use under such process) with respect to the determination of prescription drug coverage for an enrollee under the plan; and

“(ii) provide instant access to such process by enrollees through a toll-free telephone number and an Internet website.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to exceptions and appeals on or after January 1, 2012.

SEC. 3313. OFFICE OF THE INSPECTOR GENERAL STUDIES AND REPORTS.

(a) STUDY AND ANNUAL REPORT ON PART D FORMULARIES’ INCLUSION OF DRUGS COMMONLY USED BY DUAL ELIGIBLES.—

(1) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study of the extent to which formularies used by prescription drug plans and MA-PD plans under part D include drugs commonly used by full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u-5(c)(6))).

(2) ANNUAL REPORTS.—Not later than July 1 of each year (beginning with 2011), the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), together with such recommendations as the Inspector General determines appropriate.

(b) STUDY AND REPORT ON PRESCRIPTION DRUG PRICES UNDER MEDICARE PART D AND MEDICAID.—

(1) STUDY.—

(A) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct a study on prices for covered part D drugs under the Medicare prescription drug program under part D of title XVIII of the Social Security Act and for covered outpatient drugs under title XIX. Such study shall include the following:

(i) A comparison, with respect to the 200 most frequently dispensed covered part D drugs under such program and covered outpatient drugs under such title (as determined by the Inspector General based on volume and expenditures), of—

(I) the prices paid for covered part D drugs by PDP sponsors of prescription drug plans and Medicare Advantage organizations offering MA-PD plans; and

(II) the prices paid for covered outpatient drugs by a State plan under title XIX.

(ii) An assessment of—

(I) the financial impact of any discrepancies in such prices on the Federal Government; and

(II) the financial impact of any such discrepancies on enrollees under part D or individuals

eligible for medical assistance under a State plan under title XIX.

(B) PRICE.—For purposes of subparagraph (A), the price of a covered part D drug or a covered outpatient drug shall include any rebate or discount under such program or such title, respectively, including any negotiated price concession described in section 1860D-2(d)(1)(B) of the Social Security Act (42 U.S.C. 1395w-102(d)(1)(B)) or rebate under an agreement under section 1927 of the Social Security Act (42 U.S.C. 1396r-8).

(C) AUTHORITY TO COLLECT ANY NECESSARY INFORMATION.—Notwithstanding any other provision of law, the Inspector General of the Department of Health and Human Services shall be able to collect any information related to the prices of covered part D drugs under such program and covered outpatient drugs under such title XIX necessary to carry out the comparison under subparagraph (A).

(2) REPORT.—

(A) IN GENERAL.—Not later than October 1, 2011, subject to subparagraph (B), the Inspector General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Inspector General determines appropriate.

(B) LIMITATION ON INFORMATION CONTAINED IN REPORT.—The report submitted under subparagraph (A) shall not include any information that the Inspector General determines is proprietary or is likely to negatively impact the ability of a PDP sponsor or a State plan under title XIX to negotiate prices for covered part D drugs or covered outpatient drugs, respectively.

(3) DEFINITIONS.—In this section:

(A) COVERED PART D DRUG.—The term “covered part D drug” has the meaning given such term in section 1860D-2(e) of the Social Security Act (42 U.S.C. 1395w-102(e)).

(B) COVERED OUTPATIENT DRUG.—The term “covered outpatient drug” has the meaning given such term in section 1927(k) of such Act (42 U.S.C. 1396r(k)).

(C) MA-PD PLAN.—The term “MA-PD plan” has the meaning given such term in section 1860D-41(a)(9) of such Act (42 U.S.C. 1395w-151(a)(9)).

(D) MEDICARE ADVANTAGE ORGANIZATION.—The term “Medicare Advantage organization” has the meaning given such term in section 1859(a)(1) of such Act (42 U.S.C. 1395w-28(a)(1)).

(E) PDP SPONSOR.—The term “PDP sponsor” has the meaning given such term in section 1860D-41(a)(13) of such Act (42 U.S.C. 1395w-151(a)(13)).

(F) PRESCRIPTION DRUG PLAN.—The term “prescription drug plan” has the meaning given such term in section 1860D-41(a)(14) of such Act (42 U.S.C. 1395w-151(a)(14)).

SEC. 3314. INCLUDING COSTS INCURRED BY AIDS DRUG ASSISTANCE PROGRAMS AND INDIAN HEALTH SERVICE IN PROVIDING PRESCRIPTION DRUGS TOWARD THE ANNUAL OUT-OF-POCKET THRESHOLD UNDER PART D.

(a) IN GENERAL.—Section 1860D-2(b)(4)(C) of the Social Security Act (42 U.S.C. 1395w-102(b)(4)(C)) is amended—

(1) in clause (i), by striking “and” at the end;

(2) in clause (ii)—

(A) by striking “such costs shall be treated as incurred only if” and inserting “subject to clause (iii), such costs shall be treated as incurred only if”;

(B) by striking “, under section 1860D-14, or under a State Pharmaceutical Assistance Program”;

(C) by striking the period at the end and inserting “; and”;

(3) by inserting after clause (ii) the following new clause:

“(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

“(I) under section 1860D-14;

“(II) under a State Pharmaceutical Assistance Program;

“(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

“(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to costs incurred on or after January 1, 2011.

SEC. 3315. IMMEDIATE REDUCTION IN COVERAGE GAP IN 2010.

Section 1860D-2(b) of the Social Security Act (42 U.S.C. 1395w-102(b)) is amended—

(1) in paragraph (3)(A), by striking “paragraph (4)” and inserting “paragraphs (4) and (7)”; and

(2) by adding at the end the following new paragraph:

“(7) **INCREASE IN INITIAL COVERAGE LIMIT IN 2010.**—

“(A) **IN GENERAL.**—For the plan year beginning on January 1, 2010, the initial coverage limit described in paragraph (3)(B) otherwise applicable shall be increased by \$500.

“(B) **APPLICATION.**—In applying subparagraph (A)—

“(i) except as otherwise provided in this subparagraph, there shall be no change in the premiums, bids, or any other parameters under this part or part C;

“(ii) costs that would be treated as incurred costs for purposes of applying paragraph (4) but for the application of subparagraph (A) shall continue to be treated as incurred costs;

“(iii) the Secretary shall establish procedures, which may include a reconciliation process, to fully reimburse PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA-PD plans for the reduction in beneficiary cost sharing associated with the application of subparagraph (A);

“(iv) the Secretary shall develop an estimate of the additional increased costs attributable to the application of this paragraph for increased drug utilization and financing and administrative costs and shall use such estimate to adjust payments to PDP sponsors with respect to prescription drug plans under this part and MA organizations with respect to MA-PD plans under part C; and

“(v) the Secretary shall establish procedures for retroactive reimbursement of part D eligible individuals who are covered under such a plan for costs which are incurred before the date of initial implementation of subparagraph (A) and which would be reimbursed under such a plan if such implementation occurred as of January 1, 2010.

“(C) **NO EFFECT ON SUBSEQUENT YEARS.**—The increase under subparagraph (A) shall only apply with respect to the plan year beginning on January 1, 2010, and the initial coverage limit for plan years beginning on or after January 1, 2011, shall be determined as if subparagraph (A) had never applied.”.

Subtitle E—Ensuring Medicare Sustainability
SEC. 3401. REVISION OF CERTAIN MARKET BASKET UPDATES AND INCORPORATION OF PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) **INPATIENT ACUTE HOSPITALS.**—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended by section 3001(a)(3), is further amended—

(1) in clause (i)(XX), by striking “clause (viii)” and inserting “clauses (viii), (ix), (xi), and (xii)”; and

(2) in the first sentence of clause (viii), by inserting “of such applicable percentage increase (determined without regard to clause (ix), (xi), or (xii))” after “one-quarter”;

(3) in the first sentence of clause (ix)(I), by inserting “(determined without regard to clause (viii), (xi), or (xii))” after “clause (i)” the second time it appears; and

(4) by adding at the end the following new clauses:

“(xi)(I) For 2012 and each subsequent fiscal year, after determining the applicable percentage increase described in clause (i) and after application of clauses (viii) and (ix), such percentage increase shall be reduced by the productivity adjustment described in subclause (II).

“(II) The productivity adjustment described in this subclause, with respect to a percentage, factor, or update for a fiscal year, year, cost reporting period, or other annual period, is a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period).

“(III) The application of subclause (I) may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

“(xii) After determining the applicable percentage increase described in clause (i), and after application of clauses (viii), (ix), and (xi), the Secretary shall reduce such applicable percentage increase—

“(I) for each of fiscal years 2010 and 2011, by 0.25 percentage point; and

“(II) subject to clause (xiii), for each of fiscal years 2012 through 2019, by 0.2 percentage point. The application of this clause may result in the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates under this section for a fiscal year being less than such payment rates for the preceding fiscal year.

“(xiii) Clause (xii) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting ‘0.0 percentage points’ for ‘0.2 percentage point’, if for such fiscal year—

“(I) the excess (if any) of—

“(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

“(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

“(II) 5 percentage points.”.

(b) **SKILLED NURSING FACILITIES.**—Section 1888(e)(5)(B) of the Social Security Act (42 U.S.C. 1395yy(e)(5)(B)) is amended—

(1) by striking “PERCENTAGE.—The term” and inserting “PERCENTAGE.—

“(i) **IN GENERAL.**—Subject to clause (ii), the term”; and

(2) by adding at the end the following new clause:

“(ii) **ADJUSTMENT.**—For fiscal year 2012 and each subsequent fiscal year, after determining the percentage described in clause (i), the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the pre-

ceding sentence may result in such percentage being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.”.

(c) **LONG-TERM CARE HOSPITALS.**—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)) is amended by adding at the end the following new paragraphs:

“(3) **IMPLEMENTATION FOR RATE YEAR 2010 AND SUBSEQUENT YEARS.**—

“(A) **IN GENERAL.**—In implementing the system described in paragraph (1) for rate year 2010 and each subsequent rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, shall be reduced—

“(i) for rate year 2012 and each subsequent rate year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

“(ii) for each of rate years 2010 through 2019, by the other adjustment described in paragraph (4).

“(B) **SPECIAL RULE.**—The application of this paragraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

“(4) **OTHER ADJUSTMENT.**—

“(A) **IN GENERAL.**—For purposes of paragraph (3)(A)(ii), the other adjustment described in this paragraph is—

“(i) for each of rate years 2010 and 2011, 0.25 percentage point; and

“(ii) subject to subparagraph (B), for each of rate years 2012 through 2019, 0.2 percentage point.

“(B) **REDUCTION OF OTHER ADJUSTMENT.**—Subparagraph (A)(ii) shall be applied with respect to any of rate years 2014 through 2019 by substituting ‘0.0 percentage points’ for ‘0.2 percentage point’, if for such rate year—

“(i) the excess (if any) of—

“(I) the total percentage of the non-elderly insured population for the preceding rate year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

“(II) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

“(ii) 5 percentage points.”.

(d) **INPATIENT REHABILITATION FACILITIES.**—Section 1886(j)(3) of the Social Security Act (42 U.S.C. 1395ww(j)(3)) is amended—

(1) in subparagraph (C)—

(A) by striking “FACTOR.—For purposes” and inserting “FACTOR.—

“(i) **IN GENERAL.**—For purposes”; and

(B) by inserting “subject to clause (ii)” before the period at the end of the first sentence of clause (i), as added by paragraph (1); and

(C) by adding at the end the following new clause:

“(ii) **PRODUCTIVITY AND OTHER ADJUSTMENT.**—After establishing the increase factor described in clause (i) for a fiscal year, the Secretary shall reduce such increase factor—

“(I) for fiscal year 2012 and each subsequent fiscal year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

“(II) for each of fiscal years 2010 through 2019, by the other adjustment described in subparagraph (D).

The application of this clause may result in the increase factor under this subparagraph being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.”; and

(2) by adding at the end the following new subparagraph:

“(D) OTHER ADJUSTMENT.—

“(i) IN GENERAL.—For purposes of subparagraph (C)(ii)(II), the other adjustment described in this subparagraph is—

“(I) for each of fiscal years 2010 and 2011, 0.25 percentage point; and

“(II) subject to clause (ii), for each of fiscal years 2012 through 2019, 0.2 percentage point.

“(ii) REDUCTION OF OTHER ADJUSTMENT.—Clause (i)(II) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting ‘0.0 percentage points’ for ‘0.2 percentage point’, if for such fiscal year—

“(I) the excess (if any) of—

“(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

“(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

“(II) 5 percentage points.”.

(e) HOME HEALTH AGENCIES.—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

(I) in clause (ii)(V), by striking “clause (v)” and inserting “clauses (v) and (vi)”; and

(2) by adding at the end the following new clause:

“(vi) ADJUSTMENTS.—After determining the home health market basket percentage increase under clause (iii), and after application of clause (v), the Secretary shall reduce such percentage—

“(I) for 2015 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

“(II) for each of 2011 and 2012, by 1 percentage point.

The application of this clause may result in the home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system under this subsection for a year being less than such payment rates for the preceding year.”.

(f) PSYCHIATRIC HOSPITALS.—Section 1886 of the Social Security Act, as amended by sections 3001, 3008, 3025, and 3133, is amended by adding at the end the following new subsection:

“(s) PROSPECTIVE PAYMENT FOR PSYCHIATRIC HOSPITALS.—

“(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B)) and psychiatric units (as described in the matter following clause (v) of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

“(2) IMPLEMENTATION FOR RATE YEAR BEGINNING IN 2010 AND SUBSEQUENT RATE YEARS.—

“(A) IN GENERAL.—In implementing the system described in paragraph (1) for the rate year beginning in 2010 and any subsequent rate year, any update to a base rate for days during the rate year for a psychiatric hospital or unit, respectively, shall be reduced—

“(i) for the rate year beginning in 2012 and each subsequent rate year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

“(ii) for each of the rate years beginning in 2010 through 2019, by the other adjustment described in paragraph (3).

“(B) SPECIAL RULE.—The application of this paragraph may result in such update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

“(3) OTHER ADJUSTMENT.—

“(A) IN GENERAL.—For purposes of paragraph (2)(A)(ii), the other adjustment described in this paragraph is—

“(i) for each of the rate years beginning in 2010 and 2011, 0.25 percentage point; and

“(ii) subject to subparagraph (B), for each of the rate years beginning in 2012 through 2019, 0.2 percentage point.

“(B) REDUCTION OF OTHER ADJUSTMENT.—Subparagraph (A)(ii) shall be applied with respect to any of rate years 2014 through 2019 by substituting ‘0.0 percentage points’ for ‘0.2 percentage point’, if for such rate year—

“(i) the excess (if any) of—

“(I) the total percentage of the non-elderly insured population for the preceding rate year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

“(II) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

“(ii) 5 percentage points.”.

(g) HOSPICE CARE.—Section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)), as amended by section 3132, is amended by adding at the end the following new clauses:

“(iv) After determining the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, with respect to fiscal year 2013 and each subsequent fiscal year, the Secretary shall reduce such percentage—

“(I) for 2013 and each subsequent fiscal year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

“(II) subject to clause (v), for each of fiscal years 2013 through 2019, by 0.5 percentage point. The application of this clause may result in the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

“(v) Clause (iv)(II) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting ‘0.0 percentage points’ for ‘0.5 percentage point’, if for such fiscal year—

“(I) the excess (if any) of—

“(aa) the total percentage of the non-elderly insured population for the preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

“(bb) the total percentage of the non-elderly insured population for such preceding fiscal year (as estimated by the Secretary); exceeds

“(II) 5 percentage points.”.

(h) DIALYSIS.—Section 1881(b)(14)(F) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(F)) is amended—

(I) in clause (i)—

(A) by inserting “(I)” after “(F)(i)”

(B) in subclause (I), as inserted by subparagraph (A)—

(i) by striking “clause (ii)” and inserting “subclause (II) and clause (ii)”; and

(ii) by striking “minus 1.0 percentage point”; and

(C) by adding at the end the following new subclause:

“(II) For 2012 and each subsequent year, after determining the increase factor described in subclause (I), the Secretary shall reduce such increase factor by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such increase factor being less than 0.0 for a year, and may result in payment rates under the payment system under this paragraph for a year being less than such payment rates for the preceding year.”; and

(2) in clause (ii)(II)—

(A) by striking “The” and inserting “Subject to clause (i)(II), the”; and

(B) by striking “clause (i) minus 1.0 percentage point” and inserting “clause (i)(I)”.

(i) OUTPATIENT HOSPITALS.—Section 1833(t)(3) of the Social Security Act (42 U.S.C. 1395l(t)(3)) is amended—

(1) in subparagraph (C)(iv), by inserting “and subparagraph (F) of this paragraph” after “(17)”; and

(2) by adding at the end the following new subparagraphs:

“(F) PRODUCTIVITY AND OTHER ADJUSTMENT.—After determining the OPD fee schedule increase factor under subparagraph (C)(iv), the Secretary shall reduce such increase factor—

“(i) for 2012 and subsequent years, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

“(ii) for each of 2010 through 2019, by the adjustment described in subparagraph (G).

The application of this subparagraph may result in the increase factor under subparagraph (C)(iv) being less than 0.0 for a year, and may result in payment rates under the payment system under this subsection for a year being less than such payment rates for the preceding year.

“(G) OTHER ADJUSTMENT.—

“(i) ADJUSTMENT.—For purposes of subparagraph (F)(ii), the adjustment described in this subparagraph is—

“(I) for each of 2010 and 2011, 0.25 percentage point; and

“(II) subject to clause (ii), for each of 2012 through 2019, 0.2 percentage point.

“(ii) REDUCTION OF OTHER ADJUSTMENT.—Clause (i)(II) shall be applied with respect to any of 2014 through 2019 by substituting ‘0.0 percentage points’ for ‘0.2 percentage point’, if for such year—

“(I) the excess (if any) of—

“(aa) the total percentage of the non-elderly insured population for the preceding year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

“(bb) the total percentage of the non-elderly insured population for such preceding year (as estimated by the Secretary); exceeds

“(II) 5 percentage points.”.

(j) AMBULANCE SERVICES.—Section 1834(l)(3) of the Social Security Act (42 U.S.C. 1395m(l)(3)) is amended—

(1) in subparagraph (A), by striking “and” at the end;

(2) in subparagraph (B)—

(A) by inserting “, subject to subparagraph (C) and the succeeding sentence of this paragraph,” after “increased”; and

(B) by striking the period at the end and inserting “; and”;

(3) by adding at the end the following new subparagraph:

“(C) for 2011 and each subsequent year, after determining the percentage increase under subparagraph (B) for the year, reduce such percentage increase by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).”; and

(4) by adding at the end the following flush sentence:

"The application of subparagraph (C) may result in the percentage increase under subparagraph (B) being less than 0.0 for a year, and may result in payment rates under the fee schedule under this subsection for a year being less than such payment rates for the preceding year."

(k) **AMBULATORY SURGICAL CENTER SERVICES.**—Section 1833(i)(2)(D) of the Social Security Act (42 U.S.C. 1395i(i)(2)(D)) is amended—

(1) by redesignating clause (v) as clause (vi); and

(2) by inserting after clause (iv) the following new clause:

"(v) In implementing the system described in clause (i) for 2011 and each subsequent year, any annual update under such system for the year, after application of clause (iv), shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such update being less than 0.0 for a year, and may result in payment rates under the system described in clause (i) for a year being less than such payment rates for the preceding year."

(l) **LABORATORY SERVICES.**—Section 1833(h)(2)(A) of the Social Security Act (42 U.S.C. 1395i(h)(2)(A)) is amended—

(1) in clause (i)—

(A) by inserting ", subject to clause (iv)," after "year" by"; and

(B) by striking "through 2013" and inserting "and 2010"; and

(2) by adding at the end the following new clause:

"(iv) After determining the adjustment to the fee schedules under clause (i), the Secretary shall reduce such adjustment—

"(I) for 2011 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

"(II) for each of 2011 through 2015, by 1.75 percentage points.

Subclause (I) shall not apply in a year where the adjustment to the fee schedules determined under clause (i) is 0.0 or a percentage decrease for a year. The application of the productivity adjustment under subclause (I) shall not result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year. The application of subclause (II) may result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year, and may result in payment rates for a year being less than such payment rates for the preceding year."

(m) **CERTAIN DURABLE MEDICAL EQUIPMENT.**—Section 1834(a)(14) of the Social Security Act (42 U.S.C. 1395m(a)(14)) is amended—

(1) in subparagraph (K)—

(A) by striking "2011, 2012, and 2013,"; and

(B) by inserting "and" after the semicolon at the end;

(2) by striking subparagraphs (L) and (M) and inserting the following new subparagraph:

"(L) for 2011 and each subsequent year—

"(i) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

"(ii) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)."; and

(3) by adding at the end the following flush sentence:

"The application of subparagraph (L)(ii) may result in the covered item update under this paragraph being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year."

(n) **PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.**—Section 1834(h)(4) of the Social Security Act (42 U.S.C. 1395m(h)(4)) is amended—

(1) in subparagraph (A)—

(A) in clause (ix), by striking "and" at the end;

(B) in clause (x)—

(i) by striking "a subsequent year" and inserting "for each of 2007 through 2010"; and

(ii) by inserting "and" after the semicolon at the end;

(C) by adding at the end the following new clause:

"(xi) for 2011 and each subsequent year—

"(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

"(II) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)."; and

(D) by adding at the end the following flush sentence:

"The application of subparagraph (A)(xi)(II) may result in the applicable percentage increase under subparagraph (A) being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year."

(o) **OTHER ITEMS.**—Section 1842(s)(1) of the Social Security Act (42 U.S.C. 1395u(s)(1)) is amended—

(1) in the first sentence, by striking "Subject to" and inserting "(A) Subject to";

(2) by striking the second sentence and inserting the following new subparagraph:

"(B) Any fee schedule established under this paragraph for such item or service shall be updated—

"(i) for years before 2011—

"(I) subject to subclause (II), by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year; and

"(II) for items and services described in paragraph (2)(D) for 2009, section 1834(a)(14)(J) shall apply under this paragraph instead of the percentage increase otherwise applicable; and

"(ii) for 2011 and subsequent years—

"(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

"(II) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)."; and

(3) by adding at the end the following flush sentence:

"The application of subparagraph (B)(ii)(II) may result in the update under this paragraph being less than 0.0 for a year, and may result in payment rates under any fee schedule established under this paragraph for a year being less than such payment rates for the preceding year."

(p) **NO APPLICATION PRIOR TO APRIL 1, 2010.**—Notwithstanding the preceding provisions of this section, the amendments made by subsections (a), (c), and (d) shall not apply to discharges occurring before April 1, 2010.

SEC. 3402. TEMPORARY ADJUSTMENT TO THE CALCULATION OF PART B PREMIUMS.

Section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is amended—

(1) in paragraph (2), in the matter preceding subparagraph (A), by inserting "subject to paragraph (6)," after "subsection,";

(2) in paragraph (3)(A)(i), by striking "The applicable" and inserting "Subject to paragraph (6), the applicable";

(3) by redesignating paragraph (6) as paragraph (7); and

(4) by inserting after paragraph (5) the following new paragraph:

"(6) **TEMPORARY ADJUSTMENT TO INCOME THRESHOLDS.**—Notwithstanding any other provi-

sion of this subsection, during the period beginning on January 1, 2011, and ending on December 31, 2019—

"(A) the threshold amount otherwise applicable under paragraph (2) shall be equal to such amount for 2010; and

"(B) the dollar amounts otherwise applicable under paragraph (3)(C)(i) shall be equal to such dollar amounts for 2010."

SEC. 3403. INDEPENDENT MEDICARE ADVISORY BOARD.

(a) **BOARD.**—

(1) **IN GENERAL.**—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 3022, is amended by adding at the end the following new section:

"INDEPENDENT MEDICARE ADVISORY BOARD

"SEC. 1899A. (a) **ESTABLISHMENT.**—There is established an independent board to be known as the 'Independent Medicare Advisory Board'.

"(b) **PURPOSE.**—It is the purpose of this section to, in accordance with the following provisions of this section, reduce the per capita rate of growth in Medicare spending—

"(1) by requiring the Chief Actuary of the Centers for Medicare & Medicaid Services to determine in each year to which this section applies (in this section referred to as 'a determination year') the projected per capita growth rate under Medicare for the second year following the determination year (in this section referred to as 'an implementation year');

"(2) if the projection for the implementation year exceeds the target growth rate for that year, by requiring the Board to develop and submit during the first year following the determination year (in this section referred to as 'a proposal year') a proposal containing recommendations to reduce the Medicare per capita growth rate to the extent required by this section; and

"(3) by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section.

"(c) **BOARD PROPOSALS.**—

"(1) **DEVELOPMENT.**—

"(A) **IN GENERAL.**—The Board shall develop detailed and specific proposals related to the Medicare program in accordance with the succeeding provisions of this section.

"(B) **ADVISORY REPORTS.**—Beginning January 15, 2014, the Board may develop and submit to Congress advisory reports on matters related to the Medicare program, regardless of whether or not the Board submitted a proposal for such year. Such a report may, for years prior to 2020, include recommendations regarding improvements to payment systems for providers of services and suppliers who are not otherwise subject to the scope of the Board's recommendations in a proposal under this section. Any advisory report submitted under this subparagraph shall not be subject to the rules for congressional consideration under subsection (d).

"(2) **PROPOSALS.**—

"(A) **REQUIREMENTS.**—Each proposal submitted under this section in a proposal year shall meet each of the following requirements:

"(i) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination under paragraph (7)(A) in the determination year, the proposal shall include recommendations so that the proposal as a whole (after taking into account recommendations under clause (v)) will result in a net reduction in total Medicare program spending in the implementation year that is at least equal to the applicable savings target established under paragraph (7)(B) for such implementation year. In determining whether a proposal meets the requirement of the preceding sentence, reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent

that such reductions are a result of the implementation of recommendations contained in the proposal for a change in the payment rate for an item or service that was effective during such period pursuant to subsection (e)(2)(A).

“(ii) The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.

“(iii) In the case of proposals submitted prior to December 31, 2018, the proposal shall not include any recommendation that would reduce payment rates for items and services furnished, prior to December 31, 2019, by providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d)) scheduled, pursuant to the amendments made by section 3401 of the Patient Protection and Affordable Care Act, to receive a reduction to the inflationary payment updates of such providers of services and suppliers in excess of a reduction due to productivity in a year in which such recommendations would take effect.

“(iv) As appropriate, the proposal shall include recommendations to reduce Medicare payments under parts C and D, such as reductions in direct subsidy payments to Medicare Advantage and prescription drug plans specified under paragraph (1) and (2) of section 1860D–15(a) that are related to administrative expenses (including profits) for basic coverage, denying high bids or removing high bids for prescription drug coverage from the calculation of the national average monthly bid amount under section 1860D–13(a)(4), and reductions in payments to Medicare Advantage plans under clauses (i) and (ii) of section 1853(a)(1)(B) that are related to administrative expenses (including profits) and performance bonuses for Medicare Advantage plans under section 1853(n). Any such recommendation shall not affect the base beneficiary premium percentage specified under 1860D–13(a).

“(v) The proposal shall include recommendations with respect to administrative funding for the Secretary to carry out the recommendations contained in the proposal.

“(vi) The proposal shall only include recommendations related to the Medicare program.

“(B) ADDITIONAL CONSIDERATIONS.—In developing and submitting each proposal under this section in a proposal year, the Board shall, to the extent feasible—

“(i) give priority to recommendations that extend Medicare solvency;

“(ii) include recommendations that—

“(I) improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement; and

“(II) protect and improve Medicare beneficiaries’ access to necessary and evidence-based items and services, including in rural and frontier areas;

“(iii) include recommendations that target reductions in Medicare program spending to sources of excess cost growth;

“(iv) consider the effects on Medicare beneficiaries of changes in payments to providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d));

“(v) consider the effects of the recommendations on providers of services and suppliers with actual or projected negative cost margins or payment updates; and

“(vi) consider the unique needs of Medicare beneficiaries who are dually eligible for Medicare and the Medicaid program under title XIX.

“(C) NO INCREASE IN TOTAL MEDICARE PROGRAM SPENDING.—Each proposal submitted

under this section shall be designed in such a manner that implementation of the recommendations contained in the proposal would not be expected to result, over the 10-year period starting with the implementation year, in any increase in the total amount of net Medicare program spending relative to the total amount of net Medicare program spending that would have occurred absent such implementation.

“(D) CONSULTATION WITH MEDPAC.—The Board shall submit a draft copy of each proposal to be submitted under this section to the Medicare Payment Advisory Commission established under section 1805 for its review. The Board shall submit such draft copy by not later than September 1 of the determination year.

“(E) REVIEW AND COMMENT BY THE SECRETARY.—The Board shall submit a draft copy of each proposal to be submitted to Congress under this section to the Secretary for the Secretary’s review and comment. The Board shall submit such draft copy by not later than September 1 of the determination year. Not later than March 1 of the submission year, the Secretary shall submit a report to Congress on the results of such review, unless the Secretary submits a proposal under paragraph (5)(A) in that year.

“(F) CONSULTATIONS.—In carrying out its duties under this section, the Board shall engage in regular consultations with the Medicaid and CHIP Payment and Access Commission under section 1900.

“(3) TRANSMISSION OF BOARD PROPOSAL TO PRESIDENT.—

“(A) IN GENERAL.—

“(i) IN GENERAL.—Except as provided in clause (ii) and subsection (f)(3)(B), the Board shall transmit a proposal under this section to the President on January 15 of each year (beginning with 2014).

“(ii) EXCEPTION.—The Board shall not submit a proposal under clause (i) in a proposal year if the year is—

“(I) a year for which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph does not exceed the growth rate described in clause (ii) of such paragraph;

“(II) a year in which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the projected percentage increase (if any) for the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average) for the implementation year is less than the projected percentage increase (if any) in the Consumer Price Index for All Urban Consumers (all items; United States city average) for such implementation year; or

“(III) for proposal year 2019 and subsequent proposal years, a year in which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the growth rate described in paragraph (8) exceeds the growth rate described in paragraph (6)(A)(i).

“(ii) START-UP PERIOD.—The Board may not submit a proposal under clause (i) prior to January 15, 2014.

“(B) REQUIRED INFORMATION.—Each proposal submitted by the Board under subparagraph (A)(i) shall include—

“(i) the recommendations described in paragraph (2)(A)(i);

“(ii) an explanation of each recommendation contained in the proposal and the reasons for including such recommendation;

“(iii) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the proposal meets the

requirements of subparagraphs (A)(i) and (C) of paragraph (2);

“(iv) a legislative proposal that implements the recommendations; and

“(v) other information determined appropriate by the Board.

“(4) PRESIDENTIAL SUBMISSION TO CONGRESS.—Upon receiving a proposal from the Board under paragraph (3)(A)(i) or the Secretary under paragraph (5), the President shall immediately submit such proposal to Congress.

“(5) CONTINGENT SECRETARIAL DEVELOPMENT OF PROPOSAL.—If, with respect to a proposal year, the Board is required, to but fails, to submit a proposal to the President by the deadline applicable under paragraph (3)(A)(i), the Secretary shall develop a detailed and specific proposal that satisfies the requirements of subparagraphs (A) and (C) (and, to the extent feasible, subparagraph (B)) of paragraph (2) and contains the information required paragraph (3)(B)). By not later than January 25 of the year, the Secretary shall transmit—

“(A) such proposal to the President; and

“(B) a copy of such proposal to the Medicare Payment Advisory Commission for its review.

“(6) PER CAPITA GROWTH RATE PROJECTIONS BY CHIEF ACTUARY.—

“(A) IN GENERAL.—Subject to subsection (f)(3)(A), not later than April 30, 2013, and annually thereafter, the Chief Actuary of the Centers for Medicare & Medicaid Services shall determine in each such year whether—

“(i) the projected Medicare per capita growth rate for the implementation year (as determined under subparagraph (B)); exceeds

“(ii) the projected Medicare per capita target growth rate for the implementation year (as determined under subparagraph (C)).

“(B) MEDICARE PER CAPITA GROWTH RATE.—

“(i) IN GENERAL.—For purposes of this section, the Medicare per capita growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) of the growth in Medicare program spending per unduplicated enrollee.

“(ii) REQUIREMENT.—The projection under clause (i) shall—

“(I) to the extent that there is projected to be a negative update to the single conversion factor applicable to payments for physicians’ services under section 1848(d) furnished in the proposal year or the implementation year, assume that such update for such services is 0 percent rather than the negative percent that would otherwise apply; and

“(II) take into account any delivery system reforms or other payment changes that have been enacted or published in final rules but not yet implemented as of the making of such calculation.

“(C) MEDICARE PER CAPITA TARGET GROWTH RATE.—For purposes of this section, the Medicare per capita target growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) percentage increase in—

“(i) with respect to a determination year that is prior to 2018, the average of the projected percentage increase (if any) in—

“(I) the Consumer Price Index for All Urban Consumers (all items; United States city average); and

“(II) the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average); and

“(ii) with respect to a determination year that is after 2017, the nominal gross domestic product per capita plus 1.0 percentage point.

“(7) SAVINGS REQUIREMENT.—

“(A) IN GENERAL.—If, with respect to a determination year, the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination under paragraph (6)(A) that the

growth rate described in clause (i) of such paragraph exceeds the growth rate described in clause (ii) of such paragraph, the Chief Actuary shall establish an applicable savings target for the implementation year.

“(B) **APPLICABLE SAVINGS TARGET.**—For purposes of this section, the applicable savings target for an implementation year shall be an amount equal to the product of—

“(i) the total amount of projected Medicare program spending for the proposal year; and

“(ii) the applicable percent for the implementation year.

“(C) **APPLICABLE PERCENT.**—For purposes of subparagraph (B), the applicable percent for an implementation year is the lesser of—

“(i) in the case of—

“(I) implementation year 2015, 0.5 percent;

“(II) implementation year 2016, 1.0 percent;

“(III) implementation year 2017, 1.25 percent; and

“(IV) implementation year 2018 or any subsequent implementation year, 1.5 percent; and

“(ii) the projected excess for the implementation year (expressed as a percent) determined under subparagraph (A).

“(B) **PER CAPITA RATE OF GROWTH IN NATIONAL HEALTH EXPENDITURES.**—In each determination year (beginning in 2018), the Chief Actuary of the Centers for Medicare & Medicaid Services shall project the per capita rate of growth in national health expenditures for the implementation year. Such rate of growth for an implementation year shall be calculated as the projected 5-year average (ending with such year) percentage increase in national health care expenditures.

“(d) **CONGRESSIONAL CONSIDERATION.**—

“(1) **INTRODUCTION.**—

“(A) **IN GENERAL.**—On the day on which a proposal is submitted by the President to the House of Representatives and the Senate under subsection (c)(4), the legislative proposal (described in subsection (c)(3)(B)(iv)) contained in the proposal shall be introduced (by request) in the Senate by the majority leader of the Senate or by Members of the Senate designated by the majority leader of the Senate and shall be introduced (by request) in the House by the majority leader of the House or by Members of the House designated by the majority leader of the House.

“(B) **NOT IN SESSION.**—If either House is not in session on the day on which such legislative proposal is submitted, the legislative proposal shall be introduced in that House, as provided in subparagraph (A), on the first day thereafter on which that House is in session.

“(C) **ANY MEMBER.**—If the legislative proposal is not introduced in either House within 5 days on which that House is in session after the day on which the legislative proposal is submitted, then any Member of that House may introduce the legislative proposal.

“(D) **REFERRAL.**—The legislation introduced under this paragraph shall be referred by the Presiding Officers of the respective Houses to the Committee on Finance in the Senate and to the Committee on Energy and Commerce and the Committee on Ways and Means in the House of Representatives.

“(2) **COMMITTEE CONSIDERATION OF PROPOSAL.**—

“(A) **REPORTING BILL.**—Not later than April 1 of any proposal year in which a proposal is submitted by the President to Congress under this section, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate may report the bill referred to the Committee under paragraph (1)(D) with committee amendments related to the Medicare program.

“(B) **CALCULATIONS.**—In determining whether a committee amendment meets the requirement

of subparagraph (A), the reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation provisions in the committee amendment for a change in the payment rate for an item or service that was effective during such period pursuant to such amendment.

“(C) **COMMITTEE JURISDICTION.**—Notwithstanding rule XV of the Standing Rules of the Senate, a committee amendment described in subparagraph (A) may include matter not within the jurisdiction of the Committee on Finance if that matter is relevant to a proposal contained in the bill submitted under subsection (c)(3).

“(D) **DISCHARGE.**—If, with respect to the House involved, the committee has not reported the bill by the date required by subparagraph (A), the committee shall be discharged from further consideration of the proposal.

“(3) **LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS.**—

“(A) **IN GENERAL.**—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, or amendment, pursuant to this subsection or conference report thereon, that fails to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

“(B) **LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS IN OTHER LEGISLATION.**—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report (other than pursuant to this section) that would repeal or otherwise change the recommendations of the Board if that change would fail to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

“(C) **LIMITATION ON CHANGES TO THIS SUBSECTION.**—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change this subsection.

“(D) **WAIVER.**—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

“(E) **APPEALS.**—An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph.

“(4) **EXPEDITED PROCEDURE.**—

“(A) **CONSIDERATION.**—A motion to proceed to the consideration of the bill in the Senate is not debatable.

“(B) **AMENDMENT.**—

“(i) **TIME LIMITATION.**—Debate in the Senate on any amendment to a bill under this section shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader's designee.

“(ii) **GERMANY.**—No amendment that is not germane to the provisions of such bill shall be received.

“(iii) **ADDITIONAL TIME.**—The leaders, or either of them, may, from the time under their control on the passage of the bill, allot additional time to any Senator during the consideration of any amendment, debatable motion, or appeal.

“(iv) **AMENDMENT NOT IN ORDER.**—It shall not be in order to consider an amendment that

would cause the bill to result in a net reduction in total Medicare program spending in the implementation year that is less than the applicable savings target established under subsection (c)(7)(B) for such implementation year.

“(v) **WAIVER AND APPEALS.**—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

“(C) **CONSIDERATION BY THE OTHER HOUSE.**—

“(i) **IN GENERAL.**—The expedited procedures provided in this subsection for the consideration of a bill introduced pursuant to paragraph (1) shall not apply to such a bill that is received by one House from the other House if such a bill was not introduced in the receiving House.

“(ii) **BEFORE PASSAGE.**—If a bill that is introduced pursuant to paragraph (1) is received by one House from the other House, after introduction but before disposition of such a bill in the receiving House, then the following shall apply:

“(I) The receiving House shall consider the bill introduced in that House through all stages of consideration up to, but not including, passage.

“(II) The question on passage shall be put on the bill of the other House as amended by the language of the receiving House.

“(iii) **AFTER PASSAGE.**—If a bill introduced pursuant to paragraph (1) is received by one House from the other House, after such a bill is passed by the receiving House, then the vote on passage of the bill that originates in the receiving House shall be considered to be the vote on passage of the bill received from the other House as amended by the language of the receiving House.

“(iv) **DISPOSITION.**—Upon disposition of a bill introduced pursuant to paragraph (1) that is received by one House from the other House, it shall no longer be in order to consider the bill that originates in the receiving House.

“(v) **LIMITATION.**—Clauses (ii), (iii), and (iv) shall apply only to a bill received by one House from the other House if the bill—

“(I) is related only to the program under this title; and

“(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

“(D) **SENATE LIMITS ON DEBATE.**—

“(i) **IN GENERAL.**—In the Senate, consideration of the bill and on all debatable motions and appeals in connection therewith shall not exceed a total of 30 hours, which shall be divided equally between the majority and minority leaders or their designees.

“(ii) **MOTION TO FURTHER LIMIT DEBATE.**—A motion to further limit debate on the bill is in order and is not debatable.

“(iii) **MOTION OR APPEAL.**—Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal.

“(iv) **FINAL DISPOSITION.**—After 30 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all amendments not then pending before the Senate at that time and to the exclusion of all motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

“(E) **CONSIDERATION IN CONFERENCE.**—

“(i) **IN GENERAL.**—Consideration in the Senate and the House of Representatives on the conference report or any messages between Houses shall be limited to 10 hours, equally divided and

controlled by the majority and minority leaders of the Senate or their designees and the Speaker of the House of Representatives and the minority leader of the House of Representatives or their designees.

“(ii) **TIME LIMITATION.**—Debate in the Senate on any amendment under this subparagraph shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader’s designee.

“(iii) **FINAL DISPOSITION.**—After 10 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all motions not then pending before the Senate at that time or necessary to resolve the differences between the Houses and to the exclusion of all other motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

“(iv) **LIMITATION.**—Clauses (i) through (iii) shall only apply to a conference report, message or the amendments thereto if the conference report, message, or an amendment thereto—

“(I) is related only to the program under this title; and

“(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

“(F) **VETO.**—If the President vetoes the bill debate on a veto message in the Senate under this subsection shall be 1 hour equally divided between the majority and minority leaders or their designees.

“(5) **RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.**—This subsection and subsection (f)(2) are enacted by Congress—

“(A) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of bill under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

“(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

“(e) **IMPLEMENTATION OF PROPOSAL.**—

“(1) **IN GENERAL.**—Notwithstanding any other provision of law, the Secretary shall, except as provided in paragraph (3), implement the recommendations contained in a proposal submitted by the President to Congress pursuant to this section on August 15 of the year in which the proposal is so submitted.

“(2) **APPLICATION.**—

“(A) **IN GENERAL.**—A recommendation described in paragraph (1) shall apply as follows:

“(i) In the case of a recommendation that is a change in the payment rate for an item or service under Medicare in which payment rates change on a fiscal year basis (or a cost reporting period basis that relates to a fiscal year), on a calendar year basis (or a cost reporting period basis that relates to a calendar year), or on a rate year basis (or a cost reporting period basis that relates to a rate year), such recommendation shall apply to items and services furnished on the first day of the first fiscal year, calendar year, or rate year (as the case may be) that begins after such August 15.

“(ii) In the case of a recommendation relating to payments to plans under parts C and D, such recommendation shall apply to plan years beginning on the first day of the first calendar year that begins after such August 15.

“(iii) In the case of any other recommendation, such recommendation shall be addressed in the regular regulatory process timeframe and shall apply as soon as practicable.

“(B) **INTERIM FINAL RULEMAKING.**—The Secretary may use interim final rulemaking to implement any recommendation described in paragraph (1).

“(3) **EXCEPTION.**—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by the President to Congress pursuant to this section if—

“(A) prior to August 15 of the proposal year, Federal legislation is enacted that includes the following provision: ‘This Act supercedes the recommendations of the Board contained in the proposal submitted, in the year which includes the date of enactment of this Act, to Congress under section 1899A of the Social Security Act.’; and

“(B) in the case of implementation year 2020 and subsequent implementation years, a joint resolution described in subsection (f)(1) is enacted not later than August 15, 2017.

“(4) **NO AFFECT ON AUTHORITY TO IMPLEMENT CERTAIN PROVISIONS.**—Nothing in paragraph (3) shall be construed to affect the authority of the Secretary to implement any recommendation contained in a proposal or advisory report under this section to the extent that the Secretary otherwise has the authority to implement such recommendation administratively.

“(5) **LIMITATION ON REVIEW.**—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the implementation by the Secretary under this subsection of the recommendations contained in a proposal.

“(f) **JOINT RESOLUTION REQUIRED TO DISCONTINUE THE BOARD.**—

“(1) **IN GENERAL.**—For purposes of subsection (e)(3)(B), a joint resolution described in this paragraph means only a joint resolution—

“(A) that is introduced in 2017 by not later than February 1 of such year;

“(B) which does not have a preamble;

“(C) the title of which is as follows: ‘Joint resolution approving the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act’; and

“(D) the matter after the resolving clause of which is as follows: ‘That Congress approves the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act.’

“(2) **PROCEDURE.**—

“(A) **REFERRAL.**—A joint resolution described in paragraph (1) shall be referred to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

“(B) **DISCHARGE.**—In the Senate, if the committee to which is referred a joint resolution described in paragraph (1) has not reported such joint resolution (or an identical joint resolution) at the end of 20 days after the joint resolution described in paragraph (1) is introduced, such committee may be discharged from further consideration of such joint resolution upon a petition supported in writing by 30 Members of the Senate, and such joint resolution shall be placed on the calendar.

“(C) **CONSIDERATION.**—

“(i) **IN GENERAL.**—In the Senate, when the committee to which a joint resolution is referred has reported, or when a committee is discharged (under subparagraph (C)) from further consideration of a joint resolution described in paragraph (1), it is at any time thereafter in order (even though a previous motion to the same effect has been disagreed to) for a motion to proceed to the consideration of the joint resolution to be made, and all points of order against the joint resolution (and against consideration of the joint resolution) are waived, except for points of order under the Congressional Budget act of 1974 or under budget resolutions pursuant to that Act. The motion is not debatable. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the joint resolution is agreed to, the joint resolution shall remain the unfinished business of the Senate until disposed of.

“(ii) **DEBATE LIMITATION.**—In the Senate, consideration of the joint resolution, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 10 hours, which shall be divided equally between the majority leader and the minority leader, or their designees. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the joint resolution is not in order.

“(iii) **PASSAGE.**—In the Senate, immediately following the conclusion of the debate on a joint resolution described in paragraph (1), and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the Senate, the vote on passage of the joint resolution shall occur.

“(iv) **APPEALS.**—Appeals from the decisions of the Chair relating to the application of the rules of the Senate to the procedure relating to a joint resolution described in paragraph (1) shall be decided without debate.

“(D) **OTHER HOUSE ACTS FIRST.**—If, before the passage by 1 House of a joint resolution of that House described in paragraph (1), that House receives from the other House a joint resolution described in paragraph (1), then the following procedures shall apply:

“(i) The joint resolution of the other House shall not be referred to a committee.

“(ii) With respect to a joint resolution described in paragraph (1) of the House receiving the joint resolution—

“(I) the procedure in that House shall be the same as if no joint resolution had been received from the other House; but

“(II) the vote on final passage shall be on the joint resolution of the other House.

“(E) **EXCLUDED DAYS.**—For purposes of determining the period specified in subparagraph (B), there shall be excluded any days either House of Congress is adjourned for more than 3 days during a session of Congress.

“(F) **MAJORITY REQUIRED FOR ADOPTION.**—A joint resolution considered under this subsection shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn, for adoption.

“(3) **TERMINATION.**—If a joint resolution described in paragraph (1) is enacted not later than August 15, 2017—

“(A) the Chief Actuary of the Medicare & Medicaid Services shall not—

“(i) make any determinations under subsection (c)(6) after May 1, 2017; or

“(ii) provide any opinion pursuant to subsection (c)(3)(B)(iii) after January 16, 2018;

“(B) the Board shall not submit any proposals or advisory reports to Congress under this section after January 16, 2018; and

“(C) the Board and the consumer advisory council under subsection (k) shall terminate on August 16, 2018.

“(g) BOARD MEMBERSHIP; TERMS OF OFFICE; CHAIRPERSON; REMOVAL.—

“(1) MEMBERSHIP.—

“(A) IN GENERAL.—The Board shall be composed of—

“(i) 15 members appointed by the President, by and with the advice and consent of the Senate; and

“(ii) the Secretary, the Administrator of the Center for Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration, all of whom shall serve ex officio as nonvoting members of the Board.

“(B) QUALIFICATIONS.—

“(i) IN GENERAL.—The appointed membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

“(ii) INCLUSION.—The appointed membership of the Board shall include (but not be limited to) physicians and other health professionals, experts in the area of pharmaco-economics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

“(iii) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision or management of the delivery of items and services covered under this title shall not constitute a majority of the appointed membership of the Board.

“(C) ETHICAL DISCLOSURE.—The President shall establish a system for public disclosure by appointed members of the Board of financial and other potential conflicts of interest relating to such members. Appointed members of the Board shall be treated as officers in the executive branch for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95-521).

“(D) CONFLICTS OF INTEREST.—No individual may serve as an appointed member if that individual engages in any other business, vocation, or employment.

“(E) CONSULTATION WITH CONGRESS.—In selecting individuals for nominations for appointments to the Board, the President shall consult with—

“(i) the majority leader of the Senate concerning the appointment of 3 members;

“(ii) the Speaker of the House of Representatives concerning the appointment of 3 members;

“(iii) the minority leader of the Senate concerning the appointment of 3 members; and

“(iv) the minority leader of the House of Representatives concerning the appointment of 3 members.

“(2) TERM OF OFFICE.—Each appointed member shall hold office for a term of 6 years except that—

“(A) a member may not serve more than 2 full consecutive terms (but may be reappointed to 2 full consecutive terms after being appointed to fill a vacancy on the Board);

“(B) a member appointed to fill a vacancy occurring prior to the expiration of the term for which that member's predecessor was appointed shall be appointed for the remainder of such term;

“(C) a member may continue to serve after the expiration of the member's term until a successor has taken office; and

“(D) of the members first appointed under this section, 5 shall be appointed for a term of 1 year, 5 shall be appointed for a term of 3 years, and 5 shall be appointed for a term of 6 years, the term of each to be designated by the President at the time of nomination.

“(3) CHAIRPERSON.—

“(A) IN GENERAL.—The Chairperson shall be appointed by the President, by and with the advice and consent of the Senate, from among the members of the Board.

“(B) DUTIES.—The Chairperson shall be the principal executive officer of the Board, and shall exercise all of the executive and administrative functions of the Board, including functions of the Board with respect to—

“(i) the appointment and supervision of personnel employed by the Board;

“(ii) the distribution of business among personnel appointed and supervised by the Chairperson and among administrative units of the Board; and

“(iii) the use and expenditure of funds.

“(C) GOVERNANCE.—In carrying out any of the functions under subparagraph (B), the Chairperson shall be governed by the general policies established by the Board and by the decisions, findings, and determinations the Board shall by law be authorized to make.

“(D) REQUESTS FOR APPROPRIATIONS.—Requests or estimates for regular, supplemental, or deficiency appropriations on behalf of the Board may not be submitted by the Chairperson without the prior approval of a majority vote of the Board.

“(4) REMOVAL.—Any appointed member may be removed by the President for neglect of duty or malfeasance in office, but for no other cause.

“(h) VACANCIES; QUORUM; SEAL; VICE CHAIRPERSON; VOTING ON REPORTS.—

“(1) VACANCIES.—No vacancy on the Board shall impair the right of the remaining members to exercise all the powers of the Board.

“(2) QUORUM.—A majority of the appointed members of the Board shall constitute a quorum for the transaction of business, but a lesser number of members may hold hearings.

“(3) SEAL.—The Board shall have an official seal, of which judicial notice shall be taken.

“(4) VICE CHAIRPERSON.—The Board shall annually elect a Vice Chairperson to act in the absence or disability of the Chairperson or in case of a vacancy in the office of the Chairperson.

“(5) VOTING ON PROPOSALS.—Any proposal of the Board must be approved by the majority of appointed members present.

“(i) POWERS OF THE BOARD.—

“(1) HEARINGS.—The Board may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Board considers advisable to carry out this section.

“(2) AUTHORITY TO INFORM RESEARCH PRIORITIES FOR DATA COLLECTION.—The Board may advise the Secretary on priorities for health services research, particularly as such priorities pertain to necessary changes and issues regarding payment reforms under Medicare.

“(3) OBTAINING OFFICIAL DATA.—The Board may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairperson, the head of that department or agency shall furnish that information to the Board on an agreed upon schedule.

“(4) POSTAL SERVICES.—The Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

“(5) GIFTS.—The Board may accept, use, and dispose of gifts or donations of services or property.

“(6) OFFICES.—The Board shall maintain a principal office and such field offices as it deter-

mines necessary, and may meet and exercise any of its powers at any other place.

“(j) PERSONNEL MATTERS.—

“(1) COMPENSATION OF MEMBERS AND CHAIRPERSON.—Each appointed member, other than the Chairperson, shall be compensated at a rate equal to the annual rate of basic pay prescribed for level III of the Executive Schedule under section 5315 of title 5, United States Code. The Chairperson shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level II of the Executive Schedule under section 5315 of title 5, United States Code.

“(2) TRAVEL EXPENSES.—The appointed members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

“(3) STAFF.—

“(A) IN GENERAL.—The Chairperson may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Board to perform its duties. The employment of an executive director shall be subject to confirmation by the Board.

“(B) COMPENSATION.—The Chairperson may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

“(4) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

“(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

“(k) CONSUMER ADVISORY COUNCIL.—

“(1) IN GENERAL.—There is established a consumer advisory council to advise the Board on the impact of payment policies under this title on consumers.

“(2) MEMBERSHIP.—

“(A) NUMBER AND APPOINTMENT.—The consumer advisory council shall be composed of 10 consumer representatives appointed by the Comptroller General of the United States, 1 from among each of the 10 regions established by the Secretary as of the date of enactment of this section.

“(B) QUALIFICATIONS.—The membership of the council shall represent the interests of consumers and particular communities.

“(3) DUTIES.—The consumer advisory council shall, subject to the call of the Board, meet not less frequently than 2 times each year in the District of Columbia.

“(4) OPEN MEETINGS.—Meetings of the consumer advisory council shall be open to the public.

“(5) ELECTION OF OFFICERS.—Members of the consumer advisory council shall elect their own officers.

“(6) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the consumer advisory council except that section 14 of such Act shall not apply.

“(1) DEFINITIONS.—In this section:

“(1) BOARD; CHAIRPERSON; MEMBER.—The terms ‘Board’, ‘Chairperson’, and ‘Member’ mean the Independent Medicare Advisory Board established under subsection (a) and the Chairperson and any Member thereof, respectively.

“(2) MEDICARE.—The term ‘Medicare’ means the program established under this title, including parts A, B, C, and D.

“(3) MEDICARE BENEFICIARY.—The term ‘Medicare beneficiary’ means an individual who is entitled to, or enrolled for, benefits under part A or enrolled for benefits under part B.

“(4) MEDICARE PROGRAM SPENDING.—The term ‘Medicare program spending’ means program spending under parts A, B, and D net of premiums.

“(m) FUNDING.—

“(1) IN GENERAL.—There are appropriated to the Board to carry out its duties and functions—

“(A) for fiscal year 2012, \$15,000,000; and

“(B) for each subsequent fiscal year, the amount appropriated under this paragraph for the previous fiscal year increased by the annual percentage increase in the Consumer Price Index for All Urban Consumers (all items; United States city average) as of June of the previous fiscal year.

“(2) FROM TRUST FUNDS.—Sixty percent of amounts appropriated under paragraph (1) shall be derived by transfer from the Federal Hospital Insurance Trust Fund under section 1817 and 40 percent of amounts appropriated under such paragraph shall be derived by transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841.”.

(2) LOBBYING COOLING-OFF PERIOD FOR MEMBERS OF THE INDEPENDENT MEDICARE ADVISORY BOARD.—Section 207(c) of title 18, United States Code, is amended by inserting at the end the following:

“(3) MEMBERS OF THE INDEPENDENT MEDICARE ADVISORY BOARD.—

“(A) IN GENERAL.—Paragraph (1) shall apply to a member of the Independent Medicare Advisory Board under section 1899A.

“(B) AGENCIES AND CONGRESS.—For purposes of paragraph (1), the agency in which the individual described in subparagraph (A) served shall be considered to be the Independent Medicare Advisory Board, the Department of Health and Human Services, and the relevant committees of jurisdiction of Congress, including the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.”.

(b) GAO STUDY AND REPORT ON DETERMINATION AND IMPLEMENTATION OF PAYMENT AND COVERAGE POLICIES UNDER THE MEDICARE PROGRAM.—

(1) INITIAL STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States (in this section referred to as the “Comptroller General”) shall conduct a study on changes to payment policies, methodologies, and rates and coverage policies and methodologies under the Medicare program under title XVIII of the Social Security Act as a result of the recommendations contained in the proposals made by the Independent Medicare Advisory Board under section 1899A of such Act (as added by subsection (a)), including an analysis of the effect of such recommendations on—

(i) Medicare beneficiary access to providers and items and services;

(ii) the affordability of Medicare premiums and cost-sharing (including deductibles, coinsurance, and copayments);

(iii) the potential impact of changes on other government or private-sector purchasers and payers of care; and

(iv) quality of patient care, including patient experience, outcomes, and other measures of care.

(B) REPORT.—Not later than July 1, 2015, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(2) SUBSEQUENT STUDIES AND REPORTS.—The Comptroller General shall periodically conduct such additional studies and submit reports to Congress on changes to Medicare payments policies, methodologies, and rates and coverage policies and methodologies as the Comptroller General determines appropriate, in consultation with the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(c) CONFORMING AMENDMENTS.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b-6(b)) is amended—

(1) by redesignating paragraphs (4) through (8) as paragraphs (5) through (9), respectively; and

(2) by inserting after paragraph (3) the following:

“(4) REVIEW AND COMMENT ON THE INDEPENDENT MEDICARE ADVISORY BOARD OR SECRETARIAL PROPOSAL.—If the Independent Medicare Advisory Board (as established under subsection (a) of section 1899A) or the Secretary submits a proposal to the Commission under such section in a year, the Commission shall review the proposal and, not later than March 1 of that year, submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate written comments on such proposal. Such comments may include such recommendations as the Commission deems appropriate.”.

Subtitle F—Health Care Quality Improvements

SEC. 3501. HEALTH CARE DELIVERY SYSTEM RESEARCH; QUALITY IMPROVEMENT TECHNICAL ASSISTANCE.

Part D of title IX of the Public Health Service Act, as amended by section 3013, is further amended by adding at the end the following:

“Subpart II—Health Care Quality Improvement Programs

“SEC. 933. HEALTH CARE DELIVERY SYSTEM RESEARCH.

“(a) PURPOSE.—The purposes of this section are to—

“(1) enable the Director to identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices (referred to as ‘best practices’) in health care quality, safety, and value; and

“(2) ensure that the Director is accountable for implementing a model to pursue such research in a collaborative manner with other related Federal agencies.

“(b) GENERAL FUNCTIONS OF THE CENTER.—The Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the ‘Center’), or any other relevant agency or department designated by the Director, shall—

“(1) carry out its functions using research from a variety of disciplines, which may include epidemiology, health services, sociology, psychology, human factors engineering, biostatistics, health economics, clinical research, and health informatics;

“(2) conduct or support activities consistent with the purposes described in subsection (a), and for—

“(A) best practices for quality improvement practices in the delivery of health care services; and

“(B) that include changes in processes of care and the redesign of systems used by providers that will reliably result in intended health outcomes, improve patient safety, and reduce medical errors (such as skill development for health care providers in team-based health care delivery and rapid cycle process improvement) and facilitate adoption of improved workflow;

“(3) identify health care providers, including health care systems, single institutions, and individual providers, that—

“(A) deliver consistently high-quality, efficient health care services (as determined by the Secretary); and

“(B) employ best practices that are adaptable and scalable to diverse health care settings or effective in improving care across diverse settings;

“(4) assess research, evidence, and knowledge about what strategies and methodologies are most effective in improving health care delivery;

“(5) find ways to translate such information rapidly and effectively into practice, and document the sustainability of those improvements;

“(6) create strategies for quality improvement through the development of tools, methodologies, and interventions that can successfully reduce variations in the delivery of health care;

“(7) identify, measure, and improve organizational, human, or other causative factors, including those related to the culture and system design of a health care organization, that contribute to the success and sustainability of specific quality improvement and patient safety strategies;

“(8) provide for the development of best practices in the delivery of health care services that—

“(A) have a high likelihood of success, based on structured review of empirical evidence;

“(B) are specified with sufficient detail of the individual processes, steps, training, skills, and knowledge required for implementation and incorporation into workflow of health care practitioners in a variety of settings;

“(C) are designed to be readily adapted by health care providers in a variety of settings; and

“(D) where applicable, assist health care providers in working with other health care providers across the continuum of care and in engaging patients and their families in improving the care and patient health outcomes;

“(9) provide for the funding of the activities of organizations with recognized expertise and excellence in improving the delivery of health care services, including children’s health care, by involving multiple disciplines, managers of health care entities, broad development and training, patients, caregivers and families, and frontline health care workers, including activities for the examination of strategies to share best quality improvement practices and to promote excellence in the delivery of health care services; and

“(10) build capacity at the State and community level to lead quality and safety efforts through education, training, and mentoring programs to carry out the activities under paragraphs (1) through (9).

“(c) RESEARCH FUNCTIONS OF CENTER.—

“(1) IN GENERAL.—The Center shall support, such as through a contract or other mechanism, research on health care delivery system improvement and the development of tools to facilitate adoption of best practices that improve the quality, safety, and efficiency of health care delivery services. Such support may include establishing a Quality Improvement Network Research Program for the purpose of testing, scaling, and disseminating of interventions to improve quality and efficiency in health care. Recipients of funding under the Program may include national, State, multi-State, or multi-site quality improvement networks.

“(2) **RESEARCH REQUIREMENTS.**—The research conducted pursuant to paragraph (1) shall—

“(A) address the priorities identified by the Secretary in the national strategic plan established under section 399HH;

“(B) identify areas in which evidence is insufficient to identify strategies and methodologies, taking into consideration areas of insufficient evidence identified by the entity with a contract under section 1890(a) of the Social Security Act in the report required under section 399JJ;

“(C) address concerns identified by health care institutions and providers and communicated through the Center pursuant to subsection (d);

“(D) reduce preventable morbidity, mortality, and associated costs of morbidity and mortality by building capacity for patient safety research;

“(E) support the discovery of processes for the reliable, safe, efficient, and responsive delivery of health care, taking into account discoveries from clinical research and comparative effectiveness research;

“(F) allow communication of research findings and translate evidence into practice recommendations that are adaptable to a variety of settings, and which, as soon as practicable after the establishment of the Center, shall include—

“(i) the implementation of a national application of Intensive Care Unit improvement projects relating to the adult (including geriatric), pediatric, and neonatal patient populations;

“(ii) practical methods for addressing health care associated infections, including Methicillin-Resistant *Staphylococcus Aureus* and Vancomycin-Resistant *Enterococcus* infections and other emerging infections; and

“(iii) practical methods for reducing preventable hospital admissions and readmissions;

“(G) expand demonstration projects for improving the quality of children's health care and the use of health information technology, such as through Pediatric Quality Improvement Collaboratives and Learning Networks, consistent with provisions of section 1139A of the Social Security Act for assessing and improving quality, where applicable;

“(H) identify and mitigate hazards by—

“(i) analyzing events reported to patient safety reporting systems and patient safety organizations; and

“(ii) using the results of such analyses to develop scientific methods of response to such events;

“(I) include the conduct of systematic reviews of existing practices that improve the quality, safety, and efficiency of health care delivery, as well as new research on improving such practices; and

“(J) include the examination of how to measure and evaluate the progress of quality and patient safety activities.

“(d) **DISSEMINATION OF RESEARCH FINDINGS.**—

“(1) **PUBLIC AVAILABILITY.**—The Director shall make the research findings of the Center available to the public through multiple media and appropriate formats to reflect the varying needs of health care providers and consumers and diverse levels of health literacy.

“(2) **LINKAGE TO HEALTH INFORMATION TECHNOLOGY.**—The Secretary shall ensure that research findings and results generated by the Center are shared with the Office of the National Coordinator of Health Information Technology and used to inform the activities of the health information technology extension program under section 3012, as well as any relevant standards, certification criteria, or implementation specifications.

“(e) **PRIORITIZATION.**—The Director shall identify and regularly update a list of processes or systems on which to focus research and dissemination activities of the Center, taking into account—

“(1) the cost to Federal health programs;

“(2) consumer assessment of health care experience;

“(3) provider assessment of such processes or systems and opportunities to minimize distress and injury to the health care workforce;

“(4) the potential impact of such processes or systems on health status and function of patients, including vulnerable populations including children;

“(5) the areas of insufficient evidence identified under subsection (c)(2)(B); and

“(6) the evolution of meaningful use of health information technology, as defined in section 3000.

“(f) **COORDINATION.**—The Center shall coordinate its activities with activities conducted by the Center for Medicare and Medicaid Innovation established under section 1115A of the Social Security Act.

“(g) **FUNDING.**—There is authorized to be appropriated to carry out this section \$20,000,000 for fiscal years 2010 through 2014.

“SEC. 934. QUALITY IMPROVEMENT TECHNICAL ASSISTANCE AND IMPLEMENTATION.

“(a) **IN GENERAL.**—The Director, through the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the ‘Center’), shall award—

“(1) technical assistance grants or contracts to eligible entities to provide technical support to institutions that deliver health care and health care providers (including rural and urban providers of services and suppliers with limited infrastructure and financial resources to implement and support quality improvement activities, providers of services and suppliers with poor performance scores, and providers of services and suppliers for which there are disparities in care among subgroups of patients) so that such institutions and providers understand, adapt, and implement the models and practices identified in the research conducted by the Center, including the Quality Improvement Networks Research Program; and

“(2) implementation grants or contracts to eligible entities to implement the models and practices described under paragraph (1).

“(b) **ELIGIBLE ENTITIES.**—

“(1) **TECHNICAL ASSISTANCE AWARD.**—To be eligible to receive a technical assistance grant or contract under subsection (a)(1), an entity—

“(A) may be a health care provider, health care provider association, professional society, health care worker organization, Indian health organization, quality improvement organization, patient safety organization, local quality improvement collaborative, the Joint Commission, academic health center, university, physician-based research network, primary care extension program established under section 399W, a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act), or any other entity identified by the Secretary; and

“(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

“(2) **IMPLEMENTATION AWARD.**—To be eligible to receive an implementation grant or contract under subsection (a)(2), an entity—

“(A) may be a hospital or other health care provider or consortium or providers, as determined by the Secretary; and

“(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

“(c) **APPLICATION.**—

“(1) **TECHNICAL ASSISTANCE AWARD.**—To receive a technical assistance grant or contract

under subsection (a)(1), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

“(A) a plan for a sustainable business model that may include a system of—

“(i) charging fees to institutions and providers that receive technical support from the entity; and

“(ii) reducing or eliminating such fees for such institutions and providers that serve low-income populations; and

“(B) such other information as the Director may require.

“(2) **IMPLEMENTATION AWARD.**—To receive a grant or contract under subsection (a)(2), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

“(A) a plan for implementation of a model or practice identified in the research conducted by the Center including—

“(i) financial cost, staffing requirements, and timeline for implementation; and

“(ii) pre- and projected post-implementation quality measure performance data in targeted improvement areas identified by the Secretary; and

“(B) such other information as the Director may require.

“(d) **MATCHING FUNDS.**—The Director may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to \$1 for each \$5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

“(e) **EVALUATION.**—

“(1) **IN GENERAL.**—The Director shall evaluate the performance of each entity that receives a grant or contract under this section. The evaluation of an entity shall include a study of—

“(A) the success of such entity in achieving the implementation, by the health care institutions and providers assisted by such entity, of the models and practices identified in the research conducted by the Center under section 933;

“(B) the perception of the health care institutions and providers assisted by such entity regarding the value of the entity; and

“(C) where practicable, better patient health outcomes and lower cost resulting from the assistance provided by such entity.

“(2) **EFFECT OF EVALUATION.**—Based on the outcome of the evaluation of the entity under paragraph (1), the Director shall determine whether to renew a grant or contract with such entity under this section.

“(f) **COORDINATION.**—The entities that receive a grant or contract under this section shall coordinate with health information technology regional extension centers under section 3012(c) and the primary care extension program established under section 399W regarding the dissemination of quality improvement, system delivery reform, and best practices information.”.

SEC. 3502. ESTABLISHING COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME.

(a) **IN GENERAL.**—The Secretary of Health and Human Services (referred to in this section as the ‘Secretary’) shall establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams (referred to in this section as ‘health teams’) to

support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities. Grants or contracts shall be used to—

(1) establish health teams to provide support services to primary care providers; and

(2) provide capitated payments to primary care providers as determined by the Secretary.

(b) **ELIGIBLE ENTITIES.**—To be eligible to receive a grant or contract under subsection (a), an entity shall—

(1)(A) be a State or State-designated entity; or (B) be an Indian tribe or tribal organization, as defined in section 4 of the Indian Health Care Improvement Act;

(2) submit a plan for achieving long-term financial sustainability within 3 years;

(3) submit a plan for incorporating prevention initiatives and patient education and care management resources into the delivery of health care that is integrated with community-based prevention and treatment resources, where available;

(4) ensure that the health team established by the entity includes an interdisciplinary, interprofessional team of health care providers, as determined by the Secretary; such team may include medical specialists, nurses, pharmacists, nutritionists, dietitians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants;

(5) agree to provide services to eligible individuals with chronic conditions, as described in section 1945 of the Social Security Act (as added by section 2703), in accordance with the payment methodology established under subsection (c) of such section; and

(6) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) **REQUIREMENTS FOR HEALTH TEAMS.**—A health team established pursuant to a grant or contract under subsection (a) shall—

(1) establish contractual agreements with primary care providers to provide support services;

(2) support patient-centered medical homes, defined as a mode of care that includes—

(A) personal physicians;

(B) whole person orientation;

(C) coordinated and integrated care;

(D) safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements;

(E) expanded access to care; and

(F) payment that recognizes added value from additional components of patient-centered care;

(3) collaborate with local primary care providers and existing State and community based resources to coordinate disease prevention, chronic disease management, transitioning between health care providers and settings and case management for patients, including children, with priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(4) in collaboration with local health care providers, develop and implement interdisciplinary, interprofessional care plans that integrate clinical and community preventive and health promotion services for patients, including children, with a priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(5) incorporate health care providers, patients, caregivers, and authorized representatives in program design and oversight;

(6) provide support necessary for local primary care providers to—

(A) coordinate and provide access to high-quality health care services;

(B) coordinate and provide access to preventive and health promotion services;

(C) provide access to appropriate specialty care and inpatient services;

(D) provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care;

(E) provide access to pharmacist-delivered medication management services, including medication reconciliation;

(F) provide coordination of the appropriate use of complementary and alternative (CAM) services to those who request such services;

(G) promote effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care to avoid duplication of service and other medical management approaches intended to improve quality and value of health care services;

(H) provide local access to the continuum of health care services in the most appropriate setting, including access to individuals that implement the care plans of patients and coordinate care, such as integrative health care practitioners;

(I) collect and report data that permits evaluation of the success of the collaborative effort on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement; and

(J) establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems such as through the use of infolines, health information technology, or other means as determined by the Secretary;

(7) provide 24-hour care management and support during transitions in care settings including—

(A) a transitional care program that provides onsite visits from the care coordinator, assists with the development of discharge plans and medication reconciliation upon admission to and discharge from the hospitals, nursing home, or other institution setting;

(B) discharge planning and counseling support to providers, patients, caregivers, and authorized representatives;

(C) assuring that post-discharge care plans include medication management, as appropriate;

(D) referrals for mental and behavioral health services, which may include the use of infolines; and

(E) transitional health care needs from adolescence to adulthood;

(8) serve as a liaison to community prevention and treatment programs;

(9) demonstrate a capacity to implement and maintain health information technology that meets the requirements of certified EHR technology (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 300jj)) to facilitate coordination among members of the applicable care team and affiliated primary care practices; and

(10) where applicable, report to the Secretary information on quality measures used under section 399JJ of the Public Health Service Act.

(d) **REQUIREMENT FOR PRIMARY CARE PROVIDERS.**—A provider who contracts with a care team shall—

(1) provide a care plan to the care team for each patient participant;

(2) provide access to participant health records; and

(3) meet regularly with the care team to ensure integration of care.

(e) **REPORTING TO SECRETARY.**—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out by the entity under subsection (c).

(f) **DEFINITION OF PRIMARY CARE.**—In this section, the term “primary care” means the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

SEC. 3503. MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASE.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), as amended by section 3501, is further amended by inserting after section 934 the following:

“SEC. 935. GRANTS OR CONTRACTS TO IMPLEMENT MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASES.

“(a) **IN GENERAL.**—The Secretary, acting through the Patient Safety Research Center established in section 933 (referred to in this section as the ‘Center’), shall establish a program to provide grants or contracts to eligible entities to implement medication management (referred to in this section as ‘MTM’) services provided by licensed pharmacists, as a collaborative, multidisciplinary, inter-professional approach to the treatment of chronic diseases for targeted individuals, to improve the quality of care and reduce overall cost in the treatment of such diseases. The Secretary shall commence the program under this section not later than May 1, 2010.

“(b) **ELIGIBLE ENTITIES.**—To be eligible to receive a grant or contract under subsection (a), an entity shall—

“(1) provide a setting appropriate for MTM services, as recommended by the experts described in subsection (e);

“(2) submit to the Secretary a plan for achieving long-term financial sustainability;

“(3) where applicable, submit a plan for coordinating MTM services through local community health teams established in section 3502 of the Patient Protection and Affordable Care Act or in collaboration with primary care extension programs established in section 399W;

“(4) submit a plan for meeting the requirements under subsection (c); and

“(5) submit to the Secretary such other information as the Secretary may require.

“(c) **MTM SERVICES TO TARGETED INDIVIDUALS.**—The MTM services provided with the assistance of a grant or contract awarded under subsection (a) shall, as allowed by State law including applicable collaborative pharmacy practice agreements, include—

“(1) performing or obtaining necessary assessments of the health and functional status of each patient receiving such MTM services;

“(2) formulating a medication treatment plan according to therapeutic goals agreed upon by the prescriber and the patient or caregiver or authorized representative of the patient;

“(3) selecting, initiating, modifying, recommending changes to, or administering medication therapy;

“(4) monitoring, which may include access to, ordering, or performing laboratory assessments, and evaluating the response of the patient to therapy, including safety and effectiveness;

“(5) performing an initial comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events, quarterly targeted medication reviews for ongoing monitoring, and additional followup interventions on a schedule developed collaboratively with the prescriber;

“(6) documenting the care delivered and communicating essential information about such care, including a summary of the medication review, and the recommendations of the pharmacist to other appropriate health care providers of the patient in a timely fashion;

“(7) providing education and training designed to enhance the understanding and appropriate use of the medications by the patient, caregiver, and other authorized representative;

“(8) providing information, support services, and resources and strategies designed to enhance patient adherence with therapeutic regimens;

“(9) coordinating and integrating MTM services within the broader health care management services provided to the patient; and

“(10) such other patient care services allowed under pharmacist scopes of practice in use in other Federal programs that have implemented MTM services.

“(d) **TARGETED INDIVIDUALS.**—MTM services provided by licensed pharmacists under a grant or contract awarded under subsection (a) shall be offered to targeted individuals who—

“(1) take 4 or more prescribed medications (including over-the-counter medications and dietary supplements);

“(2) take any ‘high risk’ medications;

“(3) have 2 or more chronic diseases, as identified by the Secretary; or

“(4) have undergone a transition of care, or other factors, as determined by the Secretary, that are likely to create a high risk of medication-related problems.

“(e) **CONSULTATION WITH EXPERTS.**—In designing and implementing MTM services provided under grants or contracts awarded under subsection (a), the Secretary shall consult with Federal, State, private, public-private, and academic entities, pharmacy and pharmacist organizations, health care organizations, consumer advocates, chronic disease groups, and other stakeholders involved with the research, dissemination, and implementation of pharmacist-delivered MTM services, as the Secretary determines appropriate. The Secretary, in collaboration with this group, shall determine whether it is possible to incorporate rapid cycle process improvement concepts in use in other Federal programs that have implemented MTM services.

“(f) **REPORTING TO THE SECRETARY.**—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out under subsection (c), including quality measures endorsed by the entity with a contract under section 1890 of the Social Security Act, as determined by the Secretary.

“(g) **EVALUATION AND REPORT.**—The Secretary shall submit to the relevant committees of Congress a report which shall—

“(1) assess the clinical effectiveness of pharmacist-provided services under the MTM services program, as compared to usual care, including an evaluation of whether enrollees maintained better health with fewer hospitalizations and emergency room visits than similar patients not enrolled in the program;

“(2) assess changes in overall health care resource use by targeted individuals;

“(3) assess patient and prescriber satisfaction with MTM services;

“(4) assess the impact of patient-cost sharing requirements on medication adherence and recommendations for modifications;

“(5) identify and evaluate other factors that may impact clinical and economic outcomes, including demographic characteristics, clinical characteristics, and health services use of the patient, as well as characteristics of the regimen, pharmacy benefit, and MTM services provided; and

“(6) evaluate the extent to which participating pharmacists who maintain a dispensing role have a conflict of interest in the provision of MTM services, and if such conflict is found, provide recommendations on how such a conflict might be appropriately addressed.

“(h) **GRANTS OR CONTRACTS TO FUND DEVELOPMENT OF PERFORMANCE MEASURES.**—The Secretary may, through the quality measure development program under section 931 of the Public Health Service Act, award grants or contracts to eligible entities for the purpose of funding the development of performance measures that assess the use and effectiveness of medication therapy management services.”.

SEC. 3504. DESIGN AND IMPLEMENTATION OF REGIONALIZED SYSTEMS FOR EMERGENCY CARE.

(a) **IN GENERAL.**—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended—

(1) in section 1203—

(A) in the section heading, by inserting “**FOR TRAUMA SYSTEMS**” after “**GRANTS**”; and

(B) in subsection (a), by striking “Administrator of the Health Resources and Services Administration” and inserting “Assistant Secretary for Preparedness and Response”;

(2) by inserting after section 1203 the following:

“SEC. 1204. COMPETITIVE GRANTS FOR REGIONALIZED SYSTEMS FOR EMERGENCY CARE RESPONSE.

“(a) **IN GENERAL.**—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall award not fewer than 4 multiyear contracts or competitive grants to eligible entities to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems.

“(b) **ELIGIBLE ENTITY; REGION.**—In this section:

“(1) **ELIGIBLE ENTITY.**—The term ‘eligible entity’ means—

“(A) a State or a partnership of 1 or more States and 1 or more local governments; or

“(B) an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act) or a partnership of 1 or more Indian tribes.

“(2) **REGION.**—The term ‘region’ means an area within a State, an area that lies within multiple States, or a similar area (such as a multicounty area), as determined by the Secretary.

“(3) **EMERGENCY SERVICES.**—The term ‘emergency services’ includes acute, prehospital, and trauma care.

“(c) **PILOT PROJECTS.**—The Secretary shall award a contract or grant under subsection (a) to an eligible entity that proposes a pilot project to design, implement, and evaluate an emergency medical and trauma system that—

“(1) coordinates with public health and safety services, emergency medical services, medical facilities, trauma centers, and other entities in a region to develop an approach to emergency medical and trauma system access throughout the region, including 9–1–1 Public Safety Answering Points and emergency medical dispatch;

“(2) includes a mechanism, such as a regional medical direction or transport communications system, that operates throughout the region to ensure that the patient is taken to the medically appropriate facility (whether an initial facility or a higher-level facility) in a timely fashion;

“(3) allows for the tracking of prehospital and hospital resources, including inpatient bed capacity, emergency department capacity, trauma center capacity, on-call specialist coverage, ambulance diversion status, and the coordination of such tracking with regional communications and hospital destination decisions; and

“(4) includes a consistent region-wide prehospital, hospital, and interfacility data management system that—

“(A) submits data to the National EMS Information System, the National Trauma Data Bank, and others;

“(B) reports data to appropriate Federal and State databanks and registries; and

“(C) contains information sufficient to evaluate key elements of prehospital care, hospital destination decisions, including initial hospital and interfacility decisions, and relevant health outcomes of hospital care.

“(d) **APPLICATION.**—

“(1) **IN GENERAL.**—An eligible entity that seeks a contract or grant described in subsection (a) shall submit to the Secretary an application at such time and in such manner as the Secretary may require.

“(2) **APPLICATION INFORMATION.**—Each application shall include—

“(A) an assurance from the eligible entity that the proposed system—

“(i) has been coordinated with the applicable State Office of Emergency Medical Services (or equivalent State office);

“(ii) includes consistent indirect and direct medical oversight of prehospital, hospital, and interfacility transport throughout the region;

“(iii) coordinates prehospital treatment and triage, hospital destination, and interfacility transport throughout the region;

“(iv) includes a categorization or designation system for special medical facilities throughout the region that is integrated with transport and destination protocols;

“(v) includes a regional medical direction, patient tracking, and resource allocation system that supports day-to-day emergency care and surge capacity and is integrated with other components of the national and State emergency preparedness system; and

“(vi) addresses pediatric concerns related to integration, planning, preparedness, and coordination of emergency medical services for infants, children and adolescents; and

“(B) such other information as the Secretary may require.

“(e) **REQUIREMENT OF MATCHING FUNDS.**—

“(1) **IN GENERAL.**—The Secretary may not make a grant under this section unless the State (or consortia of States) involved agrees, with respect to the costs to be incurred by the State (or consortia) in carrying out the purpose for which such grant was made, to make available non-Federal contributions (in cash or in kind under paragraph (2)) toward such costs in an amount equal to not less than \$1 for each \$3 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities.

“(2) **NON-FEDERAL CONTRIBUTIONS.**—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

“(f) **PRIORITY.**—The Secretary shall give priority for the award of the contracts or grants described in subsection (a) to any eligible entity that serves a population in a medically underserved area (as defined in section 330(b)(3)).

“(g) **REPORT.**—Not later than 90 days after the completion of a pilot project under subsection (a), the recipient of such contract or grant described in shall submit to the Secretary a report containing the results of an evaluation of the program, including an identification of—

“(1) the impact of the regional, accountable emergency care and trauma system on patient health outcomes for various critical care categories, such as trauma, stroke, cardiac emergencies, neurological emergencies, and pediatric emergencies;

“(2) the system characteristics that contribute to the effectiveness and efficiency of the program (or lack thereof);

“(3) methods of assuring the long-term financial sustainability of the emergency care and trauma system;

“(4) the State and local legislation necessary to implement and to maintain the system;

“(5) the barriers to developing regionalized, accountable emergency care and trauma systems, as well as the methods to overcome such barriers; and

“(6) recommendations on the utilization of available funding for future regionalization efforts.

“(h) **DISSEMINATION OF FINDINGS.**—The Secretary shall, as appropriate, disseminate to the public and to the appropriate Committees of the Congress, the information contained in a report made under subsection (g).”; and

(3) in section 1232—

(A) in subsection (a), by striking “appropriated” and all that follows through the period at the end and inserting “appropriated \$24,000,000 for each of fiscal years 2010 through 2014.”; and

(B) by inserting after subsection (c) the following:

“(d) **AUTHORITY.**—For the purpose of carrying out parts A through C, beginning on the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall transfer authority in administering grants and related authorities under such parts from the Administrator of the Health Resources and Services Administration to the Assistant Secretary for Preparedness and Response.”.

(b) **SUPPORT FOR EMERGENCY MEDICINE RESEARCH.**—Part H of title IV of the Public Health Service Act (42 U.S.C. 289 et seq.) is amended by inserting after the section 498C the following:

“**SEC. 498D. SUPPORT FOR EMERGENCY MEDICINE RESEARCH.**

“(a) **EMERGENCY MEDICAL RESEARCH.**—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies involved in improving the emergency care system to expand and accelerate research in emergency medical care systems and emergency medicine, including—

“(1) the basic science of emergency medicine;“(2) the model of service delivery and the components of such models that contribute to enhanced patient health outcomes;

“(3) the translation of basic scientific research into improved practice; and

“(4) the development of timely and efficient delivery of health services.

“(b) **PEDIATRIC EMERGENCY MEDICAL RESEARCH.**—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies to coordinate and expand research in pediatric emergency medical care systems and pediatric emergency medicine, including—

“(1) an examination of the gaps and opportunities in pediatric emergency care research and a strategy for the optimal organization and funding of such research;

“(2) the role of pediatric emergency services as an integrated component of the overall health system;

“(3) system-wide pediatric emergency care planning, preparedness, coordination, and funding;

“(4) pediatric training in professional education; and

“(5) research in pediatric emergency care, specifically on the efficacy, safety, and health outcomes of medications used for infants, children, and adolescents in emergency care settings in order to improve patient safety.

“(c) **IMPACT RESEARCH.**—The Secretary shall support research to determine the estimated economic impact of, and savings that result from, the implementation of coordinated emergency care systems.

“(d) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.”.

SEC. 3505. TRAUMA CARE CENTERS AND SERVICE AVAILABILITY.

(a) **TRAUMA CARE CENTERS.**—

(1) **GRANTS FOR TRAUMA CARE CENTERS.**—Section 1241 of the Public Health Service Act (42 U.S.C. 300d–41) is amended by striking subsections (a) and (b) and inserting the following:

“(a) **IN GENERAL.**—The Secretary shall establish 3 programs to award grants to qualified public, nonprofit Indian Health Service, Indian tribal, and urban Indian trauma centers—

“(1) to assist in defraying substantial uncompensated care costs;

“(2) to further the core missions of such trauma centers, including by addressing costs associated with patient stabilization and transfer, trauma education and outreach, coordination with local and regional trauma systems, essential personnel and other fixed costs, and expenses associated with employee and non-employee physician services; and

“(3) to provide emergency relief to ensure the continued and future availability of trauma services.

“(b) **MINIMUM QUALIFICATIONS OF TRAUMA CENTERS.**—

“(1) **PARTICIPATION IN TRAUMA CARE SYSTEM OPERATING UNDER CERTAIN PROFESSIONAL GUIDELINES.**—Except as provided in paragraph (2), the Secretary may not award a grant to a trauma center under subsection (a) unless the trauma center is a participant in a trauma system that substantially complies with section 1213.

“(2) **EXEMPTION.**—Paragraph (1) shall not apply to trauma centers that are located in States with no existing trauma care system.

“(3) **QUALIFICATION FOR SUBSTANTIAL UNCOMPENSATED CARE COSTS.**—The Secretary shall award substantial uncompensated care grants under subsection (a)(1) only to trauma centers meeting at least 1 of the criteria in 1 of the following 3 categories:

“(A) **CATEGORY A.**—The criteria for category A are as follows:

“(i) At least 40 percent of the visits in the emergency department of the hospital in which the trauma center is located were charity or self-pay patients.

“(ii) At least 50 percent of the visits in such emergency department were Medicaid (under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)) and charity and self-pay patients combined.

“(B) **CATEGORY B.**—The criteria for category B are as follows:

“(i) At least 35 percent of the visits in the emergency department were charity or self-pay patients.

“(ii) At least 50 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

“(C) **CATEGORY C.**—The criteria for category C are as follows:

“(i) At least 20 percent of the visits in the emergency department were charity or self-pay patients.

“(ii) At least 30 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

“(4) **TRAUMA CENTERS IN 1115 WAIVER STATES.**—Notwithstanding paragraph (3), the Secretary may award a substantial uncompensated care grant to a trauma center under subsection (a)(1) if the trauma center qualifies for funds under a Low Income Pool or Safety Net Care Pool established through a waiver approved under section 1115 of the Social Security Act (42 U.S.C. 1315).

“(5) **DESIGNATION.**—The Secretary may not award a grant to a trauma center unless such trauma center is verified by the American College of Surgeons or designated by an equivalent State or local agency.

“(c) **ADDITIONAL REQUIREMENTS.**—The Secretary may not award a grant to a trauma center under subsection (a)(1) unless such trauma center—

“(1) submits to the Secretary a plan satisfactory to the Secretary that demonstrates a continued commitment to serving trauma patients regardless of their ability to pay; and

“(2) has policies in place to assist patients who cannot pay for part or all of the care they receive, including a sliding fee scale, and to ensure fair billing and collection practices.”.

(2) **CONSIDERATIONS IN MAKING GRANTS.**—Section 1242 of the Public Health Service Act (42 U.S.C. 300d–42) is amended by striking subsections (a) and (b) and inserting the following:

“(a) **SUBSTANTIAL UNCOMPENSATED CARE AWARDS.**—

“(1) **IN GENERAL.**—The Secretary shall establish an award basis for each eligible trauma center for grants under section 1241(a)(1) according to the percentage described in paragraph (2), subject to the requirements of section 1241(b)(3).

“(2) **PERCENTAGES.**—The applicable percentages are as follows:

“(A) With respect to a category A trauma center, 100 percent of the uncompensated care costs.

“(B) With respect to a category B trauma center, not more than 75 percent of the uncompensated care costs.

“(C) With respect to a category C trauma center, not more than 50 percent of the uncompensated care costs.

“(b) **CORE MISSION AWARDS.**—

“(1) **IN GENERAL.**—In awarding grants under section 1241(a)(2), the Secretary shall—

“(A) reserve 25 percent of the amount allocated for core mission awards for Level III and Level IV trauma centers; and

“(B) reserve 25 percent of the amount allocated for core mission awards for large urban Level I and II trauma centers—

“(i) that have at least 1 graduate medical education fellowship in trauma or trauma related specialties for which demand is exceeding supply;

“(ii) for which—

“(I) annual uncompensated care costs exceed \$10,000,000; or

“(II) at least 20 percent of emergency department visits are charity or self-pay or Medicaid patients; and

“(iii) that are not eligible for substantial uncompensated care awards under section 1241(a)(1).

“(c) **EMERGENCY AWARDS.**—In awarding grants under section 1241(a)(3), the Secretary shall—

“(1) give preference to any application submitted by a trauma center that provides trauma care in a geographic area in which the availability of trauma care has significantly decreased or will significantly decrease if the center is forced to close or downgrade service or growth in demand for trauma services exceeds capacity; and

“(2) reallocate any emergency awards funds not obligated due to insufficient, or a lack of qualified, applications to the significant uncompensated care award program.”.

(3) **CERTAIN AGREEMENTS.**—Section 1243 of the Public Health Service Act (42 U.S.C. 300d–43) is amended by striking subsections (a), (b), and (c) and inserting the following:

“(a) **MAINTENANCE OF FINANCIAL SUPPORT.**—The Secretary may require a trauma center receiving a grant under section 1241(a) to maintain access to trauma services at comparable levels to the prior year during the grant period.

“(b) **TRAUMA CARE REGISTRY.**—The Secretary may require the trauma center receiving a grant under section 1241(a) to provide data to a national and centralized registry of trauma cases, in accordance with guidelines developed by the American College of Surgeons, and as the Secretary may otherwise require.”.

(4) **GENERAL PROVISIONS.**—Section 1244 of the Public Health Service Act (42 U.S.C. 300d–44) is amended by striking subsections (a), (b), and (c) and inserting the following:

“(a) **APPLICATION.**—The Secretary may not award a grant to a trauma center under section 1241(a) unless such center submits an application for the grant to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

“(b) **LIMITATION ON DURATION OF SUPPORT.**—The period during which a trauma center receives payments under a grant under section 1241(a)(3) shall be for 3 fiscal years, except that the Secretary may waive such requirement for a center and authorize such center to receive such payments for 1 additional fiscal year.

“(c) **LIMITATION ON AMOUNT OF GRANT.**—Notwithstanding section 1242(a), a grant under section 1241 may not be made in an amount exceeding \$2,000,000 for each fiscal year.

“(d) **ELIGIBILITY.**—Except as provided in section 1242(b)(1)(B)(iii), acquisition of, or eligibility for, a grant under section 1241(a) shall not preclude a trauma center from being eligible for other grants described in such section.

“(e) **FUNDING DISTRIBUTION.**—Of the total amount appropriated for a fiscal year under section 1245, 70 percent shall be used for substantial uncompensated care awards under section 1241(a)(1), 20 percent shall be used for core mission awards under section 1241(a)(2), and 10 percent shall be used for emergency awards under section 1241(a)(3).

“(f) **MINIMUM ALLOWANCE.**—Notwithstanding subsection (e), if the amount appropriated for a fiscal year under section 1245 is less than \$25,000,000, all available funding for such fiscal year shall be used for substantial uncompensated care awards under section 1241(a)(1).

“(g) **SUBSTANTIAL UNCOMPENSATED CARE AWARD DISTRIBUTION AND PROPORTIONAL SHARE.**—Notwithstanding section 1242(a), of the amount appropriated for substantial uncompensated care grants for a fiscal year, the Secretary shall—

“(1) make available—

“(A) 50 percent of such funds for category A trauma center grantees;

“(B) 35 percent of such funds for category B trauma center grantees; and

“(C) 15 percent of such funds for category C trauma center grantees; and

“(2) provide available funds within each category in a manner proportional to the award basis specified in section 1242(a)(2) to each eligible trauma center.

“(h) **REPORT.**—Beginning 2 years after the date of enactment of the Patient Protection and Affordable Care Act, and every 2 years thereafter, the Secretary shall biennially report to Congress regarding the status of the grants made under section 1241 and on the overall financial stability of trauma centers.”.

(5) **AUTHORIZATION OF APPROPRIATIONS.**—Section 1245 of the Public Health Service Act (42 U.S.C. 300d–45) is amended to read as follows:

“SEC. 1245. AUTHORIZATION OF APPROPRIATIONS.

“For the purpose of carrying out this part, there are authorized to be appropriated \$100,000,000 for fiscal year 2009, and such sums as may be necessary for each of fiscal years 2010 through 2015. Such authorization of appropriations is in addition to any other authorization

of appropriations or amounts that are available for such purpose.”.

(6) **DEFINITION.**—Part D of title XII of the Public Health Service Act (42 U.S.C. 300d–41 et seq.) is amended by adding at the end the following:

“SEC. 1246. DEFINITION.

“In this part, the term ‘uncompensated care costs’ means unreimbursed costs from serving self-pay, charity, or Medicaid patients, without regard to payment under section 1923 of the Social Security Act, all of which are attributable to emergency care and trauma care, including costs related to subsequent inpatient admissions to the hospital.”.

(b) **TRAUMA SERVICE AVAILABILITY.**—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended by adding at the end the following:

“PART H—TRAUMA SERVICE AVAILABILITY
“SEC. 1281. GRANTS TO STATES.

“(a) **ESTABLISHMENT.**—To promote universal access to trauma care services provided by trauma centers and trauma-related physician specialties, the Secretary shall provide funding to States to enable such States to award grants to eligible entities for the purposes described in this section.

“(b) **AWARDING OF GRANTS BY STATES.**—Each State may award grants to eligible entities within the State for the purposes described in subparagraph (d).

“(c) **ELIGIBILITY.**—

“(1) **IN GENERAL.**—To be eligible to receive a grant under subsection (b) an entity shall—

“(A) be—

“(i) a public or nonprofit trauma center or consortium thereof that meets that requirements of paragraphs (1), (2), and (5) of section 1241(b);

“(ii) a safety net public or nonprofit trauma center that meets the requirements of paragraphs (1) through (5) of section 1241(b); or

“(iii) a hospital in an underserved area (as defined by the State) that seeks to establish new trauma services; and

“(B) submit to the State an application at such time, in such manner, and containing such information as the State may require.

“(2) **LIMITATION.**—A State shall use at least 40 percent of the amount available to the State under this part for a fiscal year to award grants to safety net trauma centers described in paragraph (1)(A)(ii).

“(d) **USE OF FUNDS.**—The recipient of a grant under subsection (b) shall carry out 1 or more of the following activities consistent with subsection (b):

“(1) Providing trauma centers with funding to support physician compensation in trauma-related physician specialties where shortages exist in the region involved, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii).

“(2) Providing for individual safety net trauma center fiscal stability and costs related to having service that is available 24 hours a day, 7 days a week, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii) located in urban, border, and rural areas.

“(3) Reducing trauma center overcrowding at specific trauma centers related to throughput of trauma patients.

“(4) Establishing new trauma services in underserved areas as defined by the State.

“(5) Enhancing collaboration between trauma centers and other hospitals and emergency medical services personnel related to trauma service availability.

“(6) Making capital improvements to enhance access and expedite trauma care, including providing helipads and associated safety infrastructure.

“(7) Enhancing trauma surge capacity at specific trauma centers.

“(8) Ensuring expedient receipt of trauma patients transported by ground or air to the appropriate trauma center.

“(9) Enhancing interstate trauma center collaboration.

“(e) **LIMITATION.**—

“(1) **IN GENERAL.**—A State may use not more than 20 percent of the amount available to the State under this part for a fiscal year for administrative costs associated with awarding grants and related costs.

“(2) **MAINTENANCE OF EFFORT.**—The Secretary may not provide funding to a State under this part unless the State agrees that such funds will be used to supplement and not supplant State funding otherwise available for the activities and costs described in this part.

“(f) **DISTRIBUTION OF FUNDS.**—The following shall apply with respect to grants provided in this part:

“(1) **LESS THAN \$10,000,000.**—If the amount of appropriations for this part in a fiscal year is less than \$10,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under section 1241(b)(3)(A).

“(2) **LESS THAN \$20,000,000.**—If the amount of appropriations in a fiscal year is less than \$20,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under subparagraphs (A) and (B) of section 1241(b)(3).

“(3) **LESS THAN \$30,000,000.**—If the amount of appropriations for this part in a fiscal year is less than \$30,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under section 1241(b)(3).

“(4) **\$30,000,000 OR MORE.**—If the amount of appropriations for this part in a fiscal year is \$30,000,000 or more, the Secretary shall divide such funding evenly among all States.

“SEC. 1282. AUTHORIZATION OF APPROPRIATIONS.

“For the purpose of carrying out this part, there is authorized to be appropriated \$100,000,000 for each of fiscal years 2010 through 2015.”.

SEC. 3506. PROGRAM TO FACILITATE SHARED DECISIONMAKING.

Part D of title IX of the Public Health Service Act, as amended by section 3503, is further amended by adding at the end the following:

“SEC. 936. PROGRAM TO FACILITATE SHARED DECISIONMAKING.

“(a) **PURPOSE.**—The purpose of this section is to facilitate collaborative processes between patients, caregivers or authorized representatives, and clinicians that engages the patient, caregiver or authorized representative in decision-making, provides patients, caregivers or authorized representatives with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan.

“(b) **DEFINITIONS.**—In this section:

“(1) **PATIENT DECISION AID.**—The term ‘patient decision aid’ means an educational tool that helps patients, caregivers or authorized representatives understand and communicate their beliefs and preferences related to their treatment options, and to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences.

“(2) **PREFERENCE SENSITIVE CARE.**—The term ‘preference sensitive care’ means medical care for which the clinical evidence does not clearly support one treatment option such that the appropriate course of treatment depends on the values of the patient or the preferences of the patient, caregivers or authorized representatives regarding the benefits, harms and scientific evidence for each treatment option, the use of such

care should depend on the informed patient choice among clinically appropriate treatment options.

“(c) ESTABLISHMENT OF INDEPENDENT STANDARDS FOR PATIENT DECISION AIDS FOR PREFERENCE SENSITIVE CARE.—

“(1) CONTRACT WITH ENTITY TO ESTABLISH STANDARDS AND CERTIFY PATIENT DECISION AIDS.—

“(A) IN GENERAL.—For purposes of supporting consensus-based standards for patient decision aids for preference sensitive care and a certification process for patient decision aids for use in the Federal health programs and by other interested parties, the Secretary shall have in effect a contract with the entity with a contract under section 1890 of the Social Security Act. Such contract shall provide that the entity perform the duties described in paragraph (2).

“(B) TIMING FOR FIRST CONTRACT.—As soon as practicable after the date of the enactment of this section, the Secretary shall enter into the first contract under subparagraph (A).

“(C) PERIOD OF CONTRACT.—A contract under subparagraph (A) shall be for a period of 18 months (except such contract may be renewed after a subsequent bidding process).

“(2) DUTIES.—The following duties are described in this paragraph:

“(A) DEVELOP AND IDENTIFY STANDARDS FOR PATIENT DECISION AIDS.—The entity shall synthesize evidence and convene a broad range of experts and key stakeholders to develop and identify consensus-based standards to evaluate patient decision aids for preference sensitive care.

“(B) ENDORSE PATIENT DECISION AIDS.—The entity shall review patient decision aids and develop a certification process whether patient decision aids meet the standards developed and identified under subparagraph (A). The entity shall give priority to the review and certification of patient decision aids for preference sensitive care.

“(d) PROGRAM TO DEVELOP, UPDATE AND PATIENT DECISION AIDS TO ASSIST HEALTH CARE PROVIDERS AND PATIENTS.—

“(1) IN GENERAL.—The Secretary, acting through the Director, and in coordination with heads of other relevant agencies, such as the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health, shall establish a program to award grants or contracts—

“(A) to develop, update, and produce patient decision aids for preference sensitive care to assist health care providers in educating patients, caregivers, and authorized representatives concerning the relative safety, relative effectiveness (including possible health outcomes and impact on functional status), and relative cost of treatment or, where appropriate, palliative care options;

“(B) to test such materials to ensure such materials are balanced and evidence based in aiding health care providers and patients, caregivers, and authorized representatives to make informed decisions about patient care and can be easily incorporated into a broad array of practice settings; and

“(C) to educate providers on the use of such materials, including through academic curricula.

“(2) REQUIREMENTS FOR PATIENT DECISION AIDS.—Patient decision aids developed and produced pursuant to a grant or contract under paragraph (1)—

“(A) shall be designed to engage patients, caregivers, and authorized representatives in informed decisionmaking with health care providers;

“(B) shall present up-to-date clinical evidence about the risks and benefits of treatment options in a form and manner that is age-appropriate

and can be adapted for patients, caregivers, and authorized representatives from a variety of cultural and educational backgrounds to reflect the varying needs of consumers and diverse levels of health literacy;

“(C) shall, where appropriate, explain why there is a lack of evidence to support one treatment option over another; and

“(D) shall address health care decisions across the age span, including those affecting vulnerable populations including children.

“(3) DISTRIBUTION.—The Director shall ensure that patient decision aids produced with grants or contracts under this section are available to the public.

“(4) NONDUPLICATION OF EFFORTS.—The Director shall ensure that the activities under this section of the Agency and other agencies, including the Centers for Disease Control and Prevention and the National Institutes of Health, are free of unnecessary duplication of effort.

“(e) GRANTS TO SUPPORT SHARED DECISION-MAKING IMPLEMENTATION.—

“(1) IN GENERAL.—The Secretary shall establish a program to provide for the phased-in development, implementation, and evaluation of shared decisionmaking using patient decision aids to meet the objective of improving the understanding of patients of their medical treatment options.

“(2) SHARED DECISIONMAKING RESOURCE CENTERS.—

“(A) IN GENERAL.—The Secretary shall provide grants for the establishment and support of Shared Decisionmaking Resource Centers (referred to in this subsection as ‘Centers’) to provide technical assistance to providers and to develop and disseminate best practices and other information to support and accelerate adoption, implementation, and effective use of patient decision aids and shared decisionmaking by providers.

“(B) OBJECTIVES.—The objective of a Center is to enhance and promote the adoption of patient decision aids and shared decisionmaking through—

“(i) providing assistance to eligible providers with the implementation and effective use of, and training on, patient decision aids; and

“(ii) the dissemination of best practices and research on the implementation and effective use of patient decision aids.

“(3) SHARED DECISIONMAKING PARTICIPATION GRANTS.—

“(A) IN GENERAL.—The Secretary shall provide grants to health care providers for the development and implementation of shared decisionmaking techniques and to assess the use of such techniques.

“(B) PREFERENCE.—In order to facilitate the use of best practices, the Secretary shall provide a preference in making grants under this subsection to health care providers who participate in training by Shared Decisionmaking Resource Centers or comparable training.

“(C) LIMITATION.—Funds under this paragraph shall not be used to purchase or implement use of patient decision aids other than those certified under the process identified in subsection (c).

“(4) GUIDANCE.—The Secretary may issue guidance to eligible grantees under this subsection on the use of patient decision aids.

“(f) FUNDING.—For purposes of carrying out this section there are authorized to be appropriated such sums as may be necessary for fiscal year 2010 and each subsequent fiscal year.”.

SEC. 3507. PRESENTATION OF PRESCRIPTION DRUG BENEFIT AND RISK INFORMATION.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”), acting through the Commissioner of Food and Drugs, shall determine

whether the addition of quantitative summaries of the benefits and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decisionmaking by clinicians and patients and consumers.

(b) REVIEW AND CONSULTATION.—In making the determination under subsection (a), the Secretary shall review all available scientific evidence and research on decisionmaking and social and cognitive psychology and consult with drug manufacturers, clinicians, patients and consumers, experts in health literacy, representatives of racial and ethnic minorities, and experts in women’s and pediatric health.

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report that provides—

(1) the determination by the Secretary under subsection (a); and

(2) the reasoning and analysis underlying that determination.

(d) AUTHORITY.—If the Secretary determines under subsection (a) that the addition of quantitative summaries of the benefits and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decisionmaking by clinicians and patients and consumers, then the Secretary, not later than 3 years after the date of submission of the report under subsection (c), shall promulgate proposed regulations as necessary to implement such format.

(e) CLARIFICATION.—Nothing in this section shall be construed to restrict the existing authorities of the Secretary with respect to benefit and risk information.

SEC. 3508. DEMONSTRATION PROGRAM TO INTEGRATE QUALITY IMPROVEMENT AND PATIENT SAFETY TRAINING INTO CLINICAL EDUCATION OF HEALTH PROFESSIONALS.

(a) IN GENERAL.—The Secretary may award grants to eligible entities or consortia under this section to carry out demonstration projects to develop and implement academic curricula that integrates quality improvement and patient safety in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity or consortium shall—

(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

(2) be or include—

(A) a health professions school;

(B) a school of public health;

(C) a school of social work;

(D) a school of nursing;

(E) a school of pharmacy;

(F) an institution with a graduate medical education program; or

(G) a school of health care administration;

(3) collaborate in the development of curricula described in subsection (a) with an organization that accredits such school or institution;

(4) provide for the collection of data regarding the effectiveness of the demonstration project; and

(5) provide matching funds in accordance with subsection (c).

(c) MATCHING FUNDS.—

(1) IN GENERAL.—The Secretary may award a grant to an entity or consortium under this section only if the entity or consortium agrees to make available non-Federal contributions toward the costs of the program to be funded under the grant in an amount that is not less than \$1 for each \$5 of Federal funds provided under the grant.

(2) **DETERMINATION OF AMOUNT CONTRIBUTED.**—Non-Federal contributions under paragraph (1) may be in cash or in-kind, fairly evaluated, including equipment or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

(d) **EVALUATION.**—The Secretary shall take such action as may be necessary to evaluate the projects funded under this section and publish, make publicly available, and disseminate the results of such evaluations on as wide a basis as is practicable.

(e) **REPORTS.**—Not later than 2 years after the date of enactment of this section, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a report that—

(1) describes the specific projects supported under this section; and

(2) contains recommendations for Congress based on the evaluation conducted under subsection (d).

SEC. 3509. IMPROVING WOMEN'S HEALTH.

(a) **HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.**—

(1) **ESTABLISHMENT.**—Part A of title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

“SEC. 229. HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.”

“(a) **ESTABLISHMENT OF OFFICE.**—There is established within the Office of the Secretary, an Office on Women's Health (referred to in this section as the ‘Office’). The Office shall be headed by a Deputy Assistant Secretary for Women's Health who may report to the Secretary.

“(b) **DUTIES.**—The Secretary, acting through the Office, with respect to the health concerns of women, shall—

“(1) establish short-range and long-range goals and objectives within the Department of Health and Human Services and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Department that relate to disease prevention, health promotion, service delivery, research, and public and health care professional education, for issues of particular concern to women throughout their lifespan;

“(2) provide expert advice and consultation to the Secretary concerning scientific, legal, ethical, and policy issues relating to women's health;

“(3) monitor the Department of Health and Human Services' offices, agencies, and regional activities regarding women's health and identify needs regarding the coordination of activities, including intramural and extramural multidisciplinary activities;

“(4) establish a Department of Health and Human Services Coordinating Committee on Women's Health, which shall be chaired by the Deputy Assistant Secretary for Women's Health and composed of senior level representatives from each of the agencies and offices of the Department of Health and Human Services;

“(5) establish a National Women's Health Information Center to—

“(A) facilitate the exchange of information regarding matters relating to health information, health promotion, preventive health services, research advances, and education in the appropriate use of health care;

“(B) facilitate access to such information;

“(C) assist in the analysis of issues and problems relating to the matters described in this paragraph; and

“(D) provide technical assistance with respect to the exchange of information (including facilitating the development of materials for such technical assistance);

“(6) coordinate efforts to promote women's health programs and policies with the private sector; and

“(7) through publications and any other means appropriate, provide for the exchange of information between the Office and recipients of grants, contracts, and agreements under subsection (c), and between the Office and health professionals and the general public.

“(c) **GRANTS AND CONTRACTS REGARDING DUTIES.**—

“(1) **AUTHORITY.**—In carrying out subsection (b), the Secretary may make grants to, and enter into cooperative agreements, contracts, and interagency agreements with, public and private entities, agencies, and organizations.

“(2) **EVALUATION AND DISSEMINATION.**—The Secretary shall directly or through contracts with public and private entities, agencies, and organizations, provide for evaluations of projects carried out with financial assistance provided under paragraph (1) and for the dissemination of information developed as a result of such projects.

“(d) **REPORTS.**—Not later than 1 year after the date of enactment of this section, and every second year thereafter, the Secretary shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under this section during the period for which the report is being prepared.

“(e) **AUTHORIZATION OF APPROPRIATIONS.**—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.”

(2) **TRANSFER OF FUNCTIONS.**—There are transferred to the Office on Women's Health (established under section 229 of the Public Health Service Act, as added by this section), all functions exercised by the Office on Women's Health of the Public Health Service prior to the date of enactment of this section, including all personnel and compensation authority, all delegation and assignment authority, and all remaining appropriations. All orders, determinations, rules, regulations, permits, agreements, grants, contracts, certificates, licenses, registrations, privileges, and other administrative actions that—

(A) have been issued, made, granted, or allowed to become effective by the President, any Federal agency or official thereof, or by a court of competent jurisdiction, in the performance of functions transferred under this paragraph; and

(B) are in effect at the time this section takes effect, or were final before the date of enactment of this section and are to become effective on or after such date,

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, the Secretary, or other authorized official, a court of competent jurisdiction, or by operation of law.

(b) **CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.**—Part A of title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

“SEC. 310A. CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.”

“(a) **ESTABLISHMENT.**—There is established within the Office of the Director of the Centers for Disease Control and Prevention, an office to be known as the Office of Women's Health (referred to in this section as the ‘Office’). The Office shall be headed by a director who shall be appointed by the Director of such Centers.

“(b) **PURPOSE.**—The Director of the Office shall—

“(1) report to the Director of the Centers for Disease Control and Prevention on the current level of the Centers' activity regarding women's health conditions across, where appropriate, age, biological, and sociocultural contexts, in all aspects of the Centers' work, including prevention programs, public and professional education, services, and treatment;

“(2) establish short-range and long-range goals and objectives within the Centers for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Centers that relate to prevention, research, education and training, service delivery, and policy development, for issues of particular concern to women;

“(3) identify projects in women's health that should be conducted or supported by the Centers;

“(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on the policy of the Centers with regard to women; and

“(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)).

“(c) **DEFINITION.**—As used in this section, the term ‘women's health conditions’, with respect to women of all age, ethnic, and racial groups, means diseases, disorders, and conditions—

“(1) unique to, significantly more serious for, or significantly more prevalent in women; and

“(2) for which the factors of medical risk or type of medical intervention are different for women, or for which there is reasonable evidence that indicates that such factors or types may be different for women.

“(d) **AUTHORIZATION OF APPROPRIATIONS.**—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.”

(c) **OFFICE OF WOMEN'S HEALTH RESEARCH.**—Section 486(a) of the Public Health Service Act (42 U.S.C. 287d(a)) is amended by inserting “and who shall report directly to the Director” before the period at the end thereof.

(d) **SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION.**—Section 501(f) of the Public Health Service Act (42 U.S.C. 290aa(f)) is amended—

(1) in paragraph (1), by inserting “who shall report directly to the Administrator” before the period;

(2) by redesignating paragraph (4) as paragraph (5); and

(3) by inserting after paragraph (3), the following:

“(4) **OFFICE.**—Nothing in this subsection shall be construed to preclude the Secretary from establishing within the Substance Abuse and Mental Health Administration an Office of Women's Health.”

(e) **AGENCY FOR HEALTHCARE RESEARCH AND QUALITY ACTIVITIES REGARDING WOMEN'S HEALTH.**—Part C of title IX of the Public Health Service Act (42 U.S.C. 299c et seq.) is amended—

(1) by redesignating sections 925 and 926 as sections 926 and 927, respectively; and

(2) by inserting after section 924 the following:

“SEC. 925. ACTIVITIES REGARDING WOMEN'S HEALTH.”

“(a) **ESTABLISHMENT.**—There is established within the Office of the Director, an Office of Women's Health and Gender-Based Research (referred to in this section as the ‘Office’). The Office shall be headed by a director who shall be appointed by the Director of Healthcare and Research Quality.

“(b) **PURPOSE.**—The official designated under subsection (a) shall—

“(1) report to the Director on the current Agency level of activity regarding women’s health, across, where appropriate, age, biological, and sociocultural contexts, in all aspects of Agency work, including the development of evidence reports and clinical practice protocols and the conduct of research into patient outcomes, delivery of health care services, quality of care, and access to health care;

“(2) establish short-range and long-range goals and objectives within the Agency for research important to women’s health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Agency that relate to health services and medical effectiveness research, for issues of particular concern to women;

“(3) identify projects in women’s health that should be conducted or supported by the Agency;

“(4) consult with health professionals, non-governmental organizations, consumer organizations, women’s health professionals, and other individuals and groups, as appropriate, on Agency policy with regard to women; and

“(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women’s Health (established under section 229(b)(4)).”.

“(c) **AUTHORIZATION OF APPROPRIATIONS.**—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.”.

(f) **HEALTH RESOURCES AND SERVICES ADMINISTRATION OFFICE OF WOMEN’S HEALTH.**—Title VII of the Social Security Act (42 U.S.C. 901 et seq.) is amended by adding at the end the following:

“SEC. 713. OFFICE OF WOMEN’S HEALTH.

“(a) **ESTABLISHMENT.**—The Secretary shall establish within the Office of the Administrator of the Health Resources and Services Administration, an office to be known as the Office of Women’s Health. The Office shall be headed by a director who shall be appointed by the Administrator.

“(b) **PURPOSE.**—The Director of the Office shall—

“(1) report to the Administrator on the current Administration level of activity regarding women’s health across, where appropriate, age, biological, and sociocultural contexts;

“(2) establish short-range and long-range goals and objectives within the Health Resources and Services Administration for women’s health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Administration that relate to health care provider training, health service delivery, research, and demonstration projects, for issues of particular concern to women;

“(3) identify projects in women’s health that should be conducted or supported by the bureaus of the Administration;

“(4) consult with health professionals, non-governmental organizations, consumer organizations, women’s health professionals, and other individuals and groups, as appropriate, on Administration policy with regard to women; and

“(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women’s Health (established under section 229(b)(4) of the Public Health Service Act).

“(c) **CONTINUED ADMINISTRATION OF EXISTING PROGRAMS.**—The Director of the Office shall assume the authority for the development, implementation, administration, and evaluation of any projects carried out through the Health Resources and Services Administration relating to women’s health on the date of enactment of this section.

“(d) **DEFINITIONS.**—For purposes of this section:

“(1) **ADMINISTRATION.**—The term ‘Administration’ means the Health Resources and Services Administration.

“(2) **ADMINISTRATOR.**—The term ‘Administrator’ means the Administrator of the Health Resources and Services Administration.

“(3) **OFFICE.**—The term ‘Office’ means the Office of Women’s Health established under this section in the Administration.

“(e) **AUTHORIZATION OF APPROPRIATIONS.**—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.”.

(g) **FOOD AND DRUG ADMINISTRATION OFFICE OF WOMEN’S HEALTH.**—Chapter X of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amended by adding at the end the following:

“SEC. 1011. OFFICE OF WOMEN’S HEALTH.

“(a) **ESTABLISHMENT.**—There is established within the Office of the Commissioner, an office to be known as the Office of Women’s Health (referred to in this section as the ‘Office’). The Office shall be headed by a director who shall be appointed by the Commissioner of Food and Drugs.

“(b) **PURPOSE.**—The Director of the Office shall—

“(1) report to the Commissioner of Food and Drugs on current Food and Drug Administration (referred to in this section as the ‘Administration’) levels of activity regarding women’s participation in clinical trials and the analysis of data by sex in the testing of drugs, medical devices, and biological products across, where appropriate, age, biological, and sociocultural contexts;

“(2) establish short-range and long-range goals and objectives within the Administration for issues of particular concern to women’s health within the jurisdiction of the Administration, including, where relevant and appropriate, adequate inclusion of women and analysis of data by sex in Administration protocols and policies;

“(3) provide information to women and health care providers on those areas in which differences between men and women exist;

“(4) consult with pharmaceutical, biologics, and device manufacturers, health professionals with expertise in women’s issues, consumer organizations, and women’s health professionals on Administration policy with regard to women;

“(5) make annual estimates of funds needed to monitor clinical trials and analysis of data by sex in accordance with needs that are identified; and

“(6) serve as a member of the Department of Health and Human Services Coordinating Committee on Women’s Health (established under section 229(b)(4) of the Public Health Service Act).

“(c) **AUTHORIZATION OF APPROPRIATIONS.**—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.”.

(h) **NO NEW REGULATORY AUTHORITY.**—Nothing in this section and the amendments made by this section may be construed as establishing regulatory authority or modifying any existing regulatory authority.

(i) **LIMITATION ON TERMINATION.**—Notwithstanding any other provision of law, a Federal office of women’s health (including the Office of Research on Women’s Health of the National Institutes of Health) or Federal appointive position with primary responsibility over women’s health issues (including the Associate Administrator for Women’s Services under the Substance Abuse and Mental Health Services Administration) that is in existence on the date of enactment of this section shall not be terminated, re-

organized, or have any of its powers or duties transferred unless such termination, reorganization, or transfer is approved by Congress through the adoption of a concurrent resolution of approval.

(j) **RULE OF CONSTRUCTION.**—Nothing in this section (or the amendments made by this section) shall be construed to limit the authority of the Secretary of Health and Human Services with respect to women’s health, or with respect to activities carried out through the Department of Health and Human Services on the date of enactment of this section.

SEC. 3510. PATIENT NAVIGATOR PROGRAM.

Section 340A of the Public Health Service Act (42 U.S.C. 256a) is amended—

(1) by striking subsection (d)(3) and inserting the following:

“(3) **LIMITATIONS ON GRANT PERIOD.**—In carrying out this section, the Secretary shall ensure that the total period of a grant does not exceed 4 years.”;

(2) in subsection (e), by adding at the end the following:

“(3) **MINIMUM CORE PROFICIENCIES.**—The Secretary shall not award a grant to an entity under this section unless such entity provides assurances that patient navigators recruited, assigned, trained, or employed using grant funds meet minimum core proficiencies, as defined by the entity that submits the application, that are tailored for the main focus or intervention of the navigator involved.”; and

(3) in subsection (m)—

(A) in paragraph (1), by striking “and \$3,500,000 for fiscal year 2010.” and inserting “\$3,500,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.”; and

(B) in paragraph (2), by striking “2010” and inserting “2015”.

SEC. 3511. AUTHORIZATION OF APPROPRIATIONS.

Except where otherwise provided in this subtitle (or an amendment made by this subtitle), there is authorized to be appropriated such sums as may be necessary to carry out this subtitle (and such amendments made by this subtitle).

Subtitle G—Protecting and Improving Guaranteed Medicare Benefits

SEC. 3601. PROTECTING AND IMPROVING GUARANTEED MEDICARE BENEFITS.

(a) **PROTECTING GUARANTEED MEDICARE BENEFITS.**—Nothing in the provisions of, or amendments made by, this Act shall result in a reduction of guaranteed benefits under title XVIII of the Social Security Act.

(b) **ENSURING THAT MEDICARE SAVINGS BENEFIT THE MEDICARE PROGRAM AND MEDICARE BENEFICIARIES.**—Savings generated for the Medicare program under title XVIII of the Social Security Act under the provisions of, and amendments made by, this Act shall extend the solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.

SEC. 3602. NO CUTS IN GUARANTEED BENEFITS.

Nothing in this Act shall result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans.

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A—Modernizing Disease Prevention and Public Health Systems

SEC. 4001. NATIONAL PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH COUNCIL.

(a) **ESTABLISHMENT.**—The President shall establish, within the Department of Health and Human Services, a council to be known as the “National Prevention, Health Promotion and

Public Health Council" (referred to in this section as the "Council").

(b) **CHAIRPERSON.**—The President shall appoint the Surgeon General to serve as the chairperson of the Council.

(c) **COMPOSITION.**—The Council shall be composed of—

- (1) the Secretary of Health and Human Services;
- (2) the Secretary of Agriculture;
- (3) the Secretary of Education;
- (4) the Chairman of the Federal Trade Commission;
- (5) the Secretary of Transportation;
- (6) the Secretary of Labor;
- (7) the Secretary of Homeland Security;
- (8) the Administrator of the Environmental Protection Agency;
- (9) the Director of the Office of National Drug Control Policy;
- (10) the Director of the Domestic Policy Council;
- (11) the Assistant Secretary for Indian Affairs;
- (12) the Chairman of the Corporation for National and Community Service; and
- (13) the head of any other Federal agency that the chairperson determines is appropriate.

(d) **PURPOSES AND DUTIES.**—The Council shall—

(1) provide coordination and leadership at the Federal level, and among all Federal departments and agencies, with respect to prevention, wellness and health promotion practices, the public health system, and integrative health care in the United States;

(2) after obtaining input from relevant stakeholders, develop a national prevention, health promotion, public health, and integrative health care strategy that incorporates the most effective and achievable means of improving the health status of Americans and reducing the incidence of preventable illness and disability in the United States;

(3) provide recommendations to the President and Congress concerning the most pressing health issues confronting the United States and changes in Federal policy to achieve national wellness, health promotion, and public health goals, including the reduction of tobacco use, sedentary behavior, and poor nutrition;

(4) consider and propose evidence-based models, policies, and innovative approaches for the promotion of transformative models of prevention, integrative health, and public health on individual and community levels across the United States;

(5) establish processes for continual public input, including input from State, regional, and local leadership communities and other relevant stakeholders, including Indian tribes and tribal organizations;

(6) submit the reports required under subsection (g); and

(7) carry out other activities determined appropriate by the President.

(e) **MEETINGS.**—The Council shall meet at the call of the Chairperson.

(f) **ADVISORY GROUP.**—

(1) **IN GENERAL.**—The President shall establish an Advisory Group to the Council to be known as the "Advisory Group on Prevention, Health Promotion, and Integrative and Public Health" (hereafter referred to in this section as the "Advisory Group"). The Advisory Group shall be within the Department of Health and Human Services and report to the Surgeon General.

(2) **COMPOSITION.**—

(A) **IN GENERAL.**—The Advisory Group shall be composed of not more than 25 non-Federal members to be appointed by the President.

(B) **REPRESENTATION.**—In appointing members under subparagraph (A), the President shall ensure that the Advisory Group includes a diverse group of licensed health professionals, including

integrative health practitioners who have experience in—

- (i) worksite health promotion;
- (ii) community services, including community health centers;
- (iii) preventive medicine;
- (iv) health coaching;
- (v) public health education;
- (vi) geriatrics; and
- (vii) rehabilitation medicine.

(3) **PURPOSES AND DUTIES.**—The Advisory Group shall develop policy and program recommendations and advise the Council on life-style-based chronic disease prevention and management, integrative health care practices, and health promotion.

(g) **NATIONAL PREVENTION AND HEALTH PROMOTION STRATEGY.**—Not later than 1 year after the date of enactment of this Act, the Chairperson, in consultation with the Council, shall develop and make public a national prevention, health promotion and public health strategy, and shall review and revise such strategy periodically. Such strategy shall—

(1) set specific goals and objectives for improving the health of the United States through federally-supported prevention, health promotion, and public health programs, consistent with ongoing goal setting efforts conducted by specific agencies;

(2) establish specific and measurable actions and timelines to carry out the strategy, and determine accountability for meeting those timelines, within and across Federal departments and agencies; and

(3) make recommendations to improve Federal efforts relating to prevention, health promotion, public health, and integrative health care practices to ensure Federal efforts are consistent with available standards and evidence.

(h) **REPORT.**—Not later than July 1, 2010, and annually thereafter through January 1, 2015, the Council shall submit to the President and the relevant committees of Congress, a report that—

(1) describes the activities and efforts on prevention, health promotion, and public health and activities to develop a national strategy conducted by the Council during the period for which the report is prepared;

(2) describes the national progress in meeting specific prevention, health promotion, and public health goals defined in the strategy and further describes corrective actions recommended by the Council and taken by relevant agencies and organizations to meet these goals;

(3) contains a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification (smoking cessation, proper nutrition, appropriate exercise, mental health, behavioral health, substance use disorder, and domestic violence screenings) and the prevention measures for the 5 leading disease killers in the United States;

(4) contains specific science-based initiatives to achieve the measurable goals of Healthy People 2010 regarding nutrition, exercise, and smoking cessation, and targeting the 5 leading disease killers in the United States;

(5) contains specific plans for consolidating Federal health programs and Centers that exist to promote healthy behavior and reduce disease risk (including eliminating programs and offices determined to be ineffective in meeting the priority goals of Healthy People 2010);

(6) contains specific plans to ensure that all Federal health care programs are fully coordinated with science-based prevention recommendations by the Director of the Centers for Disease Control and Prevention; and

(7) contains specific plans to ensure that all non-Department of Health and Human Services prevention programs are based on the science-based guidelines developed by the Centers for

Disease Control and Prevention under paragraph (4).

(i) **PERIODIC REVIEWS.**—The Secretary and the Comptroller General of the United States shall jointly conduct periodic reviews, not less than every 5 years, and evaluations of every Federal disease prevention and health promotion initiative, program, and agency. Such reviews shall be evaluated based on effectiveness in meeting metrics-based goals with an analysis posted on such agencies' public Internet websites.

SEC. 4002. PREVENTION AND PUBLIC HEALTH FUND.

(a) **PURPOSE.**—It is the purpose of this section to establish a Prevention and Public Health Fund (referred to in this section as the "Fund"), to be administered through the Department of Health and Human Services, Office of the Secretary, to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.

(b) **FUNDING.**—There are hereby authorized to be appropriated, and appropriated, to the Fund, out of any monies in the Treasury not otherwise appropriated—

- (1) for fiscal year 2010, \$500,000,000;
- (2) for fiscal year 2011, \$750,000,000;
- (3) for fiscal year 2012, \$1,000,000,000;
- (4) for fiscal year 2013, \$1,250,000,000;
- (5) for fiscal year 2014, \$1,500,000,000; and
- (6) for fiscal year 2015, and each fiscal year thereafter, \$2,000,000,000.

(c) **USE OF FUND.**—The Secretary shall transfer amounts in the Fund to accounts within the Department of Health and Human Services to increase funding, over the fiscal year 2008 level, for programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research and health screenings, such as the Community Transformation grant program, the Education and Outreach Campaign for Preventive Benefits, and immunization programs.

(d) **TRANSFER AUTHORITY.**—The Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives may provide for the transfer of funds in the Fund to eligible activities under this section, subject to subsection (c).

SEC. 4003. CLINICAL AND COMMUNITY PREVENTIVE SERVICES.

(a) **PREVENTIVE SERVICES TASK FORCE.**—Section 915 of the Public Health Service Act (42 U.S.C. 299b-4) is amended by striking subsection (a) and inserting the following:

“(a) **PREVENTIVE SERVICES TASK FORCE.**—

“(1) **ESTABLISHMENT AND PURPOSE.**—The Director shall convene an independent Preventive Services Task Force (referred to in this subsection as the ‘Task Force’) to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community, and updating previous clinical preventive recommendations, to be published in the Guide to Clinical Preventive Services (referred to in this section as the ‘Guide’), for individuals and organizations delivering clinical services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, Congress and other policy-makers, governmental public health agencies, health care quality organizations, and organizations developing national health objectives. Such recommendations shall consider clinical preventive best practice recommendations from the Agency for Healthcare Research and Quality, the National Institutes of Health, the Centers for Disease Control and Prevention, the

Institute of Medicine, specialty medical associations, patient groups, and scientific societies.

“(2) DUTIES.—The duties of the Task Force shall include—

“(A) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific sub-populations and age groups;

“(B) at least once during every 5-year period, review interventions and update recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions;

“(C) improved integration with Federal Government health objectives and related target setting for health improvement;

“(D) the enhanced dissemination of recommendations;

“(E) the provision of technical assistance to those health care professionals, agencies and organizations that request help in implementing the Guide recommendations; and

“(F) the submission of yearly reports to Congress and related agencies identifying gaps in research, such as preventive services that receive an insufficient evidence statement, and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.

“(3) ROLE OF AGENCY.—The Agency shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of the Guide's recommendations.

“(4) COORDINATION WITH COMMUNITY PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the Community Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force's recommendations interact at the nexus of clinic and community.

“(5) OPERATION.—Operation. In carrying out the duties under paragraph (2), the Task Force is not subject to the provisions of Appendix 2 of title 5, United States Code.

“(6) INDEPENDENCE.—All members of the Task Force convened under this subsection, and any recommendations made by such members, shall be independent and, to the extent practicable, not subject to political pressure.

“(7) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.”.

(b) COMMUNITY PREVENTIVE SERVICES TASK FORCE.—

(1) IN GENERAL.—Part P of title III of the Public Health Service Act, as amended by paragraph (2), is amended by adding at the end the following:

“SEC. 399U. COMMUNITY PREVENTIVE SERVICES TASK FORCE.

“(a) ESTABLISHMENT AND PURPOSE.—The Director of the Centers for Disease Control and Prevention shall convene an independent Community Preventive Services Task Force (referred to in this subsection as the ‘Task Force’) to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions for the purpose of developing recommendations, to be published in the Guide to Community Preventive Services (referred to in this section as the ‘Guide’), for individuals and organizations delivering population-based services, including primary care

professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, schools, governmental public health agencies, Indian tribes, tribal organizations and urban Indian organizations, medical groups, Congress and other policy-makers. Community preventive services include any policies, programs, processes or activities designed to affect or otherwise affecting health at the population level.

“(b) DUTIES.—The duties of the Task Force shall include—

“(1) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific populations and age groups, as well as the social, economic and physical environments that can have broad effects on the health and disease of populations and health disparities among sub-populations and age groups;

“(2) at least once during every 5-year period, review interventions and update recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions, including health impact assessment and population health modeling;

“(3) improved integration with Federal Government health objectives and related target setting for health improvement;

“(4) the enhanced dissemination of recommendations;

“(5) the provision of technical assistance to those health care professionals, agencies, and organizations that request help in implementing the Guide recommendations; and

“(6) providing yearly reports to Congress and related agencies identifying gaps in research and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.

“(c) ROLE OF AGENCY.—The Director shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of Guide recommendations.

“(d) COORDINATION WITH PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force's recommendations interact at the nexus of clinic and community.

“(e) OPERATION.—In carrying out the duties under subsection (b), the Task Force shall not be subject to the provisions of Appendix 2 of title 5, United States Code.

“(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.”.

(2) TECHNICAL AMENDMENTS.—

(A) Section 399R of the Public Health Service Act (as added by section 2 of the ALS Registry Act (Public Law 110-373; 122 Stat. 4047)) is redesignated as section 399S.

(B) Section 399R of such Act (as added by section 3 of the Prenatally and Postnatally Diagnosed Conditions Awareness Act (Public Law 110-374; 122 Stat. 4051)) is redesignated as section 399T.

SEC. 400A. EDUCATION AND OUTREACH CAMPAIGN REGARDING PREVENTIVE BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall provide for the planning and implementation of a national public-private

partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span. Such campaign shall include the dissemination of information that—

(1) describes the importance of utilizing preventive services to promote wellness, reduce health disparities, and mitigate chronic disease;

(2) promotes the use of preventive services recommended by the United States Preventive Services Task Force and the Community Preventive Services Task Force;

(3) encourages healthy behaviors linked to the prevention of chronic diseases;

(4) explains the preventive services covered under health plans offered through a Gateway;

(5) describes additional preventive care supported by the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Advisory Committee on Immunization Practices, and other appropriate agencies; and

(6) includes general health promotion information.

(b) CONSULTATION.—In coordinating the campaign under subsection (a), the Secretary shall consult with the Institute of Medicine to provide ongoing advice on evidence-based scientific information for policy, program development, and evaluation.

(c) MEDIA CAMPAIGN.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and implement a national science-based media campaign on health promotion and disease prevention.

(2) REQUIREMENT OF CAMPAIGN.—The campaign implemented under paragraph (1)—

(A) shall be designed to address proper nutrition, regular exercise, smoking cessation, obesity reduction, the 5 leading disease killers in the United States, and secondary prevention through disease screening promotion;

(B) shall be carried out through competitively bid contracts awarded to entities providing for the professional production and design of such campaign;

(C) may include the use of television, radio, Internet, and other commercial marketing venues and may be targeted to specific age groups based on peer-reviewed social research;

(D) shall not be duplicative of any other Federal efforts relating to health promotion and disease prevention; and

(E) may include the use of humor and nationally recognized positive role models.

(3) EVALUATION.—The Secretary shall ensure that the campaign implemented under paragraph (1) is subject to an independent evaluation every 2 years and shall report every 2 years to Congress on the effectiveness of such campaigns towards meeting science-based metrics.

(d) WEBSITE.—The Secretary, in consultation with private-sector experts, shall maintain or enter into a contract to maintain an Internet website to provide science-based information on guidelines for nutrition, regular exercise, obesity reduction, smoking cessation, and specific chronic disease prevention. Such website shall be designed to provide information to health care providers and consumers.

(e) DISSEMINATION OF INFORMATION THROUGH PROVIDERS.—The Secretary, acting through the Centers for Disease Control and Prevention, shall develop and implement a plan for the dissemination of health promotion and disease prevention information consistent with national priorities, to health care providers who participate in Federal programs, including programs administered by the Indian Health Service, the Department of Veterans Affairs, the Department

of Defense, and the Health Resources and Services Administration, and Medicare and Medicaid.

(f) **PERSONALIZED PREVENTION PLANS.**—

(1) **CONTRACT.**—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into a contract with a qualified entity for the development and operation of a Federal Internet website personalized prevention plan tool.

(2) **USE.**—The website developed under paragraph (1) shall be designed to be used as a source of the most up-to-date scientific evidence relating to disease prevention for use by individuals. Such website shall contain a component that enables an individual to determine their disease risk (based on personal health and family history, BMI, and other relevant information) relating to the 5 leading diseases in the United States, and obtain personalized suggestions for preventing such diseases.

(g) **INTERNET PORTAL.**—The Secretary shall establish an Internet portal for accessing risk-assessment tools developed and maintained by private and academic entities.

(h) **PRIORITY FUNDING.**—Funding for the activities authorized under this section shall take priority over funding provided through the Centers for Disease Control and Prevention for grants to States and other entities for similar purposes and goals as provided for in this section. Not to exceed \$500,000,000 shall be expended on the campaigns and activities required under this section.

(i) **PUBLIC AWARENESS OF PREVENTIVE AND OBESITY-RELATED SERVICES.**—

(1) **INFORMATION TO STATES.**—The Secretary of Health and Human Services shall provide guidance and relevant information to States and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults.

(2) **INFORMATION TO ENROLLEES.**—Each State shall design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services, with the goal of reducing incidences of obesity.

(3) **REPORT.**—Not later than January 1, 2011, and every 3 years thereafter through January 1, 2017, the Secretary of Health and Human Services shall report to Congress on the status and effectiveness of efforts under paragraphs (1) and (2), including summaries of the States' efforts to increase awareness of coverage of obesity-related services.

(j) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated such sums as may be necessary to carry out this section.

Subtitle B—Increasing Access to Clinical Preventive Services

SEC. 4101. SCHOOL-BASED HEALTH CENTERS.

(a) **GRANTS FOR THE ESTABLISHMENT OF SCHOOL-BASED HEALTH CENTERS.**—

(1) **PROGRAM.**—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall establish a program to award grants to eligible entities to support the operation of school-based health centers.

(2) **ELIGIBILITY.**—To be eligible for a grant under this subsection, an entity shall—

(A) be a school-based health center or a sponsoring facility of a school-based health center; and

(B) submit an application at such time, in such manner, and containing such information as the Secretary may require, including at a minimum an assurance that funds awarded under the grant shall not be used to provide any service that is not authorized or allowed by Federal, State, or local law.

(3) **PREFERENCE.**—In awarding grants under this section, the Secretary shall give preference

to awarding grants for school-based health centers that serve a large population of children eligible for medical assistance under the State Medicaid plan under title XIX of the Social Security Act or under a waiver of such plan or children eligible for child health assistance under the State child health plan under title XXI of that Act (42 U.S.C. 1397aa et seq.).

(4) **LIMITATION ON USE OF FUNDS.**—An eligible entity shall use funds provided under a grant awarded under this subsection only for expenditures for facilities (including the acquisition or improvement of land, or the acquisition, construction, expansion, replacement, or other improvement of any building or other facility), equipment, or similar expenditures, as specified by the Secretary. No funds provided under a grant awarded under this section shall be used for expenditures for personnel or to provide health services.

(5) **APPROPRIATIONS.**—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2010 through 2013, \$50,000,000 for the purpose of carrying out this subsection. Funds appropriated under this paragraph shall remain available until expended.

(6) **DEFINITIONS.**—In this subsection, the terms "school-based health center" and "sponsoring facility" have the meanings given those terms in section 2110(c)(9) of the Social Security Act (42 U.S.C. 1397jj(c)(9)).

(b) **GRANTS FOR THE OPERATION OF SCHOOL-BASED HEALTH CENTERS.**—Part Q of title III of the Public Health Service Act (42 U.S.C. 280h et seq.) is amended by adding at the end the following:

"SEC. 399Z-1. SCHOOL-BASED HEALTH CENTERS.

"(a) DEFINITIONS; ESTABLISHMENT OF CRITERIA.—In this section:

"(1) COMPREHENSIVE PRIMARY HEALTH SERVICES.—The term 'comprehensive primary health services' means the core services offered by school-based health centers, which shall include the following:

"(A) PHYSICAL.—Comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions, and referrals to, and follow-up for, specialty care and oral health services.

"(B) MENTAL HEALTH.—Mental health and substance use disorder assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs.

"(2) MEDICALLY UNDERSERVED CHILDREN AND ADOLESCENTS.—

"(A) IN GENERAL.—The term 'medically underserved children and adolescents' means a population of children and adolescents who are residents of an area designated as a medically underserved area or a health professional shortage area by the Secretary.

"(B) CRITERIA.—The Secretary shall prescribe criteria for determining the specific shortages of personal health services for medically underserved children and adolescents under subparagraph (A) that shall—

"(i) take into account any comments received by the Secretary from the chief executive officer of a State and local officials in a State; and

"(ii) include factors indicative of the health status of such children and adolescents of an area, including the ability of the residents of such area to pay for health services, the accessibility of such services, the availability of health professionals to such children and adolescents, and other factors as determined appropriate by the Secretary.

"(3) SCHOOL-BASED HEALTH CENTER.—The term 'school-based health center' means a health clinic that—

"(A) meets the definition of a school-based health center under section 2110(c)(9)(A) of the

Social Security Act and is administered by a sponsoring facility (as defined in section 2110(c)(9)(B) of the Social Security Act);

"(B) provides, at a minimum, comprehensive primary health services during school hours to children and adolescents by health professionals in accordance with established standards, community practice, reporting laws, and other State laws, including parental consent and notification laws that are not inconsistent with Federal law; and

"(C) does not perform abortion services.

"(b) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants for the costs of the operation of school-based health centers (referred to in this section as 'SBHCs') that meet the requirements of this section.

"(c) APPLICATIONS.—To be eligible to receive a grant under this section, an entity shall—

"(1) be an SBHC (as defined in subsection (a)(3)); and

"(2) submit to the Secretary an application at such time, in such manner, and containing—

"(A) evidence that the applicant meets all criteria necessary to be designated an SBHC;

"(B) evidence of local need for the services to be provided by the SBHC;

"(C) an assurance that—

"(i) SBHC services will be provided to those children and adolescents for whom parental or guardian consent has been obtained in cooperation with Federal, State, and local laws governing health care service provision to children and adolescents;

"(ii) the SBHC has made and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the SBHC;

"(iii) the SBHC will provide on-site access during the academic day when school is in session and 24-hour coverage through an on-call system and through its backup health providers to ensure access to services on a year-round basis when the school or the SBHC is closed;

"(iv) the SBHC will be integrated into the school environment and will coordinate health services with school personnel, such as administrators, teachers, nurses, counselors, and support personnel, as well as with other community providers co-located at the school;

"(v) the SBHC sponsoring facility assumes all responsibility for the SBHC administration, operations, and oversight; and

"(vi) the SBHC will comply with Federal, State, and local laws concerning patient privacy and student records, including regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 444 of the General Education Provisions Act; and

"(D) such other information as the Secretary may require.

"(d) PREFERENCES AND CONSIDERATION.—In reviewing applications:

"(1) The Secretary may give preference to applicants who demonstrate an ability to serve the following:

"(A) Communities that have evidenced barriers to primary health care and mental health and substance use disorder prevention services for children and adolescents.

"(B) Communities with high per capita numbers of children and adolescents who are uninsured, underinsured, or enrolled in public health insurance programs.

"(C) Populations of children and adolescents that have historically demonstrated difficulty in accessing health and mental health and substance use disorder prevention services.

"(2) The Secretary may give consideration to whether an applicant has received a grant under subsection (a) of section 4101 of the Patient Protection and Affordable Care Act.

“(e) **WAIVER OF REQUIREMENTS.**—The Secretary may—

“(1) under appropriate circumstances, waive the application of all or part of the requirements of this subsection with respect to an SBHC for not to exceed 2 years; and

“(2) upon a showing of good cause, waive the requirement that the SBHC provide all required comprehensive primary health services for a designated period of time to be determined by the Secretary.

“(f) **USE OF FUNDS.**—

“(1) **FUNDS.**—Funds awarded under a grant under this section—

“(A) may be used for—

“(i) acquiring and leasing equipment (including the costs of amortizing the principle of, and paying interest on, loans for such equipment);

“(ii) providing training related to the provision of required comprehensive primary health services and additional health services;

“(iii) the management and operation of health center programs;

“(iv) the payment of salaries for physicians, nurses, and other personnel of the SBHC; and

“(B) may not be used to provide abortions.

“(2) **CONSTRUCTION.**—The Secretary may award grants which may be used to pay the costs associated with expanding and modernizing existing buildings for use as an SBHC, including the purchase of trailers or manufactured buildings to install on the school property.

“(3) **LIMITATIONS.**—

“(A) **IN GENERAL.**—Any provider of services that is determined by a State to be in violation of a State law described in subsection (a)(3)(B) with respect to activities carried out at a SBHC shall not be eligible to receive additional funding under this section.

“(B) **NO OVERLAPPING GRANT PERIOD.**—No entity that has received funding under section 330 for a grant period shall be eligible for a grant under this section for with respect to the same grant period.

“(g) **MATCHING REQUIREMENT.**—

“(1) **IN GENERAL.**—Each eligible entity that receives a grant under this section shall provide, from non-Federal sources, an amount equal to 20 percent of the amount of the grant (which may be provided in cash or in-kind) to carry out the activities supported by the grant.

“(2) **WAIVER.**—The Secretary may waive all or part of the matching requirement described in paragraph (1) for any fiscal year for the SBHC if the Secretary determines that applying the matching requirement to the SBHC would result in serious hardship or an inability to carry out the purposes of this section.

“(h) **SUPPLEMENT, NOT SUPPLANT.**—Grant funds provided under this section shall be used to supplement, not supplant, other Federal or State funds.

“(i) **EVALUATION.**—The Secretary shall develop and implement a plan for evaluating SBHCs and monitoring quality performance under the awards made under this section.

“(j) **AGE APPROPRIATE SERVICES.**—An eligible entity receiving funds under this section shall only provide age appropriate services through a SBHC funded under this section to an individual.

“(k) **PARENTAL CONSENT.**—An eligible entity receiving funds under this section shall not provide services through a SBHC funded under this section to an individual without the consent of the parent or guardian of such individual if such individual is considered a minor under applicable State law.

“(l) **AUTHORIZATION OF APPROPRIATIONS.**—For purposes of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.”

SEC. 4102. ORAL HEALTHCARE PREVENTION ACTIVITIES.

(a) **IN GENERAL.**—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as

amended by section 3025, is amended by adding at the end the following:

“PART T—ORAL HEALTHCARE PREVENTION ACTIVITIES

“SEC. 399LL. ORAL HEALTHCARE PREVENTION EDUCATION CAMPAIGN.

“(a) **ESTABLISHMENT.**—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in consultation with professional oral health organizations, shall, subject to the availability of appropriations, establish a 5-year national, public education campaign (referred to in this section as the ‘campaign’) that is focused on oral healthcare prevention and education, including prevention of oral disease such as early childhood and other caries, periodontal disease, and oral cancer.

“(b) **REQUIREMENTS.**—In establishing the campaign, the Secretary shall—

“(1) ensure that activities are targeted towards specific populations such as children, pregnant women, parents, the elderly, individuals with disabilities, and ethnic and racial minority populations, including Indians, Alaska Natives and Native Hawaiians (as defined in section 4(c) of the Indian Health Care Improvement Act) in a culturally and linguistically appropriate manner; and

“(2) utilize science-based strategies to convey oral health prevention messages that include, but are not limited to, community water fluoridation and dental sealants.

“(c) **PLANNING AND IMPLEMENTATION.**—Not later than 2 years after the date of enactment of this section, the Secretary shall begin implementing the 5-year campaign. During the 2-year period referred to in the previous sentence, the Secretary shall conduct planning activities with respect to the campaign.

“SEC. 399LL-1. RESEARCH-BASED DENTAL CARIES DISEASE MANAGEMENT.

“(a) **IN GENERAL.**—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award demonstration grants to eligible entities to demonstrate the effectiveness of research-based dental caries disease management activities.

“(b) **ELIGIBILITY.**—To be eligible for a grant under this section, an entity shall—

“(1) be a community-based provider of dental services (as defined by the Secretary), including a Federally-qualified health center, a clinic of a hospital owned or operated by a State (or by an instrumentality or a unit of government within a State), a State or local department of health, a dental program of the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act), a health system provider, a private provider of dental services, medical, dental, public health, nursing, nutrition educational institutions, or national organizations involved in improving children’s oral health; and

“(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(c) **USE OF FUNDS.**—A grantee shall use amounts received under a grant under this section to demonstrate the effectiveness of research-based dental caries disease management activities.

“(d) **USE OF INFORMATION.**—The Secretary shall utilize information generated from grantees under this section in planning and implementing the public education campaign under section 399LL.

“SEC. 399LL-2. AUTHORIZATION OF APPROPRIATIONS.

“There is authorized to be appropriated to carry out this part, such sums as may be necessary.”

(b) **SCHOOL-BASED SEALANT PROGRAMS.**—Section 317M(c)(1) of the Public Health Service Act (42 U.S.C. 247b-14(c)(1)) is amended by striking “may award grants to States and Indian tribes” and inserting “shall award a grant to each of the 50 States and territories and to Indians, Indian tribes, tribal organizations and urban Indian organizations (as such terms are defined in section 4 of the Indian Health Care Improvement Act)”.

(c) **ORAL HEALTH INFRASTRUCTURE.**—Section 317M of the Public Health Service Act (42 U.S.C. 247b-14) is amended—

(1) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (c), the following:

“(d) **ORAL HEALTH INFRASTRUCTURE.**—

“(1) **COOPERATIVE AGREEMENTS.**—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into cooperative agreements with State, territorial, and Indian tribes or tribal organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act) to establish oral health leadership and program guidance, oral health data collection and interpretation, (including determinants of poor oral health among vulnerable populations), a multi-dimensional delivery system for oral health, and to implement science-based programs (including dental sealants and community water fluoridation) to improve oral health.

“(2) **AUTHORIZATION OF APPROPRIATIONS.**—

There is authorized to be appropriated such sums as necessary to carry out this subsection for fiscal years 2010 through 2014.”

(d) **UPDATING NATIONAL ORAL HEALTHCARE SURVEILLANCE ACTIVITIES.**—

(1) **PRAMS.**—

(A) **IN GENERAL.**—The Secretary of Health and Human Services (referred to in this subsection as the “Secretary”) shall carry out activities to update and improve the Pregnancy Risk Assessment Monitoring System (referred to in this section as “PRAMS”) as it relates to oral healthcare.

(B) **STATE REPORTS AND MANDATORY MEASUREMENTS.**—

(i) **IN GENERAL.**—Not later than 5 years after the date of enactment of this Act, and every 5 years thereafter, a State shall submit to the Secretary a report concerning activities conducted within the State under PRAMS.

(ii) **MEASUREMENTS.**—The oral healthcare measurements developed by the Secretary for use under PRAMS shall be mandatory with respect to States for purposes of the State reports under clause (i).

(C) **FUNDING.**—There is authorized to be appropriated to carry out this paragraph, such sums as may be necessary.

(2) **NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY.**—The Secretary shall develop oral healthcare components that shall include tooth-level surveillance for inclusion in the National Health and Nutrition Examination Survey. Such components shall be updated by the Secretary at least every 6 years. For purposes of this paragraph, the term “tooth-level surveillance” means a clinical examination where an examiner looks at each dental surface, on each tooth in the mouth and as expanded by the Division of Oral Health of the Centers for Disease Control and Prevention.

(3) **MEDICAL EXPENDITURES PANEL SURVEY.**—The Secretary shall ensure that the Medical Expenditures Panel Survey by the Agency for Healthcare Research and Quality includes the verification of dental utilization, expenditure, and coverage findings through conduct of a look-back analysis.

(4) **NATIONAL ORAL HEALTH SURVEILLANCE SYSTEM.**—

(A) APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary for each of fiscal years 2010 through 2014 to increase the participation of States in the National Oral Health Surveillance System from 16 States to all 50 States, territories, and District of Columbia.

(B) REQUIREMENTS.—The Secretary shall ensure that the National Oral Health Surveillance System include the measurement of early childhood caries.

SEC. 4103. MEDICARE COVERAGE OF ANNUAL WELLNESS VISIT PROVIDING A PERSONALIZED PREVENTION PLAN.

(a) COVERAGE OF PERSONALIZED PREVENTION PLAN SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (DD), by striking “and” at the end;

(B) in subparagraph (EE), by adding “and” at the end; and

(C) by adding at the end the following new subparagraph:

“(FF) personalized prevention plan services (as defined in subsection (hhh)).”

(2) CONFORMING AMENDMENTS.—Clauses (i) and (ii) of section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) are each amended by striking “subsection (ww)(1)” and inserting “subsections (ww)(1) and (hhh)”.

(b) PERSONALIZED PREVENTION PLAN SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

“Annual Wellness Visit

“(hhh)(1) The term ‘personalized prevention plan services’ means the creation of a plan for an individual—

“(A) that includes a health risk assessment (that meets the guidelines established by the Secretary under paragraph (4)(A)) of the individual that is completed prior to or as part of the same visit with a health professional described in paragraph (3); and

“(B) that—

“(i) takes into account the results of the health risk assessment; and

“(ii) may contain the elements described in paragraph (2).

“(2) Subject to paragraph (4)(H), the elements described in this paragraph are the following:

“(A) The establishment of, or an update to, the individual’s medical and family history.

“(B) A list of current providers and suppliers that are regularly involved in providing medical care to the individual (including a list of all prescribed medications).

“(C) A measurement of height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements.

“(D) Detection of any cognitive impairment.

“(E) The establishment of, or an update to, the following:

“(i) A screening schedule for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices, and the individual’s health status, screening history, and age-appropriate preventive services covered under this title.

“(ii) A list of risk factors and conditions for which primary, secondary, or tertiary prevention interventions are recommended or are underway, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (as described under subsection (ww)(1)), and a list of treatment options and their associated risks and benefits.

“(F) The furnishing of personalized health advice and a referral, as appropriate, to health

education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

“(G) Any other element determined appropriate by the Secretary.

“(3) A health professional described in this paragraph is—

“(A) a physician;

“(B) a practitioner described in clause (i) of section 1842(b)(18)(C); or

“(C) a medical professional (including a health educator, registered dietitian, or nutrition professional) or a team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician.

“(4)(A) For purposes of paragraph (1)(A), the Secretary, not later than 1 year after the date of enactment of this subsection, shall establish publicly available guidelines for health risk assessments. Such guidelines shall be developed in consultation with relevant groups and entities and shall provide that a health risk assessment—

“(i) identify chronic diseases, injury risks, modifiable risk factors, and urgent health needs of the individual; and

“(ii) may be furnished—

“(I) through an interactive telephonic or web-based program that meets the standards established under subparagraph (B);

“(II) during an encounter with a health care professional;

“(III) through community-based prevention programs; or

“(IV) through any other means the Secretary determines appropriate to maximize accessibility and ease of use by beneficiaries, while ensuring the privacy of such beneficiaries.

“(B) Not later than 1 year after the date of enactment of this subsection, the Secretary shall establish standards for interactive telephonic or web-based programs used to furnish health risk assessments under subparagraph (A)(ii)(I). The Secretary may utilize any health risk assessment developed under section 4004(f) of the Patient Protection and Affordable Care Act as part of the requirement to develop a personalized prevention plan to comply with this subparagraph.

“(C)(i) Not later than 18 months after the date of enactment of this subsection, the Secretary shall develop and make available to the public a health risk assessment model. Such model shall meet the guidelines under subparagraph (A) and may be used to meet the requirement under paragraph (1)(A).

“(ii) Any health risk assessment that meets the guidelines under subparagraph (A) and is approved by the Secretary may be used to meet the requirement under paragraph (1)(A).

“(D) The Secretary may coordinate with community-based entities (including State Health Insurance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the Administration on Aging) to—

“(i) ensure that health risk assessments are accessible to beneficiaries; and

“(ii) provide appropriate support for the completion of health risk assessments by beneficiaries.

“(E) The Secretary shall establish procedures to make beneficiaries and providers aware of the requirement that a beneficiary complete a health risk assessment prior to or at the same time as receiving personalized prevention plan services.

“(F) To the extent practicable, the Secretary shall encourage the use of, integration with, and coordination of health information technology (including use of technology that is com-

patible with electronic medical records and personal health records) and may experiment with the use of personalized technology to aid in the development of self-management skills and management of and adherence to provider recommendations in order to improve the health status of beneficiaries.

“(G)(i) A beneficiary shall only be eligible to receive an initial preventive physical examination (as defined under subsection (ww)(1)) at any time during the 12-month period after the date that the beneficiary’s coverage begins under part B and shall be eligible to receive personalized prevention plan services under this subsection provided that the beneficiary has not received such services within the preceding 12-month period.

“(ii) The Secretary shall establish procedures to make beneficiaries aware of the option to select an initial preventive physical examination or personalized prevention plan services during the period of 12 months after the date that a beneficiary’s coverage begins under part B, which shall include information regarding any relevant differences between such services.

“(H) The Secretary shall issue guidance that—

“(i) identifies elements under paragraph (2) that are required to be provided to a beneficiary as part of their first visit for personalized prevention plan services; and

“(ii) establishes a yearly schedule for appropriate provision of such elements thereafter.”

(c) PAYMENT AND ELIMINATION OF COST-SHARING.—

(1) PAYMENT AND ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) in subparagraph (N), by inserting “other than personalized prevention plan services (as defined in section 1861(hhh)(1))” after “(as defined in section 1848(j)(3))”; and

(B) by striking “and” before “(W)”; and

(C) by inserting before the semicolon at the end the following: “, and (X) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848”.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w-4(j)(3)) is amended by inserting “(2)(FF) (including administration of the health risk assessment),” after “(2)(EE).”

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking “and diagnostic mammography” and inserting “, diagnostic mammography, or personalized prevention plan services (as defined in section 1861(hhh)(1)).”

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (F), by striking “and” at the end;

(ii) in subparagraph (G)(ii), by striking the comma at the end and inserting “; and”; and

(iii) by inserting after subparagraph (G)(ii) the following new subparagraph:

“(H) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(X).”

(4) WAIVER OF APPLICATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(A) by striking “and” before “(9)”; and

(B) by inserting before the period the following: “, and (10) such deductible shall not

apply with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)).

(d) **FREQUENCY LIMITATION.**—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (N), by striking “and” at the end;

(B) in subparagraph (O), by striking the semicolon at the end and inserting “, and”; and

(C) by adding at the end the following new subparagraph:

“(P) in the case of personalized prevention plan services (as defined in section 1861(hhh)(1)), which are performed more frequently than is covered under such section;”; and

(2) in paragraph (7), by striking “or (K)” and inserting “(K), or (P)”.

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished on or after January 1, 2011.

SEC. 4104. REMOVAL OF BARRIERS TO PREVENTIVE SERVICES IN MEDICARE.

(a) **DEFINITION OF PREVENTIVE SERVICES.**—Section 1861(ddd) of the Social Security Act (42 U.S.C. 1395r(ddd)) is amended—

(1) in the heading, by inserting “; Preventive Services” after “Services”; and

(2) in paragraph (1), by striking “not otherwise described in this title” and inserting “not described in subparagraph (A) or (C) of paragraph (3)”; and

(3) by adding at the end the following new paragraph:

“(3) The term ‘preventive services’ means the following:

“(A) The screening and preventive services described in subsection (ww)(2) (other than the service described in subparagraph (M) of such subsection).

“(B) An initial preventive physical examination (as defined in subsection (ww)).

“(C) Personalized prevention plan services (as defined in subsection (hhh)(1)).”

(b) **COINSURANCE.**—

(1) **GENERAL APPLICATION.**—

(A) **IN GENERAL.**—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 4103(c)(1), is amended—

(i) in subparagraph (T), by inserting “(or 100 percent if such services are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual)” after “80 percent”; and

(ii) in subparagraph (W)—

(I) in clause (i), by inserting “(if such subparagraph were applied, by substituting ‘100 percent’ for ‘80 percent’)” after “subparagraph (D)”; and

(II) in clause (ii), by striking “80 percent” and inserting “100 percent”; and

(iii) by striking “and” before “(X)”; and

(iv) by inserting before the semicolon at the end the following: “, and (Y) with respect to preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part”.

(2) **ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.**—

(A) **EXCLUSION FROM OPD FEE SCHEDULE.**—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)), as amended by section 4103(c)(3)(A), is amended—

(i) by striking “or” before “personalized prevention plan services”; and

(ii) by inserting before the period the following: “, or preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population”.

(B) **CONFORMING AMENDMENTS.**—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)), as amended by section 4103(c)(3)(B), is amended—

(i) in subparagraph (G)(ii), by striking “and” after the semicolon at the end;

(ii) in subparagraph (H), by striking the comma at the end and inserting “; and”; and

(iii) by inserting after subparagraph (H) the following new subparagraph:

“(I) with respect to preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and are furnished by an outpatient department of a hospital and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount determined under paragraph (1)(W) or (1)(Y).”

(c) **WAIVER OF APPLICATION OF DEDUCTIBLE FOR PREVENTIVE SERVICES AND COLORECTAL CANCER SCREENING TESTS.**—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 4103(c)(4), is amended—

(1) in paragraph (1), by striking “items and services described in section 1861(s)(10)(A)” and inserting “preventive services described in subparagraph (A) of section 1861(ddd)(3) that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual.”; and

(2) by adding at the end the following new sentence: “Paragraph (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.”

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 4105. EVIDENCE-BASED COVERAGE OF PREVENTIVE SERVICES IN MEDICARE.

(a) **AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.**—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

“(n) **AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.**—Notwithstanding any other provision of this title, effective beginning on January 1, 2010, if the Secretary determines appropriate, the Secretary may—

“(1) modify—

“(A) the coverage of any preventive service described in subparagraph (A) of section 1861(ddd)(3) to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and

“(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

“(2) provide that no payment shall be made under this title for a preventive service described in subparagraph (A) of such section that has not received a grade of A, B, C, or I by such Task Force.”

(b) **CONSTRUCTION.**—Nothing in the amendment made by paragraph (1) shall be construed to affect the coverage of diagnostic or treatment services under title XVIII of the Social Security Act.

SEC. 4106. IMPROVING ACCESS TO PREVENTIVE SERVICES FOR ELIGIBLE ADULTS IN MEDICAID.

(a) **CLARIFICATION OF INCLUSION OF SERVICES.**—Section 1905(a)(13) of the Social Security Act (42 U.S.C. 1396d(a)(13)) is amended to read as follows:

“(13) other diagnostic, screening, preventive, and rehabilitative services, including—

“(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force;

“(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and

“(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;”

(b) **INCREASED FMAP.**—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), as amended by sections 2001(a)(3)(A) and 2004(c)(1), is amended in the first sentence—

(1) by striking “, and (4)” and inserting “, (4)”; and

(2) by inserting before the period the following: “, and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(13), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection), shall be increased by 1 percentage point with respect to medical assistance for such services and vaccines and for items and services described in subsection (a)(4)(D).”

(c) **EFFECTIVE DATE.**—The amendments made under this section shall take effect on January 1, 2013.

SEC. 4107. COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES FOR PREGNANT WOMEN IN MEDICAID.

(a) **REQUIRING COVERAGE OF COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE BY PREGNANT WOMEN.**—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3)(B) and 2303, is further amended—

(1) in subsection (a)(4)—

(A) by striking “and” before “(C)”; and

(B) by inserting before the semicolon at the end the following new subparagraph: “; and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb))”; and

(2) by adding at the end the following:

“(bb)(1) For purposes of this title, the term ‘counseling and pharmacotherapy for cessation of tobacco use by pregnant women’ means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use that is furnished—

“(A) by or under the supervision of a physician; or

“(B) by any other health care professional who—

“(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

“(ii) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose.

“(2) Subject to paragraph (3), such term is limited to—

“(A) services recommended with respect to pregnant women in ‘Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline’, published by the Public Health Service in May 2008, or any subsequent modification of such Guideline; and

“(B) such other services that the Secretary recognizes to be effective for cessation of tobacco use by pregnant women.

“(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this title.”.

(b) **EXCEPTION FROM OPTIONAL RESTRICTION UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.**—Section 1927(d)(2)(F) of the Social Security Act (42 U.S.C. 1396r–8(d)(2)(F)), as redesignated by section 2502(a), is amended by inserting before the period at the end the following: “, except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1905(bb)(2)(A), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation”.

(c) **REMOVAL OF COST-SHARING FOR COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE BY PREGNANT WOMEN.**—

(1) **GENERAL COST-SHARING LIMITATIONS.**—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended in each of subsections (a)(2)(B) and (b)(2)(B) by inserting “, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1905(bb)(2)(A)” after “complicate the pregnancy”.

(2) **APPLICATION TO ALTERNATE COST-SHARING.**—Section 1916A(b)(3)(B)(iii) of such Act (42 U.S.C. 1396o–1(b)(3)(B)(iii)) is amended by inserting “, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb))” after “complicate the pregnancy”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on October 1, 2010.

SEC. 4108. INCENTIVES FOR PREVENTION OF CHRONIC DISEASES IN MEDICAID.

(a) **INITIATIVES.**—

(1) **ESTABLISHMENT.**—

(A) **IN GENERAL.**—The Secretary shall award grants to States to carry out initiatives to provide incentives to Medicaid beneficiaries who—

(i) successfully participate in a program described in paragraph (3); and

(ii) upon completion of such participation, demonstrate changes in health risk and outcomes, including the adoption and maintenance of healthy behaviors by meeting specific targets (as described in subsection (c)(2)).

(B) **PURPOSE.**—The purpose of the initiatives under this section is to test approaches that may encourage behavior modification and determine scalable solutions.

(2) **DURATION.**—

(A) **INITIATION OF PROGRAM; RESOURCES.**—The Secretary shall award grants to States begin-

ning on January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier. The Secretary shall develop program criteria for initiatives under this section using relevant evidence-based research and resources, including the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry of Evidence-Based Programs and Practices.

(B) **DURATION OF PROGRAM.**—A State awarded a grant to carry out initiatives under this section shall carry out such initiatives within the 5-year period beginning on January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier. Initiatives under this section shall be carried out by a State for a period of not less than 3 years.

(3) **PROGRAM DESCRIBED.**—

(A) **IN GENERAL.**—A program described in this paragraph is a comprehensive, evidence-based, widely available, and easily accessible program, proposed by the State and approved by the Secretary, that is designed and uniquely suited to address the needs of Medicaid beneficiaries and has demonstrated success in helping individuals achieve one or more of the following:

(i) Ceasing use of tobacco products.

(ii) Controlling or reducing their weight.

(iii) Lowering their cholesterol.

(iv) Lowering their blood pressure.

(v) Avoiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition.

(B) **CO-MORBIDITIES.**—A program under this section may also address co-morbidities (including depression) that are related to any of the conditions described in subparagraph (A).

(C) **WAIVER AUTHORITY.**—The Secretary may waive the requirements of section 1902(a)(1) (relating to statewideness) of the Social Security Act for a State awarded a grant to conduct an initiative under this section and shall ensure that a State makes any program described in subparagraph (A) available and accessible to Medicaid beneficiaries.

(D) **FLEXIBILITY IN IMPLEMENTATION.**—A State may enter into arrangements with providers participating in Medicaid, community-based organizations, faith-based organizations, public-private partnerships, Indian tribes, or similar entities or organizations to carry out programs described in subparagraph (A).

(4) **APPLICATION.**—Following the development of program criteria by the Secretary, a State may submit an application, in such manner and containing such information as the Secretary may require, that shall include a proposal for programs described in paragraph (3)(A) and a plan to make Medicaid beneficiaries and providers participating in Medicaid who reside in the State aware and informed about such programs.

(b) **EDUCATION AND OUTREACH CAMPAIGN.**—

(1) **STATE AWARENESS.**—The Secretary shall conduct an outreach and education campaign to make States aware of the grants under this section.

(2) **PROVIDER AND BENEFICIARY EDUCATION.**—A State awarded a grant to conduct an initiative under this section shall conduct an outreach and education campaign to make Medicaid beneficiaries and providers participating in Medicaid who reside in the State aware of the programs described in subsection (a)(3) that are to be carried out by the State under the grant.

(c) **IMPACT.**—A State awarded a grant to conduct an initiative under this section shall develop and implement a system to—

(1) track Medicaid beneficiary participation in the program and validate changes in health risk and outcomes with clinical data, including the adoption and maintenance of health behaviors by such beneficiaries;

(2) to the extent practicable, establish standards and health status targets for Medicaid beneficiaries participating in the program and measure the degree to which such standards and targets are met;

(3) evaluate the effectiveness of the program and provide the Secretary with such evaluations;

(4) report to the Secretary on processes that have been developed and lessons learned from the program; and

(5) report on preventive services as part of reporting on quality measures for Medicaid managed care programs.

(d) **EVALUATIONS AND REPORTS.**—

(1) **INDEPENDENT ASSESSMENT.**—The Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the initiatives carried out by States under this section, for the purpose of determining—

(A) the effect of such initiatives on the use of health care services by Medicaid beneficiaries participating in the program;

(B) the extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program;

(C) the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and

(D) the administrative costs incurred by State agencies that are responsible for administration of the program.

(2) **STATE REPORTING.**—A State awarded a grant to carry out initiatives under this section shall submit reports to the Secretary, on a semi-annual basis, regarding the programs that are supported by the grant funds. Such report shall include information, as specified by the Secretary, regarding—

(A) the specific uses of the grant funds;

(B) an assessment of program implementation and lessons learned from the programs;

(C) an assessment of quality improvements and clinical outcomes under such programs; and

(D) estimates of cost savings resulting from such programs.

(3) **INITIAL REPORT.**—Not later than January 1, 2014, the Secretary shall submit to Congress an initial report on such initiatives based on information provided by States through reports required under paragraph (2). The initial report shall include an interim evaluation of the effectiveness of the initiatives carried out with grants awarded under this section and a recommendation regarding whether funding for expanding or extending the initiatives should be extended beyond January 1, 2016.

(4) **FINAL REPORT.**—Not later than July 1, 2016, the Secretary shall submit to Congress a final report on the program that includes the results of the independent assessment required under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(e) **NO EFFECT ON ELIGIBILITY FOR, OR AMOUNT OF, MEDICAID OR OTHER BENEFITS.**—Any incentives provided to a Medicaid beneficiary participating in a program described in subsection (a)(3) shall not be taken into account for purposes of determining the beneficiary's eligibility for, or amount of, benefits under the Medicaid program or any program funded in whole or in part with Federal funds.

(f) **FUNDING.**—Out of any funds in the Treasury not otherwise appropriated, there are appropriated for the 5-year period beginning on January 1, 2011, \$100,000,000 to the Secretary to carry out this section. Amounts appropriated under this subsection shall remain available until expended.

(g) **DEFINITIONS.**—In this section:

(1) **MEDICAID BENEFICIARY.**—The term “Medicaid beneficiary” means an individual who is eligible for medical assistance under a State plan or waiver under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and is enrolled in such plan or waiver.

(2) **STATE.**—The term “State” has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

Subtitle C—Creating Healthier Communities
SEC. 4201. COMMUNITY TRANSFORMATION GRANTS.

(a) **IN GENERAL.**—The Secretary of Health and Human Services (referred to in this section as the “Secretary”), acting through the Director of the Centers for Disease Control and Prevention (referred to in this section as the “Director”), shall award competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.

(b) **ELIGIBILITY.**—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be—

(A) a State governmental agency;

(B) a local governmental agency;

(C) a national network of community-based organizations;

(D) a State or local non-profit organization;

or

(E) an Indian tribe; and

(2) submit to the Director an application at such time, in such a manner, and containing such information as the Director may require, including a description of the program to be carried out under the grant; and

(3) demonstrate a history or capacity, if funded, to develop relationships necessary to engage key stakeholders from multiple sectors within and beyond health care and across a community, such as healthy futures corps and health care providers.

(c) **USE OF FUNDS.**—

(1) **IN GENERAL.**—An eligible entity shall use amounts received under a grant under this section to carry out programs described in this subsection.

(2) **COMMUNITY TRANSFORMATION PLAN.**—

(A) **IN GENERAL.**—An eligible entity that receives a grant under this section shall submit to the Director (for approval) a detailed plan that includes the policy, environmental, programmatic, and as appropriate infrastructure changes needed to promote healthy living and reduce disparities.

(B) **ACTIVITIES.**—Activities within the plan may focus on (but not be limited to)—

(i) creating healthier school environments, including increasing healthy food options, physical activity opportunities, promotion of healthy lifestyle, emotional wellness, and prevention curricula, and activities to prevent chronic diseases;

(ii) creating the infrastructure to support active living and access to nutritious foods in a safe environment;

(iii) developing and promoting programs targeting a variety of age levels to increase access to nutrition, physical activity and smoking cessation, improve social and emotional wellness, enhance safety in a community, or address any other chronic disease priority area identified by the grantee;

(iv) assessing and implementing worksite wellness programming and incentives;

(v) working to highlight healthy options at restaurants and other food venues;

(vi) prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health; and

(vii) addressing special populations needs, including all age groups and individuals with disabilities, and individuals in both urban and rural areas.

(3) **COMMUNITY-BASED PREVENTION HEALTH ACTIVITIES.**—

(A) **IN GENERAL.**—An eligible entity shall use amounts received under a grant under this section to implement a variety of programs, policies, and infrastructure improvements to promote healthier lifestyles.

(B) **ACTIVITIES.**—An eligible entity shall implement activities detailed in the community transformation plan under paragraph (2).

(C) **IN-KIND SUPPORT.**—An eligible entity may provide in-kind resources such as staff, equipment, or office space in carrying out activities under this section.

(4) **EVALUATION.**—

(A) **IN GENERAL.**—An eligible entity shall use amounts provided under a grant under this section to conduct activities to measure changes in the prevalence of chronic disease risk factors among community members participating in preventive health activities.

(B) **TYPES OF MEASURES.**—In carrying out subparagraph (A), the eligible entity shall, with respect to residents in the community, measure—

(i) changes in weight;

(ii) changes in proper nutrition;

(iii) changes in physical activity;

(iv) changes in tobacco use prevalence;

(v) changes in emotional well-being and overall mental health;

(vi) other factors using community-specific data from the Behavioral Risk Factor Surveillance Survey; and

(vii) other factors as determined by the Secretary.

(C) **REPORTING.**—An eligible entity shall annually submit to the Director a report containing an evaluation of activities carried out under the grant.

(5) **DISSEMINATION.**—A grantee under this section shall—

(A) meet at least annually in regional or national meetings to discuss challenges, best practices, and lessons learned with respect to activities carried out under the grant; and

(B) develop models for the replication of successful programs and activities and the mentoring of other eligible entities.

(d) **TRAINING.**—

(1) **IN GENERAL.**—The Director shall develop a program to provide training for eligible entities on effective strategies for the prevention and control of chronic disease and the link between physical, emotional, and social well-being.

(2) **COMMUNITY TRANSFORMATION PLAN.**—The Director shall provide appropriate feedback and technical assistance to grantees to establish community transformation plans.

(3) **EVALUATION.**—The Director shall provide a literature review and framework for the evaluation of programs conducted as part of the grant program under this section, in addition to working with academic institutions or other entities with expertise in outcome evaluation.

(e) **PROHIBITION.**—A grantee shall not use funds provided under a grant under this section to create video games or to carry out any other activities that may lead to higher rates of obesity or inactivity.

(f) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each fiscal years 2010 through 2014.

SEC. 4202. HEALTHY AGING, LIVING WELL; EVALUATION OF COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS FOR MEDICARE BENEFICIARIES.

(a) **HEALTHY AGING, LIVING WELL.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services (referred to in this section as the “Secretary”), acting through the Director of

the Centers for Disease Control and Prevention, shall award grants to State or local health departments and Indian tribes to carry out 5-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age.

(2) **ELIGIBILITY.**—To be eligible to receive a grant under paragraph (1), an entity shall—

(A) be—

(i) a State health department;

(ii) a local health department; or

(iii) an Indian tribe;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require including a description of the program to be carried out under the grant;

(C) design a strategy for improving the health of the 55-to-64 year-old population through community-based public health interventions; and

(D) demonstrate the capacity, if funded, to develop the relationships necessary with relevant health agencies, health care providers, community-based organizations, and insurers to carry out the activities described in paragraph (3), such relationships to include the identification of a community-based clinical partner, such as a community health center or rural health clinic.

(3) **USE OF FUNDS.**—

(A) **IN GENERAL.**—A State or local health department shall use amounts received under a grant under this subsection to carry out a program to provide the services described in this paragraph to individuals who are between 55 and 64 years of age.

(B) **PUBLIC HEALTH INTERVENTIONS.**—

(i) **IN GENERAL.**—In developing and implementing such activities, a grantee shall collaborate with the Centers for Disease Control and Prevention and the Administration on Aging, and relevant local agencies and organizations.

(ii) **TYPES OF INTERVENTION ACTIVITIES.**—Intervention activities conducted under this subparagraph may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles among the target population.

(C) **COMMUNITY PREVENTIVE SCREENINGS.**—

(i) **IN GENERAL.**—In addition to community-wide public health interventions, a State or local health department shall use amounts received under a grant under this subsection to conduct ongoing health screening to identify risk factors for cardiovascular disease, cancer, stroke, and diabetes among individuals in both urban and rural areas who are between 55 and 64 years of age.

(ii) **TYPES OF SCREENING ACTIVITIES.**—Screening activities conducted under this subparagraph may include—

(I) mental health/behavioral health and substance use disorders;

(II) physical activity, smoking, and nutrition; and

(III) any other measures deemed appropriate by the Secretary.

(iii) **MONITORING.**—Grantees under this section shall maintain records of screening results under this subparagraph to establish the baseline data for monitoring the targeted population

(D) **CLINICAL REFERRAL/TREATMENT FOR CHRONIC DISEASES.**—

(i) **IN GENERAL.**—A State or local health department shall use amounts received under a grant under this subsection to ensure that individuals between 55 and 64 years of age who are found to have chronic disease risk factors through the screening activities described in subparagraph (C)(ii), receive clinical referral/treatment for follow-up services to reduce such risk.

(ii) MECHANISM.—

(I) IDENTIFICATION AND DETERMINATION OF STATUS.—With respect to each individual with risk factors for or having heart disease, stroke, diabetes, or any other condition for which such individual was screened under subparagraph (C), a grantee under this section shall determine whether or not such individual is covered under any public or private health insurance program.

(II) INSURED INDIVIDUALS.—An individual determined to be covered under a health insurance program under subclause (I) shall be referred by the grantee to the existing providers under such program or, if such individual does not have a current provider, to a provider who is in-network with respect to the program involved.

(III) UNINSURED INDIVIDUALS.—With respect to an individual determined to be uninsured under subclause (I), the grantee's community-based clinical partner described in paragraph (4)(D) shall assist the individual in determining eligibility for available public coverage options and identify other appropriate community health care resources and assistance programs.

(iii) PUBLIC HEALTH INTERVENTION PROGRAM.—A State or local health department shall use amounts received under a grant under this subsection to enter into contracts with community health centers or rural health clinics and mental health and substance use disorder service providers to assist in the referral/treatment of at risk patients to community resources for clinical follow-up and help determine eligibility for other public programs.

(E) GRANTEE EVALUATION.—An eligible entity shall use amounts provided under a grant under this subsection to conduct activities to measure changes in the prevalence of chronic disease risk factors among participants.

(4) PILOT PROGRAM EVALUATION.—The Secretary shall conduct an annual evaluation of the effectiveness of the pilot program under this subsection. In determining such effectiveness, the Secretary shall consider changes in the prevalence of uncontrolled chronic disease risk factors among new Medicare enrollees (or individuals nearing enrollment, including those who are 63 and 64 years of age) who reside in States or localities receiving grants under this section as compared with national and historical data for those States and localities for the same population.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2014.

(b) EVALUATION AND PLAN FOR COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS FOR MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—The Secretary shall conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries.

(2) MEDICARE EVALUATION OF PREVENTION AND WELLNESS PROGRAMS.—

(A) IN GENERAL.—The Secretary shall evaluate community prevention and wellness programs including those that are sponsored by the Administration on Aging, are evidence-based, and have demonstrated potential to help Medicare beneficiaries (particularly beneficiaries that have attained 65 years of age) reduce their risk of disease, disability, and injury by making healthy lifestyle choices, including exercise, diet, and self-management of chronic diseases.

(B) EVALUATION.—The evaluation under subparagraph (A) shall consist of the following:

(i) EVIDENCE REVIEW.—The Secretary shall review available evidence, literature, best practices, and resources that are relevant to programs that promote healthy lifestyles and reduce risk factors for the Medicare population. The Secretary may determine the scope of the

evidence review and such issues to be considered, which shall include, at a minimum—

- (I) physical activity, nutrition, and obesity;
- (II) falls;
- (III) chronic disease self-management; and
- (IV) mental health.

(ii) INDEPENDENT EVALUATION OF EVIDENCE-BASED COMMUNITY PREVENTION AND WELLNESS PROGRAMS.—The Administrator of the Centers for Medicare & Medicaid Services, in consultation with the Assistant Secretary for Aging, shall, to the extent feasible and practicable, conduct an evaluation of existing community prevention and wellness programs that are sponsored by the Administration on Aging to assess the extent to which Medicare beneficiaries who participate in such programs—

(I) reduce their health risks, improve their health outcomes, and adopt and maintain healthy behaviors;

(II) improve their ability to manage their chronic conditions; and

(III) reduce their utilization of health services and associated costs under the Medicare program for conditions that are amenable to improvement under such programs.

(3) REPORT.—Not later than September 30, 2013, the Secretary shall submit to Congress a report that includes—

(A) recommendations for such legislation and administrative action as the Secretary determines appropriate to promote healthy lifestyles and chronic disease self-management for Medicare beneficiaries;

(B) any relevant findings relating to the evidence review under paragraph (2)(B)(i); and

(C) the results of the evaluation under paragraph (2)(B)(ii).

(4) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplemental Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of \$50,000,000 to the Centers for Medicare & Medicaid Services Program Management Account. Amounts transferred under the preceding sentence shall remain available until expended.

(5) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to the this subsection.

(6) MEDICARE BENEFICIARY.—In this subsection, the term “Medicare beneficiary” means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act and enrolled under part B of such title.

SEC. 4203. REMOVING BARRIERS AND IMPROVING ACCESS TO WELLNESS FOR INDIVIDUALS WITH DISABILITIES.

Title V of the Rehabilitation Act of 1973 (29 U.S.C. 791 et seq.) is amended by adding at the end of the following:

“SEC. 510. ESTABLISHMENT OF STANDARDS FOR ACCESSIBLE MEDICAL DIAGNOSTIC EQUIPMENT.

“(a) STANDARDS.—Not later than 24 months after the date of enactment of the Affordable Health Choices Act, the Architectural and Transportation Barriers Compliance Board shall, in consultation with the Commissioner of the Food and Drug Administration, promulgate regulatory standards in accordance with the Administrative Procedure Act (2 U.S.C. 551 et seq.) setting forth the minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physician's offices, clinics, emergency rooms, hospitals, and other medical settings. The standards shall ensure that such equipment is accessible to, and usable by, individuals with accessibility needs, and shall allow independent entry to, use of, and

exit from the equipment by such individuals to the maximum extent possible.

“(b) MEDICAL DIAGNOSTIC EQUIPMENT COVERED.—The standards issued under subsection (a) for medical diagnostic equipment shall apply to equipment that includes examination tables, examination chairs (including chairs used for eye examinations or procedures), and dental examinations or procedures, weight scales, mammography equipment, x-ray machines, and other radiological equipment commonly used for diagnostic purposes by health professionals.

“(c) REVIEW AND AMENDMENT.—The Architectural and Transportation Barriers Compliance Board, in consultation with the Commissioner of the Food and Drug Administration, shall periodically review and, as appropriate, amend the standards in accordance with the Administrative Procedure Act (2 U.S.C. 551 et seq.).”.

SEC. 4204. IMMUNIZATIONS.

(a) STATE AUTHORITY TO PURCHASE RECOMMENDED VACCINES FOR ADULTS.—Section 317 of the Public Health Service Act (42 U.S.C. 247b) is amended by adding at the end the following:

“(1) AUTHORITY TO PURCHASE RECOMMENDED VACCINES FOR ADULTS.—

“(1) IN GENERAL.—The Secretary may negotiate and enter into contracts with manufacturers of vaccines for the purchase and delivery of vaccines for adults as provided for under subsection (e).

“(2) STATE PURCHASE.—A State may obtain additional quantities of such adult vaccines (subject to amounts specified to the Secretary by the State in advance of negotiations) through the purchase of vaccines from manufacturers at the applicable price negotiated by the Secretary under this subsection.”.

(b) DEMONSTRATION PROGRAM TO IMPROVE IMMUNIZATION COVERAGE.—Section 317 of the Public Health Service Act (42 U.S.C. 247b), as amended by subsection (a), is further amended by adding at the end the following:

“(m) DEMONSTRATION PROGRAM TO IMPROVE IMMUNIZATION COVERAGE.—

“(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a demonstration program to award grants to States to improve the provision of recommended immunizations for children, adolescents, and adults through the use of evidence-based, population-based interventions for high-risk populations.

“(2) STATE PLAN.—To be eligible for a grant under paragraph (1), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a State plan that describes the interventions to be implemented under the grant and how such interventions match with local needs and capabilities, as determined through consultation with local authorities.

“(3) USE OF FUNDS.—Funds received under a grant under this subsection shall be used to implement interventions that are recommended by the Task Force on Community Preventive Services (as established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) or other evidence-based interventions, including—

“(A) providing immunization reminders or recalls for target populations of clients, patients, and consumers;

“(B) educating targeted populations and health care providers concerning immunizations in combination with one or more other interventions;

“(C) reducing out-of-pocket costs for families for vaccines and their administration;

“(D) carrying out immunization-promoting strategies for participants or clients of public programs, including assessments of immunization status, referrals to health care providers,

education, provision of on-site immunizations, or incentives for immunization;

“(E) providing for home visits that promote immunization through education, assessments of need, referrals, provision of immunizations, or other services;

“(F) providing reminders or recalls for immunization providers;

“(G) conducting assessments of, and providing feedback to, immunization providers;

“(H) any combination of one or more interventions described in this paragraph; or

“(I) immunization information systems to allow all States to have electronic databases for immunization records.

“(4) CONSIDERATION.—In awarding grants under this subsection, the Secretary shall consider any reviews or recommendations of the Task Force on Community Preventive Services.

“(5) EVALUATION.—Not later than 3 years after the date on which a State receives a grant under this subsection, the State shall submit to the Secretary an evaluation of progress made toward improving immunization coverage rates among high-risk populations within the State.

“(6) REPORT TO CONGRESS.—Not later than 4 years after the date of enactment of the Affordable Health Choices Act, the Secretary shall submit to Congress a report concerning the effectiveness of the demonstration program established under this subsection together with recommendations on whether to continue and expand such program.

“(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2014.”

(c) REAUTHORIZATION OF IMMUNIZATION PROGRAM.—Section 317(j) of the Public Health Service Act (42 U.S.C. 247b(j)) is amended—

(1) in paragraph (1), by striking “for each of the fiscal years 1998 through 2005”; and

(2) in paragraph (2), by striking “after October 1, 1997.”

(d) RULE OF CONSTRUCTION REGARDING ACCESS TO IMMUNIZATIONS.—Nothing in this section (including the amendments made by this section), or any other provision of this Act (including any amendments made by this Act) shall be construed to decrease children’s access to immunizations.

(e) GAO STUDY AND REPORT ON MEDICARE BENEFICIARY ACCESS TO VACCINES.—

(1) STUDY.—The Comptroller General of the United States (in this section referred to as the “Comptroller General”) shall conduct a study on the ability of Medicare beneficiaries who were 65 years of age or older to access routinely recommended vaccines covered under the prescription drug program under part D of title XVIII of the Social Security Act over the period since the establishment of such program. Such study shall include the following:

(A) An analysis and determination of—

(i) the number of Medicare beneficiaries who were 65 years of age or older and were eligible for a routinely recommended vaccination that was covered under part D;

(ii) the number of such beneficiaries who actually received a routinely recommended vaccination that was covered under part D; and

(iii) any barriers to access by such beneficiaries to routinely recommended vaccinations that were covered under part D.

(B) A summary of the findings and recommendations by government agencies, departments, and advisory bodies (as well as relevant professional organizations) on the impact of coverage under part D of routinely recommended adult immunizations for access to such immunizations by Medicare beneficiaries.

(2) REPORT.—Not later than June 1, 2011, the Comptroller General shall submit to the appro-

priate committees of jurisdiction of the House of Representatives and the Senate a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(3) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated \$1,000,000 for fiscal year 2010 to carry out this subsection.

SEC. 4205. NUTRITION LABELING OF STANDARD MENU ITEMS AT CHAIN RESTAURANTS.

(a) TECHNICAL AMENDMENTS.—Section 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)(A)) is amended—

(1) in subitem (i), by inserting at the beginning “except as provided in clause (H)(ii)(III),”; and

(2) in subitem (ii), by inserting at the beginning “except as provided in clause (H)(ii)(III),”.

(b) LABELING REQUIREMENTS.—Section 403(q)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)) is amended by adding at the end the following:

“(H) RESTAURANTS, RETAIL FOOD ESTABLISHMENTS, AND VENDING MACHINES.—

“(i) GENERAL REQUIREMENTS FOR RESTAURANTS AND SIMILAR RETAIL FOOD ESTABLISHMENTS.—Except for food described in subclause (vii), in the case of food that is a standard menu item that is offered for sale in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items, the restaurant or similar retail food establishment shall disclose the information described in subclauses (ii) and (iii).

“(ii) INFORMATION REQUIRED TO BE DISCLOSED BY RESTAURANTS AND RETAIL FOOD ESTABLISHMENTS.—Except as provided in subclause (vii), the restaurant or similar retail food establishment shall disclose in a clear and conspicuous manner—

“(I)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu listing the item for sale, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

“(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu and designed to enable the public to understand, in the context of a total daily diet, the significance of the caloric information that is provided on the menu;

“(II)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu board, including a drive-through menu board, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

“(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu board, designed to enable the public to understand, in the context of a total daily diet, the significance of the nutrition information that is provided on the menu board;

“(III) in a written form, available on the premises of the restaurant or similar retail establishment and to the consumer upon request, the nutrition information required under clauses (C) and (D) of subparagraph (1); and

“(IV) on the menu or menu board, a prominent, clear, and conspicuous statement regarding the availability of the information described in item (III).

“(iii) SELF-SERVICE FOOD AND FOOD ON DISPLAY.—Except as provided in subclause (vii), in the case of food sold at a salad bar, buffet line, cafeteria line, or similar self-service facility, and for self-service beverages or food that is on display and that is visible to customers, a restaurant or similar retail food establishment shall place adjacent to each food offered a sign that lists calories per displayed food item or per serving.

“(iv) REASONABLE BASIS.—For the purposes of this clause, a restaurant or similar retail food establishment shall have a reasonable basis for its nutrient content disclosures, including nutrient databases, cookbooks, laboratory analyses, and other reasonable means, as described in section 101.10 of title 21, Code of Federal Regulations (or any successor regulation) or in a related guidance of the Food and Drug Administration.

“(v) MENU VARIABILITY AND COMBINATION MEALS.—The Secretary shall establish by regulation standards for determining and disclosing the nutrient content for standard menu items that come in different flavors, varieties, or combinations, but which are listed as a single menu item, such as soft drinks, ice cream, pizza, doughnuts, or children’s combination meals, through means determined by the Secretary, including ranges, averages, or other methods.

“(vi) ADDITIONAL INFORMATION.—If the Secretary determines that a nutrient, other than a nutrient required under subclause (ii)(III), should be disclosed for the purpose of providing information to assist consumers in maintaining healthy dietary practices, the Secretary may require, by regulation, disclosure of such nutrient in the written form required under subclause (ii)(III).

“(vii) NONAPPLICABILITY TO CERTAIN FOOD.—“(I) IN GENERAL.—Subclauses (i) through (vi) do not apply to—

“(aa) items that are not listed on a menu or menu board (such as condiments and other items placed on the table or counter for general use);

“(bb) daily specials, temporary menu items appearing on the menu for less than 60 days per calendar year, or custom orders; or

“(cc) such other food that is part of a customary market test appearing on the menu for less than 90 days, under terms and conditions established by the Secretary.

“(II) WRITTEN FORMS.—Subparagraph (5)(C) shall apply to any regulations promulgated under subclauses (ii)(III) and (vi).

“(viii) VENDING MACHINES.—

“(I) IN GENERAL.—In the case of an article of food sold from a vending machine that—

“(aa) does not permit a prospective purchaser to examine the Nutrition Facts Panel before purchasing the article or does not otherwise provide visible nutrition information at the point of purchase; and

“(bb) is operated by a person who is engaged in the business of owning or operating 20 or more vending machines,

the vending machine operator shall provide a sign in close proximity to each article of food or the selection button that includes a clear and conspicuous statement disclosing the number of calories contained in the article.

“(ix) VOLUNTARY PROVISION OF NUTRITION INFORMATION.—

“(I) IN GENERAL.—An authorized official of any restaurant or similar retail food establishment or vending machine operator not subject to the requirements of this clause may elect to be subject to the requirements of such clause, by registering biannually the name and address of such restaurant or similar retail food establishment or vending machine operator with the Secretary, as specified by the Secretary by regulation.

“(II) REGISTRATION.—Within 120 days of enactment of this clause, the Secretary shall publish a notice in the Federal Register specifying the terms and conditions for implementation of item (I), pending promulgation of regulations.

“(III) RULE OF CONSTRUCTION.—Nothing in this subclause shall be construed to authorize the Secretary to require an application, review, or licensing process for any entity to register with the Secretary, as described in such item.

“(x) REGULATIONS.—

“(I) PROPOSED REGULATION.—Not later than 1 year after the date of enactment of this clause, the Secretary shall promulgate proposed regulations to carry out this clause.

“(II) CONTENTS.—In promulgating regulations, the Secretary shall—

“(aa) consider standardization of recipes and methods of preparation, reasonable variation in serving size and formulation of menu items, space on menus and menu boards, inadvertent human error, training of food service workers, variations in ingredients, and other factors, as the Secretary determines; and

“(bb) specify the format and manner of the nutrient content disclosure requirements under this subclause.

“(III) REPORTING.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a quarterly report that describes the Secretary's progress toward promulgating final regulations under this subparagraph.

“(xi) DEFINITION.—In this clause, the term ‘menu’ or ‘menu board’ means the primary writing of the restaurant or other similar retail food establishment from which a consumer makes an order selection.”

(c) NATIONAL UNIFORMITY.—Section 403A(a)(4) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343-1(a)(4)) is amended by striking “except a requirement for nutrition labeling of food which is exempt under subclause (i) or (ii) of section 403(q)(5)(A)” and inserting “except that this paragraph does not apply to food that is offered for sale in a restaurant or similar retail food establishment that is not part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items unless such restaurant or similar retail food establishment complies with the voluntary provision of nutrition information requirements under section 403(q)(5)(H)(ix)”.

(d) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed—

(1) to preempt any provision of State or local law, unless such provision establishes or continues into effect nutrient content disclosures of the type required under section 403(q)(5)(H) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)) and is expressly preempted under subsection (a)(4) of such section;

(2) to apply to any State or local requirement respecting a statement in the labeling of food that provides for a warning concerning the safety of the food or component of the food; or

(3) except as provided in section 403(q)(5)(H)(ix) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)), to apply to any restaurant or similar retail food establishment other than a restaurant or similar retail food establishment described in section 403(q)(5)(H)(i) of such Act.

SEC. 4206. DEMONSTRATION PROJECT CONCERNING INDIVIDUALIZED WELLNESS PLAN.

Section 330 of the Public Health Service Act (42 U.S.C. 245b) is amended by adding at the end the following:

“(s) DEMONSTRATION PROGRAM FOR INDIVIDUALIZED WELLNESS PLANS.—

“(1) IN GENERAL.—The Secretary shall establish a pilot program to test the impact of providing at-risk populations who utilize community health centers funded under this section an individualized wellness plan that is designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment.

“(2) AGREEMENTS.—The Secretary shall enter into agreements with not more than 10 community health centers funded under this section to conduct activities under the pilot program under paragraph (1).

“(3) WELLNESS PLANS.—

“(A) IN GENERAL.—An individualized wellness plan prepared under the pilot program under this subsection may include one or more of the following as appropriate to the individual's identified risk factors:

“(i) Nutritional counseling.

“(ii) A physical activity plan.

“(iii) Alcohol and smoking cessation counseling and services.

“(iv) Stress management.

“(v) Dietary supplements that have health claims approved by the Secretary.

“(vi) Compliance assistance provided by a community health center employee.

“(B) RISK FACTORS.—Wellness plan risk factors shall include—

“(i) weight;

“(ii) tobacco and alcohol use;

“(iii) exercise rates;

“(iv) nutritional status; and

“(v) blood pressure.

“(C) COMPARISONS.—Individualized wellness plans shall make comparisons between the individual involved and a control group of individuals with respect to the risk factors described in subparagraph (B).

“(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, such sums as may be necessary.”

SEC. 4207. REASONABLE BREAK TIME FOR NURSING MOTHERS.

Section 7 of the Fair Labor Standards Act of 1938 (29 U.S.C. 207) is amended by adding at the end the following:

“(r)(1) An employer shall provide—

“(A) a reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk; and

“(B) a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.

“(2) An employer shall not be required to compensate an employee receiving reasonable break time under paragraph (1) for any work time spent for such purpose.

“(3) An employer that employs less than 50 employees shall not be subject to the requirements of this subsection, if such requirements would impose an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer's business.

“(4) Nothing in this subsection shall preempt a State law that provides greater protections to employees than the protections provided for under this subsection.”

Subtitle D—Support for Prevention and Public Health Innovation

SEC. 4301. RESEARCH ON OPTIMIZING THE DELIVERY OF PUBLIC HEALTH SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”), acting through the Director of the Centers for Disease Control and Prevention, shall provide funding for research in the area of public health services and systems.

(b) REQUIREMENTS OF RESEARCH.—Research supported under this section shall include—

(1) examining evidence-based practices relating to prevention, with a particular focus on high priority areas as identified by the Secretary in the National Prevention Strategy or Healthy People 2020, and including comparing community-based public health interventions in terms of effectiveness and cost;

(2) analyzing the translation of interventions from academic settings to real world settings; and

(3) identifying effective strategies for organizing, financing, or delivering public health services in real world community settings, including comparing State and local health department structures and systems in terms of effectiveness and cost.

(c) EXISTING PARTNERSHIPS.—Research supported under this section shall be coordinated with the Community Preventive Services Task Force and carried out by building on existing partnerships within the Federal Government while also considering initiatives at the State and local levels and in the private sector.

(d) ANNUAL REPORT.—The Secretary shall, on an annual basis, submit to Congress a report concerning the activities and findings with respect to research supported under this section.

SEC. 4302. UNDERSTANDING HEALTH DISPARITIES: DATA COLLECTION AND ANALYSIS.

(a) UNIFORM CATEGORIES AND COLLECTION REQUIREMENTS.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

“TITLE XXXI—DATA COLLECTION, ANALYSIS, AND QUALITY

“SEC. 3101. DATA COLLECTION, ANALYSIS, AND QUALITY.

“(a) DATA COLLECTION.—

“(1) IN GENERAL.—The Secretary shall ensure that, by not later than 2 years after the date of enactment of this title, any federally conducted or supported health care or public health program, activity or survey (including Current Population Surveys and American Community Surveys conducted by the Bureau of Labor Statistics and the Bureau of the Census) collects and reports, to the extent practicable—

“(A) data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants;

“(B) data at the smallest geographic level such as State, local, or institutional levels if such data can be aggregated;

“(C) sufficient data to generate statistically reliable estimates by racial, ethnic, sex, primary language, and disability status subgroups for applicants, recipients or participants using, if needed, statistical oversamples of these subpopulations; and

“(D) any other demographic data as deemed appropriate by the Secretary regarding health disparities.

“(2) COLLECTION STANDARDS.—In collecting data described in paragraph (1), the Secretary or designee shall—

“(A) use Office of Management and Budget standards, at a minimum, for race and ethnicity measures;

“(B) develop standards for the measurement of sex, primary language, and disability status;

“(C) develop standards for the collection of data described in paragraph (1) that, at a minimum—

“(i) collects self-reported data by the applicant, recipient, or participant; and

“(ii) collects data from a parent or legal guardian if the applicant, recipient, or participant is a minor or legally incapacitated;

“(D) survey health care providers and establish other procedures in order to assess access to care and treatment for individuals with disabilities and to identify—

“(i) locations where individuals with disabilities access primary, acute (including intensive), and long-term care;

“(ii) the number of providers with accessible facilities and equipment to meet the needs of the individuals with disabilities, including medical diagnostic equipment that meets the minimum technical criteria set forth in section 510 of the Rehabilitation Act of 1973; and

“(iii) the number of employees of health care providers trained in disability awareness and patient care of individuals with disabilities; and

“(E) require that any reporting requirement imposed for purposes of measuring quality under any ongoing or federally conducted or supported health care or public health program, activity, or survey includes requirements for the collection of data on individuals receiving health care items or services under such programs activities by race, ethnicity, sex, primary language, and disability status.

“(3) DATA MANAGEMENT.—In collecting data described in paragraph (1), the Secretary, acting through the National Coordinator for Health Information Technology shall—

“(A) develop national standards for the management of data collected; and

“(B) develop interoperability and security systems for data management.

“(b) DATA ANALYSIS.—

“(1) IN GENERAL.—For each federally conducted or supported health care or public health program or activity, the Secretary shall analyze data collected under paragraph (a) to detect and monitor trends in health disparities (as defined for purposes of section 485E) at the Federal and State levels.

“(c) DATA REPORTING AND DISSEMINATION.—

“(1) IN GENERAL.—The Secretary shall make the analyses described in (b) available to—

“(A) the Office of Minority Health;

“(B) the National Center on Minority Health and Health Disparities;

“(C) the Agency for Healthcare Research and Quality;

“(D) the Centers for Disease Control and Prevention;

“(E) the Centers for Medicare & Medicaid Services;

“(F) the Indian Health Service and epidemiology centers funded under the Indian Health Care Improvement Act;

“(G) the Office of Rural health;

“(H) other agencies within the Department of Health and Human Services; and

“(I) other entities as determined appropriate by the Secretary.

“(2) REPORTING OF DATA.—The Secretary shall report data and analyses described in (a) and (b) through—

“(A) public postings on the Internet websites of the Department of Health and Human Services; and

“(B) any other reporting or dissemination mechanisms determined appropriate by the Secretary.

“(3) AVAILABILITY OF DATA.—The Secretary may make data described in (a) and (b) available for additional research, analyses, and dissemination to other Federal agencies, non-governmental entities, and the public, in accordance with any Federal agency's data user agreements.

“(d) LIMITATIONS ON USE OF DATA.—Nothing in this section shall be construed to permit the use of information collected under this section in a manner that would adversely affect any individual.

“(e) PROTECTION AND SHARING OF DATA.—

“(1) PRIVACY AND OTHER SAFEGUARDS.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that—

“(A) all data collected pursuant to subsection (a) is protected—

“(i) under privacy protections that are at least as broad as those that the Secretary applies to other health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191; 110 Stat. 2033); and

“(ii) from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary; and

“(B) all appropriate information security safeguards are used in the collection, analysis, and sharing of data collected pursuant to subsection (a).

“(2) DATA SHARING.—The Secretary shall establish procedures for sharing data collected pursuant to subsection (a), measures relating to such data, and analyses of such data, with other relevant Federal and State agencies including the agencies, centers, and entities within the Department of Health and Human Services specified in subsection (c)(1).

“(f) DATA ON RURAL UNDERSERVED POPULATIONS.—The Secretary shall ensure that any data collected in accordance with this section regarding racial and ethnic minority groups are also collected regarding underserved rural and frontier populations.

“(g) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.

“(h) REQUIREMENT FOR IMPLEMENTATION.—Notwithstanding any other provision of this section, data may not be collected under this section unless funds are directly appropriated for such purpose in an appropriations Act.

“(i) CONSULTATION.—The Secretary shall consult with the Director of the Office of Personnel Management, the Secretary of Defense, the Secretary of Veterans Affairs, the Director of the Bureau of the Census, the Commissioner of Social Security, and the head of other appropriate Federal agencies in carrying out this section.”.

(b) ADDRESSING HEALTH CARE DISPARITIES IN MEDICAID AND CHIP.—

(1) STANDARDIZED COLLECTION REQUIREMENTS INCLUDED IN STATE PLANS.—

(A) MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 2001(d), is amended—

(i) in paragraph 4), by striking “and” at the end;

(ii) in paragraph (75), by striking the period at the end and inserting “; and”; and

(iii) by inserting after paragraph (75) the following new paragraph:

“(76) provide that any data collected under the State plan meets the requirements of section 3101 of the Public Health Service Act.”.

(B) CHIP.—Section 2108(e) of the Social Security Act (42 U.S.C. 1397hh(e)) is amended by adding at the end the following new paragraph:

“(7) Data collected and reported in accordance with section 3101 of the Public Health Service Act, with respect to individuals enrolled in the State child health plan (and, in the case of enrollees under 19 years of age, their parents or legal guardians), including data regarding the primary language of such individuals, parents, and legal guardians.”.

(2) EXTENDING MEDICARE REQUIREMENT TO ADDRESS HEALTH DISPARITIES DATA COLLECTION TO MEDICAID AND CHIP.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by section 2703 is amended by adding at the end the following new section:

“SEC. 1946. ADDRESSING HEALTH CARE DISPARITIES.

“(a) EVALUATING DATA COLLECTION APPROACHES.—The Secretary shall evaluate ap-

proaches for the collection of data under this title and title XXI, to be performed in conjunction with existing quality reporting requirements and programs under this title and title XXI, that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and performance on the basis of race, ethnicity, sex, primary language, and disability status. In conducting such evaluation, the Secretary shall consider the following objectives:

“(1) Protecting patient privacy.

“(2) Minimizing the administrative burdens of data collection and reporting on States, providers, and health plans participating under this title or title XXI.

“(3) Improving program data under this title and title XXI on race, ethnicity, sex, primary language, and disability status.

“(b) REPORTS TO CONGRESS.—

“(1) REPORT ON EVALUATION.—Not later than 18 months after the date of the enactment of this section, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

“(A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status for the programs under this title and title XXI; and

“(B) include recommendations on the most effective strategies and approaches to reporting HEDIS quality measures as required under section 1852(e)(3) and other nationally recognized quality performance measures, as appropriate, on such bases.

“(2) REPORTS ON DATA ANALYSES.—Not later than 4 years after the date of the enactment of this section, and 4 years thereafter, the Secretary shall submit to Congress a report that includes recommendations for improving the identification of health care disparities for beneficiaries under this title and under title XXI based on analyses of the data collected under subsection (c).

“(c) IMPLEMENTING EFFECTIVE APPROACHES.—Not later than 24 months after the date of the enactment of this section, the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status.”.

SEC. 4303. CDC AND EMPLOYER-BASED WELLNESS PROGRAMS.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), by section 4102, is further amended by adding at the end the following:

“PART U—EMPLOYER-BASED WELLNESS PROGRAM

“SEC. 399MM. TECHNICAL ASSISTANCE FOR EMPLOYER-BASED WELLNESS PROGRAMS.

“In order to expand the utilization of evidence-based prevention and health promotion approaches in the workplace, the Director shall—

“(1) provide employers (including small, medium, and large employers, as determined by the Director) with technical assistance, consultation, tools, and other resources in evaluating such employers' employer-based wellness programs, including—

“(A) measuring the participation and methods to increase participation of employees in such programs;

“(B) developing standardized measures that assess policy, environmental and systems changes necessary to have a positive health impact on employees' health behaviors, health outcomes, and health care expenditures; and

“(C) evaluating such programs as they relate to changes in the health status of employees, the absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees; and

“(2) build evaluation capacity among workplace staff by training employers on how to evaluate employer-based wellness programs by ensuring evaluation resources, technical assistance, and consultation are available to workplace staff as needed through such mechanisms as web portals, call centers, or other means.

“SEC. 399MM-1. NATIONAL WORKSITE HEALTH POLICIES AND PROGRAMS STUDY.

“(a) *IN GENERAL.*—In order to assess, analyze, and monitor over time data about workplace policies and programs, and to develop instruments to assess and evaluate comprehensive workplace chronic disease prevention and health promotion programs, policies and practices, not later than 2 years after the date of enactment of this part, and at regular intervals (to be determined by the Director) thereafter, the Director shall conduct a national worksite health policies and programs survey to assess employer-based health policies and programs.

“(b) *REPORT.*—Upon the completion of each study under subsection (a), the Director shall submit to Congress a report that includes the recommendations of the Director for the implementation of effective employer-based health policies and programs.

“SEC. 399MM-2. PRIORITIZATION OF EVALUATION BY SECRETARY.

“The Secretary shall evaluate, in accordance with this part, all programs funded through the Centers for Disease Control and Prevention before conducting such an evaluation of privately funded programs unless an entity with a privately funded wellness program requests such an evaluation.

“SEC. 399MM-3. PROHIBITION OF FEDERAL WORKPLACE WELLNESS REQUIREMENTS.

“Notwithstanding any other provision of this part, any recommendations, data, or assessments carried out under this part shall not be used to mandate requirements for workplace wellness programs.”

SEC. 4304. EPIDEMIOLOGY-LABORATORY CAPACITY GRANTS.

Title XXVIII of the Public Health Service Act (42 U.S.C. 300hh et seq.) is amended by adding at the end the following:

“Subtitle C—Strengthening Public Health Surveillance Systems

“SEC. 2821. EPIDEMIOLOGY-LABORATORY CAPACITY GRANTS.

“(a) *IN GENERAL.*—Subject to the availability of appropriations, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an Epidemiology and Laboratory Capacity Grant Program to award grants to State health departments as well as local health departments and tribal jurisdictions that meet such criteria as the Director determines appropriate. Academic centers that assist State and eligible local and tribal health departments may also be eligible for funding under this section as the Director determines appropriate. Grants shall be awarded under this section to assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance by—

“(1) strengthening epidemiologic capacity to identify and monitor the occurrence of infectious diseases and other conditions of public health importance;

“(2) enhancing laboratory practice as well as systems to report test orders and results electronically;

“(3) improving information systems including developing and maintaining an information ex-

change using national guidelines and complying with capacities and functions determined by an advisory council established and appointed by the Director; and

“(4) developing and implementing prevention and control strategies.

“(b) *AUTHORIZATION OF APPROPRIATIONS.*—There are authorized to be appropriated to carry out this section \$190,000,000 for each of fiscal years 2010 through 2013, of which—

“(1) not less than \$95,000,000 shall be made available each such fiscal year for activities under paragraphs (1) and (4) of subsection (a);

“(2) not less than \$60,000,000 shall be made available each such fiscal year for activities under subsection (a)(3); and

“(3) not less than \$32,000,000 shall be made available each such fiscal year for activities under subsection (a)(2).”

SEC. 4305. ADVANCING RESEARCH AND TREATMENT FOR PAIN CARE MANAGEMENT.

(a) *INSTITUTE OF MEDICINE CONFERENCE ON PAIN.*—

(1) *CONVENING.*—Not later than 1 year after funds are appropriated to carry out this subsection, the Secretary of Health and Human Services shall seek to enter into an agreement with the Institute of Medicine of the National Academies to convene a Conference on Pain (in this subsection referred to as “the Conference”).

(2) *PURPOSES.*—The purposes of the Conference shall be to—

(A) increase the recognition of pain as a significant public health problem in the United States;

(B) evaluate the adequacy of assessment, diagnosis, treatment, and management of acute and chronic pain in the general population, and in identified racial, ethnic, gender, age, and other demographic groups that may be disproportionately affected by inadequacies in the assessment, diagnosis, treatment, and management of pain;

(C) identify barriers to appropriate pain care;

(D) establish an agenda for action in both the public and private sectors that will reduce such barriers and significantly improve the state of pain care research, education, and clinical care in the United States.

(3) *OTHER APPROPRIATE ENTITY.*—If the Institute of Medicine declines to enter into an agreement under paragraph (1), the Secretary of Health and Human Services may enter into such agreement with another appropriate entity.

(4) *REPORT.*—A report summarizing the Conference’s findings and recommendations shall be submitted to the Congress not later than June 30, 2011.

(5) *AUTHORIZATION OF APPROPRIATIONS.*—For the purpose of carrying out this subsection, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 and 2011.

(b) *PAIN RESEARCH AT NATIONAL INSTITUTES OF HEALTH.*—Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.) is amended by adding at the end the following:

“SEC. 409J. PAIN RESEARCH.

“(a) *RESEARCH INITIATIVES.*—

“(1) *IN GENERAL.*—The Director of NIH is encouraged to continue and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain.

“(2) *ANNUAL RECOMMENDATIONS.*—Not less than annually, the Pain Consortium, in consultation with the Division of Program Coordination, Planning, and Strategic Initiatives, shall develop and submit to the Director of NIH recommendations on appropriate pain research initiatives that could be undertaken with funds reserved under section 402A(c)(1) for the Common Fund or otherwise available for such initiatives.

“(3) *DEFINITION.*—In this subsection, the term ‘Pain Consortium’ means the Pain Consortium of the National Institutes of Health or a similar trans-National Institutes of Health coordinating entity designated by the Secretary for purposes of this subsection.

“(b) *INTERAGENCY PAIN RESEARCH COORDINATING COMMITTEE.*—

“(1) *ESTABLISHMENT.*—The Secretary shall establish not later than 1 year after the date of the enactment of this section and as necessary maintain a committee, to be known as the Interagency Pain Research Coordinating Committee (in this section referred to as the ‘Committee’), to coordinate all efforts within the Department of Health and Human Services and other Federal agencies that relate to pain research.

“(2) *MEMBERSHIP.*—

“(A) *IN GENERAL.*—The Committee shall be composed of the following voting members:

“(i) Not more than 7 voting Federal representatives appoint by the Secretary from agencies that conduct pain care research and treatment.

“(ii) 12 additional voting members appointed under subparagraph (B).

“(B) *ADDITIONAL MEMBERS.*—The Committee shall include additional voting members appointed by the Secretary as follows:

“(i) 6 non-Federal members shall be appointed from among scientists, physicians, and other health professionals.

“(ii) 6 members shall be appointed from members of the general public, who are representatives of leading research, advocacy, and service organizations for individuals with pain-related conditions.

“(C) *NONVOTING MEMBERS.*—The Committee shall include such nonvoting members as the Secretary determines to be appropriate.

“(3) *CHAIRPERSON.*—The voting members of the Committee shall select a chairperson from among such members. The selection of a chairperson shall be subject to the approval of the Director of NIH.

“(4) *MEETINGS.*—The Committee shall meet at the call of the chairperson of the Committee or upon the request of the Director of NIH, but in no case less often than once each year.

“(5) *DUTIES.*—The Committee shall—

“(A) develop a summary of advances in pain care research supported or conducted by the Federal agencies relevant to the diagnosis, prevention, and treatment of pain and diseases and disorders associated with pain;

“(B) identify critical gaps in basic and clinical research on the symptoms and causes of pain;

“(C) make recommendations to ensure that the activities of the National Institutes of Health and other Federal agencies are free of unnecessary duplication of effort;

“(D) make recommendations on how best to disseminate information on pain care; and

“(E) make recommendations on how to expand partnerships between public entities and private entities to expand collaborative, cross-cutting research.

“(6) *REVIEW.*—The Secretary shall review the necessity of the Committee at least once every 2 years.”

(c) *PAIN CARE EDUCATION AND TRAINING.*—Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by adding at the end the following new section:

“SEC. 759. PROGRAM FOR EDUCATION AND TRAINING IN PAIN CARE.

“(a) *IN GENERAL.*—The Secretary may make awards of grants, cooperative agreements, and contracts to health professions schools, hospices, and other public and private entities for the development and implementation of programs to provide education and training to health care professionals in pain care.

“(b) *CERTAIN TOPICS.*—An award may be made under subsection (a) only if the applicant

for the award agrees that the program carried out with the award will include information and education on—

“(1) recognized means for assessing, diagnosing, treating, and managing pain and related signs and symptoms, including the medically appropriate use of controlled substances;

“(2) applicable laws, regulations, rules, and policies on controlled substances, including the degree to which misconceptions and concerns regarding such laws, regulations, rules, and policies, or the enforcement thereof, may create barriers to patient access to appropriate and effective pain care;

“(3) interdisciplinary approaches to the delivery of pain care, including delivery through specialized centers providing comprehensive pain care treatment expertise;

“(4) cultural, linguistic, literacy, geographic, and other barriers to care in underserved populations; and

“(5) recent findings, developments, and improvements in the provision of pain care.

“(c) **EVALUATION OF PROGRAMS.**—The Secretary shall (directly or through grants or contracts) provide for the evaluation of programs implemented under subsection (a) in order to determine the effect of such programs on knowledge and practice of pain care.

“(d) **PAIN CARE DEFINED.**—For purposes of this section the term ‘pain care’ means the assessment, diagnosis, treatment, or management of acute or chronic pain regardless of causation or body location.

“(e) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of the fiscal years 2010 through 2012. Amounts appropriated under this subsection shall remain available until expended.”.

SEC. 4306. FUNDING FOR CHILDHOOD OBESITY DEMONSTRATION PROJECT.

Section 1139A(e)(8) of the Social Security Act (42 U.S.C. 1320b–9a(e)(8)) is amended to read as follows:

“(8) **APPROPRIATION.**—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, \$25,000,000 for the period of fiscal years 2010 through 2014.”.

Subtitle E—Miscellaneous Provisions

SEC. 4401. SENSE OF THE SENATE CONCERNING CBO SCORING.

(a) **FINDING.**—The Senate finds that the costs of prevention programs are difficult to estimate due in part because prevention initiatives are hard to measure and results may occur outside the 5 and 10 year budget windows.

(b) **SENSE OF CONGRESS.**—It is the sense of the Senate that Congress should work with the Congressional Budget Office to develop better methodologies for scoring progress to be made in prevention and wellness programs.

SEC. 4402. EFFECTIVENESS OF FEDERAL HEALTH AND WELLNESS INITIATIVES.

To determine whether existing Federal health and wellness initiatives are effective in achieving their stated goals, the Secretary of Health and Human Services shall—

(1) conduct an evaluation of such programs as they relate to changes in health status of the American public and specifically on the health status of the Federal workforce, including absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees, and health conditions, including workplace fitness, healthy food and beverages, and incentives in the Federal Employee Health Benefits Program; and

(2) submit to Congress a report concerning such evaluation, which shall include conclusions concerning the reasons that such existing programs have proven successful or not successful and what factors contributed to such conclusions.

TITLE V—HEALTH CARE WORKFORCE

Subtitle A—Purpose and Definitions

SEC. 5001. PURPOSE.

The purpose of this title is to improve access to and the delivery of health care services for all individuals, particularly low income, underserved, uninsured, minority, health disparity, and rural populations by—

(1) gathering and assessing comprehensive data in order for the health care workforce to meet the health care needs of individuals, including research on the supply, demand, distribution, diversity, and skills needs of the health care workforce;

(2) increasing the supply of a qualified health care workforce to improve access to and the delivery of health care services for all individuals;

(3) enhancing health care workforce education and training to improve access to and the delivery of health care services for all individuals; and

(4) providing support to the existing health care workforce to improve access to and the delivery of health care services for all individuals.

SEC. 5002. DEFINITIONS.

(a) **THIS TITLE.**—In this title:

(1) **ALLIED HEALTH PROFESSIONAL.**—The term ‘allied health professional’ means an allied health professional as defined in section 799B(5) of the Public Health Service Act (42 U.S.C. 295p(5)) who—

(A) has graduated and received an allied health professions degree or certificate from an institution of higher education; and

(B) is employed with a Federal, State, local or tribal public health agency, or in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences, and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.

(2) **HEALTH CARE CAREER PATHWAY.**—The term ‘healthcare career pathway’ means a rigorous, engaging, and high quality set of courses and services that—

(A) includes an articulated sequence of academic and career courses, including 21st century skills;

(B) is aligned with the needs of healthcare industries in a region or State;

(C) prepares students for entry into the full range of postsecondary education options, including registered apprenticeships, and careers;

(D) provides academic and career counseling in student-to-counselor ratios that allow students to make informed decisions about academic and career options;

(E) meets State academic standards, State requirements for secondary school graduation and is aligned with requirements for entry into postsecondary education, and applicable industry standards; and

(F) leads to 2 or more credentials, including—

(i) a secondary school diploma; and

(ii) a postsecondary degree, an apprenticeship or other occupational certification, a certificate, or a license.

(3) **INSTITUTION OF HIGHER EDUCATION.**—The term ‘institution of higher education’ has the meaning given the term in sections 101 and 102 of the Higher Education Act of 1965 (20 U.S.C. 1001 and 1002).

(4) **LOW INCOME INDIVIDUAL, STATE WORKFORCE INVESTMENT BOARD, AND LOCAL WORKFORCE INVESTMENT BOARD.**—

(A) **LOW-INCOME INDIVIDUAL.**—The term ‘low-income individual’ has the meaning given that term in section 101 of the Workforce investment Act of 1998 (29 U.S.C. 2801).

(B) **STATE WORKFORCE INVESTMENT BOARD; LOCAL WORKFORCE INVESTMENT BOARD.**—The terms ‘State workforce investment board’ and

‘local workforce investment board’, refer to a State workforce investment board established under section 111 of the Workforce Investment Act of 1998 (29 U.S.C. 2821) and a local workforce investment board established under section 117 of such Act (29 U.S.C. 2832), respectively.

(5) **POSTSECONDARY EDUCATION.**—The term ‘postsecondary education’ means—

(A) a 4-year program of instruction, or not less than a 1-year program of instruction that is acceptable for credit toward an associate or a baccalaureate degree, offered by an institution of higher education; or

(B) a certificate or registered apprenticeship program at the postsecondary level offered by an institution of higher education or a non-profit educational institution.

(6) **REGISTERED APPRENTICESHIP PROGRAM.**—The term ‘registered apprenticeship program’ means an industry skills training program at the postsecondary level that combines technical and theoretical training through structure on the job learning with related instruction (in a classroom or through distance learning) while an individual is employed, working under the direction of qualified personnel or a mentor, and earning incremental wage increases aligned to enhance job proficiency, resulting in the acquisition of a nationally recognized and portable certificate, under a plan approved by the Office of Apprenticeship or a State agency recognized by the Department of Labor.

(b) **TITLE VII OF THE PUBLIC HEALTH SERVICE ACT.**—Section 799B of the Public Health Service Act (42 U.S.C. 295p) is amended—

(1) by striking paragraph (3) and inserting the following:

“(3) **PHYSICIAN ASSISTANT EDUCATION PROGRAM.**—The term ‘physician assistant education program’ means an educational program in a public or private institution in a State that—

“(A) has as its objective the education of individuals who, upon completion of their studies in the program, be qualified to provide primary care medical services with the supervision of a physician; and

“(B) is accredited by the Accreditation Review Commission on Education for the Physician Assistant.”; and

(2) by adding at the end the following:

“(12) **AREA HEALTH EDUCATION CENTER.**—The term ‘area health education center’ means a public or nonprofit private organization that has a cooperative agreement or contract in effect with an entity that has received an award under subsection (a)(1) or (a)(2) of section 751, satisfies the requirements in section 751(d)(1), and has as one of its principal functions the operation of an area health education center. Appropriate organizations may include hospitals, health organizations with accredited primary care training programs, accredited physician assistant educational programs associated with a college or university, and universities or colleges not operating a school of medicine or osteopathic medicine.

“(13) **AREA HEALTH EDUCATION CENTER PROGRAM.**—The term ‘area health education center program’ means cooperative program consisting of an entity that has received an award under subsection (a)(1) or (a)(2) of section 751 for the purpose of planning, developing, operating, and evaluating an area health education center program and one or more area health education centers, which carries out the required activities described in section 751(c), satisfies the program requirements in such section, has as one of its principal functions identifying and implementing strategies and activities that address health care workforce needs in its service area, in coordination with the local workforce investment boards.

“(14) **CLINICAL SOCIAL WORKER.**—The term ‘clinical social worker’ has the meaning given

the term in section 1861(hh)(1) of the Social Security Act (42 U.S.C. 1395x(hh)(1)).

“(15) CULTURAL COMPETENCY.—The term ‘cultural competency’ shall be defined by the Secretary in a manner consistent with section 1707(d)(3).

“(16) DIRECT CARE WORKER.—The term ‘direct care worker’ has the meaning given that term in the 2010 Standard Occupational Classifications of the Department of Labor for Home Health Aides [31–1011], Psychiatric Aides [31–1013], Nursing Assistants [31–1014], and Personal Care Aides [39–9021].

“(17) FEDERALLY QUALIFIED HEALTH CENTER.—The term ‘Federally qualified health center’ has the meaning given that term in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).

“(18) FRONTIER HEALTH PROFESSIONAL SHORTAGE AREA.—The term ‘frontier health professional shortage area’ means an area—

“(A) with a population density less than 6 persons per square mile within the service area; and

“(B) with respect to which the distance or time for the population to access care is excessive.

“(19) GRADUATE PSYCHOLOGY.—The term ‘graduate psychology’ means an accredited program in professional psychology.

“(20) HEALTH DISPARITY POPULATION.—The term ‘health disparity population’ has the meaning given such term in section 903(d)(1).

“(21) HEALTH LITERACY.—The term ‘health literacy’ means the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health decisions.

“(22) MENTAL HEALTH SERVICE PROFESSIONAL.—The term ‘mental health service professional’ means an individual with a graduate or postgraduate degree from an accredited institution of higher education in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family counseling, school counseling, or professional counseling.

“(23) ONE-STOP DELIVERY SYSTEM CENTER.—The term ‘one-stop delivery system’ means a one-stop delivery system described in section 134(c) of the Workforce Investment Act of 1998 (29 U.S.C. 2864(c)).

“(24) PARAPROFESSIONAL CHILD AND ADOLESCENT MENTAL HEALTH WORKER.—The term ‘paraprofessional child and adolescent mental health worker’ means an individual who is not a mental or behavioral health service professional, but who works at the first stage of contact with children and families who are seeking mental or behavioral health services, including substance abuse prevention and treatment services.

“(25) RACIAL AND ETHNIC MINORITY GROUP; RACIAL AND ETHNIC MINORITY POPULATION.—The terms ‘racial and ethnic minority group’ and ‘racial and ethnic minority population’ have the meaning given the term ‘racial and ethnic minority group’ in section 1707.

“(26) RURAL HEALTH CLINIC.—The term ‘rural health clinic’ has the meaning given that term in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).”

(c) TITLE VIII OF THE PUBLIC HEALTH SERVICE ACT.—Section 801 of the Public Health Service Act (42 U.S.C. 296) is amended—

(1) in paragraph (2)—

(A) by striking “means a” and inserting “means an accredited (as defined in paragraph 6)”; and

(B) by striking the period as inserting the following: “where graduates are—

“(A) authorized to sit for the National Council Licensure EXamination—Registered Nurse (NCLEX—RN); or

“(B) licensed registered nurses who will receive a graduate or equivalent degree or training to become an advanced education nurse as defined by section 811(b).”; and

(2) by adding at the end the following:

“(16) ACCELERATED NURSING DEGREE PROGRAM.—The term ‘accelerated nursing degree program’ means a program of education in professional nursing offered by an accredited school of nursing in which an individual holding a bachelors degree in another discipline receives a BSN or MSN degree in an accelerated time frame as determined by the accredited school of nursing.

“(17) BRIDGE OR DEGREE COMPLETION PROGRAM.—The term ‘bridge or degree completion program’ means a program of education in professional nursing offered by an accredited school of nursing, as defined in paragraph (2), that leads to a baccalaureate degree in nursing. Such programs may include, Registered Nurse (RN) to Bachelor’s of Science of Nursing (BSN) programs, RN to MSN (Master of Science of Nursing) programs, or BSN to Doctoral programs.”

Subtitle B—Innovations in the Health Care Workforce

SEC. 5101. NATIONAL HEALTH CARE WORKFORCE COMMISSION.

(a) PURPOSE.—It is the purpose of this section to establish a National Health Care Workforce Commission that—

(1) serves as a national resource for Congress, the President, States, and localities;

(2) communicates and coordinates with the Departments of Health and Human Services, Labor, Veterans Affairs, Homeland Security, and Education on related activities administered by one or more of such Departments;

(3) develops and commissions evaluations of education and training activities to determine whether the demand for health care workers is being met;

(4) identifies barriers to improved coordination at the Federal, State, and local levels and recommend ways to address such barriers; and

(5) encourages innovations to address population needs, constant changes in technology, and other environmental factors.

(b) ESTABLISHMENT.—There is hereby established the National Health Care Workforce Commission (in this section referred to as the “Commission”).

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members to be appointed by the Comptroller General, without regard to section 5 of the Federal Advisory Committee Act (5 U.S.C. App.).

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of the Commission shall include individuals—

(i) with national recognition for their expertise in health care labor market analysis, including health care workforce analysis; health care finance and economics; health care facility management; health care plans and integrated delivery systems; health care workforce education and training; health care philanthropy; providers of health care services; and other related fields; and

(ii) who will provide a combination of professional perspectives, broad geographic representation, and a balance between urban, suburban, rural, and frontier representatives.

(B) INCLUSION.—

(i) IN GENERAL.—The membership of the Commission shall include no less than one representative of—

(I) the health care workforce and health professionals;

(II) employers;

(III) third-party payers;

(IV) individuals skilled in the conduct and interpretation of health care services and health economics research;

(V) representatives of consumers;

(VI) labor unions;

(VII) State or local workforce investment boards; and

(VIII) educational institutions (which may include elementary and secondary institutions, institutions of higher education, including 2 and 4 year institutions, or registered apprenticeship programs).

(ii) ADDITIONAL MEMBERS.—The remaining membership may include additional representatives from clause (i) and other individuals as determined appropriate by the Comptroller General of the United States.

(C) MAJORITY NON-PROVIDERS.—Individuals who are directly involved in health professions education or practice shall not constitute a majority of the membership of the Commission.

(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members. Members of the Commission shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978. Members of the Commission shall not be treated as special government employees under title 18, United States Code.

(3) TERMS.—

(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member’s predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member’s term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(C) INITIAL APPOINTMENTS.—The Comptroller General shall make initial appointments of members to the Commission not later than September 30, 2010.

(4) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member’s regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate. Personnel of the Commission shall not be treated as employees of the Government Accountability Office for any purpose.

(5) CHAIRMAN, VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the chairmanship or vice chairmanship, the Comptroller General may designate another member for the remainder of that member’s term.

(6) MEETINGS.—The Commission shall meet at the call of the chairman, but no less frequently than on a quarterly basis.

(d) DUTIES.—

(1) RECOGNITION, DISSEMINATION, AND COMMUNICATION.—The Commission shall—

(A) recognize efforts of Federal, State, and local partnerships to develop and offer health care career pathways of proven effectiveness;

(B) disseminate information on promising retention practices for health care professionals; and

(C) communicate information on important policies and practices that affect the recruitment, education and training, and retention of the health care workforce.

(2) REVIEW OF HEALTH CARE WORKFORCE AND ANNUAL REPORTS.—In order to develop a fiscally sustainable integrated workforce that supports a high-quality, readily accessible health care delivery system that meets the needs of patients and populations, the Commission, in consultation with relevant Federal, State, and local agencies, shall—

(A) review current and projected health care workforce supply and demand, including the topics described in paragraph (3);

(B) make recommendations to Congress and the Administration concerning national health care workforce priorities, goals, and policies;

(C) by not later than October 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing the results of such reviews and recommendations concerning related policies; and

(D) by not later than April 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing a review of, and recommendations on, at a minimum one high priority area as described in paragraph (4).

(3) SPECIFIC TOPICS TO BE REVIEWED.—The topics described in this paragraph include—

(A) current health care workforce supply and distribution, including demographics, skill sets, and demands, with projected demands during the subsequent 10 and 25 year periods;

(B) health care workforce education and training capacity, including the number of students who have completed education and training, including registered apprenticeships; the number of qualified faculty; the education and training infrastructure; and the education and training demands, with projected demands during the subsequent 10 and 25 year periods;

(C) the education loan and grant programs in titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), with recommendations on whether such programs should become part of the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.);

(D) the implications of new and existing Federal policies which affect the health care workforce, including Medicare and Medicaid graduate medical education policies, titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), the National Health Service Corps (with recommendations for aligning such programs with national health workforce priorities and goals), and other health care workforce programs, including those supported through the Workforce Investment Act of 1998 (29 U.S.C. 2801 et seq.), the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2301 et seq.), the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.), and any other Federal health care workforce programs;

(E) the health care workforce needs of special populations, such as minorities, rural populations, medically underserved populations, gender specific needs, individuals with disabilities, and geriatric and pediatric populations with recommendations for new and existing Federal policies to meet the needs of these special populations; and

(F) recommendations creating or revising national loan repayment programs and scholarship programs to require low-income, minority med-

ical students to serve in their home communities, if designated as medical underserved community.

(4) HIGH PRIORITY AREAS.—

(A) IN GENERAL.—The initial high priority topics described in this paragraph include each of the following:

(i) Integrated health care workforce planning that identifies health care professional skills needed and maximizes the skill sets of health care professionals across disciplines.

(ii) An analysis of the nature, scopes of practice, and demands for health care workers in the enhanced information technology and management workplace.

(iii) An analysis of how to align Medicare and Medicaid graduate medical education policies with national workforce goals.

(iv) The education and training capacity, projected demands, and integration with the health care delivery system of each of the following:

(I) Nursing workforce capacity at all levels.

(II) Oral health care workforce capacity at all levels.

(III) Mental and behavioral health care workforce capacity at all levels.

(IV) Allied health and public health care workforce capacity at all levels.

(V) Emergency medical service workforce capacity, including the retention and recruitment of the volunteer workforce, at all levels.

(VI) The geographic distribution of health care providers as compared to the identified health care workforce needs of States and regions.

(B) FUTURE DETERMINATIONS.—The Commission may require that additional topics be included under subparagraph (A). The appropriate committees of Congress may recommend to the Commission the inclusion of other topics for health care workforce development areas that require special attention.

(5) GRANT PROGRAM.—The Commission shall—

(A) review implementation progress reports on, and report to Congress about, the State Health Care Workforce Development Grant program established in section 5102;

(B) in collaboration with the Department of Labor and in coordination with the Department of Education and other relevant Federal agencies, make recommendations to the fiscal and administrative agent under section 5102(b) for grant recipients under section 5102;

(C) assess the implementation of the grants under such section; and

(D) collect performance and report information, including identified models and best practices, on grants from the fiscal and administrative agent under such section and distribute this information to Congress, relevant Federal agencies, and to the public.

(6) STUDY.—The Commission shall study effective mechanisms for financing education and training for careers in health care, including public health and allied health.

(7) RECOMMENDATIONS.—The Commission shall submit recommendations to Congress, the Department of Labor, and the Department of Health and Human Services about improving safety, health, and worker protections in the workplace for the health care workforce.

(8) ASSESSMENT.—The Commission shall assess and receive reports from the National Center for Health Care Workforce Analysis established under section 761(b) of the Public Health Service Act (as amended by section 5103).

(e) CONSULTATION WITH FEDERAL, STATE, AND LOCAL AGENCIES, CONGRESS, AND OTHER ORGANIZATIONS.—

(1) IN GENERAL.—The Commission shall consult with Federal agencies (including the Departments of Health and Human Services, Labor, Education, Commerce, Agriculture, Defense, and Veterans Affairs and the Environ-

mental Protection Agency), Congress, the Medicare Payment Advisory Commission, the Medicaid and CHIP Payment and Access Commission, and, to the extent practicable, with State and local agencies, Indian tribes, voluntary health care organizations, professional societies, and other relevant public-private health care partnerships.

(2) OBTAINING OFFICIAL DATA.—The Commission, consistent with established privacy rules, may secure directly from any department or agency of the Executive Branch information necessary to enable the Commission to carry out this section.

(3) DETAIL OF FEDERAL GOVERNMENT EMPLOYEES.—An employee of the Federal Government may be detailed to the Commission without reimbursement. The detail of such an employee shall be without interruption or loss of civil service status.

(f) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States determines to be necessary to ensure the efficient administration of the Commission, the Commission may—

(1) employ and fix the compensation of an executive director that shall not exceed the rate of basic pay payable for level V of the Executive Schedule and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(4) make advance, progress, and other payments which relate to the work of the Commission;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as the Commission determines to be necessary with respect to the internal organization and operation of the Commission.

(g) POWERS.—

(1) DATA COLLECTION.—In order to carry out its functions under this section, the Commission shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section, including coordination with the Bureau of Labor Statistics;

(B) carry out, or award grants or contracts for the carrying out of, original research and development, where existing information is inadequate; and

(C) adopt procedures allowing interested parties to submit information for the Commission's use in making reports and recommendations.

(2) ACCESS OF THE GOVERNMENT ACCOUNTABILITY OFFICE TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon request.

(3) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by an independent public accountant under contract to the Commission.

(h) AUTHORIZATION OF APPROPRIATIONS.—

(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations. Amounts so appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

(2) **AUTHORIZATION.**—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(3) **GIFTS AND SERVICES.**—The Commission may not accept gifts, bequests, or donations of property, but may accept and use donations of services for purposes of carrying out this section.

(i) **DEFINITIONS.**—In this section:

(1) **HEALTH CARE WORKFORCE.**—The term “health care workforce” includes all health care providers with direct patient care and support responsibilities, such as physicians, nurses, nurse practitioners, primary care providers, preventive medicine physicians, optometrists, ophthalmologists, physician assistants, pharmacists, dentists, dental hygienists, and other oral healthcare professionals, allied health professionals, doctors of chiropractic, community health workers, health care paraprofessionals, direct care workers, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, certified nurse midwives, podiatrists, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), licensed complementary and alternative medicine providers, integrative health practitioners, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.

(2) **HEALTH PROFESSIONALS.**—The term “health professionals” includes—

(A) dentists, dental hygienists, primary care providers, specialty physicians, nurses, nurse practitioners, physician assistants, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, public health professionals, clinical pharmacists, allied health professionals, doctors of chiropractic, community health workers, school nurses, certified nurse midwives, podiatrists, licensed complementary and alternative medicine providers, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), and integrative health practitioners;

(B) national representatives of health professionals;

(C) representatives of schools of medicine, osteopathy, nursing, dentistry, optometry, pharmacy, chiropractic, allied health, educational programs for public health professionals, behavioral and mental health professionals (as so defined), social workers, pharmacists, physical and occupational therapists, oral health care industry dentistry and dental hygiene, and physician assistants;

(D) representatives of public and private teaching hospitals, and ambulatory health facilities, including Federal medical facilities; and

(E) any other health professional the Comptroller General of the United States determines appropriate.

SEC. 5102. STATE HEALTH CARE WORKFORCE DEVELOPMENT GRANTS.

(a) **ESTABLISHMENT.**—There is established a competitive health care workforce development grant program (referred to in this section as the “program”) for the purpose of enabling State partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels.

(b) **FISCAL AND ADMINISTRATIVE AGENT.**—The Health Resources and Services Administration of the Department of Health and Human Services (referred to in this section as the “Adminis-

tration”) shall be the fiscal and administrative agent for the grants awarded under this section. The Administration is authorized to carry out the program, in consultation with the National Health Care Workforce Commission (referred to in this section as the “Commission”), which shall review reports on the development, implementation, and evaluation activities of the grant program, including—

(1) administering the grants;

(2) providing technical assistance to grantees; and

(3) reporting performance information to the Commission.

(c) **PLANNING GRANTS.**—

(1) **AMOUNT AND DURATION.**—A planning grant shall be awarded under this subsection for a period of not more than one year and the maximum award may not be more than \$150,000.

(2) **ELIGIBILITY.**—To be eligible to receive a planning grant, an entity shall be an eligible partnership. An eligible partnership shall be a State workforce investment board, if it includes or modifies the members to include at least one representative from each of the following: health care employer, labor organization, a public 2-year institution of higher education, a public 4-year institution of higher education, the recognized State federation of labor, the State public secondary education agency, the State P-16 or P-20 Council if such a council exists, and a philanthropic organization that is actively engaged in providing learning, mentoring, and work opportunities to recruit, educate, and train individuals for, and retain individuals in, careers in health care and related industries.

(3) **FISCAL AND ADMINISTRATIVE AGENT.**—The Governor of the State receiving a planning grant has the authority to appoint a fiscal and an administrative agency for the partnership.

(4) **APPLICATION.**—Each State partnership desiring a planning grant shall submit an application to the Administrator of the Administration at such time and in such manner, and accompanied by such information as the Administrator may reasonably require. Each application submitted for a planning grant shall describe the members of the State partnership, the activities for which assistance is sought, the proposed performance benchmarks to be used to measure progress under the planning grant, a budget for use of the funds to complete the required activities described in paragraph (5), and such additional assurance and information as the Administrator determines to be essential to ensure compliance with the grant program requirements.

(5) **REQUIRED ACTIVITIES.**—A State partnership receiving a planning grant shall carry out the following:

(A) Analyze State labor market information in order to create health care career pathways for students and adults, including dislocated workers.

(B) Identify current and projected high demand State or regional health care sectors for purposes of planning career pathways.

(C) Identify existing Federal, State, and private resources to recruit, educate or train, and retain a skilled health care workforce and strengthen partnerships.

(D) Describe the academic and health care industry skill standards for high school graduation, for entry into postsecondary education, and for various credentials and licensure.

(E) Describe State secondary and postsecondary education and training policies, models, or practices for the health care sector, including career information and guidance counseling.

(F) Identify Federal or State policies or rules to developing a coherent and comprehensive health care workforce development strategy and barriers and a plan to resolve these barriers.

(G) Participate in the Administration’s evaluation and reporting activities.

(6) **PERFORMANCE AND EVALUATION.**—Before the State partnership receives a planning grant, such partnership and the Administrator of the Administration shall jointly determine the performance benchmarks that will be established for the purposes of the planning grant.

(7) **MATCH.**—Each State partnership receiving a planning grant shall provide an amount, in cash or in kind, that is not less than 15 percent of the amount of the grant, to carry out the activities supported by the grant. The matching requirement may be provided from funds available under other Federal, State, local or private sources to carry out the activities.

(8) **REPORT.**—

(A) **REPORT TO ADMINISTRATION.**—Not later than 1 year after a State partnership receives a planning grant, the partnership shall submit a report to the Administration on the State’s performance of the activities under the grant, including the use of funds, including matching funds, to carry out required activities, and a description of the progress of the State workforce investment board in meeting the performance benchmarks.

(B) **REPORT TO CONGRESS.**—The Administration shall submit a report to Congress analyzing the planning activities, performance, and fund utilization of each State grant recipient, including an identification of promising practices and a profile of the activities of each State grant recipient.

(d) **IMPLEMENTATION GRANTS.**—

(1) **IN GENERAL.**—The Administration shall—

(A) competitively award implementation grants to State partnerships to enable such partnerships to implement activities that will result in a coherent and comprehensive plan for health workforce development that will address current and projected workforce demands within the State; and

(B) inform the Commission and Congress about the awards made.

(2) **DURATION.**—An implementation grant shall be awarded for a period of no more than 2 years, except in those cases where the Administration determines that the grantee is high performing and the activities supported by the grant warrant up to 1 additional year of funding.

(3) **ELIGIBILITY.**—To be eligible for an implementation grant, a State partnership shall have—

(A) received a planning grant under subsection (c) and completed all requirements of such grant; or

(B) completed a satisfactory application, including a plan to coordinate with required partners and complete the required activities during the 2 year period of the implementation grant.

(4) **FISCAL AND ADMINISTRATIVE AGENT.**—A State partnership receiving an implementation grant shall appoint a fiscal and an administrative agent for the implementation of such grant.

(5) **APPLICATION.**—Each eligible State partnership desiring an implementation grant shall submit an application to the Administration at such time, in such manner, and accompanied by such information as the Administration may reasonably require. Each application submitted shall include—

(A) a description of the members of the State partnership;

(B) a description of how the State partnership completed the required activities under the planning grant, if applicable;

(C) a description of the activities for which implementation grant funds are sought, including grants to regions by the State partnership to advance coherent and comprehensive regional health care workforce planning activities;

(D) a description of how the State partnership will coordinate with required partners and complete the required partnership activities during the duration of an implementation grant;

(E) a budget proposal of the cost of the activities supported by the implementation grant and a timeline for the provision of matching funds required;

(F) proposed performance benchmarks to be used to assess and evaluate the progress of the partnership activities;

(G) a description of how the State partnership will collect data to report progress in grant activities; and

(H) such additional assurances as the Administration determines to be essential to ensure compliance with grant requirements.

(6) REQUIRED ACTIVITIES.—

(A) **IN GENERAL.**—A State partnership that receives an implementation grant may reserve not less than 60 percent of the grant funds to make grants to be competitively awarded by the State partnership, consistent with State procurement rules, to encourage regional partnerships to address health care workforce development needs and to promote innovative health care workforce career pathway activities, including career counseling, learning, and employment.

(B) **ELIGIBLE PARTNERSHIP DUTIES.**—An eligible State partnership receiving an implementation grant shall—

(i) identify and convene regional leadership to discuss opportunities to engage in statewide health care workforce development planning, including the potential use of competitive grants to improve the development, distribution, and diversity of the regional health care workforce; the alignment of curricula for health care careers; and the access to quality career information and guidance and education and training opportunities;

(ii) in consultation with key stakeholders and regional leaders, take appropriate steps to reduce Federal, State, or local barriers to a comprehensive and coherent strategy, including changes in State or local policies to foster coherent and comprehensive health care workforce development activities, including health care career pathways at the regional and State levels, career planning information, retraining for dislocated workers, and as appropriate, requests for Federal program or administrative waivers;

(iii) develop, disseminate, and review with key stakeholders a preliminary statewide strategy that addresses short- and long-term health care workforce development supply versus demand;

(iv) convene State partnership members on a regular basis, and at least on a semiannual basis;

(v) assist leaders at the regional level to form partnerships, including technical assistance and capacity building activities;

(vi) collect and assess data on and report on the performance benchmarks selected by the State partnership and the Administration for implementation activities carried out by regional and State partnerships; and

(vii) participate in the Administration's evaluation and reporting activities.

(7) **PERFORMANCE AND EVALUATION.**—Before the State partnership receives an implementation grant, it and the Administrator shall jointly determine the performance benchmarks that shall be established for the purposes of the implementation grant.

(8) **MATCH.**—Each State partnership receiving an implementation grant shall provide an amount, in cash or in kind that is not less than 25 percent of the amount of the grant, to carry out the activities supported by the grant. The matching funds may be provided from funds available from other Federal, State, local, or private sources to carry out such activities.

(9) REPORTS.—

(A) **REPORT TO ADMINISTRATION.**—For each year of the implementation grant, the State partnership receiving the implementation grant shall submit a report to the Administration on

the performance of the State of the grant activities, including a description of the use of the funds, including matched funds, to complete activities, and a description of the performance of the State partnership in meeting the performance benchmarks.

(B) **REPORT TO CONGRESS.**—The Administration shall submit a report to Congress analyzing implementation activities, performance, and fund utilization of the State grantees, including an identification of promising practices and a profile of the activities of each State grantee.

(e) AUTHORIZATION FOR APPROPRIATIONS.—

(1) **PLANNING GRANTS.**—There are authorized to be appropriated to award planning grants under subsection (c) \$8,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

(2) **IMPLEMENTATION GRANTS.**—There are authorized to be appropriated to award implementation grants under subsection (d), \$150,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

SEC. 5103. HEALTH CARE WORKFORCE ASSESSMENT.

(a) **IN GENERAL.**—Section 761 of the Public Health Service Act (42 U.S.C. 294m) is amended—

(1) by redesignating subsection (c) as subsection (e);

(2) by striking subsection (b) and inserting the following:

“(b) **NATIONAL CENTER FOR HEALTH CARE WORKFORCE ANALYSIS.**—

“(1) **ESTABLISHMENT.**—The Secretary shall establish the National Center for Health Workforce Analysis (referred to in this section as the ‘National Center’).

“(2) **PURPOSES.**—The National Center, in coordination to the extent practicable with the National Health Care Workforce Commission (established in section 5101 of the Patient Protection and Affordable Care Act), and relevant regional and State centers and agencies, shall—

“(A) provide for the development of information describing and analyzing the health care workforce and workforce related issues;

“(B) carry out the activities under section 792(a);

“(C) annually evaluate programs under this title;

“(D) develop and publish performance measures and benchmarks for programs under this title; and

“(E) establish, maintain, and publicize a national Internet registry of each grant awarded under this title and a database to collect data from longitudinal evaluations (as described in subsection (d)(2)) on performance measures (as developed under sections 749(d)(3), 757(d)(3), and 762(a)(3)).

“(3) COLLABORATION AND DATA SHARING.—

“(A) **IN GENERAL.**—The National Center shall collaborate with Federal agencies and relevant professional and educational organizations or societies for the purpose of linking data regarding grants awarded under this title.

“(B) **CONTRACTS FOR HEALTH WORKFORCE ANALYSIS.**—For the purpose of carrying out the activities described in subparagraph (A), the National Center may enter into contracts with relevant professional and educational organizations or societies.

“(c) **STATE AND REGIONAL CENTERS FOR HEALTH WORKFORCE ANALYSIS.—**

“(1) **IN GENERAL.**—The Secretary shall award grants to, or enter into contracts with, eligible entities for purposes of—

“(A) collecting, analyzing, and reporting data regarding programs under this title to the National Center and to the public; and

“(B) providing technical assistance to local and regional entities on the collection, analysis, and reporting of data.

“(2) **ELIGIBLE ENTITIES.**—To be eligible for a grant or contract under this subsection, an entity shall—

“(A) be a State, a State workforce investment board, a public health or health professions school, an academic health center, or an appropriate public or private nonprofit entity; and

“(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(d) **INCREASE IN GRANTS FOR LONGITUDINAL EVALUATIONS.—**

“(1) **IN GENERAL.**—The Secretary shall increase the amount awarded to an eligible entity under this title for a longitudinal evaluation of individuals who have received education, training, or financial assistance from programs under this title.

“(2) **CAPABILITY.**—A longitudinal evaluation shall be capable of—

“(A) studying practice patterns; and

“(B) collecting and reporting data on performance measures developed under sections 749(d)(3), 757(d)(3), and 762(a)(3).

“(3) **GUIDELINES.**—A longitudinal evaluation shall comply with guidelines issued under sections 749(d)(4), 757(d)(4), and 762(a)(4).

“(4) **ELIGIBLE ENTITIES.**—To be eligible to obtain an increase under this section, an entity shall be a recipient of a grant or contract under this title.”; and

(3) in subsection (e), as so redesignated—

(A) by striking paragraph (1) and inserting the following:

“(1) **IN GENERAL.**—

“(A) **NATIONAL CENTER.**—To carry out subsection (b), there are authorized to be appropriated \$7,500,000 for each of fiscal years 2010 through 2014.

“(B) **STATE AND REGIONAL CENTERS.**—To carry out subsection (c), there are authorized to be appropriated \$4,500,000 for each of fiscal years 2010 through 2014.

“(C) **GRANTS FOR LONGITUDINAL EVALUATIONS.**—To carry out subsection (d), there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.”; and

(4) in paragraph (2), by striking “subsection (a)” and inserting “paragraph (1)”;.

(b) **TRANSFERS.**—Not later than 180 days after the date of enactment of this Act, the responsibilities and resources of the National Center for Health Workforce Analysis, as in effect on the date before the date of enactment of this Act, shall be transferred to the National Center for Health Care Workforce Analysis established under section 761 of the Public Health Service Act, as amended by subsection (a).

(c) **USE OF LONGITUDINAL EVALUATIONS.**—Section 791(a)(1) of the Public Health Service Act (42 U.S.C. 295j(a)(1)) is amended—

(1) in subparagraph (A), by striking “or” at the end;

(2) in subparagraph (B), by striking the period and inserting “; or”; and

(3) by adding at the end the following:

“(C) utilizes a longitudinal evaluation (as described in section 761(d)(2)) and reports data from such system to the national workforce database (as established under section 761(b)(2)(E)).”.

(d) **PERFORMANCE MEASURES; GUIDELINES FOR LONGITUDINAL EVALUATIONS.—**

(1) **ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY.**—Section 748(d) of the Public Health Service Act is amended—

(A) in paragraph (1), by striking “and” at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

“(3) develop, publish, and implement performance measures for programs under this part;

“(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and
 “(5) recommend appropriation levels for programs under this part.”.

(2) ADVISORY COMMITTEE ON INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES.—Section 756(d) of the Public Health Service Act is amended—

(A) in paragraph (1), by striking “and” at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

“(3) develop, publish, and implement performance measures for programs under this part;

“(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

“(5) recommend appropriation levels for programs under this part.”.

(3) ADVISORY COUNCIL ON GRADUATE MEDICAL EDUCATION.—Section 762(a) of the Public Health Service Act (42 U.S.C. 294o(a)) is amended—

(A) in paragraph (1), by striking “and” at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

“(3) develop, publish, and implement performance measures for programs under this title, except for programs under part C or D;

“(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this title, except for programs under part C or D; and

“(5) recommend appropriation levels for programs under this title, except for programs under part C or D.”.

Subtitle C—Increasing the Supply of the Health Care Workforce

SEC. 5201. FEDERALLY SUPPORTED STUDENT LOAN FUNDS.

(a) MEDICAL SCHOOLS AND PRIMARY HEALTH CARE.—Section 723 of the Public Health Service Act (42 U.S.C. 292s) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking subparagraph (B) and inserting the following:

“(B) to practice in such care for 10 years (including residency training in primary health care) or through the date on which the loan is repaid in full, whichever occurs first.”; and

(B) by striking paragraph (3) and inserting the following:

“(3) NONCOMPLIANCE BY STUDENT.—Each agreement entered into with a student pursuant to paragraph (1) shall provide that, if the student fails to comply with such agreement, the loan involved will begin to accrue interest at a rate of 2 percent per year greater than the rate at which the student would pay if compliant in such year.”; and

(2) by adding at the end the following:

“(d) SENSE OF CONGRESS.—It is the sense of Congress that funds repaid under the loan program under this section should not be transferred to the Treasury of the United States or otherwise used for any other purpose other than to carry out this section.”.

(b) STUDENT LOAN GUIDELINES.—The Secretary of Health and Human Services shall not require parental financial information for an independent student to determine financial need under section 723 of the Public Health Service Act (42 U.S.C. 292s) and the determination of need for such information shall be at the discretion of applicable school loan officer. The Secretary shall amend guidelines issued by the Health Resources and Services Administration in accordance with the preceding sentence.

SEC. 5202. NURSING STUDENT LOAN PROGRAM.

(a) LOAN AGREEMENTS.—Section 836(a) of the Public Health Service Act (42 U.S.C. 297b(a)) is amended—

(1) by striking “\$2,500” and inserting “\$3,300”;

(2) by striking “\$4,000” and inserting “\$5,200”; and

(3) by striking “\$13,000” and all that follows through the period and inserting “\$17,000 in the case of any student during fiscal years 2010 and 2011. After fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate of the loans.”.

(b) LOAN PROVISIONS.—Section 836(b) of the Public Health Service Act (42 U.S.C. 297b(b)) is amended—

(1) in paragraph (1)(C), by striking “1986” and inserting “2000”; and

(2) in paragraph (3), by striking “the date of enactment of the Nurse Training Amendments of 1979” and inserting “September 29, 1995”.

SEC. 5203. HEALTH CARE WORKFORCE LOAN REPAYMENT PROGRAMS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

“Subpart 3—Recruitment and Retention Programs

“SEC. 775. INVESTMENT IN TOMORROW'S PEDIATRIC HEALTH CARE WORKFORCE.

“(a) ESTABLISHMENT.—The Secretary shall establish and carry out a pediatric specialty loan repayment program under which the eligible individual agrees to be employed full-time for a specified period (which shall not be less than 2 years) in providing pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including substance abuse prevention and treatment services.

“(b) PROGRAM ADMINISTRATION.—Through the program established under this section, the Secretary shall enter into contracts with qualified health professionals under which—

“(1) such qualified health professionals will agree to provide pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care in an area with a shortage of the specified pediatric subspecialty that has a sufficient pediatric population to support such pediatric subspecialty, as determined by the Secretary; and

“(2) the Secretary agrees to make payments on the principal and interest of undergraduate, graduate, or graduate medical education loans of professionals described in paragraph (1) of not more than \$35,000 a year for each year of agreed upon service under such paragraph for a period of not more than 3 years during the qualified health professional's—

“(A) participation in an accredited pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental health subspecialty residency or fellowship; or

“(B) employment as a pediatric medical subspecialist, pediatric surgical specialist, or child and adolescent mental health professional serving an area or population described in such paragraph.

“(c) IN GENERAL.—

“(1) ELIGIBLE INDIVIDUALS.—

“(A) PEDIATRIC MEDICAL SPECIALISTS AND PEDIATRIC SURGICAL SPECIALISTS.—For purposes of contracts with respect to pediatric medical specialists and pediatric surgical specialists, the term ‘qualified health professional’ means a licensed physician who—

“(i) is entering or receiving training in an accredited pediatric medical subspecialty or pediatric surgical specialty residency or fellowship; or

“(ii) has completed (but not prior to the end of the calendar year in which this section is enacted) the training described in subparagraph (B).

“(B) CHILD AND ADOLESCENT MENTAL AND BEHAVIORAL HEALTH.—For purposes of contracts

with respect to child and adolescent mental and behavioral health care, the term ‘qualified health professional’ means a health care professional who—

“(i) has received specialized training or clinical experience in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family therapy, school counseling, or professional counseling; and

“(ii) has a license or certification in a State to practice allopathic medicine, osteopathic medicine, psychology, school psychology, psychiatric nursing, social work, school social work, marriage and family therapy, school counseling, or professional counseling; or

“(iii) is a mental health service professional who completed (but not before the end of the calendar year in which this section is enacted) specialized training or clinical experience in child and adolescent mental health described in clause (i).

“(2) ADDITIONAL ELIGIBILITY REQUIREMENTS.—The Secretary may not enter into a contract under this subsection with an eligible individual unless—

“(A) the individual agrees to work in, or for a provider serving, a health professional shortage area or medically underserved area, or to serve a medically underserved population;

“(B) the individual is a United States citizen or a permanent legal United States resident; and

“(C) if the individual is enrolled in a graduate program, the program is accredited, and the individual has an acceptable level of academic standing (as determined by the Secretary).

“(d) PRIORITY.—In entering into contracts under this subsection, the Secretary shall give priority to applicants who—

“(1) are or will be working in a school or other pre-kindergarten, elementary, or secondary education setting;

“(2) have familiarity with evidence-based methods and cultural and linguistic competence health care services; and

“(3) demonstrate financial need.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated \$30,000,000 for each of fiscal years 2010 through 2014 to carry out subsection (c)(1)(A) and \$20,000,000 for each of fiscal years 2010 through 2013 to carry out subsection (c)(1)(B).”.

SEC. 5204. PUBLIC HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5203, is further amended by adding at the end the following:

“SEC. 776. PUBLIC HEALTH WORKFORCE LOAN REPAYMENT PROGRAM.

“(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Loan Repayment Program (referred to in this section as the ‘Program’) to assure an adequate supply of public health professionals to eliminate critical public health workforce shortages in Federal, State, local, and tribal public health agencies.

“(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

“(1)(A) be accepted for enrollment, or be enrolled, as a student in an accredited academic educational institution in a State or territory in the final year of a course of study or program leading to a public health or health professions degree or certificate; and have accepted employment with a Federal, State, local, or tribal public health agency, or a related training fellowship, as recognized by the Secretary, to commence upon graduation;

“(B)(i) have graduated, during the preceding 10-year period, from an accredited educational

institution in a State or territory and received a public health or health professions degree or certificate; and

“(ii) be employed by, or have accepted employment with, a Federal, State, local, or tribal public health agency or a related training fellowship, as recognized by the Secretary;

“(2) be a United States citizen; and

“(3)(A) submit an application to the Secretary to participate in the Program;

“(B) execute a written contract as required in subsection (c); and

“(4) not have received, for the same service, a reduction of loan obligations under section 455(m), 428J, 428K, 428L, or 460 of the Higher Education Act of 1965.

“(c) CONTRACT.—The written contract (referred to in this section as the ‘written contract’) between the Secretary and an individual shall contain—

“(1) an agreement on the part of the Secretary that the Secretary will repay on behalf of the individual loans incurred by the individual in the pursuit of the relevant degree or certificate in accordance with the terms of the contract;

“(2) an agreement on the part of the individual that the individual will serve in the full-time employment of a Federal, State, local, or tribal public health agency or a related fellowship program in a position related to the course of study or program for which the contract was awarded for a period of time (referred to in this section as the ‘period of obligated service’) equal to the greater of—

“(A) 3 years; or

“(B) such longer period of time as determined appropriate by the Secretary and the individual;

“(3) an agreement, as appropriate, on the part of the individual to relocate to a priority service area (as determined by the Secretary) in exchange for an additional loan repayment incentive amount to be determined by the Secretary;

“(4) a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual that is conditioned thereon, is contingent on funds being appropriated for loan repayments under this section;

“(5) a statement of the damages to which the United States is entitled, under this section for the individual’s breach of the contract; and

“(6) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

“(d) PAYMENTS.—

“(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for tuition expenses incurred by the individual.

“(2) PAYMENTS FOR YEARS SERVED.—For each year of obligated service that an individual contracts to serve under subsection (c) the Secretary may pay up to \$35,000 on behalf of the individual for loans described in paragraph (1). With respect to participants under the Program whose total eligible loans are less than \$105,000, the Secretary shall pay an amount that does not exceed $\frac{1}{3}$ of the eligible loan balance for each year of obligated service of the individual.

“(3) TAX LIABILITY.—For the purpose of providing reimbursements for tax liability resulting from payments under paragraph (2) on behalf of an individual, the Secretary shall, in addition to such payments, make payments to the individual in an amount not to exceed 39 percent of the total amount of loan repayments made for the taxable year involved.

“(e) POSTPONING OBLIGATED SERVICE.—With respect to an individual receiving a degree or

certificate from a health professions or other related school, the date of the initiation of the period of obligated service may be postponed as approved by the Secretary.

“(f) BREACH OF CONTRACT.—An individual who fails to comply with the contract entered into under subsection (c) shall be subject to the same financial penalties as provided for under section 338E for breaches of loan repayment contracts under section 338B.

“(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section \$195,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.”.

SEC. 5205. ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

(a) PURPOSE.—The purpose of this section is to assure an adequate supply of allied health professionals to eliminate critical allied health workforce shortages in Federal, State, local, and tribal public health agencies or in settings where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings, as recognized by the Secretary of Health and Human Services by authorizing an Allied Health Loan Forgiveness Program.

(b) ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAM.—Section 428K of the Higher Education Act of 1965 (20 U.S.C. 1078–11) is amended—

(1) in subsection (b), by adding at the end the following:

“(18) ALLIED HEALTH PROFESSIONALS.—The individual is employed full-time as an allied health professional—

“(A) in a Federal, State, local, or tribal public health agency; or

“(B) in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.”; and

(2) in subsection (g)—

(A) by redesignating paragraphs (1) through (9) as paragraphs (2) through (10), respectively; and

(B) by inserting before paragraph (2) (as redesignated by subparagraph (A)) the following:

“(1) ALLIED HEALTH PROFESSIONAL.—The term ‘allied health professional’ means an allied health professional as defined in section 799B(5) of the Public Health Service Act (42 U.S.C. 295p(5)) who—

“(A) has graduated and received an allied health professions degree or certificate from an institution of higher education; and

“(B) is employed by a Federal, State, local or tribal public health agency, or in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.”.

SEC. 5206. GRANTS FOR STATE AND LOCAL PROGRAMS.

(a) IN GENERAL.—Section 765(d) of the Public Health Service Act (42 U.S.C. 295(d)) is amended—

(1) in paragraph (7), by striking “; or” and inserting a semicolon;

(2) by redesignating paragraph (8) as paragraph (9); and

(3) by inserting after paragraph (7) the following:

“(8) public health workforce loan repayment programs; or”.

(b) TRAINING FOR MID-CAREER PUBLIC HEALTH PROFESSIONALS.—Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5204, is further amended by adding at the end the following:

“SEC. 777. TRAINING FOR MID-CAREER PUBLIC AND ALLIED HEALTH PROFESSIONALS.

“(a) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, any eligible entity to award scholarships to eligible individuals to enroll in course or professional training programs for the purpose of enabling mid-career professionals in the public health and allied health workforce to receive additional training in the field of public health and allied health.

“(b) ELIGIBILITY.—

“(1) ELIGIBLE ENTITY.—The term ‘eligible entity’ indicates an accredited educational institution that offers a course of study, certificate program, or professional training program in public or allied health or a related discipline, as determined by the Secretary

“(2) ELIGIBLE INDIVIDUALS.—The term ‘eligible individuals’ includes those individuals employed in public and allied health positions at the Federal, State, tribal, or local level who are interested in retaining or upgrading their education.

“(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$60,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015. Fifty percent of appropriated funds shall be allotted to public health mid-career professionals and 50 percent shall be allotted to allied health mid-career professionals.”.

SEC. 5207. FUNDING FOR NATIONAL HEALTH SERVICE CORPS.

Section 338H(a) of the Public Health Service Act (42 U.S.C. 254q(a)) is amended to read as follows:

“(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated, out of any funds in the Treasury not otherwise appropriated, the following:

“(1) For fiscal year 2010, \$320,461,632.

“(2) For fiscal year 2011, \$414,095,394.

“(3) For fiscal year 2012, \$535,087,442.

“(4) For fiscal year 2013, \$691,431,432.

“(5) For fiscal year 2014, \$893,456,433.

“(6) For fiscal year 2015, \$1,154,510,336.

“(7) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

“(A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and

“(B) one plus the average percentage change in the number of individuals residing in health professions shortage areas designated under section 333 during the prior fiscal year, relative to the number of individuals residing in such areas during the previous fiscal year.”.

SEC. 5208. NURSE-MANAGED HEALTH CLINICS.

(a) PURPOSE.—The purpose of this section is to fund the development and operation of nurse-managed health clinics.

(b) GRANTS.—Subpart 1 of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by inserting after section 330A the following:

“SEC. 330A-1. GRANTS TO NURSE-MANAGED HEALTH CLINICS.

“(a) DEFINITIONS.—

“(1) COMPREHENSIVE PRIMARY HEALTH CARE SERVICES.—In this section, the term ‘comprehensive primary health care services’ means the primary health services described in section 330(b)(1).

“(2) NURSE-MANAGED HEALTH CLINIC.—The term ‘nurse-managed health clinic’ means a

nurse-practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health or social services agency.

“(b) **AUTHORITY TO AWARD GRANTS.**—The Secretary shall award grants for the cost of the operation of nurse-managed health clinics that meet the requirements of this section.

“(c) **APPLICATIONS.**—To be eligible to receive a grant under this section, an entity shall—

“(1) be an NMHC; and

“(2) submit to the Secretary an application at such time, in such manner, and containing—

“(A) assurances that nurses are the major providers of services at the NMHC and that at least 1 advanced practice nurse holds an executive management position within the organizational structure of the NMHC;

“(B) an assurance that the NMHC will continue providing comprehensive primary health care services or wellness services without regard to income or insurance status of the patient for the duration of the grant period; and

“(C) an assurance that, not later than 90 days of receiving a grant under this section, the NMHC will establish a community advisory committee, for which a majority of the members shall be individuals who are served by the NMHC.

“(d) **GRANT AMOUNT.**—The amount of any grant made under this section for any fiscal year shall be determined by the Secretary, taking into account—

“(1) the financial need of the NMHC, considering State, local, and other operational funding provided to the NMHC; and

“(2) other factors, as the Secretary determines appropriate.

“(e) **AUTHORIZATION OF APPROPRIATIONS.**—For the purposes of carrying out this section, there are authorized to be appropriated \$50,000,000 for the fiscal year 2010 and such sums as may be necessary for each of the fiscal years 2011 through 2014.”.

SEC. 5209. ELIMINATION OF CAP ON COMMISSIONED CORPS.

Section 202 of the Department of Health and Human Services Appropriations Act, 1993 (Public Law 102-394) is amended by striking “not to exceed 2,800”.

SEC. 5210. ESTABLISHING A READY RESERVE CORPS.

Section 203 of the Public Health Service Act (42 U.S.C. 204) is amended to read as follows:

“SEC. 203. COMMISSIONED CORPS AND READY RESERVE CORPS.

“(a) **ESTABLISHMENT.**—

“(1) **IN GENERAL.**—There shall be in the Service a commissioned Regular Corps and a Ready Reserve Corps for service in time of national emergency.

“(2) **REQUIREMENT.**—All commissioned officers shall be citizens of the United States and shall be appointed without regard to the civil-service laws and compensated without regard to the Classification Act of 1923, as amended.

“(3) **APPOINTMENT.**—Commissioned officers of the Ready Reserve Corps shall be appointed by the President and commissioned officers of the Regular Corps shall be appointed by the President with the advice and consent of the Senate.

“(4) **ACTIVE DUTY.**—Commissioned officers of the Ready Reserve Corps shall at all times be subject to call to active duty by the Surgeon General, including active duty for the purpose of training.

“(5) **WARRANT OFFICERS.**—Warrant officers may be appointed to the Service for the purpose of providing support to the health and delivery systems maintained by the Service and any war-

rant officer appointed to the Service shall be considered for purposes of this Act and title 37, United States Code, to be a commissioned officer within the Commissioned Corps of the Service.

“(b) **ASSIMILATING RESERVE CORP OFFICERS INTO THE REGULAR CORPS.**—Effective on the date of enactment of the Patient Protection and Affordable Care Act, all individuals classified as officers in the Reserve Corps under this section (as such section existed on the day before the date of enactment of such Act) and serving on active duty shall be deemed to be commissioned officers of the Regular Corps.

“(c) **PURPOSE AND USE OF READY RESEARCH.**—

“(1) **PURPOSE.**—The purpose of the Ready Reserve Corps is to fulfill the need to have additional Commissioned Corps personnel available on short notice (similar to the uniformed service’s reserve program) to assist regular Commissioned Corps personnel to meet both routine public health and emergency response missions.

“(2) **USES.**—The Ready Reserve Corps shall—

“(A) participate in routine training to meet the general and specific needs of the Commissioned Corps;

“(B) be available and ready for involuntary calls to active duty during national emergencies and public health crises, similar to the uniformed service reserve personnel;

“(C) be available for backfilling critical positions left vacant during deployment of active duty Commissioned Corps members, as well as for deployment to respond to public health emergencies, both foreign and domestic; and

“(D) be available for service assignment in isolated, hardship, and medically underserved communities (as defined in section 799B) to improve access to health services.

“(d) **FUNDING.**—For the purpose of carrying out the duties and responsibilities of the Commissioned Corps under this section, there are authorized to be appropriated \$5,000,000 for each of fiscal years 2010 through 2014 for recruitment and training and \$12,500,000 for each of fiscal years 2010 through 2014 for the Ready Reserve Corps.”.

Subtitle D—Enhancing Health Care Workforce Education and Training

SEC. 5301. TRAINING IN FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS, AND PHYSICIAN ASSISTANTSHIP.

Part C of title VII (42 U.S.C. 293k et seq.) is amended by striking section 747 and inserting the following:

“SEC. 747. PRIMARY CARE TRAINING AND ENHANCEMENT.

“(a) **SUPPORT AND DEVELOPMENT OF PRIMARY CARE TRAINING PROGRAMS.**—

“(1) **IN GENERAL.**—The Secretary may make grants to, or enter into contracts with, an accredited public or nonprofit private hospital, school of medicine or osteopathic medicine, academically affiliated physician assistant training program, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant or contract—

“(A) to plan, develop, operate, or participate in an accredited professional training program, including an accredited residency or internship program in the field of family medicine, general internal medicine, or general pediatrics for medical students, interns, residents, or practicing physicians as defined by the Secretary;

“(B) to provide need-based financial assistance in the form of traineeships and fellowships to medical students, interns, residents, practicing physicians, or other medical personnel, who are participants in any such program, and who plan to specialize or work in the practice of the fields defined in subparagraph (A);

“(C) to plan, develop, and operate a program for the training of physicians who plan to teach in family medicine, general internal medicine, or general pediatrics training programs;

“(D) to plan, develop, and operate a program for the training of physicians teaching in community-based settings;

“(E) to provide financial assistance in the form of traineeships and fellowships to physicians who are participants in any such programs and who plan to teach or conduct research in a family medicine, general internal medicine, or general pediatrics training program;

“(F) to plan, develop, and operate a physician assistant education program, and for the training of individuals who will teach in programs to provide such training;

“(G) to plan, develop, and operate a demonstration program that provides training in new competencies, as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act, which may include—

“(i) providing training to primary care physicians relevant to providing care through patient-centered medical homes (as defined by the Secretary for purposes of this section);

“(ii) developing tools and curricula relevant to patient-centered medical homes; and

“(iii) providing continuing education to primary care physicians relevant to patient-centered medical homes; and

“(H) to plan, develop, and operate joint degree programs to provide interdisciplinary and interprofessional graduate training in public health and other health professions to provide training in environmental health, infectious disease control, disease prevention and health promotion, epidemiological studies and injury control.

“(2) **DURATION OF AWARDS.**—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

“(b) **CAPACITY BUILDING IN PRIMARY CARE.**—

“(1) **IN GENERAL.**—The Secretary may make grants to or enter into contracts with accredited schools of medicine or osteopathic medicine to establish, maintain, or improve—

“(A) academic units or programs that improve clinical teaching and research in fields defined in subsection (a)(1)(A); or

“(B) programs that integrate academic administrative units in fields defined in subsection (a)(1)(A) to enhance interdisciplinary recruitment, training, and faculty development.

“(2) **PREFERENCE IN MAKING AWARDS UNDER THIS SUBSECTION.**—In making awards of grants and contracts under paragraph (1), the Secretary shall give preference to any qualified applicant for such an award that agrees to expend the award for the purpose of—

“(A) establishing academic units or programs in fields defined in subsection (a)(1)(A); or

“(B) substantially expanding such units or programs.

“(3) **PRIORITIES IN MAKING AWARDS.**—In awarding grants or contracts under paragraph (1), the Secretary shall give priority to qualified applicants that—

“(A) proposes a collaborative project between academic administrative units of primary care;

“(B) proposes innovative approaches to clinical teaching using models of primary care, such as the patient centered medical home, team management of chronic disease, and interprofessional integrated models of health care that incorporate transitions in health care settings and integration physical and mental health provision;

“(C) have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers trained, who enter and remain in primary care practice;

“(D) have a record of training individuals who are from underrepresented minority groups or from a rural or disadvantaged background;

“(E) provide training in the care of vulnerable populations such as children, older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with HIV/AIDS, and individuals with disabilities;

“(F) establish formal relationships and submit joint applications with federally qualified health centers, rural health clinics, area health education centers, or clinics located in underserved areas or that serve underserved populations;

“(G) teach trainees the skills to provide interprofessional, integrated care through collaboration among health professionals;

“(H) provide training in enhanced communication with patients, evidence-based practice, chronic disease management, preventive care, health information technology, or other competencies as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act; or

“(I) provide training in cultural competency and health literacy.

“(4) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

“(c) AUTHORIZATION OF APPROPRIATIONS.—

“(1) IN GENERAL.—For purposes of carrying out this section (other than subsection (b)(1)(B)), there are authorized to be appropriated \$125,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014.

“(2) TRAINING PROGRAMS.—Fifteen percent of the amount appropriated pursuant to paragraph (1) in each such fiscal year shall be allocated to the physician assistant training programs described in subsection (a)(1)(F), which prepare students for practice in primary care.

“(3) INTEGRATING ACADEMIC ADMINISTRATIVE UNITS.—For purposes of carrying out subsection (b)(1)(B), there are authorized to be appropriated \$750,000 for each of fiscal years 2010 through 2014.”

SEC. 5302. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by inserting after section 747, as amended by section 5301, the following:

“SEC. 747A. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

“(a) IN GENERAL.—The Secretary shall award grants to eligible entities to enable such entities to provide new training opportunities for direct care workers who are employed in long-term care settings such as nursing homes (as defined in section 1908(e)(1) of the Social Security Act (42 U.S.C. 1396g(e)(1)), assisted living facilities and skilled nursing facilities, intermediate care facilities for individuals with mental retardation, home and community based settings, and any other setting the Secretary determines to be appropriate.

“(b) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall—

“(1) be an institution of higher education (as defined in section 102 of the Higher Education Act of 1965 (20 U.S.C. 1002)) that—

“(A) is accredited by a nationally recognized accrediting agency or association listed under section 101(c) of the Higher Education Act of 1965 (20 U.S.C. 1001(c)); and

“(B) has established a public-private educational partnership with a nursing home or skilled nursing facility, agency or entity pro-

viding home and community based services to individuals with disabilities, or other long-term care provider; and

“(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(c) USE OF FUNDS.—An eligible entity shall use amounts awarded under a grant under this section to provide assistance to eligible individuals to offset the cost of tuition and required fees for enrollment in academic programs provided by such entity.

“(d) ELIGIBLE INDIVIDUAL.—

“(1) ELIGIBILITY.—To be eligible for assistance under this section, an individual shall be enrolled in courses provided by a grantee under this subsection and maintain satisfactory academic progress in such courses.

“(2) CONDITION OF ASSISTANCE.—As a condition of receiving assistance under this section, an individual shall agree that, following completion of the assistance period, the individual will work in the field of geriatrics, disability services, long term services and supports, or chronic care management for a minimum of 2 years under guidelines set by the Secretary.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$10,000,000 for the period of fiscal years 2011 through 2013.”

SEC. 5303. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

Part C of Title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by—

(1) redesignating section 748, as amended by section 5103 of this Act, as section 749; and

(2) inserting after section 747A, as added by section 5302, the following:

“SEC. 748. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

“(a) SUPPORT AND DEVELOPMENT OF DENTAL TRAINING PROGRAMS.—

“(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, a school of dentistry, public or nonprofit private hospital, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant or contract—

“(A) to plan, develop, and operate, or participate in, an approved professional training program in the field of general dentistry, pediatric dentistry, or public health dentistry for dental students, residents, practicing dentists, dental hygienists, or other approved primary care dental trainees, that emphasizes training for general, pediatric, or public health dentistry;

“(B) to provide financial assistance to dental students, residents, practicing dentists, and dental hygiene students who are in need thereof, who are participants in any such program, and who plan to work in the practice of general, pediatric, public health dentistry, or dental hygiene;

“(C) to plan, develop, and operate a program for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene;

“(D) to provide financial assistance in the form of traineeships and fellowships to dentists who plan to teach or are teaching in general, pediatric, or public health dentistry;

“(E) to meet the costs of projects to establish, maintain, or improve dental faculty development programs in primary care (which may be departments, divisions or other units);

“(F) to meet the costs of projects to establish, maintain, or improve predoctoral and postdoctoral training in primary care programs;

“(G) to create a loan repayment program for faculty in dental programs; and

“(H) to provide technical assistance to pediatric training programs in developing and implementing instruction regarding the oral health status, dental care needs, and risk-based clin-

ical disease management of all pediatric populations with an emphasis on underserved children.

“(2) FACULTY LOAN REPAYMENT.—

“(A) IN GENERAL.—A grant or contract under subsection (a)(1)(G) may be awarded to a program of general, pediatric, or public health dentistry described in such subsection to plan, develop, and operate a loan repayment program under which—

“(i) individuals agree to serve full-time as faculty members; and

“(ii) the program of general, pediatric or public health dentistry agrees to pay the principal and interest on the outstanding student loans of the individuals.

“(B) MANNER OF PAYMENTS.—With respect to the payments described in subparagraph (A)(ii), upon completion by an individual of each of the first, second, third, fourth, and fifth years of service, the program shall pay an amount equal to 10, 15, 20, 25, and 30 percent, respectively, of the individual's student loan balance as calculated based on principal and interest owed at the initiation of the agreement.

“(b) ELIGIBLE ENTITY.—For purposes of this subsection, entities eligible for such grants or contracts in general, pediatric, or public health dentistry shall include entities that have programs in dental or dental hygiene schools, or approved residency or advanced education programs in the practice of general, pediatric, or public health dentistry. Eligible entities may partner with schools of public health to permit the education of dental students, residents, and dental hygiene students for a master's year in public health at a school of public health.

“(c) PRIORITIES IN MAKING AWARDS.—With respect to training provided for under this section, the Secretary shall give priority in awarding grants or contracts to the following:

“(1) Qualified applicants that propose collaborative projects between departments of primary care medicine and departments of general, pediatric, or public health dentistry.

“(2) Qualified applicants that have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers, who enter and remain in general, pediatric, or public health dentistry.

“(3) Qualified applicants that have a record of training individuals who are from a rural or disadvantaged background, or from underrepresented minorities.

“(4) Qualified applicants that establish formal relationships with Federally qualified health centers, rural health centers, or accredited teaching facilities and that conduct training of students, residents, fellows, or faculty at the center or facility.

“(5) Qualified applicants that conduct teaching programs targeting vulnerable populations such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all populations.

“(6) Qualified applicants that include educational activities in cultural competency and health literacy.

“(7) Qualified applicants that have a high rate for placing graduates in practice settings that serve underserved areas or health disparity populations, or who achieve a significant increase in the rate of placing graduates in such settings.

“(8) Qualified applicants that intend to establish a special populations oral health care education center or training program for the didactic and clinical education of dentists, dental health professionals, and dental hygienists who plan to teach oral health care for people with

developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and vulnerable elderly.

“(d) APPLICATION.—An eligible entity desiring a grant under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(e) DURATION OF AWARD.—The period during which payments are made to an entity from an award of a grant or contract under subsection (a) shall be 5 years. The provision of such payments shall be subject to annual approval by the Secretary and subject to the availability of appropriations for the fiscal year involved to make the payments.

“(f) AUTHORIZATIONS OF APPROPRIATIONS.—For the purpose of carrying out subsections (a) and (b), there is authorized to be appropriated \$30,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015.

“(g) CARRYOVER FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.”.

SEC. 5304. ALTERNATIVE DENTAL HEALTH CARE PROVIDERS DEMONSTRATION PROJECT.

Subpart X of part D of title III of the Public Health Service Act (42 U.S.C. 256f et seq.) is amended by adding at the end the following:

“SEC. 340G-1. DEMONSTRATION PROGRAM.

“(a) IN GENERAL.—

“(1) AUTHORIZATION.—The Secretary is authorized to award grants to 15 eligible entities to enable such entities to establish a demonstration program to establish training programs to train, or to employ, alternative dental health care providers in order to increase access to dental health care services in rural and other underserved communities.

“(2) DEFINITION.—The term ‘alternative dental health care providers’ includes community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary determines appropriate.

“(b) TIMEFRAME.—The demonstration projects funded under this section shall begin not later than 2 years after the date of enactment of this section, and shall conclude not later than 7 years after such date of enactment.

“(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a), an entity shall—

“(1) be—

“(A) an institution of higher education, including a community college;

“(B) a public-private partnership;

“(C) a federally qualified health center;

“(D) an Indian Health Service facility or a tribe or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act);

“(E) a State or county public health clinic, a health facility operated by an Indian tribe or tribal organization, or urban Indian organization providing dental services; or

“(F) a public hospital or health system;

“(2) be within a program accredited by the Commission on Dental Accreditation or within a dental education program in an accredited institution; and

“(3) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

“(d) ADMINISTRATIVE PROVISIONS.—

“(1) AMOUNT OF GRANT.—Each grant under this section shall be in an amount that is not

less than \$4,000,000 for the 5-year period during which the demonstration project being conducted.

“(2) DISBURSEMENT OF FUNDS.—

“(A) PRELIMINARY DISBURSEMENTS.—Beginning 1 year after the enactment of this section, the Secretary may disperse to any entity receiving a grant under this section not more than 20 percent of the total funding awarded to such entity under such grant, for the purpose of enabling the entity to plan the demonstration project to be conducted under such grant.

“(B) SUBSEQUENT DISBURSEMENTS.—The remaining amount of grant funds not dispersed under subparagraph (A) shall be dispersed such that not less than 15 percent of such remaining amount is dispersed each subsequent year.

“(e) COMPLIANCE WITH STATE REQUIREMENTS.—Each entity receiving a grant under this section shall certify that it is in compliance with all applicable State licensing requirements.

“(f) EVALUATION.—The Secretary shall contract with the Director of the Institute of Medicine to conduct a study of the demonstration programs conducted under this section that shall provide analysis, based upon quantitative and qualitative data, regarding access to dental health care in the United States.

“(g) CLARIFICATION REGARDING DENTAL HEALTH AIDE PROGRAM.—Nothing in this section shall prohibit a dental health aide training program approved by the Indian Health Service from being eligible for a grant under this section.

“(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.”.

SEC. 5305. GERIATRIC EDUCATION AND TRAINING; CAREER AWARDS; COMPREHENSIVE GERIATRIC EDUCATION.

(a) WORKFORCE DEVELOPMENT; CAREER AWARDS.—Section 753 of the Public Health Service Act (42 U.S.C. 294c) is amended by adding at the end the following:

“(d) GERIATRIC WORKFORCE DEVELOPMENT.—

“(1) IN GENERAL.—The Secretary shall award grants or contracts under this subsection to entities that operate a geriatric education center pursuant to subsection (a)(1).

“(2) APPLICATION.—To be eligible for an award under paragraph (1), an entity described in such paragraph shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(3) USE OF FUNDS.—Amounts awarded under a grant or contract under paragraph (1) shall be used to—

“(A) carry out the fellowship program described in paragraph (4); and

“(B) carry out 1 of the 2 activities described in paragraph (5).

“(4) FELLOWSHIP PROGRAM.—

“(A) IN GENERAL.—Pursuant to paragraph (3), a geriatric education center that receives an award under this subsection shall use such funds to offer short-term intensive courses (referred to in this subsection as a ‘fellowship’) that focus on geriatrics, chronic care management, and long-term care that provide supplemental training for faculty members in medical schools and other health professions schools with programs in psychology, pharmacy, nursing, social work, dentistry, public health, allied health, or other health disciplines, as approved by the Secretary. Such a fellowship shall be open to current faculty, and appropriately credentialed volunteer faculty and practitioners, who do not have formal training in geriatrics, to upgrade their knowledge and clinical skills for the care of older adults and adults with functional limitations and to enhance their interdisciplinary teaching skills.

“(B) LOCATION.—A fellowship shall be offered either at the geriatric education center that is sponsoring the course, in collaboration with other geriatric education centers, or at medical schools, schools of dentistry, schools of nursing, schools of pharmacy, schools of social work, graduate programs in psychology, or allied health and other health professions schools approved by the Secretary with which the geriatric education centers are affiliated.

“(C) CME CREDIT.—Participation in a fellowship under this paragraph shall be accepted with respect to complying with continuing health profession education requirements. As a condition of such acceptance, the recipient shall agree to subsequently provide a minimum of 18 hours of voluntary instructional support through a geriatric education center that is providing clinical training to students or trainees in long-term care settings.

“(5) ADDITIONAL REQUIRED ACTIVITIES DESCRIBED.—Pursuant to paragraph (3), a geriatric education center that receives an award under this subsection shall use such funds to carry out 1 of the following 2 activities.

“(A) FAMILY CAREGIVER AND DIRECT CARE PROVIDER TRAINING.—A geriatric education center that receives an award under this subsection shall offer at least 2 courses each year, at no charge or nominal cost, to family caregivers and direct care providers that are designed to provide practical training for supporting frail elders and individuals with disabilities. The Secretary shall require such Centers to work with appropriate community partners to develop training program content and to publicize the availability of training courses in their service areas. All family caregiver and direct care provider training programs shall include instruction on the management of psychological and behavioral aspects of dementia, communication techniques for working with individuals who have dementia, and the appropriate, safe, and effective use of medications for older adults.

“(B) INCORPORATION OF BEST PRACTICES.—A geriatric education center that receives an award under this subsection shall develop and include material on depression and other mental disorders common among older adults, medication safety issues for older adults, and management of the psychological and behavioral aspects of dementia and communication techniques with individuals who have dementia in all training courses, where appropriate.

“(6) TARGETS.—A geriatric education center that receives an award under this subsection shall meet targets approved by the Secretary for providing geriatric training to a certain number of faculty or practitioners during the term of the award, as well as other parameters established by the Secretary.

“(7) AMOUNT OF AWARD.—An award under this subsection shall be in an amount of \$150,000. Not more than 24 geriatric education centers may receive an award under this subsection.

“(8) MAINTENANCE OF EFFORT.—A geriatric education center that receives an award under this subsection shall provide assurances to the Secretary that funds provided to the geriatric education center under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the geriatric education center.

“(9) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other funding available to carry out this section, there is authorized to be appropriated to carry out this subsection, \$10,800,000 for the period of fiscal year 2011 through 2014.

“(e) GERIATRIC CAREER INCENTIVE AWARDS.—

“(1) IN GENERAL.—The Secretary shall award grants or contracts under this section to individuals described in paragraph (2) to foster greater interest among a variety of health professionals

in entering the field of geriatrics, long-term care, and chronic care management.

“(2) **ELIGIBLE INDIVIDUALS.**—To be eligible to receive an award under paragraph (1), an individual shall—

“(A) be an advanced practice nurse, a clinical social worker, a pharmacist, or student of psychology who is pursuing a doctorate or other advanced degree in geriatrics or related fields in an accredited health professions school; and

“(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(3) **CONDITION OF AWARD.**—As a condition of receiving an award under this subsection, an individual shall agree that, following completion of the award period, the individual will teach or practice in the field of geriatrics, long-term care, or chronic care management for a minimum of 5 years under guidelines set by the Secretary.

“(4) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated to carry out this subsection, \$10,000,000 for the period of fiscal years 2011 through 2013.”.

(b) **EXPANSION OF ELIGIBILITY FOR GERIATRIC ACADEMIC CAREER AWARDS; PAYMENT TO INSTITUTION.**—Section 753(c) of the Public Health Service Act 294(c) is amended—

(1) by redesignating paragraphs (4) and (5) as paragraphs (5) and (6), respectively;

(2) by striking paragraph (2) through paragraph (3) and inserting the following:

“(2) **ELIGIBLE INDIVIDUALS.**—To be eligible to receive an Award under paragraph (1), an individual shall—

“(A) be board certified or board eligible in internal medicine, family practice, psychiatry, or licensed dentistry, or have completed any required training in a discipline and employed in an accredited health professions school that is approved by the Secretary;

“(B) have completed an approved fellowship program in geriatrics or have completed specialty training in geriatrics as required by the discipline and any addition geriatrics training as required by the Secretary; and

“(C) have a junior (non-tenured) faculty appointment at an accredited (as determined by the Secretary) school of medicine, osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy, or other allied health disciplines in an accredited health professions school that is approved by the Secretary.

“(3) **LIMITATIONS.**—No Award under paragraph (1) may be made to an eligible individual unless the individual—

“(A) has submitted to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, and the Secretary has approved such application;

“(B) provides, in such form and manner as the Secretary may require, assurances that the individual will meet the service requirement described in paragraph (6); and

“(C) provides, in such form and manner as the Secretary may require, assurances that the individual has a full-time faculty appointment in a health professions institution and documented commitment from such institution to spend 75 percent of the total time of such individual on teaching and developing skills in interdisciplinary education in geriatrics.

“(4) **MAINTENANCE OF EFFORT.**—An eligible individual that receives an Award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.”; and

(3) in paragraph (5), as so designated—

(A) in subparagraph (A)—

(i) by inserting “for individuals who are physicians” after “this section”; and

(ii) by inserting after the period at the end the following: “The Secretary shall determine the amount of an Award under this section for individuals who are not physicians.”; and

(B) by adding at the end the following:

“(C) **PAYMENT TO INSTITUTION.**—The Secretary shall make payments to institutions which include schools of medicine, osteopathic medicine, nursing, social work, psychology, dentistry, and pharmacy, or other allied health discipline in an accredited health professions school that is approved by the Secretary.”.

(c) **COMPREHENSIVE GERIATRIC EDUCATION.**—Section 855 of the Public Health Service Act (42 U.S.C. 298) is amended—

(1) in subsection (b)—

(A) in paragraph (3), by striking “or” at the end;

(B) in paragraph (4), by striking the period and inserting “; or”; and

(C) by adding at the end the following:

“(5) establish traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing, long-term care, gero-psychiatric nursing or other nursing areas that specialize in the care of the elderly population.”; and

(2) in subsection (e), by striking “2003 through 2007” and inserting “2010 through 2014”.

SEC. 5306. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

(a) **IN GENERAL.**—Part D of title VII (42 U.S.C. 294 et seq.) is amended by—

(1) striking section 757;

(2) redesignating section 756 (as amended by section 5103) as section 757; and

(3) inserting after section 755 the following:

“SEC. 756. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

“(a) **GRANTS AUTHORIZED.**—The Secretary may award grants to eligible institutions of higher education to support the recruitment of students for, and education and clinical experience of the students in—

“(1) baccalaureate, master’s, and doctoral degree programs of social work, as well as the development of faculty in social work;

“(2) accredited master’s, doctoral, internship, and post-doctoral residency programs of psychology for the development and implementation of interdisciplinary training of psychology graduate students for providing behavioral and mental health services, including substance abuse prevention and treatment services;

“(3) accredited institutions of higher education or accredited professional training programs that are establishing or expanding internships or other field placement programs in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse prevention and treatment, marriage and family therapy, school counseling, or professional counseling; and

“(4) State-licensed mental health nonprofit and for-profit organizations to enable such organizations to pay for programs for preservice or in-service training of paraprofessional child and adolescent mental health workers.

“(b) **ELIGIBILITY REQUIREMENTS.**—To be eligible for a grant under this section, an institution shall demonstrate—

“(1) participation in the institutions’ programs of individuals and groups from different racial, ethnic, cultural, geographic, religious, linguistic, and class backgrounds, and different genders and sexual orientations;

“(2) knowledge and understanding of the concerns of the individuals and groups described in subsection (a);

“(3) any internship or other field placement program assisted under the grant will prioritize cultural and linguistic competency;

“(4) the institution will provide to the Secretary such data, assurances, and information as the Secretary may require; and

“(5) with respect to any violation of the agreement between the Secretary and the institution, the institution will pay such liquidated damages as prescribed by the Secretary by regulation.

“(c) **INSTITUTIONAL REQUIREMENT.**—For grants authorized under subsection (a)(1), at least 4 of the grant recipients shall be historically black colleges or universities or other minority-serving institutions.

“(d) **PRIORITY.**—

“(1) In selecting the grant recipients in social work under subsection (a)(1), the Secretary shall give priority to applicants that—

“(A) are accredited by the Council on Social Work Education;

“(B) have a graduation rate of not less than 80 percent for social work students; and

“(C) exhibit an ability to recruit social workers from and place social workers in areas with a high need and high demand population.

“(2) In selecting the grant recipients in graduate psychology under subsection (a)(2), the Secretary shall give priority to institutions in which training focuses on the needs of vulnerable groups such as older adults and children, individuals with mental health or substance-related disorders, victims of abuse or trauma and of combat stress disorders such as posttraumatic stress disorder and traumatic brain injuries, homeless individuals, chronically ill persons, and their families.

“(3) In selecting the grant recipients in training programs in child and adolescent mental health under subsections (a)(3) and (a)(4), the Secretary shall give priority to applicants that—

“(A) have demonstrated the ability to collect data on the number of students trained in child and adolescent mental health and the populations served by such students after graduation or completion of preservice or in-service training;

“(B) have demonstrated familiarity with evidence-based methods in child and adolescent mental health services, including substance abuse prevention and treatment services;

“(C) have programs designed to increase the number of professionals and paraprofessionals serving high-priority populations and to applicants who come from high-priority communities and plan to serve medically underserved populations, in health professional shortage areas, or in medically underserved areas;

“(D) offer curriculum taught collaboratively with a family on the consumer and family lived experience or the importance of family-professional or family-paraprofessional partnerships; and

“(E) provide services through a community mental health program described in section 1913(b)(1).

“(e) **AUTHORIZATION OF APPROPRIATION.**—For the fiscal years 2010 through 2013, there is authorized to be appropriated to carry out this section—

“(1) \$8,000,000 for training in social work in subsection (a)(1);

“(2) \$12,000,000 for training in graduate psychology in subsection (a)(2), of which not less than \$10,000,000 shall be allocated for doctoral, postdoctoral, and internship level training;

“(3) \$10,000,000 for training in professional child and adolescent mental health in subsection (a)(3); and

“(4) \$5,000,000 for training in paraprofessional child and adolescent work in subsection (a)(4).”.

(b) **CONFORMING AMENDMENTS.**—Section 757(b)(2) of the Public Health Service Act, as redesignated by subsection (a), is amended by striking “sections 751(a)(1)(A), 751(a)(1)(B), 753(b), 754(3)(A), and 755(b)” and inserting “sections 751(b)(1)(A), 753(b), and 755(b)”.

SEC. 5307. CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITIES TRAINING.

(a) **TITLE VII.**—Section 741 of the Public Health Service Act (42 U.S.C. 293e) is amended—

(1) in subsection (a)—

(A) by striking the subsection heading and inserting “CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITY GRANTS”; and

(B) in paragraph (1), by striking “for the purpose of” and all that follows through the period at the end and inserting “for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs, and for other purposes determined as appropriate by the Secretary.”; and

(2) by striking subsection (b) and inserting the following:

“(b) **COLLABORATION.**—In carrying out subsection (a), the Secretary shall collaborate with health professional societies, licensing and accreditation entities, health professions schools, and experts in minority health and cultural competency, prevention, and public health and disability groups, community-based organizations, and other organizations as determined appropriate by the Secretary. The Secretary shall coordinate with curricula and research and demonstration projects developed under section 807.

“(c) **DISSEMINATION.**—

“(1) **IN GENERAL.**—Model curricula developed under this section shall be disseminated through the Internet Clearinghouse under section 270 and such other means as determined appropriate by the Secretary.

“(2) **EVALUATION.**—The Secretary shall evaluate the adoption and the implementation of cultural competency, prevention, and public health, and working with individuals with a disability training curricula, and the facilitate inclusion of these competency measures in quality measurement systems as appropriate.

“(d) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2015.”.

(b) **TITLE VIII.**—Section 807 of the Public Health Service Act (42 U.S.C. 296e-1) is amended—

(1) in subsection (a)—

(A) by striking the subsection heading and inserting “CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITY GRANTS”; and

(B) by striking “for the purpose of” and all that follows through “health care.” and inserting “for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs, and for other purposes determined as appropriate by the Secretary.”; and

(2) by redesignating subsection (b) as subsection (d);

(3) by inserting after subsection (a) the following:

“(b) **COLLABORATION.**—In carrying out subsection (a), the Secretary shall collaborate with the entities described in section 741(b). The Secretary shall coordinate with curricula and research and demonstration projects developed under such section 741.

“(c) **DISSEMINATION.**—Model curricula developed under this section shall be disseminated

and evaluated in the same manner as model curricula developed under section 741, as described in subsection (c) of such section.”; and

(4) in subsection (d), as so redesignated—

(A) by striking “subsection (a)” and inserting “this section”; and

(B) by striking “2001 through 2004” and inserting “2010 through 2015”.

SEC. 5308. ADVANCED NURSING EDUCATION GRANTS.

Section 811 of the Public Health Service Act (42 U.S.C. 296j) is amended—

(1) in subsection (c)—

(A) in the subsection heading, by striking “AND NURSE MIDWIFERY PROGRAMS”; and

(B) by striking “and nurse midwifery”;

(2) in subsection (f)—

(A) by striking paragraph (2); and

(B) by redesignating paragraph (3) as paragraph (2); and

(3) by redesignating subsections (d), (e), and (f) as subsections (e), (f), and (g), respectively; and

(4) by inserting after subsection (c), the following:

“(d) **AUTHORIZED NURSE-MIDWIFERY PROGRAMS.**—Midwifery programs that are eligible for support under this section are educational programs that—

“(1) have as their objective the education of midwives; and

“(2) are accredited by the American College of Nurse-Midwives Accreditation Commission for Midwifery Education.”.

SEC. 5309. NURSE EDUCATION, PRACTICE, AND RETENTION GRANTS.

(a) **IN GENERAL.**—Section 831 of the Public Health Service Act (42 U.S.C. 296p) is amended—

(1) in the section heading, by striking “retention” and inserting “quality”; and

(2) in subsection (a)—

(A) in paragraph (1), by adding “or” after the semicolon;

(B) by striking paragraph (2); and

(C) by redesignating paragraph (3) as paragraph (2);

(3) in subsection (b)(3), by striking “managed care, quality improvement” and inserting “co-ordinated care”; and

(4) in subsection (g), by inserting “, as defined in section 801(2),” after “school of nursing”; and

(5) in subsection (h), by striking “2003 through 2007” and inserting “2010 through 2014”.

(b) **NURSE RETENTION GRANTS.**—Title VIII of the Public Health Service Act is amended by inserting after section 831 (42 U.S.C. 296b) the following:

“SEC. 831A. NURSE RETENTION GRANTS.

“(a) **RETENTION PRIORITY AREAS.**—The Secretary may award grants to, and enter into contracts with, eligible entities to enhance the nursing workforce by initiating and maintaining nurse retention programs pursuant to subsection (b) or (c).

“(b) **GRANTS FOR CAREER LADDER PROGRAM.**—The Secretary may award grants to, and enter into contracts with, eligible entities for programs—

“(1) to promote career advancement for individuals including licensed practical nurses, licensed vocational nurses, certified nurse assistants, home health aides, diploma degree or associate degree nurses, to become baccalaureate prepared registered nurses or advanced education nurses in order to meet the needs of the registered nurse workforce;

“(2) developing and implementing internships and residency programs in collaboration with an accredited school of nursing, as defined by section 801(2), to encourage mentoring and the development of specialties; or

“(3) to assist individuals in obtaining education and training required to enter the nurs-

ing profession and advance within such profession.

“(c) **ENHANCING PATIENT CARE DELIVERY SYSTEMS.**—

“(1) **GRANTS.**—The Secretary may award grants to eligible entities to improve the retention of nurses and enhance patient care that is directly related to nursing activities by enhancing collaboration and communication among nurses and other health care professionals, and by promoting nurse involvement in the organizational and clinical decision-making processes of a health care facility.

“(2) **PRIORITY.**—In making awards of grants under this subsection, the Secretary shall give preference to applicants that have not previously received an award under this subsection (or section 831(c) as such section existed on the day before the date of enactment of this section).

“(3) **CONTINUATION OF AN AWARD.**—The Secretary shall make continuation of any award under this subsection beyond the second year of such award contingent on the recipient of such award having demonstrated to the Secretary measurable and substantive improvement in nurse retention or patient care.

“(d) **OTHER PRIORITY AREAS.**—The Secretary may award grants to, or enter into contracts with, eligible entities to address other areas that are of high priority to nurse retention, as determined by the Secretary.

“(e) **REPORT.**—The Secretary shall submit to the Congress before the end of each fiscal year a report on the grants awarded and the contracts entered into under this section. Each such report shall identify the overall number of such grants and contracts and provide an explanation of why each such grant or contract will meet the priority need of the nursing workforce.

“(f) **ELIGIBLE ENTITY.**—For purposes of this section, the term “eligible entity” includes an accredited school of nursing, as defined by section 801(2), a health care facility, or a partnership of such a school and facility.

“(g) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2012.”.

SEC. 5310. LOAN REPAYMENT AND SCHOLARSHIP PROGRAM.

(a) **LOAN REPAYMENTS AND SCHOLARSHIPS.**—Section 846(a)(3) of the Public Health Service Act (42 U.S.C. 297n(a)(3)) is amended by inserting before the semicolon the following: “, or in an accredited school of nursing, as defined by section 801(2), as nurse faculty”.

(b) **TECHNICAL AND CONFORMING AMENDMENTS.**—Title VIII (42 U.S.C. 296 et seq.) is amended—

(1) by redesignating section 810 (relating to prohibition against discrimination by schools on the basis of sex) as section 809 and moving such section so that it follows section 808;

(2) in sections 835, 836, 838, 840, and 842, by striking the term “this subpart” each place it appears and inserting “this part”;

(3) in section 836(h), by striking the last sentence;

(4) in section 836, by redesignating subsection (l) as subsection (k);

(5) in section 839, by striking “839” and all that follows through “(a)” and inserting “839. (a)”;

(6) in section 835(b), by striking “841” each place it appears and inserting “871”;

(7) by redesignating section 841 as section 871, moving part F to the end of the title, and redesignating such part as part I;

(8) in part G—

(A) by redesignating section 845 as section 851; and

(B) by redesignating part G as part F;

(9) in part H—

(A) by redesignating sections 851 and 852 as sections 861 and 862, respectively; and

(B) by redesignating part H as part G; and

(10) in part I—

(A) by redesignating section 855, as amended by section 5305, as section 865; and

(B) by redesignating part I as part H.

SEC. 5311. NURSE FACULTY LOAN PROGRAM.

(a) IN GENERAL.—Section 846A of the Public Health Service Act (42 U.S.C. 297n–1) is amended—

(1) in subsection (a)—

(A) in the subsection heading, by striking “ESTABLISHMENT” and inserting “SCHOOL OF NURSING STUDENT LOAN FUND”; and

(B) by inserting “accredited” after “agreement with any”;

(2) in subsection (c)—

(A) in paragraph (2), by striking “\$30,000” and all that follows through the semicolon and inserting “\$35,500, during fiscal years 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate loan;”;

(B) in paragraph (3)(A), by inserting “an accredited” after “faculty member in”;

(3) in subsection (e), by striking “a school” and inserting “an accredited school”; and

(4) in subsection (f), by striking “2003 through 2007” and inserting “2010 through 2014”.

(b) ELIGIBLE INDIVIDUAL STUDENT LOAN REPAYMENT.—Title VIII of the Public Health Service Act is amended by inserting after section 846A (42 U.S.C. 297n–1) the following:

“SEC. 847. ELIGIBLE INDIVIDUAL STUDENT LOAN REPAYMENT.

“(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may enter into an agreement with eligible individuals for the repayment of education loans, in accordance with this section, to increase the number of qualified nursing faculty.

“(b) AGREEMENTS.—Each agreement entered into under this subsection shall require that the eligible individual shall serve as a full-time member of the faculty of an accredited school of nursing, for a total period, in the aggregate, of at least 4 years during the 6-year period beginning on the later of—

“(1) the date on which the individual receives a master’s or doctorate nursing degree from an accredited school of nursing; or

“(2) the date on which the individual enters into an agreement under this subsection.

“(c) AGREEMENT PROVISIONS.—Agreements entered into pursuant to subsection (b) shall be entered into on such terms and conditions as the Secretary may determine, except that—

“(1) not more than 10 months after the date on which the 6-year period described under subsection (b) begins, but in no case before the individual starts as a full-time member of the faculty of an accredited school of nursing the Secretary shall begin making payments, for and on behalf of that individual, on the outstanding principal of, and interest on, any loan of that individual obtained to pay for such degree;

“(2) for an individual who has completed a master’s in nursing or equivalent degree in nursing—

“(A) payments may not exceed \$10,000 per calendar year; and

“(B) total payments may not exceed \$40,000 during the 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate loan); and

“(3) for an individual who has completed a doctorate or equivalent degree in nursing—

“(A) payments may not exceed \$20,000 per calendar year; and

“(B) total payments may not exceed \$80,000 during the 2010 and 2011 fiscal years (adjusted

for subsequent fiscal years as provided for in the same manner as in paragraph (2)(B)).

“(d) BREACH OF AGREEMENT.—

“(1) IN GENERAL.—In the case of any agreement made under subsection (b), the individual is liable to the Federal Government for the total amount paid by the Secretary under such agreement, and for interest on such amount at the maximum legal prevailing rate, if the individual fails to meet the agreement terms required under such subsection.

“(2) WAIVER OR SUSPENSION OF LIABILITY.—In the case of an individual making an agreement for purposes of paragraph (1), the Secretary shall provide for the waiver or suspension of liability under such paragraph if compliance by the individual with the agreement involved is impossible or would involve extreme hardship to the individual or if enforcement of the agreement with respect to the individual would be unconscionable.

“(3) DATE CERTAIN FOR RECOVERY.—Subject to paragraph (2), any amount that the Federal Government is entitled to recover under paragraph (1) shall be paid to the United States not later than the expiration of the 3-year period beginning on the date the United States becomes so entitled.

“(4) AVAILABILITY.—Amounts recovered under paragraph (1) shall be available to the Secretary for making loan repayments under this section and shall remain available for such purpose until expended.

“(e) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term ‘eligible individual’ means an individual who—

“(1) is a United States citizen, national, or lawful permanent resident;

“(2) holds an unencumbered license as a registered nurse; and

“(3) has either already completed a master’s or doctorate nursing program at an accredited school of nursing or is currently enrolled on a full-time or part-time basis in such a program.

“(f) PRIORITY.—For the purposes of this section and section 846A, funding priority will be awarded to School of Nursing Student Loans that support doctoral nursing students or Individual Student Loan Repayment that support doctoral nursing students.

“(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.”.

SEC. 5312. AUTHORIZATION OF APPROPRIATIONS FOR PARTS B THROUGH D OF TITLE VIII.

Section 871 of the Public Health Service Act, as redesignated and moved by section 5310, is amended to read as follows:

“SEC. 871. AUTHORIZATION OF APPROPRIATIONS.

“For the purpose of carrying out parts B, C, and D (subject to section 851(g)), there are authorized to be appropriated \$338,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2016.”.

SEC. 5313. GRANTS TO PROMOTE THE COMMUNITY HEALTH WORKFORCE.

(a) IN GENERAL.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

“SEC. 399V. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS AND OUTCOMES.

“(a) GRANTS AUTHORIZED.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Secretary, shall award grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.

“(b) USE OF FUNDS.—Grants awarded under subsection (a) shall be used to support community health workers—

“(1) to educate, guide, and provide outreach in a community setting regarding health problems prevalent in medically underserved communities, particularly racial and ethnic minority populations;

“(2) to educate and provide guidance regarding effective strategies to promote positive health behaviors and discourage risky health behaviors;

“(3) to educate and provide outreach regarding enrollment in health insurance including the Children’s Health Insurance Program under title XXI of the Social Security Act, Medicare under title XVIII of such Act and Medicaid under title XIX of such Act;

“(4) to identify, educate, refer, and enroll underserved populations to appropriate healthcare agencies and community-based programs and organizations in order to increase access to quality healthcare services and to eliminate duplicative care; or

“(5) to educate, guide, and provide home visitation services regarding maternal health and prenatal care.

“(c) APPLICATION.—Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary may require.

“(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants that—

“(1) propose to target geographic areas—

“(A) with a high percentage of residents who are eligible for health insurance but are uninsured or underinsured;

“(B) with a high percentage of residents who suffer from chronic diseases; or

“(C) with a high infant mortality rate;

“(2) have experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

“(3) have documented community activity and experience with community health workers.

“(e) COLLABORATION WITH ACADEMIC INSTITUTIONS AND THE ONE-STOP DELIVERY SYSTEM.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions and one-stop delivery systems under section 134(c) of the Workforce Investment Act of 1998. Nothing in this section shall be construed to require such collaboration.

“(f) EVIDENCE-BASED INTERVENTIONS.—The Secretary shall encourage community health worker programs receiving funding under this section to implement a process or an outcome-based payment system that rewards community health workers for connecting underserved populations with the most appropriate services at the most appropriate time. Nothing in this section shall be construed to require such a payment.

“(g) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for assuring the quality of the training and supervision of community health workers under the programs funded under this section and for assuring the cost-effectiveness of such programs.

“(h) MONITORING.—The Secretary shall monitor community health worker programs identified in approved applications under this section and shall determine whether such programs are in compliance with the guidelines established under subsection (g).

“(i) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to community health worker programs identified in approved applications under this section with respect to planning, developing, and operating programs under the grant.

“(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, such

sums as may be necessary to carry out this section for each of fiscal years 2010 through 2014.

“(k) DEFINITIONS.—In this section:

“(1) COMMUNITY HEALTH WORKER.—The term ‘community health worker’, as defined by the Department of Labor as Standard Occupational Classification [21–1094] means an individual who promotes health or nutrition within the community in which the individual resides—

“(A) by serving as a liaison between communities and healthcare agencies;

“(B) by providing guidance and social assistance to community residents;

“(C) by enhancing community residents’ ability to effectively communicate with healthcare providers;

“(D) by providing culturally and linguistically appropriate health or nutrition education;

“(E) by advocating for individual and community health;

“(F) by providing referral and follow-up services or otherwise coordinating care; and

“(G) by proactively identifying and enrolling eligible individuals in Federal, State, local, private or nonprofit health and human services programs.

“(2) COMMUNITY SETTING.—The term ‘community setting’ means a home or a community organization located in the neighborhood in which a participant in the program under this section resides.

“(3) ELIGIBLE ENTITY.—The term ‘eligible entity’ means a public or nonprofit private entity (including a State or public subdivision of a State, a public health department, a free health clinic, a hospital, or a Federally-qualified health center (as defined in section 1861(aa) of the Social Security Act)), or a consortium of any such entities.

“(4) MEDICALLY UNDERSERVED COMMUNITY.—The term ‘medically underserved community’ means a community identified by a State—

“(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3); and

“(B) a significant portion of which is a health professional shortage area as designated under section 332.”

SEC. 5314. FELLOWSHIP TRAINING IN PUBLIC HEALTH.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5206, is further amended by adding at the end the following:

“SEC. 778. FELLOWSHIP TRAINING IN APPLIED PUBLIC HEALTH EPIDEMIOLOGY, PUBLIC HEALTH LABORATORY SCIENCE, PUBLIC HEALTH INFORMATICS, AND EXPANSION OF THE EPIDEMIC INTELLIGENCE SERVICE.

“(a) IN GENERAL.—The Secretary may carry out activities to address documented workforce shortages in State and local health departments in the critical areas of applied public health epidemiology and public health laboratory science and informatics and may expand the Epidemic Intelligence Service.

“(b) SPECIFIC USES.—In carrying out subsection (a), the Secretary shall provide for the expansion of existing fellowship programs operated through the Centers for Disease Control and Prevention in a manner that is designed to alleviate shortages of the type described in subsection (a).

“(c) OTHER PROGRAMS.—The Secretary may provide for the expansion of other applied epidemiology training programs that meet objectives similar to the objectives of the programs described in subsection (b).

“(d) WORK OBLIGATION.—Participation in fellowship training programs under this section shall be deemed to be service for purposes of sat-

isfying work obligations stipulated in contracts under section 3381(g)).

“(e) GENERAL SUPPORT.—Amounts may be used from grants awarded under this section to expand the Public Health Informatics Fellowship Program at the Centers for Disease Control and Prevention to better support all public health systems at all levels of government.

“(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section \$39,500,000 for each of fiscal years 2010 through 2013, of which—

“(1) \$5,000,000 shall be made available in each such fiscal year for epidemiology fellowship training program activities under subsections (b) and (c);

“(2) \$5,000,000 shall be made available in each such fiscal year for laboratory fellowship training programs under subsection (b);

“(3) \$5,000,000 shall be made available in each such fiscal year for the Public Health Informatics Fellowship Program under subsection (e); and

“(4) \$24,500,000 shall be made available for expanding the Epidemic Intelligence Service under subsection (a).”

SEC. 5315. UNITED STATES PUBLIC HEALTH SCIENCES TRACK.

Title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

“PART D—UNITED STATES PUBLIC HEALTH SCIENCES TRACK

“SEC. 271. ESTABLISHMENT.

“(a) UNITED STATES PUBLIC HEALTH SERVICES TRACK.—

“(1) IN GENERAL.—There is hereby authorized to be established a United States Public Health Sciences Track (referred to in this part as the ‘Track’), at sites to be selected by the Secretary, with authority to grant appropriate advanced degrees in a manner that uniquely emphasizes team-based service, public health, epidemiology, and emergency preparedness and response. It shall be so organized as to graduate not less than—

“(A) 150 medical students annually, 10 of whom shall be awarded studentships to the Uniformed Services University of Health Sciences;

“(B) 100 dental students annually;

“(C) 250 nursing students annually;

“(D) 100 public health students annually;

“(E) 100 behavioral and mental health professional students annually;

“(F) 100 physician assistant or nurse practitioner students annually; and

“(G) 50 pharmacy students annually.

“(2) LOCATIONS.—The Track shall be located at existing and accredited, affiliated health professions education training programs at academic health centers located in regions of the United States determined appropriate by the Surgeon General, in consultation with the National Health Care Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act.

“(b) NUMBER OF GRADUATES.—Except as provided in subsection (a), the number of persons to be graduated from the Track shall be prescribed by the Secretary. In so prescribing the number of persons to be graduated from the Track, the Secretary shall institute actions necessary to ensure the maximum number of first-year enrollments in the Track consistent with the academic capacity of the affiliated sites and the needs of the United States for medical, dental, and nursing personnel.

“(c) DEVELOPMENT.—The development of the Track may be by such phases as the Secretary may prescribe subject to the requirements of subsection (a).

“(d) INTEGRATED LONGITUDINAL PLAN.—The Surgeon General shall develop an integrated longitudinal plan for health professions con-

tinuing education throughout the continuum of health-related education, training, and practice. Training under such plan shall emphasize patient-centered, interdisciplinary, and care coordination skills. Experience with deployment of emergency response teams shall be included during the clinical experiences.

“(e) FACULTY DEVELOPMENT.—The Surgeon General shall develop faculty development programs and curricula in decentralized venues of health care, to balance urban, tertiary, and inpatient venues.

“SEC. 272. ADMINISTRATION.

“(a) IN GENERAL.—The business of the Track shall be conducted by the Surgeon General with funds appropriated for and provided by the Department of Health and Human Services. The National Health Care Workforce Commission shall assist the Surgeon General in an advisory capacity.

“(b) FACULTY.—

“(1) IN GENERAL.—The Surgeon General, after considering the recommendations of the National Health Care Workforce Commission, shall obtain the services of such professors, instructors, and administrative and other employees as may be necessary to operate the Track, but utilize when possible, existing affiliated health professions training institutions. Members of the faculty and staff shall be employed under salary schedules and granted retirement and other related benefits prescribed by the Secretary so as to place the employees of the Track faculty on a comparable basis with the employees of fully accredited schools of the health professions within the United States.

“(2) TITLES.—The Surgeon General may confer academic titles, as appropriate, upon the members of the faculty.

“(3) NONAPPLICATION OF PROVISIONS.—The limitations in section 5373 of title 5, United States Code, shall not apply to the authority of the Surgeon General under paragraph (1) to prescribe salary schedules and other related benefits.

“(c) AGREEMENTS.—The Surgeon General may negotiate agreements with agencies of the Federal Government to utilize on a reimbursable basis appropriate existing Federal medical resources located in the United States (or locations selected in accordance with section 271(a)(2)). Under such agreements the facilities concerned will retain their identities and basic missions. The Surgeon General may negotiate affiliation agreements with accredited universities and health professions training institutions in the United States. Such agreements may include provisions for payments for educational services provided students participating in Department of Health and Human Services educational programs.

“(d) PROGRAMS.—The Surgeon General may establish the following educational programs for Track students:

“(1) Postdoctoral, postgraduate, and technological programs.

“(2) A cooperative program for medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students.

“(3) Other programs that the Surgeon General determines necessary in order to operate the Track in a cost-effective manner.

“(e) CONTINUING MEDICAL EDUCATION.—The Surgeon General shall establish programs in continuing medical education for members of the health professions to the end that high standards of health care may be maintained within the United States.

“(f) AUTHORITY OF THE SURGEON GENERAL.—

“(1) IN GENERAL.—The Surgeon General is authorized—

“(A) to enter into contracts with, accept grants from, and make grants to any nonprofit

entity for the purpose of carrying out cooperative enterprises in medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing research, consultation, and education;

“(B) to enter into contracts with entities under which the Surgeon General may furnish the services of such professional, technical, or clerical personnel as may be necessary to fulfill cooperative enterprises undertaken by the Track;

“(C) to accept, hold, administer, invest, and spend any gift, devise, or bequest of personal property made to the Track, including any gift, devise, or bequest for the support of an academic chair, teaching, research, or demonstration project;

“(D) to enter into agreements with entities that may be utilized by the Track for the purpose of enhancing the activities of the Track in education, research, and technological applications of knowledge; and

“(E) to accept the voluntary services of guest scholars and other persons.

“(2) **LIMITATION.**—The Surgeon General may not enter into any contract with an entity if the contract would obligate the Track to make outlays in advance of the enactment of budget authority for such outlays.

“(3) **SCIENTISTS.**—Scientists or other medical, dental, or nursing personnel utilized by the Track under an agreement described in paragraph (1) may be appointed to any position within the Track and may be permitted to perform such duties within the Track as the Surgeon General may approve.

“(4) **VOLUNTEER SERVICES.**—A person who provides voluntary services under the authority of subparagraph (E) of paragraph (1) shall be considered to be an employee of the Federal Government for the purposes of chapter 81 of title 5, relating to compensation for work-related injuries, and to be an employee of the Federal Government for the purposes of chapter 171 of title 28, relating to tort claims. Such a person who is not otherwise employed by the Federal Government shall not be considered to be a Federal employee for any other purpose by reason of the provision of such services.

“SEC. 273. STUDENTS; SELECTION; OBLIGATION.

“(a) **STUDENT SELECTION.**—

“(1) **IN GENERAL.**—Medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students at the Track shall be selected under procedures prescribed by the Surgeon General. In so prescribing, the Surgeon General shall consider the recommendations of the National Health Care Workforce Commission.

“(2) **PRIORITY.**—In developing admissions procedures under paragraph (1), the Surgeon General shall ensure that such procedures give priority to applicant medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students from rural communities and underrepresented minorities.

“(b) **CONTRACT AND SERVICE OBLIGATION.**—

“(1) **CONTRACT.**—Upon being admitted to the Track, a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student shall enter into a written contract with the Surgeon General that shall contain—

“(A) an agreement under which—

“(i) subject to subparagraph (B), the Surgeon General agrees to provide the student with tuition (or tuition remission) and a student stipend (described in paragraph (2)) in each school year for a period of years (not to exceed 4 school years) determined by the student, during which period the student is enrolled in the Track at an affiliated or other participating health professions institution pursuant to an agreement between the Track and such institution; and

“(ii) subject to subparagraph (B), the student agrees—

“(I) to accept the provision of such tuition and student stipend to the student;

“(II) to maintain enrollment at the Track until the student completes the course of study involved;

“(III) while enrolled in such course of study, to maintain an acceptable level of academic standing (as determined by the Surgeon General);

“(IV) if pursuing a degree from a school of medicine or osteopathic medicine, dental, public health, or nursing school or a physician assistant, pharmacy, or behavioral and mental health professional program, to complete a residency or internship in a specialty that the Surgeon General determines is appropriate; and

“(V) to serve for a period of time (referred to in this part as the ‘period of obligated service’) within the Commissioned Corps of the Public Health Service equal to 2 years for each school year during which such individual was enrolled at the College, reduced as provided for in paragraph (3);

“(B) a provision that any financial obligation of the United States arising out of a contract entered into under this part and any obligation of the student which is conditioned thereon, is contingent upon funds being appropriated to carry out this part;

“(C) a statement of the damages to which the United States is entitled for the student’s breach of the contract; and

“(D) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with the provisions of this part.

“(2) **TUITION AND STUDENT STIPEND.**—

“(A) **TUITION REMISSION RATES.**—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish Federal tuition remission rates to be used by the Track to provide reimbursement to affiliated and other participating health professions institutions for the cost of educational services provided by such institutions to Track students. The agreement entered into by such participating institutions under paragraph (1)(A)(i) shall contain an agreement to accept as payment in full the established remission rate under this subparagraph.

“(B) **STIPEND.**—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish and update Federal stipend rates for payment to students under this part.

“(3) **REDUCTIONS IN THE PERIOD OF OBLIGATED SERVICE.**—The period of obligated service under paragraph (1)(A)(ii)(V) shall be reduced—

“(A) in the case of a student who elects to participate in a high-needs speciality residency (as determined by the National Health Care Workforce Commission), by 3 months for each year of such participation (not to exceed a total of 12 months); and

“(B) in the case of a student who, upon completion of their residency, elects to practice in a Federal medical facility (as defined in section 781(e)) that is located in a health professional shortage area (as defined in section 332), by 3 months for year of full-time practice in such a facility (not to exceed a total of 12 months).

“(c) **SECOND 2 YEARS OF SERVICE.**—During the third and fourth years in which a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student is enrolled in the Track, training should be designed to prioritize clinical rotations in Federal medical facilities in health professional shortage areas, and emphasize a balance of hospital and community-based experiences, and training within interdisciplinary teams.

“(d) **DENTIST, PHYSICIAN ASSISTANT, PHARMACIST, BEHAVIORAL AND MENTAL HEALTH PRO-**

FESSIONAL, PUBLIC HEALTH PROFESSIONAL, AND NURSE TRAINING.—The Surgeon General shall establish provisions applicable with respect to dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students that are comparable to those for medical students under this section, including service obligations, tuition support, and stipend support. The Surgeon General shall give priority to health professions training institutions that train medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students for some significant period of time together, but at a minimum have a discrete and shared core curriculum.

“(e) **ELITE FEDERAL DISASTER TEAMS.**—The Surgeon General, in consultation with the Secretary, the Director of the Centers for Disease Control and Prevention, and other appropriate military and Federal government agencies, shall develop criteria for the appointment of highly qualified Track faculty, medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students, and graduates to elite Federal disaster preparedness teams to train and to respond to public health emergencies, natural disasters, bioterrorism events, and other emergencies.

“(f) **STUDENT DROPPED FROM TRACK IN AFFILIATE SCHOOL.**—A medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student who, under regulations prescribed by the Surgeon General, is dropped from the Track in an affiliated school for deficiency in conduct or studies, or for other reasons, shall be liable to the United States for all tuition and stipend support provided to the student.

“SEC. 274. FUNDING.

“Beginning with fiscal year 2010, the Secretary shall transfer from the Public Health and Social Services Emergency Fund such sums as may be necessary to carry out this part.”

Subtitle E—Supporting the Existing Health Care Workforce

SEC. 5401. CENTERS OF EXCELLENCE.

Section 736 of the Public Health Service Act (42 U.S.C. 293) is amended by striking subsection (h) and inserting the following:

“(h) **FORMULA FOR ALLOCATIONS.**—

“(1) **ALLOCATIONS.**—Based on the amount appropriated under subsection (i) for a fiscal year, the following subparagraphs shall apply as appropriate:

“(A) **IN GENERAL.**—If the amounts appropriated under subsection (i) for a fiscal year are \$24,000,000 or less—

“(i) the Secretary shall make available \$12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A); and

“(ii) and available after grants are made with funds under clause (i), the Secretary shall make available—

“(I) 60 percent of such amount for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting the conditions under subsection (e)); and

“(II) 40 percent of such amount for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

“(B) **FUNDING IN EXCESS OF \$24,000,000.**—If amounts appropriated under subsection (i) for a fiscal year exceed \$24,000,000 but are less than \$30,000,000—

“(i) 80 percent of such excess amounts shall be made available for grants under subsection (a) to health professions schools that meet the requirements described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e)); and

“(ii) 20 percent of such excess amount shall be made available for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

“(C) FUNDING IN EXCESS OF \$30,000,000.—If amounts appropriated under subsection (i) for a fiscal year exceed \$30,000,000 but are less than \$40,000,000, the Secretary shall make available—

“(i) not less than \$12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A);

“(ii) not less than \$12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e));

“(iii) not less than \$6,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5); and

“(iv) after grants are made with funds under clauses (i) through (iii), any remaining excess amount for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (2)(A), (3), (4), or (5) of subsection (c).

“(D) FUNDING IN EXCESS OF \$40,000,000.—If amounts appropriated under subsection (i) for a fiscal year are \$40,000,000 or more, the Secretary shall make available—

“(i) not less than \$16,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A);

“(ii) not less than \$16,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e));

“(iii) not less than \$8,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5); and

“(iv) after grants are made with funds under clauses (i) through (iii), any remaining funds for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (2)(A), (3), (4), or (5) of subsection (c).

“(2) NO LIMITATION.—Nothing in this subsection shall be construed as limiting the centers of excellence referred to in this section to the designated amount, or to preclude such entities from competing for grants under this section.

“(3) MAINTENANCE OF EFFORT.—

“(A) IN GENERAL.—With respect to activities for which a grant made under this part are authorized to be expended, the Secretary may not make such a grant to a center of excellence for any fiscal year unless the center agrees to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the center for the fiscal year preceding the fiscal year for which the school receives such a grant.

“(B) USE OF FEDERAL FUNDS.—With respect to any Federal amounts received by a center of excellence and available for carrying out activities for which a grant under this part is authorized to be expended, the center shall, before expending the grant, expend the Federal amounts obtained from sources other than the grant, unless given prior approval from the Secretary.

“(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

“(1) \$50,000,000 for each of the fiscal years 2010 through 2015; and

“(2) and such sums as are necessary for each subsequent fiscal year.”.

SEC. 5402. HEALTH CARE PROFESSIONALS TRAINING FOR DIVERSITY.

(a) LOAN REPAYMENTS AND FELLOWSHIPS REGARDING FACULTY POSITIONS.—Section 738(a)(1)

of the Public Health Service Act (42 U.S.C. 293b(a)(1)) is amended by striking “\$20,000 of the principal and interest of the educational loans of such individuals.” and inserting “\$30,000 of the principal and interest of the educational loans of such individuals.”.

(b) SCHOLARSHIPS FOR DISADVANTAGED STUDENTS.—Section 740(a) of such Act (42 U.S.C. 293d(a)) is amended by striking “\$37,000,000” and all that follows through “2002” and inserting “\$51,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2014”.

(c) REAUTHORIZATION FOR LOAN REPAYMENTS AND FELLOWSHIPS REGARDING FACULTY POSITIONS.—Section 740(b) of such Act (42 U.S.C. 293d(b)) is amended by striking “appropriated” and all that follows through the period at the end and inserting “appropriated, \$5,000,000 for each of the fiscal years 2010 through 2014.”.

(d) REAUTHORIZATION FOR EDUCATIONAL ASSISTANCE IN THE HEALTH PROFESSIONS REGARDING INDIVIDUALS FROM A DISADVANTAGED BACKGROUND.—Section 740(c) of such Act (42 U.S.C. 293d(c)) is amended by striking the first sentence and inserting the following: “For the purpose of grants and contracts under section 739(a)(1), there is authorized to be appropriated \$60,000,000 for fiscal year 2010 and such sums as may be necessary for each of the fiscal years 2011 through 2014.”.

SEC. 5403. INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES.

(a) AREA HEALTH EDUCATION CENTERS.—Section 751 of the Public Health Service Act (42 U.S.C. 294a) is amended to read as follows:

“SEC. 751. AREA HEALTH EDUCATION CENTERS.

“(a) ESTABLISHMENT OF AWARDS.—The Secretary shall make the following 2 types of awards in accordance with this section:

“(1) INFRASTRUCTURE DEVELOPMENT AWARD.—The Secretary shall make awards to eligible entities to enable such entities to initiate health care workforce educational programs or to continue to carry out comparable programs that are operating at the time the award is made by planning, developing, operating, and evaluating an area health education center program.

“(2) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT AWARD.—The Secretary shall make awards to eligible entities to maintain and improve the effectiveness and capabilities of an existing area health education center program, and make other modifications to the program that are appropriate due to changes in demographics, needs of the populations served, or other similar issues affecting the area health education center program. For the purposes of this section, the term ‘Program’ refers to the area health education center program.

“(b) ELIGIBLE ENTITIES; APPLICATION.—

“(1) ELIGIBLE ENTITIES.—

“(A) INFRASTRUCTURE DEVELOPMENT.—For purposes of subsection (a)(1), the term ‘eligible entity’ means a school of medicine or osteopathic medicine, an incorporated consortium of such schools, or the parent institutions of such a school. With respect to a State in which no area health education center program is in operation, the Secretary may award a grant or contract under subsection (a)(1) to a school of nursing.

“(B) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT.—For purposes of subsection (a)(2), the term ‘eligible entity’ means an entity that has received funds under this section, is operating an area health education center program, including an area health education center or centers, and has a center or centers that are no longer eligible to receive financial assistance under subsection (a)(1).

“(2) APPLICATION.—An eligible entity desiring to receive an award under this section shall submit to the Secretary an application at such time,

in such manner, and containing such information as the Secretary may require.

“(c) USE OF FUNDS.—

“(1) REQUIRED ACTIVITIES.—An eligible entity shall use amounts awarded under a grant under subsection (a)(1) or (a)(2) to carry out the following activities:

“(A) Develop and implement strategies, in coordination with the applicable one-stop delivery system under section 134(c) of the Workforce Investment Act of 1998, to recruit individuals from underrepresented minority populations or from disadvantaged or rural backgrounds into health professions, and support such individuals in attaining such careers.

“(B) Develop and implement strategies to foster and provide community-based training and education to individuals seeking careers in health professions within underserved areas for the purpose of developing and maintaining a diverse health care workforce that is prepared to deliver high-quality care, with an emphasis on primary care, in underserved areas or for health disparity populations, in collaboration with other Federal and State health care workforce development programs, the State workforce agency, and local workforce investment boards, and in health care safety net sites.

“(C) Prepare individuals to more effectively provide health services to underserved areas and health disparity populations through field placements or preceptorships in conjunction with community-based organizations, accredited primary care residency training programs, Federally qualified health centers, rural health clinics, public health departments, or other appropriate facilities.

“(D) Conduct and participate in interdisciplinary training that involves physicians, physician assistants, nurse practitioners, nurse midwives, dentists, psychologists, pharmacists, optometrists, community health workers, public and allied health professionals, or other health professionals, as practicable.

“(E) Deliver or facilitate continuing education and information dissemination programs for health care professionals, with an emphasis on individuals providing care in underserved areas and for health disparity populations.

“(F) Propose and implement effective program and outcomes measurement and evaluation strategies.

“(G) Establish a youth public health program to expose and recruit high school students into health careers, with a focus on careers in public health.

“(2) INNOVATIVE OPPORTUNITIES.—An eligible entity may use amounts awarded under a grant under subsection (a)(1) or subsection (a)(2) to carry out any of the following activities:

“(A) Develop and implement innovative curricula in collaboration with community-based accredited primary care residency training programs, Federally qualified health centers, rural health clinics, behavioral and mental health facilities, public health departments, or other appropriate facilities, with the goal of increasing the number of primary care physicians and other primary care providers prepared to serve in underserved areas and health disparity populations.

“(B) Coordinate community-based participatory research with academic health centers, and facilitate rapid flow and dissemination of evidence-based health care information, research results, and best practices to improve quality, efficiency, and effectiveness of health care and health care systems within community settings.

“(C) Develop and implement other strategies to address identified workforce needs and increase and enhance the health care workforce in the area served by the area health education center program.

“(d) REQUIREMENTS.—

“(1) AREA HEALTH EDUCATION CENTER PROGRAM.—In carrying out this section, the Secretary shall ensure the following:

“(A) An entity that receives an award under this section shall conduct at least 10 percent of clinical education required for medical students in community settings that are removed from the primary teaching facility of the contracting institution for grantees that operate a school of medicine or osteopathic medicine. In States in which an entity that receives an award under this section is a nursing school or its parent institution, the Secretary shall alternatively ensure that—

“(i) the nursing school conducts at least 10 percent of clinical education required for nursing students in community settings that are remote from the primary teaching facility of the school; and

“(ii) the entity receiving the award maintains a written agreement with a school of medicine or osteopathic medicine to place students from that school in training sites in the area health education center program area.

“(B) An entity receiving funds under subsection (a)(2) does not distribute such funding to a center that is eligible to receive funding under subsection (a)(1).

“(2) AREA HEALTH EDUCATION CENTER.—The Secretary shall ensure that each area health education center program includes at least 1 area health education center, and that each such center—

“(A) is a public or private organization whose structure, governance, and operation is independent from the awardee and the parent institution of the awardee;

“(B) is not a school of medicine or osteopathic medicine, the parent institution of such a school, or a branch campus or other subunit of a school of medicine or osteopathic medicine or its parent institution, or a consortium of such entities;

“(C) designates an underserved area or population to be served by the center which is in a location removed from the main location of the teaching facilities of the schools participating in the program with such center and does not duplicate, in whole or in part, the geographic area or population served by any other center;

“(D) fosters networking and collaboration among communities and between academic health centers and community-based centers;

“(E) serves communities with a demonstrated need of health professionals in partnership with academic medical centers;

“(F) addresses the health care workforce needs of the communities served in coordination with the public workforce investment system; and

“(G) has a community-based governing or advisory board that reflects the diversity of the communities involved.

“(e) MATCHING FUNDS.—With respect to the costs of operating a program through a grant under this section, to be eligible for financial assistance under this section, an entity shall make available (directly or through contributions from State, county or municipal governments, or the private sector) recurring non-Federal contributions in cash or in kind, toward such costs in an amount that is equal to not less than 50 percent of such costs. At least 25 percent of the total required non-Federal contributions shall be in cash. An entity may apply to the Secretary for a waiver of not more than 75 percent of the matching fund amount required by the entity for each of the first 3 years the entity is funded through a grant under subsection (a)(1).

“(f) LIMITATION.—Not less than 75 percent of the total amount provided to an area health education center program under subsection (a)(1) or (a)(2) shall be allocated to the area

health education centers participating in the program under this section. To provide needed flexibility to newly funded area health education center programs, the Secretary may waive the requirement in the sentence for the first 2 years of a new area health education center program funded under subsection (a)(1).

“(g) AWARD.—An award to an entity under this section shall be not less than \$250,000 annually per area health education center included in the program involved. If amounts appropriated to carry out this section are not sufficient to comply with the preceding sentence, the Secretary may reduce the per center amount provided for in such sentence as necessary, provided the distribution established in subsection (j)(2) is maintained.

“(h) PROJECT TERMS.—

“(1) IN GENERAL.—Except as provided in paragraph (2), the period during which payments may be made under an award under subsection (a)(1) may not exceed—

“(A) in the case of a program, 12 years; or

“(B) in the case of a center within a program, 6 years.

“(2) EXCEPTION.—The periods described in paragraph (1) shall not apply to programs receiving point of service maintenance and enhancement awards under subsection (a)(2) to maintain existing centers and activities.

“(i) INAPPLICABILITY OF PROVISION.—Notwithstanding any other provision of this title, section 791(a) shall not apply to an area health education center funded under this section.

“(j) AUTHORIZATION OF APPROPRIATIONS.—

“(1) IN GENERAL.—There is authorized to be appropriated to carry out this section \$125,000,000 for each of the fiscal years 2010 through 2014.

“(2) REQUIREMENTS.—Of the amounts appropriated for a fiscal year under paragraph (1)—

“(A) not more than 35 percent shall be used for awards under subsection (a)(1);

“(B) not less than 60 percent shall be used for awards under subsection (a)(2);

“(C) not more than 1 percent shall be used for grants and contracts to implement outcomes evaluation for the area health education centers; and

“(D) not more than 4 percent shall be used for grants and contracts to provide technical assistance to entities receiving awards under this section.

“(3) CARRYOVER FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.

“(k) SENSE OF CONGRESS.—It is the sense of the Congress that every State have an area health education center program in effect under this section.”.

(b) CONTINUING EDUCATIONAL SUPPORT FOR HEALTH PROFESSIONALS SERVING IN UNDERSERVED COMMUNITIES.—Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by striking section 752 and inserting the following:

“SEC. 752. CONTINUING EDUCATIONAL SUPPORT FOR HEALTH PROFESSIONALS SERVING IN UNDERSERVED COMMUNITIES.

“(a) IN GENERAL.—The Secretary shall make grants to, and enter into contracts with, eligible entities to improve health care, increase retention, increase representation of minority faculty members, enhance the practice environment, and provide information dissemination and educational support to reduce professional isolation through the timely dissemination of research findings using relevant resources.

“(b) ELIGIBLE ENTITIES.—For purposes of this section, the term ‘eligible entity’ means an entity described in section 799(b).

“(c) APPLICATION.—An eligible entity desiring to receive an award under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(d) USE OF FUNDS.—An eligible entity shall use amounts awarded under a grant or contract under this section to provide innovative supportive activities to enhance education through distance learning, continuing educational activities, collaborative conferences, and electronic and telelearning activities, with priority for primary care.

“(e) AUTHORIZATION.—There is authorized to be appropriated to carry out this section \$5,000,000 for each of the fiscal years 2010 through 2014, and such sums as may be necessary for each subsequent fiscal year.”.

SEC. 5404. WORKFORCE DIVERSITY GRANTS.

Section 821 of the Public Health Service Act (42 U.S.C. 296m) is amended—

(1) in subsection (a)—

(A) by striking “The Secretary may” and inserting the following:

“(1) AUTHORITY.—The Secretary may”; and

(B) by striking “pre-entry preparation, and retention activities” and inserting the following: “stipends for diploma or associate degree nurses to enter a bridge or degree completion program, student scholarships or stipends for accelerated nursing degree programs, pre-entry preparation, advanced education preparation, and retention activities”; and

(2) in subsection (b)—

(A) by striking “First” and all that follows through “including the” and inserting “National Advisory Council on Nurse Education and Practice and consult with nursing associations including the National Coalition of Ethnic Minority Nurse Associations.”; and

(B) by inserting before the period the following: “, and other organizations determined appropriate by the Secretary”.

SEC. 5405. PRIMARY CARE EXTENSION PROGRAM.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 5313, is further amended by adding at the end the following:

“SEC. 399W. PRIMARY CARE EXTENSION PROGRAM.

“(a) ESTABLISHMENT, PURPOSE AND DEFINITION.—

“(1) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a Primary Care Extension Program.

“(2) PURPOSE.—The Primary Care Extension Program shall provide support and assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse prevention and treatment services), and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such matters into their practice and to improve community health by working with community-based health connectors (referred to in this section as ‘Health Extension Agents’).

“(3) DEFINITIONS.—In this section:

“(A) HEALTH EXTENSION AGENT.—The term ‘Health Extension Agent’ means any local, community-based health worker who facilitates and provides assistance to primary care practices by implementing quality improvement or system redesign, incorporating the principles of the patient-centered medical home to provide high-quality, effective, efficient, and safe primary care and to provide guidance to patients in culturally and linguistically appropriate ways, and linking practices to diverse health system resources.

“(B) PRIMARY CARE PROVIDER.—The term ‘primary care provider’ means a clinician who provides integrated, accessible health care services

and who is accountable for addressing a large majority of personal health care needs, including providing preventive and health promotion services for men, women, and children of all ages, developing a sustained partnership with patients, and practicing in the context of family and community, as recognized by a State licensing or regulatory authority, unless otherwise specified in this section.

“(b) GRANTS TO ESTABLISH STATE HUBS AND LOCAL PRIMARY CARE EXTENSION AGENCIES.—

“(1) GRANTS.—The Secretary shall award competitive grants to States for the establishment of State- or multistate-level primary care Primary Care Extension Program State Hubs (referred to in this section as ‘Hubs’).

“(2) COMPOSITION OF HUBS.—A Hub established by a State pursuant to paragraph (1)—

“(A) shall consist of, at a minimum, the State health department, the entity responsible for administering the State Medicaid program (if other than the State health department), the State-level entity administering the Medicare program, and the departments of 1 or more health professions schools in the State that train providers in primary care; and

“(B) may include entities such as hospital associations, primary care practice-based research networks, health professional societies, State primary care associations, State licensing boards, organizations with a contract with the Secretary under section 1153 of the Social Security Act, consumer groups, and other appropriate entities.

“(c) STATE AND LOCAL ACTIVITIES.—

“(1) HUB ACTIVITIES.—Hubs established under a grant under subsection (b) shall—

“(A) submit to the Secretary a plan to coordinate functions with quality improvement organizations and area health education centers if such entities are members of the Hub not described in subsection (b)(2)(A);

“(B) contract with a county- or local-level entity that shall serve as the Primary Care Extension Agency to administer the services described in paragraph (2);

“(C) organize and administer grant funds to county- or local-level Primary Care Extension Agencies that serve a catchment area, as determined by the State; and

“(D) organize State-wide or multistate networks of local-level Primary Care Extension Agencies to share and disseminate information and practices.

“(2) LOCAL PRIMARY CARE EXTENSION AGENCY ACTIVITIES.—

“(A) REQUIRED ACTIVITIES.—Primary Care Extension Agencies established by a Hub under paragraph (1) shall—

“(i) assist primary care providers to implement a patient-centered medical home to improve the accessibility, quality, and efficiency of primary care services, including health homes;

“(ii) develop and support primary care learning communities to enhance the dissemination of research findings for evidence-based practice, assess implementation of practice improvement, share best practices, and involve community clinicians in the generation of new knowledge and identification of important questions for research;

“(iii) participate in a national network of Primary Care Extension Hubs and propose how the Primary Care Extension Agency will share and disseminate lessons learned and best practices; and

“(iv) develop a plan for financial sustainability involving State, local, and private contributions, to provide for the reduction in Federal funds that is expected after an initial 6-year period of program establishment, infrastructure development, and planning.

“(B) DISCRETIONARY ACTIVITIES.—Primary Care Extension Agencies established by a Hub under paragraph (1) may—

“(i) provide technical assistance, training, and organizational support for community health teams established under section 3602 of the Patient Protection and Affordable Care Act;

“(ii) collect data and provision of primary care provider feedback from standardized measurements of processes and outcomes to aid in continuous performance improvement;

“(iii) collaborate with local health departments, community health centers, tribes and tribal entities, and other community agencies to identify community health priorities and local health workforce needs, and participate in community-based efforts to address the social and primary determinants of health, strengthen the local primary care workforce, and eliminate health disparities;

“(iv) develop measures to monitor the impact of the proposed program on the health of practice enrollees and of the wider community served; and

“(v) participate in other activities, as determined appropriate by the Secretary.

“(d) FEDERAL PROGRAM ADMINISTRATION.—

“(1) GRANTS; TYPES.—Grants awarded under subsection (b) shall be—

“(A) program grants, that are awarded to State or multistate entities that submit fully-developed plans for the implementation of a Hub, for a period of 6 years; or

“(B) planning grants, that are awarded to State or multistate entities with the goal of developing a plan for a Hub, for a period of 2 years.

“(2) APPLICATIONS.—To be eligible for a grant under subsection (b), a State or multistate entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

“(3) EVALUATION.—A State that receives a grant under subsection (b) shall be evaluated at the end of the grant period by an evaluation panel appointed by the Secretary.

“(4) CONTINUING SUPPORT.—After the sixth year in which assistance is provided to a State under a grant awarded under subsection (b), the State may receive additional support under this section if the State program has received satisfactory evaluations with respect to program performance and the merits of the State sustainability plan, as determined by the Secretary.

“(5) LIMITATION.—A State shall not use in excess of 10 percent of the amount received under a grant to carry out administrative activities under this section. Funds awarded pursuant to this section shall not be used for funding direct patient care.

“(e) REQUIREMENTS ON THE SECRETARY.—In carrying out this section, the Secretary shall consult with the heads of other Federal agencies with demonstrated experience and expertise in health care and preventive medicine, such as the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Administration, the Health Resources and Services Administration, the National Institutes of Health, the Office of the National Coordinator for Health Information Technology, the Indian Health Service, the Agricultural Cooperative Extension Service of the Department of Agriculture, and other entities, as the Secretary determines appropriate.

“(f) AUTHORIZATION OF APPROPRIATIONS.—To award grants as provided in subsection (d), there are authorized to be appropriated \$120,000,000 for each of fiscal years 2011 and 2012, and such sums as may be necessary to carry out this section for each of fiscal years 2013 through 2014.”

Subtitle F—Strengthening Primary Care and Other Workforce Improvements

SEC. 5501. EXPANDING ACCESS TO PRIMARY CARE SERVICES AND GENERAL SURGERY SERVICES.

(a) INCENTIVE PAYMENT PROGRAM FOR PRIMARY CARE SERVICES.—

(1) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

“(x) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES.—

“(1) IN GENERAL.—In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

“(2) DEFINITIONS.—In this subsection:

“(A) PRIMARY CARE PRACTITIONER.—The term ‘primary care practitioner’ means an individual—

“(i) who—

“(I) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

“(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)); and

“(ii) for whom primary care services accounted for at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary.

“(B) PRIMARY CARE SERVICES.—The term ‘primary care services’ means services identified, as of January 1, 2009, by the following HCPCS codes (and as subsequently modified by the Secretary):

“(i) 99201 through 99215.

“(ii) 99304 through 99340.

“(iii) 99341 through 99350.

“(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively.

“(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of primary care practitioners under this subsection.”

(2) CONFORMING AMENDMENT.—Section 1834(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)) is amended by adding at the end the following sentence: “Section 1833(x) shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence.”

(b) INCENTIVE PAYMENT PROGRAM FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(1) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l), as amended by subsection (a)(1), is amended by adding at the end the following new subsection:

“(y) INCENTIVE PAYMENTS FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

“(1) IN GENERAL.—In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

“(2) DEFINITIONS.—In this subsection:

“(A) GENERAL SURGEON.—In this subsection, the term ‘general surgeon’ means a physician (as described in section 1861(r)(1)) who has designated CMS specialty code 02—General Surgery

as their primary specialty code in the physician's enrollment under section 1866(f).

“(B) MAJOR SURGICAL PROCEDURES.—The term ‘major surgical procedures’ means physicians’ services which are surgical procedures for which a 10-day or 90-day global period is used for payment under the fee schedule under section 1848(b).”

“(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively.”

“(4) APPLICATION.—The provisions of paragraph (2) and (4) of subsection (m) shall apply to the determination of additional payments under this subsection in the same manner as such provisions apply to the determination of additional payments under subsection (m).”

(2) CONFORMING AMENDMENT.—Section 1834(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)), as amended by subsection (a)(2), is amended by striking “Section 1833(x)” and inserting “Subsections (x) and (y) of section 1833” in the last sentence.

(c) BUDGET-NEUTRALITY ADJUSTMENT.—Section 1848(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)(B)) is amended by adding at the end the following new clause:

“(vii) ADJUSTMENT FOR CERTAIN PHYSICIAN INCENTIVE PAYMENTS.—Fifty percent of the additional expenditures under this part attributable to subsections (x) and (y) of section 1833 for a year (as estimated by the Secretary) shall be taken into account in applying clause (ii)(I) for 2011 and subsequent years. In lieu of applying the budget-neutrality adjustments required under clause (ii)(I) to relative value units to account for such costs for the year, the Secretary shall apply such budget-neutrality adjustments to the conversion factor otherwise determined for the year. For 2011 and subsequent years, the Secretary shall increase the incentive payment otherwise applicable under section 1833(m) by a percent estimated to be equal to the additional expenditures estimated under the first sentence of this clause for such year that is applicable to physicians who primarily furnish services in areas designated (under section 332(a)(1)(A) of the Public Health Service Act) as health professional shortage areas.”

SEC. 5502. MEDICARE FEDERALLY QUALIFIED HEALTH CENTER IMPROVEMENTS.

(a) EXPANSION OF MEDICARE-COVERED PREVENTIVE SERVICES AT FEDERALLY QUALIFIED HEALTH CENTERS.—

(1) IN GENERAL.—Section 1861(aa)(3)(A) of the Social Security Act (42 U.S.C. 1395w (aa)(3)(A)) is amended to read as follows:

“(A) services of the type described subparagraphs (A) through (C) of paragraph (1) and preventive services (as defined in section 1861(ddd)(3)); and”

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after January 1, 2011.

(b) PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

“(n) DEVELOPMENT AND IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—

“(1) DEVELOPMENT.—

“(A) IN GENERAL.—The Secretary shall develop a prospective payment system for payment for Federally qualified health services furnished by Federally qualified health centers under this title. Such system shall include a process for appropriately describing the services furnished by Federally qualified health centers.

“(B) COLLECTION OF DATA AND EVALUATION.—The Secretary shall require Federally qualified

health centers to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system under this paragraph and paragraph (2), respectively, including the reporting of services using HCPCS codes.

“(2) IMPLEMENTATION.—

“(A) IN GENERAL.—Notwithstanding section 1833(a)(3)(B), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2014, for payments for Federally qualified health services furnished by Federally qualified health centers under this title in accordance with the prospective payment system developed by the Secretary under paragraph (1).

“(B) PAYMENTS.—

“(i) INITIAL PAYMENTS.—The Secretary shall implement such prospective payment system so that the estimated amount of expenditures under this title for Federally qualified health services in the first year that the prospective payment system is implemented is equal to 103 percent of the estimated amount of expenditures under this title that would have occurred for such services in such year if the system had not been implemented.”

“(ii) PAYMENTS IN SUBSEQUENT YEARS.—In the year after the first year of implementation of such system, and in each subsequent year, the payment rate for Federally qualified health services furnished in the year shall be equal to the payment rate established for such services furnished in the preceding year under this subparagraph increased by the percentage increase in the MEI (as defined in 1842(i)(3)) for the year involved.”

SEC. 5503. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking “paragraph (7)” and inserting “paragraphs (7) and (8)”;

(2) in paragraph (4)(H)(i), by striking “paragraph (7)” and inserting “paragraphs (7) and (8)”;

(3) in paragraph (7)(E), by inserting “or paragraph (8)” before the period at the end; and

(4) by adding at the end the following new paragraph:

“(8) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.—

“(A) REDUCTIONS IN LIMIT BASED ON UNUSED POSITIONS.—

“(i) IN GENERAL.—Except as provided in clause (ii), if a hospital's reference resident level (as defined in subparagraph (H)(i)) is less than the otherwise applicable resident limit (as defined in subparagraph (H)(iii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 65 percent of the difference between such otherwise applicable resident limit and such reference resident level.

“(ii) EXCEPTIONS.—This subparagraph shall not apply to—

“(1) a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds;

“(2) a hospital that was part of a qualifying entity which had a voluntary residency reduction plan approved under paragraph (6)(B) or under the authority of section 402 of Public Law 90-248, if the hospital demonstrates to the Secretary that it has a specified plan in place for filling the unused positions by not later than 2 years after the date of enactment of this paragraph; or

“(3) a hospital described in paragraph (4)(H)(v).

“(B) DISTRIBUTION.—

“(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for

each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2011. The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the aggregate reduction in such limits attributable to subparagraph (A) (as estimated by the Secretary).

“(ii) REQUIREMENTS.—Subject to clause (iii), a hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning on the date of such increase, that—

“(I) the number of full-time equivalent primary care residents, as defined in paragraph (5)(H) (as determined by the Secretary), excluding any additional positions under subclause (II), is not less than the average number of full-time equivalent primary care residents (as so determined) during the 3 most recent cost reporting periods ending prior to the date of enactment of this paragraph; and

“(II) not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency (as determined by the Secretary).

The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period.

“(iii) REDISTRIBUTION OF POSITIONS IF HOSPITAL NO LONGER MEETS CERTAIN REQUIREMENTS.—In the case where the Secretary determines that a hospital described in clause (ii) does not meet either of the requirements under subclause (I) or (II) of such clause, the Secretary shall—

“(I) reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph; and

“(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

“(C) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), the Secretary shall take into account—

“(i) the demonstration likelihood of the hospital filling the positions made available under this paragraph within the first 3 cost reporting periods beginning on or after July 1, 2011, as determined by the Secretary; and

“(ii) whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv)).

“(D) PRIORITY FOR CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), subject to subparagraph (E), the Secretary shall distribute the increase to hospitals based on the following factors:

“(i) Whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile (as determined by the Secretary).

“(ii) Whether the hospital is located in a State, a territory of the United States, or the District of Columbia that is among the top 10 States, territories, or Districts in terms of the ratio of—

“(I) the total population of the State, territory, or District living in an area designated (under such section 332(a)(1)(A)) as a health professional shortage area (as of the date of enactment of this paragraph); to

“(II) the total population of the State, territory, or District (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census).

“(iii) Whether the hospital is located in a rural area (as defined in subsection (d)(2)(D)(ii)).

“(E) RESERVATION OF POSITIONS FOR CERTAIN HOSPITALS.—

“(i) IN GENERAL.—Subject to clause (ii), the Secretary shall reserve the positions available for distribution under this paragraph as follows:

“(I) 70 percent of such positions for distribution to hospitals described in clause (i) of subparagraph (D).

“(II) 30 percent of such positions for distribution to hospitals described in clause (ii) and (iii) of such subparagraph (D).

“(ii) EXCEPTION IF POSITIONS NOT REDISTRIBUTED BY JULY 1, 2011.—In the case where the Secretary does not distribute positions to hospitals in accordance with clause (i) by July 1, 2011, the Secretary shall distribute such positions to other hospitals in accordance with the considerations described in subparagraph (C) and the priority described in subparagraph (D).

“(F) LIMITATION.—A hospital may not receive more than 75 full-time equivalent additional residency positions under this paragraph.

“(G) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

“(H) DEFINITIONS.—In this paragraph:

“(i) REFERENCE RESIDENT LEVEL.—The term ‘reference resident level’ means, with respect to a hospital, the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this paragraph) of the hospital for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

“(ii) RESIDENT LEVEL.—The term ‘resident level’ has the meaning given such term in paragraph (7)(C)(i).

“(iii) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term ‘otherwise applicable resident limit’ means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).”.

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, is amended—

(A) by striking “subsection (h)(7)” and inserting “subsections (h)(7) and (h)(8)”; and

(B) by striking “it applies” and inserting “they apply”.

(2) CONFORMING AMENDMENT.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following clause:

“(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.”.

(c) CONFORMING AMENDMENT.—Section 422(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) is amended by striking “section 1886(h)(7)” and all that follows and inserting “paragraphs (7) and (8) of subsection (h) of section 1886 of the Social Security Act”.

SEC. 5504. COUNTING RESIDENT TIME IN NON-PROVIDER SETTINGS.

(a) GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended—

(1) by striking “shall be counted and that all the time” and inserting “shall be counted and that—

“(i) effective for cost reporting periods beginning before July 1, 2010, all the time;”;

(2) in clause (i), as inserted by paragraph (1), by striking the period at the end and inserting “; and”;

(3) by inserting after clause (i), as so inserted, the following new clause:

“(ii) effective for cost reporting periods beginning on or after July 1, 2010, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if a hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.”; and

(4) by adding at the end the following flush sentence:

“Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.”.

(b) IME.—Section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended—

(1) by striking “(iv) Effective for discharges occurring on or after October 1, 1997” and inserting “(iv)(I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2010”; and

(2) by inserting after clause (I), as inserted by paragraph (1), the following new subparagraph:

“(II) Effective for discharges occurring on or after July 1, 2010, all the time spent by an intern or resident in patient care activities in a non-provider setting shall be counted towards the determination of full-time equivalency if a hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting. If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.”.

(c) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).

SEC. 5505. RULES FOR COUNTING RESIDENT TIME FOR DIDACTIC AND SCHOLARLY ACTIVITIES AND OTHER ACTIVITIES.

(a) GME.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)), as amended by section 5504, is amended—

(1) in paragraph (4)—

(A) in subparagraph (E), by striking “Such rules” and inserting “Subject to subparagraphs (J) and (K), such rules”; and

(B) by adding at the end the following new subparagraphs:

“(J) TREATMENT OF CERTAIN NONPROVIDER AND DIDACTIC ACTIVITIES.—Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.

“(K) TREATMENT OF CERTAIN OTHER ACTIVITIES.—In determining the hospital’s number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.”; and

(2) in paragraph (5), by adding at the end the following new subparagraph:

“(K) NONPROVIDER SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term ‘nonprovider setting that is primarily engaged in furnishing patient care’ means a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.”.

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

“(x)(I) The provisions of subparagraph (K) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

“(II) In determining the hospital’s number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

“(aa) is recognized as a subsection (d) hospital;

“(bb) is recognized as a subsection (d) Puerto Rico hospital;

“(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

“(dd) is a provider-based hospital outpatient department.

“(III) In determining the hospital’s number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.”.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983.

(2) GME.—Section 1886(h)(4)(J) of the Social Security Act, as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2009.

(3) IME.—Section 1886(d)(5)(B)(x)(III) of the Social Security Act, as added by subsection (b), shall apply to cost reporting periods beginning

on or after October 1, 2001. Such section, as so added, shall not give rise to any inference as to how the law in effect prior to such date should be interpreted.

SEC. 5506. PRESERVATION OF RESIDENT CAP POSITIONS FROM CLOSED HOSPITALS.

(a) GME.—Section 1886(h)(4)(H) of the Social Security Act (42 U.S.C. Section 1395ww(h)(4)(H)) is amended by adding at the end the following new clause:

“(vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSURES.—

“(I) IN GENERAL.—Subject to the succeeding provisions of this clause, the Secretary shall, by regulation, establish a process under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program closes on or after a date that is 2 years before the date of enactment of this clause, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.

“(II) PRIORITY FOR HOSPITALS IN CERTAIN AREAS.—Subject to the succeeding provisions of this clause, in determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distribute the increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital):

“(aa) First, to hospitals located in the same core-based statistical area as, or a core-based statistical area contiguous to, the hospital that closed.

“(bb) Second, to hospitals located in the same State as the hospital that closed.

“(cc) Third, to hospitals located in the same region of the country as the hospital that closed.

“(dd) Fourth, only if the Secretary is not able to distribute the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (8).

“(III) REQUIREMENT HOSPITAL LIKELY TO FILL POSITION WITHIN CERTAIN TIME PERIOD.—The Secretary may only increase the otherwise applicable resident limit of a hospital under such process if the Secretary determines the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years.

“(IV) LIMITATION.—The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).

“(V) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this clause.”

(b) IME.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, as amended by section 5503, is amended by striking “subsections (h)(7) and (h)(8)” and inserting “subsections (h)(4)(H)(vi), (h)(7), and (h)(8)”.

(c) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. Section 1395ww(h)).

(d) EFFECT ON TEMPORARY FTE CAP ADJUSTMENTS.—The Secretary of Health and Human

Services shall give consideration to the effect of the amendments made by this section on any temporary adjustment to a hospital's FTE cap under section 413.79(h) of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act) in order to ensure that there is no duplication of FTE slots. Such amendments shall not affect the application of section 1886(h)(4)(H)(v) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(H)(v)).

(e) CONFORMING AMENDMENT.—Section 1886(h)(7)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(7)(E)), as amended by section 5503(a), is amended by striking “paragraph or paragraph (8)” and inserting “this paragraph, paragraph (8), or paragraph (4)(H)(vi)”.

SEC. 5507. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS; EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECTS.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended by adding at the end the following:

“SEC. 2008. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.

“(a) DEMONSTRATION PROJECTS TO PROVIDE LOW-INCOME INDIVIDUALS WITH OPPORTUNITIES FOR EDUCATION, TRAINING, AND CAREER ADVANCEMENT TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.—

“(1) AUTHORITY TO AWARD GRANTS.—The Secretary, in consultation with the Secretary of Labor, shall award grants to eligible entities to conduct demonstration projects that are designed to provide eligible individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to either experience labor shortages or be in high demand.

“(2) REQUIREMENTS.—

“(A) AID AND SUPPORTIVE SERVICES.—

“(i) IN GENERAL.—A demonstration project conducted by an eligible entity awarded a grant under this section shall, if appropriate, provide eligible individuals participating in the project with financial aid, child care, case management, and other supportive services.

“(ii) TREATMENT.—Any aid, services, or incentives provided to an eligible beneficiary participating in a demonstration project under this section shall not be considered income, and shall not be taken into account for purposes of determining the individual's eligibility for, or amount of, benefits under any means-tested program.

“(B) CONSULTATION AND COORDINATION.—An eligible entity applying for a grant to carry out a demonstration project under this section shall demonstrate in the application that the entity has consulted with the State agency responsible for administering the State TANF program, the local workforce investment board in the area in which the project is to be conducted (unless the applicant is such board), the State workforce investment board established under section 111 of the Workforce Investment Act of 1998, and the State Apprenticeship Agency recognized under the Act of August 16, 1937 (commonly known as the ‘National Apprenticeship Act’) (or if no agency has been recognized in the State, the Office of Apprenticeship of the Department of Labor) and that the project will be carried out in coordination with such entities.

“(C) ASSURANCE OF OPPORTUNITIES FOR INDIAN POPULATIONS.—The Secretary shall award at least 3 grants under this subsection to an eligible entity that is an Indian tribe, tribal organization, or Tribal College or University.

“(3) REPORTS AND EVALUATION.—

“(A) ELIGIBLE ENTITIES.—An eligible entity awarded a grant to conduct a demonstration project under this subsection shall submit interim reports to the Secretary on the activities

carried out under the project and a final report on such activities upon the conclusion of the entities' participation in the project. Such reports shall include assessments of the effectiveness of such activities with respect to improving outcomes for the eligible individuals participating in the project and with respect to addressing health professions workforce needs in the areas in which the project is conducted.

“(B) EVALUATION.—The Secretary shall, by grant, contract, or interagency agreement, evaluate the demonstration projects conducted under this subsection. Such evaluation shall include identification of successful activities for creating opportunities for developing and sustaining, particularly with respect to low-income individuals and other entry-level workers, a health professions workforce that has accessible entry points, that meets high standards for education, training, certification, and professional development, and that provides increased wages and affordable benefits, including health care coverage, that are responsive to the workforce's needs.

“(C) REPORT TO CONGRESS.—The Secretary shall submit interim reports and, based on the evaluation conducted under subparagraph (B), a final report to Congress on the demonstration projects conducted under this subsection.

“(4) DEFINITIONS.—In this subsection:

“(A) ELIGIBLE ENTITY.—The term ‘eligible entity’ means a State, an Indian tribe or tribal organization, an institution of higher education, a local workforce investment board established under section 117 of the Workforce Investment Act of 1998, a sponsor of an apprenticeship program registered under the National Apprenticeship Act or a community-based organization.

“(B) ELIGIBLE INDIVIDUAL.—

“(i) IN GENERAL.—The term ‘eligible individual’ means a individual receiving assistance under the State TANF program.

“(ii) OTHER LOW-INCOME INDIVIDUALS.—Such term may include other low-income individuals described by the eligible entity in its application for a grant under this section.

“(C) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms ‘Indian tribe’ and ‘tribal organization’ have the meaning given such terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

“(D) INSTITUTION OF HIGHER EDUCATION.—The term ‘institution of higher education’ has the meaning given that term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

“(E) STATE.—The term ‘State’ means each of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, and American Samoa.

“(F) STATE TANF PROGRAM.—The term ‘State TANF program’ means the temporary assistance for needy families program funded under part A of title IV.

“(G) TRIBAL COLLEGE OR UNIVERSITY.—The term ‘Tribal College or University’ has the meaning given that term in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1059c(b)).

“(b) DEMONSTRATION PROJECT TO DEVELOP TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL OR HOME CARE AIDES.—

“(1) AUTHORITY TO AWARD GRANTS.—Not later than 18 months after the date of enactment of this section, the Secretary shall award grants to eligible entities that are States to conduct demonstration projects for purposes of developing core training competencies and certification programs for personal or home care aides. The Secretary shall—

“(A) evaluate the efficacy of the core training competencies described in paragraph (3)(A) for newly hired personal or home care aides and the methods used by States to implement such core training competencies in accordance with the issues specified in paragraph (3)(B); and

“(B) ensure that the number of hours of training provided by States under the demonstration project with respect to such core training competencies are not less than the number of hours of training required under any applicable State or Federal law or regulation.

“(2) DURATION.—A demonstration project shall be conducted under this subsection for not less than 3 years.

“(3) CORE TRAINING COMPETENCIES FOR PERSONAL OR HOME CARE AIDES.—

“(A) IN GENERAL.—The core training competencies for personal or home care aides described in this subparagraph include competencies with respect to the following areas:

“(i) The role of the personal or home care aide (including differences between a personal or home care aide employed by an agency and a personal or home care aide employed directly by the health care consumer or an independent provider).

“(ii) Consumer rights, ethics, and confidentiality (including the role of proxy decision-makers in the case where a health care consumer has impaired decision-making capacity).

“(iii) Communication, cultural and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills.

“(iv) Personal care skills.

“(v) Health care support.

“(vi) Nutritional support.

“(vii) Infection control.

“(viii) Safety and emergency training.

“(ix) Training specific to an individual consumer's needs (including older individuals, younger individuals with disabilities, individuals with developmental disabilities, individuals with dementia, and individuals with mental and behavioral health needs).

“(x) Self-Care.

“(B) IMPLEMENTATION.—The implementation issues specified in this subparagraph include the following:

“(i) The length of the training.

“(ii) The appropriate trainer to student ratio.

“(iii) The amount of instruction time spent in the classroom as compared to on-site in the home or a facility.

“(iv) Trainer qualifications.

“(v) Content for a ‘hands-on’ and written certification exam.

“(vi) Continuing education requirements.

“(4) APPLICATION AND SELECTION CRITERIA.—

“(A) IN GENERAL.—

“(i) NUMBER OF STATES.—The Secretary shall enter into agreements with not more than 6 States to conduct demonstration projects under this subsection.

“(ii) REQUIREMENTS FOR STATES.—An agreement entered into under clause (i) shall require that a participating State—

“(I) implement the core training competencies described in paragraph (3)(A); and

“(II) develop written materials and protocols for such core training competencies, including the development of a certification test for personal or home care aides who have completed such training competencies.

“(iii) CONSULTATION AND COLLABORATION WITH COMMUNITY AND VOCATIONAL COLLEGES.—The Secretary shall encourage participating States to consult with community and vocational colleges regarding the development of curricula to implement the project with respect to activities, as applicable, which may include consideration of such colleges as partners in such implementation.

“(B) APPLICATION AND ELIGIBILITY.—A State seeking to participate in the project shall—

“(i) submit an application to the Secretary containing such information and at such time as the Secretary may specify;

“(ii) meet the selection criteria established under subparagraph (C); and

“(iii) meet such additional criteria as the Secretary may specify.

“(C) SELECTION CRITERIA.—In selecting States to participate in the program, the Secretary shall establish criteria to ensure (if applicable with respect to the activities involved)—

“(i) geographic and demographic diversity;

“(ii) that participating States offer medical assistance for personal care services under the State Medicaid plan;

“(iii) that the existing training standards for personal or home care aides in each participating State—

“(I) are different from such standards in the other participating States; and

“(II) are different from the core training competencies described in paragraph (3)(A);

“(iv) that participating States do not reduce the number of hours of training required under applicable State law or regulation after being selected to participate in the project; and

“(v) that participating States recruit a minimum number of eligible health and long-term care providers to participate in the project.

“(D) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States in developing written materials and protocols for such core training competencies.

“(5) EVALUATION AND REPORT.—

“(A) EVALUATION.—The Secretary shall develop an experimental or control group testing protocol in consultation with an independent evaluation contractor selected by the Secretary. Such contractor shall evaluate—

“(i) the impact of core training competencies described in paragraph (3)(A), including curricula developed to implement such core training competencies, for personal or home care aides within each participating State on job satisfaction, mastery of job skills, beneficiary and family caregiver satisfaction with services, and additional measures determined by the Secretary in consultation with the expert panel;

“(ii) the impact of providing such core training competencies on the existing training infrastructure and resources of States; and

“(iii) whether a minimum number of hours of initial training should be required for personal or home care aides and, if so, what minimum number of hours should be required.

“(B) REPORTS.—

“(i) REPORT ON INITIAL IMPLEMENTATION.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the initial implementation of activities conducted under the demonstration project, including any available results of the evaluation conducted under subparagraph (A) with respect to such activities, together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

“(ii) FINAL REPORT.—Not later than 1 year after the completion of the demonstration project, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under subparagraph (A), together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

“(6) DEFINITIONS.—In this subsection:

“(A) ELIGIBLE HEALTH AND LONG-TERM CARE PROVIDER.—The term ‘eligible health and long-term care provider’ means a personal or home care agency (including personal or home care public authorities), a nursing home, a home health agency (as defined in section 1861(o)), or any other health care provider the Secretary determines appropriate which—

“(i) is licensed or authorized to provide services in a participating State; and

“(ii) receives payment for services under title XIX.

“(B) PERSONAL CARE SERVICES.—The term ‘personal care services’ has the meaning given such term for purposes of title XIX.

“(C) PERSONAL OR HOME CARE AIDE.—The term ‘personal or home care aide’ means an individual who helps individuals who are elderly, disabled, ill, or mentally disabled (including an individual with Alzheimer's disease or other dementia) to live in their own home or a residential care facility (such as a nursing home, assisted living facility, or any other facility the Secretary determines appropriate) by providing routine personal care services and other appropriate services to the individual.

“(D) STATE.—The term ‘State’ has the meaning given that term for purposes of title XIX.

“(c) FUNDING.—

“(1) IN GENERAL.—Subject to paragraph (2), out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out subsections (a) and (b), \$85,000,000 for each of fiscal years 2010 through 2014.

“(2) TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL AND HOME CARE AIDES.—With respect to the demonstration projects under subsection (b), the Secretary shall use \$5,000,000 of the amount appropriated under paragraph (1) for each of fiscal years 2010 through 2012 to carry out such projects. No funds appropriated under paragraph (1) shall be used to carry out demonstration projects under subsection (b) after fiscal year 2012.

“(d) NONAPPLICATION.—

“(1) IN GENERAL.—Except as provided in paragraph (2), the preceding sections of this title shall not apply to grant awarded under this section.

“(2) LIMITATIONS ON USE OF GRANTS.—Section 2005(a) (other than paragraph (6)) shall apply to a grant awarded under this section to the same extent and in the same manner as such section applies to payments to States under this title.”

(b) EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.—Section 501(c)(1)(A)(iii) of the Social Security Act (42 U.S.C. 701(c)(1)(A)(iii)) is amended by striking “fiscal year 2009” and inserting “each of fiscal years 2009 through 2012”.

SEC. 5508. INCREASING TEACHING CAPACITY.

(a) TEACHING HEALTH CENTERS TRAINING AND ENHANCEMENT.—Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et. seq.), as amended by section 5303, is further amended by inserting after section 749 the following:

“SEC. 749A. TEACHING HEALTH CENTERS DEVELOPMENT GRANTS.

“(a) PROGRAM AUTHORIZED.—The Secretary may award grants under this section to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.

“(b) AMOUNT AND DURATION.—Grants awarded under this section shall be for a term of not more than 3 years and the maximum award may not be more than \$500,000.

“(c) USE OF FUNDS.—Amounts provided under a grant under this section shall be used to cover the costs of—

“(1) establishing or expanding a primary care residency training program described in subsection (a), including costs associated with—

“(A) curriculum development;

“(B) recruitment, training and retention of residents and faculty;

“(C) accreditation by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA); and

“(D) faculty salaries during the development phase; and

“(2) technical assistance provided by an eligible entity.

“(d) APPLICATION.—A teaching health center seeking a grant under this section shall submit an application to the Secretary at such time, in

such manner, and containing such information as the Secretary may require.

“(e) **PREFERENCE FOR CERTAIN APPLICATIONS.**—In selecting recipients for grants under this section, the Secretary shall give preference to any such application that documents an existing affiliation agreement with an area health education center program as defined in sections 751 and 799B.

“(f) **DEFINITIONS.**—In this section:

“(1) **ELIGIBLE ENTITY.**—The term ‘eligible entity’ means an organization capable of providing technical assistance including an area health education center program as defined in sections 751 and 799B.

“(2) **PRIMARY CARE RESIDENCY PROGRAM.**—The term ‘primary care residency program’ means an approved graduate medical residency training program (as defined in section 340H) in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics.

“(3) **TEACHING HEALTH CENTER.**—

“(A) **IN GENERAL.**—The term ‘teaching health center’ means an entity that—

“(i) is a community based, ambulatory patient care center; and

“(ii) operates a primary care residency program.

“(B) **INCLUSION OF CERTAIN ENTITIES.**—Such term includes the following:

“(i) A Federally qualified health center (as defined in section 1905(l)(2)(B), of the Social Security Act).

“(ii) A community mental health center (as defined in section 1861(ff)(3)(B) of the Social Security Act).

“(iii) A rural health clinic, as defined in section 1861(aa) of the Social Security Act.

“(iv) A health center operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act).

“(v) An entity receiving funds under title X of the Public Health Service Act.

“(g) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated, \$25,000,000 for fiscal year 2010, \$50,000,000 for fiscal year 2011, \$50,000,000 for fiscal year 2012, and such sums as may be necessary for each fiscal year thereafter to carry out this section. Not to exceed \$5,000,000 annually may be used for technical assistance program grants.”.

(b) **NATIONAL HEALTH SERVICE CORPS TEACHING CAPACITY.**—Section 338C(a) of the Public Health Service Act (42 U.S.C. 254m(a)) is amended to read as follows:

“(a) **SERVICE IN FULL-TIME CLINICAL PRACTICE.**—Except as provided in section 338D, each individual who has entered into a written contract with the Secretary under section 338A or 338B shall provide service in the full-time clinical practice of such individual’s profession as a member of the Corps for the period of obligated service provided in such contract. For the purpose of calculating time spent in full-time clinical practice under this subsection, up to 50 percent of time spent teaching by a member of the Corps may be counted toward his or her service obligation.”.

(c) **PAYMENTS TO QUALIFIED TEACHING HEALTH CENTERS.**—Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

“Subpart XI—Support of Graduate Medical Education in Qualified Teaching Health Centers

“SEC. 340H. PROGRAM OF PAYMENTS TO TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

“(a) **PAYMENTS.**—Subject to subsection (h)(2), the Secretary shall make payments under this

section for direct expenses and for indirect expenses to qualified teaching health centers that are listed as sponsoring institutions by the relevant accrediting body for expansion of existing or establishment of new approved graduate medical residency training programs.

“(b) **AMOUNT OF PAYMENTS.**—

“(1) **IN GENERAL.**—Subject to paragraph (2), the amounts payable under this section to qualified teaching health centers for an approved graduate medical residency training program for a fiscal year are each of the following amounts:

“(A) **DIRECT EXPENSE AMOUNT.**—The amount determined under subsection (c) for direct expenses associated with sponsoring approved graduate medical residency training programs.

“(B) **INDIRECT EXPENSE AMOUNT.**—The amount determined under subsection (d) for indirect expenses associated with the additional costs relating to teaching residents in such programs.

“(2) **CAPPED AMOUNT.**—

“(A) **IN GENERAL.**—The total of the payments made to qualified teaching health centers under paragraph (1)(A) or paragraph (1)(B) in a fiscal year shall not exceed the amount of funds appropriated under subsection (g) for such payments for that fiscal year.

“(B) **LIMITATION.**—The Secretary shall limit the funding of full-time equivalent residents in order to ensure the direct and indirect payments as determined under subsection (c) and (d) do not exceed the total amount of funds appropriated in a fiscal year under subsection (g).

“(c) **AMOUNT OF PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.**—

“(1) **IN GENERAL.**—The amount determined under this subsection for payments to qualified teaching health centers for direct graduate expenses relating to approved graduate medical residency training programs for a fiscal year is equal to the product of—

“(A) the updated national per resident amount for direct graduate medical education, as determined under paragraph (2); and

“(B) the average number of full-time equivalent residents in the teaching health center’s graduate approved medical residency training programs as determined under section 1886(h)(4) of the Social Security Act (without regard to the limitation under subparagraph (F) of such section) during the fiscal year.

“(2) **UPDATED NATIONAL PER RESIDENT AMOUNT FOR DIRECT GRADUATE MEDICAL EDUCATION.**—The updated per resident amount for direct graduate medical education for a qualified teaching health center for a fiscal year is an amount determined as follows:

“(A) **DETERMINATION OF QUALIFIED TEACHING HEALTH CENTER PER RESIDENT AMOUNT.**—The Secretary shall compute for each individual qualified teaching health center a per resident amount—

“(i) by dividing the national average per resident amount computed under section 340E(c)(2)(D) into a wage-related portion and a non-wage related portion by applying the proportion determined under subparagraph (B);

“(ii) by multiplying the wage-related portion by the factor applied under section 1886(d)(3)(E) of the Social Security Act (but without application of section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note)) during the preceding fiscal year for the teaching health center’s area; and

“(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

“(B) **UPDATING RATE.**—The Secretary shall update such per resident amount for each such qualified teaching health center as determined appropriate by the Secretary.

“(d) **AMOUNT OF PAYMENT FOR INDIRECT MEDICAL EDUCATION.**—

“(1) **IN GENERAL.**—The amount determined under this subsection for payments to qualified

teaching health centers for indirect expenses associated with the additional costs of teaching residents for a fiscal year is equal to an amount determined appropriate by the Secretary.

“(2) **FACTORS.**—In determining the amount under paragraph (1), the Secretary shall—

“(A) evaluate indirect training costs relative to supporting a primary care residency program in qualified teaching health centers; and

“(B) based on this evaluation, assure that the aggregate of the payments for indirect expenses under this section and the payments for direct graduate medical education as determined under subsection (c) in a fiscal year do not exceed the amount appropriated for such expenses as determined in subsection (g).

“(3) **INTERIM PAYMENT.**—Before the Secretary makes a payment under this subsection pursuant to a determination of indirect expenses under paragraph (1), the Secretary may provide to qualified teaching health centers a payment, in addition to any payment made under subsection (c), for expected indirect expenses associated with the additional costs of teaching residents for a fiscal year, based on an estimate by the Secretary.

“(e) **CLARIFICATION REGARDING RELATIONSHIP TO OTHER PAYMENTS FOR GRADUATE MEDICAL EDUCATION.**—Payments under this section—

“(1) shall be in addition to any payments—

“(A) for the indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act;

“(B) for direct graduate medical education costs under section 1886(h) of such Act; and

“(C) for direct costs of medical education under section 1886(k) of such Act;

“(2) shall not be taken into account in applying the limitation on the number of total full-time equivalent residents under subparagraphs (F) and (G) of section 1886(h)(4) of such Act and clauses (v), (vi)(I), and (vi)(II) of section 1886(d)(5)(B) of such Act for the portion of time that a resident rotates to a hospital; and

“(3) shall not include the time in which a resident is counted toward full-time equivalency by a hospital under paragraph (2) or under section 1886(d)(5)(B)(iv) of the Social Security Act, section 1886(h)(4)(E) of such Act, or section 340E of this Act.

“(f) **RECONCILIATION.**—The Secretary shall determine any changes to the number of residents reported by a hospital in the application of the hospital for the current fiscal year to determine the final amount payable to the hospital for the current fiscal year for both direct expense and indirect expense amounts. Based on such determination, the Secretary shall recoup any overpayments made to pay any balance due to the extent possible. The final amount so determined shall be considered a final intermediary determination for the purposes of section 1878 of the Social Security Act and shall be subject to administrative and judicial review under that section in the same manner as the amount of payment under section 1186(d) of such Act is subject to review under such section.

“(g) **FUNDING.**—To carry out this section, there are appropriated such sums as may be necessary, not to exceed \$230,000,000, for the period of fiscal years 2011 through 2015.

“(h) **ANNUAL REPORTING REQUIRED.**—

“(1) **ANNUAL REPORT.**—The report required under this paragraph for a qualified teaching health center for a fiscal year is a report that includes (in a form and manner specified by the Secretary) the following information for the residency academic year completed immediately prior to such fiscal year:

“(A) The types of primary care resident approved training programs that the qualified teaching health center provided for residents.

“(B) The number of approved training positions for residents described in paragraph (4).

“(C) The number of residents described in paragraph (4) who completed their residency training at the end of such residency academic year and care for vulnerable populations living in underserved areas.

“(D) Other information as deemed appropriate by the Secretary.

“(2) AUDIT AUTHORITY; LIMITATION ON PAYMENT.—

“(A) AUDIT AUTHORITY.—The Secretary may audit a qualified teaching health center to ensure the accuracy and completeness of the information submitted in a report under paragraph (1).

“(B) LIMITATION ON PAYMENT.—A teaching health center may only receive payment in a cost reporting period for a number of such resident positions that is greater than the base level of primary care resident positions, as determined by the Secretary. For purposes of this subparagraph, the ‘base level of primary care residents’ for a teaching health center is the level of such residents as of a base period.

“(3) REDUCTION IN PAYMENT FOR FAILURE TO REPORT.—

“(A) IN GENERAL.—The amount payable under this section to a qualified teaching health center for a fiscal year shall be reduced by at least 25 percent if the Secretary determines that—

“(i) the qualified teaching health center has failed to provide the Secretary, as an addendum to the qualified teaching health center’s application under this section for such fiscal year, the report required under paragraph (1) for the previous fiscal year; or

“(ii) such report fails to provide complete and accurate information required under any subparagraph of such paragraph.

“(B) NOTICE AND OPPORTUNITY TO PROVIDE ACCURATE AND MISSING INFORMATION.—Before imposing a reduction under subparagraph (A) on the basis of a qualified teaching health center’s failure to provide complete and accurate information described in subparagraph (A)(ii), the Secretary shall provide notice to the teaching health center of such failure and the Secretary’s intention to impose such reduction and shall provide the teaching health center with the opportunity to provide the required information within the period of 30 days beginning on the date of such notice. If the teaching health center provides such information within such period, no reduction shall be made under subparagraph (A) on the basis of the previous failure to provide such information.

“(4) RESIDENTS.—The residents described in this paragraph are those who are in part-time or full-time equivalent resident training positions at a qualified teaching health center in any approved graduate medical residency training program.

“(i) REGULATIONS.—The Secretary shall promulgate regulations to carry out this section.

“(j) DEFINITIONS.—In this section:

“(1) APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term ‘approved graduate medical residency training program’ means a residency or other postgraduate medical training program—

“(A) participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary; and

“(B) that meets criteria for accreditation (as established by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the American Dental Association).

“(2) PRIMARY CARE RESIDENCY PROGRAM.—The term ‘primary care residency program’ has the meaning given that term in section 749A.

“(3) QUALIFIED TEACHING HEALTH CENTER.—The term ‘qualified teaching health center’ has

the meaning given the term ‘teaching health center’ in section 749A.”.

SEC. 5509. GRADUATE NURSE EDUCATION DEMONSTRATION.

(a) IN GENERAL.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall establish a graduate nurse education demonstration under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) under which an eligible hospital may receive payment for the hospital’s reasonable costs (described in paragraph (2)) for the provision of qualified clinical training to advance practice nurses.

(B) NUMBER.—The demonstration shall include up to 5 eligible hospitals.

(C) WRITTEN AGREEMENTS.—Eligible hospitals selected to participate in the demonstration shall enter into written agreements pursuant to subsection (b) in order to reimburse the eligible partners of the hospital the share of the costs attributable to each partner.

(2) COSTS DESCRIBED.—

(A) IN GENERAL.—Subject to subparagraph (B) and subsection (d), the costs described in this paragraph are the reasonable costs (as described in section 1861(v) of the Social Security Act (42 U.S.C. 1395x(v))) of each eligible hospital for the clinical training costs (as determined by the Secretary) that are attributable to providing advanced practice registered nurses with qualified training.

(B) LIMITATION.—With respect to a year, the amount reimbursed under subparagraph (A) may not exceed the amount of costs described in subparagraph (A) that are attributable to an increase in the number of advanced practice registered nurses enrolled in a program that provides qualified training during the year and for which the hospital is being reimbursed under the demonstration, as compared to the average number of advanced practice registered nurses who graduated in each year during the period beginning on January 1, 2006, and ending on December 31, 2010 (as determined by the Secretary) from the graduate nursing education program operated by the applicable school of nursing that is an eligible partner of the hospital for purposes of the demonstration.

(3) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration.

(4) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this section.

(b) WRITTEN AGREEMENTS WITH ELIGIBLE PARTNERS.—No payment shall be made under this section to an eligible hospital unless such hospital has in effect a written agreement with the eligible partners of the hospital. Such written agreement shall describe, at a minimum—

(1) the obligations of the eligible partners with respect to the provision of qualified training; and

(2) the obligation of the eligible hospital to reimburse such eligible partners applicable (in a timely manner) for the costs of such qualified training attributable to partner.

(c) EVALUATION.—Not later than October 17, 2017, the Secretary shall submit to Congress a report on the demonstration. Such report shall include an analysis of the following:

(1) The growth in the number of advanced practice registered nurses with respect to a specific base year as a result of the demonstration.

(2) The growth for each of the specialties described in subparagraphs (A) through (D) of subsection (e)(1).

(3) The costs to the Medicare program under title XVIII of the Social Security Act as a result of the demonstration.

(4) Other items the Secretary determines appropriate and relevant.

(d) FUNDING.—

(1) IN GENERAL.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, \$50,000,000 for each of fiscal years 2012 through 2015 to carry out this section, including the design, implementation, monitoring, and evaluation of the demonstration.

(2) PRORATION.—If the aggregate payments to eligible hospitals under the demonstration exceed \$50,000,000 for a fiscal year described in paragraph (1), the Secretary shall prorate the payment amounts to each eligible hospital in order to ensure that the aggregate payments do not exceed such amount.

(3) WITHOUT FISCAL YEAR LIMITATION.—Amounts appropriated under this subsection shall remain available without fiscal year limitation.

(e) DEFINITIONS.—In this section:

(1) ADVANCED PRACTICE REGISTERED NURSE.—The term “advanced practice registered nurse” includes the following:

(A) A clinical nurse specialist (as defined in subsection (aa)(5) of section 1861 of the Social Security Act (42 U.S.C. 1395x)).

(B) A nurse practitioner (as defined in such subsection).

(C) A certified registered nurse anesthetist (as defined in subsection (bb)(2) of such section).

(D) A certified nurse-midwife (as defined in subsection (gg)(2) of such section).

(2) APPLICABLE NON-HOSPITAL COMMUNITY-BASED CARE SETTING.—The term “applicable non-hospital community-based care setting” means a non-hospital community-based care setting which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration. Such settings include Federally qualified health centers, rural health clinics, and other non-hospital settings as determined appropriate by the Secretary.

(3) APPLICABLE SCHOOL OF NURSING.—The term “applicable school of nursing” means an accredited school of nursing (as defined in section 801 of the Public Health Service Act) which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration.

(4) DEMONSTRATION.—The term “demonstration” means the graduate nurse education demonstration established under subsection (a).

(5) ELIGIBLE HOSPITAL.—The term “eligible hospital” means a hospital (as defined in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x)) or a critical access hospital (as defined in subsection (mm)(1) of such section) that has a written agreement in place with—

(A) 1 or more applicable schools of nursing; and

(B) 2 or more applicable non-hospital community-based care settings.

(6) ELIGIBLE PARTNERS.—The term “eligible partners” includes the following:

(A) An applicable non-hospital community-based care setting.

(B) An applicable school of nursing.

(7) QUALIFIED TRAINING.—

(A) IN GENERAL.—The term “qualified training” means training—

(i) that provides an advanced practice registered nurse with the clinical skills necessary to provide primary care, preventive care, transitional care, chronic care management, and other services appropriate for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title; and

(ii) subject to subparagraph (B), at least half of which is provided in a non-hospital community-based care setting.

(B) WAIVER OF REQUIREMENT HALF OF TRAINING BE PROVIDED IN NON-HOSPITAL COMMUNITY-

BASED CARE SETTING IN CERTAIN AREAS.—The Secretary may waive the requirement under subparagraph (A)(ii) with respect to eligible hospitals located in rural or medically underserved areas.

(8) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

Subtitle G—Improving Access to Health Care Services

SEC. 5601. SPENDING FOR FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs).

(a) IN GENERAL.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by striking paragraph (1) and inserting the following:

“(1) GENERAL AMOUNTS FOR GRANTS.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there is authorized to be appropriated the following:

“(A) For fiscal year 2010, \$2,988,821,592.

“(B) For fiscal year 2011, \$3,862,107,440.

“(C) For fiscal year 2012, \$4,990,553,440.

“(D) For fiscal year 2013, \$6,448,713,307.

“(E) For fiscal year 2014, \$7,332,924,155.

“(F) For fiscal year 2015, \$8,332,924,155.

“(G) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

“(i) one plus the average percentage increase in costs incurred per patient served; and

“(ii) one plus the average percentage increase in the total number of patients served.”.

(b) RULE OF CONSTRUCTION.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by adding at the end the following:

“(4) RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINICS.—

“(A) IN GENERAL.—Nothing in this section shall be construed to prevent a community health center from contracting with a Federally certified rural health clinic (as defined in section 1861(aa)(2) of the Social Security Act), a low-volume hospital (as defined for purposes of section 1886 of such Act), a critical access hospital, a sole community hospital (as defined for purposes of section 1886(d)(5)(D)(iii) of such Act), or a medicare-dependent share hospital (as defined for purposes of section 1886(d)(5)(G)(iv) of such Act) for the delivery of primary health care services that are available at the clinic or hospital to individuals who would otherwise be eligible for free or reduced cost care if that individual were able to obtain that care at the community health center. Such services may be limited in scope to those primary health care services available in that clinic or hospitals.

“(B) ASSURANCES.—In order for a clinic or hospital to receive funds under this section through a contract with a community health center under subparagraph (A), such clinic or hospital shall establish policies to ensure—

“(i) nondiscrimination based on the ability of a patient to pay; and

“(ii) the establishment of a sliding fee scale for low-income patients.”.

SEC. 5602. NEGOTIATED RULEMAKING FOR DEVELOPMENT OF METHODOLOGY AND CRITERIA FOR DESIGNATING MEDICALLY UNDERSERVED POPULATIONS AND HEALTH PROFESSIONS SHORTAGE AREAS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish, through a negotiated rulemaking process under subchapter 3 of chapter 5 of title 5, United States Code, a comprehensive methodology and criteria for designation of—

(A) medically underserved populations in accordance with section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3));

(B) health professions shortage areas under section 332 of the Public Health Service Act (42 U.S.C. 254e).

(2) FACTORS TO CONSIDER.—In establishing the methodology and criteria under paragraph (1), the Secretary—

(A) shall consult with relevant stakeholders who will be significantly affected by a rule (such as national, State and regional organizations representing affected entities), State health offices, community organizations, health centers and other affected entities, and other interested parties; and

(B) shall take into account—

(i) the timely availability and appropriateness of data used to determine a designation to potential applicants for such designations;

(ii) the impact of the methodology and criteria on communities of various types and on health centers and other safety net providers;

(iii) the degree of ease or difficulty that will face potential applicants for such designations in securing the necessary data; and

(iv) the extent to which the methodology accurately measures various barriers that confront individuals and population groups in seeking health care services.

(b) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this Act.

(c) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under subsection (b), and for purposes of this subsection, the “target date for publication”, as referred to in section 564(a)(5) of title 5, United States Code, shall be July 1, 2010.

(d) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

(1) the appointment of a negotiated rulemaking committee under section 565(a) of title 5, United States Code, by not later than 30 days after the end of the comment period provided for under section 564(c) of such title; and

(2) the nomination of a facilitator under section 566(c) of such title 5 by not later than 10 days after the date of appointment of the committee.

(e) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under subsection (d) shall report to the Secretary, by not later than April 1, 2010, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress toward such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this section through such other methods as the Secretary may provide.

(f) FINAL COMMITTEE REPORT.—If the committee is not terminated under subsection (e), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

(g) INTERIM FINAL EFFECT.—The Secretary shall publish a rule under this section in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 90 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications for such designations pursuant to such rules and consistent with this section.

(h) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.

SEC. 5603. REAUTHORIZATION OF THE WAKEFIELD EMERGENCY MEDICAL SERVICES FOR CHILDREN PROGRAM.

Section 1910 of the Public Health Service Act (42 U.S.C. 300w-9) is amended—

(1) in subsection (a), by striking “3-year period (with an optional 4th year” and inserting “4-year period (with an optional 5th year”;

(2) in subsection (d)—

(A) by striking “and such sums” and inserting “such sums”; and

(B) by inserting before the period the following: “, \$25,000,000 for fiscal year 2010, \$26,250,000 for fiscal year 2011, \$27,562,500 for fiscal year 2012, \$28,940,625 for fiscal year 2013, and \$30,387,656 for fiscal year 2014”.

SEC. 5604. CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb-31 et seq.) is amended by adding at the end the following:

“SEC. 520K. AWARDS FOR CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

“(a) DEFINITIONS.—In this section:

“(1) ELIGIBLE ENTITY.—The term ‘eligible entity’ means a qualified community mental health program defined under section 1913(b)(1).

“(2) SPECIAL POPULATIONS.—The term ‘special populations’ means adults with mental illnesses who have co-occurring primary care conditions and chronic diseases.

“(b) PROGRAM AUTHORIZED.—The Secretary, acting through the Administrator shall award grants and cooperative agreements to eligible entities to establish demonstration projects for the provision of coordinated and integrated services to special populations through the collocation of primary and specialty care services in community-based mental and behavioral health settings.

“(c) APPLICATION.—To be eligible to receive a grant or cooperative agreement under this section, an eligible entity shall submit an application to the Administrator at such time, in such manner, and accompanied by such information as the Administrator may require, including a description of partnerships, or other arrangements with local primary care providers, including community health centers, to provide services to special populations.

“(d) USE OF FUNDS.—

“(1) IN GENERAL.—For the benefit of special populations, an eligible entity shall use funds awarded under this section for—

“(A) the provision, by qualified primary care professionals, of on site primary care services;

“(B) reasonable costs associated with medically necessary referrals to qualified specialty care professionals, other coordinators of care or, if permitted by the terms of the grant or cooperative agreement, by qualified specialty care professionals on a reasonable cost basis on site at the eligible entity;

“(C) information technology required to accommodate the clinical needs of primary and specialty care professionals; or

“(D) facility modifications needed to bring primary and specialty care professionals on site at the eligible entity.

“(2) LIMITATION.—Not to exceed 15 percent of grant or cooperative agreement funds may be used for activities described in subparagraphs (C) and (D) of paragraph (1).

“(e) EVALUATION.—Not later than 90 days after a grant or cooperative agreement awarded under this section expires, an eligible entity shall submit to the Secretary the results of an

evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under the grant or agreement.

“(f) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section, \$50,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2014.”

SEC. 5605. KEY NATIONAL INDICATORS.

(a) **DEFINITIONS.**—In this section:

(1) **ACADEMY.**—The term “Academy” means the National Academy of Sciences.

(2) **COMMISSION.**—The term “Commission” means the Commission on Key National Indicators established under subsection (b).

(3) **INSTITUTE.**—The term “Institute” means a Key National Indicators Institute as designated under subsection (c)(3).

(b) **COMMISSION ON KEY NATIONAL INDICATORS.**—

(1) **ESTABLISHMENT.**—There is established a “Commission on Key National Indicators”.

(2) **MEMBERSHIP.**—

(A) **NUMBER AND APPOINTMENT.**—The Commission shall be composed of 8 members, to be appointed equally by the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives.

(B) **PROHIBITED APPOINTMENTS.**—Members of the Commission shall not include Members of Congress or other elected Federal, State, or local government officials.

(C) **QUALIFICATIONS.**—In making appointments under subparagraph (A), the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives shall appoint individuals who have shown a dedication to improving civic dialogue and decision-making through the wide use of scientific evidence and factual information.

(D) **PERIOD OF APPOINTMENT.**—Each member of the Commission shall be appointed for a 2-year term, except that 1 initial appointment shall be for 3 years. Any vacancies shall not affect the power and duties of the Commission but shall be filled in the same manner as the original appointment and shall last only for the remainder of that term.

(E) **DATE.**—Members of the Commission shall be appointed by not later than 30 days after the date of enactment of this Act.

(F) **INITIAL ORGANIZING PERIOD.**—Not later than 60 days after the date of enactment of this Act, the Commission shall develop and implement a schedule for completion of the review and reports required under subsection (d).

(G) **CO-CHAIRPERSONS.**—The Commission shall select 2 Co-Chairpersons from among its members.

(c) **DUTIES OF THE COMMISSION.**—

(1) **IN GENERAL.**—The Commission shall—

(A) conduct comprehensive oversight of a newly established key national indicators system consistent with the purpose described in this subsection;

(B) make recommendations on how to improve the key national indicators system;

(C) coordinate with Federal Government users and information providers to assure access to relevant and quality data; and

(D) enter into contracts with the Academy.

(2) **REPORTS.**—

(A) **ANNUAL REPORT TO CONGRESS.**—Not later than 1 year after the selection of the 2 Co-Chairpersons of the Commission, and each subsequent year thereafter, the Commission shall prepare and submit to the appropriate Committees of Congress and the President a report that contains a detailed statement of the recommendations, findings, and conclusions of the Commission on the activities of the Academy and a designated Institute related to the establishment of a Key National Indicator System.

(B) **ANNUAL REPORT TO THE ACADEMY.**—

(i) **IN GENERAL.**—Not later than 6 months after the selection of the 2 Co-Chairpersons of the Commission, and each subsequent year thereafter, the Commission shall prepare and submit to the Academy and a designated Institute a report making recommendations concerning potential issue areas and key indicators to be included in the Key National Indicators.

(ii) **LIMITATION.**—The Commission shall not have the authority to direct the Academy or, if established, the Institute, to adopt, modify, or delete any key indicators.

(3) **CONTRACT WITH THE NATIONAL ACADEMY OF SCIENCES.**—

(A) **IN GENERAL.**—As soon as practicable after the selection of the 2 Co-Chairpersons of the Commission, the Co-Chairpersons shall enter into an arrangement with the National Academy of Sciences under which the Academy shall—

(i) review available public and private sector research on the selection of a set of key national indicators;

(ii) determine how best to establish a key national indicator system for the United States, by either creating its own institutional capability or designating an independent private nonprofit organization as an Institute to implement a key national indicator system;

(iii) if the Academy designates an independent Institute under clause (ii), provide scientific and technical advice to the Institute and create an appropriate governance mechanism that balances Academy involvement and the independence of the Institute; and

(iv) provide an annual report to the Commission addressing scientific and technical issues related to the key national indicator system and, if established, the Institute, and governance of the Institute's budget and operations.

(B) **PARTICIPATION.**—In executing the arrangement under subparagraph (A), the National Academy of Sciences shall convene a multi-sector, multi-disciplinary process to define major scientific and technical issues associated with developing, maintaining, and evolving a Key National Indicator System and, if an Institute is established, to provide it with scientific and technical advice.

(C) **ESTABLISHMENT OF A KEY NATIONAL INDICATOR SYSTEM.**—

(i) **IN GENERAL.**—In executing the arrangement under subparagraph (A), the National Academy of Sciences shall enable the establishment of a key national indicator system by—

(I) creating its own institutional capability; or

(II) partnering with an independent private nonprofit organization as an Institute to implement a key national indicator system.

(ii) **INSTITUTE.**—If the Academy designates an Institute under clause (i)(II), such Institute shall be a non-profit entity (as defined for purposes of section 501(c)(3) of the Internal Revenue Code of 1986) with an educational mission, a governance structure that emphasizes independence, and characteristics that make such entity appropriate for establishing a key national indicator system.

(iii) **RESPONSIBILITIES.**—Either the Academy or the Institute designated under clause (i)(II) shall be responsible for the following:

(I) Identifying and selecting issue areas to be represented by the key national indicators.

(II) Identifying and selecting the measures used for key national indicators within the issue areas under subclause (I).

(III) Identifying and selecting data to populate the key national indicators described under subclause (II).

(IV) Designing, publishing, and maintaining a public website that contains a freely accessible database allowing public access to the key national indicators.

(V) Developing a quality assurance framework to ensure rigorous and independent processes and the selection of quality data.

(VI) Developing a budget for the construction and management of a sustainable, adaptable, and evolving key national indicator system that reflects all Commission funding of Academy and, if an Institute is established, Institute activities.

(VII) Reporting annually to the Commission regarding its selection of issue areas, key indicators, data, and progress toward establishing a web-accessible database.

(VIII) Responding directly to the Commission in response to any Commission recommendations and to the Academy regarding any inquiries by the Academy.

(iv) **GOVERNANCE.**—Upon the establishment of a key national indicator system, the Academy shall create an appropriate governance mechanism that incorporates advisory and control functions. If an Institute is designated under clause (i)(II), the governance mechanism shall balance appropriate Academy involvement and the independence of the Institute.

(v) **MODIFICATION AND CHANGES.**—The Academy shall retain the sole discretion, at any time, to alter its approach to the establishment of a key national indicator system or, if an Institute is designated under clause (i)(II), to alter any aspect of its relationship with the Institute or to designate a different non-profit entity to serve as the Institute.

(vi) **CONSTRUCTION.**—Nothing in this section shall be construed to limit the ability of the Academy or the Institute designated under clause (i)(II) to receive private funding for activities related to the establishment of a key national indicator system.

(D) **ANNUAL REPORT.**—As part of the arrangement under subparagraph (A), the National Academy of Sciences shall, not later than 270 days after the date of enactment of this Act, and annually thereafter, submit to the Co-Chairpersons of the Commission a report that contains the findings and recommendations of the Academy.

(d) **GOVERNMENT ACCOUNTABILITY OFFICE STUDY AND REPORT.**—

(1) **GAO STUDY.**—The Comptroller General of the United States shall conduct a study of previous work conducted by all public agencies, private organizations, or foreign countries with respect to best practices for a key national indicator system. The study shall be submitted to the appropriate authorizing committees of Congress.

(2) **GAO FINANCIAL AUDIT.**—If an Institute is established under this section, the Comptroller General shall conduct an annual audit of the financial statements of the Institute, in accordance with generally accepted government auditing standards and submit a report on such audit to the Commission and the appropriate authorizing committees of Congress.

(3) **GAO PROGRAMMATIC REVIEW.**—The Comptroller General of the United States shall conduct programmatic assessments of the Institute established under this section as determined necessary by the Comptroller General and report the findings to the Commission and to the appropriate authorizing committees of Congress.

(e) **AUTHORIZATION OF APPROPRIATIONS.**—

(1) **IN GENERAL.**—There are authorized to be appropriated to carry out the purposes of this section, \$10,000,000 for fiscal year 2010, and \$7,500,000 for each of fiscal year 2011 through 2018.

(2) **AVAILABILITY.**—Amounts appropriated under paragraph (1) shall remain available until expended.

Subtitle H—General Provisions

SEC. 5701. REPORTS.

(a) **REPORTS BY SECRETARY OF HEALTH AND HUMAN SERVICES.**—On an annual basis, the Secretary of Health and Human Services shall submit to the appropriate Committees of Congress a

report on the activities carried out under the amendments made by this title, and the effectiveness of such activities.

(b) **REPORTS BY RECIPIENTS OF FUNDS.**—The Secretary of Health and Human Services may require, as a condition of receiving funds under the amendments made by this title, that the entity receiving such award submit to such Secretary such reports as the such Secretary may require on activities carried out with such award, and the effectiveness of such activities.

TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY

Subtitle A—Physician Ownership and Other Transparency

SEC. 6001. LIMITATION ON MEDICARE EXCEPTION TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.

(a) **IN GENERAL.**—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended—

(1) in subsection (d)(2)—

(A) in subparagraph (A), by striking “and” at the end;

(B) in subparagraph (B), by striking the period at the end and inserting “; and”; and

(C) by adding at the end the following new subparagraph:

“(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).”;

(2) in subsection (d)(3)—

(A) in subparagraph (B), by striking “and” at the end;

(B) in subparagraph (C), by striking the period at the end and inserting “; and”; and

(C) by adding at the end the following new subparagraph:

“(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after the date of the enactment of this subparagraph.”; and

(3) by adding at the end the following new subsection:

“(i) **REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL EXCEPTION TO OWNERSHIP OR INVESTMENT PROHIBITION.**—

“(1) **REQUIREMENTS DESCRIBED.**—For purposes of subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

“(A) **PROVIDER AGREEMENT.**—The hospital had—

“(i) physician ownership or investment on February 1, 2010; and

“(ii) a provider agreement under section 1866 in effect on such date.

“(B) **LIMITATION ON EXPANSION OF FACILITY CAPACITY.**—Except as provided in paragraph (3), the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after the date of the enactment of this subsection is no greater than the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of such date.

“(C) **PREVENTING CONFLICTS OF INTEREST.**—

“(i) The hospital submits to the Secretary an annual report containing a detailed description of—

“(I) the identity of each physician owner or investor and any other owners or investors of the hospital; and

“(II) the nature and extent of all ownership and investment interests in the hospital.

“(ii) The hospital has procedures in place to require that any referring physician owner or investor discloses to the patient being referred, by a time that permits the patient to make a meaningful decision regarding the receipt of care, as determined by the Secretary—

“(I) the ownership or investment interest, as applicable, of such referring physician in the hospital; and

“(II) if applicable, any such ownership or investment interest of the treating physician.

“(iii) The hospital does not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

“(iv) The hospital discloses the fact that the hospital is partially owned or invested in by physicians—

“(I) on any public website for the hospital; and

“(II) in any public advertising for the hospital.

“(D) **ENSURING BONA FIDE INVESTMENT.**—

“(i) The percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of the date of enactment of this subsection.

“(ii) Any ownership or investment interests that the hospital offers to a physician owner or investor are not offered on more favorable terms than the terms offered to a person who is not a physician owner or investor.

“(iii) The hospital (or any owner or investor in the hospital) does not directly or indirectly provide loans or financing for any investment in the hospital by a physician owner or investor.

“(iv) The hospital (or any owner or investor in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital.

“(v) Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

“(vi) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

“(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner or investor.

“(E) **PATIENT SAFETY.**—

“(i) Insofar as the hospital admits a patient and does not have any physician available on the premises to provide services during all hours in which the hospital is providing services to such patient, before admitting the patient—

“(I) the hospital discloses such fact to a patient; and

“(II) following such disclosure, the hospital receives from the patient a signed acknowledgment that the patient understands such fact.

“(ii) The hospital has the capacity to—

“(I) provide assessment and initial treatment for patients; and

“(II) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

“(F) **LIMITATION ON APPLICATION TO CERTAIN CONVERTED FACILITIES.**—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

“(2) **PUBLICATION OF INFORMATION REPORTED.**—The Secretary shall publish, and update on an annual basis, the information sub-

mitted by hospitals under paragraph (1)(C)(i) on the public Internet website of the Centers for Medicare & Medicaid Services.

“(3) **EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.**—

“(A) **PROCESS.**—

“(i) **ESTABLISHMENT.**—The Secretary shall establish and implement a process under which an applicable hospital (as defined in subparagraph (E)) may apply for an exception from the requirement under paragraph (1)(B).

“(ii) **OPPORTUNITY FOR COMMUNITY INPUT.**—The process under clause (i) shall provide individuals and entities in the community in which the applicable hospital applying for an exception is located with the opportunity to provide input with respect to the application.

“(iii) **TIMING FOR IMPLEMENTATION.**—The Secretary shall implement the process under clause (i) on August 1, 2011.

“(iv) **REGULATIONS.**—Not later than July 1, 2011, the Secretary shall promulgate regulations to carry out the process under clause (i).

“(B) **FREQUENCY.**—The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

“(C) **PERMITTED INCREASE.**—

“(i) **IN GENERAL.**—Subject to clause (ii) and subparagraph (D), an applicable hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed above the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital (or, if the applicable hospital has been granted a previous exception under this paragraph, above the number of operating rooms, procedure rooms, and beds for which the hospital is licensed after the application of the most recent increase under such an exception).

“(ii) **100 PERCENT INCREASE LIMITATION.**—The Secretary shall not permit an increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed exceeding 200 percent of the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital.

“(iii) **BASILINE NUMBER OF OPERATING ROOMS, PROCEDURE ROOMS, AND BEDS.**—In this paragraph, the term ‘baseline number of operating rooms, procedure rooms, and beds’ means the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed as of the date of enactment of this subsection.

“(D) **INCREASE LIMITED TO FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.**—Any increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed pursuant to this paragraph may only occur in facilities on the main campus of the applicable hospital.

“(E) **APPLICABLE HOSPITAL.**—In this paragraph, the term ‘applicable hospital’ means a hospital—

“(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period (as of the date of the application under subparagraph (A)) is at least 150 percent of the percentage increase in the population growth of the State in which the hospital is located during that period, as estimated by Bureau of the Census;

“(ii) whose annual percent of total inpatient admissions that represent inpatient admissions under the program under title XIX is equal to or greater than the average percent with respect to such admissions for all hospitals located in the county in which the hospital is located;

“(iii) that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries;

“(iv) that is located in a State in which the average bed capacity in the State is less than the national average bed capacity; and

“(v) that has an average bed occupancy rate that is greater than the average bed occupancy rate in the State in which the hospital is located.

“(F) **PROCEDURE ROOMS.**—In this subsection, the term ‘procedure rooms’ includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

“(G) **PUBLICATION OF FINAL DECISIONS.**—Not later than 60 days after receiving a complete application under this paragraph, the Secretary shall publish in the Federal Register the final decision with respect to such application.

“(H) **LIMITATION ON REVIEW.**—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the process under this paragraph (including the establishment of such process).

“(4) **COLLECTION OF OWNERSHIP AND INVESTMENT INFORMATION.**—For purposes of subparagraphs (A)(i) and (D)(i) of paragraph (1), the Secretary shall collect physician ownership and investment information for each hospital.

“(5) **PHYSICIAN OWNER OR INVESTOR DEFINED.**—For purposes of this subsection, the term ‘physician owner or investor’ means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.

“(6) **CLARIFICATION.**—Nothing in this subsection shall be construed as preventing the Secretary from revoking a hospital’s provider agreement if not in compliance with regulations implementing section 1866.”

(b) **ENFORCEMENT.**—

(1) **ENSURING COMPLIANCE.**—The Secretary of Health and Human Services shall establish policies and procedures to ensure compliance with the requirements described in subsection (i)(1) of section 1877 of the Social Security Act, as added by subsection (a)(3), beginning on the date such requirements first apply. Such policies and procedures may include unannounced site reviews of hospitals.

(2) **AUDITS.**—Beginning not later than November 1, 2011, the Secretary of Health and Human Services shall conduct audits to determine if hospitals violate the requirements referred to in paragraph (1).

SEC. 6002. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

“SEC. 1128G. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

“(a) **TRANSPARENCY REPORTS.**—

“(1) **PAYMENTS OR OTHER TRANSFERS OF VALUE.**—

“(A) **IN GENERAL.**—On March 31, 2013, and on the first day of each calendar year beginning thereafter, any applicable manufacturer that provides a payment or other transfer of value to a covered recipient (or to an entity or individual at the request of or designated on behalf of a covered recipient), shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:

“(i) The name of the covered recipient.

“(ii) The business address of the covered recipient and, in the case of a covered recipient who is a physician, the specialty and National Provider Identifier of the covered recipient.

“(iii) The amount of the payment or other transfer of value.

“(iv) The dates on which the payment or other transfer of value was provided to the covered recipient.

“(v) A description of the form of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

“(I) cash or a cash equivalent;

“(II) in-kind items or services;

“(III) stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment; or

“(IV) any other form of payment or other transfer of value (as defined by the Secretary).

“(vi) A description of the nature of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

“(I) consulting fees;

“(II) compensation for services other than consulting;

“(III) honoraria;

“(IV) gift;

“(V) entertainment;

“(VI) food;

“(VII) travel (including the specified destinations);

“(VIII) education;

“(IX) research;

“(X) charitable contribution;

“(XI) royalty or license;

“(XII) current or prospective ownership or investment interest;

“(XIII) direct compensation for serving as faculty or as a speaker for a medical education program;

“(XIV) grant; or

“(XV) any other nature of the payment or other transfer of value (as defined by the Secretary).

“(vii) If the payment or other transfer of value is related to marketing, education, or research specific to a covered drug, device, biological, or medical supply, the name of that covered drug, device, biological, or medical supply.

“(viii) Any other categories of information regarding the payment or other transfer of value the Secretary determines appropriate.

“(B) **SPECIAL RULE FOR CERTAIN PAYMENTS OR OTHER TRANSFERS OF VALUE.**—In the case where an applicable manufacturer provides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the applicable manufacturer shall disclose that payment or other transfer of value under the name of the covered recipient.

“(2) **PHYSICIAN OWNERSHIP.**—In addition to the requirement under paragraph (1)(A), on March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer or applicable group purchasing organization shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information regarding any ownership or investment interest (other than an ownership or investment interest in a publicly traded security and mutual fund, as described in section 1877(c)) held by a physician (or an immediate family member of such physician (as defined for purposes of section 1877(a))) in the applicable manufacturer or applicable group purchasing organization during the preceding year:

“(A) The dollar amount invested by each physician holding such an ownership or investment interest.

“(B) The value and terms of each such ownership or investment interest.

“(C) Any payment or other transfer of value provided to a physician holding such an owner-

ship or investment interest (or to an entity or individual at the request of or designated on behalf of a physician holding such an ownership or investment interest), including the information described in clauses (i) through (viii) of paragraph (1)(A), except that in applying such clauses, ‘physician’ shall be substituted for ‘covered recipient’ each place it appears.

“(D) Any other information regarding the ownership or investment interest the Secretary determines appropriate.

“(b) **PENALTIES FOR NONCOMPLIANCE.**—

“(1) **FAILURE TO REPORT.**—

“(A) **IN GENERAL.**—Subject to subparagraph (B) except as provided in paragraph (2), any applicable manufacturer or applicable group purchasing organization that fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than \$1,000, but not more than \$10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

“(B) **LIMITATION.**—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed \$150,000.

“(2) **KNOWING FAILURE TO REPORT.**—

“(A) **IN GENERAL.**—Subject to subparagraph (B), any applicable manufacturer or applicable group purchasing organization that knowingly fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than \$10,000, but not more than \$100,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

“(B) **LIMITATION.**—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed \$1,000,000.

“(3) **USE OF FUNDS.**—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

“(c) **PROCEDURES FOR SUBMISSION OF INFORMATION AND PUBLIC AVAILABILITY.**—

“(1) **IN GENERAL.**—

“(A) **ESTABLISHMENT.**—Not later than October 1, 2011, the Secretary shall establish procedures—

“(i) for applicable manufacturers and applicable group purchasing organizations to submit information to the Secretary under subsection (a); and

“(ii) for the Secretary to make such information submitted available to the public.

“(B) **DEFINITION OF TERMS.**—The procedures established under subparagraph (A) shall provide for the definition of terms (other than those terms defined in subsection (e)), as appropriate, for purposes of this section.

“(C) **PUBLIC AVAILABILITY.**—Except as provided in subparagraph (E), the procedures established under subparagraph (A)(ii) shall ensure that, not later than September 30, 2013, and on June 30 of each calendar year beginning

thereafter, the information submitted under subsection (a) with respect to the preceding calendar year is made available through an Internet website that—

“(i) is searchable and is in a format that is clear and understandable;

“(ii) contains information that is presented by the name of the applicable manufacturer or applicable group purchasing organization, the name of the covered recipient, the business address of the covered recipient, the specialty of the covered recipient, the value of the payment or other transfer of value, the date on which the payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(v), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(vi), and the name of the covered drug, device, biological, or medical supply, as applicable;

“(iii) contains information that is able to be easily aggregated and downloaded;

“(iv) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year;

“(v) contains background information on industry-physician relationships;

“(vi) in the case of information submitted with respect to a payment or other transfer of value described in subparagraph (E)(i), lists such information separately from the other information submitted under subsection (a) and designates such separately listed information as funding for clinical research;

“(vii) contains any other information the Secretary determines would be helpful to the average consumer;

“(viii) does not contain the National Provider Identifier of the covered recipient, and

“(ix) subject to subparagraph (D), provides the applicable manufacturer, applicable group purchasing organization, or covered recipient an opportunity to review and submit corrections to the information submitted with respect to the applicable manufacturer, applicable group purchasing organization, or covered recipient, respectively, for a period of not less than 45 days prior to such information being made available to the public.

“(D) CLARIFICATION OF TIME PERIOD FOR REVIEW AND CORRECTIONS.—In no case may the 45-day period for review and submission of corrections to information under subparagraph (C)(ix) prevent such information from being made available to the public in accordance with the dates described in the matter preceding clause (i) in subparagraph (C).

“(E) DELAYED PUBLICATION FOR PAYMENTS MADE PURSUANT TO PRODUCT RESEARCH OR DEVELOPMENT AGREEMENTS AND CLINICAL INVESTIGATIONS.—

“(i) IN GENERAL.—In the case of information submitted under subsection (a) with respect to a payment or other transfer of value made to a covered recipient by an applicable manufacturer pursuant to a product research or development agreement for services furnished in connection with research on a potential new medical technology or a new application of an existing medical technology or the development of a new drug, device, biological, or medical supply, or by an applicable manufacturer in connection with a clinical investigation regarding a new drug, device, biological, or medical supply, the procedures established under subparagraph (A)(ii) shall provide that such information is made available to the public on the first date described in the matter preceding clause (i) in subparagraph (C) after the earlier of the following:

“(I) The date of the approval or clearance of the covered drug, device, biological, or medical supply by the Food and Drug Administration.

“(II) Four calendar years after the date such payment or other transfer of value was made.

“(ii) CONFIDENTIALITY OF INFORMATION PRIOR TO PUBLICATION.—Information described in clause (i) shall be considered confidential and shall not be subject to disclosure under section 552 of title 5, United States Code, or any other similar Federal, State, or local law, until on or after the date on which the information is made available to the public under such clause.

“(2) CONSULTATION.—In establishing the procedures under paragraph (1), the Secretary shall consult with the Inspector General of the Department of Health and Human Services, affected industry, consumers, consumer advocates, and other interested parties in order to ensure that the information made available to the public under such paragraph is presented in the appropriate overall context.

“(d) ANNUAL REPORTS AND RELATION TO STATE LAWS.—

“(1) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2013, the Secretary shall submit to Congress a report that includes the following:

“(A) The information submitted under subsection (a) during the preceding year, aggregated for each applicable manufacturer and applicable group purchasing organization that submitted such information during such year (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to Congress after the date on which such information is made available to the public under such subsection).

“(B) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year.

“(2) ANNUAL REPORTS TO STATES.—Not later than September 30, 2013 and on June 30 of each calendar year thereafter, the Secretary shall submit to States a report that includes a summary of the information submitted under subsection (a) during the preceding year with respect to covered recipients in the State (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to States after the date on which such information is made available to the public under such subsection).

“(3) RELATION TO STATE LAWS.—

“(A) IN GENERAL.—In the case of a payment or other transfer of value provided by an applicable manufacturer that is received by a covered recipient (as defined in subsection (e)) on or after January 1, 2012, subject to subparagraph (B), the provisions of this section shall preempt any statute or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer (as so defined) to disclose or report, in any format, the type of information (as described in subsection (a)) regarding such payment or other transfer of value.

“(B) NO PREEMPTION OF ADDITIONAL REQUIREMENTS.—Subparagraph (A) shall not preempt any statute or regulation of a State or of a political subdivision of a State that requires the disclosure or reporting of information—

“(i) not of the type required to be disclosed or reported under this section;

“(ii) described in subsection (e)(10)(B), except in the case of information described in clause (i) of such subsection;

“(iii) by any person or entity other than an applicable manufacturer (as so defined) or a covered recipient (as defined in subsection (e)); or

“(iv) to a Federal, State, or local governmental agency for public health surveillance,

investigation, or other public health purposes or health oversight purposes.

“(C) Nothing in subparagraph (A) shall be construed to limit the discovery or admissibility of information described in such subparagraph in a criminal, civil, or administrative proceeding.

“(4) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services on the implementation of this section.

“(e) DEFINITIONS.—In this section:

“(1) APPLICABLE GROUP PURCHASING ORGANIZATION.—The term ‘applicable group purchasing organization’ means a group purchasing organization (as defined by the Secretary) that purchases, arranges for, or negotiates the purchase of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

“(2) APPLICABLE MANUFACTURER.—The term ‘applicable manufacturer’ means a manufacturer of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

“(3) CLINICAL INVESTIGATION.—The term ‘clinical investigation’ means any experiment involving 1 or more human subjects, or materials derived from human subjects, in which a drug or device is administered, dispensed, or used.

“(4) COVERED DEVICE.—The term ‘covered device’ means any device for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

“(5) COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term ‘covered drug, device, biological, or medical supply’ means any drug, biological product, device, or medical supply for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

“(6) COVERED RECIPIENT.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the term ‘covered recipient’ means the following:

“(i) A physician.

“(ii) A teaching hospital.

“(B) EXCLUSION.—Such term does not include a physician who is an employee of the applicable manufacturer that is required to submit information under subsection (a).

“(7) EMPLOYEE.—The term ‘employee’ has the meaning given such term in section 1877(h)(2).

“(8) KNOWINGLY.—The term ‘knowingly’ has the meaning given such term in section 3729(b) of title 31, United States Code.

“(9) MANUFACTURER OF A COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term ‘manufacturer of a covered drug, device, biological, or medical supply’ means any entity which is engaged in the production, preparation, propagation, compounding, or conversion of a covered drug, device, biological, or medical supply (or any entity under common ownership with such entity which provides assistance or support to such entity with respect to the production, preparation, propagation, compounding, conversion, marketing, promotion, sale, or distribution of a covered drug, device, biological, or medical supply).

“(10) PAYMENT OR OTHER TRANSFER OF VALUE.—

“(A) IN GENERAL.—The term ‘payment or other transfer of value’ means a transfer of anything of value. Such term does not include a transfer of anything of value that is made indirectly to a covered recipient through a third party in connection with an activity or service in the case where the applicable manufacturer is unaware of the identity of the covered recipient.

“(B) EXCLUSIONS.—An applicable manufacturer shall not be required to submit information

under subsection (a) with respect to the following:

“(i) A transfer of anything the value of which is less than \$10, unless the aggregate amount transferred to, requested by, or designated on behalf of the covered recipient by the applicable manufacturer during the calendar year exceeds \$100. For calendar years after 2012, the dollar amounts specified in the preceding sentence shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) for the 12-month period ending with June of the previous year.

“(ii) Product samples that are not intended to be sold and are intended for patient use.

“(iii) Educational materials that directly benefit patients or are intended for patient use.

“(iv) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

“(v) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

“(vi) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

“(vii) Discounts (including rebates).

“(viii) In-kind items used for the provision of charity care.

“(ix) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

“(x) In the case of an applicable manufacturer who offers a self-insured plan, payments for the provision of health care to employees under the plan.

“(xi) In the case of a covered recipient who is a licensed non-medical professional, a transfer of anything of value to the covered recipient if the transfer is payment solely for the non-medical professional services of such licensed non-medical professional.

“(xii) In the case of a covered recipient who is a physician, a transfer of anything of value to the covered recipient if the transfer is payment solely for the services of the covered recipient with respect to a civil or criminal action or an administrative proceeding.

“(11) PHYSICIAN.—The term ‘physician’ has the meaning given that term in section 1861(r).”

SEC. 6003. DISCLOSURE REQUIREMENTS FOR IN-OFFICE ANCILLARY SERVICES EXCEPTION TO THE PROHIBITION ON PHYSICIAN SELF-REFERRAL FOR CERTAIN IMAGING SERVICES.

(a) IN GENERAL.—Section 1877(b)(2) of the Social Security Act (42 U.S.C. 1395nn(b)(2)) is amended by adding at the end the following new sentence: “Such requirements shall, with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services specified under subsection (h)(6)(D) that the Secretary determines appropriate, include a requirement that the referring physician inform the individual in writing at the time of the referral that the individual may obtain the services for which the individual is being referred from a person other than a person described in subparagraph (A)(i) and provide such individual with a written list of suppliers (as defined in section 1861(d)) who furnish such services in the area in which such individual resides.”

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after January 1, 2010.

SEC. 6004. PRESCRIPTION DRUG SAMPLE TRANSPARENCY.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section

6002, is amended by inserting after section 1128G the following new section:

“SEC. 1128H. REPORTING OF INFORMATION RELATING TO DRUG SAMPLES.

“(a) IN GENERAL.—Not later than April 1 of each year (beginning with 2012), each manufacturer and authorized distributor of record of an applicable drug shall submit to the Secretary (in a form and manner specified by the Secretary) the following information with respect to the preceding year:

“(1) In the case of a manufacturer or authorized distributor of record which makes distributions by mail or common carrier under subsection (d)(2) of section 503 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353), the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

“(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

“(B) any other category of information determined appropriate by the Secretary.

“(2) In the case of a manufacturer or authorized distributor of record which makes distributions by means other than mail or common carrier under subsection (d)(3) of such section 503, the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

“(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

“(B) any other category of information determined appropriate by the Secretary.

“(b) DEFINITIONS.—In this section:

“(1) APPLICABLE DRUG.—The term ‘applicable drug’ means a drug—

“(A) which is subject to subsection (b) of such section 503; and

“(B) for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

“(2) AUTHORIZED DISTRIBUTOR OF RECORD.—The term ‘authorized distributor of record’ has the meaning given that term in subsection (e)(3)(A) of such section.

“(3) MANUFACTURER.—The term ‘manufacturer’ has the meaning given that term for purposes of subsection (d) of such section.”

SEC. 6005. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1150 the following new section:

“SEC. 1150A. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

“(a) PROVISION OF INFORMATION.—A health benefits plan or any entity that provides pharmacy benefits management services on behalf of a health benefits plan (in this section referred to as a ‘PBM’) that manages prescription drug coverage under a contract with—

“(1) a PDP sponsor of a prescription drug plan or an MA organization offering an MA-PD plan under part D of title XVIII; or

“(2) a qualified health benefits plan offered through an exchange established by a State under section 1311 of the Patient Protection and Affordable Care Act,

shall provide the information described in subsection (b) to the Secretary and, in the case of a PBM, to the plan with which the PBM is under contract with, at such times, and in such form and manner, as the Secretary shall specify.

“(b) INFORMATION DESCRIBED.—The information described in this subsection is the following with respect to services provided by a health benefits plan or PBM for a contract year:

“(1) The percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed (generic dispensing rate), by pharmacy type (which includes an independent pharmacy, chain pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medication to the general public), that is paid by the health benefits plan or PBM under the contract.

“(2) The aggregate amount, and the type of rebates, discounts, or price concessions (excluding bona fide service fees, which include but are not limited to distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs)) that the PBM negotiates that are attributable to patient utilization under the plan, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions that were dispensed.

“(3) The aggregate amount of the difference between the amount the health benefits plan pays the PBM and the amount that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.

“(c) CONFIDENTIALITY.—Information disclosed by a health benefits plan or PBM under this section is confidential and shall not be disclosed by the Secretary or by a plan receiving the information, except that the Secretary may disclose the information in a form which does not disclose the identity of a specific PBM, plan, or prices charged for drugs, for the following purposes:

“(1) As the Secretary determines to be necessary to carry out this section or part D of title XVIII.

“(2) To permit the Comptroller General to review the information provided.

“(3) To permit the Director of the Congressional Budget Office to review the information provided.

“(4) To States to carry out section 1311 of the Patient Protection and Affordable Care Act.

“(d) PENALTIES.—The provisions of subsection (b)(3)(C) of section 1927 shall apply to a health benefits plan or PBM that fails to provide information required under subsection (a) on a timely basis or that knowingly provides false information in the same manner as such provisions apply to a manufacturer with an agreement under that section.”

Subtitle B—Nursing Home Transparency and Improvement

PART I—IMPROVING TRANSPARENCY OF INFORMATION

SEC. 6101. REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSEABLE PARTIES INFORMATION.

(a) IN GENERAL.—Section 1124 of the Social Security Act (42 U.S.C. 1320a-3) is amended by adding at the end the following new subsection:

“(c) REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSEABLE PARTIES INFORMATION.—

“(1) DISCLOSURE.—A facility shall have the information described in paragraph (2) available—

“(A) during the period beginning on the date of the enactment of this subsection and ending on the date such information is made available

to the public under section 6101(b) of the Patient Protection and Affordable Care Act for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

“(B) beginning on the effective date of the final regulations promulgated under paragraph (3)(A), for reporting such information in accordance with such final regulations.

Nothing in subparagraph (A) shall be construed as authorizing a facility to dispose of or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (3)(A).

“(2) INFORMATION DESCRIBED.—

“(A) IN GENERAL.—The following information is described in this paragraph:

“(i) The information described in subsections (a) and (b), subject to subparagraph (C).

“(ii) The identity of and information on—

“(I) each member of the governing body of the facility, including the name, title, and period of service of each such member;

“(II) each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity; and

“(III) each person or entity who is an additional disclosable party of the facility.

“(iii) The organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

“(B) SPECIAL RULE WHERE INFORMATION IS ALREADY REPORTED OR SUBMITTED.—To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the facility may provide such Form or such information submitted to meet the requirements of paragraph (1).

“(C) SPECIAL RULE.—In applying subparagraph (A)(i)—

“(i) with respect to subsections (a) and (b), ‘ownership or control interest’ shall include direct or indirect interests, including such interests in intermediate entities; and

“(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured, in whole or in part, by the entity or any of the property or assets thereof, if the interest is equal to or exceeds 5 percent of the total property or assets of the entirety.

“(3) REPORTING.—

“(A) IN GENERAL.—Not later than the date that is 2 years after the date of the enactment of this subsection, the Secretary shall promulgate final regulations requiring, effective on the date that is 90 days after the date on which such final regulations are published in the Federal Register, a facility to report the information described in paragraph (2) to the Secretary in a standardized format, and such other regulations as are necessary to carry out this subsection. Such final regulations shall ensure that the facility certifies, as a condition of participation and payment under the program under title XVIII or XIX, that the information reported by the facility in accordance with such final regulations is, to the best of the facility’s knowledge, accurate and current.

“(B) GUIDANCE.—The Secretary shall provide guidance and technical assistance to States on

how to adopt the standardized format under subparagraph (A).

“(4) NO EFFECT ON EXISTING REPORTING REQUIREMENTS.—Nothing in this subsection shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

“(5) DEFINITIONS.—In this subsection:

“(A) ADDITIONAL DISCLOSABLE PARTY.—The term ‘additional disclosable party’ means, with respect to a facility, any person or entity who—

“(i) exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

“(ii) leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or

“(iii) provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

“(B) FACILITY.—The term ‘facility’ means a disclosing entity which is—

“(i) a skilled nursing facility (as defined in section 1819(a)); or

“(ii) a nursing facility (as defined in section 1919(a)).

“(C) MANAGING EMPLOYEE.—The term ‘managing employee’ means, with respect to a facility, an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

“(D) ORGANIZATIONAL STRUCTURE.—The term ‘organizational structure’ means, in the case of—

“(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

“(ii) a limited liability company, the members and managers of the limited liability company (including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company);

“(iii) a general partnership, the partners of the general partnership;

“(iv) a limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;

“(v) a trust, the trustees of the trust;

“(vi) an individual, contact information for the individual; and

“(vii) any other person or entity, such information as the Secretary determines appropriate.”.

(b) PUBLIC AVAILABILITY OF INFORMATION.—Not later than the date that is 1 year after the date on which the final regulations promulgated under section 1124(c)(3)(A) of the Social Security Act, as added by subsection (a), are published in the Federal Register, the Secretary of Health and Human Services shall make the information reported in accordance with such final regulations available to the public in accordance with procedures established by the Secretary.

(c) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—

(A) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(B) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on the date on which the Secretary makes the information described in subsection (b)(1) available to the public under such subsection.

SEC. 6102. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES AND NURSING FACILITIES.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by sections 6002 and 6004, is amended by inserting after section 1128H the following new section:

“SEC. 1128I. ACCOUNTABILITY REQUIREMENTS FOR FACILITIES.

“(a) DEFINITION OF FACILITY.—In this section, the term ‘facility’ means—

“(1) a skilled nursing facility (as defined in section 1819(a)); or

“(2) a nursing facility (as defined in section 1919(a)).

“(b) EFFECTIVE COMPLIANCE AND ETHICS PROGRAMS.—

“(1) REQUIREMENT.—On or after the date that is 36 months after the date of the enactment of this section, a facility shall, with respect to the entity that operates the facility (in this subparagraph referred to as the ‘operating organization’ or ‘organization’), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with regulations developed under paragraph (2).

“(2) DEVELOPMENT OF REGULATIONS.—

“(A) IN GENERAL.—Not later than the date that is 2 years after such date of the enactment, the Secretary, working jointly with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

“(B) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program shall, in the case of an organization that operates 5 or more facilities, vary with the size of the organization, such that larger organizations should have a more formal program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements may specifically apply to the corporate level management of multi unit nursing home chains.

“(C) EVALUATION.—Not later than 3 years after the date of the promulgation of regulations under this paragraph, the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under this subsection. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of patient quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

“(3) REQUIREMENTS FOR COMPLIANCE AND ETHICS PROGRAMS.—In this subsection, the term ‘compliance and ethics program’ means, with respect to a facility, a program of the operating organization that—

“(A) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

“(B) includes at least the required components specified in paragraph (4).

“(4) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an operating organization are the following:

“(A) The organization must have established compliance standards and procedures to be followed by its employees and other agents that

are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

“(B) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance.

“(C) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

“(D) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

“(E) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

“(F) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

“(G) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

“(H) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

“(c) **QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.**—

“(1) **IN GENERAL.**—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this subparagraph referred to as the ‘QAPI program’) for facilities, including multi unit chains of facilities. Under the QAPI program, the Secretary shall establish standards relating to quality assurance and performance improvement with respect to facilities and provide technical assistance to facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under paragraph (2), a facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under sections 1819(b)(1)(B) and 1919(b)(1)(B), as applicable.

“(2) **REGULATIONS.**—The Secretary shall promulgate regulations to carry out this subsection.”

SEC. 6103. NURSING HOME COMPARE MEDICARE WEBSITE.

(a) **SKILLED NURSING FACILITIES.**—

(1) **IN GENERAL.**—Section 1819 of the Social Security Act (42 U.S.C. 1395i-3) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

“(i) **NURSING HOME COMPARE WEBSITE.**—

“(1) **INCLUSION OF ADDITIONAL INFORMATION.**—

“(A) **IN GENERAL.**—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the ‘Nursing Home Compare’ Medicare website) (or a successor website), the following information in a manner that is prominent, updated on a timely basis, easily accessible, readily understandable to consumers of long-term care services, and searchable:

“(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1128I(g), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

“(I) concise explanations of how to interpret the data (such as a plain English explanation of data reflecting ‘nursing home staff hours per resident day’);

“(II) differences in types of staff (such as training associated with different categories of staff);

“(III) the relationship between nurse staffing levels and quality of care; and

“(IV) an explanation that appropriate staffing levels vary based on patient case mix.

“(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report. Any such links shall be posted on a timely basis.

“(iii) The standardized complaint form developed under section 1128I(f), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

“(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

“(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

“(I) that were committed inside the facility;

“(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual abuse, or other violations or crimes that resulted in serious bodily injury; and

“(III) the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

“(B) **DEADLINE FOR PROVISION OF INFORMATION.**—

“(i) **IN GENERAL.**—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

“(ii) **EXCEPTION.**—The Secretary shall ensure that the information described in subparagraph (A)(i) is included on such website (or a successor website) not later than the date on which the requirements under section 1128I(g) are implemented.

“(2) **REVIEW AND MODIFICATION OF WEBSITE.**—

“(A) **IN GENERAL.**—The Secretary shall establish a process—

“(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

“(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

“(B) **CONSULTATION.**—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

“(i) State long-term care ombudsman programs;

“(ii) consumer advocacy groups;

“(iii) provider stakeholder groups; and

“(iv) any other representatives of programs or groups the Secretary determines appropriate.”

(2) **TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.**—

(A) **IN GENERAL.**—Section 1819(g)(5) of the Social Security Act (42 U.S.C. 1395i-3(g)(5)) is amended by adding at the end the following new subparagraph:

“(E) **SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.**—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a skilled nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.”

(B) **EFFECTIVE DATE.**—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) **SPECIAL FOCUS FACILITY PROGRAM.**—Section 1819(f) of the Social Security Act (42 U.S.C. 1395i-3(f)) is amended by adding at the end the following new paragraph:

“(8) **SPECIAL FOCUS FACILITY PROGRAM.**—

“(A) **IN GENERAL.**—The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirements of this Act.

“(B) **PERIODIC SURVEYS.**—Under such program the Secretary shall conduct surveys of each facility in the program not less than once every 6 months.”

(b) **NURSING FACILITIES.**—

(1) **IN GENERAL.**—Section 1919 of the Social Security Act (42 U.S.C. 1396r) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

“(i) **NURSING HOME COMPARE WEBSITE.**—

“(1) **INCLUSION OF ADDITIONAL INFORMATION.**—

“(A) **IN GENERAL.**—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the ‘Nursing Home Compare’ Medicare website) (or a successor website), the following information in a manner that is prominent, updated on a timely basis, easily accessible, readily understandable to consumers of long-term care services, and searchable:

“(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on

data submitted under section 11281(g), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

“(I) concise explanations of how to interpret the data (such as plain English explanation of data reflecting ‘nursing home staff hours per resident day’);

“(II) differences in types of staff (such as training associated with different categories of staff);

“(III) the relationship between nurse staffing levels and quality of care; and

“(IV) an explanation that appropriate staffing levels vary based on patient case mix.

“(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report. Any such links shall be posted on a timely basis.

“(iii) The standardized complaint form developed under section 11281(f), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

“(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

“(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

“(I) that were committed inside of the facility; and

“(II) with respect to such instances of violations or crimes committed outside of the facility, that were violations or crimes that resulted in the serious bodily injury of an elder.

“(B) DEADLINE FOR PROVISION OF INFORMATION.—

“(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

“(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) is included on such website (or a successor website) not later than the date on which the requirements under section 11281(g) are implemented.

“(2) REVIEW AND MODIFICATION OF WEBSITE.—

“(A) IN GENERAL.—The Secretary shall establish a process—

“(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

“(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

“(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

“(i) State long-term care ombudsman programs;

“(ii) consumer advocacy groups;

“(iii) provider stakeholder groups;

“(iv) skilled nursing facility employees and their representatives; and

“(v) any other representatives of programs or groups the Secretary determines appropriate.”.

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1396r(g)(5)) is amended by adding at the end the following new subparagraph:

“(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.”.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1919(f) of the Social Security Act (42 U.S.C. 1396r(f)) is amended by adding at the end of the following new paragraph:

“(10) SPECIAL FOCUS FACILITY PROGRAM.—

“(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirements of this Act.

“(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less often than once every 6 months.”.

(C) AVAILABILITY OF REPORTS ON SURVEYS, CERTIFICATIONS, AND COMPLAINT INVESTIGATIONS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i-3(d)(1)), as amended by section 6101, is amended by adding at the end the following new subparagraph:

“(C) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A skilled nursing facility must—

“(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

“(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.”.

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by section 6101, is amended by adding at the end the following new subparagraph:

“(V) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A nursing facility must—

“(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

“(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect 1 year after the date of the enactment of this Act.

(d) GUIDANCE TO STATES ON FORM 2567 STATE INSPECTION REPORTS AND COMPLAINT INVESTIGATION REPORTS.—

(1) GUIDANCE.—The Secretary of Health and Human Services (in this subtitle referred to as the “Secretary”) shall provide guidance to States on how States can establish electronic links to Form 2567 State inspection reports (or a successor form), complaint investigation reports, and a facility’s plan of correction or other response to such Form 2567 State inspection reports (or a successor form) on the Internet website of the State that provides information on skilled nursing facilities and nursing facilities and the Secretary shall, if possible, include such information on Nursing Home Compare.

(2) REQUIREMENT.—Section 1902(a)(9) of the Social Security Act (42 U.S.C. 1396a(a)(9)) is amended—

(A) by striking “and” at the end of subparagraph (B);

(B) by striking the semicolon at the end of subparagraph (C) and inserting “, and”; and

(C) by adding at the end the following new subparagraph:

“(D) that the State maintain a consumer-oriented website providing useful information to consumers regarding all skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility’s plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of long term care options and the quality of care provided by individual facilities;”.

(3) DEFINITIONS.—In this subsection:

(A) NURSING FACILITY.—The term “nursing facility” has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(B) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(C) SKILLED NURSING FACILITY.—The term “skilled nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395i-3(a)).

(e) DEVELOPMENT OF CONSUMER RIGHTS INFORMATION PAGE ON NURSING HOME COMPARE WEBSITE.—Not later than 1 year after the date of enactment of this Act, the Secretary shall ensure that the Department of Health and Human Services, as part of the information provided for comparison of nursing facilities on the Nursing Home Compare Medicare website develops and includes a consumer rights information page that contains links to descriptions of, and information with respect to, the following:

(1) The documentation on nursing facilities that is available to the public.

(2) General information and tips on choosing a nursing facility that meets the needs of the individual.

(3) General information on consumer rights with respect to nursing facilities.

(4) The nursing facility survey process (on a national and State-specific basis).

(5) On a State-specific basis, the services available through the State long-term care ombudsman for such State.

SEC. 6104. REPORTING OF EXPENDITURES.

Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

“(f) REPORTING OF DIRECT CARE EXPENDITURES.—

“(1) IN GENERAL.—For cost reports submitted under this title for cost reporting periods beginning on or after the date that is 2 years after the date of the enactment of this subsection, skilled nursing facilities shall separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff).

“(2) **MODIFICATION OF FORM.**—The Secretary, in consultation with private sector accountants experienced with Medicare and Medicaid nursing facility home cost reports, shall redesign such reports to meet the requirement of paragraph (1) not later than 1 year after the date of the enactment of this subsection.

“(3) **CATEGORIZATION BY FUNCTIONAL ACCOUNTS.**—Not later than 30 months after the date of the enactment of this subsection, the Secretary, working in consultation with the Medicare Payment Advisory Commission, the Medicaid and CHIP Payment and Access Commission, the Inspector General of the Department of Health and Human Services, and other expert parties the Secretary determines appropriate, shall take the expenditures listed on cost reports, as modified under paragraph (1), submitted by skilled nursing facilities and categorize such expenditures, regardless of any source of payment for such expenditures, for each skilled nursing facility into the following functional accounts on an annual basis:

“(A) Spending on direct care services (including nursing, therapy, and medical services).

“(B) Spending on indirect care (including housekeeping and dietary services).

“(C) Capital assets (including building and land costs).

“(D) Administrative services costs.

“(4) **AVAILABILITY OF INFORMATION SUBMITTED.**—The Secretary shall establish procedures to make information on expenditures submitted under this subsection readily available to interested parties upon request, subject to such requirements as the Secretary may specify under the procedures established under this paragraph.”.

SEC. 6105. STANDARDIZED COMPLAINT FORM.

(a) **IN GENERAL.**—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

“(f) **STANDARDIZED COMPLAINT FORM.**—

“(1) **DEVELOPMENT BY THE SECRETARY.**—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a facility.

“(2) **COMPLAINT FORMS AND RESOLUTION PROCESSES.**—

“(A) **COMPLAINT FORMS.**—The State must make the standardized complaint form developed under paragraph (1) available upon request to—

“(i) a resident of a facility; and

“(ii) any person acting on the resident's behalf.

“(B) **COMPLAINT RESOLUTION PROCESS.**—The State must establish a complaint resolution process in order to ensure that the legal representative of a resident of a facility or other responsible party is not denied access to such resident or otherwise retaliated against if they have complained about the quality of care provided by the facility or other issues relating to the facility. Such complaint resolution process shall include—

“(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

“(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint; and

“(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation.

“(3) **RULE OF CONSTRUCTION.**—Nothing in this subsection shall be construed as preventing a resident of a facility (or a person acting on the resident's behalf) from submitting a complaint

in a manner or format other than by using the standardized complaint form developed under paragraph (1) (including submitting a complaint orally).”.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6106. ENSURING STAFFING ACCOUNTABILITY.

Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

“(g) **SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.**—Beginning not later than 2 years after the date of the enactment of this subsection, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

“(1) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

“(2) include resident census data and information on resident case mix;

“(3) include a regular reporting schedule; and

“(4) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in paragraph (1) per resident per day.

Nothing in this subsection shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subsection with respect to agency and contract staff shall be kept separate from information on employee staffing.”.

SEC. 6107. GAO STUDY AND REPORT ON FIVE-STAR QUALITY RATING SYSTEM.

(a) **STUDY.**—The Comptroller General of the United States (in this section referred to as the “Comptroller General”) shall conduct a study on the Five-Star Quality Rating System for nursing homes of the Centers for Medicare & Medicaid Services. Such study shall include an analysis of—

(1) how such system is being implemented;

(2) any problems associated with such system or its implementation; and

(3) how such system could be improved.

(b) **REPORT.**—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

PART II—TARGETING ENFORCEMENT

SEC. 6111. CIVIL MONEY PENALTIES.

(a) **SKILLED NURSING FACILITIES.**—

(1) **IN GENERAL.**—Section 1819(h)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395i-3(h)(2)(B)(ii)) is amended—

(A) by striking “PENALTIES.—The Secretary” and inserting “PENALTIES.—

“(I) **IN GENERAL.**—Subject to subclause (II), the Secretary”; and

(B) by adding at the end the following new subclauses:

“(II) **REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.**—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

“(III) **PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.**—

“(aa) **REPEAT DEFICIENCIES.**—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

“(bb) **CERTAIN OTHER DEFICIENCIES.**—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

“(IV) **COLLECTION OF CIVIL MONEY PENALTIES.**—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

“(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

“(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

“(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

“(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

“(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

“(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).”.

(2) **CONFORMING AMENDMENT.**—The second sentence of section 1819(h)(5) of the Social Security Act (42 U.S.C. 1395i-3(h)(5)) is amended by inserting “(ii)(IV),” after “(i),”.

(b) **NURSING FACILITIES.**—

(1) **IN GENERAL.**—Section 1919(h)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(3)(C)) is amended—

(A) by striking “PENALTIES.—The Secretary” and inserting “PENALTIES.—

“(I) IN GENERAL.—Subject to subclause (II), the Secretary”; and

(B) by adding at the end the following new subclauses:

“(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

“(III) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

“(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

“(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

“(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

“(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

“(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

“(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

“(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

“(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

“(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).”

(2) CONFORMING AMENDMENT.—Section 1919(h)(5)(8) of the Social Security Act (42 U.S.C. 1396r(h)(5)(8)) is amended by inserting “(ii)(IV),” after “(i),”.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6112. NATIONAL INDEPENDENT MONITOR DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a demonstration project to develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.

(2) SELECTION.—The Secretary shall select chains of skilled nursing facilities and nursing facilities described in paragraph (1) to participate in the demonstration project under this section from among those chains that submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(3) DURATION.—The Secretary shall conduct the demonstration project under this section for a 2-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the demonstration project under this section not later than 1 year after the date of the enactment of this Act.

(b) REQUIREMENTS.—The Secretary shall evaluate chains selected to participate in the demonstration project under this section based on criteria selected by the Secretary, including where evidence suggests that a number of the facilities of the chain are experiencing serious safety and quality of care problems. Such criteria may include the evaluation of a chain that includes a number of facilities participating in the “Special Focus Facility” program (or a successor program) or multiple facilities with a record of repeated serious safety and quality of care deficiencies.

(c) RESPONSIBILITIES.—An independent monitor that enters into a contract with the Secretary to participate in the conduct of the demonstration project under this section shall—

(1) conduct periodic reviews and prepare root-cause quality and deficiency analyses of a chain to assess if facilities of the chain are in compliance with State and Federal laws and regulations applicable to the facilities;

(2) conduct sustained oversight of the efforts of the chain, whether publicly or privately held, to achieve compliance by facilities of the chain with State and Federal laws and regulations applicable to the facilities;

(3) analyze the management structure, distribution of expenditures, and nurse staffing levels of facilities of the chain in relation to resident census, staff turnover rates, and tenure;

(4) report findings and recommendations with respect to such reviews, analyses, and oversight to the chain and facilities of the chain, to the Secretary, and to relevant States; and

(5) publish the results of such reviews, analyses, and oversight.

(d) IMPLEMENTATION OF RECOMMENDATIONS.—

(1) RECEIPT OF FINDING BY CHAIN.—Not later than 10 days after receipt of a finding of an independent monitor under subsection (c)(4), a chain participating in the demonstration project shall submit to the independent monitor a report—

(A) outlining corrective actions the chain will take to implement the recommendations in such report; or

(B) indicating that the chain will not implement such recommendations, and why it will not do so.

(2) RECEIPT OF REPORT BY INDEPENDENT MONITOR.—Not later than 10 days after receipt of a report submitted by a chain under paragraph (1), an independent monitor shall finalize its recommendations and submit a report to the chain and facilities of the chain, the Secretary, and the State or States, as appropriate, containing such final recommendations.

(e) COST OF APPOINTMENT.—A chain shall be responsible for a portion of the costs associated with the appointment of independent monitors under the demonstration project under this section. The chain shall pay such portion to the Secretary (in an amount and in accordance with procedures established by the Secretary).

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may be necessary for the purpose of carrying out the demonstration project under this section.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(h) DEFINITIONS.—In this section:

(1) ADDITIONAL DISCLOSABLE PARTY.—The term “additional disclosable party” has the meaning given such term in section 1124(c)(5)(A) of the Social Security Act, as added by section 4201(a).

(2) FACILITY.—The term “facility” means a skilled nursing facility or a nursing facility.

(3) NURSING FACILITY.—The term “nursing facility” has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(4) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(5) SKILLED NURSING FACILITY.—The term “skilled nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(i) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall evaluate the demonstration project conducted under this section.

(2) REPORT.—Not later than 180 days after the completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program should be established on a permanent basis;

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

SEC. 6113. NOTIFICATION OF FACILITY CLOSURE.

(a) IN GENERAL.—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

“(h) NOTIFICATION OF FACILITY CLOSURE.—

“(1) IN GENERAL.—Any individual who is the administrator of a facility must—

“(A) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

“(i) subject to clause (ii), not later than the date that is 60 days prior to the date of such closure; and

“(ii) in the case of a facility where the Secretary terminates the facility’s participation under this title, not later than the date that the Secretary determines appropriate;

“(B) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

“(C) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to

closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

“(2) RELOCATION.—

“(A) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

“(B) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under paragraph (1) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.

“(3) SANCTIONS.—Any individual who is the administrator of a facility that fails to comply with the requirements of paragraph (1)—

“(A) shall be subject to a civil monetary penalty of up to \$100,000;

“(B) may be subject to exclusion from participation in any Federal health care program (as defined in section 1128B(f)); and

“(C) shall be subject to any other penalties that may be prescribed by law.

“(4) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under paragraph (3) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).”.

(b) CONFORMING AMENDMENTS.—Section 1819(h)(4) of the Social Security Act (42 U.S.C. 1395i–3(h)(4)) is amended—

(1) in the first sentence, by striking “the Secretary shall terminate” and inserting “the Secretary, subject to section 1128I(h), shall terminate”; and

(2) in the second sentence, by striking “subsection (c)(2)” and inserting “subsection (c)(2) and section 1128I(h)”.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6114. NATIONAL DEMONSTRATION PROJECTS ON CULTURE CHANGE AND USE OF INFORMATION TECHNOLOGY IN NURSING HOMES.

(a) IN GENERAL.—The Secretary shall conduct 2 demonstration projects, 1 for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement (including the development of resources for facilities to find and access funding in order to undertake culture change) and 1 for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care.

(b) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) GRANT AWARD.—Under each demonstration project conducted under this section, the Secretary shall award 1 or more grants to facility-based settings for the development of best practices described in subsection (a) with respect to the demonstration project involved. Such award shall be made on a competitive basis and may be allocated in 1 lump-sum payment.

(2) CONSIDERATION OF SPECIAL NEEDS OF RESIDENTS.—Each demonstration project conducted under this section shall take into consideration the special needs of residents of skilled nursing facilities and nursing facilities who have cognitive impairment, including dementia.

(c) DURATION AND IMPLEMENTATION.—

(1) DURATION.—The demonstration projects shall each be conducted for a period not to exceed 3 years.

(2) IMPLEMENTATION.—The demonstration projects shall each be implemented not later than 1 year after the date of the enactment of this Act.

(d) DEFINITIONS.—In this section:

(1) NURSING FACILITY.—The term “nursing facility” has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(2) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(3) SKILLED NURSING FACILITY.—The term “skilled nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(f) REPORT.—Not later than 9 months after the completion of the demonstration project, the Secretary shall submit to Congress a report on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART III—IMPROVING STAFF TRAINING

SEC. 6121. DEMENTIA AND ABUSE PREVENTION TRAINING.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(I)) is amended by inserting “(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training” before “(I)”.
(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1819(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F)) is amended by adding at the end the following flush sentence:

“Such term includes an individual who provides such services through an agency or under a contract with the facility.”.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1396r(f)(2)(A)(i)(I)) is amended by inserting “(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training” before “(I)”.
(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1396r(b)(5)(F)) is amended by adding at the end the following flush sentence:

“Such term includes an individual who provides such services through an agency or under a contract with the facility.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

Subtitle C—Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers

SEC. 6201. NATIONWIDE PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”), shall establish a program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the “nationwide program”). Except for the following modifications, the Sec-

retary shall carry out the nationwide program under similar terms and conditions as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2257), including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under subsection (b)(3)(A) and (b)(6), respectively, of such section 307:

(1) AGREEMENTS.—

(A) NEWLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has not entered into an agreement with under subsection (c)(1) of such section 307;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(B) CERTAIN PREVIOUSLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under such subsection (c)(1), but only in the case where such agreement did not require the State to conduct background checks under the program established under subsection (a) of such section 307 on a Statewide basis; and

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(2) NONAPPLICATION OF SELECTION CRITERIA.—The selection criteria required under subsection (c)(3)(B) of such section 307 shall not apply.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain State and national criminal history background checks on the prospective employee through such means as the Secretary determines appropriate, efficient, and effective that utilize a search of State-based abuse and neglect registries and databases, including the abuse and neglect registries of another State in the case where a prospective employee previously resided in that State, State criminal history records, the records of any proceedings in the State that may contain disqualifying information about prospective employees (such as proceedings conducted by State professional licensing and disciplinary boards and State Medicaid Fraud Control Units), and Federal criminal history records, including a fingerprint check using the Integrated Automated Fingerprint Identification System of the Federal Bureau of Investigation;

(B) require States to describe and test methods that reduce duplicative fingerprinting, including providing for the development of “rap back” capability by the State such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee’s fingerprints match the prints on file with the State law enforcement department, the department will immediately inform the State and the State will immediately inform the long-term care facility or provider which employs the direct patient access employee of such conviction; and

(C) require that criminal history background checks conducted under the nationwide program

remain valid for a period of time specified by the Secretary.

(4) **STATE REQUIREMENTS.**—An agreement entered into under paragraph (1) shall require that a participating State—

(A) be responsible for monitoring compliance with the requirements of the nationwide program;

(B) have procedures in place to—

(i) conduct screening and criminal history background checks under the nationwide program in accordance with the requirements of this section;

(ii) monitor compliance by long-term care facilities and providers with the procedures and requirements of the nationwide program;

(iii) as appropriate, provide for a provisional period of employment by a long-term care facility or provider of a direct patient access employee, not to exceed 60 days, pending completion of the required criminal history background check and, in the case where the employee has appealed the results of such background check, pending completion of the appeals process, during which the employee shall be subject to direct on-site supervision (in accordance with procedures established by the State to ensure that a long-term care facility or provider furnishes such direct on-site supervision);

(iv) provide an independent process by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check performed under the nationwide program, including the specification of criteria for appeals for direct patient access employees found to have disqualifying information which shall include consideration of the passage of time, extenuating circumstances, demonstration of rehabilitation, and relevancy of the particular disqualifying information with respect to the current employment of the individual;

(v) provide for the designation of a single State agency as responsible for—

(I) overseeing the coordination of any State and national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such records;

(II) overseeing the design of appropriate privacy and security safeguards for use in the review of the results of any State or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;

(III) immediately reporting to the long-term care facility or provider that requested the criminal history background check the results of such review; and

(IV) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1128E of the Social Security Act (42 U.S.C. 1320a-7e), reporting the existence of such conviction to the database established under that section;

(vi) determine which individuals are direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program;

(vii) as appropriate, specify offenses, including convictions for violent crimes, for purposes of the nationwide program; and

(viii) describe and test methods that reduce duplicative fingerprinting, including providing for the development of “rap back” capability such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee’s fingerprints match the prints on file with the State law enforcement department—

(I) the department will immediately inform the State agency designated under clause (v) and such agency will immediately inform the facility or provider which employs the direct patient access employee of such conviction; and

(II) the State will provide, or will require the facility to provide, to the employee a copy of the results of the criminal history background check conducted with respect to the employee at no charge in the case where the individual requests such a copy.

(5) **PAYMENTS.**—

(A) **NEWLY PARTICIPATING STATES.**—

(i) **IN GENERAL.**—As part of the application submitted by a State under paragraph (1)(A)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) **FEDERAL MATCH.**—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(A) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed \$3,000,000.

(B) **PREVIOUSLY PARTICIPATING STATES.**—

(i) **IN GENERAL.**—As part of the application submitted by a State under paragraph (1)(B)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) **FEDERAL MATCH.**—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed \$1,500,000.

(6) **DEFINITIONS.**—Under the nationwide program:

(A) **CONVICTION FOR A RELEVANT CRIME.**—The term “conviction for a relevant crime” means any Federal or State criminal conviction for—

(i) any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a-7); or

(ii) such other types of offenses as a participating State may specify for purposes of conducting the program in such State.

(B) **DISQUALIFYING INFORMATION.**—The term “disqualifying information” means a conviction for a relevant crime or a finding of patient or resident abuse.

(C) **FINDING OF PATIENT OR RESIDENT ABUSE.**—The term “finding of patient or resident abuse” means any substantiated finding by a State agency under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i-3(g)(1)(C), 1396r(g)(1)(C)) or a Federal agency that a direct patient access employee has committed—

(i) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

(ii) such other types of acts as a participating State may specify for purposes of conducting the program in such State.

(D) **DIRECT PATIENT ACCESS EMPLOYEE.**—The term “direct patient access employee” means any individual who has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider and has duties that involve (or may involve) one-on-one contact with a patient or resident of the facility or provider,

as determined by the State for purposes of the nationwide program. Such term does not include a volunteer unless the volunteer has duties that are equivalent to the duties of a direct patient access employee and those duties involve (or may involve) one-on-one contact with a patient or resident of the long-term care facility or provider.

(E) **LONG-TERM CARE FACILITY OR PROVIDER.**—The term “long-term care facility or provider” means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act:

(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i-3(a))).

(ii) A nursing facility (as defined in section 1919(a) of such Act (42 U.S.C. 1396r(a))).

(iii) A home health agency.

(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act (42 U.S.C. 1395r(dd)(1))).

(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of such Act (42 U.S.C. 1395ww(d)(1)(B)(iv))).

(vi) A provider of personal care services.

(vii) A provider of adult day care.

(viii) A residential care provider that arranges for, or directly provides, long-term care services, including an assisted living facility that provides a level of care established by the Secretary.

(ix) An intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act (42 U.S.C. 1396d(d))).

(x) Any other facility or provider of long-term care services under such titles as the participating State determines appropriate.

(7) **EVALUATION AND REPORT.**—

(A) **EVALUATION.**—

(i) **IN GENERAL.**—The Inspector General of the Department of Health and Human Services shall conduct an evaluation of the nationwide program.

(ii) **INCLUSION OF SPECIFIC TOPICS.**—The evaluation conducted under clause (i) shall include the following:

(I) A review of the various procedures implemented by participating States for long-term care facilities or providers, including staffing agencies, to conduct background checks of direct patient access employees under the nationwide program and identification of the most appropriate, efficient, and effective procedures for conducting such background checks.

(II) An assessment of the costs of conducting such background checks (including start up and administrative costs).

(III) A determination of the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for long-term care facilities or providers.

(IV) An assessment of the impact of the nationwide program on reducing the number of incidents of neglect, abuse, and misappropriation of resident property to the extent practicable.

(V) An evaluation of other aspects of the nationwide program, as determined appropriate by the Secretary.

(B) **REPORT.**—Not later than 180 days after the completion of the nationwide program, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the results of the evaluation conducted under subparagraph (A).

(b) **FUNDING.**—

(I) **NOTIFICATION.**—The Secretary of Health and Human Services shall notify the Secretary of the Treasury of the amount necessary to carry out the nationwide program under this section for the period of fiscal years 2010 through 2012, except that in no case shall such amount exceed \$160,000,000.

(2) TRANSFER OF FUNDS.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall provide for the transfer to the Secretary of Health and Human Services of the amount specified as necessary to carry out the nationwide program under paragraph (1). Such amount shall remain available until expended.

(B) RESERVATION OF FUNDS FOR CONDUCT OF EVALUATION.—The Secretary may reserve not more than \$3,000,000 of the amount transferred under subparagraph (A) to provide for the conduct of the evaluation under subsection (a)(7)(A).

Subtitle D—Patient-Centered Outcomes Research

SEC. 6301. PATIENT-CENTERED OUTCOMES RESEARCH.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

“PART D—COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

“COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

“SEC. 1181. (a) DEFINITIONS.—In this section:

“(1) BOARD.—The term ‘Board’ means the Board of Governors established under subsection (f).

“(2) COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH; RESEARCH.—

“(A) IN GENERAL.—The terms ‘comparative clinical effectiveness research’ and ‘research’ mean research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items described in subparagraph (B).

“(B) MEDICAL TREATMENTS, SERVICES, AND ITEMS DESCRIBED.—The medical treatments, services, and items described in this subparagraph are health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologicals), integrative health practices, and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals.

“(3) CONFLICT OF INTEREST.—The term ‘conflict of interest’ means an association, including a financial or personal association, that have the potential to bias or have the appearance of biasing an individual’s decisions in matters related to the Institute or the conduct of activities under this section.

“(4) REAL CONFLICT OF INTEREST.—The term ‘real conflict of interest’ means any instance where a member of the Board, the methodology committee established under subsection (d)(6), or an advisory panel appointed under subsection (d)(4), or a close relative of such member, has received or could receive either of the following:

“(A) A direct financial benefit of any amount deriving from the result or findings of a study conducted under this section.

“(B) A financial benefit from individuals or companies that own or manufacture medical treatments, services, or items to be studied under this section that in the aggregate exceeds \$10,000 per year. For purposes of the preceding sentence, a financial benefit includes honoraria, fees, stock, or other financial benefit and the current value of the member or close relative’s already existing stock holdings, in addition to any direct financial benefit deriving from the results or findings of a study conducted under this section.

“(b) PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—

“(1) ESTABLISHMENT.—There is authorized to be established a nonprofit corporation, to be

known as the ‘Patient-Centered Outcomes Research Institute’ (referred to in this section as the ‘Institute’) which is neither an agency nor establishment of the United States Government.

“(2) APPLICATION OF PROVISIONS.—The Institute shall be subject to the provisions of this section, and, to the extent consistent with this section, to the District of Columbia Nonprofit Corporation Act.

“(3) FUNDING OF COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH.—For fiscal year 2010 and each subsequent fiscal year, amounts in the Patient-Centered Outcomes Research Trust Fund (referred to in this section as the ‘PCORTF’) under section 9511 of the Internal Revenue Code of 1986 shall be available, without further appropriation, to the Institute to carry out this section.

“(c) PURPOSE.—The purpose of the Institute is to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments, services, and items described in subsection (a)(2)(B).

“(d) DUTIES.—

“(1) IDENTIFYING RESEARCH PRIORITIES AND ESTABLISHING RESEARCH PROJECT AGENDA.—

“(A) IDENTIFYING RESEARCH PRIORITIES.—The Institute shall identify national priorities for research, taking into account factors of disease incidence, prevalence, and burden in the United States (with emphasis on chronic conditions), gaps in evidence in terms of clinical outcomes, practice variations and health disparities in terms of delivery and outcomes of care, the potential for new evidence to improve patient health, well-being, and the quality of care, the effect on national expenditures associated with a health care treatment, strategy, or health conditions, as well as patient needs, outcomes, and preferences, the relevance to patients and clinicians in making informed health decisions, and priorities in the National Strategy for quality care established under section 399H of the Public Health Service Act that are consistent with this section.

“(B) ESTABLISHING RESEARCH PROJECT AGENDA.—The Institute shall establish and update a research project agenda for research to address the priorities identified under subparagraph (A), taking into consideration the types of research that might address each priority and the relative value (determined based on the cost of conducting research compared to the potential usefulness of the information produced by research) associated with the different types of research, and such other factors as the Institute determines appropriate.

“(2) CARRYING OUT RESEARCH PROJECT AGENDA.—

“(A) RESEARCH.—The Institute shall carry out the research project agenda established under paragraph (1)(B) in accordance with the methodological standards adopted under paragraph (9) using methods, including the following:

“(i) Systematic reviews and assessments of existing and future research and evidence including original research conducted subsequent to the date of the enactment of this section.

“(ii) Primary research, such as randomized clinical trials, molecularly informed trials, and observational studies.

“(iii) Any other methodologies recommended by the methodology committee established under paragraph (6) that are adopted by the Board under paragraph (9).

“(B) CONTRACTS FOR THE MANAGEMENT OF FUNDING AND CONDUCT OF RESEARCH.—

“(i) CONTRACTS.—

“(I) IN GENERAL.—In accordance with the research project agenda established under paragraph (1)(B), the Institute shall enter into contracts for the management of funding and conduct of research in accordance with the following:

“(aa) Appropriate agencies and instrumentalities of the Federal Government.

“(bb) Appropriate academic research, private sector research, or study-conducting entities.

“(II) PREFERENCE.—In entering into contracts under subclause (I), the Institute shall give preference to the Agency for Healthcare Research and Quality and the National Institutes of Health, but only if the research to be conducted or managed under such contract is authorized by the governing statutes of such Agency or Institutes.

“(ii) CONDITIONS FOR CONTRACTS.—A contract entered into under this subparagraph shall require that the agency, instrumentality, or other entity—

“(I) abide by the transparency and conflicts of interest requirements under subsection (h) that apply to the Institute with respect to the research managed or conducted under such contract;

“(II) comply with the methodological standards adopted under paragraph (9) with respect to such research;

“(III) consult with the expert advisory panels for clinical trials and rare disease appointed under clauses (ii) and (iii), respectively, of paragraph (4)(A);

“(IV) subject to clause (iv), permit a researcher who conducts original research under the contract for the agency, instrumentality, or other entity to have such research published in a peer-reviewed journal or other publication;

“(V) have appropriate processes in place to manage data privacy and meet ethical standards for the research;

“(VI) comply with the requirements of the Institute for making the information available to the public under paragraph (8); and

“(VII) comply with other terms and conditions determined necessary by the Institute to carry out the research agenda adopted under paragraph (2).

“(iii) COVERAGE OF COPAYMENTS OR COINSURANCE.—A contract entered into under this subparagraph may allow for the coverage of copayments or coinsurance, or allow for other appropriate measures, to the extent that such coverage or other measures are necessary to preserve the validity of a research project, such as in the case where the research project must be blinded.

“(iv) REQUIREMENTS FOR PUBLICATION OF RESEARCH.—Any research published under clause (ii)(IV) shall be within the bounds of and entirely consistent with the evidence and findings produced under the contract with the Institute under this subparagraph. If the Institute determines that those requirements are not met, the Institute shall not enter into another contract with the agency, instrumentality, or entity which managed or conducted such research for a period determined appropriate by the Institute (but not less than 5 years).

“(C) REVIEW AND UPDATE OF EVIDENCE.—The Institute shall review and update evidence on a periodic basis as appropriate.

“(D) TAKING INTO ACCOUNT POTENTIAL DIFFERENCES.—Research shall be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care treatments, services, and items as used with various subpopulations, such as racial and ethnic minorities, women, age, and groups of individuals with different comorbidities, genetic and

molecular sub-types, or quality of life preferences and include members of such subpopulations as subjects in the research as feasible and appropriate.

“(E) DIFFERENCES IN TREATMENT MODALITIES.—Research shall be designed, as appropriate, to take into account different characteristics of treatment modalities that may affect research outcomes, such as the phase of the treatment modality in the innovation cycle and the impact of the skill of the operator of the treatment modality.

“(3) DATA COLLECTION.—

“(A) IN GENERAL.—The Secretary shall, with appropriate safeguards for privacy, make available to the Institute such data collected by the Centers for Medicare & Medicaid Services under the programs under titles XVIII, XIX, and XXI, as well as provide access to the data networks developed under section 937(f) of the Public Health Service Act, as the Institute and its contractors may require to carry out this section. The Institute may also request and obtain data from Federal, State, or private entities, including data from clinical databases and registries.

“(B) USE OF DATA.—The Institute shall only use data provided to the Institute under subparagraph (A) in accordance with laws and regulations governing the release and use of such data, including applicable confidentiality and privacy standards.

“(4) APPOINTING EXPERT ADVISORY PANELS.—

“(A) APPOINTMENT.—

“(i) IN GENERAL.—The Institute may appoint permanent or ad hoc expert advisory panels as determined appropriate to assist in identifying research priorities and establishing the research project agenda under paragraph (1) and for other purposes.

“(ii) EXPERT ADVISORY PANELS FOR CLINICAL TRIALS.—The Institute shall appoint expert advisory panels in carrying out randomized clinical trials under the research project agenda under paragraph (2)(A)(ii). Such expert advisory panels shall advise the Institute and the agency, instrumentality, or entity conducting the research on the research question involved and the research design or protocol, including important patient subgroups and other parameters of the research. Such panels shall be available as a resource for technical questions that may arise during the conduct of such research.

“(iii) EXPERT ADVISORY PANEL FOR RARE DISEASE.—In the case of a research study for rare disease, the Institute shall appoint an expert advisory panel for purposes of assisting in the design of the research study and determining the relative value and feasibility of conducting the research study.

“(B) COMPOSITION.—An expert advisory panel appointed under subparagraph (A) shall include representatives of practicing and research clinicians, patients, and experts in scientific and health services research, health services delivery, and evidence-based medicine who have experience in the relevant topic, and as appropriate, experts in integrative health and primary prevention strategies. The Institute may include a technical expert of each manufacturer or each medical technology that is included under the relevant topic, project, or category for which the panel is established.

“(5) SUPPORTING PATIENT AND CONSUMER REPRESENTATIVES.—The Institute shall provide support and resources to help patient and consumer representatives effectively participate on the Board and expert advisory panels appointed by the Institute under paragraph (4).

“(6) ESTABLISHING METHODOLOGY COMMITTEE.—

“(A) IN GENERAL.—The Institute shall establish a standing methodology committee to carry out the functions described in subparagraph (C).

“(B) APPOINTMENT AND COMPOSITION.—The methodology committee established under subparagraph (A) shall be composed of not more than 15 members appointed by the Comptroller General of the United States. Members appointed to the methodology committee shall be experts in their scientific field, such as health services research, clinical research, comparative clinical effectiveness research, biostatistics, genomics, and research methodologies. Stakeholders with such expertise may be appointed to the methodology committee. In addition to the members appointed under the first sentence, the Directors of the National Institutes of Health and the Agency for Healthcare Research and Quality (or their designees) shall each be included as members of the methodology committee.

“(C) FUNCTIONS.—Subject to subparagraph (D), the methodology committee shall work to develop and improve the science and methods of comparative clinical effectiveness research by, not later than 18 months after the establishment of the Institute, directly or through subcontract, developing and periodically updating the following:

“(i) Methodological standards for research. Such methodological standards shall provide specific criteria for internal validity, generalizability, feasibility, and timeliness of research and for health outcomes measures, risk adjustment, and other relevant aspects of research and assessment with respect to the design of research. Any methodological standards developed and updated under this subclause shall be scientifically based and include methods by which new information, data, or advances in technology are considered and incorporated into ongoing research projects by the Institute, as appropriate. The process for developing and updating such standards shall include input from relevant experts, stakeholders, and decision-makers, and shall provide opportunities for public comment. Such standards shall also include methods by which patient subpopulations can be accounted for and evaluated in different types of research. As appropriate, such standards shall build on existing work on methodological standards for defined categories of health interventions and for each of the major categories of comparative clinical effectiveness research methods (determined as of the date of enactment of the Patient Protection and Affordable Care Act).

“(ii) A translation table that is designed to provide guidance and act as a reference for the Board to determine research methods that are most likely to address each specific research question.

“(D) CONSULTATION AND CONDUCT OF EXAMINATIONS.—The methodology committee may consult and contract with the Institute of Medicine of the National Academies and academic, nonprofit, or other private and governmental entities with relevant expertise to carry out activities described in subparagraph (C) and may consult with relevant stakeholders to carry out such activities.

“(E) REPORTS.—The methodology committee shall submit reports to the Board on the committee's performance of the functions described in subparagraph (C). Reports shall contain recommendations for the Institute to adopt methodological standards developed and updated by the methodology committee as well as other actions deemed necessary to comply with such methodological standards.

“(7) PROVIDING FOR A PEER-REVIEW PROCESS FOR PRIMARY RESEARCH.—

“(A) IN GENERAL.—The Institute shall ensure that there is a process for peer review of primary research described in subparagraph (A)(ii) of paragraph (2) that is conducted under such paragraph. Under such process—

“(i) evidence from such primary research shall be reviewed to assess scientific integrity and adherence to methodological standards adopted under paragraph (9); and

“(ii) a list of the names of individuals contributing to any peer-review process during the preceding year or years shall be made public and included in annual reports in accordance with paragraph (10)(D).

“(B) COMPOSITION.—Such peer-review process shall be designed in a manner so as to avoid bias and conflicts of interest on the part of the reviewers and shall be composed of experts in the scientific field relevant to the research under review.

“(C) USE OF EXISTING PROCESSES.—

“(i) PROCESSES OF ANOTHER ENTITY.—In the case where the Institute enters into a contract or other agreement with another entity for the conduct or management of research under this section, the Institute may utilize the peer-review process of such entity if such process meets the requirements under subparagraphs (A) and (B).

“(ii) PROCESSES OF APPROPRIATE MEDICAL JOURNALS.—The Institute may utilize the peer-review process of appropriate medical journals if such process meets the requirements under subparagraphs (A) and (B).

“(8) RELEASE OF RESEARCH FINDINGS.—

“(A) IN GENERAL.—The Institute shall, not later than 90 days after the conduct or receipt of research findings under this part, make such research findings available to clinicians, patients, and the general public. The Institute shall ensure that the research findings—

“(i) convey the findings of research in a manner that is comprehensible and useful to patients and providers in making health care decisions;

“(ii) fully convey findings and discuss considerations specific to certain subpopulations, risk factors, and comorbidities, as appropriate;

“(iii) include limitations of the research and what further research may be needed as appropriate;

“(iv) not be construed as mandates for practice guidelines, coverage recommendations, payment, or policy recommendations; and

“(v) not include any data which would violate the privacy of research participants or any confidentiality agreements made with respect to the use of data under this section.

“(B) DEFINITION OF RESEARCH FINDINGS.—In this paragraph, the term ‘research findings’ means the results of a study or assessment.

“(9) ADOPTION.—Subject to subsection (h)(1), the Institute shall adopt the national priorities identified under paragraph (1)(A), the research project agenda established under paragraph (1)(B), the methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i), and any peer-review process provided under paragraph (7) by majority vote. In the case where the Institute does not adopt such processes in accordance with the preceding sentence, the processes shall be referred to the appropriate staff or entity within the Institute (or, in the case of the methodological standards, the methodology committee) for further review.

“(10) ANNUAL REPORTS.—The Institute shall submit an annual report to Congress and the President, and shall make the annual report available to the public. Such report shall contain—

“(A) a description of the activities conducted under this section, research priorities identified under paragraph (1)(A) and methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i) that are adopted under paragraph (9) during the preceding year;

“(B) the research project agenda and budget of the Institute for the following year;

“(C) any administrative activities conducted by the Institute during the preceding year;

“(D) the names of individuals contributing to any peer-review process under paragraph (7), without identifying them with a particular research project; and

“(E) any other relevant information (including information on the membership of the Board, expert advisory panels, methodology committee, and the executive staff of the Institute, any conflicts of interest with respect to these individuals, and any bylaws adopted by the Board during the preceding year).

“(e) ADMINISTRATION.—

“(1) IN GENERAL.—Subject to paragraph (2), the Board shall carry out the duties of the Institute.

“(2) NONDELEGABLE DUTIES.—The activities described in subsections (d)(1) and (d)(9) are nondelegable.

“(f) BOARD OF GOVERNORS.—

“(1) IN GENERAL.—The Institute shall have a Board of Governors, which shall consist of the following members:

“(A) The Director of Agency for Healthcare Research and Quality (or the Director's designee).

“(B) The Director of the National Institutes of Health (or the Director's designee).

“(C) Seventeen members appointed, not later than 6 months after the date of enactment of this section, by the Comptroller General of the United States as follows:

“(i) 3 members representing patients and health care consumers.

“(ii) 5 members representing physicians and providers, including at least 1 surgeon, nurse, State-licensed integrative health care practitioner, and representative of a hospital.

“(iii) 3 members representing private payers, of whom at least 1 member shall represent health insurance issuers and at least 1 member shall represent employers who self-insure employee benefits.

“(iv) 3 members representing pharmaceutical, device, and diagnostic manufacturers or developers.

“(v) 1 member representing quality improvement or independent health service researchers.

“(vi) 2 members representing the Federal Government or the States, including at least 1 member representing a Federal health program or agency.

“(2) QUALIFICATIONS.—The Board shall represent a broad range of perspectives and collectively have scientific expertise in clinical health sciences research, including epidemiology, decisions sciences, health economics, and statistics. In appointing the Board, the Comptroller General of the United States shall consider and disclose any conflicts of interest in accordance with subsection (h)(4)(B). Members of the Board shall be recused from relevant Institute activities in the case where the member (or an immediate family member of such member) has a real conflict of interest directly related to the research project or the matter that could affect or be affected by such participation.

“(3) TERMS; VACANCIES.—A member of the Board shall be appointed for a term of 6 years, except with respect to the members first appointed, whose terms of appointment shall be staggered evenly over 2-year increments. No individual shall be appointed to the Board for more than 2 terms. Vacancies shall be filled in the same manner as the original appointment was made.

“(4) CHAIRPERSON AND VICE-CHAIRPERSON.—The Comptroller General of the United States shall designate a Chairperson and Vice Chairperson of the Board from among the members of the Board. Such members shall serve as Chairperson or Vice Chairperson for a period of 3 years.

“(5) COMPENSATION.—Each member of the Board who is not an officer or employee of the Federal Government shall be entitled to compensation (equivalent to the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code) and expenses incurred while performing the duties of the Board. An officer or employee of the Federal Government who is a member of the Board shall be exempt from compensation.

“(6) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—The Board may employ and fix the compensation of an Executive Director and such other personnel as may be necessary to carry out the duties of the Institute and may seek such assistance and support of, or contract with, experts and consultants that may be necessary for the performance of the duties of the Institute.

“(7) MEETINGS AND HEARINGS.—The Board shall meet and hold hearings at the call of the Chairperson or a majority of its members. Meetings not solely concerning matters of personnel shall be advertised at least 7 days in advance and open to the public. A majority of the Board members shall constitute a quorum, but a lesser number of members may meet and hold hearings.

“(g) FINANCIAL AND GOVERNMENTAL OVERSIGHT.—

“(1) CONTRACT FOR AUDIT.—The Institute shall provide for the conduct of financial audits of the Institute on an annual basis by a private entity with expertise in conducting financial audits.

“(2) REVIEW AND ANNUAL REPORTS.—

“(A) REVIEW.—The Comptroller General of the United States shall review the following:

“(i) Not less frequently than on an annual basis, the financial audits conducted under paragraph (1).

“(ii) Not less frequently than every 5 years, the processes established by the Institute, including the research priorities and the conduct of research projects, in order to determine whether information produced by such research projects is objective and credible, is produced in a manner consistent with the requirements under this section, and is developed through a transparent process.

“(iii) Not less frequently than every 5 years, the dissemination and training activities and data networks established under section 937 of the Public Health Service Act, including the methods and products used to disseminate research, the types of training conducted and supported, and the types and functions of the data networks established, in order to determine whether the activities and data are produced in a manner consistent with the requirements under this section.

“(iv) Not less frequently than every 5 years, the overall effectiveness of activities conducted under this section and the dissemination, training, and capacity building activities conducted under section 937 of the Public Health Service Act. Such review shall include an analysis of the extent to which research findings are used by health care decision-makers, the effect of the dissemination of such findings on reducing practice variation and disparities in health care, and the effect of the research conducted and disseminated on innovation and the health care economy of the United States.

“(v) Not later than 8 years after the date of enactment of this section, the adequacy and use of the funding for the Institute and the activities conducted under section 937 of the Public Health Service Act, including a determination as to whether, based on the utilization of research findings by public and private payers, funding sources for the Patient-Centered Outcomes Research Trust Fund under section 9511 of the Internal Revenue Code of 1986 are appropriate and whether such sources of funding should be continued or adjusted.

“(B) ANNUAL REPORTS.—Not later than April 1 of each year, the Comptroller General of the United States shall submit to Congress a report containing the results of the review conducted under subparagraph (A) with respect to the preceding year (or years, if applicable), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

“(h) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—The Institute shall establish procedures to ensure that the following requirements for ensuring transparency, credibility, and access are met:

“(1) PUBLIC COMMENT PERIODS.—The Institute shall provide for a public comment period of not less than 45 days and not more than 60 days prior to the adoption under subsection (d)(9) of the national priorities identified under subsection (d)(1)(A), the research project agenda established under subsection (d)(1)(B), the methodological standards developed and updated by the methodology committee under subsection (d)(6)(C)(i), and the peer-review process provided under paragraph (7), and after the release of draft findings with respect to systematic reviews of existing research and evidence.

“(2) ADDITIONAL FORUMS.—The Institute shall support forums to increase public awareness and obtain and incorporate public input and feedback through media (such as an Internet website) on research priorities, research findings, and other duties, activities, or processes the Institute determines appropriate.

“(3) PUBLIC AVAILABILITY.—The Institute shall make available to the public and disclose through the official public Internet website of the Institute the following:

“(A) Information contained in research findings as specified in subsection (d)(9).

“(B) The process and methods for the conduct of research, including the identity of the entity and the investigators conducting such research and any conflicts of interests of such parties, any direct or indirect links the entity has to industry, and research protocols, including measures taken, methods of research and analysis, research results, and such other information the Institute determines appropriate) concurrent with the release of research findings.

“(C) Notice of public comment periods under paragraph (1), including deadlines for public comments.

“(D) Subsequent comments received during each of the public comment periods.

“(E) In accordance with applicable laws and processes and as the Institute determines appropriate, proceedings of the Institute.

“(4) DISCLOSURE OF CONFLICTS OF INTEREST.—

“(A) IN GENERAL.—A conflict of interest shall be disclosed in the following manner:

“(i) By the Institute in appointing members to an expert advisory panel under subsection (d)(4), in selecting individuals to contribute to any peer-review process under subsection (d)(7), and for employment as executive staff of the Institute.

“(ii) By the Comptroller General in appointing members of the methodology committee under subsection (d)(6);

“(iii) By the Institute in the annual report under subsection (d)(10), except that, in the case of individuals contributing to any such peer review process, such description shall be in a manner such that those individuals cannot be identified with a particular research project.

“(B) MANNER OF DISCLOSURE.—Conflicts of interest shall be disclosed as described in subparagraph (A) as soon as practicable on the Internet web site of the Institute and of the Government Accountability Office. The information disclosed under the preceding sentence shall include the type, nature, and magnitude of the interests of the individual involved, except to the extent

that the individual recuses himself or herself from participating in the consideration of or any other activity with respect to the study as to which the potential conflict exists.

“(i) RULES.—The Institute, its Board or staff, shall be prohibited from accepting gifts, bequests, or donations of services or property. In addition, the Institute shall be prohibited from establishing a corporation or generating revenues from activities other than as provided under this section.

“(j) RULES OF CONSTRUCTION.—

“(1) COVERAGE.—Nothing in this section shall be construed—

“(A) to permit the Institute to mandate coverage, reimbursement, or other policies for any public or private payer; or

“(B) as preventing the Secretary from covering the routine costs of clinical care received by an individual entitled to, or enrolled for, benefits under title XVIII, XIX, or XXI in the case where such individual is participating in a clinical trial and such costs would otherwise be covered under such title with respect to the beneficiary.”.

(b) DISSEMINATION AND BUILDING CAPACITY FOR RESEARCH.—Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), as amended by section 3606, is further amended by inserting after section 936 the following:

“SEC. 937. DISSEMINATION AND BUILDING CAPACITY FOR RESEARCH.

“(a) IN GENERAL.—

“(1) DISSEMINATION.—The Office of Communication and Knowledge Transfer (referred to in this section as the ‘Office’) at the Agency for Healthcare Research and Quality (or any other relevant office designated by Agency for Healthcare Research and Quality), in consultation with the National Institutes of Health, shall broadly disseminate the research findings that are published by the Patient Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act (referred to in this section as the ‘Institute’) and other government-funded research relevant to comparative clinical effectiveness research. The Office shall create informational tools that organize and disseminate research findings for physicians, health care providers, patients, payers, and policy makers. The Office shall also develop a publicly available resource database that collects and contains government-funded evidence and research from public, private, not-for profit, and academic sources.

“(2) REQUIREMENTS.—The Office shall provide for the dissemination of the Institute’s research findings and government-funded research relevant to comparative clinical effectiveness research to physicians, health care providers, patients, vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans. Materials, forums, and media used to disseminate the findings, informational tools, and resource databases shall—

“(A) include a description of considerations for specific subpopulations, the research methodology, and the limitations of the research, and the names of the entities, agencies, instrumentalities, and individuals who conducted any research which was published by the Institute; and

“(B) not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment.

“(b) INCORPORATION OF RESEARCH FINDINGS.—The Office, in consultation with relevant medical and clinical associations, shall assist users of health information technology focused on clinical decision support to promote the timely incorporation of research findings disseminated under subsection (a) into clinical practices and to promote the ease of use of such incorporation.

“(c) FEEDBACK.—The Office shall establish a process to receive feedback from physicians, health care providers, patients, and vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans about the value of the information disseminated and the assistance provided under this section.

“(d) RULE OF CONSTRUCTION.—Nothing in this section shall preclude the Institute from making its research findings publicly available as required under section 1181(d)(8) of the Social Security Act.

“(e) TRAINING OF RESEARCHERS.—The Agency for Health Care Research and Quality, in consultation with the National Institutes of Health, shall build capacity for comparative clinical effectiveness research by establishing a grant program that provides for the training of researchers in the methods used to conduct such research, including systematic reviews of existing research and primary research such as clinical trials. At a minimum, such training shall be in methods that meet the methodological standards adopted under section 1181(d)(9) of the Social Security Act.

“(f) BUILDING DATA FOR RESEARCH.—The Secretary shall provide for the coordination of relevant Federal health programs to build data capacity for comparative clinical effectiveness research, including the development and use of clinical registries and health outcomes research data networks, in order to develop and maintain a comprehensive, interoperable data network to collect, link, and analyze data on outcomes and effectiveness from multiple sources, including electronic health records.

“(g) AUTHORITY TO CONTRACT WITH THE INSTITUTE.—Agencies and instrumentalities of the Federal Government may enter into agreements with the Institute, and accept and retain funds, for the conduct and support of research described in this part, provided that the research to be conducted or supported under such agreements is authorized under the governing statutes of such agencies and instrumentalities.”.

(c) IN GENERAL.—Part D of title XI of the Social Security Act, as added by subsection (a), is amended by adding at the end the following new section:

“LIMITATIONS ON CERTAIN USES OF COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

“SEC. 1182. (a) The Secretary may only use evidence and findings from research conducted under section 1181 to make a determination regarding coverage under title XVIII if such use is through an iterative and transparent process which includes public comment and considers the effect on subpopulations.

“(b) Nothing in section 1181 shall be construed as—

“(1) superceding or modifying the coverage of items or services under title XVIII that the Secretary determines are reasonable and necessary under section 1862(l)(1); or

“(2) authorizing the Secretary to deny coverage of items or services under such title solely on the basis of comparative clinical effectiveness research.

“(c)(1) The Secretary shall not use evidence or findings from comparative clinical effectiveness research conducted under section 1181 in determining coverage, reimbursement, or incentive programs under title XVIII in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill.

“(2) Paragraph (1) shall not be construed as preventing the Secretary from using evidence or findings from such comparative clinical effectiveness research in determining coverage, reimbursement, or incentive programs under title

XVIII based upon a comparison of the difference in the effectiveness of alternative treatments in extending an individual’s life due to the individual’s age, disability, or terminal illness.

“(d)(1) The Secretary shall not use evidence or findings from comparative clinical effectiveness research conducted under section 1181 in determining coverage, reimbursement, or incentive programs under title XVIII in a manner that precludes, or with the intent to discourage, an individual from choosing a health care treatment based on how the individual values the tradeoff between extending the length of their life and the risk of disability.

“(2)(A) Paragraph (1) shall not be construed to—

“(i) limit the application of differential copayments under title XVIII based on factors such as cost or type of service; or

“(ii) prevent the Secretary from using evidence or findings from such comparative clinical effectiveness research in determining coverage, reimbursement, or incentive programs under such title based upon a comparison of the difference in the effectiveness of alternative health care treatments in extending an individual’s life due to that individual’s age, disability, or terminal illness.

“(3) Nothing in the provisions of, or amendments made by the Patient Protection and Affordable Care Act, shall be construed to limit comparative clinical effectiveness research or any other research, evaluation, or dissemination of information concerning the likelihood that a health care treatment will result in disability.

“(e) The Patient-Centered Outcomes Research Institute established under section 1181(b)(1) shall not develop or employ a dollars-per-quality adjusted life year (or similar measure that discounts the value of a life because of an individual’s disability) as a threshold to establish what type of health care is cost effective or recommended. The Secretary shall not utilize such an adjusted life year (or such a similar measure) as a threshold to determine coverage, reimbursement, or incentive programs under title XVIII.”.

(d) IN GENERAL.—Part D of title XI of the Social Security Act, as added by subsection (a) and amended by subsection (c), is amended by adding at the end the following new section:

“TRUST FUND TRANSFERS TO PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND

“SEC. 1183. (a) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are made under title XVIII from the respective trust fund, to the Patient-Centered Outcomes Research Trust Fund (referred to in this section as the ‘PCORTF’) under section 9511 of the Internal Revenue Code of 1986, of the following:

“(1) For fiscal year 2013, an amount equal to \$1 multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII during such fiscal year.

“(2) For each of fiscal years 2014, 2015, 2016, 2017, 2018, and 2019, an amount equal to \$2 multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII during such fiscal year.

“(b) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a)(2) for such fiscal year shall be equal to the sum of such dollar amount for the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

“(1) such dollar amount for the previous fiscal year, multiplied by

“(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.”.

(e) **PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND; FINANCING FOR TRUST FUND.**—

(1) **ESTABLISHMENT OF TRUST FUND.**—

(A) **IN GENERAL.**—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to establishment of trust funds) is amended by adding at the end the following new section:

“SEC. 9511. PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND.

“(a) **CREATION OF TRUST FUND.**—There is established in the Treasury of the United States a trust fund to be known as the ‘Patient-Centered Outcomes Research Trust Fund’ (hereafter in this section referred to as the ‘PCORTF’), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

“(b) **TRANSFERS TO FUND.**—

“(1) **APPROPRIATION.**—There are hereby appropriated to the Trust Fund the following:

“(A) For fiscal year 2010, \$10,000,000.

“(B) For fiscal year 2011, \$50,000,000.

“(C) For fiscal year 2012, \$150,000,000.

“(D) For fiscal year 2013—

“(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

“(ii) \$150,000,000.

“(E) For each of fiscal years 2014, 2015, 2016, 2017, 2018, and 2019—

“(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

“(ii) \$150,000,000.

The amounts appropriated under subparagraphs (A), (B), (C), (D)(ii), and (E)(ii) shall be transferred from the general fund of the Treasury, from funds not otherwise appropriated.

“(2) **TRUST FUND TRANSFERS.**—In addition to the amounts appropriated under paragraph (1), there shall be credited to the PCORTF the amounts transferred under section 1183 of the Social Security Act.

“(3) **LIMITATION ON TRANSFERS TO PCORTF.**—No amount may be appropriated or transferred to the PCORTF on and after the date of any expenditure from the PCORTF which is not an expenditure permitted under this section. The determination of whether an expenditure is so permitted shall be made without regard to—

“(A) any provision of law which is not contained or referenced in this chapter or in a revenue Act, and

“(B) whether such provision of law is a subsequently enacted provision or directly or indirectly seeks to waive the application of this paragraph.

“(c) **TRUSTEE.**—The Secretary of the Treasury shall be a trustee of the PCORTF.

“(d) **EXPENDITURES FROM FUND.**—

“(1) **AMOUNTS AVAILABLE TO THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.**—Subject to paragraph (2), amounts in the PCORTF are available, without further appropriation, to the Patient-Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act for carrying out part D of title XI of the Social Security Act (as in effect on the date of enactment of such Act).

“(2) **TRANSFER OF FUNDS.**—

“(A) **IN GENERAL.**—The trustee of the PCORTF shall provide for the transfer from the PCORTF of 20 percent of the amounts appro-

priated or credited to the PCORTF for each of fiscal years 2011 through 2019 to the Secretary of Health and Human Services to carry out section 937 of the Public Health Service Act.

“(B) **AVAILABILITY.**—Amounts transferred under subparagraph (A) shall remain available until expended.

“(C) **REQUIREMENTS.**—Of the amounts transferred under subparagraph (A) with respect to a fiscal year, the Secretary of Health and Human Services shall distribute—

“(i) 80 percent to the Office of Communication and Knowledge Transfer of the Agency for Healthcare Research and Quality (or any other relevant office designated by Agency for Healthcare Research and Quality) to carry out the activities described in section 937 of the Public Health Service Act; and

“(ii) 20 percent to the Secretary to carry out the activities described in such section 937.

“(e) **NET REVENUES.**—For purposes of this section, the term ‘net revenues’ means the amount estimated by the Secretary of the Treasury based on the excess of—

“(1) the fees received in the Treasury under subchapter B of chapter 34, over

“(2) the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such subchapter.

“(f) **TERMINATION.**—No amounts shall be available for expenditure from the PCORTF after September 30, 2019, and any amounts in such Trust Fund after such date shall be transferred to the general fund of the Treasury.”.

(B) **CLERICAL AMENDMENT.**—The table of sections for subchapter A of chapter 98 of such Code is amended by adding at the end the following new item:

“Sec. 9511. Patient-centered outcomes research trust fund.”.

(2) **FINANCING FOR FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.**—

(A) **GENERAL RULE.**—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

“Subchapter B—Insured and Self-Insured Health Plans

“Sec. 4375. Health insurance.

“Sec. 4376. Self-insured health plans.

“Sec. 4377. Definitions and special rules.

“SEC. 4375. HEALTH INSURANCE.

“(a) **IMPOSITION OF FEE.**—There is hereby imposed on each specified health insurance policy for each policy year ending after September 30, 2012, a fee equal to the product of \$2 (\$1 in the case of policy years ending during fiscal year 2013) multiplied by the average number of lives covered under the policy.

“(b) **LIABILITY FOR FEE.**—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

“(c) **SPECIFIED HEALTH INSURANCE POLICY.**—For purposes of this section:

“(1) **IN GENERAL.**—Except as otherwise provided in this section, the term ‘specified health insurance policy’ means any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States.

“(2) **EXEMPTION FOR CERTAIN POLICIES.**—The term ‘specified health insurance policy’ does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

“(3) **TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.**—

“(A) **IN GENERAL.**—In the case of any arrangement described in subparagraph (B), such arrangement shall be treated as a specified health insurance policy, and the person referred to in such subparagraph shall be treated as the issuer.

“(B) **DESCRIPTION OF ARRANGEMENTS.**—An arrangement is described in this subparagraph if

under such arrangement fixed payments or premiums are received as consideration for any person’s agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

“(d) **ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.**—In the case of any policy year ending in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such policy year shall be equal to the sum of such dollar amount for policy years ending in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

“(1) such dollar amount for policy years ending in the previous fiscal year, multiplied by

“(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

“(e) **TERMINATION.**—This section shall not apply to policy years ending after September 30, 2019.

“SEC. 4376. SELF-INSURED HEALTH PLANS.

“(a) **IMPOSITION OF FEE.**—In the case of any applicable self-insured health plan for each plan year ending after September 30, 2012, there is hereby imposed a fee equal to \$2 (\$1 in the case of plan years ending during fiscal year 2013) multiplied by the average number of lives covered under the plan.

“(b) **LIABILITY FOR FEE.**—

“(1) **IN GENERAL.**—The fee imposed by subsection (a) shall be paid by the plan sponsor.

“(2) **PLAN SPONSOR.**—For purposes of paragraph (1) the term ‘plan sponsor’ means—

“(A) the employer in the case of a plan established or maintained by a single employer,

“(B) the employee organization in the case of a plan established or maintained by an employee organization,

“(C) in the case of—

“(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

“(ii) a multiple employer welfare arrangement, or

“(iii) a voluntary employees’ beneficiary association described in section 501(c)(9), the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

“(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

“(c) **APPLICABLE SELF-INSURED HEALTH PLAN.**—For purposes of this section, the term ‘applicable self-insured health plan’ means any plan for providing accident or health coverage if—

“(1) any portion of such coverage is provided other than through an insurance policy, and

“(2) such plan is established or maintained—

“(A) by 1 or more employers for the benefit of their employees or former employees,

“(B) by 1 or more employee organizations for the benefit of their members or former members,

“(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

“(D) by a voluntary employees’ beneficiary association described in section 501(c)(9),

“(E) by any organization described in section 501(c)(6), or

“(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a

rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

“(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any plan year ending in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such plan year shall be equal to the sum of such dollar amount for plan years ending in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

“(1) such dollar amount for plan years ending in the previous fiscal year, multiplied by

“(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

“(e) TERMINATION.—This section shall not apply to plan years ending after September 30, 2019.

“SEC. 4377. DEFINITIONS AND SPECIAL RULES.

“(a) DEFINITIONS.—For purposes of this subchapter—

“(1) ACCIDENT AND HEALTH COVERAGE.—The term ‘accident and health coverage’ means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

“(2) INSURANCE POLICY.—The term ‘insurance policy’ means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

“(3) UNITED STATES.—The term ‘United States’ includes any possession of the United States.

“(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

“(1) IN GENERAL.—For purposes of this subchapter—

“(A) the term ‘person’ includes any governmental entity, and

“(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

“(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4375 or section 4376 on any covered life under such program.

“(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term ‘exempt governmental program’ means—

“(A) any insurance program established under title XVIII of the Social Security Act,

“(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

“(C) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being members of the Armed Forces of the United States or veterans, and

“(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

“(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

“(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.”.

(B) CLERICAL AMENDMENTS.—

(i) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

“CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

“SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

“SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

“Subchapter A—Policies Issued By Foreign Insurers”.

(ii) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

“CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES”.

(f) TAX-EXEMPT STATUS OF THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—Subsection 501(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

“(4) The Patient-Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act.”.

SEC. 6302. FEDERAL COORDINATING COUNCIL FOR COMPARATIVE EFFECTIVENESS RESEARCH.

Notwithstanding any other provision of law, the Federal Coordinating Council for Comparative Effectiveness Research established under section 804 of Division A of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 299b–8), including the requirement under subsection (e)(2) of such section, shall terminate on the date of enactment of this Act.

Subtitle E—Medicare, Medicaid, and CHIP Program Integrity Provisions

SEC. 6401. PROVIDER SCREENING AND OTHER ENROLLMENT REQUIREMENTS UNDER MEDICARE, MEDICAID, AND CHIP.

(a) MEDICARE.—Section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) is amended—

(1) in paragraph (1)(A), by adding at the end the following: “Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (4), the imposition of temporary enrollment moratoria in accordance with paragraph (5), and the establishment of compliance programs in accordance with paragraph (6).”;

(2) by redesignating paragraph (2) as paragraph (7); and

(3) by inserting after paragraph (1) the following:

“(2) PROVIDER SCREENING.—

“(A) PROCEDURES.—Not later than 180 days after the date of enactment of this paragraph, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under the program under this title, the Medicaid program under title XIX, and the CHIP program under title XXI.

“(B) LEVEL OF SCREENING.—The Secretary shall determine the level of screening conducted under this paragraph according to the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening—

“(i) shall include a licensure check, which may include such checks across States; and

“(ii) may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, include—

“(I) a criminal background check;

“(II) fingerprinting;

“(III) unscheduled and unannounced site visits, including preenrollment site visits;

“(IV) database checks (including such checks across States); and

“(V) such other screening as the Secretary determines appropriate.

“(C) APPLICATION FEES.—

“(i) INDIVIDUAL PROVIDERS.—Except as provided in clause (iii), the Secretary shall impose a fee on each individual provider of medical or other items or services or supplier (such as a physician, physician assistant, nurse practitioner, or clinical nurse specialist) with respect to which screening is conducted under this paragraph in an amount equal to—

“(I) for 2010, \$200; and

“(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

“(ii) INSTITUTIONAL PROVIDERS.—Except as provided in clause (iii), the Secretary shall impose a fee on each institutional provider of medical or other items or services or supplier (such as a hospital or skilled nursing facility) with respect to which screening is conducted under this paragraph in an amount equal to—

“(I) for 2010, \$500; and

“(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

“(iii) HARDSHIP EXCEPTION; WAIVER FOR CERTAIN MEDICAID PROVIDERS.—The Secretary may, on a case-by-case basis, exempt a provider of medical or other items or services or supplier from the imposition of an application fee under this subparagraph if the Secretary determines that the imposition of the application fee would result in a hardship. The Secretary may waive the application fee under this subparagraph for providers enrolled in a State Medicaid program for whom the State demonstrates that imposition of the fee would impede beneficiary access to care.

“(iv) USE OF FUNDS.—Amounts collected as a result of the imposition of a fee under this subparagraph shall be used by the Secretary for program integrity efforts, including to cover the costs of conducting screening under this paragraph and to carry out this subsection and section 11281.

“(D) APPLICATION AND ENFORCEMENT.—

“(i) NEW PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is not enrolled in the program under this title, title XIX, or title XXI as of the date of enactment of this paragraph, on or after the date that is 1 year after such date of enactment.

“(ii) CURRENT PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is enrolled in the program under this title, title XIX, or title XXI as of such date of enactment, on or after the date that is 2 years after such date of enactment.

“(iii) REVALIDATION OF ENROLLMENT.—Effective beginning on the date that is 180 days after such date of enactment, the screening under this paragraph shall apply with respect to the revalidation of enrollment of a provider of medical or other items or services or supplier in the program under this title, title XIX, or title XXI.

“(iv) LIMITATION ON ENROLLMENT AND REVALIDATION OF ENROLLMENT.—In no case may a provider of medical or other items or services or supplier who has not been screened under this paragraph be initially enrolled or reenrolled in the program under this title, title XIX, or title

XXI on or after the date that is 3 years after such date of enactment.

“(E) EXPEDITED RULEMAKING.—The Secretary may promulgate an interim final rule to carry out this paragraph.

“(3) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS OF SERVICES AND SUPPLIERS.—

“(A) IN GENERAL.—The Secretary shall establish procedures to provide for a provisional period of not less than 30 days and not more than 1 year during which new providers of medical or other items or services and suppliers, as the Secretary determines appropriate, including categories of providers or suppliers, would be subject to enhanced oversight, such as prepayment review and payment caps, under the program under this title, the Medicaid program under title XIX, and the CHIP program under title XXI.

“(B) IMPLEMENTATION.—The Secretary may establish by program instruction or otherwise the procedures under this paragraph.

“(4) INCREASED DISCLOSURE REQUIREMENTS.—

“(A) DISCLOSURE.—A provider of medical or other items or services or supplier who submits an application for enrollment or revalidation of enrollment in the program under this title, title XIX, or title XXI on or after the date that is 1 year after the date of enactment of this paragraph shall disclose (in a form and manner and at such time as determined by the Secretary) any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services or supplier that has uncollected debt, has been or is subject to a payment suspension under a Federal health care program (as defined in section 1128B(f)), has been excluded from participation under the program under this title, the Medicaid program under title XIX, or the CHIP program under title XXI, or has had its billing privileges denied or revoked.

“(B) AUTHORITY TO DENY ENROLLMENT.—If the Secretary determines that such previous affiliation poses an undue risk of fraud, waste, or abuse, the Secretary may deny such application. Such a denial shall be subject to appeal in accordance with paragraph (7).

“(5) AUTHORITY TO ADJUST PAYMENTS OF PROVIDERS OF SERVICES AND SUPPLIERS WITH THE SAME TAX IDENTIFICATION NUMBER FOR PAST-DUE OBLIGATIONS.—

“(A) IN GENERAL.—Notwithstanding any other provision of this title, in the case of an applicable provider of services or supplier, the Secretary may make any necessary adjustments to payments to the applicable provider of services or supplier under the program under this title in order to satisfy any past-due obligations described in subparagraph (B)(ii) of an obligated provider of services or supplier.

“(B) DEFINITIONS.—In this paragraph:

“(i) IN GENERAL.—The term ‘applicable provider of services or supplier’ means a provider of services or supplier that has the same taxpayer identification number assigned under section 6109 of the Internal Revenue Code of 1986 as is assigned to the obligated provider of services or supplier under such section, regardless of whether the applicable provider of services or supplier is assigned a different billing number or national provider identification number under the program under this title than is assigned to the obligated provider of services or supplier.

“(ii) OBLIGATED PROVIDER OF SERVICES OR SUPPLIER.—The term ‘obligated provider of services or supplier’ means a provider of services or supplier that owes a past-due obligation under the program under this title (as determined by the Secretary).

“(6) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS.—

“(A) IN GENERAL.—The Secretary may impose a temporary moratorium on the enrollment of

new providers of services and suppliers, including categories of providers of services and suppliers, in the program under this title, under the Medicaid program under title XIX, or under the CHIP program under title XXI if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse under either such program.

“(B) LIMITATION ON REVIEW.—There shall be no judicial review under section 1869, section 1878, or otherwise, of a temporary moratorium imposed under subparagraph (A).

“(7) COMPLIANCE PROGRAMS.—

“(A) IN GENERAL.—On or after the date of implementation determined by the Secretary under subparagraph (C), a provider of medical or other items or services or supplier within a particular industry sector or category shall, as a condition of enrollment in the program under this title, title XIX, or title XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category.

“(B) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A) for providers or suppliers within a particular industry or category.

“(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry or category. The Secretary shall, in determining such date of implementation, consider the extent to which the adoption of compliance programs by a provider of medical or other items or services or supplier is widespread in a particular industry sector or with respect to a particular provider or supplier category.”.

(b) MEDICAID.—

(1) STATE PLAN AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 4302(b), is amended—

(A) in subsection (a)—

(i) by striking “and” at the end of paragraph (75);

(ii) by striking the period at the end of paragraph (76) and inserting a semicolon; and

(iii) by inserting after paragraph (76) the following:

“(77) provide that the State shall comply with provider and supplier screening, oversight, and reporting requirements in accordance with subsection (ii);”;

(B) by adding at the end the following:

“(ii) PROVIDER AND SUPPLIER SCREENING, OVERSIGHT, AND REPORTING REQUIREMENTS.—For purposes of subsection (a)(77), the requirements of this subsection are the following:

“(1) SCREENING.—The State complies with the process for screening providers and suppliers under this title, as established by the Secretary under section 1886(j)(2).

“(2) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS AND SUPPLIERS.—The State complies with procedures to provide for a provisional period of enhanced oversight for new providers and suppliers under this title, as established by the Secretary under section 1886(j)(3).

“(3) DISCLOSURE REQUIREMENTS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to comply with the disclosure requirements established by the Secretary under section 1886(j)(4).

“(4) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS.—

“(A) TEMPORARY MORATORIUM IMPOSED BY THE SECRETARY.—

“(i) IN GENERAL.—Subject to clause (ii), the State complies with any temporary moratorium on the enrollment of new providers or suppliers imposed by the Secretary under section 1886(j)(6).

“(ii) EXCEPTION.—A State shall not be required to comply with a temporary moratorium described in clause (i) if the State determines that the imposition of such temporary moratorium would adversely impact beneficiaries’ access to medical assistance.

“(B) MORATORIUM ON ENROLLMENT OF PROVIDERS AND SUPPLIERS.—At the option of the State, the State imposes, for purposes of entering into participation agreements with providers or suppliers under the State plan or under a waiver of the plan, periods of enrollment moratoria, or numerical caps or other limits, for providers or suppliers identified by the Secretary as being at high-risk for fraud, waste, or abuse as necessary to combat fraud, waste, or abuse, but only if the State determines that the imposition of any such period, cap, or other limits would not adversely impact beneficiaries’ access to medical assistance.

“(5) COMPLIANCE PROGRAMS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to establish, in accordance with the requirements of section 1886(j)(7), a compliance program that contains the core elements established under subparagraph (B) of that section 1886(j)(7) for providers or suppliers within a particular industry or category.

“(6) REPORTING OF ADVERSE PROVIDER ACTIONS.—The State complies with the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, in accordance with regulations of the Secretary.

“(7) ENROLLMENT AND NPI OF ORDERING OR REFERRING PROVIDERS.—The State requires—

“(A) all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the plan as a participating provider; and

“(B) the national provider identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

“(8) OTHER STATE OVERSIGHT.—Nothing in this subsection shall be interpreted to preclude or limit the ability of a State to engage in provider and supplier screening or enhanced provider and supplier oversight activities beyond those required by the Secretary.”.

(2) DISCLOSURE OF MEDICARE TERMINATED PROVIDERS AND SUPPLIERS TO STATES.—The Administrator of the Centers for Medicare & Medicaid Services shall establish a process for making available to the each State agency with responsibility for administering a State Medicaid plan (or a waiver of such plan) under title XIX of the Social Security Act or a child health plan under title XXI the name, national provider identifier, and other identifying information for any provider of medical or other items or services or supplier under the Medicare program under title XVIII or under the CHIP program under title XXI that is terminated from participation under that program within 30 days of the termination (and, with respect to all such providers or suppliers who are terminated from the Medicare program on the date of enactment of this Act, within 90 days of such date).

(3) CONFORMING AMENDMENT.—Section 1902(a)(23) of the Social Security Act (42 U.S.C. 1396a), is amended by inserting before the semicolon at the end the following: “or by a provider or supplier to which a moratorium under subsection (ii)(4) is applied during the period of such moratorium”.

(c) CHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by section 2101(d), is amended—

(1) by redesignating subparagraphs (D) through (M) as subparagraphs (E) through (N), respectively; and

(2) by inserting after subparagraph (C), the following:

“(D) Subsections (a)(77) and (ii) of section 1902 (relating to provider and supplier screening, oversight, and reporting requirements).”.

SEC. 6402. ENHANCED MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

(a) IN GENERAL.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by sections 6002, 6004, and 6102, is amended by inserting after section 1128I the following new section:

“SEC. 1128J. MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

“(a) DATA MATCHING.—

“(1) INTEGRATED DATA REPOSITORY.—

“(A) INCLUSION OF CERTAIN DATA.—

“(i) IN GENERAL.—The Integrated Data Repository of the Centers for Medicare & Medicaid Services shall include, at a minimum, claims and payment data from the following:

“(I) The programs under titles XVIII and XIX (including parts A, B, C, and D of title XVIII).

“(II) The program under title XXI.

“(III) Health-related programs administered by the Secretary of Veterans Affairs.

“(IV) Health-related programs administered by the Secretary of Defense.

“(V) The program of old-age, survivors, and disability insurance benefits established under title II.

“(VI) The Indian Health Service and the Contract Health Service program.

“(ii) PRIORITY FOR INCLUSION OF CERTAIN DATA.—Inclusion of the data described in subclause (I) of such clause in the Integrated Data Repository shall be a priority. Data described in subclauses (II) through (VI) of such clause shall be included in the Integrated Data Repository as appropriate.

“(B) DATA SHARING AND MATCHING.—

“(i) IN GENERAL.—The Secretary shall enter into agreements with the individuals described in clause (ii) under which such individuals share and match data in the system of records of the respective agencies of such individuals with data in the system of records of the Department of Health and Human Services for the purpose of identifying potential fraud, waste, and abuse under the programs under titles XVIII and XIX.

“(ii) INDIVIDUALS DESCRIBED.—The following individuals are described in this clause:

“(I) The Commissioner of Social Security.

“(II) The Secretary of Veterans Affairs.

“(III) The Secretary of Defense.

“(IV) The Director of the Indian Health Service.

“(iii) DEFINITION OF SYSTEM OF RECORDS.—For purposes of this paragraph, the term ‘system of records’ has the meaning given such term in section 552a(a)(5) of title 5, United States Code.

“(2) ACCESS TO CLAIMS AND PAYMENT DATA-BASES.—For purposes of conducting law enforcement and oversight activities and to the extent consistent with applicable information, privacy, security, and disclosure laws, including the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 552a of title 5, United States Code, and subject to any information systems security requirements under such laws or otherwise required by the Secretary, the Inspector General of the Department of Health and Human Services and the Attorney General shall have access to claims and payment data of the Department of Health and Human Services and its contractors related to titles XVIII, XIX, and XXI.

“(b) OIG AUTHORITY TO OBTAIN INFORMATION.—

“(1) IN GENERAL.—Notwithstanding and in addition to any other provision of law, the Inspector General of the Department of Health and Human Services may, for purposes of protecting the integrity of the programs under titles XVIII and XIX, obtain information from any individual (including a beneficiary provided all applicable privacy protections are followed) or entity that—

“(A) is a provider of medical or other items or services, supplier, grant recipient, contractor, or subcontractor; or

“(B) directly or indirectly provides, orders, manufactures, distributes, arranges for, prescribes, supplies, or receives medical or other items or services payable by any Federal health care program (as defined in section 1128B(f)) regardless of how the item or service is paid for, or to whom such payment is made.

“(2) INCLUSION OF CERTAIN INFORMATION.—Information which the Inspector General may obtain under paragraph (1) includes any supporting documentation necessary to validate claims for payment or payments under title XVIII or XIX, including a prescribing physician’s medical records for an individual who is prescribed an item or service which is covered under part B of title XVIII, a covered part D drug (as defined in section 1860D-2(e)) for which payment is made under an MA-PD plan under part C of such title, or a prescription drug plan under part D of such title, and any records necessary for evaluation of the economy, efficiency, and effectiveness of the programs under titles XVIII and XIX.

“(c) ADMINISTRATIVE REMEDY FOR KNOWING PARTICIPATION BY BENEFICIARY IN HEALTH CARE FRAUD SCHEME.—

“(1) IN GENERAL.—In addition to any other applicable remedies, if an applicable individual has knowingly participated in a Federal health care fraud offense or a conspiracy to commit a Federal health care fraud offense, the Secretary shall impose an appropriate administrative penalty commensurate with the offense or conspiracy.

“(2) APPLICABLE INDIVIDUAL.—For purposes of paragraph (1), the term ‘applicable individual’ means an individual—

“(A) entitled to, or enrolled for, benefits under part A of title XVIII or enrolled under part B of such title;

“(B) eligible for medical assistance under a State plan under title XIX or under a waiver of such plan; or

“(C) eligible for child health assistance under a child health plan under title XXI.

“(d) REPORTING AND RETURNING OF OVERPAYMENTS.—

“(1) IN GENERAL.—If a person has received an overpayment, the person shall—

“(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

“(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

“(2) DEADLINE FOR REPORTING AND RETURNING OVERPAYMENTS.—An overpayment must be reported and returned under paragraph (1) by the later of—

“(A) the date which is 60 days after the date on which the overpayment was identified; or

“(B) the date any corresponding cost report is due, if applicable.

“(3) ENFORCEMENT.—Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title.

“(4) DEFINITIONS.—In this subsection:

“(A) KNOWING AND KNOWINGLY.—The terms ‘knowing’ and ‘knowingly’ have the meaning given those terms in section 3729(b) of title 31, United States Code.

“(B) OVERPAYMENT.—The term ‘overpayment’ means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.

“(C) PERSON.—

“(i) IN GENERAL.—The term ‘person’ means a provider of services, supplier, medicare managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D-41(a)(13)).

“(ii) EXCLUSION.—Such term does not include a beneficiary.

“(e) INCLUSION OF NATIONAL PROVIDER IDENTIFIER ON ALL APPLICATIONS AND CLAIMS.—The Secretary shall promulgate a regulation that requires, not later than January 1, 2011, all providers of medical or other items or services and suppliers under the programs under titles XVIII and XIX that qualify for a national provider identifier to include their national provider identifier on all applications to enroll in such programs and on all claims for payment submitted under such programs.”.

(b) ACCESS TO DATA.—

(1) MEDICARE PART D.—Section 1860D-15(f)(2) of the Social Security Act (42 U.S.C. 1395w-116(f)(2)) is amended by striking “may be used by” and all that follows through the period at the end and inserting “may be used—

“(A) by officers, employees, and contractors of the Department of Health and Human Services for the purposes of, and to the extent necessary in—

“(i) carrying out this section; and

“(ii) conducting oversight, evaluation, and enforcement under this title; and

“(B) by the Attorney General and the Comptroller General of the United States for the purposes of, and to the extent necessary in, carrying out health oversight activities.”.

(2) DATA MATCHING.—Section 552a(a)(8)(B) of title 5, United States Code, is amended—

(A) in clause (vii), by striking “or” at the end;

(B) in clause (viii), by inserting “or” after the semicolon; and

(C) by adding at the end the following new clause:

“(ix) matches performed by the Secretary of Health and Human Services or the Inspector General of the Department of Health and Human Services with respect to potential fraud, waste, and abuse, including matches of a system of records with non-Federal records.”.

(3) MATCHING AGREEMENTS WITH THE COMMISSIONER OF SOCIAL SECURITY.—Section 205(r) of the Social Security Act (42 U.S.C. 405(r)) is amended by adding at the end the following new paragraph:

“(9)(A) The Commissioner of Social Security shall, upon the request of the Secretary or the Inspector General of the Department of Health and Human Services—

“(i) enter into an agreement with the Secretary or such Inspector General for the purpose of matching data in the system of records of the Social Security Administration and the system of records of the Department of Health and Human Services; and

“(ii) include in such agreement safeguards to assure the maintenance of the confidentiality of any information disclosed.

“(B) For purposes of this paragraph, the term ‘system of records’ has the meaning given such term in section 552a(a)(5) of title 5, United States Code.”.

(c) WITHHOLDING OF FEDERAL MATCHING PAYMENTS FOR STATES THAT FAIL TO REPORT ENROLLEE ENCOUNTER DATA IN THE MEDICAID STATISTICAL INFORMATION SYSTEM.—Section 1903(i)

of the Social Security Act (42 U.S.C. 1396b(i)) is amended—

(1) in paragraph (23), by striking “or” at the end;

(2) in paragraph (24), by striking the period at the end and inserting “; or”; and

(3) by adding at the end the following new paragraph:

“(25) with respect to any amounts expended for medical assistance for individuals for whom the State does not report enrollee encounter data (as defined by the Secretary) to the Medicaid Statistical Information System (MSIS) in a timely manner (as determined by the Secretary).”

(d) PERMISSIVE EXCLUSIONS AND CIVIL MONETARY PENALTIES.—

(1) PERMISSIVE EXCLUSIONS.—Section 1128(b) of the Social Security Act (42 U.S.C. 1320a-7(b)) is amended by adding at the end the following new paragraph:

“(16) MAKING FALSE STATEMENTS OR MISREPRESENTATION OF MATERIAL FACTS.—Any individual or entity that knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program (as defined in section 1128B(f)), including Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans.”

(2) CIVIL MONETARY PENALTIES.—

(A) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a-7a(a)) is amended—

(i) in paragraph (1)(D), by striking “was excluded” and all that follows through the period at the end and inserting “was excluded from the Federal health care program (as defined in section 1128B(f)) under which the claim was made pursuant to Federal law.”;

(ii) in paragraph (6), by striking “or” at the end;

(iii) by inserting after paragraph (7), the following new paragraphs:

“(8) orders or prescribes a medical or other item or service during a period in which the person was excluded from a Federal health care program (as so defined), in the case where the person knows or should know that a claim for such medical or other item or service will be made under such a program;

“(9) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a Federal health care program (as so defined), including Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;

“(10) knows of an overpayment (as defined in paragraph (4) of section 1128J(d)) and does not report and return the overpayment in accordance with such section;”;

(iv) in the first sentence—

(I) by striking the “or” after “prohibited relationship occurs;”;

(II) by striking “(act)” and inserting “act; or in cases under paragraph (9), \$50,000 for each false statement or misrepresentation of a material fact”; and

(v) in the second sentence, by striking “purpose” and inserting “purpose; or in cases under

paragraph (9), an assessment of not more than 3 times the total amount claimed for each item or service for which payment was made based upon the application containing the false statement or misrepresentation of a material fact”.

(B) CLARIFICATION OF TREATMENT OF CERTAIN CHARITABLE AND OTHER INNOCUOUS PROGRAMS.—Section 1128A(i)(6) of the Social Security Act (42 U.S.C. 1320a-7a(i)(6)) is amended—

(i) in subparagraph (C), by striking “or” at the end;

(ii) in subparagraph (D), as redesignated by section 4331(e) of the Balanced Budget Act of 1997 (Public Law 105-33), by striking the period at the end and inserting a semicolon;

(iii) by redesignating subparagraph (D), as added by section 4523(c) of such Act, as subparagraph (E) and striking the period at the end and inserting “; or”; and

(iv) by adding at the end the following new subparagraphs:

“(F) any other remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs (as defined in section 1128B(f) and designated by the Secretary under regulations);

“(G) the offer or transfer of items or services for free or less than fair market value by a person, if—

“(i) the items or services consist of coupons, rebates, or other rewards from a retailer;

“(ii) the items or services are offered or transferred on equal terms available to the general public, regardless of health insurance status; and

“(iii) the offer or transfer of the items or services is not tied to the provision of other items or services reimbursed in whole or in part by the program under title XVIII or a State health care program (as defined in section 1128(h));

“(H) the offer or transfer of items or services for free or less than fair market value by a person, if—

“(i) the items or services are not offered as part of any advertisement or solicitation;

“(ii) the items or services are not tied to the provision of other services reimbursed in whole or in part by the program under title XVIII or a State health care program (as so defined);

“(iii) there is a reasonable connection between the items or services and the medical care of the individual; and

“(iv) the person provides the items or services after determining in good faith that the individual is in financial need; or

“(I) effective on a date specified by the Secretary (but not earlier than January 1, 2011), the waiver by a PDP sponsor of a prescription drug plan under part D of title XVIII or an MA organization offering an MA-PD plan under part C of such title of any payment for the first fill of a covered part D drug (as defined in section 1860D-2(e)) that is a generic drug for individuals enrolled in the prescription drug plan or MA-PD plan, respectively.”

(c) TESTIMONIAL SUBPOENA AUTHORITY IN EXCLUSION-ONLY CASES.—Section 1128(f) of the Social Security Act (42 U.S.C. 1320a-7(f)) is amended by adding at the end the following new paragraph:

“(4) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.”

(f) HEALTH CARE FRAUD.—

(1) KICKBACKS.—Section 1128B of the Social Security Act (42 U.S.C. 1320a-7b) is amended by adding at the end the following new subsection:

“(g) In addition to the penalties provided for in this section or section 1128A, a claim that in-

cludes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31, United States Code.”

(2) REVISING THE INTENT REQUIREMENT.—Section 1128B of the Social Security Act (42 U.S.C. 1320a-7b), as amended by paragraph (1), is amended by adding at the end the following new subsection:

“(h) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.”

(g) SURETY BOND REQUIREMENTS.—

(1) DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(16)(B) of the Social Security Act (42 U.S.C. 1395m(a)(16)(B)) is amended by inserting “that the Secretary determines is commensurate with the volume of the billing of the supplier” before the period at the end.

(2) HOME HEALTH AGENCIES.—Section 1861(o)(7)(C) of the Social Security Act (42 U.S.C. 1395x(o)(7)(C)) is amended by inserting “that the Secretary determines is commensurate with the volume of the billing of the home health agency” before the semicolon at the end.

(3) REQUIREMENTS FOR CERTAIN OTHER PROVIDERS OF SERVICES AND SUPPLIERS.—Section 1862 of the Social Security Act (42 U.S.C. 1395y) is amended by adding at the end the following new subsection:

“(n) REQUIREMENT OF A SURETY BOND FOR CERTAIN PROVIDERS OF SERVICES AND SUPPLIERS.—

“(1) IN GENERAL.—The Secretary may require a provider of services or supplier described in paragraph (2) to provide the Secretary on a continuing basis with a surety bond in a form specified by the Secretary in an amount (not less than \$50,000) that the Secretary determines is commensurate with the volume of the billing of the provider of services or supplier. The Secretary may waive the requirement of a bond under the preceding sentence in the case of a provider of services or supplier that provides a comparable surety bond under State law.

“(2) PROVIDER OF SERVICES OR SUPPLIER DESCRIBED.—A provider of services or supplier described in this paragraph is a provider of services or supplier the Secretary determines appropriate based on the level of risk involved with respect to the provider of services or supplier, and consistent with the surety bond requirements under sections 1834(a)(16)(B) and 1861(o)(7)(C).”

(h) SUSPENSION OF MEDICARE AND MEDICAID PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—

(1) MEDICARE.—Section 1862 of the Social Security Act (42 U.S.C. 1395y), as amended by subsection (g)(3), is amended by adding at the end the following new subsection:

“(o) SUSPENSION OF PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—

“(1) IN GENERAL.—The Secretary may suspend payments to a provider of services or supplier under this title pending an investigation of a credible allegation of fraud against the provider of services or supplier, unless the Secretary determines there is good cause not to suspend such payments.

“(2) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services in determining whether there is a credible allegation of fraud against a provider of services or supplier.

“(3) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection and section 1903(i)(2)(C).”

(2) MEDICAID.—Section 1903(i)(2) of such Act (42 U.S.C. 1396b(i)(2)) is amended—

(A) in subparagraph (A), by striking “or” at the end; and

(B) by inserting after subparagraph (B), the following:

“(C) by any individual or entity to whom the State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of section 1862(o) and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments; or”.

(I) INCREASED FUNDING TO FIGHT FRAUD AND ABUSE.—

(1) IN GENERAL.—Section 1817(k) of the Social Security Act (42 U.S.C. 1395i(k)) is amended—

(A) by adding at the end the following new paragraph:

“(7) ADDITIONAL FUNDING.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional \$10,000,000 to such Account from such Trust Fund for each of fiscal years 2011 through 2020. The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended.”; and

(B) in paragraph (4)(A), by inserting “until expended” after “appropriation”.

(2) INDEXING OF AMOUNTS APPROPRIATED.—

(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—Section 1817(k)(3)(A)(i) of the Social Security Act (42 U.S.C. 1395i(k)(3)(A)(i)) is amended—

(i) in subclause (III), by inserting “and” at the end;

(ii) in subclause (IV)—

(I) by striking “for each of fiscal years 2007, 2008, 2009, and 2010” and inserting “for each fiscal year after fiscal year 2006”; and

(II) by striking “; and” and inserting a period; and

(iii) by striking subclause (V).

(B) OFFICE OF THE INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—Section 1817(k)(3)(A)(ii) of such Act (42 U.S.C. 1395i(k)(3)(A)(ii)) is amended—

(i) in subclause (VIII), by inserting “and” at the end;

(ii) in subclause (IX)—

(I) by striking “for each of fiscal years 2008, 2009, and 2010” and inserting “for each fiscal year after fiscal year 2007”; and

(II) by striking “; and” and inserting a period; and

(iii) by striking subclause (X).

(C) FEDERAL BUREAU OF INVESTIGATION.—Section 1817(k)(3)(B) of the Social Security Act (42 U.S.C. 1395i(k)(3)(B)) is amended—

(i) in clause (vii), by inserting “and” at the end;

(ii) in clause (viii)—

(I) by striking “for each of fiscal years 2007, 2008, 2009, and 2010” and inserting “for each fiscal year after fiscal year 2006”; and

(II) by striking “; and” and inserting a period; and

(iii) by striking clause (ix).

(D) MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4)(C) of the Social Security Act (42 U.S.C. 1395i(k)(4)(C)) is amended by adding at the end the following new clause:

“(ii) For each fiscal year after 2010, by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.”.

(J) MEDICARE INTEGRITY PROGRAM AND MEDICAID INTEGRITY PROGRAM.—

(1) MEDICARE INTEGRITY PROGRAM.—

(A) REQUIREMENT TO PROVIDE PERFORMANCE STATISTICS.—Section 1893(c) of the Social Security Act (42 U.S.C. 1395ddd(c)) is amended—

(i) in paragraph (3), by striking “and” at the end;

(ii) by redesignating paragraph (4) as paragraph (5); and

(iii) by inserting after paragraph (3) the following new paragraph:

“(4) the entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request; and”.

(B) EVALUATIONS AND ANNUAL REPORT.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

“(i) EVALUATIONS AND ANNUAL REPORT.—

“(1) EVALUATIONS.—The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.

“(2) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2011), the Secretary shall submit a report to Congress which identifies—

“(A) the use of funds, including funds transferred from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Insurance Trust Fund under section 1841, to carry out this section; and

“(B) the effectiveness of the use of such funds.”.

(C) FLEXIBILITY IN PURSUING FRAUD AND ABUSE.—Section 1893(a) of the Social Security Act (42 U.S.C. 1395ddd(a)) is amended by inserting “, or otherwise,” after “entities”.

(2) MEDICAID INTEGRITY PROGRAM.—

(A) REQUIREMENT TO PROVIDE PERFORMANCE STATISTICS.—Section 1936(c)(2) of the Social Security Act (42 U.S.C. 1396u-6(c)(2)) is amended—

(i) by redesignating subparagraph (D) as subparagraph (E); and

(ii) by inserting after subparagraph (C) the following new subparagraph:

“(D) The entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request.”.

(B) EVALUATIONS AND ANNUAL REPORT.—Section 1936(e) of the Social Security Act (42 U.S.C. 1396u-7(e)) is amended—

(i) by redesignating paragraph (4) as paragraph (5); and

(ii) by inserting after paragraph (3) the following new paragraph:

“(4) EVALUATIONS.—The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.”.

(K) EXPANDED APPLICATION OF HARDSHIP WAIVERS FOR EXCLUSIONS.—Section 1128(c)(3)(B) of the Social Security Act (42 U.S.C. 1320a-7(c)(3)(B)) is amended by striking “individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both” and inserting “beneficiaries (as defined in section 1128A(i)(5) of that program”.

SEC. 6403. ELIMINATION OF DUPLICATION BETWEEN THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK AND THE NATIONAL PRACTITIONER DATA BANK.

(A) INFORMATION REPORTED BY FEDERAL AGENCIES AND HEALTH PLANS.—Section 1128E of

the Social Security Act (42 U.S.C. 1320a-7e) is amended—

(1) by striking subsection (a) and inserting the following:

“(a) IN GENERAL.—The Secretary shall maintain a national health care fraud and abuse data collection program under this section for the reporting of certain final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (d), and shall furnish the information collected under this section to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).”;

(2) by striking subsection (d) and inserting the following:

“(d) ACCESS TO REPORTED INFORMATION.—

“(1) AVAILABILITY.—The information collected under this section shall be available from the National Practitioner Data Bank to the agencies, authorities, and officials which are provided under section 1921(b) information reported under section 1921(a).

“(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.”;

(3) by striking subsection (f) and inserting the following:

“(f) APPROPRIATE COORDINATION.—In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1921.”; and

(4) in subsection (g)—

(A) in paragraph (1)(A)—

(i) in clause (ii)—

(I) by striking “or State” each place it appears;

(II) by redesignating subclauses (II) and (III) as subclauses (III) and (IV), respectively; and

(III) by inserting after subclause (I) the following new subclause:

“(II) any dismissal or closure of the proceedings by reason of the provider, supplier, or practitioner surrendering their license or leaving the State or jurisdiction”; and

(ii) by striking clause (iv) and inserting the following:

“(iv) Exclusion from participation in a Federal health care program (as defined in section 1128B(f)).”;

(B) in paragraph (3)—

(i) by striking subparagraphs (D) and (E); and

(ii) by redesignating subparagraph (F) as subparagraph (D); and

(C) in subparagraph (D) (as so redesignated), by striking “or State”.

(b) INFORMATION REPORTED BY STATE LAW OR FRAUD ENFORCEMENT AGENCIES.—Section 1921 of the Social Security Act (42 U.S.C. 1396r-2) is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) by striking “SYSTEM.—The State” and all that follows through the semicolon and inserting SYSTEM.—

“(A) LICENSING OR CERTIFICATION ACTIONS.—The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by a State licensing or certification agency.”;

(ii) by redesignating subparagraphs (A) through (D) as clauses (i) through (iv), respectively, and indenting appropriately;

(iii) in subparagraph (A)(iii) (as so redesignated)—

(I) by striking “the license of” and inserting “license or the right to apply for, or renew, a license by”; and

(II) by inserting “nonrenewability,” after “voluntary surrender.”; and

(iv) by adding at the end the following new subparagraph:

“(B) OTHER FINAL ADVERSE ACTIONS.—The State must have in effect a system of reporting information with respect to any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner by a State law or fraud enforcement agency.”; and

(B) in paragraph (2), by striking “the authority described in paragraph (1)” and inserting “a State licensing or certification agency or State law or fraud enforcement agency”;

(2) in subsection (b)—

(A) by striking paragraph (2) and inserting the following:

“(2) to State licensing or certification agencies and Federal agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners.”;

(B) in each of paragraphs (4) and (6), by inserting “, but only with respect to information provided pursuant to subsection (a)(1)(A)” before the comma at the end;

(C) by striking paragraph (5) and inserting the following:

“(5) to State law or fraud enforcement agencies.”;

(D) by redesignating paragraphs (7) and (8) as paragraphs (8) and (9), respectively; and

(E) by inserting after paragraph (6) the following new paragraph:

“(7) to health plans (as defined in section 1128C(c)).”;

(3) by redesignating subsection (d) as subsection (h), and by inserting after subsection (c) the following new subsections:

“(d) DISCLOSURE AND CORRECTION OF INFORMATION.—

“(1) DISCLOSURE.—With respect to information reported pursuant to subsection (a)(1), the Secretary shall—

“(A) provide for disclosure of the information, upon request, to the health care practitioner who, or the entity that, is the subject of the information reported; and

“(B) establish procedures for the case where the health care practitioner or entity disputes the accuracy of the information reported.

“(2) CORRECTIONS.—Each State licensing or certification agency and State law or fraud enforcement agency shall report corrections of information already reported about any formal proceeding or final adverse action described in subsection (a), in such form and manner as the Secretary prescribes by regulation.

“(e) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.

“(f) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including any agency designated by the Secretary in subsection (b), shall be held liable in any civil action with respect to any reporting of information as required under this section, without knowledge of the falsity of the information contained in the report.

“(g) REFERENCES.—For purposes of this section:

“(1) STATE LICENSING OR CERTIFICATION AGENCY.—The term ‘State licensing or certification

agency’ includes any authority of a State (or of a political subdivision thereof) responsible for the licensing of health care practitioners (or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners) or entities.

“(2) STATE LAW OR FRAUD ENFORCEMENT AGENCY.—The term ‘State law or fraud enforcement agency’ includes—

“(A) a State law enforcement agency; and

“(B) a State Medicaid fraud control unit (as defined in section 1903(q)).

“(3) FINAL ADVERSE ACTION.—

“(A) IN GENERAL.—Subject to subparagraph (B), the term ‘final adverse action’ includes—

“(i) civil judgments against a health care provider, supplier, or practitioner in State court related to the delivery of a health care item or service;

“(ii) State criminal convictions related to the delivery of a health care item or service;

“(iii) exclusion from participation in State health care programs (as defined in section 1128(h));

“(iv) any licensing or certification action described in subsection (a)(1)(A) taken against a supplier by a State licensing or certification agency; and

“(v) any other adjudicated actions or decisions that the Secretary shall establish by regulation.

“(B) EXCEPTION.—Such term does not include any action with respect to a malpractice claim.”; and

(4) in subsection (h), as so redesignated, by striking “The Secretary” and all that follows through the period at the end and inserting “In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1128E.”.

(c) CONFORMING AMENDMENT.—Section 1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a-7c(a)(1)) is amended—

(1) in subparagraph (C), by adding “and” after the comma at the end;

(2) in subparagraph (D), by striking “, and” and inserting a period; and

(3) by striking subparagraph (E).

(d) TRANSITION PROCESS; EFFECTIVE DATE.—

(1) IN GENERAL.—Effective on the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall implement a transition process under which, by not later than the end of the transition period described in paragraph (5), the Secretary shall cease operating the Healthcare Integrity and Protection Data Bank established under section 1128E of the Social Security Act (as in effect before the effective date specified in paragraph (6)) and shall transfer all data collected in the Healthcare Integrity and Protection Data Bank to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.). During such transition process, the Secretary shall have in effect appropriate procedures to ensure that data collection and access to the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank are not disrupted.

(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out the amendments made by subsections (a) and (b).

(3) FUNDING.—

(A) AVAILABILITY OF FEES.—Fees collected pursuant to section 1128E(d)(2) of the Social Security Act prior to the effective date specified in paragraph (6) for the disclosure of information in the Healthcare Integrity and Protection Data Bank shall be available to the Secretary, without fiscal year limitation, for payment of costs related to the transition process described in

paragraph (1). Any such fees remaining after the transition period is complete shall be available to the Secretary, without fiscal year limitation, for payment of the costs of operating the National Practitioner Data Bank.

(B) AVAILABILITY OF ADDITIONAL FUNDS.—In addition to the fees described in subparagraph (A), any funds available to the Secretary or to the Inspector General of the Department of Health and Human Services for a purpose related to combating health care fraud, waste, or abuse shall be available to the extent necessary for operating the Healthcare Integrity and Protection Data Bank during the transition period, including systems testing and other activities necessary to ensure that information formerly reported to the Healthcare Integrity and Protection Data Bank will be accessible through the National Practitioner Data Bank after the end of such transition period.

(4) SPECIAL PROVISION FOR ACCESS TO THE NATIONAL PRACTITIONER DATA BANK BY THE DEPARTMENT OF VETERANS AFFAIRS.—

(A) IN GENERAL.—Notwithstanding any other provision of law, during the 1-year period that begins on the effective date specified in paragraph (6), the information described in subparagraph (B) shall be available from the National Practitioner Data Bank to the Secretary of Veterans Affairs without charge.

(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is the information that would, but for the amendments made by this section, have been available to the Secretary of Veterans Affairs from the Healthcare Integrity and Protection Data Bank.

(5) TRANSITION PERIOD DEFINED.—For purposes of this subsection, the term “transition period” means the period that begins on the date of enactment of this Act and ends on the later of—

(A) the date that is 1 year after such date of enactment; or

(B) the effective date of the regulations promulgated under paragraph (2).

(6) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall take effect on the first day after the final day of the transition period.

SEC. 6404. MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) REDUCING MAXIMUM PERIOD FOR SUBMISSION.—

(1) PART A.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)(1)) is amended—

(A) in paragraph (1), by striking “period of 3 calendar years” and all that follows through the semicolon and inserting “period ending 1 calendar year after the date of service.”; and

(B) by adding at the end the following new sentence: “In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.”

(2) PART B.—

(A) Section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)(B)) is amended—

(i) in subparagraph (B), in the flush language following clause (ii), by striking “close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year)” and inserting “period ending 1 calendar year after the date of service.”; and

(ii) by adding at the end the following new sentence: “In applying subparagraph (B), the Secretary may specify exceptions to the 1 calendar year period specified in such subparagraph.”

(B) Section 1835(a) of such Act (42 U.S.C. 1395n(a)) is amended—

(i) in paragraph (1), by striking “period of 3 calendar years” and all that follows through

the semicolon and inserting “period ending 1 calendar year after the date of service;”;

(ii) by adding at the end the following new sentence: “In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.”

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 2010.

(2) SERVICES FURNISHED BEFORE 2010.—In the case of services furnished before January 1, 2010, a bill or request for payment under section 1814(a)(1), 1842(b)(3)(B), or 1835(a) shall be filed not later than December 31, 2010.

SEC. 6405. PHYSICIANS WHO ORDER ITEMS OR SERVICES REQUIRED TO BE MEDICARE ENROLLED PHYSICIANS OR ELIGIBLE PROFESSIONALS.

(a) DME.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by striking “physician” and inserting “physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B) that is enrolled under section 1866(j)”.

(b) HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2) of such Act (42 U.S.C. 1395(a)(2)) is amended in the matter preceding subparagraph (A) by inserting “in the case of services described in subparagraph (C), a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B),” before “or, in the case of services”.

(2) PART B.—Section 1835(a)(2) of such Act (42 U.S.C. 1395n(a)(2)) is amended in the matter preceding subparagraph (A) by inserting “, or in the case of services described in subparagraph (A), a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B),” after “a physician”.

(c) APPLICATION TO OTHER ITEMS OR SERVICES.—The Secretary may extend the requirement applied by the amendments made by subsections (a) and (b) to durable medical equipment and home health services (relating to requiring certifications and written orders to be made by enrolled physicians and health professions) to all other categories of items or services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including covered part D drugs as defined in section 1860D-2(e) of such Act (42 U.S.C. 1395w-102), that are ordered, prescribed, or referred by a physician enrolled under section 1866(j) of such Act (42 U.S.C. 1395cc(j)) or an eligible professional under section 1848(k)(3)(B) of such Act (42 U.S.C. 1395w-4(k)(3)(B)).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to written orders and certifications made on or after July 1, 2010.

SEC. 6406. REQUIREMENT FOR PHYSICIANS TO PROVIDE DOCUMENTATION ON REFERRALS TO PROGRAMS AT HIGH RISK OF WASTE AND ABUSE.

(a) PHYSICIANS AND OTHER SUPPLIERS.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following new paragraph:

“(9) The Secretary may revoke enrollment, for a period of not more than one year for each act, for a physician or supplier under section 1866(j) if such physician or supplier fails to maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such physician or supplier under this title, as specified by the Secretary.”.

(b) PROVIDERS OF SERVICES.—Section 1866(a)(1) of such Act (42 U.S.C. 1395cc) is further amended—

(1) in subparagraph (U), by striking at the end “and”;

(2) in subparagraph (V), by striking the period at the end and adding “; and”; and

(3) by adding at the end the following new subparagraph:

“(W) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary.”.

(c) OIG PERMISSIVE EXCLUSION AUTHORITY.—Section 1128(b)(11) of the Social Security Act (42 U.S.C. 1320a-7(b)(11)) is amended by inserting “, ordering, referring for furnishing, or certifying the need for” after “furnishing”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to orders, certifications, and referrals made on or after January 1, 2010.

SEC. 6407. FACE TO FACE ENCOUNTER WITH PATIENT REQUIRED BEFORE PHYSICIANS MAY CERTIFY ELIGIBILITY FOR HOME HEALTH SERVICES OR DURABLE MEDICAL EQUIPMENT UNDER MEDICARE.

(a) CONDITION OF PAYMENT FOR HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2)(C) of such Act is amended—

(A) by striking “and such services” and inserting “such services”; and

(B) by inserting after “care of a physician” the following: “, and, in the case of a certification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician himself or herself has had a face-to-face encounter (including through use of telehealth, subject to the requirements in section 1834(m), and other than with respect to encounters that are incident to services involved) with the individual within a reasonable timeframe as determined by the Secretary”.

(2) PART B.—Section 1835(a)(2)(A) of the Social Security Act is amended—

(A) by striking “and” before “(iii)”;

(B) by inserting after “care of a physician” the following: “, and (iv) in the case of a certification after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary”.

(b) CONDITION OF PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended—

(1) by striking “ORDER.—The Secretary” and inserting “ORDER.—

“(i) IN GENERAL.—The Secretary”; and

(2) by adding at the end the following new clause:

“(ii) REQUIREMENT FOR FACE TO FACE ENCOUNTER.—The Secretary shall require that such an order be written pursuant to the physician documenting that a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) has had a face-to-face encounter (including through use of telehealth under subsection (m) and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by the Secretary.”.

(c) APPLICATION TO OTHER AREAS UNDER MEDICARE.—The Secretary may apply the face-to-face encounter requirement described in the amendments made by subsections (a) and (b) to other items and services for which payment is provided under title XVIII of the Social Security

Act based upon a finding that such an decision would reduce the risk of waste, fraud, or abuse.

(d) APPLICATION TO MEDICAID.—The requirements pursuant to the amendments made by subsections (a) and (b) shall apply in the case of physicians making certifications for home health services under title XIX of the Social Security Act in the same manner and to the same extent as such requirements apply in the case of physicians making such certifications under title XVIII of such Act.

SEC. 6408. ENHANCED PENALTIES.

(a) CIVIL MONETARY PENALTIES FOR FALSE STATEMENTS OR DELAYING INSPECTIONS.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a-7a(a)), as amended by section 5002(d)(2)(A), is amended—

(1) in paragraph (6), by striking “or” at the end; and

(2) by inserting after paragraph (7) the following new paragraphs:

“(8) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program; or

“(9) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;”;

(3) in the first sentence—

(A) by striking “or in cases under paragraph (7)” and inserting “in cases under paragraph (7)”;

(B) by striking “act)” and inserting “act, in cases under paragraph (8), \$50,000 for each false record or statement, or in cases under paragraph (9), \$15,000 for each day of the failure described in such paragraph)”.

(b) MEDICARE ADVANTAGE AND PART D PLANS.—

(1) ENSURING TIMELY INSPECTIONS RELATING TO CONTRACTS WITH MA ORGANIZATIONS.—Section 1857(d)(2) of such Act (42 U.S.C. 1395w-27(d)(2)) is amended—

(A) in subparagraph (A), by inserting “time-ly” before “inspect”; and

(B) in subparagraph (B), by inserting “time-ly” before “audit and inspect”.

(2) MARKETING VIOLATIONS.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w-27(g)(1)) is amended—

(A) in subparagraph (F), by striking “or” at the end;

(B) by inserting after subparagraph (G) the following new subparagraphs:

“(H) except as provided under subparagraph (C) or (D) of section 1860D-1(b)(1), enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;

“(I) transfers an individual enrolled under this part from one plan to another without the prior consent of the individual or the designee of the individual or solely for the purpose of earning a commission;

“(J) fails to comply with marketing restrictions described in subsections (h) and (j) of section 1851 or applicable implementing regulations or guidance; or

“(K) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (J) of this paragraph;”;

(C) by adding at the end the following new sentence: “The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any

provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (K) of this paragraph.”.

(3) **PROVISION OF FALSE INFORMATION.**—Section 1857(g)(2)(A) of the Social Security Act (42 U.S.C. 1395w–27(g)(2)(A)) is amended by inserting “except with respect to a determination under subparagraph (E), an assessment of not more than the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved,” after “for each such determination.”.

(c) **OBSTRUCTION OF PROGRAM AUDITS.**—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a–7(b)(2)) is amended—

(1) in the heading, by inserting “OR AUDIT” after “INVESTIGATION”; and

(2) by striking “investigation into” and all that follows through the period and inserting “investigation or audit related to—”

“(i) any offense described in paragraph (1) or in subsection (a); or

“(ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1128B(f)).”.

(d) **EFFECTIVE DATE.**—

(1) **IN GENERAL.**—Except as provided in paragraph (2), the amendments made by this section shall apply to acts committed on or after January 1, 2010.

(2) **EXCEPTION.**—The amendments made by subsection (b)(1) take effect on the date of enactment of this Act.

SEC. 6409. MEDICARE SELF-REFERRAL DISCLOSURE PROTOCOL.

(a) **DEVELOPMENT OF SELF-REFERRAL DISCLOSURE PROTOCOL.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services, in cooperation with the Inspector General of the Department of Health and Human Services, shall establish, not later than 6 months after the date of the enactment of this Act, a protocol to enable health care providers of services and suppliers to disclose an actual or potential violation of section 1877 of the Social Security Act (42 U.S.C. 1395nn) pursuant to a self-referral disclosure protocol (in this section referred to as an “SRDP”). The SRDP shall include direction to health care providers of services and suppliers on—

(A) a specific person, official, or office to whom such disclosures shall be made; and

(B) instruction on the implication of the SRDP on corporate integrity agreements and corporate compliance agreements.

(2) **PUBLICATION ON INTERNET WEBSITE OF SRDP INFORMATION.**—The Secretary of Health and Human Services shall post information on the public Internet website of the Centers for Medicare & Medicaid Services to inform relevant stakeholders of how to disclose actual or potential violations pursuant to an SRDP.

(3) **RELATION TO ADVISORY OPINIONS.**—The SRDP shall be separate from the advisory opinion process set forth in regulations implementing section 1877(g) of the Social Security Act.

(b) **REDUCTION IN AMOUNTS OWED.**—The Secretary of Health and Human Services is authorized to reduce the amount due and owing for all violations under section 1877 of the Social Security Act to an amount less than that specified in subsection (g) of such section. In establishing such amount for a violation, the Secretary may consider the following factors:

(1) The nature and extent of the improper or illegal practice.

(2) The timeliness of such self-disclosure.

(3) The cooperation in providing additional information related to the disclosure.

(4) Such other factors as the Secretary considers appropriate.

(c) **REPORT.**—Not later than 18 months after the date on which the SRDP protocol is estab-

lished under subsection (a)(1), the Secretary shall submit to Congress a report on the implementation of this section. Such report shall include—

(1) the number of health care providers of services and suppliers making disclosures pursuant to the SRDP;

(2) the amounts collected pursuant to the SRDP;

(3) the types of violations reported under the SRDP; and

(4) such other information as may be necessary to evaluate the impact of this section.

SEC. 6410. ADJUSTMENTS TO THE MEDICARE DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES COMPETITIVE ACQUISITION PROGRAM.

(a) **EXPANSION OF ROUND 2 OF THE DME COMPETITIVE BIDDING PROGRAM.**—Section 1847(a)(1) of the Social Security Act (42 U.S.C. 1395w–3(a)(1)) is amended—

(1) in subparagraph (B)(i)(II), by striking “70” and inserting “91”; and

(2) in subparagraph (D)(ii)—

(A) in subclause (I), by striking “and” at the end;

(B) by redesignating subclause (II) as subclause (III); and

(C) by inserting after subclause (I) the following new subclause:

“(II) the Secretary shall include the next 21 largest metropolitan statistical areas by total population (after those selected under subclause (I)) for such round; and”.

(b) **REQUIREMENT TO EITHER COMPETITIVELY BID AREAS OR USE COMPETITIVE BID PRICES BY 2016.**—Section 1834(a)(1)(F) of the Social Security Act (42 U.S.C. 1395m(a)(1)(F)) is amended—

(1) in clause (i), by striking “and” at the end;

(2) in clause (ii)—

(A) by inserting “(and, in the case of covered items furnished on or after January 1, 2016, subject to clause (iii), shall)” after “may”; and

(B) by striking the period at the end and inserting “; and”; and

(3) by adding at the end the following new clause:

“(iii) in the case of covered items furnished on or after January 1, 2016, the Secretary shall continue to make such adjustments described in clause (ii) as, under such competitive acquisition programs, additional covered items are phased in or information is updated as contracts under section 1847 are recompeted in accordance with section 1847(b)(3)(B).”.

SEC. 6411. EXPANSION OF THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM.

(a) **EXPANSION TO MEDICAID.**—

(1) **STATE PLAN AMENDMENT.**—Section 1902(a)(42) of the Social Security Act (42 U.S.C. 1396a(a)(42)) is amended—

(A) by striking “that the records” and inserting “that—

“(A) the records”; and

(B) by inserting “and” after the semicolon; and

(C) by adding at the end the following:

“(B) not later than December 31, 2010, the State shall—

“(i) establish a program under which the State contracts (consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1893(h), subject to such exceptions or requirements as the Secretary may require for purposes of this title or a particular State) with 1 or more recovery audit contractors for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver; and

“(ii) provide assurances satisfactory to the Secretary that—

“(I) under such contracts, payment shall be made to such a contractor only from amounts recovered; and

“(II) from such amounts recovered, payment—
“(aa) shall be made on a contingent basis for collecting overpayments; and

“(bb) may be made in such amounts as the State may specify for identifying underpayments; and

“(III) the State has an adequate process for entities to appeal any adverse determination made by such contractors; and

“(IV) such program is carried out in accordance with such requirements as the Secretary shall specify, including—

“(aa) for purposes of section 1903(a)(7), that amounts expended by the State to carry out the program shall be considered amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan; and

“(bb) that section 1903(d) shall apply to amounts recovered under the program; and

“(cc) that the State and any such contractors under contract with the State shall coordinate such recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, including efforts with Federal and State law enforcement with respect to the Department of Justice, including the Federal Bureau of Investigations, the Inspector General of the Department of Health and Human Services, and the State medicaid fraud control unit; and”.

(2) **COORDINATION; REGULATIONS.**—

(A) **IN GENERAL.**—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall coordinate the expansion of the Recovery Audit Contractor program to Medicaid with States, particularly with respect to each State that enters into a contract with a recovery audit contractor for purposes of the State’s Medicaid program prior to December 31, 2010.

(B) **REGULATIONS.**—The Secretary of Health and Human Services shall promulgate regulations to carry out this subsection and the amendments made by this subsection, including with respect to conditions of Federal financial participation, as specified by the Secretary.

(b) **EXPANSION TO MEDICARE PARTS C AND D.**—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking “part A or B” and inserting “this title”; and

(2) in paragraph (2), by striking “parts A and B” and inserting “this title”; and

(3) in paragraph (3), by inserting “(not later than December 31, 2010, in the case of contracts relating to payments made under part C or D)” after “2010”; and

(4) in paragraph (4), in the matter preceding subparagraph (A), by striking “part A or B” and inserting “this title”; and

(5) by adding at the end the following:

“(9) **SPECIAL RULES RELATING TO PARTS C AND D.**—The Secretary shall enter into contracts under paragraph (1) to require recovery audit contractors to—

“(A) ensure that each MA plan under part C has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan; and

“(B) ensure that each prescription drug plan under part D has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan; and

“(C) examine claims for reinsurance payments under section 1860D–15(b) to determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under paragraph (2) of that section; and

“(D) review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.”

(c) **ANNUAL REPORT.**—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall submit an annual report to Congress concerning the effectiveness of the Recovery Audit Contractor program under Medicaid and Medicare and shall include such reports recommendations for expanding or improving the program.

Subtitle F—Additional Medicaid Program Integrity Provisions

SEC. 6501. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN.

Section 1902(a)(39) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is amended by inserting after “1128A,” the following: “terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1128(c)(3)(B) and 1128(d)(3)(B)) participation of such individual or entity is terminated under title XVIII or any other State plan under this title.”

SEC. 6502. MEDICAID EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 6401(b), is amended by inserting after paragraph (77) the following:

“(78) provide that the State agency described in paragraph (9) exclude, with respect to a period, any individual or entity from participation in the program under the State plan if such individual or entity owns, controls, or manages an entity that (or if such entity is owned, controlled, or managed by an individual or entity that)—

“(A) has unpaid overpayments (as defined by the Secretary) under this title during such period determined by the Secretary or the State agency to be delinquent;

“(B) is suspended or excluded from participation under or whose participation is terminated under this title during such period; or

“(C) is affiliated with an individual or entity that has been suspended or excluded from participation under this title or whose participation is terminated under this title during such period.”

SEC. 6503. BILLING AGENTS, CLEARINGHOUSES, OR OTHER ALTERNATE PAYEES REQUIRED TO REGISTER UNDER MEDICAID.

(a) **IN GENERAL.**—Section 1902(a) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)), as amended by section 6502(a), is amended by inserting after paragraph (78), the following:

“(79) provide that any agent, clearinghouse, or other alternate payee (as defined by the Secretary) that submits claims on behalf of a health care provider must register with the State and the Secretary in a form and manner specified by the Secretary.”

SEC. 6504. REQUIREMENT TO REPORT EXPANDED SET OF DATA ELEMENTS UNDER MMIS TO DETECT FRAUD AND ABUSE.

(a) **IN GENERAL.**—Section 1903(r)(1)(F) of the Social Security Act (42 U.S.C. 1396b(r)(1)(F)) is amended by inserting after “necessary” the following: “and including, for data submitted to the Secretary on or after January 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and adminis-

tration, at such frequency as the Secretary shall determine”.

(b) MANAGED CARE ORGANIZATIONS.—

(1) **IN GENERAL.**—Section 1903(m)(2)(A)(xi) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(xi)) is amended by inserting “and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary” after “patients”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply with respect to contract years beginning on or after January 1, 2010.

SEC. 6505. PROHIBITION ON PAYMENTS TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396b(a)), as amended by section 6503, is amended by inserting after paragraph (79) the following new paragraph:

“(80) provide that the State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.”

SEC. 6506. OVERPAYMENTS.

(a) **EXTENSION OF PERIOD FOR COLLECTION OF OVERPAYMENTS DUE TO FRAUD.**—

(1) **IN GENERAL.**—Section 1903(d)(2) of the Social Security Act (42 U.S.C. 1396b(d)(2)) is amended—

(A) in subparagraph (C)—

(i) in the first sentence, by striking “60 days” and inserting “1 year”; and

(ii) in the second sentence, by striking “60 days” and inserting “1-year period”; and

(B) in subparagraph (D)—

(i) in inserting “(i)” after “(D)”; and

(ii) by adding at the end the following:

“(ii) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity due to fraud within 1 year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof) before the date that is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.”

(2) **EFFECTIVE DATE.**—The amendments made by this subsection take effect on the date of enactment of this Act and apply to overpayments discovered on or after that date.

(b) **CORRECTIVE ACTION.**—The Secretary shall promulgate regulations that require States to correct Federally identified claims overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate corrective action.

SEC. 6507. MANDATORY STATE USE OF NATIONAL CORRECT CODING INITIATIVE.

Section 1903(r) of the Social Security Act (42 U.S.C. 1396b(r)) is amended—

(1) in paragraph (1)(B)—

(A) in clause (ii), by striking “and” at the end;

(B) in clause (iii), by adding “and” after the semi-colon; and

(C) by adding at the end the following new clause:

“(iv) effective for claims filed on or after October 1, 2010, incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (4);” and

(2) by adding at the end the following new paragraph:

“(4) For purposes of paragraph (1)(B)(iv), the Secretary shall do the following:

“(A) Not later than September 1, 2010:

“(i) Identify those methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under this title.

“(ii) Identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under this title with respect to items or services for which States provide medical assistance under this title and no national correct coding methodologies have been established under such Initiative with respect to title XVIII.

“(iii) Notify States of—

“(I) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

“(II) how States are to incorporate such methodologies into claims filed under this title.

“(B) Not later than March 1, 2011, submit a report to Congress that includes the notice to States under clause (iii) of subparagraph (A) and an analysis supporting the identification of the methodologies made under clauses (i) and (ii) of subparagraph (A).”

SEC. 6508. GENERAL EFFECTIVE DATE.

(a) **IN GENERAL.**—Except as otherwise provided in this subtitle, this subtitle and the amendments made by this subtitle take effect on January 1, 2011, without regard to whether final regulations to carry out such amendments and subtitle have been promulgated by that date.

(b) **DELAY IF STATE LEGISLATION REQUIRED.**—

In the case of a State plan for medical assistance under title XIX of the Social Security Act or a child health plan under title XXI of such Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this subtitle, the State plan or child health plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Subtitle G—Additional Program Integrity Provisions

SEC. 6601. PROHIBITION ON FALSE STATEMENTS AND REPRESENTATIONS.

(a) **PROHIBITION.**—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.) is amended by adding at the end the following:

“SEC. 519. PROHIBITION ON FALSE STATEMENTS AND REPRESENTATIONS.

“No person, in connection with a plan or other arrangement that is multiple employer welfare arrangement described in section 3(40), shall make a false statement or false representation of fact, knowing it to be false, in connection with the marketing or sale of such plan or arrangement, to any employee, any member of an employee organization, any beneficiary, any employer, any employee organization, the Secretary, or any State, or the representative or agent of any such person, State, or the Secretary, concerning—

“(1) the financial condition or solvency of such plan or arrangement;

“(2) the benefits provided by such plan or arrangement;

“(3) the regulatory status of such plan or other arrangement under any Federal or State law governing collective bargaining, labor management relations, or intern union affairs; or

“(4) the regulatory status of such plan or other arrangement regarding exemption from state regulatory authority under this Act.

This section shall not apply to any plan or arrangement that does not fall within the meaning of the term ‘multiple employer welfare arrangement’ under section 3(40)(A).”.

(b) **CRIMINAL PENALTIES.**—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting “(a)” before “Any person”; and

(2) by adding at the end the following:

“(b) Any person that violates section 519 shall upon conviction be imprisoned not more than 10 years or fined under title 18, United States Code, or both.”.

(c) **CONFORMING AMENDMENT.**—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following:

“Sec. 519. Prohibition on false statement and representations.”.

SEC. 6602. CLARIFYING DEFINITION.

Section 24(a)(2) of title 18, United States Code, is amended by inserting “or section 411, 518, or 511 of the Employee Retirement Income Security Act of 1974,” after “1954 of this title”.

SEC. 6603. DEVELOPMENT OF MODEL UNIFORM REPORT FORM.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.) is amended by adding at the end the following:

“SEC. 2794. UNIFORM FRAUD AND ABUSE REFERRAL FORMAT.

“The Secretary shall request the National Association of Insurance Commissioners to develop a model uniform report form for private health insurance issuer seeking to refer suspected fraud and abuse to State insurance departments or other responsible State agencies for investigation. The Secretary shall request that the National Association of Insurance Commissioners develop recommendations for uniform reporting standards for such referrals.”.

SEC. 6604. APPLICABILITY OF STATE LAW TO COMBAT FRAUD AND ABUSE.

(a) **IN GENERAL.**—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.), as amended by section 6601, is further amended by adding at the end the following:

“SEC. 520. APPLICABILITY OF STATE LAW TO COMBAT FRAUD AND ABUSE.

“The Secretary may, for the purpose of identifying, preventing, or prosecuting fraud and abuse, adopt regulatory standards establishing, or issue an order relating to a specific person establishing, that a person engaged in the business of providing insurance through a multiple employer welfare arrangement described in section 3(40) is subject to the laws of the States in which such person operates which regulate insurance in such State, notwithstanding section 514(b)(6) of this Act or the Liability Risk Retention Act of 1986, and regardless of whether the law of the State is otherwise preempted under any of such provisions. This section shall not apply to any plan or arrangement that does not fall within the meaning of the term ‘multiple employer welfare arrangement’ under section 3(40)(A).”.

(b) **CONFORMING AMENDMENT.**—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 6601, is further amended by adding at the end the following:

“Sec. 520. Applicability of State law to combat fraud and abuse.”.

SEC. 6605. ENABLING THE DEPARTMENT OF LABOR TO ISSUE ADMINISTRATIVE SUMMARY CEASE AND DESIST ORDERS AND SUMMARY SEIZURES ORDERS AGAINST PLANS THAT ARE IN FINANCIALLY HAZARDOUS CONDITION.

(a) **IN GENERAL.**—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.), as amended by section 6604, is further amended by adding at the end the following:

“SEC. 521. ADMINISTRATIVE SUMMARY CEASE AND DESIST ORDERS AND SUMMARY SEIZURE ORDERS AGAINST MULTIPLE EMPLOYER WELFARE ARRANGEMENTS IN FINANCIALLY HAZARDOUS CONDITION.

“(a) **IN GENERAL.**—The Secretary may issue a cease and desist (ex parte) order under this title if it appears to the Secretary that the alleged conduct of a multiple employer welfare arrangement described in section 3(40), other than a plan or arrangement described in subsection (g), is fraudulent, or creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury.

“(b) **HEARING.**—A person that is adversely affected by the issuance of a cease and desist order under subsection (a) may request a hearing by the Secretary regarding such order. The Secretary may require that a proceeding under this section, including all related information and evidence, be conducted in a confidential manner.

“(c) **BURDEN OF PROOF.**—The burden of proof in any hearing conducted under subsection (b) shall be on the party requesting the hearing to show cause why the cease and desist order should be set aside.

“(d) **DETERMINATION.**—Based upon the evidence presented at a hearing under subsection (b), the cease and desist order involved may be affirmed, modified, or set aside by the Secretary in whole or in part.

“(e) **SEIZURE.**—The Secretary may issue a summary seizure order under this title if it appears that a multiple employer welfare arrangement is in a financially hazardous condition.

“(f) **REGULATIONS.**—The Secretary may promulgate such regulations or other guidance as may be necessary or appropriate to carry out this section.

“(g) **EXCEPTION.**—This section shall not apply to any plan or arrangement that does not fall within the meaning of the term ‘multiple employer welfare arrangement’ under section 3(40)(A).”.

(b) **CONFORMING AMENDMENT.**—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 6604, is further amended by adding at the end the following:

“Sec. 521. Administrative summary cease and desist orders and summary seizure orders against health plans in financially hazardous condition.”.

SEC. 6606. MEWA PLAN REGISTRATION WITH DEPARTMENT OF LABOR.

Section 101(g) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021(g)) is amended—

(1) by striking “Secretary may” and inserting “Secretary shall”; and

(2) by inserting “to register with the Secretary prior to operating in a State and may, by regulation, require such multiple employer welfare arrangements” after “not group health plans”.

SEC. 6607. PERMITTING EVIDENTIARY PRIVILEGE AND CONFIDENTIAL COMMUNICATIONS.

Section 504 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1134) is amended by adding at the end the following:

“(d) The Secretary may promulgate a regulation that provides an evidentiary privilege for, and provides for the confidentiality of communications between or among, any of the following entities or their agents, consultants, or employees:

“(1) A State insurance department.

“(2) A State attorney general.

“(3) The National Association of Insurance Commissioners.

“(4) The Department of Labor.

“(5) The Department of the Treasury.

“(6) The Department of Justice.

“(7) The Department of Health and Human Services.

“(8) Any other Federal or State authority that the Secretary determines is appropriate for the purposes of enforcing the provisions of this title.

“(e) The privilege established under subsection (d) shall apply to communications related to any investigation, audit, examination, or inquiry conducted or coordinated by any of the agencies. A communication that is privileged under subsection (d) shall not waive any privilege otherwise available to the communicating agency or to any person who provided the information that is communicated.”.

Subtitle H—Elder Justice Act

SEC. 6701. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the “Elder Justice Act of 2009”.

SEC. 6702. DEFINITIONS.

Except as otherwise specifically provided, any term that is defined in section 2011 of the Social Security Act (as added by section 6703(a)) and is used in this subtitle has the meaning given such term by such section.

SEC. 6703. ELDER JUSTICE.

(a) **ELDER JUSTICE.**—

(1) **IN GENERAL.**—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended—

(A) in the heading, by inserting “**AND ELDER JUSTICE**” after “**SOCIAL SERVICES**”; and

(B) by inserting before section 2001 the following:

“Subtitle A—Block Grants to States for Social Services”;

and

(C) by adding at the end the following:

“Subtitle B—Elder Justice

“SEC. 2011. DEFINITIONS.

“In this subtitle:

“(1) **ABUSE.**—The term ‘abuse’ means the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.

“(2) **ADULT PROTECTIVE SERVICES.**—The term ‘adult protective services’ means such services provided to adults as the Secretary may specify and includes services such as—

“(A) receiving reports of adult abuse, neglect, or exploitation;

“(B) investigating the reports described in subparagraph (A);

“(C) case planning, monitoring, evaluation, and other case work and services; and

“(D) providing, arranging for, or facilitating the provision of medical, social service, economic, legal, housing, law enforcement, or other protective, emergency, or support services.

“(3) **CAREGIVER.**—The term ‘caregiver’ means an individual who has the responsibility for the care of an elder, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law, and means a family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) compensated or uncompensated care to an elder who needs supportive services in any setting.

“(4) **DIRECT CARE.**—The term ‘direct care’ means care by an employee or contractor who provides assistance or long-term care services to a recipient.

“(5) **ELDER.**—The term ‘elder’ means an individual age 60 or older.

“(6) **ELDER JUSTICE.**—The term ‘elder justice’ means—

“(A) from a societal perspective, efforts to—

“(i) prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and

“(ii) protect elders with diminished capacity while maximizing their autonomy; and

“(B) from an individual perspective, the recognition of an elder’s rights, including the right to be free of abuse, neglect, and exploitation.

“(7) **ELIGIBLE ENTITY.**—The term ‘eligible entity’ means a State or local government agency, Indian tribe or tribal organization, or any other public or private entity that is engaged in and has expertise in issues relating to elder justice or in a field necessary to promote elder justice efforts.

“(8) **EXPLOITATION.**—The term ‘exploitation’ means the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets.

“(9) **FIDUCIARY.**—The term ‘fiduciary’—

“(A) means a person or entity with the legal responsibility—

“(i) to make decisions on behalf of and for the benefit of another person; and

“(ii) to act in good faith and with fairness; and

“(B) includes a trustee, a guardian, a conservator, an executor, an agent under a financial power of attorney or health care power of attorney, or a representative payee.

“(10) **GRANT.**—The term ‘grant’ includes a contract, cooperative agreement, or other mechanism for providing financial assistance.

“(11) **GUARDIANSHIP.**—The term ‘guardianship’ means—

“(A) the process by which a State court determines that an adult individual lacks capacity to make decisions about self-care or property, and appoints another individual or entity known as a guardian, as a conservator, or by a similar term, as a surrogate decisionmaker;

“(B) the manner in which the court-appointed surrogate decisionmaker carries out duties to the individual and the court; or

“(C) the manner in which the court exercises oversight of the surrogate decisionmaker.

“(12) **INDIAN TRIBE.**—

“(A) **IN GENERAL.**—The term ‘Indian tribe’ has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

“(B) **INCLUSION OF PUEBLO AND RANCHERIA.**—The term ‘Indian tribe’ includes any Pueblo or Rancheria.

“(13) **LAW ENFORCEMENT.**—The term ‘law enforcement’ means the full range of potential responders to elder abuse, neglect, and exploitation including—

“(A) police, sheriffs, detectives, public safety officers, and corrections personnel;

“(B) prosecutors;

“(C) medical examiners;

“(D) investigators; and

“(E) coroners.

“(14) **LONG-TERM CARE.**—

“(A) **IN GENERAL.**—The term ‘long-term care’ means supportive and health services specified by the Secretary for individuals who need assistance because the individuals have a loss of capacity for self-care due to illness, disability, or vulnerability.

“(B) **LOSS OF CAPACITY FOR SELF-CARE.**—For purposes of subparagraph (A), the term ‘loss of capacity for self-care’ means an inability to engage in 1 or more activities of daily living, including eating, dressing, bathing, management of one’s financial affairs, and other activities the Secretary determines appropriate.

“(15) **LONG-TERM CARE FACILITY.**—The term ‘long-term care facility’ means a residential care provider that arranges for, or directly provides, long-term care.

“(16) **NEGLECT.**—The term ‘neglect’ means—

“(A) the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder; or

“(B) self-neglect.

“(17) **NURSING FACILITY.**—

“(A) **IN GENERAL.**—The term ‘nursing facility’ has the meaning given such term under section 1919(a).

“(B) **INCLUSION OF SKILLED NURSING FACILITY.**—The term ‘nursing facility’ includes a skilled nursing facility (as defined in section 1819(a)).

“(18) **SELF-NEGLECT.**—The term ‘self-neglect’ means an adult’s inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including—

“(A) obtaining essential food, clothing, shelter, and medical care;

“(B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or

“(C) managing one’s own financial affairs.

“(19) **SERIOUS BODILY INJURY.**—

“(A) **IN GENERAL.**—The term ‘serious bodily injury’ means an injury—

“(i) involving extreme physical pain;

“(ii) involving substantial risk of death;

“(iii) involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or

“(iv) requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

“(B) **CRIMINAL SEXUAL ABUSE.**—Serious bodily injury shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or 2242 (relating to sexual abuse) of title 18, United States Code, or any similar offense under State law.

“(20) **SOCIAL.**—The term ‘social’, when used with respect to a service, includes adult protective services.

“(21) **STATE LEGAL ASSISTANCE DEVELOPER.**—The term ‘State legal assistance developer’ means an individual described in section 731 of the Older Americans Act of 1965.

“(22) **STATE LONG-TERM CARE OMBUDSMAN.**—The term ‘State Long-Term Care Ombudsman’ means the State Long-Term Care Ombudsman described in section 712(a)(2) of the Older Americans Act of 1965.

“SEC. 2012. GENERAL PROVISIONS.

“(a) **PROTECTION OF PRIVACY.**—In pursuing activities under this subtitle, the Secretary shall ensure the protection of individual health privacy consistent with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 and applicable State and local privacy regulations.

“(b) **RULE OF CONSTRUCTION.**—Nothing in this subtitle shall be construed to interfere with or abridge an elder’s right to practice his or her religion through reliance on prayer alone for healing when this choice—

“(1) is contemporaneously expressed, either orally or in writing, with respect to a specific illness or injury which the elder has at the time of the decision by an elder who is competent at the time of the decision;

“(2) is previously set forth in a living will, health care proxy, or other advance directive

document that is validly executed and applied under State law; or

“(3) may be unambiguously deduced from the elder’s life history.

“PART I—NATIONAL COORDINATION OF ELDER JUSTICE ACTIVITIES AND RESEARCH

“Subpart A—Elder Justice Coordinating Council and Advisory Board on Elder Abuse, Neglect, and Exploitation

“SEC. 2021. ELDER JUSTICE COORDINATING COUNCIL.

“(a) **ESTABLISHMENT.**—There is established within the Office of the Secretary an Elder Justice Coordinating Council (in this section referred to as the ‘Council’).

“(b) **MEMBERSHIP.**—

“(1) **IN GENERAL.**—The Council shall be composed of the following members:

“(A) The Secretary (or the Secretary’s designee).

“(B) The Attorney General (or the Attorney General’s designee).

“(C) The head of each Federal department or agency or other governmental entity identified by the Chair referred to in subsection (d) as having responsibilities, or administering programs, relating to elder abuse, neglect, and exploitation.

“(2) **REQUIREMENT.**—Each member of the Council shall be an officer or employee of the Federal Government.

“(c) **VACANCIES.**—Any vacancy in the Council shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

“(d) **CHAIR.**—The member described in subsection (b)(1)(A) shall be Chair of the Council.

“(e) **MEETINGS.**—The Council shall meet at least 2 times per year, as determined by the Chair.

“(f) **DUTIES.**—

“(1) **IN GENERAL.**—The Council shall make recommendations to the Secretary for the coordination of activities of the Department of Health and Human Services, the Department of Justice, and other relevant Federal, State, local, and private agencies and entities, relating to elder abuse, neglect, and exploitation and other crimes against elders.

“(2) **REPORT.**—Not later than the date that is 2 years after the date of enactment of the Elder Justice Act of 2009 and every 2 years thereafter, the Council shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report that—

“(A) describes the activities and accomplishments of, and challenges faced by—

“(i) the Council; and

“(ii) the entities represented on the Council; and

“(B) makes such recommendations for legislation, model laws, or other action as the Council determines to be appropriate.

“(g) **POWERS OF THE COUNCIL.**—

“(1) **INFORMATION FROM FEDERAL AGENCIES.**—Subject to the requirements of section 2012(a), the Council may secure directly from any Federal department or agency such information as the Council considers necessary to carry out this section. Upon request of the Chair of the Council, the head of such department or agency shall furnish such information to the Council.

“(2) **POSTAL SERVICES.**—The Council may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

“(h) **TRAVEL EXPENSES.**—The members of the Council shall not receive compensation for the performance of services for the Council. The members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates

authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Council. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Council.

“(i) **DETAIL OF GOVERNMENT EMPLOYEES.**—Any Federal Government employee may be detailed to the Council without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

“(j) **STATUS AS PERMANENT COUNCIL.**—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Council.

“(k) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated such sums as are necessary to carry out this section.

“SEC. 2022. ADVISORY BOARD ON ELDER ABUSE, NEGLECT, AND EXPLOITATION.

“(a) **ESTABLISHMENT.**—There is established a board to be known as the ‘Advisory Board on Elder Abuse, Neglect, and Exploitation’ (in this section referred to as the ‘Advisory Board’) to create short- and long-term multidisciplinary strategic plans for the development of the field of elder justice and to make recommendations to the Elder Justice Coordinating Council established under section 2021.

“(b) **COMPOSITION.**—The Advisory Board shall be composed of 27 members appointed by the Secretary from among members of the general public who are individuals with experience and expertise in elder abuse, neglect, and exploitation prevention, detection, treatment, intervention, or prosecution.

“(c) **SOLICITATION OF NOMINATIONS.**—The Secretary shall publish a notice in the Federal Register soliciting nominations for the appointment of members of the Advisory Board under subsection (b).

“(d) **TERMS.**—

“(1) **IN GENERAL.**—Each member of the Advisory Board shall be appointed for a term of 3 years, except that, of the members first appointed—

“(A) 9 shall be appointed for a term of 3 years;

“(B) 9 shall be appointed for a term of 2 years; and

“(C) 9 shall be appointed for a term of 1 year.

“(2) **VACANCIES.**—

“(A) **IN GENERAL.**—Any vacancy on the Advisory Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

“(B) **FILLING UNEXPIRED TERM.**—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

“(3) **EXPIRATION OF TERMS.**—The term of any member shall not expire before the date on which the member’s successor takes office.

“(e) **ELECTION OF OFFICERS.**—The Advisory Board shall elect a Chair and Vice Chair from among its members. The Advisory Board shall elect its initial Chair and Vice Chair at its initial meeting.

“(f) **DUTIES.**—

“(1) **ENHANCE COMMUNICATION ON PROMOTING QUALITY OF, AND PREVENTING ABUSE, NEGLECT, AND EXPLOITATION IN, LONG-TERM CARE.**—The Advisory Board shall develop collaborative and innovative approaches to improve the quality of, including preventing abuse, neglect, and exploitation in, long-term care.

“(2) **COLLABORATIVE EFFORTS TO DEVELOP CONSENSUS AROUND THE MANAGEMENT OF CERTAIN QUALITY-RELATED FACTORS.**—

“(A) **IN GENERAL.**—The Advisory Board shall establish multidisciplinary panels to address, and develop consensus on, subjects relating to improving the quality of long-term care. At least

1 such panel shall address, and develop consensus on, methods for managing resident-to-resident abuse in long-term care.

“(B) **ACTIVITIES CONDUCTED.**—The multidisciplinary panels established under subparagraph (A) shall examine relevant research and data, identify best practices with respect to the subject of the panel, determine the best way to carry out those best practices in a practical and feasible manner, and determine an effective manner of distributing information on such subject.

“(3) **REPORT.**—Not later than the date that is 18 months after the date of enactment of the Elder Justice Act of 2009, and annually thereafter, the Advisory Board shall prepare and submit to the Elder Justice Coordinating Council, the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing—

“(A) information on the status of Federal, State, and local public and private elder justice activities;

“(B) recommendations (including recommended priorities) regarding—

“(i) elder justice programs, research, training, services, practice, enforcement, and coordination;

“(ii) coordination between entities pursuing elder justice efforts and those involved in related areas that may inform or overlap with elder justice efforts, such as activities to combat violence against women and child abuse and neglect; and

“(iii) activities relating to adult fiduciary systems, including guardianship and other fiduciary arrangements;

“(C) recommendations for specific modifications needed in Federal and State laws (including regulations) or for programs, research, and training to enhance prevention, detection, and treatment (including diagnosis) of, intervention in (including investigation of), and prosecution of elder abuse, neglect, and exploitation;

“(D) recommendations on methods for the most effective coordinated national data collection with respect to elder justice, and elder abuse, neglect, and exploitation; and

“(E) recommendations for a multidisciplinary strategic plan to guide the effective and efficient development of the field of elder justice.

“(g) **POWERS OF THE ADVISORY BOARD.**—

“(1) **INFORMATION FROM FEDERAL AGENCIES.**—Subject to the requirements of section 2012(a), the Advisory Board may secure directly from any Federal department or agency such information as the Advisory Board considers necessary to carry out this section. Upon request of the Chair of the Advisory Board, the head of such department or agency shall furnish such information to the Advisory Board.

“(2) **SHARING OF DATA AND REPORTS.**—The Advisory Board may request from any entity pursuing elder justice activities under the Elder Justice Act of 2009 or an amendment made by that Act, any data, reports, or recommendations generated in connection with such activities.

“(3) **POSTAL SERVICES.**—The Advisory Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

“(h) **TRAVEL EXPENSES.**—The members of the Advisory Board shall not receive compensation for the performance of services for the Advisory Board. The members shall be allowed travel expenses for up to 4 meetings per year, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Advisory Board. Notwithstanding section 1342 of title 31, United States Code, the Secretary may

accept the voluntary and uncompensated services of the members of the Advisory Board.

“(i) **DETAIL OF GOVERNMENT EMPLOYEES.**—Any Federal Government employee may be detailed to the Advisory Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

“(j) **STATUS AS PERMANENT ADVISORY COMMITTEE.**—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the advisory board.

“(k) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated such sums as are necessary to carry out this section.

“SEC. 2023. RESEARCH PROTECTIONS.

“(a) **GUIDELINES.**—The Secretary shall promulgate guidelines to assist researchers working in the area of elder abuse, neglect, and exploitation, with issues relating to human subject protections.

“(b) **DEFINITION OF LEGALLY AUTHORIZED REPRESENTATIVE FOR APPLICATION OF REGULATIONS.**—For purposes of the application of subpart A of part 46 of title 45, Code of Federal Regulations, to research conducted under this subpart, the term ‘legally authorized representative’ means, unless otherwise provided by law, the individual or judicial or other body authorized under the applicable law to consent to medical treatment on behalf of another person.

“SEC. 2024. AUTHORIZATION OF APPROPRIATIONS.

“There are authorized to be appropriated to carry out this subpart—

“(1) for fiscal year 2011, \$6,500,000; and

“(2) for each of fiscal years 2012 through 2014, \$7,000,000.

“Subpart B—Elder Abuse, Neglect, and Exploitation Forensic Centers

“SEC. 2031. ESTABLISHMENT AND SUPPORT OF ELDER ABUSE, NEGLECT, AND EXPLOITATION FORENSIC CENTERS.

“(a) **IN GENERAL.**—The Secretary, in consultation with the Attorney General, shall make grants to eligible entities to establish and operate stationary and mobile forensic centers, to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect, and exploitation.

“(b) **STATIONARY FORENSIC CENTERS.**—The Secretary shall make 4 of the grants described in subsection (a) to institutions of higher education with demonstrated expertise in forensics or commitment to preventing or treating elder abuse, neglect, or exploitation, to establish and operate stationary forensic centers.

“(c) **MOBILE CENTERS.**—The Secretary shall make 6 of the grants described in subsection (a) to appropriate entities to establish and operate mobile forensic centers.

“(d) **AUTHORIZED ACTIVITIES.**—

“(1) **DEVELOPMENT OF FORENSIC MARKERS AND METHODOLOGIES.**—An eligible entity that receives a grant under this section shall use funds made available through the grant to assist in determining whether abuse, neglect, or exploitation occurred and whether a crime was committed and to conduct research to describe and disseminate information on—

“(A) forensic markers that indicate a case in which elder abuse, neglect, or exploitation may have occurred; and

“(B) methodologies for determining, in such a case, when and how health care, emergency service, social and protective services, and legal service providers should intervene and when the providers should report the case to law enforcement authorities.

“(2) **DEVELOPMENT OF FORENSIC EXPERTISE.**—An eligible entity that receives a grant under this section shall use funds made available through the grant to develop forensic expertise regarding elder abuse, neglect, and exploitation in order to provide medical and forensic evaluation, therapeutic intervention, victim support and advocacy, case review, and case tracking.

“(3) **COLLECTION OF EVIDENCE.**—The Secretary, in coordination with the Attorney General, shall use data made available by grant recipients under this section to develop the capacity of geriatric health care professionals and law enforcement to collect forensic evidence, including collecting forensic evidence relating to a potential determination of elder abuse, neglect, or exploitation.

“(e) **APPLICATION.**—To be eligible to receive a grant under this section, an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

“(f) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section—

“(1) for fiscal year 2011, \$4,000,000;

“(2) for fiscal year 2012, \$6,000,000; and

“(3) for each of fiscal years 2013 and 2014, \$8,000,000.

“PART II—PROGRAMS TO PROMOTE ELDER JUSTICE

“SEC. 2041. ENHANCEMENT OF LONG-TERM CARE.

“(a) **GRANTS AND INCENTIVES FOR LONG-TERM CARE STAFFING.**—

“(1) **IN GENERAL.**—The Secretary shall carry out activities, including activities described in paragraphs (2) and (3), to provide incentives for individuals to train for, seek, and maintain employment providing direct care in long-term care.

“(2) **SPECIFIC PROGRAMS TO ENHANCE TRAINING, RECRUITMENT, AND RETENTION OF STAFF.**—

“(A) **COORDINATION WITH SECRETARY OF LABOR TO RECRUIT AND TRAIN LONG-TERM CARE STAFF.**—The Secretary shall coordinate activities under this subsection with the Secretary of Labor in order to provide incentives for individuals to train for and seek employment providing direct care in long-term care.

“(B) **CAREER LADDERS AND WAGE OR BENEFIT INCREASES TO INCREASE STAFFING IN LONG-TERM CARE.**—

“(i) **IN GENERAL.**—The Secretary shall make grants to eligible entities to carry out programs through which the entities—

“(I) offer, to employees who provide direct care to residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity, continuing training and varying levels of certification, based on observed clinical care practices and the amount of time the employees spend providing direct care; and

“(II) provide, or make arrangements to provide, bonuses or other increased compensation or benefits to employees who achieve certification under such a program.

“(ii) **APPLICATION.**—To be eligible to receive a grant under this subparagraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

“(iii) **AUTHORITY TO LIMIT NUMBER OF APPLICANTS.**—Nothing in this subparagraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subparagraph.

“(3) **SPECIFIC PROGRAMS TO IMPROVE MANAGEMENT PRACTICES.**—

“(A) **IN GENERAL.**—The Secretary shall make grants to eligible entities to enable the entities to provide training and technical assistance.

“(B) **AUTHORIZED ACTIVITIES.**—An eligible entity that receives a grant under subparagraph (A) shall use funds made available through the grant to provide training and technical assistance regarding management practices using methods that are demonstrated to promote retention of individuals who provide direct care, such as—

“(i) the establishment of standard human resource policies that reward high performance, including policies that provide for improved wages and benefits on the basis of job reviews;

“(ii) the establishment of motivational and thoughtful work organization practices;

“(iii) the creation of a workplace culture that respects and values caregivers and their needs;

“(iv) the promotion of a workplace culture that respects the rights of residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity and results in improved care for the residents or the individuals; and

“(v) the establishment of other programs that promote the provision of high quality care, such as a continuing education program that provides additional hours of training, including on-the-job training, for employees who are certified nurse aides.

“(C) **APPLICATION.**—To be eligible to receive a grant under this paragraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

“(D) **AUTHORITY TO LIMIT NUMBER OF APPLICANTS.**—Nothing in this paragraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this paragraph.

“(4) **ACCOUNTABILITY MEASURES.**—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection benefit individuals who provide direct care and increase the stability of the long-term care workforce.

“(5) **DEFINITIONS.**—In this subsection:

“(A) **COMMUNITY-BASED LONG-TERM CARE.**—The term ‘community-based long-term care’ has the meaning given such term by the Secretary.

“(B) **ELIGIBLE ENTITY.**—The term ‘eligible entity’ means the following:

“(i) A long-term care facility.

“(ii) A community-based long-term care entity (as defined by the Secretary).

“(b) **CERTIFIED EHR TECHNOLOGY GRANT PROGRAM.**—

“(1) **GRANTS AUTHORIZED.**—The Secretary is authorized to make grants to long-term care facilities for the purpose of assisting such entities in offsetting the costs related to purchasing, leasing, developing, and implementing certified EHR technology (as defined in section 1848(o)(4)) designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors.

“(2) **USE OF GRANT FUNDS.**—Funds provided under grants under this subsection may be used for any of the following:

“(A) Purchasing, leasing, and installing computer software and hardware, including handheld computer technologies.

“(B) Making improvements to existing computer software and hardware.

“(C) Making upgrades and other improvements to existing computer software and hardware to enable e-prescribing.

“(D) Providing education and training to eligible long-term care facility staff on the use of such technology to implement the electronic transmission of prescription and patient information.

“(3) **APPLICATION.**—

“(A) **IN GENERAL.**—To be eligible to receive a grant under this subsection, a long-term care facility shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the long-term

care facility is located with respect to carrying out activities funded under the grant).

“(B) **AUTHORITY TO LIMIT NUMBER OF APPLICANTS.**—Nothing in this subsection shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subsection.

“(4) **PARTICIPATION IN STATE HEALTH EXCHANGES.**—A long-term care facility that receives a grant under this subsection shall, where available, participate in activities conducted by a State or a qualified State-designated entity (as defined in section 3013(f) of the Public Health Service Act) under a grant under section 3013 of the Public Health Service Act to coordinate care and for other purposes determined appropriate by the Secretary.

“(5) **ACCOUNTABILITY MEASURES.**—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection help improve patient safety and reduce adverse events and health care complications resulting from medication errors.

“(c) **ADOPTION OF STANDARDS FOR TRANS-ACTIONS INVOLVING CLINICAL DATA BY LONG-TERM CARE FACILITIES.**—

“(1) **STANDARDS AND COMPATIBILITY.**—The Secretary shall adopt electronic standards for the exchange of clinical data by long-term care facilities, including, where available, standards for messaging and nomenclature. Standards adopted by the Secretary under the preceding sentence shall be compatible with standards established under part C of title XI, standards established under subsections (b)(2)(B)(i) and (e)(4) of section 1860D–4, standards adopted under section 3004 of the Public Health Service Act, and general health information technology standards.

“(2) **ELECTRONIC SUBMISSION OF DATA TO THE SECRETARY.**—

“(A) **IN GENERAL.**—Not later than 10 years after the date of enactment of the Elder Justice Act of 2009, the Secretary shall have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities pursuant to the standards adopted under paragraph (1).

“(B) **RULE OF CONSTRUCTION.**—Nothing in this subsection shall be construed to require a long-term care facility to submit clinical data electronically to the Secretary.

“(3) **REGULATIONS.**—The Secretary shall promulgate regulations to carry out this subsection. Such regulations shall require a State, as a condition of the receipt of funds under this part, to conduct such data collection and reporting as the Secretary determines are necessary to satisfy the requirements of this subsection.

“(d) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section—

“(1) for fiscal year 2011, \$20,000,000;

“(2) for fiscal year 2012, \$17,500,000; and

“(3) for each of fiscal years 2013 and 2014, \$15,000,000.

“SEC. 2042. ADULT PROTECTIVE SERVICES FUNCTIONS AND GRANT PROGRAMS.

“(a) **SECRETARIAL RESPONSIBILITIES.**—

“(1) **IN GENERAL.**—The Secretary shall ensure that the Department of Health and Human Services—

“(A) provides funding authorized by this part to State and local adult protective services offices that investigate reports of the abuse, neglect, and exploitation of elders;

“(B) collects and disseminates data annually relating to the abuse, exploitation, and neglect of elders in coordination with the Department of Justice;

“(C) develops and disseminates information on best practices regarding, and provides training on, carrying out adult protective services;

“(D) conducts research related to the provision of adult protective services; and

“(E) provides technical assistance to States and other entities that provide or fund the provision of adult protective services, including through grants made under subsections (b) and (c).

“(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, \$3,000,000 for fiscal year 2011 and \$4,000,000 for each of fiscal years 2012 through 2014.

“(b) GRANTS TO ENHANCE THE PROVISION OF ADULT PROTECTIVE SERVICES.—

“(1) ESTABLISHMENT.—There is established an adult protective services grant program under which the Secretary shall annually award grants to States in the amounts calculated under paragraph (2) for the purposes of enhancing adult protective services provided by States and local units of government.

“(2) AMOUNT OF PAYMENT.—

“(A) IN GENERAL.—Subject to the availability of appropriations and subparagraphs (B) and (C), the amount paid to a State for a fiscal year under the program under this subsection shall equal the amount appropriated for that year to carry out this subsection multiplied by the percentage of the total number of elders who reside in the United States who reside in that State.

“(B) GUARANTEED MINIMUM PAYMENT AMOUNT.—

“(i) 50 STATES.—Subject to clause (ii), if the amount determined under subparagraph (A) for a State for a fiscal year is less than 0.75 percent of the amount appropriated for such year, the Secretary shall increase such determined amount so that the total amount paid under this subsection to the State for the year is equal to 0.75 percent of the amount so appropriated.

“(ii) TERRITORIES.—In the case of a State other than 1 of the 50 States, clause (i) shall be applied as if each reference to ‘0.75’ were a reference to ‘0.1’.

“(C) PRO RATA REDUCTIONS.—The Secretary shall make such pro rata reductions to the amounts described in subparagraph (A) as are necessary to comply with the requirements of subparagraph (B).

“(3) AUTHORIZED ACTIVITIES.—

“(A) ADULT PROTECTIVE SERVICES.—Funds made available pursuant to this subsection may only be used by States and local units of government to provide adult protective services and may not be used for any other purpose.

“(B) USE BY AGENCY.—Each State receiving funds pursuant to this subsection shall provide such funds to the agency or unit of State government having legal responsibility for providing adult protective services within the State.

“(C) SUPPLEMENT NOT SUPPLANT.—Each State or local unit of government shall use funds made available pursuant to this subsection to supplement and not supplant other Federal, State, and local public funds expended to provide adult protective services in the State.

“(4) STATE REPORTS.—Each State receiving funds under this subsection shall submit to the Secretary, at such time and in such manner as the Secretary may require, a report on the number of elders served by the grants awarded under this subsection.

“(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, \$100,000,000 for each of fiscal years 2011 through 2014.

“(c) STATE DEMONSTRATION PROGRAMS.—

“(1) ESTABLISHMENT.—The Secretary shall award grants to States for the purposes of conducting demonstration programs in accordance with paragraph (2).

“(2) DEMONSTRATION PROGRAMS.—Funds made available pursuant to this subsection may be used by States and local units of government to conduct demonstration programs that test—

“(A) training modules developed for the purpose of detecting or preventing elder abuse;

“(B) methods to detect or prevent financial exploitation of elders;

“(C) methods to detect elder abuse;

“(D) whether training on elder abuse forensics enhances the detection of elder abuse by employees of the State or local unit of government; or

“(E) other matters relating to the detection or prevention of elder abuse.

“(3) APPLICATION.—To be eligible to receive a grant under this subsection, a State shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

“(4) STATE REPORTS.—Each State that receives funds under this subsection shall submit to the Secretary a report at such time, in such manner, and containing such information as the Secretary may require on the results of the demonstration program conducted by the State using funds made available under this subsection.

“(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, \$25,000,000 for each of fiscal years 2011 through 2014.

“SEC. 2043. LONG-TERM CARE OMBUDSMAN PROGRAM GRANTS AND TRAINING.

“(a) GRANTS TO SUPPORT THE LONG-TERM CARE OMBUDSMAN PROGRAM.—

“(1) IN GENERAL.—The Secretary shall make grants to eligible entities with relevant expertise and experience in abuse and neglect in long-term care facilities or long-term care ombudsman programs and responsibilities, for the purpose of—

“(A) improving the capacity of State long-term care ombudsman programs to respond to and resolve complaints about abuse and neglect;

“(B) conducting pilot programs with State long-term care ombudsman offices or local ombudsman entities; and

“(C) providing support for such State long-term care ombudsman programs and such pilot programs (such as through the establishment of a national long-term care ombudsman resource center).

“(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection—

“(A) for fiscal year 2011, \$5,000,000;

“(B) for fiscal year 2012, \$7,500,000; and

“(C) for each of fiscal years 2013 and 2014, \$10,000,000.

“(b) OMBUDSMAN TRAINING PROGRAMS.—

“(1) IN GENERAL.—The Secretary shall establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and State long-term care ombudsman programs.

“(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, for each of fiscal years 2011 through 2014, \$10,000,000.

“SEC. 2044. PROVISION OF INFORMATION REGARDING, AND EVALUATIONS OF, ELDER JUSTICE PROGRAMS.

“(a) PROVISION OF INFORMATION.—To be eligible to receive a grant under this part, an applicant shall agree—

“(1) except as provided in paragraph (2), to provide the eligible entity conducting an evaluation under subsection (b) of the activities funded through the grant with such information as the eligible entity may require in order to conduct such evaluation; or

“(2) in the case of an applicant for a grant under section 2041(b), to provide the Secretary with such information as the Secretary may require to conduct an evaluation or audit under subsection (c).

“(b) USE OF ELIGIBLE ENTITIES TO CONDUCT EVALUATIONS.—

“(1) EVALUATIONS REQUIRED.—Except as provided in paragraph (2), the Secretary shall—

“(A) reserve a portion (not less than 2 percent) of the funds appropriated with respect to each program carried out under this part; and

“(B) use the funds reserved under subparagraph (A) to provide assistance to eligible entities to conduct evaluations of the activities funded under each program carried out under this part.

“(2) CERTIFIED EHR TECHNOLOGY GRANT PROGRAM NOT INCLUDED.—The provisions of this subsection shall not apply to the certified EHR technology grant program under section 2041(b).

“(3) AUTHORIZED ACTIVITIES.—A recipient of assistance described in paragraph (1)(B) shall use the funds made available through the assistance to conduct a validated evaluation of the effectiveness of the activities funded under a program carried out under this part.

“(4) APPLICATIONS.—To be eligible to receive assistance under paragraph (1)(B), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

“(5) REPORTS.—Not later than a date specified by the Secretary, an eligible entity receiving assistance under paragraph (1)(B) shall submit to the Secretary, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report containing the results of the evaluation conducted using such assistance together with such recommendations as the entity determines to be appropriate.

“(c) EVALUATIONS AND AUDITS OF CERTIFIED EHR TECHNOLOGY GRANT PROGRAM BY THE SECRETARY.—

“(1) EVALUATIONS.—The Secretary shall conduct an evaluation of the activities funded under the certified EHR technology grant program under section 2041(b). Such evaluation shall include an evaluation of whether the funding provided under the grant is expended only for the purposes for which it is made.

“(2) AUDITS.—The Secretary shall conduct appropriate audits of grants made under section 2041(b).

“SEC. 2045. REPORT.

“Not later than October 1, 2014, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report—

“(1) compiling, summarizing, and analyzing the information contained in the State reports submitted under subsections (b)(4) and (c)(4) of section 2042; and

“(2) containing such recommendations for legislative or administrative action as the Secretary determines to be appropriate.

“SEC. 2046. RULE OF CONSTRUCTION.

“Nothing in this subtitle shall be construed as—

“(1) limiting any cause of action or other relief related to obligations under this subtitle that is available under the law of any State, or political subdivision thereof; or

“(2) creating a private cause of action for a violation of this subtitle.”

(2) OPTION FOR STATE PLAN UNDER PROGRAM FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES.—

(A) IN GENERAL.—Section 402(a)(1)(B) of the Social Security Act (42 U.S.C. 602(a)(1)(B)) is amended by adding at the end the following new clause:

“(v) The document shall indicate whether the State intends to assist individuals to train for, seek, and maintain employment—

“(I) providing direct care in a long-term care facility (as such terms are defined under section 2011); or

“(II) in other occupations related to elder care determined appropriate by the State for which the State identifies an unmet need for service personnel, and, if so, shall include an overview of such assistance.”

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect on January 1, 2011.

(b) PROTECTING RESIDENTS OF LONG-TERM CARE FACILITIES.—

(1) NATIONAL TRAINING INSTITUTE FOR SURVEYORS.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract with an entity for the purpose of establishing and operating a National Training Institute for Federal and State surveyors. Such Institute shall provide and improve the training of surveyors with respect to investigating allegations of abuse, neglect, and misappropriation of property in programs and long-term care facilities that receive payments under title XVIII or XIX of the Social Security Act.

(B) ACTIVITIES CARRIED OUT BY THE INSTITUTE.—The contract entered into under subparagraph (A) shall require the Institute established and operated under such contract to carry out the following activities:

(i) Assess the extent to which State agencies use specialized surveyors for the investigation of reported allegations of abuse, neglect, and misappropriation of property in such programs and long-term care facilities.

(ii) Evaluate how the competencies of surveyors may be improved to more effectively investigate reported allegations of such abuse, neglect, and misappropriation of property, and provide feedback to Federal and State agencies on the evaluations conducted.

(iii) Provide a national program of training, tools, and technical assistance to Federal and State surveyors on investigating reports of such abuse, neglect, and misappropriation of property.

(iv) Develop and disseminate information on best practices for the investigation of such abuse, neglect, and misappropriation of property.

(v) Assess the performance of State complaint intake systems, in order to ensure that the intake of complaints occurs 24 hours per day, 7 days a week (including holidays).

(vi) To the extent approved by the Secretary of Health and Human Services, provide a national 24 hours per day, 7 days a week (including holidays), back-up system to State complaint intake systems in order to ensure optimum national responsiveness to complaints of such abuse, neglect, and misappropriation of property.

(vii) Analyze and report annually on the following:

(I) The total number and sources of complaints of such abuse, neglect, and misappropriation of property.

(II) The extent to which such complaints are referred to law enforcement agencies.

(III) General results of Federal and State investigations of such complaints.

(viii) Conduct a national study of the cost to State agencies of conducting complaint investigations of skilled nursing facilities and nursing facilities under sections 1819 and 1919, respectively, of the Social Security Act (42 U.S.C. 1395i-3; 1396r), and making recommendations to the Secretary of Health and Human Services with respect to options to increase the efficiency and cost-effectiveness of such investigations.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for

the period of fiscal years 2011 through 2014, \$12,000,000.

(2) GRANTS TO STATE SURVEY AGENCIES.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall make grants to State agencies that perform surveys of skilled nursing facilities or nursing facilities under sections 1819 or 1919, respectively, of the Social Security Act (42 U.S.C. 1395i-3; 1395r).

(B) USE OF FUNDS.—A grant awarded under subparagraph (A) shall be used for the purpose of designing and implementing complaint investigations systems that—

(i) promptly prioritize complaints in order to ensure a rapid response to the most serious and urgent complaints;

(ii) respond to complaints with optimum effectiveness and timeliness; and

(iii) optimize the collaboration between local authorities, consumers, and providers, including—

(I) such State agency;

(II) the State Long-Term Care Ombudsman;

(III) local law enforcement agencies;

(IV) advocacy and consumer organizations;

(V) State aging units;

(VI) Area Agencies on Aging; and

(VII) other appropriate entities.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for each of fiscal years 2011 through 2014, \$5,000,000.

(3) REPORTING OF CRIMES IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 6005, is amended by inserting after section 1150A the following new section:

“REPORTING TO LAW ENFORCEMENT OF CRIMES OCCURRING IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES

“SEC. 1150B. (a) DETERMINATION AND NOTIFICATION.—

“(1) DETERMINATION.—The owner or operator of each long-term care facility that receives Federal funds under this Act shall annually determine whether the facility received at least \$10,000 in such Federal funds during the preceding year.

“(2) NOTIFICATION.—If the owner or operator determines under paragraph (1) that the facility received at least \$10,000 in such Federal funds during the preceding year, such owner or operator shall annually notify each covered individual (as defined in paragraph (3)) of that individual's obligation to comply with the reporting requirements described in subsection (b).

“(3) COVERED INDIVIDUAL DEFINED.—In this section, the term ‘covered individual’ means each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility that is the subject of a determination described in paragraph (1).

“(b) REPORTING REQUIREMENTS.—

“(1) IN GENERAL.—Each covered individual shall report to the Secretary and 1 or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility.

“(2) TIMING.—If the events that cause the suspicion—

“(A) result in serious bodily injury, the individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion; and

“(B) do not result in serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion.

“(c) PENALTIES.—

“(1) IN GENERAL.—If a covered individual violates subsection (b)—

“(A) the covered individual shall be subject to a civil money penalty of not more than \$200,000; and

“(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

“(2) INCREASED HARM.—If a covered individual violates subsection (b) and the violation exacerbates the harm to the victim of the crime or results in harm to another individual—

“(A) the covered individual shall be subject to a civil money penalty of not more than \$300,000; and

“(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

“(3) EXCLUDED INDIVIDUAL.—During any period for which a covered individual is classified as an excluded individual under paragraph (1)(B) or (2)(B), a long-term care facility that employs such individual shall be ineligible to receive Federal funds under this Act.

“(4) EXTENUATING CIRCUMSTANCES.—

“(A) IN GENERAL.—The Secretary may take into account the financial burden on providers with underserved populations in determining any penalty to be imposed under this subsection.

“(B) UNDERSERVED POPULATION DEFINED.—In this paragraph, the term ‘underserved population’ means the population of an area designated by the Secretary as an area with a shortage of elder justice programs or a population group designated by the Secretary as having a shortage of such programs. Such areas or groups designated by the Secretary may include—

“(i) areas or groups that are geographically isolated (such as isolated in a rural area);

“(ii) racial and ethnic minority populations; and

“(iii) populations underserved because of special needs (such as language barriers, disabilities, alien status, or age).

“(d) ADDITIONAL PENALTIES FOR RETALIATION.—

“(1) IN GENERAL.—A long-term care facility may not—

“(A) discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee; or

“(B) file a complaint or a report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee, for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to subsection (b)(1).

“(2) PENALTIES FOR RETALIATION.—If a long-term care facility violates subparagraph (A) or (B) of paragraph (1) the facility shall be subject to a civil money penalty of not more than \$200,000 or the Secretary may classify the entity as an excluded entity for a period of 2 years pursuant to section 1128(b), or both.

“(3) REQUIREMENT TO POST NOTICE.—Each long-term care facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of employees under this section. Such sign shall include a statement that an employee may file a complaint with the Secretary against a long-term care facility that violates the provisions of this subsection and information with respect to the manner of filing such a complaint.

“(e) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and

the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under this section in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(f) DEFINITIONS.—In this section, the terms ‘elder justice’, ‘long-term care facility’, and ‘law enforcement’ have the meanings given those terms in section 2011.”

(c) NATIONAL NURSE AIDE REGISTRY.—

(1) DEFINITION OF NURSE AIDE.—In this subsection, the term “nurse aide” has the meaning given that term in sections 1819(b)(5)(F) and 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F); 1396r(b)(5)(F)).

(2) STUDY AND REPORT.—

(A) IN GENERAL.—The Secretary, in consultation with appropriate government agencies and private sector organizations, shall conduct a study on establishing a national nurse aide registry.

(B) AREAS EVALUATED.—The study conducted under this subsection shall include an evaluation of—

- (i) who should be included in the registry;
- (ii) how such a registry would comply with Federal and State privacy laws and regulations;
- (iii) how data would be collected for the registry;
- (iv) what entities and individuals would have access to the data collected;
- (v) how the registry would provide appropriate information regarding violations of Federal and State law by individuals included in the registry;
- (vi) how the functions of a national nurse aide registry would be coordinated with the nationwide program for national and State background checks on direct patient access employees of long-term care facilities and providers under section 4301; and
- (vii) how the information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i–3(e)(2); 1396r(e)(2)(2)) would be provided as part of a national nurse aide registry.

(C) CONSIDERATIONS.—In conducting the study and preparing the report required under this subsection, the Secretary shall take into consideration the findings and conclusions of relevant reports and other relevant resources, including the following:

- (i) The Department of Health and Human Services Office of Inspector General Report, *Nurse Aide Registries: State Compliance and Practices* (February 2005).
- (ii) The General Accounting Office (now known as the Government Accountability Office) Report, *Nursing Homes: More Can Be Done to Protect Residents from Abuse* (March 2002).
- (iii) The Department of Health and Human Services Office of the Inspector General Report, *Nurse Aide Registries: Long-Term Care Facility Compliance and Practices* (July 2005).
- (iv) The Department of Health and Human Services Health Resources and Services Administration Report, *Nursing Aides, Home Health Aides, and Related Health Care Occupations—National and Local Workforce Shortages and Associated Data Needs* (2004) (in particular with respect to chapter 7 and appendix F).
- (v) The 2001 Report to CMS from the School of Rural Public Health, Texas A&M University, *Preventing Abuse and Neglect in Nursing Homes: The Role of Nurse Aide Registries*.
- (vi) Information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i–3(e)(2); 1396r(e)(2)(2)).

(D) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021 of the So-

cial Security Act, as added by section 1805(a), the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing the findings and recommendations of the study conducted under this paragraph.

(E) FUNDING LIMITATION.—Funding for the study conducted under this subsection shall not exceed \$500,000.

(3) CONGRESSIONAL ACTION.—After receiving the report submitted by the Secretary under paragraph (2)(D), the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives shall, as they deem appropriate, take action based on the recommendations contained in the report.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for the purpose of carrying out this subsection.

(d) CONFORMING AMENDMENTS.—

(1) TITLE XX.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.), as amended by section 6703(a), is amended—

(A) in the heading of section 2001, by striking “TITLE” and inserting “SUBTITLE”; and

(B) in subtitle 1, by striking “this title” each place it appears and inserting “this subtitle”.

(2) TITLE IV.—Title IV of the Social Security Act (42 U.S.C. 601 et seq.) is amended—

(A) in section 404(d)—

(i) in paragraphs (1)(A), (2)(A), and (3)(B), by inserting “subtitle 1 of” before “title XX” each place it appears;

(ii) in the heading of paragraph (2), by inserting “SUBTITLE 1 OF” before “TITLE XX”; and

(B) in sections 422(b), 471(a)(4), 472(h)(1), and 473(b)(2), by inserting “subtitle 1 of” before “title XX” each place it appears.

(3) TITLE XI.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended—

(A) in section 1128(h)(3)—

(i) by inserting “subtitle 1 of” before “title XX”; and

(ii) by striking “such title” and inserting “such subtitle”; and

(B) in section 1128A(i)(1), by inserting “subtitle 1 of” before “title XX”.

Subtitle I—Sense of the Senate Regarding Medical Malpractice

SEC. 6801. SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE.

It is the sense of the Senate that—

(1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance;

(2) States should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual’s right to seek redress in court; and

(3) Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims.

TITLE VII—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

Subtitle A—Biologics Price Competition and Innovation

SEC. 7001. SHORT TITLE.

(a) IN GENERAL.—This subtitle may be cited as the “Biologics Price Competition and Innovation Act of 2009”.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that a biosimilars pathway balancing

innovation and consumer interests should be established.

SEC. 7002. APPROVAL PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting “under this subsection or subsection (k)” after “biologics license”; and

(2) by adding at the end the following:

“(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—

“(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

“(2) CONTENT.—

“(A) IN GENERAL.—

“(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

“(I) the biological product is biosimilar to a reference product based upon data derived from—

“(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

“(bb) animal studies (including the assessment of toxicity); and

“(cc) a clinical study or studies (including the assessment of immunogenicity and pharmacokinetics or pharmacodynamics) that are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which licensure is sought for the biological product;

“(II) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanism or mechanisms of action are known for the reference product;

“(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

“(IV) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

“(V) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent.

“(ii) DETERMINATION BY SECRETARY.—The Secretary may determine, in the Secretary’s discretion, that an element described in clause (i)(I) is unnecessary in an application submitted under this subsection.

“(iii) ADDITIONAL INFORMATION.—An application submitted under this subsection—

“(I) shall include publicly-available information regarding the Secretary’s previous determination that the reference product is safe, pure, and potent; and

“(II) may include any additional information in support of the application, including publicly-available information with respect to the reference product or another biological product.

“(B) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this subsection may include information demonstrating that the biological product meets the standards described in paragraph (4).

“(3) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

“(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

“(i) is biosimilar to the reference product; or

“(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

“(B) the applicant (or other appropriate person) consents to the inspection of the facility that is the subject of the application, in accordance with subsection (c).

“(4) SAFETY STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product to be interchangeable with the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that—

“(A) the biological product—

“(i) is biosimilar to the reference product; and

“(ii) can be expected to produce the same clinical result as the reference product in any given patient; and

“(B) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

“(5) GENERAL RULES.—

“(A) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

“(B) REVIEW.—An application submitted under this subsection shall be reviewed by the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

“(C) RISK EVALUATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsection (a).

“(6) EXCLUSIVITY FOR FIRST INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability for any condition of use, the Secretary shall not make a determination under paragraph (4) that the second or subsequent biological product is interchangeable for any condition of use until the earlier of—

“(A) 1 year after the first commercial marketing of the first interchangeable biosimilar biological product to be approved as interchangeable for that reference product;

“(B) 18 months after—

“(i) a final court decision on all patents in suit in an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

“(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

“(C)(i) 42 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(6) and such litigation is still ongoing within such 42-month period; or

“(ii) 18 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has not been sued under subsection (l)(6).

For purposes of this paragraph, the term ‘final court decision’ means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

“(7) EXCLUSIVITY FOR REFERENCE PRODUCT.—

“(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—Approval of an application under this subsection may not be made effective by the Secretary until the date that is 12 years after the date on which the reference product was first licensed under subsection (a).

“(B) FILING PERIOD.—An application under this subsection may not be submitted to the Secretary until the date that is 4 years after the date on which the reference product was first licensed under subsection (a).

“(C) FIRST LICENSURE.—Subparagraphs (A) and (B) shall not apply to a license for or approval of—

“(i) a supplement for the biological product that is the reference product; or

“(ii) a subsequent application filed by the same sponsor or manufacturer of the biological product that is the reference product (or a licensor, predecessor in interest, or other related entity) for—

“(I) a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosing schedule, dosage form, delivery system, delivery device, or strength; or

“(II) a modification to the structure of the biological product that does not result in a change in safety, purity, or potency.

“(8) GUIDANCE DOCUMENTS.—

“(A) IN GENERAL.—The Secretary may, after opportunity for public comment, issue guidance in accordance, except as provided in subparagraph (B)(i), with section 701(h) of the Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

“(B) PUBLIC COMMENT.—

“(i) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance.

“(ii) INPUT REGARDING MOST VALUABLE GUIDANCE.—The Secretary shall establish a process through which the public may provide the Secretary with input regarding priorities for issuing guidance.

“(C) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

“(D) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

“(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

“(ii) the criteria, if available, that the Secretary will use to determine whether a biological product meets the standards described in paragraph (4).

“(E) CERTAIN PRODUCT CLASSES.—

“(i) GUIDANCE.—The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance, with respect to a product or product class (not including any recombinant protein) does not allow approval of an application for a license as provided under this subsection for such product or product class.

“(ii) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under subparagraph (A) to modify or reverse a guidance document under clause (i).

“(iii) NO EFFECT ON ABILITY TO DENY LICENSE.—Clause (i) shall not be construed to require the Secretary to approve a product with respect to which the Secretary has not indicated in a guidance document that the science and experience, as described in clause (i), does not allow approval of such an application.

“(l) PATENTS.—

“(1) CONFIDENTIAL ACCESS TO SUBSECTION (k) APPLICATION.—

“(A) APPLICATION OF PARAGRAPH.—Unless otherwise agreed to by a person that submits an application under subsection (k) (referred to in this subsection as the ‘subsection (k) applicant’) and the sponsor of the application for the reference product (referred to in this subsection as the ‘reference product sponsor’), the provisions of this paragraph shall apply to the exchange of information described in this subsection.

“(B) IN GENERAL.—

“(i) PROVISION OF CONFIDENTIAL INFORMATION.—When a subsection (k) applicant submits an application under subsection (k), such applicant shall provide to the persons described in clause (ii), subject to the terms of this paragraph, confidential access to the information required to be produced pursuant to paragraph (2) and any other information that the subsection (k) applicant determines, in its sole discretion, to be appropriate (referred to in this subsection as the ‘confidential information’).

“(ii) RECIPIENTS OF INFORMATION.—The persons described in this clause are the following:

“(I) OUTSIDE COUNSEL.—One or more attorneys designated by the reference product sponsor who are employees of an entity other than the reference product sponsor (referred to in this paragraph as the ‘outside counsel’), provided that such attorneys do not engage, formally or informally, in patent prosecution relevant or related to the reference product.

“(II) IN-HOUSE COUNSEL.—One attorney that represents the reference product sponsor who is an employee of the reference product sponsor, provided that such attorney does not engage, formally or informally, in patent prosecution relevant or related to the reference product.

“(iii) PATENT OWNER ACCESS.—A representative of the owner of a patent exclusively licensed to a reference product sponsor with respect to the reference product and who has retained a right to assert the patent or participate in litigation concerning the patent may be provided the confidential information, provided that the representative informs the reference product sponsor and the subsection (k) applicant of his or her agreement to be subject to the confidentiality provisions set forth in this paragraph, including those under clause (ii).

“(C) LIMITATION ON DISCLOSURE.—No person that receives confidential information pursuant to subparagraph (B) shall disclose any confidential information to any other person or entity, including the reference product sponsor employees, outside scientific consultants, or other outside counsel retained by the reference product sponsor, without the prior written consent of the subsection (k) applicant, which shall not be unreasonably withheld.

“(D) USE OF CONFIDENTIAL INFORMATION.—Confidential information shall be used for the sole and exclusive purpose of determining, with respect to each patent assigned to or exclusively licensed by the reference product sponsor, whether a claim of patent infringement could reasonably be asserted if the subsection (k) applicant engaged in the manufacture, use, offering for sale, sale, or importation into the United States of the biological product that is the subject of the application under subsection (k).

“(E) OWNERSHIP OF CONFIDENTIAL INFORMATION.—The confidential information disclosed under this paragraph is, and shall remain, the property of the subsection (k) applicant. By providing the confidential information pursuant to this paragraph, the subsection (k) applicant does not provide the reference product sponsor or the outside counsel any interest in or license to use the confidential information, for purposes other than those specified in subparagraph (D).

“(F) EFFECT OF INFRINGEMENT ACTION.—In the event that the reference product sponsor files a patent infringement suit, the use of confidential information shall continue to be governed by the terms of this paragraph until such time as a court enters a protective order regarding the information. Upon entry of such order, the subsection (k) applicant may redesignate confidential information in accordance with the terms of that order. No confidential information shall be included in any publicly-available complaint or other pleading. In the event that the reference product sponsor does not file an infringement action by the date specified in paragraph (6), the reference product sponsor shall return or destroy all confidential information received under this paragraph, provided that if the reference product sponsor opts to destroy such information, it will confirm destruction in writing to the subsection (k) applicant.

“(G) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

“(i) as an admission by the subsection (k) applicant regarding the validity, enforceability, or infringement of any patent; or

“(ii) as an agreement or admission by the subsection (k) applicant with respect to the competency, relevance, or materiality of any confidential information.

“(H) EFFECT OF VIOLATION.—The disclosure of any confidential information in violation of this paragraph shall be deemed to cause the subsection (k) applicant to suffer irreparable harm for which there is no adequate legal remedy and the court shall consider immediate injunctive relief to be an appropriate and necessary remedy for any violation or threatened violation of this paragraph.

“(2) SUBSECTION (k) APPLICATION INFORMATION.—Not later than 20 days after the Secretary notifies the subsection (k) applicant that the application has been accepted for review, the subsection (k) applicant—

“(A) shall provide to the reference product sponsor a copy of the application submitted to the Secretary under subsection (k), and such other information that describes the process or processes used to manufacture the biological product that is the subject of such application; and

“(B) may provide to the reference product sponsor additional information requested by or on behalf of the reference product sponsor.

“(3) LIST AND DESCRIPTION OF PATENTS.—

“(A) LIST BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after the receipt of the application and information under paragraph (2), the reference product sponsor shall provide to the subsection (k) applicant—

“(i) a list of patents for which the reference product sponsor believes a claim of patent infringement could reasonably be asserted by the reference product sponsor, or by a patent owner that has granted an exclusive license to the reference product sponsor with respect to the reference product, if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application; and

“(ii) an identification of the patents on such list that the reference product sponsor would be prepared to license to the subsection (k) applicant.

“(B) LIST AND DESCRIPTION BY SUBSECTION (k) APPLICANT.—Not later than 60 days after receipt of the list under subparagraph (A), the subsection (k) applicant—

“(i) may provide to the reference product sponsor a list of patents to which the subsection (k) applicant believes a claim of patent infringement could reasonably be asserted by the reference product sponsor if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application; and

“(ii) shall provide to the reference product sponsor, with respect to each patent listed by the reference product sponsor under subparagraph (A) or listed by the subsection (k) applicant under clause (i)—

“(I) a detailed statement that describes, on a claim by claim basis, the factual and legal basis of the opinion of the subsection (k) applicant that such patent is invalid, unenforceable, or will not be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application; or

“(II) a statement that the subsection (k) applicant does not intend to begin commercial marketing of the biological product before the date that such patent expires; and

“(iii) shall provide to the reference product sponsor a response regarding each patent identified by the reference product sponsor under subparagraph (A)(ii).

“(C) DESCRIPTION BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after receipt of the list and statement under subparagraph (B), the reference product sponsor shall provide to the subsection (k) applicant a detailed statement that describes, with respect to each patent described in subparagraph (B)(ii)(I), on a claim by claim basis, the factual and legal basis of the opinion of the reference product sponsor that such patent will be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application and a response to the statement concerning validity and enforceability provided under subparagraph (B)(ii)(I).

“(4) PATENT RESOLUTION NEGOTIATIONS.—

“(A) IN GENERAL.—After receipt by the subsection (k) applicant of the statement under paragraph (3)(C), the reference product sponsor and the subsection (k) applicant shall engage in good faith negotiations to agree on which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6).

“(B) FAILURE TO REACH AGREEMENT.—If, within 15 days of beginning negotiations under subparagraph (A), the subsection (k) applicant and the reference product sponsor fail to agree on a final and complete list of which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6), the provisions of paragraph (5) shall apply to the parties.

“(5) PATENT RESOLUTION IF NO AGREEMENT.—

“(A) NUMBER OF PATENTS.—The subsection (k) applicant shall notify the reference product sponsor of the number of patents that such applicant will provide to the reference product sponsor under subparagraph (B)(i)(I).

“(B) EXCHANGE OF PATENT LISTS.—

“(i) IN GENERAL.—On a date agreed to by the subsection (k) applicant and the reference product sponsor, but in no case later than 5 days after the subsection (k) applicant notifies the reference product sponsor under subparagraph (A), the subsection (k) applicant and the reference product sponsor shall simultaneously exchange—

“(I) the list of patents that the subsection (k) applicant believes should be the subject of an action for patent infringement under paragraph (6); and

“(II) the list of patents, in accordance with clause (ii), that the reference product sponsor believes should be the subject of an action for patent infringement under paragraph (6).

“(ii) NUMBER OF PATENTS LISTED BY REFERENCE PRODUCT SPONSOR.—

“(I) IN GENERAL.—Subject to subclause (II), the number of patents listed by the reference product sponsor under clause (i)(II) may not exceed the number of patents listed by the subsection (k) applicant under clause (i)(I).

“(II) EXCEPTION.—If a subsection (k) applicant does not list any patent under clause (i)(I), the reference product sponsor may list 1 patent under clause (i)(II).

“(6) IMMEDIATE PATENT INFRINGEMENT ACTION.—

“(A) ACTION IF AGREEMENT ON PATENT LIST.—If the subsection (k) applicant and the reference product sponsor agree on patents as described in paragraph (4), not later than 30 days after such agreement, the reference product sponsor shall bring an action for patent infringement with respect to each such patent.

“(B) ACTION IF NO AGREEMENT ON PATENT LIST.—If the provisions of paragraph (5) apply to the parties as described in paragraph (4)(B), not later than 30 days after the exchange of lists under paragraph (5)(B), the reference product sponsor shall bring an action for patent infringement with respect to each patent that is included on such lists.

“(C) NOTIFICATION AND PUBLICATION OF COMPLAINT.—

“(i) NOTIFICATION TO SECRETARY.—Not later than 30 days after a complaint is served to a subsection (k) applicant in an action for patent infringement described under this paragraph, the subsection (k) applicant shall provide the Secretary with notice and a copy of such complaint.

“(ii) PUBLICATION BY SECRETARY.—The Secretary shall publish in the Federal Register notice of a complaint received under clause (i).

“(7) NEWLY ISSUED OR LICENSED PATENTS.—In the case of a patent that—

“(A) is issued to, or exclusively licensed by, the reference product sponsor after the date that the reference product sponsor provided the list to the subsection (k) applicant under paragraph (3)(A); and

“(B) the reference product sponsor reasonably believes that, due to the issuance of such patent, a claim of patent infringement could reasonably be asserted by the reference product sponsor if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application,

not later than 30 days after such issuance or licensing, the reference product sponsor shall provide to the subsection (k) applicant a supplement to the list provided by the reference product sponsor under paragraph (3)(A) that includes such patent, not later than 30 days after such supplement is provided, the subsection (k) applicant shall provide a statement to the reference product sponsor in accordance with paragraph (3)(B), and such patent shall be subject to paragraph (8).

“(8) NOTICE OF COMMERCIAL MARKETING AND PRELIMINARY INJUNCTION.—

“(A) NOTICE OF COMMERCIAL MARKETING.—The subsection (k) applicant shall provide notice to the reference product sponsor not later than 180 days before the date of the first commercial marketing of the biological product licensed under subsection (k).

“(B) PRELIMINARY INJUNCTION.—After receiving the notice under subparagraph (A) and before such date of the first commercial marketing

of such biological product, the reference product sponsor may seek a preliminary injunction prohibiting the subsection (k) applicant from engaging in the commercial manufacture or sale of such biological product until the court decides the issue of patent validity, enforcement, and infringement with respect to any patent that is—

“(i) included in the list provided by the reference product sponsor under paragraph (3)(A) or in the list provided by the subsection (k) applicant under paragraph (3)(B); and

“(ii) not included, as applicable, on—

“(I) the list of patents described in paragraph (4); or

“(II) the lists of patents described in paragraph (5)(B).

“(C) REASONABLE COOPERATION.—If the reference product sponsor has sought a preliminary injunction under subparagraph (B), the reference product sponsor and the subsection (k) applicant shall reasonably cooperate to expedite such further discovery as is needed in connection with the preliminary injunction motion.

“(9) LIMITATION ON DECLARATORY JUDGMENT ACTION.—

“(A) SUBSECTION (k) APPLICATION PROVIDED.—If a subsection (k) applicant provides the application and information required under paragraph (2)(A), neither the reference product sponsor nor the subsection (k) applicant may, prior to the date notice is received under paragraph (8)(A), bring any action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that is described in clauses (i) and (ii) of paragraph (8)(B).

“(B) SUBSEQUENT FAILURE TO ACT BY SUBSECTION (k) APPLICANT.—If a subsection (k) applicant fails to complete an action required of the subsection (k) applicant under paragraph (3)(B)(ii), paragraph (5), paragraph (6)(C)(i), paragraph (7), or paragraph (8)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent included in the list described in paragraph (3)(A), including as provided under paragraph (7).

“(C) SUBSECTION (k) APPLICATION NOT PROVIDED.—If a subsection (k) applicant fails to provide the application and information required under paragraph (2)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that claims the biological product or a use of the biological product.”.

(b) DEFINITIONS.—Section 351(i) of the Public Health Service Act (42 U.S.C. 262(i)) is amended—

(1) by striking “In this section, the term ‘biological product’ means” and inserting the following: “In this section:

“(1) The term ‘biological product’ means”;

(2) in paragraph (1), as so designated, by inserting “protein (except any chemically synthesized polypeptide),” after “allergenic product,”; and

(3) by adding at the end the following:

“(2) The term ‘biosimilar’ or ‘biosimilarity’, in reference to a biological product that is the subject of an application under subsection (k), means—

“(A) that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components; and

“(B) there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

“(3) The term ‘interchangeable’ or ‘interchangeability’, in reference to a biological product that is shown to meet the standards described in subsection (k)(4), means that the biological product may be substituted for the reference product without the intervention of the health care provider who prescribed the reference product.

“(4) The term ‘reference product’ means the single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k).”.

(c) CONFORMING AMENDMENTS RELATING TO PATENTS.—

(1) PATENTS.—Section 271(e) of title 35, United States Code, is amended—

(A) in paragraph (2)—

(i) in subparagraph (A), by striking “or” at the end;

(ii) in subparagraph (B), by adding “or” at the end; and

(iii) by inserting after subparagraph (B) the following:

“(C)(i) with respect to a patent that is identified in the list of patents described in section 351(l)(3) of the Public Health Service Act (including as provided under section 351(l)(7) of such Act), an application seeking approval of a biological product, or

“(ii) if the applicant for the application fails to provide the application and information required under section 351(l)(2)(A) of such Act, an application seeking approval of a biological product for a patent that could be identified pursuant to section 351(l)(3)(A)(i) of such Act,”; and

(iv) in the matter following subparagraph (C) (as added by clause (iii)), by striking “or veterinary biological product” and inserting “, veterinary biological product, or biological product”;

(B) in paragraph (4)—

(i) in subparagraph (B), by—

(I) striking “or veterinary biological product” and inserting “, veterinary biological product, or biological product”; and

(II) striking “and” at the end;

(ii) in subparagraph (C), by—

(I) striking “or veterinary biological product” and inserting “, veterinary biological product, or biological product”; and

(II) striking the period and inserting “, and”;

(iii) by inserting after subparagraph (C) the following:

“(D) the court shall order a permanent injunction prohibiting any infringement of the patent by the biological product involved in the infringement until a date which is not earlier than the date of the expiration of the patent that has been infringed under paragraph (2)(C), provided the patent is the subject of a final court decision, as defined in section 351(k)(6) of the Public Health Service Act, in an action for infringement of the patent under section 351(l)(6) of such Act, and the biological product has not yet been approved because of section 351(k)(7) of such Act.”; and

(iv) in the matter following subparagraph (D) (as added by clause (iii)), by striking “and (C)” and inserting “(C), and (D)”;

(C) by adding at the end the following:

“(6)(A) Subparagraph (B) applies, in lieu of paragraph (4), in the case of a patent—

“(i) that is identified, as applicable, in the list of patents described in section 351(l)(4) of the Public Health Service Act or the lists of patents described in section 351(l)(5)(B) of such Act with respect to a biological product; and

“(ii) for which an action for infringement of the patent with respect to the biological product—

“(I) was brought after the expiration of the 30-day period described in subparagraph (A) or (B), as applicable, of section 351(l)(6) of such Act; or

“(II) was brought before the expiration of the 30-day period described in subclause (I), but which was dismissed without prejudice or was not prosecuted to judgment in good faith.

“(B) In an action for infringement of a patent described in subparagraph (A), the sole and exclusive remedy that may be granted by a court, upon a finding that the making, using, offering to sell, selling, or importation into the United States of the biological product that is the subject of the action infringed the patent, shall be a reasonable royalty.

“(C) The owner of a patent that should have been included in the list described in section 351(l)(3)(A) of the Public Health Service Act, including as provided under section 351(l)(7) of such Act for a biological product, but was not timely included in such list, may not bring an action under this section for infringement of the patent with respect to the biological product.”.

(2) CONFORMING AMENDMENT UNDER TITLE 28.—Section 2201(b) of title 28, United States Code, is amended by inserting before the period the following: “, or section 351 of the Public Health Service Act”.

(d) CONFORMING AMENDMENTS UNDER THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.—

(1) CONTENT AND REVIEW OF APPLICATIONS.—Section 505(b)(5)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)(5)(B)) is amended by inserting before the period at the end of the first sentence the following: “or, with respect to an applicant for approval of a biological product under section 351(k) of the Public Health Service Act, any necessary clinical study or studies”.

(2) NEW ACTIVE INGREDIENT.—Section 505B of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355e) is amended by adding at the end the following:

“(m) NEW ACTIVE INGREDIENT.—

“(1) NON-INTERCHANGEABLE BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is biosimilar to a reference product under section 351 of the Public Health Service Act, and that the Secretary has not determined to meet the standards described in subsection (k)(4) of such section for interchangeability with the reference product, shall be considered to have a new active ingredient under this section.

“(2) INTERCHANGEABLE BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is interchangeable with a reference product under section 351 of the Public Health Service Act shall not be considered to have a new active ingredient under this section.”.

(e) PRODUCTS PREVIOUSLY APPROVED UNDER SECTION 505.—

(1) REQUIREMENT TO FOLLOW SECTION 351.—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) EXCEPTION.—An application for a biological product may be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if—

(A) such biological product is in a product class for which a biological product in such product class is the subject of an application approved under such section 505 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this subtitle as the “Secretary”) before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) LIMITATION.—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C.

355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(4) **DEEMED APPROVED UNDER SECTION 351.**—An approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) shall be deemed to be a license for the biological product under such section 351 on the date that is 10 years after the date of enactment of this Act.

(5) **DEFINITIONS.**—For purposes of this subsection, the term “biological product” has the meaning given such term under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(f) **FOLLOW-ON BIOLOGICS USER FEES.**—

(1) **DEVELOPMENT OF USER FEES FOR BIOSIMILAR BIOLOGICAL PRODUCTS.**—

(A) **IN GENERAL.**—Beginning not later than October 1, 2010, the Secretary shall develop recommendations to present to Congress with respect to the goals, and plans for meeting the goals, for the process for the review of biosimilar biological product applications submitted under section 351(k) of the Public Health Service Act (as added by this Act) for the first 5 fiscal years after fiscal year 2012. In developing such recommendations, the Secretary shall consult with—

- (i) the Committee on Health, Education, Labor, and Pensions of the Senate;
- (ii) the Committee on Energy and Commerce of the House of Representatives;
- (iii) scientific and academic experts;
- (iv) health care professionals;
- (v) representatives of patient and consumer advocacy groups; and
- (vi) the regulated industry.

(B) **PUBLIC REVIEW OF RECOMMENDATIONS.**—After negotiations with the regulated industry, the Secretary shall—

- (i) present the recommendations developed under subparagraph (A) to the Congressional committees specified in such subparagraph;
- (ii) publish such recommendations in the Federal Register;
- (iii) provide for a period of 30 days for the public to provide written comments on such recommendations;
- (iv) hold a meeting at which the public may present its views on such recommendations; and
- (v) after consideration of such public views and comments, revise such recommendations as necessary.

(C) **TRANSMITTAL OF RECOMMENDATIONS.**—Not later than January 15, 2012, the Secretary shall transmit to Congress the revised recommendations under subparagraph (B), a summary of the views and comments received under such subparagraph, and any changes made to the recommendations in response to such views and comments.

(2) **ESTABLISHMENT OF USER FEE PROGRAM.**—It is the sense of the Senate that, based on the recommendations transmitted to Congress by the Secretary pursuant to paragraph (1)(C), Congress should authorize a program, effective on October 1, 2012, for the collection of user fees relating to the submission of biosimilar biological product applications under section 351(k) of the Public Health Service Act (as added by this Act).

(3) **TRANSITIONAL PROVISIONS FOR USER FEES FOR BIOSIMILAR BIOLOGICAL PRODUCTS.**—

(A) **APPLICATION OF THE PRESCRIPTION DRUG USER FEE PROVISIONS.**—Section 735(1)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379g(1)(B)) is amended by striking “section 351” and inserting “subsection (a) or (k) of section 351”.

(B) **EVALUATION OF COSTS OF REVIEWING BIOSIMILAR BIOLOGICAL PRODUCT APPLICATIONS.**—During the period beginning on the date of enactment of this Act and ending on October 1, 2010, the Secretary shall collect and evaluate data regarding the costs of reviewing applications for biological products submitted under section 351(k) of the Public Health Service Act (as added by this Act) during such period.

(C) **AUDIT.**—

(i) **IN GENERAL.**—On the date that is 2 years after first receiving a user fee applicable to an application for a biological product under section 351(k) of the Public Health Service Act (as added by this Act), and on a biennial basis thereafter until October 1, 2013, the Secretary shall perform an audit of the costs of reviewing such applications under such section 351(k). Such an audit shall compare—

(1) the costs of reviewing such applications under such section 351(k) to the amount of the user fee applicable to such applications; and

(II)(aa) such ratio determined under subclause (I); to

(bb) the ratio of the costs of reviewing applications for biological products under section 351(a) of such Act (as amended by this Act) to the amount of the user fee applicable to such applications under such section 351(a).

(ii) **ALTERATION OF USER FEE.**—If the audit performed under clause (i) indicates that the ratios compared under subclause (II) of such clause differ by more than 5 percent, then the Secretary shall alter the user fee applicable to applications submitted under such section 351(k) to more appropriately account for the costs of reviewing such applications.

(iii) **ACCOUNTING STANDARDS.**—The Secretary shall perform an audit under clause (i) in conformance with the accounting principles, standards, and requirements prescribed by the Comptroller General of the United States under section 3511 of title 31, United States Code, to ensure the validity of any potential variability.

(4) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated to carry out this subsection such sums as may be necessary for each of fiscal years 2010 through 2012.

(g) **PEDIATRIC STUDIES OF BIOLOGICAL PRODUCTS.**—

(1) **IN GENERAL.**—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended by adding at the end the following:

“(m) **PEDIATRIC STUDIES.**—

“(1) **APPLICATION OF CERTAIN PROVISIONS.**—The provisions of subsections (a), (d), (e), (f), (i), (j), (k), (l), (p), and (q) of section 505A of the Federal Food, Drug, and Cosmetic Act shall apply with respect to the extension of a period under paragraphs (2) and (3) to the same extent and in the same manner as such provisions apply with respect to the extension of a period under subsection (b) or (c) of section 505A of the Federal Food, Drug, and Cosmetic Act.

“(2) **MARKET EXCLUSIVITY FOR NEW BIOLOGICAL PRODUCTS.**—If, prior to approval of an application that is submitted under subsection (a), the Secretary determines that information relating to the use of a new biological product in the pediatric population may produce health benefits in that population, the Secretary makes a written request for pediatric studies (which shall include a timeframe for completing such studies), the applicant agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

“(A) the periods for such biological product referred to in subsection (k)(7) are deemed to be 4 years and 6 months rather than 4 years and 12 years and 6 months rather than 12 years; and

“(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

“(3) **MARKET EXCLUSIVITY FOR ALREADY-MARKETED BIOLOGICAL PRODUCTS.**—If the Secretary determines that information relating to the use of a licensed biological product in the pediatric population may produce health benefits in that population and makes a written request to the holder of an approved application under subsection (a) for pediatric studies (which shall include a timeframe for completing such studies), the holder agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

“(A) the periods for such biological product referred to in subsection (k)(7) are deemed to be 4 years and 6 months rather than 4 years and 12 years and 6 months rather than 12 years; and

“(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

“(4) **EXCEPTION.**—The Secretary shall not extend a period referred to in paragraph (2)(A), (2)(B), (3)(A), or (3)(B) if the determination under section 505A(d)(3) is made later than 9 months prior to the expiration of such period.”.

(2) **STUDIES REGARDING PEDIATRIC RESEARCH.**—

(A) **PROGRAM FOR PEDIATRIC STUDY OF DRUGS.**—Subsection (a)(1) of section 4091 of the Public Health Service Act (42 U.S.C. 284m) is amended by inserting “, biological products,” after “including drugs”.

(B) **INSTITUTE OF MEDICINE STUDY.**—Section 505A(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355b(p)) is amended by striking paragraphs (4) and (5) and inserting the following:

“(4) review and assess the number and importance of biological products for children that are being tested as a result of the amendments made by the Biologics Price Competition and Innovation Act of 2009 and the importance for children, health care providers, parents, and others of labeling changes made as a result of such testing;

“(5) review and assess the number, importance, and prioritization of any biological products that are not being tested for pediatric use; and

“(6) offer recommendations for ensuring pediatric testing of biological products, including consideration of any incentives, such as those provided under this section or section 351(m) of the Public Health Service Act.”.

(h) **ORPHAN PRODUCTS.**—If a reference product, as defined in section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act) has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition, a biological product seeking approval for such disease or condition under subsection (k) of such section 351 as biosimilar to, or interchangeable with, such reference product may be licensed by the Secretary only after the expiration for such reference product of the later of—

(1) the 7-year period described in section 527(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360cc(a)); and

(2) the 12-year period described in subsection (k)(7) of such section 351.

SEC. 7003. SAVINGS.

(a) **DETERMINATION.**—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall for each fiscal year determine the amount of savings to the

Federal Government as a result of the enactment of this subtitle.

(b) *USE*.—Notwithstanding any other provision of this subtitle (or an amendment made by this subtitle), the savings to the Federal Government generated as a result of the enactment of this subtitle shall be used for deficit reduction.

Subtitle B—More Affordable Medicines for Children and Underserved Communities

SEC. 7101. EXPANDED PARTICIPATION IN 340B PROGRAM.

(a) *EXPANSION OF COVERED ENTITIES RECEIVING DISCOUNTED PRICES*.—Section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)) is amended by adding at the end the following:

“(M) A children’s hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(iii) of the Social Security Act, or a free-standing cancer hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(v) of the Social Security Act, that would meet the requirements of subparagraph (L), including the disproportionate share adjustment percentage requirement under clause (ii) of such subparagraph, if the hospital were a subsection (d) hospital as defined by section 1886(d)(1)(B) of the Social Security Act.

“(N) An entity that is a critical access hospital (as determined under section 1820(c)(2) of the Social Security Act), and that meets the requirements of subparagraph (L)(i).

“(O) An entity that is a rural referral center, as defined by section 1886(d)(5)(C)(i) of the Social Security Act, or a sole community hospital, as defined by section 1886(d)(5)(C)(iii) of such Act, and that both meets the requirements of subparagraph (L)(i) and has a disproportionate share adjustment percentage equal to or greater than 8 percent.”.

(b) *EXTENSION OF DISCOUNT TO INPATIENT DRUGS*.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(1) in paragraphs (2), (5), (7), and (9) of subsection (a), by striking “outpatient” each place it appears; and

(2) in subsection (b)—

(A) by striking “OTHER DEFINITION” and all that follows through “In this section” and inserting the following: “OTHER DEFINITIONS.—

“(1) *IN GENERAL*.—In this section”; and

(B) by adding at the end the following new paragraph:

“(2) *COVERED DRUG*.—In this section, the term ‘covered drug’—

(A) means a covered outpatient drug (as defined in section 1927(k)(2) of the Social Security Act); and

(B) includes, notwithstanding paragraph (3)(A) of section 1927(k) of such Act, a drug used in connection with an inpatient or outpatient service provided by a hospital described in subparagraph (L), (M), (N), or (O) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section.”.

(c) *PROHIBITION ON GROUP PURCHASING ARRANGEMENTS*.—Section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)) is amended—

(1) in paragraph (4)(L)—

(A) in clause (i), by adding “and” at the end;

(B) in clause (ii), by striking “; and” and inserting a period; and

(C) by striking clause (iii); and

(2) in paragraph (5), as amended by subsection (b)—

(A) by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E); respectively; and

(B) by inserting after subparagraph (B), the following:

“(C) *PROHIBITION ON GROUP PURCHASING ARRANGEMENTS*.—

“(i) *IN GENERAL*.—A hospital described in subparagraph (L), (M), (N), or (O) of paragraph (4) shall not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement, except as permitted or provided for pursuant to clauses (ii) or (iii).

“(ii) *INPATIENT DRUGS*.—Clause (i) shall not apply to drugs purchased for inpatient use.

“(iii) *EXCEPTIONS*.—The Secretary shall establish reasonable exceptions to clause (i)—

(I) with respect to a covered outpatient drug that is unavailable to be purchased through the program under this section due to a drug shortage problem, manufacturer noncompliance, or any other circumstance beyond the hospital’s control;

(II) to facilitate generic substitution when a generic covered outpatient drug is available at a lower price; or

(III) to reduce in other ways the administrative burdens of managing both inventories of drugs subject to this section and inventories of drugs that are not subject to this section, so long as the exceptions do not create a duplicate discount problem in violation of subparagraph (A) or a diversion problem in violation of subparagraph (B).

(iv) *PURCHASING ARRANGEMENTS FOR INPATIENT DRUGS*.—The Secretary shall ensure that a hospital described in subparagraph (L), (M), (N), or (O) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section shall have multiple options for purchasing covered drugs for inpatients, including by utilizing a group purchasing organization or other group purchasing arrangement, establishing and utilizing its own group purchasing program, purchasing directly from a manufacturer, and any other purchasing arrangements that the Secretary determines is appropriate to ensure access to drug discount pricing under this section for inpatient drugs taking into account the particular needs of small and rural hospitals.”.

(d) *MEDICAID CREDITS ON INPATIENT DRUGS*.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended by striking subsection (c) and inserting the following:

“(c) *MEDICAID CREDIT*.—Not later than 90 days after the date of filing of the hospital’s most recently filed Medicare cost report, the hospital shall issue a credit as determined by the Secretary to the State Medicaid program for inpatient covered drugs provided to Medicaid recipients.”.

(e) *EFFECTIVE DATES*.—

(1) *IN GENERAL*.—The amendments made by this section and section 7102 shall take effect on January 1, 2010, and shall apply to drugs purchased on or after January 1, 2010.

(2) *EFFECTIVENESS*.—The amendments made by this section and section 7102 shall be effective and shall be taken into account in determining whether a manufacturer is deemed to meet the requirements of section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)), notwithstanding any other provision of law.

SEC. 7102. IMPROVEMENTS TO 340B PROGRAM INTEGRITY.

(a) *INTEGRITY IMPROVEMENTS*.—Subsection (d) of section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended to read as follows:

“(d) *IMPROVEMENTS IN PROGRAM INTEGRITY*.—

(1) *MANUFACTURER COMPLIANCE*.—

(A) *IN GENERAL*.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by manufacturers with the requirements of this section in order to prevent overcharges and other violations of the discounted pricing requirements specified in this section.

(B) *IMPROVEMENTS*.—The improvements described in subparagraph (A) shall include the following:

“(i) The development of a system to enable the Secretary to verify the accuracy of ceiling prices calculated by manufacturers under subsection (a)(1) and charged to covered entities, which shall include the following:

(I) Developing and publishing through an appropriate policy or regulatory issuance, precisely defined standards and methodology for the calculation of ceiling prices under such subsection.

(II) Comparing regularly the ceiling prices calculated by the Secretary with the quarterly pricing data that is reported by manufacturers to the Secretary.

(III) Performing spot checks of sales transactions by covered entities.

(IV) Inquiring into the cause of any pricing discrepancies that may be identified and either taking, or requiring manufacturers to take, such corrective action as is appropriate in response to such price discrepancies.

(ii) The establishment of procedures for manufacturers to issue refunds to covered entities in the event that there is an overcharge by the manufacturers, including the following:

(I) Providing the Secretary with an explanation of why and how the overcharge occurred, how the refunds will be calculated, and to whom the refunds will be issued.

(II) Oversight by the Secretary to ensure that the refunds are issued accurately and within a reasonable period of time, both in routine instances of retroactive adjustment to relevant pricing data and exceptional circumstances such as erroneous or intentional overcharging for covered drugs.

(iii) The provision of access through the Internet website of the Department of Health and Human Services to the applicable ceiling prices for covered drugs as calculated and verified by the Secretary in accordance with this section, in a manner (such as through the use of password protection) that limits such access to covered entities and adequately assures security and protection of privileged pricing data from unauthorized re-disclosure.

(iv) The development of a mechanism by which—

(I) rebates and other discounts provided by manufacturers to other purchasers subsequent to the sale of covered drugs to covered entities are reported to the Secretary; and

(II) appropriate credits and refunds are issued to covered entities if such discounts or rebates have the effect of lowering the applicable ceiling price for the relevant quarter for the drugs involved.

(v) Selective auditing of manufacturers and wholesalers to ensure the integrity of the drug discount program under this section.

(vi) The imposition of sanctions in the form of civil monetary penalties, which—

(I) shall be assessed according to standards established in regulations to be promulgated by the Secretary not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act;

(II) shall not exceed \$5,000 for each instance of overcharging a covered entity that may have occurred; and

(III) shall apply to any manufacturer with an agreement under this section that knowingly and intentionally charges a covered entity a price for purchase of a drug that exceeds the maximum applicable price under subsection (a)(1).

(2) *COVERED ENTITY COMPLIANCE*.—

(A) *IN GENERAL*.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by covered entities with the requirements of this section in order to prevent diversion and violations of the duplicate discount provision and other requirements specified under subsection (a)(5).

“(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

“(i) The development of procedures to enable and require covered entities to regularly update (at least annually) the information on the Internet website of the Department of Health and Human Services relating to this section.

“(ii) The development of a system for the Secretary to verify the accuracy of information regarding covered entities that is listed on the website described in clause (i).

“(iii) The development of more detailed guidance describing methodologies and options available to covered entities for billing covered drugs to State Medicaid agencies in a manner that avoids duplicate discounts pursuant to subsection (a)(5)(A).

“(iv) The establishment of a single, universal, and standardized identification system by which each covered entity site can be identified by manufacturers, distributors, covered entities, and the Secretary for purposes of facilitating the ordering, purchasing, and delivery of covered drugs under this section, including the processing of chargebacks for such drugs.

“(v) The imposition of sanctions, in appropriate cases as determined by the Secretary, additional to those to which covered entities are subject under subsection (a)(5)(E), through one or more of the following actions:

“(I) Where a covered entity knowingly and intentionally violates subsection (a)(5)(B), the covered entity shall be required to pay a monetary penalty to a manufacturer or manufacturers in the form of interest on sums for which the covered entity is found liable under subsection (a)(5)(E), such interest to be compounded monthly and equal to the current short term interest rate as determined by the Federal Reserve for the time period for which the covered entity is liable.

“(II) Where the Secretary determines a violation of subsection (a)(5)(B) was systematic and egregious as well as knowing and intentional, removing the covered entity from the drug discount program under this section and disqualifying the entity from re-entry into such program for a reasonable period of time to be determined by the Secretary.

“(III) Referring matters to appropriate Federal authorities within the Food and Drug Administration, the Office of Inspector General of Department of Health and Human Services, or other Federal agencies for consideration of appropriate action under other Federal statutes, such as the Prescription Drug Marketing Act (21 U.S.C. 353).

“(3) ADMINISTRATIVE DISPUTE RESOLUTION PROCESS.—

“(A) IN GENERAL.—Not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations to establish and implement an administrative process for the resolution of claims by covered entities that they have been overcharged for drugs purchased under this section, and claims by manufacturers, after the conduct of audits as authorized by subsection (a)(5)(D), of violations of subsections (a)(5)(A) or (a)(5)(B), including appropriate procedures for the provision of remedies and enforcement of determinations made pursuant to such process through mechanisms and sanctions described in paragraphs (1)(B) and (2)(B).

“(B) DEADLINES AND PROCEDURES.—Regulations promulgated by the Secretary under subparagraph (A) shall—

“(i) designate or establish a decision-making official or decision-making body within the Department of Health and Human Services to be responsible for reviewing and finally resolving claims by covered entities that they have been charged prices for covered drugs in excess of the

ceiling price described in subsection (a)(1), and claims by manufacturers that violations of subsection (a)(5)(A) or (a)(5)(B) have occurred;

“(ii) establish such deadlines and procedures as may be necessary to ensure that claims shall be resolved fairly, efficiently, and expeditiously;

“(iii) establish procedures by which a covered entity may discover and obtain such information and documents from manufacturers and third parties as may be relevant to demonstrate the merits of a claim that charges for a manufacturer's product have exceeded the applicable ceiling price under this section, and may submit such documents and information to the administrative official or body responsible for adjudicating such claim;

“(iv) require that a manufacturer conduct an audit of a covered entity pursuant to subsection (a)(5)(D) as a prerequisite to initiating administrative dispute resolution proceedings against a covered entity;

“(v) permit the official or body designated under clause (i), at the request of a manufacturer or manufacturers, to consolidate claims brought by more than one manufacturer against the same covered entity where, in the judgment of such official or body, consolidation is appropriate and consistent with the goals of fairness and economy of resources; and

“(vi) include provisions and procedures to permit multiple covered entities to jointly assert claims of overcharges by the same manufacturer for the same drug or drugs in one administrative proceeding, and permit such claims to be asserted on behalf of covered entities by associations or organizations representing the interests of such covered entities and of which the covered entities are members.

“(C) FINALITY OF ADMINISTRATIVE RESOLUTION.—The administrative resolution of a claim or claims under the regulations promulgated under subparagraph (A) shall be a final agency decision and shall be binding upon the parties involved, unless invalidated by an order of a court of competent jurisdiction.

“(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for fiscal year 2010 and each succeeding fiscal year.”

(b) CONFORMING AMENDMENTS.—Section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)) is amended—

(1) in subsection (a)(1), by adding at the end the following: “Each such agreement shall require that the manufacturer furnish the Secretary with reports, on a quarterly basis, of the price for each covered drug subject to the agreement that, according to the manufacturer, represents the maximum price that covered entities may permissibly be required to pay for the drug (referred to in this section as the ‘ceiling price’), and shall require that the manufacturer offer each covered entity covered drugs for purchase at or below the applicable ceiling price if such drug is made available to any other purchaser at any price.”; and

(2) in the first sentence of subsection (a)(5)(E), as redesignated by section 7101(c), by inserting “after audit as described in subparagraph (D) and” after “finds.”

SEC. 7103. GAO STUDY TO MAKE RECOMMENDATIONS ON IMPROVING THE 340B PROGRAM.

(a) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that examines whether those individuals served by the covered entities under the program under section 340B of the Public Health Service Act (42 U.S.C. 256b) (referred to in this section as the “340B program”) are receiving optimal health care services.

(b) RECOMMENDATIONS.—The report under subsection (a) shall include recommendations on the following:

(1) Whether the 340B program should be expanded since it is anticipated that the 47,000,000 individuals who are uninsured as of the date of enactment of this Act will have health care coverage once this Act is implemented.

(2) Whether mandatory sales of certain products by the 340B program could hinder patients access to those therapies through any provider.

(3) Whether income from the 340B program is being used by the covered entities under the program to further the program objectives.

TITLE VIII—CLASS ACT

SEC. 8001. SHORT TITLE OF TITLE.

This title may be cited as the “Community Living Assistance Services and Supports Act” or the “CLASS Act”.

SEC. 8002. ESTABLISHMENT OF NATIONAL VOLUNTARY INSURANCE PROGRAM FOR PURCHASING COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORT.

(a) ESTABLISHMENT OF CLASS PROGRAM.—

(1) IN GENERAL.—The Public Health Service Act (42 U.S.C. 201 et seq.), as amended by section 4302(a), is amended by adding at the end the following:

“TITLE XXXII—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

“SEC. 3201. PURPOSE.

“The purpose of this title is to establish a national voluntary insurance program for purchasing community living assistance services and supports in order to—

“(1) provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports;

“(2) establish an infrastructure that will help address the Nation's community living assistance services and supports needs;

“(3) alleviate burdens on family caregivers; and

“(4) address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community.”

“SEC. 3202. DEFINITIONS.

“In this title:

“(1) ACTIVE ENROLLEE.—The term ‘active enrollee’ means an individual who is enrolled in the CLASS program in accordance with section 3204 and who has paid any premiums due to maintain such enrollment.

“(2) ACTIVELY EMPLOYED.—The term ‘actively employed’ means an individual who—

“(A) is reporting for work at the individual's usual place of employment or at another location to which the individual is required to travel because of the individual's employment (or in the case of an individual who is a member of the uniformed services, is on active duty and is physically able to perform the duties of the individual's position); and

“(B) is able to perform all the usual and customary duties of the individual's employment on the individual's regular work schedule.

“(3) ACTIVITIES OF DAILY LIVING.—The term ‘activities of daily living’ means each of the following activities specified in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986:

“(A) Eating.

“(B) Toileting.

“(C) Transferring.

“(D) Bathing.

“(E) Dressing.

“(F) Continence.

“(4) CLASS PROGRAM.—The term ‘CLASS program’ means the program established under this title.

“(5) ELIGIBILITY ASSESSMENT SYSTEM.—The term ‘Eligibility Assessment System’ means the

entity established by the Secretary under section 3205(a)(2) to make functional eligibility determinations for the CLASS program.

“(6) ELIGIBLE BENEFICIARY.—

“(A) IN GENERAL.—The term ‘eligible beneficiary’ means any individual who is an active enrollee in the CLASS program and, as of the date described in subparagraph (B)—

“(i) has paid premiums for enrollment in such program for at least 60 months;

“(ii) has earned, with respect to at least 3 calendar years that occur during the first 60 months for which the individual has paid premiums for enrollment in the program, at least an amount equal to the amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage under section 213(d) of the Social Security Act for the year; and

“(iii) has paid premiums for enrollment in such program for at least 24 consecutive months, if a lapse in premium payments of more than 3 months has occurred during the period that begins on the date of the individual’s enrollment and ends on the date of such determination.

“(B) DATE DESCRIBED.—For purposes of subparagraph (A), the date described in this subparagraph is the date on which the individual is determined to have a functional limitation described in section 3203(a)(1)(C) that is expected to last for a continuous period of more than 90 days.

“(C) REGULATIONS.—The Secretary shall promulgate regulations specifying exceptions to the minimum earnings requirements under subparagraph (A)(ii) for purposes of being considered an eligible beneficiary for certain populations.

“(7) HOSPITAL; NURSING FACILITY; INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED; INSTITUTION FOR MENTAL DISEASES.—The terms ‘hospital’, ‘nursing facility’, ‘intermediate care facility for the mentally retarded’, and ‘institution for mental diseases’ have the meanings given such terms for purposes of Medicaid.

“(8) CLASS INDEPENDENCE ADVISORY COUNCIL.—The term ‘CLASS Independence Advisory Council’ or ‘Council’ means the Advisory Council established under section 3207 to advise the Secretary.

“(9) CLASS INDEPENDENCE BENEFIT PLAN.—The term ‘CLASS Independence Benefit Plan’ means the benefit plan developed and designated by the Secretary in accordance with section 3203.

“(10) CLASS INDEPENDENCE FUND.—The term ‘CLASS Independence Fund’ or ‘Fund’ means the fund established under section 3206.

“(11) MEDICAID.—The term ‘Medicaid’ means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

“(12) POVERTY LINE.—The term ‘poverty line’ has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

“(13) PROTECTION AND ADVOCACY SYSTEM.—The term ‘Protection and Advocacy System’ means the system for each State established under section 143 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15043).

“SEC. 3203. CLASS INDEPENDENCE BENEFIT PLAN.

“(a) PROCESS FOR DEVELOPMENT.—

“(1) IN GENERAL.—The Secretary, in consultation with appropriate actuaries and other experts, shall develop at least 3 actuarially sound benefit plans as alternatives for consideration for designation by the Secretary as the CLASS Independence Benefit Plan under which eligible beneficiaries shall receive benefits under this title. Each of the plan alternatives developed shall be designed to provide eligible beneficiaries with the benefits described in section 3205 consistent with the following requirements:

“(A) PREMIUMS.—

“(i) IN GENERAL.—Beginning with the first year of the CLASS program, and for each year thereafter, subject to clauses (ii) and (iii), the Secretary shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period.

“(ii) NOMINAL PREMIUM FOR POOREST INDIVIDUALS AND FULL-TIME STUDENTS.—

“(1) IN GENERAL.—The monthly premium for enrollment in the CLASS program shall not exceed the applicable dollar amount per month determined under subclause (II) for—

“(aa) any individual whose income does not exceed the poverty line; and

“(bb) any individual who has not attained age 22, and is actively employed during any period in which the individual is a full-time student (as determined by the Secretary).

“(II) APPLICABLE DOLLAR AMOUNT.—The applicable dollar amount described in this subclause is the amount equal to \$5, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for each year occurring after 2009 and before such year.

“(iii) CLASS INDEPENDENCE FUND RESERVES.—At such time as the CLASS program has been in operation for 10 years, the Secretary shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis that accumulated reserves in the CLASS Independence Fund would not decrease in that year. At such time as the Secretary determines the CLASS program demonstrates a sustained ability to finance expected yearly expenses with expected yearly premiums and interest credited to the CLASS Independence Fund, the Secretary may decrease the required amount of CLASS Independence Fund reserves.

“(B) VESTING PERIOD.—A 5-year vesting period for eligibility for benefits.

“(C) BENEFIT TRIGGERS.—A benefit trigger for provision of benefits that requires a determination that an individual has a functional limitation, as certified by a licensed health care practitioner, described in any of the following clauses that is expected to last for a continuous period of more than 90 days:

“(i) The individual is determined to be unable to perform at least the minimum number (which may be 2 or 3) of activities of daily living as are required under the plan for the provision of benefits without substantial assistance (as defined by the Secretary) from another individual.

“(ii) The individual requires substantial supervision to protect the individual from threats to health and safety due to substantial cognitive impairment.

“(iii) The individual has a level of functional limitation similar (as determined under regulations prescribed by the Secretary) to the level of functional limitation described in clause (i) or (ii).

“(D) CASH BENEFIT.—Payment of a cash benefit that satisfies the following requirements:

“(i) MINIMUM REQUIRED AMOUNT.—The benefit amount provides an eligible beneficiary with not less than an average of \$50 per day (as determined based on the reasonably expected distribution of beneficiaries receiving benefits at various benefit levels).

“(ii) AMOUNT SCALED TO FUNCTIONAL ABILITY.—The benefit amount is varied based on a scale of functional ability, with not less than 2, and not more than 6, benefit level amounts.

“(iii) DAILY OR WEEKLY.—The benefit is paid on a daily or weekly basis.

“(iv) NO LIFETIME OR AGGREGATE LIMIT.—The benefit is not subject to any lifetime or aggregate limit.

“(E) COORDINATION WITH SUPPLEMENTAL COVERAGE OBTAINED THROUGH THE EXCHANGE.—The

benefits allow for coordination with any supplemental coverage purchased through an Exchange established under section 1311 of the Patient Protection and Affordable Care Act.

“(2) REVIEW AND RECOMMENDATION BY THE CLASS INDEPENDENCE ADVISORY COUNCIL.—The CLASS Independence Advisory Council shall—

“(A) evaluate the alternative benefit plans developed under paragraph (1); and

“(B) recommend for designation as the CLASS Independence Benefit Plan for offering to the public the plan that the Council determines best balances price and benefits to meet enrollees’ needs in an actuarially sound manner, while optimizing the probability of the long-term sustainability of the CLASS program.

“(3) DESIGNATION BY THE SECRETARY.—Not later than October 1, 2012, the Secretary, taking into consideration the recommendation of the CLASS Independence Advisory Council under paragraph (2)(B), shall designate a benefit plan as the CLASS Independence Benefit Plan. The Secretary shall publish such designation, along with details of the plan and the reasons for the selection by the Secretary, in a final rule that allows for a period of public comment.

“(b) ADDITIONAL PREMIUM REQUIREMENTS.—

“(1) ADJUSTMENT OF PREMIUMS.—

“(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), (D), and (E), the amount of the monthly premium determined for an individual upon such individual’s enrollment in the CLASS program shall remain the same for as long as the individual is an active enrollee in the program.

“(B) RECALCULATED PREMIUM IF REQUIRED FOR PROGRAM SOLVENCY.—

“(i) IN GENERAL.—Subject to clause (ii), if the Secretary determines, based on the most recent report of the Board of Trustees of the CLASS Independence Fund, the advice of the CLASS Independence Advisory Council, and the annual report of the Inspector General of the Department of Health and Human Services, and waste, fraud, and abuse, or such other information as the Secretary determines appropriate, that the monthly premiums and income to the CLASS Independence Fund for a year are projected to be insufficient with respect to the 20-year period that begins with that year, the Secretary shall adjust the monthly premiums for individuals enrolled in the CLASS program as necessary (but maintaining a nominal premium for enrollees whose income is below the poverty line or who are full-time students actively employed).

“(ii) EXEMPTION FROM INCREASE.—Any increase in a monthly premium imposed as result of a determination described in clause (i) shall not apply with respect to the monthly premium of any active enrollee who—

“(I) has attained age 65;

“(II) has paid premiums for enrollment in the program for at least 20 years; and

“(III) is not actively employed.

“(C) RECALCULATED PREMIUM IF REENROLLMENT AFTER MORE THAN A 3-MONTH LAPSE.—

“(i) IN GENERAL.—The reenrollment of an individual after a 90-day period during which the individual failed to pay the monthly premium required to maintain the individual’s enrollment in the CLASS program shall be treated as an initial enrollment for purposes of age-adjusting the premium for enrollment in the program.

“(ii) CREDIT FOR PRIOR MONTHS IF REENROLLED WITHIN 5 YEARS.—An individual who reenrolls in the CLASS program after such a 90-day period and before the end of the 5-year period that begins with the first month for which the individual failed to pay the monthly premium required to maintain the individual’s enrollment in the program shall be—

“(I) credited with any months of paid premiums that accrued prior to the individual’s lapse in enrollment; and

“(II) notwithstanding the total amount of any such credited months, required to satisfy section 3202(6)(A)(ii) before being eligible to receive benefits.

“(D) NO LONGER STATUS AS A FULL-TIME STUDENT.—An individual subject to a nominal premium on the basis of being described in subsection (a)(1)(A)(ii)(I)(bb) who ceases to be described in that subsection, beginning with the first month following the month in which the individual ceases to be so described, shall be subject to the same monthly premium as the monthly premium that applies to an individual of the same age who first enrolls in the program under the most similar circumstances as the individual (such as the first year of eligibility for enrollment in the program or in a subsequent year).

“(E) PENALTY FOR REENROLLMENT AFTER 5-YEAR LAPSE.—In the case of an individual who reenrolls in the CLASS program after the end of the 5-year period described in subparagraph (C)(ii), the monthly premium required for the individual shall be the age-adjusted premium that would be applicable to an initially enrolling individual who is the same age as the reenrolling individual, increased by the greater of—

“(i) an amount that the Secretary determines is actuarially sound for each month that occurs during the period that begins with the first month for which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the CLASS program and ends with the month preceding the month in which the reenrollment is effective; or

“(ii) 1 percent of the applicable age-adjusted premium for each such month occurring in such period.

“(2) ADMINISTRATIVE EXPENSES.—In determining the monthly premiums for the CLASS program the Secretary may factor in costs for administering the program, not to exceed for any year in which the program is in effect under this title, an amount equal to 3 percent of all premiums paid during the year.

“(3) NO UNDERWRITING REQUIREMENTS.—No underwriting (other than on the basis of age in accordance with subparagraphs (D) and (E) of paragraph (1)) shall be used to—

“(A) determine the monthly premium for enrollment in the CLASS program; or

“(B) prevent an individual from enrolling in the program.

“(c) SELF-ATTESTATION AND VERIFICATION OF INCOME.—The Secretary shall establish procedures to—

“(1) permit an individual who is eligible for the nominal premium required under subsection (a)(1)(A)(ii), as part of their automatic enrollment in the CLASS program, to self-attest that their income does not exceed the poverty line or that their status as a full-time student who is actively employed;

“(2) verify, using procedures similar to the procedures used by the Commissioner of Social Security under section 1631(e)(1)(B)(ii) of the Social Security Act and consistent with the requirements applicable to the conveyance of data and information under section 1942 of such Act, the validity of such self-attestation; and

“(3) require an individual to confirm, on at least an annual basis, that their income does not exceed the poverty line or that they continue to maintain such status.

“SEC. 3204. ENROLLMENT AND DISENROLLMENT REQUIREMENTS.

“(a) AUTOMATIC ENROLLMENT.—

“(1) IN GENERAL.—Subject to paragraph (2), the Secretary, in coordination with the Secretary of the Treasury, shall establish procedures under which each individual described in subsection (c) may be automatically enrolled in the CLASS program by an employer of such individual in the same manner as an employer

may elect to automatically enroll employees in a plan under section 401(k), 403(b), or 457 of the Internal Revenue Code of 1986.

“(2) ALTERNATIVE ENROLLMENT PROCEDURES.—The procedures established under paragraph (1) shall provide for an alternative enrollment process for an individual described in subsection (c) in the case of such an individual—

“(A) who is self-employed;

“(B) who has more than 1 employer; or

“(C) whose employer does not elect to participate in the automatic enrollment process established by the Secretary.

“(3) ADMINISTRATION.—

“(A) IN GENERAL.—The Secretary and the Secretary of the Treasury shall, by regulation, establish procedures to ensure that an individual is not automatically enrolled in the CLASS program by more than 1 employer.

“(B) FORM.—Enrollment in the CLASS program shall be made in such manner as the Secretary may prescribe in order to ensure ease of administration.

“(b) ELECTION TO OPT-OUT.—An individual described in subsection (c) may elect to waive enrollment in the CLASS program at any time in such form and manner as the Secretary and the Secretary of the Treasury shall prescribe.

“(c) INDIVIDUAL DESCRIBED.—For purposes of enrolling in the CLASS program, an individual described in this paragraph is an individual—

“(1) who has attained age 18;

“(2) who—

“(A) receives wages on which there is imposed a tax under section 3201(a) of the Internal Revenue Code of 1986; or

“(B) derives self-employment income on which there is imposed a tax under section 1401(a) of the Internal Revenue Code of 1986;

“(3) who is actively employed; and

“(4) who is not—

“(A) a patient in a hospital or nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases and receiving medical assistance under Medicaid; or

“(B) confined in a jail, prison, other penal institution or correctional facility, or by court order pursuant to conviction of a criminal offense or in connection with a verdict or finding described in section 202(x)(1)(A)(ii) of the Social Security Act (42 U.S.C. 402(x)(1)(A)(ii)).

“(d) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as requiring an active enrollee to continue to satisfy subparagraph (B) or (C) of subsection (c)(1) in order to maintain enrollment in the CLASS program.

“(e) PAYMENT.—

“(1) PAYROLL DEDUCTION.—An amount equal to the monthly premium for the enrollment in the CLASS program of an individual shall be deducted from the wages or self-employment income of such individual in accordance with such procedures as the Secretary, in coordination with the Secretary of the Treasury, shall establish for employers who elect to deduct and withhold such premiums on behalf of enrolled employees.

“(2) ALTERNATIVE PAYMENT MECHANISM.—The Secretary, in coordination with the Secretary of the Treasury, shall establish alternative procedures for the payment of monthly premiums by an individual enrolled in the CLASS program—

“(A) who does not have an employer who elects to deduct and withhold premiums in accordance with subparagraph (A); or

“(B) who does not earn wages or derive self-employment income.

“(f) TRANSFER OF PREMIUMS COLLECTED.—

“(1) IN GENERAL.—During each calendar year the Secretary of the Treasury shall deposit into the CLASS Independence Fund a total amount equal, in the aggregate, to 100 percent of the premiums collected during that year.

“(2) TRANSFERS BASED ON ESTIMATES.—The amount deposited pursuant to paragraph (1) shall be transferred in at least monthly payments to the CLASS Independence Fund on the basis of estimates by the Secretary and certified to the Secretary of the Treasury of the amounts collected in accordance with subparagraphs (A) and (B) of paragraph (5). Proper adjustments shall be made in amounts subsequently transferred to the Fund to the extent prior estimates were in excess of, or were less than, actual amounts collected.

“(g) OTHER ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—The Secretary, in coordination with the Secretary of the Treasury, shall establish procedures under which—

“(1) an individual who, in the year of the individual's initial eligibility to enroll in the CLASS program, has elected to waive enrollment in the program, is eligible to elect to enroll in the program, in such form and manner as the Secretaries shall establish, only during an open enrollment period established by the Secretaries that is specific to the individual and that may not occur more frequently than biennially after the date on which the individual first elected to waive enrollment in the program; and

“(2) an individual shall only be permitted to disenroll from the program (other than for nonpayment of premiums) during an annual disenrollment period established by the Secretaries and in such form and manner as the Secretaries shall establish.

“SEC. 3205. BENEFITS.

“(a) DETERMINATION OF ELIGIBILITY.—

“(1) APPLICATION FOR RECEIPT OF BENEFITS.—The Secretary shall establish procedures under which an active enrollee shall apply for receipt of benefits under the CLASS Independence Benefit Plan.

“(2) ELIGIBILITY ASSESSMENTS.—

“(A) IN GENERAL.—Not later than January 1, 2012, the Secretary shall—

“(i) establish an Eligibility Assessment System (other than a service with which the Commissioner of Social Security has entered into an agreement, with respect to any State, to make disability determinations for purposes of title II or XVI of the Social Security Act) to provide for eligibility assessments of active enrollees who apply for receipt of benefits;

“(ii) enter into an agreement with the Protection and Advocacy System for each State to provide advocacy services in accordance with subsection (d); and

“(iii) enter into an agreement with public and private entities to provide advice and assistance counseling in accordance with subsection (e).

“(B) REGULATIONS.—The Secretary shall promulgate regulations to develop an expedited nationally equitable eligibility determination process, as certified by a licensed health care practitioner, an appeals process, and a redetermination process, as certified by a licensed health care practitioner, including whether an active enrollee is eligible for a cash benefit under the program and if so, the amount of the cash benefit (in accordance the sliding scale established under the plan).

“(C) PRESUMPTIVE ELIGIBILITY FOR CERTAIN INSTITUTIONALIZED ENROLLEES PLANNING TO DISCHARGE.—An active enrollee shall be deemed presumptively eligible if the enrollee—

“(i) has applied for, and attests is eligible for, the maximum cash benefit available under the sliding scale established under the CLASS Independence Benefit Plan;

“(ii) is a patient in a hospital (but only if the hospitalization is for long-term care), nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases; and

“(iii) is in the process of, or about to begin the process of, planning to discharge from the hospital, facility, or institution, or within 60 days

from the date of discharge from the hospital, facility, or institution.

“(D) APPEALS.—The Secretary shall establish procedures under which an applicant for benefits under the CLASS Independence Benefit Plan shall be guaranteed the right to appeal an adverse determination.

“(b) BENEFITS.—An eligible beneficiary shall receive the following benefits under the CLASS Independence Benefit Plan:

“(1) CASH BENEFIT.—A cash benefit established by the Secretary in accordance with the requirements of section 3203(a)(1)(D) that—

“(A) the first year in which beneficiaries receive the benefits under the plan, is not less than the average dollar amount specified in clause (i) of such section; and

“(B) for any subsequent year, is not less than the average per day dollar limit applicable under this subparagraph for the preceding year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) over the previous year.

“(2) ADVOCACY SERVICES.—Advocacy services in accordance with subsection (d).

“(3) ADVICE AND ASSISTANCE COUNSELING.—Advice and assistance counseling in accordance with subsection (e).

“(4) ADMINISTRATIVE EXPENSES.—Advocacy services and advice and assistance counseling services under paragraphs (2) and (3) of this subsection shall be included as administrative expenses under section 3203(b)(3).

“(c) PAYMENT OF BENEFITS.—

“(1) LIFE INDEPENDENCE ACCOUNT.—

“(A) IN GENERAL.—The Secretary shall establish procedures for administering the provision of benefits to eligible beneficiaries under the CLASS Independence Benefit Plan, including the payment of the cash benefit for the beneficiary into a Life Independence Account established by the Secretary on behalf of each eligible beneficiary.

“(B) USE OF CASH BENEFITS.—Cash benefits paid into a Life Independence Account of an eligible beneficiary shall be used to purchase non-medical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of their choice in the community, including (but not limited to) home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support. Nothing in the preceding sentence shall prevent an eligible beneficiary from using cash benefits paid into a Life Independence Account for obtaining assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions.

“(C) ELECTRONIC MANAGEMENT OF FUNDS.—The Secretary shall establish procedures for—

“(i) crediting an account established on behalf of a beneficiary with the beneficiary's cash daily benefit;

“(ii) allowing the beneficiary to access such account through debit cards; and

“(iii) accounting for withdrawals by the beneficiary from such account.

“(D) PRIMARY PAYOR RULES FOR BENEFICIARIES WHO ARE ENROLLED IN MEDICAID.—In the case of an eligible beneficiary who is enrolled in Medicaid, the following payment rules shall apply:

“(i) INSTITUTIONALIZED BENEFICIARY.—If the beneficiary is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental dis-

eases, the beneficiary shall retain an amount equal to 5 percent of the beneficiary's daily or weekly cash benefit (as applicable) (which shall be in addition to the amount of the beneficiary's personal needs allowance provided under Medicaid), and the remainder of such benefit shall be applied toward the facility's cost of providing the beneficiary's care, and Medicaid shall provide secondary coverage for such care.

“(ii) BENEFICIARIES RECEIVING HOME AND COMMUNITY-BASED SERVICES.—

“(1) 50 PERCENT OF BENEFIT RETAINED BY BENEFICIARY.—Subject to subclause (II), if a beneficiary is receiving medical assistance under Medicaid for home and community based services, the beneficiary shall retain an amount equal to 50 percent of the beneficiary's daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

“(II) REQUIREMENT FOR STATE OFFSET.—A State shall be paid the remainder of a beneficiary's daily or weekly cash benefit under subclause (I) only if the State home and community-based waiver under section 1115 of the Social Security Act (42 U.S.C. 1315) or subsection (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n), or the State plan amendment under subsection (i) of such section does not include a waiver of the requirements of section 1902(a)(1) of the Social Security Act (relating to statewideness) or of section 1902(a)(10)(B) of such Act (relating to comparability) and the State offers at a minimum case management services, personal care services, habilitation services, and respite care under such a waiver or State plan amendment.

“(III) DEFINITION OF HOME AND COMMUNITY-BASED SERVICES.—In this clause, the term ‘home and community-based services’ means any services which may be offered under a home and community-based waiver authorized for a State under section 1115 of the Social Security Act (42 U.S.C. 1315) or subsection (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n) or under a State plan amendment under subsection (i) of such section.

“(iii) BENEFICIARIES ENROLLED IN PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).—

“(1) IN GENERAL.—Subject to subclause (II), if a beneficiary is receiving medical assistance under Medicaid for PACE program services under section 1934 of the Social Security Act (42 U.S.C. 1396u-4), the beneficiary shall retain an amount equal to 50 percent of the beneficiary's daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

“(II) INSTITUTIONALIZED RECIPIENTS OF PACE PROGRAM SERVICES.—If a beneficiary receiving assistance under Medicaid for PACE program services is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall be treated as in institutionalized beneficiary under clause (i).

“(2) AUTHORIZED REPRESENTATIVES.—

“(A) IN GENERAL.—The Secretary shall establish procedures to allow access to a beneficiary's cash benefits by an authorized representative of the eligible beneficiary on whose behalf such benefits are paid.

“(B) QUALITY ASSURANCE AND PROTECTION AGAINST FRAUD AND ABUSE.—The procedures es-

tablished under subparagraph (A) shall ensure that authorized representatives of eligible beneficiaries comply with standards of conduct established by the Secretary, including standards requiring that such representatives provide quality services on behalf of such beneficiaries, do not have conflicts of interest, and do not misuse benefits paid on behalf of such beneficiaries or otherwise engage in fraud or abuse.

“(3) COMMENCEMENT OF BENEFITS.—Benefits shall be paid to, or on behalf of, an eligible beneficiary beginning with the first month in which an application for such benefits is approved.

“(4) ROLLOVER OPTION FOR LUMP-SUM PAYMENT.—An eligible beneficiary may elect to—

“(A) defer payment of their daily or weekly benefit and to rollover any such deferred benefits from month-to-month, but not from year-to-year; and

“(B) receive a lump-sum payment of such deferred benefits in an amount that may not exceed the lesser of—

“(i) the total amount of the accrued deferred benefits; or

“(ii) the applicable annual benefit.

“(5) PERIOD FOR DETERMINATION OF ANNUAL BENEFITS.—

“(A) IN GENERAL.—The applicable period for determining with respect to an eligible beneficiary the applicable annual benefit and the amount of any accrued deferred benefits is the 12-month period that commences with the first month in which the beneficiary began to receive such benefits, and each 12-month period thereafter.

“(B) INCLUSION OF INCREASED BENEFITS.—The Secretary shall establish procedures under which cash benefits paid to an eligible beneficiary that increase or decrease as a result of a change in the functional status of the beneficiary before the end of a 12-month benefit period shall be included in the determination of the applicable annual benefit paid to the eligible beneficiary.

“(C) RECOUPMENT OF UNPAID, ACCRUED BENEFITS.—

“(i) IN GENERAL.—The Secretary, in coordination with the Secretary of the Treasury, shall recoup any accrued benefits in the event of—

“(I) the death of a beneficiary; or

“(II) the failure of a beneficiary to elect under paragraph (4)(B) to receive such benefits as a lump-sum payment before the end of the 12-month period in which such benefits accrued.

“(ii) PAYMENT INTO CLASS INDEPENDENCE FUND.—Any benefits recouped in accordance with clause (i) shall be paid into the CLASS Independence Fund and used in accordance with section 3206.

“(6) REQUIREMENT TO RECERTIFY ELIGIBILITY FOR RECEIPT OF BENEFITS.—An eligible beneficiary shall periodically, as determined by the Secretary—

“(A) recertify by submission of medical evidence the beneficiary's continued eligibility for receipt of benefits; and

“(B) submit records of expenditures attributable to the aggregate cash benefit received by the beneficiary during the preceding year.

“(7) SUPPLEMENT, NOT SUPPLANT OTHER HEALTH CARE BENEFITS.—Subject to the Medicaid payment rules under paragraph (1)(D), benefits received by an eligible beneficiary shall supplement, but not supplant, other health care benefits for which the beneficiary is eligible under Medicaid or any other Federally funded program that provides health care benefits or assistance.

“(d) ADVOCACY SERVICES.—An agreement entered into under subsection (a)(2)(A)(ii) shall require the Protection and Advocacy System for the State to—

“(1) assign, as needed, an advocacy counselor to each eligible beneficiary that is covered by

such agreement and who shall provide an eligible beneficiary with—

“(A) information regarding how to access the appeals process established for the program;

“(B) assistance with respect to the annual recertification and notification required under subsection (c)(6); and

“(C) such other assistance with obtaining services as the Secretary, by regulation, shall require; and

“(2) ensure that the System and such counselors comply with the requirements of subsection (h).

“(e) **ADVICE AND ASSISTANCE COUNSELING.**—An agreement entered into under subsection (a)(2)(A)(iii) shall require the entity to assign, as requested by an eligible beneficiary that is covered by such agreement, an advice and assistance counselor who shall provide an eligible beneficiary with information regarding—

“(1) accessing and coordinating long-term services and supports in the most integrated setting;

“(2) possible eligibility for other benefits and services;

“(3) development of a service and support plan;

“(4) information about programs established under the Assistive Technology Act of 1998 and the services offered under such programs;

“(5) available assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions; and

“(6) such other services as the Secretary, by regulation, may require.

“(f) **NO EFFECT ON ELIGIBILITY FOR OTHER BENEFITS.**—Benefits paid to an eligible beneficiary under the CLASS program shall be disregarded for purposes of determining or continuing the beneficiary's eligibility for receipt of benefits under any other Federal, State, or locally funded assistance program, including benefits paid under titles II, XVI, XVIII, XIX, or XXI of the Social Security Act (42 U.S.C. 401 et seq., 1381 et seq., 1395 et seq., 1396 et seq., 1397aa et seq.), under the laws administered by the Secretary of Veterans Affairs, under low-income housing assistance programs, or under the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

“(g) **RULE OF CONSTRUCTION.**—Nothing in this title shall be construed as prohibiting benefits paid under the CLASS Independence Benefit Plan from being used to compensate a family caregiver for providing community living assistance services and supports to an eligible beneficiary.

“(h) **PROTECTION AGAINST CONFLICT OF INTERESTS.**—The Secretary shall establish procedures to ensure that the Eligibility Assessment System, the Protection and Advocacy System for a State, advocacy counselors for eligible beneficiaries, and any other entities that provide services to active enrollees and eligible beneficiaries under the CLASS program comply with the following:

“(1) If the entity provides counseling or planning services, such services are provided in a manner that fosters the best interests of the active enrollee or beneficiary.

“(2) The entity has established operating procedures that are designed to avoid or minimize conflicts of interest between the entity and an active enrollee or beneficiary.

“(3) The entity provides information about all services and options available to the active enrollee or beneficiary, to the best of its knowl-

edge, including services available through other entities or providers.

“(4) The entity assists the active enrollee or beneficiary to access desired services, regardless of the provider.

“(5) The entity reports the number of active enrollees and beneficiaries provided with assistance by age, disability, and whether such enrollees and beneficiaries received services from the entity or another entity.

“(6) If the entity provides counseling or planning services, the entity ensures that an active enrollee or beneficiary is informed of any financial interest that the entity has in a service provider.

“(7) The entity provides an active enrollee or beneficiary with a list of available service providers that can meet the needs of the active enrollee or beneficiary.

“SEC. 3206. CLASS INDEPENDENCE FUND.

“(a) **ESTABLISHMENT OF CLASS INDEPENDENCE FUND.**—There is established in the Treasury of the United States a trust fund to be known as the ‘CLASS Independence Fund’. The Secretary of the Treasury shall serve as Managing Trustee of such Fund. The Fund shall consist of all amounts derived from payments into the Fund under sections 3204(f) and 3205(c)(5)(C)(ii), and remaining after investment of such amounts under subsection (b), including additional amounts derived as income from such investments. The amounts held in the Fund are appropriated and shall remain available without fiscal year limitation—

“(1) to be held for investment on behalf of individuals enrolled in the CLASS program;

“(2) to pay the administrative expenses related to the Fund and to investment under subsection (b); and

“(3) to pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.

“(b) **INVESTMENT OF FUND BALANCE.**—The Secretary of the Treasury shall invest and manage the CLASS Independence Fund in the same manner, and to the same extent, as the Federal Supplementary Medical Insurance Trust Fund may be invested and managed under subsections (c), (d), and (e) of section 1841(d) of the Social Security Act (42 U.S.C. 1395t).

“(c) **BOARD OF TRUSTEES.**—

“(1) **IN GENERAL.**—With respect to the CLASS Independence Fund, there is hereby created a body to be known as the Board of Trustees of the CLASS Independence Fund (hereinafter in this section referred to as the ‘Board of Trustees’) composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of 4 years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

“(2) **DUTIES.**—

“(A) **IN GENERAL.**—It shall be the duty of the Board of Trustees to do the following:

“(i) Hold the CLASS Independence Fund.

“(ii) Report to the Congress not later than the first day of April of each year on the operation and status of the CLASS Independence Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years.

“(iii) Report immediately to the Congress whenever the Board is of the opinion that the amount of the CLASS Independence Fund is not actuarially sound in regards to the projection under section 3203(b)(1)(B)(i).

“(iv) Review the general policies followed in managing the CLASS Independence Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the CLASS Independence Fund is to be managed.

“(B) **REPORT.**—The report provided for in subparagraph (A)(ii) shall—

“(i) include—

“(I) a statement of the assets of, and the disbursements made from, the CLASS Independence Fund during the preceding fiscal year;

“(II) an estimate of the expected income to, and disbursements to be made from, the CLASS Independence Fund during the current fiscal year and each of the next 2 fiscal years;

“(III) a statement of the actuarial status of the CLASS Independence Fund for the current fiscal year, each of the next 2 fiscal years, and as projected over the 75-year period beginning with the current fiscal year; and

“(IV) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable; and

“(ii) be printed as a House document of the session of the Congress to which the report is made.

“(C) **RECOMMENDATIONS.**—If the Board of Trustees determines that enrollment trends and expected future benefit claims on the CLASS Independence Fund are not actuarially sound in regards to the projection under section 3203(b)(1)(B)(i) and are unlikely to be resolved with reasonable premium increases or through other means, the Board of Trustees shall include in the report provided for in subparagraph (A)(ii) recommendations for such legislative action as the Board of Trustees determine to be appropriate, including whether to adjust monthly premiums or impose a temporary moratorium on new enrollments.

“SEC. 3207. CLASS INDEPENDENCE ADVISORY COUNCIL.

“(a) **ESTABLISHMENT.**—There is hereby created an Advisory Committee to be known as the ‘CLASS Independence Advisory Council’.

“(b) **MEMBERSHIP.**—

“(1) **IN GENERAL.**—The CLASS Independence Advisory Council shall be composed of not more than 15 individuals, not otherwise in the employ of the United States—

“(A) who shall be appointed by the President without regard to the civil service laws and regulations; and

“(B) a majority of whom shall be representatives of individuals who participate or are likely to participate in the CLASS program, and shall include representatives of older and younger workers, individuals with disabilities, family caregivers of individuals who require services and supports to maintain their independence at home or in another residential setting of their choice in the community, individuals with expertise in long-term care or disability insurance, actuarial science, economics, and other relevant disciplines, as determined by the Secretary.

“(2) TERMS.—

“(A) IN GENERAL.—The members of the CLASS Independence Advisory Council shall serve overlapping terms of 3 years (unless appointed to fill a vacancy occurring prior to the expiration of a term, in which case the individual shall serve for the remainder of the term).

“(B) LIMITATION.—A member shall not be eligible to serve for more than 2 consecutive terms.

“(3) CHAIR.—The President shall, from time to time, appoint one of the members of the CLASS Independence Advisory Council to serve as the Chair.

“(c) DUTIES.—The CLASS Independence Advisory Council shall advise the Secretary on matters of general policy in the administration of the CLASS program established under this title and in the formulation of regulations under this title including with respect to—

“(1) the development of the CLASS Independence Benefit Plan under section 3203;

“(2) the determination of monthly premiums under such plan; and

“(3) the financial solvency of the program.

“(d) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14 of that Act, shall apply to the CLASS Independence Advisory Council.

“(e) AUTHORIZATION OF APPROPRIATIONS.—

“(1) IN GENERAL.—There are authorized to be appropriated to the CLASS Independence Advisory Council to carry out its duties under this section, such sums as may be necessary for fiscal year 2011 and for each fiscal year thereafter.

“(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this section shall remain available, without fiscal year limitation, until expended.

“SEC. 3208. SOLVENCY AND FISCAL INDEPENDENCE; REGULATIONS; ANNUAL REPORT.

“(a) SOLVENCY.—The Secretary shall regularly consult with the Board of Trustees of the CLASS Independence Fund and the CLASS Independence Advisory Council, for purposes of ensuring that enrollees premiums are adequate to ensure the financial solvency of the CLASS program, both with respect to fiscal years occurring in the near-term and fiscal years occurring over 20- and 75-year periods, taking into account the projections required for such periods under subsections (a)(1)(A)(i) and (b)(1)(B)(i) of section 3202.

“(b) NO TAXPAYER FUNDS USED TO PAY BENEFITS.—No taxpayer funds shall be used for payment of benefits under a CLASS Independent Benefit Plan. For purposes of this subsection, the term ‘taxpayer funds’ means any Federal funds from a source other than premiums deposited by CLASS program participants in the CLASS Independence Fund and any associated interest earnings.

“(c) REGULATIONS.—The Secretary shall promulgate such regulations as are necessary to carry out the CLASS program in accordance with this title. Such regulations shall include provisions to prevent fraud and abuse under the program.

“(d) ANNUAL REPORT.—Beginning January 1, 2014, the Secretary shall submit an annual report to Congress on the CLASS program. Each report shall include the following:

“(1) The total number of enrollees in the program.

“(2) The total number of eligible beneficiaries during the fiscal year.

“(3) The total amount of cash benefits provided during the fiscal year.

“(4) A description of instances of fraud or abuse identified during the fiscal year.

“(5) Recommendations for such administrative or legislative action as the Secretary determines is necessary to improve the program, ensure the solvency of the program, or to prevent the occurrence of fraud or abuse.

“SEC. 3209. INSPECTOR GENERAL’S REPORT.

“The Inspector General of the Department of Health and Human Services shall submit an annual report to the Secretary and Congress relating to the overall progress of the CLASS program and of the existence of waste, fraud, and abuse in the CLASS program. Each such report shall include findings in the following areas:

“(1) The eligibility determination process.

“(2) The provision of cash benefits.

“(3) Quality assurance and protection against waste, fraud, and abuse.

“(4) Recouping of unpaid and accrued benefits.

“SEC. 3210. TAX TREATMENT OF PROGRAM.

“The CLASS program shall be treated for purposes of the Internal Revenue Code of 1986 in the same manner as a qualified long-term care insurance contract for qualified long-term care services.”

(2) CONFORMING AMENDMENTS TO MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 6505, is amended by inserting after paragraph (80) the following:

“(81) provide that the State will comply with such regulations regarding the application of primary and secondary payor rules with respect to individuals who are eligible for medical assistance under this title and are eligible beneficiaries under the CLASS program established under title XXXII of the Public Health Service Act as the Secretary shall establish; and”.

(b) ASSURANCE OF ADEQUATE INFRASTRUCTURE FOR THE PROVISION OF PERSONAL CARE ATTENDANT WORKERS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (a)(2), is amended by inserting after paragraph (81) the following:

“(82) provide that, not later than 2 years after the date of enactment of the Community Living Assistance Services and Supports Act, each State shall—

“(A) assess the extent to which entities such as providers of home care, home health services, home and community service providers, public authorities created to provide personal care services to individuals eligible for medical assistance under the State plan, and nonprofit organizations, are serving or have the capacity to serve as fiscal agents for, employers of, and providers of employment-related benefits for, personal care attendant workers who provide personal care services to individuals receiving benefits under the CLASS program established under title XXXII of the Public Health Service Act, including in rural and underserved areas;

“(B) designate or create such entities to serve as fiscal agents for, employers of, and providers of employment-related benefits for, such workers to ensure an adequate supply of the workers for individuals receiving benefits under the CLASS program, including in rural and underserved areas; and

“(C) ensure that the designation or creation of such entities will not negatively alter or impede existing programs, models, methods, or administration of service delivery that provide for consumer controlled or self-directed home and community services and further ensure that such entities will not impede the ability of individuals to direct and control their home and community services, including the ability to select, manage, dismiss, co-employ, or employ such workers or inhibit such individuals from relying on family members for the provision of personal care services.”.

(c) PERSONAL CARE ATTENDANTS WORKFORCE ADVISORY PANEL.—

(1) ESTABLISHMENT.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall establish a Personal Care Attendants Workforce Advisory Panel for the purpose of examining

and advising the Secretary and Congress on workforce issues related to personal care attendant workers, including with respect to the adequacy of the number of such workers, the salaries, wages, and benefits of such workers, and access to the services provided by such workers.

(2) MEMBERSHIP.—In appointing members to the Personal Care Attendants Workforce Advisory Panel, the Secretary shall ensure that such members include the following:

(A) Individuals with disabilities of all ages.

(B) Senior individuals.

(C) Representatives of individuals with disabilities.

(D) Representatives of senior individuals.

(E) Representatives of workforce and labor organizations.

(F) Representatives of home and community-based service providers.

(G) Representatives of assisted living providers.

(d) INCLUSION OF INFORMATION ON SUPPLEMENTAL COVERAGE IN THE NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION; EXTENSION OF FUNDING.—Section 6021(d) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396p note) is amended—

(1) in paragraph (2)(A)—

(A) in clause (ii), by striking “and” at the end;

(B) in clause (iii), by striking the period at the end and inserting “; and”; and

(C) by adding at the end the following:

“(iv) include information regarding the CLASS program established under title XXXII of the Public Health Service Act and coverage available for purchase through a Exchange established under section 1311 of the Patient Protection and Affordable Care Act that is supplemental coverage to the benefits provided under a CLASS Independence Benefit Plan under that program, and information regarding how benefits provided under a CLASS Independence Benefit Plan differ from disability insurance benefits.”; and

(2) in paragraph (3), by striking “2010” and inserting “2015”.

(e) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (d) take effect on January 1, 2011.

(f) RULE OF CONSTRUCTION.—Nothing in this title or the amendments made by this title are intended to replace or displace public or private disability insurance benefits, including such benefits that are for income replacement.

TITLE IX—REVENUE PROVISIONS

Subtitle A—Revenue Offset Provisions

SEC. 9001. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986, as amended by section 1513, is amended by adding at the end the following:

“SEC. 49801. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

“(a) IMPOSITION OF TAX.—If—

“(1) an employee is covered under any applicable employer-sponsored coverage of an employer at any time during a taxable period, and

“(2) there is any excess benefit with respect to the coverage,

there is hereby imposed a tax equal to 40 percent of the excess benefit.

“(b) EXCESS BENEFIT.—For purposes of this section—

“(1) IN GENERAL.—The term ‘excess benefit’ means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts determined under paragraph (2) for months during the taxable period.

“(2) MONTHLY EXCESS AMOUNT.—The excess amount determined under this paragraph for any month is the excess (if any) of—

“(A) the aggregate cost of the applicable employer-sponsored coverage of the employee for the month, over

“(B) an amount equal to $\frac{1}{12}$ of the annual limitation under paragraph (3) for the calendar year in which the month occurs.

“(3) ANNUAL LIMITATION.—For purposes of this subsection—

“(A) IN GENERAL.—The annual limitation under this paragraph for any calendar year is the dollar limit determined under subparagraph (C) for the calendar year.

“(B) APPLICABLE ANNUAL LIMITATION.—The annual limitation which applies for any month shall be determined on the basis of the type of coverage (as determined under subsection (f)(1)) provided to the employee by the employer as of the beginning of the month.

“(C) APPLICABLE DOLLAR LIMIT.—Except as provided in subparagraph (D)—

“(i) 2013.—In the case of 2013, the dollar limit under this subparagraph is—

“(I) in the case of an employee with self-only coverage, \$8,500, and

“(II) in the case of an employee with coverage other than self-only coverage, \$23,000.

“(ii) EXCEPTION FOR CERTAIN INDIVIDUALS.—In the case of an individual who is a qualified retiree or who participates in a plan sponsored by an employer the majority of whose employees are engaged in a high-risk profession or employed to repair or install electrical or telecommunications lines—

“(I) the dollar amount in clause (i)(I) (determined after the application of subparagraph (D)) shall be increased by \$1,350, and

“(II) the dollar amount in clause (i)(II) (determined after the application of subparagraph (D)) shall be increased by \$3,000.

“(iii) SUBSEQUENT YEARS.—In the case of any calendar year after 2013, each of the dollar amounts under clauses (i) and (ii) shall be increased to the amount equal to such amount as in effect for the calendar year preceding such year, increased by an amount equal to the product of—

“(I) such amount as so in effect, multiplied by

“(II) the cost-of-living adjustment determined under section 1(f)(3) for such year (determined by substituting the calendar year that is 2 years before such year for ‘1992’ in subparagraph (B) thereof), increased by 1 percentage point.

If any amount determined under this clause is not a multiple of \$50, such amount shall be rounded to the nearest multiple of \$50.

“(D) TRANSITION RULE FOR STATES WITH HIGH-EST COVERAGE COSTS.—

“(i) IN GENERAL.—If an employee is a resident of a high cost State on the first day of any month beginning in 2013, 2014, or 2015, the annual limitation under this paragraph for such month with respect to such employee shall be an amount equal to the applicable percentage of the annual limitation (determined without regard to this subparagraph or subparagraph (C)(ii)).

“(ii) APPLICABLE PERCENTAGE.—The applicable percentage is 120 percent for 2013, 110 percent for 2014, and 105 percent for 2015.

“(iii) HIGH COST STATE.—The term ‘high cost State’ means each of the 17 States which the Secretary of Health and Human Services, in consultation with the Secretary, estimates had the highest average cost during 2012 for employer-sponsored coverage under health plans. The Secretary’s estimate shall be made on the basis of aggregate premiums paid in the State for such health plans, determined using the most recent data available as of August 31, 2012.

“(c) LIABILITY TO PAY TAX.—

“(1) IN GENERAL.—Each coverage provider shall pay the tax imposed by subsection (a) on

its applicable share of the excess benefit with respect to an employee for any taxable period.

“(2) COVERAGE PROVIDER.—For purposes of this subsection, the term ‘coverage provider’ means each of the following:

“(A) HEALTH INSURANCE COVERAGE.—If the applicable employer-sponsored coverage consists of coverage under a group health plan which provides health insurance coverage, the health insurance issuer.

“(B) HSA AND MSA CONTRIBUTIONS.—If the applicable employer-sponsored coverage consists of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the employer.

“(C) OTHER COVERAGE.—In the case of any other applicable employer-sponsored coverage, the person that administers the plan benefits.

“(3) APPLICABLE SHARE.—For purposes of this subsection, a coverage provider’s applicable share of an excess benefit for any taxable period is the amount which bears the same ratio to the amount of such excess benefit as—

“(A) the cost of the applicable employer-sponsored coverage provided by the provider to the employee during such period, bears to

“(B) the aggregate cost of all applicable employer-sponsored coverage provided to the employee by all coverage providers during such period.

“(4) RESPONSIBILITY TO CALCULATE TAX AND APPLICABLE SHARES.—

“(A) IN GENERAL.—Each employer shall—

“(i) calculate for each taxable period the amount of the excess benefit subject to the tax imposed by subsection (a) and the applicable share of such excess benefit for each coverage provider, and

“(ii) notify, at such time and in such manner as the Secretary may prescribe, the Secretary and each coverage provider of the amount so determined for the provider.

“(B) SPECIAL RULE FOR MULTIEMPLOYER PLANS.—In the case of applicable employer-sponsored coverage made available to employees through a multiemployer plan (as defined in section 414(f)), the plan sponsor shall make the calculations, and provide the notice, required under subparagraph (A).

“(d) APPLICABLE EMPLOYER-SPONSORED COVERAGE; COST.—For purposes of this section—

“(1) APPLICABLE EMPLOYER-SPONSORED COVERAGE.—

“(A) IN GENERAL.—The term ‘applicable employer-sponsored coverage’ means, with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee’s gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).

“(B) EXCEPTIONS.—The term ‘applicable employer-sponsored coverage’ shall not include—

“(i) any coverage (whether through insurance or otherwise) described in section 9832(c)(1)(A) or for long-term care, or

“(ii) any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

“(C) COVERAGE INCLUDES EMPLOYEE PAID PORTION.—Coverage shall be treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage.

“(D) SELF-EMPLOYED INDIVIDUAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), coverage under any group health plan providing health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(l) with respect to all or any portion of the cost of the coverage.

“(E) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

“(2) DETERMINATION OF COST.—

“(A) IN GENERAL.—The cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 4980B(f)(4), except that in determining such cost, any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account and the amount of such cost shall be calculated separately for self-only coverage and other coverage. In the case of applicable employer-sponsored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.

“(B) HEALTH FSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 106(c)(2)), the cost of the coverage shall be equal to the sum of—

“(i) the amount of employer contributions under any salary reduction election under the arrangement, plus

“(ii) the amount determined under subparagraph (A) with respect to any reimbursement under the arrangement in excess of the contributions described in clause (i).

“(C) ARCHER MSAS AND HSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

“(D) ALLOCATION ON A MONTHLY BASIS.—If cost is determined on other than a monthly basis, the cost shall be allocated to months in a taxable period on such basis as the Secretary may prescribe.

“(e) PENALTY FOR FAILURE TO PROPERLY CALCULATE EXCESS BENEFIT.—

“(1) IN GENERAL.—If, for any taxable period, the tax imposed by subsection (a) exceeds the tax determined under such subsection with respect to the total excess benefit calculated by the employer or plan sponsor under subsection (c)(4)—

“(A) each coverage provider shall pay the tax on its applicable share (determined in the same manner as under subsection (c)(4)) of the excess, but no penalty shall be imposed on the provider with respect to such amount, and

“(B) the employer or plan sponsor shall, in addition to any tax imposed by subsection (a), pay a penalty in an amount equal to such excess, plus interest at the underpayment rate determined under section 6621 for the period beginning on the due date for the payment of tax imposed by subsection (a) to which the excess relates and ending on the date of payment of the penalty.

“(2) LIMITATIONS ON PENALTY.—

“(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by paragraph (1)(B) on any failure to properly calculate the excess benefit during any period for which it is established to the satisfaction of the Secretary that the employer or plan sponsor neither knew, nor exercising reasonable diligence would have known, that such failure existed.

“(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be imposed by paragraph (1)(B) on any such failure if—

“(i) such failure was due to reasonable cause and not to willful neglect, and

“(ii) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

“(C) **WAIVER BY SECRETARY.**—In the case of any such failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by paragraph (1), to the extent that the payment of such penalty would be excessive or otherwise inequitable relative to the failure involved.

“(f) **OTHER DEFINITIONS AND SPECIAL RULES.**—For purposes of this section—

“(1) **COVERAGE DETERMINATIONS.**—

“(A) **IN GENERAL.**—Except as provided in subparagraph (B), an employee shall be treated as having self-only coverage with respect to any applicable employer-sponsored coverage of an employee.

“(B) **MINIMUM ESSENTIAL COVERAGE.**—An employee shall be treated as having coverage other than self-only coverage only if the employee is enrolled in coverage other than self-only coverage in a group health plan which provides minimum essential coverage (as defined in section 5000A(f)) to the employee and at least one other beneficiary, and the benefits provided under such minimum essential coverage do not vary based on whether any individual covered under such coverage is the employee or another beneficiary.

“(2) **QUALIFIED RETIREE.**—The term ‘qualified retiree’ means any individual who—

“(A) is receiving coverage by reason of being a retiree,

“(B) has attained age 55, and

“(C) is not entitled to benefits or eligible for enrollment under the Medicare program under title XVIII of the Social Security Act.

“(3) **EMPLOYEES ENGAGED IN HIGH-RISK PROFESSION.**—The term ‘employees engaged in a high-risk profession’ means law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. Such term includes an employee who is retired from a high-risk profession described in the preceding sentence, if such employee satisfied the requirements of such sentence for a period of not less than 20 years during the employee’s employment.

“(4) **GROUP HEALTH PLAN.**—The term ‘group health plan’ has the meaning given such term by section 5000(b)(1).

“(5) **HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.**—

“(A) **HEALTH INSURANCE COVERAGE.**—The term ‘health insurance coverage’ has the meaning given such term by section 9832(b)(1) (applied without regard to subparagraph (B) thereof, except as provided by the Secretary in regulations).

“(B) **HEALTH INSURANCE ISSUER.**—The term ‘health insurance issuer’ has the meaning given such term by section 9832(b)(2).

“(6) **PERSON THAT ADMINISTERS THE PLAN BENEFITS.**—The term ‘person that administers the plan benefits’ shall include the plan sponsor if the plan sponsor administers benefits under the plan.

“(7) **PLAN SPONSOR.**—The term ‘plan sponsor’ has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

“(8) **TAXABLE PERIOD.**—The term ‘taxable period’ means the calendar year or such shorter period as the Secretary may prescribe. The Secretary may have different taxable periods for employers of varying sizes.

“(9) **AGGREGATION RULES.**—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.

“(10) **DENIAL OF DEDUCTION.**—For denial of a deduction for the tax imposed by this section, see section 275(a)(6).

“(g) **REGULATIONS.**—The Secretary shall prescribe such regulations as may be necessary to carry out this section.”.

(b) **CLERICAL AMENDMENT.**—The table of sections for chapter 43 of such Code, as amended by section 1513, is amended by adding at the end the following new item:

“Sec. 4980I. Excise tax on high cost employer-sponsored health coverage.”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 9002. INCLUSION OF COST OF EMPLOYER-SPONSORED HEALTH COVERAGE ON W-2.

(a) **IN GENERAL.**—Section 6051(a) of the Internal Revenue Code of 1986 (relating to receipts for employees) is amended by striking “and” at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting “; and”, and by adding after paragraph (13) the following new paragraph:

“(14) the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of applicable employer-sponsored coverage (as defined in section 4980I(d)(1)), except that this paragraph shall not apply to—

“(A) coverage to which paragraphs (11) and (12) apply, or

“(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125).”.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9003. DISTRIBUTIONS FOR MEDICINE QUALIFIED ONLY IF FOR PRESCRIBED DRUG OR INSULIN.

(a) **HSAS.**—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: “Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.”.

(b) **ARCHER MSAS.**—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: “Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.”.

(c) **HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.**—Section 106 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

“(f) **REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.**—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.”.

(d) **EFFECTIVE DATES.**—

(1) **DISTRIBUTIONS FROM SAVINGS ACCOUNTS.**—The amendments made by subsections (a) and (b) shall apply to amounts paid with respect to taxable years beginning after December 31, 2010.

(2) **REIMBURSEMENTS.**—The amendment made by subsection (c) shall apply to expenses incurred with respect to taxable years beginning after December 31, 2010.

SEC. 9004. INCREASE IN ADDITIONAL TAX ON DISTRIBUTIONS FROM HSAS AND ARCHER MSAS NOT USED FOR QUALIFIED MEDICAL EXPENSES.

(a) **HSAS.**—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “10 percent” and inserting “20 percent”.

(b) **ARCHER MSAS.**—Section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “15 percent” and inserting “20 percent”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to distributions made after December 31, 2010.

SEC. 9005. LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.

(a) **IN GENERAL.**—Section 125 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subsections (i) and (j) as subsections (j) and (k), respectively, and

(2) by inserting after subsection (h) the following new subsection:

“(i) **LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.**—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of \$2,500 made to such arrangement.”.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9006. EXPANSION OF INFORMATION REPORTING REQUIREMENTS.

(a) **IN GENERAL.**—Section 6041 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsections:

“(h) **APPLICATION TO CORPORATIONS.**—Notwithstanding any regulation prescribed by the Secretary before the date of the enactment of this subsection, for purposes of this section the term ‘person’ includes any corporation that is not an organization exempt from tax under section 501(a).

“(i) **REGULATIONS.**—The Secretary may prescribe such regulations and other guidance as may be appropriate or necessary to carry out the purposes of this section, including rules to prevent duplicative reporting of transactions.”.

(b) **PAYMENTS FOR PROPERTY AND OTHER GROSS PROCEEDS.**—Subsection (a) of section 6041 of the Internal Revenue Code of 1986 is amended—

(1) by inserting “amounts in consideration for property,” after “wages,”,

(2) by inserting “gross proceeds,” after “emoluments, or other,” and

(3) by inserting “gross proceeds,” after “setting forth the amount of such”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to payments made after December 31, 2011.

SEC. 9007. ADDITIONAL REQUIREMENTS FOR CHARITABLE HOSPITALS.

(a) **REQUIREMENTS TO QUALIFY AS SECTION 501(C)(3) CHARITABLE HOSPITAL ORGANIZATION.**—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (r) as subsection (s) and by inserting after subsection (q) the following new subsection:

“(r) **ADDITIONAL REQUIREMENTS FOR CERTAIN HOSPITALS.**—

“(1) **IN GENERAL.**—A hospital organization to which this subsection applies shall not be treated as described in subsection (c)(3) unless the organization—

“(A) meets the community health needs assessment requirements described in paragraph (3),

“(B) meets the financial assistance policy requirements described in paragraph (4),

“(C) meets the requirements on charges described in paragraph (5), and

“(D) meets the billing and collection requirements described in paragraph (6).

“(2) HOSPITAL ORGANIZATIONS TO WHICH SUBSECTION APPLIES.—

“(A) IN GENERAL.—This subsection shall apply to—

“(i) an organization which operates a facility which is required by a State to be licensed, registered, or similarly recognized as a hospital, and

“(ii) any other organization which the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under subsection (c)(3) (determined without regard to this subsection).

“(B) ORGANIZATIONS WITH MORE THAN 1 HOSPITAL FACILITY.—If a hospital organization operates more than 1 hospital facility—

“(i) the organization shall meet the requirements of this subsection separately with respect to each such facility, and

“(ii) the organization shall not be treated as described in subsection (c)(3) with respect to any such facility for which such requirements are not separately met.

“(3) COMMUNITY HEALTH NEEDS ASSESSMENTS.—

“(A) IN GENERAL.—An organization meets the requirements of this paragraph with respect to any taxable year only if the organization—

“(i) has conducted a community health needs assessment which meets the requirements of subparagraph (B) in such taxable year or in either of the 2 taxable years immediately preceding such taxable year, and

“(ii) has adopted an implementation strategy to meet the community health needs identified through such assessment.

“(B) COMMUNITY HEALTH NEEDS ASSESSMENT.—A community health needs assessment meets the requirements of this paragraph if such community health needs assessment—

“(i) takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and

“(ii) is made widely available to the public.

“(4) FINANCIAL ASSISTANCE POLICY.—An organization meets the requirements of this paragraph if the organization establishes the following policies:

“(A) FINANCIAL ASSISTANCE POLICY.—A written financial assistance policy which includes—

“(i) eligibility criteria for financial assistance, and whether such assistance includes free or discounted care,

“(ii) the basis for calculating amounts charged to patients,

“(iii) the method for applying for financial assistance,

“(iv) in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment, including collections action and reporting to credit agencies, and

“(v) measures to widely publicize the policy within the community to be served by the organization.

“(B) POLICY RELATING TO EMERGENCY MEDICAL CARE.—A written policy requiring the organization to provide, without discrimination, care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)) to individuals regardless of their eligibility under the financial assistance policy described in subparagraph (A).

“(5) LIMITATION ON CHARGES.—An organization meets the requirements of this paragraph if the organization—

“(A) limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy described in paragraph (4)(A) to not more than the lowest amounts charged to individuals who have insurance covering such care, and

“(B) prohibits the use of gross charges.

“(6) BILLING AND COLLECTION REQUIREMENTS.—An organization meets the requirement of this paragraph only if the organization does not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy described in paragraph (4)(A).

“(7) REGULATORY AUTHORITY.—The Secretary shall issue such regulations and guidance as may be necessary to carry out the provisions of this subsection, including guidance relating to what constitutes reasonable efforts to determine the eligibility of a patient under a financial assistance policy for purposes of paragraph (6).”.

(b) EXCISE TAX FOR FAILURES TO MEET HOSPITAL EXEMPTION REQUIREMENTS.—

(1) IN GENERAL.—Subchapter D of chapter 42 of the Internal Revenue Code of 1986 (relating to failure by certain charitable organizations to meet certain qualification requirements) is amended by adding at the end the following new section:

“SEC. 4959. TAXES ON FAILURES BY HOSPITAL ORGANIZATIONS.

“If a hospital organization to which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to \$50,000.”.

(2) CONFORMING AMENDMENT.—The table of sections for subchapter D of chapter 42 of such Code is amended by adding at the end the following new item:

“Sec. 4959. Taxes on failures by hospital organizations.”.

(c) MANDATORY REVIEW OF TAX EXEMPTION FOR HOSPITALS.—The Secretary of the Treasury or the Secretary's delegate shall review at least once every 3 years the community benefit activities of each hospital organization to which section 501(r) of the Internal Revenue Code of 1986 (as added by this section) applies.

(d) ADDITIONAL REPORTING REQUIREMENTS.—

(1) COMMUNITY HEALTH NEEDS ASSESSMENTS AND AUDITED FINANCIAL STATEMENTS.—Section 6033(b) of the Internal Revenue Code of 1986 (relating to certain organizations described in section 501(c)(3)) is amended by striking “and” at the end of paragraph (14), by redesignating paragraph (15) as paragraph (16), and by inserting after paragraph (14) the following new paragraph:

“(15) in the case of an organization to which the requirements of section 501(r) apply for the taxable year—

“(A) a description of how the organization is addressing the needs identified in each community health needs assessment conducted under section 501(r)(3) and a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed, and

“(B) the audited financial statements of such organization (or, in the case of an organization the financial statements of which are included in a consolidated financial statement with other organizations, such consolidated financial statement).”.

(2) TAXES.—Section 6033(b)(10) of such Code is amended by striking “and” at the end of subparagraph (B), by inserting “and” at the end of subparagraph (C), and by adding at the end the following new subparagraph:

“(D) section 4959 (relating to taxes on failures by hospital organizations).”.

(e) REPORTS.—

(1) REPORT ON LEVELS OF CHARITY CARE.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate an annual report on the following:

(A) Information with respect to private tax-exempt, taxable, and government-owned hospitals regarding—

(i) levels of charity care provided,

(ii) bad debt expenses,

(iii) unreimbursed costs for services provided with respect to means-tested government programs, and

(iv) unreimbursed costs for services provided with respect to non-means tested government programs.

(B) Information with respect to private tax-exempt hospitals regarding costs incurred for community benefit activities.

(2) REPORT ON TRENDS.—

(A) STUDY.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall conduct a study on trends in the information required to be reported under paragraph (1).

(B) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit a report on the study conducted under subparagraph (A) to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

(2) COMMUNITY HEALTH NEEDS ASSESSMENT.—The requirements of section 501(r)(3) of the Internal Revenue Code of 1986, as added by subsection (a), shall apply to taxable years beginning after the date which is 2 years after the date of the enactment of this Act.

(3) EXCISE TAX.—The amendments made by subsection (b) shall apply to failures occurring after the date of the enactment of this Act.

SEC. 9008. IMPOSITION OF ANNUAL FEE ON BRANDED PRESCRIPTION PHARMACEUTICAL MANUFACTURERS AND IMPORTERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of manufacturing or importing branded prescription drugs shall pay to the Secretary of the Treasury not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term “annual payment date” means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to \$2,300,000,000 as—

(A) the covered entity's branded prescription drug sales taken into account during the preceding calendar year, bear to

(B) the aggregate branded prescription drug sales of all covered entities taken into account during such preceding calendar year.

(2) **SALES TAKEN INTO ACCOUNT.**—For purposes of paragraph (1), the branded prescription drug

sales taken into account during any calendar year with respect to any covered entity shall be

determined in accordance with the following table:

With respect to a covered entity's aggregate branded prescription drug sales during the calendar year that are:	The percentage of such sales taken into account is:
Not more than \$5,000,000	0 percent
More than \$5,000,000 but not more than \$125,000,000	10 percent
More than \$125,000,000 but not more than \$225,000,000	40 percent
More than \$225,000,000 but not more than \$400,000,000	75 percent
More than \$400,000,000	100 percent.

(3) **SECRETARIAL DETERMINATION.**—The Secretary of the Treasury shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary of the Treasury shall determine such covered entity's branded prescription drug sales on the basis of reports submitted under subsection (g) and through the use of any other source of information available to the Secretary of the Treasury.

(c) **TRANSFER OF FEES TO MEDICARE PART B TRUST FUND.**—There is hereby appropriated to the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act an amount equal to the fees received by the Secretary of the Treasury under subsection (a).

(d) **COVERED ENTITY.**—

(1) **IN GENERAL.**—For purposes of this section, the term “covered entity” means any manufacturer or importer with gross receipts from branded prescription drug sales.

(2) **CONTROLLED GROUPS.**—

(A) **IN GENERAL.**—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity.

(B) **INCLUSION OF FOREIGN CORPORATIONS.**—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(e) **BRANDED PRESCRIPTION DRUG SALES.**—For purposes of this section—

(1) **IN GENERAL.**—The term “branded prescription drug sales” means sales of branded prescription drugs to any specified government program or pursuant to coverage under any such program.

(2) **BRANDED PRESCRIPTION DRUGS.**—

(A) **IN GENERAL.**—The term “branded prescription drug” means—

(i) any prescription drug the application for which was submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)), or

(ii) any biological product the license for which was submitted under section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)).

(B) **PRESCRIPTION DRUG.**—For purposes of subparagraph (A)(i), the term “prescription drug” means any drug which is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)).

(3) **EXCLUSION OF ORPHAN DRUG SALES.**—The term “branded prescription drug sales” shall not include sales of any drug or biological product with respect to which a credit was allowed for any taxable year under section 45C of the Internal Revenue Code of 1986. The preceding sentence shall not apply with respect to any such drug or biological product after the date on which such drug or biological product is approved by the Food and Drug Administration for marketing for any indication other than the treatment of the rare disease or condition with respect to which such credit was allowed.

(4) **SPECIFIED GOVERNMENT PROGRAM.**—The term “specified government program” means—

(A) the Medicare Part D program under part D of title XVIII of the Social Security Act,

(B) the Medicare Part B program under part B of title XVIII of the Social Security Act,

(C) the Medicaid program under title XIX of the Social Security Act,

(D) any program under which branded prescription drugs are procured by the Department of Veterans Affairs,

(E) any program under which branded prescription drugs are procured by the Department of Defense, or

(F) the TRICARE retail pharmacy program under section 1074g of title 10, United States Code.

(f) **TAX TREATMENT OF FEES.**—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code, shall be considered to be a tax described in section 275(a)(6).

(g) **REPORTING REQUIREMENT.**—Not later than the date determined by the Secretary of the Treasury following the end of any calendar year, the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense shall report to the Secretary of the Treasury, in such manner as the Secretary of the Treasury prescribes, the total branded prescription drug sales for each covered entity with respect to each specified government program under such Secretary's jurisdiction using the following methodology:

(1) **MEDICARE PART D PROGRAM.**—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part D program, the product of—

(A) the per-unit ingredient cost, as reported to the Secretary of Health and Human Services by prescription drug plans and Medicare Advantage prescription drug plans, minus any per-unit rebate, discount, or other price concession provided by the covered entity, as reported to the Secretary of Health and Human Services by the prescription drug plans and Medicare Advantage prescription drug plans, and

(B) the number of units of the branded prescription drug paid for under the Medicare Part D program.

(2) **MEDICARE PART B PROGRAM.**—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part B program under section 1862(a) of the Social Security Act, the product of—

(A) the per-unit average sales price (as defined in section 1847A(c) of the Social Security Act) or the per-unit Part B payment rate for a separately paid branded prescription drug without a reported average sales price, and

(B) the number of units of the branded prescription drug paid for under the Medicare Part B program.

The Centers for Medicare and Medicaid Services shall establish a process for determining the units and the allocated price for purposes of this section for those branded prescription drugs

that are not separately payable or for which National Drug Codes are not reported.

(3) **MEDICAID PROGRAM.**—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered under the Medicaid program, the product of—

(A) the per-unit ingredient cost paid to pharmacies by States for the branded prescription drug dispensed to Medicaid beneficiaries, minus any per-unit rebate paid by the covered entity under section 1927 of the Social Security Act and any State supplemental rebate, and

(B) the number of units of the branded prescription drug paid for under the Medicaid program.

(4) **DEPARTMENT OF VETERANS AFFAIRS PROGRAMS.**—The Secretary of Veterans Affairs shall report, for each covered entity and for each branded prescription drug of the covered entity the total amount paid for each such branded prescription drug procured by the Department of Veterans Affairs for its beneficiaries.

(5) **DEPARTMENT OF DEFENSE PROGRAMS AND TRICARE.**—The Secretary of Defense shall report, for each covered entity and for each branded prescription drug of the covered entity, the sum of—

(A) the total amount paid for each such branded prescription drug procured by the Department of Defense for its beneficiaries, and

(B) for each such branded prescription drug dispensed under the TRICARE retail pharmacy program, the product of—

(i) the per-unit ingredient cost, minus any per-unit rebate paid by the covered entity, and

(ii) the number of units of the branded prescription drug dispensed under such program.

(h) **SECRETARY.**—For purposes of this section, the term “Secretary” includes the Secretary's delegate.

(i) **GUIDANCE.**—The Secretary of the Treasury shall publish guidance necessary to carry out the purposes of this section.

(j) **APPLICATION OF SECTION.**—This section shall apply to any branded prescription drug sales after December 31, 2008.

(k) **CONFORMING AMENDMENT.**—Section 1841(a) of the Social Security Act is amended by inserting “or section 9008(c) of the Patient Protection and Affordable Care Act of 2009” after “this part”.

SEC. 9009. IMPOSITION OF ANNUAL FEE ON MEDICAL DEVICE MANUFACTURERS AND IMPORTERS.

(a) **IMPOSITION OF FEE.**—

(1) **IN GENERAL.**—Each covered entity engaged in the business of manufacturing or importing medical devices shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) **ANNUAL PAYMENT DATE.**—For purposes of this section, the term “annual payment date” means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) **DETERMINATION OF FEE AMOUNT.**—

(1) **IN GENERAL.**—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to \$2,000,000,000 as—

(A) the covered entity's gross receipts from medical device sales taken into account during the preceding calendar year, bear to

(B) the aggregate gross receipts of all covered entities from medical device sales taken into account during such preceding calendar year.

(2) GROSS RECEIPTS FROM SALES TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the

gross receipts from medical device sales taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's aggregate gross receipts from medical device sales during the calendar year that are:	The percentage of gross receipts taken into account is:
Not more than \$5,000,000	0 percent
More than \$5,000,000 but not more than \$25,000,000	50 percent
More than \$25,000,000	100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's gross receipts from medical device sales on the basis of reports submitted by the covered entity under subsection (f) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term "covered entity" means any manufacturer or importer with gross receipts from medical device sales.

(2) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity.

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(d) MEDICAL DEVICE SALES.—For purposes of this section—

(1) IN GENERAL.—The term "medical device sales" means sales for use in the United States of any medical device, other than the sales of a medical device that—

(A) has been classified in class II under section 513 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360c) and is primarily sold to consumers at retail for not more than \$100 per unit, or

(B) has been classified in class I under such section.

(2) UNITED STATES.—For purposes of paragraph (1), the term "United States" means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(3) MEDICAL DEVICE.—For purposes of paragraph (1), the term "medical device" means any device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h))) intended for humans.

(e) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code, shall be considered to be a tax described in section 275(a)(6).

(f) REPORTING REQUIREMENT.—

(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the gross receipts from medical device sales of such covered entity during such calendar year.

(2) PENALTY FOR FAILURE TO REPORT.—

(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid by the covered entity failing to file such report, an amount equal to—

(i) \$10,000, plus

(ii) the lesser of—

(I) an amount equal to \$1,000, multiplied by the number of days during which such failure continues, or

(II) the amount of the fee imposed by this section for which such report was required.

(B) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A)—

(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,

(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and

(iii) with respect to which only civil actions for refund under procedures of such subtitle F shall apply.

(g) SECRETARY.—For purposes of this section, the term "Secretary" means the Secretary of the Treasury or the Secretary's delegate.

(h) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section, including identification of medical devices described in subsection (d)(1)(A) and with respect to the treatment of gross receipts from sales of medical devices to another covered entity or to another entity by reason of the application of subsection (e)(2).

(i) APPLICATION OF SECTION.—This section shall apply to any medical device sales after December 31, 2008.

SEC. 9010. IMPOSITION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of providing health insurance shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term "annual payment date" means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to \$6,700,000,000 as—

(A) the sum of—

(i) the covered entity's net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, plus

(ii) 200 percent of the covered entity's third party administration agreement fees that are taken into account during the preceding calendar year, bears to

(B) the sum of—

(i) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year, plus

(ii) 200 percent of the aggregate third party administration agreement fees of all covered entities that are taken into account during such preceding calendar year.

(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1)—

(A) NET PREMIUMS WRITTEN.—The net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

The percentage of net premiums written that are taken into account is:

Not more than \$25,000,000	0 percent
More than \$25,000,000 but not more than \$50,000,000	50 percent
More than \$50,000,000	100 percent.

(B) THIRD PARTY ADMINISTRATION AGREEMENT FEES.—The third party administration agree-

ment fees that are taken into account during any calendar year with respect to any covered

entity shall be determined in accordance with the following table:

The percentage of third party administration agreement fees that are taken into account is:

With respect to a covered entity's third party administration agreement fees during the calendar year that are:	
Not more than \$5,000,000	0 percent
More than \$5,000,000 but not more than \$10,000,000	50 percent

With respect to a covered entity's third party administration agreement fees during the calendar year that are:

More than \$10,000,000 100 percent.

(3) **SECRETARIAL DETERMINATION.**—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's net premiums written with respect to any United States health risk and third party administration agreement fees on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.

(c) **COVERED ENTITY.**—

(1) **IN GENERAL.**—For purposes of this section, the term "covered entity" means any entity which provides health insurance for any United States health risk.

(2) **EXCLUSION.**—Such term does not include—

(A) any employer to the extent that such employer self-insures its employees' health risks, or
(B) any governmental entity (except to the extent such an entity provides health insurance coverage through the community health insurance option under section 1323).

(3) **CONTROLLED GROUPS.**—

(A) **IN GENERAL.**—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity (or employer for purposes of paragraph (2)).

(B) **INCLUSION OF FOREIGN CORPORATIONS.**—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(d) **UNITED STATES HEALTH RISK.**—For purposes of this section, the term "United States health risk" means the health risk of any individual who is—

(1) a United States citizen,

(2) a resident of the United States (within the meaning of section 7701(b)(1)(A) of the Internal Revenue Code of 1986), or

(3) located in the United States, with respect to the period such individual is so located.

(e) **THIRD PARTY ADMINISTRATION AGREEMENT FEES.**—For purposes of this section, the term "third party administration agreement fees" means, with respect to any covered entity, amounts received from an employer which are in excess of payments made by such covered entity for health benefits under an arrangement under which such employer self-insures the United States health risk of its employees.

(f) **TAX TREATMENT OF FEES.**—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code shall be considered to be a tax described in section 275(a)(6).

(g) **REPORTING REQUIREMENT.**—

(1) **IN GENERAL.**—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the covered entity's net premiums written with respect to health insurance for any United States health risk and third party administration agreement fees for such calendar year.

(2) **PENALTY FOR FAILURE TO REPORT.**—

(A) **IN GENERAL.**—In the case of any failure to make a report containing the information re-

quired by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid by the covered entity failing to file such report, an amount equal to—

(i) \$10,000, plus

(ii) the lesser of—

(I) an amount equal to \$1,000, multiplied by the number of days during which such failure continues, or

(II) the amount of the fee imposed by this section for which such report was required.

(B) **TREATMENT OF PENALTY.**—The penalty imposed under subparagraph (A)—

(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,

(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and

(iii) with respect to which only civil actions for refund under procedures of such subtitle F shall apply.

(h) **ADDITIONAL DEFINITIONS.**—For purposes of this section—

(1) **SECRETARY.**—The term "Secretary" means the Secretary of the Treasury or the Secretary's delegate.

(2) **UNITED STATES.**—The term "United States" means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(3) **HEALTH INSURANCE.**—The term "health insurance" shall not include insurance for long-term care or disability.

(i) **GUIDANCE.**—The Secretary shall publish guidance necessary to carry out the purposes of this section.

(j) **APPLICATION OF SECTION.**—This section shall apply to any net premiums written after December 31, 2008, with respect to health insurance for any United States health risk, and any third party administration agreement fees received after such date.

SEC. 9011. STUDY AND REPORT OF EFFECT ON VETERANS HEALTH CARE.

(a) **IN GENERAL.**—The Secretary of Veterans Affairs shall conduct a study on the effect (if any) of the provisions of sections 9008, 9009, and 9010 on—

(1) the cost of medical care provided to veterans, and

(2) veterans' access to medical devices and branded prescription drugs.

(b) **REPORT.**—The Secretary of Veterans Affairs shall report the results of the study under subsection (a) to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate not later than December 31, 2012.

SEC. 9012. ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.

(a) **IN GENERAL.**—Section 139A of the Internal Revenue Code of 1986 is amended by striking the second sentence.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9013. MODIFICATION OF ITEMIZED DEDUCTION FOR MEDICAL EXPENSES.

(a) **IN GENERAL.**—Subsection (a) of section 213 of the Internal Revenue Code of 1986 is amended by striking "7.5 percent" and inserting "10 percent".

(b) **TEMPORARY WAIVER OF INCREASE FOR CERTAIN SENIORS.**—Section 213 of the Internal

Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(f) **SPECIAL RULE FOR 2013, 2014, 2015, AND 2016.**—In the case of any taxable year beginning after December 31, 2012, and ending before January 1, 2017, subsection (a) shall be applied with respect to a taxpayer by substituting '7.5 percent' for '10 percent' if such taxpayer or such taxpayer's spouse has attained age 65 before the close of such taxable year."

(c) **CONFORMING AMENDMENT.**—Section 56(b)(1)(B) of the Internal Revenue Code of 1986 is amended by striking "by substituting '10 percent' for '7.5 percent'" and inserting "without regard to subsection (f) of such section".

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 9014. LIMITATION ON EXCESSIVE REMUNERATION PAID BY CERTAIN HEALTH INSURANCE PROVIDERS.

(a) **IN GENERAL.**—Section 162(m) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

"(6) **SPECIAL RULE FOR APPLICATION TO CERTAIN HEALTH INSURANCE PROVIDERS.**—

"(A) **IN GENERAL.**—No deduction shall be allowed under this chapter—

"(i) in the case of applicable individual remuneration which is for any disqualified taxable year beginning after December 31, 2012, and which is attributable to services performed by an applicable individual during such taxable year, to the extent that the amount of such remuneration exceeds \$500,000, or

"(ii) in the case of deferred deduction remuneration for any taxable year beginning after December 31, 2012, which is attributable to services performed by an applicable individual during any disqualified taxable year beginning after December 31, 2009, to the extent that the amount of such remuneration exceeds \$500,000 reduced (but not below zero) by the sum of—

"(I) the applicable individual remuneration for such disqualified taxable year, plus

"(II) the portion of the deferred deduction remuneration for such services which was taken into account under this clause in a preceding taxable year (or which would have been taken into account under this clause in a preceding taxable year if this clause were applied by substituting 'December 31, 2009' for 'December 31, 2012' in the matter preceding subclause (I)).

"(B) **DISQUALIFIED TAXABLE YEAR.**—For purposes of this paragraph, the term 'disqualified taxable year' means, with respect to any employer, any taxable year for which such employer is a covered health insurance provider.

"(C) **COVERED HEALTH INSURANCE PROVIDER.**—

For purposes of this paragraph—

"(i) **IN GENERAL.**—The term 'covered health insurance provider' means—

"(I) with respect to taxable years beginning after December 31, 2009, and before January 1, 2013, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and which receives premiums from providing health insurance coverage (as defined in section 9832(b)(1)), and

"(II) with respect to taxable years beginning after December 31, 2012, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and with respect to which not less than 25 percent of the gross premiums received from providing health insurance coverage (as defined in section 9832(b)(1)) is from minimum essential coverage (as defined in section 5000A(f)).

The percentage of third party administration agreement fees that are taken into account is:

“(ii) **AGGREGATION RULES.**—Two or more persons who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer, except that in applying section 1563(a) for purposes of any such subsection, paragraphs (2) and (3) thereof shall be disregarded.

“(D) **APPLICABLE INDIVIDUAL REMUNERATION.**—For purposes of this paragraph, the term ‘applicable individual remuneration’ means, with respect to any applicable individual for any disqualified taxable year, the aggregate amount allowable as a deduction under this chapter for such taxable year (determined without regard to this subsection) for remuneration (as defined in paragraph (4) without regard to subparagraphs (B), (C), and (D) thereof) for services performed by such individual (whether or not during the taxable year). Such term shall not include any deferred deduction remuneration with respect to services performed during the disqualified taxable year.

“(E) **DEFERRED DEDUCTION REMUNERATION.**—For purposes of this paragraph, the term ‘deferred deduction remuneration’ means remuneration which would be applicable individual remuneration for services performed in a disqualified taxable year but for the fact that the deduction under this chapter (determined without regard to this paragraph) for such remuneration is allowable in a subsequent taxable year.

“(F) **APPLICABLE INDIVIDUAL.**—For purposes of this paragraph, the term ‘applicable individual’ means, with respect to any covered health insurance provider for any disqualified taxable year, any individual—

“(i) who is an officer, director, or employee in such taxable year, or

“(ii) who provides services for or on behalf of such covered health insurance provider during such taxable year.

“(G) **COORDINATION.**—Rules similar to the rules of subparagraphs (F) and (G) of paragraph (4) shall apply for purposes of this paragraph.

“(H) **REGULATORY AUTHORITY.**—The Secretary may prescribe such guidance, rules, or regulations as are necessary to carry out the purposes of this paragraph.”

(b) **EFFECTIVE DATE.**—The amendment made by this section shall apply to taxable years beginning after December 31, 2009, with respect to services performed after such date.

SEC. 9015. ADDITIONAL HOSPITAL INSURANCE TAX ON HIGH-INCOME TAXPAYERS.

(a) **FICA.**

(1) **IN GENERAL.**—Section 3101(b) of the Internal Revenue Code of 1986 is amended—

(A) by striking “In addition” and inserting the following:

“(1) **IN GENERAL.**—In addition”,

(B) by striking “the following percentages of the” and inserting “1.45 percent of the”,

(C) by striking “(as defined in section 3121(b))” and all that follows and inserting “(as defined in section 3121(b)).”, and

(D) by adding at the end the following new paragraph:

“(2) **ADDITIONAL TAX.**—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) a tax equal to 0.5 percent of wages which are received with respect to employment (as defined in section 3121(b)) during any taxable year beginning after December 31, 2012, and which are in excess of—

“(A) in the case of a joint return, \$250,000, and

“(B) in any other case, \$200,000.”

(2) **COLLECTION OF TAX.**—Section 3102 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

“(f) **SPECIAL RULES FOR ADDITIONAL TAX.**—

“(1) **IN GENERAL.**—In the case of any tax imposed by section 3101(b)(2), subsection (a) shall only apply to the extent to which the taxpayer receives wages from the employer in excess of \$200,000, and the employer may disregard the amount of wages received by such taxpayer’s spouse.

“(2) **COLLECTION OF AMOUNTS NOT WITHHELD.**—To the extent that the amount of any tax imposed by section 3101(b)(2) is not collected by the employer, such tax shall be paid by the employee.

“(3) **TAX PAID BY RECIPIENT.**—If an employer, in violation of this chapter, fails to deduct and withhold the tax imposed by section 3101(b)(2) and thereafter the tax is paid by the employee, the tax so required to be deducted and withheld shall not be collected from the employer, but this paragraph shall in no case relieve the employer from liability for any penalties or additions to tax otherwise applicable in respect of such failure to deduct and withhold.”

(b) **SECA.**

(1) **IN GENERAL.**—Section 1401(b) of the Internal Revenue Code of 1986 is amended—

(A) by striking “In addition” and inserting the following:

“(1) **IN GENERAL.**—In addition”, and

(B) by adding at the end the following new paragraph:

“(2) **ADDITIONAL TAX.**—

“(A) **IN GENERAL.**—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) for each taxable year beginning after December 31, 2012, a tax equal to 0.5 percent of the self-employment income for such taxable year which is in excess of—

“(i) in the case of a joint return, \$250,000, and

“(ii) in any other case, \$200,000.

“(B) **COORDINATION WITH FICA.**—The amounts under clauses (i) and (ii) of subparagraph (A) shall be reduced (but not below zero) by the amount of wages taken into account in determining the tax imposed under section 3121(b)(2) with respect to the taxpayer.”

(2) **NO DEDUCTION FOR ADDITIONAL TAX.**

(A) **IN GENERAL.**—Section 164(f) of such Code is amended by inserting “(other than the taxes imposed by section 1401(b)(2))” after “section 1401)”

(B) **DEDUCTION FOR NET EARNINGS FROM SELF-EMPLOYMENT.**—Subparagraph (B) of section 1402(a)(12) is amended by inserting “(determined without regard to the rate imposed under paragraph (2) of section 1401(b))” after “for such year”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to remuneration received, and taxable years beginning, after December 31, 2012.

SEC. 9016. MODIFICATION OF SECTION 833 TREATMENT OF CERTAIN HEALTH ORGANIZATIONS.

(a) **IN GENERAL.**—Subsection (c) of section 833 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

“(5) **NONAPPLICATION OF SECTION IN CASE OF LOW MEDICAL LOSS RATIO.**—Notwithstanding the preceding paragraphs, this section shall not apply to any organization unless such organization’s percentage of total premium revenue expended on reimbursement for clinical services provided to enrollees under its policies during such taxable year (as reported under section 2718 of the Public Health Service Act) is not less than 85 percent.”

(b) **EFFECTIVE DATE.**—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.

SEC. 9017. EXCISE TAX ON ELECTIVE COSMETIC MEDICAL PROCEDURES.

(a) **IN GENERAL.**—Subtitle D of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new chapter:

“CHAPTER 49—ELECTIVE COSMETIC MEDICAL PROCEDURES

“Sec. 5000B. Imposition of tax on elective cosmetic medical procedures.

“SEC. 5000B. IMPOSITION OF TAX ON ELECTIVE COSMETIC MEDICAL PROCEDURES.

“(a) **IN GENERAL.**—There is hereby imposed on any cosmetic surgery and medical procedure a tax equal to 5 percent of the amount paid for such procedure (determined without regard to this section), whether paid by insurance or otherwise.

“(b) **COSMETIC SURGERY AND MEDICAL PROCEDURE.**—For purposes of this section, the term ‘cosmetic surgery and medical procedure’ means any cosmetic surgery (as defined in section 213(d)(9)(B)) or other similar procedure which—

“(1) is performed by a licensed medical professional, and

“(2) is not necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.

“(c) **PAYMENT OF TAX.**—

“(1) **IN GENERAL.**—The tax imposed by this section shall be paid by the individual on whom the procedure is performed.

“(2) **COLLECTION.**—Every person receiving a payment for procedures on which a tax is imposed under subsection (a) shall collect the amount of the tax from the individual on whom the procedure is performed and remit such tax quarterly to the Secretary at such time and in such manner as provided by the Secretary.

“(3) **SECONDARY LIABILITY.**—Where any tax imposed by subsection (a) is not paid at the time payments for cosmetic surgery and medical procedures are made, then to the extent that such tax is not collected, such tax shall be paid by the person who performs the procedure.”

(b) **CLERICAL AMENDMENT.**—The table of chapters for subtitle D of the Internal Revenue Code of 1986, as amended by this Act, is amended by inserting after the item relating to chapter 48 the following new item:

“CHAPTER 49—ELECTIVE COSMETIC MEDICAL PROCEDURES”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to procedures performed on or after January 1, 2010.

Subtitle B—Other Provisions

SEC. 9021. EXCLUSION OF HEALTH BENEFITS PROVIDED BY INDIAN TRIBAL GOVERNMENTS.

(a) **IN GENERAL.**—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 139C the following new section:

“SEC. 139D. INDIAN HEALTH CARE BENEFITS.

“(a) **GENERAL RULE.**—Except as otherwise provided in this section, gross income does not include the value of any qualified Indian health care benefit.

“(b) **QUALIFIED INDIAN HEALTH CARE BENEFIT.**—For purposes of this section, the term ‘qualified Indian health care benefit’ means—

“(1) any health service or benefit provided or purchased, directly or indirectly, by the Indian Health Service through a grant to or a contract or compact with an Indian tribe or tribal organization, or through a third-party program funded by the Indian Health Service,

“(2) medical care provided or purchased by, or amounts to reimburse for such medical care provided by, an Indian tribe or tribal organization for, or to, a member of an Indian tribe, including a spouse or dependent of such a member,

“(3) coverage under accident or health insurance (or an arrangement having the effect of accident or health insurance), or an accident or health plan, provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe, include a spouse or dependent of such a member, and

“(4) any other medical care provided by an Indian tribe or tribal organization that supplements, replaces, or substitutes for a program or service relating to medical care provided by the Federal government to Indian tribes or members of such a tribe.

“(c) DEFINITIONS.—For purposes of this section—

“(1) INDIAN TRIBE.—The term ‘Indian tribe’ has the meaning given such term by section 45A(c)(6).

“(2) TRIBAL ORGANIZATION.—The term ‘tribal organization’ has the meaning given such term by section 4(l) of the Indian Self-Determination and Education Assistance Act.

“(3) MEDICAL CARE.—The term ‘medical care’ has the same meaning as when used in section 213.

“(4) ACCIDENT OR HEALTH INSURANCE; ACCIDENT OR HEALTH PLAN.—The terms ‘accident or health insurance’ and ‘accident or health plan’ have the same meaning as when used in section 105.

“(5) DEPENDENT.—The term ‘dependent’ has the meaning given such term by section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof.

“(d) DENIAL OF DOUBLE BENEFIT.—Subsection (a) shall not apply to the amount of any qualified Indian health care benefit which is not includible in gross income of the beneficiary of such benefit under any other provision of this chapter, or to the amount of any such benefit for which a deduction is allowed to such beneficiary under any other provision of this chapter.”

(b) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 139C the following new item:

“Sec. 139D. Indian health care benefits.”

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits and coverage provided after the date of the enactment of this Act.

(d) NO INFERENCE.—Nothing in the amendments made by this section shall be construed to create an inference with respect to the exclusion from gross income of—

(1) benefits provided by an Indian tribe or tribal organization that are not within the scope of this section, and

(2) benefits provided prior to the date of the enactment of this Act.

SEC. 9022. ESTABLISHMENT OF SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans), as amended by this Act, is amended by redesignating subsections (j) and (k) as subsections (k) and (l), respectively, and by inserting after subsection (i) the following new subsection:

“(j) SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.—

“(1) IN GENERAL.—An eligible employer maintaining a simple cafeteria plan with respect to which the requirements of this subsection are met for any year shall be treated as meeting any applicable nondiscrimination requirement during such year.

“(2) SIMPLE CAFETERIA PLAN.—For purposes of this subsection, the term ‘simple cafeteria plan’ means a cafeteria plan—

“(A) which is established and maintained by an eligible employer, and

“(B) with respect to which the contribution requirements of paragraph (3), and the eligibility and participation requirements of paragraph (4), are met.

“(3) CONTRIBUTION REQUIREMENTS.—

“(A) IN GENERAL.—The requirements of this paragraph are met if, under the plan the employer is required, without regard to whether a qualified employee makes any salary reduction contribution, to make a contribution to provide qualified benefits under the plan on behalf of each qualified employee in an amount equal to—

“(i) a uniform percentage (not less than 2 percent) of the employee’s compensation for the plan year, or

“(ii) an amount which is not less than the lesser of—

“(I) 6 percent of the employee’s compensation for the plan year, or

“(II) twice the amount of the salary reduction contributions of each qualified employee.

“(B) MATCHING CONTRIBUTIONS ON BEHALF OF HIGHLY COMPENSATED AND KEY EMPLOYEES.—The requirements of subparagraph (A)(ii) shall not be treated as met if, under the plan, the rate of contributions with respect to any salary reduction contribution of a highly compensated or key employee at any rate of contribution is greater than that with respect to an employee who is not a highly compensated or key employee.

“(C) ADDITIONAL CONTRIBUTIONS.—Subject to subparagraph (B), nothing in this paragraph shall be treated as prohibiting an employer from making contributions to provide qualified benefits under the plan in addition to contributions required under subparagraph (A).

“(D) DEFINITIONS.—For purposes of this paragraph—

“(i) SALARY REDUCTION CONTRIBUTION.—The term ‘salary reduction contribution’ means, with respect to a cafeteria plan, any amount which is contributed to the plan at the election of the employee and which is not includible in gross income by reason of this section.

“(ii) QUALIFIED EMPLOYEE.—The term ‘qualified employee’ means, with respect to a cafeteria plan, any employee who is not a highly compensated or key employee and who is eligible to participate in the plan.

“(iii) HIGHLY COMPENSATED EMPLOYEE.—The term ‘highly compensated employee’ has the meaning given such term by section 414(q).

“(iv) KEY EMPLOYEE.—The term ‘key employee’ has the meaning given such term by section 416(i).

“(4) MINIMUM ELIGIBILITY AND PARTICIPATION REQUIREMENTS.—

“(A) IN GENERAL.—The requirements of this paragraph shall be treated as met with respect to any year if, under the plan—

“(i) all employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate, and

“(ii) each employee eligible to participate in the plan may, subject to terms and conditions applicable to all participants, elect any benefit available under the plan.

“(B) CERTAIN EMPLOYEES MAY BE EXCLUDED.—For purposes of subparagraph (A)(i), an employer may elect to exclude under the plan employees—

“(i) who have not attained the age of 21 before the close of a plan year,

“(ii) who have less than 1 year of service with the employer as of any day during the plan year,

“(iii) who are covered under an agreement which the Secretary of Labor finds to be a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer, or

“(iv) who are described in section 410(b)(3)(C) (relating to nonresident aliens working outside the United States).

A plan may provide a shorter period of service or younger age for purposes of clause (i) or (ii).

“(5) ELIGIBLE EMPLOYER.—For purposes of this subsection—

“(A) IN GENERAL.—The term ‘eligible employer’ means, with respect to any year, any employer if such employer employed an average of 100 or fewer employees on business days during either of the 2 preceding years. For purposes of this subparagraph, a year may only be taken into account if the employer was in existence throughout the year.

“(B) EMPLOYERS NOT IN EXISTENCE DURING PRECEDING YEAR.—If an employer was not in existence throughout the preceding year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current year.

“(C) GROWING EMPLOYERS RETAIN TREATMENT AS SMALL EMPLOYER.—

“(i) IN GENERAL.—If—

“(I) an employer was an eligible employer for any year (a ‘qualified year’), and

“(II) such employer establishes a simple cafeteria plan for its employees for such year, then, notwithstanding the fact the employer fails to meet the requirements of subparagraph (A) for any subsequent year, such employer shall be treated as an eligible employer for such subsequent year with respect to employees (whether or not employees during a qualified year) of any trade or business which was covered by the plan during any qualified year.

“(ii) EXCEPTION.—This subparagraph shall cease to apply if the employer employs an average of 200 or more employees on business days during any year preceding any such subsequent year.

“(D) SPECIAL RULES.—

“(i) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

“(ii) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (n) or (o) of section 414, shall be treated as one person.

“(6) APPLICABLE NONDISCRIMINATION REQUIREMENT.—For purposes of this subsection, the term ‘applicable nondiscrimination requirement’ means any requirement under subsection (b) of this section, section 79(d), section 105(h), or paragraph (2), (3), (4), or (8) of section 129(d).

“(7) COMPENSATION.—The term ‘compensation’ has the meaning given such term by section 414(s).”

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to years beginning after December 31, 2010.

SEC. 9023. QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.

(a) IN GENERAL.—Subpart E of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 48C the following new section:

“SEC. 48D. QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.

“(a) IN GENERAL.—For purposes of section 46, the qualifying therapeutic discovery project credit for any taxable year is an amount equal to 50 percent of the qualified investment for such taxable year with respect to any qualifying therapeutic discovery project of an eligible taxpayer.

“(b) QUALIFIED INVESTMENT.—

“(1) IN GENERAL.—For purposes of subsection (a), the qualified investment for any taxable year is the aggregate amount of the costs paid or incurred in such taxable year for expenses necessary for and directly related to the conduct of a qualifying therapeutic discovery project.

“(2) **LIMITATION.**—The amount which is treated as qualified investment for all taxable years with respect to any qualifying therapeutic discovery project shall not exceed the amount certified by the Secretary as eligible for the credit under this section.

“(3) **EXCLUSIONS.**—The qualified investment for any taxable year with respect to any qualifying therapeutic discovery project shall not take into account any cost—

“(A) for remuneration for an employee described in section 162(m)(3),

“(B) for interest expenses,

“(C) for facility maintenance expenses,

“(D) which is identified as a service cost under section 1.263A-1(e)(4) of title 26, Code of Federal Regulations, or

“(E) for any other expense as determined by the Secretary as appropriate to carry out the purposes of this section.

“(4) **CERTAIN PROGRESS EXPENDITURE RULES MADE APPLICABLE.**—In the case of costs described in paragraph (1) that are paid for property of a character subject to an allowance for depreciation, rules similar to the rules of subsections (c)(4) and (d) of section 46 (as in effect on the day before the date of the enactment of the Revenue Reconciliation Act of 1990) shall apply for purposes of this section.

“(5) **APPLICATION OF SUBSECTION.**—An investment shall be considered a qualified investment under this subsection only if such investment is made in a taxable year beginning in 2009 or 2010.

“(c) **DEFINITIONS.**—

“(1) **QUALIFYING THERAPEUTIC DISCOVERY PROJECT.**—The term ‘qualifying therapeutic discovery project’ means a project which is designed—

“(A) to treat or prevent diseases or conditions by conducting pre-clinical activities, clinical trials, and clinical studies, or carrying out research protocols, for the purpose of securing approval of a product under section 505(b) of the Federal Food, Drug, and Cosmetic Act or section 351(a) of the Public Health Service Act,

“(B) to diagnose diseases or conditions or to determine molecular factors related to diseases or conditions by developing molecular diagnostics to guide therapeutic decisions, or

“(C) to develop a product, process, or technology to further the delivery or administration of therapeutics.

“(2) **ELIGIBLE TAXPAYER.**—

“(A) **IN GENERAL.**—The term ‘eligible taxpayer’ means a taxpayer which employs not more than 250 employees in all businesses of the taxpayer at the time of the submission of the application under subsection (d)(2).

“(B) **AGGREGATION RULES.**—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (m) or (o) of section 414, shall be so treated for purposes of this paragraph.

“(3) **FACILITY MAINTENANCE EXPENSES.**—The term ‘facility maintenance expenses’ means costs paid or incurred to maintain a facility, including—

“(A) mortgage or rent payments,

“(B) insurance payments,

“(C) utility and maintenance costs, and

“(D) costs of employment of maintenance personnel.

“(d) **QUALIFYING THERAPEUTIC DISCOVERY PROJECT PROGRAM.**—

“(1) **ESTABLISHMENT.**—

“(A) **IN GENERAL.**—Not later than 60 days after the date of the enactment of this section, the Secretary, in consultation with the Secretary of Health and Human Services, shall establish a qualifying therapeutic discovery project program to consider and award certifications for qualified investments eligible for credits under this section to qualifying therapeutic discovery project sponsors.

“(B) **LIMITATION.**—The total amount of credits that may be allocated under the program shall not exceed \$1,000,000,000 for the 2-year period beginning with 2009.

“(2) **CERTIFICATION.**—

“(A) **APPLICATION PERIOD.**—Each applicant for certification under this paragraph shall submit an application containing such information as the Secretary may require during the period beginning on the date the Secretary establishes the program under paragraph (1).

“(B) **TIME FOR REVIEW OF APPLICATIONS.**—The Secretary shall take action to approve or deny any application under subparagraph (A) within 30 days of the submission of such application.

“(C) **MULTI-YEAR APPLICATIONS.**—An application for certification under subparagraph (A) may include a request for an allocation of credits for more than 1 of the years described in paragraph (1)(B).

“(3) **SELECTION CRITERIA.**—In determining the qualifying therapeutic discovery projects with respect to which qualified investments may be certified under this section, the Secretary—

“(A) shall take into consideration only those projects that show reasonable potential—

“(i) to result in new therapies—

“(I) to treat areas of unmet medical need, or

“(II) to prevent, detect, or treat chronic or acute diseases and conditions,

“(ii) to reduce long-term health care costs in the United States, or

“(iii) to significantly advance the goal of curing cancer within the 30-year period beginning on the date the Secretary establishes the program under paragraph (1), and

“(B) shall take into consideration which projects have the greatest potential—

“(i) to create and sustain (directly or indirectly) high quality, high-paying jobs in the United States, and

“(ii) to advance United States competitiveness in the fields of life, biological, and medical sciences.

“(4) **DISCLOSURE OF ALLOCATIONS.**—The Secretary shall, upon making a certification under this subsection, publicly disclose the identity of the applicant and the amount of the credit with respect to such applicant.

“(e) **SPECIAL RULES.**—

“(1) **BASIS ADJUSTMENT.**—For purposes of this subtitle, if a credit is allowed under this section for an expenditure related to property of a character subject to an allowance for depreciation, the basis of such property shall be reduced by the amount of such credit.

“(2) **DENIAL OF DOUBLE BENEFIT.**—

“(A) **BONUS DEPRECIATION.**—A credit shall not be allowed under this section for any investment for which bonus depreciation is allowed under section 168(k), 1400L(b)(1), or 1400N(d)(1).

“(B) **DEDUCTIONS.**—No deduction under this subtitle shall be allowed for the portion of the expenses otherwise allowable as a deduction taken into account in determining the credit under this section for the taxable year which is equal to the amount of the credit determined for such taxable year under subsection (a) attributable to such portion. This subparagraph shall not apply to expenses related to property of a character subject to an allowance for depreciation the basis of which is reduced under paragraph (1), or which are described in section 280C(g).

“(C) **CREDIT FOR RESEARCH ACTIVITIES.**—

“(i) **IN GENERAL.**—Except as provided in clause (ii), any expenses taken into account under this section for a taxable year shall not be taken into account for purposes of determining the credit allowable under section 41 or 45C for such taxable year.

“(ii) **EXPENSES INCLUDED IN DETERMINING BASE PERIOD RESEARCH EXPENSES.**—Any expenses for any taxable year which are qualified research

expenses (within the meaning of section 41(b)) shall be taken into account in determining base period research expenses for purposes of applying section 41 to subsequent taxable years.

“(f) **COORDINATION WITH DEPARTMENT OF TREASURY GRANTS.**—In the case of any investment with respect to which the Secretary makes a grant under section 9023(e) of the Patient Protection and Affordable Care Act of 2009—

“(1) **DENIAL OF CREDIT.**—No credit shall be determined under this section with respect to such investment for the taxable year in which such grant is made or any subsequent taxable year.

“(2) **RECAPTURE OF CREDITS FOR PROGRESS EXPENDITURES MADE BEFORE GRANT.**—If a credit was determined under this section with respect to such investment for any taxable year ending before such grant is made—

“(A) the tax imposed under subtitle A on the taxpayer for the taxable year in which such grant is made shall be increased by so much of such credit as was allowed under section 38,

“(B) the general business carryforwards under section 39 shall be adjusted so as to recapture the portion of such credit which was not so allowed, and

“(C) the amount of such grant shall be determined without regard to any reduction in the basis of any property of a character subject to an allowance for depreciation by reason of such credit.

“(3) **TREATMENT OF GRANTS.**—Any such grant shall not be includible in the gross income of the taxpayer.”.

(b) **INCLUSION AS PART OF INVESTMENT CREDIT.**—Section 46 of the Internal Revenue Code of 1986 is amended—

(1) by adding a comma at the end of paragraph (2),

(2) by striking the period at the end of paragraph (5) and inserting “, and”, and

(3) by adding at the end the following new paragraph:

“(6) the qualifying therapeutic discovery project credit.”.

(c) **CONFORMING AMENDMENTS.**—

(1) Section 49(a)(1)(C) of the Internal Revenue Code of 1986 is amended—

(A) by striking “and” at the end of clause (iv),

(B) by striking the period at the end of clause (v) and inserting “, and”, and

(C) by adding at the end the following new clause:

“(vi) the basis of any property to which paragraph (1) of section 48D(e) applies which is part of a qualifying therapeutic discovery project under such section 48D.”.

(2) Section 280C of such Code is amended by adding at the end the following new subsection:

“(g) **QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.**—

“(1) **IN GENERAL.**—No deduction shall be allowed for that portion of the qualified investment (as defined in section 48D(b)) otherwise allowable as a deduction for the taxable year which—

“(A) would be qualified research expenses (as defined in section 41(b)), basic research expenses (as defined in section 41(e)(2)), or qualified clinical testing expenses (as defined in section 45C(b)) if the credit under section 41 or section 45C were allowed with respect to such expenses for such taxable year, and

“(B) is equal to the amount of the credit determined for such taxable year under section 48D(a), reduced by—

“(i) the amount disallowed as a deduction by reason of section 48D(e)(2)(B), and

“(ii) the amount of any basis reduction under section 48D(e)(1).

“(2) **SIMILAR RULE WHERE TAXPAYER CAPITALIZES RATHER THAN DEDUCTS EXPENSES.**—In the case of expenses described in paragraph (1)(A)

taken into account in determining the credit under section 48D for the taxable year, if—

“(A) the amount of the portion of the credit determined under such section with respect to such expenses, exceeds

“(B) the amount allowable as a deduction for such taxable year for such expenses (determined without regard to paragraph (1)),

the amount chargeable to capital account for the taxable year for such expenses shall be reduced by the amount of such excess.

“(3) CONTROLLED GROUPS.—Paragraph (3) of subsection (b) shall apply for purposes of this subsection.”

(d) CLERICAL AMENDMENT.—The table of sections for subpart E of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 48C the following new item:

“Sec. 48D. Qualifying therapeutic discovery project credit.”

(e) GRANTS FOR QUALIFIED INVESTMENTS IN THERAPEUTIC DISCOVERY PROJECTS IN LIEU OF TAX CREDITS.—

(1) IN GENERAL.—Upon application, the Secretary of the Treasury shall, subject to the requirements of this subsection, provide a grant to each person who makes a qualified investment in a qualifying therapeutic discovery project in the amount of 50 percent of such investment. No grant shall be made under this subsection with respect to any investment unless such investment is made during a taxable year beginning in 2009 or 2010.

(2) APPLICATION.—

(A) IN GENERAL.—At the stated election of the applicant, an application for certification under section 48D(d)(2) of the Internal Revenue Code of 1986 for a credit under such section for the taxable year of the applicant which begins in 2009 shall be considered to be an application for a grant under paragraph (1) for such taxable year.

(B) TAXABLE YEARS BEGINNING IN 2010.—An application for a grant under paragraph (1) for a taxable year beginning in 2010 shall be submitted—

(i) not earlier than the day after the last day of such taxable year, and

(ii) not later than the due date (including extensions) for filing the return of tax for such taxable year.

(C) INFORMATION TO BE SUBMITTED.—An application for a grant under paragraph (1) shall include such information and be in such form as the Secretary may require to state the amount of the credit allowable (but for the receipt of a grant under this subsection) under section 48D for the taxable year for the qualified investment with respect to which such application is made.

(3) TIME FOR PAYMENT OF GRANT.—

(A) IN GENERAL.—The Secretary of the Treasury shall make payment of the amount of any grant under paragraph (1) during the 30-day period beginning on the later of—

(i) the date of the application for such grant, or

(ii) the date the qualified investment for which the grant is being made is made.

(B) REGULATIONS.—In the case of investments of an ongoing nature, the Secretary shall issue regulations to determine the date on which a qualified investment shall be deemed to have been made for purposes of this paragraph.

(4) QUALIFIED INVESTMENT.—For purposes of this subsection, the term “qualified investment” means a qualified investment that is certified under section 48D(d) of the Internal Revenue Code of 1986 for purposes of the credit under such section 48D.

(5) APPLICATION OF CERTAIN RULES.—

(A) IN GENERAL.—In making grants under this subsection, the Secretary of the Treasury shall apply rules similar to the rules of section 50 of

the Internal Revenue Code of 1986. In applying such rules, any increase in tax under chapter 1 of such Code by reason of an investment ceasing to be a qualified investment shall be imposed on the person to whom the grant was made.

(B) SPECIAL RULES.—

(i) RECAPTURE OF EXCESSIVE GRANT AMOUNTS.—If the amount of a grant made under this subsection exceeds the amount allowable as a grant under this subsection, such excess shall be recaptured under subparagraph (A) as if the investment to which such excess portion of the grant relates had ceased to be a qualified investment immediately after such grant was made.

(ii) GRANT INFORMATION NOT TREATED AS RETURN INFORMATION.—In no event shall the amount of a grant made under paragraph (1), the identity of the person to whom such grant was made, or a description of the investment with respect to which such grant was made be treated as return information for purposes of section 6103 of the Internal Revenue Code of 1986.

(6) EXCEPTION FOR CERTAIN NON-TAXPAYERS.—The Secretary of the Treasury shall not make any grant under this subsection to—

(A) any Federal, State, or local government (or any political subdivision, agency, or instrumentality thereof),

(B) any organization described in section 501(c) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code,

(C) any entity referred to in paragraph (4) of section 54(j) of such Code, or

(D) any partnership or other pass-thru entity any partner (or other holder of an equity or profits interest) of which is described in subparagraph (A), (B) or (C).

In the case of a partnership or other pass-thru entity described in subparagraph (D), partners and other holders of any equity or profits interest shall provide to such partnership or entity such information as the Secretary of the Treasury may require to carry out the purposes of this paragraph.

(7) SECRETARY.—Any reference in this subsection to the Secretary of the Treasury shall be treated as including the Secretary's delegate.

(8) OTHER TERMS.—Any term used in this subsection which is also used in section 48D of the Internal Revenue Code of 1986 shall have the same meaning for purposes of this subsection as when used in such section.

(9) DENIAL OF DOUBLE BENEFIT.—No credit shall be allowed under section 46(6) of the Internal Revenue Code of 1986 by reason of section 48D of such Code for any investment for which a grant is awarded under this subsection.

(10) APPROPRIATIONS.—There is hereby appropriated to the Secretary of the Treasury such sums as may be necessary to carry out this subsection.

(11) TERMINATION.—The Secretary of the Treasury shall not make any grant to any person under this subsection unless the application of such person for such grant is received before January 1, 2013.

(12) PROTECTING MIDDLE CLASS FAMILIES FROM TAX INCREASES.—It is the sense of the Senate that the Senate should reject any procedural maneuver that would raise taxes on middle class families, such as a motion to commit the pending legislation to the Committee on Finance, which is designed to kill legislation that provides tax cuts for American workers and families, including the affordability tax credit and the small business tax credit.

(f) EFFECTIVE DATE.—The amendments made by subsections (a) through (d) of this section shall apply to amounts paid or incurred after December 31, 2008, in taxable years beginning after such date.

TITLE X—STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Provisions Relating to Title I

SEC. 10101. AMENDMENTS TO SUBTITLE A.

(a) Section 2711 of the Public Health Service Act, as added by section 1001(5) of this Act, is amended to read as follows:

“SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.

“(a) PROHIBITION.—

“(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—

“(A) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

“(B) except as provided in paragraph (2), annual limits on the dollar value of benefits for any participant or beneficiary.

“(2) ANNUAL LIMITS PRIOR TO 2014.—With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, as determined by the Secretary. In defining the term ‘restricted annual limit’ for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.

“(b) PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, to the extent that such limits are otherwise permitted under Federal or State law.”

(b) Section 2715(a) of the Public Health Service Act, as added by section 1001(5) of this Act, is amended by striking “and providing to enrollees” and inserting “and providing to applicants, enrollees, and policyholders or certificate holders”.

(c) Subpart II of part A of title XXVII of the Public Health Service Act, as added by section 1001(5), is amended by inserting after section 2715, the following:

“SEC. 2715A. PROVISION OF ADDITIONAL INFORMATION.

“A group health plan and a health insurance issuer offering group or individual health insurance coverage shall comply with the provisions of section 1311(e)(3) of the Patient Protection and Affordable Care Act, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public.”

(d) Section 2716 of the Public Health Service Act, as added by section 1001(5) of this Act, is amended to read as follows:

“SEC. 2716. PROHIBITION ON DISCRIMINATION IN FAVOR OF HIGHLY COMPENSATED INDIVIDUALS.

“(a) IN GENERAL.—A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(h)(2) of the Internal Revenue Code of 1986 (relating to prohibition on discrimination in favor of highly compensated individuals).

“(b) RULES AND DEFINITIONS.—For purposes of this section—

“(1) CERTAIN RULES TO APPLY.—Rules similar to the rules contained in paragraphs (3), (4), and (8) of section 105(h) of such Code shall apply.

“(2) **HIGHLY COMPENSATED INDIVIDUAL.**—The term ‘highly compensated individual’ has the meaning given such term by section 105(h)(5) of such Code.”.

(e) Section 2717 of the Public Health Service Act, as added by section 1001(5) of this Act, is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b), the following:

“(c) **PROTECTION OF SECOND AMENDMENT GUN RIGHTS.**—

“(1) **WELLNESS AND PREVENTION PROGRAMS.**—A wellness and health promotion activity implemented under subsection (a)(1)(D) may not require the disclosure or collection of any information relating to—

“(A) the presence or storage of a lawfully-possessed firearm or ammunition in the residence or on the property of an individual; or

“(B) the lawful use, possession, or storage of a firearm or ammunition by an individual.

“(2) **LIMITATION ON DATA COLLECTION.**—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used for the collection of any information relating to—

“(A) the lawful ownership or possession of a firearm or ammunition;

“(B) the lawful use of a firearm or ammunition; or

“(C) the lawful storage of a firearm or ammunition.

“(3) **LIMITATION ON DATABASES OR DATA BANKS.**—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used to maintain records of individual ownership or possession of a firearm or ammunition.

“(4) **LIMITATION ON DETERMINATION OF PREMIUM RATES OR ELIGIBILITY FOR HEALTH INSURANCE.**—A premium rate may not be increased, health insurance coverage may not be denied, and a discount, rebate, or reward offered for participation in a wellness program may not be reduced or withheld under any health benefit plan issued pursuant to or in accordance with the Patient Protection and Affordable Care Act or an amendment made by that Act on the basis of, or on reliance upon—

“(A) the lawful ownership or possession of a firearm or ammunition; or

“(B) the lawful use or storage of a firearm or ammunition.

“(5) **LIMITATION ON DATA COLLECTION REQUIREMENTS FOR INDIVIDUALS.**—No individual shall be required to disclose any information under any data collection activity authorized under the Patient Protection and Affordable Care Act or an amendment made by that Act relating to—

“(A) the lawful ownership or possession of a firearm or ammunition; or

“(B) the lawful use, possession, or storage of a firearm or ammunition.”.

(f) Section 2718 of the Public Health Service Act, as added by section 1001(5), is amended to read as follows:

“SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

“(a) **CLEAR ACCOUNTING FOR COSTS.**—A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting

for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

“(1) on reimbursement for clinical services provided to enrollees under such coverage;

“(2) for activities that improve health care quality; and

“(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

“(b) **ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.**—

“(1) **REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.**—

“(A) **REQUIREMENT.**—Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

“(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

“(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.

“(B) **REBATE AMOUNT.**—

“(i) **CALCULATION OF AMOUNT.**—The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—

“(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and

“(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

“(ii) **CALCULATION BASED ON AVERAGE RATIO.**—Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

“(2) **CONSIDERATION IN SETTING PERCENTAGES.**—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

“(3) **ENFORCEMENT.**—The Secretary shall promulgate regulations for enforcing the provisions

of this section and may provide for appropriate penalties.

“(c) **DEFINITIONS.**—Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

“(d) **ADJUSTMENTS.**—The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

“(e) **STANDARD HOSPITAL CHARGES.**—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.”.

(g) Section 2719 of the Public Health Service Act, as added by section 1001(4) of this Act, is amended to read as follows:

“SEC. 2719. APPEALS PROCESS.

“(a) **INTERNAL CLAIMS APPEALS.**—

“(1) **IN GENERAL.**—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

“(A) have in effect an internal claims appeal process;

“(B) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes; and

“(C) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

“(2) **ESTABLISHED PROCESSES.**—To comply with paragraph (1)—

“(A) a group health plan and a health insurance issuer offering group health coverage shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503–1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70256), and shall update such process in accordance with any standards established by the Secretary of Labor for such plans and issuers; and

“(B) a health insurance issuer offering individual health coverage, and any other issuer not subject to subparagraph (A), shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures set forth under applicable law (as in existence on the date of enactment of this section), and shall update such process in accordance with any standards established by the Secretary of Health and Human Services for such issuers.

“(b) **EXTERNAL REVIEW.**—A group health plan and a health insurance issuer offering group or individual health insurance coverage—

“(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National

Association of Insurance Commissioners and is binding on such plans; or

“(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—

“(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or

“(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).

“(C) SECRETARY AUTHORITY.—The Secretary may deem the external review process of a group health plan or health insurance issuer, in operation as of the date of enactment of this section, to be in compliance with the applicable process established under subsection (b), as determined appropriate by the Secretary.”

(h) Subpart II of part A of title XVIII of the Public Health Service Act, as added by section 1001(5) of this Act, is amended by inserting after section 2719 the following:

“SEC. 2719A. PATIENT PROTECTIONS.

“(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

“(b) COVERAGE OF EMERGENCY SERVICES.—

“(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

“(A) without the need for any prior authorization determination; and

“(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

“(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

“(i) by a nonparticipating health care provider with or without prior authorization; or

“(ii)(I) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

“(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

“(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of this Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

“(2) DEFINITIONS.—In this subsection:

“(A) EMERGENCY MEDICAL CONDITION.—The term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and med-

icine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

“(B) EMERGENCY SERVICES.—The term ‘emergency services’ means, with respect to an emergency medical condition—

“(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

“(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

“(C) STABILIZE.—The term ‘to stabilize’, with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

“(c) ACCESS TO PEDIATRIC CARE.—

“(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer in the group or individual market, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider if such provider participates in the network of the plan or issuer.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

“(d) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

“(1) GENERAL RIGHTS.—

“(A) DIRECT ACCESS.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan’s or issuer’s policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

“(B) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

“(2) APPLICATION OF PARAGRAPH.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in this paragraph is a group health plan or coverage that—

“(A) provides coverage for obstetric or gynecologic care; and

“(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

“(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to—

“(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

“(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.”

(i) Section 2794 of the Public Health Service Act, as added by section 1003 of this Act, is amended—

(1) in subsection (c)(1)—

(A) in subparagraph (A), by striking “and” at the end;

(B) in subparagraph (B), by striking the period and inserting “; and”; and

(C) by adding at the end the following:

“(C) in establishing centers (consistent with subsection (d)) at academic or other nonprofit institutions to collect medical reimbursement information from health insurance issuers, to analyze and organize such information, and to make such information available to such issuers, health care providers, health researchers, health care policy makers, and the general public.”; and

(2) by adding at the end the following:

“(d) MEDICAL REIMBURSEMENT DATA CENTERS.—

“(1) FUNCTIONS.—A center established under subsection (c)(1)(C) shall—

“(A) develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates;

“(B) use the best available statistical methods and data processing technology to develop such fee schedules and other database tools;

“(C) regularly update such fee schedules and other database tools to reflect changes in charges for medical services;

“(D) make health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services; and

“(E) regularly publish information concerning the statistical methodologies used by the center to analyze health charge data and make such data available to researchers and policy makers.

“(2) CONFLICTS OF INTEREST.—A center established under subsection (c)(1)(C) shall adopt bylaws that ensures that the center (and all members of the governing board of the center) is independent and free from all conflicts of interest. Such by-laws shall ensure that the center is not controlled or influenced by, and does not have any corporate relation to, any individual or entity that may make or receive payments for health care services based on the center’s analysis of health care costs.

“(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to permit a center established under subsection (c)(1)(C) to compel health insurance issuers to provide data to the center.”

SEC. 10102. AMENDMENTS TO SUBTITLE B.

(a) Section 1102(a)(2)(B) of this Act is amended—

(1) in the matter preceding clause (i), by striking “group health benefits plan” and inserting “group benefits plan providing health benefits”; and

(2) in clause (i)(I), by inserting “or any agency or instrumentality of any of the foregoing” before the closed parenthetical.

(b) Section 1103(a) of this Act is amended—

(1) in paragraph (1), by inserting “, or small business in,” after “residents of any”; and

(2) by striking paragraph (2) and inserting the following:

“(2) CONNECTING TO AFFORDABLE COVERAGE.—An Internet website established under paragraph (1) shall, to the extent practicable, provide ways for residents of, and small businesses

in, any State to receive information on at least the following coverage options:

“(A) Health insurance coverage offered by health insurance issuers, other than coverage that provides reimbursement only for the treatment or mitigation of—

“(i) a single disease or condition; or

“(ii) an unreasonably limited set of diseases or conditions (as determined by the Secretary).

“(B) Medicaid coverage under title XIX of the Social Security Act.

“(C) Coverage under title XXI of the Social Security Act.

“(D) A State health benefits high risk pool, to the extent that such high risk pool is offered in such State; and

“(E) Coverage under a high risk pool under section 1101.

“(F) Coverage within the small group market for small businesses and their employees, including reinsurance for early retirees under section 1102, tax credits available under section 45R of the Internal Revenue Code of 1986 (as added by section 1421), and other information specifically for small businesses regarding affordable health care options.”.

SEC. 10103. AMENDMENTS TO SUBTITLE C.

(a) Section 2701(a)(5) of the Public Health Service Act, as added by section 1201(4) of this Act, is amended by inserting “(other than self-insured group health plans offered in such market)” after “such market”.

(b) Section 2708 of the Public Health Service Act, as added by section 1201(4) of this Act, is amended by striking “or individual”.

(c) Subpart I of part A of title XXVII of the Public Health Service Act, as added by section 1201(4) of this Act, is amended by inserting after section 2708, the following:

“SEC. 2709. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

“(a) COVERAGE.—

“(1) IN GENERAL.—If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage to a qualified individual, then such plan or issuer—

“(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

“(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

“(C) may not discriminate against the individual on the basis of the individual's participation in such trial.

“(2) ROUTINE PATIENT COSTS.—

“(A) INCLUSION.—For purposes of paragraph (1)(B), subject to subparagraph (B), routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.

“(B) EXCLUSION.—For purposes of paragraph (1)(B), routine patient costs do not include—

“(i) the investigational item, device, or service, itself;

“(ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

“(iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

“(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating

provider if the provider will accept the individual as a participant in the trial.

“(4) USE OF OUT-OF-NETWORK.—Notwithstanding paragraph (3), paragraph (1) shall apply to a qualified individual participating in an approved clinical trial that is conducted outside the State in which the qualified individual resides.

“(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ‘qualified individual’ means an individual who is a participant or beneficiary in a health plan or with coverage described in subsection (a)(1) and who meets the following conditions:

“(1) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.

“(2) Either—

“(A) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

“(B) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

“(c) LIMITATIONS ON COVERAGE.—This section shall not be construed to require a group health plan, or a health insurance issuer offering group or individual health insurance coverage, to provide benefits for routine patient care services provided outside of the plan's (or coverage's) health care provider network unless out-of-network benefits are otherwise provided under the plan (or coverage).

“(d) APPROVED CLINICAL TRIAL DEFINED.—

“(1) IN GENERAL.—In this section, the term ‘approved clinical trial’ means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

“(A) FEDERALLY FUNDED TRIALS.—The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

“(i) The National Institutes of Health.

“(ii) The Centers for Disease Control and Prevention.

“(iii) The Agency for Health Care Research and Quality.

“(iv) The Centers for Medicare & Medicaid Services.

“(v) cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

“(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

“(vii) Any of the following if the conditions described in paragraph (2) are met:

“(I) The Department of Veterans Affairs.

“(II) The Department of Defense.

“(III) The Department of Energy.

“(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

“(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

“(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

“(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

“(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

“(e) LIFE-THREATENING CONDITION DEFINED.—In this section, the term ‘life-threatening condition’ means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

“(f) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

“(g) APPLICATION TO FEHBP.—Notwithstanding any provision of chapter 89 of title 5, United States Code, this section shall apply to health plans offered under the program under such chapter.

“(h) PREEMPTION.—Notwithstanding any other provision of this Act, nothing in this section shall preempt State laws that require a clinical trials policy for State regulated health insurance plans that is in addition to the policy required under this section.”.

(d) Section 1251(a) of this Act is amended—

(1) in paragraph (2), by striking “With” and inserting “Except as provided in paragraph (3), with”; and

(2) by adding at the end the following:

“(3) APPLICATION OF CERTAIN PROVISIONS.—The provisions of sections 2715 and 2718 of the Public Health Service Act (as added by subtitle A) shall apply to grandfathered health plans for plan years beginning on or after the date of enactment of this Act.”.

(e) Section 1253 of this Act is amended insert before the period the following: “, except that—

“(1) section 1251 shall take effect on the date of enactment of this Act; and

“(2) the provisions of section 2704 of the Public Health Service Act (as amended by section 1201), as they apply to enrollees who are under 19 years of age, shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act.”.

(f) Subtitle C of title I of this Act is amended—

(1) by redesignating section 1253 as section 1255; and

(2) by inserting after section 1252, the following:

“SEC. 1253. ANNUAL REPORT ON SELF-INSURED PLANS.

“Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary of Labor shall prepare an aggregate annual report, using data collected from the Annual Return/Report of Employee Benefit Plan (Department of Labor Form 5500), that shall include general information on self-insured group health plans (including plan type, number of participants, benefits offered, funding arrangements, and benefit arrangements) as well as data from the financial filings of self-insured employers (including information on assets, liabilities, contributions, investments, and expenses). The Secretary shall submit such reports to the appropriate committees of Congress.

“SEC. 1254. STUDY OF LARGE GROUP MARKET.

“(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study of the fully-insured and self-insured group health plan markets to—

“(1) compare the characteristics of employers (including industry, size, and other characteristics as determined appropriate by the Secretary), health plan benefits, financial solvency, capital reserve levels, and the risks of becoming insolvent; and

“(2) determine the extent to which new insurance market reforms are likely to cause adverse selection in the large group market or to encourage small and midsize employers to self-insure.

“(b) **COLLECTION OF INFORMATION.**—In conducting the study under subsection (a), the Secretary, in coordination with the Secretary of Labor, shall collect information and analyze—

“(1) the extent to which self-insured group health plans can offer less costly coverage and, if so, whether lower costs are due to more efficient plan administration and lower overhead or to the denial of claims and the offering very limited benefit packages;

“(2) claim denial rates, plan benefit fluctuations (to evaluate the extent that plans scale back health benefits during economic downturns), and the impact of the limited recourse options on consumers; and

“(3) any potential conflict of interest as it relates to the health care needs of self-insured enrollees and self-insured employer’s financial contribution or profit margin, and the impact of such conflict on administration of the health plan.

“(c) **REPORT.**—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a report concerning the results of the study conducted under subsection (a).”.

SEC. 10104. AMENDMENTS TO SUBTITLE D.

(a) Section 1301(a) of this Act is amended by striking paragraph (2) and inserting the following:

“(2) **INCLUSION OF CO-OP PLANS AND MULTI-STATE QUALIFIED HEALTH PLANS.**—Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 1322, and a multi-State plan under section 1334, unless specifically provided for otherwise.

“(3) **TREATMENT OF QUALIFIED DIRECT PRIMARY CARE MEDICAL HOME PLANS.**—The Secretary of Health and Human Services shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plan.

“(4) **VARIATION BASED ON RATING AREA.**—A qualified health plan, including a multi-State qualified health plan, may as appropriate vary premiums by rating area (as defined in section 2701(a)(2) of the Public Health Service Act).”.

(b) Section 1302 of this Act is amended—

(1) in subsection (d)(2)(B), by striking “may issue” and inserting “shall issue”; and

(2) by adding at the end the following:

“(g) **PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.**—If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.”.

(c) Section 1303 of this Act is amended to read as follows:

“SEC. 1303. SPECIAL RULES.

“(a) **STATE OPT-OUT OF ABORTION COVERAGE.**—

“(1) **IN GENERAL.**—A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition.

“(2) **TERMINATION OF OPT OUT.**—A State may repeal a law described in paragraph (1) and provide for the offering of such services through the Exchange.

“(b) **SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.**—

“(1) **VOLUNTARY CHOICE OF COVERAGE OF ABORTION SERVICES.**—

“(A) **IN GENERAL.**—Notwithstanding any other provision of this title (or any amendment made by this title)—

“(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(i) or (B)(ii) as part of its essential health benefits for any plan year; and

“(ii) subject to subsection (a), the issuer of a qualified health plan shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year.

“(B) **ABORTION SERVICES.**—

“(i) **ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.**—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

“(ii) **ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED.**—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

“(2) **PROHIBITION ON THE USE OF FEDERAL FUNDS.**—

“(A) **IN GENERAL.**—If a qualified health plan provides coverage of services described in paragraph (1)(B)(i), the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services:

“(i) The credit under section 36B of the Internal Revenue Code of 1986 (and the amount (if any) of the advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).

“(ii) Any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act (and the amount (if any) of the advance payment of the reduction under section 1412 of the Patient Protection and Affordable Care Act).

“(B) **ESTABLISHMENT OF ALLOCATION ACCOUNTS.**—In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall—

“(i) collect from each enrollee in the plan (without regard to the enrollee’s age, sex, or family status) a separate payment for each of the following:

“(1) an amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the plan of services other than services described in paragraph (1)(B)(i) (after reduction for credits and cost-sharing reductions described in subparagraph (A)); and

“(2) an amount equal to the actuarial value of the coverage of services described in paragraph (1)(B)(i), and

“(ii) shall deposit all such separate payments into separate allocation accounts as provided in subparagraph (C).

In the case of an enrollee whose premium for coverage under the plan is paid through employer payroll deposit, the separate payments required under this subparagraph shall each be paid by a separate deposit.

“(C) **SEGREGATION OF FUNDS.**—

“(i) **IN GENERAL.**—The issuer of a plan to which subparagraph (A) applies shall establish allocation accounts described in clause (ii) for enrollees receiving amounts described in subparagraph (A).

“(ii) **ALLOCATION ACCOUNTS.**—The issuer of a plan to which subparagraph (A) applies shall deposit—

“(1) all payments described in subparagraph (B)(i)(I) into a separate account that consists solely of such payments and that is used exclusively to pay for services other than services described in paragraph (1)(B)(i); and

“(2) all payments described in subparagraph (B)(i)(II) into a separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (1)(B)(i).

“(D) **ACTUARIAL VALUE.**—

“(i) **IN GENERAL.**—The issuer of a qualified health plan shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under the qualified health plan of the services described in paragraph (1)(B)(i).

“(ii) **CONSIDERATIONS.**—In making such estimate, the issuer—

“(1) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

“(2) shall estimate such costs as if such coverage were included for the entire population covered; and

“(3) may not estimate such a cost at less than \$1 per enrollee, per month.

“(E) **ENSURING COMPLIANCE WITH SEGREGATION REQUIREMENTS.**—

“(i) **IN GENERAL.**—Subject to clause (ii), State health insurance commissioners shall ensure that health plans comply with the segregation requirements in this subsection through the segregation of plan funds in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office.

“(ii) **CLARIFICATION.**—Nothing in clause (i) shall prohibit the right of an individual or health plan to appeal such action in courts of competent jurisdiction.

“(3) **RULES RELATING TO NOTICE.**—

“(A) **NOTICE.**—A qualified health plan that provides for coverage of the services described in paragraph (1)(B)(i) shall provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage.

“(B) **RULES RELATING TO PAYMENTS.**—The notice described in subparagraph (A), any advertising used by the issuer with respect to the plan, any information provided by the Exchange, and any other information specified by the Secretary shall provide information only with respect to the total amount of the combined payments for services described in paragraph (1)(B)(i) and other services covered by the plan.

“(4) **NO DISCRIMINATION ON BASIS OF PROVISION OF ABORTION.**—No qualified health plan offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions

“(c) **APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.**—

“(1) **NO PREEMPTION OF STATE LAWS REGARDING ABORTION.**—Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

“(2) **NO EFFECT ON FEDERAL LAWS REGARDING ABORTION.**—

“(A) **IN GENERAL.**—Nothing in this Act shall be construed to have any effect on Federal laws regarding—

“(i) conscience protection;
“(ii) willingness or refusal to provide abortion; and

“(iii) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

“(3) NO EFFECT ON FEDERAL CIVIL RIGHTS LAW.—Nothing in this subsection shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964.

“(d) APPLICATION OF EMERGENCY SERVICES LAWS.—Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as ‘EMTALA’).”.

(d) Section 1304 of this Act is amended by adding at the end the following:

“(e) EDUCATED HEALTH CARE CONSUMERS.—The term ‘educated health care consumer’ means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters.”.

(e) Section 1311(d) of this Act is amended—

(1) in paragraph (3)(B), by striking clause (ii) and inserting the following:

“(ii) STATE MUST ASSUME COST.—A State shall make payments—

“(I) to an individual enrolled in a qualified health plan offered in such State; or

“(II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled;

to defray the cost of any additional benefits described in clause (i).”; and

(2) in paragraph (6)(A), by inserting “educated” before “health care”.

(f) Section 1311(e) of this Act is amended—

(1) in paragraph (2), by striking “may” in the second sentence and inserting “shall”; and

(2) by adding at the end the following:

“(3) TRANSPARENCY IN COVERAGE.—

“(A) IN GENERAL.—The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, accurate and timely disclosure of the following information:

“(i) Claims payment policies and practices.

“(ii) Periodic financial disclosures.

“(iii) Data on enrollment.

“(iv) Data on disenrollment.

“(v) Data on the number of claims that are denied.

“(vi) Data on rating practices.

“(vii) Information on cost-sharing and payments with respect to any out-of-network coverage.

“(viii) Information on enrollee and participant rights under this title.

“(ix) Other information as determined appropriate by the Secretary.

“(B) USE OF PLAIN LANGUAGE.—The information required to be submitted under subparagraph (A) shall be provided in plain language. The term ‘plain language’ means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

“(C) COST SHARING TRANSPARENCY.—The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual’s plan or cov-

erage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an Internet website and such other means for individuals without access to the Internet.

“(D) GROUP HEALTH PLANS.—The Secretary of Labor shall update and harmonize the Secretary’s rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Secretary under subparagraph (A).”.

(g) Section 1311(g)(1) of this Act is amended—

(1) in subparagraph (C), by striking “; and” and inserting a semicolon;

(2) in subparagraph (D), by striking the period and inserting “; and”; and

(3) by adding at the end the following:

“(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.”.

(h) Section 1311(i)(2)(B) of this Act is amended by striking “small business development centers” and inserting “resource partners of the Small Business Administration”.

(i) Section 1312 of this Act is amended—

(1) in subsection (a)(1), by inserting “and for which such individual is eligible” before the period;

(2) in subsection (e)—

(A) in paragraph (1), by inserting “and employers” after “enroll individuals”; and

(B) by striking the flush sentence at the end; and

(3) in subsection (f)(1)(A)(ii), by striking the parenthetical.

(j)(1) Subparagraph (B) of section 1313(a)(6) of this Act is hereby deemed null, void, and of no effect.

(2) Section 3730(e) of title 31, United States Code, is amended by striking paragraph (4) and inserting the following:

“(4)(A) The court shall dismiss an action or claim under this section, unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed—

“(i) in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party;

“(ii) in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or

“(iii) from the news media,

unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

“(B) For purposes of this paragraph, “original source” means an individual who either (i) prior to a public disclosure under subsection (e)(4)(a), has voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or (2) who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing an action under this section.”.

(k) Section 1313(b) of this Act is amended—

(1) in paragraph (3), by striking “and” at the end;

(2) by redesignating paragraph (4) as paragraph (5); and

(3) by inserting after paragraph (3) the following:

“(4) a survey of the cost and affordability of health care insurance provided under the Ex-

changes for owners and employees of small business concerns (as defined under section 3 of the Small Business Act (15 U.S.C. 632)), including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges; and”.

(l) Section 1322(b) of this Act is amended—

(1) by redesignating paragraph (3) as paragraph (4); and

(2) by inserting after paragraph (2), the following:

“(3) REPAYMENT OF LOANS AND GRANTS.—Not later than July 1, 2013, and prior to awarding loans and grants under the CO-OP program, the Secretary shall promulgate regulations with respect to the repayment of such loans and grants in a manner that is consistent with State solvency regulations and other similar State laws that may apply. In promulgating such regulations, the Secretary shall provide that such loans shall be repaid within 5 years and such grants shall be repaid within 15 years, taking into consideration any appropriate State reserve requirements, solvency regulations, and requisite surplus note arrangements that must be constructed in a State to provide for such repayment prior to awarding such loans and grants.”.

(m) Part III of subtitle D of title I of this Act is amended by striking section 1323.

(n) Section 1324(a) of this Act is amended by striking “, a community health” and all that follows through “1333(b)” and inserting “, or a multi-State qualified health plan under section 1334”.

(o) Section 1331 of this Act is amended—

(1) in subsection (d)(3)(A)(i), by striking “85” and inserting “95”; and

(2) in subsection (e)(1)(B), by inserting before the semicolon the following: “, or, in the case of an alien lawfully present in the United States, whose income is not greater than 133 percent of the poverty line for the size of the family involved but who is not eligible for the Medicaid program under title XIX of the Social Security Act by reason of such alien status”.

(p) Section 1333 of this Act is amended by striking subsection (b).

(q) Part IV of subtitle D of title I of this Act is amended by adding at the end the following:

“SEC. 1334. MULTI-STATE PLANS.

“(a) OVERSIGHT BY THE OFFICE OF PERSONNEL MANAGEMENT.—

“(1) IN GENERAL.—The Director of the Office of Personnel Management (referred to in this section as the ‘Director’) shall enter into contracts with health insurance issuers (which may include a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark), without regard to section 5 of title 41, United States Code, or other statutes requiring competitive bidding, to offer at least 2 multi-State qualified health plans through each Exchange in each State. Such plans shall provide individual, or in the case of small employers, group coverage.

“(2) TERMS.—Each contract entered into under paragraph (1) shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party. In entering into such contracts, the Director shall ensure that health benefits coverage is provided in accordance with the types of coverage provided for under section 2701(a)(1)(A)(i) of the Public Health Service Act.

“(3) NON-PROFIT ENTITIES.—In entering into contracts under paragraph (1), the Director shall ensure that at least one contract is entered into with a non-profit entity.

“(4) ADMINISTRATION.—The Director shall implement this subsection in a manner similar to the manner in which the Director implements

the contracting provisions with respect to carriers under the Federal employees health benefit program under chapter 89 of title 5, United States Code, including (through negotiating with each multi-State plan)—

“(A) a medical loss ratio;

“(B) a profit margin;

“(C) the premiums to be charged; and

“(D) such other terms and conditions of coverage as are in the interests of enrollees in such plans.

“(5) **AUTHORITY TO PROTECT CONSUMERS.**—The Director may prohibit the offering of any multi-State health plan that does not meet the terms and conditions defined by the Director with respect to the elements described in subparagraphs (A) through (D) of paragraph (4).

“(6) **ASSURED AVAILABILITY OF VARIED COVERAGE.**—In entering into contracts under this subsection, the Director shall ensure that with respect to multi-State qualified health plans offered in an Exchange, there is at least one such plan that does not provide coverage of services described in section 1303(b)(1)(B)(i).

“(7) **WITHDRAWAL.**—Approval of a contract under this subsection may be withdrawn by the Director only after notice and opportunity for hearing to the issuer concerned without regard to subchapter II of chapter 5 and chapter 7 of title 5, United States Code.

“(b) **ELIGIBILITY.**—A health insurance issuer shall be eligible to enter into a contract under subsection (a)(1) if such issuer—

“(1) agrees to offer a multi-State qualified health plan that meets the requirements of subsection (c) in each Exchange in each State;

“(2) is licensed in each State and is subject to all requirements of State law not inconsistent with this section, including the standards and requirements that a State imposes that do not prevent the application of a requirement of part A of title XXVII of the Public Health Service Act or a requirement of this title;

“(3) otherwise complies with the minimum standards prescribed for carriers offering health benefits plans under section 8902(e) of title 5, United States Code, to the extent that such standards do not conflict with a provision of this title; and

“(4) meets such other requirements as determined appropriate by the Director, in consultation with the Secretary.

“(c) **REQUIREMENTS FOR MULTI-STATE QUALIFIED HEALTH PLAN.**—

“(1) **IN GENERAL.**—A multi-State qualified health plan meets the requirements of this subsection if, in the determination of the Director—

“(A) the plan offers a benefits package that is uniform in each State and consists of the essential benefits described in section 1302;

“(B) the plan meets all requirements of this title with respect to a qualified health plan, including requirements relating to the offering of the bronze, silver, and gold levels of coverage and catastrophic coverage in each State Exchange;

“(C) except as provided in paragraph (5), the issuer provides for determinations of premiums for coverage under the plan on the basis of the rating requirements of part A of title XXVII of the Public Health Service Act; and

“(D) the issuer offers the plan in all geographic regions, and in all States that have adopted adjusted community rating before the date of enactment of this Act.

“(2) **STATES MAY OFFER ADDITIONAL BENEFITS.**—Nothing in paragraph (1)(A) shall preclude a State from requiring that benefits in addition to the essential health benefits required under such paragraph be provided to enrollees of a multi-State qualified health plan offered in such State.

“(3) **CREDITS.**—

“(A) **IN GENERAL.**—An individual enrolled in a multi-State qualified health plan under this sec-

tion shall be eligible for credits under section 36B of the Internal Revenue Code of 1986 and cost sharing assistance under section 1402 in the same manner as an individual who is enrolled in a qualified health plan.

“(B) **NO ADDITIONAL FEDERAL COST.**—A requirement by a State under paragraph (2) that benefits in addition to the essential health benefits required under paragraph (1)(A) be provided to enrollees of a multi-State qualified health plan shall not affect the amount of a premium tax credit provided under section 36B of the Internal Revenue Code of 1986 with respect to such plan.

“(4) **STATE MUST ASSUME COST.**—A State shall make payments—

“(A) to an individual enrolled in a multi-State qualified health plan offered in such State; or

“(B) on behalf of an individual described in subparagraph (A) directly to the multi-State qualified health plan in which such individual is enrolled;

to defray the cost of any additional benefits described in paragraph (2).

“(5) **APPLICATION OF CERTAIN STATE RATING REQUIREMENTS.**—With respect to a multi-State qualified health plan that is offered in a State with age rating requirements that are lower than 3:1, the State may require that Exchanges operating in such State only permit the offering of such multi-State qualified health plans if such plans comply with the State's more protective age rating requirements.

“(d) **PLANS DEEMED TO BE CERTIFIED.**—A multi-State qualified health plan that is offered under a contract under subsection (a) shall be deemed to be certified by an Exchange for purposes of section 1311(d)(4)(A).

“(e) **PHASE-IN.**—Notwithstanding paragraphs (1) and (2) of subsection (b), the Director shall enter into a contract with a health insurance issuer for the offering of a multi-State qualified health plan under subsection (a) if—

“(1) with respect to the first year for which the issuer offers such plan, such issuer offers the plan in at least 60 percent of the States;

“(2) with respect to the second such year, such issuer offers the plan in at least 70 percent of the States;

“(3) with respect to the third such year, such issuer offers the plan in at least 85 percent of the States; and

“(4) with respect to each subsequent year, such issuer offers the plan in all States.

“(f) **APPLICABILITY.**—The requirements under chapter 89 of title 5, United States Code, applicable to health benefits plans under such chapter shall apply to multi-State qualified health plans provided for under this section to the extent that such requirements do not conflict with a provision of this title.

“(g) **CONTINUED SUPPORT FOR FEHBP.**—

“(1) **MAINTENANCE OF EFFORT.**—Nothing in this section shall be construed to permit the Director to allocate fewer financial or personnel resources to the functions of the Office of Personnel Management related to the administration of the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.

“(2) **SEPARATE RISK POOL.**—Enrollees in multi-State qualified health plans under this section shall be treated as a separate risk pool apart from enrollees in the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.

“(3) **AUTHORITY TO ESTABLISH SEPARATE ENTITIES.**—The Director may establish such separate units or offices within the Office of Personnel Management as the Director determines to be appropriate to ensure that the administration of multi-State qualified health plans under this section does not interfere with the effective administration of the Federal Employees Health

Benefit Program under chapter 89 of title 5, United States Code.

“(4) **EFFECTIVE OVERSIGHT.**—The Director may appoint such additional personnel as may be necessary to enable the Director to carry out activities under this section.

“(5) **ASSURANCE OF SEPARATE PROGRAM.**—In carrying out this section, the Director shall ensure that the program under this section is separate from the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code. Premiums paid for coverage under a multi-State qualified health plan under this section shall not be considered to be Federal funds for any purposes.

“(6) **FEHBP PLANS NOT REQUIRED TO PARTICIPATE.**—Nothing in this section shall require that a carrier offering coverage under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code, also offer a multi-State qualified health plan under this section.

“(h) **ADVISORY BOARD.**—The Director shall establish an advisory board to provide recommendations on the activities described in this section. A significant percentage of the members of such board shall be comprised of enrollees in a multi-State qualified health plan, or representatives of such enrollees.

“(i) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated, such sums as may be necessary to carry out this section.”

(r) Section 1341 of this Act is amended—

(1) in the section heading, by striking “**AND SMALL GROUP MARKETS**” and inserting “**MARKET**”;

(2) in subsection (b)(2)(B), by striking “paragraph (1)(A)” and inserting “paragraph (1)(B)”;

(3) in subsection (c)(1)(A), by striking “and small group markets” and inserting “market”.

SEC. 10105. AMENDMENTS TO SUBTITLE E.

(a) Section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986, as added by section 1401(a) of this Act, is amended by striking “is in excess of” and inserting “equals or exceeds”.

(b) Section 36B(c)(1)(A) of the Internal Revenue Code of 1986, as added by section 1401(a) of this Act, is amended by inserting “equals or” before “exceeds”.

(c) Section 36B(c)(2)(C)(iv) of the Internal Revenue Code of 1986, as added by section 1401(a) of this Act, is amended by striking “subsection (b)(3)(A)(ii)” and inserting “subsection (b)(3)(A)(iii)”.

(d) Section 1401(d) of this Act is amended by adding at the end the following:

“(3) Section 6211(b)(4)(A) of the Internal Revenue Code of 1986 is amended by inserting ‘36B,’ after ‘36A,’.”

(e)(1) Subparagraph (B) of section 45R(d)(3) of the Internal Revenue Code of 1986, as added by section 1421(a) of this Act, is amended to read as follows:

“(B) **DOLLAR AMOUNT.**—For purposes of paragraph (1)(B) and subsection (c)(2)—

“(i) 2010, 2011, 2012, AND 2013.—The dollar amount in effect under this paragraph for taxable years beginning in 2010, 2011, 2012, or 2013 is \$25,000.

“(ii) **SUBSEQUENT YEARS.**—In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be equal to \$25,000, multiplied by the cost-of-living adjustment under section 1(f)(3) for the calendar year, determined by substituting ‘calendar year 2012’ for ‘calendar year 1992’ in subparagraph (B) thereof.”

(2) Subsection (g) of section 45R of the Internal Revenue Code of 1986, as added by section 1421(a) of this Act, is amended by striking “2011” both places it appears and inserting “2010, 2011”.

(3) Section 280C(h) of the Internal Revenue Code of 1986, as added by section 1421(d)(1) of this Act, is amended by striking “2011” and inserting “2010, 2011”.

(4) Section 1421(f) of this Act is amended by striking “2010” both places it appears and inserting “2009”.

(5) The amendments made by this subsection shall take effect as if included in the enactment of section 1421 of this Act.

(f) Part I of subtitle E of title I of this Act is amended by adding at the end of subpart B, the following:

“SEC. 1416. STUDY OF GEOGRAPHIC VARIATION IN APPLICATION OF FPL.

“(a) IN GENERAL.—The Secretary shall conduct a study to examine the feasibility and implication of adjusting the application of the Federal poverty level under this subtitle (and the amendments made by this subtitle) for different geographic areas so as to reflect the variations in cost-of-living among different areas within the United States. If the Secretary determines that an adjustment is feasible, the study should include a methodology to make such an adjustment. Not later than January 1, 2013, the Secretary shall submit to Congress a report on such study and shall include such recommendations as the Secretary determines appropriate.

“(b) INCLUSION OF TERRITORIES.—

“(1) IN GENERAL.—The Secretary shall ensure that the study under subsection (a) covers the territories of the United States and that special attention is paid to the disparity that exists among poverty levels and the cost of living in such territories and to the impact of such disparity on efforts to expand health coverage and ensure health care.

“(2) TERRITORIES DEFINED.—In this subsection, the term ‘territories of the United States’ includes the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and any other territory or possession of the United States.”.

SEC. 10106. AMENDMENTS TO SUBTITLE F.

(a) Section 1501(a)(2) of this Act is amended to read as follows:

“(2) EFFECTS ON THE NATIONAL ECONOMY AND INTERSTATE COMMERCE.—The effects described in this paragraph are the following:

“(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

“(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from \$2,500,000,000,000, or 17.6 percent of the economy, in 2009 to \$4,700,000,000,000 in 2019. Private health insurance spending is projected to be \$854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

“(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

“(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar require-

ment has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

“(E) The economy loses up to \$207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

“(F) The cost of providing uncompensated care to the uninsured was \$43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over \$1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

“(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

“(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

“(I) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

“(J) Administrative costs for private health insurance, which were \$90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.”.

(b)(1) Section 5000A(b)(1) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended to read as follows:

“(1) IN GENERAL.—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).”.

(2) Paragraphs (1) and (2) of section 5000A(c) of the Internal Revenue Code of 1986, as so added, are amended to read as follows:

“(1) IN GENERAL.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

“(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

“(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

“(2) MONTHLY PENALTY AMOUNTS.—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

“(A) FLAT DOLLAR AMOUNT.—An amount equal to the lesser of—

“(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

“(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

“(B) PERCENTAGE OF INCOME.—An amount equal to the following percentage of the taxpayer's household income for the taxable year:

“(i) 0.5 percent for taxable years beginning in 2014.

“(ii) 1.0 percent for taxable years beginning in 2015.

“(iii) 2.0 percent for taxable years beginning after 2015.”.

(3) Section 5000A(c)(3) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended by striking “\$350” and inserting “\$495”.

(c) Section 5000A(d)(2)(A) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended to read as follows:

“(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—

“(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

“(ii) an adherent of established tenets or teachings of such sect or division as described in such section.”.

(d) Section 5000A(e)(1)(C) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended to read as follows:

“(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to required contribution of the employee.”.

(e) Section 4980H(b) of the Internal Revenue Code of 1986, as added by section 1513(a) of this Act, is amended to read as follows:

“(b) LARGE EMPLOYERS WITH WAITING PERIODS EXCEEDING 60 DAYS.—

“(1) IN GENERAL.—In the case of any applicable large employer which requires an extended waiting period to enroll in any minimum essential coverage under an employer-sponsored plan (as defined in section 5000A(f)(2)), there is hereby imposed on the employer an assessable payment of \$600 for each full-time employee of the employer to whom the extended waiting period applies.

“(2) EXTENDED WAITING PERIOD.—The term ‘extended waiting period’ means any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) which exceeds 60 days.”.

(f)(1) Subparagraph (A) of section 4980H(d)(4) of the Internal Revenue Code of 1986, as added by section 1513(a) of this Act, is amended by inserting “, with respect to any month,” after “means”.

(2) Section 4980H(d)(2) of the Internal Revenue Code of 1986, as added by section 1513(a) of this Act, is amended by adding at the end the following:

“(D) APPLICATION TO CONSTRUCTION INDUSTRY EMPLOYERS.—In the case of any employer the substantial annual gross receipts of which are attributable to the construction industry—

“(i) subparagraph (A) shall be applied by substituting ‘who employed an average of at least 5 full-time employees on business days during the preceding calendar year and whose annual payroll expenses exceed \$250,000 for such preceding calendar year’ for ‘who employed an average of at least 50 full-time employees on business days during the preceding calendar year’, and

“(ii) subparagraph (B) shall be applied by substituting ‘5’ for ‘50’.”

(3) The amendment made by paragraph (2) shall apply to months beginning after December 31, 2013.

(g) Section 6056(b) of the Internal Revenue Code of 1986, as added by section 1514(a) of the Act, is amended by adding at the end the following new flush sentence:

“The Secretary shall have the authority to review the accuracy of the information provided under this subsection, including the applicable large employer’s share under paragraph (2)(C)(iv).”

SEC. 10107. AMENDMENTS TO SUBTITLE G.

(a) Section 1562 of this Act is amended, in the amendment made by subsection (a)(2)(B)(iii), by striking “subpart 1” and inserting “subparts I and II”; and

(b) Subtitle G of title I of this Act is amended—

(1) by redesignating section 1562 (as amended) as section 1563; and

(2) by inserting after section 1561 the following:

“SEC. 1562. GAO STUDY REGARDING THE RATE OF DENIAL OF COVERAGE AND ENROLLMENT BY HEALTH INSURANCE ISSUERS AND GROUP HEALTH PLANS.

“(a) IN GENERAL.—The Comptroller General of the United States (referred to in this section as the ‘Comptroller General’) shall conduct a study of the incidence of denials of coverage for medical services and denials of applications to enroll in health insurance plans, as described in subsection (b), by group health plans and health insurance issuers.

“(b) DATA.—

“(1) IN GENERAL.—In conducting the study described in subsection (a), the Comptroller General shall consider samples of data concerning the following:

“(A)(i) denials of coverage for medical services to a plan enrollees, by the types of services for which such coverage was denied; and

“(ii) the reasons such coverage was denied; and

“(B)(i) incidents in which group health plans and health insurance issuers deny the application of an individual to enroll in a health insurance plan offered by such group health plan or issuer; and

“(ii) the reasons such applications are denied.

“(2) SCOPE OF DATA.—

“(A) FAVORABLY RESOLVED DISPUTES.—The data that the Comptroller General considers under paragraph (1) shall include data concerning denials of coverage for medical services and denials of applications for enrollment in a plan by a group health plan or health insurance issuer, where such group health plan or health insurance issuer later approves such coverage or application.

“(B) ALL HEALTH PLANS.—The study under this section shall consider data from varied group health plans and health insurance plans offered by health insurance issuers, including qualified health plans and health plans that are not qualified health plans.

“(c) REPORT.—Not later than one year after the date of enactment of this Act, the Comptroller General shall submit to the Secretaries of Health and Human Services and Labor a report describing the results of the study conducted under this section.

“(d) PUBLICATION OF REPORT.—The Secretaries of Health and Human Services and Labor shall make the report described in subsection (c) available to the public on an Internet website.

“SEC. 1563. SMALL BUSINESS PROCUREMENT.

“Part 19 of the Federal Acquisition Regulation, section 15 of the Small Business Act (15 U.S.C. 644), and any other applicable laws or regulations establishing procurement requirements relating to small business concerns (as defined in section 3 of the Small Business Act (15 U.S.C. 632)) may not be waived with respect to any contract awarded under any program or other authority under this Act or an amendment made by this Act.”

SEC. 10108. FREE CHOICE VOUCHERS.

(a) IN GENERAL.—An offering employer shall provide free choice vouchers to each qualified employee of such employer.

(b) OFFERING EMPLOYER.—For purposes of this section, the term “offering employer” means any employer who—

(1) offers minimum essential coverage to its employees consisting of coverage through an eligible employer-sponsored plan; and

(2) pays any portion of the costs of such plan.

(c) QUALIFIED EMPLOYEE.—For purposes of this section—

(1) IN GENERAL.—The term “qualified employee” means, with respect to any plan year of an offering employer, any employee—

(A) whose required contribution (as determined under section 5000A(e)(1)(B)) for minimum essential coverage through an eligible employer-sponsored plan—

(i) exceeds 8 percent of such employee’s household income for the taxable year described in section 1412(b)(1)(B) which ends with or within in the plan year; and

(ii) does not exceed 9.8 percent of such employee’s household income for such taxable year;

(B) whose household income for such taxable year is not greater than 400 percent of the poverty line for a family of the size involved; and

(C) who does not participate in a health plan offered by the offering employer.

(2) INDEXING.—In the case of any calendar year beginning after 2014, the Secretary shall adjust the 8 percent under paragraph (1)(A)(i) and 9.8 percent under paragraph (1)(A)(ii) for the calendar year to reflect the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(d) FREE CHOICE VOUCHER.—

(1) AMOUNT.—

(A) IN GENERAL.—The amount of any free choice voucher provided under subsection (a) shall be equal to the monthly portion of the cost of the eligible employer-sponsored plan which would have been paid by the employer if the employee were covered under the plan with respect to which the employer pays the largest portion of the cost of the plan. Such amount shall be equal to the amount the employer would pay for an employee with self-only coverage unless such employee elects family coverage (in which case such amount shall be the amount the employer would pay for family coverage).

(B) DETERMINATION OF COST.—The cost of any health plan shall be determined under the rules

similar to the rules of section 2204 of the Public Health Service Act, except that such amount shall be adjusted for age and category of enrollment in accordance with regulations established by the Secretary.

(2) USE OF VOUCHERS.—An Exchange shall credit the amount of any free choice voucher provided under subsection (a) to the monthly premium of any qualified health plan in the Exchange in which the qualified employee is enrolled and the offering employer shall pay any amounts so credited to the Exchange.

(3) PAYMENT OF EXCESS AMOUNTS.—If the amount of the free choice voucher exceeds the amount of the premium of the qualified health plan in which the qualified employee is enrolled for such month, such excess shall be paid to the employee.

(e) OTHER DEFINITIONS.—Any term used in this section which is also used in section 5000A of the Internal Revenue Code of 1986 shall have the meaning given such term under such section 5000A.

(f) EXCLUSION FROM INCOME FOR EMPLOYEE.—

(1) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 139C the following new section:

“SEC. 139D. FREE CHOICE VOUCHERS.

“Gross income shall not include the amount of any free choice voucher provided by an employer under section 10108 of the Patient Protection and Affordable Care Act to the extent that the amount of such voucher does not exceed the amount paid for a qualified health plan (as defined in section 1301 of such Act) by the taxpayer.”

(2) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of such Code is amended by inserting after the item relating to section 139C the following new item:

“Sec. 139D. Free choice vouchers.”

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to vouchers provided after December 31, 2013.

(g) DEDUCTION ALLOWED TO EMPLOYER.—

(1) IN GENERAL.—Section 162(a) of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: “For purposes of paragraph (1), the amount of a free choice voucher provided under section 10108 of the Patient Protection and Affordable Care Act shall be treated as an amount for compensation for personal services actually rendered.”

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to vouchers provided after December 31, 2013.

(h) VOUCHER TAKEN INTO ACCOUNT IN DETERMINING PREMIUM CREDIT.—

(1) IN GENERAL.—Subsection (c)(2) of section 36B of the Internal Revenue Code of 1986, as added by section 1401, is amended by adding at the end the following new subparagraph:

“(D) EXCEPTION FOR INDIVIDUAL RECEIVING FREE CHOICE VOUCHERS.—The term ‘coverage month’ shall not include any month in which such individual has a free choice voucher provided under section 10108 of the Patient Protection and Affordable Care Act.”

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 2013.

(i) COORDINATION WITH EMPLOYER RESPONSIBILITIES.—

(1) SHARED RESPONSIBILITY PENALTY.—

(A) IN GENERAL.—Subsection (c) of section 4980H of the Internal Revenue Code of 1986, as added by section 1513, is amended by adding at the end the following new paragraph:

“(3) SPECIAL RULES FOR EMPLOYERS PROVIDING FREE CHOICE VOUCHERS.—No assessable payment shall be imposed under paragraph (1)

for any month with respect to any employee to whom the employer provides a free choice voucher under section 10108 of the Patient Protection and Affordable Care Act for such month.”.

(B) **EFFECTIVE DATE.**—The amendment made by this paragraph shall apply to months beginning after December 31, 2013.

(2) **NOTIFICATION REQUIREMENT.**—Section 18B(a)(3) of the Fair Labor Standards Act of 1938, as added by section 1512, is amended—

(A) by inserting “and the employer does not offer a free choice voucher” after “Exchange”; and

(B) by striking “will lose” and inserting “may lose”.

(j) **EMPLOYER REPORTING.**—

(1) **IN GENERAL.**—Subsection (a) of section 6056 of the Internal Revenue Code of 1986, as added by section 1514, is amended by inserting “and every offering employer” before “shall”.

(2) **OFFERING EMPLOYERS.**—Subsection (f) of section 6056 of such Code, as added by section 1514, is amended to read as follows:

“(f) **DEFINITIONS.**—For purposes of this section—

“(1) **OFFERING EMPLOYER.**—

“(A) **IN GENERAL.**—The term ‘offering employer’ means any offering employer (as defined in section 10108(b) of the Patient Protection and Affordable Care Act) if the required contribution (within the meaning of section 5000A(e)(1)(B)(i)) of any employee exceeds 8 percent of the wages (as defined in section 3121(a)) paid to such employee by such employer.

“(B) **INDEXING.**—In the case of any calendar year beginning after 2014, the 8 percent under subparagraph (A) shall be adjusted for the calendar year to reflect the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

“(2) **OTHER DEFINITIONS.**—Any term used in this section which is also used in section 4980H shall have the meaning given such term by section 4980H.”.

(3) **CONFORMING AMENDMENTS.**—

(A) The heading of section 6056 of such Code, as added by section 1514, is amended by striking “**LARGE**” and inserting “**CERTAIN**”.

(B) Section 6056(b)(2)(C) of such Code is amended—

(i) by inserting “in the case of an applicable large employer,” before “the length” in clause (i);

(ii) by striking “and” at the end of clause (iii);

(iii) by striking “applicable large employer” in clause (iv) and inserting “employer”;

(iv) by inserting “and” at the end of clause (iv); and

(v) by inserting at the end the following new clause:

“(v) in the case of an offering employer, the option for which the employer pays the largest portion of the cost of the plan and the portion of the cost paid by the employer in each of the enrollment categories under such option.”.

(C) Section 6056(d)(2) of such Code is amended by inserting “or offering employer” after “applicable large employer”.

(D) Section 6056(e) of such Code is amended by inserting “or offering employer” after “applicable large employer”.

(E) Section 6724(d)(1)(B)(xv) of such Code, as added by section 1514, is amended by striking “large” and inserting “certain”.

(F) Section 6724(d)(2)(HH) of such Code, as added by section 1514, is amended by striking “large” and inserting “certain”.

(G) The table of sections for subpart D of part III of subchapter A of chapter 1 of such Code, as amended by section 1514, is amended by striking “Large employers” in the item relating to section 6056 and inserting “Certain employers”.

(4) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply to periods beginning after December 31, 2013.

SEC. 10109. DEVELOPMENT OF STANDARDS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.

(a) **ADDITIONAL TRANSACTION STANDARDS AND OPERATING RULES.**—

(1) **DEVELOPMENT OF ADDITIONAL TRANSACTION STANDARDS AND OPERATING RULES.**—Section 1173(a) of the Social Security Act (42 U.S.C. 1320d–2(a)), as amended by section 1104(b)(2), is amended—

(A) in paragraph (1)(B), by inserting before the period the following: “, and subject to the requirements under paragraph (5)”;

(B) by adding at the end the following new paragraph:

“(5) **CONSIDERATION OF STANDARDIZATION OF ACTIVITIES AND ITEMS.**—

“(A) **IN GENERAL.**—For purposes of carrying out paragraph (1)(B), the Secretary shall solicit, not later than January 1, 2012, and not less than every 3 years thereafter, input from entities described in subparagraph (B) on—

“(i) whether there could be greater uniformity in financial and administrative activities and items, as determined appropriate by the Secretary; and

“(ii) whether such activities should be considered financial and administrative transactions (as described in paragraph (1)(B)) for which the adoption of standards and operating rules would improve the operation of the health care system and reduce administrative costs.

“(B) **SOLICITATION OF INPUT.**—For purposes of subparagraph (A), the Secretary shall seek input from—

“(i) the National Committee on Vital and Health Statistics, the Health Information Technology Policy Committee, and the Health Information Technology Standards Committee; and

“(ii) standard setting organizations and stakeholders, as determined appropriate by the Secretary.”.

(b) **ACTIVITIES AND ITEMS FOR INITIAL CONSIDERATION.**—For purposes of section 1173(a)(5) of the Social Security Act, as added by subsection (a), the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall, not later than January 1, 2012, seek input on activities and items relating to the following areas:

(1) Whether the application process, including the use of a uniform application form, for enrollment of health care providers by health plans could be made electronic and standardized.

(2) Whether standards and operating rules described in section 1173 of the Social Security Act should apply to the health care transactions of automobile insurance, worker’s compensation, and other programs or persons not described in section 1172(a) of such Act (42 U.S.C. 1320d–1(a)).

(3) Whether standardized forms could apply to financial audits required by health plans, Federal and State agencies (including State auditors, the Office of the Inspector General of the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services), and other relevant entities as determined appropriate by the Secretary.

(4) Whether there could be greater transparency and consistency of methodologies and processes used to establish claim edits used by health plans (as described in section 1171(f) of the Social Security Act (42 U.S.C. 1320d(5))).

(5) Whether health plans should be required to publish their timeliness of payment rules.

(c) **ICD CODING CROSSWALKS.**—

(1) **ICD–9 TO ICD–10 CROSSWALK.**—The Secretary shall task the ICD–9–CM Coordination and Maintenance Committee to convene a meet-

ing, not later than January 1, 2011, to receive input from appropriate stakeholders (including health plans, health care providers, and clinicians) regarding the crosswalk between the Ninth and Tenth Revisions of the International Classification of Diseases (ICD–9 and ICD–10, respectively) that is posted on the website of the Centers for Medicare & Medicaid Services, and make recommendations about appropriate revisions to such crosswalk.

(2) **REVISION OF CROSSWALK.**—For purposes of the crosswalk described in paragraph (1), the Secretary shall make appropriate revisions and post any such revised crosswalk on the website of the Centers for Medicare & Medicaid Services.

(3) **USE OF REVISED CROSSWALK.**—For purposes of paragraph (2), any revised crosswalk shall be treated as a code set for which a standard has been adopted by the Secretary for purposes of section 1173(c)(1)(B) of the Social Security Act (42 U.S.C. 1320d–2(c)(1)(B)).

(4) **SUBSEQUENT CROSSWALKS.**—For subsequent revisions of the International Classification of Diseases that are adopted by the Secretary as a standard code set under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)), the Secretary shall, after consultation with the appropriate stakeholders, post on the website of the Centers for Medicare & Medicaid Services a crosswalk between the previous and subsequent version of the International Classification of Diseases not later than the date of implementation of such subsequent revision.

Subtitle B—Provisions Relating to Title II

PART I—MEDICAID AND CHIP

SEC. 10201. AMENDMENTS TO THE SOCIAL SECURITY ACT AND TITLE II OF THIS ACT.

(a)(1) Section 1902(a)(10)(A)(i)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IX)), as added by section 2004(a), is amended to read as follows:

“(IX) who—

“(aa) are under 26 years of age;

“(bb) are not described in or enrolled under any of subclauses (I) through (VII) of this clause or are described in any of such subclauses but have income that exceeds the level of income applicable under the State plan for eligibility to enroll for medical assistance under such subclause;

“(cc) were in foster care under the responsibility of the State on the date of attaining 18 years of age or such higher age as the State has elected under section 475(8)(B)(iii); and

“(dd) were enrolled in the State plan under this title or under a waiver of the plan while in such foster care.”.

(2) Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)), as amended by section 2001(a)(5)(A), is amended in the matter following subparagraph (G), by striking “and (XV)” and inserting “(XV)”, and by inserting “and (XVI) if an individual is described in subclause (IX) of subparagraph (A)(i) and is also described in subclause (VIII) of that subparagraph, the medical assistance shall be made available to the individual through subclause (IX) instead of through subclause (VIII)” before the semicolon.

(3) Section 2004(d) of this Act is amended by striking “2019” and inserting “2014”.

(b) Section 1902(k)(2) of the Social Security Act (42 U.S.C. 1396a(k)(2)), as added by section 2001(a)(4)(A), is amended by striking “January 1, 2011” and inserting “April 1, 2010”.

(c) Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3), 2001(a)(5)(C), 2006, and 4107(a)(2), is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by inserting in clause (xiv), “or 1902(a)(10)(A)(i)(IX)” before the comma;

(2) in subsection (b), in the first sentence, by inserting “, (z),” before “and (aa)”;

(3) in subsection (y)—

(A) in paragraph (1)(B)(ii)(II), in the first sentence, by inserting “includes inpatient hospital services,” after “100 percent of the poverty line, that”; and

(B) in paragraph (2)(A), by striking “on the date of enactment of the Patient Protection and Affordable Care Act” and inserting “as of December 1, 2009”;

(4) by inserting after subsection (y) the following:

“(z) **EQUITABLE SUPPORT FOR CERTAIN STATES.**—

“(1)(A) During the period that begins on January 1, 2014, and ends on September 30, 2019, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to a fiscal year occurring during that period shall be increased by 2.2 percentage points for any State described in subparagraph (B) for amounts expended for medical assistance for individuals who are not newly eligible (as defined in subsection (y)(2)) individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).

“(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

“(i) is an expansion State described in subsection (y)(1)(B)(ii)(II);

“(ii) the Secretary determines will not receive any payments under this title on the basis of an increased Federal medical assistance percentage under subsection (y) for expenditures for medical assistance for newly eligible individuals (as so defined); and

“(iii) has not been approved by the Secretary to divert a portion of the DSH allotment for a State to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.

“(2)(A) During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to all or any portion of a fiscal year occurring during that period shall be increased by .5 percentage point for a State described in subparagraph (B) for amounts expended for medical assistance under the State plan under this title or under a waiver of that plan during that period.

“(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

“(i) is described in clauses (i) and (ii) of paragraph (1)(B); and

“(ii) is the State with the highest percentage of its population insured during 2008, based on the Current Population Survey.

“(3) Notwithstanding subsection (b) and paragraphs (1) and (2) of this subsection, the Federal medical assistance percentage otherwise determined under subsection (b) with respect to all or any portion of a fiscal year that begins on or after January 1, 2017, for the State of Nebraska, with respect to amounts expended for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be determined as provided for under subsection (y)(1)(A) (notwithstanding the period provided for in such paragraph).

“(4) The increase in the Federal medical assistance percentage for a State under paragraphs (1), (2), or (3) shall apply only for purposes of this title and shall not apply with respect to—

“(A) disproportionate share hospital payments described in section 1923;

“(B) payments under title IV;

“(C) payments under title XXI; and

“(D) payments under this title that are based on the enhanced FMAP described in section 2105(b).”;

(5) in subsection (aa), is amended by striking “without regard to this subsection and subsection (y)” and inserting “without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act” each place it appears;

(6) by adding after subsection (bb), the following:

“(cc) **REQUIREMENT FOR CERTAIN STATES.**—Notwithstanding subsections (y), (z), and (aa), in the case of a State that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures required under the State plan under section 1902(a)(2), the State shall not be eligible for an increase in its Federal medical assistance percentage under such subsections if it requires that political subdivisions pay a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1923, than the respective percentages that would have been required by the State under the State plan under this title, State law, or both, as in effect on December 31, 2009, and without regard to any such increase. Voluntary contributions by a political subdivision to the non-Federal share of expenditures under the State plan under this title or to the non-Federal share of payments under section 1923, shall not be considered to be required contributions for purposes of this subsection. The treatment of voluntary contributions, and the treatment of contributions required by a State under the State plan under this title, or State law, as provided by this subsection, shall also apply to the increases in the Federal medical assistance percentage under section 5001 of the American Recovery and Reinvestment Act of 2009.”

(d) Section 1108(g)(4)(B) of the Social Security Act (42 U.S.C. 1308(g)(4)(B)), as added by section 2005(b), is amended by striking “income eligibility level in effect for that population under title XIX or under a waiver” and inserting “the highest income eligibility level in effect for parents under the commonwealth’s or territory’s State plan under title XIX or under a waiver of the plan”.

(e)(1) Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)), as amended by section 2551, is amended—

(A) in paragraph (6)—

(i) by striking the paragraph heading and inserting the following: “ALLOTMENT ADJUSTMENTS”; and

(ii) in subparagraph (B), by adding at the end the following:

“(iii) **ALLOTMENT FOR 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012, FISCAL YEAR 2013, AND SUCCEEDING FISCAL YEARS.**—Notwithstanding the table set forth in paragraph (2) or paragraph (7):

“(I) 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012.—The DSH allotment for Hawaii for the 2d, 3rd, and 4th quarters of fiscal year 2012 shall be \$7,500,000.

“(II) **TREATMENT AS A LOW-DSH STATE FOR FISCAL YEAR 2013 AND SUCCEEDING FISCAL YEARS.**—With respect to fiscal year 2013, and each fiscal year thereafter, the DSH allotment for Hawaii shall be increased in the same manner as allotments for low DSH States are increased for such fiscal year under clause (iii) of paragraph (5)(B).

“(III) **CERTAIN HOSPITAL PAYMENTS.**—The Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST section 1115 Demonstration Project except to the extent that such limitation is necessary to ensure that a hospital does not receive payments in excess of the amounts described in subsection (g), or as necessary to ensure that such payments under the waiver and such payments pursuant to the allotment provided in this

clause do not, in the aggregate in any year, exceed the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project.”; and

(B) in paragraph (7)—

(i) in subparagraph (A), in the matter preceding clause (i), by striking “subparagraph (E)” and inserting “subparagraphs (E) and (G)”; and

(ii) in subparagraph (B)—

(I) in clause (i), by striking subclauses (I) and (II), and inserting the following:

“(I) if the State is a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 25 percent;

“(II) if the State is a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 17.5 percent;

“(III) if the State is not a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 50 percent; and

“(IV) if the State is not a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 35 percent.”;

(II) in clause (ii), by striking subclauses (I) and (II), and inserting the following:

“(I) if the State is a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 27.5 percent;

“(II) if the State is a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 20 percent;

“(III) if the State is not a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 55 percent; and

“(IV) if the State is not a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 40 percent.”;

(III) in subparagraph (E), by striking “35 percent” and inserting “50 percent”; and

(IV) by adding at the end the following:

“(G) **NONAPPLICATION.**—The preceding provisions of this paragraph shall not apply to the

DSH allotment determined for the State of Hawaii for a fiscal year under paragraph (6).”.

(f) Section 2551 of this Act is amended by striking subsection (b).

(g) Section 2105(d)(3)(B) of the Social Security Act (42 U.S.C. 1397ee(d)(3)(B)), as added by section 2101(b)(1), is amended by adding at the end the following: “For purposes of eligibility for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 and reduced cost-sharing under section 1402 of the Patient Protection and Affordable Care Act, children described in the preceding sentence shall be deemed to be ineligible for coverage under the State child health plan.”.

(h) Clause (i) of subparagraph (C) of section 513(b)(2) of the Social Security Act, as added by section 2953 of this Act, is amended to read as follows:

“(i) Healthy relationships, including marriage and family interactions.”.

(i) Section 1115 of the Social Security Act (42 U.S.C. 1315) is amended by inserting after subsection (c) the following:

“(d)(1) An application or renewal of any experimental, pilot, or demonstration project undertaken under subsection (a) to promote the objectives of title XIX or XXI in a State that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to a State program under title XIX or XXI (in this subsection referred to as a ‘demonstration project’) shall be considered by the Secretary in accordance with the regulations required to be promulgated under paragraph (2).

“(2) Not later than 180 days after the date of enactment of this subsection, the Secretary shall promulgate regulations relating to applications for, and renewals of, a demonstration project that provide for—

“(A) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

“(B) requirements relating to—

“(i) the goals of the program to be implemented or renewed under the demonstration project;

“(ii) the expected State and Federal costs and coverage projections of the demonstration project; and

“(iii) the specific plans of the State to ensure that the demonstration project will be in compliance with title XIX or XXI;

“(C) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input;

“(D) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the demonstration project; and

“(E) a process for the periodic evaluation by the Secretary of the demonstration project.

“(3) The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for demonstration projects under this section.”.

(j) Subtitle F of title III of this Act is amended by adding at the end the following:

“SEC. 3512. GAO STUDY AND REPORT ON CAUSES OF ACTION.

“(a) STUDY.—

“(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of whether the development, recognition, or implementation of any guideline or other standards under a provision described in paragraph (2) would result in the establishment of a new cause of action or claim.

“(2) PROVISIONS DESCRIBED.—The provisions described in this paragraph include the following:

“(A) Section 2701 (adult health quality measures).

“(B) Section 2702 (payment adjustments for health care acquired conditions).

“(C) Section 3001 (Hospital Value-Based Purchase Program).

“(D) Section 3002 (improvements to the Physician Quality Reporting Initiative).

“(E) Section 3003 (improvements to the Physician Feedback Program).

“(F) Section 3007 (value based payment modifier under physician fee schedule).

“(G) Section 3008 (payment adjustment for conditions acquired in hospitals).

“(H) Section 3013 (quality measure development).

“(I) Section 3014 (quality measurement).

“(J) Section 3021 (Establishment of Center for Medicare and Medicaid Innovation).

“(K) Section 3025 (hospital readmission reduction program).

“(L) Section 3501 (health care delivery system research, quality improvement).

“(M) Section 4003 (Task Force on Clinical and Preventive Services).

“(N) Section 4301 (research to optimize delivery of public health services).

“(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General of the United States shall submit to the appropriate committees of Congress, a report containing the findings made by the Comptroller General under the study under subsection (a).”.

SEC. 10202. INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES.

(a) STATE BALANCING INCENTIVE PAYMENTS PROGRAM.—Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), in the case of a balancing incentive payment State, as defined in subsection (b), that meets the conditions described in subsection (c), during the balancing incentive period, the Federal medical assistance percentage determined for the State under section 1905(b) of such Act and, if applicable, increased under subsection (2) or (aa) shall be increased by the applicable percentage points determined under subsection (d) with respect to eligible medical assistance expenditures described in subsection (e).

(b) BALANCING INCENTIVE PAYMENT STATE.—A balancing incentive payment State is a State—

(1) in which less than 50 percent of the total expenditures for medical assistance under the State Medicaid program for a fiscal year for long-term services and supports (as defined by the Secretary under subsection (f)(1)(B)) are for non-institutionally-based long-term services and supports described in subsection (f)(1)(B);

(2) that submits an application and meets the conditions described in subsection (c); and

(3) that is selected by the Secretary to participate in the State balancing incentive payment program established under this section.

(c) CONDITIONS.—The conditions described in this subsection are the following:

(1) APPLICATION.—The State submits an application to the Secretary that includes, in addition to such other information as the Secretary shall require—

(A) a proposed budget that details the State’s plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program during the balancing incentive period and achieve the target spending percentage applicable to the State under paragraph (2), including through structural changes to how the State furnishes such assistance, such as through the establishment of a “no wrong door—single entry point system”, optional presumptive eligibility, case management services, and the use of core standardized assessment instruments, and that includes a de-

scription of the new or expanded offerings of such services that the State will provide and the projected costs of such services; and

(B) in the case of a State that proposes to expand the provision of home and community-based services under its State Medicaid program through a State plan amendment under section 1915(i) of the Social Security Act, at the option of the State, an election to increase the income eligibility for such services from 150 percent of the poverty line to such higher percentage as the State may establish for such purpose, not to exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1) of the Social Security Act (42 U.S.C. 1382(b)(1)).

(2) TARGET SPENDING PERCENTAGES.—

(A) In the case of a balancing incentive payment State in which less than 25 percent of the total expenditures for long-term services and supports under the State Medicaid program for fiscal year 2009 are for home and community-based services, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 25 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.

(B) In the case of any other balancing incentive payment State, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 50 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.

(3) MAINTENANCE OF ELIGIBILITY REQUIREMENTS.—The State does not apply eligibility standards, methodologies, or procedures for determining eligibility for medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program that are more restrictive than the eligibility standards, methodologies, or procedures in effect for such purposes on December 31, 2010.

(4) USE OF ADDITIONAL FUNDS.—The State agrees to use the additional Federal funds paid to the State as a result of this section only for purposes of providing new or expanded offerings of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program.

(5) STRUCTURAL CHANGES.—The State agrees to make, not later than the end of the 6-month period that begins on the date the State submits an application under this section, the following changes:

(A) “NO WRONG DOOR—SINGLE ENTRY POINT SYSTEM”.—Development of a statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that shall provide information regarding the availability of such services, how to apply for such services, referral services for services and supports otherwise available in the community, and determinations of financial and functional eligibility for such services and supports, or assistance with assessment processes for financial and functional eligibility.

(B) CONFLICT-FREE CASE MANAGEMENT SERVICES.—Conflict-free case management services to develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary’s caregivers) in directing the provision of services and supports for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary’s needs and achieve intended outcomes.

(C) CORE STANDARDIZED ASSESSMENT INSTRUMENTS.—Development of core standardized assessment instruments for determining eligibility

for non-institutionally-based long-term services and supports described in subsection (f)(1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs.

(6) **DATA COLLECTION.**—The State agrees to collect from providers of services and through such other means as the State determines appropriate the following data:

(A) **SERVICES DATA.**—Services data from providers of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) on a per-beneficiary basis and in accordance with such standardized coding procedures as the State shall establish in consultation with the Secretary.

(B) **QUALITY DATA.**—Quality data on a selected set of core quality measures agreed upon by the Secretary and the State that are linked to population-specific outcomes measures and accessible to providers.

(C) **OUTCOMES MEASURES.**—Outcomes measures data on a selected set of core population-specific outcomes measures agreed upon by the Secretary and the State that are accessible to providers and include—

(i) measures of beneficiary and family caregiver experience with providers;

(ii) measures of beneficiary and family caregiver satisfaction with services; and

(iii) measures for achieving desired outcomes appropriate to a specific beneficiary, including employment, participation in community life, health stability, and prevention of loss in function.

(d) **APPLICABLE PERCENTAGE POINTS INCREASE IN FMAP.**—The applicable percentage points increase is—

(1) in the case of a balancing incentive payment State subject to the target spending percentage described in subsection (c)(2)(A), 5 percentage points; and

(2) in the case of any other balancing incentive payment State, 2 percentage points.

(e) **ELIGIBLE MEDICAL ASSISTANCE EXPENDITURES.**—

(1) **IN GENERAL.**—Subject to paragraph (2), medical assistance described in this subsection is medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) that is provided by a balancing incentive payment State under its State Medicaid program during the balancing incentive payment period.

(2) **LIMITATION ON PAYMENTS.**—In no case may the aggregate amount of payments made by the Secretary to balancing incentive payment States under this section during the balancing incentive period exceed \$3,000,000,000.

(f) **DEFINITIONS.**—In this section:

(1) **LONG-TERM SERVICES AND SUPPORTS DEFINED.**—The term “long-term services and supports” has the meaning given that term by Secretary and may include any of the following (as defined for purposes of State Medicaid programs):

(A) **INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.**—Services provided in an institution, including the following:

(i) Nursing facility services.

(ii) Services in an intermediate care facility for the mentally retarded described in subsection (a)(15) of section 1905 of such Act.

(B) **NON-INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.**—Services not provided in an institution, including the following:

(i) Home and community-based services provided under subsection (c), (d), or (i) of section 1915 of such Act or under a waiver under section 1115 of such Act.

(ii) Home health care services.

(iii) Personal care services.

(iv) Services described in subsection (a)(26) of section 1905 of such Act (relating to PACE program services).

(v) Self-directed personal assistance services described in section 1915(j) of such Act.

(2) **BALANCING INCENTIVE PERIOD.**—The term “balancing incentive period” means the period that begins on October 1, 2011, and ends on September 30, 2015.

(3) **POVERTY LINE.**—The term “poverty line” has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397j(c)(5)).

(4) **STATE MEDICAID PROGRAM.**—The term “State Medicaid program” means the State program for medical assistance provided under a State plan under title XIX of the Social Security Act and under any waiver approved with respect to such State plan.

SEC. 10203. EXTENSION OF FUNDING FOR CHIP THROUGH FISCAL YEAR 2015 AND OTHER CHIP-RELATED PROVISIONS.

(a) Section 1311(c)(1) of this Act is amended by striking “and” at the end of subparagraph (G), by striking the period at the end of subparagraph (H) and inserting “; and”, and by adding at the end the following:

“(I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act.”.

(b) Effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3):

(1) Section 1906(e)(2) of the Social Security Act (42 U.S.C. 1396e(e)(2)) is amended by striking “means” and all that follows through the period and inserting “has the meaning given that term in section 2105(c)(3)(A).”.

(2)(A) Section 1906A(a) of the Social Security Act (42 U.S.C. 1396e-1(a)), is amended by inserting before the period the following: “and the offering of such a subsidy is cost-effective, as defined for purposes of section 2105(c)(3)(A).”.

(B) This Act shall be applied without regard to subparagraph (A) of section 2003(a)(1) of this Act and that subparagraph and the amendment made by that subparagraph are hereby deemed null, void, and of no effect.

(3) Section 2105(c)(10) of the Social Security Act (42 U.S.C. 1397ee(c)(10)) is amended—

(A) in subparagraph (A), in the first sentence, by inserting before the period the following: “if the offering of such a subsidy is cost-effective, as defined for purposes of paragraph (3)(A)”;

(B) by striking subparagraph (M); and

(C) by redesignating subparagraph (N) as subparagraph (M).

(4) Section 2105(c)(3)(A) of the Social Security Act (42 U.S.C. 1397ee(c)(3)(A)) is amended—

(A) in the matter preceding clause (i), by striking “to” and inserting “to—”; and

(B) in clause (ii), by striking the period and inserting a semicolon.

(c) Section 2105 of the Social Security Act (42 U.S.C. 1397ee), as amended by section 2101, is amended—

(1) in subsection (b), in the second sentence, by striking “2013” and inserting “2015”; and

(2) in subsection (d)(3)—

(A) in subparagraph (A)—

(i) in the first sentence, by inserting “as a condition of receiving payments under section 1903(a),” after “2019.”;

(ii) in clause (i), by striking “or” at the end;

(iii) by redesignating clause (ii) as clause (iii); and

(iv) by inserting after clause (i), the following:

“(ii) after September 30, 2015, enrolling children eligible to be targeted low-income children under the State child health plan in a qualified

health plan that has been certified by the Secretary under subparagraph (C); or”;

(B) in subparagraph (B), by striking “provided coverage” and inserting “screened for eligibility for medical assistance under the State plan under title XIX or a waiver of that plan and, if found eligible, enrolled in such plan or a waiver. In the case of such children who, as a result of such screening, are determined to not be eligible for medical assistance under the State plan or a waiver under title XIX, the State shall establish procedures to ensure that the children are enrolled in a qualified health plan that has been certified by the Secretary under subparagraph (C) and is offered”; and

(C) by adding at the end the following:

“(C) **CERTIFICATION OF COMPARABILITY OF PEDIATRIC COVERAGE OFFERED BY QUALIFIED HEALTH PLANS.**—With respect to each State, the Secretary, not later than April 1, 2015, shall review the benefits offered for children and the cost-sharing imposed with respect to such benefits by qualified health plans offered through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act and shall certify those plans that offer benefits for children and impose cost-sharing with respect to such benefits that the Secretary determines are at least comparable to the benefits offered and cost-sharing protections provided under the State child health plan.”.

(d)(1) Section 2104(a) of such Act (42 U.S.C. 1397dd(a)) is amended—

(A) in paragraph (15), by striking “and” at the end; and

(B) by striking paragraph (16) and inserting the following:

“(16) for fiscal year 2013, \$17,406,000,000;

“(17) for fiscal year 2014, \$19,147,000,000; and

“(18) for fiscal year 2015, for purposes of making 2 semi-annual allotments—

“(A) \$2,850,000,000 for the period beginning on October 1, 2014, and ending on March 31, 2015, and

“(B) \$2,850,000,000 for the period beginning on April 1, 2015, and ending on September 30, 2015.”.

(2)(A) Section 2104(m) of such Act (42 U.S.C. 1397dd(m)), as amended by section 2102(a)(1), is amended—

(i) in the subsection heading, by striking “2013” and inserting “2015”;

(ii) in paragraph (2)—

(I) in the paragraph heading, by striking “2012” and inserting “2014”; and

(II) by adding at the end the following:

“(B) **FISCAL YEARS 2013 AND 2014.**—Subject to paragraphs (4) and (6), from the amount made available under paragraphs (16) and (17) of subsection (a) for fiscal years 2013 and 2014, respectively, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for each such fiscal year as follows:

“(i) **REBASING IN FISCAL YEAR 2013.**—For fiscal year 2013, the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2012 (including payments made to the State under subsection (n) for fiscal year 2012 as well as amounts redistributed to the State in fiscal year 2012), multiplied by the allotment increase factor under paragraph (5) for fiscal year 2013.

“(ii) **GROWTH FACTOR UPDATE FOR FISCAL YEAR 2014.**—For fiscal year 2014, the allotment of the State is equal to the sum of—

“(I) the amount of the State allotment under clause (i) for fiscal year 2013; and

“(II) the amount of any payments made to the State under subsection (n) for fiscal year 2013, multiplied by the allotment increase factor under paragraph (5) for fiscal year 2014.”;

(iii) in paragraph (3)—
(I) in the paragraph heading, by striking “2013” and inserting “2015”;

(II) in subparagraphs (A) and (B), by striking “paragraph (16)” each place it appears and inserting “paragraph (18)”;

(III) in subparagraph (C)—
(aa) by striking “2012” each place it appears and inserting “2014”; and

(bb) by striking “2013” and inserting “2015”; and

(IV) in subparagraph (D)—
(aa) in clause (i)(I), by striking “subsection (a)(16)(A)” and inserting “subsection (a)(18)(A)”; and

(bb) in clause (ii)(II), by striking “subsection (a)(16)(B)” and inserting “subsection (a)(18)(B)”;

(iv) in paragraph (4), by striking “2013” and inserting “2015”;

(v) in paragraph (6)—
(I) in subparagraph (A), by striking “2013” and inserting “2015”; and

(II) in the flush language after and below subparagraph (B)(ii), by striking “or fiscal year 2012” and inserting “, fiscal year 2012, or fiscal year 2014”; and

(vi) in paragraph (8)—
(I) in the paragraph heading, by striking “2013” and inserting “2015”; and

(II) by striking “2013” and inserting “2015”.

(B) Section 2104(n) of such Act (42 U.S.C. 1397dd(n)) is amended—

(i) in paragraph (2)—

(I) in subparagraph (A)(ii)—

(aa) by striking “2012” and inserting “2014”; and

(bb) by striking “2013” and inserting “2015”;

(II) in subparagraph (B)—

(aa) by striking “2012” and inserting “2014”; and

(bb) by striking “2013” and inserting “2015”; and

(ii) in paragraph (3)(A), by striking “or a semi-annual allotment period for fiscal year 2013” and inserting “fiscal year 2013, fiscal year 2014, or a semi-annual allotment period for fiscal year 2015”.

(C) Section 2105(g)(4) of such Act (42 U.S.C. 1397ee(g)(4)) is amended—

(i) in the paragraph heading, by striking “2013” and inserting “2015”; and

(ii) in subparagraph (A), by striking “2013” and inserting “2015”.

(D) Section 2110(b) of such Act (42 U.S.C. 1397jj(b)) is amended—

(i) in paragraph (2)(B), by inserting “except as provided in paragraph (6),” before “a child”; and

(ii) by adding at the end the following new paragraph:

“(6) EXCEPTIONS TO EXCLUSION OF CHILDREN OF EMPLOYEES OF A PUBLIC AGENCY IN THE STATE.—

“(A) IN GENERAL.—A child shall not be considered to be described in paragraph (2)(B) if—

“(i) the public agency that employs a member of the child’s family to which such paragraph applies satisfies subparagraph (B); or

“(ii) subparagraph (C) applies to such child.

“(B) MAINTENANCE OF EFFORT WITH RESPECT TO PER PERSON AGENCY CONTRIBUTION FOR FAMILY COVERAGE.—For purposes of subparagraph (A)(i), a public agency satisfies this subparagraph if the amount of annual agency expenditures made on behalf of each employee enrolled in health coverage paid for by the agency that includes dependent coverage for the most recent State fiscal year is not less than the amount of such expenditures made by the agency for the 1997 State fiscal year, increased by the percentage increase in the medical care expenditure category of the Consumer Price Index for All-Urban Consumers (all items: U.S. City Average) for such preceding fiscal year.

“(C) HARDSHIP EXCEPTION.—For purposes of subparagraph (A)(ii), this subparagraph applies to a child if the State determines, on a case-by-case basis, that the annual aggregate amount of premiums and cost-sharing imposed for coverage of the family of the child would exceed 5 percent of such family’s income for the year involved.”.

(E) Section 2113 of such Act (42 U.S.C. 1397mm) is amended—

(i) in subsection (a)(1), by striking “2013” and inserting “2015”; and

(ii) in subsection (g), by striking “\$100,000,000 for the period of fiscal years 2009 through 2013” and inserting “\$140,000,000 for the period of fiscal years 2009 through 2015”.

(F) Section 108 of Public Law 111–3 is amended by striking “\$11,706,000,000” and all that follows through the second sentence and inserting “\$15,361,000,000 to accompany the allotment made for the period beginning on October 1, 2014, and ending on March 31, 2015, under section 2104(a)(18)(A) of the Social Security Act (42 U.S.C. 1397dd(a)(18)(A)), to remain available until expended. Such amount shall be used to provide allotments to States under paragraph (3) of section 2104(m) of the Social Security Act (42 U.S.C. 1397dd(m)) for the first 6 months of fiscal year 2015 in the same manner as allotments are provided under subsection (a)(18)(A) of such section 2104 and subject to the same terms and conditions as apply to the allotments provided from such subsection (a)(18)(A).”.

PART II—SUPPORT FOR PREGNANT AND PARENTING TEENS AND WOMEN

SEC. 10211. DEFINITIONS.

In this part:

(1) ACCOMPANIMENT.—The term “accompaniment” means assisting, representing, and accompanying a woman in seeking judicial relief for child support, child custody, restraining orders, and restitution for harm to persons and property, and in filing criminal charges, and may include the payment of court costs and reasonable attorney and witness fees associated therewith.

(2) ELIGIBLE INSTITUTION OF HIGHER EDUCATION.—The term “eligible institution of higher education” means an institution of higher education (as such term is defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001)) that has established and operates, or agrees to establish and operate upon the receipt of a grant under this part, a pregnant and parenting student services office.

(3) COMMUNITY SERVICE CENTER.—The term “community service center” means a non-profit organization that provides social services to residents of a specific geographical area via direct service or by contract with a local governmental agency.

(4) HIGH SCHOOL.—The term “high school” means any public or private school that operates grades 10 through 12, inclusive, grades 9 through 12, inclusive or grades 7 through 12, inclusive.

(5) INTERVENTION SERVICES.—The term “intervention services” means, with respect to domestic violence, sexual violence, sexual assault, or stalking, 24-hour telephone hotline services for police protection and referral to shelters.

(6) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(7) STATE.—The term “State” includes the District of Columbia, any commonwealth, possession, or other territory of the United States, and any Indian tribe or reservation.

(8) SUPPORTIVE SOCIAL SERVICES.—The term “supportive social services” means transitional and permanent housing, vocational counseling, and individual and group counseling aimed at preventing domestic violence, sexual violence, sexual assault, or stalking.

(9) VIOLENCE.—The term “violence” means actual violence and the risk or threat of violence.

SEC. 10212. ESTABLISHMENT OF PREGNANCY ASSISTANCE FUND.

(a) IN GENERAL.—The Secretary, in collaboration and coordination with the Secretary of Education (as appropriate), shall establish a Pregnancy Assistance Fund to be administered by the Secretary, for the purpose of awarding competitive grants to States to assist pregnant and parenting teens and women.

(b) USE OF FUND.—A State may apply for a grant under subsection (a) to carry out any activities provided for in section 10213.

(c) APPLICATIONS.—To be eligible to receive a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the purposes for which the grant is being requested and the designation of a State agency for receipt and administration of funding received under this part.

SEC. 10213. PERMISSIBLE USES OF FUND.

(a) IN GENERAL.—A State shall use amounts received under a grant under section 10212 for the purposes described in this section to assist pregnant and parenting teens and women.

(b) INSTITUTIONS OF HIGHER EDUCATION.—

(1) IN GENERAL.—A State may use amounts received under a grant under section 10212 to make funding available to eligible institutions of higher education to enable the eligible institutions to establish, maintain, or operate pregnant and parenting student services. Such funding shall be used to supplement, not supplant, existing funding for such services.

(2) APPLICATION.—An eligible institution of higher education that desires to receive funding under this subsection shall submit an application to the designated State agency at such time, in such manner, and containing such information as the State agency may require.

(3) MATCHING REQUIREMENT.—An eligible institution of higher education that receives funding under this subsection shall contribute to the conduct of the pregnant and parenting student services office supported by the funding an amount from non-Federal funds equal to 25 percent of the amount of the funding provided. The non-Federal share may be in cash or in-kind, fairly evaluated, including services, facilities, supplies, or equipment.

(4) USE OF FUNDS FOR ASSISTING PREGNANT AND PARENTING COLLEGE STUDENTS.—An eligible institution of higher education that receives funding under this subsection shall use such funds to establish, maintain or operate pregnant and parenting student services and may use such funding for the following programs and activities:

(A) Conduct a needs assessment on campus and within the local community—

(i) to assess pregnancy and parenting resources, located on the campus or within the local community, that are available to meet the needs described in subparagraph (B); and

(ii) to set goals for—

(I) improving such resources for pregnant, parenting, and prospective parenting students; and

(II) improving access to such resources.

(B) Annually assess the performance of the eligible institution in meeting the following needs of students enrolled in the eligible institution who are pregnant or are parents:

(i) The inclusion of maternity coverage and the availability of riders for additional family members in student health care.

(ii) Family housing.

(iii) Child care.

(iv) Flexible or alternative academic scheduling, such as telecommuting programs, to enable pregnant or parenting students to continue their education or stay in school.

(v) Education to improve parenting skills for mothers and fathers and to strengthen marriages.

(vi) Maternity and baby clothing, baby food (including formula), baby furniture, and similar items to assist parents and prospective parents in meeting the material needs of their children.

(vii) Post-partum counseling.

(C) Identify public and private service providers, located on the campus of the eligible institution or within the local community, that are qualified to meet the needs described in subparagraph (B), and establishes programs with qualified providers to meet such needs.

(D) Assist pregnant and parenting students, fathers or spouses in locating and obtaining services that meet the needs described in subparagraph (B).

(E) If appropriate, provide referrals for prenatal care and delivery, infant or foster care, or adoption, to a student who requests such information. An office shall make such referrals only to service providers that serve the following types of individuals:

(i) Parents.

(ii) Prospective parents awaiting adoption.

(iii) Women who are pregnant and plan on parenting or placing the child for adoption.

(iv) Parenting or prospective parenting couples.

(5) REPORTING.—

(A) ANNUAL REPORT BY INSTITUTIONS.—

(i) IN GENERAL.—For each fiscal year that an eligible institution of higher education receives funds under this subsection, the eligible institution shall prepare and submit to the State, by the date determined by the State, a report that—

(I) itemizes the pregnant and parenting student services office's expenditures for the fiscal year;

(II) contains a review and evaluation of the performance of the office in fulfilling the requirements of this section, using the specific performance criteria or standards established under subparagraph (B)(i); and

(III) describes the achievement of the office in meeting the needs listed in paragraph (4)(B) of the students served by the eligible institution, and the frequency of use of the office by such students.

(ii) PERFORMANCE CRITERIA.—Not later than 180 days before the date the annual report described in clause (i) is submitted, the State—

(I) shall identify the specific performance criteria or standards that shall be used to prepare the report; and

(II) may establish the form or format of the report.

(B) REPORT BY STATE.—The State shall annually prepare and submit a report on the findings under this subsection, including the number of eligible institutions of higher education that were awarded funds and the number of students served by each pregnant and parenting student services office receiving funds under this section, to the Secretary.

(c) SUPPORT FOR PREGNANT AND PARENTING TEENS.—A State may use amounts received under a grant under section 10212 to make funding available to eligible high schools and community service centers to establish, maintain or operate pregnant and parenting services in the same general manner and in accordance with all conditions and requirements described in subsection (b), except that paragraph (3) of such subsection shall not apply for purposes of this subsection.

(d) IMPROVING SERVICES FOR PREGNANT WOMEN WHO ARE VICTIMS OF DOMESTIC VIOLENCE, SEXUAL VIOLENCE, SEXUAL ASSAULT, AND STALKING.—

(I) IN GENERAL.—A State may use amounts received under a grant under section 10212 to make funding available to its State Attorney General to assist Statewide offices in providing—

(A) intervention services, accompaniment, and supportive social services for eligible pregnant

women who are victims of domestic violence, sexual violence, sexual assault, or stalking.

(B) technical assistance and training (as described in subsection (c)) relating to violence against eligible pregnant women to be made available to the following:

(i) Federal, State, tribal, territorial, and local governments, law enforcement agencies, and courts.

(ii) Professionals working in legal, social service, and health care settings.

(iii) Nonprofit organizations.

(iv) Faith-based organizations.

(2) ELIGIBILITY.—To be eligible for a grant under paragraph (1), a State Attorney General shall submit an application to the designated State agency at such time, in such manner, and containing such information, as specified by the State.

(3) TECHNICAL ASSISTANCE AND TRAINING DESCRIBED.—For purposes of paragraph (1)(B), technical assistance and training is—

(A) the identification of eligible pregnant women experiencing domestic violence, sexual violence, sexual assault, or stalking;

(B) the assessment of the immediate and short-term safety of such a pregnant woman, the evaluation of the impact of the violence or stalking on the pregnant woman's health, and the assistance of the pregnant woman in developing a plan aimed at preventing further domestic violence, sexual violence, sexual assault, or stalking, as appropriate;

(C) the maintenance of complete medical or forensic records that include the documentation of any examination, treatment given, and referrals made, recording the location and nature of the pregnant woman's injuries, and the establishment of mechanisms to ensure the privacy and confidentiality of those medical records; and

(D) the identification and referral of the pregnant woman to appropriate public and private nonprofit entities that provide intervention services, accompaniment, and supportive social services.

(4) ELIGIBLE PREGNANT WOMAN.—In this subsection, the term "eligible pregnant woman" means any woman who is pregnant on the date on which such woman becomes a victim of domestic violence, sexual violence, sexual assault, or stalking or who was pregnant during the one-year period before such date.

(e) PUBLIC AWARENESS AND EDUCATION.—A State may use amounts received under a grant under section 10212 to make funding available to increase public awareness and education concerning any services available to pregnant and parenting teens and women under this part, or any other resources available to pregnant and parenting women in keeping with the intent and purposes of this part. The State shall be responsible for setting guidelines or limits as to how much of funding may be utilized for public awareness and education in any funding award.

SEC. 10214. APPROPRIATIONS.

There is authorized to be appropriated, and there are appropriated, \$25,000,000 for each of fiscal years 2010 through 2019, to carry out this part.

PART III—INDIAN HEALTH CARE IMPROVEMENT

SEC. 10221. INDIAN HEALTH CARE IMPROVEMENT.

(a) IN GENERAL.—Except as provided in subsection (b), S. 1790 entitled "A bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.", as reported by the Committee on Indian Affairs of the Senate in December 2009, is enacted into law.

(b) AMENDMENTS.—

(1) Section 119 of the Indian Health Care Improvement Act (as amended by section 111 of the bill referred to in subsection (a)) is amended—

(A) in subsection (d)—

(i) in paragraph (2), by striking "In establishing" and inserting "Subject to paragraphs (3) and (4), in establishing"; and

(ii) by adding at the end the following:

"(3) ELECTION OF INDIAN TRIBE OR TRIBAL ORGANIZATION.—

"(A) IN GENERAL.—Subparagraph (B) of paragraph (2) shall not apply in the case of an election made by an Indian tribe or tribal organization located in a State (other than Alaska) in which the use of dental health aide therapist services or midlevel dental health provider services is authorized under State law to supply such services in accordance with State law.

"(B) ACTION BY SECRETARY.—On an election by an Indian tribe or tribal organization under subparagraph (A), the Secretary, acting through the Service, shall facilitate implementation of the services elected.

"(4) VACANCIES.—The Secretary shall not fill any vacancy for a certified dentist in a program operated by the Service with a dental health aide therapist."; and

(B) by adding at the end the following:

"(e) EFFECT OF SECTION.—Nothing in this section shall restrict the ability of the Service, an Indian tribe, or a tribal organization to participate in any program or to provide any service authorized by any other Federal law."

(2) The Indian Health Care Improvement Act (as amended by section 134(b) of the bill referred to in subsection (a)) is amended by striking section 125 (relating to treatment of scholarships for certain purposes).

(3) Section 806 of the Indian Health Care Improvement Act (25 U.S.C. 1676) is amended—

(A) by striking "Any limitation" and inserting the following:

"(a) HHS APPROPRIATIONS.—Any limitation"; and

(B) by adding at the end the following:

"(b) LIMITATIONS PURSUANT TO OTHER FEDERAL LAW.—Any limitation pursuant to other Federal laws on the use of Federal funds appropriated to the Service shall apply with respect to the performance or coverage of abortions."

(4) The bill referred to in subsection (a) is amended by striking section 201.

Subtitle C—Provisions Relating to Title III

SEC. 10301. PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR AMBULATORY SURGICAL CENTERS.

(a) IN GENERAL.—Section 3006 is amended by adding at the end the following new subsection:

"(f) AMBULATORY SURGICAL CENTERS.—

"(I) IN GENERAL.—The Secretary shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for ambulatory surgical centers (as described in section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i))).

"(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

"(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A of such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in ambulatory surgical centers.

"(B) The reporting, collection, and validation of quality data.

"(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

"(D) Methods for the public disclosure of information on the performance of ambulatory surgical centers.

“(E) Any other issues determined appropriate by the Secretary.

“(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall—

“(A) consult with relevant affected parties; and

“(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

“(4) REPORT TO CONGRESS.—Not later than January 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).”.

(b) TECHNICAL.—Section 3006(a)(2)(A) is amended by striking clauses (i) and (ii).

SEC. 10302. REVISION TO NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE.

Section 399HH(a)(2)(B)(iii) of the Public Health Service Act, as added by section 3011, is amended by inserting “(taking into consideration the limitations set forth in subsections (c) and (d) of section 1182 of the Social Security Act)” after “information”.

SEC. 10303. DEVELOPMENT OF OUTCOME MEASURES.

(a) DEVELOPMENT.—Section 931 of the Public Health Service Act, as added by section 3013(a), is amended by adding at the end the following new subsection:

“(f) DEVELOPMENT OF OUTCOME MEASURES.—“(1) IN GENERAL.—The Secretary shall develop, and periodically update (not less than every 3 years), provider-level outcome measures for hospitals and physicians, as well as other providers as determined appropriate by the Secretary.

“(2) CATEGORIES OF MEASURES.—The measures developed under this subsection shall include, to the extent determined appropriate by the Secretary—

“(A) outcome measurement for acute and chronic diseases, including, to the extent feasible, the 5 most prevalent and resource-intensive acute and chronic medical conditions; and

“(B) outcome measurement for primary and preventative care, including, to the extent feasible, measurements that cover provision of such care for distinct patient populations (such as healthy children, chronically ill adults, or infirm elderly individuals).

“(3) GOALS.—In developing such measures, the Secretary shall seek to—

“(A) address issues regarding risk adjustment, accountability, and sample size;

“(B) include the full scope of services that comprise a cycle of care; and

“(C) include multiple dimensions.

“(4) TIMEFRAME.—

“(A) ACUTE AND CHRONIC DISEASES.—Not later than 24 months after the date of enactment of this Act, the Secretary shall develop not less than 10 measures described in paragraph (2)(A).

“(B) PRIMARY AND PREVENTIVE CARE.—Not later than 36 months after the date of enactment of this Act, the Secretary shall develop not less than 10 measures described in paragraph (2)(B).”.

(b) HOSPITAL-ACQUIRED CONDITIONS.—Section 1890A of the Social Security Act, as amended by section 3013(b), is amended by adding at the end the following new subsection:

“(f) HOSPITAL ACQUIRED CONDITIONS.—The Secretary shall, to the extent practicable, publicly report on measures for hospital-acquired conditions that are currently utilized by the Centers for Medicare & Medicaid Services for the adjustment of the amount of payment to hospitals based on rates of hospital-acquired infections.”.

(c) CLINICAL PRACTICE GUIDELINES.—Section 304(b) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law

110-275) is amended by adding at the end the following new paragraph:

“(4) IDENTIFICATION.—

“(A) IN GENERAL.—Following receipt of the report submitted under paragraph (2), and not less than every 3 years thereafter, the Secretary shall contract with the Institute to employ the results of the study performed under paragraph (1) and the best methods identified by the Institute for the purpose of identifying existing and new clinical practice guidelines that were developed using such best methods, including guidelines listed in the National Guideline Clearinghouse.

“(B) CONSULTATION.—In carrying out the identification process under subparagraph (A), the Secretary shall allow for consultation with professional societies, voluntary health care organizations, and expert panels.”.

SEC. 10304. SELECTION OF EFFICIENCY MEASURES.

Sections 1890(b)(7) and 1890A of the Social Security Act, as added by section 3014, are amended by striking “quality” each place it appears and inserting “quality and efficiency”.

SEC. 10305. DATA COLLECTION; PUBLIC REPORTING.

Section 399II(a) of the Public Health Service Act, as added by section 3015, is amended to read as follows:

“(a) IN GENERAL.—

“(1) ESTABLISHMENT OF STRATEGIC FRAMEWORK.—The Secretary shall establish and implement an overall strategic framework to carry out the public reporting of performance information, as described in section 399JJ. Such strategic framework may include methods and related timelines for implementing nationally consistent data collection, data aggregation, and analysis methods.

“(2) COLLECTION AND AGGREGATION OF DATA.—The Secretary shall collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery, and may award grants or contracts for this purpose. The Secretary shall align such collection and aggregation efforts with the requirements and assistance regarding the expansion of health information technology systems, the interoperability of such technology systems, and related standards that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

“(3) SCOPE.—The Secretary shall ensure that the data collection, data aggregation, and analysis systems described in paragraph (1) involve an increasingly broad range of patient populations, providers, and geographic areas over time.”.

SEC. 10306. IMPROVEMENTS UNDER THE CENTER FOR MEDICARE AND MEDICAID INNOVATION.

Section 1115A of the Social Security Act, as added by section 3021, is amended—

(1) in subsection (a), by inserting at the end the following new paragraph:

“(5) TESTING WITHIN CERTAIN GEOGRAPHIC AREAS.—For purposes of testing payment and service delivery models under this section, the Secretary may elect to limit testing of a model to certain geographic areas.”;

(2) in subsection (b)(2)—

(A) in subparagraph (A)—

(i) in the second sentence, by striking “the preceding sentence may include” and inserting “this subparagraph may include, but are not limited to,”; and

(ii) by inserting after the first sentence the following new sentence: “The Secretary shall focus on models expected to reduce program costs under the applicable title while preserving or enhancing the quality of care received by individuals receiving benefits under such title.”;

(B) in subparagraph (B), by adding at the end the following new clauses:

“(xix) Utilizing, in particular in entities located in medically underserved areas and facilities of the Indian Health Service (whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act)), telehealth services—

“(I) in treating behavioral health issues (such as post-traumatic stress disorder) and stroke; and

“(II) to improve the capacity of non-medical providers and non-specialized medical providers to provide health services for patients with chronic complex conditions.

“(xx) Utilizing a diverse network of providers of services and suppliers to improve care coordination for applicable individuals described in subsection (a)(4)(A)(i) with 2 or more chronic conditions and a history of prior-year hospitalization through interventions developed under the Medicare Coordinated Care Demonstration Project under section 4016 of the Balanced Budget Act of 1997 (42 U.S.C. 1395b-1 note).”; and

(C) in subparagraph (C), by adding at the end the following new clause:

“(viii) Whether the model demonstrates effective linkage with other public sector or private sector payers.”;

(3) in subsection (b)(4), by adding at the end the following new subparagraph:

“(C) MEASURE SELECTION.—To the extent feasible, the Secretary shall select measures under this paragraph that reflect national priorities for quality improvement and patient-centered care consistent with the measures described in 1890(b)(7)(B).”; and

(4) in subsection (c)—

(A) in paragraph (1)(B), by striking “care and reduce spending; and” and inserting “patient care without increasing spending;”;

(B) in paragraph (2), by striking “reduce program spending under applicable titles.” and inserting “reduce (or would not result in any increase in) net program spending under applicable titles; and”;

(C) by adding at the end the following:

“(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable title for applicable individuals.

In determining which models or demonstration projects to expand under the preceding sentence, the Secretary shall focus on models and demonstration projects that improve the quality of patient care and reduce spending.”.

SEC. 10307. IMPROVEMENTS TO THE MEDICARE SHARED SAVINGS PROGRAM.

Section 1899 of the Social Security Act, as added by section 3022, is amended by adding at the end the following new subsections:

“(i) OPTION TO USE OTHER PAYMENT MODELS.—

“(1) IN GENERAL.—If the Secretary determines appropriate, the Secretary may use any of the payment models described in paragraph (2) or (3) for making payments under the program rather than the payment model described in subsection (d).

“(2) PARTIAL CAPITATION MODEL.—

“(A) IN GENERAL.—Subject to subparagraph (B), a model described in this paragraph is a partial capitation model in which an ACO is at financial risk for some, but not all, of the items and services covered under parts A and B, such as at risk for some or all physicians' services or all items and services under part B. The Secretary may limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary.

“(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments to an ACO for items and services under this title for beneficiaries for a

year under the partial capitation model shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the model were not implemented, as estimated by the Secretary.

“(3) OTHER PAYMENT MODELS.—

“(A) IN GENERAL.—Subject to subparagraph (B), a model described in this paragraph is any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under this title.

“(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) in a similar manner as such subparagraph (B) applies to the payment model under paragraph (2).

“(j) INVOLVEMENT IN PRIVATE PAYER AND OTHER THIRD PARTY ARRANGEMENTS.—The Secretary may give preference to ACOs who are participating in similar arrangements with other payers.

“(k) TREATMENT OF PHYSICIAN GROUP PRACTICE DEMONSTRATION.—During the period beginning on the date of the enactment of this section and ending on the date the program is established, the Secretary may enter into an agreement with an ACO under the demonstration under section 1866A, subject to rebasing and other modifications deemed appropriate by the Secretary.”.

SEC. 10308. REVISIONS TO NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

(a) **IN GENERAL.—**Section 1866D of the Social Security Act, as added by section 3023, is amended—

(1) in paragraph (a)(2)(B), in the matter preceding clause (i), by striking “8 conditions” and inserting “10 conditions”;

(2) by striking subsection (c)(1)(B) and inserting the following:

“(B) EXPANSION.—The Secretary may, at any point after January 1, 2016, expand the duration and scope of the pilot program, to the extent determined appropriate by the Secretary, if—

“(i) the Secretary determines that such expansion is expected to—

“(I) reduce spending under title XVIII of the Social Security Act without reducing the quality of care; or

“(II) improve the quality of care and reduce spending;

“(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under such title XVIII; and

“(iii) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under this title for individuals.”; and

(3) by striking subsection (g) and inserting the following new subsection:

“(g) APPLICATION OF PILOT PROGRAM TO CONTINUING CARE HOSPITALS.—

“(1) IN GENERAL.—In conducting the pilot program, the Secretary shall apply the provisions of the program so as to separately pilot test the continuing care hospital model.

“(2) SPECIAL RULES.—In pilot testing the continuing care hospital model under paragraph (1), the following rules shall apply:

“(A) Such model shall be tested without the limitation to the conditions selected under subsection (a)(2)(B).

“(B) Notwithstanding subsection (a)(2)(D), an episode of care shall be defined as the full period that a patient stays in the continuing care hospital plus the first 30 days following discharge from such hospital.

“(3) CONTINUING CARE HOSPITAL DEFINED.—In this subsection, the term ‘continuing care hospital’ means an entity that has demonstrated

the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units (as defined in section 1886(d)(1)(B)(ii)), long term care hospitals (as defined in section 1886(d)(1)(B)(iv)(I)), and skilled nursing facilities (as defined in section 1819(a)) that are located in a hospital described in section 1886(d).”.

(b) TECHNICAL AMENDMENTS.—

(1) Section 3023 is amended by striking “1886C” and inserting “1866C”.

(2) Title XVIII of the Social Security Act is amended by redesignating section 1866D, as added by section 3024, as section 1866E.

SEC. 10309. REVISIONS TO HOSPITAL READMISSIONS REDUCTION PROGRAM.

Section 1886(q)(1) of the Social Security Act, as added by section 3025, in the matter preceding subparagraph (A), is amended by striking “the Secretary shall reduce the payments” and all that follows through “the product of” and inserting “the Secretary shall make payments (in addition to the payments described in paragraph (2)(A)(ii)) for such a discharge to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) in an amount equal to the product of”.

SEC. 10310. REPEAL OF PHYSICIAN PAYMENT UPDATE.

The provisions of, and the amendment made by, section 3101 are repealed.

SEC. 10311. REVISIONS TO EXTENSION OF AMBULANCE ADD-ONS.

(a) **GROUND AMBULANCE.—**Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)), as amended by section 3105(a), is further amended—

(1) in the matter preceding clause (i)—

(A) by striking “2007, for” and inserting “2007, and for”; and

(B) by striking “2010, and for such services furnished on or after April 1, 2010, and before January 1, 2011” and inserting “2011”; and

(2) in each of clauses (i) and (ii)—

(A) by striking “, and on or after April 1, 2010, and before January 1, 2011” each place it appears; and

(B) by striking “January 1, 2010” and inserting “January 1, 2011” each place it appears.

(b) **AIR AMBULANCE.—**Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275), as amended by section 3105(b), is further amended by striking “December 31, 2009, and during the period beginning on April 1, 2010, and ending on January 1, 2011” and inserting “December 31, 2010”.

(c) **SUPER RURAL AMBULANCE.—**Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)), as amended by section 3105(c), is further amended by striking “2010, and on or after April 1, 2010, and before January 1, 2011” and inserting “2011”.

SEC. 10312. CERTAIN PAYMENT RULES FOR LONG-TERM CARE HOSPITAL SERVICES AND MORATORIUM ON THE ESTABLISHMENT OF CERTAIN HOSPITALS AND FACILITIES.

(a) **CERTAIN PAYMENT RULES.—**Section 114(c) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395vww note), as amended by section 4302(a) of the American Recovery and Reinvestment Act (Public Law 111-5) and section 3106(a) of this Act, is further amended by striking “4-year period” each place it appears and inserting “5-year period”.

(b) **MORATORIUM.—**Section 114(d) of such Act (42 U.S.C. 1395vww note), as amended by section 3106(b) of this Act, in the matter preceding subparagraph (A), is amended by striking “4-year period” and inserting “5-year period”.

SEC. 10313. REVISIONS TO THE EXTENSION FOR THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) **IN GENERAL.—**Subsection (g) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; 117 Stat. 2272), as added by section 3123(a) of this Act, is amended to read as follows:

“(g) FIVE-YEAR EXTENSION OF DEMONSTRATION PROGRAM.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 5-year period (in this section referred to as the ‘5-year extension period’) that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

“(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding subsection (a)(2), during the 5-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 5-year period.

“(3) INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding subsection (a)(4), during the 5-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

“(4) HOSPITALS IN DEMONSTRATION PROGRAM ON DATE OF ENACTMENT.—In the case of a rural community hospital that is participating in the demonstration program under this section as of the last day of the initial 5-year period, the Secretary—

“(A) shall provide for the continued participation of such rural community hospital in the demonstration program during the 5-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may specify, to discontinue such participation; and

“(B) in calculating the amount of payment under subsection (b) to the rural community hospital for covered inpatient hospital services furnished by the hospital during such 5-year extension period, shall substitute, under paragraph (1)(A) of such subsection—

“(i) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the first day of the 5-year extension period, for

“(ii) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program.”.

(b) **CONFORMING AMENDMENTS.—**Subsection (a)(5) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; 117 Stat. 2272), as amended by section 3123(b) of this Act, is amended by striking “1-year extension” and inserting “5-year extension”.

SEC. 10314. ADJUSTMENT TO LOW-VOLUME HOSPITAL PROVISION.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395vww(d)(12)), as amended by section 3125, is amended—

(1) in subparagraph (C)(i), by striking “1,500 discharges” and inserting “1,600 discharges”; and

(2) in subparagraph (D), by striking “1,500 discharges” and inserting “1,600 discharges”.

SEC. 10315. REVISIONS TO HOME HEALTH CARE PROVISIONS.

(a) **REBASING.—**Section 1895(b)(3)(A)(iii) of the Social Security Act, as added by section 3131, is amended—

(1) in the clause heading, by striking “2013” and inserting “2014”;

(2) in subclause (I), by striking “2013” and inserting “2014”; and

(3) in subclause (II), by striking “2016” and inserting “2017”.

(b) REVISION OF HOME HEALTH STUDY AND REPORT.—Section 3131(d) is amended to read as follows:

“(d) STUDY AND REPORT ON THE DEVELOPMENT OF HOME HEALTH PAYMENT REVISIONS IN ORDER TO ENSURE ACCESS TO CARE AND PAYMENT FOR SEVERITY OF ILLNESS.—

“(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ‘Secretary’) shall conduct a study on home health agency costs involved with providing ongoing access to care to low-income Medicare beneficiaries or beneficiaries in medically underserved areas, and in treating beneficiaries with varying levels of severity of illness. In conducting the study, the Secretary may analyze items such as the following:

“(A) Methods to potentially revise the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to account for costs related to patient severity of illness or to improving beneficiary access to care, such as—

“(i) payment adjustments for services that may involve additional or fewer resources;

“(ii) changes to reflect resources involved with providing home health services to low-income Medicare beneficiaries or Medicare beneficiaries residing in medically underserved areas;

“(iii) ways outlier payments might be revised to reflect costs of treating Medicare beneficiaries with high levels of severity of illness; and

“(iv) other issues determined appropriate by the Secretary.

“(B) Operational issues involved with potential implementation of potential revisions to the home health payment system, including impacts for both home health agencies and administrative and systems issues for the Centers for Medicare & Medicaid Services, and any possible payment vulnerabilities associated with implementing potential revisions.

“(C) Whether additional research might be needed.

“(D) Other items determined appropriate by the Secretary.

“(2) CONSIDERATIONS.—In conducting the study under paragraph (1), the Secretary may consider whether patient severity of illness and access to care could be measured by factors, such as—

“(A) population density and relative patient access to care;

“(B) variations in service costs for providing care to individuals who are dually eligible under the Medicare and Medicaid programs;

“(C) the presence of severe or chronic diseases, which might be measured by multiple, discontinuous home health episodes;

“(D) poverty status, such as evidenced by the receipt of Supplemental Security Income under title XVI of the Social Security Act; and

“(E) other factors determined appropriate by the Secretary.

“(3) REPORT.—Not later than March 1, 2014, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

“(4) CONSULTATIONS.—In conducting the study under paragraph (1), the Secretary shall consult with appropriate stakeholders, such as groups representing home health agencies and groups representing Medicare beneficiaries.

“(5) MEDICARE DEMONSTRATION PROJECT BASED ON THE RESULTS OF THE STUDY.—

“(A) IN GENERAL.—Subject to subparagraph (D), taking into account the results of the study

conducted under paragraph (1), the Secretary may, as determined appropriate, provide for a demonstration project to test whether making payment adjustments for home health services under the Medicare program would substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries.

“(B) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset any increase in payments during such period resulting from the application of the payment adjustments under subparagraph (A).

“(C) NO EFFECT ON SUBSEQUENT PERIODS.—A payment adjustment resulting from the application of subparagraph (A) for a period—

“(i) shall not apply to payments for home health services under title XVIII after such period; and

“(ii) shall not be taken into account in calculating the payment amounts applicable for such services after such period.

“(D) DURATION.—If the Secretary determines it appropriate to conduct the demonstration project under this subsection, the Secretary shall conduct the project for a four year period beginning not later than January 1, 2015.

“(E) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of \$500,000,000 for the period of fiscal years 2015 through 2018. Such funds shall be made available for the study described in paragraph (1) and the design, implementation and evaluation of the demonstration described in this paragraph. Amounts available under this subparagraph shall be available until expended.

“(F) EVALUATION AND REPORT.—If the Secretary determines it appropriate to conduct the demonstration project under this subsection, the Secretary shall—

“(i) provide for an evaluation of the project; and

“(ii) submit to Congress, by a date specified by the Secretary, a report on the project.

“(G) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply with respect to this subsection.”.

SEC. 10316. MEDICARE DSH.

Section 1886(r)(2)(B) of the Social Security Act, as added by section 3133, is amended—

(1) in clause (i)—

(A) in the matter preceding subclause (I), by striking “(divided by 100)”;

(B) in subclause (I), by striking “2012” and inserting “2013”;

(C) in subclause (II), by striking the period at the end and inserting a comma; and

(D) by adding at the end the following flush matter:

“minus 1.5 percentage points.”.

(2) in clause (ii)—

(A) in the matter preceding subclause (I), by striking “(divided by 100)”;

(B) in subclause (I), by striking “2012” and inserting “2013”;

(C) in subclause (II), by striking the period at the end and inserting a comma; and

(D) by adding at the end the following flush matter:

“and, for each of 2018 and 2019, minus 1.5 percentage points.”.

SEC. 10317. REVISIONS TO EXTENSION OF SECTION 508 HOSPITAL PROVISIONS.

Section 3137(a) is amended to read as follows:

“(a) EXTENSION.—

“(1) IN GENERAL.—Subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note), as amended by section 117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173) and section 124 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275), is amended by striking ‘September 30, 2009’ and inserting ‘September 30, 2010’.

“(2) SPECIAL RULE FOR FISCAL YEAR 2010.—

“(A) IN GENERAL.—Subject to subparagraph (B), for purposes of implementation of the amendment made by paragraph (1), including (notwithstanding paragraph (3) of section 117(a) of the Medicare, Medicaid and SCHIP Extension Act of 2007 (Public Law 110-173), as amended by section 124(b) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275)) for purposes of the implementation of paragraph (2) of such section 117(a), during fiscal year 2010, the Secretary of Health and Human Services (in this subsection referred to as the ‘Secretary’) shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on August 27, 2009 (74 Fed. Reg. 43754), and any subsequent corrections.

“(B) EXCEPTION.—Beginning on April 1, 2010, in determining the wage index applicable to hospitals that qualify for wage index reclassification, the Secretary shall include the average hourly wage data of hospitals whose reclassification was extended pursuant to the amendment made by paragraph (1) only if including such data results in a higher applicable reclassified wage index.

“(3) ADJUSTMENT FOR CERTAIN HOSPITALS IN FISCAL YEAR 2010.—

“(A) IN GENERAL.—In the case of a subsection (d) hospital (as defined in subsection (d)(1)(B) of section 1886 of the Social Security Act (42 U.S.C. 1395wv)) with respect to which—

“(i) a reclassification of its wage index for purposes of such section was extended pursuant to the amendment made by paragraph (1); and

“(ii) the wage index applicable for such hospital for the period beginning on October 1, 2009, and ending on March 31, 2010, was lower than for the period beginning on April 1, 2010, and ending on September 30, 2010, by reason of the application of paragraph (2)(B);

the Secretary shall pay such hospital an additional payment that reflects the difference between the wage index for such periods.

“(B) TIMEFRAME FOR PAYMENTS.—The Secretary shall make payments required under subparagraph by not later than December 31, 2010.”.

SEC. 10318. REVISIONS TO TRANSITIONAL EXTRA BENEFITS UNDER MEDICARE ADVANTAGE.

Section 1853(p)(3)(A) of the Social Security Act, as added by section 3201(h), is amended by inserting “in 2009” before the period at the end.

SEC. 10319. REVISIONS TO MARKET BASKET ADJUSTMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1886(b)(3)(B)(xii) of the Social Security Act, as added by section 3401(a), is amended—

(1) in subclause (I), by striking “and” at the end;

(2) by redesignating subclause (II) as subclause (III);

(3) by inserting after subclause (II) the following new subclause:

“(II) for each of fiscal years 2012 and 2013, by 0.1 percentage point; and”;

(4) in subclause (III), as redesignated by paragraph (2), by striking “2012” and inserting “2014”.

(b) LONG-TERM CARE HOSPITALS.—Section 1886(m)(4) of the Social Security Act, as added by section 3401(c), is amended—

(1) in subparagraph (A)—
 (A) in clause (i)—
 (i) by striking “each of rate years 2010 and 2011” and inserting “rate year 2010”; and
 (ii) by striking “and” at the end;
 (B) by redesignating clause (ii) as clause (iv);
 (C) by inserting after clause (i) the following new clauses:

“(ii) for rate year 2011, 0.50 percentage point;
 “(iii) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point; and”; and
 (D) in clause (iv), as redesignated by subparagraph (B), by striking “2012” and inserting “2014”; and

(2) in subparagraph (B), by striking “(A)(ii)” and inserting “(A)(iv)”.

(c) **INPATIENT REHABILITATION FACILITIES.**—Section 1886(j)(3)(D)(i) of the Social Security Act, as added by section 3401(d), is amended—

(1) in subclause (I), by striking “and” at the end;

(2) by redesignating subclause (II) as subclause (III);

(3) by inserting after subclause (II) the following new subclause:

“(II) for each of fiscal years 2012 and 2013, 0.1 percentage point; and”; and

(4) in subclause (III), as redesignated by paragraph (2), by striking “2012” and inserting “2014”.

(d) **HOME HEALTH AGENCIES.**—Section 1895(b)(3)(B)(vi)(II) of such Act, as added by section 3401(e), is amended by striking “and 2012” and inserting “, 2012, and 2013”.

(e) **PSYCHIATRIC HOSPITALS.**—Section 1886(s)(3)(A) of the Social Security Act, as added by section 3401(f), is amended—

(1) in clause (i), by striking “and” at the end;

(2) by redesignating clause (ii) as clause (iii);

(3) by inserting after clause (ii) the following new clause:

“(ii) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point; and”; and

(4) in clause (iii), as redesignated by paragraph (2), by striking “2012” and inserting “2014”.

(f) **HOSPICE CARE.**—Section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)), as amended by section 3401(g), is amended—

(1) in clause (iv)(II), by striking “0.5” and inserting “0.3”; and

(2) in clause (v), in the matter preceding subclause (I), by striking “0.5” and inserting “0.3”.

(g) **OUTPATIENT HOSPITALS.**—Section 1833(t)(3)(G)(i) of the Social Security Act, as added by section 3401(i), is amended—

(1) in subclause (I), by striking “and” at the end;

(2) by redesignating subclause (II) as subclause (III);

(3) by inserting after subclause (II) the following new subclause:

“(II) for each of 2012 and 2013, 0.1 percentage point; and”; and

(4) in subclause (III), as redesignated by paragraph (2), by striking “2012” and inserting “2014”.

SEC. 10320. EXPANSION OF THE SCOPE OF, AND ADDITIONAL IMPROVEMENTS TO, THE INDEPENDENT MEDICARE ADVISORY BOARD.

(a) **IN GENERAL.**—Section 1899A of the Social Security Act, as added by section 3403, is amended—

(1) in subsection (c)—

(A) in paragraph (1)(B), by adding at the end the following new sentence: “In any year (beginning with 2014) that the Board is not required to submit a proposal under this section, the Board shall submit to Congress an advisory report on matters related to the Medicare program.”;

(B) in paragraph (2)(A)—

(i) in clause (iv), by inserting “or the full premium subsidy under section 1860D–14(a)” before the period at the end of the last sentence; and

(ii) by adding at the end the following new clause:

“(vii) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination described in subsection (e)(3)(B)(i)(II) in the determination year, the proposal shall be designed to help reduce the growth rate described in paragraph (8) while maintaining or enhancing beneficiary access to quality care under this title.”;

(C) in paragraph (2)(B)—

(i) in clause (v), by striking “and” at the end;

(ii) in clause (vi), by striking the period at the end and inserting “; and”; and

(iii) by adding at the end the following new clause:

“(vii) take into account the data and findings contained in the annual reports under subsection (n) in order to develop proposals that can most effectively promote the delivery of efficient, high quality care to Medicare beneficiaries.”;

(D) in paragraph (3)—

(i) in the heading, by striking “TRANSMISSION OF BOARD PROPOSAL TO PRESIDENT” and inserting “SUBMISSION OF BOARD PROPOSAL TO CONGRESS AND THE PRESIDENT”;

(ii) in subparagraph (A)(i), by striking “transmit a proposal under this section to the President” and insert “submit a proposal under this section to Congress and the President”; and

(iii) in subparagraph (A)(ii)—

(I) in subclause (I), by inserting “or” at the end;

(II) in subclause (II), by striking “; or” and inserting a period; and

(III) by striking subclause (III);

(E) in paragraph (4)—

(i) by striking “the Board under paragraph (3)(A)(i) or”; and

(ii) by striking “immediately” and inserting “within 2 days”;

(F) in paragraph (5)—

(i) by striking “to but” and inserting “but”; and

(ii) by inserting “Congress and” after “submit a proposal to”; and

(G) in paragraph (6)(B)(i), by striking “per unduplicated enrollee” and inserting “(calculated as the sum of per capita spending under each of parts A, B, and D)”;

(2) in subsection (d)—

(A) in paragraph (1)(A)—

(i) by inserting “the Board or” after “a proposal is submitted by”; and

(ii) by inserting “subsection (c)(3)(A)(i) or” after “the Senate under”; and

(B) in paragraph (2)(A), by inserting “the Board or” after “a proposal is submitted by”; and

(3) in subsection (e)—

(A) in paragraph (1), by inserting “the Board or” after “a proposal submitted by”; and

(B) in paragraph (3)—

(i) by striking “EXCEPTION.—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by” and inserting “EXCEPTIONS.—

“(A) **IN GENERAL.**—The Secretary shall not implement the recommendations contained in a proposal submitted in a proposal year by the Board or”; and

(ii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting appropriately; and

(iii) by adding at the end the following new subparagraph:

“(B) **LIMITED ADDITIONAL EXCEPTION.**—

“(i) **IN GENERAL.**—Subject to clause (ii), the Secretary shall not implement the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in a proposal year (beginning with proposal year 2019) if—

“(I) the Board was required to submit a proposal to Congress under this section in the year preceding the proposal year; and

“(II) the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the growth rate described in subsection (c)(8) exceeds the growth rate described in subsection (c)(6)(A)(i).”

“(ii) **LIMITED ADDITIONAL EXCEPTION MAY NOT BE APPLIED IN TWO CONSECUTIVE YEARS.**—This subparagraph shall not apply if the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in the year preceding the proposal year were not required to be implemented by reason of this subparagraph.

“(iii) **NO AFFECT ON REQUIREMENT TO SUBMIT PROPOSALS OR FOR CONGRESSIONAL CONSIDERATION OF PROPOSALS.**—Clause (i) and (ii) shall not affect—

“(I) the requirement of the Board or the President to submit a proposal to Congress in a proposal year in accordance with the provisions of this section; or

“(II) Congressional consideration of a legislative proposal (described in subsection (c)(3)(B)(iv)) contained such a proposal in accordance with subsection (d).”;

(4) in subsection (f)(3)(B)—

(A) by striking “or advisory reports to Congress” and inserting “, advisory reports, or advisory recommendations”; and

(B) by inserting “or produce the public report under subsection (n)” after “this section”; and

(5) by adding at the end the following new subsections:

“(n) **ANNUAL PUBLIC REPORT.**—

“(I) **IN GENERAL.**—Not later than July 1, 2014, and annually thereafter, the Board shall produce a public report containing standardized information on system-wide health care costs, patient access to care, utilization, and quality-of-care that allows for comparison by region, types of services, types of providers, and both private payers and the program under this title.

“(2) **REQUIREMENTS.**—Each report produced pursuant to paragraph (1) shall include information with respect to the following areas:

“(A) The quality and costs of care for the population at the most local level determined practical by the Board (with quality and costs compared to national benchmarks and reflecting rates of change, taking into account quality measures described in section 1890(b)(7)(B)).

“(B) Beneficiary and consumer access to care, patient and caregiver experience of care, and the cost-sharing or out-of-pocket burden on patients.

“(C) Epidemiological shifts and demographic changes.

“(D) The proliferation, effectiveness, and utilization of health care technologies, including variation in provider practice patterns and costs.

“(E) Any other areas that the Board determines affect overall spending and quality of care in the private sector.

“(o) **ADVISORY RECOMMENDATIONS FOR NON-FEDERAL HEALTH CARE PROGRAMS.**—

“(1) **IN GENERAL.**—Not later than January 15, 2015, and at least once every two years thereafter, the Board shall submit to Congress and the President recommendations to slow the growth in national health expenditures (excluding expenditures under this title and in other Federal health care programs) while preserving or enhancing quality of care, such as recommendations—

“(A) that the Secretary or other Federal agencies can implement administratively;

“(B) that may require legislation to be enacted by Congress in order to be implemented;

“(C) that may require legislation to be enacted by State or local governments in order to be implemented;

“(D) that private sector entities can voluntarily implement; and

“(E) with respect to other areas determined appropriate by the Board.

“(2) COORDINATION.—In making recommendations under paragraph (1), the Board shall coordinate such recommendations with recommendations contained in proposals and advisory reports produced by the Board under subsection (c).

“(3) AVAILABLE TO PUBLIC.—The Board shall make recommendations submitted to Congress and the President under this subsection available to the public.”.

(b) NAME CHANGE.—Any reference in the provisions of, or amendments made by, section 3403 to the “Independent Medicare Advisory Board” shall be deemed to be a reference to the “Independent Payment Advisory Board”.

(c) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall preclude the Independent Medicare Advisory Board, as established under section 1899A of the Social Security Act (as added by section 3403), from solely using data from public or private sources to carry out the amendments made by subsection (a)(4).

SEC. 10321. REVISION TO COMMUNITY HEALTH TEAMS.

Section 3502(c)(2)(A) is amended by inserting “or other primary care providers” after “physicians”.

SEC. 10322. QUALITY REPORTING FOR PSYCHIATRIC HOSPITALS.

(a) IN GENERAL.—Section 1886(s) of the Social Security Act, as added by section 3401(f), is amended by adding at the end the following new paragraph:

“(4) QUALITY REPORTING.—

“(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

“(i) IN GENERAL.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a psychiatric hospital or psychiatric unit that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (2), shall be reduced by 2 percentage points.

“(ii) SPECIAL RULE.—The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

“(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

“(C) SUBMISSION OF QUALITY DATA.—For rate year 2014 and each subsequent rate year, each psychiatric hospital and psychiatric unit shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

“(D) QUALITY MEASURES.—

“(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

“(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Sec-

retary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

“(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

“(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a psychiatric hospital and a psychiatric unit has the opportunity to review the data that is to be made public with respect to the hospital or unit prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in psychiatric hospitals and psychiatric units on the Internet website of the Centers for Medicare & Medicaid Services.”.

(b) CONFORMING AMENDMENT.—Section 1890(b)(7)(B)(i)(I) of the Social Security Act, as added by section 3014, is amended by inserting “1886(s)(4)(D),” after “1886(o)(2),”.

SEC. 10323. MEDICARE COVERAGE FOR INDIVIDUALS EXPOSED TO ENVIRONMENTAL HEALTH HAZARDS.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1881 the following new section:

“SEC. 1881A. MEDICARE COVERAGE FOR INDIVIDUALS EXPOSED TO ENVIRONMENTAL HEALTH HAZARDS.

“(a) DEEMING OF INDIVIDUALS AS ELIGIBLE FOR MEDICARE BENEFITS.—

“(1) IN GENERAL.—For purposes of eligibility for benefits under this title, an individual determined under subsection (c) to be an environmental exposure affected individual described in subsection (e)(2) shall be deemed to meet the conditions specified in section 226(a).

“(2) DISCRETIONARY DEEMING.—For purposes of eligibility for benefits under this title, the Secretary may deem an individual determined under subsection (c) to be an environmental exposure affected individual described in subsection (e)(3) to meet the conditions specified in section 226(a).

“(3) EFFECTIVE DATE OF COVERAGE.—An individual who is deemed eligible for benefits under this title under paragraph (1) or (2) shall be—

“(A) entitled to benefits under the program under Part A as of the date of such deeming; and

“(B) eligible to enroll in the program under Part B beginning with the month in which such deeming occurs.

“(b) PILOT PROGRAM FOR CARE OF CERTAIN INDIVIDUALS RESIDING IN EMERGENCY DECLARATION AREAS.—

“(1) PROGRAM; PURPOSE.—

“(A) PRIMARY PILOT PROGRAM.—The Secretary shall establish a pilot program in accordance with this subsection to provide innovative approaches to furnishing comprehensive, coordinated, and cost-effective care under this title to individuals described in paragraph (2)(A).

“(B) OPTIONAL PILOT PROGRAMS.—The Secretary may establish a separate pilot program, in accordance with this subsection, with respect to each geographic area subject to an emergency declaration (other than the declaration of June 17, 2009), in order to furnish such comprehensive, coordinated and cost-effective care to individuals described in subparagraph (2)(B) who reside in each such area.

“(2) INDIVIDUAL DESCRIBED.—For purposes of paragraph (1), an individual described in this paragraph is an individual who enrolls in part B, submits to the Secretary an application to

participate in the applicable pilot program under this subsection, and—

“(A) is an environmental exposure affected individual described in subsection (e)(2) who resides in or around the geographic area subject to an emergency declaration made as of June 17, 2009; or

“(B) is an environmental exposure affected individual described in subsection (e)(3) who—

“(i) is deemed under subsection (a)(2); and

“(ii) meets such other criteria or conditions for participation in a pilot program under paragraph (1)(B) as the Secretary specifies.

“(3) FLEXIBLE BENEFITS AND SERVICES.—A pilot program under this subsection may provide for the furnishing of benefits, items, or services not otherwise covered or authorized under this title, if the Secretary determines that furnishing such benefits, items, or services will further the purposes of such pilot program (as described in paragraph (1)).

“(4) INNOVATIVE REIMBURSEMENT METHODOLOGIES.—For purposes of the pilot program under this subsection, the Secretary—

“(A) shall develop and implement appropriate methodologies to reimburse providers for furnishing benefits, items, or services for which payment is not otherwise covered or authorized under this title, if such benefits, items, or services are furnished pursuant to paragraph (3); and

“(B) may develop and implement innovative approaches to reimbursing providers for any benefits, items, or services furnished under this subsection.

“(5) LIMITATION.—Consistent with section 1862(b), no payment shall be made under the pilot program under this subsection with respect to benefits, items, or services furnished to an environmental exposure affected individual (as defined in subsection (e)) to the extent that such individual is eligible to receive such benefits, items, or services through any other public or private benefits plan or legal agreement.

“(6) WAIVER AUTHORITY.—The Secretary may waive such provisions of this title and title XI as are necessary to carry out pilot programs under this subsection.

“(7) FUNDING.—For purposes of carrying out pilot programs under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in such proportion as the Secretary determines appropriate, of such sums as the Secretary determines necessary, to the Centers for Medicare & Medicaid Services Program Management Account.

“(8) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall not require that pilot programs under this subsection be budget neutral with respect to expenditures under this title.

“(c) DETERMINATIONS.—

“(1) BY THE COMMISSIONER OF SOCIAL SECURITY.—For purposes of this section, the Commissioner of Social Security, in consultation with the Secretary, and using the cost allocation method prescribed in section 201(g), shall determine whether individuals are environmental exposure affected individuals.

“(2) BY THE SECRETARY.—The Secretary shall determine eligibility for pilot programs under subsection (b).

“(d) EMERGENCY DECLARATION DEFINED.—For purposes of this section, the term ‘emergency declaration’ means a declaration of a public health emergency under section 104(a) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

“(e) ENVIRONMENTAL EXPOSURE AFFECTED INDIVIDUAL DEFINED.—

“(1) IN GENERAL.—For purposes of this section, the term ‘environmental exposure affected individual’ means—

“(A) an individual described in paragraph (2); and

“(B) an individual described in paragraph (3).

“(2) INDIVIDUAL DESCRIBED.—

“(A) IN GENERAL.—An individual described in this paragraph is any individual who—

“(i) is diagnosed with 1 or more conditions described in subparagraph (B);

“(ii) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to an emergency declaration specified in subsection (b)(2)(A), during a period ending—

“(I) not less than 10 years prior to such diagnosis; and

“(II) prior to the implementation of all the remedial and removal actions specified in the Record of Decision for Operating Unit 4 and the Record of Decision for Operating Unit 7;

“(iii) files an application for benefits under this title (or has an application filed on behalf of the individual), including pursuant to this section; and

“(iv) is determined under this section to meet the criteria in this subparagraph.

“(B) CONDITIONS DESCRIBED.—For purposes of subparagraph (A), the following conditions are described in this subparagraph:

“(i) Asbestosis, pleural thickening, or pleural plaques as established by—

“(I) interpretation by a ‘B Reader’ qualified physician of a plain chest x-ray or interpretation of a computed tomographic radiograph of the chest by a qualified physician, as determined by the Secretary; or

“(II) such other diagnostic standards as the Secretary specifies,

except that this clause shall not apply to pleural thickening or pleural plaques unless there are symptoms or conditions requiring medical treatment as a result of these diagnoses.

“(ii) Mesothelioma, or malignancies of the lung, colon, rectum, larynx, stomach, esophagus, pharynx, or ovary, as established by—

“(I) pathologic examination of biopsy tissue;

“(II) cytology from bronchioalveolar lavage; or

“(III) such other diagnostic standards as the Secretary specifies.

“(iii) Any other diagnosis which the Secretary, in consultation with the Commissioner of Social Security, determines is an asbestos-related medical condition, as established by such diagnostic standards as the Secretary specifies.

“(3) OTHER INDIVIDUAL DESCRIBED.—An individual described in this paragraph is any individual who—

“(A) is not an individual described in paragraph (2);

“(B) is diagnosed with a medical condition caused by the exposure of the individual to a public health hazard to which an emergency declaration applies, based on such medical conditions, diagnostic standards, and other criteria as the Secretary specifies;

“(C) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to the emergency declaration involved, during a period determined appropriate by the Secretary;

“(D) files an application for benefits under this title (or has an application filed on behalf of the individual), including pursuant to this section; and

“(E) is determined under this section to meet the criteria in this paragraph.”.

(b) PROGRAM FOR EARLY DETECTION OF CERTAIN MEDICAL CONDITIONS RELATED TO ENVIRONMENTAL HEALTH HAZARDS.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.), as amended by section 5507, is amended by adding at the end the following:

“SEC. 2009. PROGRAM FOR EARLY DETECTION OF CERTAIN MEDICAL CONDITIONS RELATED TO ENVIRONMENTAL HEALTH HAZARDS.

“(a) PROGRAM ESTABLISHMENT.—The Secretary shall establish a program in accordance with this section to make competitive grants to eligible entities specified in subsection (b) for the purpose of—

“(1) screening at-risk individuals (as defined in subsection (c)(1)) for environmental health conditions (as defined in subsection (c)(3)); and

“(2) developing and disseminating public information and education concerning—

“(A) the availability of screening under the program under this section;

“(B) the detection, prevention, and treatment of environmental health conditions; and

“(C) the availability of Medicare benefits for certain individuals diagnosed with environmental health conditions under section 1881A.

“(b) ELIGIBLE ENTITIES.—

“(1) IN GENERAL.—For purposes of this section, an eligible entity is an entity described in paragraph (2) which submits an application to the Secretary in such form and manner, and containing such information and assurances, as the Secretary determines appropriate.

“(2) TYPES OF ELIGIBLE ENTITIES.—The entities described in this paragraph are the following:

“(A) A hospital or community health center.

“(B) A Federally qualified health center.

“(C) A facility of the Indian Health Service.

“(D) A National Cancer Institute-designated cancer center.

“(E) An agency of any State or local government.

“(F) A nonprofit organization.

“(G) Any other entity the Secretary determines appropriate.

“(c) DEFINITIONS.—In this section:

“(1) AT-RISK INDIVIDUAL.—The term ‘at-risk individual’ means an individual who—

“(A)(i) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to an emergency declaration specified under paragraph (2), during a period ending—

“(I) not less than 10 years prior to the date of such individual’s application under subparagraph (B); and

“(II) prior to the implementation of all the remedial and removal actions specified in the Record of Decision for Operating Unit 4 and the Record of Decision for Operating Unit 7; or

“(ii) meets such other criteria as the Secretary determines appropriate considering the type of environmental health condition at issue; and

“(B) has submitted an application (or has an application submitted on the individual’s behalf), to an eligible entity receiving a grant under this section, for screening under the program under this section.

“(2) EMERGENCY DECLARATION.—The term ‘emergency declaration’ means a declaration of a public health emergency under section 104(a) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

“(3) ENVIRONMENTAL HEALTH CONDITION.—The term ‘environmental health condition’ means—

“(A) asbestosis, pleural thickening, or pleural plaques, as established by—

“(i) interpretation by a ‘B Reader’ qualified physician of a plain chest x-ray or interpretation of a computed tomographic radiograph of the chest by a qualified physician, as determined by the Secretary; or

“(ii) such other diagnostic standards as the Secretary specifies;

“(B) mesothelioma, or malignancies of the lung, colon, rectum, larynx, stomach, esophagus, pharynx, or ovary, as established by—

“(i) pathologic examination of biopsy tissue;

“(ii) cytology from bronchioalveolar lavage; or

“(iii) such other diagnostic standards as the Secretary specifies; and

“(C) any other medical condition which the Secretary determines is caused by exposure to a hazardous substance or pollutant or contaminant at a Superfund site to which an emergency declaration applies, based on such criteria and as established by such diagnostic standards as the Secretary specifies.

“(4) HAZARDOUS SUBSTANCE; POLLUTANT; CONTAMINANT.—The terms ‘hazardous substance’, ‘pollutant’, and ‘contaminant’ have the meanings given those terms in section 101 of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9601).

“(5) SUPERFUND SITE.—The term ‘Superfund site’ means a site included on the National Priorities List developed by the President in accordance with section 105(a)(8)(B) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9605(a)(8)(B)).

“(d) HEALTH COVERAGE UNAFFECTED.—Nothing in this section shall be construed to affect any coverage obligation of a governmental or private health plan or program relating to an at-risk individual.

“(e) FUNDING.—

“(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary, to carry out the program under this section—

“(A) \$23,000,000 for the period of fiscal years 2010 through 2014; and

“(B) \$20,000,000 for each 5-fiscal year period thereafter.

“(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

“(f) NONAPPLICATION.—

“(1) IN GENERAL.—Except as provided in paragraph (2), the preceding sections of this title shall not apply to grants awarded under this section.

“(2) LIMITATIONS ON USE OF GRANTS.—Section 2005(a) shall apply to a grant awarded under this section to the same extent and in the same manner as such section applies to payments to States under this title, except that paragraph (4) of such section shall not be construed to prohibit grantees from conducting screening for environmental health conditions as authorized under this section.”.

SEC. 1032A. PROTECTIONS FOR FRONTIER STATES.

(a) FLOOR ON AREA WAGE INDEX FOR HOSPITALS IN FRONTIER STATES.—

(1) IN GENERAL.—Section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(A) in clause (i), by striking “clause (ii)” and inserting “clause (ii) or (iii)”; and

(B) by adding at the end the following new clause:

“(iii) FLOOR ON AREA WAGE INDEX FOR HOSPITALS IN FRONTIER STATES.—

“(I) IN GENERAL.—Subject to subclause (IV), for discharges occurring on or after October 1, 2010, the area wage index applicable under this subparagraph to any hospital which is located in a frontier State (as defined in subclause (II)) may not be less than 1.00.

“(II) FRONTIER STATE DEFINED.—In this clause, the term ‘frontier State’ means a State in which at least 50 percent of the counties in the State are frontier counties.

“(III) FRONTIER COUNTY DEFINED.—In this clause, the term ‘frontier county’ means a county in which the population per square mile is less than 6.

“(IV) LIMITATION.—This clause shall not apply to any hospital located in a State that receives a non-labor related share adjustment under paragraph (5)(H).”.

(2) **WAIVING BUDGET NEUTRALITY.**—Section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395wv(d)(3)(E)), as amended by subsection (a), is amended in the third sentence by inserting “and the amendments made by section 10324(a)(1) of the Patient Protection and Affordable Care Act” after “2003”.

(b) **FLOOR ON AREA WAGE ADJUSTMENT FACTOR FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES IN FRONTIER STATES.**—Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), as amended by section 3138, is amended—

(1) in paragraph (2)(D), by striking “the Secretary” and inserting “subject to paragraph (19), the Secretary”; and

(2) by adding at the end the following new paragraph:

“(19) FLOOR ON AREA WAGE ADJUSTMENT FACTOR FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES IN FRONTIER STATES.—

“(A) **IN GENERAL.**—Subject to subparagraph (B), with respect to covered OPD services furnished on or after January 1, 2011, the area wage adjustment factor applicable under the payment system established under this subsection to any hospital outpatient department which is located in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II)) may not be less than 1.00. The preceding sentence shall not be applied in a budget neutral manner.

“(B) **LIMITATION.**—This paragraph shall not apply to any hospital outpatient department located in a State that receives a non-labor related share adjustment under section 1886(d)(5)(H).”.

(c) **FLOOR FOR PRACTICE EXPENSE INDEX FOR PHYSICIANS' SERVICES FURNISHED IN FRONTIER STATES.**—Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)), as amended by section 3102, is amended—

(1) in subparagraph (A), by striking “and (H)” and inserting “(H), and (I)”; and

(2) by adding at the end the following new subparagraph:

“(I) FLOOR FOR PRACTICE EXPENSE INDEX FOR SERVICES FURNISHED IN FRONTIER STATES.—

“(i) **IN GENERAL.**—Subject to clause (ii), for purposes of payment for services furnished in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II)) on or after January 1, 2011, after calculating the practice expense index in subparagraph (A)(i), the Secretary shall increase any such index to 1.00 if such index would otherwise be less than 1.00. The preceding sentence shall not be applied in a budget neutral manner.

“(ii) **LIMITATION.**—This subparagraph shall not apply to services furnished in a State that receives a non-labor related share adjustment under section 1886(d)(5)(H).”.

SEC. 10325. REVISION TO SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.

(a) **TEMPORARY DELAY OF RUG-IV.**—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to October 1, 2011, implement Version 4 of the Resource Utilization Groups (in this subsection referred to as “RUG-IV”) published in the Federal Register on August 11, 2009, entitled “Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2010; Minimum Data Set, Version 3.0 for Skilled Nursing Facilities and Medicaid Nursing Facilities” (74 Fed. Reg. 40288). Beginning on October 1, 2010, the Secretary of Health and Human Services shall implement the change specific to therapy furnished on a concurrent basis that is a component of RUG-IV and changes to the lookback period to ensure that only those services furnished after admission to a skilled nursing facility are used as factors in determining a case mix classification under the skilled nursing facility prospective payment system under sec-

tion 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)).

(b) **CONSTRUCTION.**—Nothing in this section shall be interpreted as delaying the implementation of Version 3.0 of the Minimum Data Sets (MDS 3.0) beyond the planned implementation date of October 1, 2010.

SEC. 10326. PILOT TESTING PAY-FOR-PERFORMANCE PROGRAMS FOR CERTAIN MEDICARE PROVIDERS.

(a) **IN GENERAL.**—Not later than January 1, 2016, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall, for each provider described in subsection (b), conduct a separate pilot program under title XVIII of the Social Security Act to test the implementation of a value-based purchasing program for payments under such title for the provider.

(b) **PROVIDERS DESCRIBED.**—The providers described in this paragraph are the following:

(1) Psychiatric hospitals (as described in clause (i) of section 1886(d)(1)(B) of such Act (42 U.S.C. 1395wv(d)(1)(B))) and psychiatric units (as described in the matter following clause (v) of such section).

(2) Long-term care hospitals (as described in clause (iv) of such section).

(3) Rehabilitation hospitals (as described in clause (ii) of such section).

(4) PPS-exempt cancer hospitals (as described in clause (v) of such section).

(5) Hospice programs (as defined in section 1861(dd)(2) of such Act (42 U.S.C. 1395x(dd)(2))).

(c) **WAIVER AUTHORITY.**—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary solely for purposes of carrying out the pilot programs under this section.

(d) **NO ADDITIONAL PROGRAM EXPENDITURES.**—Payments under this section under the separate pilot program for value based purchasing (as described in subsection (a)) for each provider type described in paragraphs (1) through (5) of subsection (b) for applicable items and services under title XVIII of the Social Security Act for a year shall be established in a manner that does not result in spending more under each such value based purchasing program for such year than would otherwise be expended for such provider type for such year if the pilot program were not implemented, as estimated by the Secretary.

(e) **EXPANSION OF PILOT PROGRAM.**—The Secretary may, at any point after January 1, 2018, expand the duration and scope of a pilot program conducted under this subsection, to the extent determined appropriate by the Secretary, if—

(1) the Secretary determines that such expansion is expected to—

(A) reduce spending under title XVIII of the Social Security Act without reducing the quality of care; or

(B) improve the quality of care and reduce spending;

(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under such title XVIII; and

(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under such title XIII for Medicare beneficiaries.

SEC. 10327. IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM.

(a) **IN GENERAL.**—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w-4(m)) is amended by adding at the end the following new paragraph:

“(7) **ADDITIONAL INCENTIVE PAYMENT.**—

“(A) **IN GENERAL.**—For 2011 through 2014, if an eligible professional meets the requirements described in subparagraph (B), the applicable

quality percent for such year, as described in clauses (iii) and (iv) of paragraph (1)(B), shall be increased by 0.5 percentage points.

“(B) **REQUIREMENTS DESCRIBED.**—In order to qualify for the additional incentive payment described in subparagraph (A), an eligible professional shall meet the following requirements:

“(i) The eligible professional shall—

“(I) satisfactorily submit data on quality measures for purposes of paragraph (1) for a year; and

“(II) have such data submitted on their behalf through a Maintenance of Certification Program (as defined in subparagraph (C)(i)) that meets—

“(aa) the criteria for a registry (as described in subsection (k)(4)); or

“(bb) an alternative form and manner determined appropriate by the Secretary.

“(ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—

“(I) participates in such a Maintenance of Certification program for a year; and

“(II) successfully completes a qualified Maintenance of Certification Program practice assessment (as defined in subparagraph (C)(ii)) for such year.

“(iii) A Maintenance of Certification program submits to the Secretary, on behalf of the eligible professional, information—

“(I) in a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of clause (ii) (which may be in the form of a structural measure);

“(II) if requested by the Secretary, on the survey of patient experience with care (as described in subparagraph (C)(ii)(II)); and

“(III) as the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

“(C) **DEFINITIONS.**—For purposes of this paragraph:

“(i) The term ‘Maintenance of Certification Program’ means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism. Such a program shall include the following:

“(I) The program requires the physician to maintain a valid, unrestricted medical license in the United States.

“(II) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

“(III) The program requires a physician to demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.

“(IV) The program requires successful completion of a qualified Maintenance of Certification Program practice assessment as described in clause (ii).

“(ii) The term ‘qualified Maintenance of Certification Program practice assessment’ means an assessment of a physician’s practice that—

“(I) includes an initial assessment of an eligible professional’s practice that is designed to demonstrate the physician’s use of evidence-based medicine;

“(II) includes a survey of patient experience with care; and

“(III) requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under subclause (I) and then to re-measure to assess performance improvement after such intervention.”.

(b) **AUTHORITY.**—Section 3002(c) of this Act is amended by adding at the end the following new paragraph:

“(3) **AUTHORITY.**—For years after 2014, if the Secretary of Health and Human Services determines it to be appropriate, the Secretary may incorporate participation in a Maintenance of Certification Program and successful completion of a qualified Maintenance of Certification Program practice assessment into the composite of measures of quality of care furnished pursuant to the physician fee schedule payment modifier, as described in section 1848(p)(2) of the Social Security Act (42 U.S.C. 1395w-4(p)(2)).”.

(c) **ELIMINATION OF MA REGIONAL PLAN STABILIZATION FUND.**—

(1) **IN GENERAL.**—Section 1858 of the Social Security Act (42 U.S.C. 1395w-27a) is amended by striking subsection (e).

(2) **TRANSITION.**—Any amount contained in the MA Regional Plan Stabilization Fund as of the date of the enactment of this Act shall be transferred to the Federal Supplementary Medical Insurance Trust Fund.

SEC. 10328. IMPROVEMENT IN PART D MEDICATION THERAPY MANAGEMENT (MTM) PROGRAMS.

(a) **IN GENERAL.**—Section 1860D-4(c)(2) of the Social Security Act (42 U.S.C. 1395w-104(c)(2)) is amended—

(1) by redesignating subparagraphs (C), (D), and (E) as subparagraphs (E), (F), and (G), respectively; and

(2) by inserting after subparagraph (B) the following new subparagraphs:

“(C) **REQUIRED INTERVENTIONS.**—For plan years beginning on or after the date that is 2 years after the date of the enactment of the Patient Protection and Affordable Care Act, prescription drug plan sponsors shall offer medication therapy management services to targeted beneficiaries described in subparagraph (A)(ii) that include, at a minimum, the following to increase adherence to prescription medications or other goals deemed necessary by the Secretary:

“(i) An annual comprehensive medication review furnished person-to-person or using telehealth technologies (as defined by the Secretary) by a licensed pharmacist or other qualified provider. The comprehensive medication review—

“(I) shall include a review of the individual’s medications and may result in the creation of a recommended medication action plan or other actions in consultation with the individual and with input from the prescriber to the extent necessary and practicable; and

“(II) shall include providing the individual with a written or printed summary of the results of the review.

The Secretary, in consultation with relevant stakeholders, shall develop a standardized format for the action plan under subclause (I) and the summary under subclause (II).

“(ii) Follow-up interventions as warranted based on the findings of the annual medication review or the targeted medication enrollment and which may be provided person-to-person or using telehealth technologies (as defined by the Secretary).

“(D) **ASSESSMENT.**—The prescription drug plan sponsor shall have in place a process to assess, at least on a quarterly basis, the medication use of individuals who are at risk but not enrolled in the medication therapy management program, including individuals who have experienced a transition in care, if the prescription drug plan sponsor has access to that information.

“(E) **AUTOMATIC ENROLLMENT WITH ABILITY TO OPT-OUT.**—The prescription drug plan sponsor shall have in place a process to—

“(i) subject to clause (ii), automatically enroll targeted beneficiaries described in subparagraph (A)(ii), including beneficiaries identified under subparagraph (D), in the medication therapy management program required under this subsection; and

“(ii) permit such beneficiaries to opt-out of enrollment in such program.”.

(b) **RULE OF CONSTRUCTION.**—Nothing in this section shall limit the authority of the Secretary of Health and Human Services to modify or broaden requirements for a medication therapy management program under part D of title XVIII of the Social Security Act or to study new models for medication therapy management through the Center for Medicare and Medicaid Innovation under section 1115A of such Act, as added by section 3021.

SEC. 10329. DEVELOPING METHODOLOGY TO ASSESS HEALTH PLAN VALUE.

(a) **DEVELOPMENT.**—The Secretary of Health and Human Services (referred to in this section as the “Secretary”), in consultation with relevant stakeholders including health insurance issuers, health care consumers, employers, health care providers, and other entities determined appropriate by the Secretary, shall develop a methodology to measure health plan value. Such methodology shall take into consideration, where applicable—

(1) the overall cost to enrollees under the plan;

(2) the quality of the care provided for under the plan;

(3) the efficiency of the plan in providing care;

(4) the relative risk of the plan’s enrollees as compared to other plans;

(5) the actuarial value or other comparative measure of the benefits covered under the plan; and

(6) other factors determined relevant by the Secretary.

(b) **REPORT.**—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report concerning the methodology developed under subsection (a).

SEC. 10330. MODERNIZING COMPUTER AND DATA SYSTEMS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES TO SUPPORT IMPROVEMENTS IN CARE DELIVERY.

(a) **IN GENERAL.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall develop a plan (and detailed budget for the resources needed to implement such plan) to modernize the computer and data systems of the Centers for Medicare & Medicaid Services (in this section referred to as “CMS”).

(b) **CONSIDERATIONS.**—In developing the plan, the Secretary shall consider how such modernized computer system could—

(1) in accordance with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, make available data in a reliable and timely manner to providers of services and suppliers to support their efforts to better manage and coordinate care furnished to beneficiaries of CMS programs; and

(2) support consistent evaluations of payment and delivery system reforms under CMS programs.

(c) **POSTING OF PLAN.**—By not later than 9 months after the date of the enactment of this Act, the Secretary shall post on the website of the Centers for Medicare & Medicaid Services the plan described in subsection (a).

SEC. 10331. PUBLIC REPORTING OF PERFORMANCE INFORMATION.

(a) **IN GENERAL.**—

(1) **DEVELOPMENT.**—Not later than January 1, 2011, the Secretary shall develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program under section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) and other eligible professionals who participate in the Physician Quality Reporting Initiative under section 1848 of such Act (42 U.S.C. 1395w-4).

(2) **PLAN.**—Not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, the Secretary shall also implement a plan for making publicly available through Physician Compare, consistent with subsection (c), information on physician performance that provides comparable information for the public on quality and patient experience measures with respect to physicians enrolled in the Medicare program under such section 1866(j). To the extent scientifically sound measures that are developed consistent with the requirements of this section are available, such information, to the extent practicable, shall include—

(A) measures collected under the Physician Quality Reporting Initiative;

(B) an assessment of patient health outcomes and the functional status of patients;

(C) an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;

(D) an assessment of efficiency;

(E) an assessment of patient experience and patient, caregiver, and family engagement;

(F) an assessment of the safety, effectiveness, and timeliness of care; and

(G) other information as determined appropriate by the Secretary.

(b) **OTHER REQUIRED CONSIDERATIONS.**—In developing and implementing the plan described in subsection (a)(2), the Secretary shall, to the extent practicable, include—

(1) processes to assure that data made public, either by the Centers for Medicare & Medicaid Services or by other entities, is statistically valid and reliable, including risk adjustment mechanisms used by the Secretary;

(2) processes by which a physician or other eligible professional whose performance on measures is being publicly reported has a reasonable opportunity, as determined by the Secretary, to review his or her individual results before they are made public;

(3) processes by the Secretary to assure that the implementation of the plan and the data made available on Physician Compare provide a robust and accurate portrayal of a physician’s performance;

(4) data that reflects the care provided to all patients seen by physicians, under both the Medicare program and, to the extent practicable, other payers, to the extent such information would provide a more accurate portrayal of physician performance;

(5) processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of a patient;

(6) processes to ensure timely statistical performance feedback is provided to physicians concerning the data reported under any program subject to public reporting under this section; and

(7) implementation of computer and data systems of the Centers for Medicare & Medicaid Services that support valid, reliable, and accurate public reporting activities authorized under this section.

(c) **ENSURING PATIENT PRIVACY.**—The Secretary shall ensure that information on physician performance and patient experience is not disclosed under this section in a manner that violates sections 552 or 552a of title 5, United States Code, with regard to the privacy of individually identifiable health information.

(d) **FEEDBACK FROM MULTI-STAKEHOLDER GROUPS.**—The Secretary shall take into consideration input provided by multi-stakeholder groups, consistent with sections 1890(b)(7) and 1890A of the Social Security Act, as added by section 3014 of this Act, in selecting quality measures for use under this section.

(e) **CONSIDERATION OF TRANSITION TO VALUE-BASED PURCHASING.**—In developing the plan under this subsection (a)(2), the Secretary shall, as the Secretary determines appropriate, consider the plan to transition to a value-based purchasing program for physicians and other practitioners developed under section 131 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275).

(f) **REPORT TO CONGRESS.**—Not later than January 1, 2015, the Secretary shall submit to Congress a report on the Physician Compare Internet website developed under subsection (a)(1). Such report shall include information on the efforts of and plans made by the Secretary to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(g) **EXPANSION.**—At any time before the date on which the report is submitted under subsection (f), the Secretary may expand (including expansion to other providers of services and suppliers under title XVIII of the Social Security Act) the information made available on such website.

(h) **FINANCIAL INCENTIVES TO ENCOURAGE CONSUMERS TO CHOOSE HIGH QUALITY PROVIDERS.**—The Secretary may establish a demonstration program, not later than January 1, 2019, to provide financial incentives to Medicare beneficiaries who are furnished services by high quality physicians, as determined by the Secretary based on factors in subparagraphs (A) through (G) of subsection (a)(2). In no case may Medicare beneficiaries be required to pay increased premiums or cost sharing or be subject to a reduction in benefits under title XVIII of the Social Security Act as a result of such demonstration program. The Secretary shall ensure that any such demonstration program does not disadvantage those beneficiaries without reasonable access to high performing physicians or create financial inequities under such title.

(i) **DEFINITIONS.**—In this section:

(1) **ELIGIBLE PROFESSIONAL.**—The term “eligible professional” has the meaning given that term for purposes of the Physician Quality Reporting Initiative under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(2) **PHYSICIAN.**—The term “physician” has the meaning given that term in section 1861(r) of such Act (42 U.S.C. 1395x(r)).

(3) **PHYSICIAN COMPARE.**—The term “Physician Compare” means the Internet website developed under subsection (a)(1).

(4) **SECRETARY.**—The term “Secretary” means the Secretary of Health and Human Services.

SEC. 10332. AVAILABILITY OF MEDICARE DATA FOR PERFORMANCE MEASUREMENT.

(a) **IN GENERAL.**—Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

“(e) **AVAILABILITY OF MEDICARE DATA.**—

“(1) **IN GENERAL.**—Subject to paragraph (4), the Secretary shall make available to qualified entities (as defined in paragraph (2)) data described in paragraph (3) for the evaluation of the performance of providers of services and suppliers.

“(2) **QUALIFIED ENTITIES.**—For purposes of this subsection, the term ‘qualified entity’ means a public or private entity that—

“(A) is qualified (as determined by the Secretary) to use claims data to evaluate the per-

formance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use; and

“(B) agrees to meet the requirements described in paragraph (4) and meets such other requirements as the Secretary may specify, such as ensuring security of data.

“(3) **DATA DESCRIBED.**—The data described in this paragraph are standardized extracts (as determined by the Secretary) of claims data under parts A, B, and D for items and services furnished under such parts for one or more specified geographic areas and time periods requested by a qualified entity. The Secretary shall take such actions as the Secretary deems necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts.

“(4) **REQUIREMENTS.**—

“(A) **FEE.**—Data described in paragraph (3) shall be made available to a qualified entity under this subsection at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited into the Federal Supplementary Medical Insurance Trust Fund under section 1841.

“(B) **SPECIFICATION OF USES AND METHODOLOGIES.**—A qualified entity requesting data under this subsection shall—

“(i) submit to the Secretary a description of the methodologies that such qualified entity will use to evaluate the performance of providers of services and suppliers using such data;

“(ii)(I) except as provided in subclause (II), if available, use standard measures, such as measures endorsed by the entity with a contract under section 1890(a) and measures developed pursuant to section 931 of the Public Health Service Act; or

“(II) use alternative measures if the Secretary, in consultation with appropriate stakeholders, determines that use of such alternative measures would be more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by such standard measures;

“(iii) include data made available under this subsection with claims data from sources other than claims data under this title in the evaluation of performance of providers of services and suppliers;

“(iv) only include information on the evaluation of performance of providers and suppliers in reports described in subparagraph (C);

“(v) make available to providers of services and suppliers, upon their request, data made available under this subsection; and

“(vi) prior to their release, submit to the Secretary the format of reports under subparagraph (C).

“(C) **REPORTS.**—Any report by a qualified entity evaluating the performance of providers of services and suppliers using data made available under this subsection shall—

“(i) include an understandable description of the measures, which shall include quality measures and the rationale for use of other measures described in subparagraph (B)(ii)(II), risk adjustment methods, physician attribution methods, other applicable methods, data specifications and limitations, and the sponsors, so that consumers, providers of services and suppliers, health plans, researchers, and other stakeholders can assess such reports;

“(ii) be made available confidentially, to any provider of services or supplier to be identified in such report, prior to the public release of such report, and provide an opportunity to appeal and correct errors;

“(iii) only include information on a provider of services or supplier in an aggregate form as determined appropriate by the Secretary; and

“(iv) except as described in clause (ii), be made available to the public.

“(D) **APPROVAL AND LIMITATION OF USES.**—The Secretary shall not make data described in

paragraph (3) available to a qualified entity unless the qualified entity agrees to release the information on the evaluation of performance of providers of services and suppliers. Such entity shall only use such data, and information derived from such evaluation, for the reports under subparagraph (C). Data released to a qualified entity under this subsection shall not be subject to discovery or admission as evidence in judicial or administrative proceedings without consent of the applicable provider of services or supplier.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on January 1, 2012.

SEC. 10333. COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following new subpart:

“Subpart XI—Community-Based Collaborative Care Network Program

“SEC. 340H. COMMUNITY-BASED COLLABORATIVE CARE NETWORK PROGRAM.

“(a) **IN GENERAL.**—The Secretary may award grants to eligible entities to support community-based collaborative care networks that meet the requirements of subsection (b).

“(b) **COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.**—

“(1) **DESCRIPTION.**—A community-based collaborative care network (referred to in this section as a ‘network’) shall be a consortium of health care providers with a joint governance structure (including providers within a single entity) that provides comprehensive coordinated and integrated health care services (as defined by the Secretary) for low-income populations.

“(2) **REQUIRED INCLUSION.**—A network shall include the following providers (unless such provider does not exist within the community, declines or refuses to participate, or places unreasonable conditions on their participation):

“(A) A hospital that meets the criteria in section 1923(b)(1) of the Social Security Act; and

“(B) All Federally qualified health centers (as defined in section 1861(aa) of the Social Security Act) located in the community.

“(3) **PRIORITY.**—In awarding grants, the Secretary shall give priority to networks that include—

“(A) the capability to provide the broadest range of services to low-income individuals;

“(B) the broadest range of providers that currently serve a high volume of low-income individuals; and

“(C) a county or municipal department of health.

“(c) **APPLICATION.**—

“(1) **APPLICATION.**—A network described in subsection (b) shall submit an application to the Secretary.

“(2) **RENEWAL.**—In subsequent years, based on the performance of grantees, the Secretary may provide renewal grants to prior year grant recipients.

“(d) **USE OF FUNDS.**—

“(1) **USE BY GRANTEES.**—Grant funds may be used for the following activities:

“(A) Assist low-income individuals to—

“(i) access and appropriately use health services;

“(ii) enroll in health coverage programs; and

“(iii) obtain a regular primary care provider or a medical home.

“(B) Provide case management and care management.

“(C) Perform health outreach using neighborhood health workers or through other means.

“(D) Provide transportation.

“(E) Expand capacity, including through telehealth, after-hours services or urgent care.

“(F) Provide direct patient care services.

“(2) **GRANT FUNDS TO HRSA GRANTEES.**—The Secretary may limit the percent of grant funding

that may be spent on direct care services provided by grantees of programs administered by the Health Resources and Services Administration or impose other requirements on such grantees deemed necessary.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2011 through 2015.”

SEC. 10334. MINORITY HEALTH.

(a) OFFICE OF MINORITY HEALTH.—

(1) IN GENERAL.—Section 1707 of the Public Health Service Act (42 U.S.C. 300u-6) is amended—

(A) in subsection (a), by striking “within the Office of Public Health and Science” and all that follows through the end and inserting “. The Office of Minority Health as existing on the date of enactment of the Patient Protection and Affordable Care Act shall be transferred to the Office of the Secretary in such manner that there is established in the Office of the Secretary, the Office of Minority Health, which shall be headed by the Deputy Assistant Secretary for Minority Health who shall report directly to the Secretary, and shall retain and strengthen authorities (as in existence on such date of enactment) for the purpose of improving minority health and the quality of health care minorities receive, and eliminating racial and ethnic disparities. In carrying out this subsection, the Secretary, acting through the Deputy Assistant Secretary, shall award grants, contracts, enter into memoranda of understanding, cooperative, interagency, intra-agency and other agreements with public and nonprofit private entities, agencies, as well as Departmental and Cabinet agencies and organizations, and with organizations that are indigenous human resource providers in communities of color to assure improved health status of racial and ethnic minorities, and shall develop measures to evaluate the effectiveness of activities aimed at reducing health disparities and supporting the local community. Such measures shall evaluate community outreach activities, language services, workforce cultural competence, and other areas as determined by the Secretary.”; and

(B) by striking subsection (h) and inserting the following:

“(h) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2016.”

(2) TRANSFER OF FUNCTIONS.—There are transferred to the Office of Minority Health in the office of the Secretary of Health and Human Services, all duties, responsibilities, authorities, accountabilities, functions, staff, funds, award mechanisms, and other entities under the authority of the Office of Minority Health of the Public Health Service as in effect on the date before the date of enactment of this Act, which shall continue in effect according to the terms in effect on the date before such date of enactment, until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, the Secretary, a court of competent jurisdiction, or by operation of law.

(3) REPORTS.—Not later than 1 year after the date of enactment of this section, and biennially thereafter, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under section 1707 of the Public Health Service Act (as amended by this subsection) during the period for which the report is being prepared. Not later than 1 year after the date of enactment of this section, and biennially thereafter, the heads of each of the agencies of the Department of Health and Human Services shall submit to the Deputy As-

sistant Secretary for Minority Health a report summarizing the minority health activities of each of the respective agencies.

(b) ESTABLISHMENT OF INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—

(1) IN GENERAL.—Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended by inserting after section 1707 the following section:

“SEC. 1707A. INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN THE DEPARTMENT.

“(a) IN GENERAL.—The head of each agency specified in subsection (b)(1) shall establish within the agency an office to be known as the Office of Minority Health. The head of each such Office shall be appointed by the head of the agency within which the Office is established, and shall report directly to the head of the agency. The head of such agency shall carry out this section (as this section relates to the agency) acting through such Director.

“(b) SPECIFIED AGENCIES.—The agencies referred to in subsection (a) are the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services.

“(c) DIRECTOR; APPOINTMENT.—Each Office of Minority Health established in an agency listed in subsection (a) shall be headed by a director, with documented experience and expertise in minority health services research and health disparities elimination.

“(d) REFERENCES.—Except as otherwise specified, any reference in Federal law to an Office of Minority Health (in the Department of Health and Human Services) is deemed to be a reference to the Office of Minority Health in the Office of the Secretary.

“(e) FUNDING.—

“(1) ALLOCATIONS.—Of the amounts appropriated for a specified agency for a fiscal year, the Secretary must designate an appropriate amount of funds for the purpose of carrying out activities under this section through the minority health office of the agency. In reserving an amount under the preceding sentence for a minority health office for a fiscal year, the Secretary shall reduce, by substantially the same percentage, the amount that otherwise would be available for each of the programs of the designated agency involved.

“(2) AVAILABILITY OF FUNDS FOR STAFFING.—The purposes for which amounts made available under paragraph may be expended by a minority health office include the costs of employing staff for such office.”

(2) NO NEW REGULATORY AUTHORITY.—Nothing in this subsection and the amendments made by this subsection may be construed as establishing regulatory authority or modifying any existing regulatory authority.

(3) LIMITATION ON TERMINATION.—Notwithstanding any other provision of law, a Federal office of minority health or Federal appointive position with primary responsibility over minority health issues that is in existence in an office of agency of the Department of Health and Human Services on the date of enactment of this section shall not be terminated, reorganized, or have any of its power or duties transferred unless such termination, reorganization, or transfer is approved by an Act of Congress.

(c) REDESIGNATION OF NATIONAL CENTER ON MINORITY HEALTH AND HEALTH DISPARITIES.—

(1) REDESIGNATION.—Title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended—

(A) by redesignating subpart 6 of part E as subpart 20;

(B) by transferring subpart 20, as so redesignated, to part C of such title IV;

(C) by inserting subpart 20, as so redesignated, after subpart 19 of such part C; and

(D) in subpart 20, as so redesignated—

(i) by redesignating sections 485E through 485H as sections 464z-3 through 464z-6, respectively;

(ii) by striking “National Center on Minority Health and Health Disparities” each place such term appears and inserting “National Institute on Minority Health and Health Disparities”; and

(iii) by striking “Center” each place such term appears and inserting “Institute”.

(2) PURPOSE OF INSTITUTE; DUTIES.—Section 464z-3 of the Public Health Service Act, as so redesignated, is amended—

(A) in subsection (h)(1), by striking “research endowments at centers of excellence under section 736.” and inserting the following: “research endowments—

“(1) at centers of excellence under section 736; and

“(2) at centers of excellence under section 464z-4.”;

(B) in subsection (h)(2)(A), by striking “average” and inserting “median”; and

(C) by adding at the end the following:

“(h) INTERAGENCY COORDINATION.—The Director of the Institute, as the primary Federal official with responsibility for coordinating all research and activities conducted or supported by the National Institutes of Health on minority health and health disparities, shall plan, coordinate, review and evaluate research and other activities conducted or supported by the Institutes and Centers of the National Institutes of Health.”

(3) TECHNICAL AND CONFORMING AMENDMENTS.—

(A) Section 401(b)(24) of the Public Health Service Act (42 U.S.C. 281(b)(24)) is amended by striking “Center” and inserting “Institute”.

(B) Subsection (d)(1) of section 903 of the Public Health Service Act (42 U.S.C. 299a-1(d)(1)) is amended by striking “section 485E” and inserting “section 464z-3”.

SEC. 10335. TECHNICAL CORRECTION TO THE HOSPITAL VALUE-BASED PURCHASING PROGRAM.

Section 1886(o)(2)(A) of the Social Security Act, as added by section 3001, is amended, in the first sentence, by inserting “, other than measures of readmissions,” after “shall select measures”.

SEC. 10336. GAO STUDY AND REPORT ON MEDICARE BENEFICIARY ACCESS TO HIGH-QUALITY DIALYSIS SERVICES.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on the impact on Medicare beneficiary access to high-quality dialysis services of including specified oral drugs that are furnished to such beneficiaries for the treatment of end stage renal disease in the bundled prospective payment system under section 1881(b)(14) of the Social Security Act (42 U.S.C. 1395rr(b)(14)) (pursuant to the proposed rule published by the Secretary of Health and Human Services in the Federal Register on September 29, 2009 (74 Fed. Reg. 49922 et seq.)). Such study shall include an analysis of—

(A) the ability of providers of services and renal dialysis facilities to furnish specified oral drugs or arrange for the provision of such drugs;

(B) the ability of providers of services and renal dialysis facilities to comply, if necessary, with applicable State laws (such as State pharmacy licensure requirements) in order to furnish specified oral drugs;

(C) whether appropriate quality measures exist to safeguard care for Medicare beneficiaries being furnished specified oral drugs by

providers of services and renal dialysis facilities; and

(D) other areas determined appropriate by the Comptroller General.

(2) SPECIFIED ORAL DRUG DEFINED.—For purposes of paragraph (1), the term “specified oral drug” means a drug or biological for which there is no injectable equivalent (or other non-oral form of administration).

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

Subtitle D—Provisions Relating to Title IV

SEC. 10401. AMENDMENTS TO SUBTITLE A.

(a) Section 4001(h)(4) and (5) of this Act is amended by striking “2010” each place such appears and inserting “2020”.

(b) Section 4002(c) of this Act is amended—

(1) by striking “research and health screenings” and inserting “research, health screenings, and initiatives”; and

(2) by striking “for Preventive” and inserting “Regarding Preventive”.

(c) Section 4004(a)(4) of this Act is amended by striking “a Gateway” and inserting “an Exchange”.

SEC. 10402. AMENDMENTS TO SUBTITLE B.

(a) Section 399Z–1(a)(1)(A) of the Public Health Service Act, as added by section 4101(b) of this Act, is amended by inserting “and vision” after “oral”.

(b) Section 1861(hhh)(4)(G) of the Social Security Act, as added by section 4103(b), is amended to read as follows:

“(G) A beneficiary shall be eligible to receive only an initial preventive physical examination (as defined under subsection (www)(1)) during the 12-month period after the date that the beneficiary’s coverage begins under part B and shall be eligible to receive personalized prevention plan services under this subsection each year thereafter provided that the beneficiary has not received either an initial preventive physical examination or personalized prevention plan services within the preceding 12-month period.”

SEC. 10403. AMENDMENTS TO SUBTITLE C.

Section 4201 of this Act is amended—

(1) in subsection (a), by adding before the period the following: “, with not less than 20 percent of such grants being awarded to rural and frontier areas”; and

(2) in subsection (c)(2)(B)(vii), by striking “both urban and rural areas” and inserting “urban, rural, and frontier areas”; and

(3) in subsection (f), by striking “each fiscal years” and inserting “each of fiscal year”.

SEC. 10404. AMENDMENTS TO SUBTITLE D.

Section 399MM(2) of the Public Health Service Act, as added by section 4303 of this Act, is amended by striking “by ensuring” and inserting “and ensuring”.

SEC. 10405. AMENDMENTS TO SUBTITLE E.

Subtitle E of title IV of this Act is amended by striking section 4401.

SEC. 10406. AMENDMENT RELATING TO WAIVING COINSURANCE FOR PREVENTIVE SERVICES.

Section 4104(b) of this Act is amended to read as follows:

“(b) PAYMENT AND ELIMINATION OF COINSURANCE IN ALL SETTINGS.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 4103(c)(1), is amended—

“(1) in subparagraph (T), by inserting ‘(or 100 percent if such services are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or popu-

lation and are appropriate for the individual)’ after ‘80 percent’;

“(2) in subparagraph (W)—

“(A) in clause (i), by inserting ‘(if such subparagraph were applied, by substituting ‘100 percent’ for ‘80 percent’)’ after ‘subparagraph (D)’; and

“(B) in clause (ii), by striking ‘80 percent’ and inserting ‘100 percent’;

“(3) by striking ‘and’ before ‘(X)’; and

“(4) by inserting before the semicolon at the end the following: ‘, and (Y) with respect to preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount paid shall be 100 percent of (i) except as provided in clause (ii), the lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part, and (ii) in the case of such services that are covered OPD services (as defined in subsection (t)(1)(B)), the amount determined under subsection (t)’.”

SEC. 10407. BETTER DIABETES CARE.

(a) SHORT TITLE.—This section may be cited as the “Catalyst to Better Diabetes Care Act of 2009”.

(b) NATIONAL DIABETES REPORT CARD.—

(1) IN GENERAL.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention (referred to in this section as the “Director”), shall prepare on a biennial basis a national diabetes report card (referred to in this section as a “Report Card”) and, to the extent possible, for each State.

(2) CONTENTS.—

(A) IN GENERAL.—Each Report Card shall include aggregate health outcomes related to individuals diagnosed with diabetes and prediabetes including—

(i) preventative care practices and quality of care;

(ii) risk factors; and

(iii) outcomes.

(B) UPDATED REPORTS.—Each Report Card that is prepared after the initial Report Card shall include trend analysis for the Nation and, to the extent possible, for each State, for the purpose of—

(i) tracking progress in meeting established national goals and objectives for improving diabetes care, costs, and prevalence (including Healthy People 2010); and

(ii) informing policy and program development.

(3) AVAILABILITY.—The Secretary, in collaboration with the Director, shall make each Report Card publicly available, including by posting the Report Card on the Internet.

(c) IMPROVEMENT OF VITAL STATISTICS COLLECTION.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in collaboration with appropriate agencies and States, shall—

(A) promote the education and training of physicians on the importance of birth and death certificate data and how to properly complete these documents, including the collection of such data for diabetes and other chronic diseases;

(B) encourage State adoption of the latest standard revisions of birth and death certificates; and

(C) work with States to re-engineer their vital statistics systems in order to provide cost-effective, timely, and accurate vital systems data.

(2) DEATH CERTIFICATE ADDITIONAL LANGUAGE.—In carrying out this subsection, the Secretary may promote improvements to the col-

lection of diabetes mortality data, including the addition of a question for the individual certifying the cause of death regarding whether the deceased had diabetes.

(d) STUDY ON APPROPRIATE LEVEL OF DIABETES MEDICAL EDUCATION.—

(1) IN GENERAL.—The Secretary shall, in collaboration with the Institute of Medicine and appropriate associations and councils, conduct a study of the impact of diabetes on the practice of medicine in the United States and the appropriateness of the level of diabetes medical education that should be required prior to licensure, board certification, and board recertification.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report on the study under paragraph (1) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

SEC. 10408. GRANTS FOR SMALL BUSINESSES TO PROVIDE COMPREHENSIVE WORKPLACE WELLNESS PROGRAMS.

(a) ESTABLISHMENT.—The Secretary shall award grants to eligible employers to provide their employees with access to comprehensive workplace wellness programs (as described under subsection (c)).

(b) SCOPE.—

(1) DURATION.—The grant program established under this section shall be conducted for a 5-year period.

(2) ELIGIBLE EMPLOYER.—The term “eligible employer” means an employer (including a non-profit employer) that—

(A) employs less than 100 employees who work 25 hours or greater per week; and

(B) does not provide a workplace wellness program as of the date of enactment of this Act.

(c) COMPREHENSIVE WORKPLACE WELLNESS PROGRAMS.—

(1) CRITERIA.—The Secretary shall develop program criteria for comprehensive workplace wellness programs under this section that are based on and consistent with evidence-based research and best practices, including research and practices as provided in the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry for Effective Programs.

(2) REQUIREMENTS.—A comprehensive workplace wellness program shall be made available by an eligible employer to all employees and include the following components:

(A) Health awareness initiatives (including health education, preventive screenings, and health risk assessments).

(B) Efforts to maximize employee engagement (including mechanisms to encourage employee participation).

(C) Initiatives to change unhealthy behaviors and lifestyle choices (including counseling, seminars, online programs, and self-help materials).

(D) Supportive environment efforts (including workplace policies to encourage healthy lifestyles, healthy eating, increased physical activity, and improved mental health).

(d) APPLICATION.—An eligible employer desiring to participate in the grant program under this section shall submit an application to the Secretary, in such manner and containing such information as the Secretary may require, which shall include a proposal for a comprehensive workplace wellness program that meet the criteria and requirements described under subsection (c).

(e) AUTHORIZATION OF APPROPRIATION.—For purposes of carrying out the grant program under this section, there is authorized to be appropriated \$200,000,000 for the period of fiscal

years 2011 through 2015. Amounts appropriated pursuant to this subsection shall remain available until expended.

SEC. 10409. CURES ACCELERATION NETWORK.

(a) **SHORT TITLE.**—This section may be cited as the “Cures Acceleration Network Act of 2009”.

(b) **REQUIREMENT FOR THE DIRECTOR OF NIH TO ESTABLISH A CURES ACCELERATION NETWORK.**—Section 402(b) of the Public Health Service Act (42 U.S.C. 282(b)) is amended—

(1) in paragraph (22), by striking “and” at the end;

(2) in paragraph (23), by striking the period and inserting “; and”; and

(3) by inserting after paragraph (23), the following:

“(24) implement the Cures Acceleration Network described in section 402C.”.

(c) **ACCEPTING GIFTS TO SUPPORT THE CURES ACCELERATION NETWORK.**—Section 499(c)(1) of the Public Health Service Act (42 U.S.C. 290b(c)(1)) is amended by adding at the end the following:

“(E) The Cures Acceleration Network described in section 402C.”.

(d) **ESTABLISHMENT OF THE CURES ACCELERATION NETWORK.**—Part A of title IV of the Public Health Service Act is amended by inserting after section 402B (42 U.S.C. 282b) the following:

“SEC. 402C. CURES ACCELERATION NETWORK.

“(a) **DEFINITIONS.**—In this section:

“(1) **BIOLOGICAL PRODUCT.**—The term ‘biological product’ has the meaning given such term in section 351 of the Public Health Service Act.

“(2) **DRUG; DEVICE.**—The terms ‘drug’ and ‘device’ have the meanings given such terms in section 201 of the Federal Food, Drug, and Cosmetic Act.

“(3) **HIGH NEED CURE.**—The term ‘high need cure’ means a drug (as that term is defined by section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act, biological product (as that term is defined by section 262(i)), or device (as that term is defined by section 201(h) of the Federal Food, Drug, and Cosmetic Act) that, in the determination of the Director of NIH—

“(A) is a priority to diagnose, mitigate, prevent, or treat harm from any disease or condition; and

“(B) for which the incentives of the commercial market are unlikely to result in its adequate or timely development.

“(4) **MEDICAL PRODUCT.**—The term ‘medical product’ means a drug, device, biological product, or product that is a combination of drugs, devices, and biological products.

“(b) **ESTABLISHMENT OF THE CURES ACCELERATION NETWORK.**—Subject to the appropriation of funds as described in subsection (g), there is established within the Office of the Director of NIH a program to be known as the Cures Acceleration Network (referred to in this section as ‘CAN’), which shall—

“(1) be under the direction of the Director of NIH, taking into account the recommendations of a CAN Review Board (referred to in this section as the ‘Board’), described in subsection (d); and

“(2) award grants and contracts to eligible entities, as described in subsection (e), to accelerate the development of high need cures, including through the development of medical products and behavioral therapies.

“(c) **FUNCTIONS.**—The functions of the CAN are to—

“(1) conduct and support revolutionary advances in basic research, translating scientific discoveries from bench to bedside;

“(2) award grants and contracts to eligible entities to accelerate the development of high need cures;

“(3) provide the resources necessary for government agencies, independent investigators, re-

search organizations, biotechnology companies, academic research institutions, and other entities to develop high need cures;

“(4) reduce the barriers between laboratory discoveries and clinical trials for new therapies; and

“(5) facilitate review in the Food and Drug Administration for the high need cures funded by the CAN, through activities that may include—

“(A) the facilitation of regular and ongoing communication with the Food and Drug Administration regarding the status of activities conducted under this section;

“(B) ensuring that such activities are coordinated with the approval requirements of the Food and Drug Administration, with the goal of expediting the development and approval of countermeasures and products; and

“(C) connecting interested persons with additional technical assistance made available under section 565 of the Federal Food, Drug, and Cosmetic Act.

“(d) **CAN BOARD.**—

“(1) **ESTABLISHMENT.**—There is established a Cures Acceleration Network Review Board (referred to in this section as the ‘Board’), which shall advise the Director of NIH on the conduct of the activities of the Cures Acceleration Network.

“(2) **MEMBERSHIP.**—

“(A) **IN GENERAL.**—

“(i) **APPOINTMENT.**—The Board shall be comprised of 24 members who are appointed by the Secretary and who serve at the pleasure of the Secretary.

“(ii) **CHAIRPERSON AND VICE CHAIRPERSON.**—The Secretary shall designate, from among the 24 members appointed under clause (i), one Chairperson of the Board (referred to in this section as the ‘Chairperson’) and one Vice Chairperson.

“(B) **TERMS.**—

“(i) **IN GENERAL.**—Each member shall be appointed to serve a 4-year term, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which the member’s predecessor was appointed shall be appointed for the remainder of such term.

“(ii) **CONSECUTIVE APPOINTMENTS; MAXIMUM TERMS.**—A member may be appointed to serve not more than 3 terms on the Board, and may not serve more than 2 such terms consecutively.

“(C) **QUALIFICATIONS.**—

“(i) **IN GENERAL.**—The Secretary shall appoint individuals to the Board based solely upon the individual’s established record of distinguished service in one of the areas of expertise described in clause (ii). Each individual appointed to the Board shall be of distinguished achievement and have a broad range of disciplinary interests.

“(ii) **EXPERTISE.**—The Secretary shall select individuals based upon the following requirements:

“(I) For each of the fields of—

“(aa) basic research;

“(bb) medicine;

“(cc) biopharmaceuticals;

“(dd) discovery and delivery of medical products;

“(ee) bioinformatics and gene therapy;

“(ff) medical instrumentation; and

“(gg) regulatory review and approval of medical products,

the Secretary shall select at least 1 individual who is eminent in such fields.

“(II) At least 4 individuals shall be recognized leaders in professional venture capital or private equity organizations and have demonstrated experience in private equity investing.

“(III) At least 8 individuals shall represent disease advocacy organizations.

“(3) **EX-OFFICIO MEMBERS.**—

“(A) **APPOINTMENT.**—In addition to the 24 Board members described in paragraph (2), the

Secretary shall appoint as ex-officio members of the Board—

“(i) a representative of the National Institutes of Health, recommended by the Secretary of the Department of Health and Human Services;

“(ii) a representative of the Office of the Assistant Secretary of Defense for Health Affairs, recommended by the Secretary of Defense;

“(iii) a representative of the Office of the Under Secretary for Health for the Veterans Health Administration, recommended by the Secretary of Veterans Affairs;

“(iv) a representative of the National Science Foundation, recommended by the Chair of the National Science Board; and

“(v) a representative of the Food and Drug Administration, recommended by the Commissioner of Food and Drugs.

“(B) **TERMS.**—Each ex-officio member shall serve a 3-year term on the Board, except that the Chairperson may adjust the terms of the initial ex-officio members in order to provide for a staggered term of appointment for all such members.

“(4) **RESPONSIBILITIES OF THE BOARD AND THE DIRECTOR OF NIH.**—

“(A) **RESPONSIBILITIES OF THE BOARD.**—

“(i) **IN GENERAL.**—The Board shall advise, and provide recommendations to, the Director of NIH with respect to—

“(I) policies, programs, and procedures for carrying out the duties of the Director of NIH under this section; and

“(II) significant barriers to successful translation of basic science into clinical application (including issues under the purview of other agencies and departments).

“(ii) **REPORT.**—In the case that the Board identifies a significant barrier, as described in clause (i)(II), the Board shall submit to the Secretary a report regarding such barrier.

“(B) **RESPONSIBILITIES OF THE DIRECTOR OF NIH.**—With respect to each recommendation provided by the Board under subparagraph (A)(i), the Director of NIH shall respond in writing to the Board, indicating whether such Director will implement such recommendation. In the case that the Director of NIH indicates a recommendation of the Board will not be implemented, such Director shall provide an explanation of the reasons for not implementing such recommendation.

“(5) **MEETINGS.**—

“(A) **IN GENERAL.**—The Board shall meet 4 times per calendar year, at the call of the Chairperson.

“(B) **QUORUM; REQUIREMENTS; LIMITATIONS.**—

“(i) **QUORUM.**—A quorum shall consist of a total of 13 members of the Board, excluding ex-officio members, with diverse representation as described in clause (iii).

“(ii) **CHAIRPERSON OR VICE CHAIRPERSON.**—Each meeting of the Board shall be attended by either the Chairperson or the Vice Chairperson.

“(iii) **DIVERSE REPRESENTATION.**—At each meeting of the Board, there shall be not less than one scientist, one representative of a disease advocacy organization, and one representative of a professional venture capital or private equity organization.

“(6) **COMPENSATION AND TRAVEL EXPENSES.**—

“(A) **COMPENSATION.**—Members shall receive compensation at a rate to be fixed by the Chairperson but not to exceed a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which the member is engaged in the performance of the duties of the Board. All members of the Board who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

“(B) TRAVEL EXPENSES.—Members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for persons employed intermittently by the Federal Government under section 5703(b) of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

“(e) GRANT PROGRAM.—

“(1) SUPPORTING INNOVATION.—To carry out the purposes described in this section, the Director of NIH shall award contracts, grants, or cooperative agreements to the entities described in paragraph (2), to—

“(A) promote innovation in technologies supporting the advanced research and development and production of high need cures, including through the development of medical products and behavioral therapies.

“(B) accelerate the development of high need cures, including through the development of medical products, behavioral therapies, and biomarkers that demonstrate the safety or effectiveness of medical products; or

“(C) help the award recipient establish protocols that comply with Food and Drug Administration standards and otherwise permit the recipient to meet regulatory requirements at all stages of development, manufacturing, review, approval, and safety surveillance of a medical product.

“(2) ELIGIBLE ENTITIES.—To receive assistance under paragraph (1), an entity shall—

“(A) be a public or private entity, which may include a private or public research institution, an institution of higher education, a medical center, a biotechnology company, a pharmaceutical company, a disease advocacy organization, a patient advocacy organization, or an academic research institution;

“(B) submit an application containing—

“(i) a detailed description of the project for which the entity seeks such grant or contract;

“(ii) a timetable for such project;

“(iii) an assurance that the entity will submit—

“(I) interim reports describing the entity’s—

“(aa) progress in carrying out the project; and

“(bb) compliance with all provisions of this section and conditions of receipt of such grant or contract; and

“(II) a final report at the conclusion of the grant period, describing the outcomes of the project; and

“(iv) a description of the protocols the entity will follow to comply with Food and Drug Administration standards and regulatory requirements at all stages of development, manufacturing, review, approval, and safety surveillance of a medical product; and

“(C) provide such additional information as the Director of NIH may require.

“(3) AWARDS.—

“(A) THE CURES ACCELERATION PARTNERSHIP AWARDS.—

“(i) INITIAL AWARD AMOUNT.—Each award under this subparagraph shall be not more than \$15,000,000 per project for the first fiscal year for which the project is funded, which shall be payable in one payment.

“(ii) FUNDING IN SUBSEQUENT FISCAL YEARS.—An eligible entity receiving an award under clause (i) may apply for additional funding for such project by submitting to the Director of NIH the information required under subparagraphs (B) and (C) of paragraph (2). The Director may fund a project of such eligible entity in an amount not to exceed \$15,000,000 for a fiscal year subsequent to the initial award under clause (i).

“(iii) MATCHING FUNDS.—As a condition for receiving an award under this subsection, an eligible entity shall contribute to the project non-Federal funds in the amount of \$1 for every \$3

awarded under clauses (i) and (ii), except that the Director of NIH may waive or modify such matching requirement in any case where the Director determines that the goals and objectives of this section cannot adequately be carried out unless such requirement is waived.

“(B) THE CURES ACCELERATION GRANT AWARDS.—

“(i) INITIAL AWARD AMOUNT.—Each award under this subparagraph shall be not more than \$15,000,000 per project for the first fiscal year for which the project is funded, which shall be payable in one payment.

“(ii) FUNDING IN SUBSEQUENT FISCAL YEARS.—An eligible entity receiving an award under clause (i) may apply for additional funding for such project by submitting to the Board the information required under subparagraphs (B) and (C) of paragraph (2). The Director of NIH may fund a project of such eligible entity in an amount not to exceed \$15,000,000 for a fiscal year subsequent to the initial award under clause (i).

“(C) THE CURES ACCELERATION FLEXIBLE RESEARCH AWARDS.—If the Director of NIH determines that the goals and objectives of this section cannot adequately be carried out through a contract, grant, or cooperative agreement, the Director of NIH shall have flexible research authority to use other transactions to fund projects in accordance with the terms and conditions of this section. Awards made under such flexible research authority for a fiscal year shall not exceed 20 percent of the total funds appropriated under subsection (g)(1) for such fiscal year.

“(4) SUSPENSION OF AWARDS FOR DEFAULTS, NONCOMPLIANCE WITH PROVISIONS AND PLANS, AND DIVERSION OF FUNDS; REPAYMENT OF FUNDS.—The Director of NIH may suspend the award to any entity upon noncompliance by such entity with provisions and plans under this section or diversion of funds.

“(5) AUDITS.—The Director of NIH may enter into agreements with other entities to conduct periodic audits of the projects funded by grants or contracts awarded under this subsection.

“(6) CLOSEOUT PROCEDURES.—At the end of a grant or contract period, a recipient shall follow the closeout procedures under section 74.71 of title 45, Code of Federal Regulations (or any successor regulation).

“(7) REVIEW.—A determination by the Director of NIH as to whether a drug, device, or biological product is a high need cure (for purposes of subsection (a)(3)) shall not be subject to judicial review.

“(f) COMPETITIVE BASIS OF AWARDS.—Any grant, cooperative agreement, or contract awarded under this section shall be awarded on a competitive basis.

“(g) AUTHORIZATION OF APPROPRIATIONS.—

“(1) IN GENERAL.—For purposes of carrying out this section, there are authorized to be appropriated \$500,000,000 for fiscal year 2010, and such sums as may be necessary for subsequent fiscal years. Funds appropriated under this section shall be available until expended.

“(2) LIMITATION ON USE OF FUNDS OTHERWISE APPROPRIATED.—No funds appropriated under this Act, other than funds appropriated under paragraph (1), may be allocated to the Cures Acceleration Network.”.

SEC. 10410. CENTERS OF EXCELLENCE FOR DEPRESSION.

(a) SHORT TITLE.—This section may be cited as the “Establishing a Network of Health-Advancing National Centers of Excellence for Depression Act of 2009” or the “ENHANCED Act of 2009”.

(b) CENTERS OF EXCELLENCE FOR DEPRESSION.—Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb et seq.) is amended by inserting after section 520A the following:

“SEC. 520B. NATIONAL CENTERS OF EXCELLENCE FOR DEPRESSION.

“(a) DEPRESSIVE DISORDER DEFINED.—In this section, the term ‘depressive disorder’ means a mental or brain disorder relating to depression, including major depression, bipolar disorder, and related mood disorders.

“(b) GRANT PROGRAM.—

“(1) IN GENERAL.—The Secretary, acting through the Administrator, shall award grants on a competitive basis to eligible entities to establish national centers of excellence for depression (referred to in this section as ‘Centers’), which shall engage in activities related to the treatment of depressive disorders.

“(2) ALLOCATION OF AWARDS.—If the funds authorized under subsection (f) are appropriated in the amounts provided for under such subsection, the Secretary shall allocate such amounts so that—

“(A) not later than 1 year after the date of enactment of the ENHANCED Act of 2009, not more than 20 Centers may be established; and

“(B) not later than September 30, 2016, not more than 30 Centers may be established.

“(3) GRANT PERIOD.—

“(A) IN GENERAL.—A grant awarded under this section shall be for a period of 5 years.

“(B) RENEWAL.—A grant awarded under subparagraph (A) may be renewed, on a competitive basis, for 1 additional 5-year period, at the discretion of the Secretary. In determining whether to renew a grant, the Secretary shall consider the report cards issued under subsection (e)(2).

“(4) USE OF FUNDS.—Grant funds awarded under this subsection shall be used for the establishment and ongoing activities of the recipient of such funds.

“(5) ELIGIBLE ENTITIES.—

“(A) REQUIREMENTS.—To be eligible to receive a grant under this section, an entity shall—

“(i) be an institution of higher education or a public or private nonprofit research institution; and

“(ii) submit an application to the Secretary at such time and in such manner as the Secretary may require, as described in subparagraph (B).

“(B) APPLICATION.—An application described in subparagraph (A)(ii) shall include—

“(i) evidence that such entity—

“(I) provides, or is capable of coordinating with other entities to provide, comprehensive health services with a focus on mental health services and subspecialty expertise for depressive disorders;

“(II) collaborates with other mental health providers, as necessary, to address co-occurring mental illnesses;

“(III) is capable of training health professionals about mental health; and

“(ii) such other information, as the Secretary may require.

“(C) PRIORITIES.—In awarding grants under this section, the Secretary shall give priority to eligible entities that meet 1 or more of the following criteria:

“(i) Demonstrated capacity and expertise to serve the targeted population.

“(ii) Existing infrastructure or expertise to provide appropriate, evidence-based and culturally and linguistically competent services.

“(iii) A location in a geographic area with disproportionate numbers of underserved and at-risk populations in medically underserved areas and health professional shortage areas.

“(iv) Proposed innovative approaches for outreach to initiate or expand services.

“(v) Use of the most up-to-date science, practices, and interventions available.

“(vi) Demonstrated capacity to establish cooperative and collaborative agreements with community mental health centers and other community entities to provide mental health, social, and human services to individuals with depressive disorders.

“(6) NATIONAL COORDINATING CENTER.—

“(A) IN GENERAL.—The Secretary, acting through the Administrator, shall designate 1 recipient of a grant under this section to be the coordinating center of excellence for depression (referred to in this section as the ‘coordinating center’). The Secretary shall select such coordinating center on a competitive basis, based upon the demonstrated capacity of such center to perform the duties described in subparagraph (C).

“(B) APPLICATION.—A Center that has been awarded a grant under paragraph (1) may apply for designation as the coordinating center by submitting an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

“(C) DUTIES.—The coordinating center shall—

“(i) develop, administer, and coordinate the network of Centers under this section;

“(ii) oversee and coordinate the national database described in subsection (d);

“(iii) lead a strategy to disseminate the findings and activities of the Centers through such database; and

“(iv) serve as a liaison with the Administration, the National Registry of Evidence-based Programs and Practices of the Administration, and any Federal interagency or interagency forum on mental health.

“(7) MATCHING FUNDS.—The Secretary may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to \$1 for each \$5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

“(c) ACTIVITIES OF THE CENTERS.—Each Center shall carry out the following activities:

“(1) GENERAL ACTIVITIES.—Each Center shall—

“(A) integrate basic, clinical, or health services interdisciplinary research and practice in the development, implementation, and dissemination of evidence-based interventions;

“(B) involve a broad cross-section of stakeholders, such as researchers, clinicians, consumers, families of consumers, and voluntary health organizations, to develop a research agenda and disseminate findings, and to provide support in the implementation of evidence-based practices;

“(C) provide training and technical assistance to mental health professionals, and engage in and disseminate translational research with a focus on meeting the needs of individuals with depressive disorders; and

“(D) educate policy makers, employers, community leaders, and the public about depressive disorders to reduce stigma and raise awareness of treatments.

“(2) IMPROVED TREATMENT STANDARDS, CLINICAL GUIDELINES, DIAGNOSTIC PROTOCOLS, AND CARE COORDINATION PRACTICE.—Each Center shall collaborate with other Centers in the network to—

“(A) develop and implement treatment standards, clinical guidelines, and protocols that emphasize primary prevention, early intervention, treatment for, and recovery from, depressive disorders;

“(B) foster communication with other providers attending to co-occurring physical health conditions such as cardiovascular, diabetes, cancer, and substance abuse disorders;

“(C) leverage available community resources, develop and implement improved self-management programs, and, when appropriate, involve

family and other providers of social support in the development and implementation of care plans; and

“(D) use electronic health records and telehealth technology to better coordinate and manage, and improve access to, care, as determined by the coordinating center.

“(3) TRANSLATIONAL RESEARCH THROUGH COLLABORATION OF CENTERS AND COMMUNITY-BASED ORGANIZATIONS.—Each Center shall—

“(A) demonstrate effective use of a public-private partnership to foster collaborations among members of the network and community-based organizations such as community mental health centers and other social and human services providers;

“(B) expand interdisciplinary, translational, and patient-oriented research and treatment; and

“(C) coordinate with accredited academic programs to provide ongoing opportunities for the professional and continuing education of mental health providers.

“(d) NATIONAL DATABASE.—

“(1) IN GENERAL.—The coordinating center shall establish and maintain a national, publicly available database to improve prevention programs, evidence-based interventions, and disease management programs for depressive disorders, using data collected from the Centers, as described in paragraph (2).

“(2) DATA COLLECTION.—Each Center shall submit data gathered at such center, as appropriate, to the coordinating center regarding—

“(A) the prevalence and incidence of depressive disorders;

“(B) the health and social outcomes of individuals with depressive disorders;

“(C) the effectiveness of interventions designed, tested, and evaluated;

“(D) other information, as the Secretary may require.

“(3) SUBMISSION OF DATA TO THE ADMINISTRATOR.—The coordinating center shall submit to the Administrator the data and financial information gathered under paragraph (2).

“(4) PUBLICATION USING DATA FROM THE DATABASE.—A Center, or an individual affiliated with a Center, may publish findings using the data described in paragraph (2) only if such center submits such data to the coordinating center, as required under such paragraph.

“(e) ESTABLISHMENT OF STANDARDS; REPORT CARDS AND RECOMMENDATIONS; THIRD PARTY REVIEW.—

“(1) ESTABLISHMENT OF STANDARDS.—The Secretary, acting through the Administrator, shall establish performance standards for—

“(A) each Center; and

“(B) the network of Centers as a whole.

“(2) REPORT CARDS.—The Secretary, acting through the Administrator, shall—

“(A) for each Center, not later than 3 years after the date on which such center of excellence is established and annually thereafter, issue a report card to the coordinating center to rate the performance of such Center; and

“(B) not later than 3 years after the date on which the first grant is awarded under subsection (b)(1) and annually thereafter, issue a report card to Congress to rate the performance of the network of centers of excellence as a whole.

“(3) RECOMMENDATIONS.—Based upon the report cards described in paragraph (2), the Secretary shall, not later than September 30, 2015—

“(A) make recommendations to the Centers regarding improvements such centers shall make; and

“(B) make recommendations to Congress for expanding the Centers to serve individuals with other types of mental disorders.

“(4) THIRD PARTY REVIEW.—Not later than 3 years after the date on which the first grant is

awarded under subsection (b)(1) and annually thereafter, the Secretary shall arrange for an independent third party to conduct an evaluation of the network of Centers to ensure that such centers are meeting the goals of this section.

“(f) AUTHORIZATION OF APPROPRIATIONS.—

“(1) IN GENERAL.—To carry out this section, there are authorized to be appropriated—

“(A) \$100,000,000 for each of the fiscal years 2011 through 2015; and

“(B) \$150,000,000 for each of the fiscal years 2016 through 2020.

“(2) ALLOCATION OF FUNDS AUTHORIZED.—Of the amount appropriated under paragraph (1) for a fiscal year, the Secretary shall determine the allocation of each Center receiving a grant under this section, but in no case may the allocation be more than \$5,000,000, except that the Secretary may allocate not more than \$10,000,000 to the coordinating center.”.

SEC. 10411. PROGRAMS RELATING TO CONGENITAL HEART DISEASE.

(a) SHORT TITLE.—This subtitle may be cited as the “Congenital Heart Futures Act”.

(b) PROGRAMS RELATING TO CONGENITAL HEART DISEASE.—

(1) NATIONAL CONGENITAL HEART DISEASE SURVEILLANCE SYSTEM.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 5405, is further amended by adding at the end the following:

“SEC. 399V-2. NATIONAL CONGENITAL HEART DISEASE SURVEILLANCE SYSTEM.

“(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may—

“(1) enhance and expand infrastructure to track the epidemiology of congenital heart disease and to organize such information into a nationally-representative, population-based surveillance system that compiles data concerning actual occurrences of congenital heart disease, to be known as the ‘National Congenital Heart Disease Surveillance System’; or

“(2) award a grant to one eligible entity to undertake the activities described in paragraph (1).

“(b) PURPOSE.—The purpose of the Congenital Heart Disease Surveillance System shall be to facilitate further research into the types of health services patients use and to identify possible areas for educational outreach and prevention in accordance with standard practices of the Centers for Disease Control and Prevention.

“(c) CONTENT.—The Congenital Heart Disease Surveillance System—

“(1) may include information concerning the incidence and prevalence of congenital heart disease in the United States;

“(2) may be used to collect and store data on congenital heart disease, including data concerning—

“(A) demographic factors associated with congenital heart disease, such as age, race, ethnicity, sex, and family history of individuals who are diagnosed with the disease;

“(B) risk factors associated with the disease;

“(C) causation of the disease;

“(D) treatment approaches; and

“(E) outcome measures, such that analysis of the outcome measures will allow derivation of evidence-based best practices and guidelines for congenital heart disease patients; and

“(3) may ensure the collection and analysis of longitudinal data related to individuals of all ages with congenital heart disease, including infants, young children, adolescents, and adults of all ages.

“(d) PUBLIC ACCESS.—The Congenital Heart Disease Surveillance System shall be made available to the public, as appropriate, including congenital heart disease researchers.

“(e) PATIENT PRIVACY.—The Secretary shall ensure that the Congenital Heart Disease Surveillance System is maintained in a manner that

complies with the regulations promulgated under section 264 of the Health Insurance Portability and Accountability Act of 1996.

“(f) **ELIGIBILITY FOR GRANT.**—To be eligible to receive a grant under subsection (a)(2), an entity shall—

“(1) be a public or private nonprofit entity with specialized experience in congenital heart disease; and

“(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.”.

(2) **CONGENITAL HEART DISEASE RESEARCH.**—Subpart 2 of part C of title IV of the Public Health Service Act (42 U.S.C. 285b et seq.) is amended by adding at the end the following:

“SEC. 425. CONGENITAL HEART DISEASE.

“(a) **IN GENERAL.**—The Director of the Institute may expand, intensify, and coordinate research and related activities of the Institute with respect to congenital heart disease, which may include congenital heart disease research with respect to—

“(1) causation of congenital heart disease, including genetic causes;

“(2) long-term outcomes in individuals with congenital heart disease, including infants, children, teenagers, adults, and elderly individuals;

“(3) diagnosis, treatment, and prevention;

“(4) studies using longitudinal data and retrospective analysis to identify effective treatments and outcomes for individuals with congenital heart disease; and

“(5) identifying barriers to life-long care for individuals with congenital heart disease.

“(b) **COORDINATION OF RESEARCH ACTIVITIES.**—The Director of the Institute may coordinate research efforts related to congenital heart disease among multiple research institutions and may develop research networks.

“(c) **MINORITY AND MEDICALLY UNDERSERVED COMMUNITIES.**—In carrying out the activities described in this section, the Director of the Institute shall consider the application of such research and other activities to minority and medically underserved communities.”.

(c) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out the amendments made by this section such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 10412. AUTOMATED DEFIBRILLATION IN ADAM'S MEMORY ACT.

Section 312 of the Public Health Service Act (42 U.S.C. 244) is amended—

(1) in subsection (c)(6), after “clearinghouse” insert “, that shall be administered by an organization that has substantial expertise in pediatric education, pediatric medicine, and electrophysiology and sudden death.”; and

(2) in the first sentence of subsection (e), by striking “fiscal year 2003” and all that follows through “2006” and inserting “for each of fiscal years 2003 through 2014”.

SEC. 10413. YOUNG WOMEN'S BREAST HEALTH AWARENESS AND SUPPORT OF YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.

(a) **SHORT TITLE.**—This section may be cited as the “Young Women's Breast Health Education and Awareness Requires Learning Young Act of 2009” or the “EARLY Act”.

(b) **AMENDMENT.**—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by this Act, is further amended by adding at the end the following:

“PART V—PROGRAMS RELATING TO BREAST HEALTH AND CANCER

“SEC. 399NN. YOUNG WOMEN'S BREAST HEALTH AWARENESS AND SUPPORT OF YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.

“(a) **PUBLIC EDUCATION CAMPAIGN.**—

“(1) **IN GENERAL.**—The Secretary, acting through the Director of the Centers for Disease

Control and Prevention, shall conduct a national evidence-based education campaign to increase awareness of young women's knowledge regarding—

“(A) breast health in young women of all racial, ethnic, and cultural backgrounds;

“(B) breast awareness and good breast health habits;

“(C) the occurrence of breast cancer and the general and specific risk factors in women who may be at high risk for breast cancer based on familial, racial, ethnic, and cultural backgrounds such as Ashkenazi Jewish populations;

“(D) evidence-based information that would encourage young women and their health care professional to increase early detection of breast cancers; and

“(E) the availability of health information and other resources for young women diagnosed with breast cancer.

“(2) **EVIDENCE-BASED, AGE APPROPRIATE MESSAGES.**—The campaign shall provide evidence-based, age-appropriate messages and materials as developed by the Centers for Disease Control and Prevention and the Advisory Committee established under paragraph (4).

“(3) **MEDIA CAMPAIGN.**—In conducting the education campaign under paragraph (1), the Secretary shall award grants to entities to establish national multimedia campaigns oriented to young women that may include advertising through television, radio, print media, billboards, posters, all forms of existing and especially emerging social networking media, other Internet media, and any other medium determined appropriate by the Secretary.

“(4) **ADVISORY COMMITTEE.**—

“(A) **ESTABLISHMENT.**—Not later than 60 days after the date of the enactment of this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an advisory committee to assist in creating and conducting the education campaigns under paragraph (1) and subsection (b)(1).

“(B) **MEMBERSHIP.**—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall appoint to the advisory committee under subparagraph (A) such members as deemed necessary to properly advise the Secretary, and shall include organizations and individuals with expertise in breast cancer, disease prevention, early detection, diagnosis, public health, social marketing, genetic screening and counseling, treatment, rehabilitation, palliative care, and survivorship in young women.

“(b) **HEALTH CARE PROFESSIONAL EDUCATION CAMPAIGN.**—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, and in consultation with the Administrator of the Health Resources and Services Administration, shall conduct an education campaign among physicians and other health care professionals to increase awareness—

“(1) of breast health, symptoms, and early diagnosis and treatment of breast cancer in young women, including specific risk factors such as family history of cancer and women that may be at high risk for breast cancer, such as Ashkenazi Jewish population;

“(2) on how to provide counseling to young women about their breast health, including knowledge of their family cancer history and importance of providing regular clinical breast examinations;

“(3) concerning the importance of discussing healthy behaviors, and increasing awareness of services and programs available to address overall health and wellness, and making patient referrals to address tobacco cessation, good nutrition, and physical activity;

“(4) on when to refer patients to a health care provider with genetics expertise;

“(5) on how to provide counseling that addresses long-term survivorship and health concerns of young women diagnosed with breast cancer; and

“(6) on when to provide referrals to organizations and institutions that provide credible health information and substantive assistance and support to young women diagnosed with breast cancer.

“(c) **PREVENTION RESEARCH ACTIVITIES.**—The Secretary, acting through—

“(1) the Director of the Centers for Disease Control and Prevention, shall conduct prevention research on breast cancer in younger women, including—

“(A) behavioral, survivorship studies, and other research on the impact of breast cancer diagnosis on young women;

“(B) formative research to assist with the development of educational messages and information for the public, targeted populations, and their families about breast health, breast cancer, and healthy lifestyles;

“(C) testing and evaluating existing and new social marketing strategies targeted at young women; and

“(D) surveys of health care providers and the public regarding knowledge, attitudes, and practices related to breast health and breast cancer prevention and control in high-risk populations; and

“(2) the Director of the National Institutes of Health, shall conduct research to develop and validate new screening tests and methods for prevention and early detection of breast cancer in young women.

“(d) **SUPPORT FOR YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.**—

“(1) **IN GENERAL.**—The Secretary shall award grants to organizations and institutions to provide health information from credible sources and substantive assistance directed to young women diagnosed with breast cancer and preneoplastic breast diseases.

“(2) **PRIORITY.**—In making grants under paragraph (1), the Secretary shall give priority to applicants that deal specifically with young women diagnosed with breast cancer and preneoplastic breast disease.

“(e) **NO DUPLICATION OF EFFORT.**—In conducting an education campaign or other program under subsections (a), (b), (c), or (d), the Secretary shall avoid duplicating other existing Federal breast cancer education efforts.

“(f) **MEASUREMENT; REPORTING.**—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

“(1) measure—

“(A) young women's awareness regarding breast health, including knowledge of family cancer history, specific risk factors and early warning signs, and young women's proactive efforts at early detection;

“(B) the number or percentage of young women utilizing information regarding lifestyle interventions that foster healthy behaviors;

“(C) the number or percentage of young women receiving regular clinical breast exams; and

“(D) the number or percentage of young women who perform breast self exams, and the frequency of such exams, before the implementation of this section;

“(2) not less than every 3 years, measure the impact of such activities; and

“(3) submit reports to the Congress on the results of such measurements.

“(g) **DEFINITION.**—In this section, the term “young women” means women 15 to 44 years of age.

“(h) **AUTHORIZATION OF APPROPRIATIONS.**—To carry out subsections (a), (b), (c)(1), and (d), there are authorized to be appropriated \$9,000,000 for each of the fiscal years 2010 through 2014.”.

Subtitle E—Provisions Relating to Title V**SEC. 10501. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT, THE SOCIAL SECURITY ACT, AND TITLE V OF THIS ACT.**

(a) Section 5101 of this Act is amended—

(1) in subsection (c)(2)(B)(i)(II), by inserting “, including representatives of small business and self-employed individuals” after “employers”;

(2) in subsection (d)(4)(A)—

(A) by redesignating clause (iv) as clause (v); and

(B) by inserting after clause (iii) the following:

“(iv) An analysis of, and recommendations for, eliminating the barriers to entering and staying in primary care, including provider compensation.”; and

(3) in subsection (i)(2)(B), by inserting “optometrists, ophthalmologists,” after “occupational therapists.”.

(b) Subtitle B of title V of this Act is amended by adding at the end the following:

“SEC. 5104. INTERAGENCY TASK FORCE TO ASSESS AND IMPROVE ACCESS TO HEALTH CARE IN THE STATE OF ALASKA.

“(a) **ESTABLISHMENT.**—There is established a task force to be known as the ‘Interagency Access to Health Care in Alaska Task Force’ (referred to in this section as the ‘Task Force’).

“(b) **DUTIES.**—The Task Force shall—

“(1) assess access to health care for beneficiaries of Federal health care systems in Alaska; and

“(2) develop a strategy for the Federal Government to improve delivery of health care to Federal beneficiaries in the State of Alaska.

“(c) **MEMBERSHIP.**—The Task Force shall be comprised of Federal members who shall be appointed, not later than 45 days after the date of enactment of this Act, as follows:

“(1) The Secretary of Health and Human Services shall appoint one representative of each of the following:

“(A) The Department of Health and Human Services.

“(B) The Centers for Medicare and Medicaid Services.

“(C) The Indian Health Service.

“(2) The Secretary of Defense shall appoint one representative of the TRICARE Management Activity.

“(3) The Secretary of the Army shall appoint one representative of the Army Medical Department.

“(4) The Secretary of the Air Force shall appoint one representative of the Air Force, from among officers at the Air Force performing medical service functions.

“(5) The Secretary of Veterans Affairs shall appoint one representative of each of the following:

“(A) The Department of Veterans Affairs.

“(B) The Veterans Health Administration.

“(6) The Secretary of Homeland Security shall appoint one representative of the United States Coast Guard.

“(d) **CHAIRPERSON.**—One chairperson of the Task Force shall be appointed by the Secretary at the time of appointment of members under subsection (c), selected from among the members appointed under paragraph (1).

“(e) **MEETINGS.**—The Task Force shall meet at the call of the chairperson.

“(f) **REPORT.**—Not later than 180 days after the date of enactment of this Act, the Task Force shall submit to Congress a report detailing the activities of the Task Force and containing the findings, strategies, recommendations, policies, and initiatives developed pursuant to the duty described in subsection (b)(2). In preparing such report, the Task Force shall consider completed and ongoing efforts by Federal agencies

to improve access to health care in the State of Alaska.

“(g) **TERMINATION.**—The Task Force shall be terminated on the date of submission of the report described in subsection (f).”.

(c) Section 399V of the Public Health Service Act, as added by section 5313, is amended—

(1) in subsection (b)(4), by striking “identify, educate, refer, and enroll” and inserting “identify and refer”; and

(2) in subsection (k)(1), by striking “, as defined by the Department of Labor as Standard Occupational Classification [21–1094]”.

(d) Section 738(a)(3) of the Public Health Service Act (42 U.S.C. 293b(a)(3)) is amended by inserting “schools offering physician assistant education programs,” after “public health.”.

(e) Subtitle D of title V of this Act is amended by adding at the end the following:

“SEC. 5316. DEMONSTRATION GRANTS FOR FAMILY NURSE PRACTITIONER TRAINING PROGRAMS.

“(a) **ESTABLISHMENT OF PROGRAM.**—The Secretary of Health and Human Services (referred to in this section as the ‘Secretary’) shall establish a training demonstration program for family nurse practitioners (referred to in this section as the ‘program’) to employ and provide 1-year training for nurse practitioners who have graduated from a nurse practitioner program for careers as primary care providers in Federally qualified health centers (referred to in this section as ‘FQHCs’) and nurse-managed health clinics (referred to in this section as ‘NMHCs’).

“(b) **PURPOSE.**—The purpose of the program is to enable each grant recipient to—

“(1) provide new nurse practitioners with clinical training to enable them to serve as primary care providers in FQHCs and NMHCs;

“(2) train new nurse practitioners to work under a model of primary care that is consistent with the principles set forth by the Institute of Medicine and the needs of vulnerable populations; and

“(3) create a model of FQHC and NMHC training for nurse practitioners that may be replicated nationwide.

“(c) **GRANTS.**—The Secretary shall award 3-year grants to eligible entities that meet the requirements established by the Secretary, for the purpose of operating the nurse practitioner primary care programs described in subsection (a) in such entities.

“(d) **ELIGIBLE ENTITIES.**—To be eligible to receive a grant under this section, an entity shall—

“(1)(A) be a FQHC as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)); or

“(B) be a nurse-managed health clinic, as defined in section 330A–1 of the Public Health Service Act (as added by section 5208 of this Act); and

“(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(e) **PRIORITY IN AWARDED GRANTS.**—In awarding grants under this section, the Secretary shall give priority to eligible entities that—

“(1) demonstrate sufficient infrastructure in size, scope, and capacity to undertake the requisite training of a minimum of 3 nurse practitioners per year, and to provide to each awardee 12 full months of full-time, paid employment and benefits consistent with the benefits offered to other full-time employees of such entity;

“(2) will assign not less than 1 staff nurse practitioner or physician to each of 4 precepted clinics;

“(3) will provide to each awardee specialty rotations, including specialty training in prenatal care and women’s health, adult and child psychiatry, orthopedics, geriatrics, and at least 3 other high-volume, high-burden specialty areas;

“(4) provide sessions on high-volume, high-risk health problems and have a record of training health care professionals in the care of children, older adults, and underserved populations; and

“(5) collaborate with other safety net providers, schools, colleges, and universities that provide health professions training.

“(f) **ELIGIBILITY OF NURSE PRACTITIONERS.**—

“(1) **IN GENERAL.**—To be eligible for acceptance to a program funded through a grant awarded under this section, an individual shall—

“(A) be licensed or eligible for licensure in the State in which the program is located as an advanced practice registered nurse or advanced practice nurse and be eligible or board-certified as a family nurse practitioner; and

“(B) demonstrate commitment to a career as a primary care provider in a FQHC or in a NMHC.

“(2) **PREFERENCE.**—In selecting awardees under the program, each grant recipient shall give preference to bilingual candidates that meet the requirements described in paragraph (1).

“(3) **DEFERRAL OF CERTAIN SERVICE.**—The starting date of required service of individuals in the National Health Service Corps Service program under title II of the Public Health Service Act (42 U.S.C. 202 et seq.) who receive training under this section shall be deferred until the date that is 22 days after the date of completion of the program.

“(g) **GRANT AMOUNT.**—Each grant awarded under this section shall be in an amount not to exceed \$600,000 per year. A grant recipient may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary.

“(h) **TECHNICAL ASSISTANCE GRANTS.**—The Secretary may award technical assistance grants to 1 or more FQHCs or NMHCs that have demonstrated expertise in establishing a nurse practitioner residency training program. Such technical assistance grants shall be for the purpose of providing technical assistance to other recipients of grants under subsection (c).

“(i) **AUTHORIZATION OF APPROPRIATIONS.**—To carry out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2014.”.

(f)(1) Section 399W of the Public Health Service Act, as added by section 5405, is redesignated as section 399V–1.

(2) Section 399V–1 of the Public Health Service Act, as so redesignated, is amended in subsection (b)(2)(A) by striking “and the departments of 1 or more health professions schools in the State that train providers in primary care” and inserting “and the departments that train providers in primary care in 1 or more health professions schools in the State”.

(3) Section 934 of the Public Health Service Act, as added by section 3501, is amended by striking “399W” each place such term appears and inserting “399V–1”.

(4) Section 935(b) of the Public Health Service Act, as added by section 3503, is amended by striking “399W” and inserting “399V–1”.

(g) Part P of title III of the Public Health Service Act 42 U.S.C. 280g et seq.), as amended by section 10411, is amended by adding at the end the following:

“SEC. 399V–3. NATIONAL DIABETES PREVENTION PROGRAM.

“(a) **IN GENERAL.**—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a national diabetes prevention program (referred to in this section as the ‘program’) targeted at adults at high risk for diabetes in order to eliminate the preventable burden of diabetes.

“(b) **PROGRAM ACTIVITIES.**—The program described in subsection (a) shall include—

“(1) a grant program for community-based diabetes prevention program model sites;

“(2) a program within the Centers for Disease Control and Prevention to determine eligibility of entities to deliver community-based diabetes prevention services;

“(3) a training and outreach program for lifestyle intervention instructors; and

“(4) evaluation, monitoring and technical assistance, and applied research carried out by the Centers for Disease Control and Prevention.

“(c) **ELIGIBLE ENTITIES.**—To be eligible for a grant under subsection (b)(1), an entity shall be a State or local health department, a tribal organization, a national network of community-based non-profits focused on health and wellbeing, an academic institution, or other entity, as the Secretary determines.

“(d) **AUTHORIZATION OF APPROPRIATIONS.**—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.”.

(h) The provisions of, and amendment made by, section 5501(c) of this Act are repealed.

(i)(1) The provisions of, and amendments made by, section 5502 of this Act are repealed.

(2)(A) Section 1861(aa)(3)(A) of the Social Security Act (42 U.S.C. 1395u(aa)(3)(A)) is amended to read as follows:

“(A) services of the type described in subparagraphs (A) through (C) of paragraph (1) and preventive services (as defined in section 1861(ddd)(3)); and”.

(B) The amendment made by subparagraph (A) shall apply to services furnished on or after January 1, 2011.

(3)(A) Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by section 4105, is amended by adding at the end the following new subsection:

“(o) **DEVELOPMENT AND IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.**—

“(1) **DEVELOPMENT.**—

“(A) **IN GENERAL.**—The Secretary shall develop a prospective payment system for payment for Federally qualified health center services furnished by Federally qualified health centers under this title. Such system shall include a process for appropriately describing the services furnished by Federally qualified health centers and shall establish payment rates for specific payment codes based on such appropriate descriptions of services. Such system shall be established to take into account the type, intensity, and duration of services furnished by Federally qualified health centers. Such system may include adjustments, including geographic adjustments, determined appropriate by the Secretary.

“(B) **COLLECTION OF DATA AND EVALUATION.**—By not later than January 1, 2011, the Secretary shall require Federally qualified health centers to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system under this subsection, including the reporting of services using HCPCS codes.

“(2) **IMPLEMENTATION.**—

“(A) **IN GENERAL.**—Notwithstanding section 1833(a)(3)(A), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2014, for payments of prospective payment rates for Federally qualified health center services furnished by Federally qualified health centers under this title in accordance with the prospective payment system developed by the Secretary under paragraph (1).

“(B) **PAYMENTS.**—

“(i) **INITIAL PAYMENTS.**—The Secretary shall implement such prospective payment system so that the estimated aggregate amount of prospective payment rates (determined prior to the application of section 1833(a)(1)(Z)) under this title for Federally qualified health center services in the first year that such system is implemented is

equal to 100 percent of the estimated amount of reasonable costs (determined without the application of a per visit payment limit or productivity screen and prior to the application of section 1866(a)(2)(A)(ii)) that would have occurred for such services under this title in such year if the system had not been implemented.

“(ii) **PAYMENTS IN SUBSEQUENT YEARS.**—Payment rates in years after the year of implementation of such system shall be the payment rates in the previous year increased—

“(I) in the first year after implementation of such system, by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved; and

“(II) in subsequent years, by the percentage increase in a market basket of Federally qualified health center goods and services as promulgated through regulations, or if such an index is not available, by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.

“(C) **PREPARATION FOR PPS IMPLEMENTATION.**—Notwithstanding any other provision of law, the Secretary may establish and implement by program instruction or otherwise the payment codes to be used under the prospective payment system under this section.”.

(B) Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 4104, is amended—

(i) by striking “and” before “(Y)”; and

(ii) by inserting before the semicolon at the end the following: “, and (Z) with respect to Federally qualified health center services for which payment is made under section 1834(o), the amounts paid shall be 80 percent of the lesser of the actual charge or the amount determined under such section”.

(C) Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended—

(i) in paragraph (3)(B)(i)—

(I) by inserting “(I)” after “otherwise been provided”; and

(II) by inserting “, or (II) in the case of such services furnished on or after the implementation date of the prospective payment system under section 1834(o), under such section (calculated as if ‘100 percent’ were substituted for ‘80 percent’ in such section) for such services if the individual had not been so enrolled” after “been so enrolled”; and

(ii) by adding at the end the following flush sentence:

“Paragraph (3)(A) shall not apply to Federally qualified health center services furnished on or after the implementation date of the prospective payment system under section 1834(o).”.

(j) Section 5505 is amended by adding at the end the following new subsection:

“(d) **APPLICATION.**—The amendments made by this section shall not be applied in a manner that requires reopening of any settled cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).”.

(k) Subtitle G of title V of this Act is amended by adding at the end the following:

“**SEC. 5606. STATE GRANTS TO HEALTH CARE PROVIDERS WHO PROVIDE SERVICES TO A HIGH PERCENTAGE OF MEDICALLY UNDERSERVED POPULATIONS OR OTHER SPECIAL POPULATIONS.**

“(a) **IN GENERAL.**—A State may award grants to health care providers who treat a high percentage, as determined by such State, of medically underserved populations or other special populations in such State.

“(b) **SOURCE OF FUNDS.**—A grant program established by a State under subsection (a) may

not be established within a department, agency, or other entity of such State that administers the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and no Federal or State funds allocated to such Medicaid program, the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), or the TRICARE program under chapter 55 of title 10, United States Code, may be used to award grants or to pay administrative costs associated with a grant program established under subsection (a).”.

(l) Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended—

(1) after the part heading, by inserting the following:

“**Subpart I—Medical Training Generally**”;

and

(2) by inserting at the end the following:

“**Subpart II—Training in Underserved Communities**

“**SEC. 749B. RURAL PHYSICIAN TRAINING GRANTS.**

“(a) **IN GENERAL.**—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a grant program for the purposes of assisting eligible entities in recruiting students most likely to practice medicine in underserved rural communities, providing rural-focused training and experience, and increasing the number of recent allopathic and osteopathic medical school graduates who practice in underserved rural communities.

“(b) **ELIGIBLE ENTITIES.**—In order to be eligible to receive a grant under this section, an entity shall—

“(1) be a school of allopathic or osteopathic medicine accredited by a nationally recognized accrediting agency or association approved by the Secretary for this purpose, or any combination or consortium of such schools; and

“(2) submit an application to the Secretary that includes a certification that such entity will use amounts provided to the institution as described in subsection (d)(1).

“(c) **PRIORITY.**—In awarding grant funds under this section, the Secretary shall give priority to eligible entities that—

“(1) demonstrate a record of successfully training students, as determined by the Secretary, who practice medicine in underserved rural communities;

“(2) demonstrate that an existing academic program of the eligible entity produces a high percentage, as determined by the Secretary, of graduates from such program who practice medicine in underserved rural communities;

“(3) demonstrate rural community institutional partnerships, through such mechanisms as matching or contributory funding, documented in-kind services for implementation, or existence of training partners with interprofessional expertise in community health center training locations or other similar facilities; or

“(4) submit, as part of the application of the entity under subsection (b), a plan for the long-term tracking of where the graduates of such entity practice medicine.

“(d) **USE OF FUNDS.**—

“(1) **ESTABLISHMENT.**—An eligible entity receiving a grant under this section shall use the funds made available under such grant to establish, improve, or expand a rural-focused training program (referred to in this section as the ‘Program’) meeting the requirements described in this subsection and to carry out such program.

“(2) **STRUCTURE OF PROGRAM.**—An eligible entity shall—

“(A) enroll no fewer than 10 students per class year into the Program; and

“(B) develop criteria for admission to the Program that gives priority to students—

“(i) who have originated from or lived for a period of 2 or more years in an underserved rural community; and

“(ii) who express a commitment to practice medicine in an underserved rural community.

“(3) CURRICULA.—The Program shall require students to enroll in didactic coursework and clinical experience particularly applicable to medical practice in underserved rural communities, including—

“(A) clinical rotations in underserved rural communities, and in applicable specialties, or other coursework or clinical experience deemed appropriate by the Secretary; and

“(B) in addition to core school curricula, additional coursework or training experiences focused on medical issues prevalent in underserved rural communities.

“(4) RESIDENCY PLACEMENT ASSISTANCE.—Where available, the Program shall assist all students of the Program in obtaining clinical training experiences in locations with postgraduate programs offering residency training opportunities in underserved rural communities, or in local residency training programs that support and train physicians to practice in underserved rural communities.

“(5) PROGRAM STUDENT COHORT SUPPORT.—The Program shall provide and require all students of the Program to participate in group activities designed to further develop, maintain, and reinforce the original commitment of such students to practice in an underserved rural community.

“(e) ANNUAL REPORTING.—An eligible entity receiving a grant under this section shall submit an annual report to the Secretary on the success of the Program, based on criteria the Secretary determines appropriate, including the residency program selection of graduating students who participated in the Program.

“(f) REGULATIONS.—Not later than 60 days after the date of enactment of this section, the Secretary shall by regulation define ‘underserved rural community’ for purposes of this section.

“(g) SUPPLEMENT NOT SUPPLANT.—Any eligible entity receiving funds under this section shall use such funds to supplement, not supplant, any other Federal, State, and local funds that would otherwise be expended by such entity to carry out the activities described in this section.

“(h) MAINTENANCE OF EFFORT.—With respect to activities for which funds awarded under this section are to be expended, the entity shall agree to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the entity for the fiscal year preceding the fiscal year for which the entity receives a grant under this section.

“(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated \$4,000,000 for each of the fiscal years 2010 through 2013.”

(m)(1) Section 768 of the Public Health Service Act (42 U.S.C. 295c) is amended to read as follows:

“SEC. 768. PREVENTIVE MEDICINE AND PUBLIC HEALTH TRAINING GRANT PROGRAM.

“(a) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall award grants to, or enter into contracts with, eligible entities to provide training to graduate medical residents in preventive medicine specialties.

“(b) ELIGIBILITY.—To be eligible for a grant or contract under subsection (a), an entity shall be—

“(1) an accredited school of public health or school of medicine or osteopathic medicine;

“(2) an accredited public or private nonprofit hospital;

“(3) a State, local, or tribal health department; or

“(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

“(c) USE OF FUNDS.—Amounts received under a grant or contract under this section shall be used to—

“(1) plan, develop (including the development of curricula), operate, or participate in an accredited residency or internship program in preventive medicine or public health;

“(2) defray the costs of practicum experiences, as required in such a program; and

“(3) establish, maintain, or improve—

“(A) academic administrative units (including departments, divisions, or other appropriate units) in preventive medicine and public health; or

“(B) programs that improve clinical teaching in preventive medicine and public health.

“(d) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.”

(2) Section 770(a) of the Public Health Service Act (42 U.S.C. 295e(a)) is amended to read as follows:

“(a) IN GENERAL.—For the purpose of carrying out this subpart, there is authorized to be appropriated \$43,000,000 for fiscal year 2011, and such sums as may be necessary for each of the fiscal years 2012 through 2015.”

(n)(1) Subsection (i) of section 331 of the Public Health Service Act (42 U.S.C. 254d) of the Public Health Service Act is amended—

(A) in paragraph (1), by striking “In carrying out subpart III” and all that follows through the period and inserting “In carrying out subpart III, the Secretary may, in accordance with this subsection, issue waivers to individuals who have entered into a contract for obligated service under the Scholarship Program or the Loan Repayment Program under which the individuals are authorized to satisfy the requirement of obligated service through providing clinical practice that is half time.”;

(B) in paragraph (2)—

(i) in subparagraphs (A)(ii) and (B), by striking “less than full time” each place it appears and inserting “half time”;

(ii) in subparagraphs (C) and (F), by striking “less than full-time service” each place it appears and inserting “half-time service”;

(iii) by amending subparagraphs (D) and (E) to read as follows:

“(D) the entity and the Corps member agree in writing that the Corps member will perform half-time clinical practice;

“(E) the Corps member agrees in writing to fulfill all of the service obligations under section 338C through half-time clinical practice and either—

“(i) double the period of obligated service that would otherwise be required; or

“(ii) in the case of contracts entered into under section 338B, accept a minimum service obligation of 2 years with an award amount equal to 50 percent of the amount that would otherwise be payable for full-time service; and”;

(C) in paragraph (3), by striking “In evaluating a demonstration project described in paragraph (1)” and inserting “In evaluating waivers issued under paragraph (1)”.

(2) Subsection (j) of section 331 of the Public Health Service Act (42 U.S.C. 254d) is amended by adding at the end the following:

“(5) The terms ‘full time’ and ‘full-time’ mean a minimum of 40 hours per week in a clinical practice, for a minimum of 45 weeks per year.

“(6) The terms ‘half time’ and ‘half-time’ mean a minimum of 20 hours per week (not to exceed 39 hours per week) in a clinical practice, for a minimum of 45 weeks per year.”

(3) Section 337(b)(1) of the Public Health Service Act (42 U.S.C. 254j(b)(1)) is amended by striking “Members may not be reappointed to the Council.”.

(4) Section 338B(g)(2)(A) of the Public Health Service Act (42 U.S.C. 254l-1(g)(2)(A)) is amended by striking “\$35,000” and inserting “\$50,000, plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation.”.

(5) Subsection (a) of section 338C of the Public Health Service Act (42 U.S.C. 254m), as amended by section 5508, is amended—

(A) by striking the second sentence and inserting the following: “The Secretary may treat teaching as clinical practice for up to 20 percent of such period of obligated service.”; and

(B) by adding at the end the following: “Notwithstanding the preceding sentence, with respect to a member of the Corps participating in the teaching health centers graduate medical education program under section 340H, for the purpose of calculating time spent in full-time clinical practice under this section, up to 50 percent of time spent teaching by such member may be counted toward his or her service obligation.”.

SEC. 10502. INFRASTRUCTURE TO EXPAND ACCESS TO CARE.

(a) APPROPRIATION.—There are authorized to be appropriated, and there are appropriated to the Department of Health and Human Services, \$100,000,000 for fiscal year 2010, to remain available for obligation until September 30, 2011, to be used for debt service on, or direct construction or renovation of, a health care facility that provides research, inpatient tertiary care, or outpatient clinical services. Such facility shall be affiliated with an academic health center at a public research university in the United States that contains a State’s sole public academic medical and dental school.

(b) REQUIREMENT.—Amount appropriated under subsection (a) may only be made available by the Secretary of Health and Human Services upon the receipt of an application from the Governor of a State that certifies that—

(1) the new health care facility is critical for the provision of greater access to health care within the State;

(2) such facility is essential for the continued financial viability of the State’s sole public medical and dental school and its academic health center;

(3) the request for Federal support represents not more than 40 percent of the total cost of the proposed new facility; and

(4) the State has established a dedicated funding mechanism to provide all remaining funds necessary to complete the construction or renovation of the proposed facility.

SEC. 10503. COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS FUND.

(a) PURPOSE.—It is the purpose of this section to establish a Community Health Center Fund (referred to in this section as the “CHC Fund”), to be administered through the Office of the Secretary of the Department of Health and Human Services to provide for expanded and sustained national investment in community health centers under section 330 of the Public Health Service Act and the National Health Service Corps.

(b) FUNDING.—There is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, to the CHC Fund—

(1) to be transferred to the Secretary of Health and Human Services to provide enhanced funding for the community health center program under section 330 of the Public Health Service Act—

(A) \$700,000,000 for fiscal year 2011;

(B) \$800,000,000 for fiscal year 2012;

(C) \$1,000,000,000 for fiscal year 2013;
 (D) \$1,600,000,000 for fiscal year 2014; and
 (E) \$2,900,000,000 for fiscal year 2015; and
 (2) to be transferred to the Secretary of Health and Human Services to provide enhanced funding for the National Health Service Corps—
 (A) \$290,000,000 for fiscal year 2011;
 (B) \$295,000,000 for fiscal year 2012;
 (C) \$300,000,000 for fiscal year 2013;
 (D) \$305,000,000 for fiscal year 2014; and
 (E) \$310,000,000 for fiscal year 2015.

(c) CONSTRUCTION.—There is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, \$1,500,000,000 to be available for fiscal years 2011 through 2015 to be used by the Secretary of Health and Human Services for the construction and renovation of community health centers.

(d) USE OF FUND.—The Secretary of Health and Human Services shall transfer amounts in the CHC Fund to accounts within the Department of Health and Human Services to increase funding, over the fiscal year 2008 level, for community health centers and the National Health Service Corps.

(e) AVAILABILITY.—Amounts appropriated under subsections (b) and (c) shall remain available until expended.

SEC. 10504. DEMONSTRATION PROJECT TO PROVIDE ACCESS TO AFFORDABLE CARE.

(a) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the “Secretary”), acting through the Health Resources and Services Administration, shall establish a 3 year demonstration project in up to 10 States to provide access to comprehensive health care services to the uninsured at reduced fees. The Secretary shall evaluate the feasibility of expanding the project to additional States.

(b) ELIGIBILITY.—To be eligible to participate in the demonstration project, an entity shall be a State-based, nonprofit, public-private partnership that provides access to comprehensive health care services to the uninsured at reduced fees. Each State in which a participant selected by the Secretary is located shall receive not more than \$2,000,000 to establish and carry out the project for the 3-year demonstration period.

(c) AUTHORIZATION.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

Subtitle F—Provisions Relating to Title VI

SEC. 10601. REVISIONS TO LIMITATION ON MEDICARE EXCEPTION TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.

(a) IN GENERAL.—Section 1877(i) of the Social Security Act, as added by section 6001(a), is amended—

(1) in paragraph (1)(A)(i), by striking “February 1, 2010” and inserting “August 1, 2010”; and

(2) in paragraph (3)(A)—

(A) in clause (iii), by striking “August 1, 2011” and inserting “February 1, 2012”; and

(B) in clause (iv), by striking “July 1, 2011” and inserting “January 1, 2012”.

(b) CONFORMING AMENDMENT.—Section 6001(b)(2) of this Act is amended by striking “November 1, 2011” and inserting “May 1, 2012”.

SEC. 10602. CLARIFICATIONS TO PATIENT-CENTERED OUTCOMES RESEARCH.

Section 1181 of the Social Security Act (as added by section 6301) is amended—

(1) in subsection (d)(2)(B)—

(A) in clause (ii)(IV)—

(i) by inserting “, as described in subparagraph (A)(ii),” after “original research”; and

(ii) by inserting “, as long as the researcher enters into a data use agreement with the Insti-

tute for use of the data from the original research, as appropriate” after “publication”; and

(B) by amending clause (iv) to read as follows:

“(iv) SUBSEQUENT USE OF THE DATA.—The Institute shall not allow the subsequent use of data from original research in work-for-hire contracts with individuals, entities, or instrumentalities that have a financial interest in the results, unless approved under a data use agreement with the Institute.”;

(2) in subsection (d)(8)(A)(iv), by striking “not be construed as mandates for” and inserting “do not include”; and

(3) in subsection (f)(1)(C), by amending clause (ii) to read as follows:

“(ii) 7 members representing physicians and providers, including 4 members representing physicians (at least 1 of whom is a surgeon), 1 nurse, 1 State-licensed integrative health care practitioner, and 1 representative of a hospital.”.

SEC. 10603. STRIKING PROVISIONS RELATING TO INDIVIDUAL PROVIDER APPLICATION FEES.

(a) IN GENERAL.—Section 1866(j)(2)(C) of the Social Security Act, as added by section 6401(a), is amended—

(1) by striking clause (i);

(2) by redesignating clauses (ii) through (iv), respectively, as clauses (i) through (iii); and

(3) in clause (i), as redesignated by paragraph (2), by striking “clause (iii)” and inserting “clause (ii)”.

(b) TECHNICAL CORRECTION.—Section 6401(a)(2) of this Act is amended to read as follows:

“(2) by redesignating paragraph (2) as paragraph (8); and”.

SEC. 10604. TECHNICAL CORRECTION TO SECTION 6405.

Paragraphs (1) and (2) of section 6405(b) are amended to read as follows:

“(1) PART A.—Section 1814(a)(2) of the Social Security Act (42 U.S.C. 1395(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ‘, or, in the case of services described in subparagraph (C), a physician enrolled under section 1866(j),’ after ‘in collaboration with a physician.’.

“(2) PART B.—Section 1835(a)(2) of the Social Security Act (42 U.S.C. 1395n(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ‘, or, in the case of services described in subparagraph (A), a physician enrolled under section 1866(j),’ after ‘a physician.’.”.

SEC. 10605. CERTAIN OTHER PROVIDERS PERMITTED TO CONDUCT FACE TO FACE ENCOUNTER FOR HOME HEALTH SERVICES.

(a) PART A.—Section 1814(a)(2)(C) of the Social Security Act (42 U.S.C. 1395f(a)(2)(C)), as amended by section 6407(a)(1), is amended by inserting “, or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5)) under the supervision of the physician,” after “himself or herself”.

(b) PART B.—Section 1835(a)(2)(A)(iv) of the Social Security Act, as added by section 6407(a)(2), is amended by inserting “, or a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5)) under the supervision of the physician,” after “must document that the physician”.

SEC. 10606. HEALTH CARE FRAUD ENFORCEMENT.

(a) FRAUD SENTENCING GUIDELINES.—

(1) DEFINITION.—In this subsection, the term “Federal health care offense” has the meaning given that term in section 24 of title 18, United States Code, as amended by this Act.

(2) REVIEW AND AMENDMENTS.—Pursuant to the authority under section 994 of title 28, United States Code, and in accordance with this subsection, the United States Sentencing Commission shall—

(A) review the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses;

(B) amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs to provide that the aggregate dollar amount of fraudulent bills submitted to the Government health care program shall constitute prima facie evidence of the amount of the intended loss by the defendant; and

(C) amend the Federal Sentencing Guidelines to provide—

(i) a 2-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than \$1,000,000 and less than \$7,000,000;

(ii) a 3-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than \$7,000,000 and less than \$20,000,000;

(iii) a 4-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than \$20,000,000; and

(iv) if appropriate, otherwise amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs.

(3) REQUIREMENTS.—In carrying this subsection, the United States Sentencing Commission shall—

(A) ensure that the Federal Sentencing Guidelines and policy statements—

(i) reflect the serious harms associated with health care fraud and the need for aggressive and appropriate law enforcement action to prevent such fraud; and

(ii) provide increased penalties for persons convicted of health care fraud offenses in appropriate circumstances;

(B) consult with individuals or groups representing health care fraud victims, law enforcement officials, the health care industry, and the Federal judiciary as part of the review described in paragraph (2);

(C) ensure reasonable consistency with other relevant directives and with other guidelines under the Federal Sentencing Guidelines;

(D) account for any aggravating or mitigating circumstances that might justify exceptions, including circumstances for which the Federal Sentencing Guidelines, as in effect on the date of enactment of this Act, provide sentencing enhancements;

(E) make any necessary conforming changes to the Federal Sentencing Guidelines; and

(F) ensure that the Federal Sentencing Guidelines adequately meet the purposes of sentencing.

(b) INTENT REQUIREMENT FOR HEALTH CARE FRAUD.—Section 1347 of title 18, United States Code, is amended—

(1) by inserting “(a)” before “Whoever knowingly”; and

(2) by adding at the end the following:

“(b) With respect to violations of this section, a person need not have actual knowledge of this

section or specific intent to commit a violation of this section.”.

(c) **HEALTH CARE FRAUD OFFENSE.**—Section 24(a) of title 18, United States Code, is amended—

(1) in paragraph (1), by striking the semicolon and inserting “or section 1128B of the Social Security Act (42 U.S.C. 1320a-7b); or”; and

(2) in paragraph (2)—

(A) by inserting “1349,” after “1343,”; and

(B) by inserting “section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331), or section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131),” after “title,”.

(d) **SUBPOENA AUTHORITY RELATING TO HEALTH CARE.**—

(1) **SUBPOENAS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.**—Section 1510(b) of title 18, United States Code, is amended—

(A) in paragraph (1), by striking “to the grand jury”; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking “grand jury subpoena” and inserting “subpoena for records”; and

(ii) in the matter following subparagraph (B), by striking “to the grand jury”.

(2) **SUBPOENAS UNDER THE CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT.**—The Civil Rights of Institutionalized Persons Act (42 U.S.C. 1997 et seq.) is amended by inserting after section 3 the following:

“SEC. 3A. SUBPOENA AUTHORITY.

“(a) **AUTHORITY.**—The Attorney General, or at the direction of the Attorney General, any officer or employee of the Department of Justice may require by subpoena access to any institution that is the subject of an investigation under this Act and to any document, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report relating to any institution that is the subject of an investigation under this Act to determine whether there are conditions which deprive persons residing in or confined to the institution of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States.

“(b) **ISSUANCE AND ENFORCEMENT OF SUBPOENAS.**—

“(1) **ISSUANCE.**—Subpoenas issued under this section—

“(A) shall bear the signature of the Attorney General or any officer or employee of the Department of Justice as designated by the Attorney General; and

“(B) shall be served by any person or class of persons designated by the Attorney General or a designated officer or employee for that purpose.

“(2) **ENFORCEMENT.**—In the case of contumacy or failure to obey a subpoena issued under this section, the United States district court for the judicial district in which the institution is located may issue an order requiring compliance. Any failure to obey the order of the court may be punished by the court as a contempt that court.

“(c) **PROTECTION OF SUBPOENAED RECORDS AND INFORMATION.**—Any document, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report or other information obtained under a subpoena issued under this section—

“(1) may not be used for any purpose other than to protect the rights, privileges, or immunities secured or protected by the Constitution or laws of the United States of persons who reside, have resided, or will reside in an institution;

“(2) may not be transmitted by or within the Department of Justice for any purpose other than to protect the rights, privileges, or immuni-

ties secured or protected by the Constitution or laws of the United States of persons who reside, have resided, or will reside in an institution; and

“(3) shall be redacted, obscured, or otherwise altered if used in any publicly available manner so as to prevent the disclosure of any personally identifiable information.”.

SEC. 10607. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by this Act, is further amended by adding at the end the following:

“SEC. 399V-4. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

“(a) **IN GENERAL.**—The Secretary is authorized to award demonstration grants to States for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. In awarding such grants, the Secretary shall ensure the diversity of the alternatives so funded.

“(b) **DURATION.**—The Secretary may award grants under subsection (a) for a period not to exceed 5 years.

“(c) **CONDITIONS FOR DEMONSTRATION GRANTS.**—

“(1) **REQUIREMENTS.**—Each State desiring a grant under subsection (a) shall develop an alternative to current tort litigation that—

“(A) allows for the resolution of disputes over injuries allegedly caused by health care providers or health care organizations; and

“(B) promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes resolved under subparagraph (A) by organizations that engage in efforts to improve patient safety and the quality of health care.

“(2) **ALTERNATIVE TO CURRENT TORT LITIGATION.**—Each State desiring a grant under subsection (a) shall demonstrate how the proposed alternative described in paragraph (1)(A)—

“(A) makes the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes;

“(B) encourages the efficient resolution of disputes;

“(C) encourages the disclosure of health care errors;

“(D) enhances patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events;

“(E) improves access to liability insurance;

“(F) fully informs patients about the differences in the alternative and current tort litigation;

“(G) provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative;

“(H) would not conflict with State law at the time of the application in a way that would prohibit the adoption of an alternative to current tort litigation; and

“(I) would not limit or curtail a patient’s existing legal rights, ability to file a claim in or access a State’s legal system, or otherwise abrogate a patient’s ability to file a medical malpractice claim.

“(3) **SOURCES OF COMPENSATION.**—Each State desiring a grant under subsection (a) shall identify the sources from and methods by which compensation would be paid for claims resolved under the proposed alternative to current tort litigation, which may include public or private funding sources, or a combination of such

sources. Funding methods shall to the extent practicable provide financial incentives for activities that improve patient safety.

“(4) **SCOPE.**—

“(A) **IN GENERAL.**—Each State desiring a grant under subsection (a) shall establish a scope of jurisdiction (such as Statewide, designated geographic region, a designated area of health care practice, or a designated group of health care providers or health care organizations) for the proposed alternative to current tort litigation that is sufficient to evaluate the effects of the alternative. No scope of jurisdiction shall be established under this paragraph that is based on a health care payer or patient population.

“(B) **NOTIFICATION OF PATIENTS.**—A State shall demonstrate how patients would be notified that they are receiving health care services that fall within such scope, and the process by which they may opt out of or voluntarily withdraw from participating in the alternative. The decision of the patient whether to participate or continue participating in the alternative process shall be made at any time and shall not be limited in any way.

“(5) **PREFERENCE IN AWARDED DEMONSTRATION GRANTS.**—In awarding grants under subsection (a), the Secretary shall give preference to States—

“(A) that have developed the proposed alternative through substantive consultation with relevant stakeholders, including patient advocates, health care providers and health care organizations, attorneys with expertise in representing patients and health care providers, medical malpractice insurers, and patient safety experts;

“(B) that make proposals that are likely to enhance patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events; and

“(C) that make proposals that are likely to improve access to liability insurance.

“(d) **APPLICATION.**—

“(1) **IN GENERAL.**—Each State desiring a grant under subsection (a) shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

“(2) **REVIEW PANEL.**—

“(A) **IN GENERAL.**—In reviewing applications under paragraph (1), the Secretary shall consult with a review panel composed of relevant experts appointed by the Comptroller General.

“(B) **COMPOSITION.**—

“(i) **NOMINATIONS.**—The Comptroller General shall solicit nominations from the public for individuals to serve on the review panel.

“(ii) **APPOINTMENT.**—The Comptroller General shall appoint, at least 9 but not more than 13, highly qualified and knowledgeable individuals to serve on the review panel and shall ensure that the following entities receive fair representation on such panel:

“(I) Patient advocates.

“(II) Health care providers and health care organizations.

“(III) Attorneys with expertise in representing patients and health care providers.

“(IV) Medical malpractice insurers.

“(V) State officials.

“(VI) Patient safety experts.

“(C) **CHAIRPERSON.**—The Comptroller General, or an individual within the Government Accountability Office designated by the Comptroller General, shall be the chairperson of the review panel.

“(D) **AVAILABILITY OF INFORMATION.**—The Comptroller General shall make available to the review panel such information, personnel, and administrative services and assistance as the review panel may reasonably require to carry out its duties.

“(E) INFORMATION FROM AGENCIES.—The review panel may request directly from any department or agency of the United States any information that such panel considers necessary to carry out its duties. To the extent consistent with applicable laws and regulations, the head of such department or agency shall furnish the requested information to the review panel.

“(e) REPORTS.—

“(1) BY STATE.—Each State receiving a grant under subsection (a) shall submit to the Secretary an annual report evaluating the effectiveness of activities funded with grants awarded under such subsection. Such report shall, at a minimum, include the impact of the activities funded on patient safety and on the availability and price of medical liability insurance.

“(2) BY SECRETARY.—The Secretary shall submit to Congress an annual compendium of the reports submitted under paragraph (1) and an analysis of the activities funded under subsection (a) that examines any differences that result from such activities in terms of the quality of care, number and nature of medical errors, medical resources used, length of time for dispute resolution, and the availability and price of liability insurance.

“(f) TECHNICAL ASSISTANCE.—

“(1) IN GENERAL.—The Secretary shall provide technical assistance to the States applying for or awarded grants under subsection (a).

“(2) REQUIREMENTS.—Technical assistance under paragraph (1) shall include—

“(A) guidance on non-economic damages, including the consideration of individual facts and circumstances in determining appropriate payment, guidance on identifying avoidable injuries, and guidance on disclosure to patients of health care errors and adverse events; and

“(B) the development, in consultation with States, of common definitions, formats, and data collection infrastructure for States receiving grants under this section to use in reporting to facilitate aggregation and analysis of data both within and between States.

“(3) USE OF COMMON DEFINITIONS, FORMATS, AND DATA COLLECTION INFRASTRUCTURE.—States not receiving grants under this section may also use the common definitions, formats, and data collection infrastructure developed under paragraph (2)(B).

“(g) EVALUATION.—

“(1) IN GENERAL.—The Secretary, in consultation with the review panel established under subsection (d)(2), shall enter into a contract with an appropriate research organization to conduct an overall evaluation of the effectiveness of grants awarded under subsection (a) and to annually prepare and submit a report to Congress. Such an evaluation shall begin not later than 18 months following the date of implementation of the first program funded by a grant under subsection (a).

“(2) CONTENTS.—The evaluation under paragraph (1) shall include—

“(A) an analysis of the effects of the grants awarded under subsection (a) with regard to the measures described in paragraph (3);

“(B) for each State, an analysis of the extent to which the alternative developed under subsection (c)(1) is effective in meeting the elements described in subsection (c)(2);

“(C) a comparison among the States receiving grants under subsection (a) of the effectiveness of the various alternatives developed by such States under subsection (c)(1);

“(D) a comparison, considering the measures described in paragraph (3), of States receiving grants approved under subsection (a) and similar States not receiving such grants; and

“(E) a comparison, with regard to the measures described in paragraph (3), of—

“(i) States receiving grants under subsection (a);

“(ii) States that enacted, prior to the date of enactment of the Patient Protection and Affordable Care Act, any cap on non-economic damages; and

“(iii) States that have enacted, prior to the date of enactment of the Patient Protection and Affordable Care Act, a requirement that the complainant obtain an opinion regarding the merit of the claim, although the substance of such opinion may have no bearing on whether the complainant may proceed with a case.

“(3) MEASURES.—The evaluations under paragraph (2) shall analyze and make comparisons on the basis of—

“(A) the nature and number of disputes over injuries allegedly caused by health care providers or health care organizations;

“(B) the nature and number of claims in which tort litigation was pursued despite the existence of an alternative under subsection (a);

“(C) the disposition of disputes and claims, including the length of time and estimated costs to all parties;

“(D) the medical liability environment;

“(E) health care quality;

“(F) patient safety in terms of detecting, analyzing, and helping to reduce medical errors and adverse events;

“(G) patient and health care provider and organization satisfaction with the alternative under subsection (a) and with the medical liability environment; and

“(H) impact on utilization of medical services, appropriately adjusted for risk.

“(4) FUNDING.—The Secretary shall reserve 5 percent of the amount appropriated in each fiscal year under subsection (k) to carry out this subsection.

“(h) MEDPAC AND MACPAC REPORTS.—

“(1) MEDPAC.—The Medicare Payment Advisory Commission shall conduct an independent review of the alternatives to current tort litigation that are implemented under grants under subsection (a) to determine the impact of such alternatives on the Medicare program under title XVIII of the Social Security Act, and its beneficiaries.

“(2) MACPAC.—The Medicaid and CHIP Payment and Access Commission shall conduct an independent review of the alternatives to current tort litigation that are implemented under grants under subsection (a) to determine the impact of such alternatives on the Medicaid or CHIP programs under titles XIX and XXI of the Social Security Act, and their beneficiaries.

“(3) REPORTS.—Not later than December 31, 2016, the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission shall each submit to Congress a report that includes the findings and recommendations of each respective Commission based on independent reviews conducted under paragraphs (1) and (2), including an analysis of the impact of the alternatives reviewed on the efficiency and effectiveness of the respective programs.

“(i) OPTION TO PROVIDE FOR INITIAL PLANNING GRANTS.—Of the funds appropriated pursuant to subsection (k), the Secretary may use a portion not to exceed \$500,000 per State to provide planning grants to such States for the development of demonstration project applications meeting the criteria described in subsection (c). In selecting States to receive such planning grants, the Secretary shall give preference to those States in which State law at the time of the application would not prohibit the adoption of an alternative to current tort litigation.

“(j) DEFINITIONS.—In this section:

“(1) HEALTH CARE SERVICES.—The term ‘health care services’ means any services provided by a health care provider, or by any individual working under the supervision of a health care provider, that relate to—

“(A) the diagnosis, prevention, or treatment of any human disease or impairment; or

“(B) the assessment of the health of human beings.

“(2) HEALTH CARE ORGANIZATION.—The term ‘health care organization’ means any individual or entity which is obligated to provide, pay for, or administer health benefits under any health plan.

“(3) HEALTH CARE PROVIDER.—The term ‘health care provider’ means any individual or entity—

“(A) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or

“(B) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

“(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, \$50,000,000 for the 5-fiscal year period beginning with fiscal year 2011.

“(l) CURRENT STATE EFFORTS TO ESTABLISH ALTERNATIVE TO TORT LITIGATION.—Nothing in this section shall be construed to limit any prior, current, or future efforts of any State to establish any alternative to tort litigation.

“(m) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as limiting states’ authority over or responsibility for their state justice systems.”

SEC. 10608. EXTENSION OF MEDICAL MALPRACTICE COVERAGE TO FREE CLINICS.

(a) IN GENERAL.—Section 224(o)(1) of the Public Health Service Act (42 U.S.C. 233(o)(1)) is amended by inserting after “to an individual” the following: “, or an officer, governing board member, employee, or contractor of a free clinic shall in providing services for the free clinic.”

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the date of enactment of this Act and apply to any act or omission which occurs on or after that date.

SEC. 10609. LABELING CHANGES.

Section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended by adding at the end the following:

“(10)(A) If the proposed labeling of a drug that is the subject of an application under this subsection differs from the listed drug due to a labeling revision described under clause (i), the drug that is the subject of such application shall, notwithstanding any other provision of this Act, be eligible for approval and shall not be considered misbranded under section 502 if—

“(i) the application is otherwise eligible for approval under this subsection but for expiration of patent, an exclusivity period, or of a delay in approval described in paragraph (5)(B)(iii), and a revision to the labeling of the listed drug has been approved by the Secretary within 60 days of such expiration;

“(ii) the labeling revision described under clause (i) does not include a change to the ‘Warnings’ section of the labeling;

“(iii) the sponsor of the application under this subsection agrees to submit revised labeling of the drug that is the subject of such application not later than 60 days after the notification of any changes to such labeling required by the Secretary; and

“(iv) such application otherwise meets the applicable requirements for approval under this subsection.

“(B) If, after a labeling revision described in subparagraph (A)(i), the Secretary determines that the continued presence in interstate commerce of the labeling of the listed drug (as in effect before the revision described in subparagraph (A)(i)) adversely impacts the safe use of the drug, no application under this subsection shall be eligible for approval with such labeling.”

Subtitle G—Provisions Relating to Title VIII
SEC. 10801. PROVISIONS RELATING TO TITLE VIII.

(a) Title XXXII of the Public Health Service Act, as added by section 8002(a)(1), is amended—

(1) in section 3203—

(A) in subsection (a)(1), by striking subparagraph (E);

(B) in subsection (b)(1)(C)(i), by striking “for enrollment” and inserting “for reenrollment”; and

(C) in subsection (c)(1), by striking “, as part of their automatic enrollment in the CLASS program,”; and

(2) in section 3204—

(A) in subsection (c)(2), by striking subparagraph (A) and inserting the following:

“(A) receives wages or income on which there is imposed a tax under section 3101(a) or 3201(a) of the Internal Revenue Code of 1986; or”;

(B) in subsection (d), by striking “subparagraph (B) or (C) of subsection (c)(1)” and inserting “subparagraph (A) or (B) of subsection (c)(2)”;

(C) in subsection (e)(2)(A), by striking “subparagraph (A)” and inserting “paragraph (1)”;

(D) in subsection (g)(1), by striking “has elected to waive enrollment” and inserting “has not enrolled”.

(b) Section 8002 of this Act is amended in the heading for subsection (d), by striking “INFORMATION ON SUPPLEMENTAL COVERAGE” and inserting “CLASS PROGRAM INFORMATION”.

(c) Section 6021(d)(2)(A)(iv) of the Deficit Reduction Act of 2005, as added by section 8002(d) of this Act, is amended by striking “and coverage available” and all that follows through “that program.”.

Subtitle H—Provisions Relating to Title IX
SEC. 10901. MODIFICATIONS TO EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

(a) LONGSHORE WORKERS TREATED AS EMPLOYEES ENGAGED IN HIGH-RISK PROFESSIONS.—Paragraph (3) of section 49801(f) of the Internal Revenue Code of 1986, as added by section 9001 of this Act, is amended by inserting “individuals whose primary work is longshore work (as defined in section 258(b) of the Immigration and Nationality Act (8 U.S.C. 1288(b)), determined without regard to paragraph (2) thereof),” before

“and individuals engaged in the construction, mining”.

(b) EXEMPTION FROM HIGH-COST INSURANCE TAX INCLUDES CERTAIN ADDITIONAL EXCEPTED BENEFITS.—Clause (i) of section 49801(d)(1)(B) of the Internal Revenue Code of 1986, as added by section 9001 of this Act, is amended by striking “section 9832(c)(1)(A)” and inserting “section 9832(c)(1) (other than subparagraph (G) thereof)”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 10902. INFLATION ADJUSTMENT OF LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.

(a) IN GENERAL.—Subsection (i) of section 125 of the Internal Revenue Code of 1986, as added by section 9005 of this Act, is amended to read as follows:

“(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

“(1) IN GENERAL.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of \$2,500 made to such arrangement.

“(2) ADJUSTMENT FOR INFLATION.—In the case of any taxable year beginning after December 31, 2011, the dollar amount in paragraph (1) shall be increased by an amount equal to—

“(A) such amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting ‘calendar year 2010’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If any increase determined under this paragraph is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.”.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 10903. MODIFICATION OF LIMITATION ON CHARGES BY CHARITABLE HOSPITALS.

(a) IN GENERAL.—Subparagraph (A) of section 501(r)(5) of the Internal Revenue Code of 1986, as added by section 9007 of this Act, is amended by striking “the lowest amounts charged” and inserting “the amounts generally billed”.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

SEC. 10904. MODIFICATION OF ANNUAL FEE ON MEDICAL DEVICE MANUFACTURERS AND IMPORTERS.

(a) IN GENERAL.—Section 9009 of this Act is amended—

(1) by striking “2009” in subsection (a)(1) and inserting “2010”;

(2) by inserting “(\$3,000,000,000 after 2017)” after “\$2,000,000,000”, and

(3) by striking “2008” in subsection (i) and inserting “2009”.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 9009.

SEC. 10905. MODIFICATION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.

(a) DETERMINATION OF FEE AMOUNT.—Subsection (b) of section 9010 of this Act is amended to read as follows:

“(b) DETERMINATION OF FEE AMOUNT.—

“(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to the applicable amount as—

“(A) the covered entity’s net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, bears to

“(B) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year.

“(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

“With respect to a covered entity’s net premiums written during the calendar year that are:

The percentage of net premiums written that are taken into account is:

Not more than \$25,000,000	0 percent
More than \$25,000,000 but not more than \$50,000,000	50 percent
More than \$50,000,000	100 percent.

“(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity’s fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity’s net premiums written with respect to any United

States health risk on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.”.

(b) APPLICABLE AMOUNT.—Subsection (e) of section 9010 of this Act is amended to read as follows:

“(e) APPLICABLE AMOUNT.—For purposes of subsection (b)(1), the applicable amount shall be determined in accordance with the following table:

“Calendar year

Calendar year	Applicable amount
2011	\$2,000,000,000
2012	\$4,000,000,000
2013	\$7,000,000,000
2014, 2015 and 2016	\$9,000,000,000
2017 and thereafter	\$10,000,000,000.”.

(c) EXEMPTION FROM ANNUAL FEE ON HEALTH INSURANCE FOR CERTAIN NONPROFIT ENTITIES.—Section 9010(c)(2) of this Act is amended by striking “or” at the end of subparagraph (A), by striking the period at the end of subparagraph (B) and inserting a comma, and by adding at the end the following new subparagraphs:

“(C) any entity—

“(i)(I) which is incorporated as, is a wholly owned subsidiary of, or is a wholly owned affiliate of, a nonprofit corporation under a State law, or

“(II) which is described in section 501(c)(4) of the Internal Revenue Code of 1986 and the activities of which consist of providing commer-

cial-type insurance (within the meaning of section 501(m) of such Code),

“(ii) the premium rate increases of which are regulated by a State authority,

“(iii) which, as of the date of the enactment of this section, acts as the insurer of last resort in the State and is subject to State guarantee issue requirements, and

“(iv) for which the medical loss ratio (determined in a manner consistent with the determination of such ratio under section 2718(b)(1)(A) of the Public Health Service Act) with respect to the individual insurance market for such entity for the calendar year is not less than 100 percent,

“(D) any entity—

“(i)(I) which is incorporated as a nonprofit corporation under a State law, or

“(II) which is described in section 501(c)(4) of the Internal Revenue Code of 1986 and the activities of which consist of providing commercial-type insurance (within the meaning of section 501(m) of such Code), and

“(ii) for which the medical loss ratio (as so determined)—

“(I) with respect to each of the individual, small group, and large group insurance markets for such entity for the calendar year is not less than 90 percent, and

“(II) with respect to all such markets for such entity for the calendar year is not less than 92 percent, or

“(E) any entity—

“(i) which is a mutual insurance company,

“(ii) which for the period reported on the 2008 Accident and Health Policy Experience Exhibit of the National Association of Insurance Commissioners had—

“(I) a market share of the insured population of a State of at least 40 but not more than 60 percent, and

“(II) with respect to all markets described in subparagraph (D)(ii)(I), a medical loss ratio of not less than 90 percent, and

“(iii) with respect to annual payment dates in calendar years after 2011, for which the medical loss ratio (determined in a manner consistent with the determination of such ratio under section 2718(b)(1)(A) of the Public Health Service Act) with respect to all such markets for such entity for the preceding calendar year is not less than 89 percent (except that with respect to such annual payment date for 2012, the calculation under 2718(b)(1)(B)(ii) of such Act is determined by reference to the previous year, and with respect to such annual payment date for 2013, such calculation is determined by reference to the average for the previous 2 years).”

(d) CERTAIN INSURANCE EXEMPTED FROM FEE.—Paragraph (3) of section 9010(h) of this Act is amended to read as follows:

“(3) HEALTH INSURANCE.—The term ‘health insurance’ shall not include—

“(A) any insurance coverage described in paragraph (1)(A) or (3) of section 9832(c) of the Internal Revenue Code of 1986,

“(B) any insurance for long-term care, or

“(C) any medicare supplemental health insurance (as defined in section 1882(g)(1) of the Social Security Act).”

(e) ANTI-AVOIDANCE GUIDANCE.—Subsection (i) of section 9010 of this Act is amended by inserting “and shall prescribe such regulations as are necessary or appropriate to prevent avoidance of the purposes of this section, including inappropriate actions taken to qualify as an exempt entity under subsection (c)(2)” after “section”.

(f) CONFORMING AMENDMENTS.—

(1) Section 9010(a)(1) of this Act is amended by striking “2009” and inserting “2010”.

(2) Section 9010(c)(2)(B) of this Act is amended by striking “(except)” and all that follows through “1323”.

(3) Section 9010(c)(3) of this Act is amended by adding at the end the following new sentence: “If any entity described in subparagraph (C)(i)(I), (D)(i)(I), or (E)(i) of paragraph (2) is treated as a covered entity by reason of the application of the preceding sentence, the net premiums written with respect to health insurance for any United States health risk of such entity shall not be taken into account for purposes of this section.”

(4) Section 9010(g)(1) of this Act is amended by striking “and third party administration agreement fees”.

(5) Section 9010(j) of this Act is amended—

(A) by striking “2008” and inserting “2009”, and

(B) by striking “, and any third party administration agreement fees received after such date”.

(g) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 9010.

SEC. 10906. MODIFICATIONS TO ADDITIONAL HOSPITAL INSURANCE TAX ON HIGH-INCOME TAXPAYERS.

(a) FICA.—Section 3101(b)(2) of the Internal Revenue Code of 1986, as added by section 9015(a)(1) of this Act, is amended by striking “0.5 percent” and inserting “0.9 percent”.

(b) SECA.—Section 1401(b)(2)(A) of the Internal Revenue Code of 1986, as added by section 9015(b)(1) of this Act, is amended by striking “0.5 percent” and inserting “0.9 percent”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration received, and taxable years beginning, after December 31, 2012.

SEC. 10907. EXCISE TAX ON INDOOR TANNING SERVICES IN LIEU OF ELECTIVE COSMETIC MEDICAL PROCEDURES.

(a) IN GENERAL.—The provisions of, and amendments made by, section 9017 of this Act are hereby deemed null, void, and of no effect.

(b) EXCISE TAX ON INDOOR TANNING SERVICES.—Subtitle D of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new chapter:

“CHAPTER 49—COSMETIC SERVICES

“Sec. 5000B. Imposition of tax on indoor tanning services.

“SEC. 5000B. IMPOSITION OF TAX ON INDOOR TANNING SERVICES.

“(a) IN GENERAL.—There is hereby imposed on any indoor tanning service a tax equal to 10 percent of the amount paid for such service (determined without regard to this section), whether paid by insurance or otherwise.

“(b) INDOOR TANNING SERVICE.—For purposes of this section—

“(1) IN GENERAL.—The term ‘indoor tanning service’ means a service employing any electronic product designed to incorporate 1 or more ultraviolet lamps and intended for the irradiation of an individual by ultraviolet radiation, with wavelengths in air between 200 and 400 nanometers, to induce skin tanning.

“(2) EXCLUSION OF PHOTOTHERAPY SERVICES.—Such term does not include any phototherapy service performed by a licensed medical professional.

“(c) PAYMENT OF TAX.—

“(1) IN GENERAL.—The tax imposed by this section shall be paid by the individual on whom the service is performed.

“(2) COLLECTION.—Every person receiving a payment for services on which a tax is imposed under subsection (a) shall collect the amount of the tax from the individual on whom the service is performed and remit such tax quarterly to the Secretary at such time and in such manner as provided by the Secretary.

“(3) SECONDARY LIABILITY.—Where any tax imposed by subsection (a) is not paid at the time payments for indoor tanning services are made, then to the extent that such tax is not collected, such tax shall be paid by the person who performs the service.”

(c) CLERICAL AMENDMENT.—The table of chapter for subtitle D of the Internal Revenue Code of 1986, as amended by this Act, is amended by inserting after the item relating to chapter 48 the following new item:

“CHAPTER 49—COSMETIC SERVICES”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services performed on or after July 1, 2010.

SEC. 10908. EXCLUSION FOR ASSISTANCE PROVIDED TO PARTICIPANTS IN STATE STUDENT LOAN REPAYMENT PROGRAMS FOR CERTAIN HEALTH PROFESSIONALS.

(a) IN GENERAL.—Paragraph (4) of section 108(f) of the Internal Revenue Code of 1986 is amended to read as follows:

“(4) PAYMENTS UNDER NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM AND CERTAIN STATE LOAN REPAYMENT PROGRAMS.—In the case of an individual, gross income shall not include any amount received under section 338B(g) of the Public Health Service Act, under a State program described in section 338I of such Act, or under any other State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas (as determined by such State).”

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to amounts received by an individual in taxable years beginning after December 31, 2008.

SEC. 10909. EXPANSION OF ADOPTION CREDIT AND ADOPTION ASSISTANCE PROGRAMS.

(a) INCREASE IN DOLLAR LIMITATION.—

(1) ADOPTION CREDIT.—

(A) IN GENERAL.—Paragraph (1) of section 23(b) of the Internal Revenue Code of 1986 (relating to dollar limitation) is amended by striking “\$10,000” and inserting “\$13,170”.

(B) CHILD WITH SPECIAL NEEDS.—Paragraph (3) of section 23(a) of such Code (relating to \$10,000 credit for adoption of child with special needs regardless of expenses) is amended—

(i) in the text by striking “\$10,000” and inserting “\$13,170”, and

(ii) in the heading by striking “\$10,000” and inserting “\$13,170”.

(C) CONFORMING AMENDMENT TO INFLATION ADJUSTMENT.—Subsection (h) of section 23 of such Code (relating to adjustments for inflation) is amended to read as follows:

“(h) ADJUSTMENTS FOR INFLATION.—

“(1) DOLLAR LIMITATIONS.—In the case of a taxable year beginning after December 31, 2010, each of the dollar amounts in subsections (a)(3) and (b)(1) shall be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting ‘calendar year 2009’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of \$10, such amount shall be rounded to the nearest multiple of \$10.

“(2) INCOME LIMITATION.—In the case of a taxable year beginning after December 31, 2002, the dollar amount in subsection (b)(2)(A)(i) shall be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting ‘calendar year 2001’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of \$10, such amount shall be rounded to the nearest multiple of \$10.”

(2) ADOPTION ASSISTANCE PROGRAMS.—

(A) IN GENERAL.—Paragraph (1) of section 137(b) of the Internal Revenue Code of 1986 (relating to dollar limitation) is amended by striking “\$10,000” and inserting “\$13,170”.

(B) CHILD WITH SPECIAL NEEDS.—Paragraph (2) of section 137(a) of such Code (relating to \$10,000 exclusion for adoption of child with special needs regardless of expenses) is amended—

(i) in the text by striking “\$10,000” and inserting “\$13,170”, and

(ii) in the heading by striking “\$10,000” and inserting “\$13,170”.

(C) CONFORMING AMENDMENT TO INFLATION ADJUSTMENT.—Subsection (f) of section 137 of such Code (relating to adjustments for inflation) is amended to read as follows:

“(f) ADJUSTMENTS FOR INFLATION.—

“(1) DOLLAR LIMITATIONS.—In the case of a taxable year beginning after December 31, 2010, each of the dollar amounts in subsections (a)(2) and (b)(1) shall be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting ‘calendar year 2009’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of \$10, such amount shall be rounded to the nearest multiple of \$10.

“(2) INCOME LIMITATION.—In the case of a taxable year beginning after December 31, 2002, the dollar amount in subsection (b)(2)(A) shall be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting ‘calendar year 2001’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of \$10, such amount shall be rounded to the nearest multiple of \$10.”.

(b) CREDIT MADE REFUNDABLE.—

(1) CREDIT MOVED TO SUBPART RELATING TO REFUNDABLE CREDITS.—The Internal Revenue Code of 1986 is amended—

(A) by redesignating section 23, as amended by subsection (a), as section 36C, and

(B) by moving section 36C (as so redesignated) from subpart A of part IV of subchapter A of chapter 1 to the location immediately before section 37 in subpart C of part IV of subchapter A of chapter 1.

(2) CONFORMING AMENDMENTS.—

(A) Section 24(b)(3)(B) of such Code is amended by striking “23,”.

(B) Section 25(e)(1)(C) of such Code is amended by striking “23,” both places it appears.

(C) Section 25A(i)(5)(B) of such Code is amended by striking “23, 25D,” and inserting “25D”.

(D) Section 25B(g)(2) of such Code is amended by striking “23,”.

(E) Section 26(a)(1) of such Code is amended by striking “23,”.

(F) Section 30(c)(2)(B)(ii) of such Code is amended by striking “23, 25D,” and inserting “25D”.

(G) Section 30B(g)(2)(B)(ii) of such Code is amended by striking “23,”.

(H) Section 30D(c)(2)(B)(ii) of such Code is amended by striking “sections 23 and” and inserting “section”.

(I) Section 36C of such Code, as so redesignated, is amended—

(i) by striking paragraph (4) of subsection (b), and

(ii) by striking subsection (c).

(J) Section 137 of such Code is amended—

(i) by striking “section 23(d)” in subsection (d) and inserting “section 36C(d)”, and

(ii) by striking “section 23” in subsection (e) and inserting “section 36C”.

(K) Section 904(i) of such Code is amended by striking “23,”.

(L) Section 1016(a)(26) is amended by striking “23(g)” and inserting “36C(g)”.

(M) Section 1400C(d) of such Code is amended by striking “23,”.

(N) Section 6211(b)(4)(A) of such Code is amended by inserting “36C,” before “53(e)”.

(O) The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code of 1986 is amended by striking the item relating to section 23.

(P) Paragraph (2) of section 1324(b) of title 31, United States Code, as amended by this Act, is amended by inserting “36C,” after “36B,”.

(Q) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986, as amended by this Act, is amended by inserting after the item relating to section 36B the following new item:

“Sec. 36C. Adoption expenses.”.

(c) APPLICATION AND EXTENSION OF EGTRRA SUNSET.—Notwithstanding section 901 of the Economic Growth and Tax Relief Reconciliation Act of 2001, such section shall apply to the amendments made by this section and the amendments made by section 202 of such Act by substituting “December 31, 2011” for “December 31, 2010” in subsection (a)(1) thereof.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2009.

Amend the title so as to read: “An Act entitled The Patient Protection and Affordable Care Act.”.

Mr. DURBIN. Mr. President, I move to reconsider the vote.

Mr. MENENDEZ. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. KYL. Mr. President, I ask unanimous consent that two newspaper articles be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

FLAWED AID FOR LONG-TERM CARE—A PIECE OF HEALTH REFORM WITH TOO MUCH FINANCIAL RISK

An estimated 10 million elderly and disabled Americans need some sort of long-term care and help with the tasks of daily living. That number will grow as America ages. But the only federal program that pays for such services is Medicaid: Individuals who need long-term care have to spend down their assets to become poor enough to qualify. So does it make sense to establish a federal program under which people could buy long-term care insurance? Does it make sense to do this within the context of health reform? The House and Senate proposals contain such a program. We are sympathetic to the need but have doubts about its advisability.

The program, known as the Community Living Assistance Services and Supports ((CLASS) Act, would be an innovative, voluntary insurance program run by the federal government. Employers could choose to have workers automatically enrolled unless they opt out, and premiums would be deducted from their paychecks. After paying in for five years, they would be entitled, if they become disabled, to a cash benefit—at least \$50 a day—to pay for the non-medical services they need to remain at home rather than going to a nursing home. The premiums and benefits are required to be set at a level that will ensure the program is actuarially sound for 75 years.

Sounds good, yet there are serious concerns about whether the program will work—or whether, because of low participation rates that would leave it mostly enrolling sicker people, it will end up having to set premiums so high or offer benefits so skimpy

that lawmakers will be moved to bail it out. The Obama administration says not. “We’re entirely persuaded that reasonable premiums, solid participation rates and financial solvency over the 75-year period can be maintained.” Richard Frank, deputy assistant secretary for the Office of Disability, Aging and Long-Term Care Policy at the Department of Health and Human Services, told a Kaiser Family Foundation conference.

But both the Congressional Budget Office and the chief actuary for the Medicare program have expressed misgivings. The Medicare actuary, Richard S. Foster, cited “a very serious risk”: Adverse selection—sicker people signing up for the program and the healthier staying away—“would make the CLASS program unsustainable.” He said that even beginning premiums would have to be \$240 a month. Likewise, CBO director Douglas W. Elmendorf warned that “the CLASS program could be subject to considerable financial risk in the future if it were unable to attract a sufficiently healthy group of enrollees.”

There are already enough risks and uncertainties in health reform. Long-term care is an important topic, but it is one that deserves more careful scrutiny than has taken place in the context of the broader health-reform debate.

[From the Washington Post, Dec. 23, 2009]

YES, IT’S ALL ABOUT HIM

(Robert Samuelson)

Barack Obama’s quest for historic health-care legislation has turned into a parody of leadership. We usually associate presidential leadership with the pursuit of goals that, though initially unpopular, serve America’s long-term interests. Obama has reversed this. He’s championing increasingly unpopular legislation that threatens the country’s long-term interests. “This isn’t about me,” he likes to say, “I have great health insurance.” But of course, it is about him: about the legacy he covets as the president who achieved “universal” health insurance. He’ll be disappointed.

Even if Congress passes legislation—a good bet—the finished product will fall far short of Obama’s extravagant promises. It will not cover everyone. It will not control costs. It will worsen the budget outlook. It will lead to higher taxes. It will disrupt how, or whether, companies provide insurance for their workers. As the real-life (as opposed to rhetorical) consequences unfold, they will rebut Obama’s claim that he has “solved” the health-care problem. His reputation will suffer.

It already has. Despite Obama’s eloquence and command of the airwaves, public suspicions are rising. In April, 57 percent of Americans approved his “handling of health care” and 29 percent disapproved, reports the Post-ABC News poll; in the latest survey, 44 percent approved and 53 percent disapproved. About half worried that their care would deteriorate and that health costs would rise.

These fears are well-grounded. The various health-care proposals represent atrocious legislation. To be sure, they would provide insurance to 30 million or more Americans by 2019. People would enjoy more security. But even these gains must be qualified. Some of the newly insured will get healthier, but how many and by how much is unclear. The uninsured now receive 50 to 70 percent as much care as the insured. The administration argues that today’s system has massive waste. If so, greater participation in the waste by the newly insured may not make them much better off.

The remaining uninsured may also exceed estimates. Under the Senate bill, they would total 24 million in 2019, reckons Richard Foster, chief actuary of the Centers for Medicare & Medicaid Services. But a wild card is immigration. From 1999 to 2008, about 60 percent of the increase in the uninsured occurred among Hispanics. That was related to immigrants and their children (many American-born). Most illegal immigrants aren't covered by Obama's proposal. If we don't curb immigration of the poor and unskilled—people who can't afford insurance—Obama's program will be less effective and more expensive than estimated. Hardly anyone mentions immigrants' impact, because it seems insensitive.

Meanwhile, the health-care proposals would impose substantial costs. Remember: The country already faces huge increases in federal spending and taxes or deficits because an aging population will receive more Social Security and Medicare. Projections the Congressional Budget Office made in 2007 suggested that federal spending might rise almost 50 percent by 2030 as a share of the economy (gross domestic product). Since that estimate, the recession and massive deficits have further bloated the national debt.

Obama's plan might add almost an additional \$1 trillion in spending over a decade—and more later. Even if this is fully covered, as Obama contends, by higher taxes and cuts in Medicare reimbursements, this revenue could have been used to cut the existing deficits. But the odds are that the new spending isn't fully covered, because Congress might reverse some Medicare reductions before they take effect. Projected savings seem “unrealistic” says Foster. Similarly, the legislation creates a voluntary long-term care insurance program that's supposedly paid by private premiums. Foster suspects it's “unsustainable,” suggesting a need for big federal subsidies.

Obama's overhaul would also change how private firms insure workers. Perhaps 18 million workers could lose coverage and 16 million gain it, as companies adapt to new regulations and subsidies, estimates the Levin Group, a consulting firm. Private insurers argue that premiums in the individual and small-group markets, where many workers would end up, might rise an extra 25 to 50 percent over a decade. The administration and the CBO disagree. The dispute underlines the bills' immense uncertainties. As for cost control, even generous estimates have health spending growing faster than the economy. Changing that is the first imperative of sensible policy.

So Obama's plan amounts to this: partial coverage of the uninsured; modest improvements (possibly) in their health; sizable budgetary costs worsening a bleak outlook; significant, unpredictable changes in insurance markets; weak spending control. This is a bad bargain. Health benefits are overstated, long-term economic costs understated. The country would be the worse for this legislation's passage. What it's become is an exercise in political symbolism: Obama's self-indulgent crusade to seize the liberal holy grail of “universal coverage.” What it's not is leadership.

Mr. ENSIGN. Mr. President, I really hoped that this day would not come. I am not the only one. The American public is not behind the bill that we voted on. For good reason. I fear that when this effort is written about in history books, it will represent a time

when our Nation took a turn for the worse—when we were presented with two paths, but the wrong path was chosen.

There is a term that originated with television critics called “jumping the shark.” It refers to a plot or character twist that pretty much throws off the balance of the show. The show is never the same and usually heads downhill after that. I believe that this health care bill will be seen as the moment the Democrats jumped the shark for our country.

There have been many pieces of bad legislation leading up to this—obscene amounts of taxpayer money being used to grow the government like never before. But this bill, this health care reform bill, may be the pinnacle vote when the Democratic agenda did itself in.

I don't deny that the motives of my colleagues on the other side of the aisle are genuine. We all want to improve access to health insurance for Americans, but this is not the way to do it. And the American public sees that. They see it, and they are frustrated that the majority in Congress is ignoring their pleas.

Over the past several months, I have talked to tens of thousands of Nevadans about this bill. Nevadans have told me loud and clear that this is not the cure for our broken health care system.

I have heard from small business owners, like Boyd Betteridge, in Winnemucca, NV. Boyd and his wife have worked hard to build a small business over the past 15 years. They employ about 25 employees and fear that if this bill passes, they will have no choice but to fire employees or even close shop.

Boyd says that government regulation makes it harder for him to survive. He is frustrated and upset that politicians in Washington, DC, don't feel the pain of the small business owners working hard to make ends meet and to create jobs. Boyd serves his community—he sits on the school board, he is part of the engine of our economy, and he is in real pain. This health care bill doesn't help Boyd Betteridge.

And it doesn't help Dan Grigsby. He is the controller at Renner Equipment Company in Yerington, NV. Dan works for a company that employs about 25 to 30 people. The owners have committed over the years to provide health insurance to their employees. Because costs have increased, they have taken advantage of health savings accounts as a way of providing for their employees in a more cost-effective way. Health savings accounts have been very well received at Renner Equipment in Yerington and at similar businesses around the country. They help patients become consumers in the health care marketplace. That is an important step in reducing health care costs.

Unfortunately, it appears that the minimum benefit standards in the bill before us today could take away the ability of Americans like Dan Grigsby to keep an HSA. Prohibiting the use of HSA funds to purchase over-the-counter medications will further limit the options that employers have to provide meaningful health care to their employees.

And it sure doesn't help the more than 100,000 Nevada seniors who choose a Medicare Advantage plan. Their extra benefits will be reduced by more than half. While we are at it, this bill doesn't help the typical Nevada family who purchases health insurance in the individual market. Their premiums will go up 10 to 13 percent.

This bill doesn't help middle-income union workers in Nevada either. Our hard-working hotel maids, casino restaurant workers, airline workers, teachers, and police officers will share the burden of the \$200 billion tax on health insurance holders. This bill doesn't help the hospice community—they face about a \$7.7 billion cut in payments.

Many of the hospices in Nevada—including the one where my grandmother received care—may not be able to survive these reimbursement cuts.

In another hit for an integral part of our health care system, the home health community will see cuts of approximately \$40 billion in this bill. For Nevada home health providers, that means about \$264 million in cuts over 10 years, according to some estimates. This bill surely doesn't help them.

So, let's see. So far, this bill doesn't help small business owners, Americans with health savings accounts, families purchasing health insurance, union workers, seniors, hospices, or home health. If you aren't in one of these groups, don't breathe a sigh of relief just yet.

Fifteen million American workers will pay for new taxes and “penalties” with reduced wages and lost jobs. And then there are taxes on prescription drugs, clinical lab work, and medical devices—all passed on to consumers. An over 2,700-page bill full of new taxes on Americans, funding cuts for programs they rely on, and raised premiums. That is why the Nevadans are not behind this bill, and that is why the American public is not behind this bill.

Beyond the financial impact of this bill, Democrats set a dangerous precedent by requiring every American citizen to purchase health insurance coverage. Americans who fail to buy health insurance that meets the minimum requirements would be subject to financial penalties. Is it really constitutional for this body to tell all Americans that they must buy health insurance coverage? And, if so what is next? What personal liberty or property will the Congress seek to take

away from Americans next? Will we consider legislation in the future requiring every American to buy a car? Will we consider legislation in the future requiring every American to buy a house? Where do we draw the line or will we even draw one at all?

I don't think Congress has ever required Americans to buy a product or service like health insurance under penalty of law. I doubt that Congress has that power in the first place. As the CBO explained in the 1990s, "A mandate requiring all individuals to purchase health insurance would be an unprecedented form of federal action. The government has never required people to buy any good or service as a condition of lawful residence in the United States."

There is no doubt that we need to change health care in this Nation. Americans don't want billions in new taxes, they don't want to lose their current insurance coverage or the choice to decide their coverage, and they don't want a bureaucrat coming between them and their doctor.

This vote isn't about voting for this bill or doing nothing. We can go back to the drawing board, take the best ideas from each side, and put together health reform that will take us into the future.

Republicans have come up with many ideas on ways to fix our Nation's broken health care system. The answer is not with unbearable taxes, unsustainable growth of the government, or paying for a brand new entitlement program. Those aren't the qualities of comprehensive health care reform. They are the qualities of terrible policy that will lead to devastating results for Americans and our health care system. There is a better way. It will take time, but if we can change the way that Americans think about health care, than we can create a better system.

Imagine a system where Americans get to keep their choices in health care and where they are allowed to buy insurance across State lines. Imagine a system where there is transparency—where you know how much a doctor's visit will cost and how much your surgery will be—where you can shop around for the best value for your money. Imagine a system that rewards individuals for engaging in healthy behaviors. Imagine a system where you are not punished for having a pre-existing condition. Imagine a system that allows small businesses to pool their purchasing power to provide health insurance to their employees through Small business health plans. Imagine a system where doctors can practice medicine to heal patients instead of practicing medicine with the goal of not being sued. And imagine a patient-centered health care system, not an insurance-centered or government-centered health care system.

These are all standards that we should work toward. We shouldn't assume that this bill before us is our last, best option for health care reform. We can't afford to settle for this bill.

The Democrats see how close they are with this bill, and they want a victory so badly. They are working every possible angle to get the 60 votes they need. They have literally given sweetheart deals to a few just to get their votes. They think this is the political victory that is going to help them win over the American people. And they are borrowing trillions of dollars from our children and grandchildren to get the job done—and that is just with this health care bill.

We simply cannot survive the Democratic agenda of taxing and spending away our future. We can't survive it, and we can't afford it.

Mr. AKAKA. Mr. President, I am proud of the health care system that we have in Hawaii. We have developed innovative approaches to provide health insurance coverage. Hawaii consistently is ranked amongst States with the highest rates of health insurance coverage. An October article in the New York Times pointed out that Hawaii's health insurance premiums are tied with North Dakota for the lowest in the country and its Medicare cost per beneficiary is the lowest in the Nation. Our residents also tend to live longer than individuals living elsewhere in the country.

Our system is not perfect. An increase in unemployment has led to more people losing their health insurance. Insurance premiums have been rising. Our health care providers are struggling to meet the increasing burdens imposed on them by greater numbers of uninsured patients and rising costs. There are substantial access issues in many areas of Hawaii, especially on the neighbor islands. We have a significant shortage of health care professionals, particularly in certain specialties.

I support the Patient Protection and Affordable Care Act because it will improve the Nation's health care system and help address many of the problems in Hawaii. This legislation expands access to coverage, includes policies aimed at improving the quality and availability of health care services, and attempts to slow increasing health care costs. The legislation will also ensure that individuals with preexisting conditions will be able to get insurance. Additionally, the bill will prohibit unfair lifetime limits imposed by health insurance companies on individuals.

The bill strengthens the health workforce and primary care systems. Improvements to the National Health Service Corps, scholarship, and loan repayment programs will help train additional health care professionals. Additional investments in federally quali-

fied community health centers will improve access to primary care services.

The act improves access to quality and affordable care nationally, while recognizing the unique health care needs of Hawaii. I appreciate the inclusion of two provisions in the legislation of tremendous importance to my home State. A significant contributing factor to Hawaii having a high percentage of residents insured is our employer-mandated health care system. Our employer mandated health care system depends on our longstanding exemption from the Employee Retirement Income Security Act, ERISA. I appreciate the inclusion in the Patient Protection and Affordable Care Act of a rule of construction that is intended to preserve our unique ERISA exemption and the employer-mandated insurance that the exemption enables. This rule of construction will ensure that the employer-provided insurance, as mandated by the Hawaii Prepaid Health Care Act, is maintained and that nothing in this act will be used to take away the health benefits provided to workers in Hawaii or alter the responsibilities imposed on employers. It is essential that as we try to expand access to health care that we build upon the existing system of coverage in Hawaii rather than replace it.

The hospitals in Hawaii continue to have difficulties trying to care for uninsured and Medicaid beneficiaries. Medicaid disproportionate share hospital, DSH, payments are intended to support hospitals that care for significant numbers of Medicaid and uninsured patients. Hawaii does not have a permanent Medicaid DSH allotment.

The Balanced Budget Act of 1997 created specific DSH allotments for each State based on their actual DSH expenditures for fiscal year 1995. In 1994, Hawaii implemented the QUEST Medicaid demonstration program. The prior Medicaid DSH program was incorporated into QUEST. As a result of the demonstration program, Hawaii did not have DSH expenditures in 1995 and was not provided a DSH allotment. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 modified the DSH program, which included the establishment of a floor for DSH allotments. States without allotments were again left out. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 made modifications to DSH program, which included an increase for low DSH States. States without allotments were left out again.

The Tax Relief and Health Care Act of 2006 temporarily restored Hawaii's allotment. Hawaii's temporary allotment was extended by the Medicare, Medicaid, and SCHIP Extension Act of 2007, the Medicare Improvements for Patients and Providers Act of 2008 and the CHIP Reauthorization Act of 2009.

However, Hawaii's temporary DSH allotment will end after December 31, 2011.

This bill will permanently restore Hawaii's Medicaid DSH allotment. This restoration authorizes the submission by the State of Hawaii of a State plan amendment covering a DSH payment methodology to hospitals that is consistent with the requirements of existing law relating to DSH payments. The purpose of providing a DSH allotment for Hawaii is to provide additional funding to the State of Hawaii to permit a greater contribution toward the uncompensated costs of hospitals that are providing indigent care. It is not meant to alter existing arrangements between the State of Hawaii and the Centers for Medicare and Medicaid Services, CMS, or to reduce in any way the level of federal funding for Hawaii's QUEST program.

I look forward to continuing to work to further improve the legislation and bring about the enactment of health care reform legislation.

Mr. LEAHY. Mr. President, we have reached a defining moment for the Senate and for the American people. The bill we have considered will rank alongside other major decisions such as the creation of Social Security and Medicare and the Civil Rights Act. Health insurance reform has been talked about and attempted for seven decades. The American people for years have named health insurance as among the greatest concerns in their daily lives. Now, here at hand, is the opportunity to act.

This has been an arduous process. The President has rightly noted that if health insurance reform were easy, it would have been done long ago. The defenders of the status quo have spared no expense—nor have they been sparing in their distortions—to keep the system that pays them so handsomely. Health reform will benefit every American of today's generations. But let us especially think ahead one, two or three generations. If we were to abandon our responsibility now, saying it was too difficult, that would be an excuse for doing nothing that our children and grandchildren would never accept.

For many reasons, including the health of public discourse on the most pressing issues we face as Americans, it is regrettable that the defenders of the status quo, doing their utmost to influence this debate from their comfortable perches outside the Senate, have stooped to new levels to obstruct health insurance reform. Friction is a byproduct of reform, especially when well-funded and entrenched special interests rally to protect the status quo. The heat of this debate is a measure of the cozy setups that these reforms will unsettle. This year alone Senate Democrats have been forced to contend with 101 filibusters by the minority Repub-

licans. Even on an issue this important, health insurance reform is still being subject to filibuster and parliamentary delay to a level I have not seen in 35 years in the Senate.

Opponents of reform unfortunately have wasted much of the public's time by provoking arguments over their distortions about what health reform really means. The country suffers when there is a failure to act on serious challenges that millions of ordinary Americans face in their daily lives.

The arguments that we hear today to prop up the status quo by knocking down challenges to the way things are seem eerily similar to those made against creating Medicare nearly 45 years ago. Opponents then tried to demonize the plan and claimed it would never work. During the debate decades ago on Medicare, one Senator said: "It would achieve little for those who need it, while subjecting the very fabric of American life to the strain of severe and unnecessary sacrifices."

Eventually during that historic debate, Members from both sides of the aisle worked together to pass a bill that is one of the most successful, purposeful and popular programs today. The Medicare Program, like Social Security, was not perfect when it began, but improvements have been made over time. Vermonters can be proud that our State's congressional delegation, all Republican at the time, supported passage of that landmark legislation.

The Senate has overcome the stalling and delay tactics, the filibusters and the roadblocks to the consideration of health care reform, and now we are closer than ever to passing comprehensive and meaningful health insurance reform.

Is the Senate health care bill without any problems? No. Is the bill before us the one I would have drafted or the one that any other Member of the Senate would have drafted? Of course not. Extensive negotiations and refinement were needed to produce a bill of this scope and importance, as it should be in the legislative process. The difficulty was magnified by the minority's calculated decision to spend their efforts to undermine, instead of to constructively engage. Not only majorities but supermajorities were required at several steps in the Senate's work on this bill. There are 100 Senators and 435 Members of the other body who will have to stand up and be counted in this historic process. The votes of most, I believe, will be tallied on the right side of history and of the real-life, everyday needs of the American people for real health insurance reform.

Some say the bill before us does not go far enough. Others say it goes too far. What everyone can agree on is what will happen if we do nothing.

In the next decade, without reform, half of all nonelderly adults will find themselves without coverage at some

point. The number of people without insurance will jump by more than 30 percent in 29 States and by at least 10 percent in every State. American families will continue to pay a hidden tax of \$1,100 on their health insurance premiums to pay for the costs of care for the uninsured. The very same insurance coverage a family has in 2008 is projected to nearly double to \$24,291 by 2016, consuming a whopping 45 percent of projected median family incomes. Premiums will continue to double every several years, making health insurance vastly unaffordable for many Americans. Economists project that if health insurance reform fails, the resulting lower gross domestic product, GDP, will reduce family incomes by \$10,000 by 2030. Small businesses will continue to struggle and fewer and fewer will be able to offer coverage to their employees.

Furthermore, as our population ages, Medicare is projected to be insolvent within 10 years, jeopardizing coverage for millions of American seniors. Each day that passes without reform, 14,000 Americans lose health insurance coverage. These are not minor problems to be brushed aside or kicked yet again down the road for another generation of Americans to tackle. These problems are on the Senate's doorstep, right here, right now. Keeping the status quo guarantees a struggling economy in the future, with more Americans unable to afford lifesaving treatments because of the rising cost of insurance.

In 2001, 46 percent of all bankruptcies were attributable to medical costs. By 2007, that number had grown to 62 percent. While hard-working Americans were losing their jobs, homes and savings simply because they got sick, insurance and pharmaceutical company executives were making record profits. In 2000, the 10 largest publicly traded health insurance companies had profits of \$2.4 billion. By 2007, profits at those firms had jumped to \$12.9 billion, a 428-percent increase. In 2007, CEO salaries at these firms were \$118.6 million or \$11.9 million for each CEO. In 2007, prescription drug companies had a profit margin of 15.8 percent. The same year, profit margins at all Fortune 500 firms were 5.7 percent.

Since the Nation's last attempt to pass health reform 16 years ago, millions of Americans have lost their insurance and costs have skyrocketed. In the absence of a fair and sensible health insurance system, families, businesses and taxpayers have been dragged along by an inflationary curve that only worsens with time. Next year, small businesses—already suffering from skyrocketing medical costs—will see their premiums rise by an average of 15 percent—twice the rate of last year's increases. Drug companies have boosted prices of brand-name drugs by about 9 percent over the

last year, the steepest increase in years.

Even though Vermont has long recognized the importance of building a health care system that includes all Vermonters, individual States acting alone cannot make enough progress without comprehensive health insurance reform. Tens of thousands of Vermonters still lack basic health insurance. Workers nationwide are losing insurance for their families when they change or lose jobs. Insurance companies can and do discriminate against sick people.

I know so very many of these Vermonters. Many of them are my neighbors, my friends. Some of these Vermonters without health insurance went to school with me. Some grew up as I did in Montpelier, VT. Some are people I have known all our lives. They are hard-working, good, honest, decent people. It is a travesty that after working so hard and playing by the rules they still cannot begin to have the kind of health coverage that Federal employees—including those of us in this Chamber—are able to have because of earlier reforms of the Federal workforce health insurance system.

Too many Vermont families live in the shadow of constant insecurity because they know that if they have an illness or if they lose a job, it might mean the end of their health insurance. Too many Vermonters are forced to sell their homes or file for bankruptcy to pay their health insurance bills. In no other modern society are families confronted with such heartbreaking dilemmas.

Let me give a personal example. I heard recently from a Vermonter who only periodically had health insurance throughout his life and now goes without prevention and screenings and pays for everything out of pocket because he cannot afford any health care that is not urgently needed. Tragically, his wife was in a car accident, and even though the couple paid thousands in treatments, they “had to stop short” in giving her the necessary physical therapy and medications her doctors recommended because of the costs involved.

Another Vermonter, who is lucky enough to have insurance, says her family pays almost \$1,100 each month in premiums, and yet they have to reach a \$3,000 deductible before the insurance company will pay a dime. She told me that “as the cost of health insurance continues to rise, it feels like we will be swallowed whole by it.”

These should not be stories heard in today's America. We remain the only industrialized Nation in the world that lets its citizens fend for themselves without health coverage.

The bill before us would make giant leaps toward reforming our health insurance system. Under the Senate bill, 31 million more Americans would have

health insurance, bringing coverage to 94 percent—the highest level of insured Americans ever in our history. More low-income Americans will be able to access the State Medicaid Programs, and middle-income families will get enough help to be able to buy health insurance through State-based health insurance exchanges, which will be closely monitored. Insurance companies will never be able to drop your coverage, charge you more, or deny you or your children coverage because of a preexisting health condition. This bill also sets standards for qualifying health insurance so the insurance companies can no longer sell you coverage that does not actually help when you are sick. The legislation also contains a Patient Bill of Rights, long championed by Senator Kennedy, which guarantees that patients have a right to appeal denials or decisions by their health insurance companies.

The insurance industry will no longer be allowed to pay excessive executive bonuses and salaries on the backs of their customers. All insurance companies will be required to spend more of their premium revenues on clinical services and quality activities, with less going to administrative costs and profits—or else they will have to pay rebates to policyholders. This change will improve quality of care and will hold the insurance industry accountable for their spending.

Small businesses, which make up more than 80 percent of the businesses in Vermont, at long last will have access to affordable care under this bill. This bill will make tax credits available to small businesses to help them offer health insurance to their employees. These tax credits will make health insurance more affordable both for small businesses and for their workers.

The nonpartisan Congressional Budget Office confirmed that the reforms in the bill—including lower administrative costs, increased competition, and better pooling for risk—will lower premiums for American families. CBO estimates premiums for the overall population will be reduced by 8.4 percent.

In addition to the consumer protections and industry accountability provisions, this bill also takes significant strides to slow the growth of the spiraling health spending that has the potential to cripple our economy in the years to come. A substantial portion of the Senate bill is devoted to testing ways to reduce health care costs while improving quality over time. The bill contains pilots for efforts like Vermont's Blueprint for Health, under which patient care is coordinated to reduce unnecessary hospital visits and to keep patients healthy. Other programs will test various ways to pay doctors and hospitals that could be more efficient than the current fee-for-service structure. A greater emphasis on prevention—long supported by Senators

KENNEDY and HARKIN in the Health, Education, Labor, and Pensions Committee—will reduce preventable deaths and hospitalizations.

While these improvements to our health care system are significant and noteworthy, I am disappointed that the bill no longer includes a public insurance option to compete with private plans, nor does it include a provision I have proposed to repeal the antitrust exemption for health and medical malpractice insurers. Though there are differing views on the best ways to inject competition into the health insurance market, we can all agree that health and medical malpractice insurers should not be allowed to engage in blatantly anticompetitive practices, such as colluding to set prices and allocating markets. My legislation would ensure that basic rules of fair competition apply to insurers. I believe that repealing this antitrust exemption, combined with the public option, would go far in providing fair competition and choice in the health insurance marketplace.

With all the progress the Senate's health care bill makes in the area of women's health—such as prohibiting insurance companies from discriminating against women through higher premiums and by allowing women free access to vital preventative services—it is unfortunate the bill also threatens to chip away at women's reproductive choices. Before a restrictive provision was added in the managers' amendment, the bill would have maintained current law by restricting Federal funds for abortions. The original Senate bill would have required insurance companies to segregate public and private funds to ensure no public funds would go to abortion services. Now, instead, the Senate bill would require women who purchase insurance on the exchanges to make two payments if they wish to have a wide range of choices. States could also opt out of allowing abortion to be covered at all on their exchanges, leaving women with fewer choices than they have now on the individual insurance market. While this language is far less restrictive than the language in the House-passed legislation, there is legitimate concern that despite the interest of women to have this choice available in the marketplace, this language would prompt private insurers to stop offering such options at all. I hope a better solution comes in conference.

After one of the cliffhanger votes over the course of this long Senate debate, I spoke privately with Vicki Reggie Kennedy, the courageous and insightful widow of our beloved friend, Senator Edward Kennedy. This is a bittersweet time for her and for all who know how fully he was committed to winning this battle to lighten the load for the ordinary Americans who are struggling so mightily today. Health

reform was the first of the many causes of his life and of his work in this body.

We talked about how he would have relished this moment, and we talked about how he would have pressed his shoulder to the tiller to steer the Senate toward the right outcome for the American people. Though Senator Kennedy strongly supported including a public option, as I have, along with other reforms such as ending health insurers' antitrust exemption, Vicki Kennedy knows, as I do, that he would be fighting to pass this bill. This is the Senate's opportunity to advance real reform. This is a bill that reflects the core principles the President outlined in beginning this debate early this year.

This is reform based on the existing system of employer-based insurance, offered by private insurers with health services delivered largely within the private sector. But any objective reading of this bill makes crystal clear that this is real reform. This is a bill that will improve the lives of every American. This is a bill that is a credit to this good and great Nation and its people.

At its best, the Senate through our history has been able to act as the conscience of the Nation. Those moments were forged amid fervent debate and with the purpose of advancing a pressing national interest. This is such a time, and my hope and belief is that the Senate did rise to the occasion.

Mr. DORGAN. Mr. President, the health care reform bill we voted on today in the U.S. Senate merited my support because it is a fiscally responsible bill that will expand health care coverage to tens of millions of Americans who are currently uninsured, reduce health care costs for families and small businesses and strengthen our health care system in rural America.

While I recognize that this is a very controversial issue, I believe that the status quo is unsustainable. Our country spends nearly twice as much on health care as most other countries in the world. And the cost of health care and its claim on our economy is increasing every single year.

There are some tens of millions of Americans who are not covered with health insurance and whose health care costs are then transferred to the rest of the American people to pay. It is estimated that those with insurance pay, on average, \$1,000 per year in a hidden tax to cover the uncompensated care given to those who don't now have health insurance.

So, I think it is important for us to try to put the brakes on increasing health care costs, and also to extend health care coverage to those who now don't have it.

I told citizens of North Dakota that I would not support a government takeover of health care. This legislation is not a government takeover. I have said

that I would not support public funding for abortion. This legislation does not provide public funding for abortion. I have promised that I would not support legislation that provides health care for illegal immigrants. This legislation does not.

But you wouldn't know those facts if you heard the negative advertising about the bill. In North Dakota alone, nearly \$2.2 million has been spent on advertising that, in many cases, is just not honest. These ads are paid for by out-of-State groups and big interests that have a lot at stake and will do anything to defeat the health care reform bill. The first amendment allows these groups to do this but it does nothing to advance the debate since most of these attacks have been based on lies and scare tactics.

This health care bill includes important protections that will stop insurance companies from taking advantage of patients. It begins to reform the delivery of health care in a way that would control costs and improve the quality of health care. It will increase competition in the insurance market by allowing insurance companies to compete across State lines and by offering nationwide plans. It also establishes pilot programs to support creative ways to deal with medical malpractice reform.

In addition to being paid for, the legislation also extends help to individuals and small businesses that need assistance to afford health insurance.

And the legislation contains important provisions to strengthen health care in rural America, including a provision I added called the Frontier Amendment, with Senator CONRAD.

For the first time in many decades, this bill finally provides fair reimbursement to North Dakota and several other States who have the highest quality health care, but the lowest reimbursements under Medicare. This new fair payment system will mean a strengthened health care system for senior citizens on Medicare. It will also mean a better health care system for all North Dakotans because there will be less cost shifting among individuals with private policies in order to cover the shortfall in Medicare reimbursement.

The bill guarantees that Medicare services to senior citizens will not be cut or affected in any way. In fact, the bill improves the solvency of Medicare.

The health care reform bill in the Senate is being supported by the American Association of Retired Persons, AARP, the National Committee to Save Social Security and Medicare, American Hospital Association, American Medical Association, and many, many consumer groups across the country.

So this bill is about a lot of things. It is about standing up for American business and growth in our economy. It is

about standing up for senior citizens and Medicare. It is about creating a better health care program for all Americans. For those reasons, I voted yes to move this process along in the hope this bill will be further improved in the weeks ahead.

This is not a perfect piece of legislation for sure. But voting for this legislation in the Senate moves it along to a conference with the House of Representatives, which is another step in determining whether we can write legislation that advances our country's interests.

Mrs. FEINSTEIN. Mr. President—I voted to support of the Patient Protection and Affordable Care Act of 2009, which will reform our Nation's health care system.

This is our chance to fix a broken system. We tried in 1993 and 1994 and failed. Over 15 years have passed since our last effort. This may be our last, best opportunity before we are forced to wait another 15 years for real reform. And our country cannot afford to wait another 15 years. Our system is simply unsustainable.

Now this bill is not perfect, and without question there are items I would like to change. I believe it is a work in progress. However, it accomplishes several important objectives.

The bill is incremental. There will be time to make needed adjustments before it is fully effective.

It expands insurance coverage and provides new consumer protections from insurance company abuses.

It does all this in a fiscally responsible way, reducing the deficit and prolonging the solvency of the Medicare trust fund.

Throughout this process, I have argued that health reform should be incremental. I believe that in many ways, this bill is incremental.

It leaves the best of our health care system in place. The majority of Americans with coverage continually say they are happy with their insurance. Under this legislation, they can keep what they like.

The bill also will be phased in over the next several years. People in need of coverage will receive immediate help in many forms.

Beginning in 2010, next year, the Federal Government will spend \$5 billion to establish a high-risk pool, which will provide subsidized coverage for those who have been denied private insurance on account of a preexisting condition.

Young adults will be able to remain on their parents' health insurance until age 26. Many young adults currently lose their coverage as soon as they graduate from college; this will allow them to maintain their coverage while they find a job.

Seniors enrolled in the Medicare prescription drug benefit will receive an additional \$500 in drug coverage before

they encounter the so-called doughnut hole coverage gap. This is the coverage gap that occurs after seniors spend \$2,830 on prescription drug costs. They are then required to pay the full amount out of pocket, until their costs total \$4,550. This additional \$500 of coverage means that seniors will encounter a small gap in their drug coverage and pay less out of pocket.

There will be new limits on the amount of premium dollars that can be spent on non-health care expenses by all health insurance companies. This is very important—I have long worried that insurance companies spend too much on administrative expenses, like medical underwriting, claims processing, overhead, and profits and salary, and not enough on actual medical care. Starting next year, plans sold in the individual and small group markets must devote at least 80 percent of premium dollars to health care expenses; and plans sold to large groups must spend at least 85 percent of the premium funds they collect on health care services. This provision will give people the assurance that most of their premium dollars go to pay for care.

Also next year, small business can receive tax credits to help cover the cost of covering their employees. These credits will be available on a sliding scale to employers with 25 or fewer employees, with average annual wages of \$50,000 or under.

Expansion of community health centers. Beginning in 2011, the Federal program that supports community health centers will begin to receive significant additional funding, totaling \$10 billion through 2015.

This expansion of community care helps guarantee that we are providing not just coverage for medical care but also access. A health insurance card does no good if no physician will accept it. These clinics provide care for all and in many places will be the backbone of a reformed health care system.

Finally, in 2014, the full scope of the reform effort will come in place. People will be able to compare their coverage options in newly created exchanges, and in many cases they will receive tax credits to help them purchase coverage.

This allows plenty of time to see how reforms are working and, if necessary, for Congress, the administration, and States to make adjustments to ensure that health reform is effective.

The bill contains several critical insurance industry reforms that will help cover 31 million additional Americans. I am convinced that our country's for-profit health insurance industry operates with profits, not people, in mind. And this legislation will contain a number of new standards that this industry will need to meet.

They will not be allowed to discriminate based on gender.

They will not be able to take away coverage once a person gets sick.

They will not be able to charge more, or deny coverage entirely, based on an individual's health history or pre-existing conditions.

Insurance will be sold in regulated markets called exchanges, where consumers can easily compare their different insurance options. Web sites allow Americans to easily compare prices when shopping for airline tickets, and this will extend the idea to health insurance.

These exchanges will work on behalf of consumers to negotiate lower prices and to ensure that participating plans meet high standards. Consumers will receive clear information about what is covered and how much it will cost. They will have several different levels of coverage from which to choose.

Every exchange will also offer two national plans, overseen by the Federal Office of Personnel Management. This office ensures that Federal workers and Members of Congress have good health plan choices. One of the included plans will be offered by a nonprofit company. For consumers in highly concentrated markets with only a few choices, these national plans will provide a new option for quality coverage.

Most importantly, these exchanges will consider the previous behavior of insurance plans. If a company raises rates unfairly over the next several years, exchanges will consider this and decide whether they should be allowed to sell in these new markets.

This is a strong incentive for plans to treat consumers fairly.

All of this is accomplished in a fiscally responsible manner. The bill saves money, and it saves Medicare.

It is clear that we cannot afford to continue on our current path.

It expands coverage to an additional 31 million Americans while reducing the Federal budget deficit by \$132 billion by 2019. Deficit reduction increases in the second 10-year period that the bill will be in effect.

Now, this is a major point of contention. I continue to hear the other side say that this bill will cost \$2.5 trillion over 10 years. Even the Republicans' own analysis shows that the bill will reduce the budget deficit. The Budget Committee's minority staff released an analysis that examines the bill's net cost and savings over the next several decades.

The Republican staff projects that the bill will reduce the deficit by \$176 billion from 2014 to 2023.

This number grows to \$1.032 trillion from 2020 to 2029.

The total net deficit reduction, according to Republicans, is \$1.165 trillion from 2010 to 2029.

Let me say it again. These are partisan estimates, produced by Republican staff, and they show significant, meaningful deficit reduction.

The bill also takes a first step at prolonging the solvency of the Medicare

Program. Without action, Medicare will be insolvent in 2017. That is 9 short years from now.

This bill extends Medicare's solvency by approximately 4 to 5 years. Make no mistake, more must be done. The Chief Actuary at the Centers for Medicare and Medicaid estimates that it extends solvency to 2026. And I believe this bill lays the groundwork to help make Medicare more sustainable.

It contains a Medicare Commission, which will examine the program and make recommendations to Congress on an expedited basis.

It creates accountable care organizations, in which physicians work together to provide more efficient care for patients, while sharing in some of the savings they generate for the Medicare Program.

Controlling entitlement spending must be a priority, and I believe this is an important step in the right direction.

Throughout the health reform process, I have emphasized the importance of a health reform bill that meets the needs of large and complex States such as California.

My State, without question, has one of the largest and most complex health care systems. As a result, we face some of the most complex challenges.

Over 6.6 million Californians are uninsured. The State is experiencing an unprecedented budget crisis. And even after health reform, the State will still have as many as 2 million undocumented, which will continue to strain public hospitals, emergency rooms, clinics and other providers.

California's public hospitals play a key role in meeting these needs and care for the poorest of the poor. These hospitals rely on payments called Medicaid disproportionate share hospital, DSH, funding to cover their costs, both for the uninsured that they cover and the very low reimbursement rates their receive from the Medicaid Program. DSH funding accounts for, on average, 40 percent of public hospitals' total funding.

I am pleased that the managers' amendment has slightly reduced the annual cut to Medicaid DSH funding that California and other States that use their full allotments will receive.

Under the original bill, California would have received a 50 percent cut in Medicaid DSH once the rate of the uninsured in the state dropped by 45 percent under this version, the state's allotment will only be cut by 35 percent. This reduces a \$550 million cut to \$385 million, for a savings of approximately \$165 million per year to California.

States are now guaranteed to keep at least 50 percent of their current Medicaid DSH allotments, which will provide long-term stability to this critical program.

I am grateful to Senator REID for making these adjustments, and I will

continue to work with my colleagues in the House to keep as much of this critical funding intact as possible as the process moves forward.

The cost to California from the expansion of Medicaid remains a serious concern.

The bill will cover the full cost through 2016 generated by opening the program to all adults who earn less than \$14,400 per year, which is 133 percent of the Federal Poverty Level, FPL. However, California will need to maintain this expansion and will also have to find a sufficient number of doctors willing to take patients newly eligible for Medicaid.

This will cost money. Health reform should not bankrupt large States like California. Ensuring that health reform works for my State will be a top priority as this legislation moves to conference.

I am also concerned that the structure of the annual tax on the health insurance sector may have unintended consequences that will have a disproportionate impact on California. This tax will generate roughly \$60 billion over the next 10 years.

The impact of this provision would be disproportionate on States such as California, which have a high proportion of fully insured coverage. For example, 77 percent of the commercially enrolled population in California is enrolled in fully insured health plans. This includes public employee plans such as CalPERS and the city and county of San Francisco.

The net result is that California would pay upwards of one-third more than the average State on a per capita basis. Many integrated nonprofit health plans, some of which have been cited as models of efficiency, would face additional expenses and consumers would be impacted through higher premiums and limited choices.

Now, an exemption is provided for nonprofit insurers in the managers' amendment—for example, nonprofits with an overall medical loss ratio of 90 percent or better or nonprofits in a State which regulates premium increases could be exempt from the tax.

But this would have a limited impact in California and our two largest nonprofit insurers—Kaiser Permanente and Blue Cross/Blue Shield may not qualify for the exemption. Because California lacks an entity to regulate premium increases, the only way nonprofit insurers in our State will likely qualify for an exemption is by meeting the medical loss ratio requirements, set at 90 percent overall in the bill. This is a high hurdle to meet, and I worry these additional costs could appear in the premiums paid by Californians.

The most important component of successful health reform remains controlling health insurance premium increases. I remain concerned that com-

panies will attempt to take advantage of the period of time between the passage of legislation, and 2014, when exchanges are up and running with new consumer protections. We have seen this with credit card companies since credit card reform legislation passed, and I fear health insurance will be no different.

I proposed an amendment to create a Medical Insurance Rate Authority and to ensure that all insurance companies are subject to some type of rate review.

The amendment asks the National Association of Insurance Commissioners to produce a report, detailing the rate review laws and capabilities in all 50 States. The Secretary of HHS will then use these findings to determine which States are capable of doing sufficient rate reviews to protect consumers.

In States where insurance commissioners have authority to review rates, they will continue to do so. In States without sufficient authority or resources, the Secretary of HHS will review rates and take any appropriate action to deny unfair requests. This could mean blocking unjustified rate increases, or requiring rebates, if an unfair increase is already in effect. This will provide all American consumers with another layer of protection from an unfair premium increase.

The amendment would also require the Secretary of Health and Human Services to establish a Medical Insurance Rate Authority as part of the process in the bill that enables her to monitor premium costs.

The Rate Authority would advise the Secretary on insurance rate review and would be composed of seven officials who represent the full scope of the health care system including at least two consumers, at least one medical professional, and one representative of the medical insurance industry. The remaining members would be experts in health economics, actuarial science, or other sectors of the health care system.

Unfortunately, this amendment was not included, at the insistence of one member of our caucus. I look forward to working with conferees to find some way to ensure that more Americans are protected from unfair premium increases.

With all the debate over offsets, CBO projections, premiums, and matching funds, it is easy to forget that at the end of the day, we are talking about people. The bill we are debating, I believe, will save lives.

A lack of health insurance is more than an inconvenience; it can be deadly. Americans age 64 and under who lack health insurance have a 40-percent higher risk of death than those who have coverage. This is Dr. David Himmelstein from a Harvard Medical School Study of September 2009.

These are real people, who die earlier than they need to because of problems

getting coverage and problems with our health care system. Expanding health coverage is a moral issue, one that, I believe, reflects the character of our Nation. In the richest country in the world, no one should die because they cannot afford health coverage.

For all of this bill's imperfections, I am convinced that it will mean the difference between life and death for some people. And it is not every day that we can say that about a piece of legislation.

We could not pass up this opportunity.

I have joined my colleagues in supporting this bill.

Ms. MIKULSKI. Mr. President, today is a historic day. After decades of discussions and promises, we have taken a giant step forward in providing universal access to health care. I was proud to vote for the Patient Protection and Affordable Care Act. It extends coverage to 31 million Americans who don't have health insurance now.

Our bill is a step forward in achieving my four principles of health care reform: saving and strengthening Medicare; ending punitive insurance company practices that deny coverage based on preexisting health conditions, age and gender; providing universal access; and emphasizing quality, prevention and integrative health to save lives and save money.

I like the Patient Protection and Affordable Care Act because it saves and strengthens Medicare. The bill extends Medicare solvency; promotes care based on value not volume; closes the prescription drug coverage gap with a 50-percent discount on brand-name medications for seniors who fall into the gap; stops insurance companies from charging seniors four or five times more for insurance than young people; and removes the cost barrier to preventive care by eliminating deductibles, copayments and other cost sharing for seniors.

This bill helps the good guy businesses that want to provide insurance, but can't because it costs too much. I come from a small business family. My father was a grocer and my grandmother ran a small bakery. So I grew up in a family that knew what it was to face a weekly payroll.

The Patient Protection and Affordable Care Act protects small businesses with fewer than 50 employees. It gives them tax credits to be able to afford insurance for their employees. The Senate bill creates new insurance exchanges for small businesses and individuals who don't get insurance through work. It is like an online shopping mall for insurance. It provides individuals and businesses the same bargaining power as if they were a large group. It gives them the choice and the opportunity to select the best plan they can afford with the care that best meets their needs.

The Senate bill promotes cost savings and greater doctor-patient satisfaction through administrative simplification. The bill creates single standards for electronic transactions that will mean less paperwork and more doctor-patient time.

The Patient Protection and Affordable Care Act will control costs through a new emphasis on integrative health, prevention, and quality. New funding for wellness and prevention programs will support innovative approaches. That includes local initiatives using grassroots strategies to create healthier communities.

The Patient Protection and Affordable Care Act also improves the quality of care. As a member of the Senate Health, Education, Labor, and Pensions Committee, I was charged with establishing our bill's section on improving quality and delivery systems in health care. This section creates a national strategy to improve lives, save lives and reduce costs. This is achieved by promoting best practices like simplifying drug labels, and promoting discharge planning and medication management. These practices save money and improve patient outcomes through reduced hospital readmissions, improved patient safety, and better care coordination.

For example, the Senate bill creates grants to identify, disseminate, and implement innovative best practices to local providers and patients. One such practice is the Pronovost Checklist from Dr. Peter Pronovost at Johns Hopkins University. He developed simple steps to properly insert a catheter and eliminate line infections. When used in Michigan for 1 year, it saved 2,000 lives and \$200 million. We make his checklist—and others like it—available to hospitals across the country.

We also expand the use of medical homes by establishing community health teams. These teams include providers from the primary care physician to specialists and nutritionists. In North Carolina, medical homes save \$175 million each year. Our bill makes medical homes available across the country. These provisions—and more like them—not only save lives, they save money.

I am particularly proud of my women's preventive health amendment included in this bill. Right now, women pay more and get less in health care. For far too long, many insurance companies have treated simply being a woman as a pre-existing condition. They have used every trick in the book to deny coverage to women.

The Mikulski amendment guarantees access to preventive tests that save money and save women's lives. It requires insurance companies to cover preventive care and screenings at no added cost to women.

Without my amendment, there would be no guarantee that women under 50

would be covered for mammograms, no guarantee of an annual women's health exam that would include screenings for heart disease, and no guarantee that women would have access to this preventive care at no cost.

In the Patient Protection and Affordable Care Act I stood up for Maryland. I preserved the Maryland Medicare waiver, which I authored more than 30 years ago. This Maryland waiver is crucial in allowing hospitals to provide uncompensated care without jeopardizing their own financial stability.

What else does this health care reform bill mean for Maryland? It means that more than 1 million Marylanders who aren't covered now will have access to affordable insurance. It gives a helping hand to 50,000 small businesses in Maryland. It means lower costs for the 130,000 Marylanders who fall into Medicare's prescription drug coverage gap. It means that young adults in Maryland can stay on their parents' policies until they are 26 and that they'll have access to affordable coverage after that.

It means that families who are just a layoff, a job switch or an illness away from losing coverage will have health care stability and security. It means that if you like the insurance you have now, you can keep it. Or if you don't have it, you can get it.

And it means that health care reform will be affordable to families and to the nation. We can't let health care bankrupt our families or the government. The non-partisan Congressional Budget Office says the Senate bill will reduce the deficit by \$132 billion over the next 10 years.

And while I support the Patient Protection and Affordable Care Act, I have some serious yellow flashing lights. I hope these issues will be resolved in a more favorable way in conference.

I am for a more robust and transparent public framework to ensure competition and choice in the marketplace. I like public options. Two of my favorite public options are Social Security and Medicare. The Senate bill creates a lot of new customers for insurance companies by mandating insurance coverage. But like big banks, insurance companies don't show remorse for past transgressions. We can't simply trust them to do the right thing. The Senate bill relies heavily on regulation to achieve what could be done with a public framework. I prefer the House public option.

I also continue to oppose the excise tax included in the Senate bill. I am not for taxing the health care benefits of retired public employees and union members to pay for health reform. Some call them Cadillac plans. I call it a "Clunker Idea." The excise tax will just shift costs onto workers through higher deductibles, copayments, and less generous coverage. I am against this back-door tax on middle America

& retirees. Again, I prefer the House version on this.

So we have some work to do.

I will keep fighting for health care reform. Because it is absolutely terrible when you hear—I am sorry your insurance doesn't cover that. It is horrifying when you have no insurance at all because you lost your job or your benefits and you face losing your life savings to pay for the care you need.

I can assure you I will be fighting on the side of Maryland and the American people to complete health care reform in early 2010.

CONTINUED FINANCING OF GOVERNMENT OPERATIONS

The VICE PRESIDENT. The clerk will report H.R. 4314.

The legislative clerk read as follows:

A bill (H.R. 4314) to permit continued financing of Government operations.

The VICE PRESIDENT. The question is on the third reading of the bill.

The bill (H.R. 4314) was ordered to a third reading and was read the third time.

Mr. CONRAD. I ask for the yeas and nays.

The VICE PRESIDENT. Is there a sufficient second?

There appears to be a sufficient second.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. KYL. The following Senator is necessarily absent: the Senator from Kentucky (Mr. BUNNING).

Further, if present and voting, the Senator from Kentucky (Mr. BUNNING) would have voted "nay."

The VICE PRESIDENT. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 60, nays 39, as follows:

[Rollcall Vote No. 397 Leg.]

YEAS—60

Akaka	Gillibrand	Murray
Baucus	Hagan	Nelson (NE)
Begich	Harkin	Nelson (FL)
Bennet	Inouye	Pryor
Bingaman	Johnson	Reed
Boxer	Kaufman	Reid
Brown	Kerry	Rockefeller
Burris	Kirk	Sanders
Byrd	Klobuchar	Schumer
Cantwell	Kohl	Shaheen
Cardin	Landrieu	Specter
Carper	Lautenberg	Stabenow
Casey	Leahy	Tester
Conrad	Levin	Udall (CO)
Dodd	Lieberman	Udall (NM)
Dorgan	Lincoln	Volnovich
Durbin	McCaskill	Warner
Feingold	Menendez	Webb
Feinstein	Merkley	Whitehouse
Franken	Mikulski	Wyden

NAYS—39

Alexander	Coburn	Enzi
Barrasso	Cochran	Graham
Bayh	Collins	Grassley
Bennett	Corker	Gregg
Bond	Cornyn	Hatch
Brownback	Crapo	Hutchison
Burr	DeMint	Inhofe
Chambliss	Ensign	Isakson

Johanns
Kyl
LeMieux
Lugar
McCain

McConnell
Murkowski
Risch
Roberts
Sessions

Shelby
Snowe
Thune
Vitter
Wicker

NOT VOTING—1

Bunning

The VICE PRESIDENT. On this vote, the yeas are 60, the nays are 39. Under the previous order requiring 60 votes for the passage of this act, the act is passed.

Mr. DURBIN. Mr. President, I move to reconsider the vote.

Mr. REID. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. ENZI. Mr. President, we have debated whether to increase the amount of money the Federal Government can borrow at the same time that we created a massive new entitlement program that will cost the Federal taxpayer trillions of dollars over the coming decade.

Sponsors of the Reid bill have claimed that their bill would reduce the deficit and extend the solvency of the Medicare trust fund. We heard today from the nonpartisan Congressional Budget Office that these claims are false.

In reviewing the Reid bill, CBO stated that claims that the bill would both improve the government's ability to pay future Medicare benefits and financing new spending outside of Medicare would double count a large share of those savings and overstate the improvement in the government's fiscal position.

My Republican colleagues and I have argued for 3 weeks now that the Reid bill takes money from Medicare and spends it on a new, unsustainable health care entitlement. Instead of strengthening the Medicare Program, today we received confirmation that the Reid bill robs Medicare to the tune of nearly \$½ trillion and threatens its solvency.

CBO has said that this robbery does not really strengthen the solvency of the Medicare Program. Instead the bill uses government accounting gimmicks to merely make it look like it is doing something to help the Medicare Program.

The Reid bill cuts \$470 billion from the Medicare Program. Rather than reserving those monies to pay for future Medicare benefits, the bill spends those monies to pay for a new program to provide health insurance for the uninsured.

But because of government accounting rules, any savings are assumed to be used to purchase government bonds that will be saved to pay for future expenses. That allows sponsors of the bill to claim that they are extending the solvency of the Medicare trust fund.

As the only accountant in the Senate, I find it disturbing to see the gov-

ernment using its accounting rules to allow it to spend these savings twice. The sponsors of the Reid bill are counting the savings towards the Medicare Program at the same time those monies are being spent to pay for other Federal spending.

This would constitute fraud in the private sector. If they had to come under the same laws as private business, the administration and Congress would go to jail.

If there is any doubt, listen to what the Congressional Budget Office said:

Unified budget accounting shows that the majority of the [Medicare] trust fund savings would be used to pay for other spending under the [Reid bill] and would not enhance the ability of the government to redeem the bonds credited to the trust fund to pay for future Medicare benefits.

This means the claim that the Reid bill strengthens Medicare is false. The bill robs Medicare to pay for new spending.

Unfortunately this example of government accounting is just one example of the growing problems that our Nation faces. Our Nation's debt is now more than \$12 trillion and our deficit for fiscal year 2009 was over \$1.4 trillion. As a percentage of the economy, our deficit is 10 percent of GDP—the highest it has been since the Second World War. We are faced with increasing the debt limit at a time when our Nation's credit card is maxed out.

I worry about the country that I am leaving for my children and grandchildren. Our Nation is being buried under a mountain of debt, which poses a deadly threat to the future of our Nation.

The government will make up the current deficit by borrowing more money, mostly from China and other foreign governments. These levels of debt are not sustainable. The Chinese Government already made it very clear that they are growing apprehensive about our ability to pay these debts.

As China's apprehension grows, the interest rates we pay on our debt will grow. That means that it will soon cost us considerably more to allow Washington to continue to borrow the money it needs to fund its current spending binge.

As the Chinese Government grows concerned about financing Washington's appetite for rampant spending, it should give everyone in this Chamber pause. Our most fundamental duty as Members of Congress is to wisely manage the power of the purse for our Nation. Congress is currently failing to carry out this obligation.

According to David Walker, the former head of the GAO, at the end of fiscal 2000, the Federal Government had about \$20.4 trillion in total liabilities, commitments, and unfunded promises for Social Security and Medicare. That number rose to \$56.4 trillion at the end of fiscal 2008—a 176-percent

increase in just 8 years. By the end of this year, that number is expected to have risen to \$63 trillion.

On January 15 of this year, the Senate Budget Committee held a hearing on the long-term outlook for Federal debt. We heard testimony from a bipartisan panel of experts, including Dr. Richard Berner, chief global economist for Morgan Stanley; Dr. Allen Sinai, president and chief global economist/strategist for Decision Economics, Inc.; and Dr. Douglas Holtz-Eakin, former Director of the Congressional Budget Office.

Some of these economists were Democrats and some were Republicans, yet all three agreed that the long-term outlook for U.S. debt was grim and that our Nation's creditworthiness was at risk without a plan to address the costs of future entitlements and the multiple bailout/stimulus proposals Congress has passed.

All three panelists endorsed bipartisan commission concepts to address entitlement spending such as the one sponsored by Senators CONRAD and GREGG. And the experts all agreed that the current budget process needs to be reformed to remove incentives to deficit spend. Yet none of those recommendations are evident in the legislation we are voting on today.

Dr. Sinai—one of the Democrat's invited witnesses from that day—testified that we have exceeded several tipping points in creditworthiness in the U.S. economy, but the only reason we don't feel the effects of it now is because "everyone else is drowning too" and investors are fleeing to quality. But how long can that continue?

Further, Dr. Sinai states:

The deficit and debt prospects under almost any scenario are daunting, with deficit-to-GDP and debt-to-GDP ratios not seen before in a G-7 country. This territory is uncharted with no real historical analogue to this kind of financial situation for a major global economic power. . . The answer to whether the U.S. can afford all of the initiatives on its wish list—economic, societal, defense, and otherwise—is no.

Dr. Holtz-Eakin echoed similar statements from other panelists and strongly urged Congress to adopt a plan that conveys to markets a clear path for stabilizing and reducing the debt burden.

That panel appeared before us in January, but we still lack any coherent plan to stabilize our debt. Just last week on Tuesday, Dec. 14, the Peterson-Pew Commission released its first report, *Red Ink Rising: A Call to Action to Stem the Mounting Federal Debt*, which encourages lawmakers to act immediately to stabilize the national debt.

Crafted over the past year by former heads of the CBO, OMB, GAO, and the congressional budget committees, the report strongly urges Congress and the President to commit immediately to stabilize the debt at 60 percent of GDP

by 2018 and develop a specific and credible debt stabilization package in 2010. But there is nothing in this debt limit bill that does either of these things.

Some Senators will argue today that raising the debt ceiling is the only fiscally responsible choice before us. I disagree. A vote to raise the debt ceiling is merely a vote to raise taxes on our children and grandchildren.

This cycle of kicking our responsibilities to the next generation must stop and it must stop today. In my view, the only fiscally responsible choice is to live within our means and balance our Federal budget.

A newspaper columnist, Diane Badget from Lovell, WY, said it best when she wrote how her mother would react to what is happening in Washington today. Diane wrote, "Momma always said, 'If you don't have enough money to buy a quart of milk you don't take someone else's hard-earned cash and buy ice cream.'"

If we fail to heed that warning, we will be responsible for passing along unsustainable costs and obligations to our children and grandchildren. That is where the Reid bill is taking our country.

The only remaining question is whether we will have the courage to stop this process and preserve our Nation's strength for future generations.

Mr. HATCH. Mr. President, I rise today to express my great concern about the need for the legislation before us, which would increase the Nation's debt limit.

It is sad and disturbing that the last vote we will take this year before recessing for the Christmas holiday is one to increase the already almost unimaginably high \$12 trillion debt ceiling.

What a horrible gift to deliver to the American taxpayer on this Christmas Eve. In a season when most families have cut back their own spending and, in many cases, cut up their own credit cards, the Democratic majority is asking us to increase the Nation's credit card limit so that they can continue to take on more debt to cover their voracious appetite for spending.

Up until a few days ago, the Democratic leadership was actually looking for a way to increase the debt limit by more than \$1.8 trillion, which would have been more than twice as much as the largest previous increase in the debt limit. They were looking for a virtual blank check to continue their unrestrained deficit spending all the way through next year's election.

The fact that the majority party could not come to a consensus among its own ranks on this outrageous plan is evidence enough of the brashness and hubris of the other side. Apparently, even a drunken sailor can be embarrassed enough to show a modicum of restraint if the price tag is high enough.

Plain and simple, we need to take control of this out-of-control government spending before we see the hopes and dreams of our children, grandchildren, and all subsequent generations of Americans dashed against the rocks.

Federal spending is now taking the largest share of our national income since the early 1950s and the current deficit is as large as it has been since World War II. This is bad enough, Mr. President, but there is no end in sight to the profligacy.

Based on current projections, which will probably get much worse, 10 years from now it will be shown that this President and this Democratic majority have left a shameful legacy. The CBO estimates that in 2019, the Federal deficit will still be over \$1 trillion for that 1 year and that our total national debt will be over \$20 trillion. Most of our new borrowing will be needed just to pay interest on the previous debt.

At some nearby place, which we are fast approaching, we will reach a tipping point where we will be in total bondage to this debt. When we get to the time that we are borrowing vast and ever-increasing sums just to pay the interest on previous debt, the hopes of ever escaping from the vortex of financial destruction will fade and we will have consigned the next generations to a permanent substandard of living.

The other side keeps making the pathetically lame excuse that they inherited eight years of bad economic policy, which they say is the real culprit of our fiscal problems. What is conveniently forgotten around here is the fact that the final two of those eight years were under a Democratically led Congress.

I am the first to admit that Republicans in Congress were too eager to spend and that President Bush should have wielded his veto pen more aggressively. There is some accountability there. But let us face it, our side are rank amateurs compared to the consummate spenders we now have in charge.

For proof, we need look no further than the President's budget, the trillion dollar stimulus bill, this \$2.5 trillion health care bill, and the recent \$1.1 trillion omnibus spending bill with its double digit percentage increases over last year's spending. The deficit has grown exponentially this year alone.

The numbers themselves tell the story. The Treasury Department's Monthly Treasury Statement for November shows a deficit over the first two months of this new fiscal year alone of nearly \$300 billion. This 2-month deficit is greater than the full-year deficits in 2002, 2006, and 2007, which, by the way, are part of the past eight years that were supposed to represent the ultimate in reckless spending.

I am scared. All Americans should be frightened as well. We are on an unstable raft in the middle of an increasingly raging river. The currents are swirling around us and we are beginning to lose control of where we are going. Sharp rocks are starting to appear in the river that threaten our destruction.

Our alarm grows as we begin to hear a sound off in the distance that slowly gets louder as we head downstream on these increasingly wild rapids. The sound we hear is the cataract that represents our fall from the greatest nation in the history of mankind to that of a second-rate player on the world stage. Can you hear it? Can we find a way to turn this boat around before it is too late to avoid the fall? Many of my fellow Utahns can hear it and they are begging me to find a way to get us off this destructive course and get us back to safe waters.

The first step is to reject this debt limit increase. Let us cut up the credit card and stop this frightening spending spree before it takes us to the precipice.

It is a good thing we are recessing for a few days. The Members of this Senate need to go home and get a reality check from those who have sent us here. I hope that over the recess each of us will get a message, loud and clear, from our recession and debt-weary constituents that they are sick and tired of this fiscal irresponsibility. They are demanding change, and they will get it, one way or the other.

I hope that in the new year, we can consider these messages and find a new resolve to come together, to find the restraint that is simply lacking now, and to reverse this reckless spending so we do not send our country down the river.

The VICE PRESIDENT. The majority leader is recognized.

RECESS SUBJECT TO THE CALL OF THE CHAIR

Mr. REID. Mr. President, the minority leader and I have some things to discuss, so I ask unanimous consent that we recess subject to the call of the Chair.

There being no objection, the Senate, at 7:35 a.m., recessed until 8:26 a.m., and reassembled when called to order by the Presiding Officer (Ms. CANTWELL).

The PRESIDING OFFICER. The Senator from Nebraska.

HEALTH CARE REFORM

Mr. NELSON of Nebraska. Madam President, during the consideration of the health care bill, one of my primary concerns has been ensuring that the longstanding Hyde amendment would be incorporated into the bill. I have strongly held views on the subject, and

I fought hard to prevent tax dollars from being used to subsidize abortions.

I was pleased that the House included strong abortion provisions in its health care bill in the form of the Stupak amendment. I modified this language to meet the Senate bill and offered the Nelson-Hatch-Casey amendment to prohibit Federal funding of abortion, and I was disappointed to see that amendment was tabled by a vote of 54 to 45.

I knew then that the underlying bill did not adequately prohibit Federal funding of abortion and, consequently, I would not be able to support it. So I began to look for other language to accomplish the goal that no public funds should cover abortion in the new health care bill. After long days of negotiations, I believe we came up with a true compromise that stays faithful to my principles.

I want to be clear, I stuck to my guns and stood for my pro-life principles. I did not look for weaker language. I looked for clearer language, and my goal stayed the same: to maintain the standard that we have had in Federal law since the mid-1970s.

While I respect the opinion of the Senator from Kansas, I have to respectfully disagree. The Senate language fully upholds the Hyde principle like the language in the House bill. The wording may be different, but the principle is, in fact, upheld.

Under the health care bill, if you cannot afford insurance, you will receive Federal assistance to help pay for a private health care plan. The Stupak language prohibits that Federal assistance from paying for insurance that covers abortions. If you like a plan that covers abortion, you must purchase a rider or an endorsement to your plan with your own funds. You could do that as well by writing just one check to the insurer. For that you get a separate piece of paper addressing abortion.

The Senate language, with my added compromise, also prohibits Federal funds from paying for private insurance that covers abortion. The only difference is that in the Senate bill, if you are receiving Federal assistance to buy insurance, and if that plan has any abortion coverage, the insurance company must bill you separately, and you must pay separately from your own personal funds—perhaps a credit card transaction, your separate personal check, or automatic withdrawal from your bank account—for that abortion coverage.

Now, let me say that again. You have to write two checks: one for the basic policy and one for the additional coverage for abortion. The latter has to be entirely from personal funds.

So under both the Stupak and the new Senate language, no Federal funds can be used to pay for a plan that covers abortion, and if you choose to pur-

chase abortion coverage—if it is available—you must pay out of your own pocket.

Furthermore, the Senate language allows States the right to ban public and private insurance from supplying abortion coverage. Already, 12 States ban abortion coverage on public plans and 5 States ban abortion coverage on both private and public plans. So, in short, the Senate bill ensures, once again, no Federal funds would be used for abortion.

I would like to note that the Senate bill goes beyond Stupak in two life-promoting ways. One, it adds funding to support pregnant and parenting teens and women and, two, it expands the adoption tax credit to help adoptive parents with the considerable expense of adoption by making that credit a refundable tax credit. This means many potential parents who lack the regular resources to adopt will now be in a better position to do so.

The Senate bill also contains the same strong conscience protections included in the Stupak language. We tried winning approval for the Nelson-Hatch-Casey abortion language in the Senate, but we were unsuccessful. However, we did not give up. I know people have very strong feelings about the issue of abortion, and I respect those who disagree with my position, but I could not support health reform that did not maintain the 30-year standard barring public funding of abortion. I did not compromise my pro-life principles; we just found different wording, different language, and both will work. I believe people will see that no public funding will go to abortion.

In addition, my provision empowers the States to pass laws banning the sale of insurance that covers abortion. We make it clear that this new law, this new bill does not in any way preempt the rights of States to be able to continue to make that ban in the decisions they might make legislatively, and we want to make certain there is no doubt but that this bill has no preemption of the States rights.

Despite what some partisans and talk show hosts say in their scare tactics, the conscience clause remains. Also, despite what those same people and even some of my colleagues have said, the bottom line is that the Senate health care bill will not allow taxpayer money to pay for abortion, period.

Thank you, Madam President. I yield the floor.

MORNING BUSINESS

Mr. NELSON of Nebraska. Madam President, I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. NELSON of Nebraska. Madam President, I note the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BROWN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BROWN. Madam President, I ask unanimous consent to speak as in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BROWN. Madam President, I come to the floor today to talk about the Patient Protection and Affordable Care Act, which, in a historic vote only an hour and a half ago, the Senate overwhelmingly passed. I wish to talk for a moment about how that bill will improve the health of children across our country, particularly for children in my State of Ohio.

Ohio is home to six of the best children's hospitals that house a combined 1,749 beds. Ohio is also home to 218,400 uninsured children. The health reform bill which we have been debating on this Senate floor for 26 straight days will help cover Ohio's uninsured children and help our children's hospitals provide the right care at the right time in the right place. This legislation will make sure the children have access to oral and vision care. It will keep children healthy by eliminating copays and deductibles for recommended preventive care.

Similarly, in the Medicare section of the Patient Protection and Affordable Care Act, senior citizens in Olympia, Redmond, Seattle, Cleveland, Akron, and Canton will be able to get free mammograms and colonoscopies and preventive care and annual checkups. Children, too, under this legislation will have copays and deductibles eliminated for recommended preventive care.

It will extend the Children's Health Insurance Program for an additional 2 years and provide States with additional funding to ensure children have access to this program. It will increase the number of pediatric primary care physicians and pediatric specialists. And we now know how important it is, as I learned at Akron's Children's Hospital a decade and a half ago, that the government assist in helping with training and providing funding through Medicare and through appropriations to train pediatric primary care physicians and specialists.

Perhaps most important of all is this legislation will do something Senator LAUTENBERG, Representative SCHWARTZ, and I have tried to do for 3 years: it will eliminate immediately the preexisting coverage exclusion for children. For the past two Congresses,

Senator LAUTENBERG, Representative SCHWARTZ, and I have introduced the Children's Health Protection Act, legislation that would prevent insurers from denying children needed medical care.

Twenty percent of school-age children suffer from a chronic illness—20 percent. All too often, these children face challenges accessing affordable and adequate health insurance due to their preexisting conditions. Children have preexisting conditions too. Yet children with preexisting conditions are so often denied medical insurance by insurance companies.

Our bill, which is largely included in the Senate health reform legislation which we passed an hour and a half ago, would ensure children suffering from chronic and debilitating and life-threatening illnesses have access to comprehensive and affordable health care coverage.

This bill will help children such as Shaunell Johnson from Ohio. When her parents were unable to care for her, Shaunell was adopted by her grandparents, Dorothy and Jack Johnson. Because their income exceeded the limits for medical income eligibility, they turned to the private health insurance market for Shaunell. However, due to her asthma, a preexisting condition, the Johnsons were unable to afford health insurance because they earn more than would qualify Shaunell for Medicaid but they don't earn enough to afford the \$8,700 a year for private insurance coverage for a child with a preexisting condition.

Children with serious medical conditions shouldn't be cherry-picked out of health insurance policies while their families struggle to provide care and pay medical bills.

The time has come for Congress to act on behalf of children such as Shaunell and the Senate has acted today.

We must insure that children most in need are no longer denied access to health coverage. We must immediately prevent the insurance industry from denying millions of children the health care they need.

The health care reform legislation we passed an hour and a half ago will do that.

Let me explain again why this matters and give some examples. A woman named Renee has a 5-year old boy in Ohio with hydrocephalus. He has a shunt that drains the fluid from his brain down to his belly. That said, he is a healthy, smart, and extremely happy little boy.

His neurosurgeon said he is truly a best-case scenario—very healthy. However, no insurance company will take him—no quote, no interest in looking at his medical charts, nothing.

Renee said her family is truly left with no options for health care, unless she and her husband close down their

business and go to work for corporate America and get in a huge health insurance pool plan.

Renee, writing about her son, says she can't get him health insurance because he has a preexisting condition. This bill, as soon as the President signs it, will say to the health insurance industry: You can no longer deny, refuse, or lock out insurance for a family because they have a child with a preexisting condition.

Think of the progress and of the thousands whom I mentioned in the beginning and the 1,700 children's hospital beds in the children's hospitals in my State. There are 200,000 uninsured children in Ohio. Many of them are sick enough that they are deemed by the insurance company as having a preexisting condition. No longer.

When the President signs this bill in January, children from Seattle to Cleveland, from Cincinnati to Tacoma, will be able to be on their parents' health insurance policy and be able to get the coverage they need.

I will share two other stories.

Laurie writes:

As a mother who had to deal with a baby born with problems and had many days of hospital stays, and many months of in-and-out-of appointments and check-ups, I realized the vital importance of health care.

I was one of the lucky ones I guess, as I did have good insurance at the time.

As a healthcare provider myself, I see too often parents not being able to get their child seen [by a physician] due to lack of insurance that does not cover the costs of anything true.

It is our children who will be our future and those in Congress' future. When will enough be enough?

An hour and a half ago, we answered that question, when will enough be enough, when we made this decision collectively—60 of us, an overwhelming majority in the Senate—that children with preexisting conditions will no longer be denied health insurance.

Cassandra, a 14-year-old from Toledo, is uninsured simply because she is sick. She suffers from seizures and, as a result, no insurance company will cover her.

Cassandra is a nationally ranked figure skater and once skated with Michelle Kwan, but after selling their home and everything else they own and putting \$30,000 on their credit cards just to pay for Cassandra's care, the family had to finally sell her ice skating equipment on eBay.

Her parents do everything they can to protect their daughter, including buying dim lights and blackout drapes and making sure there aren't too many breakable items in the house.

Cassandra gets treatment for her seizures through the State's Bureau for Children's Medical Handicaps, but they are on their own for Cassandra's basic medical needs.

Cassandra's life will get better. Her family's life will get better because of

what the Senate did an hour and a half ago. When the President signs the bill, she will not be denied insurance for a preexisting condition. Her family will be able to pay—at a reasonable cost—for insurance so Cassandra will not have to rely on this State program that only takes care of procedures but can get the comprehensive care she and every other child in this country deserve.

That is why I introduced this amendment, and that is why Senator LAUTENBERG and I worked on this legislation.

Every year in my State, over 2 million kids are treated at Ohio's children's hospitals. Next year will be the first year that, when they leave the hospital, they will not have to worry about insurance companies denying them care based on a preexisting condition.

COMPREHENSIVE IRAN SANCTIONS, ACCOUNTABILITY, AND DIVESTMENT ACT

Mr. REID. I want to speak today about S.2799, the Comprehensive Iran Sanctions, Accountability, and Divestment Act of 2009. This important piece of legislation, which combines legislation written by Senator DODD with legislation introduced by Senators BAYH, LIEBERMAN and KYL, was passed by the Banking Committee earlier this month. It would impose new sanctions on Iran's refined petroleum sector and tighten existing U.S. sanctions in an effort to create new pressure on the Iranian regime and help stop Iran from acquiring a nuclear weapon.

I know that Senator KERRY, the chairman of the Foreign Relations Committee, has been working hard, along with other colleagues, to get a UC agreement so we can get this legislation passed. I understand that we are making good progress towards reaching that goal.

As we move forward with these negotiations, I want everyone to know that I am committed to getting this legislation to the floor sometime after we return in January.

Mr. DODD. I thank the majority leader for all of his help in trying to move this legislation forward. This comprehensive sanctions legislation would arm the administration with critical tools to apply additional pressure on the Iranian regime and disrupt its proliferation and terrorist activities at a pivotal time—a time when Iran's leaders continue to flaunt the will of the international community, trample on the rights of its own people, and threaten the national interests of the United States and our strongest allies, including Israel.

It is now clearer than ever that tougher sanctions must be a key element of our comprehensive Iran strategy going forward. My primary goal with this bill is to prevent Iran from

developing a nuclear weapons capability. That is why this measure passed the Senate Banking Committee unanimously in October, and I had hoped that we would be able to consider it in the Senate and move toward a conference with the House before we went out for the holidays. While I would have strongly preferred that, I recognize that given the delays on health care reform, we will not now have time to do that. I am also aware that the administration continues to have some concerns about how to create incentives in the bill for countries to cooperate more closely with U.S. efforts to impose tough new multilateral sanctions. I believe we have made some progress in our discussions of recent days, and I am grateful that the majority leader has indicated his willingness to move forward on the bill as soon as possible after we return.

Mr. KERRY. I appreciate Senator REID's commitment to move forward with this legislation and his support of the progress we are making towards a UC agreement. We all share the goal of creating maximum leverage in our efforts to prevent Iran from developing a nuclear weapon—this is a vital national security goal of the United States, and obviously of critical importance to our allies in Israel and around the world.

I believe that this legislation has the potential to make an important contribution to that effort. Having the Senate stand united with the administration behind this legislation would send a very strong and positive signal. That is why many of us are committed to working with the administration and the bill's sponsors to craft an amendment that all can agree on. I know these discussions will be continuing during recess with the intention of reaching a mutually agreeable resolution so that this legislation can be considered as soon as possible when we get back.

TRIBUTE TO CHARLES E. BRUEGGEMAN

Mr. DURBIN. Madam President, today I would like to recognize the extraordinary work of First Deputy Director Charles E. Brueggemann of the Illinois State Police. Mr. Brueggemann has served with distinction for 25 years with the Illinois State Police, including as second in command of the department since April 1, 2008.

Mr. Brueggemann began his outstanding career with the Illinois State Police in 1985, serving in patrol, as well as a variety of investigative positions to include narcotics, homicides and crimes against persons. He also served during his tenure in management positions that contributed greatly to the department and community he served. Those positions included district commander, executive officer, assistant

deputy director, deputy director and first deputy director.

As first deputy director, Mr. Brueggemann oversaw the agency's five divisions—operations, forensics, information and technology command, internal investigations, and administration. He was responsible for the oversight of the director's principal advisors assigned to legislative affairs, public information, inspections and budget.

In his prior position, Mr. Brueggemann had oversight of the operations division, with wide-ranging responsibilities including patrol, investigations, homeland security and gaming. While serving in that capacity, Mr. Brueggemann was charged with coordinating a plan to reduce highway fatalities. Under his leadership, the division developed a remarkable strategy that reduced highway crashes to their lowest level in 87 years.

In other honors, he was selected in 2005 by the FBI to attend a counterterrorism leadership program that involved traveling abroad with seven other major city, State, and Federal law enforcement executives to share information and open lines of communications between different nations in the fight against terrorism. Law enforcement officials from Scotland, England, Northern Ireland, and Canada also participated.

Mr. Brueggemann received his bachelor's degree from McKendree University and a masters degree in Homeland Defense and Security from the Naval Postgraduate School. Married for more than two decades to his wife Susan, they have two daughters Beth and Ali.

I congratulate Mr. Brueggemann on his retirement and thank him for his service to the people of Illinois.

SENATE PARLIAMENTARIANS

Mr. DEMINT. Madam President, one of the important officers in the Senate is the Senate Parliamentarian. The Senate rules are arcane and often vague, and the Parliamentarian is responsible for making sure they are properly applied. Our four Parliamentarians put in long, thankless hours in service to their country. They get no glory, no public accolades. They rarely get high fives for getting the rulings right, but we are always too happy to tell them when we think they got it wrong. Often our disagreement is not with the Parliamentarians, but with the precedents themselves.

The Senate often chooses to sidestep its rules, creating precedents that become loopholes in the rules, which bind the Parliamentarian in the future. We should be careful to avoid these situations because we can unwittingly trample on the right of the minority.

I want to make it clear that while I do have occasional disagreements with the Parliamentarian's office, I still be-

lieve they are doing their best to be fair and to apply the rules and precedents as they see them.

HONORING OUR ARMED FORCES

CORPORAL XHACOB LA TORRE

Mr. DODD. Madam President, it is with a heavy heart that I rise today to mark the passing and honor the service of Marine CPL Xhacob LaTorre of Waterbury, CT.

Corporal LaTorre died this week of wounds he sustained from a roadside bomb while on patrol in Afghanistan's Helmand province. He would have celebrated his 22nd birthday last Saturday.

Corporal LaTorre graduated from Crosby High School where he was active in the ROTC program. A born leader, he joined the Marine Corps in 2005. He was on his third tour of duty, having served two tours in Iraq and was awarded a good conduct citation and a Purple Heart.

In his too short time, Corporal LaTorre proved himself as a soldier and a patriot. The bravery and dedication he showed as a marine, however, was just one side of his personality. To his friends and family, Xhacob will be remembered as an outgoing and energetic young man with a kind heart, a penchant for mischief, and an infectious sense of humor.

As a young boy, Xhacob earned pocket money by going from table to table at a restaurant, charming patrons and earning a dollar for each joke he told.

That young boy grew into a man of integrity and courage. His service and his sacrifice are a credit to his parents, Daniel and Nicole. I know how proud they are of him, and I hope they know that we grieve alongside them. They, along with Xhacob's wife, Frances, and his young son, Javier, are in our hearts.

It may seem at times a sad irony that our best and brightest young men and women are the ones who go into battle and sometimes do not come home, having given their lives in service to their country. But that is what keeps our Nation strong and free.

All of us in Connecticut and across America mourn the loss of CPL Xhacob LaTorre. And none of us will ever forget the debt of gratitude we owe to him and his family.

I ask unanimous consent to have printed in the RECORD the attached articles.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

FAMILY AND FRIENDS SAY GOODBYE TO
FALLEN MARINE

(By Amanda Raus and Doug Greene)

Family, friends and fellow Marines went to the Chase Parkway Memorial on Wednesday to pay their respects to Corporal Xhacob LaTorre, a proud Marine dedicated to serving his country who lost his life fighting for it.

On Thursday morning, the Patriot Riders were there, with flags to salute the fallen Marine on a bitterly cold December morning.

"It is a very sad day for us," LaTorre's aunt, Carmen Lasalle, said. "May God help us all overcome such a big loss. We will make sure we all teach little Javy the same values we taught you and from Heaven where you will be resting in peace and looking after your son and wife, I hope to feel your smile."

"It's deeply moving, a debt of honor. We're indebted to him for the service he's provided to our country," said Peter Verseckas, a former Naval Reserve man on Wednesday.

LaTorre was in his third tour of duty, stationed in Afghanistan, when he was injured by a terrorist bomb in August. He lost both his legs but never lost his spirit. For four months he fought for his life with his wife, Frances, by his side the whole time.

"I got the call he was going to die at any moment. I went running, and I was there, and as soon as I got there, he died," said Frances LaTorre.

Even at the very end, LaTorre was happy. That's how his family always knew him to be. They say he was a fun-loving person who put others before himself.

"He was wonderful, he was always there for everyone. Every person that he touched was special, special to him," said his aunt, Carmen LaSalle.

The people most special and closest to his heart were his family members, especially his 18-month-old son Javier. Frances says he's already a spitting image of his father.

"He looks just like him. He does a lot of the same things his father does," she said.

"To me, it's like he never left. Seeing his son, is seeing him grow up all over again," said Xhacob's brother, Danny LaTorre.

And while they watch Javier grow, they'll remember the dedicated husband, brother, nephew, father and Marine LaTorre was.

"Everybody makes great sacrifices. He made his. I'll always honor and treasure that," said Danny LaTorre.

A funeral service was held on Thursday morning at 10:30 a.m. at the Chase Parkway Memorial. Then Corporal LaTorre will be buried with full military honors at the State Veteran's Cemetery in Middletown.

WATERBURY MARINE DIES IN AFGHANISTAN

WATERBURY (WTNH)—A Marine from Waterbury has died from wounds he received in Afghanistan, the Defense Dept said Thursday.

He's identified as Corporal Xhacob LaTorre, and he was 21 years old.

The DoD says Cpl. LaTorre died Dec. 8th "of wounds sustained while supporting combat operations in Helmand province, Afghanistan."

LaTorre graduated from Crosby High school in 2005. His family still lives in Waterbury.

"I know the city of Waterbury will rally in support of the family and for his dedicated service," said Mayor Michael Jarjura (D-Waterbury).

LaTorre leaves behind a wife and son.

In a statement posted on Facebook, Cpl. LaTorre's sister said "Thank you so much for loving Xhacob and for the time you all shared with him. He was unique and will always be with us."

Cpl. LaTorre was assigned to 2nd Battalion, 8th Marine Regiment, 2nd Marine Division, II Marine Expeditionary Force out of Camp Lejeune, N.C.

Waterbury lowered the flag over City Hall to half staff in Cpl. LaTorre's honor.

Gov. Jodi Rell ordered all flags in the state to be lowered to half-staff until sundown after LaTorre's funeral.

"On behalf of all Connecticut residents, I extend heartfelt condolences to Corporal LaTorre's family and friends," Governor Rell said. "He made the ultimate sacrifice to protect our country and our way of life, and we will honor his selfless service by lowering our flags. Corporal LaTorre is truly a hero."

There was no word on funeral arrangements.

GOVERNOR RELL: FLAGS AT HALF STAFF TO HONOR FALLEN MARINE

Governor M. Jodi Rell today ordered U.S. and State of Connecticut flags to half staff to honor a U.S. Marine from Waterbury who was supporting Operation Enduring Freedom in Afghanistan.

Cpl. Xhacob LaTorre, 21, died December 8 of wounds sustained while supporting combat operations in Helmand province, Afghanistan. He was assigned to 2nd Battalion, 8th Marine Regiment, 2nd Marine Division, II Marine Expeditionary Force, Camp Lejeune, N.C.

"On behalf of all Connecticut residents, I extend heartfelt condolences to Corporal LaTorre's family and friends," Governor Rell said. "He made the ultimate sacrifice to protect our country and our way of life, and we will honor his selfless service by lowering our flags. Corporal LaTorre is truly a hero."

Flags will remain at half staff until sundown on the day of Cpl. LaTorre's funeral. Arrangements are to be announced.

For additional background information, please contact the II Marine Expeditionary Force public affairs office at 910-451-7200.

TRIAL OF LIU XIAOBO

Mr. DORGAN. Madam President, I want to briefly draw your attention to an extraordinary trial that took place in Beijing yesterday morning. Mr. Liu Xiaobo is a 53-year-old writer and social critic and one of China's most prominent advocates of democratic reform. After being detained without charges for over a year, he went on trial yesterday morning in a 3-hour proceeding closed to the public. If convicted, Mr. Liu faces up to 15 years in prison. His verdict is likely to come on Friday, Christmas Day.

What was Mr. Liu's crime?

He was tried on charges officially defined as "incitement to subvert state power." Mr. Liu's calls for open elections and free speech were viewed as a threat to the ruling Communist Party.

What precisely did he do that got him into trouble?

He contributed to "Charter 08," a political manifesto calling for human rights and the rule of law in China. The manifesto was posted on line last December and quickly gained thousands of signatures by Chinese workers, teachers, and retired party members. Its name is a reference to Charter 77, a Soviet-era petition by Czech dissidents like Vaclav Havel.

Mr. Liu's crimes are nonexistent. Yet his fate has been predetermined. In short, his trial is a travesty of justice:

Mr. Liu's 3-hour trial was closed to the public. Even his wife was not allowed to attend. She has been relentlessly harassed and unable to speak to him since March.

Officials warned Mr. Liu's supporters to stay away from the trial and not write about it online. Police detained some people who came to the courthouse to show support.

His verdict will be announced on Christmas Day. This is an obvious calculation so that the verdict's announcement will garner less international attention.

According to his brother, one of the two family members allowed in the courtroom, Mr. Liu told the judge that "if he was sent to jail, it might bring others freedom of speech."

I was struck by a report in yesterday morning's New York Times that an unemployed meat plant worker took an 18-hour train ride from his far-flung province to show solidarity outside of the courthouse in Beijing. The worker said he had never met Mr. Liu, but that they had exchanged emails.

He also said proudly that he had signed "Charter 08" and pulled out a copy of it from his backpack and handed it to a courthouse official. The worker's intent was clear: "I am not afraid. I love China. I just want my country to have freedom and human rights."

The trial of Mr. Liu is a sad milestone that has further diminished hopes that China's economic rise would bring about significant political and legal reforms. During the past year, as the Congressional-Executive Commission on China's reporting has shown, the government has tightened restrictions on the Internet, harassed the country's human rights lawyers, and jailed muckrakers, working with grieving parents, blamed shoddy school construction for the deaths of thousands of children during the 2008 Sichuan earthquake.

We will learn the court's verdict and its jail sentence for Mr. Liu on Christmas Day. I call on China's leaders to demonstrate compassion and genuine commitment, not just in words but in deeds, to the rule of law and fundamental rights by dismissing the case against Mr. Liu. In doing so, the Chinese Government would be recognizing the serious procedural flaws that have taken place in this case. It would also signal to the rest of the world that the Chinese Government is committed to developing the rule of law and upholding international human rights standards.

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Saunders, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United

States submitting nominations which were referred to the Committee on the Judiciary.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGE FROM THE HOUSE

ENROLLED BILLS SIGNED

At 9:52 a.m., a message from the House of Representatives, delivered by Ms. Miller, the Clerk of the House, announced that the Speaker pro tempore (Mr. HOYER) has signed the following enrolled bills:

H.R. 3819. An act to extend the commercial space transportation liability regime.

H.R. 4314. An act to permit continued financing of Government operations.

The enrolled bills were subsequently signed by the Vice President (Mr. BIDEN).

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 1147. An act to implement the recommendations of the Federal Communications Commission report to the Congress regarding low-power FM service; to the Committee on Commerce, Science, and Transportation.

H.R. 2489. An act to authorize a national cooperative geospatial imagery program through the United States Geological Survey to promote use of remote sensing data; to the Committee on Commerce, Science, and Transportation.

H.R. 3224. An act to authorize the Board of Regents of the Smithsonian Institution to plan, design, and construct a vehicle maintenance building at the vehicle maintenance branch of the Smithsonian Institution located in Suitland, Maryland, and for other purposes; to the Committee on Rules and Administration.

MEASURES READ THE FIRST TIME

The following bills were read the first time:

H.R. 3961. An act to amend title XVIII of the Social Security Act to reform the Medicare SGR payment system for physicians and to reinstitute and update the Pay-As-You-Go requirement of budget neutrality on new tax and mandatory spending legislation, enforced by the threat of annual, automatic sequestration.

H.R. 4154. An act to amend the Internal Revenue Code of 1986 to repeal the new carryover basis rules in order to prevent tax increases and the imposition of compliance burdens on many more estates than would benefit from repeal, to retain the estate tax with a \$3,500,000 exemption, to reinstitute and update the Pay-As-You-Go requirement of budget neutrality on new tax and mandatory spending legislation, enforced by the threat of annual, automatic sequestration, and for other purposes.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first

and second times by unanimous consent, and referred as indicated:

By Mr. CARDIN (for himself, Mr. WARNER, Mr. WEBB, and Ms. MIKULSKI):

S.J. Res. 25. A joint resolution granting the consent and approval of Congress to amendments made by the State of Maryland, the Commonwealth of Virginia, and the District of Columbia to the Washington Metropolitan Area Transit Regulation Compact; to the Committee on the Judiciary.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. INOUE (for himself, Mr. REID, and Mr. AKAKA):

S. Res. 387. A resolution urging the people of the United States to observe Global Family Day and One Day of Peace and Sharing on January 1, 2010; to the Committee on the Judiciary.

ADDITIONAL COSPONSORS

S. 619

At the request of Ms. SNOWE, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 619, a bill to amend the Federal Food, Drug, and Cosmetic Act to preserve the effectiveness of medically important antibiotics used in the treatment of human and animal diseases.

S. 891

At the request of Mr. BROWNBACK, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 891, a bill to require annual disclosure to the Securities and Exchange Commission of activities involving columbite-tantalite, cassiterite, and wolframite from the Democratic Republic of Congo, and for other purposes.

S. 1076

At the request of Mr. DODD, his name was added as a cosponsor of S. 1076, a bill to improve the accuracy of fur product labeling, and for other purposes.

S. 2781

At the request of Ms. MIKULSKI, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of S. 2781, a bill to change references in Federal law to mental retardation to references to an intellectual disability, and to change references to a mentally retarded individual to references to an individual with an intellectual disability.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 387—URGING THE PEOPLE OF THE UNITED STATES TO OBSERVE GLOBAL FAMILY DAY AND ONE DAY OF PEACE AND SHARING ON JANUARY 1, 2010

Mr. INOUE (for himself, Mr. REID, and Mr. AKAKA) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 387

Whereas in 2009, the people of the world suffered many calamitous events, including devastation from tsunamis, terror attacks, wars, famines, genocides, hurricanes, earthquakes, political and religious conflicts, diseases, poverty, and rioting, all necessitating global cooperation, compassion, and unity previously unprecedented among diverse cultures, faiths, and economic classes;

Whereas grave global challenges in 2010 may require cooperation and innovative problem-solving among citizens and nations on an even greater scale;

Whereas on December 15, 2000, Congress adopted Senate Concurrent Resolution 138, expressing the sense of Congress that the President of the United States should issue a proclamation each year calling upon the people of the United States and interested organizations to observe an international day of peace and sharing at the beginning of each year;

Whereas in 2001, the United Nations General Assembly adopted Resolution 56/2, which invited "Member States, intergovernmental and non-governmental organizations and all the peoples of the world to celebrate One Day in Peace, 1 January 2002, and every year thereafter";

Whereas many foreign heads of State have recognized the importance of establishing Global Family Day, a special day of international unity, peace, and sharing, on the first day of each year; and

Whereas family is the basic structure of humanity, thus, we must all look to the stability and love within our individual families to create stability in the global community: Now, therefore, be it

Resolved, That the Senate urgently requests—

(1) the people of the United States to observe Global Family Day and One Day of Peace and Sharing on January 1, 2010, with appropriate activities stressing the need—

(A) to eradicate violence, hunger, poverty, and suffering; and

(B) to establish greater trust and fellowship among peace-loving countries and families everywhere; and

(2) American businesses, labor organizations, and faith and civic leaders to join in promoting appropriate activities for Americans and in extending appropriate greetings from the families of the United States to families in the rest of the world.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3298. Mr. REID proposed an amendment to the bill H.R. 3590, entitled The Patient Protection and Affordable Care Act.

TEXT OF AMENDMENTS

SA 3298. Mr. REID proposed an amendment to the bill H.R. 3590, entitled The Patient Protection and Affordable Care Act, as follows:

Amend the title so as to read "An act entitled The Patient Protection and Affordable Care Act".

ORDER FOR NOMINATIONS RECEIVED

Mr. CARDIN. As in executive session, I ask unanimous consent that all the nominations received by the Senate during the 111th Congress, first session, remain in status quo, notwithstanding the December 24, 2009, adjournment of the Senate, and that the provisions of rule XXXI, paragraph 6, of the Standing Rules of the Senate, with the following exceptions: PN1119, COL David Teeples; Calendar No. 32, Dawn Johnsen; Calendar No. 205, Mary Smith; Calendar No. 312, Christopher Schroeder; Calendar No. 488, Edward Chen; Nos. 491 and 492, Craig Becker, and Calendar No. 579, Louis Butler.

The PRESIDING OFFICER (Mr. PRYOR). Without objection, it is so ordered.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. CARDIN. Mr. President, I ask unanimous consent the Senate proceed to executive session to consider en bloc Executive Calendar Nos. 264, 280, 303, 315, 429, 478, 489, 490, 582, 583, 584, 585, 586, 587, 593, 594, 595, 596, 597, 598, 599, 600, 601, 611, 612, 613, 621, 624, 626, 632, 633, 634, 635, 636, 637, 638, 639 and all nominations on the Secretary's Desk in the Coast Guard, Foreign Service, and NOAA; the nominations be confirmed en bloc, the motions to reconsider be laid on the table en bloc; that no further motions be in order; that any statements relating to the nominations be printed in the RECORD, and the President be immediately notified of the Senate's action and the Senate resume legislative session.

The PRESIDING OFFICER (Mr. KIRK). Without objection, it is so ordered.

The nominations considered and confirmed en bloc are as follows:

ENVIRONMENTAL PROTECTION AGENCY

Paul T. Anastas, of Connecticut, to be an Assistant Administrator of the Environmental Protection Agency.

Robert Perciasepe, of New York, to be Deputy Administrator of the Environmental Protection Agency.

EXECUTIVE OFFICE OF THE PRESIDENT

Miriam E. Sapiro, of the District of Columbia, to be a Deputy United States Trade Representative, with the rank of Ambassador.

DEPARTMENT OF STATE

Thomas Alfred Shannon, Jr., of Virginia, a Career Member of the Senior Foreign Service,

Class of Career Minister, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Federative Republic of Brazil.

Alan D. Solomont, of Massachusetts, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Spain, and to serve concurrently and without additional compensation as Ambassador Extraordinary and Plenipotentiary of the United States of America to Andorra.

FEDERAL ENERGY REGULATORY COMMISSION

John R. Norris, of the District of Columbia, to be a Member of the Federal Energy Regulatory Commission for the remainder of the term expiring June 30, 2012, vice Joseph Timothy Kelliher.

THE JUDICIARY

Dolly M. Gee, of California, to be United States District Judge for the Central District of California.

Richard Seeborg, of California, to be United States District Judge for the Northern District of California.

DEPARTMENT OF JUSTICE

Sharon Jeanette Lubinski, of Minnesota, to be United States Marshal for the District of Minnesota for the term of four years.

Mary Elizabeth Phillips, of Missouri, to be United States Attorney for the Western District of Missouri for the term of four years.

Sanford C. Coats, of Oklahoma, to be United States Attorney for the Western District of Oklahoma for the term of four years.

Stephen James Smith, of Georgia, to be United States Marshal for the Southern District of Georgia for the term of four years.

DEPARTMENT OF COMMERCE

Scott Boyer Quehl, of Pennsylvania, to be Chief Financial Officer, Department of Commerce.

Scott Boyer Quehl, of Pennsylvania, to be an Assistant Secretary of Commerce.

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

Rajiv J. Shah, of Washington, to be Administrator of the United States Agency for International Development.

DEPARTMENT OF STATE

Mary Burce Warlick, of Virginia, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Serbia.

James B. Warlick, Jr., of Virginia, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Bulgaria.

Eleni Tsakopoulos Kounalakis, of California, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Hungary.

Leslie V. Rowe, of Washington, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Mozambique.

Alberto M. Fernandez, of Virginia, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Equatorial Guinea.

Mary Jo Wills, of the District of Columbia, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary

of the United States of America to the Republic of Mauritius, and to serve concurrently and without additional compensation as Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Seychelles.

Anne Slaughter Andrew, of Indiana, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Costa Rica.

David Daniel Nelson, of Minnesota, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Oriental Republic of Uruguay.

DEPARTMENT OF JUSTICE

Richard G. Callahan, of Missouri, to be United States Attorney for the Eastern District of Missouri for the term of four years.

John Gibbons, of Massachusetts, to be United States Marshal for the District of Massachusetts for the term of four years.

John Leroy Kammerzell, of Colorado, to be United States Marshal for the District of Colorado for the term of four years.

NATIONAL FOUNDATION ON THE ARTS AND THE HUMANITIES

Adele Logan Alexander, of the District of Columbia, to be a Member of the National Council on the Humanities for a term expiring January 26, 2014.

DEPARTMENT OF EDUCATION

Lynnae M. Rutledge, of Washington, to be Commissioner of the Rehabilitation Services Administration, Department of Education.

DEPARTMENT OF HOMELAND SECURITY

Grayling Grant Williams of Maryland, to be Director of the Office of Counternarcotics Enforcement, Department of Homeland Security.

FEDERAL MARITIME COMMISSION

Michael A. Khouri, of Kentucky, to be a Federal Maritime Commissioner for a term expiring June 30, 2011.

DEPARTMENT OF TRANSPORTATION

David L. Strickland, of Georgia, to be Administrator of the National Highway Traffic Safety Administration.

IN THE COAST GUARD

The following named officer for appointment in the United States Coast Guard Reserve to the grade indicated under title 10, U.S.C., section 12203:

To be rear admiral

Rear Adm. (lh) Steven E. Day

DEPARTMENT OF JUSTICE

Mark Anthony Martinez, of Nebraska, to be United States Marshal for the District of Nebraska for the term of four years.

Michael W. Cotter, of Montana, to be United States Attorney for the District of Montana for the term of four years.

Barbara L. McQuade, of Michigan, to be United States Attorney for the Eastern District of Michigan for the term of four years.

James L. Santelle, of Wisconsin, to be United States Attorney for the Eastern District of Wisconsin for the term of four years.

Christopher A. Crofts, of Wyoming, to be United States Attorney for the District of Wyoming for the term of four years.

NOMINATIONS PLACED ON THE SECRETARY'S DESK

IN THE COAST GUARD

PN1186 COAST GUARD nomination of Andrew G. Liske, which was received by the Senate and appeared in the Congressional Record of November 17, 2009.

PN1263 COAST GUARD nomination of Robert A. Moomaw, which was received by the Senate and appeared in the Congressional Record of December 9, 2009.

FOREIGN SERVICE

PN1009-1 FOREIGN SERVICE nominations (152) beginning Christopher William Dell, and ending Mark J. Steakley, which nominations were received by the Senate and appeared in the Congressional Record of September 24, 2009.

PN1017-1 FOREIGN SERVICE nominations (27) beginning Carleene H. Dei, and ending Robert E. Wuertz, which nominations were received by the Senate and appeared in the Congressional Record of September 25, 2009.

PN1157 FOREIGN SERVICE nominations (277) beginning Jeffrey D. Adler, and ending Conrad William Turner, which nominations were received by the Senate and appeared in the Congressional Record of November 9, 2009.

NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION

PN1262 NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION nominations (16) beginning KEITH E. TUCKER, and ending JASON P.R. WILSON, which nominations were received by the Senate and appeared in the Congressional Record of December 9, 2009.

AMENDMENT NO. 3298—H.R. 3590

Mr. CARDIN. Mr. President, I ask unanimous consent that the title amendment No. 3298, which is at the desk, be considered and agreed to, and the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 3298) was agreed to, as follows:

Amend the title so as to read "An act entitled The Patient Protection and Affordable Care Act".

ORDER FOR PRINTING—H.R. 3590

Mr. CARDIN. Mr. President, I ask unanimous consent that H.R. 3590, as amended, be printed.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDER FOR APPOINTMENTS AUTHORITY

Mr. CARDIN. Mr. President, I ask unanimous consent that notwithstanding the upcoming recess or adjournment of the Senate, the President of the Senate, the President pro tempore, and the majority and minority leaders be authorized to make appointments to commissions, committees, boards, conferences, or interparliamentary conferences authorized by law, by concurrent action of the two Houses or by order of the Senate.

The PRESIDING OFFICER. Without objection, it is so ordered.

MEASURES READ THE FIRST TIME—H.R. 3961 and H.R. 4154

Mr. CARDIN. Mr. President, I understand there are two bills at the desk, and I ask for their first reading en bloc.

The PRESIDING OFFICER. The clerk report the bills by title.

The assistant legislative clerk read as follows:

A bill (H.R. 3961) to amend title XVIII of the Social Security Act to reform the Medicare SGR payment system for physicians and to reinstitute and update the Pay-As-You-Go requirement of budget neutrality on new tax and mandatory spending legislation, enforced by the threat of annual, automatic sequestration.

A bill (H.R. 4154) to amend the Internal Revenue Code of 1986 to repeal the new carryover basis rules in order to prevent tax increases and the imposition of compliance burdens on many more estates than would benefit from repeal, to retain the estate tax with a \$3,500,000 exemption, to reinstitute and update the Pay-As-You-Go requirement of budget neutrality on new tax and mandatory spending legislation, enforced by the threat of annual, automatic sequestration, and for other purposes.

Mr. CARDIN. I now ask for a second reading en bloc, and I object to my own request en bloc.

The PRESIDING OFFICER. Objection is heard. The bills will have their second reading on the next legislative day.

PROVIDING FOR THE SINE DIE ADJOURNMENT OF THE FIRST SESSION OF THE ONE HUNDRED ELEVENTH CONGRESS

Mr. CARDIN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of H. Con. Res. 223, the adjournment resolution, received from the House and at the desk.

The PRESIDING OFFICER. The clerk will report the concurrent resolution by title.

The assistant legislative clerk read as follows:

A concurrent resolution (H. Con. Res. 223) providing for the sine die adjournment of the first session of the One Hundred Eleventh Congress.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mr. CARDIN. Mr. President, I ask unanimous consent that the concurrent resolution be agreed to and the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The concurrent resolution (H. Con. Res. 223) was agreed to, as follows:

H. CON. RES. 223

Resolved by the House of Representatives (the Senate concurring), That when the House adjourns on any legislative day from Wednesday, December 16, 2009, through Saturday, January 2, 2010, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand adjourned sine die, or until the time of any reassembly pursuant to section 3 of this concurrent resolution; and that when the Senate adjourns on any day from Friday, December 18, 2009, through Saturday, January 2, 2010, on a motion offered pursuant to this concurrent res-

olution by its Majority Leader or his designee, it stand adjourned sine die, or until the time of any reassembly pursuant to section 3 of this concurrent resolution.

SEC. 2. When the House adjourns on any legislative day of the second session of the One Hundred Eleventh Congress from Tuesday, January 5, 2010, through Saturday, January 9, 2010, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it shall stand adjourned until noon on Tuesday, January 12, 2010, or until the time of any reassembly pursuant to section 3 of this concurrent resolution, whichever occurs first; and that when the Senate recesses or adjourns on any day of the second session of the One Hundred Eleventh Congress from Tuesday, January 5, 2010, through Saturday, January 9, 2010, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it shall stand recessed or adjourned until noon on Tuesday, January 19, 2010, or until such other time on that day as may be specified by its Majority Leader or his designee in the motion to recess or adjourn, or until the time of any reassembly pursuant to section 3 of this concurrent resolution, whichever occurs first.

SEC. 3. The Speaker of the House and the Majority Leader of the Senate, or their respective designees, acting jointly after consultation with the Minority Leader of the House and the Minority Leader of the Senate, shall notify the Members of the House and the Senate, respectively, to reassemble at such place and time as they may designate if, in their opinion, the public interest shall warrant it.

ORDERS THROUGH JANUARY 20, 2010

Mr. CARDIN. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn sine die until noon on Tuesday, January 5, 2010, for a pro forma session only, with no business conducted, and under the provisions of H. Con. Res. 223; that following the pro forma session, the Senate adjourn until 11 a.m., Tuesday, January 19, 2010, for a pro forma session only, with no business conducted; further that the Senate adjourn until 10 a.m., Wednesday, January 20, 2010; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate proceed to a period of morning business for 1 hour, equally divided between the two leaders or their designees, with Senators permitted to speak for up to 10 minutes each; that following morning business, the Senate proceed to executive session to consider the nomination of Beverly Baldwin Martin of Georgia to be a U.S. circuit judge for the Eleventh Circuit, as provided under a previous order; further that the Senate recess on Wednesday from 12:30 to 2:15 p.m. for the weekly party conference lunches.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. CARDIN. Mr. President, the next rollcall vote will be on the confirmation of the Martin nomination, and it is expected to occur prior to the caucus lunches on Wednesday, January 20.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. CARDIN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. CARDIN. Mr. President, as I previously indicated, the next vote is expected to take place prior to the caucus luncheons on Wednesday, January 20.

ADJOURNMENT SINE DIE

Mr. CARDIN. I again want to wish everyone a very happy holiday season. I know everybody has been looking forward to this particular request, and that is, if there is no further business to come before the Senate, I ask unanimous consent that it stand adjourned under the provisions of H. Con. Res. 223.

There being no objection, the Senate, at 10:19 a.m., adjourned sine die.

NOMINATIONS

Executive nominations received by the Senate:

THE JUDICIARY

TIMOTHY S. BLACK, OF OHIO, TO BE UNITED STATES DISTRICT JUDGE FOR THE SOUTHERN DISTRICT OF OHIO, VICE SANDRA S. BECKWITH, RETIRED.

GLORIA M. NAVARRO, OF NEVADA, TO BE UNITED STATES DISTRICT JUDGE FOR THE DISTRICT OF NEVADA, VICE BRIAN EDWARD SANDOVAL, RESIGNED.

NOMINATIONS RETURNED TO THE PRESIDENT

Thursday, December 24, 2009

The following nominations transmitted by the President of the United States to the Senate during the first session of the 111th Congress, and upon which no action was had at the time of the sine die adjournment of the Senate, failed of confirmation under the provisions of Rule XXXI, paragraph 6, of the Standing Rules of the Senate.

DEPARTMENT OF JUSTICE

DAWN ELIZABETH JOHNSON, OF INDIANA, TO BE AN ASSISTANT ATTORNEY GENERAL.

MARY L. SMITH, OF ILLINOIS, TO BE AN ASSISTANT ATTORNEY GENERAL.

CHRISTOPHER H. SCHROEDER, OF NORTH CAROLINA, TO BE AN ASSISTANT ATTORNEY GENERAL.

NATIONAL LABOR RELATIONS BOARD

CRAIG BECKER, OF ILLINOIS, TO BE A MEMBER OF THE NATIONAL LABOR RELATIONS BOARD FOR THE TERM OF FIVE YEARS EXPIRING DECEMBER 16, 2009.

CRAIG BECKER, OF ILLINOIS, TO BE A MEMBER OF THE NATIONAL LABOR RELATIONS BOARD FOR THE TERM OF FIVE YEARS EXPIRING DECEMBER 16, 2014.

THE JUDICIARY

EDWARD MILTON CHEN, OF CALIFORNIA, TO BE UNITED STATES DISTRICT JUDGE FOR THE NORTHERN DISTRICT OF CALIFORNIA.

LOUIS B. BUTLER, JR., OF WISCONSIN, TO BE UNITED STATES DISTRICT JUDGE FOR THE WESTERN DISTRICT OF WISCONSIN.

IN THE ARMY

ARMY NOMINATION OF COL. DAVID A. TEEPLES, TO BE BRIGADIER GENERAL.

CONFIRMATIONS

Executive nominations confirmed by the Senate, Thursday, December 24, 2009:

ENVIRONMENTAL PROTECTION AGENCY

PAUL T. ANASTAS, OF CONNECTICUT, TO BE AN ASSISTANT ADMINISTRATOR OF THE ENVIRONMENTAL PROTECTION AGENCY.

ROBERT PERCIASEPE, OF NEW YORK, TO BE DEPUTY ADMINISTRATOR OF THE ENVIRONMENTAL PROTECTION AGENCY.

EXECUTIVE OFFICE OF THE PRESIDENT

MIRIAM E. SAPIRO, OF THE DISTRICT OF COLUMBIA, TO BE A DEPUTY UNITED STATES TRADE REPRESENTATIVE, WITH THE RANK OF AMBASSADOR.

DEPARTMENT OF STATE

THOMAS ALFRED SHANNON, JR., OF VIRGINIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF CAREER MINISTER, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE FEDERATIVE REPUBLIC OF BRAZIL.

ALAN D. SOLOMONT, OF MASSACHUSETTS, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO SPAIN, AND TO SERVE CONCURRENTLY AND WITHOUT ADDITIONAL COMPENSATION AS AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO ANDORRA.

FEDERAL ENERGY REGULATORY COMMISSION

JOHN R. NORRIS, OF THE DISTRICT OF COLUMBIA, TO BE A MEMBER OF THE FEDERAL ENERGY REGULATORY COMMISSION FOR THE REMAINDER OF THE TERM EXPIRING JUNE 30, 2012.

DEPARTMENT OF COMMERCE

SCOTT BOYER QUEHL, OF PENNSYLVANIA, TO BE CHIEF FINANCIAL OFFICER, DEPARTMENT OF COMMERCE.

SCOTT BOYER QUEHL, OF PENNSYLVANIA, TO BE AN ASSISTANT SECRETARY OF COMMERCE.

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

RAJIV J. SHAH, OF WASHINGTON, TO BE ADMINISTRATOR OF THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT.

DEPARTMENT OF STATE

MARY BURCE WARLICK, OF VIRGINIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF SERBIA.

JAMES B. WARLICK, JR., OF VIRGINIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF BULGARIA.

ELENI TSAKOPOULOS KOUNALAKIS, OF CALIFORNIA, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF HUNGARY.

LESLIE V. ROWE, OF WASHINGTON, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF MOZAMBIQUE.

ALBERTO M. FERNANDEZ, OF VIRGINIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF EQUATORIAL GUINEA.

MARY JO WILLS, OF THE DISTRICT OF COLUMBIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF MAURITIUS, AND TO SERVE CONCURRENTLY AND WITHOUT ADDITIONAL COMPENSATION AS AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE REPUBLIC OF SEYCHELLES.

ANNE SLAUGHTER ANDREW, OF INDIANA, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF

THE UNITED STATES OF AMERICA TO THE REPUBLIC OF COSTA RICA.

DAVID DANIEL NELSON, OF MINNESOTA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER-COUNSELOR, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO THE ORIENTAL REPUBLIC OF URUGUAY.

NATIONAL FOUNDATION ON THE ARTS AND THE HUMANITIES

ADELE LOGAN ALEXANDER, OF THE DISTRICT OF COLUMBIA, TO BE A MEMBER OF THE NATIONAL COUNCIL ON THE HUMANITIES FOR A TERM EXPIRING JANUARY 26, 2014.

DEPARTMENT OF EDUCATION

LYNNAE M. RUTLEDGE, OF WASHINGTON, TO BE COMMISSIONER OF THE REHABILITATION SERVICES ADMINISTRATION, DEPARTMENT OF EDUCATION.

DEPARTMENT OF HOMELAND SECURITY

GRAYLING GRANT WILLIAMS, OF MARYLAND, TO BE DIRECTOR OF THE OFFICE OF COUNTERNARCOTICS ENFORCEMENT, DEPARTMENT OF HOMELAND SECURITY.

FEDERAL MARITIME COMMISSION

MICHAEL A. KHOURI, OF KENTUCKY, TO BE A FEDERAL MARITIME COMMISSIONER FOR A TERM EXPIRING JUNE 30, 2011.

DEPARTMENT OF TRANSPORTATION

DAVID L. STRICKLAND, OF GEORGIA, TO BE ADMINISTRATOR OF THE NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION.

IN THE COAST GUARD

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES COAST GUARD RESERVE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

To be rear admiral

REAR ADM. (LH) STEVEN E. DAY

THE ABOVE NOMINATIONS WERE APPROVED SUBJECT TO THE NOMINEES' COMMITMENT TO RESPOND TO REQUESTS TO APPEAR AND TESTIFY BEFORE ANY DULY CONSTITUTED COMMITTEE OF THE SENATE.

THE JUDICIARY

DOLLY M. GEE, OF CALIFORNIA, TO BE UNITED STATES DISTRICT JUDGE FOR THE CENTRAL DISTRICT OF CALIFORNIA.

RICHARD SEEBORG, OF CALIFORNIA, TO BE UNITED STATES DISTRICT JUDGE FOR THE NORTHERN DISTRICT OF CALIFORNIA.

DEPARTMENT OF JUSTICE

SHARON JEANETTE LUBINSKI, OF MINNESOTA, TO BE UNITED STATES MARSHAL FOR THE DISTRICT OF MINNESOTA FOR THE TERM OF FOUR YEARS.

MARY ELIZABETH PHILLIPS, OF MISSOURI, TO BE UNITED STATES ATTORNEY FOR THE WESTERN DISTRICT OF MISSOURI FOR THE TERM OF FOUR YEARS.

SANFORD C. COATS, OF OKLAHOMA, TO BE UNITED STATES ATTORNEY FOR THE WESTERN DISTRICT OF OKLAHOMA FOR THE TERM OF FOUR YEARS.

STEPHEN JAMES SMITH, OF GEORGIA, TO BE UNITED STATES MARSHAL FOR THE SOUTHERN DISTRICT OF GEORGIA FOR THE TERM OF FOUR YEARS.

RICHARD G. CALLAHAN, OF MISSOURI, TO BE UNITED STATES ATTORNEY FOR THE EASTERN DISTRICT OF MISSOURI FOR THE TERM OF FOUR YEARS.

JOHN GIBBONS, OF MASSACHUSETTS, TO BE UNITED STATES MARSHAL FOR THE DISTRICT OF MASSACHUSETTS FOR THE TERM OF FOUR YEARS.

JOHN LEROY KAMMERZELL, OF COLORADO, TO BE UNITED STATES MARSHAL FOR THE DISTRICT OF COLORADO FOR THE TERM OF FOUR YEARS.

MARK ANTHONY MARTINEZ, OF NEBRASKA, TO BE UNITED STATES MARSHAL FOR THE DISTRICT OF NEBRASKA FOR THE TERM OF FOUR YEARS.

MICHAEL W. COTTER, OF MONTANA, TO BE UNITED STATES ATTORNEY FOR THE DISTRICT OF MONTANA FOR THE TERM OF FOUR YEARS.

BARBARA L. MCQUADE, OF MICHIGAN, TO BE UNITED STATES ATTORNEY FOR THE EASTERN DISTRICT OF MICHIGAN FOR THE TERM OF FOUR YEARS.

JAMES L. SANTELLE, OF WISCONSIN, TO BE UNITED STATES ATTORNEY FOR THE EASTERN DISTRICT OF WISCONSIN FOR THE TERM OF FOUR YEARS.

CHRISTOPHER A. CROFTS, OF WYOMING, TO BE UNITED STATES ATTORNEY FOR THE DISTRICT OF WYOMING FOR THE TERM OF FOUR YEARS.

IN THE COAST GUARD

COAST GUARD NOMINATION OF ANDREW G. LISKE, TO BE CAPTAIN.

COAST GUARD NOMINATION OF ROBERT A. MOOMAW, TO BE LIEUTENANT.

FOREIGN SERVICE

FOREIGN SERVICE NOMINATIONS BEGINNING WITH CHRISTOPHER WILLIAM DELL AND ENDING WITH MARK J. STEAKLEY, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON SEPTEMBER 24, 2009.

FOREIGN SERVICE NOMINATIONS BEGINNING WITH CARLEENE H. DEI AND ENDING WITH ROBERT E. WUERTZ,

WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON SEPTEMBER 25, 2009.

FOREIGN SERVICE NOMINATIONS BEGINNING WITH JEFFREY D. ADLER AND ENDING WITH CONRAD WILLIAM TURNER, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON NOVEMBER 9, 2009.

NATIONAL OCEANIC AND ATMOSPHERIC
ADMINISTRATION

NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION NOMINATIONS BEGINNING WITH KEITH E. TUCKER AND ENDING WITH JASON P.R. WILSON, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON DECEMBER 9, 2009.